Michele J. Karel, PhD
Professional Self-Study Statement for ABGERO
May 1, 2014

A. Professional Activities:
Please describe your professional work, past and current, both within the specialty of Geropsychology and in other areas of professional practice. Include a description of your experience providing services in the Assessment, Intervention, and/or Consultation domains (such a description might include a self- review of your geropsychology competencies via self-administration of the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool). Also, please include a brief statement describing your reasons for wishing to seek board certification.

After 16 years working as a clinical geropsychologist at the Brockton VA Medical Center of VA Boston Healthcare System, focusing primarily on clinical and supervision activities, I transitioned to a full-time administrative position in Mental Health Services at VA Central Office. In September, 2011, I was hired to serve as Program Coordinator for the Home Based Primary Care Mental Health Initiative. Approximately a year ago, my title changed to Psychogeriatrics Coordinator, to reflect the broader range of programs/activities I oversee. Until very recently, I worked for Dr. Brad Karlin in this position. I provide this information by way of background because, as I review my experiences and self-appraisal of my competencies in geropsychology assessment, intervention, and consultation, it is with the caveat that I have not provided direct clinical care for about 2.5 years. I do provide a fair amount of consultation, program management, and training in my current role (more later).

I have identified as a geropsychologist since graduate school at USC, an identity that was consolidated during my geropsychology postdoctoral training at Hillside Hospital, Long Island Jewish Medical Center (see history below). After training in diverse adult and geriatric programs and settings in graduate school, internship, and postdoc, I had my first experience working in the VA health care system when I joined the Brockton VA Medical Center as a staff psychologist in 1995. I was hired at the time to work with geropsychologist Dr. Jenny Moye, and an interdisciplinary mental health team, on the UBPEAT clinical demonstration project. UPBEAT stands for Unified Biopsychosocial Psychogeriatric Evaluation and Treatment, and was a multi-site project that compared a mental health care coordination model to "usual care" for Veterans who screened positive for depressive, anxiety, or alcohol misuse symptoms during a medical or surgical hospital stay. This program provided me a crash course in integrated care for Veterans with complex biopsychosocial problems, allowed for initial home visits for clinical evaluation after hospital discharge, and helped me learn about methodological challenges for a large program evaluation effort.

Once the UPBEAT program wrapped up, showing decreased hospital days and costs for those enrolled in the intervention arm, Jenny Moye and I worked to build a geriatric mental health outpatient clinic that grew out of the UPBEAT experience. We worked with psychiatrists, social workers, nurse practitioners, geropsychology fellows and interns, and intermittent psychiatry residents and social work and nursing students in this very busy clinic. The clinic provided individual, group, and couple/family services, psychopharmacological treatment, care coordination including, eventually, specialized dementia care coordination, and lots of training. Jenny and I also, for years, provided geropsychology training in our VA Community Living Center (formerly known as the nursing home care unit), where there was NO devoted psychology time until 2008. We provided psychology services in the CLC through our psychology Fellows and Interns; I did a bit of consultation in that setting over the years.

In these clinical settings, my assessment activities focused primarily on interview-based psychodiagnostic assessment, which typically included use of standardized measures of mood, cognition, and other clinical

domains as indicated (e.g., substance use, anxiety, grief). I included collaterals in interviews as appropriate, with the patient's consent. I have done several cognitive and capacity evaluations over the years, but I am not trained as a neuropsychologist and do not consider that to be my area of expertise (although I do have great interest, knowledge, and research experience regarding capacity evaluation). In the Pikes Peak assessment knowledge and skill domains, I believe I function in the proficient to expert level in most areas (with a solid appreciation for interdisciplinary and multimodal assessment approaches, contextual considerations, differential diagnosis, risk assessment, and communication of results to various stakeholders). As above, I need consultation when complex medical, medication, or neurological issues must be considered in forming a diagnostic impression. Other specific areas for growth include assessment of substance use disorders, especially as cohorts of adults now aging are bringing a wider range of substance use into old age.

My intervention work has focused on individual psychotherapy with older, mostly male Veterans; couple's therapy, often with spouse functioning in relatively new role as caregiver, and group therapy. My work focused primarily on treatment of mood and anxiety disorders, adjustment to late life functional and/or interpersonal changes, and caregiver strain. As discussed further below, my approach has been integrative, including behavioral, systems, interpersonal and pragmatic, problem-solving approaches. I believe I function in the proficient to expert level in the Pikes Peak intervention knowledge and skill domains, with a solid appreciation of ethical/legal standards, complex and interacting problems often addressed in psychological treatment, contexts of chronic illness and various settings for care delivery, and the evidence base and person-centered adaptations. Areas for continued growth include more training/application of motivational interviewing and addressing health issues including adherence, chronic pain, and insomnia; more training in mindfulness/acceptance-based approaches (I took a workshop on ACT but need more training/consultation), and continued training in a range of evidence-based psychotherapies (e.g., IPT, PST). Of note, I am learning a lot recently about behavioral interventions for challenging behaviors in individuals with dementia (working with Dr. Linda Teri and colleagues on STAR-VA training program in VA CLC settings) as well as Problem-Solving Therapy (in a pilot of Problem Solving Training in Home Based Primary Care, working with Drs. Art and Chris Nezu).

