Elizabeth A. Mulligan, PhD
Professional Self-Study Statement
October 11, 2014

A. Professional Activities

I am currently employed as a staff psychologist in an outpatient Geriatric Mental Health Clinic at the VA Boston Healthcare System. I also hold an appointment as an Instructor in the Department of Psychiatry at Harvard Medical School. I applied for this position when it became available during my fellowship year and I became a staff member in September 2012.

In my position I divide my time between direct clinical service and supervision of trainees providing direct clinical service (70%), administration (10%) and researching and teaching (20%). Within the domain of assessment, I complete psychodiagnostic evaluations for veterans over the age of 65 with a variety of presenting issues including but not limited to depression, anxiety, PTSD, grief, adjustment-related issues, behavioral health concerns, caregiver strain, relational distress, cognitive concerns, and other psychosocial challenges. I am especially attuned to assessing for various types of risk within this population (e.g., suicidality, financial exploitation, self-neglect). When indicated, I conduct cognitive screens and refer for more comprehensive neuropsychological evaluations if necessary. I also complete capacity evaluations at times. Within the domain of interventions, I provide individual, couples/family, and group psychotherapy that is patient-centered and evidence-based, drawing from cognitive behavioral therapy, interpersonal therapy, problem-solving therapy, values-based interventions, and life review among others. Consultation is an integral part of my job. As a member of an interprofessional Geriatric Mental Health Team, I regularly consult with other team members (e.g., Psychiatry, Social Work) for the purpose of treatment planning and care coordination. On a case-by-case basis I collaborate with various other providers within the VA system (Primary Care, Suicide Prevention, Neurology, Speech Pathology, Sleep Clinic, etc.) as well as family members and community resources including Elder Services. I also supervise 3-4 geropsychology interns and fellows each year as they provide assessment, intervention, and consultation services in this setting.

My administrative responsibilities include serving as the Track Coordinator for Geropsychology Training at VA Boston. In this role, I oversee training at the internship, fellowship and practicum levels, organize the efforts of the 6 other faculty members who serve as supervisors, and co-coordinate a weekly Geriatric Mental Health Seminar for trainees and interdisciplinary staff members.

My research and teaching responsibilities include serving as a collaborator on a team that is focused on investigating the broad spectrum of rehabilitation needs among cancer survivors. I teach a yearly course for psychiatry residents at Harvard Medical School that is a combination of education regarding cognitive behavioral therapy and group supervision in these techniques. Additionally, I present multiple invited lectures on aging-related and early career-related issues both locally and regionally each year.

I have utilized the Pikes Peak Tool at multiple points throughout my training and early career. I find it incredibly helpful for identifying areas for further growth and for tracking my development as a geropsychologist over time. At present, I rate myself as proficient across most domains. I am not exposed to issues related to insurance on a regular basis given my VA position so I consider myself advanced in the ability to “practice appropriate business of geropsychology,” but I try to stay up-to-date by reading relevant materials that are distributed via aging-related listservs. I also rate myself as advanced in my ability to “implement organizational change” due to less experience in this area and would seek out mentorship if needed. I believe I am striving towards “expert” ratings in domains related to using evidence-based treatment for older adults as I continue to gain experience in this area and participate in continuing education opportunities.

Seeking board certification in geropsychology is appealing to me for several reasons. First, I am very grateful to leaders in the field for their tireless work delineating core competencies and establishing geropsychology as an area of specialty, and I want to support these efforts by participating in the process. Second, I believe being evaluated by experts in the field is an important way of solidifying my own knowledge and experience while identifying possible areas for growth. Third, I believe the process of board certification can serve as an important mechanism for ensuring quality of care for the many older adults we serve. Fourth, as someone who cares deeply about training, I believe that ABGERO will serve as one way for students to know that they are receiving high-quality geropsychology supervision. Finally, I believe the board certification process may make it easier to describe the value of specialized training in geropsychology to members of other disciplines that have similar specializations.

B. Professional Development

Like many people in the field of geropsychology, I was influenced by strong older adult role models, namely my grandmothers. They were incredibly different people. My maternal grandmother was quite conservative and insisted on wearing a suit every day to pick me up from school, while my paternal grandmother was known for her loves of George Carlin and Andre Agassi. However, they were both resilient in the face of the deaths of their husbands at relatively young ages, devoted caregivers for their own mothers when they became ill, and models for the value of remaining active in later life. In high school, I happened upon a volunteer position at the "Senior Supper Club," which involved serving low cost meals to community-dwelling older adults on a weekly basis for almost 2 years. This was by far my favorite volunteer position, primarily because of the incredible stories the patrons shared with me. Around the same time, I took AP Psychology and I found it absolutely fascinating. I was hooked on studying the mind and human behavior.

