

# MULTICULTURAL COMPETENCY IN GEROPSYCHOLOGY

**A Report of the APA Committee on Aging and its  
Working Group on Multicultural Competency in  
Geropsychology**



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# MULTICULTURAL COMPETENCY IN GEROPSYCHOLOGY

## Section 1: Introduction

This report summarizes the work of the American Psychological Association Committee on Aging and its Working Group on Multicultural Competency in Geropsychology. The purpose of this report is to: explore the key issues regarding the infusion of multicultural competence throughout geropsychology; make recommendations for future action addressing practice, research, education and training, and public policy issues; and inform psychologists of existing resources to improve their own multicultural competence in working with older adults.

“As we focus on the aging process through a cultural lens, this changing racial and ethnic minority population will represent unique groups of individuals. As culture has affected their lifetime experiences, it will also affect their aging experiences”  
(Jackson, Antonucci & Brown, 2004, p. 225).

### Definitions

Before exploring issues pertaining to multicultural competency in geropsychology, it may be helpful to review what we mean when using the terms geropsychology and multicultural competence. Geropsychology is the specialized field of psychology concerned with the psychological, behavioral, biological, and social aspects of aging. The science of geropsychology further presumes that these aging processes are iterative and interactive; taking form within a context/environment that influences outcomes and experiences.

The literature most commonly refers not to multicultural competence but to cultural competence, the latter being viewed as a specific form of competency. The term cultural competence has a history extending back at least 30 years (e.g. Sue, 1977). As used with respect to health care, multicultural competence often refers to the adequacy of care provided to racial/ethnic minorities.

However, the U.S. Department of Health and Human Services Office of Minority Health (OMH) broadens this definition to include individuals and organizations less directly linked to the actual provision of care, such as religious and social groups. Cultural and linguistic competency are defined by OMH as “The capacity for individuals and organizations to work and communicate effectively in cross-cultural situations through the adoption and implementation of strategies to ensure appropriate awareness, attitudes, and actions and through the use of policies, structures, practices, procedures, and dedicated resources that support this capacity.” ‘Culture’ refers to integrated patterns of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups as well as religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes” (OMH, 2013, p.138, 139). The OMH definitions emphasize that cultural competence is a term that applies not only to the individual provider but to the provider organization, and to the health care system as a whole.

For the individual provider, cultural competence involves awareness and acceptance of difference; awareness of one’s own cultural values; understanding the dynamics of difference;

development of cultural knowledge; and ability to adapt practice to the cultural context of the client. For the provider organization, elements of cultural competence include valuing diversity; conducting self assessment; managing for the dynamics of difference; institutionalizing cultural knowledge; and adapting to diversity in its policies, structures, and services.

### **Building upon Psychology's Efforts to Develop Competencies**

APA's efforts related to multicultural competencies in geropsychology begin on a firm foundation. Industrial and organizational (IO) psychology has contributed much to the modern notion of competencies. Job analysis was one of the first systematic procedures created to identify competency requirements (McCormick, 1976; Harvey, 1991). Specifically, job analysis data is in the format of job knowledge (K), skills (S), abilities (A), and other characteristics (O). Collectively referred to as KSAs or KSAOs, procedures were developed to directly (K/S) and indirectly (A/O) measure attributes that can help differentiate high from average or poor job performance. Closely related to the KSAO approach is industrial organizational psychology's method of competency modeling (McClelland, 1973).

The area of multicultural competency has been a major focus within the counseling psychology profession. For the past few decades, counseling psychologists have worked to conceptualize multicultural competency (Arrendondo et al., 1996; Sue et al., 1982, 1988; Sue, Arrendondo, & McDavis, 1992; Pederson, 1994; Pope-Davis & Coleman, 1997; Ponterotto, Fuertes, & Chen, 2000). To date, a three-component model of multicultural competency – Awareness (of Attitudes), Knowledge, and Skills – is widely accepted and used in multicultural counseling training and education. The three-component model was further delineated by D. W. Sue and D. Sue (2003) in their consecutive editions of *Counseling the Culturally Diverse: Theory and practice*. Now in its seventh edition, this work addresses the politics, sociopolitical considerations, barriers, intervention strategies, and cultural identity aspects for individual and organizational multicultural competence. Similar to the industrial organizational model of competencies described above, counseling psychology references a core group of characteristics associated with competence, although the ordering is different, placing an emphasis on awareness of values and biases first: attitudes and beliefs, knowledge, and skills. Counseling psychology's competency models have spawned several instruments to measure multicultural competency, including self-report tools for individuals as well as inventories for organizations (Arredondo, et al., 1996).

There has been a long history of competency efforts within Professional Psychology. The 2002 Association of Psychology Postdoctoral and Internship Centers (APPIC)'s [\*Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology\*](#) (Kaslow, et al., 2004) helped to consolidate information regarding competencies as applied to the education, training, and credentialing of psychologists. A newer model for competency development, the "Competency Cube" originated from one of the conference's work groups. The Rodolfa, et al. (2005) Cube Model for competency development builds upon Sue's Counseling Model of Attitudes, Knowledge and Skills relevant to multicultural competency issues. It elaborates on foundational competency domains, functional competency domains, and stages of professional development. In 2006, the [\*APA Task Force on the Assessment of Competence in Professional Psychology: Final Report\*](#) reviewed current practices in the measurement and assessment of competence in professional education, training and credentialing in psychology and other health-related professions and made recommendations regarding models and methods for the assessment of competencies in psychology education and training. Subsequent to this report, the Assessment of Competency Benchmarks Work

Group made a series of recommendations and developed guiding principles for the assessment of competence (Kaslow et al., 2007). In 2011, the Revised Competency Benchmarks for Professional Psychology were developed. One core competency area is: “Individual and Cultural Diversity: Awareness, sensitivity and skills in working professionally with diverse individuals, groups and communities who represent various cultural and personal background and characteristics defined broadly and consistent with APA policy” (APA, 2011). A *Practical Guidebook for Competency Benchmarks, A Competency Assessment Toolkit for Professional Psychology*, and related resources can be found on the Competency Initiatives in Professional Psychology [webpage](#).

