APA GUIDELINES for Psychological Practice With Older Adults

GUIDELINES FOR PSYCHOLOGICAL PRACTICE WITH OLDER ADULTS REVISION WORKING GROUP

APPROVED BY APA COUNCIL OF REPRESENTATIVES
FEBRUARY 2024

AMERICAN PSYCHOLOGICAL ASSOCIATION

Suggested Citation
American Psychological Association (2024). Guidelines for Psychological Practice With Older Adults.
Retrieved from https://www.apa.org/practice/guidelines/older-adults.pdf

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Guidelines for Psychological Practice with Older Adults Revision Working Group

Erin E. Emery-Tiburcio, PhD, ABPP (cochair)
Center for Excellence in Aging at RUSH University Medical Center

Richard Zweig, PhD, ABPP (cochair)
Yeshiva University

Mark Brennan-Ing, PhD
Brookdale Center for Healthy Aging at Hunter College, the City University of New York

Bonnie Sachs, PhD, ABPP
Wake Forest University School of Medicine

Veronica Shead, PhD
VA St. Louis Health Care System

Ira Yenko, PsyD
Zucker School of Medicine at Hofstra/ Northwell, Psychiatry

APA Aging Portfolio Director and Workgroup Group Liaisons

Latrice Vinson, PhD, MPH
Office on Aging

Amani Basker
Governance Office

Rose Burke
Intern

Laurie Chin, MA
Intern

Nicole Herrera, MS
Intern

Caitlin Reynolds
Intern

Claire Williams
Intern

TABLE OF CONTENTS

Introduction

The "Guidelines for Psychological Practice with Older Adults" are intended to assist psychologists in evaluating their own readiness for working with older adults, as well as seeking and using appropriate education and training to increase their knowledge, skills, and experience relevant to this area of practice. Although "older adults" typically refers to persons 60-65 years of age and older, gerontological researchers and policy makers increasingly recognize that this demarcation is socially constructed, and is linked to many socio-cultural referents, including family status, lived experience, and health conditions that vary widely across generational cohorts and socioeconomic and cultural groups (Baltes & Smith, 2003; Diehl et al., 2020; United Nations [UN], 1991; World Health Organization [WHO], 2017b). It is notable that adults over age 50 with problems such as serious mental illness (Chan et al., 2022; Olfson et al., 2015) or human immunodeficiency virus (HIV; High et al., 2012), and those who are sexual and gender minorities (SGM) are often considered "older adults" given their experience of increased incidence of multiple chronic conditions, sometimes shorter expected lifespan, and similar challenges to those faced by adults age 65 and older (Brennan-Ing et al., 2014; Fredriksen-Goldsen et al., 2013; Lampe et al., 2023; Melo, et al., 2023; Stacey & WIslar, 2023). The current Guidelines draw on research which flexibly employs various age cutoffs consistent with this nuanced approach. We use "older adults" in this document since it is commonly used by geropsychologists and is the recommended term in American Psychological Association publications (American Psychological Association [APA], 2010a) and inclusive language Guidelines (https://www.apa.org/about/apa/equity-diversity-inclusion/language-Guidelines).

The specific goals of these professional practice Guidelines are to provide practitioners with (a) a frame of reference for engaging in professional work with older adults; and (b) basic information and further references in the areas of attitudes, general aspects of aging and broad impacts of intersectionality, clinical issues, assessment, intervention, consultation, professional issues, and continuing education and training relevant to practice. The Guidelines recognize and appreciate that there are numerous methods and pathways whereby psychologists may gain expertise and/or seek training in working with older adults. This document is designed to offer recommendations on those areas of awareness, knowledge and clinical skills considered as applicable to this work, rather than prescribing specific training methods to be followed (see Hinrichsen et al., 2018 and Hinrichsen & Emery-Tiburcio, 2022 for more guidance). The Guidelines also recognize that some psychologists will specialize in the provision of services to older adults and may therefore seek more extensive training consistent with practicing within the formally recognized specialty of Geropsychology (APA, 2010b, 2008a), at the doctoral, internship, postdoctoral, or post-licensure levels (Council of Professional Geropsychology Training Programs [CoPGTP], 2022; American Board of Geropsychology [ABGERO], 2022).

These professional practice Guidelines are an update of "Guidelines for Psychological Practice with Older Adults" (APA, 2014a) completed by the Guidelines for Psychological Practice with Older Adults Revision Working Group convened by the Committee on Aging, APA Division 20 (Adult Development and Aging) and APA Division 12, Section II (Society of Clinical Geropsychology) and approved as policy of APA by the Council of Representatives in August 2013. The term "Guidelines" refers to pronouncements, statements, or declarations that suggest or recommend specific professional competencies, behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Thus, Guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help ensure a high level of professional practice by psychologists. These professional practice Guidelines (heretofore referred to as "Guidelines") are not intended to be mandatory or exhaustive and may not be applicable to every clinical situation.

The Guidelines should not be construed as definitive and are not intended to take precedence over the professional judgment of psychologists. Guidelines essentially involve recommendations regarding professional conduct and issues to be considered in particular areas of psychological practice. Professional practice Guidelines are consistent with current APA policy. It is important to note that professional practice Guidelines are superseded by federal and state law and must be consistent with the current APA Ethical Principles of Psychologists and Code of Conduct (APA, 2017a). These Guidelines were developed for use in the United States but may be appropriate for adaptation in other countries.

Need

A revision of the Guidelines is warranted at this time as psychological science and practice in the area of geropsychology have evolved rapidly. Clinicians and researchers have made impressive strides toward identifying the unique aspects of knowledge that facilitate the accurate psychological assessment and effective treatment of older adults as the psychological literature in this area continues to burgeon.

As noted in the 2013 Guidelines for Psychological Practice with Older Adults (APA, 2014a), professional psychology practice with older adults has been increasing, due to the changing demography of the population, changes in service settings such as telehealth, and market forces. The inclusion of psychologists in Medicare in 1989 markedly expanded reimbursement options for psychological services to older adults. Today, psychologists provide care to older adults in a wide range of settings from home and community-based clinics, to telehealth, integrated primary care, and long-term care settings. Nonetheless, older adults with mental disorders are less likely than younger and middle-aged adults to receive mental health services and, when they do, are less likely to receive care from a mental health specialist than younger persons (Bogner et al., 2009; Choi et al., 2015; Institute of Medicine, 2012; Jacobs & Bamonti, 2022). Further, older people of color are less likely to receive adequate mental health care (Chen et al, 2022; Jimenez et al., 2013). The (2021) *Resolution on APA, human rights, and psychology* notes the role psychology plays in protecting older persons and other vulnerable populations from discrimination, repression, and environmental injustice; including the promotion of economic, social, and cultural wellbeing; and working to reduce the suffering caused by individual and systemic violations of human rights.

Unquestionably, the demand for psychologists with a substantial understanding of later life wellness, cultural, and clinical issues will expand as the older population grows and becomes more diverse, and as cohorts of younger individuals who are receptive to psychological services move into old age (Carpenter et al., 2022; Karel et al., 2012). However, psychologists' training devoted to care of older adults does not and likely will not meet the anticipated need (Hoge et al, 2015; Karel, et al., 2012; Moye et al., 2018; See also 2018 *APA: A Summary of Psychologist Workforce Projections*). Indeed, across disciplines, the mental health care workforce is not adequately trained to meet the health and mental health needs of the aging population (Hinrichsen et al., 2018; Hoge et al., 2015; Institute of Medicine, 2012).

Older adults are served by psychologists across subfields, including clinical, counseling, family, geropsychology, health, Industrial-organizational psychology, neuropsychology, and rehabilitation. The 2018 APA Center for Workforce Studies survey of over 4000 U.S. Psychologists (61% female, 86.7% non-minority, 92.6% heterosexual) found that only 1% of respondents viewed older adults as their primary focus, although 37% reported that they provide some type of psychological services to older adults (Moye et al., 2018). However, relatively few psychologists have received formal training in geropsychology. Fewer than one third of APA member practicing psychologists conducting clinical work with older adults reported any graduate coursework in geropsychology, and fewer than one in four received any supervised practicum or internship experience with older adults (Qualls et al., 2002; Segal et al., 2012; Moye et al., 2018). Many psychologists may be reluctant to work with older adults, citing perceived low Medicare reimbursement rates, or because they feel they lack the requisite knowledge and skills. In the practitioner survey conducted by Qualls and colleagues (2002), a high proportion of the respondents (58%) reported that they needed further training in professional work with older adults, and 70% said that they were interested in attending specialized education programs in clinical geropsychology. In the APA Workforce study, there was strong interest in further training in aging among psychologists (Moye et al., 2018).

Compatibility

These Guidelines build upon APA's Ethics Code (APA, 2017a) and are consistent with the "Criteria for Practice Guideline Development and Evaluation" (APA, 2002) and preexisting APA policy related to aging issues. These policies include but are not limited to the "Resolution on Ageism" (APA, 2020a), "Presidential Task Force on Integrated Health Care for An Aging Population" (APA, 2008b), "Resolution on Family Caregivers" (APA, 2011b), "Resolution on Palliative Care and End-of-Life Issues" (APA, 2017d), "Resolution on Assisted Dying" (APA, 2017c), Resolution of the 2015 White House Conference on Aging" (APA, 2015b) and the "Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change" (APA, APA Task Force for the Evaluation of Dementia and Age-Related Cognitive Change, 2021).

The Guidelines are also consistent with the efforts that psychology has exerted over the past two decades to focus greater attention on the strengths and needs of older adults, and to develop workforce competency in working with older adults. Building on the adoption of the Guidelines for Psychological Practice with Older Adults (APA, 2004), the National Conference on Training in Geropsychology was held in 2006 (funded in part by APA) and resulted in the development of the Pikes Peak Model for Training in Professional Geropsychology at the doctoral, internship, postdoctoral, and postlicensure levels (Knight et al., 2009). That same year, the Council of Professional Geropsychology Training Programs (CoPGTP) was established "to promote state-of-the-art education and training in geropsychology among its members, to provide a forum for sharing resources and advancements in and among training programs, and to support activities that prepare psychologists for competent and ethical geropsychology practice" (CoPGTP, 2022). This organization has developed geropsychology training taxonomy Guidelines at the predoctoral, internship, and postdoctoral levels (APA, 2020c). In 2010, the APA Commission on the Recognition of Specialties and Proficiencies in Professional Psychology recognized Geropsychology as a specialty in professional psychology. In 2014, the American Board of Professional Psychology Geropsychology specialty board launched board certification in geropsychology (ABPP; ABGERO, 2022). There are now multiple paths for psychologists to gain geropsychology competencies and have these certified by well-recognized credentialing bodies (https://gerocentral.org/training-career/seminarsce/). For example, the E4 Center of Excellence for Behavioral Health Disparities in Aging and CATCH-ON Geriatric Workforce Enhancement Program have created an online certificate program in the Foundational Competencies for Older Adult Mental Health that is certified by the Council of Professional Geropsychology Training Programs (https://e4center.org/training-andtechnical-assistance/foundational-competencies-in-older-adult-mental-health-certificateprogram/). Recognizing that there will not be enough geropsychologists to meet the mental health needs of older adults in the foreseeable future, a workgroup of the Council of Professional Geropsychology Training Programs (CoPGTP) led by Hinrichsen and colleagues (2018) surveyed geropsychologists to determine which of the Pikes Peak competencies were critical for generalists to develop basic competency. Results indicated weighting of each of the competencies in a 16-hour exposure-level training. Subsequently, a special issue of *Clinical Psychology: Science and Practice* (see Hinrichsen & Emery-Tiburcio, 2022) was devoted to delineating these basic competencies with foundational knowledge for all psychologists.

Within APA, the Committee on Aging (CONA) and several directorates and offices have ongoing initiatives to actively advocate for the application of psychological knowledge to issues affecting the health and well-being of older adults and to promote education and training in aging for all psychologists at all levels of training and at post licensure (See APA, 2021a). In the past two decades, aging has been a major focus of three APA Presidential Initiatives – Dr. Sharon Brehm's Integrated Health Care for an Aging Population initiative (APA, 2008b), Dr. Alan Kazdin's Psychology's Grand Challenges: Prolonging Vitality initiative (APA, 2014b), and Dr. Carol Goodheart's Family Caregivers initiative (APA, 2011b). Further, many divisions within APA, in addition to Division 20 (Adult Development and Aging) and Division 12-Section II (Society for Clinical Geropsychology), and some state, provincial and territorial psychological associations have initiated aging interest groups and other efforts directed toward practice with older adults.

Development Process

In 2021, the APA Policy and Planning Board (P&P) in accordance with Association Rule 30-8.4, provided notice to Division 20, Division 12-Section II, and the Aging Portfolio that on December 31, 2023, the APA Guidelines for Psychological Practice with Older Adults would expire. The Board of Professional Affairs (BPA) and the Committee on Professional Practice and Standards (COPPS) then conducted a review and recommended that the Guidelines should not sunset, and that revision was appropriate. Upon notice of expiration, the Presidents of Division 20, Division 12-Section II, and the Chair of CONA made recommendations for members of the Guidelines for Psychological Practice with Older Adults Revision Working Group who represented multiple diverse constituent groups – practice (including independent practice), science, multicultural diversity, early career psychologists, and those with experience in Guidelines development. CONA's parent board, the Board for the Advancement of Psychology in the Public Interest (BAPPI), concurred with the proposed members of the Working Group, who were then approved by the APA Board of Directors.

The members of the Guidelines for Psychological Practice with Older Adults Revision Working Group are: Erin

E. Emery-Tiburcio, Ph.D., ABPP (Co-Chair), Richard Zweig, Ph.D., ABPP (Co-Chair), Mark Brennan-Ing, Ph.D., Bonnie Sachs, Ph.D., ABPP, Veronica Shead, Ph.D., and Ira Yenko, Psy.D., with support from APA Aging Portfolio Director and Workgroup Group Liaisons Latrice Vinson, Ph.D, MPH and Amani Basker, and interns Rose Burke, Laurie Chin, M.A., Nicole Herrera M.S., Caitlin Reynolds, and Claire Williams. Working Group members considered the recent relevant background literature as well as the references contained in the initial Guidelines for inclusion in the revision of the Guidelines. They participated in formulating and/or reviewing all portions of the Guidelines document and made suggestions about the inclusion of specific content and literature citations. No financial support was received from any group or individual, and no financial benefit to the Working Group members or their sponsoring organizations is anticipated from approval or implementation of these Guidelines.

These Guidelines have been re-organized into six sections to be consistent with the Pikes Peak competencies (Knight et al., 2009): (a) Attitudes; (b) General Knowledge about Adult Development, Aging, and the Older Adult Population; (c) Foundations of Geropsychology Practice; (d) Assessment; I Intervention; and (f) Consultation. Efforts were made to identify the best fit for each guideline, with recognition that some Guidelines may span multiple Pikes Peak competencies. Reorganization of the

Guidelines was based upon consensus of workgroup members and informed by subject matter experts. Additionally, it is notable that two significant revisions were made to the structure of the 2013 Guidelines. First, the original Guideline 11 was deemed to be redundant with other Guidelines, and thus was removed. Second, given increased technology and telehealth use, an additional guideline was developed to provide recommendations for psychologists in the provision of telehealth care to older adults. Consideration was given to including telehealth in Guideline 8, which focuses on settings of care. The Task Force determined that the significant emergence of telehealth in recent years, along with common misperceptions about older adult use of telehealth, warranted the development of its own guideline.

Attitudes

GUIDELINE 1

Psychologists are encouraged to work with older adults within their scope of competence.

Rationale

Professional psychology training provides general skills that can be applied for the potential benefit of older adults. Many older adults have presenting issues similar to those of other ages and generally respond to the repertoire of skills and techniques possessed by all professional psychologists. Given some commonalities across age groups, considerably more psychologists may want to work with older adults, as many of their existing skills can be effective with these clients (Karel et al., 2012; Moye et al., 2018). However, in some circumstances, special skills and knowledge may be essential for assessing and treating certain problems in the context of later life (Segal et al., 2018; Qualls, 2022). Psychologists working with older adults can benefit from specific preparation for professional work with this population. Education and training in the biopsychosocial processes of aging along with an appreciation for and understanding of cohort factors can help ascertain the nature of the older adult's clinical issues. Although it would be ideal for all practice-oriented psychologists to have completed courses relating to the aging process and older adulthood as part of their clinical training (Karel et al., 2010), this is not the case for most. One barrier is the small number of training programs and increasing movement of first exposure to geropsychology content later in training due to barriers in sustaining the current geropsychological academic workforce (Dorman et al. 2021, Strong et al, 2021). Psychologists who frequently work with older adults strive to obtain training in gerontology in order to practice within their scope of competence (Moye et al., 2018).

Application

Psychologists are often called upon to evaluate and/or assist older adults with life stress or crisis (Brown et al., 2012) and adaptation to late life issues (e.g., chronic medical problems affecting daily functioning, caregiver stress; Moye et al., 2019). Psychologists play an equally important role facilitating the maintenance of healthy functioning, accomplishment of new life-cycle developmental tasks, and achievement of positive psychological growth in the later years (O'Rourke et al., 2018). However, other problems may be more prevalent among older adults than younger adults (e.g., sleep disorders, dementia, delirium), or may manifest differently across the lifespan (e.g., anxiety, depression, loneliness, substance use), or may require modifications to treatment approaches (Jacobs & Bamonti, 2022; Ong et al., 2016; Yardley et al., 2015).Clinical work with older adults may involve a complex interplay of factors, including developmental issues specific to later life, cohort (generational) perspectives and beliefs (e.g., family obligations, perceptions of mental disorders), comorbid physical illnesses, the potential for and effects of polypharmacy, cognitive or sensory impairments, a history of medical or mental disorders, and psychosocial issues such as social isolation and loneliness, or financial insecurity (Donovan & Blazer, 2020; Pharr et al., 2014; Raposo et al., 2014; Thompson et al., 2016; Wastesson et al., 2018). The potential interaction of these factors makes the field highly challenging and calls for psychologists to skillfully apply psychological knowledge and methods. Additionally, consideration of the client's age, gender identity and expression, sexual orientation, relationship style and status, cultural background, immigration status or history, degree of health literacy, prior experience with mental health providers, resiliencies, and usual means of coping with life problems inform interventions (Barker, 2019; Clauss-Ehlers et al., 2019; Layland et al., 2020; Musich et al., 2018).

Psychologists can match the extent and types of their work with their scope of competence (APA 2017a) and can seek consultation or make appropriate referrals when the problems encountered lie outside of their expertise. The Guidelines also may help psychologists who wish to further expand their knowledge base in this area through continuing education and self-study. Further, the Council of Professional Geropsychology Training Programs (CoPGTP) published recommendations for foundational competencies all psychologists endeavor to attain in working with older adults (Hinrichsen et al., 2018).

Psychologists may reflect on their competencies to engage in practice with older adults in line with section 2.01 of the APA Ethics Code (APA, 2017a). A similar process of self-reflection and commitment to learning also extends to psychologists serving as teachers and/or supervisors to students along a wide continuum of training. When supervising doctoral and postdoctoral psychology students, psychologists are encouraged to consider their own level of awareness, knowledge, training, and experience in working with older adults, especially given the movement toward a competence-based model of supervision (Falender & Shafranske, 2017). In addition to self-reflection, standardized self-evaluation tools, such as the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool, can be helpful with this process for both the supervisor and trainee (Karel et al., 2010; Karel, et al., 2012). The following Guidelines, particularly Guideline 12, direct the reader to resources for psychologists interested in furthering their knowledge of aging and older adults.

GUIDELINE 2

Psychologists are encouraged to recognize ways in which their attitudes and beliefs about aging and about older adults may be relevant to their assessment and treatment of older adults, and to seek consultation or further education about these issues when indicated.

Rationale

The attitudes and beliefs of psychologists about aging and older individuals can significantly impact their assessment and treatment of older adults. It is crucial for psychologists to recognize their own perspectives and biases when working with this population. Principle E of the APA Ethics Code (APA, 2017a) emphasizes the importance of eliminating cultural and sociodemographic stereotypes and biases, including ageism, in professional practice. The APA Council of Representatives passed an update to their 2002 resolution opposing ageism and continued to commit the Association to its elimination as a matter of APA policy (APA, 2020a).

Ageism has been recognized by the World Health Organization as a global public health issue (WHO, 2021). It is essential for psychologists to challenge and address these biases to ensure the provision of ethical and effective care. Moreover, recognizing the diverse strengths and resilience of older adults is vital for promoting their well-being and countering age-related stereotypes.

Psychologists strive to be aware of the potential impact of their attitudes and beliefs on their clinical work and the importance of seeking consultation or further education when needed. By developing a deeper understanding of intersectionality, psychologists can enhance their assessment and treatment approaches to better serve older adults. Taking steps to examine and overcome personal biases will contribute to more realistic perceptions of older adults' capabilities, strengths, and vulnerabilities. We recognize that older adults represent an extremely vibrant group that demonstrates a multitude of strengths including enhanced resilience and coping abilities (Fuller et al., 2021; Chen et al., 2018). Overall, this guideline aims to promote equitable and inclusive care for older adults by addressing and eliminating ageism within the field of psychology.

Application

Self-Reflection and Awareness: The concept of ageism has evolved over time, now conceptualized as a "form of oppression deeply embedded in social structures" (Krekula et al., 2018, p. 33), and operating on multiple levels: intra/interpersonal (micro level), within social networks and communities (meso level), and through institutional policies and cultural traditions (macro level; Iversen et al., 2009). Ageist attitudes can also operate discreetly and without intentional malice (i.e., implicit biases; Nelson, 2005). Further, the targets of these negative attitudes can be other-directed (e.g., what we think about other older adults) or self-directed (e.g., possessing negative feelings regarding one's own aging; Ayalon & Tesch-Romer, 2017). Elderspeak, a simplified way of speaking to older adults which mimics baby talk, is patronizing (Mungas et al., 2021). Even persons with severe dementia respond with behavioral resistance when spoken to in an infantilizing manner (Shaw et al., 2018). Psychologists engage in self-reflection to identify their own attitudes and beliefs about aging and older individuals. This introspective process helps in recognizing any biases or stereotypes that may influence their work. Increasing self-awareness allows psychologists to approach their practice with a more objective and unbiased mindset.

Consultation and Education: When psychologists recognize the need for further understanding or guidance regarding ageism and related issues, they seek consultation or pursue continuing education opportunities. Consulting with colleagues, experts in the field, or specialized training programs can provide valuable insights and strategies for addressing ageism in practice.

Intersectionality Perspective

In order to foster a nuanced understanding of ageism and its outcomes, researchers have emphasized the importance of viewing ageism from an Intersectionality Perspective (Ayalon et al., 2018; Rocha et al., 2022). Intersectionality, a term coined by Kimberle Crenshaw (Crenshaw, 2017) acknowledges that age intersects with other aspects of identity, such as race/ethnicity, gender identity, class, and sexual orientation (Ayalon et al., 2018). Understanding the interconnectedness of these factors helps psychologists consider the unique experiences and challenges faced by older adults from diverse backgrounds.

Challenging Stereotypes: There are many inaccurate stereotypes of older adults that can contribute to negative biases (Lamont et al., 2015) and affect the delivery of psychological services, such as providers being less willing to work with older adults or being skeptical of the efficacy of psychotherapy with this population (Ayalon & TeschRömer, 2018, Bodner et al., 2018; Knight, 2009, Whitbourne & Martins, 2020). These stereotypes are enmeshed within society and characterize older adults as possessing homogeneous, often undesirable, traits. For example, stereotypes include the views that age invariably results in dementia or decline in general ability; older adults are unemployable due to their inefficiency; all employees should retire at the same fixed age; older adults are inflexible and stubborn; older adults are socially isolated or dependent; and older adults have no interest in sex or intimacy (Abrams et al., 2016; Lyons, 2009). These stereotypes conflict with reality as research finds that the vast majority of older adults remain cognitively intact into later life, have lower rates of depression than younger persons (Fiske et al., 2009; Haigh et al., 2018), are adaptive and in good functional health (Bosnes et al., 2017; Depp & Jeste, 2006), and have meaningful interpersonal and sexual relationships

(Carstensen et al., 2011; Hillman, 2012; Træen et al., 2017).

Additional stereotypes persist, including those of older women being warmer and less competent than younger women (Vale, Bisconti, & Sublett (2020), as well as less sexually desiring and desirable (Montemurro & Chewning, 2018). Research has also illuminated gendered stereotypes affecting how older adult women and men are perceived differently. For example, older adult women are viewed as nicer, more nurturing, and more sensitive than older adult men. In contrast, older adult men are stereotyped as wiser, more competent, and more intelligent than older adult women. The stereotype that older adult women are "nicer" than older adult men can enhance older adult women's likability. At the same time, it carries into older adulthood the expectation that women focus on pleasing and accommodating others (Canetto, Kaminski, & Felicio, 1995). Older adult women are often rated more positively in domains that have social and family linkages compared with older adult men who are rated more positively in work and financial domains (Kornadt, Voss, & Rothermund, 2013). Problematic stereotypic beliefs about older adults by sexual orientation also exist, as older lesbians are presumed similar to heterosexual men and gay men similar to heterosexual women with regard to gender-stereotypic traits (Wright & Canetto, 2009).

Older adults themselves can also harbor negative age stereotypes (Levy, 2009) which have been found to predict an array of adverse outcomes such as worse cognitive performance (Lamont et al., 2015; Robertson et al., 2016), poorer physical health and functioning (Jackson et al., 2019; Tovel et al., 2019), worse mental health (Freeman et al., 2016; Han & Richardson, 2015), poorer work performance (Naegele et al., 2018), reduced engagement in preventative health behaviors and in help seeking behaviors (Sargent-Cox & Anstey, 2015), reduced longevity (Sargent-Cox et al., 2014), and reduced will to live (Marques et al., 2014; Levy et al., 2020). Further, subgroups of older adults may hold culturally consistent beliefs about aging processes that are different from mainstream biomedical and Western conceptions of aging (Cole et al., 2009; Dilworth-Anderson & Gibson, 2002). For example, in Chinese culture dementia disorders may be viewed not as a consequence of a neurological disorder but as a result of fate, "wrongdoing," or excess worry (Sun et al., 2012).

As negative self-beliefs and stereotypes toward aging represent a significant risk to the health and well-being of older adults, psychologists would benefit from an individualized understanding of the beliefs and stereotypes held by an older client, and the impact of these beliefs on their health and behavior (Levy, 2022). Psychologists endeavor to actively challenge and combat negative stereotypes of older adults. This can be achieved by educating themselves about the realities of aging, staying updated on research findings, and promoting accurate dissemination of information about the capabilities, strengths, and contributions of older adults. Engaging in public advocacy efforts against ageism can also help raise awareness and change societal perceptions.

Specialized Training: Psychologists seek to gain specialized clinical exposure and training in working with older adults, and this may be completed at any point in the career trajectory. In examining efforts to reduce ageism and age biases across the lifespan, research has demonstrated positive results for education and intergenerational contact in younger adults (Burnes et al., 2019) and reframing interventions for adults of all ages (Busso et al., 2019). Increasing intergroup interactions provide opportunities for experiences that challenge pre-existing stereotypes (Chopik et al., 2017). Further, reframing messages about aging may be helpful in decreasing implicit bias (Busso et al., 2019). For psychology trainees, specialized clinical exposure and training with older adults appears to be particularly important in fostering positive attitudes toward this population (Koder & Helmes, 2008; Karel et al., 2012). This targeted training enhances their skills and knowledge in providing effective and compassionate care. It also fosters positive attitudes toward older adults, dispelling any misconceptions or biases that may hinder the therapeutic process.

Engaging in Reframing Interventions: There are also broader efforts to address ageism and implicit biases and improve care for older adults. The Reframing Aging Initiative, led by the National Center to Reframe Aging, is a social change initiative that seeks to improve the public understanding of aging and older adulthood (Gerontological Society of America [GSA], 2022a). Age-Friendly Health Systems is an initiative that seeks to improve how health care systems address the unique needs of older adults through the provision of evidence-based interventions and reliable implementation of the 4Ms framework of high-quality care: What Matters, Medication, Mentation, and Mobility (Fulmer, 2021). Another helpful tool for this is the Harvard Implicit Bias test regarding aging (see https://implicit.harvard.edu/implicit/takeatest.html). Psychologists can utilize reframing interventions to challenge and modify implicit biases. By reframing messages about aging, emphasizing positive aspects of older adulthood, and dispelling common stereotypes, psychologists can contribute to reducing ageist attitudes in both themselves and their clients.

Collaboration and Advocacy: Psychologists seek to collaborate with other professionals and organizations to address ageism on a broader scale. Participating in initiatives like the Reframing Aging Initiative and the Age-Friendly Health Systems promotes understanding, impedes ageist practices, and advocates for improved care and support for older adults.

By applying these strategies, psychologists can create a more inclusive and age sensitive practice environment. They can contribute to reducing

ageism's impact on clinical outcomes, provision of care, research inclusion, and societal participation of older adults. Through ongoing self-reflection and continuous education, psychologists can better serve this diverse and vibrant population with dignity, respect, and tailored interventions.

GUIDELINE 3

Psychologists are encouraged to increase their knowledge, understanding, and skills with respect to working with older adults through training, supervision, consultation, and continuing education, and to apply their expertise in advocacy to support the psychological well-being of older adults.

Rationale

As the need for psychological services grows in the older population, additional health care providers will be required, especially those with knowledge and skills in working with older adults (Institute of Medicine, 2012; Moye et al., 2018). Practitioners often work competently with older adults who have issues similar to those of younger clients. With increasing complexity of older adult client problems, psychological practice benefits from the acquisition and application of specialized knowledge and skills (Hoge et al., 2015). For example, older adults can present with a range of unique, life-stage challenges including adjustment to retirement, aging with acquired and congenital disabilities, chronic illnesses, progressive cognitive impairment, and end-of-life issues that young and middle-aged adults tend to encounter less frequently (Karel et al., 2016). As such, a persistent call has been made for additional training in aging across all levels of professional development (Dorman et al., 2021; Holtzer et al., 2012; Karel, Sakai, et al., 2016; Moye et al., 2018; Strong et al., 2021).

Training recommendations to prepare psychologists to work with older adults have been offered at the graduate, internship, and postdoctoral levels (Hinrichsen et al., 2018; Hoge et al, 2015; Karel, Sakai, et al., 2016). The development of the Pikes Peak Model for training in professional geropsychology (Knight et al., 2009) recognized that entry into psychological practice with older adults can occur at different stages of a psychologist's career with many pathways to achieve competency.

Application

Foundational knowledge can be obtained through multiple pathways including doctoral and respecialization programs, internship, postdoctoral fellowships, continuing education activities (workshops, in-service training/seminars, distance learning), self-study and/or supervised self-study, or combinations of such alternatives.

The Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel et al., 2010, 2012) is a structured self-evaluation of learning needs to assist psychologists in evaluating their own scope of competence for working with older adults. The tool is intended for use by professional psychologists who are currently working with older adults, as well as trainees and their supervisors to rate progress over the course of a training experience (Karel et al., 2012; available at https://copgtp.org/resources/online-resources/). Psychologists can match the extent and types of their work with their competence and as needed, seek additional knowledge and skills.

Psychologists who see any older adults in clinical practice are encouraged to pursue continuing education to develop and enhance their competence in providing psychological services to older adults (Karel et al., 2010; Moye et al., 2018). Psychologists may also gain additional education and access useful materials through interactions with professional organizations, including APA Division 20 (https://www.apadivisions.org/division-20); Division 12-Section II, the Society for Clinical Geropsychology (http://www.geropsychology.org/); and the APA Aging and Older Adults topic page (https://www.apa.org/topics/aging-older-adults) and Continuing Education (http://www.apa.org/ed/ce/index.aspx), as well as The Council of Professional Geropsychology Training Programs (http://www.copgtp.org/), Psychologists in Long-term care (PLTC; http://www.pltcweb.org/index.php), the Gerontological Society of America (GSA; http://www.geron.org/), the American Society on Aging (ASA; https://www.asaging.org/), The American Board of Geropsychology (ABGERO; https://abgero.org/); and the E4 Center of Excellence for Behavioral Health Disparities in Aging (https://e4center.org/).

Psychologists are encouraged to apply their competencies in geropsychology and experience working with older adults to advocate for improving the health care and psychological health of this population (Karel et al., 2012). Psychologists strive to take a population health perspective on older adults. The goal is to support the population of older adults with regard to wellbeing and morbidity across intersectionalities, consistent with APA's commitment to advance population health and the United Nation Initiatives on Healthy Aging (APA, 2022; WHO, n.d.). While older adults may have a lower prevalence of certain mental health problems than younger adults, they are also less likely to seek or be offered mental health treatment (Karel et al., 2012), and this underutilization of psychological services is exacerbated among some populations such as sexual and gender minorities and older people of color (Fredriksen-Goldsen et al., 2014a, 2014b; Rastogi et al., 2012). Advocacy for older adults can be practiced in myriad contexts including care and service delivery settings, academic and research institutions, and at local, state, and federal levels of government.

General Knowledge About Adult Development, Aging, and the Older Adult Population

GUIDELINE 4

Psychologists strive to gain knowledge about theory and research in aging.

Rationale

To provide effective clinical services to older adults, psychologists strive to gain comprehensive knowledge about theory and research in aging. APA-supported training conferences emphasize the importance of psychologists becoming familiar with the biological, psychological, cultural, and social content and contexts associated with normal aging as part of their knowledge base for working clinically with older adults (Diehl & Wahl, 2020; Knight, et al., 2009; Woodhead & Yochim, 2022). As many practicing psychologists will likely work with clients, family members, and caregivers of diverse ages, a rounded preparatory education encompassing training with a lifespan developmental perspective is very useful (Hinrichsen et al., 2018).

APA accreditation criteria now require that students be exposed to the current body of knowledge in human development across the lifespan as well as didactic and experiential training on diversity factors including age (Commission on Accreditation Implementing Regulations, Section C: https://irp.cdn-website.com/a14f9462/files/uploaded/section-c-soa.pdf).

Over the past half-century, the field of psychology of aging has made significant progress, as evidenced by a wealth of scholarly publications. 'PA's publication "f "The Psychology of Adult Development and Aging" (Eisdorfer & Lawton, 1973) marked a pivotal moment in summarizing the current state of substantive knowledge, theory, and methods in psychology and aging. Subsequent overviews further advanced understanding in areas such as normal aging, psychological assessment, and intervention with older adults (e.g., Bengtson & Settersten, 2016; Lichtenberg et al., 2015a, 2015b; Pachana & Laidlaw, 2014; Pachana et al., 2015; Scogin & Shah, 2012).

By developing and maintaining expertise in aging-related theory and research, psychologists can deliver better-informed and more effective care to older adults, contributing to their overall well-being and quality of life.

Application

To effectively implement Guideline 4 psychologists working with older adults can consider the following strategies:
Continuous Professional Development: Practitioners can stay updated with the latest research and theories in geropsychology by engaging in continuous education and professional development activities. Attend conferences, workshops, and training sessions that focus on aging-related topics to enhance their knowledge and skills.

A 2022 publication by members of the Council of Professional Geropsychology Training Programs provides an overview of foundational competencies in geropsychology (Garrison-Diehn et al., 2022; Hinrichsen & Emery-Tiburcio, 2022; Jacobs & Bamonti, 2022; Lind et al., 2022; Mast et al., 2022; Woodhead, E. L., & Yochim, 2022).

Extensive information on resource materials is now available for instructional coursework or self-study in geropsychology, including course syllabi, textbooks, videotapes, online modules, and literature references at various websites. A brief list of websites is presented at the end of this document.

Lifespan Perspective Training: Seek out educational opportunities that provide a lifespan perspective, including such topics as concepts of age and aging, longitudinal change and cross-sectional differences, cohort effects (differences between persons born during different historical periods of time), theories of aging, and research designs for adult development and aging (e.g., Zelinski et al., 2009; Fingerman et al., 2010; Pachana et al., 2014; Bengtson & Settersten, 2016; Segal et al., 2018). Understanding these concepts will aid in contextualizing the experiences and challenges faced by older adults (see Guidelines 5 and 11 for further discussion as well as Diehl & Wahl, 2020 and APA, 2022b), and aid practitioners in the application of empirical findings to their work.

Collaborate With Interdisciplinary Teams: Foster collaboration with professionals from other disciplines who specialize in geriatrics and gerontology. Interdisciplinary teamwork can provide a comprehensive approach to address the multifaceted needs of older adults. By working together, psychologists can benefit from the expertise and perspectives of other professionals, enhancing the quality of care provided to older adults. Practicing integrated teams may consider development and implementation of brown bag consultation series, as this may foster professional identity development and interprofessional teamwork at all levels of professional development (Halli-Tierney et al., 2021).

Cultural Competence: Recognize the importance of cultural and social contexts in aging. Be attentive to the diversity within the older adult population, including differences in cultural backgrounds, beliefs, and values. Consider how these factors may influence the experiences, preferences, and needs of older adults when developing treatment plans and interventions.

Promote Aging Well: Be aware of the components that promote late life development and well-being (e.g., Bundick, Yeager, King, & Damon, 2010; Liverman et al., 2015). While aging includes the need to adapt to physical changes, functional limitations, and other changes in psychological and social functioning, the majority of older adults adapt successfully to these changes and have resiliencies to assist in meeting these challenges (Manning et al., 2019; Ong et al., 2018). Despite biological decrements associated with aging, considerable potential exists for positive psychological growth and maturation in late life (Hill, 2005; Steverink,

2014). As such, it would be beneficial to utilize a strengths-based approach when promoting healthy aging practices. Encourage older adults to engage in activities that enhance their physical, cognitive, and social well-being and draw upon psychological and social resilience built over the course of life to effectively address current late life problems (Pachana et al., 2015; Lichtenberg et al., 2015b).

GUIDELINE 5

Psychologists strive to be aware of the social and psychological dynamics of the aging process.

Rationale

Aging is a dynamic process that challenges each of us to make continuing behavioral adaptations as part of the broader lifespan developmental continuum (Carpentieri et al, 2017; Jeste et al., 2013; Tovel & Carmel, 2014). Just as younger individuals' developmental pathways are shaped by their ability to adapt to anticipated early life transitions (Crockett & Beal, 2012), older individuals' developmental trajectories are molded by their ability to contend successfully with anticipated later life transitions such as retirement (Dawson & Sterns, 2012), residential relocations, changes in relationships with partners or in sexual functioning, grandparenting, bereavement, widowhood, and planning for the end of life (Bennett & Soulsby, 2012; Brennan-Ing et al., 2020; Hayslip et al., 2019; Hillman, 2012; Settersten & Thogmartin, 2018). Late life development is also shaped by the development of wisdom as well as unanticipated experiences such as health problems or disability, traumatic events, or social isolation and loneliness (Heid et al., 2017; Lloyd et al., 2014; Schilling et al., 2013; Whitehead & Torossian, 2021).

Application

Psychologists remain cognizant of the strengths older people possess, the commonalities they have with younger adults, the continuity of their sense of self, and opportunities for using their skills and adaptations developed over their lifespan for continued psychological growth (Thumala Dockendorff, 2014). Most older adults contend successfully with myriad potential losses including persons, objects, animals, roles, belongings, independence, health, and financial well-being (Thumala Dockendorff, 2014). These losses may trigger problematic reactions, particularly in individuals predisposed to depression, anxiety, or other mental disorders (Neupert et al., 2017). Because these losses are often multiple, their effects may be synergistic (Calderón-Larrañaga et al., 2019; Viljanen et al., 2014). Despite these stresses, older adults have a lower prevalence of psychological disorders (other than cognitive) and substance use disorders than do younger adults (Kessler et al., 2012; Schulte & Hser, 2013). Further, many older adults challenged by loss find unique possibilities for achieving reconciliation, healing, or deeper wisdom (Howell & Peterson, 2021; Jeste & Lee, 2019). Moreover, most older people maintain positive emotions, improve their affect regulation with age (Burr et al., 2021; Carstensen, 2021), and enjoy high life satisfaction (Charles, 2011; Scheibe & Carstensen, 2010).

Late life development is characterized by both stability and change (Baltes, 1997; Lang et al., 2011). For example, although personality traits demonstrate substantial stability across the lifespan (Bleidorn et al., 2021; Lodi-Smith et al., 2011), growing evidence suggests a greater degree of plasticity of personality across the second half of life than was previously believed (Costa & McCrae, 2011; Mroczek, 2014; Roberts et al., 2006). Of particular interest are mechanisms of continuity and change such as how a sense of well-being is maintained. For example, although people of all ages reminisce about the past, older adults are more likely to use reminiscence in psychologically intense ways to integrate experiences (Demiray et al., 2019; O'Rourke et al., 2011).

Clinicians working with older adults strive to be knowledgeable of issues specific to later life, including the need to integrate or come to terms with one's personal lifetime of aspirations, achievements, and failures (Butler, 1969; Chochinov, 2012). There is considerable empirical evidence that aging typically brings a heightened awareness that one's remaining time and opportunities are limited (Carstensen et al., 1999). With this shortened time horizon, older adults are motivated to place increasing emphasis on emotionally meaningful goals.

Psychologists carefully appraise older adults' social supports (Edelstein et al., 2012) and are mindful of the fact that an older adult's difficulties may impact the well-being of involved family members (Adelman et al., 2014; Allen et al., 2014). Later-life family, intimate, friendship and other social relations and intergenerational relationships are integral to sustaining well-being in older adulthood (Antonucci et al., 2011; Blieszner & Roberto, 2012; Fingerman et al., 2011; Thomas et al., 2017). Older adults tend to prune social networks and selectively invest in proximal relationships that are emotionally satisfying, such as those with family and close associates, which promotes emotion regulation and enhances well-being (Carstensen, 2006; Carstensen et al., 2020; Carstensen, et al., 2011). Working with older adults often involves their families and other supports, while in some cases older adults are isolated and lack such supports (APA, Presidential Task Force on Integrated Health Care for An Aging Population, 2008; Brennan-Ing et al., 2017). Thus, psychologists may seek solutions that strike a balance between respecting the older person's dignity and autonomy and recognizing the views of others about their need for care (see Guideline 10).

Psychologists may encounter complex and varied relationships including extended families, stepfami-

lies, as well as both monogamous and consensually nonmonogamous families with diverse relationship agreements (Labriola, 2022). The individuals who care for older adults are often biological family members related by blood ties or marriage. However, psychologists endeavor to be aware of the diverse configurations of social support in the lives of older adults. For example, fictive kin, the term used to describe unrelated significant others who are considered family, are important sources of support for many older people of color (Taylor et al., 2021). Similarly, chosen families play a prominent role in the social networks of sexual and gender minority individuals (Brennan-Ing et al., 2017; Cloyes et al., 2018; Knauer, 2016). Consensual nonmonogamy is an umbrella term for relationships in which all partners give explicit consent to engage in romantic, intimate, and/or sexual relationships with multiple people (Moors, Ramos, & Schechinger, 2021). All of these relationships are integral to older adults' patterns of intimacy, residence, and support. This document uses the term "family" broadly to include all people considered family by the older person and recognizes that continuing changes in the composition of families are likely in future generations. Awareness of and training in these issues can be useful to psychologists in dealing with older adults in matters of the diverse nature of family relationships and supports.

GUIDELINE 6

Psychologists strive to understand diversity in the aging process, particularly how sociocultural factors such as sex, gender identity, race, ethnicity, socioeconomic status, immigration status, sexual orientation, disability status, religion, spirituality, employment status, and urban/rural residence may influence the experience and expression of health and of psychological problems in later life.

Rationale

The older adult population is highly diverse and is expected to become even more so in coming decades (Administration on Aging, 2011, Carpenter et al., 2022; U.S. Census, 2017). The heterogeneity among older adults surpasses that seen in other age groups (Cosentino et al., 2011; Liu et al., 2015). Diversity in terms of age cohort, gender identity, race, ethnicity and cultural background, sexual orientation, rural/urban environment, employment status, education and socioeconomic status, and religion, may impact psychological issues experienced by older adults differently. Psychologists endeavor to be aware of the intersectionality of these characteristics of diversity, and that the interplay of these factors may have multiplicative effects on the well-being of older adults (Crenshaw, 2017; Porter & Brennan-Ing, 2019). It should be noted that age may be a weaker predictor of outcomes than factors such as demographic characteristics, physical health, functional ability, or living situation (Lichtenberg, 2015b; Schaie, 1990). For example, clinical presentations of symptoms and syndromes may reflect interactions among these factors and type of clinical setting or living situation (Luhmann & Hawkley, 2016).

Application

Consider the influence of cohort or generational issues when providing psychological services to older adults (see Guideline 3). Each generation has unique historical circumstances that shape that generation's health as well as their collective social and psychological perspectives throughout the lifespan. These formative values may influence attitudes toward mental health issues and professionals. Generations that came of age during the first half of the twentieth century may hold values of self-reliance (Elder et al., 2009) more strongly than later cohorts. The "Baby Boom" generation, born between 1946 and 1964, which is beginning to dominate the older adult population, may be more knowledgeable about health care and assertive in obtaining the care they need (Kahana & Kahana, 2014), yet has poorer health and fewer social resources than previous generations (Moody, 2017; Zheng, 2021). Thus, older adults from earlier generational cohorts may be more reluctant than those from later cohorts to perceive a need for mental health services when experiencing symptoms and to accept a psychological frame for problems (Karel, et al., 2012). Current and emerging cohorts of older adults have generational perspectives that differentiate them from earlier cohorts, and these generational perspectives will continue to profoundly influence the experience and expression of health and psychological problems. For example, this generation is more assertive and actively engaged with health care providers (Kahana & Kahana, 2014; Moody, 2017). Finally, psychologists work to be aware of how societal attitudes towards older adults that may influence their practice have shifted over time, from ageist early 20th Century views of older adults as needy or dependent to current views of older adults as advantaged, entitled, and selfish (Carney, 2018; Hudson & Gonyea, 2012).

Psychologists are aware that sex as a biological factor has a strong association with the aging process. A striking demographic fact of late life is the

preponderance of women surviving to older ages (See National Population Projections Tables: https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html), which highlights the intersectionality of age and sex in later life (Carney, 2018). Notably, women experience greater longevity than men. This greater longevity has many ramifications. For example, as women age, they are more likely to become caregivers to others, experience widowhood, and be at increased risk themselves for health conditions associated with advanced age (APA Girls and Women Guidelines Group, 2018). Moreover, some cohorts of older women were less likely to have been in the paid workforce than younger generations and therefore may have fewer economic resources in later life than older men (APA Girls and Women Guidelines Group, 2018; Whitbourne & Whitbourne, 2012). Financial instability may be particularly salient for the growing numbers of female grandparents raising grandchildren (Choi et al., 2016).

Older adult women live longer but have higher rates of physical illness and disability than older adult men (Canetto, 2001; Crimmins, Kim, Sole-Auro, 2011). The prevalence of multiple chronic medical conditions is greater for women (28.4%) than for men (25.9%) across adulthood (18+), a difference that grows with increased age (Boersma, Black, & Ward, 2020). Women are particularly vulnerable to chronic conditions that limit mobility, and twice as many older adult women than older adult men become housebound (Canetto, 2001).

Older men may have an experience of aging that is different from women (Vacha-Haase et al., 2011). For example, due to social norms prevalent during their youth, some men may want to appear "strong" and "in control," yet as older adults they may struggle as they encounter situations (e.g., forced retirement from work, declining health, death of a loved one) where control seems to elude them. Further, an older man's military service and combat experience may be relevant to his overall well-being, as well as have a negative impact on health-related changes with age (Wilmoth et al., 2010). These issues have practice implications, as older men may be less willing to seek help for mental health challenges (Kieley et al., 2019), and may be more likely to seek care for mental health in primary care settings. Therefore, awareness of issues germane both to older women and men enhances the process of assessing and treating them (Kieley et al., 2019; Vacha-Haase, et al., 2011).

Psychologists strive to be aware of the diversity of gender identity in addition to sex assigned at birth. Gender identity refers to a person's intrinsic sense of their gender as feminine or being a woman, masculine or being a man, or being some combination of male and female or some other gender (APA, 2015a). In many cultures, gender has been conceived along a binary, that is, either male or female. However, we now know that gender identity is better described along a continuum, with some people having gender identities with varying degrees of male and female attributes, or in some cases, having nonbinary identities which may be some combination of these attributes, or attributes which do not fall in the binary categories of male/female, man/woman. People who are transgender have gender identities that do not align with their sex assigned at birth, while people whose gender identities do align with their sex assigned at birth are described as cisgender (APA, 2015a). For some people who are transgender, the misalignment of their gender identities with their sex assigned at birth can result in gender dysphoria. People who are transgender or gender diverse (TGD) may go through a process of social transitioning by adopting names, pronouns, and social presentations in line with their gender identities, or medical transitioning involving gender affirming treatment such as hormone therapies or surgery, so their appearance is more congruent with their gender identities. The degree of transitioning among people who are TGD is highly variable, and some people who are TGD may not undertake the transitioning process until late adulthood (APA; 2015; Porter et al, 2016; Services and Advocacy for GLBT Elders [SAGE] & National Center for Transgender Equality [NCTE], 2012). Guideline 9 of the "Guidelines for Psychological Practice with Transgender and Gender Nonconforming People" discusses the challenges faced by older adults who are TGD (APA, 2015a). Many older adults who are TGD have experienced lifetimes of stigma, discrimination, and violence that may affect their mental health and willingness to access health care services (Fredriksen-Goldsen et al., 2014a; Witten, 2015). Further, many people who are TGD have had negative experiences with health care providers, and few mental health providers have had adequate training on gender diversity issues (McCann & Sharek, 2016). Psychologists working with older people who are TGD are encouraged to respect these clients by using the names and personal pronouns that affirm their gender identities (APA, 2015a; Hagen & Galupo, 2014; Porter et al, 2016).

Psychologists strive to be aware of diversity as it relates to sexual orientation, including persons identifying as lesbian, gay, or bisexual (LGB; Fredriksen-Goldsen et al., 2013; Pereira et al, 2019). Minority sexual orientation is defined in terms of identity, attraction, or sexual behavior involving a person of the same biological sex (APA, 2021b). While sexual orientation may involve attraction to different aspects of another person's gender, people who are lesbian, gay, bisexual or another sexual minority may possess a variety of gender identities (cisgender, transgender, non-binary, etc.), and psychologists must avoid conflating sexual orientation and gender identity (APA, 2021b). It is important to be mindful that sexual orientation identity intersects with other aspects of identity (e.g., sex, gender identity, race, ethnicity, disability status). Older

adults who are LGB have often suffered discrimination from the larger society for decades (APA, 2021b), including the mental health professions, which previously labeled sexual variation as psychopathology and utilized psychological and biological treatments to try to alter sexual orientation. This past discrimination may make older LGB adults reluctant to access health and mental health care services resulting in unmet needs (Brennan-Ing et al., 2014; Pereira et al., 2019). As with other minoritized persons, these discriminatory life experiences can negatively result in health disparities (Fredricksen-Goldsen, 2017). APA's Guidelines for Psychological Practice with Sexual Minority Persons (2021) discusses particular challenges faced by older adults who are LGB.

It is critical also to consider the pervasive influence of cultural factors associated with race and ethnicity on the experience of aging (Hill et al., 2015; Tazeau, 2011; Westerhof et al., 2012; Whitfield, Thorpe, & Szanton, 2011). In the U.S. at present, the population of older adults is predominantly non-Hispanic White. By the year 2050, people of color are expected to comprise 39% of the older population compared to 21% in 2012 (Ortman et al., 2014). Historical and cultural factors, such as the experience of bias and prejudice, may influence the identities of older adults of color and thereby affect their experience of aging and patterns of coping (Crewe, 2019; Wallace et al., 2016). The cumulative impact of experiences of racism and discrimination can result in the experience of race-based trauma, which may manifest with symptoms similar to posttraumatic stress disorder (Hemmings & Evans, 2018). Many older communities of color faced discrimination and were denied access to quality education, jobs, housing, health care, and other services. As a result, many older adults of color have fewer economic resources than non-Hispanic Whites although this may change in future generations (Assari, 2018). For example, non-Hispanic Black, Indigenous, and Hispanic older adults have faced greater economic insecurity over the life course compared with non-Hispanic Whites (Hacker et al., 2014).

As a consequence of these and other factors (such as educational attainment and quality, underinsured status and income disparities), older adults of color have more physical health problems than the older non-Hispanic Whites, and they often delay or refrain from accessing needed health and mental health services, which may be attributable, in part, to an historical mistrust of the mental health and larger healthcare system (Armstrong et al., 2013; Cook et al., 2017; Luo et al., 2012; Powell et al., 2019). Being an older person of color is referred to as "double jeopardy" due to the often-multiplied negative impact of the intersecting identities (Chatters et al., 2020; Crewe, 2019). Similarly, systemic sexism is traumatic and negatively impacts the physical, mental, economic, and social health of women through the lifespan (Homan, 2021), with consequences for all of women's health indices in late adulthood. One's access to the opportunity structure earlier in the life course can perpetuate inequalities across individuals, families, and communities over time, a process known as cumulative disadvantage and advantage (Dannefer, 2020). Thus, psychologists endeavor to be aware that the health, income, and social inequalities experienced by their older clients may be rooted in a lifetime of disadvantage and deprivation. Psychologists may consult APA's 2017 *Multicultural Guidelines: An Ecological Approach to Contest, Identity, and Intersectionality* for more guidance on practice with older adults of color (APA, 2017b).

In order to provide culturally appropriate services and avoid a "one size fits all" approach, psychologists also strive to differentiate late life inequalities associated with cultural factors from those due to a history of low income and economic marginalization which affect older adults of all cultural backgrounds (APA, 2019; Juntunen et al., 2022).

Further, while women experience poverty at higher rates than men at all ages, this is especially true in later life (United Nations, 2022). Poverty is associated with poorer physical and mental health outcomes for older adult women (Ervin, Milner, Kavanagh, & King, 2021). Women's poverty in later adulthood often reflects an accumulation of disadvantages across the life course (e.g., less education, lower pay and fewer benefits, family responsibilities that interfere with continuous employment, unpaid family caregiving) (Canetto, 2001). Additionally, older women who are widowed, divorced, or separated experience higher rates of poverty (United Nations, 2022).

Aging presents special issues for individuals with developmental or acquired disabilities (e.g., intellectual disabilities, autism, cerebral palsy, seizure disorders, spinal cord injury, traumatic brain injury), as well as physical impairments such as blindness, deafness, and musculoskeletal impairments (APA, 2022a; Rose, 2012). Given available supports, life expectancy for persons with serious disability may approach or equal that of the general population (Kripke, 2018). Many chronic impairments may affect risk for and presentation of psychological problems in late life (Tsiouris et al., 2011; Walpert et al., 2019), and/or may have implications for psychological assessment, diagnosis, and treatment of persons who are aging with these conditions (APA, 2012).

Aging is also a reflection of the interaction of the person with the environment and geographical location (Wahl et al., 2012). For example, older adults residing in rural areas often have difficulty accessing aging-related resources (e.g., transportation, community centers, meal programs) and may experience low levels of social support and high levels of isolation (Arbore, 2019; Morthland & Scogin, 2011; Winterton et al., 2016). Older adults living in rural areas also have less access to community mental health services and to mental health specialists in nursing homes compared to those not residing in rural areas and may find seeking services for mental

health to be stigmatizing (Averill, 2012; Brenes et al., 2015; Stewart et al., 2015). Recent models that draw upon standardized treatments (Gellis & Bruce, 2010), telehealth technologies (Dautovich et al., 2014), or utilize paraprofessionals to address provider shortages (Arbore, 2019) have begun to expand access to mental health care for homebound and rural older adults but confront issues of lower technology access in rural areas.

GUIDELINE 7

Psychologists strive to be familiar with current information about biological and health-related aspects of aging.

Rationale

In working with older adults, psychologists are encouraged to be informed about the normal biological changes that accompany aging. Although there are considerable individual differences in these changes, with advancing age, the older adult almost inevitably experiences changes in sensory acuity, physical appearance, body composition, hormone levels, peak performance capacity of most body organ systems, immunological responses and increased susceptibility to illness (Saxon et al., 2022). Disease accelerates age-related decline in sensory, motor, and cognitive functioning, while lifestyle and psychosocial factors may either mitigate or exacerbate the effects of aging on functioning (Aldwin et al., 2018). Such biological aging processes may have significant hereditary or genetic components (Khan et al., 2017; Sierra, 2016) about which older adults and their families may have concerns. Adjusting to age-related physical change is a core task of normal psychological aging process (Saxon, et al., 2022). Fortunately, lifestyle changes, psychological interventions, the use of assistive devices, and addressing social determinants of health can lessen the burden of some of these changes.

Application

Psychologists strive to be able to distinguish normative patterns of change from non-normative changes, and to determine the extent to which an older adult's presenting problems are symptoms of physical illness or represent the adverse consequences of medication. This information aids in devising appropriate interventions. The psychologist may help the older adult cope with physical changes, acute health crises, and chronic medical conditions (Niknejad et al., 2018; Zis et al., 2017). Most older adults have multiple chronic health conditions (Federal Interagency Forum on Aging-Related Statistics [FIFAS], 2020), each requiring medication and/or management. The most common chronic health conditions of late life include arthritis, hypertension, diabetes, cancer, chronic kidney disease, and heart disease (FIFAS, 2020; National Center for Chronic Disease Control and Health Promotion, 2022). Other common medical illnesses include osteoporosis, vascular diseases, neurological diseases (including stroke), and respiratory diseases (including asthma and COPD).

Many of these physical conditions are associated with mental health and/or cognitive disorders (Dening, 2019; Feinkohl et al., 2018; Ohrnberger et al., 2017), either through direct physiological contributions (e.g., post-stroke depression; vascular cognitive impairment) or in reaction to disability, pain, or prognosis (Khan et al., 2016; Portacolone et al., 2018).

Psychologists strive to be knowledgeable about common pharmacological interventions for mental and physical disorders in later life. Older adults frequently take medications for health problems, and polypharmacy is common in older adults. Knowledge of medications would include, for example, familiarity with prescription terminology (e.g., "prn" means "as needed"), brand and generic names of commonly used medications, common side effects of these medications, classes of medications (e.g., anticholinergic medications), common drug interactions, and age-related differences in the pharmacodynamics and pharmacokinetics of these medications (Arnold, 2015). It is also important for psychologists to be aware of high-risk medications for older adults included in the Beers Criteria (By the 2023 American Geriatrics Society Beers Criteria® Update Expert Panel, 2023). Many older adults with mental disorders who are seen for assessment or treatment by psychologists are prescribed psychotropic medications (Arnold, 2015; Ćurković et al., 2016). Although pharmacological treatment of older adults with mental disorders is a common and often effective treatment for depression (Lavretsky et al., 2020), anxiety (Wolitzky-Taylor et al., 2010), and psychosis (Chan et al., 2011), adverse side effects of these medications are common and potentially harmful. Adverse effects are particularly common for older adults with neurocognitive disorders. The Food and Drug Administration (FDA) issued a black box warning against prescribing select antipsychotics to older adults with major neurocognitive disorders because they face increased risk of stroke and transient ischemic events with atypical antipsychotic use, and death with both atypical and conventional antipsychotic medications, but regulations to limit these medications have had mixed results in improving outcomes (Jin, et al., 2013; Rubino et al. 2020).

Multi-morbidity and polypharmacy are common in older adults, and result in increased complexity of care (Dahal & Bista, 2022). Thus, increased awareness and interventions aimed at reducing exposure and minimizing the risks associated with medications and their interactions in older adults are important in the community and especially in long-term care settings (Abrahamson et al., 2017; Bergman-Evans, 2020; Dahal & Bista, 2022; Halli-Tierney et al., 2019). Psychologists can play critical roles in identifying side effects and

adverse events and discussing observations with prescribers, as well as discussing overall polypharmacy with prescribers who may be less familiar with the options for deprescribing.

Psychologists may help older adults with lifestyle and behavioral issues in maintenance or improvement of health, such as nutrition, diet, and exercise (Aldwin et al., 2007) and the treatment of sleep disorders (McCurry et al., 2007). They can help older adults achieve pain control (Turk & Burwinkle, 2005) and manage their chronic illnesses and associated medications with greater adherence to prescribed regimens (Aldwin et al., 2007). Other health-related issues include prevention of falls and associated injury (WHO, 2008) and management of incontinence (Markland et al., 2011). Older adults confronting terminal illness can also benefit from psychological interventions (Doka, 2008). Clinical health psychology approaches have great potential for contributing to effective and humane older adult health care and improving older adults' functional status and health-related quality of life (Aldwin et al. 2018).

Foundations of Geropsychology Practice

GUIDELINE 8

Psychologists strive to be knowledgeable about psychopathology within the aging population and cognizant of the prevalence and nature of that psychopathology when providing services to older adults.

Rationale

Older adults may present a broad array of psychological issues for clinical attention, but may exhibit differences from younger adults in onset, presentation of symptoms, risk and protective factors, and comorbid mental disorders or health problems that are more common in later life (Jacobs & Bamonti, 2022). Some problems that rarely affect younger adults, notably major neurocognitive disorders due to degenerative brain diseases and stroke, sleep-wake disorders, and suicide are much more common in later life (see Guideline 9). Familiarity with mental disorders in late life commonly seen in clinical settings, their presentations in older adults, and their relationship with physical health problems will facilitate accurate recognition of and appropriate therapeutic response to these syndromes.