My consultation experience includes (1) providing feedback to family members, primary care providers, and other specialty care providers in collaborative care for Veterans; (2) providing staff training/support on various topics over the years in the VA CLC; (3) serving for many years on the VA Boston Ethics Advisory Committee and, in that role, meeting with teams to review their concerns and provide feedback; and, (4) in my current role, consulting to national communities of mental health providers as we develop aspirational models of integrated care, particularly in HBPC. I have done a lot of work in developing training workshops over the years, and continue to play and important role in training program and clinical resource development for a national community of VA HBPC and CLC MH Providers. Likewise, I coordinate VA national training and dissemination of the STAR-VA intervention, which entails close interprofessional collaboration with Nursing and Geriatrics and Extended Care colleagues. I feel well-grounded in consultation knowledge and skills, although learned this domain primarily "on the job" rather than in any formal learning setting. In my VA work over the years, I have come to value the psychologist's role on the interdisciplinary team and have emphasized this role in our geropsychology training programs. It can be very difficult to develop one's "voice" as a psychologist in medically oriented, interprofessional care settings. As above, I now am responsible for such communications on a national leadership level. I continue to learn and develop strategies for negotiating the needs and interests of multiple leadership and stakeholder groups.

I am interested to seek board certification in geropsychology due to my strong professional identity as a geropsychologist and my dedication to the ongoing development of our field. I am so grateful that our field has now been recognized as a specialty area of practice. It is important for us to be able to recognize,

and count, individuals who have developed specialty competence. I hope that my application will contribute to the "early adopters" of the GERO ABPP and encourage others to pursue it as well.

B. Professional Development:
Describe your development as a Geropsychology specialist by examining the major influences, both personal and theoretical, for your work. In addition, discuss specific academic, training, supervisory, or personal experiences that have led you to the beliefs and skills you bring as a Geropsychologist to the certification process.

I discovered my interest in geropsychology relatively early in my education. I started college considering a pre-med major, but soon discovered I was more interested in psychology than organic chemistry and physics. I majored in psychology and was exposed to remarkable teachers and thinkers in animal behavior, brain science, social psychology, developmental psychology, behavioral genetics, and clinical psychology. I took a course on childhood development, and on the psychology of adolescence. It struck me, even as an undergraduate, that none of my courses addressed life after the age of ~20 years old.

During this time, my paternal grandmother, who at that time lived in North Miami Beach, was developing what we now know as Alzheimer's disease. I vividly recall a visit to her small apartment with my college roommate – grandma Fannie came out of her bedroom 4-5 times to ask me and Polly, sleeping on the pull-out couch, if we had everything we needed that night. Yes, she was an anxious woman, but she appeared to have no recollection that she had asked us the same question just a few minutes prior. In any case, my father's sister – my dear aunt Elsie (who, sadly died of Alzheimer's disease at the age of 89 this past year) – was taking on increasing caregiving responsibility for my grandmother.

This personal context was what inspired me to devote my junior and senior year independent research projects at Princeton to issues of aging: junior papers on mental health in late life and on adjustment to retirement, and a senior thesis on attitudes of young adults and their parents towards filial responsibility/caregiving. As an undergraduate, I also chose to volunteer at a local nursing home and, in addition to helping run bingo games and other group activities, I befriended a resident whose name I now cannot recall (so sad) and visited with her ~weekly. While I have trouble remembering the details of our conversations, I do recall her combination of wisdom, eccentricity, likely cognitive impairment, and devilish nature. One clear memory is getting in trouble because, while I had permission to take her outside adjacent to the parking area to chat in the fresh air, I did not have permission to leave her there alone while I ran to a local store to buy her the candy bar she requested of me.

After college I worked for two years in New York City in the business world (marketing for the J. Crew catalog) and decided that was not for me. I decided to apply to graduate school in clinical psychology and found myself drawn to graduate programs that had tracks or opportunities to do clinical work and/or research with older adults. I was fortunate to be offered a chance to study at the University of Southern California, with both Margy Gatz and Bob Knight. I read a book during that time by Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society*, which argued for carefully rationing health care to individuals over the age of 80 (if I recall correctly). I was torn, because I agreed that aggressive, curative end-of-life care was very expensive, did not usually improve quality of life, and was likely not what most people wanted but, on the other hand, choosing a particular age as a criterion for making decisions about medical care seemed pretty arbitrary to me. This issue inspired my dissertation research and my continuing interest in how we can help older adults communicate what is most important in terms of their life values and goals, in terms of making late-in-life care decisions (see more below). My training at USC provided a solid background in research training, both cognitive-behavioral and family systems approaches to psychotherapy, some experience with neuropsychological evaluation, and exposure to the field of gerontology.