Foundational competencies are skills needed for basic practice. With regard to multicultural diversity, these are designated as reflective practice, scientific knowledge and methods, relationships, ethical-legal standards-policy, individual-cultural diversity and interdisciplinary systems. Functional competencies then build on the foundational ones. With regard to multicultural diversity, this would include assessment, case conceptualization, consultation, research-evaluation, supervision-teaching and management-administration. Finally, stage of professional development, from graduate education through licensure and beyond, is highlighted. It is expected that the foundational and functional competencies in multicultural issues will evolve across the individual’s career development.

Specific to multicultural competency, the initial version of the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2002) spoke to the profession’s recognition of the important role that diversity and multiculturalism plays, both in terms of how individuals and groups define themselves, and how they approach others within the United States and globally. However, these Guidelines “defined multicultural narrowly, to refer to interactions between individuals from minority ethnic and racial groups in the United States and the dominant European-American culture.” Since that time, there has been significant growth in research and theory regarding multicultural contexts. The *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (APA, 2017), replaced the 2002 guidelines as APA policy, and are conceptualized from a need to reconsider diversity and multicultural practice within professional psychology with intersectionality as its primary purview. Psychologists are encouraged to consider how knowledge and understanding of identity (including age) develops from and is disseminated within professional psychological practice. Endemic to this understanding is an approach that incorporates developmental and contextual antecedents of identity and how they can be acknowledged, addressed and embraced to engender more effective models of professional engagement.

The premise of this present report is that one critical aspect of culture is age itself and this culture also continues to evolve. Since older people from a given cohort have been exposed to events, conditions, and changes different from what was experienced by their counterparts from another cohort, one finds between-cohorts differences in attitudes, values, and behaviors. For example, the beliefs and practices of cohort retiring during the next ten years would differ significantly from the cohort that retired in the 1950’s. These changes, in turn, will affect the experiences and expectations of future cohorts as they age. In addition to the differences across cohorts of older adults, there is substantial variability within each cohort as well. Thus, at any given point in time the members of the older cohort are not only different from their younger counterparts but they are also different from each other. They comprise a group with diverse characteristics and needs that are often overlooked. It is therefore essential that those who work with older adults are equipped with multicultural competence.

Furthermore, addressing the needs of the diverse population requires attention and collaboration across the discipline of psychology – including cultural specialists, geropsychologists, and psychology practitioners and researchers from all subfields. In addition, we must also link our efforts and engage all sectors within the larger professional community to address the needs and to support the strengths of the growing number of diverse elders.

## **Section 2: Competencies with Older Adults: A Precursor Model for Cultural Competencies**

The Geropsychology field has progressed through a series of developmental tasks to define the competencies needed to practice with older adults (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009), which serve as the foundation for the development of cultural competencies for working with older adults. The developmental tasks include specification of guidelines for practice, a conference at which the geropsychology training model was outlined, publication of the competencies, and the formation of a council of training programs. Each step in the process provided building blocks for subsequent steps.

The initial steps toward defining competencies for work with older adults took the form of practice guidelines. The first version of the *Guidelines for Psychological Practice with Older Adults* were developed in 2004 and updated in 2014 (the updated Guidelines can be found [here](#)). Guideline 5 is particularly relevant to the present report, “Psychologists strive to understand diversity in the aging process, particularly how sociocultural factors such as gender, ethnicity, socioeconomic status, sexual orientation, disability status, and urban/rural residence may influence the experience and expression of health and of psychological problems in later life” (APA, 2014).

The National Conference on Training in Professional Geropsychology was convened with support from APA in 2006 and built upon the practice guidelines to develop a competency-based training model delineating the attitudes, knowledge base, and skill competencies that should characterize the competencies that psychologists aspire to attain for competent practice when engaging in specialized work with older adults. Of particular relevance to this report is the call for psychologists to “expand their awareness of how individual diversity in all of its manifestations (including gender, age, cohort, ethnicity, language, religion, socioeconomic status, sexual orientation, gender identity, disability status, and urban/rural residence) interacts with attitudes and beliefs about aging, to utilize this awareness to inform their assessment and treatment of older adults, and to seek consultation or further education when indicated” (Knight et al., 2009).