Application

Older adults have lower rates of depression, anxiety, schizophrenia, bipolar disorder, and substance use disorders than do younger adults (Jacobs & Bamonti, 2022). Prevalence estimates suggest that approximately 20-22% of community-dwelling older adults may meet criteria for some form of mental disorder, including major neurocognitive disorder (Carpenter et al., 2022; Jeste et al., 1999; Karel et al., 2012). Among older adults, men have higher rates of substance use and personality disorders, whereas older women have higher rates of anxiety and depression (Reynolds et al., 2015), and rates vary across cultures and ethnicities (Jimenez et al., 2010). Differences across age, gender, cultural groups, and other diverse identities may be due to cohort effects, differential mortality, diagnostic methods, and reporting biases due to stigma (Byers et al., 2010), as well as broader structural issues (see Guideline 6 and Jimenez et al, 2022 for further discussion of these issues). For example, lower subjective well-being for older women compared to their male counterparts is most likely due to disadvantages older women experience in regard to health, SES, and widowhood (Byers et al., 2010; Pinquart & Sörensen, 2001; Reynolds et al., 2015). For older adults living in a long-term care (LTC) setting, estimates of mental disorders are much higher, with two-thirds exhibiting cognitive impairment and 25% experiencing depression (Molinari et al., 2021).

Among older adults seeking health services in clinical settings, depression and anxiety disorders, substance use, personality disorders and adjustment disorders are common, as well as problems related to chronic pain and insomnia (Byers et al., 2010; Jacobs & Bamonti, 2022; Reynolds et al., 2015). The vast majority of older adults with mental health problems seek help in primary medical care settings, rather than in specialty mental health facilities, and prefer to receive behavioral health interventions such as psychotherapy rather than medication management (Areán & Gum, 2013).

Suicide is a particular concern in conjunction with depression in late life, as suicide rates in older adults—particularly older white men living in rural areas—are among the highest of any age group (Ehlman et al., 2020; see Guideline 20). Suicide is a cultural and gendered phenomenon. In the United States, suicide rates among older adults vary greatly across ethnicity and sex, with European-descent older men recording the highest rates (Canetto, 2017). Older-adult suicide is not fully explained by depression in later life. For example, in the United States, older adult men have lower rates of depression than older women, but higher rates of suicide. Older-adult suicide is also not an inevitable response to challenges of aging. European-descent older adult men have less exposure than older adult women to many of the conditions (e.g., chronic illnesses and functional disabilities, financial difficulties, widowhood, and living alone) assumed to increase suicide risk in older adults. The higher suicide mortality of European American older men is likely explained by cultural beliefs of European American majority communities, including the permissibility of older adult suicide and the association of taking one's life with masculinity (Canetto, 2017, Winterrowd, et al. 2017).

Physician-assisted suicide and euthanasia (PAS/E) are also relevant issues in later adulthood as older adults represent the majority of PAS/E cases. Of note, in Oregon—the state where PAS has been accessible since 1997—older adult women comprised approximately one-half (46%) of the assisted suicides, yet only 16.3% of the unassisted suicide cases (Canetto & McIntosh, 2022). Approximately one half of people who died of assisted suicide reported concerns of being a burden, compared to a minority who reported concerns related to pain (Canetto & McIntosh, 2022). It has been suggested that PAS/E may be more acceptable than unassisted suicide for older adult women as PAS is medicalized and packaged as a gentle and graceful death, and also because older adult women may view it as a way to relieve others of the burden of care (Canetto, 2019).Older adults may experience chronic or recurrent psychological disorders ("early onset") or develop new problems ("late onset") in the context of the unique stresses of old age or neuropathology (Whitbourne & Meeks, 2011; Jacobs & Bamonti, 2022). The majority of older adults who experience clinical depression, for example, have early onset depression which first occurred in earlier adulthood (Haigh et al., 2018). In those with early onset disorders, including serious mental illness or personality disorder, present-

ing symptoms may change in later life or become further complicated because of cognitive impairment, medical comorbidity, chronic pain, polypharmacy, and end-of-life issues (Balsis et al., 2015; Feldman & Periyakoil, 2006; King et al., 2005; Zis et al., 2017). Indeed, those older adults with serious mental illness, such as schizophrenia or bipolar disorder which most commonly has an early onset, present particular assessment and intervention challenges in part due to reduced social support that may result in housing instability, inappropriate admission to long-term care facilities, and early mortality (Jeste et al., 2011; Mausbach & Ho, 2015).Being alert to comorbid physical and mental health problems and the presence of multiple comorbid conditions (multimorbidity) is a key concept in evaluating and treating older adults. For example, those with a mood disorder may also manifest concurrent anxiety, substance use disorders, and personality disorders (Jacobs & Bamonti, 2022; Romirowsky et al., 2018; Substance Abuse and Mental Health Services Administration [SAMHSA], 2020), and those with major neurocognitive disorders typically evidence coexistent psychological symptoms, which may include depression, anxiety, paranoia, and behavioral disturbances which also may present as prodromal symptoms of dementia (Cohen-Mansfield, 2015). Additionally, behavioral disturbances such as hallucinations and delusions represent core clinical symptoms of some neurodegenerative disorders, such as Lewy Body dementia, making differential diagnosis complicated. Because chronic physical diseases are more prevalent in later life than earlier, mental disorders are frequently comorbid and have reciprocal relationships with physical illnesses including cardiovascular disease and diabetes (Aldwin et al., 2007; Luo et al., 2020; Park & Reynolds, 2015). Further complicating the clinical picture, many older adults take multiple medications (polypharmacy), and experience higher rates of side effects of many medications. Further, older adults are more likely to have co-occurring sensory or motor disabilities. All these factors may interact in ways that are difficult to disentangle diagnostically and challenge treatment planning. For example, sometimes depressive symptoms in older adults are caused by physical illnesses. At other times, depression is a response to the experience of physical illness (Luo et al., 2020). Depression may augment functional impairment due to physical illness, increase the risk that physical illness will recur, reduce treatment adherence, or otherwise dampen the outcomes of medical care (Turan et al., 2014). Growing evidence links depression in older adults to increased mortality not attributable to suicide (Edelstein et al., 2015; Kozlov et al., 2019; Luo et al., 2020).

Several mental disorders such as depression and anxiety, especially when arising for the first time in late life, may be less common or have unique presentations in older adults, and are frequently comorbid with other mental disorders. For example, major depression, which is less prevalent in older adults than in younger adults, may have first onset in later life and coexist with a major neurocognitive disorder, a mild neurocognitive disorder that impairs executive functioning, or may be expressed in forms that lack overt manifestations of sadness (Fiske et al., 2009; Jacobs & Bamonti, 2022). It may thus be difficult to determine whether symptoms such as apathy and withdrawal are due to a primary mood disorder, a primary neurocognitive disorder, a medical or neurologic condition such as Parkinson's disease, or a combination of disorders. Generally, older adults' self-reports of depressive symptoms are similar to those described by DSM-5 criteria (Haigh et al., 2018), but age of onset may affect the experience of depression, as those with later onset depression tend to emphasize cognitive or somatic rather than affective symptoms (Edelstein et al., 2015).

Furthermore, depressive symptoms may at times reflect older adults' confrontation with developmentally challenging aspects of aging, coming to terms with the existential reality of physical decline and death, loss of significant others, or spiritual crises (Aziz & Steffens, 2013).

Anxiety disorders are among the most commonly occurring mental health problems in older adults (Jacobs & Bamonti, 2022; Ramos & Stanley, 2018; Wolitzky-Taylor et al., 2010). The patterns and content of presenting anxiety symptoms in older adults may differ from those of younger adults. For example, the content of older adults' fears and worries tends to be age-related (e.g., health and economic concerns; fears of falling; Lenze & Wetherell, 2022). Some have found that older adults who present with panic disorder or post-traumatic stress disorder (PTSD) tend to exhibit patterns of symptoms (e.g., fewer arousal symptoms, less avoidance, or more intrusive recollections) that differ from those of younger adults (Lauderdale et al., 2011; Rutherford et al., 2020). Further, while first onset of an anxiety disorder in older adulthood is uncommon, this is especially true for some anxiety disorders (e.g., panic disorder; social anxiety disorder) more than others wherein late onset is common (e.g., generalized anxiety disorder; Ramos & Stanley, 2018; Wolitzky-Taylor et al., 2010). Anxiety symptoms in older persons often co-exist with and may be difficult to distinguish from symptoms attributable to co-existing depression, medical problems, medications, or cognitive decline. Reciprocal relationships are also observed; for example, when an anxiety problem (e.g., avoidance of walking due to a fear of falling) develops following a medical stressor, it may significantly complicate an older person's fall risk and physical rehabilitation. Further, research suggests that the common co-occurrence of anxiety with depression may slow treatment response for depressed older adults (Andreescu et al., 2009; Lenze & Wetherell, 2022, and that even sub-threshold levels of anxiety symptoms may be the fruitful focus of

clinical efforts (Ramos & Stanley, 2018; Wolitzky-Taylor et al., 2010).

By the time they reach older adulthood, 50% to 90% of adults will have been exposed to a traumatic event (Monson et al., 2016; Moye et al, 2021). This is particularly true for older veterans of military service, who are at heightened risk to experience both combat trauma and sexual trauma (Gibson et al., 2020). Rates of PTSD in older adults range from 1-3% for full PTSD (Glaesmer et al., 2010; Jimenez et al., 2010) but are higher, averaging 8% in veterans (Williamson et al., 2018). Trauma-related symptoms may present differently in older veterans with more engagement with traumatic memories and less avoidance of stimuli associated with the traumatic experience (Rutherford et al., 2020). This leads to high rates of clinically significant sub-threshold PTSD symptoms between 7-17% (Glaesmer et al., 2010; Jimenez et al., 2010; Moye et al, 2021), which may put older individuals at risk for negative outcomes including suicidal ideation and attempt (Moye et al, 2021). The phenomenon of increased engagement in trauma memories later in life is consistent with gerontological notions of life review in which age-related factors and role transitions my drive processes of meaning making to form coherence of one's life story, which has been termed Later Adulthood Trauma Re-Engagement (LATR; Davison et al., 2016).

Substance use disorders have become increasingly prevalent in older adults (SAMHSA, 2020; Yarnell et al, 2020). Alcohol-related problems are most common, as almost 15% of older adults in clinical settings engage in "at risk" drinking, and 3.7% of older adults living in the community have an alcohol use disorder (Kuerbis, 2020). Older adults are at increased risk for alcohol-related problems due to age-related physiological and metabolic changes, health problems, and interactions with medications, but these problems often go undetected (SAMHSA, 2020; Barry & Blow, 2016). Less prevalent are problems with illicit drugs such as cocaine, heroin, or methamphetamine, but rates are expected to increase as the current cohort of older adults ages (Yarnell et al., 2020). Older adults are also at higher risk of prolonged use or misuse of medications, such as opioids, and rates of death and suicide caused by opioid misuse are increasing (SAMHSA, 2020). The growing legalization of recreational cannabis and the use of medical marijuana may offer therapeutic benefits to some older adults, but more research is needed to assure safe use (Kaskie et al., 2017; Manning & Bouchard, 2021).

Other problems or disorders seen in older adult clients that may differ from younger adults in regard to symptom presentation or late-life context include insomnia (Dzierzewski et al., 2018), psychotic disorders, including schizophrenia and delusional disorders (Jeste et al., 2011), personality disorders (Balsis et al., 2015; Segal et al., 2006), chronic pain (Hadjistavropoulos, 2015; Zis et al., 2017; Niknejad, et al., 2018), sexual dysfunction (Hillman 2012, 2017), prolonged grief disorder (Shear, 2015), and disruptive behaviors (e.g., wandering, aggressive behavior) which can be present in individuals suffering from major or minor neurocognitive disorders (Cohen-Mansfield, 2015). Many comprehensive reference volumes are available as resources for clinicians with respect to late-life mental disorders (e.g., Hinrichsen, 2019; Knight & Pachana, 2015; Lichtenberg et al., 2015a; Lichtenberg et al., 2015b; Pachana et al., 2021; Segal et al., 2018), and the literature in this area is rapidly expanding.

GUIDELINE 9

Psychologists strive to be familiar with current knowledge about normal and disease-mediated cognitive changes in older adults.

Rationale

From a clinical perspective, one of the greatest challenges facing practitioners who work with older adults is knowing when to attribute subtle observed cognitive changes to normal developmental shifts *versus* an underlying neurodegenerative condition. Further, several moderating and mediating factors contribute to, and confound age-associated cognitive changes within and across individuals. As such, psychologists' knowledge about cognitive changes in older adulthood is critical to their ability to provide services to this population.

Application

Most cognitive changes older adults experience as part of the normal aging process are mild and do not significantly interfere with daily functioning, though there are notable inter-individual differences. For most older adults, age-associated changes in cognitive trajectories are nuanced, with some abilities remaining relatively stable into late life, while others change beginning decades earlier. The vast majority of older adults continue to engage in longstanding pursuits, interact intellectually with others, actively solve real-life problems, and achieve new learning. Cognitive functions that are better preserved with age include aspects of language such as vocabulary and general semantic knowledge, and other skills that rely primarily on stored information and knowledge (Park & Festini, 2017).

Most older adults do experience age-related changes in cognitive abilities, and psychologists aim to inform themselves about this process. While

there are multiple models proposed to explain cognitive changes with age, most studies agree that decline typically begins in early adulthood and is most prominent in the domains of processing speed, along with aspects of attention, working memory, and memory processing. Specifically, changes in more complex aspects of attention, such as divided attention and multitasking, in addition to executive functions and reasoning abilities, tend to be impacted more significantly than basic attention or vigilance abilities (Salthouse, 2019). The changes likely reflect subtle non-specific, widespread cortical and subcortical dysfunction. Attention is also affected, particularly the ability to divide attention, shift focus rapidly, and deal with complex situations. Memory functioning refers to implicit or explicit recall of recently and distantly encoded information. Several aspects of memory show decline with normal aging (Park & Schwarz, 2012). These include: working memory (retaining information while using it in performance of another mental task), episodic memory (the explicit recollection of events), source memory (the context in which information was learned), and short-term memory (the passive short-term storage of information). These changes in memory occur despite relatively preserved semantic memory (the recall of general or factual acquired knowledge), procedural memory (skill learning and recall) and priming (a type of implicit memory where the response to a probe has been influenced by a previous exposure to a stimulus). Numerous seminal reference volumes offer comprehensive coverage of research on cognitive aging (e.g., Park & Festini, 2017; Schaie & Willis, 2011).

Many factors influence cognition and patterns of maintenance or decline in intellectual performance in later life, including genetic, health and sensory variables, personality traits, affective state, and social determinants of health. Sensory deficits, particularly vision and hearing impairments, often impede and limit older adults' cognitive functioning (Whitson et al., 2018). Poorly controlled vascular disease in mid- and late life (e.g., hypertension, heart disease, diabetes) may impact cognitive functioning as well as certain medications used to treat illnesses in older adults (Exalto et al., 2014). Cumulatively, such factors may account for much of the decline that older adults experience in cognitive functioning, as opposed to simply the normal aging process. In addition to sensory integrity and physical health factors, psychological and life-course experiential factors may influence older adults' cognition. In recent years, certain personality traits, affective disorders, and experiences of poverty, discrimination and oppression have all been linked to cognitive functioning in late life (Aschwanden et al., 2021; Fuller-Iglesias et al., 2009; Zahodne, 2021).

Similarly, there also are numerous biological and psychological causes of cognitive impairment in later life that may be reversible if identified and treated (e.g., certain medications, polypharmacy, thyroid disorders, vitamin B12 deficiency, depression, infectious diseases; Ladika & Gurevitz, 2011). Acute confusional states (delirium, also known as acute brain failure) often signal underlying illness, infection processes, or toxic reactions to medications or drugs of abuse, which can be lethal if not treated, but may be ameliorated or reversed with prompt medical attention (Hshieh et al., 2020). Clinicians educate themselves to be familiar with the characteristics of delirium, and knowledgeable about screening tools that can help identify relevant symptoms (De & Ward, 2015).

Some older adults experience significant cognitive decline that is greater than what would be expected for normal aging, but not severe enough to substantially impact functional abilities. The term "mild cognitive impairment" (MCI) has historically been applied to describe these individuals, which is now largely captured under the terminology, "Mild Neurocognitive Disorder" in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; APA, 2013). Of note, slightly different diagnostic frameworks exist for both MCI and various forms of dementia, and psychologists strive to familiarize themselves with these in addition to those specified in the DSM-5 (Albert et al., 2011; Sachdev et al., 2014; Sperling et al., 2011). MCI can be subdivided into various descriptive subtypes (e.g., amnestic versus non-amnestic, single versus multiple domains affected) which may have some prognostic utility with respect to future cognitive decline and underlying etiology. For example, amnestic subtypes are more likely to progress to Alzheimer's dementia (AD) than others (Smith & Bondi, 2013). While there is definite heterogeneity within groups of persons who are deemed to have MCI, there is evidence that it does indeed represent a risk state for the development of additional cognitive decline and dementia.

A minority of older adults experience significantly impaired cognition that impacts functional abilities. Major Neurocognitive Disorder is diagnosed when there is evidence of cognitive decline in one or more domains (memory, attention, executive functioning, language, perceptual, or social cognition) that is severe enough to impact basic or instrumental activities of daily living and is not better accounted for by another condition. The prevalence of Major Neurocognitive Disorder increases dramatically with age; for example, 5% of people aged 65-74 years have Alzheimer's dementia (AD), the most common form of dementia, compared with 33% of people over the age of 85 (Rajan, Weuve, Barnes et al., 2021). The most common forms of Major Neurocognitive Disorder are Alzheimer's disease, vascular dementia (VaD), frontotemporal dementia (FTD) and dementia with Lewy bodies (DLB); however, there is growing recognition that most cases of clinically diagnosed dementia syndromes reflect underlying mixed pathology (NIA, 2017; Corriveau et al., 2017). While a primary and early

impairment in memory is a hallmark of the cognitive symptoms of AD, the illness can present quite variably, and other neurodegenerative disorders may have similar symptoms. However, early disproportionate deficits in visuospatial or executive functions may indicate other etiologies, such as dementia with Lewy bodies (DLB) or frontotemporal dementia (FTD). Less common causes include progressive supranuclear palsy (PSP), cortico-basal syndrome (CBS), Creutzfeldt-Jakob disease (CJD), chronic traumatic encephalopathy (CTE), and others.

The current clinical standard is still to diagnose Alzheimer's dementia and other Major Neurocognitive Disorders due to neurodegeneration via symptom clusters rather than primarily via neuroimaging, genetics, or other physical markers. The primary DSM-5 criteria for a diagnosis of Major Neurocognitive Disorder include: 1) Progressive cognitive and/or behavioral impairment, 2) noticeable to the person themselves, family, or clinicians, 3) that represents a decline from a previously higher level of functioning, 4) is not attributable to other medical or clinical etiologies (e.g., delirium, major depressive disorder), and 5) results in associated impairment in IADL's, (DSM–5; APA, 2013; McKhann et al., 2011). However, decades of research into the biology of AD and various other neurodegenerative diseases have led to a greater understanding of the cascade of biological changes that may be responsible for the phenotypic syndromes associated with these diseases (Bondi et al., 2017). As such, techniques that utilize biological indicators, or biomarkers, such as blood, CSF, or neuroimaging tools, have been developed. While most of these tools are not yet commonplace, psychologists strive to understand the biological changes related to neurodegenerative diseases and their associated clinical symptom pattern.

While no curative agents known to reverse the symptoms of MCI or dementia currently exist, there have been very recent pharmacological developments in the treatment of these symptoms, namely, the FDA approval of monoclonal antibodies that target the underlying amyloid accumulation associated with AD. As this field is rapidly evolving, psychologists make concerted efforts to keep abreast of these developments in the treatment of AD and other neurodegenerative diseases.

Psychologists also make efforts to stay informed about modifiable lifestyle factors that may impact cognition in late life. These include factors such as vascular health, blood pressure, diabetes, history of smoking, heart disease, and obesity, which have each been linked with suboptimal cognitive aging and to increased risk for neurodegenerative conditions such as Alzheimer's disease (Norton et al., 2014). As such, there is burgeoning interest in determining whether prosocial health-related behaviors, such as optimal control of vascular disease, engagement in regular aerobic exercise, engagement in cognitively and socially stimulating activities, and adherence to a healthy "Mediterranean-style" diet may help preserve cognition in late life (Kane et al., 2017; Livingston et al., 2020; Morris et al., 2015; Ngandu et al., 2015; Tolpannen et al., 2015).

GUIDELINE 10

Psychologists strive to understand and address issues pertaining to the provision of services in the specific settings in which older adults are typically located or encountered.

Rationale

Psychologists often work with older adults in a variety of settings, reflecting the continuum of care along which most services are delivered (Brink & Lichtenberg, 2014). The varied settings often have their own culture, protocols, and procedures, along with unique legal and ethical issues psychologists must be aware of. Psychologists seek to augment generalist competencies when working with interdisciplinary teams providing services to older adults in these settings (Labott, 2019; Moye, et al., 2019a)

Application

These service delivery sites encompass multiple community settings older people engage with, including community-based and in-home care settings (e.g., senior centers, their own houses or apartments; see Yang et al., 2009 and Boland, 2019 for issues in provision of in-home services); outpatient settings (e.g., mental health or primary care clinics, independent practitioner offices, or outpatient group programs); day programs serving older adults with multiple or complex problems (e.g., adult day centers or psychiatric partial hospitalization programs); inpatient medical or psychiatric hospital settings, and long-term care settings (e.g., nursing homes, assisted living, hospice and other congregate living sites). Psychologists recognize the stakeholders in each setting, including family, staff, unique payment or insurance structures, and the health system itself. Understanding team dynamics, physical structures, unique health issues of the population in the context of that setting, and issues related to transitions of care between them is critical. A set of specific practice Guidelines is available for psychologists who provide services in long-term care settings (Molinari et al., 2021), as well as useful volumes and resources discussing various facets of such professional practice (O'Shea Carney & Norris, 2017; Long, 2014; see also *Psychological Services for Long-term care Resource Guide,* APA, 2013). Some psychologists provide services within the criminal justice system to the growing number of older adults who are or have been incarcerated (Fazel et al., 2016). Psychologists strive to

develop the basic knowledge, skills, and setting-specific competencies to provide psychological services to older adults with psychological problems common to these varied settings (Lind et al., 2022; O'Shea Carney et al., 2015).

Some institutions include a variety of care settings. For example, consultation in continuing care retirement communities may range from older adults living in independent apartments to assisted living settings to the skilled nursing facility. Any of these settings may be the site of psychological and behavioral palliative and hospice care service provision. Because residence patterns are often concentrated by virtue of service needs, older adults seen in these various contexts usually differ in degree of impairment and functional ability. In the outpatient setting, for instance, a psychologist will most likely see functionally capable older adults, whereas in long-term care facilities the practitioner will usually provide services to older people with functional or cognitive limitations. Psychologists increasingly provide care to varied settings via telehealth; please see Guideline 11 in this document for more on that setting of care.

GUIDELINE 11

Psychologists strive to be familiar with the application of telehealth practices and policies in assessing and treating older adults across settings and living situations.

Rationale

Older adults are becoming increasingly comfortable with technology (Alexandrakis, 2019; Anderson & Perrin, 2017). At least 75% of older adults are internet users, 61% own a smartphone, and differences between age groups regarding technology use are rapidly shrinking (Faverio, 2022). Technology can improve access to care via telehealth for older adults, especially for those who have transportation difficulties, live great distances from health care facilities, or have health issues or caregiving duties that make attending in-person appointments difficult (Choi et al., 2022). Telehealth use among older adults increased rapidly during the Covid-19 pandemic – from 4.6% to 21.1% (Choi et al., 2022). Research support for the effectiveness of telehealth among older adults is strong across a variety of settings and clinical activities (Doraiswamy et al., 2021; Gentry et al., 2019; Turgoose et al., 2018). Technology has also been effective in reducing social isolation and loneliness, thus decreasing risk for depression (Gorenko et al., 2021). Thus, telehealth is appropriate for psychologists to engage older adults as both a mode of service provision and for intervention elements.

Application

Psychologists engaging older adults in telehealth visits strive to be familiar with both the APA Guidelines for the Practice of Telepsychology (Joint Task Force, 2013) and the APA Committee on Aging recommendations on telehealth services for older adults (APA Committee on Aging, 2020), including the need to evaluate and seek remedies for potential barriers to effective telehealth services such as sensorimotor changes and neurocognitive disorders. Additional guidance specific to neuropsychological assessment via telehealth is available from the Inter-Organizational Practice Committee (Bilder et al., 2020). Recommendations for engaging older adults in telehealth include an assessment of the older adult's digital health literacy and/or availability of assistance in the home prior to service provision (Gould & Hantke, 2020), along with internet, microphone, and camera quality, with a phone backup plan in the event of connectivity issues (Onorato et al., 2021). For some, it may be optimal to include caregivers in the session, either in the same room as the older adult or utilizing telehealth functionality from another location. If others in the home are assisting with technology, informed consent and confidentiality must be addressed (APA, 2017a). Completion of targeted release of information forms may be necessary.

Barriers to effective use of technology for telehealth by older adults include user interface; physical, sensory, and cognitive deficits; internet access; socioeconomic status; digital literacy; and internalized ageism (Kottl et al., 2021). Although programs to improve access increased in availability during the Covid-19 pandemic (Waggoner & Dono, 2022), internet access is limited for many older adults, especially those in rural areas and with low socioeconomic status (Latulippe et al., 2017). Some of those who do have access lack the training to operate an internet-ready device (Latulippe et al., 2017; Wilson et al., 2021) and benefit from individual coaching (Wilson et al., 2021). Screen, text, and image size on smaller screens with poor optimization for vision changes are challenging for older adults with visual difficulties (Wilson, et al., 2021). Older adults with hearing loss may have difficulty with telehealth audio features (Foster & Sethares, 2014). Older adults with cognitive impairment may also struggle to utilize telehealth independently (Doraiswamy et al., 2021). Psychologists must be aware of these potential barriers and assure that clients are ready, willing, and able to engage in this format.

GUIDELINE 12

In working with older adults, psychologists are encouraged to understand the importance of interfacing with other disciplines, and to make referrals to other disciplines and/or to work with them in collaborative teams and across a range of sites, as appropriate.

Rationale

In their work with older adults, psychologists are encouraged to be cognizant of the importance of a coordinated care approach and may collaborate with other health, mental health, or social service professionals who are responsible for and/or provide particular forms of care to the same older individuals. Given that many older adults experience chronic health problems for which medications have been prescribed, coordination with the prescribing professionals is often very useful. Other disciplines typically involved in coordinated care, either as part of a team or those to whom referrals may be appropriate include physicians, nurses, social workers, pharmacists, and associated others such as direct care workers, clergy, and lawyers (Partnership for Health in Aging Workgroup on Interdisciplinary Team Training in Geriatrics, 2014). Psychologists can help a group of professionals become an interdisciplinary team rather than a multidisciplinary one by generating effective communication, implementing strategies focused on skills integration, and coordinating of services provided by the various team members (Segal et al., 2020; Zeiss & Thompson, 2003). Psychologists are increasingly serving older adults in interprofessional settings and are also training in these settings which requires identifying these skills as additional competencies, as outlined in the Interprofessional Education Collaborative's (2016) *Core Competencies for Interprofessional Collaborative Practice: 2016 Update.*

Application

For effective collaboration with other professionals, whether through actual teamwork or referrals, it is useful for psychologists to be knowledgeable about services available from other disciplines and their potential contributions to care coordination. It is also useful for psychologists to develop an awareness of potential conflicts or ethical challenges that may arise when working in integrated care settings (Bush et al., 2017; Chenneville & Gabbidon, 2020). To make their particular contribution to such an effort, psychologists may often find it important to educate others as to the skills and role of the psychologist and to present both clinical and didactic material in language understandable to other disciplines. The ability to communicate, educate, and coordinate with other concerned individuals (e.g., providers, family members) may often be a key element in providing effective psychological services to older adults (HalliTierney et al, 2021; Steffen et al., 2014; Steffen et al., 2017; Areán & Gum, 2013) To provide psychological services in a particular setting, it is important to be familiar with the culture, institutional dynamics, roles of other providers and challenges of providing mental health services to older adults (Bush et al., 2017; Moye et al., 2019).

Sometimes psychologists in independent practice or settings that lack close linkages with other disciplines have limited contact with those who provide care to the older adult. In such cases, psychologists are encouraged to be proactively involved in outreach to and coordination with the relevant professionals. To provide the most comprehensive care to older adults, psychologists are encouraged to familiarize themselves with aging-relevant resources in their communities (e.g., Area Agencies on Aging, https://www.usaging.org; the Administration for Community Living (ACL), https://acl.gov) and make appropriate referrals..

GUIDELINE 13

Psychologists strive to understand the special ethical and/or legal issues entailed in providing services to older adults.

Rationale

Psychologists endeavor to safeguard Psychologists endeavor to safeguard the rights of older adults and engage in practice that adheres to the Ethical Principles of Psychologists and Code of Conduct (APA, 2017a), with particular attention to principles of beneficence and nonmaleficence, justice, and respect for people's rights and dignity. Elder abuse is strikingly common

(Lachs & Pillemer, 2015; Yon et al., 2019). In addition, conflicts sometimes arise among family members, professional caregivers, and physically frail or cognitively impaired older adults because concerned individuals may believe that these older adults do not possess the capacity for self-determination on issues that affect their safety and wellbeing (Albright et al., 2020). Psychologists are often called upon to evaluate one or more domains of capacity of older adults (e.g., medical decision-making, financial, contractual, testamentary, independent living, etc.; Moye et al., 2013; Moye, 2020). The Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change (APA, 2021b) and Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists (ABA & APA, 2008) provide further information as to evaluations of capacity.

Application

Psychologists working with older adults are encouraged to be prepared to work through difficult ethical dilemmas in ways that balance considerations of the ethical principles of beneficence and autonomy. That is, guard the older adult's safety and wellbeing as well as recognize the individual's right to autonomy and to make their own

decisions to the extent possible (APA, 2017a; Bush et al., 2017; Marson et al., 2011). This dilemma is especially relevant to older adults living in long-term care settings (Molinari et al., 2021).