I completed my psychology internship at the Yale School of Medicine, where I was exposed to psychodynamic theory and therapy as well as terrific experiences in community mental health. I gained experience working with individuals with serious mental illness and the interpersonal ravages of poverty and violence. It was a very challenging year in which I grew tremendously as a clinician. I could not have been more thrilled when I was accepted to the Geropsychology Postdoctoral Fellowship at Hillside Hospital, with Greg Hinrichsen. At that time, Greg was just starting to explore his interest in Interpersonal Psychotherapy so I didn't have the chance to train formally with him in IPT. I had the chance during that year to work in mental health outpatient, inpatient, and day hospital settings, as well as gaining neuropsychology experience and a bit of experience in a nursing home setting.

From my postdoc, I went to the Brockton VA Medical Center, where I worked from 1995 until 2011, and where I discovered my love of supervision and mentoring in coordinating geropsychology internship and fellowship training there. A seminal event for my professional development was being offered the opportunity to co-chair the Pikes Peak training conference with Bob Knight - myself representing the Society of Clinical Geropsychology and Bob representing APA Division 20, Adult Development and Aging.

I share this background by way of explaining that I have a broad and diverse background in geropsychology, but do not have a particularly strong background in one theoretical orientation. I consider my clinical approach to be integrative, which has pros and cons. Over time, I wished I had more solid training in emerging evidence-based psychotherapies, especially to help train our students. At the same time, I feel that I (along with Jenny Moye) could offer broad clinical perspectives, helping students to do individualized assessment to inform individualized treatment plans that integrated evidence-based approaches according to patient-centered needs and preferences. At the same time, I feel I have very strong "foundational knowledge and skills" with special interests in ethics, interdisciplinary care, and relational aspects of care, training, and consultation.

My broad experience in geropsychology serves me well in my current national leadership position. I am grateful for the Pikes Peak conference, subsequent development of the assessment tool, and subsequent leadership in CoPGTP for helping to build my confidence in my leadership skills, now being put to good use.

C. Services to the Profession:
Description of the services and activities you have provided to the profession of psychology in general, as well as services and activities related specifically to Geropsychology (e.g., participation in aging associations or committees, presentations at gerontological conferences, consultation at the local, state, or national level).

I feel strongly connected to the geropsychology community and have always been committed to professional service. Through excellent mentorship, I was encouraged to participate and grew to play a significant national role in development of the field of geropsychology. Since graduate school, I have belonged to APA (Division 12, "12-2", and Division 20), GSA, and PLTC. Many years ago, I served as membership chair of the Society of Clinical Geropsychology ("12-2"). I have contributed to efforts to learn about and develop geropsychology training for years. In the late 1990's, I collaborated with Victor Molinari, Dolores Gallagher-Thompson, and others to survey graduates of geropsychology postdoctoral training programs at that time, to learn about their training experiences and career paths. As part of a now defunct VA Geropsychology Technical Advisory Group, I collaborated with a number of VA geropsychologists to propose "Recommendations about the knowledge and skills required of psychologists working with older adults."

This early interest in competencies and training for geropsychology practice blossomed in my participation as co-chair of the 2006 National Conference on Training in Professional Geropsychology (i.e., Pikes Peak conference). I became active in the Council of Professional Geropsychology Training Programs (CoPGTP) and served as Chair in 2010. I am currently collaborating with Brain Carpenter, Jenny Moye, and Victor Molinari on a CoPGTP-funded research project to survey graduates of geropsychology doctoral and postdoctoral programs, to learn about their training experiences, career paths, and facilitators/barriers to taking on leadership roles in our field. Currently I serve as the Society of Clinical Geropsychology representative to the Society of Clinical Psychology (APA Division 12) Board.

Beyond Geropsychology, I have had several opportunities in recent years to contribute to professional psychology more broadly. I served on the APA Continuing Education Committee from 2009-2011, chosen in part due to my ability to represent geropsychology interests. While that assignment was a LOT of work, it was extremely valuable for me to gain "birds-eye" view of continuing education activities in our field and realize how little of it is targeting competencies related to the care of older adults. In 2012-2013, I represented Division 20, along with Sara Qualls, to a Presidential Task Force that developed competencies for Psychology Practice in Primary Care Settings.

Note that many of my academic projects have had professional service in mind. I enjoy writing overviews of aspects of our field that I hope will be helpful to practicing clinicians, including chapters on ethics related to geropsychology practice, a book on assessing and treating depression in late life, chairing the team that developed and published the Pikes Peak knowledge and skill assessment tool, and working with Margy Gatz and Mick Smyer to write their decade review of the state of mental health and aging, published in *American Psychologist* in 2012.