The Pikes Peak Model of Professional Geropsychology Training developed during the 2006 conference organized the training model around competencies in attitudes, knowledge, and skill. This approach extends that used in clinical psychology more generally (Kaslow et al, 2004) where the shift from specifying training mechanisms (e.g., predoctoral training curriculum) to focus directly on the desired attainments has been addressed in several training conferences in the last two decades. There are two ways in which this shift is foundational to establishing standards related to multi-cultural competency in geropsychology. First, the competencies approach leaves to the discretion of the training program the mechanism, maximizing flexibility to exploit distinct strengths of particular programs. Thus, the model declined to specify how content would be delivered (e.g., in one course or infused within many courses), relying instead on specification of aspirational goals for the trainees. A similar approach is recommended here for the infusion of multicultural diversity

throughout geropsychology using mechanisms that may be developed distinctly in particular programs but that achieve a common set of competencies during the training process. Additionally, competencies are specified in all domains, and cannot be considered complete until attitudes, knowledge, and skill have been addressed.

Another outcome of the National Conference was the genesis of a new organization, the [Council of Professional Geropsychology Training Programs](#) (CoPGTP). Where the Pikes Peak Model for Geropsychology Training delineated the attitude, knowledge and skill competencies recommended for professional geropsychology practice, and made recommendations for training at graduate, internship, postdoctoral, and post-licensure levels, CoPGTP developed the [Pikes Peak Geropsychology Knowledge and Skill Assessment Tool](#) to help psychologists evaluate the development of geropsychology practice competencies in themselves, or in their students. This evaluation tool is intended to inform geropsychology education and training plans for individual psychologists, as well as to help geropsychology training programs assure that their students are developing competencies consistent with training program goals. Most recently, recommendations have been developed for foundational knowledge competencies at the basic “exposure” level of training for all psychologist who work with older adults (Hinrichsen, Emery-Tiburcio, Gooblar, & Molinari, 2018).

### **Section 3: Key Issues Regarding the Infusion of Multicultural Diversity throughout Geropsychology**

Keeping these previously noted efforts in mind, we next explore the key issues to consider as we apply the multicultural literature and expand these already-significant efforts to geropsychology.

#### **1. The Need to Recognize Age as a Critical Component of Multicultural Diversity**

Although age is not explicitly identified as a component of diversity in most discussions of cultural competency, the importance of considering age as a key component of diversity was noted decades ago in seminal aging policy documents including, *Older adults and mental health, Issues and opportunities* (AOA, 2001); and [Mental health: A report of the Surgeon General](#) (USDHHS, 1999).

In addition to considering age as a key component of diversity, the importance of examining diversity within the aging population itself, has been noted in [Mental Health: Culture, Race and Ethnicity - A Supplement to Mental Health: Report of the Surgeon General](#) (USDHHS, 2001), and by the Institute of Medicine (IOM)/National Academies of Sciences, Engineering, and Medicine (NASEM) reports, [Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare](#) (2002) and [How Far Have We Come in Reducing Health Disparities? Progress Since 2000](#) (2012). As described in these reports, in virtually every area of physical and mental health, most racially and ethnically diverse elders have as many or more problems than the majority population. The reports demonstrated the complexities of health care disparities. For example, racially and ethnically diverse elders are more likely to live in poverty and to be underinsured. In addition, the problems of health disparities are present even when income and access are plentiful. African American older adults, for example, are much less likely to receive routine diagnostic screenings for cancer and are less likely



to be referred to specialists for heart disease, pain control and a host of other disorders. The reports conclude that many social factors are at the root of disparities, including racism and unconscious stereotyping. Multicultural competencies are thus necessary to assist practitioners in avoiding, sustaining or increasing disparities through subtle behaviors and attitudes.

## **2. Demographic Diversity in the Aging Population**

In addition to accepting age as an essential component of diversity, psychologists must be prepared to competently address the needs and support the strengths of a *diverse* older adult population, defined by race and ethnicity, country of origin, religion, disability, age, gender, or sexual orientation. The demographic data that follow highlight the increasing diversity of our aging population, a group that defies simple characterization and encompasses divergent historical, social, and cultural experiences.

At this time, over 49 million Americans are currently age 65 and over, about one in every seven Americans (Administration on Community Living [ACL]/Administration on Aging [AOA], 2018). This population is projected to almost double by 2060. (U.S. Census Bureau, 2017). Over the next 40 years, not only will the overall number of persons 65 and over grow, but diversity among older adults will increase. Currently racial/ethnic minority elders comprise over 23 percent of all older Americans--9% were African-Americans (not Hispanic), 4% were Asian or Pacific Islander (not Hispanic), 0.5% were Native American (not Hispanic), 0.1% were Native Hawaiian/Pacific Islander, (not Hispanic), and 7% of persons 65+ identified themselves as being of two or more races. Persons of Hispanic origin (who may be of any race) represented 8% of the older population. Their rates of growth are expected to exceed those of Caucasians over the next 50 years. Between 2016 and 2030, the White (not Hispanic) population 65+ is projected to increase by 39% compared to 89% for older racial and ethnic minority populations, including Hispanics (112%), African-Americans (not Hispanic) (73%), American Indian and Native Alaskans (not Hispanic) (72%), and Asians (not Hispanic) (81%) (ACL/AOA, 2018).

Within racial/ethnic minority groups there is further diversity. For example, Asian Americans comprise 26-census-defined sub-ethnic groups. While some segments of the Asian population have been in the United States for many generations, others have arrived only recently. They have come from more than two dozen countries. They do not share a common language, a common religion, or a common cultural background.

Older women represent over 56 percent of the U.S. population aged 65 years and over, and 66 percent of the population age 85 years and over (Federal Interagency Forum on Aging-Related Statistics, 2016). The U.S. Census Bureau projects that by 2030, the number of women aged 65 years and over will double to 40 million (U.S. Census Bureau Population Division, 2006).