I entered Williams College as an undergraduate with a plan to major in psychology and to complete all of the requirements for medical school. I had a loose idea that I might want to be a psychiatrist. A series of experiences shaped my eventual path to graduate school in clinical psychology including: (1) After taking a clinical neuroscience course with Dr. Paul Solomon, I designed an independent study course under his direction that involved conducting psychometric assessments at The Memory Clinic in Bennington, Vermont and organizing community memory screening days; (2) After taking an abnormal psychology course with Dr. Laurie Heatherington, I was hired as a research assistant for her studies on family relationships; and (3) I spent two months in London working at Mosaic Clubhouse, a recovery-based facility offering people with serious mental illness vocational, educational, and social opportunities. As I sat down and opened up MCAT preparation book my senior year, I realized it was time to seriously reevaluate my future goals. With the help of excellent mentorship, I applied to a number of graduate schools in clinical psychology with aging, health psychology, and neuropsychology focuses. I was instantly drawn to Dr. Brian Carpenter's laboratory at Washington University in St. Louis because he was investigating both the psychosocial consequences of receiving a dementia diagnosis and family relationships. I was delighted when I was accepted into this program.

My time at Washington University in the Clinical and Aging and Development tracks solidified my interest in aging and introduced me to the idea of identifying myself as a geropsychologist. I completed extensive geropsychology coursework that covered topics ranging from cognitive aging to ethical and legal issues in late-life. My classes provided me with a comprehensive biopsychosocial framework for thinking about my clinical work and research with older adults. I sought out clinical practica in multiple settings, including palliative care and geriatric units at a VA, an inpatient rehabilitation hospital, and an outpatient clinic. Across these settings I learned from supervisors with varied clinical orientations and conducted individual, couples, and group interventions with clients who were diverse in terms of their backgrounds and presenting problems. I also sought out clinical research experiences that allowed me to

improve my assessment skills by conducting standardized neuropsychological testing and structured diagnostic interviews. I was supported and encouraged to challenge myself by Brian as I developed my research interests in how late-life illness and disability affect individuals and their families, culminating in a dissertation focused on the assessment of predeath grief among family caregivers of people with dementia. Brian also introduced me to the community of geropsychology by encouraging me to join organizations such as GSA and 12:2 and to present at conferences. During this time, I also watched as both of my grandmothers declined both in terms of their health and their functional abilities and eventually passed away. Witnessing their declines as well as my parents' struggles during this time period was difficult and sad, but it reaffirmed my passion for working with older adults.

I applied almost entirely to VA medical centers for internship because of both the excellent training and career opportunities for geropsychologists and my fascinating practicum experience that highlighted the unique challenges and resilience factors within the veteran population. I felt incredibly fortunate to match to the Geropsychology primary rotation at the Boston Consortium as well as to have the opportunity to stay on as a Geropsychology postdoctoral fellow the following year. I have grown immensely since I entered internship just over 4 years ago. I credit this growth to being challenged and nurtured by a variety of knowledgeable supervisors during my time here and to internship and fellowship programs that were carefully designed to give me assessment, intervention, and consultation experiences in various settings across the continuum of care for older veterans (e.g., outpatient geriatric mental health, Community Living Center geriatric neuropsychology, Home-Based Primary Care, and inpatient geropsychiatry). I was encouraged to build confidence in existing skills and to stretch myself with less familiar patient populations, interventions, and competencies (e.g., supervision). I was also able to seek out training opportunities in PTSD and substance use disorder clinics that enable me to provide better care to the variety of older adults within the VA system. I was supported as I took an active role on various interprofessional teams and as I became a collaborator on a research team dedicated to identifying the broad spectrum of physical, social, and psychological needs of cancer survivors. Perhaps most importantly, I was surrounded by people whose passion for geropsychology and whose deep commitment to training and service to this field were contagious, especially Jenny Moye and Michele Karel.

I attribute my current position in part to fortuitous timing. Michele Karel accepted her VA Central Office position as I was beginning my fellowship and confirming that my true passions within geropsychology include the provision of evidence-based mental health interventions to older adults and training the next generation of psychologists and other mental health providers in this area. I am acutely aware of the legacy of training at VA Boston and feel a personal responsibility to maintain the quality of this training program and to contribute to the field of geropsychology more broadly.