D. Continuing Education:

Description of the APA-approved continuing education you have received and provided in Geropsychology during the preceding five years, including online courses, workshops, and independent readings.

In my current VA role, I am helping to develop a number of continuing education offerings for VA psychologists and psychiatrists who work in Home Based Primary Care and Community Living Center settings. Several of these efforts:

1. STAR-VA training program: I am coordinating our 2nd year of training for VA CLC Mental Health Providers (mostly psychologists, a few psychiatrists) and Nurse leaders in the STAR-VA approach for managing challenging behaviors among residents with dementia. STAR-VA is adapted from Linda Teri's STAR program (Staff Training in Assisted Living Residences), and emphasizes the importance of helping the interdisciplinary team to have realistic expectations of individuals with dementia, to evaluate the antecedents and consequences of behaviors and developing behavioral plans accordingly, and integrated pleasant events into the lives of individuals with dementia. The 2.5 day in-person training workshop (with multiple faculty) is offered for CE, and is then followed by 6-months of weekly consultation group calls with an Expert Consultant (not me) for the Mental Health Providers.
2. Problem Solving Training in Home Based Primary Care: Working closely with Drs. Art and Chris Nezu, we are piloting a 6-session PST intervention for Veterans in the VA HBPC program. I co-coordinated a 2-5 day in-person training workshop (I was not faculty except for programmatic issues) offered for CE, and continue to co-coordinate six-months of consultation and implementation.

3. Webcourse Series on Integrated Mental Health Care in HBPC: I am coordinating the development and production of a series of webcourses for HBPC mental health providers (and other team members) to provide an overview of a model of integrated mental health care in HBPC. The first course, which is complete, focused on the MH Provider's role in this interdisciplinary, integrated model of care (offers 1.5 CE/CME credits). The second course, just starting production, focuses on integrated mental health assessment in HBPC (will likely offer 2 CE/CME credits). We are planning to develop a third course, on integrated mental health intervention in HBPC.
4. I also coordinate (not develop) monthly CE series for both HBPC and CLC MH Providers, with expert invited speakers on a range of topic relevant to behavioral and mental health practice in these settings. See some example topics below.

I have participated in several CE workshops over the past year or so, as follows:

- September 2103: Invited speaker at VA Geriatric Scholars Program for Psychologists at Palo Alto VA – I presented talks on *Assessment of Mood and Evidence-Based Practice Interventions* and *Integrated Health Care and Interdisciplinary Teams.* (I received 14 CE credits for attending this conference for 2 full days, including talks by many geropsychology experts)
- May 2013: Invited speaker at Aging with Dignity Conference at the Bedford VA – I presented talk on *Late Life Depression: A Person-Centered, Integrative Perspective*.
- April 2012: Invited speaker at Vermont Geriatrics Conference – I presented talk on *Posttraumatic Stress Disorder in Late Life*.

I have taken a number of APA-approved continuing education courses related to geropsychology in the past five years. Several examples include:

- Attending many monthly offerings of the VA Boston Capacity and Geriatric Neuropsychology rounds from 2010-2013.
- APA conference CE offerings, including, for example:
    - 2010: Clinical Health Psychology Grand Rounds on Insomnia
    - 2011: Reducing the Risk of Alzheimer's Disease: Knowns and Unknowns (Gatz)
      What Gets Aging Families in Trouble? Stuctures and Processes (Qualls)
    - 2012: Integrated Approaches to Geriatric Health Care
      Geriatric mental health workforce: Current Initiatives and Critical Issues
      Innovative Psychotherapy Treatment for Older Adults

VA Offerings including:

- Increase Your Suicide Prevention Skills with Older Veterans
- PTSD and Memory Problems in Older Veterans

- Many monthly HBPC MH speaker series, from 2012-2014. Topics include (just a selection):
    - Suicide Prevention in the HBPC Setting
    - Substance Use Disorders in HBPC
    - Hoarding
    - Pharmacological Approaches to Dementia Care
    - Conducting Prolonged Exposure Therapy with Older Adults
    - IPT for Late Life Depression
    - CBT for Chronic Pain Management
    - CBT for Insomnia
    - Family Caregiver Therapy

- Acceptance and Commitment Therapy in application in HBPC

- Many monthly CLC MH speaker series, from 2012-2014. Topics include (just a selection):
  - Suicide Prevention in the CLC Setting
  - Evaluating and Respecting Resident Values and Preferences in LTC
  - PTSD in Late Life
  - Delirium
  - Wandering Behaviors in the CLC
  - Montessori-Based Programming for People with Dementia
  - Sexuality in Long-Term Care Settings

E. Scientific Base:

Please provide evidence of the ways in which you utilize or contribute to the current science base by addressing one of the two following points: (a) the evidence base that informs your practice, including how you determine if your activities as a Professional Geropsychologist are effective; or (b) describe your own current clinical research activities and how these inform your practice. Your discussion should include enumeration of the key scientific issues, key research findings and areas of controversy, design considerations, decision-making models, limitations of current empirical findings, outcome research you rely upon or conduct, and other scientific considerations. If your practice includes use of instruments, please describe the key issues you consider in selecting these instruments, how you evaluate results, and how you make use of your evaluative findings.