In 2014, 22 percent of the population age 65 and over reported having a disability as defined by limitations in vision, hearing, mobility, communication, cognition, and self-care. Older women were more likely to report any disability than older men (24 percent versus 19 percent). Non-Hispanic Blacks age 65 and over were more likely to report having any disability than non-Hispanic Whites (26 percent compared with 21 percent). The percentage of those age 65 and over reporting difficulties with cognition and self-care was higher among Hispanics compared with non-Hispanic Whites (6 percent versus 3 percent, and 5 percent versus 2 percent, respectively). Although



racial/ethnic minority groups have also shown a decline in disability over the decades, those who are living in poverty have shown the smallest declines in disability (Schoeni, Martin, Andreski, & Freedman, 2005). Thus, the intersection of race, ethnicity and poverty can account for increased disability.

Mental disabilities in late life are also on the rise. Of the approximately 20 percent of older adults will experience mental health problems, up to 4.8 percent have a Severe Mental Illness (SMI). Older adults with an SMI have substantially higher rates of diabetes, lung disease, cardiovascular disease and other comorbidities that are associated with early mortality, disability, and poor function (Bartels, 2011). They also have significant impairments in psychosocial functioning (Lin, Ahang, Leung, & Clark, 2011).

There are 4.5 million immigrants 65 years of age or older living in the United States, 12% of the immigrant population. Their top 10 countries of origin are Mexico (615,000, or 13.8 percent), Cuba (280,000, or 6.3 percent), the Philippines (259,000, or 5.8 percent), China (236,000, or 5.3 percent), Germany (232,000, or 5.2 percent), Canada (215,000, or 4.8 percent), Italy (195,000, or 4.4 percent), India (122,000, or 2.7 percent), Vietnam (120,000, or 2.7 percent), and Korea (116,000 or 2.6 percent) (Migration Policy Institute, 2009). In 2050, 16 million of the projected 81 million older adults will be foreign born (Pew Center, 2008).

The number of lesbian/gay/bisexual/transgender (LGBT) older adults is increasing. SAGE Advocacy & Services for LGBT Elders estimates that there are currently approximately 3 million LGBT adults over age 50. That number is expected to grow to 7 million by 2030 (SAGE, 2018). At later life, this issue commingles with age in many ways that expand the need for cultural competencies beyond that of just getting older and having an LGBT identity. If the essence of cultural competence is to affirm and value the dignity of the person different from the mode, then issues of age and LGBT require special attention (see APA Guidelines for Psychological Practice with Lesbian, Gay & Bisexual Clients, 2011; APA Guidelines for Psychological Practice with Transgender and Gender Nonconforming People, 2015; National Gay and Lesbian Task Force, 2005; SAGE, 2018).

While most older adults are not poor, poverty, including deep poverty, is growing in individuals over age 65. Ten percent of people age 65 and over live below the poverty threshold (Federal Interagency Forum on Aging-Related Statistics, 2016). Additionally, the proportion of older adults living in financially strained circumstances (that is, living at or below 50% of their area median income, the definition HUD uses to determine eligibility for social programs) is even higher and is estimated to be approximately 10% of the older population (Areán et al., 2010). According to analysis by the National Women's Law Center, the rate of deep poverty for men age 65 and older increased 23 percent between 2011 and 2012. For older women, it went up 18 percent. Overall, a total of 442,000 older adult men and 733,000 older women were living in deep poverty in America in 2012. Those in poor health are 1.5 times more likely to be in poverty (Renwick & Fox 2016). Being a woman doubles the odds of poverty, and being black triples the odds (Proctor, Semega, & Kollar 2016).

Religious beliefs and behaviors represent another area of diversity and are an important consideration when working with older people and their families. The United States has become the most religiously diverse nation in the world. In recent years, Muslims, Hindus, and Buddhists, and followers of many other religions have arrived here from every part of the globe, radically altering

the religious landscape of the United States. National surveys indicate that older adults attach a high value to their religious beliefs and behaviors. Research consistently shows that older people tend to be more deeply involved in religious activities than younger individuals. Ethnic and racial minority elders show a particularly high degree of participation in both organizational and nonorganizational (private) religious activities. Examples: older African Americans report significantly higher levels of religious participation than older Whites. In addition to church attendance, this participation may include reading religious materials, watching television programs, listening to religious music, and engaging in private prayers. Such activities can serve as a protective factor for psychological distress and well-being among older African Americans, although their absence may suggest a greater vulnerability (Jang, Borenstein, Chiriboga, Phillips, & Mortimer, 2006). As is true for older African Americans, the majority of older Hispanics view themselves as religious, attend religious services, and engage in private prayers and meditation. Such involvement is correlated with greater hope and optimism, a greater sense of meaning and purpose, and greater social support; and each of these mechanisms is thought to benefit mental health. In addition, church attendance represents a unique form of social engagement that may influence cognitive functioning (Hill, Burdette, Angel, & Angel, 2006). Since religious traditions and beliefs affect views about birth, life, and death, providers of psychological services need to have an understanding of these traditions.