Similar considerations regarding informed consent for treatment apply in work with older adults as in work with younger people (APA, 2017a, sections on Human Relations and Privacy and Confidentiality). Ethical and legal issues may enter the picture when some degree of cognitive impairment is present, when the older individual lacks familiarity with treatment options, or when other conditions exist that suggest an older adult cannot provide valid consent. For example, some older adults may initially display an unwillingness to consent to participate in psychotherapy. However, once informed of what treatment entails, consent is often given. When older adults are brought in for therapy or assessment by family members, practitioners are encouraged to take steps to ensure that it is the older adult's decision whether to participate in the process or not, independent of the desires of the family**.** In fact, obtaining the individual's consent and reminding the individual and the family about the confidentiality of the treatment or evaluation process may be an important part of building initial rapport with the older adult (Bush et al., 2017; Hays & Jennings, 2015).

A diagnosis of major neurocognitive disorder is not necessarily equivalent to lacking capacity in one or more areas, and respect for the rights and dignity of older persons is a core ethical principle (APA, 2017a; Bush et al., 2017). Even older adults with dementia often maintain the capacity to give or withhold consent well into illness progression (ABA & APA, 2008; Bush et al., 2015). The transitional period wherein a person with dementia progresses from having capacity to lacking capacity within one or more domains requires careful evaluation. Even after the older adult is assessed as lacking a specific capacity, the individual often remains capable of expressing core values and indicating assent with treatment decisions. Assessment of one or more domains of capacity requires an understanding of both clinical and legal models of diminished capacity, functional abilities linked to legal standards, and appropriate use of instruments to assess functional abilities, neurocognitive abilities, and psychiatric symptoms (Bush et al., 2015). An understanding of the person's long-held system of beliefs and values, including those formed by intersectional identities, is also essential, as is an assessment of ways to potentially enhance capacity and maximize functional abilities.

Often the psychologist may need to determine if a capacity assessment is warranted, or if the situation can be resolved through supportive decision making or in another manner. Knowledge of geriatric support services as well as legal tools and mechanisms for shared, supportive, or substitute decision making, such as powers of attorney, are critical (Hays & Jennings, 2015; Lind et al., 2022). Older adults with apparent diminished capacity and who have few or no social connections are especially vulnerable and require careful evaluation and, as needed, advocacy on their behalf, such as the development of supportive decision-making agreements (Bush & Heck, 2018; Catlin et al., 2022; Stanziani et al., 2020). Recent guardianship law emphasizes "supported decision making" as a paradigm shift away from the concepts of diminished capacity and surrogate decision making (Moye & Wood, 2020). Supported decision making is a series of relationships and agreements, which may be more or less formal, designed to assist persons in making and communicating decisions to others. This emphasis on supported decision making is consistent with long-standing approaches in geropsychology which emphasize respect for persons and recognizing and including supportive others and supportive services in care plans when it is consistent with the individual's cultural beliefs and values.

Psychologists working with older adults who are at risk due to diminished capacity may often encounter confidentiality issues in situations that involve families, interdisciplinary teams, long-term care settings, other support systems, or HIPAA protections regarding the electronic transfer of personal health information. A common ethical dilemma with regard to confidentiality involves older adults who are moderately to severely cognitively impaired and as a result may be in some danger of causing harm to themselves or others. In select situations, a careful balance of ethical considerations of beneficence and respect for autonomy includes tolerating some at-risk behavior (APA 2017a; ABA & APA, 2008; Bush et al., 2017; Lind et al., 2022). Except in limited circumstances (e.g., elder abuse, presenting danger to self or others, guardianship), older adults in treatment relationships have as much right to full confidentiality as younger adults, and must provide documented consent to permit the sharing of information with others (APA 2017a; Hays & Jennings, 2015).

Another set of ethical issues involves handling potential conflicts of interest between older adults and family members, particularly in situations of substitute decision making. Even when cognitive incapacity interferes with a person's ability to exercise autonomy in the present, it is often possible to ascertain what the individual's values are or have been in the past and act according to those values. When there is a substitute decision maker, there may be some risk that the surrogate will act for his or her own good rather than in the best interests of the older adult with dementia (ABA & APA, 2008; Moye, 2020). This potential for conflict of interest arises both with formally and legally appointed guardians as well as decision making by family members. Such conflict can also arise during decisions about end-of-life care for older family members (Carpen-

ter & Merz, 2020). Because situations involving death and dying are more common in later life, psychologists who work with older adults must be well informed about legal concerns and professional ethics surrounding these matters (APA, 2017a).

Psychologists may experience role conflicts when working in long-term care facilities. For example, instances arise in which the best interests of the older adult may be at odds with those of the staff or facility management. Such ethical dilemmas are best resolved by placing uppermost priority on serving the best interests of the older adult even when the psychologist has been hired by the facility (APA 2017a; Lind, et al., 2022; Molinari et al., 2021).

In most U.S. states, practitioners are legally obligated to report suspected abuse and neglect to appropriate authorities (Lachs & Pillemer, 2015). Serving older adults under these circumstances entails being knowledgeable about applicable statutory requirements and local community resources, as well as collaborating in arranging for the involvement of adult protective services (APA, 2012; APA 2017a). Psychologists often collaborate with other healthcare professionals to enhance detection and intervention in cases of suspected elder abuse (Ejaz, et al, 2020).

GUIDELINE 14

Psychologists strive to be knowledgeable about public policy, state and federal laws and regulations related to the provision of and reimbursement for psychological services to older adults and the business of practice.

Rationale

With a changing policy climate, the health care landscape continues to evolve. Psychologists who serve older adults are encouraged to be alert to changes in health care policy and practice that will impact their professional work including practice establishment, state laws that govern practice, potential for litigation, and reimbursement for services.

Medicare, the federal health insurance program for persons 65+ years of age and younger persons with disabilities, is a chief payer of mental health services for older adults. Psychologists were named as independent providers under Medicare in 1989 and the regulations that govern provision of services as well as reimbursement rules and regulations have evolved in the intervening years (Hinrichsen & Emery-Tiburcio, 2022).

Application

It is important for those who provide psychological services to older adults to be knowledgeable of the structure of the Medicare program and the rules that govern provision of and reimbursement for services (Norris, 2015). Medicare Advantage Plans, also known as "Part C" or "MA Plans," have become increasingly popular in recent years. Medicare Advantage Plans are provided by private insurance companies approved by Medicare to follow Medicare rules. Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Private Fee-for-Service (PFFS), and Special Needs Plans (SNPs) are offered, and most include Part D, or medication coverage ("Medicare Advantage Plans," n.d.).

Roughly 20% of older adults also have insurance that supplements Medicare coverage called "Medigap" policies. Knowledge of Medicaid (the federal/state insurance program for low-income Americans) is also useful for psychologists, as some states provide reimbursement for mental health services for older adults who have both Medicare and Medicaid ("dual eligibles").

The business of psychological practice with older adults requires a practical knowledge of not only requirements for reimbursement but also office management, collaboration with other professionals, protection from potential litigation, and practice development (Hartman-Stein, 2006; Vacha-Haase, 2011). For those who provide services in hospital and long-term care settings, substantive knowledge of institutional policies (e.g., reimbursement, documentation, protection of patient privacy) is critical (Molinari et al, 2021).

Assessment

GUIDELINE 15

Psychologists strive to understand the functional capacity of older adults in their own social and physical environment.

Rationale

Most older adults maintain high levels of functioning, suggesting that factors related to health, lifestyle, social determinants of health, and the match between functional abilities and environmental demands more powerfully determine performance than does age (Abdi et al., 2019; Chatterji, et al., 2015). Attention to assessing functional capacity in the context of person-environment fit is a part of competent clinical practice with older adults. The degree to which an older adult retains or does not retain the ability to function independently versus relying on others for basic self-care determines the need for support in the living environment (Abdi et al., 2019). Further, older adults' level of cognitive and physical functioning weighs heavily in decisions they make about employment, health care, relationships, leisure activities, and living environment. For example, many older adults may wish or need to remain in the work force (Dawson & Sterns, 2012; Solem et al., 2016), but the accumulation of health problems and their effect on functioning may make that difficult for some older adults.

Application

Theoretical perspectives on person-environment fit (Park et al., 2017) have considerable applicability when older adults evidence functional decline. Most older adults with mild cognitive or functional impairment successfully adapt to environments that impose few demands on them. As an older adult's functional abilities decline, the environment becomes increasingly important in maximizing functioning and maintaining quality of life (Abdi et al., 2019). Reablement, or enhanced home care, programs have demonstrated some success in improving functioning to increase opportunities to age in place at home (Flemming et al., 2021). Technological advances have also offered options for keeping older adults safe at home (Chiu et al., 2020), though ethical issues have arisen related to privacy and autonomy (Meiland et al., 2017; Sánchez et al., 2017). As such, psychologists working with older adults need to become familiar with processes for encouraging referrals to occupational therapy services; in-home assessments can lead to recommendations for home modifications that maximize person-environment fit and enhance daily functioning. In engaging the older adult in a conversation about adding supports to their living environment, it is important to balance the person's need for autonomy and quality of life with safety. For example, for some older adults, health problems make it difficult to engage in activities of daily living which may necessitate home health care. Many older adults find the presence of health care assistants in their homes to be stressful because of the financial demands of such care, differences in expectations about how care will be provided, racial and cultural differences between care provider and recipient, beliefs that family members are the only acceptable caregivers, or preference to not have anyone in their home for any reason (AP-NORC Center for Public Affairs Research, 2016).

Changes in functional capacity may prompt changes in social roles and may place an emotional strain on both the individual and family members involved in their care (Whitehead et al., 2018). Most families are involved in reciprocal patterns of assistance in which supports flow back and forth across multiple generations in a bidirectional pattern (Fingerman et al., 2020). Older adults and their family members often confront difficult decisions about whether the older person with waning cognitive or physical ability can manage finances, drive, live independently, manage medications, and many other issues (Feng et al., 2020; Tannou et al., 2020). Older adults must be included in these decisions at every level possible. Changes in functional capacity that were not previously apparent may appear when a spouse or caregiver who had been compensating for the older adult's cognitive decline dies or leaves their caregiving role for other reasons. Widowhood itself has also been associated with accelerated cognitive decline (Shin et al., 2018), as well as physical (Carey et al, 2014) and mental health changes, especially for men (Jadhav & Wier, 2018).

GUIDELINE 16

Psychologists strive to be familiar with the theory, research, and practice of various methods of assessment with older adults, and knowledgeable of assessment instruments that are culturally and psychometrically suitable for use with them.

Rationale

Older adults are assessed for a variety of reasons using myriad approaches including clinical interviewing, use of self-report measures, cognitive performance testing, direct behavioral observation, role play, psychophysiological techniques, neuroimaging, and use of family and/or informant data.

Application

In many contexts, particularly hospital and outpatient care settings, psychologists are frequently asked to evaluate older adults with regard to depression, anxiety, cognitive impairment, sleep disturbance, suicide risk factors, psychotic symptoms, various types of decision-making capacity, and the

management of behavior problems associated with these and other disorders. Given these complexities, a thorough assessment is preferably an interdisciplinary one, focusing on both strengths and weaknesses, determining how problems interrelate and taking account of contributing factors.

Developing knowledge and skill with respect to standardized assessment measures involves a high level of training and experience in, including but not limited to, psychometric theory, principles of test development and standardization, and appropriate selection of test instruments and normative samples to which test performances are compared (American Educational Research Association [AERA], APA, & National Council on Measurement in Education [NCME], 2014). When possible, assessors are encouraged to utilize instruments that have been developed and normed for older adults specifically (See https://aria.ua.edu/measurement-archive/; see also *Website Resources for Psychological Practice with Older Adults* below). When these do not exist, clinicians are encouraged to rely upon assessment instruments developed with young adults for which older adult normative data are available, and for which there is validity and reliability evidence to support their use with this population. The practitioner strives to understand the limitations of using certain instruments (Kim et. al., 2011), to consider that this approach leaves open the question of content validity (i.e., the age-relevant item content coverage for the construct being measured), and to interpret the assessment results accordingly, identifying any non-standardized approaches or limitations of their assessment. Multiple resources about this are available (e.g., Balsis et al, 2015; Edelstein et al., 2015; Pachana & Laidlaw, 2014).

Age is not the only potential factor to consider when utilizing diagnostic and standardized assessment instruments in older adult populations. Issues of culture, race, education, sex and gender identity, and language can also play a significant role in the process and outcome of assessment (see Guideline 6 for detailed discussion). It is important for psychologists to conduct culturally sensitive assessments, appreciating the intersectionality of age and culture, and potential cultural influences on the psychometric characteristics of assessment instruments. Culturally appropriate norms are not always available for assessment instruments, so it behooves the psychologist to be informed about which measures are most appropriate for diverse populations. Furthermore, psychologists work to understand the potential limitations and consequences of using other normative data and related ethical issues when assessing racially, culturally, and linguistically diverse older adults (e.g., APA, 2017a; Fujii, 2016; Irani, 2022; Kim et al. 2011; Rivera-Mindt, Byrd, Saez et al., 2010; Sisko et al, 2015). This includes, but is not limited to, assessing recent immigrants and refugees, first and second-generation Americans, and Americans from culturally or linguistically distinct regions of the U.S. (e.g., Appalachian, Creole, or Indigenous communities). Test items considered commonplace or benign in certain populations may be considered obscure or offensive to others, which can complicate interpretation of low scores on select assessment measures.

The validity of assessment instruments can be easily compromised by cross-cultural differences in the experience and presentation of certain psychological disorders in late life (e.g., depression; Futterman et al., 1997). Response styles to test items can vary across cultural groups and introduce unwanted variance into the outcome of assessment results. For example, some Asian American individuals with lower levels of acculturation may have a tendency to avoid reporting psychological or emotional symptoms and instead often report only somatic symptoms of mental health problems (Kim et al., 2020). However, considerable within-group and between-group differences can be found among diverse cultures, and clinical presentations may vary through differences in the degree of assimilation, educational experience, acculturation, and possible cohort experiences (Peterson et al., 2021). Finally, it is crucial that the psychologist synthesize assessment results with an eye to the cultural and linguistic characteristics of the person being assessed—along with knowledge of measure and norm congruence with the person's individual background—and document any limitations to their assessment (AERA & NCME, 2014, APA, 2017).

In addition to diagnostic and other standardized assessment, behavioral assessment has many applications in working with older adults, particularly for psychologists working in hospital, rehabilitation, or other institutional settings (Curyto, Trevino, Oglan-Hand & Lichtenberg, 2012). Functional analysis and assessment are often useful with individuals who exhibit problems such as wandering aggression and agitation (Cohen-Mansfield, 2015; Karel et al., 2016) by enabling the clinician to identify the antecedents to problem behaviors. The combination of norm-based standardized testing and behavioral assessment also can be valuable. In assessing older adults, particularly those with more advanced symptoms of Major Neurocognitive Disorder, it is important that psychologists recognize the dimensionality of cognitive impairment and implement a flexible approach to assessment. This may mean choosing an assessment measure specifically developed for individuals with advanced disease or relying more heavily on data provided by other informants such as family, physicians, or other allied health staff. It is useful to be aware of effective ways of gathering such information, and general considerations about how to interpret it in relation to other data. Likewise, evaluations of older adults, particularly those with cognitive impairment, may often be clarified by conducting repeated assessments over time.

Repeated assessment over time may be particularly useful with respect to such matters as the older adult's affective state, or with regard to functional capacities, and can help in examining the degree to which these are stable or vary according to contextual factors (e.g., time of day, activities, presence or absence of other individuals; Kazdin, 2003). Moreover, repeated assessment over time is useful when evaluating the effects of a medical intervention or rehabilitation (Haynes et al., 2011). Psychologists who conduct repeat assessments strive to be informed about possible practice effects that can occur with repeat administration of the same, or similar, assessment instruments as well as methods to detect meaningful change over time (Chelune & Duff, 2019; Hinton-Bayre & Kwapil, 2017).

In evaluating older adults, it is also important to ascertain the possible contributing or confounding influence of medications and medical disorders, in addition to the psychological factors being assessed. Medications with anticholinergic properties, for instance, span multiple medication classes including antihistamines and bladder control compounds, and can negatively impact cognition in older adults (American Geriatrics Society [AGS], 2023; Arnold, 2015). Similarly, medications such as steroids and opioids can commonly affect mood. Other possible influences to assess include immediate environmental factors on the presenting problem(s), and the nature and extent of the individual's familial or other social support. .

Finally, balanced and thorough evaluations of older adults include not only attention to potential deficits, but also the identification of strengths (e.g., cognitive, functional, social) that can be garnered to aid in treatment or for the development of compensatory strategies to address deficits. Successful communication of these strengths and associated, targeted compensatory strategies is a critically important outcome of psychological assessments. This information can aid the older adults themselves, their family and loved ones, and their medical and cultural communities in providing appropriate support and resources.

GUIDELINE 17

Psychologists strive to develop skill at conducting and interpreting cognitive and functional ability evaluations with older adults.

Rationale

When evaluating older adults, psychologists may need to use specialized procedures to help determine the individual's cognitive and other strengths and weaknesses, functional abilities, and to understand their behaviors.

Application

Psychologists may be asked to characterize an older adult's current cognitive or functional status and determine whether it represents a significant change from an earlier time and, if so, whether the observed problems are due to a specific neurodegenerative process, a psychiatric or medical condition, and/or other causes (Morris & Brookes, 2013). Assessments can range from a brief screening to in-depth diagnostic evaluation..

Cognitive screening typically involves the use of brief screening instruments targeted at identifying global impairment with adequate sensitivity but with relatively low diagnostic specificity. These screening tools are typically short (less than ten minutes) and relatively simple to administer and score. While there is currently no evidence-based treatment for reversing cognitive impairment associated with neurodegenerative disease, brief cognitive screening may still be appropriate for older adults who are at risk for dementia or have suspected cognitive decline due to an underlying neurologic or medical condition, or a mental disorder. Identifying cognitive strengths and weaknesses can be helpful to generate compensatory strategies and target modifiable risk factors (e.g., increasing physical activity) to improve function and quality of life (Lisko et al., 2021). Federal legislation provides for screening for cognitive impairment during annual wellness visits for Medicare beneficiaries (Andrulis, et.al., Patient Protection and Affordable Care Act, 2010) and subsequent publications have provided recommendations to help clinicians operationalize methods of assessment in primary care (Liss et al., 2021). .

On the other hand, differentiating factors contributing to cognitive impairment among older adults is much more challenging and often requires a comprehensive neuropsychological evaluation (See the *APA Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change* (2021) for more information). Consistent with the APA Ethics Code (2.01 Boundaries of Competence (APA Ethical Principles of Psychologists and Code of Conduct (APA, 2017a) and Guideline 1, these types of evaluations are conducted by psychologists with relevant training, experience, and demonstrated competencies in neuropsychological assessment. A neuropsychological evaluation includes objective measurement of cognitive performance using standardized psychometric instruments that assess various cognitive domains. Results are integrated with information obtained from family, friends, or staff that know the person well, in addition to historical, neurological, psychiatric, medical, and other diagnostic information. Psychologists with these competencies compare standardized test performance with culturally and demographically appropriate normative data in order to determine whether the cognitive profile is consistent with those known to occur in later life, or whether it represents a significant decline from the individual's baseline level of functioning. Using profile analy-

sis, the pattern of test performance can help differentiate the possible sources of cognitive impairment. Prompt evaluation of cognitive complaints may be useful in identifying potentially reversible causes of cognitive impairment, and identifying cognitive impairment that may be due to factors such as depression or anxiety (APA, 2021b). Repeated neuropsychological evaluation over time can help further characterize the nature and course of cognitive impairment. Consideration of practice or exposure effects is an important element of repeated assessment (Hinton-Bayre & Kwapil, 2017).

The ability to ethically conduct valid assessments, develop recommendations, and provide feedback to patients or other providers depends, in part, upon knowledge of expected age-related changes in cognitive abilities (see Guideline 9). In conducting such assessments, clinicians also rely upon their expertise in psychometric properties of tests of cognition, demographically-appropriate normative data for tests of cognitive functioning, the client's premorbid cognitive abilities, issues of performance validity, and consideration of the quality of education in addition to the absolute number of years of education (Byrd, 2022; Fujii, 2016; Manly & Echemendia, 2007; Ravdin & Katzen, 2019; Salthouse, 2019; Schaie & Willis, 2011; Sisco et al., 2015; Sweet et al., 2021). Neuropsychologists also utilize their knowledge of age-related brain changes and myriad conditions that affect the brain when conducting comprehensive evaluations. While brief cognitive screening tests do not substitute for a thorough evaluation, some older adults may be unable to tolerate long assessment batteries due to frailty, severe cognitive impairment, or other reasons. Psychologists recognize their boundaries of competence and make referrals to clinical neuropsychologists (for comprehensive neuropsychological assessments), geropsychologists, rehabilitation psychologists, neurologists, geriatricians, or other specialists as appropriate. See the *APA Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change* (2021) for more information..

In addition to the evaluation of cognitive functioning, psychologists are often called upon to assess the functional abilities of older adults, which typically include the ability to perform activities of daily living (ADLs; e.g., bathing, eating, dressing) and instrumental activities of daily living (IADLs; e.g., managing finances, preparing meals, managing medications and appointments). All these abilities require a combination of cognitive and behavioral skills. In 2019, approximately 44% of the older adult U.S. population reported having one or more disabilities (CDC, 2019), though it is noteworthy that advancing age and functional decline are not necessarily linearly related. In addition, psychologists are increasingly being asked to evaluate older adults' decision-making capacity (See Guideline 15; also Moye, 2020).

Psychologists are encouraged to be proficient in the functional assessment of strengths and limitations in ADLs and IADLs in the context of environmental demands and supports. Aging in itself does not typically result in disability for most older adults. However, disabilities among older adults are often due to some combination of age-related cognitive and physical changes (e.g., sensory system, cardiovascular system, musculoskeletal system) and the direct and indirect effects of chronic diseases. To make ecologically valid recommendations in these areas, the psychologist often integrates the assessment results obtained from the use of standardized assessments, such as the Katz IADL assessment (Katz et al., 1963, 1970) and the Independent Living Scales (Loeb, 1996) with clinical interview information gathered from both the older adult and collateral sources, direct observations of the older adult's functional performance (ABA & APA, 2008), along with other pertinent considerations (e.g., the immediate physical environment, available social supports, or local legal standards; see Guideline 13). Several approaches can be taken to assess functional abilities, ranging from questionnaires to performance-based evaluation.

Intervention

GUIDELINE 18

Psychologists strive to be familiar with the theory, research, and practice of various methods of intervention with older adults, particularly with current research evidence about their efficacy with this age group.

Rationale

The APA Guidelines for Evidence-Based Psychological Practice in Health Care (APA, 2021b) calls for psychologists to "maintain and enhance their knowledge of the research and scholarly literature applicable to their practice." Working with older adults thus requires knowledge of the literature on this population. While some interventions have required significant adaptation for older adults, others have required little, and still others have not been tested at all with older adults. It is critical for psychologists to be aware of the evidence base for treatments, along with necessary adaptations, to provide effective care for older adults.

Application

Many theoretical approaches have been applied to older adults, including cognitive behavioral therapy, interpersonal psychotherapy, problem-solving therapy, psychodynamic psychotherapy, behavior modification, as well as emerging evidence for the "third wave" cognitive and behavioral therapies (e.g., Acceptance and Commitment Therapy [ACT], Dialectical Behavior Therapy [DBT], Metacognitive Therapy [MCT], and Mindfulness-Based Interventions [MBIs]). Please see Lind, Poon and Birdsall (2022) for a thorough review. In addition, efforts have been made to use the knowledge base from research on adult development and aging to inform intervention efforts with older adults in a way that draws upon psychological and social capacities developed during the individual's lifespan (Anderson et al., 2012; Griffin et al., 2015; Hinrichsen, 2020).

Older adults respond well to a variety of forms of psychotherapy and can benefit from psychological interventions to a degree comparable with younger adults (APA, 2020d; Scogin & Shah, 2012; Saunders et al., 2021). Both individual and group psychotherapies have demonstrated efficacy in older adults (Agronin, 2009; Tavares & Barbosa, 2018). Cognitive-behavioral, cognitive bibliotherapy, interpersonal, problem-solving, psychodynamic, reminiscence, and other approaches have shown utility in the treatment of specific problems among older adults (Cuijpers et al., 2014; O'Rourke et al., 2017; Scogin & Shah, 2012; Steffen & Schmidt, 2022). Preliminary evidence is emerging for the use of acceptance and commitment therapy with older adults, particularly those with chronic pain (Davison et al., 2017; Gould et al., 2021) and for dialectical behavior therapy for those with personality disorder and depression (Lynch et al., 2007).

The problems for which efficacious psychological interventions have been demonstrated in older adults (Scogin & Shah, 2012) include depression (Edelstein et al., 2015) anxiety (Goncalves & Byrne, 2012), insomnia (Hinrichsen & Leipzig, 2021) and alcohol misuse (Blow & Barry, 2012; Substance Abuse & Mental Health Services Administration, 2020). In addition, behavior therapy and modification strategies, problem-solving therapy, socio-environmental modifications, and related interventions have been found useful in treating depression, reducing behavioral disturbances, and improving functional abilities in cognitively impaired older adults (Cohen-Mansfield, 2015; Kirkham et al., 2012; Kiosses et al., 2015). Reminiscence or life review therapy has shown utility as a technique in various applications for the treatment of depression (Alqam, 2018; Westerhof & Slatman, 2019), including for those with cognitive impairment (Cuevas et al, 2020). Preliminary evidence suggests that exposure-based therapies (prolonged exposure [PE]; cognitive processing therapy; narrative exposure therapy) for older adult trauma survivors are effective (Böttche et al., 2016; Lely et al., 2019; Robjant & Fazel, 2010), with indication from the first randomized controlled trial of PE that older adults may benefit from longer than standard treatment (Thorpe et al., 2019). The research is more limited on efficacy of psychological interventions with older adults from communities of color as compared with non-Hispanic Whites, though the few tailored interventions for specific groups of older adults have been found to be effective (Chavez-Korell et al., 2012; Emery-Tiburcio et al., 2019; Iwamasa & Hays, 2018; Lau & Kinoshita, 2019; Pratap et al., 2018).

The settings and scope of targets "or psychotherapeutic interventions continue to grow. Psychotherapies delivered as part of integrated care models have also been found to be effective in the treatment of depression in primary care settings (Bruce & Sirey, 2019; Emery-Tiburcio et al., 2019). Psychological interventions are also effective in the behavioral medicine arena as adjunctive approaches for managing a variety of issues in care for those with primary medical conditions, such as managing pain (Niknejad et al., 2018) and behavioral aspects of urinary incontinence (Burgio, 2013). They also can provide valuable assistance to older adults experiencing prolonged grief disorder (Roberts et al., 2019), adapting to changing life circumstances, improving interpersonal relationships, and/or experiencing sexual concerns, or other issues (Hinrichsen, 2008; Hillman, 2012; Sinković & Towler, 2019). Insomnia is also a common issue in later life; cognitive behavioral therapy for insomnia (CBTi) has been found to be effective in treating insomnia in older adults by replacing maladaptive thoughts and sleep habits (Brewster et al., 2018). As with other age groups, practitioners are encouraged to use evidence-based practices with older adults (APA, 2021b).

GUIDELINE 19

Psychologists strive to develop skills in adapting psychotherapeutic interventions, including environmental modification, in a manner sensitive to cultural and other individual differences among older adults.

Rationale

Some interventions, such as individual, group, couples, and family therapies, may be readily adapted to treat specific problems among older adults, whereas others have been uniquely developed to address common problems in older adults. Further, psychotherapy informed by "gero-diversity," which, broadly speaking, is a multicultural approach to issues of aging, incorporates aspects of the older adult's reference group identities and corresponding values, beliefs, cultural practices, and customs in order to align interventions in a person-centered, culturally humble manner and decrease stigma (APA, 2017a, 2018; Iwasaki et al., 2009). It is also important to adapt interventions to the clinical setting such as private office, home, hospital, or long-term care facility (see Guideline 10 for more on this issue). It is the degree of functional impairment (physical, cognitive, and social), rather than age, that is the primary determinant of whether and how to modify standard treatments, and this forms the basis of careful evaluations of functioning.

Application

The research literature provides evidence of the importance of specialized skills in working with older adults (Jacobs & Bamonti, 2022; Mast et al., 2022; Qualls, 2022). A variety of specific issues characterize work with older adults that may require sensitivity to age-related issues and utilization of specialized intervention techniques (see *Psychotherapy and Older Adults Resource Guide*, APA, 2009b). In addition, some older adults from historically marginalized groups (e.g., communities of color, LGBTQ+, TGD) experienced healthcare institutions as untrustworthy due to past experiences or have been harmed by mental health services. Practitioners then take active efforts to engage them and discuss their concerns from a stance of cultural humility, and offer healing and corrective experiences (Jimenez et al., 2012; Hillman & Hinrichsen, 2014; Kim et al., 2017; Vinson, et al., 2014).

Targeted interventions developed or modified for problems more common in older adults than younger populations include: reminiscence and life review (Westerhof & Slatman, 2019); facilitation of normative grief reactions (Steffen et al., 2022a); complicated grief therapy (Roberts et al., 2019; Shear et al., 2015); psychotherapy focusing on role transitions, developmental issues and behavioral adaptations in late life (Knight & Pachana, 2015; Roseborough et al., 2013); treatments for depression in those with cognitive impairment (Kiosses et al., 2015), acute or chronic medical problems, or elevated suicide risk (Raue et al., 2017); methods for enhancing cognitive function in later years; palliative and end of life care interventions (Iani et al., 2020); and interventions and psychoeducational programs for older adults, family members and other caregivers (APA, 2011a, 2020b; Cheng et al., 2020; Karlin et al., 2017; Qualls, 2016; Schultz et al., 2020). No single modality of psychological intervention will be efficacious for all older adults. The selection of the most appropriate treatments and modes of delivery depends on the nature of the problem(s) involved, clinical goals, the immediate situation, and the individual patient's characteristics, preferences, reference group identities (Jimenez et al.,2012; Hillman & Hinrichsen, 2014; Kim et al., 2017; Vinson et al., 2014), place on the continuum of care settings (for case examples, see Karel et al., 2002; Knight, 2009; Pachana et al., 2010) and, as noted earlier, availability of an evidence-based practice.

Because physical health issues are so commonly present, psychological interventions with older adults frequently address the older adult's adaptation to medical problems, such as pain management or enhancing adherence with medical treatment (Hadjistavropoulos, 2015). When facing life limiting health problems, older adults may require assistance with managing this end-of-life process for which therapeutic models exist (APA, 2017; Allen et al, 2014; Carpenter, 2015; Kasl-Godley et al., 2014). It is of utmost importance that interventions that assist older adults to cope with medical problems, potential environmental modifications (such as home health care), or end of life care be informed by gero-diversity, approached with cultural humility, and focused upon what matters most to the older adult (see Guidelines 2 and 6 regarding cultural attitudes regarding aging and incorporating diversity into geropsychology practice)..