I will describe be my own research/evaluation program, which has focused in four areas: (1) professional geropsychology competencies/training/supervision/mentoring; (2) capacity evaluation; (3) values and advance care planning; (4) national program evaluation for VA clinical programs.

(1) Professional geropsychology competencies/training/supervision. Shortly after the 2006 Pikes Peak conference and the formation of CoPGTP, I volunteered to chair a CoPGTP Task Force to develop a tool that could be used to help evaluate the development of the geropsychology knowledge and skill competencies. The main task was to translate each competency into behavioral indicators – how would you know it if you saw it, in oneself or in a trainee you were evaluating? The task force of experienced geropsychologists and students worked to develop those indicators, as well as to research options for competency rating scales. As part of the development of the tool, we sought feedback from geropsychologists. Later, another group (with overlapping members of the first group) designed a study that could allow us to evaluate the tool's use among geropsychologist and geropsychology trainees. While our methods did not allow us to demonstrate construct validity (e.g., we had no external measure of the "truth" of someone's capacity in various domains), we were able to illustrate internal consistency of competency domains and predictable relationships (e.g., those with more training had higher competency self-ratings). I have also written a number of papers to share our experiences providing geropsychology training and mentoring. Several years ago, I collaborated with a postdoctoral Fellow, Abby Altman, as well as Rick Zweig and Greg Hinrichsen, to survey geropsychologists and trainees re: their experiences providing and receiving geropsychology supervision. This study helped to identify areas of particular challenge for geropsychology trainees, and areas in which trainees may tend to overestimate their abilities.

(2) Capacity evaluation. I am grateful for my long collaboration with Jenny Moye, in research as well as clinical and training activities. She has done groundbreaking work in the area of capacity evaluation of older adults, and I was an eager collaborator for years. Issues of decision-making

capacity - particularly for aging adults who have had a lifetime of full capacity and, in the context of dementia or other neurocognitive disorders, face changed decision-making and functional abilities - pose ethical and clinical dilemmas for most geriatric healthcare teams. Jenny was one of few investigators leading the way to study validity of decision making capacity constructs (understanding, appreciation, reasoning, choice) and to develop framework/tools to help in the clinical evaluation of various capacities (APA/ABA Handbooks). In our work on capacity assessment in individuals with and without dementia, we were able to demonstrate neuropsychological correlates of the capacity constructs, the challenges of measuring the appreciation construct in particular, and the deficits in understanding and reasoning demonstrated by a minority of participants with dementia. I was able to integrate my interest in evaluating values for healthcare decision making into this capacity research, and demonstrate that individuals with mild to moderate dementia often remain able to express consistent values related to their health care and quality of life.

(3) Values and advance care planning. I never lost my early, undergraduate, interest in ethical issues related to healthcare decision making near the end of life. We know there are limitations to instructional advance directives – it can be hard for most of us to imagine how we'd feel and what we would want in various potential states of health/illness/injury. But, I've wondered whether we do have core personal values, related to conceptions of quality of life, relationships, and decision-making style, that might remain stable and could be communicated to others (e.g., family members who may someday serve as surrogate decision makers, health care team). Well, it turns out this is a very complicated area to try to study and I've really been "dabbling" in it for years. I've looked at various ways to ask people to express these "health care values" – e.g., rating scales, forced choice, open-ended questions, discussions with a healthcare proxy – and there are limitations all around. This is all complicated by the phenomenally complex reality of human decision making (e.g., rational vs intuitive) and to what extent people are even consciously aware of or can communicate explicitly what is important to them. Most recently, I am collaborating again with Jenny Moye and geriatrician Dr. Aanand Naik, in their multisite study of Veterans who have been diagnosed and treated for an oral-digestive cancer. This longitudinal study is looking at a wide range of physical, psychological, and spiritual influences and outcomes in these mostly older adult male cancer survivors. As part of the study, we asked these Veterans to rate the importance of a number of life abilities/activities to their quality of life, and to respond to open-ended questions regarding what is most important in life, that they'd want others to know about them, in the context of making ongoing cancer care decisions. Based on this work, we are proposing a taxonomy of healthcare values domains that may be important to consider with patients as part of healthcare decision making or advance care planning discussions.