While we celebrate the rich diversity in the population of aged persons, culturally diverse older adults do not share the same advantages as older adults with greater lifetime resources and access to health care (Bowen & González, 2008). Culturally diverse older Americans often are at greater risk of poor health, social isolation, and poverty, than are their younger counterparts. Evidence of racial and ethnic disparities can be found across a broad spectrum of health conditions and outcomes. Excessive deaths and excess morbidity and disability are prevalent among racial and ethnic minority elders. In 2013–2014, among people age 65 and over, non-Hispanic Blacks reported higher levels of hypertension and diabetes than non-Hispanic Whites (71 percent compared with 54 percent for hypertension, and 32 percent compared with 18 percent for diabetes). Hispanic older adults also reported higher levels of diabetes (32 percent) than non-Hispanic Whites, but lower levels of arthritis than non-Hispanic Whites (44 percent compared with 50 percent) (Federal Interagency Forum on Aging-Related Statistics, 2016).

Similarly, racial and ethnic minority and poor older adults are overrepresented in many subgroups at high risk for the development of mental illnesses, and they have less access to mental health services than Whites, are less likely to receive needed services, and often receive a lower quality of care. As a result, they incur a disproportionately high disability burden. This is especially the case with the minority elder who has a serious mental illness (Karlin, Duffy, & Gleaves, 2008). In addition, ten percent of people over the age of 65 live at or below the poverty line, and have higher rates of major depression (9 percent) than do community dwelling older adults (3.8 percent) (Gum, Areán, & Bostrom, 2007).

Compared with their U.S. born age peers (excluding Native Americans), older immigrants were more likely to have low incomes, although older immigrant men were more likely to remain in the workforce than White older men. Over one in every five older immigrants have limited mobility and one of every six report memory problems (Migration Policy Institute, 2009).

It has been documented that LGBT elders often do not access adequate health care, housing, caregiving and other social services that they need, due to institutionalized heterosexism. Several studies - of nursing home administrators, Area Administration on Aging directors, and health care

providers - document widespread homophobia among those entrusted with the care of America's older adults (National Gay and Lesbian Task Force, 2005). Many LGBT older adults are forced to hide their gender identity or sexual orientation in order to receive health care. LGBT older adults have higher rates of poor physical health and mental distress and 41 percent report having a disability, compared to 35 percent of heterosexual older adults (SAGE, 2018).

As discussed in the chapter, "Integrated healthcare and marginalized populations" by Banks, Buki, Gallardo, and Yee (2007) in *Humanizing healthcare: A handbook for healthcare integration: Volume I. Mind-body medicine*, the impact of marginalization on health care access must be considered. *Blueprint for Change: Integrated Health Care for an Aging Population* notes, "While many under-represented minority groups have limited access to health care, the issue of marginalization is also examined at the intersection of socioeconomic status (particularly poverty), gender and racial/ethnic identities. Rural older adults, for instance, be they non-Hispanic White or African American, may face the same marginalization issues when interacting with the health care system. As with ageism, health care providers themselves must be aware of their own biases and seek to limit the impact of these on patient care" (APA, 2007).

### **3. The Impact of Ageism on Cultural Diversity Efforts in Geropsychology Research, Education and Practice**

The search for a better understanding of the needs of elders from diverse populations can be informed by the substantial research dealing with a conceptually related problem: age discrimination, or ageism. Ageism is defined in the APA Resolution on Ageism (2001) as prejudice toward, stereotyping of, and/or discrimination against any person or persons directly and solely as a function of their having attained a chronological age which the social group defines as "old." Much research has demonstrated the pervasive and institutionalized nature of prejudice against older persons in the United States (Nelson, 2015; Ng, Allore, Trentalange, Monin, & Levy, 2015). Ageism is not only an endemic problem faced by older adults, but one that may disproportionately affect older persons of color. Several researchers (e.g., Munoz & Mendelson, 2005), for example, noted multiple jeopardy concerning older members of minority groups (e.g., older women of color). Aging with its attendant likelihood of discrimination may pose additional problems to persons who are vulnerable to discrimination or stereotypes by virtue of their sex, gender, ethnicity, race, disability status or sexual orientation.

As an important theory in psychology, Gordon Allport's Social Categorization Theory (Allport, 1954) provides a basic understanding why stereotypes about older adults may be negative and destructive. According to the theory, discrimination occurs through the creation of an "in-group" and an "out group" whereby people make sense of their world by creating categories and separate these categories into people like themselves or unlike themselves. Applying the backdrop of ageism, the older person is invariably relegated to the "out group." As a non-dominant (out) group, older adults are often viewed as homogeneous and possessed of a variety of negative characteristics. When compared to younger adults, older adults are more often viewed as (1) alike; (2) alone and lonely, (3) sick, frail and dependent, (4) depressed, (5) rigid and (6) unable to cope (Hinrichsen, 2006). This pervasive view ignores the incredible heterogeneity of the experience of aging, wide individual differences and the strengths, positive attributes and resilience of older adults.

Angus & Reeve (2006) cautioned that despite attempts at promoting views of successful or resourceful aging, negative images of aging and older adults endure among professionals. Regardless

of this warning, it is clear that ageism still affects health care practice. *Ageism in America* first documented the problem: thirty-five percent of physicians erroneously consider an increase in blood pressure to be a normal process of aging; 60% of older adults do not receive recommended preventive services; and only 10% receive appropriate screening tests for bone density, colorectal and prostate cancer, and glaucoma (International Longevity Center, 2006). Recent research confirms that older patients receive less treatment, and had more limitations in life-sustaining treatments, even when controlling for severity of illness (Brandberg, Blomqvist, & Jirwe, 2013).

