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The Pennsylvania Psychologist

September 2011
QUARTERLY

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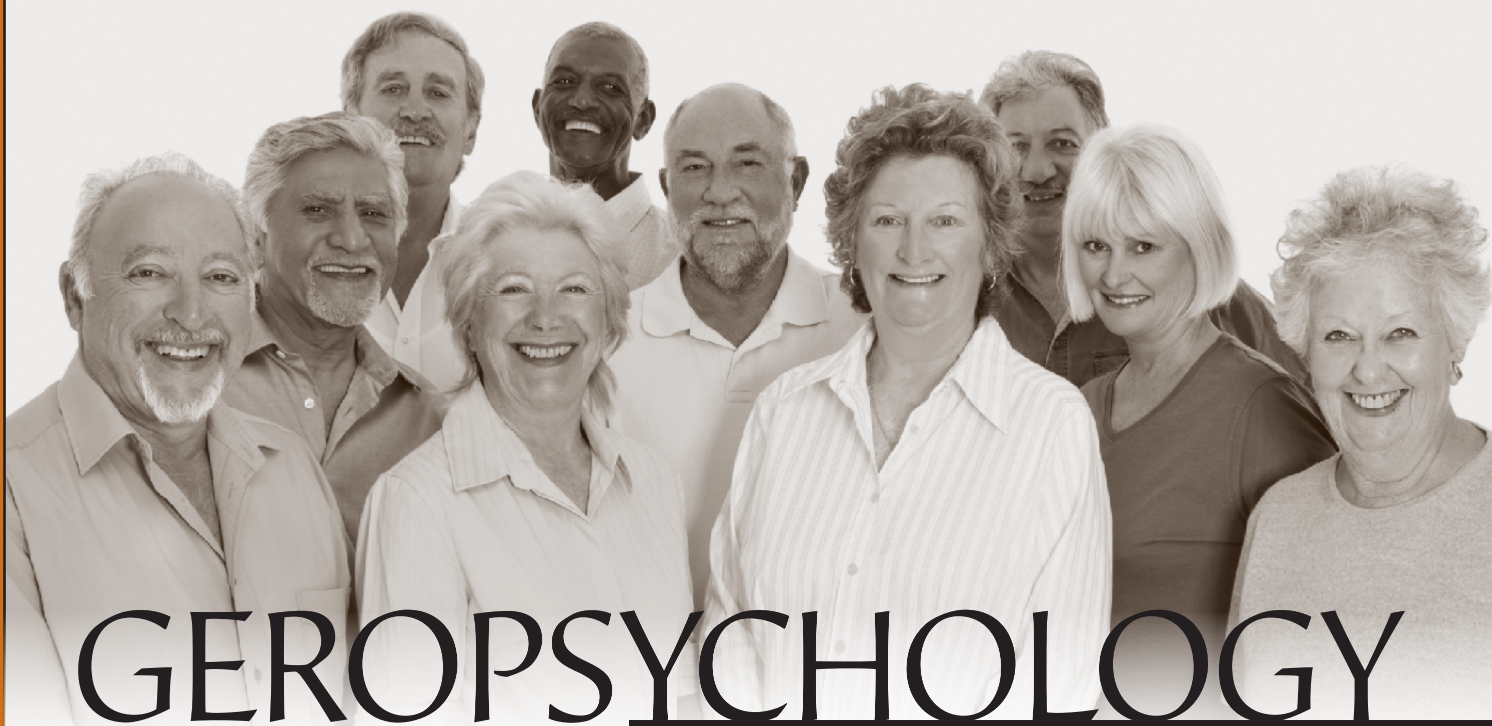

GEROPSYCHOLOGY

ALSO IN THIS ISSUE

- PPA's annual report
- Legal column: restrictive covenants
- School-based intergenerational programs
- 2011 convention photos

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Psychologist

Editor: Andrea L. Nelken, PsyD

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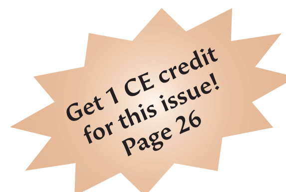


REGULAR FEATURES

2 | Presidential Perspective
4 | Executive Director's Report
5 | Legal Column
7 | The Bill Box
8 | PPA Governance 2010-11
23 | Psych Tech
26 | CE Questions for This Issue

SPECIAL SECTION — *Geropsychology*

9 | Responding to the Call: An Introduction to the Geropsychology Training Initiative
10 | Geropsychology: Crossroads of Interdisciplinary Treatment
11 | Practice in Long-Term Care: Not for the Timid
12 | Equipping Your Kit: Tools for Geropsychology Competency
13 | Beyond the Data: Suicide Attempts in the Older Adult; the Treatment Lies Within Their Stories
14 | The Psychosocial Debris Field: When Medical Illness Strikes in Middle Age
16 | Siblings of Suicide: The Lost Survivors

STUDENT SECTION

16 | Aging as a Non-Heterosexual

SCHOOL PSYCHOLOGY SECTION

21 | School-Based Intergenerational Programs
22 | School Psychology Board Has New Leadership

ALSO INSIDE

17 | Amendment to Bylaws Proposed by General Assembly Vote Needed by Membership
17 | In Memoriam
18 | PPA Convention 2011: Unconventional Psychologists
20 | PPA 2012 Award Nominations Sought
21 | Member News
22 | Welcome New Members
24 | Sustaining Members, 2010-11
25 | Classifieds

Advocacy, Public Education, and Volunteerism

Judith Blau, PhD

Dr. Judith Blau

PPA enjoys an outstanding reputation and record of achievement among state organizations. This past March, as president-elect, I was privileged to attend the annual APA-sponsored State Leadership Conference in Washington, DC. The eyes of other leaders widened when they heard about our organization: With 3,000 members, we are the second largest state association after California, fully 10% of our members are active volunteers, and we have a longstanding staff highly respected for their knowledge, innovations, and achievements.

PPA has a rich and remarkable history. Three years ago, I chaired the task force for our 75th anniversary, the theme of which was "Celebrating Our Past and Creating Our Future." In those three years, we have made great strides, and our pace cannot falter in the coming year. Fire up, my colleagues: I want you all to be part of this endeavor. We are the richness of PPA.

When I ran for this post, I wrote this to you: "Together, we have goals to achieve: to keep our profession strong and promote high standards of practice based on science; to be in the forefront of health care and to advocate for more access to our services through a carefully planned legislative agenda; and to serve the public through education about mental health and what psychologists have to offer." I said attracting new members from all careers and specialties as well as from diverse cultures was vital, as was adding value for PPA psychologists as we continued to offer cutting-edge training and networking. Strength, I wrote, came from building solid relationships with allied professions, regional psychological associations, governmental agencies, legislators, and the media. I advocated that we advance our use of electronic communications and address the emergent ethical/legal considerations for our profession.

I stand by what I said. It is critical to add to PPA's strength, service, and value. This year, I want to further the goals of our strategic plan, including the vision and mission statements offered within it. Our vision is that PPA is a member-driven organization dedicated to advancing psychology in Pennsylvania, advocating for public access to our services, and enhancing human welfare while supporting the development of competent and ethical psychologists. Our mission is to update and inform the public and our members about cutting-edge psychological theory and practice through training and public policy initiatives. Within this context, I have identified three pressing goals for this year: advocacy, public education, and volunteerism.

Advocacy: We all must participate in the legislative process by contacting our legislators by e-mail, phone, or in person, attending advocacy days, and contributing to PennPsyPAC. So, please donate. Attend PAC events. Buy raffle tickets. Watch for opportunities on our listserv and through the mail. And please respond to every legislative action alert: Our staff is extremely savvy about negotiating the legislative waters. It only takes a few minutes to send an email via Capwiz when asked. Government regulation influences how we practice and how we serve the public. If we do not speak up and support our lobbyists, we have no say in what happens.

Public education: My second goal this year is to teach more people how psychology can improve their daily lives. It means getting the word to the public about the benefits of assessment and treatment, and educating people about a healthier emotional and physical lifestyle.

PPA's active and productive Communications Board comprises five committees. Each committee is charged with an aspect of public education, but the Public Education Committee (PEC) and E-Newsletter Committee are key in reaching people. Members of the PEC have given workshops, provided interviews, made guest appearances, written press releases, articles, and books, and promoted and presented mind/body health workshops for the public at our June convention.

> *While we are already the envy of many other state psychological organizations, we can do more. Wherever your interest lies, there are countless opportunities.*

Our e-newsletter, "Psychological News You Can Use," circulates four times a year to about 3,500 individuals. Among its readership are APA representatives from other states, members of the public, and other mental health professionals. All PPA members are automatically subscribed, but we want to extend our reach. If you don't already receive the e-newsletter, please sign up. Please spread the word to others and let them know how to sign up: simply go to www.PaPsy.org, click "Public," and select the e-newsletter link. We're aiming for at least 4,000 subscribers by June 2012.

Individually, we can educate the public about any topic of interest to us. I thank the many members who do. I also want to underline the importance of the APA Public Education Campaign and the resources available to us. The Public Education Campaign began in 1996, when the Council of Representatives enjoined APA to educate the public about the value of psychological services and to elevate psychology's visibility.

The campaign began after APA, assessing public understanding of psychology and mental health, discovered a vast gap between public awareness and

Continued on page 8

Annual Report: What Has PPA Done for You Lately?

Thomas H. DeWall, CAE

Thomas H. DeWall

PPA provided value to our members in many ways in the program year that ended June 30, 2011. Our strategic plan calls for us to promote and advance psychology in Pennsylvania, including the professional development of our members. One of the principal ways we have done that is through this publication, the *Pennsylvania Psychologist*. We have produced quarterly journals, each with a main theme, a school psychology section, and a column on technology; we printed monthly updates in between. Our legal columns have covered important subjects including e-mail and boundaries, mandated reporting laws and confidentiality, release of information on patients, confidentiality in cases of suicide, and advice on fictitious names and forming professional corporations. The themes of the quarterly issues were digital boundaries, world psychology, the annual convention (with a "mini-theme" on disabilities), and suicide. Other significant articles throughout the year were advice on ethics issues; how to bill testing codes in Medicare; information on corrections, probation, and parole; and advocacy on public policy.

One of the principal resources we provide the membership is the consultation that members get from Dr. Samuel Knapp and Rachael Baturin. Together they respond to thousands of inquiries each year on ethics, insurance, regulatory, and other practice issues. Perhaps this is one reason that the rate of being disciplined by the State Board of Psychology is far lower for PPA members than for nonmembers. During the year, as a result of the hard work of the Communications Board and staffer Iva Brimmer, we accomplished a major upgrade to our website, www.PaPsy.org, making it easier to navigate while increasing our wealth of information on psychology in Pennsylvania. Our listserv served as an important communications vehicle for more than 700 members. We continued our public education campaign in conjunction with APA, promoting speaking engagements and media interviews, summarized in Marti Evans's semiannual columns. We published an e-newsletter for the public, "Psychological News You Can Use," which provided information on a wide range of issues.

One of the principal resources we provide the membership is the consultation that members get from Dr. Samuel Knapp and Rachael Baturin. Together they respond to thousands of inquiries each year.

PPA provided a great deal of continuing education, for which our members received significant discounts. The number of registrants was 207 for our 2010 fall conference, 120 for a risk management workshop in the fall, and 148 for our spring conference. At the fall and spring conferences members saved $45 for each 3-hour workshop compared to the nonmember rate. We calculate that the cumulative savings to members for those conferences was more than $19,000. At the risk management workshop members saved $130 apiece, and senior members saved $60 each. The amount of savings for PPA members there was about $13,000. At our successful annual convention, which took place over four days in June, we welcomed 327 registrants. The many members who registered for the entire convention saved $195 each for the high-quality presentations. In addition to all of those CE opportunities we made 10 home studies available, the newest of which is "Ethical Practice Is Multicultural Practice." This is in addition to CE available online at PaPsy.org.