C. Services to the Profession

I have been a student member/member of the Gerontological Society of America since 2005 and APA's Society of Clinical Geropsychology since 2006. I attend GSA consistently and regularly present on topics related to coping with late life illness and disability. I have served as a reviewer for *Clinical Gerontologist, Journal of Gerontology: Psychological Sciences, American Journal of Alzheimer's Disease & Other Dementias*, and *Psychology and Aging*, often in collaboration with my mentors.

Initially, I gravitated towards service opportunities on the local level, including positions on the Clinical Studies Committee and the Psychology Graduate Student Association during my time at Washington University as well as positions on the Brockton VA Training Committee and the Intern Seminar Curriculum Committee during my training at VA Boston. Through mentorship and self-reflection, I recognized that I wanted to develop a professional identify that incorporated service more broadly to the

geropsychology community. Fortunately, I have had the opportunity to serve on the Council of Professional Geropsychology Training Programs (CoPGTP), first as the internship member-at-large and now as secretary. This has been an incredibly valuable experience that has allowed me to work with leaders in the field who are grappling with issues including delineating core competencies for working with older adults in varied settings and developing methods for expanding the geropsychology workforce. As an early career psychologist, I am extremely grateful for the work of my mentors and other leaders who are responsible for many initiatives that have helped to define and expand the field of geropsychology. I believe it is my responsibility to build upon this work via service to the field.

Finally, I consider teaching to be a service activity. Given the shortage of providers with specialized training in geriatric mental health described in the 2012 Institute of Medicine Report, I believe it is important to educate psychologists and other mental health providers on this topic. I have presented multiple invited lectures on aging-related issues for interdisciplinary audiences at both local and regional levels. In addition to my role co-coordinating the weekly Geriatric Mental Health Seminar for trainees and interdisciplinary staff members, I also infuse geropsychology-related information into the cognitive behavioral therapy course I co-teach for psychiatry residents. Additionally, I co-authored a section with Michele Karel for the upcoming Encyclopedia of Mental Health on mental health and aging. I hope to expand upon this work in the future.

D. Continuing Education

CE Lectures Provided in Past Five Years (APA-approved)

06/01/12	Resolving Clinical Dilemmas in Complex Capacity Cases Capacity and Geriatric Neuropsychology Rounds VA Boston Healthcare System
9/12/12	Capacity Assessment and the Guardianship Process as Opportunities for Collaboration Capacity and Geriatric Neuropsychology Rounds VA Boston Healthcare System
9/27/12	PTSD and the Aging Process: WWII, Korea, & Vietnam Vet Center Training Mystic, CT
11/23/13	The Social Intrusiveness of Side Effects of Cancer and their Associations with Depressive Symptoms Symposium presented at the annual meeting of the Gerontological Society of America New Orleans, LA

CE received* (APA-approved)
***Please note that this list reflects CE credits for the approximately 2 years since I obtained licensure.**

ACTIVITY TITLE	**Location**	**Date**	**# CE**
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	10/3/12	1
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	11/7/12	1
65th Annual Scientific Meeting of the Gerontological Society of America	San Diego, CA	11/14/13-11/18/13	13
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	12/14/12	1
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	1/9/13	1
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	2/6/13	1
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	3/6/13	1
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	4/3/13	1
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	6/5/13	1
Emerging Perspectives in Classification: DSM-V, RDoC, and Developments in Diagnosis	VA Boston Healthcare System	7/24/13	6
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	8/7/13	1
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	10/3/13	1
66th Annual Scientific Meeting of the Gerontological Society of America	New Orleans, LA	11/20/13-11/24/13	11
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	12/4/13	1
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	1/8/14	1
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	3/7/14	1
Multicultural Considerations in Neuropsychology	VA Boston Healthcare System	3/20/14	1.5
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	4/2/14	1
Capacity and Geriatric Neuropsychology Rounds	VA Boston Healthcare System	5/7/14	1
Total			**46.5**

E. Scientific Base

As noted above, my current staff psychologist position at VA Boston primarily involves direct clinical care including psychodiagnostic assessment, brief cognitive screens, and individual, couples and group psychotherapy as well as supervision of trainees as they provide clinical services. This work is strongly influenced by my clinical science training at Washington University.

