# Geropsychology Training in a Specialist Geropsychology Doctoral Program

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**ABSTRACT.** The first PhD specialty program in Geropsychology that launched in fall, 2004 at CU-Colorado Springs is described. Consistent with a scientist-practitioner model, the curriculum sequence builds systematically from basic to complex knowledge and skills across the domains of scientific psychology, research methodology, general clinical, geropsychology science, and clinical geropsychology. Practicum experiences also build skills in core clinical competencies needed by geropsychologists, including assessment, psychotherapy, neuropsychological evaluations, caregiver consultation and counseling, health psychology, and outreach/prevention. Research mentoring prepares students with the skills needed to conduct independent research useful to the clinical practice of geropsychology. Challenges faced in the process of developing the program include the development of a training clinic, balancing specialty

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and generalized training, building a specialty culture while maintaining faculty integration, attracting faculty and students during a start-up phase, and defining an identity within the field. The mental health services center that was launched to meet training needs while addressing a services niche in the community contributes substantially to the essence of this program, and is described in some detail. Future opportunities and challenges include program funding, heavy demands of specialty training on top of generalist training, maintaining congruence between expectations of clinical and non-clinical faculty, providing interdisciplinary experience, and expansion of practicum opportunities. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2005 by The Haworth Press, Inc. All rights reserved.]*

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The new program launched in fall, 2004 at CU-Colorado Springs represents the first Geropsychology PhD specialty training program at the doctoral level in the United States. Other specialty programs exist that focus on other populations (e.g., children) or skills (e.g., neuropsychology). For the field of aging, however, this is a first. In this article, we describe the rationale for the program, the training model, and challenges and opportunities embraced by this model. We conclude with future goals for the program.

## *WHY BUILD A SPECIALTY PROGRAM IN GEROPSYCHOLOGY?*

The emergence of specialty programs requires demonstration of both demand and disciplinary maturity to warrant the recruitment and training of clinicians devoted to particular populations at the doctoral level. All of the training models described in this Special Issue are a response to the current dramatic demographic aging revolution which culminates in the aging of the Baby Boomer population, a group expected to consume health care at a higher rate than any previous cohort. Client demand for geropsychologists' services can be calculated by multiplying the number of older adults by the percentage that need mental health services, estimated at 20%-28% (Gatz & Smyer, 2001; Halpain, Harris, McClure, & Jeste, 1999). Although that statistic may be inflated by including people who need, but will not access mental health services, the discrepancy between the projected need and the existing workforce is staggering.

Nationally, the number of psychologists who devote a maximum of half time in their practices to older adults is between 200 to 700 of 76,000 active clinical psychologists (Gatz & Finkel, 1995). Of that small number, less than one-fourth have specialty training to work with older adults. The typical practicing psychologist provides services to fewer than two older adults per week with a combined ability to meet less than 60% of current demand (Qualls et al., 2002). The American Psychological Association estimates a need for 5,000 full-time doctoral level geropsychology practitioners by 2020. Their estimate is based on the assumption that only 10% of the elderly population will receive services (as opposed to all those who need them, which would require 14,000 full-time equivalent psychologists by 2020) (Halpain et al., 1999). A recent evaluation of the geriatric mental health professional workforce by leaders in the main disciplines (psychiatry, psychology, social work) recommended strongly that incentives be increased to draw people into specialty training in geriatric mental health because of the projected crisis (Halpain et al., 1999).

The field has identified clearly the need for additional training programs to produce geropsychologists. Two training conferences on geropsychology (in Boulder in 1980 and in Washington D.C. in 1992) that were sponsored by the APA, major foundations, and the Public Health Service recommended curriculum for specialized training programs (Knight, Teri, Wohlford, & Santos, 1992; Santos & VandenBos, 1982). Additionally, the education committees of two divisions of the APA summarized their needs assessment of training opportunities by stating that specialty training programs are needed to produce the next generation of geropsychologists (Gatz, Eisdorfer, & Kaszniak, 1991; Zarit et al., 1990).

A second component of demand is student interest and availability. Existing tracks within clinical training programs at other universities report having far more applicants than they can enroll, as is typical of clinical doctoral training programs. Demand is well documented by institutions that have a separate application pool for admission into an aging track within clinical psychology (e.g., University of Southern California and Washington University at St. Louis). Although they report a lower number of applicants to those tracks than to their general programs, the demand is solid (6:1 applicant:acceptance ratio) and their placement rate is excellent.