Four companies in Pennsylvania won this year's Psychologically Healthy Workplace Award and two of last year's winners won the national award, presented by APA in Washington, DC. PPA's Ethics Committee established a frequently updated blog, also available on the website. Dr. Knapp organized the annual Ethics Educators Conference in the fall and the Doctoral Summit in the spring. He also provided staff support for our active Practice-Research Network, whose results have been published in peer-reviewed journals.

Our second main strategic action is advocating for public access to psychological services. In pursuit of this goal, we were very active on the legislative front. We advocated for years for mental health courts to divert people with mental illnesses from prisons and into treatment. A bill accomplishing this was finally enacted in June 2010. We won passage of a comprehensive update to the child custody statutes that creates greater fairness and objectivity in this system. We saw passage of a series of bills requiring psychological evaluations of candidates for police and firefighter positions, and authorizing psychologists to conduct them. Recently a bill on the management of concussions among high school athletes, authorizing psychologists to make return-to-play decisions, has been at the top of our priority list. This bill passed the state Senate in June 2011 but was not voted on by the House, though we anticipate that it will be taken up in the fall. PPA was also instrumental in obtaining introduction of a bill in the state House authorizing psychologists to make recommendations on insanity in criminal cases.

PPA is also constantly monitoring the actions of the State Board of Psychology, commenting on them officially, and

Continued on page 4

EXECUTIVE DIRECTOR'S REPORT

Continued from page 3

informing the membership about new regulations. An example is an article in September 2010 on new post-doctoral supervision requirements. We formed a task force on licensure issues, with a mix of clinical and school psychologists, which spent the year studying and making recommendations on improvements to the Professional Psychologists Practice Act. We will be informing the membership and taking action on those recommendations in the near future.

In addition to advocacy at the state level we organized grassroots activity on national legislation, guided by APA—especially on Medicare issues. In most of the legislative alerts on them, our state association had the highest member response rate of all of the states. We conducted a survey, in part developed by APA, of our members' experience with health insurance companies. We released results in October of the best and worst companies in terms of providing patient access to services, among other measures.

The Pennsylvania Psychological Political Action Committee had a successful year. PennPsyPAC consistently raises more money than any other state psychological association PAC. In calendar year 2010 PennPsyPAC contributed $37,200 to candidates for the legislature, which constituted 81% of all expenditures. Only 5% of the expenditures were for administration other than fundraising. The total of funds raised was $52,000. PennPsyPAC also underwrote our successful advocacy day in Harrisburg in addition to a smaller event in Pittsburgh.

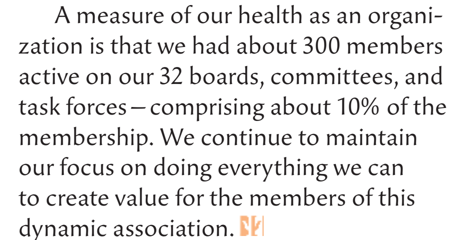
The third leg of our strategic plan calls on us to build and maintain organizational strength. This includes finances, leadership development, membership, and a focus on early career psychologists (ECP). Our total membership numbers stayed the same as the prior year—a positive development because they had been declining since the recession in 2008. Credit goes to our Membership Committee and Board of Directors, who work hard to recruit and retain members. Our dues collections increased slightly from the prior fiscal year, and our Sustaining Membership program saw an increase. We have not had a significant dues increase since 1995. We continued to offer important direct benefits to members such as health insurance, merchant credit cards at a very competitive rate, and an online career center. Each year we have an audit conducted, and once again we received a clean bill of financial health. This is due in large part to an engaged Budget and Finance Committee and to Ms. Brimmer.

We conducted a successful Leadership Academy, partially underwritten by PennPsyPAC, in which 46 invited members experienced a day of training on aspects of advocacy, leadership generally, and PPA's governance structure in particular. We aligned our foundation more closely with PPA so that we could do more to reach both organizations' goals, especially in underwriting the annual Education Awards and public education efforts.

A Bylaws Task Force made recommendations to revise and streamline the bylaws, leading to a vote of approval by the membership. Again this year our Nominations Committee nominated excellent candidates for each of five positions, and the election was conducted online, saving valuable resources. In the apportionment voting last fall, we again won two seats on APA's Council of Representatives, with far more votes than any other state association.

We had an active ECP Committee and Pennsylvania Psychological Association of Graduate Students (PPAGS), which helped promote the interests of our newer psychologist and student members. Most issues of the *Pennsylvania Psychologist* contained articles by and for ECPs and students. At the annual convention several awards were given to ECPs and students, including a student multicultural award.

A measure of our health as an organization is that we had about 300 members active on our 32 boards, committees, and task forces—comprising about 10% of the membership. We continue to maintain our focus on doing everything we can to create value for the members of this dynamic association.



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You will find:

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- **Information on PPAGS, PPA's student organization**

Understanding Restrictive Covenants: An Employer's Perspective

Rachael L. Baturin, MPH, JD, Professional Affairs Associate
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Rachael L. Baturin

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Imagine that you have a practice and you employ other psychologists and other mental health professionals. One of your mental health employees informs you that he is leaving the practice and will be starting his own practice 10 miles away. You are concerned that he will take his clients with him and away from your business. What do you do? Did you put a restrictive covenant in your employment contract? Is it enforceable? Can you stop the mental health professional from taking the clients with him? What is your remedy?

Public policy encourages free trade. Restrictive covenants place a restriction or a restraint on free trade. Restrictive covenants, therefore, will be scrutinized in a strict fashion. If they are deemed to be reasonable, however, and if they are not deemed to be against public policy, they will be enforced.

To be valid and enforceable in Pennsylvania, a restrictive covenant must meet the following four requirements:

1. the covenant must be ancillary to the employment relationship;
2. the covenant must be supported by adequate consideration;
3. the restriction sought to be imposed must be reasonably necessary to safeguard a legitimate interest of the employer; and
4. the restriction sought to be imposed must be reasonably limited in duration and geographic extent (*Hess v. Gebhard,* 2002; *Nat. Bus. Services v. Wright,* 1998).

A "covenant ancillary to the employment relationship" is defined as a restrictive covenant that is entered into as part of the initial employment contract, or if it is executed subsequent to the beginning of employment, where there is a change in the employment status (e.g., moving up in status from a part-time to a full-time position; *Jacobson & Co. v. Int'l Env't Corp.,* 1967). A restrictive covenant entered into independent of an employment contract is void since it is against public policy (*Morgan's Home Equip. Corp. v. Martucci*, 1957).

"Adequate consideration" requires that the restrictive covenant is signed at the inception of the employment relationship, or shortly thereafter (*Nat. Bus. Services v. Wright,* 1998), or after the relationship has begun, as long as there is a beneficial change to the employee's employment status. If an employee enters into a restrictive covenant during an ongoing employment relationship without receiving an additional benefit, there is not adequate consideration. Additional benefits include, but are not limited to, an increase in employment status, a pay increase, or a bonus.

The safeguarding of a legitimate interest of the employer includes (1) the employer's relationship with its customers (goodwill), (2) specialized training and skills, and (3) trade secrets and confidential information (*Hess v. Gebhard,* 2002). Intake forms and other forms developed by the psychology practice most likely would not fulfill this requirement in that similar forms readily are available online or from other sources, as compared to the development of a new test instrument. Generally, restrictive covenants that tend to repress competition or gain an economic advantage over a departing employee will not be enforced.

Lastly, a restrictive covenant must be reasonably limited in duration and geographic scope. Courts have considerable flexibility in determining the reasonableness of the restrictions. There is no hard-line rule for what constitutes reasonable duration or geographic scope. Each case will be decided on its own facts.

In Pennsylvania, courts have ruled against covenants in which the time is unlimited. Courts have, however, upheld one-year restrictions.

In general, courts will review the geographic scope of the covenant by analyzing the geographic area in question. For example, a practice located in a rural area might support a large geographic restriction, whereas a practice located in a larger city might prohibit a large geographical restriction.

The court also may consider the ability of a patient to secure treatment by a similarly qualified professional. For example, if there is a shortage of qualified professionals in the restricted geographic area, the court may be less inclined to uphold the geographic restriction.

If the employee is terminated, and retaining the employee is not in the best interests of the employer, it may be deemed unreasonable for the employer to retain control of the employee through a restrictive covenant. Conversely, if the employee is terminated, and the employee's conduct resulted in the termination, the restrictive covenant may be enforced. The length of time that the employee has worked for the employer also may affect whether a restrictive covenant will be upheld.

An employer who seeks to enforce a restrictive covenant has two remedies: a preliminary injunction or enforcement of a liquidated damages clause.

To obtain injunctive relief, the employer must prove that there was actual, irreparable harm caused by

Continued on page 6

Continued from page 5

the breach of the restrictive covenant. Often, this is a heavy burden to prove. More specifically, the employer must show that (1) the injunction is necessary to prevent immediate and irreparable harm that cannot be compensated by an award of monetary damages, (2) greater injury would result by refusing to grant the injunction than by granting the injunction, and (3) the injunction properly restores the parties' status as it existed immediately prior to the allegedly wrongful conduct.

If the original employment contract contains a liquidated damages clause, it generally will be upheld if the damages reasonably are calculated and are not intended merely to punish the employee. It will be the employer's burden to prove that a reasonable effort was made to calculate the economic damages resulting from the breach of the covenant.

There are several types of restrictive covenants that employers may put in the employment contract. These restrictive covenants include the following :

1. Non-competition covenants (non-compete clauses) – These covenants provide the strongest types of restrictions. Typically, a non-compete clause prohibits a former employee from working with a competitor or treating patients for a period of time in a particular geographic area.

The treatment of former patients raises a unique issue in mental health practice – namely, the concept of abandonment. Psychologists are prohibited from abandoning their patients. Patient have a right to seek treatment from the provider of their choice. Thus, the enforcement of a restrictive covenant that prohibits a former employee from treating a former patient for a future period of time raises abandonment issues.

2. Non-solicitation covenants – These types of covenants typically prohibit a former employee from soliciting patients of the employer, or employees of the employer, to be treated by or to work for the former employee.

3. Confidentiality/non-disclosure agreement – These types of covenants protect information that the employer finds important, rather than preventing a former employee from working for a competitor. For example, confidentiality agreements may prohibit the former employee from disclosing information or utilizing property that belongs to the employer.

4. Assignment of intellectual property rights – These types of covenants are used to assign to the employer the right to patent any invention that the employee may develop.

Restrictive covenants must be drafted precisely. To be effective, and later to be upheld, they should not contain boilerplate language. They should include a description of the circumstances in which the covenant is being entered, the activities that are prohibited, the duration of the restrictions, and the geographic scope of the restrictions.

The covenant should be tailored to serve the particular needs of the employer. For example, a non-compete or non-solicitation covenant should be restricted to restraining the former employee from contacting or doing business with any of the employer's current or prospective patients. It should not restrict activities to the public at-large. It also is advisable to provide that the restrictions will begin at the end of the employee's employment. The contract should state that if the covenant is violated, the restrictive period will begin immediately, and will terminate only if and when a court disallows the restrictive covenant.

Practically, what steps should you take if you learn that one of your employees is violating a restrictive covenant? First, you may need to seek legal advice. A preliminary step may be to notify the former employee in writing that she is in violation of her employment contract. If this written notice is ineffective, it may be necessary to institute a legal action to enforce the employment contract.

EXAMPLES

❶ Employer has a practice in downtown Philadelphia. He has an employee who has worked for him for five years and the employee told the employer that he is leaving. The employer had the employee sign a restrictive covenant as part of the original employment contract. The restrictive covenant states that the employee may not contact any of the employer's clients or work within a radius of 30 miles of the employer for one year. Is this covenant reasonable?