Psychologists recognize that most community dwelling older adults who have high physical and mental functional ability respond well to the standard forms of psychotherapy that are often delivered in outpatient settings (e.g., individual, group, family therapies). For some older adults, standard therapeutic approaches can be modified with respect to process or content. Examples of process change might include modifying the pace of therapy, accommodating sensory limitations by reducing ambient noise and glare, speaking more slowly or closer to the ear of the older adult, encouraging the use of sound amplifiers ("pocket talkers") or hearing aids, or involving a caregiver. Modification to the content of therapy may include more attention to physical illness, grief, cognitive decline, and stressful practical problems experienced by some older adults than is usually the case with younger adults (Lind et al., 2022; Steffen et al., 2022).

Consultation

GUIDELINE 20

Psychologists strive to recognize and address issues related to the provision of prevention and health promotion services for older adults.

Rationale

Psychologists play a crucial role in contributing to the health and well-being of older adults through various means, including providing psychoeducational programs, participating in prevention efforts, engaging in community-oriented interventions, and advocating within healthcare and political legal systems (e.g., Reijnders et al., 2017; Alegria et al, 2019; Hirst et al., 2013). By integrating their clinical knowledge and techniques with consultation skills, strategic interventions, and preventive programming, psychologists can positively impact a significant number of older adults. Understanding the specific risk factors and resources available in the community is vital for effective outreach, case finding, referral, and early intervention targeting at-risk older adults (e.g., Fredriksen-Goldsen et al., 2014).

Application

To effectively implement Guideline 20 psychologists working with older adults can consider the following strategies:

Provide psychoeducation, appropriate screenings, and referrals. There are several areas of health promotion and prevention efforts relevant to psychologists working with older adults. Depression and concomitant risk of suicide, loneliness and isolation, sexual and health concerns, and alcohol and substance misuse among older adults are areas of particular concern (Schmutte & Wilkinson, 2020; Chhatre et al., 2017; Tillman & Mark, 2015; Gerst-Emerson & Jayawardhana, 2015; Ong et al., 2016).Practitioners are encouraged to be vigilant about assessing suicide risk and substance use in a variety of settings, including primary care. Further, it is important to enlist primary care physicians in efforts to recognize depressive symptoms and other risk factors for suicide (Huh et al., 2012) and provide referrals for appropriate treatment (Fiske et al., 2015).

Since loneliness in older adults may not be readily apparent, practitioners working with this population are encouraged to consider screening patients for loneliness, and if detected, make referrals to programs and interventions designed to increase social connectedness including psychotherapy and telephone support interventions (Perissinotto et al., 2019).

Practitioners are also encouraged to provide psychoeducation and/or deliver educational programs that focus on topics relevant to older adults, such as cognitive health, memory enhancement, caregiver support, and healthy aging. These programs can be conducted in various settings, including community centers, senior living facilities, and healthcare clinics (Reijnders et al., 2017).

Engage in prevention efforts and community-oriented interventions. Collaborate with community organizations, healthcare providers, and policymakers to develop and implement prevention programs and interventions. These initiatives can target specific issues affecting older adults, such as falls prevention, social isolation, substance misuse, and mental health promotion. An important aspect of these efforts is for psychologists to understand the strengths and limitations of local community resources relative to their domains of practice and the risk factors affecting the older adult group of concern (Seidel et al., 2017).

Similarly, relative to fostering older adults' general sense of well-being, it might be useful to advocate for more health promotion activities designed to facilitate their participation in exercise, good nutrition, and healthy lifestyles (Clark et al., 2012). By actively participating in community-oriented activities, psychologists can have a broader impact on the well-being of older adults (Alegria et al., 2019; Hirst et al., 2013). .

Advocate within healthcare and political legal systems. Psychologists can utilize their expertise to advocate for older adults' needs within healthcare systems and legal and political arenas (Karel, et al., 2012; Monahan et al., 2020; Schulz et al., 2020). In such activities, psychologists integrate their knowledge of clinical problems and techniques with consultation skills, strategic interventions, and preventive community or organizational programming to benefit substantial numbers of older adults (Clark et al., 2012). .

Psychologists can contribute to policy development, resource allocation, and the implementation of evidence-based practices that promote the health and well-being of older adults through active involvement in professional organizations and community coalitions.

GUIDELINE 21

Psychologists strive to understand issues pertaining to the provision of consultation services in assisting older adults.

Rationale

Psychologists who work with older adults are frequently asked to provide consultation on aging-related issues to a variety of groups and individuals. Many psychologists possess a complement of knowledge and skills that are especially valuable in the provision of consultation including social psychology, developmental psychology, diversity and inclusion, group dynamics, communications, program design and evaluation, and others. Given the anticipated dearth of aging specialists as the size of the older population rapidly grows, psychologists with relevant expertise will likely play important roles

in educating other professionals about aging (Institute of Medicine, 2012; Ward et al., 2018).

Application

Often psychologists provide services to older adults as active participants in family, social, or institutional systems. Therefore, in working with older adults, psychologists may need to intervene at various levels of these systems. For example, psychologists may assist family members by providing education and/or emotional support, facilitating conceptualization of problems and potential solutions, and improving communication and the coordination of care (Qualls, 2016). Or the psychologist may provide behavioral training and consultation on environmental modifications to long-term care staff for dementia related problem behaviors (Cohen-Mansfield, 2015). Psychologists working in interdisciplinary settings strive to employ frameworks for interdisciplinary collaboration such as the Interprofessional Core Competencies (https://www.ipecollaborative.org/ipec-core-competencies), especially interprofessional communication competencies such as values and ethics, roles and responsibilities, and team-based practice that are fundamental to providing collaborative services to older adults (Moye et al, 2019; O'Shea Carney et al., 2015). .

Psychologists who work with older adults strive to draw upon knowledge and skills with specific relevance to the older adult age group in providing consultation or training to families, healthcare providers, or other professionals (Bensadon, 2015). For example, once consent is obtained, psychologists frequently consult with and provide psychoeducation for family members of older relatives who have been diagnosed with mental health or cognitive concerns, especially those with dementia, on how to best support these aging family members. .

In consultation with other professionals, institutions, agencies, and community organizations psychologists may play key roles in training and educating staff who work

directly with older adults in many different settings (Garzonis et al., 2015; Halli-Tierney et al, 2021; Lee et al., 2020; Molinari et al., 2021; O'Shea Carney et al., 2015). In the staff training role, psychologists teach basic knowledge of normal aging and development, improved communication with older adults (Gerontological Society of America, 2022a), appropriate management of cognitive and behavioral issues (Teri et al., 2020), and facilitate social engagement given the adverse consequences of social isolation (Van Orden et al., 2020). For example, many long-term-care staff members recognize that they lack adequate knowledge of how to implement evidence-based nonpsychopharmacological protocols to address the mental health needs of residents, particularly those with serious mental illness or major neurocognitive disorder (Karel, Teri, et al., 2016). More staff consultation and training in behavioral principles may result in a reduction in the over-use of psychoactive medications and improved quality of life for this vulnerable population (Arnold, 2015). Psychologists may contribute to program development, evaluation and quality assurance related to aging services (O'Shea Carney et al., 2017). When consulting with health care teams or organizations, psychologists can facilitate increased collaboration among members of interdisciplinary care teams especially those that have client populations with complex medical and psychosocial needs (Farrell et al., 2018; Geriatrics Interdisciplinary Advisory Group, 2006; Halli-Tierney et al, 2021; McDaniel et al., 2014).

Conclusion

We remind our readers that these Guidelines are aspirational and do not represent mandatory standards for working with older adults. While it was our goal to make the Guidelines as broad and informative as possible, psychologists working with older adults may desire additional in-depth training on certain topics and we have provided some resources (see Appendix 1) within this document to facilitate such activities. We would also reiterate the myriad resources provided by the APA Aging and Older Adults topic page (see https://www.apa.org/topics/aging-older-adults), for psychologists working with the older population. Lastly, we would like to emphasize that although these Guidelines emphasize how psychologists strive to address psychological problems for older adults in their practice, most older adults live vibrant and productive lives and have considerable reservoirs of resilience that have enabled them to survive into late adulthood. First and foremost, psychologists seek to be cognizant of these positive aspects of aging when we engage in psychological practice with older adults. .

APPENDIX 1

Website Resources for Psychological Practice With Older Adults

Name	Website
Alabama Research Institute on Aging – Measurement Archive	https://aria.ua.edu/measurement-archive/
American Board of Geropsychology	https://abgero.org
APA Aging and Older Adults Topic Page	https://www.apa.org/topics/aging-older-adults
APA Center for Workforce Studies	https://www.apa.org/workforce
APA Presidential Task Force on Integrated Health Care for An Aging Population	https://www.apa.org/pi/aging/programs/integrated/overview
APA Division 20	https://www.apa.org/about/division/div20
APA Division 44 Resources	https://www.apadivisions.org/division-44/resources
Area Agencies on Aging	https://www.usaging.org
Caregiver Briefcase	http://www.apa.org/pi/about/publications/caregivers/index.aspx
Committee on Aging	https://www.apa.org/pi/aging/cona
Division 12 – Section II: the Society for Clinical Geropsychology	http://www.geropsychology.org
E4 Center of Excellence for Behavioral Health Disparities in Aging	https://e4center.org/
GeroCentral	https://gerocentral.org/
Gerontological Society of America (GSA)	http://www.geron.org/
GSA KAER Toolkit, Fall 2020 Edition	https://www.geron.org/publications/kaer-toolkit
Integrated Health Care for an Aging Population	http://www.apa.org/pi/aging/programs/integrated/index.aspx
National Population Projections Tables	https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html
The Pikes Peak Geropsychology Knowledge and Skill Assessment Tool	https://coaportal.apa.org/uploads/uploads_overflow2/83DC3565_671/Pikes_Peak_Evaluation_Tool.pdf
Project Implicit	https://implicit.harvard.edu/implicit/takeatest.html
Psychologist in Long-Term Care	http://www.pltcweb.org/index.php
SAMHSA Treatment Improvement Protocol (TIP) 26 Treating Substance Use Disorder in Older Adults	https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-011%20PDF%20508c.pdf
The Administration for Community Living (ACL)	https://acl.gov
The American Society on Aging	https://www.asaging.org/
The World Health Organization (WHO)	https://www.who.int/news-room/questions-and-answers/item/ageing-ageism

References

Abdi, S., Spann, A., Borilovic, J., de Witte, L., & Hawley, M. (2019). Understanding the care and support needs of older people: A scoping review and categorisation using the WHO international classification of functioning, disability and health framework (ICF). *BMC Geriatrics, 19*(1), 195. https://doi.org/10.1186/s12877019-1189-9

ABGERO: American Board of Geropsychology. (2022). *American Board of Geropsychology*. https://abgero.org/

Abrahamson, K., Nazir, A., & Pressler, K. (2017). A novel approach to deprescribing in long-term care settings: The SMART campaign. *Research in Social and Administrative Pharmacy, 13*(6), 1202–1203. https://doi.org/1016/j.sapharm2016.11.012

Abrams, D., Swift, H. J., & Drury, L. (2016). Old and unemployable? How age-based stereotypes affect willingness to hire job candidates. *The Journal of Social Issues, 72*(1), 105–121. https://doi.org/10.1111/josi.12158

Adelman, R. D., Tmanova, L. L., Delgado, D., Dion, S., & Lachs, M. S. (2014). Caregiver burden: a clinical review. *Journal of the American Medical Association,311*(10), 1052–1060. https://doi.org/10.1001/jama.2014.304

Administration on Aging. (2011). *Department of Health and Human Services*. https://acl.gov/sites/default/files/about-acl/2017-04/AOA_2011_AnnualReport.pdf

Albert, M. S., DeKosky, S. T., Dickson, D., Dubois, B., Feldman, H. H., Fox, N. C., Gamst, A., Holtzman, D. M., Jagust, W. J., Petersen, R. C., Snyder, P. J., Carrillo, M. C., Thies, B., & Phelps, C. H. (2011). The diagnosis of mild cognitive impairment due to Alzheimer's disease: recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic Guidelines for Alzheimer's disease. *Alzheimer's & dementia, 7*(3), 270–279. https://doi.org/10.1016/j.jalz.2011.03.008

Albright, A. E., Hilgeman, M. M., & Allen, R. S. (2020). Addressing family conflicts when assessing capacities. In J. Moye (Ed.) *Assessing capacities of older adults: A casebook to guide difficult decisions* (pp. 299–325). American Psychological Association. https://doi.org.10.1037/0000184-013

Aldwin, C. M., & Igarashi, H. (2016). Coping, optimal aging, and resilience in a sociocultural context. In V. L. Bengtson & R. A. Settersten. Jr. (Eds.). *Handbook of the theories of aging, 3*, 551–576.

Aldwin, C. M., Igarashi, H., Gilmer, D. F., & Levenson, M. R. (2017). *Health, illness, and optimal aging: Biological and psychosocial perspectives.* Springer Publishing Company.

Aldwin, C. M., Park, C. L., & Spiro, A. (Eds.). (2007). *Handbook of health psychology and aging*. Guilford Press.

Alegria, M., Frontera, W., Cruz-Gonzalez, M., Markle, S.L., Trinh-Shevrin, C., Wang, Y., Herrera, L., Ishikawa, R.Z., Velazquez, E., Fuentes, L., Guo, Y., Pan, J., Cheung, M., Wong, J., Genatios, U., Jimenez, A., Ramos, Z., Perez, G., Wong, J.Y... Shrout, P. E. (2019). Effectiveness of a disability preventive intervention for minority and immigrant elders. The positive minds-strong bodies randomized clinical trial. *The American Journal of Geriatric Psychiatry, 27*(12), 1299–1313. https://doi.org/10.1016/j.jagp.2019.08.008

Alexandrakis, D., Chorianopoulos, K., & Tselios, N. (2020). Older adults and web 2.0 storytelling technologies: Probing the technology acceptance model through an age-related perspective. *International Journal of Human–Computer Interaction, 36*(17), 1623–1635. https://doi.org/10.1080/10447318.2020.1768673

Allen, R. S., Harris, G. M., Burgio, L. D., Azuero, C. B., Miller, L. A., Shin, H., Eichorst, M. K., Csikai, E .L., DeCoster, J., Dunn, L. L., Kvale, E. A., & Parmelee, P. (2014). Can senior volunteers deliver reminiscence and creative activity interventions? Results of the Legacy Intervention Family Enactment randomized controlled trial. *Journal of Pain and Symptom Management, 48*(4), 590–601. DOI: 10.1016/j.painsymman.2013.11.012

Alquam, B. M. (2018). The effects of reminiscence therapy on depressive symptoms among elderly: An evidence-based review. *Trauma Acute Care, 3*(1), 1.

American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults. *Journal of the American Geriatrics Society, 71*(7), 2052–2081. https://doi.org/10.1111/jgs.18372

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association. (2002). Criteria for practice guideline development and evaluation. *American Psychologist, 57*(12), 1048–1051. https://doi.org/10.1037/0003-066X.57.12.1048

American Psychological Association. (2004). Guidelines for psychological practice with older adults. *American Psychologist, 59*(4), 236–260. https://doi.org/10.1037/0003-066X.59.4.236

American Psychological Association. (2008a). *Geropsychology*. https://www.apa.org/ed/graduate/specialize/geropsychology

American Psychological Association. (2008b). Presidential Task Force on Integrated Health Care for an Aging Population. *Blueprint for change: Achieving integrated health care for an aging population.* www.apa.org/pi/aging/programs/integrated/integrated-healthcare-report.pdf

American Psychological Association. (2010a). Ethical principles of psychologists and code of conduct including 2010 amendments. http://www.apa.org/ethics/code/index.aspx

American Psychological Association. (2010b). *Publication Manual of the American Psychological Association* (6th ed.).

American Psychological Association. (2011a). Psychological practice with caregivers. https://www.apa.org/pi/about/publications/caregivers/practice-settings
American Psychological Association. (2011b). Resolution on family caregivers. http://www.apa.org/pi/about/publications/caregivers/index.aspx
American Psychological Association (2014a). Guidelines for psychological practice with older adults. *American Psychologist, 69*(1), 34–65. https://doi.org/10.1037/a0035063
American Psychological Association (2014b). Prolonging vitality. https://www.apa.org/pi/aging/resources/prolonging-vitality
American Psychological Association. (2015a). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist, 70*(9), 832-864. https://doi.org/10.1037/a0039906
American Psychological Association. (2015b). Resolution on the 2015 White House Conference on Aging. https://www.apa.org/about/policy/white-house-aging
American Psychological Association. (2017a). Ethical principles of psychologists and code of conduct (2002, Amended June 1, 2010, and January 1, 2017). http://www.apa.org/ethics/code/index.aspx
American Psychological Association. (2017b). Multicultural Guidelines: An ecological approach to context, identity, and intersectionality. https://www.apa.org/about/policy/multicultural-Guidelines.pdf
American Psychological Association. (2017c). Resolution on assisted dying. http://www.apa.org/about/policy/assisted-dying-resolution
American Psychological Association. (2017d). Resolution on palliative care and end-of-life issues. http://www.apa.org/about/policy/palliative-care-eol
American Psychological Association. (2019). Guidelines for psychological practice for people with low-income and economic marginalization. www.apa.org/about/policy/Guidelines-lowincome.pdf
American Psychological Association. (2020a). APA resolution on ageism. https://www.apa.org/about/policy/resolution-ageism.pdf
American Psychological Association. (2020b). Caregiver briefcase. https://www.apa.org/pi/about/publications/caregivers
American Psychological Association. (2020c). Education and training guidelines: A taxonomy for education and training in professional psychology health service specialties and subspecialties. https://www.apa.org/ed/graduate/specialize/taxonomy.pdf
American Psychological Association. (2020d). How to provide telehealth to older adults. https://www.apaservices.org/practice/clinic/telehealth-older-adults
American Psychological Association. (2021). Resolution on APA, psychology, and human rights. https://www.apa.org/about/policy/resolution-psychology-humanrights.pdf
American Psychological Association. (2021a). Aging. https://www.apa.org/pi/aging/index
American Psychological Association. (2021b). Professional practice guidelines for evidence-based psychological practice in health care. www.apa.org/about/policy/psychological-practice-health-care.pdf
American Psychological Association (2022). Psychology's role in advancing population health. https://www.apa.org/about/policy/population-health-statement.pdf
American Psychological Association. (2022a). Elder abuse: How to spot warning signs, get help, and report mistreatment. https://www.apa.org/topics/aging-olderadults/elder-abuse
American Psychological Association, APA Task Force on Guidelines for Assessment and Intervention with Persons with Disabilities. (2022b). Guidelines for Assessment and Intervention with Persons with Disabilities. https://www.apa.org/about/policy/guidelines-assessment-interventiondisabilities.pdf
American Psychological Association, APA Task Force for the Evaluation of Dementia and Age-Related Cognitive Change. (2021). Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change. https://www.apa.org/practice/Guidelines/
American Psychological Association, APA Task Force on Psychological Practice with Sexual Minority Persons. (2021). Guidelines for psychological practice with sexual minority persons. https://www.apa.org/about/policy/psychological-practicesexual-minority-persons.pdf
American Psychological Association, Girls and Women Guidelines Group. (2018). APA Guidelines for psychological practice with girls and women. https://www.apa.org/about/policy/psychological-practice-girls-women.pdf
American Psychological Association, Working Group on Assisted Suicide and End-of-Life Decisions. (2000). Report to the Board of Directors. https://www.apa.org/pi/aging/programs/eol/index
Anderson, G. & Thayer, C. (2018). Loneliness and Social Connections: A National Survey of Adults 45 and Older. Washington, DC: *AARP Research*. https://doi.org/10.26419/res.00246.001
Anderson, M., & Perrin, A. (2017). *Technology use among seniors.* Washington, DC: Pew Research Center for Internet & Technology.
Andreescu, C., Lenze, E. J., Mulsant, B. H., Wetherell, J. L., Begley, A. E., Mazumdar, S., & Reynolds III, C. F. (2009). High worry severity is associated with poorer acute and maintenance efficacy of antidepressants in late-life depression. *Depression and Anxiety, 26*(3), 266–272. https://doi.org/10.1002/da.20544
Andrulis, D. P., Siddiqui, N. J., Purtle, J., & Duchon, L. (2010). Patient Protection and Affordable Care Act of 2010: Advancing health equity for racially and ethnically diverse populations. https://core.ac.uk/download/pdf/77145023.pdf
Antonucci, T. C., Birdett, K. S., & Ajrouch, K. (2011). Convoys of social relations: Past, present and future. In K. L. Fingerman, C. A. Berg, J. Smith, & T. C. Antonucci (Eds.), *Handbook of life-span development, 2*(1),161–182.
APA Division 12 Section 2 Society of Clinical Geropsychology. (2022). Society of Clinical Geropsychology. https://geropsychology.org
APA Division 20 Adult Development and Aging. (2022). APA Div. 20: Adult Development and Aging. http://apadivisions.org/division-20/

AP-NORC Center for Public Affairs Research. (2016). *Long-term care in America: Expectations and preferences for care and caregiving*. https://www.longtermcarepoll.org/wp-content/uploads/2017/11/AP-NORC-Longterm-Care-2016_Trend_Report.pdf

Arbore, P. (2019). Suicide prevention among rural older adults. *Generations, 43*(2), 6265. https://jstor.org/stable/26760116

Areán, P. A., & Gum, A. M. (2013). Psychologists at the table in health care reform: The case of geropsychology and integrated care. *Professional Psychology: Research and Practice, 44*(3), 142. https://doi.org/10.1037/a0031083

Armstrong, K., Putt, M., Halbert, C. H., Grande, D., Schwartz, J. S., Liao, K., Marcus, N., Demeter, M. B., & Shea, J. A. (2013). Prior experiences of racial discrimination and racial differences in health care system distrust. *Medical Care, 51*(2), 144-150. https://doi.org/10.1097/MLR.0b013e31827310a1

Arnold, M. (2015). Psychopharmacology and polypharmacy. In P. A. Lichtenberg, B. T. Mast, B. D. Carpenter, & J. E. Loebach Wetherell (Eds.), *APA handbook of clinical geropsychology, Vol. 1: History and status of the field and perspectives on aging* (pp. 587–605). American Psychological Association. https://doi.org/10.1037/14458-025

Aschwanden, D., Strickhouser, J. E., Luchetti, M., Stephan, Y., Sutin, A. R., & Terracciano, A. (2021). Is personality associated with dementia risk? A meta-analytic investigation. *Ageing Research Reviews, 67*, 101269. https://doi.org/10.1016/j.arr.2021.101269

Assari, S. (2018). Unequal gain of equal resources across racial groups. *International Journal of Health Policy and Management, 7*(1), 1–9. https://doi.org/10.15171/ijhpm.2017.90

Averill, J. B. (2012). Priorities for action in a rural older adults study. *Family & community health, 35*(4), 358. https://doi.org/10.1097/FCH.0b013e318266686e

Ayalon, L., & Tesch-Romer, C. (2017). Taking a closer look at ageism: Self- and other-directed ageist attitudes and discrimination. *European Journal on Aging,14*(1), 1– 4. https://doi.org/10.1007/s10433-016-0409-9

Ayalon, L., & Tesch-Römer, C. (2018). Introduction to the section: Ageism—Concept and origins. *Contemporary perspectives on ageism*, 1–10. https://link.springer.com/chapter/10.1007/978-3-319-73820-8_1

Aziz, R., & Steffens, D. C. (2013). What are the causes of late-life depression?. *Psychiatric Clinics, 36*(4), 497-516. https://doi.org/10.1016/j.psc.2013.08.001

Balsis, S., Zweig, R. A., & Molinari, V. (2015). Personality disorders in later life. In P. A. Lichtenberg, B. T. Mast, B. D. Carpenter, & J. E. Loebach Wetherell (Eds.), *APA handbook of clinical geropsychology, Vol. 2. Assessment, treatment, and issues of later life* (pp. 79–94). American Psychological Association. https://doi.org/10.1037/14459-003

Baltes, P. B. (1997). On the incomplete architecture of human ontogeny: Selection, optimization, and compensation as foundation of developmental theory. *American psychologist, 52*(4), 366. https://doi.org/10.1037/0003-066X.52.4.366

Baltes, P. B., & Smith, J. (2003). New frontiers in the future of aging: From successful aging of the young old to the dilemmas of the fourth age. *Gerontology, 49*(2), 123–135. https://doi.org/10.1159/000067946

Barker, M. (2019). Good practices across the counseling professions 001: Gender, sexual, and relationship diversity (GRSD). *British Association for Counseling and Psychotherapy*. https://bacp.co.uk/media/5877/bacp-gender-sexual-relationshipdiversity-gpacp001-april19.pdf

Barry, K. L., Blow, F. C. (2012). Alcohol and substance misuse in older adults. *Current Psychiatry Reports, 14,* 310–319. https://doi.org/10.1007/s11920-012-0292-9

Barry, K. L., Blow, F. C. (2016). Drinking over the lifespan: Focus on older adults. *Alcohol Research: Current Reviews, 38*(1),115–20. https://pubmed.ncbi.nlm.nih.gov/27159818/

Bengtson V.L. & Settersten, R. (Eds.). (2016). *Handbook of theories of aging* (3rd ed.). Springer Publishing Company.

Bennett, K. M., & Soulsby, L. K. (2012). Wellbeing in bereavement and widowhood. *Illness, Crisis & Loss, 20*(4), 321–337. https://dx.doi.org/10.2190/IL.20.4.b

Bergman-Evans, B. (2020). A nurse practitioner led protocol to address polypharmacy in long-term care. *Geriatric Nursing, 41*(6), 956–961. https://doi.org/10.1016/j.gerinurse.2020.07.002

Bleidorn, W., Hopwood, C. J., Back, M. D., Denissen, J. J., Hennecke, M., Hill, P. L., Jokela, M., Kandler, C., Lucas, R.E., Luhmann, M., Orth, U., Roberts, B. W., Wagner, J., Wrzus, C., & Zimmermann, J. (2021). Personality trait stability and change. *Personality Science, 2*, 1–20. https://doi.org/10.5964/ps.6009

Blieszner, R., & Roberto, K. A. (2012). Partners and friends in adulthood. In S. K. Whitbourne & M. J. Sliwinski (Eds.). *The Wiley-Blackwell handbook of adulthood and aging* (pp. 381–398). John Wiley & Sons. https://doi.org/10.1002/9781118392966.ch19

Bilder, R. M., Postal, K. S., Barisa, M., Aase, D. M., Cullum, C. M., Gillaspy, S. R., Harder, L., Kanter, G., Lanca, M., Lechuga, D. M., Morgan, J. M., Most, R., Puente, A. E., Salinas, C. M., & Woodhouse, J. (2020). Inter organizational practice committee recommendations/guidance for teleneuropsychology in response to the COVID-19 Pandemic. *Archives of Clinical Neuropsychology, 35*(6), 647–659. https://doi.org/10.1093/arclin/acaa046

Boersma, P., Black, L. I., & Ward, B. W. (2020). Prevalence of multiple chronic conditions among US adults, 2018. *Preventing Chronic Disease*, *17*, E106. https://doi.org/10.5888/pcd17.200130

Bodner, E., Palgi, Y., & Wyman, M. F. (2018). Ageism in mental health assessment and treatment of older adults. *Contemporary Perspectives on Ageism*, *19,* 241–262. Springer. https://doi.org/10.1007/978-3-319-73820-8_15

Bogner, H. R., de Vries, H. F., Maulik, P. K., & Unützer, J. (2009). Mental health services use: Baltimore epidemiologic catchment area follow-up. *American Journal of Geriatric Psychiatry, 17*(8), 706–715. doi: 10.1097/JGP.0b013e3181aad5c5

Boland, K. M. (2019). Ethical considerations for providing in-home mental health services for homebound individuals, *Ethics & Behavior, 29*(4), 287–304. https://doi.org/10.1080/10508422.2018.1518138

Bondi, M. W., Edmonds, E. C., & Salmon, D. P. (2017). Alzheimer's Disease: Past, present, and future. *Journal of the International Neuropsychological Society, 23*(9–10), 818–831. https://doi.org/10.1017/S135561771700100X

Bosnes, I., Almkvist, O., Bosnes, O., Stordal, E., Romild, U., & Nordahl, H. M. (2017). Prevalence and correlates of successful aging in a population-based sample of older adults: the HUNT study. *International Psychogeriatrics, 29*(3), 431–440. https://doi.org/10.1017/S1041610216001861

Böttche, M., Kuwert, P., Pietrzak, R. H., & Knaevelsrud, C. (2016). Predictors of outcome of an Internet-based cognitive-behavioural therapy for post-traumatic stress disorder in older adults. *Psychology and Psychotherapy: Theory, Research and Practice, 89*(1), 82–96. https://doi.org/10.1111/papt.12069

Brenes, G. A., Danhauer, S. C., Lyles, M. F., Hogan, P. E., & Miller, M. E. (2015). Barriers to mental health treatment in rural older adults. *The American Journal of Geriatric Psychiatry, 23*(11), 1172–1178. https://doi.org/10.1016/j.jagp.2015.06.002

Brennan-Ing, M., Kaufman, J. E., Larson, B., Gamarel, K. E., Seidel, L., & Karpiak, S. E. (2020). Sexual health among lesbian, gay, bisexual, and heterosexual older adults: An exploratory analysis. *Clinical Gerontologist, 44*(3), 222–234. https://doi.org/10.1080/07317115.2020.1846103

Brennan-Ing, M., Seidel, L., Larson, B., & Karpiak, S. E. (2014). Social care networks and older LGBT adults: Challenges for the future. *Journal of Homosexuality, 61*(1), 21–52. https://doi.org/10.1080/00918369.2013.835235

Brennan-Ing, M., Seidel, L., & Karpiak, S. E. (2017). Social support systems and social network characteristics of older adults with HIV. In M. Brennan-Ing and R. F. DeMarco (Eds.), *HIV and aging: Interdisciplinary topics in gerontology* (Vol. 42, pp. 159–172). Karger.

Brennan-Ing, M., Seidel, L, Larson, B., & Karpiak, S. E. (2017). Social networks and supports among older gay and bisexual men: The impact of HIV. In J. M. Wilmoth and M. D. Silverstein (Eds.), *Later-life social support and service provision in diverse and vulnerable populations* (pp. 54–76). Routledge.

Bensadon, B. A., Hundt, N. E., Stanley M. A. (2015). Coping mediates the relationship between disease severity and illness intrusiveness among chronically ill patients. *Journal of Health Psychology*, *20*(9), 1186–1195. doi:10.1177/1359105313509845

Brewster, G.S., Riegel, B., Gehrman, P.R. (2018). Insomnia in the older adult. *Sleep Medicine Clinics, 13*(1), 13–19. https://doi.org/10.1016/j.jsmc.2017.09.002

Brink, T. L., & Lichtenberg, P. A. (2014). *Mental health practice in geriatric health care settings.* Routledge.