I view myself as an evidence-based, integrative psychotherapist. When presented with a new patient, I use a combination of validated self-report measures and other assessment devices as needed (e.g., GDS, GAI, PCL, CAPS) as well as more unstructured methods. When indicated, I also gather information from other sources, including members of the interprofessional team and family members with the patient's consent. This approach helps me with the process of differential diagnosis and provides me with knowledge about each particular patient's unique challenges, areas of strength, and biopsychosocial resources. I tend to conceptualize patients from a lifespan developmental, biopsychosocial, and cognitive behavioral framework.

I then work collaboratively with each patient to develop and prioritize treatment goals. I provide the patient with psychoeducational information about specific interventions that may be helpful given their goals, the relevant research literature, and their individual values, resources, and challenges. My treatment plan flexibly evolves based on input from the patient and from ongoing assessment. Although I lead with behavioral interventions with many patients, I often weave in cognitive, interpersonal, values-based, problem-solving and/or mindfulness-related interventions as indicated. When I encounter less familiar patient populations, I actively seek out information in the literature (GeroCentral is always a great place to start) and consult with colleagues. I also believe in the value of case management and of thinking about the range of VA and community resources that may be helpful for patients and their family members.

When providing supervision to geropsychology interns and fellows and psychiatry residents, I believe a key part of my role is to help each trainee develop their own style as a therapist. I strive to be a source of information on the evidence-based literature and to maintain my own knowledge by regularly attending conferences, participating in other CE activities, and keeping up to date on relevant journal articles. I also encourage trainees to stretch themselves by gaining exposure to less familiar types of interventions. I find that some of the most interesting conversations in supervision involve discussing how to adapt existing interventions to the variety of patients within our clinic, including patients with cognitive and/or medical comorbidities. I try to bring this same spirit of exploring the most current research literature to my role as co-coordinator of our weekly Geriatric Mental Health Seminar.

I believe my clinical science background has also played an integral role in my thinking about innovations within the Geriatric Mental Health Clinic. Over the past 2 years, I have spearheaded an effort to offer time-limited groups that specifically address common presenting issues in this population on a more consistent basis. We currently offer 6 time-limited, evidence-based groups: CBT for chronic pain, bereavement, guided autobiography, CBT for insomnia, behaviorally-based stress management, and memory education. I have been responsible for adapting existing materials and/or developing new materials for each group, facilitating or supervising trainees facilitating the groups, measuring their effectiveness, and making changes based on feedback from veterans. This ongoing process is very rewarding for me.

Finally, I remain involved in clinically-relevant research related to how older adults and their family members respond to late-life medical illness. I am currently a collaborator on a team led by Jenny Moye that is investigating the physical and psychological effects of cancer. My roles on this team have included mentoring an undergraduate student, assisting in grant preparation, consulting on questions regarding data analysis, and serving as an author on papers regarding psychological (e.g., PTSD, worry), social, and

cognitive consequences of cancer. I also co-chaired a symposium at GSA in 2013 that focused on presenting findings from various aspects of this project. I am very excited to be a part of this team that is dedicated to identifying the broad spectrum of rehabilitation needs of cancer survivors and developing the tools to address these needs.

F. Ethical Base

I declare that there are no ethical complaints or judgments against me. Grappling with ethical issues is a frequent component of my job. I feel very fortunate that I have the *APA Ethical Principles of Psychologists and Code of Conduct*, state and federal laws, seminal writing about models for negotiating ethical dilemmas, and consultation with colleagues to guide me.

Example #1

My first example is a veteran I currently follow in the outpatient Geriatric Mental Health Clinic, primarily for the purpose of case management and monitoring risk. Mr. P is an 80-year-old, Korean era combat veteran who has been participating in treatment in the clinic since 1998, including faithfully attending a support group for veterans with chronic mental health needs, isolation, and/or a history of risk issues since 2002. His psychiatric history is significant for schizotypal personality disorder and alcohol use disorder in remission. He first came under my care in October 2012 when his group facilitator asked for additional support given her concerns that the veteran was vulnerable to financial exploitation. A fellow under my supervision initially followed him, and he was transferred to my care following that fellow's training-related departure from the clinic. There have been a series of ethical issues that have arisen with this veteran over the past 2 years. In the interest of space, I am going to focus on the veteran's refusal of recommendations including Home-Based Primary Care and a driving evaluation, but I will attempt to place it in the context of previous concerns.