Answer: The geographic restriction is questionable. An argument could be made that since Philadelphia is a densely populated area, the geographic limitation should be stricken.

❷ Employer has a practice in downtown Philadelphia. He has an employee who has worked for him for 10 years and the employee told the employer that he is leaving. The employer had the employee sign a restrictive covenant one year after signing the original employment contract, at which time there was no benefit to the employee. The restrictive covenant stated that the employee may not contact any of the employer's clients or work within a radius of five miles of the employer for one year. Is this covenant reasonable?

Answer: Probably not. The restrictive covenant was signed independent of the original contract. The employee received no benefit for signing the restrictive covenant. Therefore, there was not adequate consideration for entering into the restrictive covenant.

❸ Employer has a practice in rural Pennsylvania. She has an employee who has worked for her for three years and the employee told the employer that he is leaving. The employer had the employee sign a restrictive covenant as part of the original employment contract. The restrictive covenant stated that the employee may not contact any of the employer's clients or work within a radius of 20 miles of the employer for one year. Is this covenant reasonable?

Answer: Probably. The restrictive covenant appears reasonable in duration and geographic location.

❹ Employer has a practice in Harrisburg. He has an employee who has worked for him for three months, and the employee told the employer that he is leaving. The employer had the employee sign a restrictive covenant as part of the original employment contract. The restrictive covenant stated that the employee may not contact any of the employer's clients

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists

As of June 30, 2011

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action
SB 115 HB 58	Provides for involuntary commitment to outpatient treatment - Sen. Stewart J. Greenleaf (R-Montgomery) - Rep. Mario M. Scavello (R-Monroe)	Opposed unless amended	In Public Health & Welfare Committee	In Human Services Committee
SB 200 HB 200	Provides for management of head injuries among high school athletes and evaluation by psychologist or other provider - Sen. Patrick M. Browne (R-Lehigh) - Rep. Timothy P. Briggs (D-Montgomery)	For	Passed 6/22/11, 50-0	Passed by Education Committee, 24-0, 6/28/11. On House tabled calendar
SB 850	Provides for the offense of cyberbullying and sexting by minors - Sen. Stewart J. Greenleaf (R-Montgomery)	For	Passed by Judiciary Committee, 4/12/11. In Appropriations	None
HB 42	Prohibits Pennsylvania from implementing the federal health care mandate - Rep. Matthew E. Baker (R-Tioga)	Opposed	None	Passed by Health Committee, 2/7/11, 14-9. In Appropriations
HB 663	Restricts insurance companies' retroactive denial of reimbursement - Rep. Stephen E. Barrar (R-Delaware Co.)	For	None	In Insurance Committee
HB 978	Credentials drug and alcohol counselors based solely on their life experience - Rep. Louise Williams Bishop (D-Philadelphia)	Opposed	None	In Human Services Committee
HB 1405	Authorizes psychologists to testify in court on the determination of insanity - Rep. Glen R. Grell (R-Cumberland)	For	None	In Judiciary Committee

Information on any bill can be obtained from http://www.legis.state.pa.us/WU01/LI/BI/billroom.htm

or work within a radius of five miles of the employer for one year. Is this covenant reasonable?

Answer: Probably not. The restrictive covenant most likely would be stricken in that the employee has worked for the employer for only three months.

❺ Employer has a practice in Pittsburgh. She has an employee who has worked for her for 15 years, and the employee told the employer that he is leaving. The employer had the employee sign a restrictive covenant as part of the original employment contract. The restrictive covenant stated that the employee may not contact any of the employer's clients or work within a radius of five miles of the employer for one year, and the employee may not take any confidential information with him, including but not limited to, client files, intake forms, other forms developed by the practice, and evaluation instruments. Is this covenant reasonable?

Answer: Yes and no. The restrictive covenant dealing with duration and geographic location are reasonable; however, the restriction on intake forms and other forms developed by the practice most likely would be stricken in that they do not constitute trade secrets.

References

Hess v. Gebhard & Co., Inc., 570 Pa. 148, 157, 808 A.2d. 912, 917 (2002).

Jacobson & Co., Inc., v. Int'l Env't Corp., 427 Pa. 439, 449-51, 235 A.2d 612, 618-19 (1967).

Morgan's Home Equip. Corp. v. Martucci, 390 Pa. 618, 629, 136 A.2d 838, 845 (1957).

Nat. Bus. Services, Inc., v. Wright, 2 F. Supp. 2d 701, 707 (E.D. Pa. 1998).

Editor's note: *PPA's first legal column was in August 1991. Since then, including this one, we have had 71 legal columns. Dr. Tepper has been an author on 69 of them and first author on 27. Dr. Knapp has been an author on 56 of them and first author on 40. Ms. Baturin has been an author on 26 of them, and first author on 4.*

PRESIDENTIAL PERSPECTIVE
Continued from page 2

the realities and practice of psychology. In response, APA developed "Talk to Someone Who Can Help," a campaign to increase the public's knowledge of our profession and the value of services. From it sprang "Warning Signs, a Youth Anti-Violence Initiative," released in response to the Columbine massacre to increase awareness of bullying; "Aftermath, the Road to Resilience" after 9/11; and "Homecoming: Resilience in a Time of War" for our soldiers returning from service. In addition, since 2003, APA has promoted the Psychologically Healthy Workplace Awards. In 2011, two of our state award winners, eXude Benefits Group and VisitPittsburgh, won on the national level and were honored in Washington, DC.

To promote health, APA launched the Stress in America Survey in 2006 and has partnered with the national YMCA. The 2010 Stress in America Survey concluded that many Americans are caught in a vicious cycle of managing stress in unhealthy ways, such as overeating. It indicated that parents underestimate their children's stress and the impact of their own stress on their children who, as young as age 8, reported physical and emotional health concerns associated with stress. A press kit describing these results can be found at www.stressinamerica.org.

In partnering with YMCA of the USA, APA provides families with resources for healthy living. The joint effort promotes healthy eating and regular physical activity to reduce risk of chronic diseases and educates parents and caregivers about lifestyle and behavior changes, and the effects of the home environment on health.

Together, APA and the YMCA are offering co-branded workshop materials for psychologists to present at their local Y and are collaborating in the annual YMCA Healthy Kids® Day and programs to help individuals and families improve their health and well-being. With more than 2,600 YMCAs nationally, serving more than 20 million people, we can be more directly connected to the public.

APA offers top-flight resources to members and the public through www.APAhelpcenter.org and www.stressinamerica.org. Toolkits to guide workshops and media contact are available to APA members and members of state associations.

I have been involved with many PPA committees, but particularly with the Communications Board, chairing the board for four years, from 1999 to 2003, and chairing the PEC in 2009-10. As a continuing PEC member, I'm excited that we have started a Healthy Living Subcommittee, charged with identifying ways to promote healthy living. If you are interested, please let me know.

We also ask that you tell Marti Evans of any public education you provide. The information is sent to APA and included in a yearly report. Funding for our public education campaign is contingent upon these activities. Also, Marti writes a biennial column, "Thanks to Our Members," for the *Pennsylvania Psychologist*, acknowledging your efforts.

VOLUNTEERISM. This organization is us! — is you! While we are already the envy of many other state psychological organizations, we can do more. Wherever your interest lies, there are countless opportunities. While I have focused on the Communications Board, five other boards, having 24 committees, address different and vital aspects of our profession. Please participate and share your knowledge and enthusiasm with us!

When we pull together to increase the strength, service, and value of PPA, we *all* gain by ensuring psychology continues to be the premier health-care profession. We have exciting goals to accomplish together!

PPA Governance 2010-11

Sincere thanks and appreciation are due to the 300 members (about 10% of the membership), who during the 2010-11 program year devoted their time, energy, and talents to the Pennsylvania Psychological Association. All of the board chairs, committee chairs, and committee members are listed on our website at www.PaPsy.org. The officers for the past year were:

President	Mark A. Hogue, PsyD
President-elect	Judith S. Blau, PhD
Past President	Steven R. Cohen, PhD
Secretary	Cheryll Rothery-Jackson, PsyD
Treasurer	Vincent J. Bellwoar, PhD

Responding to the Call: An Introduction to the Geropsychology Training Initiative

William Davis Jr., PsyD, Widener University

Dr. William Davis Jr.

On behalf of the members of the Geropsychology Training Initiative (GTI), I'd like to welcome you to this issue of the *Pennsylvania Psychologist*. We're especially excited to bring you into a longstanding, national conversation about the 78 million aging baby boomers and their impact on the health care system. Policymakers and researchers have been bustling to respond to the health care needs of older adults, but convincing evidence suggests we psychologists must also step up our pace to address older adults' medical, social, and psychological concerns (American Psychological Association, 2004). Particularly in serving this population, we may need to expand our current practice paradigm from that of solitary psychological practice to one of integrated health care (American Psychological Association, 2008). Regardless of our approach, we are fortunate that psychologists have been at the forefront of this conversation from the beginning, and even more fortunate that PPA has responded to the call by sanctioning the creation of the GTI. This article briefly traces our history and describes what we do.

History of the GTI

The GTI formed as a result of casual conversation among several PPA members who wanted to learn more about serving older adults and find training for themselves and other clinicians. With this in mind, the group approached the Committee on Multiculturalism (CoM), developed into a subgroup, and later sought recognition as a project group. In August 2009, the project group was formally sanctioned by PPA and tasked with the following: (1) to infuse PPA with geropsychology training such as continuing education workshops and informative articles, and (2) to informally assess the quality and quantity of geropsychology training in Pennsylvania by surveying students and faculty from around the state. Accomplishing these goals has been influenced by fluctuating membership and participation; as of this writing we have five members, including one student. The committee touches base quarterly by phone or in person to chart our course.

Meeting Our Mandates

Continuing Education

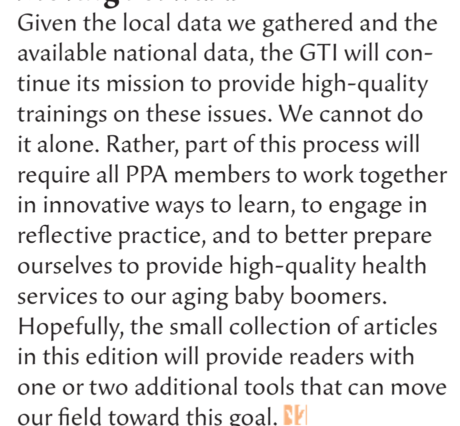
Since our inception, the GTI has offered two continuing education courses. The first, offered at the PPA Annual Convention in 2010, described the demographic composition of aging baby boomers and the training opportunities available to those who might be interested in working with older adults. The second, offered March 2011 at the annual Spring Ethics Conference, explained geropsychology as a discipline and offered case examples to distinguish generalist practice with older adults from specialty service provision (i.e., geropsychology). Participants of each workshop indicated an interest in advanced presentations in the future.

Training Evaluation

In preparation for offering workshops, the GTI set out to accomplish the first of our two mandates by conducting an informal evaluation of geropsychology training opportunities. We wanted to identify the kinds of training opportunities that might best benefit novice and seasoned psychologists practicing in Pennsylvania. To do so, we began by asking regionally trained psychologists how well they had been prepared to work with older adults. We informally surveyed graduate students and faculty from Pennsylvania's clinical and counseling psychology doctoral programs.

The results of our non-scientific evaluation were grim, to say the least. About 70% of respondents reported that their doctoral program did not offer even one geropsychology course. Fifty-three percent of those surveyed suggested their doctoral program did not offer any geropsychology practicum rotations. None of the doctoral programs represented in the study had a geropsychology prespecialization or certificate program, and fewer than 10% of the programs employed geropsychologist faculty and/or psychologists who were researching older adult issues. These results paralleled what was seen nationally. In one study, the vast majority of psychologists surveyed were providing services to older adults; however, fewer than 20% of them had participated in supervised practicum or internship experiences with older adults, and only 30% of those surveyed had ever taken a graduate course in geropsychology (Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002). Over all, we need more geropsychology training opportunities both nationally and regionally.