Mental health professionals too, have historically displayed "professional ageism" dating back to Freud, who was pessimistic about psychological change or the benefits of therapy in later life (Kimmel & Moody, 1990). Indeed, ageism can translate into a professional's feelings of hopelessness and pessimism with the expectation of poor progress creating self-fulfilling prophecies and poor healthcare outcomes. Some mental health professionals show an age bias against older clients, and tend to avoid working with older clients due to negative stereotypes such as *old people are just lonely and want someone to talk to* (Adelman, Greene, Charon, & Friedman, 1990; Cuddy, Norton, & Fiske, 2005). Ageism also underlies findings such as the under-utilization of screening for functional ability, cognitive and affective functioning and the over-estimation of late life depression by many health providers who work with older adults (Lichtenberg, 2010). It has also been identified as one of the reasons why providers underestimate suicide risk in older patients (Institute of Medicine, 2012; Uncapher & Areán, 2000). Significantly, fewer suicidal older adult patients who were discharged home from an emergency department received a mental health evaluation when compared to similar younger adults (Arias, et al., 2017). Additional information regarding the impact of ageism on the attitudes and behaviors of health professionals can be found in Guideline 2 of the *Guidelines for Psychological Practice with Older Adults* (APA, 2014).

Ageism has a negative impact on professional training and education. Across professions, the geriatric mental health care workforce is not adequately trained to meet the health and mental health needs of the aging population (Institute of Medicine, 2012). This shortage is especially pronounced in states where there are substantial numbers of ethnically and racially diverse older adults. Gawande (2007) examined how the field of geriatrics is impacted by values, perception values, perceptions and feelings about growing old and old age. He concluded that despite the greatly increased numbers of older adults, there are fewer geriatric specialty training programs.

Geropsychology evidences a similar problem. While the 1992 Older Boulder conference reported significant progress made in the availability of geropsychology within clinical psychology programs since the early 1980's, there remained few programs available for students to choose from or to meet the growing workforce needs. At the 2006 National Conference on Training in Professional Geropsychology (Pikes Peak Conference) it was noted that there had been no increases in geropsychology programs during the past decade. There remain relatively few opportunities for formal geropsychology training at the graduate level, with only 10-15 programs offering a special geropsychology track (Perry & Boccaccini, 2009; Qualls, Scogin, Zweig, & Whitbourne, 2010). The 2018 Association of Psychology Postdoctoral and Internship Centers (APPIC) directory listed 101 accredited programs in the U.S. that provide a major rotation in geropsychology. While there are few training programs that focus on geropsychology, there are even fewer that provide in depth training in culturally competent geropsychology.

The paucity of training programs in professional geropsychology perpetuates the severe shortage of qualified and culturally competent mental and behavioral health professionals, including

psychologists, to provide services to America's aging population and the growing number of diverse elders. These shortages will only become more troublesome as the population ages and the demand for specialized mental health services increases. Currently, only 1.2% of practicing psychologists described geropsychology as their specialty area, although 37.2% reported seeing older adults frequently or very frequently, most often from the specialties of rehabilitation psychology, clinical neuropsychology, and clinical health psychology (APA, 2016). This number of psychologists will not be able to address the projected demand among the older adult population, which is the largest projected demand in 2030 among age groups within the U.S. The demand translates to 16,540 FTE psychologists, an increase of 5,790 FTEs from 2015. The increase consists of a 2,330 FTE increase in demand within the population of ages 65 to 74 years, and a 3,460 FTE increase within the population 75 years and older (APA, 2018).

At the scientific level, research shows that older adults are less likely to be included in clinical trials (Zulman et al., 2011). Clinical trials have traditionally involved predominantly white, human subjects, yet subsequent diagnostic tests and procedures have been used across age, racial and ethnic groups (Johnson & Smith, 2002). Likewise, screening tools such as the CES-D are often found to display systematic differences across racial/ethnic groups in how individuals respond to items (Kim, Chiriboga & Jang, 2009). In addition, age-related differences have also been reported in response to commonly used questionnaires to assess the cognitive functioning of older persons, using such screening tests as the Mini Mental State Examination, where increasing age and associated variables are related to poorer performance in the absence of any significant cognitive impairment (e.g., Crum, Anthony, & Bassett, 1993). For additional information on issues related to psychological assessment of older adults, see the guidelines 10-12 in the [\*Guidelines for Psychological Practice with Older Adults\*](#) (APA, 2014) and in [\*Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists\*](#), Appendices B-F (ABA & APA, 2008). In addition, older adults are often excluded from clinical trials even though they are often disproportionately affected by the diseases being studied. For example, older adults are significantly underrepresented in clinical treatment trials for all types of cancer, especially in trials for treatment of breast cancer (International Longevity Center, 2006).

Finally, ageism affects the physical and psychological health of older adults, as older adults themselves can harbor negative age stereotypes (Levy, 2009). These negative age stereotypes have been found to predict an array of adverse outcomes such as worse physical performance (Levy, Slade, & Kasl, 2002), worse memory performance (Levy, Zonderman, Slade, & Ferrucci, 2012) and reduced survival (Levy, Slade, Kunkel, & Kasl, 2002). Conversely, positive self-perceptions of aging predict better functional health over time. Older individuals with more positive self-perceptions of aging, measured up to 23 years earlier, lived 7.5 years longer than those with less positive self-perceptions (Levy, Slade, Kunkel, & Kasl, 2002). We believe that culturally sensitive interventions must facilitate these person constructs and in general maximize accessibility of interventions and services, given the cultural values and beliefs of the client in the population in question.