(4) VHA program evaluation. In the past few years, I have been devoting more time to program development, implementation, and evaluation. For example, the integration of mental health services into VA Home Based Primary Care programs was a new initiative in 2007/2008 and we have wanted to learn about implementation and outcomes. When I began my position at VA Central Office, I was handed a large data set that entailed responses from 132 HBPC Mental Health Providers (mostly psychologists, a few psychiatrists) and 116 HBPC Program Directors nationally, asking them many questions about emerging mental health practices in HBPC and the impact of integrating mental health providers on HBPC team functioning. These responses provided important information about emerging models of mental health care in the HBPC programs and the generally very positive impact that Program Directors perceived. We have been able to look at utilization data and have many additional program evaluation goals. Likewise, I have been coordinating implementation of the STAR-VA training program in VA Community Living Centers, which includes an extensive program evaluation effort. For CLC sites that are trained, we are looking at clinical outcomes for enrolled Veterans (frequency and severity of

target behaviors, depression, anxiety, agitation), competencies for trained MH Providers, self-rated knowledge and skills for trained MH Providers and Nurses, and perceptions of program impact by trainees and CLC interdisciplinary staff. Likewise, we are currently doing a small pilot of teaching a time-limited Problem Solving Therapy intervention to HBPC psychologists, and will evaluate Veteran clinical outcomes and trainee outcomes. Finally, there are many program evaluation opportunities to examine how we are doing providing mental health care to our aging Veterans that I hope to explore in the coming years.

F. Ethical Base:

Please describe two or three meaningful and challenging ethical dilemmas that you have personally encountered in your practice of Geropsychology. Your description should include the manner in which these issues relate to specific aspects of the APA *Ethical Principles of Psychologists and Code of Conduct*. Also, please indicate how you chose to resolve and manage the outcome of these dilemmas.

1. One clinical ethical dilemma which remains on my mind, despite the situation having occurred some years ago, entailed a case on which I consulted with the Ethics Advisory Committee. A long-term resident of the VA Community Living Center (CLC) was in the final stages of his life. He had multiple chronic illnesses, had two leg amputations due to complications of diabetes, had advanced dementia and was no longer verbally communicative. He was well-loved by the CLC staff and had a large and devoted family. The CLC team consulted the Ethics Advisory Committee because they did not feel comfortable with the family's stated goals of care, which included maintaining their father as "full-code" and minimizing the use of pain medication so that he remained alert when they visited. This Veteran did not have a written advance directive on file. Family was considered legally recognized "next of kin" with surrogate decision-making power.

   This situation was painful for the CLC staff, as they felt the Veteran was suffering and could benefit from consistently higher levels of pain medication. They also felt that it would not be humane to attempt CPR on this frail older gentleman in the event of cardiac arrest. This African-American family (multiple adult children/spouses/grandchildren) was likewise clearly concerned for their father's well-being, did not want to see him "over-medicated," and felt strongly that he deserved all efforts at life-sustaining treatment.

   As part of the Ethics consult, I facilitated a large family meeting with approximately 5-6 family members and the CLC team - physician, physician's assistant (who was the primary care provider), nursing representatives, dietician, psychologist, and perhaps others - in attendance. The family assumed a defensive posture but were able to engage with education about the purpose of the meeting and empathic attention to their concerns for their father. We worked to establish shared purpose and goals of care, which included providing excellent care and ensuring the Veterans' comfort/reduce suffering to the extent possible. With education by team members, they were ultimately able to understand that, at this stage of his advanced illness and mutual goals of minimizing suffering, that use of pain medication was important even if the cost was some degree of sedation. The group was able to reach consensus on this goal of care.

   The team also provided education about the use of CPR in someone in this Veteran's condition, that the likelihood of reviving him in the case of cardiac or pulmonary arrest was very small and that the risks of injury or other adverse consequences were relatively high. The family remained committed to their goal of "doing everything" for their father and insisted on maintaining him in full code status. Religious and/or cultural beliefs likely influenced this choice. It is unclear to

what extent concerns about equitable access to care played a role in this ethnic minority family who wanted to ensure that their father benefited from all and the best care. Of note, the PA Primary Care Provider was an African-American woman. The family's defensiveness (perhaps reflecting distrust in the system) was equally exhibited in relationship to this PA of similar racial background.

We did not have documentation, through a living will, of what this Veteran would have wanted in this situation. It is not clear that the family was able to offer a clear statement of a "substituted judgment," representing the Veteran's previously stated preferences. Unfortunately, I am unable to recall if there was a formally documented health care proxy document in the medical record. In any case, in consultation with the full Ethics Advisory Committee, it was decided that this Veteran's Next of Kin had the right to make care decisions on his behalf and that the hospital did not have the right to override their preference that he remain on full code status. The team continued to provide education to the family about the risks and benefits of different treatment options and to work with the family to optimize the Veteran's comfort to the extent possible.

2. [Removed from example given sensitivity of an ethical dilemma related to training]

In conjunction with the submission of the PSS, the applicant must submit a statement declaring that there are no ethical complaints or judgments against them to facilitate the Board's review of the applicant's ethical standing. *It is the applicant's responsibility to notify the Board of any prior adverse ethical or licensure determinations and any pending allegations and their resolution.*

My statement:

I have had no ethical complains or judgments against me in my practice of psychology.