Moving Forward



Given the local data we gathered and the available national data, the GTI will continue its mission to provide high-quality trainings on these issues. We cannot do it alone. Rather, part of this process will require all PPA members to work together in innovative ways to learn, to engage in reflective practice, and to better prepare ourselves to provide high-quality health services to our aging baby boomers. Hopefully, the small collection of articles in this edition will provide readers with one or two additional tools that can move our field toward this goal.

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Geropsychology: Crossroads of Interdisciplinary Treatment

Ann Durshaw, PsyD, drdurshaw@aol.com

All personal identifying information of any client mentioned in this article has been changed and certain circumstances modified to protect the identity of the client(s).

Dr. Ann Durshaw

On August 12, 2010, geropsychology was formally recognized as a specialty area of practice within professional psychology by the American Psychological Association Council of Representatives, a landmark for the field and a tribute to those who shepherded it through (American Psychological Association [APA] *Division 20 News*, 2010). This recognition opens many doors in geropsychology, including research, practice, internship, and postdoctoral fellowship accreditation (Knight, 2010).

Along with the tremendous benefits of specialization comes the risk of a narrowed scope of public perception, which may fail to recognize a geropsychologist's field as a panorama of opportunities for multiple and overlapping clinical and research specialties. The advantages of specialty status permit us to welcome specialists in other fields, including those who initially may not see opportunities for interdisciplinary practice. At this threshold, I would like to offer a broader perspective of the field, because there is something for everyone in geropsychology.

During my training, I was fortunate to be introduced to the older adult population at a long-term care facility that offered a rare opportunity for multi-generational interaction and learning. This retirement community offered a variety of housing and care options ranging from family housing through skilled nursing care on one campus. By morning, I worked with young families who were struggling through food stamp and Medical Assistance applications; by afternoon, I was helping older adults with similar challenges or assisting families stricken by a parent's Alzheimer's diagnosis.

These presenting features could apply to an adolescent or an older adult, and they have.

During this time, I was struck by the similarities between the adolescent and aging adult populations. Consider the following scenario: An individual presents for treatment for the first time, referred by a family member for symptoms of depression and anxiety exhibited as acting out in public places, isolation, and conflict with peers. This patient has difficulty adjusting to a recent, forced move and is upset that driving privileges have been suspended for exceeding the speed limit. Add a little alcohol, mix with medications borrowed from friends to ease emotional distress, and the clinical picture becomes even further complex.

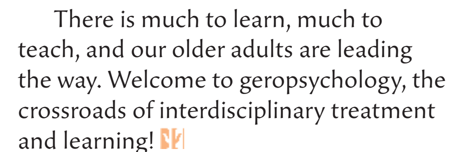
Age was omitted intentionally: These presenting features could apply to an adolescent or an older adult, and they have. When I have suggested multi-generational activities as part of a treatment plan, I have said more than once to both younger and older patients, "You two have more in common than you think!" I have observed close bonds created between the adolescent and older adult populations, who often share a common complaint: "Nobody understands me."

Over time, the similarities I perceived during my adolescent and older adult clinical specialties were also evident in assessment. Learning, memory, and cognition are all key variables in determining whether a child will be mainstreamed into a classroom, or an older adult will be transferred to a dementia care unit from independent living.

Those who work with patients struggling with chronic, acute, terminal illness or with neurological disorders will see many of these medical challenges in the middle-aged through older adult, as well as how patients have lived successfully with these conditions and pushed beyond the expected lifespan. I've felt honored to work with individuals – heroes, really, in my eyes – who have survived severe mental illness for more than 50 years and lived to tell about it. Imagine what can be learned from such a survivor!

Individual, family, group therapy? Geropsychology has it all. Family therapy in particular can be an enormous help when middle-aged children become parents to their parents, while also raising their own children and holding down a job or two. I have witnessed the constraining power of a patriarchal family system when I worked with a family of lawyers and medical doctors with lives established in other states who shrank in the presence of their father, the patriarch of the family, when he flatly refused to move their mother to a skilled nursing facility even though she chose to stroll down local highways at 3:00 a.m.

Daily opportunities exist for the practice of ethics and advocacy, whether in advocating for a patient with Alzheimer's who wants to leave a clinical trial because she is tired of the fight, or becoming familiar with the responsibilities and legalities entailed in billing for services. For the administrators among us, opportunities include working collaboratively among staff, patients, and families within the health care system, during a critical time in the fight against the epidemic of Alzheimer's disease and other long-term illnesses.



There is much to learn, much to teach, and our older adults are leading the way. Welcome to geropsychology, the crossroads of interdisciplinary treatment and learning!

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Practice in Long-Term Care: Not for the Timid

Kelly O'Shea Carney, PhD, CMC

Dr. Kelly O'Shea Carney

In recent years, awareness of the mental health needs of older adults has grown and with it, happily, efforts directed at meeting those needs. From the recognition by APA of geropsychology as a clinical specialty, to the establishment of the National Behavioral Health and Aging Coalition, to states' efforts to address the mental health needs of older adults through community-based interventions and older adult peer support programs, professionals are mobilizing to recognize and address the mental health issues faced by elders. Given the adverse impact of unmet behavioral health needs on the health, function, and even the mortality of older adults, increased attention to this population is imperative. However, most current efforts are focused on community-dwelling older adults, and insofar as these efforts are reimbursed under Medicare, the interventions tend to be traditional: psychotherapy and medications. While valuable for some elders, these interventions often are not appropriate, sufficient, or effective with our most vulnerable older adults: those with significant physical, functional, and cognitive impairment who require long-term care to ensure their safety and well-being.

The need for mental health services within long-term care settings far outstrips the number of professionals equipped and willing to address that need. For example, studies have placed rates of major depression and/or clinically significant depressive symptoms within long-term care settings to be from 12% to 35%, yet fewer than 50% of these cases are recognized by nursing and social work staff (Thakur & Blazer, 2008). When other mental health issues such as anxiety, dementia, and psychotic disorders are factored in, prevalence rates of mental illness within long-term care are substantially higher (Conn & Snowdon, 2010). Within clinical samples of select nursing home settings taken by Eldercare Assessment and Resources, a Community Services Group Program in Bethlehem, PA, as many as 90% of residents have been diagnosed with mental illness. Nevertheless, many long-term care settings offer little more than medication management and social work support to address the mental health needs of older adults.

This service gap invites the entry of psychologists who demonstrate initiative, creativity, and determination. First, consistent with the APA guidelines for working with older adults, psychologists practicing geropsychology need training and supervised experience within the specialty area, yet this is often not the case (APA, 2004). To effectively serve the frailest older adults residing in long-term care settings, psychologists require working knowledge of chronic illnesses and their treatment, pharmacology and the effect of medications on an aging body, cognitive changes due to age and disease, and organizational and regulatory guidelines within long-term care. While traditional behavioral health interventions reimbursed under Medicare such as assessment and therapy are helpful, they are often insufficient to fully address the needs of this special population. Rather, to adequately address the needs of elders who may be experiencing losses related to health, function, social support, and cognition due to age and illness, support requires the coordination of multiple resources.

Not unlike the "wraparound" approach used with children, frail older adults benefit most when interventions incorporate the efforts of primary caregivers and the systems within which they live. Moreover, quality of care within long-term care settings is improved when primary caregivers are provided the tools necessary to understand, conceptualize, and address the behavioral health needs of elders in their care. While a 50-minute therapy session may be insufficient to address the depressive symptoms of an 85-year-old woman who has lost her husband, her home, and her independence, that same therapy in conjunction with the emotional support of nursing home staff who are available 24/7 to provide empathy and engagement may effectively reduce the depression. This type of wraparound approach to care is consistent with the multipronged interventions documented in the recent CDC brief on evidence-based practices for treating depression in older adults. Within each of the practices described in the brief, interdisciplinary team approaches are used to provide interventions combining traditional mental health services with education about depression, engagement, and involvement in activities, social support, and coordination of care (CDC, 2009).

> *Given the adverse impact of unmet behavioral health needs on the health, function, and even the mortality of older adults, increased attention to this population is imperative.*

Within long-term care settings, psychologists are uniquely positioned to provide leadership in this wraparound approach on behalf of frail elders who struggle with mental health issues. Specifically, psychologists working within long-term care are well equipped to train direct care staff about behavioral health in older adults, facilitate the development of empathy for the struggles faced by residents, and provide guidance to the interdisciplinary team in creating the individualized environmental and interpersonal supports necessary to reduce

Continued on page 15

Equipping Your Kit: Tools for Geropsychology Competency

William Davis Jr., PsyD, Widener University

If you recognize geropsychology as a promising field and want to boost your competency, several routes exist. Two very do-able strategies are self-study and continuing education, each of which is reviewed here. I've peppered this review with a few tools that have been helpful to me and to others along the way. For clarity, my own tips are listed separately at the end of the article.

Self-Study Options

The APA Ethics Code requires psychologists to practice within the boundaries of their competence. Regarding work with diverse populations (e.g., older adults), the code implores psychologists to be aware of the current literature for work with members of these groups and to "have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or [to] make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies" (APA, 2010). Organizing a solid self-study plan can be an effective first step in developing competency (Rodolfa, Bent, Eisman, Nelson, Rehm, & Ritchie, 2005).

The Pikes Peak Geropsychology Knowledge and Skills Assessment Tool

Designing a self-study plan requires knowledge of one's competencies and growth areas. In geropsychology, the assessment tool that best accomplishes this is the Pikes Peak Geropsychology Knowledge and Skills Assessment Tool. The Pikes Peak is a publication of the Council on Professional Geropsychology Training Programs (CoPGTP). The CoPGTP is the nonprofit training organization responsible for establishing geropsychology as a professional specialization. The Pikes Peak tool was created to help psychologists and trainees evaluate their level of competence in addressing the health needs of older adults. The tool can be used to identify progress in acquiring geropsychology competency. The Pikes Peak is available in the public domain (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009).

APA Guidelines for Practice With Older Adults

The APA Guidelines for Practice With Older Adults is another noteworthy addition to a self-study plan. In 2004, the American Psychological Association published guidelines as aspirational goals and recommendations that psychologists were encouraged to employ in their work with older adults. There are 20 guidelines spread across six domains, including: *Attitudes; General Knowledge About Adult Development, Aging, and Older Adults; Clinical Issues; Assessment; Intervention, Consultation and Other Service Provision; Assessment;* and *Education*. As an example, in the first domain, *Attitudes*, psychologists are encouraged to practice within the boundaries of their own competence and to consult and refer as appropriate (Guideline 1). Psychologists are also encouraged to combat ageist attitudes that might impact assessment and treatment of older adults and to obtain additional education and supervision as needed (Guideline 2). The *Education* domain rounds out the guidelines by encouraging psychologists to acquire continuing education, supervision, and consultation for work with older adults as needed (Guideline 20; APA, 2004). Overall, psychologists interested in working more skillfully with older adults can use the guidelines as behavioral guideposts that can later be measured by the Pikes Peak Report from the APA Task Force on Integrated Healthcare for an Aging Population.

By far, integrated health care is the preferred approach with older adults, but this concept may require a paradigm shift for psychologists accustomed to practicing solo. In 2008, then-APA President Sharon Brehm created a Presidential Task Force on Integrated Healthcare for an Aging Population (IHAP). The task force was created to plan how best to prepare and deliver health care for the aging baby boomer population. After a series of meetings and consultations, the task force produced an executive summary recommending integrated care as more effective than individualistic, patient-provider health care for vulnerable populations such as the elderly. Of note to readers, Chapter 3 of the IHAP report describes an Integrated Care Model that involves individual assessments by various health care practitioners combined with a team approach to sharing information and developing a comprehensive intervention plan. The authors propose this model of care for almost any setting, including primary care, long-term health care, and specialized medical clinics. Chapter 6 of the document presents case examples that describe integrated health care in various settings. The "blueprint" concludes with recommendations for the APA now being implemented by the Committee on Aging (APA Presidential Task Force on Integrated Health Care for an Aging Population, 2008).