The maturity of the discipline is another key indicator that a specialty program in Geropsychology was appropriate to develop. Several facts demonstrate that geropsychology is a well established field of study. The Adult Development and Aging division within the APA recently celebrated its 50-year anniversary. A large number of journals and handbooks are available within the field, as are specialty organizations that sponsor conferences and publications. Indeed, psychologists have been among the pioneers in the field of gerontology and have contributed significant basic and applied research

findings on patterns of pathological, normal, and successful human aging. Examples of particularly important findings include the well documented declines in cognition and memory with advancing age, the increased probability of cognitive disabilities due to vascular disease and Alzheimer's disease, evidence for the interaction between emotional processes and chronic medical disorders, the importance of maintaining a sense of control and autonomy even in advanced old age, and effective treatments for older adults with depression, anxiety, and other mental disorders.

The training background that qualifies a practitioner to work with older adults has been specified in a report of the Interdivisional Task Force on Qualifications in Geropsychology that was approved by APA Council in 2003 (APA, 2004). In 1998, the APA approved the recognition of Clinical Geropsychology as a proficiency area that warrants its own credentialing. A degree in a specialty program was discussed as one of the mechanisms by which one would demonstrate competence. The President of the APA in 1997-98 selected the Psychology of Aging as the focus of his presidential initiatives which included the establishment of a standing Office (and Committee) on Aging within the organization and the development of practice standards in specific areas (e.g., assessment of memory problems).

The idea of a specialist Geropsychology doctoral program arose at CU-Colorado Springs over 20 years ago, prior to any of the authors' involvement with the program. Faculty who were not specialists in aging correctly recognized that the aging of the population would generate increased demand for psychologists who would commit to serving older adults. The initial vision was also shaped by two political realities. First, with excellence in training and research as the priority, a focused area for specialization made sense for a small department. The faculty recognized that a growing campus would be able to support excellence in a focused area, but would be decades away from being large enough to support excellence in the range of major subdisciplines of psychology that are represented in many graduate departments. The second reality was idiosyncratic to the state of Colorado where program approval requires new graduate programs be non-duplicative of existing ones in the state. A specialty program in Geropsychology addressed a growing need that was not being addressed by anyone else in the state and region, and could be offered with excellent depth in a relatively small department.

## *A TRAINING MODEL FOR A SPECIALIST DOCTORAL PROGRAM*

The Scientist-Practitioner model is the foundation for the design of this program, so subsequent discussion presumes the selection of that model of training. Specifically, the goal of the CU program is to produce clinical

psychologists who will provide leadership in delivering services, training, and scholarly research in clinical geropsychology. The program is designed to provide broad-based training in clinical psychology (general clinical skills, basic scientific foundation knowledge, and research methodology), and supplemental specialized training in geropsychology. Functionally, the geropsychology training serves as a required minor for all students. Training tools include curriculum design, clinical practica, research laboratory training, and professional development opportunities. Each is discussed below, including an outline of the operational plan and challenges faced in implementing it to date. Program requirements are designed specifically to meet standards for accreditation by the APA. Consultants provide regular feedback on the alignment of this program with accreditation standards and guidelines.

### *Research Training*

Consistent with the scientist-practitioner model, all students are engaged in ongoing work in a faculty laboratory throughout their participation in the program. A rigorous empirical MA thesis and PhD dissertation of original scholarship are required. Both projects involve student presentation of proposal to a committee of faculty, and defense of the final product before the same committee in an oral examination. Faculty all have active research programs, the majority of which receive external funding. Student projects typically integrate with the mentor's ongoing research program, but are characterized by increasing creative autonomy at more advanced levels, culminating in a relatively independently derived dissertation. The research culture is enriched by a research colloquium series sponsored by the Gerontology Center to which doctoral students are expected to contribute presentations and attend all lectures. The series includes nationally renowned experts in a range of topics within psychology that are relevant to aging processes (e.g., health psychology, neuroscience, medicine).

### *Curriculum Sequencing*

As seen in Table 1, the psychology foundations portion of the curriculum includes a required 3 course research methodology sequence and research proseminar, proseminars in substantive areas of psychology (including biological, social, cognitive, and developmental bases of behavior), and a class in the history of psychology. Advanced electives are available in specialty topics, research methods, and statistics. Simultaneously, students are working in the laboratory of a research mentor. Very limited electives are available, because students have significant clinical coursework and practicum work, as