At one point during our treatment, the veteran's son T attempted to contact me to express concerns about his father's cognition and independent living skills. Although the veteran refused a joint meeting with his son, he did sign a release of information for me to speak with him. T's primary areas of concern were related to the state of the veteran's home, including that the veteran was using a fireplace even though the chimney was not clear, that there were mice living in his mattress, and that he continued to drive a 1979 Buick that was in need of repairs. T reported that he had made a series of changes to his father's home over time to insure his safety, but he was feeling frustrated that they would often fight over the nature of these changes. My ability to interpret this report was complicated by several things including: (1) the fact that several providers including myself had filed APS reports on the veteran's behalf regarding potential financial exploitation, verbal abuse, and at least one threat of physical violence perpetrated by T; (2) the veteran's long-standing, documented difficulties with communication including circumstantial and tangential speech and trouble with word finding; and (3) the veteran's long-standing value of being thrifty, with money-saving behaviors including washing his clothes in a bucket in his bedroom and hanging them to dry and bathing twice/week. Fortunately, Mr. P allowed me to gather additional information, first via a cognitive screen (MoCA = 20/30) and then via a referral for a more comprehensive evaluation of his cognitive abilities and his capacity to live independently via the neuropsychological service. They diagnosed him with Cognitive Disorder NOS, with notable impairments documented in processing speed, executive functioning and strengths in verbal recall and confrontation naming. He was determined to have marginal capacity to live independently and referrals for a driving evaluation and Home-Based Primary Care were both strongly recommended. The time that followed was a series of false starts when it came to the driving evaluation and HBPC. At several points during our sessions, the veteran agreed to these referrals, but he later changed his mind and declined to schedule evaluations.

This example reflects the commonly encountered issue of autonomy versus safety and the balance between the general ethical principles of respect for people's rights and dignity with nonmaleficence. The stakeholders in this situation include the patient, his son, and the public (if his driving is in fact impaired, it may be putting others at risk). In our individual interactions, I gathered information from the veteran regarding his perceptions of his driving abilities and his ability to manage various tasks at home. He denied concerns in either of these areas as well as any specific safety issues (e.g., MVAs, traffic violations, missed medications). I also continued to explore the veteran's motivation for repeatedly declining these referrals. His difficulties with communication often made it challenging to understand the veteran's reasoning in these decisions, but it seemed to be related primarily to a combination of his long-standing suspiciousness of his providers, his rigid beliefs about his home and his health, and his belief that HBPC providers would make changes to many of his existing systems (e.g., medication management). Neither gently challenging some of these beliefs nor problem-solving regarding potential solutions (e.g., alternative forms of transportation) were well-received by the veteran.

Throughout this process, I also consulted with colleagues including members of the Geriatric Mental Health Clinic interprofessional team on multiple occasions. I also spoke with VA Regional Counsel regarding policy on reporting to state departments of motor vehicles, which states "a VA health care facility can still report the patient to the State DMV if the patient's driving would be a **serious threat** to the health or safety of the patient or the public. The patient's VA provider must document in VistA/CPRS his opinion and the **compelling circumstances** (e.g., blindness, epilepsy, etc.) that make the patient a serious threat to himself or other drivers if the patient continues to drive a vehicle and coordinate the disclosure with the facility Privacy Officer".

Within the last month, the veteran agreed to the HBPC referral after having a positive experience with a visiting nurse following a medical evaluation, and I have made sure to consult with HBPC providers regarding his past reluctance to agree to this intervention. He continues to drive locally to run errands, although he takes public transportation to his VA appointments. For now, I have decided not to disclose information regarding the veteran's refusal to obtain a driving evaluation to the local DMV in favor of maintaining confidentiality. The veteran's impairments in executive functioning and processing speed are likely affecting his driving. However, I do not believe that his situation has yet risen to the level of a serious thereat to the patient or the public in the absence of additional evidence regarding his driving difficulties (e.g., a MVA or moving violation), especially given that the person most concerned about this issue (T) may be unreliable and have ulterior motives. Admittedly, I experience my own ambivalence at times about the veteran's abilities and if I am striking the right balance between considering autonomy and safety. I intend to continue revisiting this issue periodically during our work together. I have also made the veteran's son aware that he has the right to contact the DMV with his concerns.

Example #2

This example came from my yearlong rotation in the Community Living Center during my fellowship. Mr. Q was a Korean-era Army combat veteran whose psychiatric history was notable for chronic PTSD, panic disorder, depression, and recurrent suicidal ideation with a history of attempts in 2011. He had also been diagnosed with Cognitive Disorder NOS, with notable impairments in attention/working memory and executive functioning and limited insight (SLUMS = 20/30). I followed Mr. Q for therapy and behavioral management throughout my entire fellowship. When we began our work, he had been in long-term care for several years and he was confined to a power wheelchair due to medical issues including an above the knee amputation and obesity.