The Pikes Peak tool was created to help psychologists and trainees evaluate their level of competence in addressing the health needs of older adults.

Multicultural Competency in Geropsychology

A final recommended reading for a geropsychology self-study plan is the Multicultural Competencies in Geropsychology, a document produced by the APA Committee on Aging (2009).

Continued on page 15

Beyond the Data: Suicide Attempts in the Older Adult; the Treatment Lies Within Their Stories

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All personal identifying information of any client referenced in this article has been changed and certain circumstances modified to protect the identity of the client(s).

In our clinical training, many of us were warned that during the course of our clinical practice we were likely to lose at least one patient to suicide. A multitude of variables including race, illness, and relationship status may contribute to this possibility. For those of us who serve older adults, these variables contribute to a higher risk for completed suicide, particularly for men (Conwell, 2007; National Institute of Mental Health [NIMH], 2010).

Sullivan & Bongar, in their chapter *Assessing Suicide Risk in the Adult Patient* (as cited in Kleespies, 2009) found that "...our evaluative strategies are generally based more on professional judgment than on evidence-based approaches" (p. 74). Our professional judgment in suicide risk assessment is drawn chiefly from resources established through the American Psychological Association, the Canadian Coalition for Seniors of Mental Health, and our military, among others. Key among the list of suicide risk factors is hopelessness, a factor I have found to be predominant among depressed older adults.

On a Friday evening before a holiday, I was assessing the suicide risk of Mr. Jones, an elderly gentleman who scored high on indicators, including hopelessness. The resources I was relying on were the stark honesty and courage of this gentleman to tell his story, the caring sister who served as my primary historian for biopsychosocial background, and my years of clinical experience in geropsychology to help me determine, "Is Mr. Jones going to try to kill himself – again?"

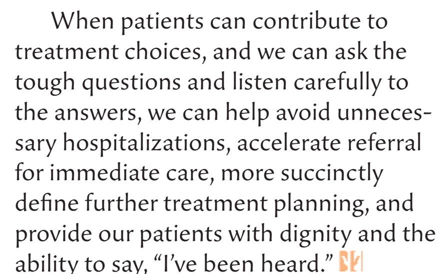
Mr. Jones represented a high-risk population for suicide completion: an elderly, white, widowed male. Additionally, he had a lifelong history of depression, had lost any sense of purpose, and was nervous about moving to a higher level of care, though he was battling several medical problems and recovering from a prior suicide attempt. He'd simply run out of options, and out of hope.

While my training helped me to better understand Mr. Jones's journey through these systems of care, in that particular moment everything boiled down to Mr. Jones's and his sister's narratives, and they led me to decide against re-hospitalization that night. Treatment lies in part within the story our patients provide, and the questions we must ask.

Did Mr. Jones have any plan to harm himself that evening? No. He didn't have the energy. According to Mr. Jones, any motivation for re-hospitalization was to hide from other concerns, not because he was intent on self-harm or wanted to die or even felt he could better improve in a hospital. He didn't enjoy living because he didn't know how to live without health and work. But by revealing his fears, he gave us the chance to address them, and we did. With help, he got up and moving, and hope crept back in. While his providers were vigilant for the next few days, Mr. Jones found reasons to live, and one, he said, was feeling heard. Empowered, he planned his own wellness activities, scuttling programs he had not found useful before.

Those who survive a suicide attempt – the patients and their families – have much to offer about the best treatment approach for them. In working with Mr. Jones and others like him, I am reminded often of the basic tenets of our training:

1. Be present. With the older adult, you may be the only person listening.
2. Be detailed in your questioning. Only the client can tell you the reasons underpinning a suicidal impulse.
3. "Do no harm" contracts are only as good as the intent of the patient signing one, and an older adult's insight and cognitive capacity can be further compromised by problems such as polypharmacy or delirium.
4. Not all persons who attempt to commit suicide are clinically depressed. You may need to look elsewhere for a person's reasons for self-harm. A medical exam is indicated to rule out other etiologies for depressed mood, including central nervous system disorders, endocrine disorders, and medication side effects, among other possible causes (Bhalla & Moraille-Bhalla, 2010).
5. Expand the web of risk assessment resources beyond the patient to the family, significant others, and medical and ancillary care teams.
6. Assess for risk of suicide contagion. It may prove helpful to assess the spouse or others close to the suicide survivor about their own suicide risk.



When patients can contribute to treatment choices, and we can ask the tough questions and listen carefully to the answers, we can help avoid unnecessary hospitalizations, accelerate referral for immediate care, more succinctly define further treatment planning, and provide our patients with dignity and the ability to say, "I've been heard." ■

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The Psychosocial Debris Field: When Medical Illness Strikes in Middle Age

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While the identities of those mentioned in this article have been changed to protect their privacy, both have given permission for their stories and reflections to be used in this article.

"Well, it's done. Our marriage as we knew it is over." Out of context we might guess this patient was facing separation or divorce. Jim, however, misses the nuances of his relationship with his wife: the spontaneous laughter, the inside jokes, the trips to their favorite restaurants, the sharing of tasks and family decisions. Couples together for many years can often finish each other's sentences. Now Jim struggles to understand his wife's thoughts as her words trail off mid-sentence. Her laughter has faded, and their inside jokes remain but a memory for him to carry alone. As for the trips to restaurants, she relies solely on her husband to choose her meals in locations she can barely recollect, while family decisions and household tasks fall increasingly to him, as primary caretaker for his wife. Their marriage as they knew it is over. His wife is dying by inches in front of his eyes. Jim's wife, Mary, was diagnosed with early-onset Alzheimer's disease at the age of 54.

As the epidemic of persons suffering from Alzheimer's disease continues to surge in our country, their caregivers have joined the ranks of other caregivers for persons who have suffered a devastating injury or disease that has overtaken them early in life. In my clinical work with individuals and families with chronic, progressive, acute, and/or terminal illnesses, I have learned that the disease itself is only part of the challenge.

In 2011 our nation – let alone our world – has suffered several environmental disasters. For each disaster there is a point of impact from which a debris field results. According to those who study such sites, we can learn a lot about the impact of the disaster by studying the debris collected at the primary, secondary, and tertiary levels of spread. Similarly, medical illness has its own unmistakable impact, and we can understand its psychosocial, eco-systemic [force] by examining the debris and its ripple effect beyond the patient. Unfortunately in chronic, progressive illness, the debris field is often so vast, the duration of the trauma so extended, that many caregivers end up picking up the pieces of the impact themselves as friends, family, and medical personnel disappear.

According to the caregivers, patients, and families I have worked with over the years, less has been explored about the impact of illness at mid-life than at other ages. In older adults, declining health is likely to be viewed as almost expected. The young facing serious illness are often met by a highly aggressive approach to care that involves multiple layers of interventions, fueled in part by the disbelief and sadness of witnessing someone so very young suffering such tragedy.

The middle-aged fall into the "not too old, no longer young" category. I have worked with many persons in mid-life who have worked incredibly hard to begin to enjoy their lives, and then tragedy hits. Whether from Alzheimer's disease, heart attack, stroke, cancer, or other illness, their lives are changed forever. Retirement funds are depleted. There is no financial wellspring for our vast number of unpaid caregivers in this country. For Alzheimer's disease alone, "caregivers work 12.5 billion unpaid hours each year to care for these individuals. The total economic value of this unpaid caregiving exceeds $144 billion annually and is growing" (Markey & Smith, 2011).

Todd, a psychologist who works with our military, and his wife, Judy, were in their late 50s when Judy was diagnosed with Stage 4 carcinoma. As Judy's caregiver in a very long battle, Todd offered the following for this article. During one particular period in Judy's cancer treatment "time had been bought" due to advances in cancer treatment. "Key word, time. Time costs money. And there is the rub," Todd said. He continued, "My work with the sick and dying every day reminds me how much suffering goes unnoticed, and how much we owe to the dedicated and loving in-home caregivers, millions of families with loved ones sick and dying, with health care aides earning minimum wage for highly skilled work, with spouses providing 24/7 care, most struggling near poverty, isolated and afraid. ... But we are not alone; far from it, we have many blessings to help us through these times. For those of you in the 'normal' world, love joyfully, forgive generously, and give thanks every day for your great blessings."

No matter the disease, the fight may begin personally and resonate slowly through the systems of care, or hit with an impact demanding immediate medical and psychosocial supports. It is within the everyday, intimate, minute-to-minute tasks that we may overlook the need for understanding, empathy, and support. While women are primarily in the caregiver role, in the two cases I have mentioned in this article, the husband is the primary caregiver. Middle-aged persons are leaving their jobs at the top of their career to make sure that the moments left with their loved ones are good ones, or simply that there are moments left.

How can we help as mental health professionals? I would like to encourage each of us to consider a biopsychosocial model of treatment care, working collectively with the patient, caregiver(s), medical and ancillary care teams, either on a multi-disciplinary care team or in whatever capacity serves best. Even those who do not come from a systems theoretical background can contribute greatly into the bigger system, picking up the vast debris of medical illness together.

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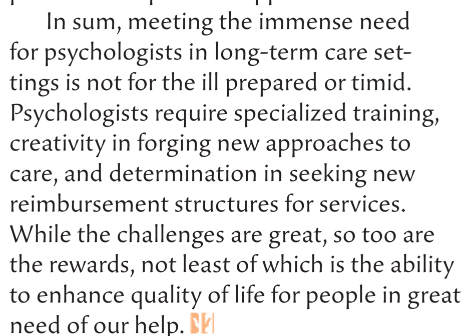
PRACTICE IN LONG-TERM CARE: NOT FOR THE TIMID

Continued from page 11

depressive symptoms and challenging behaviors. Psychologists established within long-term care settings possess knowledge and skills that can be shared with others to enhance the quality of life and psychological well-being of residents, but to do so, may need to think "outside the box" to create structures through which these resources can be shared.

Too often, psychologists working within long-term care settings operate only within the confines of Medicare reimbursement. While this is one avenue for reimbursement, psychologists may also want to consider other reimbursement options that will allow them to share their expertise more broadly with the long-term care system. For example, grants, research projects, and contractual agreements with the long-term care organization are all funding sources used by psychologists to bring the breadth of their expertise to bear on behalf of the frail elders served within long-term care settings. Through our Eldercare program at Community Services Group, we provide comprehensive consulting services to long-term care settings, the costs of which are shared by the families of residents, the long-term care facility, and insurances, allowing us to offer a range of traditional and non-traditional services that effectively provide a wraparound approach to care.



In sum, meeting the immense need for psychologists in long-term care settings is not for the ill prepared or timid. Psychologists require specialized training, creativity in forging new approaches to care, and determination in seeking new reimbursement structures for services. While the challenges are great, so too are the rewards, not least of which is the ability to enhance quality of life for people in great need of our help.