TABLE 1. Course Sequence for PhD in Clinical Geropsychology

| Year | Fall | | Spring | | Summer |
|---|---|---|---|---|---|
| 1 | Statistics/Methods I | | Statistics/Methods 2 | | Thesis |
| | Clinical Skill Lab | | Assessment 1: Cognitive | | Clinical Practicum |
| | Psychopathology | | Psychotherapy | | Clinical Neuropsychology Assessment |
| | Psych Aging 1 | | Psych Aging 2 | | |
| | | | | | |
| 2 | Professional Development 1: Ethics and Standards of Clinical Practice | | Professional Development 2: Cultural and Family Systems | | Clinical Practicum |
| | Assessment 2: Diagnostic Interviewing and Personality | | Multivariate Research Methods | | Dissertation |
| | Social Proseminar | | Developmental Proseminar | | |
| | Clinical Practicum and Clinical Neuropsychology Lab | | Clinical Practicum and Clinical Neuropsychology Lab | | |
| | | | Research Practicum | | |
| | | | | | |
| 3 | Clinical Geropsychology 1: Settings and Contexts of Practice | | Clinical Geropsychology 2: Assessment and Treatment | | Clinical Practicum |
| | Clinical Practicum | | Clinical Practicum | | Dissertation |
| | Cognitive Proseminar | | Biological Proseminar | | |
| | Research Practicum | | COMPREHENSIVE EXAM | | |
| | | | | | |
| | | | | | |
| 4 | History of Psych | | Pharmacology | | Dissertation |
| | Clinical Practicum | | Clinical Practicum | | |
| | Methods/Design for Analyzing Change (elective) | | | | |
| | Dissertation | | Dissertation | | |

well as aging coursework that functionally create for them a minor in Adult Development and Aging.

Consistent with a scientist-practitioner model, students are trained in the core knowledge of the broad clinical discipline during their first two years. Courses in assessment provide training in evaluation of cognitive functioning, personality, and psychopathology, including psychometrics. The psychotherapy course provides an overview of various models with a focus on empirically validated intervention methods. The psychopathology class provides an overview of diagnosis, classification, assessment, and treatment of mental disorders across the lifespan.

The clinical program focuses on professional and clinical skill development through a sequence of courses (see Table 2), through the specific assignments within our courses, practicum placements, and professional development activities. The goal of the curriculum is to move the student from the role of student to that of a clinical geropsychology professional. The curriculum begins with the basic building blocks of counseling skills and moves students progressively through more complex skills in multiple domains. The sequence culminates in a clinical comprehensive evaluation, advanced clinical placements, and a clinical internship in geropsychology.

The specific clinical curriculum builds skills systematically in each major category of skills required by clinical psychologists. As depicted in Table 2, the courses that contribute to each domain lead to development of particular skills. The domains include Clinical Interviewing Skills, Assessment Skills, Case Conceptualization, Intervention Skills, and Professional Functioning. For example, in our clinical skills lab course students learn micro-counseling techniques, clinical interviewing, case conceptualization, intervention skills, and professional development. We continue this in subsequent courses such as the psychotherapy class where students are required to conceptualize cases, develop treatment plans, and conduct clinical interviews based on the case material. This promotes further development in a number of domains including the micro-counseling skills, interviewing techniques, case conceptualization abilities, and working in a professional role. Upon completion of the basic core courses in clinical training, students progress into more advanced courses that focus on integrating psychotherapeutic theory and counseling skills. Students apply the skills learned in courses on clinical interviewing and psychological assessment in their clinical practicum.

Building on foundational courses in the psychology of adult development and aging during their first year, advanced training in clinical geropsychology extends these basic skills into specialization skills with older adults. The clinical geropsychology sequence covers conceptualization of aging client cases in the context of service network, housing, and health systems as well as specific

TABLE 2. Curriculum Building-Block Model Knowledge and Skills by Domain and Course

| Courses | Skills |
|---|---|
| | **Clinical Interviewing Skills** |
| Clinical Skills Lab | Basic listening skills<br>Interviewing skills: paraphrasing questioning, confrontation |
| Clinical Interviewing/ Personality Assessment | Directed interviewing<br>Mental status evaluation<br>Social history |
| Psychotherapy | Interviewing in different theoretical frameworks |
| Clinical Practicum | Clinical interviews with clients |
| | **Assessment Skills** |
| Cognitive Assessment | Framing the assessment problem, choosing tests, administering and scoring tests, interpreting and conceptualizing data, report writing |
| Neuropsychological Assessment | Choosing tests, administering and scoring tests, interpreting and conceptualizing data, integrating findings from multiple tests, feedback in writing and orally |
| Clinical Practicum | Assessment of psychopathology, cognitive impairment, family systems, community systems |
| Clinical Interviewing and Personality Assessment | Objective assessment of personality and psychopathology, integrating testing results with clinical interview, report writing |
| | **Case Conceptualization** |
| Clinical Skill Lab | Conceptualizing information from behavioral observation and interview analysis |
| Psychotherapy | Knowledge of conceptual frameworks of major theoretical orientations, choosing framework match for client and therapist, conceptualizing cases from selected frameworks |
| Professional Development 2: Diversity | Conceptualizing cases using social/cultural and family systems models, conceptualizing cases from practicum site |
| Clinical Geropsychology 1 –Settings and Contexts | Conceptualizing aging client cases in context of service network, housing, and health systems |
| Clinical Geropsychology 2 –Assessment/Treatment | Conceptualizing aging client cases using major theoretical frameworks and empirical research base, analyzing and evaluating ongoing treatment process with aging clients |
| Clinical Practicum | Conceptualizing cases in clinical practice settings |
| | **Intervention Skills** |
| Clinical Skill Lab | Interviewing skills as interventions |
| Psychotherapy | Linking theoretical frameworks with intervention strategies |
| Clinical Geropsychology 2 –Assessment/Treatment | Intervention strategies for older clients associated with major theoretical frameworks |
| Clinical Practicum | Intervention skills in clinical practicum setting |