In early spring, a member of the Nursing staff expressed concern about the veteran's ability to use his power chair safely after she witnessed him attempting to cross a busy intersection near the VA without waiting for a walk signal. In speaking to the veteran, he admitted that he "got excited and did not wait for the signal," but he insisted that he had learned his lesson and that it would not happen again. Some team

members also noted that the veteran had several minor accidents (e.g., bumping into walls) without injury and wondered if his power chair should be taken away for his own protection. Other team members expressed concern about this plan because they noted that the veteran really valued his independence and would be much more limited in a manual chair due to difficulties propelling himself. They also expressed awareness that his mental health symptoms tended to increase when he was less active and pointed out that the frequency of his accidents had actually improved since a behavioral plan related to his driving was implemented several months earlier.

This example also reflects the issue of autonomy versus safety and the balance between the general principles of respect for people's rights and dignity with nonmaleficence. There were clearly multiple stakeholders in the process, including the veteran, members of the team, and other patients (if his unsafe driving was felt to put other patients at risk). Issues included the VA's right to restrict use of equipment that they had paid for and the possibility that the veteran's ability to fully understand, appreciate, and reason through the risks and benefits of continuing to use his power chair was compromised given his cognitive impairment and evidence for poor judgment. After multiple meetings with the veteran, the nurse who witnessed the incident, and the team, ultimately I provided the veteran with a written behavioral management plan that strongly encouraged him to maintain certain precautions such as attaching an orange safety flag to his wheelchair, limiting his travel such that he did not cross the main street without an escort and that he only did so once per week, and not traveling off campus in the dark. In addition, we discussed him completing additional training with OT regarding how to use his wheelchair, and he agreed. The veteran required occasional reminders of the stipulations of the plan, but in general he abided by it for my remaining time working with him.

G. Complex Relationships

Complex relationships are such an inherent part of being a geropsychologist that I admittedly had some difficulty selecting the most appropriate examples to discuss within this application. I could provide various examples that reflect the complicated nature of working with older adults in a biopsychosocial context that considers their living environment, other members of their treatment team, and caregivers/other family members. I could also provide examples of my everyday interactions with caregivers given that I frequently work with veterans in individual and group therapy with mild cognitive impairment and dementia and that many of my patients express a preference for involving their family members in their care. In the end, I chose an example that reflects the potential benefits of involving family members in the treatment process at times and an example that reflects the challenges of being an early career psychologist within the small field of geropsychology.

Example #1:
My first example is a veteran I began seeing in the outpatient Geriatric Mental Health Clinic during my internship. At the time of our initial session, Mr. I was an 82-year-old, married, Filipino veteran who served for the United States in World War II with a history of chronic PTSD. In addition to being a good example of complex relationships, this case also emphasizes the importance of understanding the historical context of a person's life and doing additional reading if necessary. Mr. I was recruited to the Filipino Army at age 14. Since the Philippines was a US Commonwealth during WWII, the US military promised full benefits to Filipinos who volunteered to serve. Mr. I was one of many people who volunteered, but President Truman reneged on this promise when he signed the Recession Act in 1946. Mr. I attempted to seek treatment for his PTSD symptoms in the Philippines in 1964, but he was unable to afford this treatment. After Filipino veterans were finally recognized and provided with additional benefits by President Clinton, the veteran immigrated to the United States in 2000 seeking medical care. His wife followed in 2002, but the rest of their family remains in the Philippines. Prior to our initial encounter, his only mental health treatment was seeing another Geropsychology trainee for 5 sessions

focused primarily on behavioral interventions for improving sleep, mood, and interactions with medical providers, all of which were somewhat helpful.

At our initial session, Mr. I continued to endorse significant PTSD. He described a desire to understand why he was experiencing these symptoms and to feel some relief. He also declined medications at that time due to a concern about potential side effects. Finally, he had a clear drive to tell the story of what had happened to him, as he began providing unprompted details in his initial session. One issue complicating treatment was the veteran's limited ability to speak English. His wife of over 50 years had attended all of his medical appointments in the United States, including the sessions with his previous therapist, as her ability to speak English was more advanced and she was able to assist with translation. I believed that this veteran could benefit from trauma-focused treatment and I was acutely aware that he had been denied treatment throughout much of his life. However, I was concerned about completing trauma-focused treatment with his wife in the room due to concerns about his confidentiality, the often intensely private and emotional experience of recalling information about trauma, and the potential negative effects on his wife's mental health of this vicarious trauma exposure. I attempted to gather information about alternative options including translation services, but they were quite limited and the veteran expressed a clear preference for his wife to attend our sessions. They also both assured me that the veteran had already shared many details regarding his trauma exposure with his wife.