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EQUIPPING YOUR KIT: TOOLS FOR GEROPSYCHOLOGY COMPETENCY

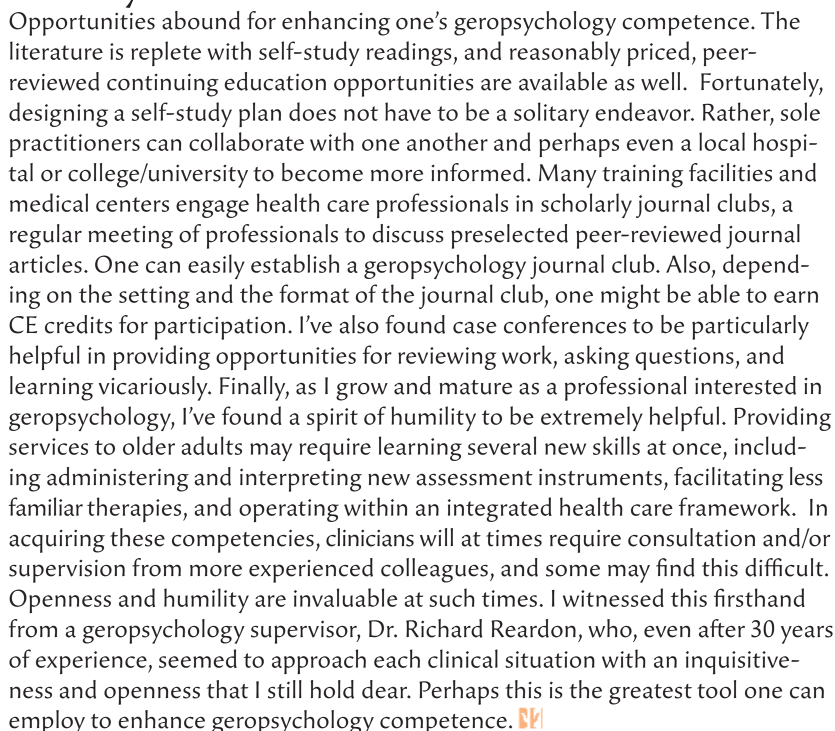
Continued from page 12

These guidelines were produced in response to population projections that suggest that not only is society experiencing a "graying," but also a co-occurring "browning" – an increasing number of older adults from minority populations – that adds a layer of complexity to health care. Additionally, various domains of diversity might further complicate health service provision for older adults, as explained in the guidelines themselves. Again, in my opinion, this document is a must-read for those who want to re-specialize or enhance basic competency, used in conjunction with the Pikes Peak model for tracking progress.

Continuing Education

A wealth of web-based and regional continuing education trainings exist for those who are interested in enhancing geropsychology competency such as:

- the APA Office of Continuing Education, which offers 12 low-cost trainings in geriatrics;
- the American Geriatrics Society, which sponsors regional and national conferences on geriatric concerns;
- the Gerontology Society of America, which also sponsors regional and national conferences on geriatrics.



Summary

Opportunities abound for enhancing one's geropsychology competence. The literature is replete with self-study readings, and reasonably priced, peer-reviewed continuing education opportunities are available as well. Fortunately, designing a self-study plan does not have to be a solitary endeavor. Rather, sole practitioners can collaborate with one another and perhaps even a local hospital or college/university to become more informed. Many training facilities and medical centers engage health care professionals in scholarly journal clubs, a regular meeting of professionals to discuss preselected peer-reviewed journal articles. One can easily establish a geropsychology journal club. Also, depending on the setting and the format of the journal club, one might be able to earn CE credits for participation. I've also found case conferences to be particularly helpful in providing opportunities for reviewing work, asking questions, and learning vicariously. Finally, as I grow and mature as a professional interested in geropsychology, I've found a spirit of humility to be extremely helpful. Providing services to older adults may require learning several new skills at once, including administering and interpreting new assessment instruments, facilitating less familiar therapies, and operating within an integrated health care framework. In acquiring these competencies, clinicians will at times require consultation and/or supervision from more experienced colleagues, and some may find this difficult. Openness and humility are invaluable at such times. I witnessed this firsthand from a geropsychology supervisor, Dr. Richard Reardon, who, even after 30 years of experience, seemed to approach each clinical situation with an inquisitiveness and openness that I still hold dear. Perhaps this is the greatest tool one can employ to enhance geropsychology competence.

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Aging as a Non-Heterosexual

Chris Grundy, MS, grundyc@chc.edu

Chris Grundy

An old saying goes, "Growing old is tough – but it beats the alternative." How we age and prepare for our eventual death is an integral part of our development. Life expectancy in the United States has increased dramatically in the last century, making individuals age 65 or older the fastest growing segment of the population. The baby boomer generation, those born between 1946 and 1964, is the largest cohort in American history. As they continue to age, the number of Americans over age 65 will double from 35 million to an estimated 70 million over the next few decades (U.S. Census Bureau, 2000). Within this group, the number of gay or lesbian elders, conservatively estimated at 3-5% of the population by the National Gay and Lesbian Task Force (1999), will also continue to dramatically increase. Therefore, understanding the unique needs and vulnerabilities of this significant population is paramount to the provision of adequate services and culturally competent care.

Research on lesbian and gay aging suggests healthy psychological adjustment within this population, indicating older gay males and lesbians are no more or less depressed than their heterosexual peers (Dorfman, et al., 1995; D'Augelli & Grossman, 2001). These studies did much to dispel earlier stereotypes of older gays and lesbians as lonely and depressed. However, older gay men have reported internalized homophobia, alcohol abuse, and suicidal thoughts at significantly higher rates than lesbians. Thus, the complexity of aging within this population requires further examination (Grossman, D'Augelli, & O'Connell, 2001).

Another mental health factor to consider when working with the gay and lesbian culture is the impact of victimization. In an examination of the lifetime incidence of victimization based on

Because the majority of services are provided by mainstream care agencies, many in the gay and lesbian community have expressed concern that their sexual orientation may affect the quality of services provided.

sexual orientation, researchers found that nearly three-quarters of a sample of gay and lesbian individuals reported some kind of sexual orientation-based victimization, either verbal or physical, at some point during their lives. Those who had been physically attacked reported lower self-esteem, more loneliness, and poorer mental health than others. Additionally, more suicide attempts were reported among older adults who had been physically attacked than those who had not (D'Augelli & Grossman, 2001). These results show an association between past victimization and aspects of current mental health. Thus, it is crucial for clinicians to create nonjudgmental, welcoming contexts for older adults and to process any longstanding distress associated with past victimization in order to mitigate its negative effects on mental health.

Additionally, those who are lesbian and gay express concern about the effects of age on their health, about growing older in the LGB community, and about accessing mainstream services in later years. One primary concern is a sense of being alone in older age and maintaining social networks. The lack of LGB-specific accommodations in later life also continues to be highlighted as a major concern by older gay men and lesbians (Hughes, 2009). Because the majority of services are provided by mainstream care agencies, many in the gay and lesbian community have expressed concern that their sexual orientation may affect the quality of services provided. Further research is needed to understand the patterns of sexual orientation-based discrimination within care settings for the elderly in order to evaluate the impact of expected versus actual discrimination on mental health when receiving age-related services.

As models for living continue to evolve in contemporary culture, the context in which people age will be impacted. Research on older gay men and lesbians can offer insights into aging in an increasingly mobile and interconnected world (Heaphy, Yip, & Thompson, 2004). In addition, virtually all clinical psychologists will work with at least one gay, lesbian, or bisexual client at some point in their professional careers (Lyons, Bieschke, Dendy, Worthington, & Georgemiller, 2010). Understanding this subgroup of seniors and the unique circumstances under which they age in our society is necessary for ethically informed treatment.

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In Memoriam

Dr. Bernard Yadoff died at age 84 in May. He had been president of PPA in 1970-71, during the final push by our association for licensure of psychologists, which was passed by the legislature in 1972. The son of Russian immigrants, he received his PhD in clinical psychology from the University of Pittsburgh in 1958. He worked as a clinical psychologist in the Pittsburgh area for many years, including at the Pittsburgh Child Guidance Center, Children's Hospital of Pittsburgh, and Mercy Hospital, in addition to maintaining a private practice. He joined PPA in 1961 and became president of the Clinical Division in 1965. He moved to Massachusetts in 1976 but maintained his membership in PPA until his death.

Dr. Michael Moran died in Pittsburgh in June at age 77. He had been a member of PPA since 1990. He earned his PhD in educational psychology from the University of Pittsburgh in 1969. He completed post-doctoral work in neuropsychology at the University of Arizona and the Naval Graduate Center in Monterey, Ca., in 1975. He was a tenured professor and director of the graduate program at Duquesne University from 1969 until 1996. Following that he worked in private practice as a neuropsychologist in Pittsburgh and Altoona.

Dr. Leon Kalson, of Pittsburgh, died on June 14, two days short of his 90th birthday. He maintained a full-time private practice as a consulting psychologist and retired in 1992. He had received a PhD degree in rehabilitation counseling from the University of Pittsburgh in 1976. He joined PPA in 1982.

Dr. Robert M. Gilligan, who retired to Brigantine, N.J., in 1996, died in July. He had been an associate professor at LaSalle University in Philadelphia since 1968. He earned his PhD degree in experimental psychology from Temple University in 1975 and had joined PPA in 1973.

Amendment to Bylaws Proposed by General Assembly

Vote Needed by Membership

PPA's Bylaws Task Force identified concerns about the structure of the Budget and Finance Committee (BFC) relating to the number of members on the committee and the method of appointment of those members. The BFC is limited to seven members and includes the president, president-elect, treasurer, and four additional members. This was felt to artificially limit the committee. The committee may often need to add members with expertise or interest in specialized areas, and the limited membership may constrain its function. The BFC is one of two committees where the specific members and selection of members is specified in the bylaws. In this case, the additional four members are selected by the president-elect. This stands in contrast to most other committees whose members serve at the pleasure of the president. In addition, although the president is ex-officio a member of all PPA committees, it was felt appropriate to list the president as a member to emphasize the importance of the president's involvement in that committee.

The task force made the following recommendation to amend the bylaws as follows (with underlined text to be added and bracketed text to be deleted):

> Article VIII (B)(2.2 a) Budget and Finance Committee: It shall be the responsibility of this committee to oversee the preparation and submission for approval by the Board of Directors, a budget for the fiscal year at the first meeting of the incoming president's administration. This committee shall also review the financial condition of the Association and make recommendations for enhancing its financial stability. [There shall be up to seven members, including] <u>The committee shall include</u> the president-elect, treasurer, current president, and [up to four] <u>other</u> individuals to be selected by <u>the president in consultation with</u> the president-elect. In those years in which there is a treasurer-elect, that person shall become a member of this committee following the election.

The General Assembly approved submitting this amendment to the membership and recommends a positive vote. Please return the ballot below with your vote on this amendment.

Ballot for Bylaws Amendment

☐ I approve the bylaws amendment regarding the Budget and Finance Committee.

☐ I disapprove the bylaws amendment regarding the Budget and Finance Committee.

Name *(please print)* ____

Signature____

Return mail this ballot by **September 30, 2011**, to the PPA office, 416 Forster Street, Harrisburg, PA 17102, or fax it to 717-232-7294.

Unconventional Psychologists

❶ *At the annual banquet outgoing president Dr. Mark Hogue passed the gavel to incoming president Dr. Judith Blau.*

❷ *Dr. Daniel Gould, of Michigan State University, gave the keynote address on the topic of sport psychology as a laboratory of understanding human performance in mind, body, and spirit.*

❸ *APA's Director of Ethics Dr. Stephen H. Behnke spoke at the Psychology in Pennsylvania Luncheon on ethics in the age of the Internet.*

The 2011 Annual Convention's theme was "Celebrating Human Performance in Mind, Body, Spirit, and Community." It took place in June in Harrisburg and was praised as a success by the 328 people who attended. It included 5 plenary sessions, 49 workshops, and other events. The photos on these pages feature a few of the highlights and several of the awards that were presented. Additional awards presentations will be printed in the October *Pennsylvania Psychologist*.