TABLE 2 (continued)

| | **Professional Functioning** |
|---|---|
| Clinical Skill Lab | Professional role development; ethics of interviewing |
| Professional Development 1 | Ethics and standards of clinical practice |
| Professional Development 2: Diversity | Cultural and family diversity |
| Clinical Geropsychology 1 –Settings and Contexts | Working in variety of settings relevant to older adults |
| Clinical Practicum | Functioning in clinical setting with appropriate ethics, standards of practice, and clinical skill while using supervision well |

empirically-based diagnostic, assessment, and intervention strategies for older clients associated with major theoretical frameworks.

A clinical comprehensive exam is used as a culminating evaluation of the students' foundational clinical knowledge and skill, taken during the spring semester of the third year. The comprehensive exam and dissertation proposal are required prior to application for internship. A motivated student could potentially complete the program in five years (four years on site and one year of clinical internship), although the national trend reflects longer on-campus training periods.

### *Course Assignments*

Examples of assignments from different courses demonstrate how the different domains of development are addressed. In the psychotherapy class, students are required to write a paper on their development as a psychotherapist. The paper has two sections. The first focuses on what brought the students into the field of psychotherapy, with specific emphasis on (a) the students' development/family history, (b) how they chose to go into the field, and (c) their personality. This section of the paper pushes students to gain greater self-awareness which is critical to becoming a successful therapist. The second section of the paper is a personal "theory" of how people change. This section builds upon the theoretical and practical information covered in the course. Also in this course, students are required to work with multiple cases where they must utilize a specific theory of psychotherapy to conceptualize the case and develop a treatment plan. Role-plays with a mock client for each case allows the cases to come alive for the students emphasizing their

professional role as a mental health professional, rather than the cases remaining an abstract academic exercise.

In the advanced psychopathology course the students gain case conceptualization skills through the use of videos of interviews with clients where the students "staff" the case focusing on differential diagnosis and initial case conceptualization. In a subsequent semester, the clinical interviewing and personality assessment class trains students in more comprehensive case presentations after conducting full initial clinical interviews. Within this course the students also complete a series of role-plays and interviews with undergraduate volunteers. They refine their interviewing skills, and write multiple drafts of intake reports to continue to develop case conceptualization and professional writing skills. Each of these exercises promotes a variety of clinical competencies including clinical interviewing, case conceptualization, intervention knowledge, and professional development.

Key themes that faculty want to emphasize throughout the program are integrated into all clinical courses. Cultural diversity is one important theme that warrants both its own course, and careful integration throughout the curriculum. Professional ethics and standards of practice, therapist self-awareness, empirically supported treatments, and lifespan developmental contexts of aging are also core themes that are introduced in the opening retreat, are covered in depth in particular courses, and cross-cut the entire curriculum.

### *Practicum Experiences*

Clinical trainees have opportunities to train with non-aging populations in a variety of sites in the community and on campus, but much of the training focuses on adults who are mid-life or older. Placement in clinical practica begins in the second year and continues throughout the students' training. The program requires students to provide 8-15 hours per week at their site (number of hours varies across the years) in a combination of clinical activities. In the Professional Development classes students are taught to present a case formally in a presentation format that includes a case conceptualization, treatment plan, and treatment process discussion.

The majority of their clinical geropsychology training is provided by the CU Aging Center (see description of development below), a community based geriatric mental health services clinic run by the Psychology Department in support of this specialty training program. Students begin their training experiences conducting diagnostic interviews and psychotherapy. A neuropsychology rotation trains students in administering neuropsychological tests, conducting collateral interviews, interpreting test data, integrating test data with medical and social reports, writing neuropsychological reports, and conducting feedback sessions. Group psychotherapy is conducted at two sites

(at the CU Aging Center with outpatients, and in a nursing home with residents) by licensed providers, who supervise a student's co-leadership of each group. A caregiver rotation trains students to conduct consultations with family members, counsel family caregivers who are distressed, and coach family caregivers who need assistance implementing care plans. This program is coordinated with a Caregiver Support Center operated by the Area Agency on Aging to provide care planning, a collaborative arrangement that teaches students how to work effectively across agencies and disciplines. Finally, an in-home services rotation links students with two other collaborative agencies (a senior services agency and Goodwill) to provide mental health to frail, disabled adults and their families within the home setting. Advanced practicum students will gain experience in primary and long term care settings that provide experience with multiple health care disciplines.