Michele J. Karel, PhD

G. Complex Relationships:
Please provide two or three examples of how you have handled complex interpersonal interactions (e.g., challenging relationships with older clients/patients; as a consultant, how do you determine who is your client – is it the establishment that employs you, the family member who pays for treatment, or the older client you are asked to help?) in one or more of the domains of Assessment, Intervention, Consultation, supervision, research inquiry, and professional development.

Much of my clinical work through the VA entailed negotiating relationships among the Veterans I served and their family members and, occasionally, other care providers or community agencies. While most of the mental health services I provided entailed individual or group psychotherapy, I also did a fair amount of couple's/family therapy and, even in the context of individual/group therapy, I often communicated with the Veteran's family members, with the Veteran's consent. It was often helpful to interview family members to get their perspective on the Veteran's functioning at home and/or to help coordinate care. At times, it became clear that a Veteran's goals differed from those of his/her family members/caregivers; these situations required communication of empathy for each person's perspective and concerns, clarity regarding who had the right/ability to make decisions, and – when appropriate – efforts to reach consensus on common goals.

One example comes to mind. An aging Veteran with a history of anxiety and depression symptoms, social isolation, and an "eccentric" lifestyle participated in a weekly support group for many years. For complex reasons, he had been estranged from his adult children for many years. He had returned to his family home in which he had grown up to take care of his mother who was dying from cancer; at this time, he was also separating from and ultimately divorcing his wife. After his mother died, he remained in his family home. He was a very private man who valued his independence and frugality (saving his limited income to pay for home care should he ever need it in his future). After knowing him for years, complex legal issues emerged regarding who had control of the estate (an estranged son) and with some evidence of financial exploitation. Another estranged son re-entered the Veteran's life, expressing concern for his father's living situation and possible financial exploitation by his brother. The Veteran was ambivalent about having this son return to his life – appreciative but also distressed by the son's "bullying" nature. The Veteran ultimately allowed the son and son's girlfriend to participate in a family meeting with me (several meetings/communications occurred over time). The son expressed feeling that the Veteran was not capable to care for the house, given he found it ill-maintained. The Veteran was committed to staying in that house. This was a case where we made an Adult Protective Service report, both due to the possible financial exploitation and to help evaluate the Veteran's safety at home. In our team's opinion, the Veteran maintained capacity to live on his own and to make decisions regarding his residence and finances; the son did not appreciate that conclusion and needed education about his father's rights and how he might best be of assistance. I left the VA while this complex situation continued to emerge and resolve. In this case, I felt I was carefully balancing my commitment to the Veteran as a still-capable (albeit with different values than many other people) man facing very stressful psychosocial circumstances, while also respecting the son's concerns (and balancing my own concerns for the son's potential self-interest in the estate, etc) and engaging social and legal service professionals to the extent the Veteran allowed or my legal adult protective duties demanded.

Another situation regarding complex relationships entailed a research situation in which I needed to balance my commitment to my students, respectfully negotiate concerns with a … colleague, and consider my obligations to the institution. [Example removed due to sensitivity of the situation….]

H. Individual & Cultural Diversity:
Please discuss how your work in Geropsychology is informed by an awareness of, and sensitivity to, diversity (i.e., individuals, groups and communities who represent various cultural and personal backgrounds and characteristics in older adults).

In my clinical work, I was always very aware of cohort differences and, early on, learned to ask clients to explain historical references with which I was unfamiliar (if not clinically contraindicated). In most cases, clients enjoyed the opportunity to share their knowledge and experience. Cohort differences could be challenging in working with a population of mostly older white men (mostly from Irish and Italian Catholic, Jewish, and various Protestant backgrounds), whose notions about gender roles and race did not always match my own. Many comments made by very well-intentioned men over the years reflected their socialization rather than explicit ill will. Issues for aging men and, in particular, aging Veterans, were important for me to understand. Likewise, in working with many wives and daughters (and some older female Veterans), it has been important for me to understand their varying conceptions of gender roles, marriage, communication, sexuality, etc. I worked with gay and transgender older Veterans over the years as well, and understanding the interaction of their experiences as gay/transgender men and the historical times/places in which they grew up, entered the military, and lived their adult lives has been very important.

Apart from cohort, gender, sexual preference, and gender identity, it has been important for me to understand racial/ethnic, religious, socioeconomic, and regional influences on individuals' values, beliefs,

and approaches to living and coping with challenges of aging. As described above, I am very interested in the values people bring to late life health care decisions and have had great interest in learning from clients their unique perspectives on healthcare, caregiving, relationships, death/dying/grief informed by their particular cultural backgrounds and life experiences.