Brookes, R. L., Hannesdottir, K., Markus, H. S., & Morris, R. G. (2013). Lack of awareness of neuropsychological deficit in cerebral small vessel disease: the relationship with executive and episodic memory functions. *Journal of neuropsychology*, *7*(1), 19–28. https://doi.org/10.1111/j.1748-6653.2012.02032.x

Brown, L. M., Gibson, M., & Elmore, D. (2012). Disaster behavioral health and older adults: American and Canadian readiness and response. In J. L. Framingham & M. L. Teasley (Eds.), *Behavioral health response to disasters* (pp. 159–174). CRC. DOI:10.1201/b11954-14

Bruce, M. L, Sirey, J. A., Dawson, A., Raue, P. J., & Berman, J. (2019). Lay-delivered behavioral activation for depressed senior center clients: Pilot RCT. *International Journal of Geriatric Psychiatry, 34*(11), 1715–1723. https://doi.org/10.1002/gps.5186

Bundick, M. J., Yeager, D. S., King, P. E., & Damon, W. (2010). Thriving across the life span. In Overton, W.F., & Lerner, R.M. (Eds.). *The handbook of life-span development*, Vol. 1. Cognition, biology, and methods (pp. 882–923). John Wiley & Sons, Inc. https://doi.org/10.1002/9780470880166.hlsd001024

Burgio, L. D., & Wynn, M. J. (2021). The REACH OUT caregiver support program: A skills training program for caregivers of persons with dementia. *Clinician guide*. Oxford University Press.

Burnes, D., Sheppard, C., Henderson Jr, C. R., Wassel, M., Cope, R., Barber, C., & Pillemer, K. (2019). Interventions to reduce ageism against older adults: A systematic review and meta-analysis. *American Journal of Public Health, 109*(8), e1–e9. https://doi.org/10.2105/AJPH.2019.305123

Burr, D. A., Castrellon, J. J., Zald, D. H., & Samanez-Larkin, G. R. (2021). Emotion dynamics across adulthood in everyday life: Older adults are more emotionally stable and better at regulating desires. *Emotion, 21*(3), 453–464. https://doi.org/10.1037/emo0000734

Bush, S. S., Allen, R. S., Heck, A. L., & Moye, J. (2015). Ethical issues in geropsychology: Clinical and forensic perspectives. *Psychological Injury and the Law, 8*, 348–356. https://doi.org/10.1007/s12207-015-9242-2

Bush, S.S., Allen, R.A., & Molinari, V.A. (2017). *Ethical practice in geropsychology*. American Psychological Association. https://doi.org/10.1037/0000010-000

Bush, S.S. & Heck, A.L. (2018). *Forensic geropsychology: Practice essentials.* American Psychological Association. https://doi.org/10.1037/0000082-000

Busso, D. S., Volmert, A., & Kendall-Taylor, N. (2019). Reframing aging: Effect of a short-term framing intervention on implicit measures of age bias. *Journals of Gerontology: Series B, 74*(4), 559–564. https://doi.org/101.1093/geronb/gby080

Butler, R. N. (1969). Age-ism: Another form of bigotry. *The Gerontologist, 9*(4, Pt. 1), 243–246. https://doi.org/10.1093/geront/9.4_Part_1.243

Byers, A. L., Yaffe, K., Covinsky, K. E., Friedman, M. B., & Bruce, M. L. (2010). High occurrence of mood and anxiety disorders among older adults: The National Comorbidity Survey Replication. *Archives of General Psychiatry, 67*(5), 489–496. https://doi.org/10.1001/archgenpsychiatry.2010.35

Byrd, D. A., & Rivera-Mindt, M. G. (2022). Neuropsychology's race problem does not begin or end with demographically adjusted norms. *Nature reviews: Neurology*, *18*, 125–126. https://doi.org/10.1038/s41582-021-00607-4

Calderón-Larrañaga, A., Vetrano, D. L., Ferrucci, L., Mercer, S. W., Marengoni, A., Onder, G., Eriksdotter, M., & Fratiglioni, L. (2019). Multimorbidity and functional impairment–bidirectional interplay, synergistic effects and common pathways. *Journal of Internal Medicine, 285*(3), 255–271. https://doi.org/10.1111/joim.12843

Canetto, S. S. (2001). Older adult women: Issues, resources, and challenges. In R. K. Unger (Ed.), *Handbook of the psychology of women and gender* (pp. 183–197). Wiley.

Canetto, S. S. (2011). Legal physician-assisted suicide in the U.S.: Issues, roles and implications for clinicians. In S. H. Qualls & J. Kasl-Godley (Eds.), *End of life care and bereavement* (pp. 263–284). Wiley.

Canetto, S. S. (2017). Suicide: Why are older men so vulnerable? *Men and Masculinities, 20,* 49–70. doi.org/10.1177/1097184X15613832

Canetto, S. S. (2019). If physician-assisted suicide is the modern woman's last powerful choice, why are White women its leading advocates and main users? *Professional Psychology: Research and Practice*, 50, 39–50. doi.org/10.1037/pro0000210

Canetto, S. S., Kaminski, P. L., & Felicio, D. M. (1995). Typical and optimal aging in women and men: Is there a double standard? *International Journal of Aging and Human Development, 40*, 1–21.

Canetto, S. S., & McIntosh, J. L. (2022). A comparison of physician-assisted/Death-with-Dignity-Act death and suicide patterns in older adult women and men. *American Journal of Geriatric Psychiatry*, *30*, 211–220. doi.org/10.1016/j.jagp.2021.06.003

Carey, I.M., Shah, S.M., DeWilde, S., Harris, T., Victor, C.R., Cook, D. (2-14). Increased risk of acute cardiovascular events after partner bereavement: A matched cohort study. *JAMA Internal Medicine*, *174*(4), 598–605. doi:10.1001/jamainternmed.2013.14558Carney, G. M. (2018). Toward a gender politics of aging. *Journal of Women & Aging, 30*(3), 242–258. https://doi.org/10.1080/08952841.2017.1301163

Carpenter, B. D., & Merz, C. C. (2020). Assessment of capacity in medical aid in dying. In Moye, J. (Ed.), *Assessing capacities of older adults: A casebook to guide difficult decisions* (pp. 243–267). American Psychological Association. https://doi.org/10.1037/0000184-011

Carpenter, B. D., Gatz, M., & Smyer, M. A. (2022). Mental health and aging in the 2020s. *American Psychologist, 77*(4), 538–550. https://doi.org/10.1037/amp0000873

Carpentieri, J. D., Elliott, J., Brett, C. E., & Deary, I. J. (2017). Adapting to aging: Older people talk about their use of selection, optimization, and compensation to maximize well-being in the context of physical decline. *The Journals of Gerontology: Series B, 72*(2), 351–361. https://doi.org/10.1093/geronb/gbw132

Carstensen, L. L. (2006). The influence of a sense of time on human development. *Science, 312*(5782), 1913–1915. https://doi.org/10.1126/science.1127488

Carstensen, L. L. (2021). Socioemotional selectivity theory: The role of perceived endings in human motivation. *The Gerontologist, 61*(8), 1188–1196. https://doi.org/10.1093/geront/gnab116

Carstensen, L. L., Isaacowitz, D. M., & Charles, S. T. (1999). Taking time seriously: A theory of socioemotional selectivity. *American Psychologist, 54*(3), 165–181. https://doi.org/10.1037/0003-066X.54.3.165

Carstensen, L. L., Shavit, Y. Z., & Barnes, J. T. (2020). Age advantages in emotional experience persist even under threat from the COVID-19 pandemic. *Psychological Science, 31*(11), 1374–1385. https://doi.org/10.1177/0956797620967261

Carstensen, L. L., Turan, B., Scheibe, S., Ram, N., Ersner-Hershfield, H., Samanez-Larkin, G. R., Brooks, K. P., & Nesselroade, J. R. (2011). Emotional experience improves with age: Evidence based on over 10 years of experience sampling. *Psychology and Aging, 26*(1), 21–33. https://doi.org/10.1037/a0021285

Catlin, C. C., Connors, H. L., Teaster, P. B., Wood, E., Sager, Z. S., & Moye, J. (2022). Unrepresented adults face adverse healthcare consequences: The role of guardians, public guardianship reform, and alternative policy solutions. *Journal of Aging & Social Policy, 34*(3), 418-437. https://doi.org/10.1080/08959420.2020.1851433

Chan, W., Chiu-wa Lam, L., & Yu-hai Chen, E. (2011). Recent advances in pharmacological treatment of psychosis in late life. *Current Opinion in Psychiatry, 24*(6), 455–460. https://doi.org/10.1097/YCO.0b013e32834a3f47

Chan, J., Tong, C., Wong, C., Chen, E., & Chang, W. C. (2022). Life expectancy and years of potential life lost in bipolar disorder: Systematic review and meta-analysis. *The British Journal of Psychiatry: The Journal of Mental Science,* 1–10. Advance online publication. https://doi.org/10.1192/bjp.2022.19

Charles, S. T. (2011). Emotional experience and regulation in later life. In Schaie, K.W., & Willis, S. (Eds.), *Handbook of the psychology of aging* (7th ed., pp. 295–310). Burlington, MA: Elsevier Academic Press. https://doi.org/10.1016/B978-0-12380882-0.00019-X.

Chatterji, S., Byles, J., Cutler, D., Seeman, T., & Verdes, E. (2015). Health, functioning, and disability in older adults: Present status and future implications. *The Lancet*, *385*(9967), 563–575. https://doi.org/10.1016/S0140-6736(14)61462-8

Chatters, L. M., Taylor, H. O., & Taylor, R. J. (2020). Older Black Americans during COVID-19: Race and age double jeopardy. *Health Education & Behavior, 47*(6), 855–860. https://doi.org/10.1177/1090198120965513

Chavez-Korell, S., Rendón, A. D., Beer, J., Rodriguez, N., Garr, A. D., Pine, C. A., Farías, R., Larson, L., & Malcolm, E. (2012). Improving access and reducing barriers to depression treatment for Latino elders: Un Nuevo Amanecer (A New Dawn). *Professional Psychology: Research and Practice, 43*(3), 217–226. https://doi.org/10.1037/a0026695

Chelune, G. J., & Duff, K. (2019). The assessment of change: Serial assessments in dementia evaluations. In L. D. Ravdin & H. L. Katzen (Eds.), *Handbook on the neuropsychology of aging and dementia* (pp. 61–76). Springer Nature Switzerland AG. https://doi-org/10.1007/978-3-319-93497-6_5

Chen, J., McLaren, H., Jones, M., & Shams, L. (2022). The aging experiences of LGBTQ ethnic minority older adults: A systematic review. *The Gerontologist, 62*(3), e162–e177. https://doi.org/10.1093/geront/gnaa134

Chen, Y., Peng, Y., Xu, H., & O'Brien, W. H. (2018). Age differences in stress and coping: Problem-focused strategies mediate the relationship between age and positive affect. *International Journal of Aging & Human Development, 86*(4), 347–363. https://doi.org/10.1177/0091415017720890

Cheng, S.-T., Li, K.-K., Losada, A., Zhang, F., Au, A., Thompson, L. W., & Gallagher-Thompson, D. (2020). The effectiveness of nonpharmacological interventions for informal dementia caregivers: An updated systematic review and meta-analysis. *Psychology and Aging, 35*(1), 55–77. https://doi-org/10.1037/pag0000401

Chenneville, T., & Gabbidon, K. (2020). Application of the APA ethics code for psychologists working in integrated care settings: Potential conflicts and resolutions. *Ethics & Behavior, 30*(4), 264–274. https://doi.org/10.1080/10508422.2019.1683739

Chhatre, S., Cook, R., Mallik, E., Jayadevappa, R. (2017). Trends in substance use admissions among older adults. *BMC Health Services Research*, *17*(1), 584. https://doi.org/10.1186/s12913-017-2538-z

Chiu, C. J., Hu, J. C., Lo, Y. H., & Chang, E. Y. (2020). Health Promotion and disease prevention interventions for the elderly: A scoping review from 2015-2019. *International Journal of Environmental Research and Public Health, 17*(15), 5335. https://doi.org/10.3390/ijerph17155335

Chochinov, H., Cann, B., Cullihall, K., Kristjanson, L., Harlos, M., McClement, S., Hassard, T. (2012). Dignity therapy: A feasibility study of elders in long-term care. *Palliative & Supportive Care, 10*(1), 3–15. https://doi.org/10.1017/s1478951511000538

Choi, N. G., DiNitto, D. M., & Marti, C. N. (2015). Alcohol and other substance use, mental health treatment use, and perceived unmet treatment need: Comparison between baby boomers and older adults. *The American Journal on Addictions, 24*(4), 299–307. https://doi.org/10.1111/ajad.12225

Choi, N. G., DiNitto, D. M., Marti, C. N., & Choi, B. Y. (2022). Telehealth use among older adults during COVID-19: Associations with sociodemographic and health characteristics, technology device ownership, and technology learning. *Journal of Applied Gerontology, 41*(3), 600–609. https://doi.org/10.1177/07334648211047347

Choi, M., Sprang, G., & Eslinger, J. G. (2016). Grandparents raising grandchildren: A synthetic review and theoretical model for interventions. *Family & Community Health, 39*(2), 120–128. https://doi.org/10.1097/FCH.0000000000000097

Chopik, W. J., & Giasson, H. L. (2017). Age differences in explicit and implicit age attitudes across the life span. *The Gerontologist, 57*(suppl_2), S169–S177. https://doi.org/10.1093/geront/gnx058

Clark, F., Jackson, J., Carlson, M., Chou, C.P., Cherry, B.J., Jordan-Marsh, M., & Azen, S.P. (2012). Effectiveness of a lifestyle intervention in promoting the well-being of independently living older people: Results of the Well Elderly 2 Randomised Controlled Trial. *Journal of Epidemiology and Community Health, 66*(9), 782–790.

Clauss-Ehlers, C. S., Chiriboga, D. A., Hunter, S. J., Roysircar, G., & Tummala-Narra, P. (2019). APA multicultural guidelines executive summary: Ecological approach to context, identity, and intersectionality. *American Psychologist, 74*(2), 232–244. https://doi.org/10.1037/amp0000382

Clerveau, G., Ochieng, N., Cubanski, J., & Neuman, T. (2023, August). A snapshot of sources of coverage among Medicare beneficiaries. *KFF*. Retrieved from: htpps://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries

Cloyes, K. G., Hull, W., & Davis, A. (2018, February). Palliative and end-of-life care for lesbian, gay, bisexual, and transgender (LGBT) cancer patients and their caregivers. *Seminars in oncology nursing*, *34*(1), 60–71. https://doi.org/10.1016/j.soncn.2017.12.003

Cohen-Mansfield, J., Dakheel-Ali, M., Marx, M. S., Thein, K., & Regier, N. G. (2015). Which unmet needs contribute to behavior problems in persons with advanced dementia? *Psychiatry Research, 228*(1), 59–64. https://doi.org/10.1016/j.psychres.2015.03.043

Cole, E., Stevenson, M., & Rodgers, B. (2009). The influence of cultural health beliefs on self-reported mental health status and mental health service utilization in an ethnically diverse sample of older adults. *Journal of Feminist Family Therapy, 21*(1), 1–17. https://doi.org/10.1080/08952830802683657

Cook, B. L., Trinh, N. H., Li, Z., Hou, S. S. Y., & Progovac, A. M. (2017). Trends in racial-ethnic disparities in access to mental health care, 2004–2012. *Psychiatric Services, 68*(1), 9-16. https://doi.org/10.1176/appi.ps.201500453

COPGTP: Council of Professional Geropsychology Training Programs (2022). http://www.copgtp.org

Corriveau, R. A., Koroshetz, W. J., Gladman, J. T., Jeon, S., Babcock, D., Bennett, D. A., Carmichael, S. T., Dickinson, S. L., Dickson, D. W., Emr, M., Fillit, H., Greenberg, S. M., Hutton, M. L., Knopman, D. S., Manly, J. J., Marder, K. S., Moy, C. S., Phelps, C. H., Scott, P. A., Seeley, W. W., ... Holtzman, D. M. (2017). Alzheimer's Disease-Related Dementias Summit 2016: National research priorities. *Neurology, 89*(23), 2381–2391. https://doi.org/10.1212/WNL.0000000000004717

Cosentino, S., Brickman, A. M., & Manly, J. J. (2011). Neuropsychological assessment of the dementias of late life. In Schaie, K.W., & Willis, S.L. (Eds.), *Handbook of the psychology of aging* (7th ed., pp. 339–352). Elsevier Academic Press. https://doi.org/10.1016/B978-0-12-380882-0.00022-X

Costa, P. T., Jr., & McCrae, R. R. (2011). The Five-Factor Model, Five-Factor Theory, and interpersonal psychology. In L.M., Horowitz, & S., Strack (Eds.), *Handbook of interpersonal psychology: Theory, research, assessment, and therapeutic interventions.* (pp. 91–104). John Wiley & Sons, Inc.

Crenshaw, K. W. (2017). *On intersectionality: Essential writings.* The New Press.

Crewe, S. E. (2019). The task is far from completed: Double jeopardy and older African Americans. *Social Work in Public Health, 34*(1), 122-133. https://doi.org/10.1080/19371918.2018.1562398

Crimmins, E. M., Kim, J. K., & Solé-Auró, A. (2011). Gender differences in health: results from SHARE, ELSA and HRS. *European Journal of Public Health*, *21*(1), 81–91. doi: 10.1093/eurpub/ckq022.

Crockett, L. J., & Beal, S. J. (2012). The life course in the making: Gender and the development of adolescents' expected timing of adult role transitions. *Developmental Psychology, 48*(6), 1727. https://doi.org/10.1037/a0027538

Cuevas, P.E.G., Davidson, P.M., Mejilla, J.L. and Rodney, T.W. (2020), Reminiscence therapy for older adults with Alzheimer's disease: A literature review. *International Journal of Mental Health Nursing, 29*(3), 364–371. https://doi.org/10.1111/inm.12692

Cuijpers, P., Karyotaki, E., Pot, A. M., Park, M., & Reynolds, C. F. (2014). Managing depression in older age: Psychological interventions. *Maturitas, 79*(2), 160–169. https://doi.org/10.1016/j.maturitas.2014.05.027

Ćurković, M., Dodig-Ćurković, K., Erić, A. P., Kralik, K., & Pivac, N. (2016). Psychotropic medications in older adults: A review. *Psychiatria Danubina, 28*(1), 13–22.

Curyto, K.J., Trevino, K.M., Ogland-Hand, S., & Lichtenberg, P. (2012). Evidence-based treatments for behavioral disturbances in long-term care. In Scogin, F., & Shah, A. (Eds.), *Making evidence-based psychological treatments work with older adults* (pp. 167–223). American Psychological Association. https://doi.org/10.1037/13753-006.

Dahal, R. & Bista, S. (2022). Strategies to reduce polypharmacy in the elderly. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK574550/

Dannefer, D. (2020). Systemic and reflexive: Foundations of cumulative dis/advantage and life-course processes. *The Journals of Gerontology: Series B, 75*(6), 1249–1263. https://doi.org/10.1093/geronb/gby118

Dautovich, N. D., Shoji, K. D., Stripling, A. M., & Dzierzewski, J. M. (2014). Clinical geropsychology: Treatment and research approaches with rural older adults. *The Clinical Gerontologist, 37*(1), 64–75. https://doi.org/10.1080/07317115.2014.847312

Davison, E. H., Kaiser, A. P., Spiro, A., 3rd, Moye, J., King, L. A., & King, D. W. (2016). From late-onset stress symptomatology to later-adulthood trauma reengagement in aging combat veterans: Taking a broader view. *Gerontologist, 56*(1), 14–21. https://doi.org/10.1093/geront/gnv097

Dawson, N. T., & Sterns, H. L. (2012). Emerging perspectives on resilience in adulthood and later life: Work, retirement, and resilience. *Annual Review of Gerontology and Geriatrics, 32*(1), 211–230. https://doi.org/10.1891/0198-8794.32.211

De, J., & Ward, A.P.F. (2015). Delirium screening: A systematic review of delirium screening tools in hospitalized patients. *The Gerontologist, 55*(6), 1079–1099. https://doi.org/10.1093/geront/gnv100

DeLiema, M., Deevy, M., Lusardi, A., & Mitchell, O. S. (2020). Financial fraud among older Americans: Evidence and implications. *The Journals of Gerontology: Series B, 75*(4), 861–868. https://doi.org/10.1093/geronb/gby151

Demiray, B., Mischler, M., & Martin, M. (2019). Reminiscence in everyday conversations: a naturalistic observation study of older adults. *The Journals of Gerontology: Series B, 74*(5), 745–755. https://doi.org/10.1093/geronb/gbx141

Dening, K.H. (2019). Differentiating between dementia, delirium and depression in older people. *Nursing Standard, 35*(1), 43–50. https://doi.org/10.7748/ns.2019.e11361

Depp, C. A., & Jeste, D. V. (2006). Definitions and predictors of successful aging: A comprehensive review of larger quantitative studies. *The American Journal of Geriatric Psychiatry, 14*(1), 6–20. https://doi.org/10.1097/01.JGP.0000192501.03069.bc

Diehl, M., Smyer, M. A., & Mehrotra, C. M. (2020). Optimizing aging: A call for a new narrative. *American Psychologist, 75*(4), 577–589. https://doi.org/10.1037/amp0000598

Diehl, M. & Wahl, H. W. (2020). *The psychology of later life: A contextual perspective.* American Psychological Association.

Dilworth-Anderson, P., & Gibson, B. E. (2002). The cultural influence of values, norms, meanings, and perceptions in understanding dementia in ethnic minorities. *Alzheimer's Disease and Associated Disorders, 16,* S56–S63. doi:10.1097/00002093-200200002-00005

Doka, K. J. (2008). Religious and spiritual perspectives on life-threatening illness, dying, and death. In *Decision making near the end of life* (pp. 307–326). Routledge.

Donovan, N. J., & Blazer, D. (2020). Social isolation and loneliness in older adults: review and commentary of a National Academies report. *The American Journal of Geriatric Psychiatry, 28*(12), 1233-1244. https://doi.org/10.1016/j.jagp.2020.08.005

Doraiswamy, S., Jithesh, A., Mamtani, R., Abraham, A., & Cheema, S. (2021). Telehealth use in geriatrics care during the COVID-19 pandemic: A scoping review and evidence synthesis. *International Journal of Environmental Research and Public Health, 18*(4), 1755. https://doi.org/10.2196/24087

Dorman, H. R., Strong, J. V., Tighe, C.A., Mast, B.T., & Allen, R.S. (2021). Geropsychology career pipeline perceptions. *Journal of Clinical Psychology, 77*(1), 90–104. https://doi.org/10.1002/jclp.23035

Dzierzewski, J. M., Griffin, S. C., Ravyts, S., & Rybarczyk, B. (2018). Psychological interventions for late-life insomnia: Current and emerging science. *Current Sleep Medicine Reports, 4*(4), 268–277. https://doi.org/10.1007/s40675-018-0129-0

E4 Center of Excellence for Behavioral Health Disparities in Aging. (2022). *Engage, Educate, and Empower for Equity: E4 Center of Excellence for Behavioral Health Disparities in Aging.* https://e4center.org

Edelstein, B. A., Bamonti, P. M., Gregg, J. J., & Gerolimatos, L. A. (2015). Depression in later life. In P. A. Lichtenberg, B. T. Mast, B.D. Carpenter, & J. Loebach Wetherell (Eds.), *APA handbook of clinical peropsychology, vol. 2: Assessment, treatment, and issues of later life* (pp. 3–47). American Psychological Association. https://doi.org/10.1037/14459-001

Edelstein, B. A., Martin, R. R., & Gerolimatos, L. A. (2012). Assessment in geriatric settings. In J. R. Graham & J. A. Naglieri (Eds.), *Handbook of psychology: Assessment psychology* (pp. 425–448). Wiley.

Ehlman, D.C., Yard, E., Stone, D.M., Jones, C.M., Mack, K.A. (2020). Changes in suicide rates — United States, 2019 and 2020. *MMWR. Morbidity and Mortality Weekly Report, 71,* 306–312. http://dx.doi.org/10.15585/mmwr.mm7108a5

Eisdorfer, C., & Lawton, M. P. (Eds.) (1973). *The psychology of adult development and aging.* American Psychological Association. http://doi.org/10.1037/10044-000

Ejaz. F. K., Rose, M., Reynolds, C., Bingle, C., Billa, D., & Kirsch, R. (2020). A novel intervention to identify and report suspected abuse in older, primary care patients. *Journal of the American Geriatrics Society, 68*(8), 1748–1754. https://doi.org/10.1111/jgs.16433

Elder Jr, G. H., Clipp, E. C., Brown, J. S., Martin, L. R., & Friedman, H. S. (2009). The lifelong mortality risks of World War II experiences. *Research on Aging, 31*(4), 391–412. https://doi.org/10.1177/0164027509333447

Emery-Tiburcio, E. E., Rothschild, S. K., Avery, E. F., Wang, Y., Mack, L., Golden, R. L., Holmgreen, L., Hobfoll, S., Richardson, D., & Powell, L. H. (2019). BRIGHTEN heart intervention for depression in minority older adults: Randomized controlled trial. *Health Psychology, 38*(1), 1–11. https://doi.org/10.1037/hea0000684

Ervin, J. L., Milner, A., Kavanagh, A. M., & King, T. L. (2021). The double burden of poverty and marital loss on the mental health of older Australian women: A longitudinal regression analysis using 17 annual waves of the HILDA cohort. *Social Psychiatry and Psychiatric Epidemiology*, *56*(6), 1059–1068. https://doi.org/10.1007/s00127-020-02019-z

Exalto, L. G., Quesenberry, C. P., Barnes, D., Kivipelto, M., Biessels, G. J., & Whitmer, R. A. (2014). Midlife risk score for the prediction of dementia four decades later. *Alzheimer's & Dementia, 10*(5), 562–570. https://doi.org/10.1016/j.jalz.2013.05.1772

Falender, C. A., & Shafranske, E. P. (2017). Competency-based clinical supervision: Status, opportunities, tensions, and the future. *Australian Psychologist, 52*(2), 8693. https://doi.org/10.1111/ap.12265

Farrell, T. W., Luptak, M. K., Supiano, K. P., Pacala, J. T., & De Lisser, R. (2018). State of the science: Interprofessional approaches to aging, dementia, and mental health. *Journal of the American Geriatrics Society, 66*, S40–S47.

Faverio, M. (2022). Share of those 65 and older who are tech users has grown in the past decade. *Pew Research Center for Internet & Technology*. https://www.pewresearch.org/fact-tank/2022/01/13/share-of-those-65-and-older-who-are-tech-users-has-grown-in-the-past-decade/

Fazel, S., Hayes, A. J., Bartellas, K., Clerici, M., & Trestman, R. (2016). Mental health of prisoners: prevalence, adverse outcomes, and interventions. *The Lancet Psychiatry, 3*(9), 871–881. https://doi.org/10.1016/S2215-0366(16)30142-0

Federal Interagency Forum on Aging-Related Statistics (2020). Older Americans 2020: Key indicators of well-being. AgingStats.gov. https://agingstats.gov/docs/LatestReport/OA20_508_10142020.pdf

Feinkohl, I., Lachmann, G., Brockahus, W-R., Borchers, F., Piper, S. K., Ottens, T. H., Nathoe, H. M., Sauer, A-M., Dieleman, J. M., Radtke, F. M., van Dijk, D., Pischon, T., & Spies, C. (2018). Association of obesity, diabetes and hypertension with cognitive impairment in older age. *Clinical Epidemiology, 10*, 853–862. https://doi.org/10.2147/CLEP.S164793

Feldman, D. B., Periyakoil, V. S. (2006). Posttraumatic Stress Disorder at the End of Life. *Journal of Palliative Medicine, 9*(1), 213–218. http://doi.org/10.1089/jpm.2006.9.213

Feng, Y. R., Meuleners, L., Stevenson, M., Heyworth, J., Murray, K., & Maher, S. (2020). Driver self-regulation practices in older drivers with and without mild cognitive impairment. *Clinical Interventions in Aging, 15*, 217–224. https://doi.org/10.2147/CIA.S236998

Fingerman, K. L., Berg, C., Smith, J., & Antonucci, T. C. (Eds.). (2010). *Handbook of life-span development.* Springer Publishing Company.

Fingerman, K. L., Brown, B. B., & Blieszner, R. (2011). Informal ties across the life span: Peers, consequential strangers, and people we encounter in daily life. In Fingerman, K.L., Berg, C.A., Smith, J., & Antonucci, T.C. (Eds.), *Handbook of life-span development* (pp. 487–511). Springer Publishing Company.

Fingerman, K. L., Huo, M., & Birditt, K. S. (2020). A decade of research on intergenerational ties: Technological, economic, political, and demographic changes. *Journal of Marriage and Family, 82*(1), 383-403. https://doi.org/10.1111/jomf.12604

Fiske, A., Wetherell, J. L., & Gatz, M. (2009). Depression in older adults. *Annual review of clinical psychology, 5,* 363–389. https://doi.org/10.1146/annurev.clinpsy.032408.153621

Flemming, J., Armijo-Olivo, S., Dennett, L., Lapointe, P., Robertson, D., Wang, J., & Ohinmaa, A. (2021). Enhanced home care interventions for community residing adults compared with usual care on health and cost-effectiveness outcomes: A systematic review. *American Journal of Physical Medicine & Rehabilitation, 100*(9), 906–917. doi.10.1097/PHM.0000000000001734

Foster, M. V., & Sethares, K. A. (2014). Facilitators and barriers to the adoption of telehealth in older adults: An integrative review. *CIN: Computers, Informatics, Nursing, 32*(11), 523–533. doi: 10.1097/CIN.0000000000000105

Fredriksen-Goldsen, K. I., Cook-Daniels, L., Kim, H. J., Erosheva, E. A., Emlet, C. A., Hoy-Ellis, C. P., & Muraco, A. (2014a). Physical and mental health of transgender older adults: An at-risk and underserved population. *The Gerontologist, 54*(3), 488–500. https://doi.org/10.1093/geront/gnt021

Fredriksen-Goldsen, K. I., Hoy-Ellis, C. P., Goldsen, J., Emlet, C. A., & Hooyman, N. R. (2014b). Creating a vision for the future: Key competencies and strategies for culturally competent practice with lesbian, gay, bisexual, and transgender (LGBT) older adults in the health and human services. *Journal of Gerontological Social Work, 57*(2–4), 80–107. https://doi.org/10.1080/01634372.2014.890690

Fredriksen-Goldsen, K. I., Kim, H. J., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2013). Health disparities among lesbian, gay, and bisexual older adults: results

from a population-based study. *American Journal of Public Health*, *103*(10), 1802–1809. https://doi.org/10.2105/AJPH.2012.301110

Freeman, A. T., Santini, Z. I., Tyrovolas, S., Rummel-Kluge, C., Haro, J. M., & Koyanagi, A. (2016). Negative perceptions of ageing predict the onset and persistence of depression and anxiety: Findings from a prospective analysis of the Irish Longitudinal Study on Ageing (TILDA). *Journal of Affective Disorders, 199*, 132–138. https://doi.org/10.1016/j.jad.2016.03.042

Fujii, T., Moriel, G., Kramer, D. R., Attenello, F., & Zada, G. (2016). Prognostic factors of early outcome and discharge status in patients undergoing surgical intervention following traumatic intracranial hemorrhage. *Journal of Clinical Neuroscience: Official Journal of the Neurosurgical Society of Australasia*, *31*, 152–156. https://doi.org/10.1016/j.jocn.2016.03.007

Fuller, H. R., & Huseth-Zosel, A. (2021). Lessons in resilience: Initial coping among older adults during the COVID-19 pandemic. *The Gerontologist, 61*(1), 114-125. doi:10.1093/geront/gnaa170

Fuller-Iglesias, H., Smith, J., & Antonucci, T. C. (2010). Theories of aging from a life-course and life-span perspective: An overview. In T. C. Antonucci & J. S. Jackson (Eds.), *Annual review of gerontology and geriatrics, 2009: Life-course perspectives on late-life health inequalities* (pp. 3–25). Springer Publishing Company.