As with the clinical curriculum, students' practicum experiences are presented in a graded fashion that helps students transition from simpler to more complex clinical challenges. During the initial practicum year, students learn the fundamentals of assessment and treatment. The following years allow students to build on those skills with more challenging cases, more independent functioning with community agencies relevant to clients' lives, and specialized skill development. During the advanced years, students write and present evidence-based practice protocols before their peers. Each student also learns outreach skills by writing an article for a local senior newspaper and offering psychoeducational classes in the community. Advanced students handle more complex cases on the neuropsychology team.

At all levels of training, supervision is very hands-on, with faculty and students working side by side in many of these rotations, and meeting weekly with the rotation team to discuss each case in depth. The demand on faculty is substantial and faculty are credited in the course assignments.

### *Professional Development Activities: Fostering Student/Faculty Interaction*

Activities outside the classroom are designed to mentor students toward developing a stronger and stronger personal identity as a professional clinical geropsychologist. A fall retreat with incoming graduate students sets the stage for helping them understand themselves and their future role as professionals. Faculty use this experience as an opportunity to interact with students in a less formal environment fostering the development of trusting mentoring relationships. Retreats during the professional development course also provide opportunities for structured interactions that allow students to question and evaluate their future role as a psychologist. Specific team building exercises are interspersed throughout the retreats to

foster a supportive group atmosphere that allows students to take greater risks in their own personal development as clinical professionals. In addition, activities are provided that give students opportunities to talk about their concerns and needs from peers and faculty (e.g., how to receive feedback, how to identify and seek out the kind of support they need) as they work toward becoming a mental health professional.

### *Clinical Comprehensive Evaluation*

As a culminating clinical experience we have adopted a Clinical Comprehensive Evaluation. Students are required to analyze a clinical case involving an older adult, including results from personality, cognitive, and/or neuropsychological assessments; pharmacological information; psychopathology issues; and basic psychotherapeutic conceptualization. In addition, students demonstrate clinical interviewing ability by submitting a video-tape of a therapy session with a written analysis of the client, their framework for the work, and an analysis of the empirical foundation of their approach. The primary purpose of this exam is to critically evaluate the students in order to identify difficulties that need remediation (i.e., a gatekeeper function) prior to internship. Secondarily, the comprehensive exam performance is reviewed by faculty to determine whether the curriculum is building competence consistent with the goals of the program. This portion of the comprehensive exam compliments the exam over the broader knowledge base of the discipline.

### *Teaching Experience*

Students have the option of taking a seminar in "How to Teach More Effectively" and serving as a teaching assistant. Faculty frequently engage doctoral students as guest lecturers in their areas of expertise. Advanced students have the option of fully teaching an undergraduate class under the mentorship of a faculty member. Additional opportunities to learn about teaching include mentoring within the vertically organized lab teams many faculty oversee, clinical supervision training for advanced students, and offering psychoeducational classes to the general public.

### *Program Infrastructure*

Implementation of this new program required significant resource investment from the university. In addition to the existing 14 tenure-track faculty lines, two additional lines were allocated to be hired in the first five years. Faculty lines are equally divided between clinical and experimental faculty. Among the entire faculty, six focus their research primarily in aging, and an additional five have a secondary interest in aging processes. The faculty re-

flect breadth in the field, as required to provide curriculum breadth at both undergraduate and graduate levels. All faculty teach in the undergraduate program as well as the graduate program, and all maintain active research laboratories.

The program is administered under the oversight of the Department Chair, the Director of Clinical Training (DCT), and the Director of Graduate Training. The DCT maintains responsibility for admissions, curriculum and practicum experiences, internship application, clinical evaluation, and program accreditation.

## *PRELIMINARY FINDINGS*

Describing a program that is new is fraught with the danger of idealism that has not yet met its reality. The Geropsychology specialty doctoral program has faced challenges in the planning stages that warrant note, if only to assist others in the planning stages.

### *Developing a Training Clinic in the Community*

A crucial component of our PhD program in Geropsychology is the "CU Aging Center" which is the Psychology Department's training clinic in geropsychology. Operating in a senior services complex in the community, the Center has a dual identity as both training clinic and mental health center for the community. Reflecting this shared identity, the mission of the Center is to provide state-of-the-art psychological assessment and treatment services to older persons and their families, to train graduate students in the practice of clinical geropsychology, and to study psychological aging processes. The Center has been operational for five years, training students from institutions around the region, including MA students from our own program.