It was incredibly helpful to be able to talk about these concerns with my supervisor and I ultimately decided to offer the veteran a form of modified Cognitive Processing Therapy. Throughout this process, I had individual check ins with the veteran regarding his ongoing thoughts and feelings about having his wife in the room. I also regularly checked in with her regarding her reactions to what she was hearing. Interventions included providing psychoeducational information on common symptoms of PTSD and the idea of PTSD as a disorder of non-recovery. The veteran noted that he was "going and going" for much of his life as a way of distracting himself from traumatic experiences, but had more difficulty doing so over time as he had to "slow down and think of [his] health". As part of the preparation phase of treatment, I encouraged the veteran to continue engaging in coping strategies he found helpful (e.g., regular exercise, prayer) and taught him additional strategies (e.g., relaxation). It was useful to have his wife present for this portion as she often encouraged him to practice these strategies at home. The veteran then wrote a detailed account of his most traumatic event in his native language (Tagalog). In order to increase his access to and expression of his emotions related to this event and allow their natural resolution, I had him read the account aloud in session in Tagalog and then he and his wife provided me with some of the details in English. He also read it aloud to himself on a daily basis for some time. In spite of his language limitations, we were able to challenge some of his unhelpful and unrealistic thoughts related to his concerns about his safety and his sense of esteem. It was also quite helpful to have his wife present as the veteran talked about his thoughts about not being a good father or a good man given his irritability and emotional distance from his family for many years. His wife was able to emphasize that she and his children had forgiven him for this behavior and that they understood it was related to his time in combat. In the end, I believe it was a combination of these interventions and the veteran's increased willingness to talk with a psychiatric provider about potential medications (namely prazosin) that helped him to improve. I am glad I decided to proceed with trauma-focused treatment, but I recognize it was a risk given the potential effects it could have had on his relationship with his wife and on her mental health.

Example #2:
REDACTED FOR CONFIDENTIALITY

H. Individual and Cultural Diversity

I believe that being a sensitive and culturally competent clinician is an ongoing process that includes a combination of exposure to diverse populations, continuous reading and didactic training in this area, an ongoing process of self-reflection, and a healthy amount of natural curiosity.

Admittedly, my thinking about individual and cultural diversity has evolved over time. After living in a predominantly Caucasian, upper middle class New Jersey suburb for much of my life, I completed my graduate school as well as my internship and fellowship training in cities with a large amount of racial, cultural, and socioeconomic diversity (St. Louis and Boston). I have lived in urban and suburban areas each with their own character, but I have been struck by the amount of racial and economic segregation within both metropolitan areas. In addition to obtaining direct experience with varied populations throughout my clinical training, attention was paid to diversity in every course I took in graduate school, ranging from psychopathology to assessment to interventions. However, because our department lacked a specific course on theory, research, and professional issues related to diversity, two other graduate students and I lobbied for an additional course to address this need. Thankfully, a professor agreed to teach the class, and we selected the readings and developed the syllabus in collaboration with her. This course helped me to critically consider cross-cultural research, better understand issues such as differences in access to psychological treatment, and come to terms with my own values and biases when providing interventions to diverse populations.

Although diversity is often thought about in terms of race or ethnicity, I have come to appreciate it in a much broader sense thanks to a number of informative training and clinical experiences. Within my clinical work, I consider the rich, unique background of each patient throughout the process of case conceptualization, assessment, and treatment. During the assessment and case conceptualization process, I think about patients from a biopsychosocial framework that considers information including age, gender, generational cohort, past life experiences including military service, SES, sexual orientation, physical and cognitive ability status, geographic factors, and religious affiliation among many other things. I pay special attention to how personal history may affect things such as symptom presentation and openness to psychological treatment. I strive to be aware of the assumptions I make about patients and to remind myself to encourage them to educate me because they are the experts on their own experience. When developing a treatment plan, I try to consider how diversity factors intersect with each patient's unique challenges and strengths. For example, across multiple settings I have often had to be creative about ideas for behavioral activation given patients' financial and physical limitations, to modify treatments given patients' perceptual and cognitive changes, and to take a case management role in providing low income patients with information about resources (e.g., SNAP, fuel assistance).