Fulmer, T. (2021). Age-friendly health systems transform care for older adults. *Modern Healthcare.* https://www.johnahartford.org/images/uploads/reports/ModernHealthcareExecutiveInsight_TF_2.11.19.pdf

Futterman, A, Thompson, L., Gallagher-Thompson, D., Ferris, R. (1997). Depression in later life: Epidemiology, assessment, etiology and treatment. In E. E. Beckham & W. R. Leber (Eds.), *Handbook of depression* (2nd ed., pp. 494–525). Guilford Press.Garrison-Diehn, C., Rummel, C., Au, Y. H., & Scherer, K. (2022). Attitudes toward older adults and aging: A foundational geropsychology knowledge competency. *Clinical Psychology: Science and Practice, 29*(1), 4–15. https://doi.org/10.1037/cps0000043

Garzonis, K., Mann, E., Wyrzykowska, A., Kanellakis, P. (2015). Improving patient outcomes: Effectively training healthcare staff in psychological practice skills: A mixed systematic literature review. *Europe's Journal of Psychology, 11*(3), 535556. https://doi.org/10.5964/ejop.v11i3.923. PMID: 27247676; PMCID: PMC4873062

Gellis, Z.D., Bruce, M.L. (2010). Problem-solving therapy for subthreshold depression in home healthcare patients with cardiovascular disease. *The American Journal of Geriatric Psychiatry, 8*(6), 464–474. ISSN 1064-7481, https://doi.org/10.1097/JGP.0b013e3181b21442

Gentry, M. T., Lapid, M. I., & Rummans, T. A. (2019). Geriatric telepsychiatry: Systematic review and policy considerations. *The American Journal of Geriatric Psychiatry, 27*(2), 109–127. https://doi.org/10.1016/j.jagp.2018.10.009

GeroCentral. (2022). *GeroCentra*l. www.gerocentral.org.

Gerontological Society of America (2022a). *Reframing aging initiative*. https://www.geron.org/programs-services/reframing-aging-initiative

Gerontological Society of America (2022b). *Reframing aging: Journal manuscript Guidelines.* https://static.primary.prod.gcms.the-infra.com/static/site/gsa/document/Reframing_Aging_Journal_Manuscript_Guidel ines.pdf?node=412d7ccc31fac597b9de

Gerst-Emerson, K., & Jayawardhana, J. (2015). Loneliness as a public health issue: The impact of loneliness on health care utilization among older adults. *American Journal of Public Health, 105*, 1013–1019. https://doi.org/10.2105/AJPH.2014.302427

Gibson, C. J., Maguen, S., Xia, F., Barnes, D. E., Peltz, C. B., & Yaffe, K. (2020). Military sexual trauma in older women veterans: Prevalence and comorbidities. *Journal of General Internal Medicine, 35*(1), 207–213. https://doi.org/10.1007/s11606-019-05342-7

Glaesmer, H., Gunzelmann, T., Braehler, E., Forstmeier, S., & Maercker, A. (2010). Traumatic experiences and post-traumatic stress disorder among elderly

Germans: Results of a representative population-based survey. *International Psychogeriatrics, 22*(4), 661–670. https://doi.org/10.1017/S1041610210000027X

Gonçalves, D.C., Byrne, G.J. (2012). Interventions for generalized anxiety disorder in older adults: Systematic review and meta-analysis. *Journal of Anxiety Disorders, 26*(1), 1–11. ISSN 0887-6185, https://doi.org/10.1016/j.janxdis.2011.08.010

Gorenko, J. A., Moran, C., Flynn, M., Dobson, K., & Konnert, C. (2021). Social isolation and psychological distress among older adults related to COVID-19: A narrative review of remotely delivered interventions and recommendations. *Journal of Applied Gerontology, 40*(1), 3–13. https://doi.org/10.1177/0733464820958550

Gould, C.E., & Hantke, N.C. (2020). Promoting technology and virtual visits to improve older adult mental health in the face of COVID-19. *American Journal of Geriatric Psychiatry, 28*(8), 889–890. https://doi.org/10.1016/j.jagp.2020.05.011

Griffin, P., Mroczek, D., & Wesbecher, K. (2015). Personality Development Across the Lifespan: Theory, Research, and Application. In P., Lichtenberg, & B., Mast, (Eds.), *APA Handbook of Clinical Geropsychology,* (Vol. 1, pp. 217–234). Washington, D.C.: American Psychological Association.

Hacker, J. S., Huber, G. A., Nichols, A., Rehm, P., Schlesinger, M., Valletta, R., & Craig, S. (2014). The economic security index: A new measure for research and policy analysis. *Review of Income and Wealth, 60*(1), S5–S32. https://doi.org/10.1111/roiw.12053

Hadjistavropoulos, T. (2015). Pain assessment and management in older adults. In Lichtenberg, P.A., Mast, B.T., Carpenter, B.D., & Loebach Wetherell, J. (Eds.), *APA handbook of clinical geropsychology, Vol. 2: Assessment, treatment, and issues of later life* (pp. 413–439). American Psychological Association. https://doi.org/10.1037/14459-016

Hagen, D. B., & Galupo, M. P. (2014). Trans* individuals' experiences of gendered language with health care providers: Recommendations for practitioners. *International Journal of Transgenderism, 15*(1), 16–34. http://dx.doi.org/10.1080/15532739.2014.890560

Haigh, E. A., Bogucki, O. E., Sigmon, S. T., & Blazer, D. G. (2018). Depression among older adults: A 20-year update on five common myths and misconceptions. *The American Journal of Geriatric Psychiatry, 26*(1), 107–122. https://doi.org/10.1016/j.jagp.2017.06.011

Halli-Tierney, A. D., McKinney Jr., R. E, Gold, A. E., Allen, R. S., & Carroll, D. G. (2021). Development of interprofessional case discussion series from an interprofessional geriatrics clinic and its influence on professional identity formation. *New Directions for Teaching and Learning, 2021*(168), 103–115.

Halli-Tierney, A.D., Scarbrough, C., & Carroll, D. (2019). Polypharmacy: Evaluating risks and deprescribing. *American Family Physician, 100*(1), 32–38. https://www.aafp.org/pubs/afp/issues/2019/0701/p32.html

Han, J., & Richardson, V. E. (2015). The relationships among perceived discrimination, self-perceptions of aging, and depressive symptoms: A longitudinal examination of age discrimination. *Aging & Mental Health, 19*(8), 747–755. https://doi.org/10.1080/13607863.2014.962007

Hartman-Stein, P. E. (2006). The basics of building and managing a geropsychology practice. In S. H. Qualls & B. G. Knight (Eds.), *Psychotherapy for depression in older adults* (pp. 229–249). John Wiley & Sons, Inc.Haynes, P. L., Parthasarathy, S., Kersh, B., & Bootzin, R. R. (2011). Examination of insomnia and insomnia treatment in psychiatric inpatients. *International journal of mental health nursing*, *20*(2), 130–136. https://doi.org/10.1111/j.14470349.2010.00711.x

Hays, J. R., & Jennings, F. L. (2015). Ethics in geropsychology: Status and challenges. In P. A. Lichtenberg, B. T. Mast, B. D. Carpenter, & J. Loebach Wetherell (Eds.), *APA handbook of clinical geropsychology, Vol. 1. History and status of the field and perspectives on aging* (pp. 177–192). American Psychological Association. https://doi.org/10.1037/14458-008

Hayslip Jr, B., Fruhauf, C. A., & Dolbin-MacNab, M. L. (2019). Grandparents raising grandchildren: What have we learned over the past decade? *The Gerontologist, 59*(3), e152–e163. https://doi.org/10.1093/geront/gnx106

Heid, A. R., Pruchno, R., Cartwright, F. P., & Wilson-Genderson, M. (2017). Exposure to Hurricane Sandy, neighborhood collective efficacy, and post-traumatic stress symptoms in older adults. *Aging & Mental Health, 21*(7), 742–750. https://doi.org/10.1080/13607863.2016.1154016

Hemmings, C., & Evans, A. M. (2018). Identifying and treating race-based trauma in counseling. *Journal of Multicultural Counseling and Development, 46*(1), 20–39. https://doi.org/10.1002/jmcd.12090

High, K. P., Brennan-Ing, M., Clifford, D. B., Cohen, M. H., Currier, J., Deeks, S. G., Deren, S., Effros, R. B., Gebo, K., Goronzy, J.J., Justice, A. C., Landay, A., Levin, J., Miotti, P. G., Munk, R. J., Nass, H., Rinaldo, C. R. Jr., Shlipak, M., ...OAR Working Group on HIV and Aging (2012). HIV and aging: State of knowledge and areas of critical need for research. A report to the NIH Office of AIDS Research by the HIV and Aging Working Group. *JAIDS Journal of Acquired Immune Deficiency Syndromes, 60*, S1–S18. https://doi.org/10.1097/QAI.0b013e31825a3668

Hill, R. (2005). *Positive aging: A guide for mental health professionals and consumers*. W. W. Norton.

Hill, C. V., Pérez-Stable, E. J., Anderson, N. A., & Bernard, M. A. (2015). The National Institute on Aging health disparities research framework. *Ethnicity & Disease, 25*(3), 245. https://doi.org/10.18865/ed.25.3.245

Hillman, J. L. (2012). *Sexuality and aging: Clinical perspectives*. Springer.

Hinrichsen, G. A. (2020). *Assessment and treatment of older adults: A guide for mental health professionals*. American Psychological Association. https://doi.org/10.1037/0000146-000

Hinrichsen, G.A., & Emery-Tiburcio, E. E. (2022). Introduction to Special Issue: Foundational Knowledge Competencies in Geropsychology. *Clinical Psychology: Science and Practice, 29*(1), 1–3. https://doi.org/10.1037/cps0000066

Hinrichsen, G. A., Emery-Tiburcio, E. E., Gooblar, J., & Molinari, V. A. (2018). Building foundational knowledge competencies in professional geropsychology: Council of Professional Geropsychology Training Programs (CoPGTP) recommendations. *Clinical Psychology: Science and Practice, 25*(2), Article e12236. https://doi.org/10.1111/cpsp.12236

Hinton-Bayre, A. D., & Kwapil, K. J. (2017). Best practice approaches for evaluating significant change for individuals. In S. C. Bowden (Ed.), *Neuropsychological assessment in the age of evidence-based practice: Diagnostic and treatment evaluations* (pp. 121–154). Oxford University Press.

Hirst, S.P., Lane, A., Stares, R. (2013) Health promotion with older adults experiencing mental health challenges: A literature review of strength-based approaches. *Clinical Gerontologist, 36*(4), 329–355. https://doi.org/10.1080/07317115.2013.788118

Hoge, M. A., Karel, M. J., Zeiss, A. M., Alegria, M., & Moye, J. (2015). Strengthening psychology's workforce for older adults: Implications of the Institute of Medicine's report to Congress. *American Psychologist, 70*(3), 265–278. https://doi.org/10.1037/a0038927

Holtzer, R., Zweig, R. A., & Siegel, L. J. (2012). Learning from the past and planning for the future: The challenges of and solutions for integrating aging into doctoral psychology training. *Training and Education in Professional Psychology, 6*(3), 142–150. https://doi.org/10.1037/a0029365

Homan, P. (2021). Sexism and health: Advancing knowledge through structural and intersectional approaches. Journal of Public Health, 11(10):1725–1727. DOI: https://doi.org/10.2105/AJPH.2021.306480

Howell, B. M., & Peterson, J. R. (2020). "With age comes wisdom:" A qualitative review of elder perspectives on healthy aging in the circumpolar north. *Journal of Cross Cultural Gerontology, 35*(2), 113–131. https://doi.org/10.1007/s10823-020-09399-4

Hshieh, T. T., Inouye, S. K., & Oh, E. S. (2020). Delirium in the elderly. *Clinics in Geriatric Medicine, 36*(2), 183–199. https://doi.org/10.1016/j.cger.2019.11.001

Hudson, R. B., & Gonyea, J. G. (2012). Baby boomers and the shifting political construction of old age. *The Gerontologist, 52*(2), 272–282. https://doi.org/10.1093/geront/gnr129

Huh, J. T., Weaver, C. M., Martin, J. L., Caskey, N. H., O'Riley, A. and Kramer, B. J. (2012), Effects of a late-life suicide risk: Assessment training on multidisciplinary healthcare providers. *Journal of the American Geriatrics Society, 60*(4), 775–780. https://doi.org/10.1111/j.1532-5415.2011.03843.x

Iani, L., De Vincenzo, F., Maruelli, A., Chochinov, H.M., Ragghianti, M., Durante, S., & Lombardo, L. (2020). Dignity therapy helps terminally ill patients maintain a sense of peace: Early results of a randomized controlled trial. *Frontiers in Psychology, 11,* Article 1468. Doi: https://doi.org/10.3389/fpsyg.2020.01468

Institute of Medicine. (2012). *The mental health and substance use workforce for older adults: In whose hands?* http://www.iom.edu/Reports/2012/The-Mental-Healthand-Substance-UseWorkforce-for-Older-Adults.aspx

Irani, F. (Ed.). (2022). *Cultural diversity in neuropsychological assessment: Developing understanding through global case studies* (1st ed.). Routledge. https://doi.org/10.4324/9781003051862

Iversen, T. N., Larsen, L., & Solem, P. E. (2009). A conceptual analysis of ageism. *Nordic Psychology, 61*(3), 4–22. https://doi.org/10.1027/1901-2276.61.3.4

Iwamasa, G. Y., & Hays, P. A. (2019). *Culturally responsive cognitive behavior therapy: Practice and supervision* (pp. xi-348). American Psychological Association.

Iwasaki, M., Tazeau, Y.N., Kimmel, D., Baker, N.L., McCallum, T.J. (2009). Gerodiversity and social justice: Voices of minority elders. In J.L., Chin, (Eds.), *Diversity in Mind and Action: Social, Psychological, and Political Challenges, vol. 4*, Westport, CT: Praeger.

Jackson, S. E., Hackett, R. A., & Steptoe, A. (2019). Associations between age discrimination and health and wellbeing: cross-sectional and prospective analysis of the English longitudinal study of ageing. *The Lancet Public Health, 4*(4), e200e208. https://doi.org/10.1016/S2468-2667(19)30035-0 Jacobs, M. L., & Bamonti, P. M. (2022). Clinical practice: A foundational geropsychology knowledge competency. *Clinical Psychology: Science and Practice, 29*(1), 28–42. https://doi.org/10.1037/cps0000046

Jadhav, A., & Weir, D. (2018). Widowhood and depression in a cross-national perspective: Evidence from the United States, Europe, Korea, and China. *The Journals of Gerontology: Series B, 73*(8), e143–e153.Jeste, D. V., Alexopoulos, G. S., Bartels, S. J., Cummings, J. L., Gallo, J. J., Gottlieb, G. L., Halpain, M. C., Palmer, B. W., Patterson, T. L., Reynolds III, C. F., & Lebowitz, B. D. (1999). Consensus statement on the upcoming crisis in geriatric mental health: research agenda for the next 2 decades. *Archives of general psychiatry, 56*(9), 848–853. doi:10.1001/archpsyc.56.9.848

Jeste, D. V., & Lee, E. E. (2019). Emerging empirical science of wisdom: Definition, measurement, neurobiology, longevity, and interventions. *Harvard Review of Psychiatry, 27*(3), 127. https://doi.org/10.1097/HRP.0000000000000205

Jeste, D. V., Savla, G. N., Thompson, W. K., Vahia, I. V., Glorioso, D. K., Martin, A. S., Palmer, B.W., Rock, D., Golshan, S., Kraemer, H.C., & Depp, C. A. (2013). Association between older age and more successful aging: Critical role of resilience and depression. *American Journal of Psychiatry, 170*(2), 188–196. https://doi.org/10.1176.appi.ajp.2012.12030386Jeste, D. V., Wolkowitz, O. M., & Palmer, B. W. (2011). Divergent trajectories of physical, cognitive, and psychosocial aging in schizophrenia. *Schizophrenia Bulletin, 37*(3), 451–455. https://doi.org/10.1093/schbul/sbr026

Jimenez, D. E., Alegria, M., Chen, C., Chan, D., & Laderman, M. (2010). Prevalence of psychiatric illnesses in older ethnic minority adults. *Journal of the American Geriatrics Society, 58*, 256–264. https://doi.org/10.1186/s12888-018-1647-5

Jimenez, D. E., Cook, B., Bartels, S. J., & Alegría, M. (2013). Disparities in mental health service use of racial and ethnic minority elderly adults. *Journal of the American Geriatrics Society, 61*(1), 18–25. https://doi.org/10.1111/jgs.12063

Jimenez, D. E., Park, M., Rosen, D., Joo, J. H., Garza, D. M., Weinstein, E. R., Conner, K., Silva, C., & Okereke, O. (2022). Centering culture in mental health: Differences in diagnosis, treatment, and access to care among older people of color. *The American Journal of Geriatric Psychiatry.* Advance online publication. DOI: 10.1016/j.jagp.2022.07.001

Jin, H., Shih, P. B., Golshan, S., Mudaliar, S., Henry, R., Glorioso, D. K., Arndt, S., Kraemer, H. C., & Jeste, D. V. (2013). Comparison of longer-term safety and effectiveness of 4 atypical antipsychotics in patients over age 40: A trial using equipoise-stratified randomization. *The Journal of Clinical Psychiatry, 74*(1), 1–5. https://doi.org/10.4088/JCP.12m08001

Joint Task Force for the Development of Telepsychology Guidelines for Psychologists. (2013). Guidelines for the practice of telepsychology. *American Psychologist, 68*(9), 791–800. https://doi.org/10.1037/a0035001

Juntunen, C. L., Pietrantonio, K. R., Hirsch, J. K., Greig, A., Thompson, M. N., Ross, D. E., & Peterman, A. H. (2022). Guidelines for psychological practice for people with low-income and economic marginalization: Executive summary. *American Psychologist, 77*(2), 291–303. https://doi.org/10.1037/amp0000826

Kahana, E., & Kahana, B. (2014). Baby boomers' expectations of health and medicine. *The Virtual Mentor,16*(5), 380–384. https://doi.org/10.1001/virtualmentor.2014.16.05.msoc2-1405

Kane, R. L., Butler, M., Fink, H. A., Brasure, M., Davila, H., Desai, P., Jutkowitz, E., McCreedy, E., Nelson, V. A., McCarten, J. R., Calvert, C., Ratner, E., Hemmy, L. S., & Barclay, T. (2017). *Interventions to prevent age-related cognitive decline, mild cognitive impairment, and clinical Alzheimer's-type dementia*. Agency for Healthcare Research and Quality (US). https://www.ncbi.nlm.nih.gov/sites/books/NBK442425/

Karel, M. J., Gatz, M., & Smyer, M. A. (2012). Aging and mental health in the decade ahead: What psychologists need to know. *American Psychologist, 67*(3), 184– 198. https://doi.org/10.1037/a0025393

Karel, M. J., Knight, B. G., Duffy, M., Hinrichsen, G. A., & Zeiss, A. M. (2010). 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*(2), 75–84. https://doi.org/10.1037/a0018372

Karel, M. J., Sakai, E. Y., Molinari, V., Moye, J., & Carpenter, B. (2016). Training for geropsychology supervision and practice: Perspectives of geropsychology program graduates. *Training and Education in Professional Psychology, 10*(1), 37–44. https://doi.org/10.1037/tep0000101

Karel, M. J., Teri, L., McConnell, E., Visnic, S., & Karlin, B. E. (2016). Effectiveness of expanded implementation of STAR-VA for managing dementia-related behaviors among veterans. *The Gerontologist, 56*(1), 126–134. https://doi.org/10.1093/geront/gnv068

Kaskie, B., Ayyagari, P., Milavetz, G., Shane, D., & Arora, K. (2017). The increasing use of cannabis among older Americans: A public health crisis or viable policy alternative? *The Gerontologist, 57*(6), 1166–1172.Kasl-Godley, J. E., King, D. A., & Quill, T. E. (2014). Opportunities for psychologists in palliative care: Working with patients and families across the disease continuum. *American Psychologist, 69*(4), 364–376. https://doi.org/10.1037/a0036735

Katz, S., Down, T. D., Cash, H. R., & Grotz, R. C. (1970). Progress in the development of the index of ADL. *The Gerontologist, 10*(1), 20–30. https://doi.org/10.1093/geront/10.4_Part_1.274

Katz, S., Ford, A. B., Moskowitz, R. W., Jackson, B. A., & Jaffe, M. W. (1963). Studies of illness in the aged: The index of ADL: A standardized measure of biological and psychosocial function. *Journal of the American Medical Association, 185*(12), 914–919. doi:10.1001/jama.1963.03060120024016

Kessler, R. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Wittchen, H. U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research, 21*(3), 169–184. https://doi.org/10.1002/mpr.1359

Khan, S.S., Singer, B.D., & Vaughan, D.E. (2017). Molecular and physiological manifestations and measurement of aging in humans. *Aging Cell: Anatomical Society, 16*(4), 624–633. https://doi.org/10.1111/acel.12601

Kiely, K. M., Brady, B., & Byles, J. (2019). Gender, mental health and ageing. *Maturitas, 129*, 76-84. https://doi.org/10.1016/j.maturitas.2019.09.004

Kim, G., Loi, C., X.A., Chiriboga, D.A., Jang, Y., Parmelee, P., & Allen, R.S. (2011). Limited English proficiency as a barrier to mental health services use: A study of Latino and Asian immigrants with psychiatric disorders. *Journal of Psychiatric Research, 45*(1), 104–110.

Kim, G., Wang, S. Y., Park, S., & Yun, S. W. (2020). Mental health of Asian American older adults: Contemporary issues and future directions. *Innovation in Aging*, *4*(5), igaa037. https://doi.org/10.1093/geroni/igaa037

Kim, H., Jen, S., & Fredriksen-Goldsen, K. I. (2017). Race/ethnicity and health-related quality of life among LGBT older adults. *The Gerontologist, 57* (suppl 1). S30–S39. https://doi.org/10.1093/geront/gnw172

King, D. A., Heisel, M. J., & Lyness, J. M. (2005). Assessment and psychological treatment of depression in older adults with terminal or life-threatening illness. *Clinical Psychology: Science and Practice, 12*(3), 339–353. https://doi.org/10.1093/clipsy.bpi029

Kiosses, D. N., Ravdin, L. D., Gross, J. J., Raue, P., Kotbi, N., & Alexopoulos, G. S. (2015). Problem adaptation therapy for older adults with major depression and cognitive impairment: a randomized clinical trial. *JAMA Psychiatry*, *72*(1), 22–30.

Kirkham, J., Seitz, D., & Choi, N. G. (2015). Meta-analysis of problem-solving therapy for the treatment of depression in older adults. *The American Journal of Geriatric Psychiatry*, *23*(3), S129–S130.Knauer, N. J. (2016). LGBT older adults, chosen family, and caregiving. *Journal of Law and Religion, 31*(2), 150–168. https://doi.org/10.1017/jlr.2016.23

Knight, B. G., Lee, L.O. (2009). Attentional bias for threat in older adults: moderation of the positivity bias by trait anxiety and stimulus modality. *Psychology and Aging*, *24*(3), 741.

Knight, B. G., Poon, C.Y. (2009). Influence of sad mood and old age schema on older adults' attention to physical symptoms. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *64*(1), 41–44.

Knight, B. G., Karel, M. J., Hinrichsen, G. A., Qualls, S. H., & Duffy, M. (2009). Pikes Peak model for training in professional geropsychology. *American Psychologist, 64*(3), 205–214. https://doi.org/10.1037/a0015059

Knight, B. G., & Pachana, N. A. (2015). *Psychological assessment and therapy with older adults.* Oxford University Press.Koder, D. A., & Helmes, E. (2008). Predictors of interest in working with older adults: A survey of postgraduate trainee psychologists. *Gerontology & Geriatrics Education, 29*(2), 158–171. https://doi.org/10.1080/02701960802223233

Kornadt, A. E., Voss, P., & Rothermund, K. (2013). Multiple standards of aging: gender-specific age stereotypes in different life domains. *European Journal of Ageing*, *10*(4), 335–344. doi: 10.1007/s10433-013-0281-9.

Köttl, H., Gallistl, V., Rohner, R., & Ayalon, L. (2021). "But at the age of 85? Forget it!": Internalized ageism, a barrier to technology use. *Journal of Aging Studies, 59,* 100971. https://doi.org/10.1016/j.jaging.2021.100971

Kozlov, E., Phongtankuel, V., Prigerson, H., Adelman, R., Shalev, A., Czaja, S., Dignam, R., Baughn, R., & Reid, M. C. (2019). Prevalence, severity, and correlates of symptoms of anxiety and depression at the very end of life. *Journal of Pain and Symptom Management, 58*(1), 80–85. https://doi.org/10.1016/j.jpainsymman.2019.04.012

Krekula, C., Nikander, P., & Wilińska, M. (2018). Multiple marginalizations based on age: Gendered ageism and beyond. In *Contemporary Perspectives on Ageism* (pp. 33–50). Springer, Cham.Kripke, C. (2018). Adults with developmental disabilities: a comprehensive approach to medical care. *American Family Physician, 97*(10), 649–656.

Kuerbis, A. (2020). Substance use among older adults: an update on prevalence, etiology, assessment, and intervention. *Gerontology*, *66*(3), 249-258.

Labott, S. M. (2019). *Health psychology consultation in the inpatient medical setting*. American Psychological Association. https://doi.org/10.1037/0000108-0

Labriola, K. (2022). *Polyamorous Elders: Aging in Open Relationships*. Rowman and Littlefield.

Lachs, M. & Pillemer, K.A. (2015). Elder Abuse. *New England Journal of Medicine, 373*(20), 1947-56. https://doi.org/10.1056/NEJMra1404688

Ladika, D. J., & Gurevitz, S. L. (2011). Identifying the most common causes of reversible dementias: A review: many dementia syndromes can be fully reversed if caught early. Prompt diagnosis can save patients and families from an otherwise very difficult and challenging course in life. *JAAPA-Journal of the American Academy of Physicians Assistants, 24*(3), 28–33.

Lamberty, G. J., & Bares, K. K. (2013). Neuropsychological assessment and management of older adults with multiple somatic symptoms. In L. D. Ravdin & H. L. Katzen (Eds.), *Handbook on the neuropsychology of aging and dementia* (pp. 121–134). Springer Science + Business Media. https://doi.org/10.1007/978-1-4614-3106-0_9

Lamont, R. A., Swift, H. J., & Abrams, D. (2015). A review and meta-analysis of age-based stereotype threat: negative stereotypes, not facts, do the damage. *Psychology and Aging, 30*(1), 18. https://psycnet.apa.org/doi/10.1037/pag0000269

Lampe, N. M., Barbee, H., Tran, N. M., Bastow, S., & McKay, T. (2023). Health disparities among lesbian, gay, bisexual, transgender, and queer older adults: A structural competency approach. *International Journal of Aging & Human Development*, 914150231171838. Advance online publication. https://doi.org/10.1177/00914150231171838

Lang, F. R., Rohr, M. K., & Williger, B. (2011). Modeling success in life-span psychology: The principles of selection, optimization, and compensation. In K. L. Fingerman, C. A. Berg, J. Smith, & T. C. Antonucci (Eds). *Handbook of lifespan development* (pp. 57-85). Springer Publishing Company.Latulippe, K., Hamel, C., & Giroux, D. (2017). Social health inequalities and eHealth: A literature review with qualitative synthesis of theoretical and empirical studies.

Journal of Medical Internet Research, 19(4), e136. https://doi.org/10.2196/jmir.6731

Lau, A. W., & Kinoshita, L. M. (2019). Cognitive behavior therapy with culturally diverse older adults. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (pp. 231–256). American Psychological Association. https://doi.org/10.1037/0000119-010

Lauderdale, S. A., Cassidy-Eagle, E. L., Nguyen, C., & Sheikh, J. I. (2011). Late life anxiety disorders. In M. E. Agronin & G. J. Maletta (Eds.), *Principles and practice of geriatric psychiatry* (2nd ed., pp. 493-514). Lippincott, Williams & Wilkins.

Lavretsky, H., Laird, K. T., Krause-Sorio, B., Heimberg, B. F., Yeargin, J., Grzenda, A., Wu, P., Thana-Udom, K., Ercoli, L., & M. Siddarth, P. (2020). A randomized double-blind placebo-controlled trial of combined escitalopram and memantine for older adults with major depression and subjective memory complaints. *The American Journal of Geriatric Psychiatry, 28*(2), 178-190. https://doi.org/10.1016/j.jagp.2019.08.011

Layland, E. K., Carter, J. A., Perry, N. S., Cienfuegos-Szalay, J., Nelson, K. M., Bonner, C. P., & Rendina, H. J. (2020). A systematic review of stigma in sexual and gender minority health interventions. *Translational Behavioral Medicine, 10*(5), 1200-1210. https://doi.org/10.1093/tbm/ibz200

Lee, L., Hillier, L. M., Patel, T., & Weston, W. W. (2020). A decade of dementia care training: Learning needs of primary care clinicians. *Journal of Continuing Education in the Health Professions, 40*(2), 131–140.