The Center is intensively integrated into the local community. Indeed, it is a primary referral site for neuropsychological assessments, outpatient mental health services among indigent older adults, and caregivers. Two unique aspects set the Center apart from other local agencies. First, it serves all older adults on a sliding scale basis (e.g., psychotherapy fees range from $5 to $70 per session), or for free under grant funded programs such as the Caregiver Counseling Program that receives funds authorized in the Older Americans Act. Thus, all community members are eligible to receive services without regard to insurance or ability to pay. Second, the Center is rooted in the standards and resources of an academic environment, and thus is able to apply faculty and graduate student expertise and time to provide state-of-the-art services. Steady growth in referrals over its first five years is evidence of a strong linkage between the Center and other community resources for older adults.

The primary direct services offered at the Center are assessment, psychotherapy (individual, couples/marital, family, group), memory and neuropsychological evaluations, and caregiver assessment and counseling. These services are provided by teams composed of faculty (all are licensed Clinical Psychologists), graduate students, and post-doctoral trainees. Like other psychology training clinics, the faculty member is responsible for all clinical services, most of which are implemented by the graduate students. Our shared philosophy is to train students to provide empirically supported assessment and intervention strategies. Students conduct intake evaluations, provide psychotherapy services, conduct neuropsychological testing, provide consultation and counseling to caregivers, participate in supervision sessions, maintain records and other case management tasks, and engage in outreach. The Center has a detailed orientation program for trainees, which is held prior to the rotation.

Several significant challenges were faced in developing the Center, with the most pressing initial ones concerning location and financing. Space on campus was simply not available, especially space accessible to an older adult clientele. We were fortunate to find an excellent location–next door to the local Senior Center (which serves approximately 8,500 older adults each month) in a city-owned human services complex that has several other "senior service" businesses. This complex is also centrally located and has ample parking. Moreover, because we are next door to the Senior Center, transportation is enhanced because of easy bus access (both city buses and many senior living facilities provide buses that frequent the complex).

The interior space was renovated to be conducive to a geriatric mental health setting, with a pleasant reception and waiting room area in the front, wheelchair accessibility, rooms with good sound-proofing for privacy, furniture suitable for older adults, several individual therapy/assessment rooms, and one larger group room. To support the research mission of the Center, several rooms were designated as research space for faculty and students engaged in aging research. To support training, an observation area allows trainees and supervisors to observe live psychotherapy or assessment sessions through one way mirrors into two rooms. Video- and/or audio-taping are available in all therapy rooms.

Despite many advantages of our community location, it came at a significant price–namely greater financial resources needed to pay rent for the space. This development required us to engage in the type of fundraising that is not typical of most psychology training clinics. Although the university currently funds faculty time to supervise the students' work, a half-time staff administrator, and pays the lease, there was only funding for faculty supervision and very limited faculty administrative oversight in the initial years. The renovation of space and early operations costs were funded by community organiza-

tions and trusts who shared the mission of providing care to indigent seniors (approximately $100,000 raised during the first three years).

Financing the operations of the Center continues to require significant administrative time and creativity. As a primarily low-fee clinic, services generate a small portion of the overall budget (approximately $20,000 of a $90,000 budget). Services are not eligible for Medicare reimbursement because the trainees cannot be licensed until after completion of their training. A future goal is to add licensed staff that can provide services to Medicare insured older adults. However, a benefit of not receiving third party reimbursement is that the Center can focus on needs that no other agency in the community can address including the mental health needs of uninsured and indigent older adults and model services not traditionally reimbursed (e.g., in-home mental health, family consultation). This mission is congruent with certain local foundations and trusts who have been consistent and enthusiastic financial supporters of the Center.

Outreach and linking with the community are important and ongoing functions of the Center. Outreach services enhance the community by providing support, aiding with prevention, and providing feedback to the Center in order to better serve the mental health needs of our community. In addition, community outreach activities educate community residents and professionals about the mental health needs of older adults and about our services. As part of our ongoing outreach program, several constituent groups have been targeted: older persons, families, health providers (especially geriatricians), senior housing professionals, attorneys and courts, and senior services professionals. We have made numerous outreach and marketing efforts to each of the constituent groups. Since 2000, we have collaborated with a local senior's newspaper to write regular columns on aging and mental health. All trainees at the Center author at least one article for the magazine during their training. We also have strong ties to the Senior Center where we regularly provide presentations about mental health topics to their visitors. We have hosted the National Depression Screening Day for several years. Collaborative relationships with the local senior service providers and Goodwill's home-based program have been funded to provide in-home mental health services for frail older adults. Finally, to promote our services a web site for the Center has been designed and published (*http://web.uccs.edu/agingcenter*).

The evolution of the Center as a training clinic and geropsychology community mental health center has, over a brief span of five years, seen concurrent advancement in community connections and enhanced training opportunities for graduate students. Most notably, several collaborative agency projects have been developed and expanded. With significant support from the community, recent projects have made psychological services available to home-bound older adults in conjunction with agencies providing non-medical

home services. The Center is integral to an ongoing collaborative effort with the local Area Agency on Aging to deliver a comprehensive Caregiver Counseling Program to aging families. The Center has cultivated productive relationships with the probate court, local geriatricians, elder law attorneys, senior care centers, and social service agencies. We are consulting with a community health center project designed to screen and treat depression as part of a thorough medical evaluation that seniors receive at that center. Each of these collaborative community projects solidifies the Center's systemic connections with the local community, affords greater access to psychological services for underinsured and indigent older adults, and creates novel clinical training environments for our graduate students.