## **Section 4: Recommendations for Geropsychology Practice, Training, Research and Public Policy with Diverse Elders**

The Committee on Aging (CONA) and its Working Group on Multicultural Competency in Geropsychology offer the following recommendations for consideration by APA governance, divisions, other constituent groups, and members. Given the breadth of this issue, CONA believes that the process of prioritizing the recommendations and developing an implementation plan are beyond the scope of what could be accomplished during one face-to-face meeting of its Working Group. The intent of this document is to spur future initiatives through consideration of the multitude of actions that could be taken to promote and achieve multicultural competency in geropsychology.

CONA and the APA Office on Aging continue the work begun by the Working Group. In addition, CONA encourages other APA governance and constituent groups to review these recommendations and think about how they could best change their approach to practice, education and training, research, and policy in their organizations or other professional activities. CONA welcomes collaboration with other APA entities and professional groups in the implementation of these recommendations.

### Overarching Recommendations

*Recommendation 1:* Psychologists are encouraged to counter ageism in their professional and personal lives. This first recommendation impacts all of the following recommendations. Unfortunately, ageism is at the stage of awareness in the general public and among psychologists that racism and sexism were 25 years ago. This aspiration recommendation can best be realized by an openness that fosters, in the professional, an adaptation that is sensitive to racial and ethnic minority issues, a review of cultural values, and openness to multicultural context and complexity.

*Recommendation 2:* Psychologists are encouraged to consider age as a critical component of cultural diversity and to appreciate the diversity within the aging population itself. The existing multicultural theoretical frameworks can and should be applied to geropsychology and older adults both as a group and as diverse individuals. As one example in the practice arena, D.W. Sue and D. Sue (2002) believe that the helping agent should gain skills to supplement the effective practices and coping and support systems which already exist in a given culture rather than replacing them with the mainstream approach to mental health care. The psychologist may need to perform unconventional roles (e.g., outreach, ombudsman, consultant, and facilitator of support systems) outside of his or her office. These roles are particularly relevant to practice with older adults. For example, the psychologist might assume the ombudsman role to facilitate communication between the client and the nursing staff in a long-term care facility.

*Recommendation 3:* Psychologists are encouraged to take into consideration both the individual aspects of diversity and the intersection of cultural identity within the aging population. It is essential that psychologists be knowledgeable about the ways in which people's position in terms of gender, race and ethnicity, country of origin, religion, disability, age gender, sexual orientation, and social class affect (a) their exposure to risk factors associated with physical and mental health; (b) their health status; and (c) the quantity and quality of health care resources available to them.

*Recommendation 4:* Psychologists working with older persons from various ethnic and racial backgrounds should consider characteristics that can affect adjustment and well being, including:

country of origin - culture, beliefs, traditions, and values; immigration history – circumstances and time in U.S.; perceived importance of interacting with mainstream society; English proficiency; educational attainment; religious affiliation and practices and beliefs about life and death; sexual orientation; income and other economic resources; and social support.

*Recommendation 5:* Psychologists are encouraged to view culture and difference/diversity as a strength and to build upon the skills an older adult has developed over a lifetime of experience in coping and building support networks. Many older adults have learned important ways of coping with life's stressors and have developed impressive resilience that is informed, not only by their experiences but also by their specific cultural beliefs and values. Variations in culture and experience bring variations in perspective and ways of coping.

#### Education and Training Recommendations

*Recommendation 6:* Insure that aging is a vital component of the core diversity competency that is a required part of APA-approved graduate programs and internships in a matter that reflects the relevant issues of the life span. This will enable all psychologists to have a basic understanding and appreciation for age as one component of diversity.

*Recommendation 7:* Develop a plan of action to increase the number of programs with geropsychology emphases at graduate, internship, and post doctoral levels. Require that multicultural aging be included as an integral component in these programs.

*Recommendation 8:* Develop an ethnogeriatric curriculum for training in mental health and aging among diverse ethnic groups for psychologists, comparable to the set developed by Stanford Geriatric Education Center for nurses, social workers, occupational therapists, and other professions (<https://geriatrics.stanford.edu/ethnomed.html>).

*Recommendation 9:* Psychologists in training and currently in practice should seek independent learning opportunities in multicultural geropsychology and avail themselves of opportunities for training at professional meetings and through continuing education programs. Such training can focus on the relationship between the 21 specified areas of the *Guidelines for Psychological Practice with Older Adults* and how these relate to multicultural aging competence. This is one mechanism to counter the lack of formal education and training opportunities previously noted, and the resulting dearth of competently trained psychologists to deal effectively with the complex area of sociocultural realities with which older adults must contend. In addition, there is a need to develop multimedia resources and other innovative technology, such as web-based CE, for teaching multicultural geropsychology topics.

*Recommendation 10:* Design and conduct a professional education campaign aimed at increasing widespread awareness and understanding that health beliefs, behaviors, and outcomes are affected by the intersections of elements of diversity such as gender, race and ethnicity, religious affiliation, socioeconomic status, community location, and sexual orientation.

*Recommendation 11:* Educate the public about common mental disorders among older individuals to eliminate stigma and discrimination, and reduce barriers to access mental and behavioral health services utilizing culturally sensitive materials and dissemination vehicles.