In my current administrative role, I am working to address issues of diversity more fully in our CE series for HBPC Mental Health Providers. Last year, we organized a panel discussion of clinicians' experiences of racism during the course of clinical care and team interactions in HBPC. I have been mentoring ….[Information removed due to sensitivity of information…] …. There had been several listserv postings related to these issues [i.e., experiences of racism by psychologists working on interdisciplinary team…], and I invited volunteers to participate in a panel discussion. It was a rich discussion and lead to creation of a mail group for those who wished to have a supportive forum to bring these issues. Unfortunately, mail group activity was short-lived and I regret not "checking back" with the group. We are working to re-invigorate community discussion about issues of diversity and have decided to devote much of our 2015 monthly speaker series to diversity themes. HBPC team members visit homes of Veterans all around this country and see every conceivable living condition - from inner city slums to rural homesteads and everything in between (including Native American lands), rich and poor, mostly older but some younger, and from widely diverse racial/ethnic/cultural backgrounds. I am very excited to work with our planning committee to organize a meaningful series to address diversity issues in HBPC mental health practice for the coming year.

I. Self-Assessment:
Discuss how you have evolved, grown and improved as a psychologist in the specialty of Geropsychology, and what improvements you seek to make in your professional functioning.

My self-assessment is based so closely on the type of work I am doing now. If I were still actively doing clinical care, I would have one set of goals/improvements. Now that I am doing administration/program coordination, I am working on another set of goals/improvements. However, at some point I may return to clinical work, so I don't want to let go of those goals!

In any case, I often cannot believe that I completed graduate school at USC 20 years ago. I feel I have grown significantly since that time, expanding my clinical skills across settings of care, developing skills as a supervisor and mentor, maintaining and developing some new skills as a researcher/evaluator, and developing leadership skills that I never could have imagined possible for me (a shy person with not-too-much-self-confidence). I feel I have a very solid appreciation for the field of geropsychology, what we have to offer, how to train others to appreciate that, and how to develop guidance and resources to support excellent clinical behavioral and mental health care of older Veterans. I often feel that I know a little about a lot of things, rather than having great depth of specialization in a particular area within our field. It turns out that is quite helpful for my current position.

As I described above, if/when I return to clinical work, I really want to develop solid skills in at least two evidence-based psychotherapy protocols that we know have support for use with older adults (likely, Interpersonal Psychotherapy and Problem Solving Therapy and, perhaps, Acceptance and Commitment Therapy). While I understand basic principles of these approaches, I would like to be trained and supervised by experts to implement them well. I envision any future clinical practice might include doing capacity evaluations (which I've done research on and thought a lot about, but done very few of in a clinical setting). I'd like to develop my skills in neurocognitive assessment to help complement capacity evaluation. I would seek mentorship in this area. We'll see what the future holds.

In my current role, I have so many areas for ongoing growth. I am learning about population-based approaches to health care and continue to need training/mentoring for how to think about meeting the

behavioral and mental health care needs of the large population of older Veterans. I want to learn more about program evaluation given available data sources. I want to learn more about identifying priority areas for program development – how can we get the most "bang for our buck?" How can we capitalize on collaborations, shared goals/interests across program areas? In this area, I also will continue to seek continuing education and mentorship opportunities.

Work Examples

I attach the following articles/chapter for review, as examples of my work in different areas.

Karel, M. J. (2014). Draft content for CE webcourse, *Integrated Mental Health Assessment in Home Based Primary Care*, second section entitled, *Framework for Mental Health Evaluation in HBPC*.

Karel, M. J. (2008). Ethical issues. In E Rosowsky, J Casciani & M Arnold (Eds.) *Geropsychology and long term care: A practitioner's guide* (pp. 111-123). New York: Springer.
(Regrets for attaching a proof version, do not have final electronic version)

Karel, M. J., Altman, A. N., Zweig, R. A., Hinrichsen, G. A. (2014). Supervision in professional geropsychology training: Perspectives of supervisors and supervisees. *Training and Education in Professional Psychology, 8*, 43-50.

Karel, M. J., Gatz, M., & Smyer, M. (2012). Aging and mental health in the decade ahead: What psychologists need to know. *American Psychologist, 67,* 184-198.

Karel, M.J., Knight, B. G., Duffy, M., Hinrichsen, G. A., & Zeiss, A. (2014). Attitude, knowledge and skill competencies for practice in professional geropsychology: Implications for training and building a geropsychology workforce. *Training and Education in Professional Psychology; 4,* 75-84.

Karel, M. J., Moye, J., Bank, A., & Azar, A.R. (2007). Three methods of assessing values for advance care planning: Comparing persons with and without dementia. *The Journal of Aging and Health,19,* 123-151.

Karel, M. J., Powell, J., & Cantor, M.D. (2004). Using a values discussion guide to facilitate communication in advance care planning. *Patient Education and Counseling, 55*, 22-31.

Karlin, B. E., & Karel, M. J. (2013). National integration of mental health providers in VA Home-Based Primary Care: An innovative model for mental health care delivery with older adults. *The Gerontologist*, doi: 10.1093/geront/gnt142, First published online: December 3, 2013.