Congratulations to Our Award Winners

❹ *Dr. Richard F. Small (left) presented the Distinguished Service Award to Dr. John D. Gavazzi.*

❺ *Dr. Arnold T. Shienvold (left) received the Award for Distinguished Contributions to the Science and Profession of Psychology from Dr. Jeffrey Pincus.*

❻ *Former state Representative Kathy Manderino was presented the Public Service Award by Dr. Samuel Knapp.*

❼ *Dr. David J. Palmiter Jr. (left) presented the Psychology in the Media Award to Dr. Ari Tuckman.*

❽ *Dr. Dennis Valone received the Award for Distinguished Contributions to School Psychology from Dr. Gail Karafin.*

Pennsylvania Psychological Association

2012 Award Nominations Sought

For each nomination you would like to make for the categories below, please prepare a one-page narrative describing the person's contributions and his/her vitae with contact information, and send the information to the following address by the deadline listed.

Pennsylvania Psychological Association, 416 Forster Street, Harrisburg, PA 17102-1748

Award for Distinguished Contributions to the Science and/or Profession of Psychology to be given to a Pennsylvania psychologist for outstanding scientific and/or professional achievement in areas of expertise related to psychology, including teaching, research, clinical work, and publications. Deadline for entries is **October 20, 2011.**

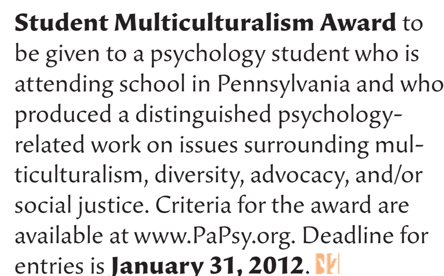
Distinguished Service Award to be given to a member of the association for outstanding service to the Pennsylvania Psychological Association. Deadline for entries is **October 20, 2011.**

Public Service Award to be given to a member (individual or organization) of the Pennsylvania community in recognition of a significant contribution to the public welfare consistent with the aims of the association. Deadline for entries is **October 20, 2011.**

Award for Distinguished Contributions to School Psychology: The School Psychology Board of the Pennsylvania Psychological Association nominates a candidate annually for this award. Criteria for nominations include persons who have contributed significant research in the fields of child, adolescent, school, or educational psychology; have contributed significant public service to children, families, or schools; have made major contributions to the field of assessment; have made significant contributions in the media; have advocated politically for children, families, or schools; have been a voice advocating for school psychologists in Pennsylvania; and/or have made significant contributions to the Pennsylvania Psychological Association. Deadline for entries is **December 31, 2011.**

Psychology in the Media Award: Deadline for entries is **December 31, 2011.** Members of the Pennsylvania Psychological Association and members of the media in Pennsylvania who have presented psychology and psychological issues to the public are encouraged to apply for the 2012 Psychology in the Media Award. Members who have written newspaper or magazine articles or books, have hosted, reported or produced radio or television shows or commercials about psychology or psychological issues, or have designed psychologically oriented websites are eligible for the award. We are seeking candidates who have had a depth and breadth of involvement in these areas with the media over a period of time. Some of the work must have been published or broadcast during 2011. An application form, which is available at www.PaPsy.org, must accompany all entries for this award. Applicants who have received this award in the past are not eligible.

Early Career Psychologist of the Year Award to be given to a Pennsylvania Early Career Psychologist who, in his or her practice as an early career psychologist, is making a significant contribution to the practice of psychology in Pennsylvania. Criteria for the award are available at www.PaPsy.org. Deadline for entries is **January 31, 2012**.



Student Multiculturalism Award to be given to a psychology student who is attending school in Pennsylvania and who produced a distinguished psychology-related work on issues surrounding multiculturalism, diversity, advocacy, and/or social justice. Criteria for the award are available at www.PaPsy.org. Deadline for entries is **January 31, 2012**.

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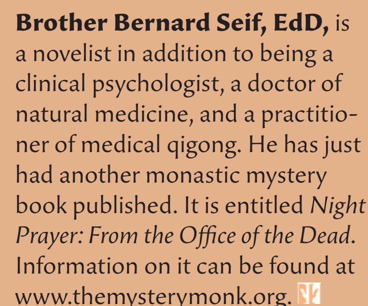


Member News

Brother Bernard Seif, EdD, is a novelist in addition to being a clinical psychologist, a doctor of natural medicine, and a practitioner of medical qigong. He has just had another monastic mystery book published. It is entitled *Night Prayer: From the Office of the Dead*. Information on it can be found at www.themysterymonk.org.

School-Based Intergenerational Programs

Erin Serock, MA, elynnhinder@msn.com, and Susan Edgar-Smith, PhD, sedgarsm@eastern.edu

Four years ago, while teaching second-graders in Philadelphia, the first author was introduced to the practice of partnering school-aged children with adult senior citizens for mentoring. The school had implemented the Reading Buddies program, founded in 1982 by Patricia Quigg (http://www.fpcphila.org/reading-buddies/), which has served 24 school locations for more than 29 years. Originally started at the First Presbyterian Church at 21st and Walnut Streets in Philadelphia, Reading Buddies now engages 175 seniors from churches, nursing homes, and low-income housing units located throughout the city. Each location has a partner school, and its seniors meet students once a week for an hour to read together and talk.

Over the past decade, intergenerational tutoring has blossomed, along with programming (Kaplan & Larkin, 2004) and efficacy research. Many, such as Reading Buddies and Experience Corps, serve urban populations (http://www.experiencecorps.org/index.cfm). Most encouraging about research findings is that all participants profit from intergenerational programming.

Recent studies conducted within six Baltimore elementary schools (three schools incorporated Experience Corps members; another three schools were established as controls) with more than 125 senior adult tutors and some 2,000 students showed promising results (Morrow-Howell, Jonson-Reid, McCrary, Lee, & Spitznagel, 2009). Third graders paired with senior tutors scored significantly higher on word attack and comprehension tests than students from control schools. Although students in regular education showed the most significant improvement, students identified with reading disabilities also demonstrated progress. Meier and Invernizzi (2001) found similar reading gains when evaluating the Book Buddies intergenerational tutoring model. While academic benefits were expected, the behavioral benefits found in these studies were most surprising. The referrals to administration for

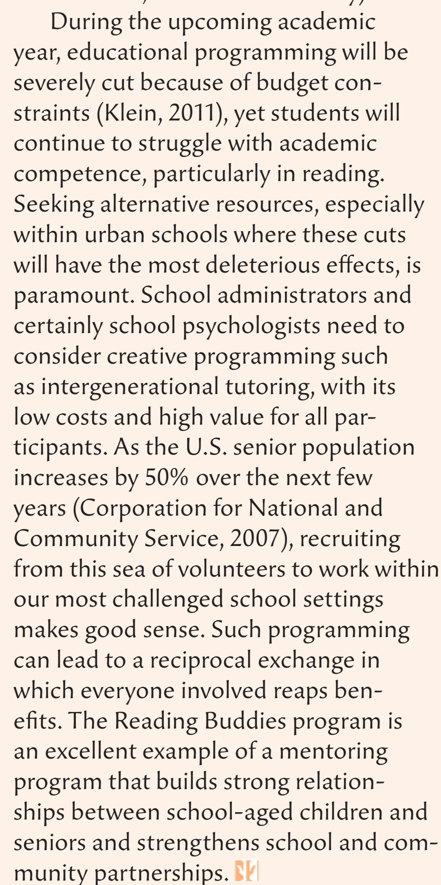
Erin Serock

Dr. Susan Edgar-Smith

classroom misbehavior decreased by 50% in schools that incorporated intergenerational programming, while those referrals in the control groups did not change.

As a participating teacher, the first author witnesses the benefits of Reading Buddies in action: The children, encouraged to read, fall in love with books. Students also enjoy comparisons between school when their reading buddies were young and current classrooms. Furthermore, students value the relationships they form with their reading buddies. Because many of these students come from single-parent homes with a number of siblings, they crave individual attention from an adult who actively listens to them. They thrive on that weekly meeting. Not surprisingly, research indicates that the more positive the relationship between a student and the senior tutor, the better the academic and behavioral outcomes for the student (Morrow-Howell, Jonson-Reid, McCrary, Lee, & Spitznagel, 2009).

Not only does the Reading Buddies Program benefit the children, the seniors gain as well. In a conversation with Patricia Quigg, she stated, "Sometimes the seniors feel isolated and not useful throughout any given day, but on the days that they meet with their student reading buddy, they seem to forget about themselves and just concentrate on the kids" (P. Quigg, personal communication, June 8, 2011). The program permits seniors to lend an able hand. Findings from the Experience Corps research study also found substantial health benefits, such as increased physical activity and strength and increases in cognitive ability (Fried et al., 2004). Providing a wider social network and overall participant satisfaction



were additional benefits for seniors, suggesting the impact of this type of volunteering on older adults. "Giving back to your community may slow the aging process in ways that lead to a higher quality of life in older adults," says Linda Fried, MD, the director of the Center on Aging and Health at Johns Hopkins (Morrow-Howell et al., Executive Summary).

During the upcoming academic year, educational programming will be severely cut because of budget constraints (Klein, 2011), yet students will continue to struggle with academic competence, particularly in reading. Seeking alternative resources, especially within urban schools where these cuts will have the most deleterious effects, is paramount. School administrators and certainly school psychologists need to consider creative programming such as intergenerational tutoring, with its low costs and high value for all participants. As the U.S. senior population increases by 50% over the next few years (Corporation for National and Community Service, 2007), recruiting from this sea of volunteers to work within our most challenged school settings makes good sense. Such programming can lead to a reciprocal exchange in which everyone involved reaps benefits. The Reading Buddies program is an excellent example of a mentoring program that builds strong relationships between school-aged children and seniors and strengthens school and community partnerships.

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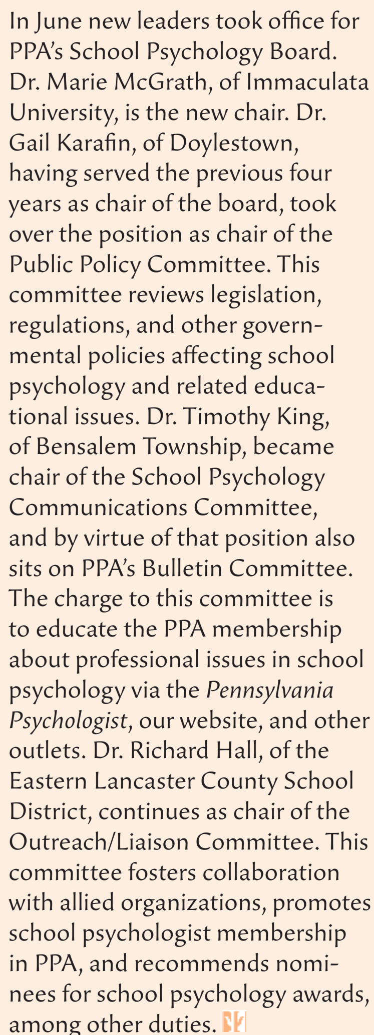
Continued on page 22

School Psychology Board Has New Leadership



In June new leaders took office for PPA's School Psychology Board. Dr. Marie McGrath, of Immaculata University, is the new chair. Dr. Gail Karafin, of Doylestown, having served the previous four years as chair of the board, took over the position as chair of the Public Policy Committee. This committee reviews legislation, regulations, and other governmental policies affecting school psychology and related educational issues. Dr. Timothy King, of Bensalem Township, became chair of the School Psychology Communications Committee, and by virtue of that position also sits on PPA's Bulletin Committee. The charge to this committee is to educate the PPA membership about professional issues in school psychology via the *Pennsylvania Psychologist*, our website, and other outlets. Dr. Richard Hall, of the Eastern Lancaster County School District, continues as chair of the Outreach/Liaison Committee. This committee fosters collaboration with allied organizations, promotes school psychologist membership in PPA, and recommends nominees for school psychology awards, among other duties.