## Practice Recommendations

*Recommendation 12:* “Psychologists are encouraged to recognize how their attitudes and beliefs about aging and about older individuals may be relevant to their assessment and treatment of older adults, and to seek consultation or further education about these issues when indicated” (APA Guidelines for Psychological Practice with Older Adults, 2014).

*Recommendation 13:* Health and mental/behavioral health services for older adults, including outreach and identification; screening; assessment; health promotion; chronic disease management; and psychotherapeutic interventions should be tailored to the needs and preferences of older adults, with particular attention to diversity within the older adult population served. “Special clinical problems can arise uniquely in old age, and may require additional diagnostic skills or intervention methods that can be applied, with appropriate adaptations, to the particular circumstances of older adults” (APA, 2014). In addition, cultural and linguistic competency issues may challenge the psychologist in a multitude of situations such as when the older adult makes decisions or presents issues that are influenced by religious and/or spiritual beliefs.

*Recommendation 14:* A necessary addition to psychology training programs is the inclusion of rotations in primary care medicine and home health care settings working where diverse elders are served. Trainees can learn the nuances of working with in these settings, as well as the interventions that work best with diverse populations. Several studies have shown that older adults prefer to be treated in primary care medicine with the involvement of their physicians. Although there have been advances in the integration of mental health care into primary care medicine, these models are only effective if psychological interventions are tailored for the primary care setting (e.g. Problem-Solving Treatment) and the population served, and are readily available in these settings. For example, approximately 50% of all older adults state a preference for counseling services over medication management; with older African Americans particularly inclined toward counseling services. Additionally, frail and disabled older adults have difficulty even accessing primary care medicine. Interventions tailored to the needs of these diverse groups are necessary.

*Recommendation 15:* Promote the latest evidence-based treatments/interventions with increased emphasis on community-based treatment approaches, as well as approaches suited to health care settings; cultural and linguistic competence and related approaches for reducing racial and ethnic disparities in access, treatment, and outcomes; and interdisciplinary treatment approaches and services, including primary health and mental and behavioral health care.

*Recommendation 16:* Client language and knowledge barriers must be addressed. Limited English proficiency (LEP) is increasingly common and represents a particular challenge to those who provide a “talking cure.” “Literacy generally, and health literacy specifically, greatly impact the effectiveness of engaging patients in self-management of chronic disease. The issues of language, health literacy and cultural differences all can affect willingness to enter into treatment and follow through on the health care recommendations” (APA Blueprint for Change: Achieving Integrated Health Care for an Aging Population, 2007).

## Research Recommendations

*Recommendation 17:* Greater attention must be given to expanding the research knowledge base related to the efficacy of psychological interventions for late-life mental disorders and in particular with respect to racially and ethnically diverse older adults.

*Recommendation 18:* Apply Guideline 9 of the APA Multicultural Guidelines to geropsychology research: “Psychologists strive to conduct culturally appropriate and informed research, teaching, supervision, consultation, assessment, interpretation, diagnosis, dissemination, and evaluation of efficacy as they address the first four levels of the *Layered Ecological Model of the Multicultural Guidelines*” (APA, 2017 p. 83). A cadre of researchers sensitive to the impact of multicultural diversity issues in geropsychology and skilled in methodologies capable of examining variability due to cultural diversity is necessary to prepare for increasing diversity of the growing older adult population.

*Recommendation 19:* Institutes that are part of the National Institutes of Health, such as the National Institute of Mental Health, and the National Institute on Aging, must pay greater attention to the development of research focusing on the health and well-being of diverse elders. For example, there is widespread failure of governmental and academic researchers to include questions about sexual orientation or gender identity in their studies of older adults (National Gay and Lesbian Task Force, 2005).

#### Public Policy Recommendations

*Recommendation 20:* Support federal initiatives to train psychologists to address the mental health workforce needs of our increasingly diverse population of elders, including the geropsychology training grants in the Graduate Psychology Education (GPE) Program and expansion of the geriatric education and training programs under Title VII of the Public Health Service Act.

*Recommendation 21:* Support existing and develop additional programs to recruit, develop and retain researchers sensitive to cultural diversity issues in geropsychology and skilled in methodologies for appropriately examining issues of cultural diversity, including MANIP, RCMAR, and the Minority Fellowship Program.

*Recommendation 22:* Increase funding for federal programs (including Medicare, Medicaid, and the Older Americans Act) to expand the availability of quality mental and behavioral health and related supportive services for older adults.

*Recommendation 23:* Support initiatives that integrate mental and behavioral health in primary care and other settings where racially and ethnically diverse older adults receive services.

*Recommendation 24:* Support federal initiatives to eliminate disparities in mental health status and mental health care of older adults through the use of psychological and behavioral research and services that are culturally and linguistically competent.

*Recommendation 25:* Advocate for increased federal funding for the National Institute on Aging (NIA) and the National Institute on Mental Health (NIMH) for multicultural geropsychology research, particularly regarding mental health and mental health care disparities among the aging population.

## **Resources in Multicultural Competence and Aging**

Additional resources that address issues related to multicultural competence and aging are available in the Multicultural Aging Resource Guide developed and regularly updated by the APA Office on Aging. The Guide can be found here:

<http://www.apa.org/pi/aging/resources/guides/multicultural.aspx>

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