Additional growth is anticipated at the Center in the near future, requiring vigilance to ensure proper staff-student training ratios and maintain quality services for community seniors. Currently, two Candidates for Licensure assist with supervision and direct services and psychologist volunteers assist with clinic programming, for which they receive select university privileges. With the start of our doctoral program, the clinical training is shifting to a vertical team rotation model. The continuity of services will be enhanced as select masters students work closely with advanced doctoral students who have already completed one year or more of training at the Center. In addition, we see potential in new collaborative projects where graduate student assistantships may be exchanged for direct services provided by students at the agency site. We view the future of the Center with optimism and we are excited to face the challenges and opportunities that lie ahead.

### *Balancing Specialization and Breadth*

Balancing the focus on general and specialized training has been the focus of many faculty discussions. Foundational training in clinical psychology and the science of the field is critical, regardless of specialty. How much time should be devoted to the specialty, and at what point in the training? We determined to devise a building block approach that would introduce students to fundamentals of scientific foundations, methodology, clinical knowledge, clinical skills, as well as specialty knowledge and specialty skills in a sequential fashion proceeding from the first semester to the dissertation defense and internship. A consequence of this choice is a very intensively structured program that provides thoughtful guidance through a complex curriculum but leaves little choice to the student in electives.

Building a specialty culture in a broad department has also challenged the faculty. There were multiple re-decision points over the years when the broader faculty re-examined the focus on aging. At the root of this issue was the challenge of keeping the entire faculty engaged fully in graduate training.

Several outstanding faculty mentors were not engaged in aging focused work, and thus were concerned about how their contributions to the program would be valued, how they would be able to enjoy the role of mentor, and whether they would end up in a service role to the department, teaching primarily the required undergraduate courses. Our particular solutions for this challenge would not necessarily apply to another program, but essentially involved the principles of mutual respect, commitment to ensuring that the new program's policies hurt no one, and encouragement of collaborative efforts to engage other faculty in aging research at least as a secondary focus of their work. Perhaps most importantly, we committed to maintain our generalist master's program that ensures all faculty of the opportunity to attract and train graduate students.

### *Attracting Faculty and Students During a Start-Up Phase*

Attracting faculty to a future program that is not assured of political approval or accreditation for years after the hire was another challenge for us. We focused on hiring bright new faculty whose values were consistent with building a strong aging program and who had the skills to contribute to the program, once implemented. Truth in advertising also required us to be honest and forthright about what we could and could not promise, a practice which paid off substantially because the faculty were aware of what would be required to succeed in building a new program as well as what their career would look like if the program were ultimately not implemented. Administrative support is key to addressing this challenge, as resources must be allocated for competitive salaries and start-up packages in order to back up the rhetoric about program support.

Criteria for student admission include adequate preparation in psychology, strong GREs, outstanding letters of recommendation, clinical experience and readiness, outstanding GPA, and research preparation. The inaugural class had solid academic credentials (undergraduate GPA of 3.42, graduate GPA of 3.95, and mean GRE scores of 586 Verbal and 630 Quantitative). Three of the five inaugural class members had completed their MA degree in our department, and had demonstrated outstanding knowledge and skills in both research and clinical work. All five entering students had a minimum of one year of clinical and research experience post-undergraduate.

We expect to provide funding for all graduate students during their training, although it cannot be guaranteed. Current students are all funded with fellowships or assistantships provided from a variety of sources. Funding was allocated by the Dean of the college for two research assistantships. Consistent with its mandate to support research on all CU campuses, the Coleman Institute for Cognitive Disabilities contributed fellowships for students whose re-

search focuses on cognitive disabilities in later life. Funded research programs provide research assistantships, and services contracts at the CU Aging Center provide at least one clinical assistantship. The graduate school provides tuition fellowships on a competitive basis as well.

Recruiting students to a program prior to accreditation is certainly a challenge. Students are appropriately wary of the implications of pre-accreditation status to their own professional futures. Full truth in advertising is necessary so initial students understand that the program is likely not to be accredited prior to their graduation. We can only note that we have been blunt about the risks to prospective students, while assuring them that every action we can take to assure our success will be enacted.