SCHOOL PSYCHOLOGY

Continued from page 21

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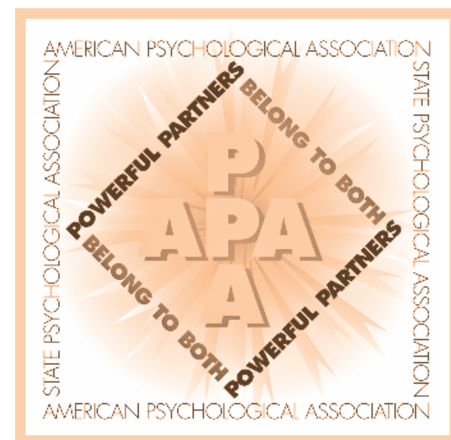
Welcome New Members



We offer a warm, wild, and wonderful welcome to the following new members who joined the association between May 1 and July 31, 2011.

NEW FELLOWS

Allison G. Bashe, PhD
Gibsonia, PA

Irene T. Blackford, PhD
Erie, PA

Catherine M. Cahill, PsyD
Langhorne, PA

Michael S. Driscoll, PhD
Lewisburg, PA

Marc Duome, PsyD
Buckingham, PA

Joan F. Goodman, EdD
Philadelphia, PA

David F. O'Connell, PhD
Pottsville, PA

David G. Rising, EdD
Muncy, PA

MEMBER TO FELLOW

Ilene M. Dyller, PhD
Philadelphia, PA

NEW MEMBERS

William F. Anzalone Jr., PsyD
Wilkes-Barre, PA

Dustan A. Barabas, PsyD
Stroudsburg, PA

Stephen H. Beckjord, PsyD
Pittsburgh, PA

Richard A. Bollinger, PhD
Philadelphia, PA

Salvatrice Bonefas, PsyD
Philadelphia, PA

Abbey J. Carcarey, PsyD
Pottstown, PA

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Prospecting for Prospective Memory

Edward L. Zuckerman, PhD

"As I get older I spend more time thinking about the hereafter."
"Yes, I too find spiritual concerns becoming more important at this time."
"No, I mean that often when I go into another room, I think, 'What am I here after?' "

Dr. Ed Zuckerman

Prospective memory (ProM) is the ability to become aware of a previously formed plan at the right time and place to carry it out, or simply, remembering to remember. For example: remembering to take medicine at night before going to bed, remembering to deliver a message to a friend, and remembering to pick up flowers for a significant other on an anniversary. Because a great deal of each day is spent forming intentions and acting on those intentions, it is no surprise that at least half of everyday forgetting is due to prospective memory failures (Crovitz & Daniel, 1984; McDaniel, 2011).

When considering our deficits, we should not panic. First, we are likely to be wrong about our memory. "Self-report measures of prospective memory are reliable but not valid" (Uttl & Kibreab, 2011). It seems to be part of our personalities and style to distort this recall: "... a substantial proportion of variability in ProM self-report scores was due to verbal intelligence, personality (conscientiousness, neuroticism), activities and event involvement (busyness), and use of memory strategies and aids" (Uttl & Kibreab, 2011).

Second, aging may not be the most relevant variable in understanding our failures. Masumoto et al. (2011) report that "previous studies comparing prospective memory between the elderly and young adults have shown that elderly adults perform better in naturalistic settings, while young adults perform better in laboratory settings." So, laboratory research findings in this area may not generalize to our real lives. Marsh, Hicks and Landau (1998) emphasize that in natural settings, ProM depends on many non-memory cognitive functions beyond those typically assessed, especially "metamemory, attentional capacities, and planning processes that reprioritize intentions according to the demands of everyday life. ..."

Last, usually we won't forget the important stuff. Penningroth, Scott, and Freuen (2011) report that overall findings suggest that social ProM tasks are viewed as more important than nonsocial ProM tasks and are more likely to be performed. However, the best meta-analysis (Uttl, 2011) indicates our losses of ProM are about as bad as our losses of retrospective memory (recalling the past).

What can we do to improve our ProM?

First, don't try to continually monitor and remind yourself of planned actions. This effortful, cognitive-capacity-consuming retrieval process simply does not improve ProM. However, these familiar, helpful methods can be enlisted:

- Link the future action to something that you are very unlikely to forget. For example, put the letters to be mailed next to the keys you always take when you leave the house.
- Put some element of the action where you are likely to see it (as a visual cue) when you will need it. For example, put the letters to be mailed by the front door.
- Incorporate regular repeated actions into other daily routines. For example, if you always eat breakfast before leaving the house, make collecting the outgoing mail a prelude to eating breakfast each day.
- Visualize the action paired with an essential component and take it to the nth degree. Imagine your car turning into a giant mailbox so that when you next see it, you will recall the letters to be mailed.
- Whenever possible, as soon as you retrieve the intention, perform the task.

Strategies being investigated include these:

- Add a clear mental statement of your intention to the mental image of the action. Visualize the steps of mailing the letters and say, "Just before I leave the house today, I will put those letters in my right coat pocket."
- Predict how well you will do in recalling the task when you need it: "Based on my recent experience, I think the likelihood that I will remember to mail letters is 70%." Being more detailed, such as specifying "mailing them today at 11 a.m." is less likely to be effective (Meier, et al., 2011).

Interruptions intrude on prospective memory, so consider these:

- Create a cue for the intended action by moving an object to an unusual place or position. For example, put the letters on your desk phone or keyboard when you answer the telephone.
- Visualize a mental cue. For example, imagine the letters in the place where you picked up your phone, so that when you replace the phone you will recall the letters.

For many of us, cell phones have become a central part of life. Can smartphones become ProM aids? There are already many calendar/timer applications that will send a notification or alarm to remind the user. These time- and event-based reminders would often be more useful. By entering a reminder note into your contact for Mary, you can elicit a prompt when you next call her, reminding you to tell her about the meeting. Using the phone's GPS function, location-based prompts can be sent to remind the user who is nearing an ATM to deposit a check. If speech-to-text capability permitted users to set prompts without typing, such a tool would greatly aid ProM.

Resources

- A test exists for ProM: the Cambridge Test of Prospective Memory (CAMPROMPT), which also provides valid data for planning programs aimed at remediating prospective memory difficulties.
- For a little levity, the AAADD (Age-Activated Attention Deficit Disorder) site is available: http://www.northofseveycorners.com/aaadd.htm.

Continued on page 24

Sustaining Members, 2010-11

Special thanks to our Sustaining Members for the fiscal year that ended June 30! PPA appreciates your additional support. Sustaining Members contribute an extra $100 or more at the time of their dues renewal. Members' dues are due in the quarter in which they joined, so please look for the Sustaining Member notice with your dues statement. This program helps PPA maintain a strong organization with a balanced budget. For more information, please visit the PPA website, www.PaPsy.org. We raised $6,300 in the last fiscal year with this effort.

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PSYCH TECH

Continued from page 23

A very helpful and concise review of memory types, changes in abilities, and even six electronic tools can be found in Caprani, Greaney & Porter (2006). Uttl (2011) offers a fuller explanation and easy online access to all the central research in the field. The best easily accessible book, by two leading researchers in the field, Mark A. McDaniel and Giles O. Einstein, is *Prospective Memory: An Overview and Synthesis of an Emerging Field* (2007).

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Learning objectives: The articles in this issue will enable readers to (1) assess and explain current issues in professional psychology, and (2) describe and act on new developments in Pennsylvania that affect the provision of psychological services.

DeWall

1. Compared to nonmembers PPA members saved:
   a. $45 for each 3-hour workshop at the fall and spring conferences
   b. $130 apiece for the risk management workshop
   c. $195 by registering for the entire convention
   d. all of the above

Davis, Introduction to the GTI

2. Results from geropsychology training studies suggest:
   a. There has been a dearth of geropsychology training opportunities at the state/regional level.
   b. There has been a dearth of geropsychology training opportunities at the national level.
   c. There have been more than enough geropsychology training opportunities available at the regional/national level throughout this decade.
   d. Both a and b

Durshaw, Crossroads of Interdisciplinary Treatment

3. The treatment populations of adolescent and older adult have shown similarities in the areas of presenting symptoms, diagnoses, psychosocial stressors, and treatment options.
   True
   False

Carney

4. Current best practices in treating depression in older adults, as promoted by the Centers for Disease Control, do not include the following intervention:
   a. coordination of care
   b. activation and engagement
   c. intensive outpatient services
   d. social support
   e. education

Durshaw, Suicide Attempts in the Older Adult

5. Demographically, elderly, white, widowed males are considered to be at high risk for suicide attempts but at low risk for suicide completion.
   True
   False

6. In regard to suicide assessment in the older adult population, authors Sullivan & Bongar, as cited in this article, found that our evaluative strategies are generally based more on which of the following?
   a. evidence-based approaches
   b. professional judgment
   c. professional journals

Durshaw, The Psychosocial Debris Field

7. As a result of the advances made in the fight against Alzheimer's disease, the number of persons diagnosed is now decreasing.
   True
   False

8. According to the caregivers, patients, and families affected by Alzheimer's disease, less has been explored about the impact of the disease on a person's income, relationships, quality of life and other psychosocial indicators at which time of life:
   a. Mid-life (ages 40-65)
   b. Later life (age 66 and beyond)

Grundy

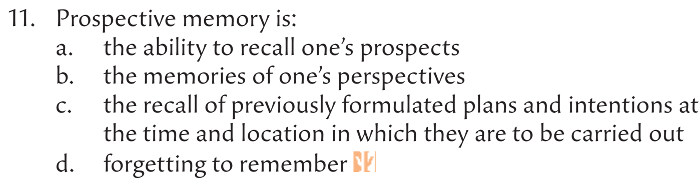
9. The number of older gay men and lesbians is conservatively estimated to be ___ % of the general population:
   a. 8-10
   b. 2-3
   c. 3-5
   d. greater than 10

Serock and Edgar-Smith

10. Benefits derived from intergenerational tutoring include the following:
    a. improved reading scores and reduced classroom misbehavior for youth, but limited benefits for the senior adult
    b. improved reading scores, decreased classroom misbehavior and increased physical and cognitive activity for senior adults
    c. improved reading scores, a slight increase in classroom misbehavior and increases in adult senior physical activity

Zuckerman

11. Prospective memory is:
    a. the ability to recall one's prospects
    b. the memories of one's perspectives
    c. the recall of previously formulated plans and intentions at the time and location in which they are to be carried out
    d. forgetting to remember



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The *Pennsylvania Psychologist,* September 2011

Please circle the letter corresponding to the correct answer for each question.

1.	a	b	c	d		**7.**	True	False		
2.	a	b	c	d		**8.**	a	b		
3.	True	False				**9.**	a	b	c	d
4.	a	b	c	d	e	**10.**	a	b	c	
5.	True	False				**11.**	a	b	c	d
6.	a	b	c							

Satisfaction Rating

Overall, I found this issue of the *Pennsylvania Psychologist*

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

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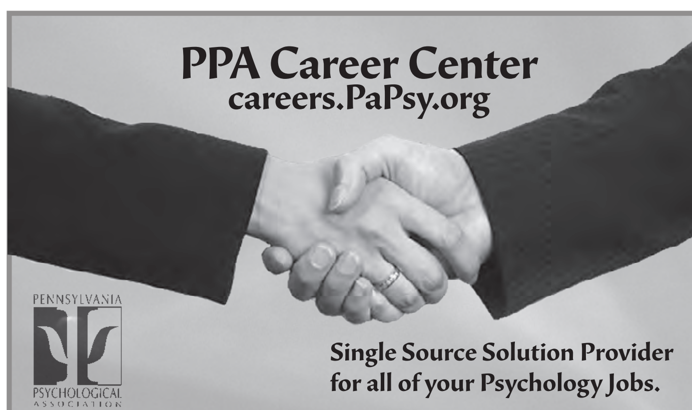

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