I also have made an effort to become more mindful of how patients might perceive me as a Caucasian woman in my early 30s with certain privileges working primarily with male veterans in their 60s-90s. For example, with a number of patients who had a general distrust of medical providers and a number of patients who doubted my ability to help them given our age discrepancy, I have learned the value of having frank discussions regarding their concerns. Finally, I think it is also critical to be aware of these issues in various other relationships, including on interprofessional teams and with supervisees.

I. **Self-Assessment**

Writing this statement has been a fascinating way for me to think back on my development as a geropsychologist. My graduate school experiences confirmed my interest in this area and allowed me to gain foundational knowledge in many of the Pikes Peak competencies including but not limited to theories of aging, psychopathology, strengths/limitations of various assessment methods, evidence-based practice, common medical conditions, ethical and legal standards, and diversity within the older adult population. My internship and fellowship years were when I really developed my confidence and my style as a clinician as I gained experience working with older adults in a wide variety of contexts across the continuum of care. These years were especially critical for giving me additional training in less familiar areas like neuropsychological and capacity assessment and for challenging me to work in less comfortable settings like hospice and palliative care. I also had supervisors who encouraged self-reflection and critical

thinking about the process of psychotherapy. Additionally, I expanded upon my views of the many roles of therapists by serving as an advocate and care coordinator for many of my patients. I slowly began to think of myself less as a sponge who was taking in the expert wisdom and suggestions of my supervisors and mentors and more as someone with clinical instincts and knowledge of my own. I developed my voice as someone who had information and suggestions to offer in interprofessional team meetings, talks, etc.

The first 2+ years of my professional career have been an expansion of developing confidence in my voice and my various roles as clinician, supervisor, consultant, administrator, and research collaborator. A key part of this process has been my development as a supervisor. Although I was exposed to theories of supervision and was able to gain experience supervising less advanced students throughout my training, much of my thinking about this role has evolved in the time since I became a staff member. Each year, I supervise 3-4 interns and fellows in a range of assessment, intervention, and consultation activities in the outpatient Geriatric Mental Health Clinic as well as 3-4 psychiatry residents in the provision of cognitive behavioral therapy to ~2 veterans each across various outpatient clinics. This range of supervision experiences has really underscored the importance of having a flexible approach that can be adapted to each student's developmental level and training-related goals. I have benefitted from frequently attending monthly meetings with a group of other psychologists at this medical center that are a combination of discussing readings about supervision and consulting about issues that arise. Supervision-related issues are also a frequent topic in the weekly training-related lunch meetings I have with two of my geropsychology colleagues. Finally, eliciting feedback from every student I have supervised has allowed me to better identify my strengths and potential areas for growth as a supervisor. Providing supervision is one of the most rewarding aspects of my job and I view my development in this area as an ongoing process.

I also view my evolution as a clinician as an ongoing process, in keeping with the continuous developments in the evidence base for the assessment and treatment of older adults and a continuous process of self-reflection. I believe risk assessment is one area in which I will continue to grow. Although I feel confident in my ability to conduct assessments regarding suicidality, homicidality, elder abuse, and neglect, I often consult with colleagues when it comes to the more grey areas of striking the appropriate balance between the veteran's right to autonomy and concerns for safety. I was recently provided with an opportunity to do additional training in Urgent Care psychiatry triage and I am really looking forward to this experiential learning.

As I have become more confident in my voice, I have also recognized that I can make a contribution via service to the profession. I have dipped my feet into this area, especially through my roles on CoPGTP, and have been inspired by the incredible work of leaders in the field to establish the specialty area of geropsychology. My involvement in CoPGTP has allowed me to better understand the major current issues in this field and to think about the role of geropsychologists as an advocate for the interests of older adults in a much broader sense. I hope to continue my involvement in CoPGTP and to take on additional responsibilities and potential leadership roles in this organization and/or in others that serve the geropsychology community.

Finally, I believe my level of involvement in research and program evaluation will continue to evolve as I think critically about my professional goals and areas of strength. I have already developed awareness that I am most satisfied working as a collaborator rather than as a PI. I am also aware that I am really drawn to variety within my job and with the chance to help older adults on multiple levels (i.e., through direct interactions as well as through clinically-relevant research that may inform the practice of others). Finally, I have recognized that certain types of writing (e.g., book chapters) lend themselves well to my passion for education and training.

Thank you for this opportunity to think critically about where I have been and where I hope to be as a geropsychologist. To summarize and quote one of many examples of resiliency in late life (Julia Child), “You’ll never know everything about anything, especially something you love”.