### *Defining Identity Within the Field*

Implementing a specialty program in Geropsychology on a campus that is only loosely connected to the CU medical school in Denver (70 miles away) was a challenge that helped us define our expertise. The local success of the CU Aging Center helped us recognize that our distinctive expertise lay in the opportunity to train students for service delivery and research in the community. Many current geropsychologists were trained within a VA or medical school setting and later had to learn the full array of community systems and mental health services that impact older adults. As the focus of this program solidified around our community identity, we became aware of the freedom to work within multiple models that are not always available in settings that operate within the medical model. Simultaneously, we have collaborations that link the CU Aging Center to primary and long term care services as well.

## *CONCLUSIONS AND FUTURE DIRECTIONS*

The emergence of this first specialty program advances the dialogue about the most appropriate ways to provide doctoral level training in geropsychology. Our program has selected a sequential approach to curriculum development in each of the domains of clinical, scientific psychology, research methodology, and geropsychology knowledge, and skill. Graded practicum experiences within the CU Aging Center compliment this approach. Outside activities are designed to maintain a culture of supportive challenge for students at all levels of training. Although we believe we will be successful, our success in training remains to be judged by the field and we eagerly await constructive feedback from our peers.

Even at this early stage, we are keenly aware of challenges and opportunities ahead. Funding a new graduate program at this moment in the history of higher education's battle with state budget cuts is challenging, at best. Ad-

ministrative intentions to support new programs must be backed up with strong space and funding commitments. Faculty and department-level administrators (chair, directors of graduate and clinical training) are likely to be asked to maintain a particularly heavy financial responsibility for student support, through grants, contracts, and private fundraising efforts. The heavy coursework and practicum demands of the program provide strong foundational knowledge and skills but leave students with less time for the laboratory than will be desired by some students and some faculty. In particular, nonclinical faculty who mentor the research component of the program will have to adjust their expectations for these clinical specialists who have less time available for lab work than a typical student in experimental sub-disciplines. Exposing students to interdisciplinary health training settings, or at least the foundational knowledge to participate well in those settings on internship, is a challenge outside of a medical school or hospital setting. However, within our community-focused model, we are positioned to train students to work effectively with physicians, nurses, social workers, care managers, housing administrators, and social service providers from diverse community settings. Opportunities for clinical service development at the CU Aging Center abound, constrained primarily by time, space, and funding. Students will benefit from new rotations that are in development in primary care, rehabilitation, minority outreach, and nursing home settings. Future rotations could also include guardianship mediation services and inpatient hospital settings.

Faculty interested in developing a specialty training program will likely find the process rewarding and fraught with unforeseen challenges. Our excitement continues to grow with each new challenge of bringing this program into creation. We found the guidance of our predecessors to be invaluable, and publicly want to acknowledge the very useful suggestions and support of Norman Abeles, Margaret Gatz, Bob Knight, Forest Scogin, and especially Martha Storandt, over many years. We look forward to sharing our experiences as well, to whomever may find them useful in launching the next specialty programs, and continuing to dialogue about training models.

## REFERENCES

American Psychological Association (2004). Guidelines for psychological practice with older adults. *American Psychologist*, *59*, 236-260.

Gatz, M., Eisdorfer, C., & Kaszniak, A. (1991). Recommendations to Division 12 on the kind of education and training experiences needed by clinical trainees in order to be competent to work with older adults. *The Clinical Psychologist*, *44*(3), 37-38.

Gatz, M., & Finkel, S. I. (1995). Education and training of mental health service providers. In M. Gatz (Ed.), *Emerging issues in mental health and aging* (pp. 282-302). Washington, D.C.: American Psychological Association.

Gatz, M., & Smyer, M.A. (2001) Mental health and aging at the outset of the twenty-first century. In J. E. Birren & K. W. Schaie (Eds.), *Handbook of the psychology of aging* (5th edition). San Diego, CA: Academic Press.

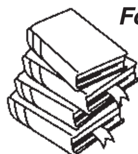
Halpain, M. C., Harris, M. J., McClure, F. S., & Jeste, D. V. (1999). Training in geriatric mental health: Needs and strategies. *Psychiatric Services*, *50*, 1205-1208.

Knight, B. G., Teri, L., Wohlford, P., & Santos, J.(Eds.) (1995). *Mental health services for older adults*. Washington, D.C.: American Psychological Association.

Qualls, S. H., Segal, D. L., Normans, S., Niederehe, G. N., & Gallagher-Thompson, D. (2002). Psychologists in practice with older adults: Current patterns, sources of training, and need for continuing education. *Professional Psychology: Research and Practice*, *33*, 435-442.

Santos, J. F., & VandenBos, G. R. (1982). *Psychology and the older adult: Challenges for training in the 1980's*. Washington, D.C.: American Psychological Association.

Zarit, J. M., Zarit, S. H., Hartman-Stein, P., Frazer, D. W., Knight, B., & Teri, L. (August, 1990). *Training in clinical geropsychology*. Report of the Division 20 Education Subcommittee on Clinical Practice and Training. Washington, D.C.: American Psychological Association.



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