Lely, J., Knipscheer, J., Moerbeek, M., Ter Heide, F., Van den Bout, J., & Kleber, R. (2019). Randomised controlled trial comparing narrative exposure therapy with present-centred therapy for older patients with post-traumatic stress disorder. *The British Journal of Psychiatry, 214*(6), 369-377. https://doi:10.1192/bjp.2019.59

Lenze, E. J., & Wetherell, J. L. (2022). A lifespan view of anxiety disorders. *Dialogues in Clinical Neuroscience, 13*(4), 381-399. https://doi.org/10.31887/DCNS.2011.13.4/elenze

Levy, B. (2009). Stereotype embodiment: A psychosocial approach to aging. *Current Directions in Psychological Science, 18*, 332–336. https://doi.org/10.1111/j.14678721.2009.01662.x

Levy, B. R., & Myers, L. M. (2004). Preventive health behaviors influenced by self-perceptions of aging. *Preventive Medicine, 39*(3), 625– 629. https://doi.org/10.1016/j.ypmed.2004.02.029

Levy, B. R., Slade, M. D., Chang, E. -S., Kannoth, S., & Wang, S.-Y. (2020). Ageism amplifies cost and prevalence of health conditions. *The Gerontologist, 60*(1), 174–181. https://doi.org/10.1093/geront/gny131

Levy, B. R. (2022). The role of structural ageism in age beliefs and health of older persons. *JAMA Network Open*, *5*(2), e2147802-e2147802.Lichtenberg, P. A., Mast, B. T., Carpenter, B. D., & Loebach Wetherell, J. E. (2015a). *APA handbook of clinical geropsychology, Vol. 1: History and status of the field and perspectives on aging*. American Psychological Association.

Lichtenberg, P. A., Mast, B. T., Carpenter, B. D., & Loebach Wetherell, J. E. (2015b). *APA handbook of clinical geropsychology, Vol. 2: Assessment, treatment, and issues of later life*. American Psychological Association.

Lind, L. M., Poon, C. Y. M., & Birdsall, J. A. (2022). Intervention, consultation, and other service provision: A foundational geropsychology knowledge competency.

Clinical Psychology: Science and Practice, 29(1), 59–75. https://doi.org/10.1037/cps0000050Lisko, I., Kulmala, J., Annetorp, M., Ngandu, T., Mangialasche, F., & Kivipelto, M. (2021). How can dementia and disability be prevented in older adults: Where are we today and where are we going? *Journal of Internal Medicine, 289*(6), 807830. https://doi.org/10.1111/joim.13227

Liss, J. L., Seleri Assunção, S., Cummings, J., Atri, A., Geldmacher, D. S., Candela, S. F., Devanand, D. P., Fillit, H. M., Susman, J., Mintzer, J., Bittner, T., Brunton, S.

A., Kerwin, D. R., Jackson, W. C., Small, G. W., Grossberg, G. T., Clevenger, C. K., Cotter, V., Stefanacci, R., A. ... & Sabbagh, M. N. (2021). Practical recommendations for timely, accurate diagnosis of symptomatic Alzheimer's disease (MCI and dementia) in primary care: A review and synthesis. *Journal of Internal Medicine, 290*(2), 310–334. https://doi.org/10.1111/joim.13244

Liu, S. Y., Glymour, M. M., Zahodne, L. B., Weiss, C., & Manly, J. J. (2015). Role of place in explaining racial heterogeneity in cognitive outcomes among older adults. *Journal of the International Neuropsychological Society, 21*(9), 677–687. https://doi.org/10.1017/S1355617715000806

Liverman, C. T., Yaffe, K., & Blazer, D. G. (Eds.). (2015). Cognitive aging: Progress in understanding and opportunities for action. *The National Academies Collection: Reports funded by National Institutes of Health*. https://doi.org/10.17226/21693

Livingston, G., Huntley, J., Sommerlad, A., Ames, D., Ballard, C., Banerjee, S., Brayne, C., Burns, A., Cohen-Mansfield, J., Cooper, C., Costafreda, S. G., Dias, A., Fox, N., Gitlin, L. N., Howard, R., Kales, H. C., Kivimäki, M., Larson, E. B., Ogunniyi, A., Orgeta, V., Ritchie, K., Rockwood, K., Sampson, E. L., Samus, Q., Schneider, L. S., Selbæk, G., Teri, L., & Mukadam, N. (2020). Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. *The Lancet, 396*(10248), 413–446. https://doi.org/10.1016/S0140-6736(20)30367-6

Lodi-Smith, J., Turiano, N., & Mroczek, D. (2011). Personality trait development across the life span. In K. L. Fingerman, C. A. Berg, J. Smith, & T. C. Antonucci (Eds.), *Handbook of life-span development* (pp. 513–529). Springer Publishing Company.

Loeb, P. A. (1996). *Independent living scales manual*. San Antonio, TX: Psychological Corporation.

Long, S. W. (2014). *Caring for people with challenging behaviors: Essential skills and successful strategies in long-term care* (2nd ed). Health Professions Press.

Lloyd, L., Calnan, M., Cameron, A., Seymour, J., & Smith, R. (2014). Identity in the fourth age: Perseverance, adaptation and maintaining dignity. *Ageing & Society, 34*(1), 1–19. https://doi.org/10.1017/S0144686X12000761

Luhmann, M., & Hawkley, L. C. (2016). Age differences in loneliness from late adolescence to oldest old age. *Developmental Psychology, 52*(6), 943. https://doi.org/10.1037/dev0000117

Luo, M. S., Chui, E. W. T., & Li, L. W. (2020). The longitudinal associations between physical health and mental health among older adults. *Aging & Mental Health, 24*(12), 1990–1998. https://doi.org/10.1080/13607863.2019.1655706

Luo, Y., Xu, J., Granberg, E., & Wentworth, W. M. (2012). A longitudinal study of social status, perceived discrimination, and physical and emotional health among older adults. *Research on Aging, 34*(3), 275-301. https://doi.org/10.1177/0164027511426151

Lynch, T. R. , Cheavens, J. S., Cukrowicz, K. C., Thorp, S. R., Bronner, L., & Beyer, J. (2007). Treatment of older adults with co-morbid personality disorder and depression: A dialectical behavior therapy approach. *International Journal of Geriatric Psychiatry, 22*(2), 131–143. https://doi.org/10.1002/gps.1703

Lyons, I. (2009). *Public perceptions of older people and ageing* [Report no. 1]. National Centre for the Protection of Older People (NCPOP) [Ireland].

Manning, L., & Bouchard, L. (2021). Medical cannabis use: Exploring the perceptions and experiences of older adults with chronic conditions. *Clinical Gerontologist, 44*(1), 32–41. https://doi.org/10.1080/07317115.2020.1853299

Manly, J. J., & Echemendia, R. J. (2007). Race-specific norms: Using the model of hypertension to understand issues of race, culture, and education in neuropsychology. *Archives of Clinical Neuropsychology*, *22*(3), 319–325.

Manning, L., Ferris, M., Narvaez Rosario, C., Prues, M., & Bouchard, L. (2019). Spiritual resilience: Understanding the protection and promotion of well-being in the later life. *Journal of Religion, Spirituality & Aging, 31*(2), 168–186. https://doi.org/10.1080/15528030.2018.1532859

Markland, A. D., Vaughan, C. P., Johnson II, T. M., Goode, P. S., Redden, D. T., & Burgio, K. L. (2011). Prevalence of nocturia in United States men: Results from the National Health and Nutrition Examination Survey. *The Journal of Urology, 185*(3), 998–1002. https://doi.org/10.1016/j.juro.2010.10.083

Marques, S. Lima, M.L. Abrams, D., & Swift, H. (2014). Will to live in older people's medical decisions: Immediate and delayed effects of aging stereotypes. *Journal of Applied Social Psychology, 44*, 399–408. https://doi.org/10.1111/jasp.12231

Marson, D. C., Hebert, K., & Solomon, A. C. (2011). Assessing civil competencies in older adults with dementia: Consent capacity, financial capacity, and testamentary capacity. In G. J. Larrabee (Ed.), *Forensic neuropsychology. A scientific approach* (2nd ed., pp. 401–437). Oxford University Press.

Mast, B. T., Fiske, A., & Lichtenberg, P. A. (2022). Assessment: A foundational geropsychology knowledge competency. *Clinical Psychology: Science and Practice, 29*(1), 43–58. https://doi.org/10.1037/cps0000055Mausbach & Ho (2015). Schizophrenia in late life. In P. Lichtenberg, & B. Mast (Eds.), *APA Handbook of clinical geropsychology* (Vol. 2, pp. 95–120). Washington, D.C.: American Psychological Association.

McCann, E., & Sharek, D. (2016). Mental health needs of people who identify as transgender: A review of the literature. *Archives of Psychiatric Nursing, 30*(2), 280–285. https://doi.org/10.1016/j.apnu.2015.07.003

McCurry, S. M., Logsdon, R. G., Teri, L., & Vitiello, M. V. (2007). Evidence-based psychological treatments for insomnia in older adults. *Psychology and Aging, 22*(1), 18–27. https://doi.org/10.1037/0882-7974.22.1.18

McDaniel, S. H., Grus, C. L., Cubic, B. A., Hunter, C. L., Kearney, L. K., Schuman, C. C., Karel, M. J., Kessler, R. S., Larkin, K. T., McCutcheon, S., Miller, B. F., Nash, J., Qualls, S. H., Connolly, K. S., Stancin, T., Stanton, A. L., Sturm, L. A., & Johnson, S. B. (2014). Competencies for psychology practice in primary care. *The American psychologist*, *69*(4), 409–429. https://doi.org/10.1037/a0036072

McKhann, G. M., Knopman, D. S., Chertkow, H., Hyman, B. T., Jack, C. R., Jr, Kawas, C. H., Klunk, W. E., Koroshetz, W. J., Manly, J. J., Mayeux, R., Mohs, R. C.,

Morris, J. C., Rossor, M. N., Scheltens, P., Carrillo, M. C., Thies, B., Weintraub, S., & Phelps, C. H. (2011). The diagnosis of dementia due to Alzheimer's disease: Recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. Alzheimer's & Dementia: *The Journal of the Alzheimer's Association, 7*(3), 263– 269. https://doi.org/10.1016/j.jalz.2011.03.005NIA

Meiland, F., Innes, A., Mountain, G., Robinson, L., van der Roest, H., García-Casal, J. A., Gove, D., Thyrian, J. R., Evans, S., Dröes, R. M., Kelly, F., Kurz, A., Casey, D., Szcześniak, D., Dening, T., Craven, M. P., Span, M., Felzmann, H., Tsolaki, M., & Franco-Martin, M. (2017). Technologies to support community-dwelling persons with dementia: A position paper on issues regarding development, usability, effectiveness and cost-effectiveness, deployment, and ethics. *JMIR Rehabilitation and Assistive Technologies, 4*(1), e1. https://doi.org/10.2196/rehab.6376

Melo, L. R., Crenitte, M. R. F., Jacob Filho, W., & Avelino-Silva, T. J. (2023). *Frailty over the rainbow: a cross-sectional study on LGBT+ adults over fifty*. Research Square Platform LLC. https://doi.org/10.21203/rs.3.rs-2485556/v1

Molinari, V., Edelstein, B., Gibson, R., Lind, L., Norris, M., O'Shea Carney, K., Bush, S. S., Heck, A. L., Moye, J., Gordon, B. H., & Hiroto, K. (2021). Psychologists in Long-Term Care (PLTC) guidelines for psychological and behavioral health services in long-term care settings. *Professional Psychology: Research and Practice, 52*(1), 34–45. https://doi.org/10.1037/pro0000298

Monahan, C., Macdonald, J., Lytle, A., Apriceno, M., & Levy, S. R. (2020). COVID-19 and ageism: How positive and negative responses impact older adults and society. *American Psychologist*, *75*(7), 887.Monson, E., Lonergan, M., Caron, J., & Brunet, A. (2016). Assessing trauma and posttraumatic stress disorder: Single, open-ended question versus list-based inventory. *Psychological Assessment, 28*(8), 1001–1008. https://doi.org/10.1037/pas0000223

Montemurro, B., & Chewning, L. (2018). Unscripted: Exploring representations of older unpartnered women's sexuality. *Journal of Women & Aging*, *30*(2), 127–144. https://doi.org/10.1080/08952841.2017.1290987

Moody, H. R. (2017). Baby Boomers: From great expectations to a crisis of meaning. *Generations, 41*(2), 95-100. https://www.ingentaconnect.com/content/asag/gen/2017/00000041/00000002/art 00014

Moors, A. C., Ramos, A., & Schechinger, H. (2023). Bridging the science communication gap: The development of a fact sheet for clinicians and researchers about consensually nonmonogamous relationships. *Psychology of Sexual Orientation and Gender Diversity, 10*(1), 166–174. https://doi.org/10.1037/sgd0000487

Morris, M. C., Tangney, C. C., Wang, Y., Sacks, F. M., Bennett, D. A., & Aggarwal, N. T. (2015). MIND diet associated with reduced incidence of Alzheimer's disease. *Alzheimer's & Dementia: The Journal of the Alzheimer's Association, 11*(9), 1007–1014. https://doi.org/10.1016/j.jalz.2014.11.009

Morthland, M., & Scogin, F. (2011). Mental health concerns for caregivers in rural communities. In R. C. Talley, K. Chwalisz, & K. C. Buckwalter (Eds.), *Rural caregiving in the United States: Research, practice, policy* (pp. 85–102). Springer Science + Business Media. https://doi.org/10.1007/978-1-4614-0302-9_6Moye, J, (Ed.), (2020). *Assessing capacities of older adults: A casebook to guide difficult decisions*. American Psychological Association. https://doi.org/10.1037/0000184-000Moye, J., Harris, G., Kube, E., Hicken, B., Adjognon, O., Shay, K., & Sullivan, J. L. (2019). Mental health integration in geriatric patient aligned care teams in the Department of Veterans Affairs. *The American Journal of Geriatric Psychiatry, 27*(2), 100–108. https://doi.org/10.1016/j.jagp.2018.09.001

Moye, J., Karel, M. J., Stamm, K. E., Qualls, S. H., Segal, D. L., Tazeau, Y. N., & DiGilio, D. A. (2018). Workforce analysis of psychological practice with older adults: Growing crisis requires urgent action. *Training and Education in Professional Psychology, 13*(1), 46–55. https://doi.org/10.1037/tep0000206

Moye, J., Kaiser, A. P., Cook, J., & Pietrzak, R. H. (2021). Post-traumatic stress disorder in older U.S. military veterans: Prevalence, characteristics, and psychiatric and functional burden. *American Journal of Geriatric Psychiatry, 30*(5), 606–618. https://doi.org/10.1016/j.jagp.2021.10.011

Moye, J., & Wood, E. (2020). Understanding legal and clinical capacities. In J. Moye (Ed.) *Assessing capacities of older adults: A casebook to guide difficult decisions*. Washington DC: American Psychological Association.Moye, J., Marson, D. C., & Edelstein, B. (2013). Assessment of capacity in an aging society. *American Psychologist, 68*(3), 158–171. https://doi.org/10.1037/a0032159

Musich, S., Wang, S. S., Kraemer, S., Hawkins, K., & Wicker, E. (2018). Purpose in life and positive health outcomes among older adults. *Population Health Management, 21*(2), 139–147. https://doi.org/10.1089/pop.2017.0063

Mroczek D. K. (2014). Personality plasticity, healthy aging, and interventions. *Developmental Psychology, 50*(5), 1470–1474. https://doi.org/10.1037/a0036028

Naegele, L. De Tavernier, W., & Hess, M. (2018). Work environment and the origin of ageism. In *Contemporary perspectives on ageism* (pp. 73–90). Springer.

National Center for Chronic Disease and Health Promotion (2022). *Chronic diseases in America*. CDC. https://www.cdc.gov/chronicdisease/pdf/infographics/chronicdisease-H.pdf

National Committee for the Prevention of Elder Abuse & MetLife Mature Market Institute (2012). *The essentials: Preventing elder abuse*. https://www.metlife.com/assets/cao/mmi/publications/essentials/mmi-preventingelder-abuse-essentials.pdf

National Institute on Aging (2017). *What is dementia? Symptoms, types, and diagnosis*. https://www.nia.nih.gov/health/what-is-dementia

Nelson, T. D. (2005). Ageism: Prejudice against our feared future self. *Journal of Social Issues, 61*(2), 207–221. https://doi.org/10.1111/j.1540-4560.2005.00402.x

Neupert, S. D., & Bellingtier, J. A. (2017). Aging attitudes and daily awareness of age-related change interact to predict negative affect. *The Gerontologist, 57*(suppl_2), S187–S192. https://doi.org/10.1093/geront/gnx055

Ngandu, T., Lehtisalo, J., Solomon, A., Levälahti, E., Ahutiluoto, S., Antikainen, R., Bäckman, L., Hännien, T., Jula, A., Laatikainen, T., Lindström, J., Mangialasche, F., Paajanen, T., Pajala, S., Peltonen, M., Rauramaa, R., Stigsdotter-Neely, A., Strandberg, T., Tuomilehto, J., Soininen, H., & Kivipelto, M. (2015). A 2-year multidomain intervention of diet, exercise, cognitive training, and vascular risk monitoring versus control to prevent cognitive decline in at-risk elderly people (FINGER): A randomised controlled trial. *Lancet, 385*(9984), 2255–2263. https://doi.org/10.1016/S0140-6736(15)-60461-5

Niknejad, B., Bolier, R., Henderson Jr., C.R., Delgado, D., Kozlov, E., Lockenhoff, C.E., & Read, M.C. (2018). Association between psychological interventions and chronic pain outcomes in older adults: A systematic review and meta-analysis. *JAMA Internal Medicine, 178*(6), 830–839. https://doi.org/10.1001/jamainternmed.2018.0756

Norris, M. P. (2015). Evolutions and revolutions in Medicare policy and reimbursement of geropsychology services. In P. A. Lichtenberg, B. T. Mast, B. D. Carpenter, & J. Loebach Wetherell (Eds.), *APA handbook of clinical geropsychology, Vol. 1: History and status of the field and perspectives on aging* (pp. 45–69). American Psychological Association. https://doi.org/10.1037/14458-004

Norton, S., Matthews, F. E., Barnes, D. E., Yaffe, K., & Brayne, C. (2014). Potential for primary prevention of Alzheimer's disease: An analysis of population-based data. *The Lancet Neurology, 13*(8), 788-794. https://doi.org/10.1016/S14744422(14)70136-X

Ohrnberger, J. Fichera, E., & Sutton, M. (2017). The dynamics of physical and mental health in the older adult population. *The Journal of the Economics of Aging, 9*, 52–62. https://doi.org/10.1016/j.jeoa.2016.07.002

Olfson, M., Gerhard, T., Huang, C., Crystal, S., & Stroup, T. S. (2015). Premature mortality among adults with schizophrenia in the United States. *JAMA Psychiatry, 72*(12), 1172–1181. https://doi.org/10.1001/jamapsychiatry.2015.1737

Ong, H. L., Vaingankar, J. A., Abdin, E., Sambasivam, R., Fauziana, R., Tan, M.-E., Chong, S. A., Goveas, R. R., Chiam, P. C., & Subramaniam, M. (2018). Resilience and burden in caregivers of older adults: Moderating and mediating effects of perceived social support. *BMC Psychiatry, 18*(1), 1–9. https://doi.org/10.1186/s12888-018-1616-z

Onorato, S., Joshi, A., & Schwartz, A. W. (2021). Lights, camera, action: Optimizing virtual video visits to provide high-quality care. *Journal of General Internal Medicine, 36*(6), 1751–1754. https://doi.org/10.1007/s11606-020-06278-z

O'Rourke, N., Heisel, M. J., Canham, S. L., Sixsmith, A., & BADAS Study Team (2017). Predictors of suicide ideation among older adults with bipolar disorder. *PloS one, 12*(11), e0187632. https://doi.org/10.1371/journal.pone.0187632

O'Rourke, H. M., Collins, L., & Sidani, S. (2018). Interventions to address social connectedness and loneliness for older adults: A scoping review. *BMC Geriatrics, 18*(1), 1-13. https://doi.org/10.1186/s12877-018-0897-x

Ortman, J. M., Velkoff, V. A., & Hogan, H. (2014, May). An aging nation: The older population in the United States. *Current Population Reports, P25-1140*. U.S. Census Bureau. https://www.census.gov/library/publications/2014/demo/p251140.html#:~:text=In%202050%2C%20the%20population%20aged,over%20the %20age%20of%2085.

O'Shea Carney, K., Gum, A. M., & Zeiss, A. M. (2015). Geropsychology in interprofessional teams across different practice settings. In P. A. Lichtenberg, B. T. Mast, B. D. Carpenter, & J. Loebach Wetherell (Eds.), *APA handbook of clinical geropsychology, Vol. 1: History and status of the field and perspectives on aging* (pp. 73–99). American Psychological Association. https://doi.org/10.1037/14458-005

O'Shea Carney, K. and Norris, M. (2017). *Transforming long term care: Expanded roles for mental health professionals.* American Psychological Association Press.

Pachana N. A., & Laidlaw, K. (Eds.). (2014). *The Oxford handbook of clinical geropsychology*. Oxford Library of Psychology (online ed., Oxford Academic).

Pachana, N. A., Mitchell, L. K., & Knight, B. G. (2015). Using the CALTAP lifespan developmental framework with older adults. *GeroPsych: The Journal of Gerontopsychology and Geriatric Psychiatry, 28*(2), 77–86. https://doi.org/10.1024/1662-9647/a000126

Pachana, N.A., Molinari, V., Thompson, L.W., & Gallagher-Thompson, D. (Eds.) (2021). *Psychological assessment and treatment of older adults*. Hogrefe Publishing.

Park, S., Han, Y., Kim, B., & Dunkle, R. E. (2017). Aging in place of vulnerable older adults: Person-environment fit perspective. *Journal of Applied Gerontology: The Official Journal of the Southern Gerontological Society, 36*(11), 1327–1350. https://doi.org/10.1177/0733464815617286

Park, D. C., & Festini, S. B. (2017). Theories of memory and aging: A look at the past and a glimpse of the future. *The Journals of Gerontology: Series B, 72*(1), 82–90. https://doi.org/10.1093/geronb/gbw066Park, M., & Reynolds, C. F. (2015). Depression among older adults with diabetes mellitus. *Clinics in Geriatric Medicine, 31*(1), 117–137. https://doi.org/10.1016/j.cger.2014.08.022

Park, D., & Schwarz, N. (2012). *Cognitive aging: A primer*. Psychology Press.

Partnership for Health in Aging Workgroup on Interdisciplinary Team Training in Geriatrics. (2014). Position statement on interdisciplinary team training in geriatrics: An essential component of quality healthcare for older adults. *Journal of the American Geriatrics Society, 62*(5), 961–965. https://doi.org/10.1111/jgs.12822

Pereira, H., De Vries, B., Serzedelo, A., Serrano, J. P., Afonso, R. M., Esgalhado, G., & Monteiro, S. (2019). Growing older out of the closet: A descriptive study of older LGB persons living in Lisbon, Portugal. *The International Journal of Aging and Human Development, 88*(4), 422–439. https://doi.org/10.1177/0091415019836107

Perissinotto, C., Holt-Lunstad, J., Periyakoil, V. S., & Covinsky, K. (2019). A practical approach to assessing and mitigating loneliness and isolation in older adults. *Journal of the American Geriatrics Society*, *67*(4), 657–662.

Peterson, R. L., George, K. M., Barnes, L. L., Gilsanz, P., Mayeda, E. R., Glymour, M. M., Mungas, D. M., & Whitmer, R. A. (2021). Association of timing of school desegregation in the United States with late-life cognition in the study of healthy aging in African Americans (STAR) cohort. *JAMA Network Open*, *4*(10). https://doi.org/10.1001/jamanetworkopen.2021.29052

Pharr, J. R., Dodge Francis, C., Terry, C., & Clark, M. C. (2014). Culture, caregiving, and health: Exploring the influence of culture on family caregiver experiences. *International Scholarly Research Notices, 2014*, 1–8. http://dx.doi.org/10.1155/2014/689826

Pinquart, M., & Sorensen, S. (2001). Influences on loneliness in older adults: A meta-analysis. *Basic and Applied Social Psychology, 23*(4), 245–266. https://doi.org/10.1207/153248301753225702

Portacolone, E., Johnson, J.K., Covinsky, K.E., Halpern, J., & Rubinstein, R.L. (2018). The effects and meanings of receiving a diagnosis of mild cognitive impairment or Alzheimer's Disease when one lives alone. *Journal of Alzheimer's Disease, 61*(4), 1517–1529. https://doi.org/10.3233/JAD-170723

Porter, K. E., Brennan-Ing, M., Chang, S. C., Dickey, L. M., Singh, A. A., Bower, K. L., & Witten, T. M. (2016). Providing competent and affirming services for transgender and gender nonconforming older adults. *Clinical Gerontologist, 39*(5), 366-388. https://doi.org/10.1080/07317115.2016.1203383

Porter, K. E., Brennan-Ing, M. (2019). The intersection of transgender identities, HIV, and aging. In C. Hardacker, K. Ducheny, M. Houlberg (Eds.). *Transgender and Gender Nonconforming Health and Aging* (pp.61–77). Springer. https://doi.org/10.1007/9783-319-95031-0_4

Powell, W., Richmond, J., Mohottige, D., Yen, I., Joslyn, A., & Corbie-Smith, G. (2019). Medical mistrust, racism, and delays in preventive health screening among African American men. *Behavioral Medicine, 45*(2), 102–117. https://doi.org/10.1080/08964289.2019.1585327

Pratap, A., Renn, B. N., Volponi, J., Mooney, S. D., Gazzaley, A., Arean, P. A., & Anguera, J. A. (2018). Using mobile apps to assess and treat depression in Hispanic and Latino populations: Fully remote randomized clinical trial. *Journal of Medical Internet Research*, *20*(8), e10130.

Qualls, S. H. (2016). Caregiving families within the long-term services and support system for older adults. *American Psychologist*, *71*(4), 283.Qualls, S. H. (2022). Knowledge of aging reduces risk of harm: Why you need to read this special issue. *Clinical Psychology: Science and Practice, 29*(1), 76–78. https://doi-org.elibrary.einsteinmed.edu/10.1037/cps0000062

Qualls, S. H., Segal, D., Norman, S., Niederehe, G., & Gallagher-Thompson, D. (2002). Psychologists in practice with older adults: Current patterns, sources of training, and need for continuing education. *Professional Psychology: Research and Practice, 33*, 435–442. http://dx.doi.org/10.1037/0735-7028.33.5.435

Rajan, K. B., Weuve, J., Barnes, L. L., McAninch, E. A., Wilson, R. S., & Evans, D. A. (2021). Population estimate of people with clinical Alzheimer's disease and mild cognitive impairment in the United States (2020–2060). *Alzheimer's & Dementia: The Journal of the Alzheimer's Association, 17*(12), 1966–1975. https://doi.org/10.1002/alz.12362

Ramos, K., & Stanley, M. A. (2018). Anxiety disorders in late life. *Psychiatric Clinics, 41*(1), 55–64. https://doi.org/10.1016/j.psc.2017.10.005

Raposo, S. M., Mackenzie, C. S., Henriksen, C. A., & Afifi, T. O. (2014). Time does not heal all wounds: Older adults who experienced childhood adversities have higher odds of mood, anxiety, and personality disorders. *The American Journal of Geriatric Psychiatry, 22*(11), 1241–1250. https://doi.org/10.1016/j.jagp.2013.04.009

Rastogi, M., Massey-Hastings, N., & Wieling, E. (2012). Barriers to seeking mental health services in the Latino/a community: A qualitative analysis. *Journal of Systemic Therapies, 31*(4), 1–17. https://doi.org/10.1521/jsyt.2012.31.4.1

Raue, P. J., McGovern, A. R., Kiosses, D. N., & Sirey, J. A. (2017). Advances in psychotherapy for depressed older adults. *Current Psychiatry Reports, 19*(9), 57. https://doi.org/10.1007/s11920-017-0812-8

Reynolds, K., Pietrzak, R. H., El-Gabalawy, R., Mackenzie, C. S., & Sareen, J. (2015). Prevalence of psychiatric disorders in US older adults: Findings from a nationally representative survey. *World Psychiatry, 14*(1), 74-81.

Roberts, B. W., Walton, K. E., & Viechtbauer, W. (2006). Patterns of mean-level change in personality traits across the life course: A meta-analysis of longitudinal studies. *Psychological Bulletin, 132*(1). https://doi.org/10.1037/0033-2909.132.1.1

Roberts, K. E., Walsh, L. E., Saracino, R. M., Fogarty, J., Coats, T., Goldberg, J., ... & Lichtenthal, W. G. (2019). A systematic review of treatment options for grieving older adults. *Current Treatment Options in Psychiatry*, *6*, 422–449.

Robertson, D. A., & Kenny, R. A. (2016). Negative perceptions of aging modify the association between frailty and cognitive function in older adults. *Personality and Individual Differences, 100*, 120–125. https://doi.org/10.1016/j.paid.2015.12.010

Robjant, K., & Fazel, M. (2010). The emerging evidence for narrative exposure therapy: A review. *Clinical Psychology Review, 30*(8), 1030–1039. https://doi.org/10.1016/j.cpr.2010.07.004

Rocha, N. M. F. D., Maia, R. D. S., Marques, G. M. V., & Bandeira, R. L. (2022). Intersectionalities and old age: Ageism in the crossroads of race, gender, and age. In L. Dutra-Thomé, D. Rabelo, & D. Ramos (Eds.) *Racism and human development* (pp. 163–172). Springer.

Romirowsky, A., Zweig, R., Glick Baker, L., & Sirey, J. A. (2018). The relationship between maladaptive personality and social role impairment in depressed older adults in primary care. *Clinical Gerontologist, 44*(2), 192–205. https://doi.org/10.1080/07317115.2018.1536687

Rose, J. (2012). Lessons for spinal cord injury rehabilitation taken from adult developmental psychology: 2011 Essie Morgan Lecture. *Journal of Spinal Cord Medicine, 35*(2), 133–139. https://doi.org/10.1179/2045772312Y.0000000006

Roseborough, D. J., Luptak, M., McLeod, J., & Bradshaw, W. (2013). Effectiveness of psychodynamic psychotherapy with older adults: A longitudinal study. *Clinical Gerontologist, 36*(1), 1–16. https://doi.org/10.1080/07317115.2012.731476

Rubino, A., Sanon, M., Ganz, M. L., Simpson, A., Fenton, M. C., Verma, S., Hartry, A., Baker, R. A., Duffy, R. A., Gwin, K., & Fillit, H. (2020). Association of the US food and drug administration antipsychotic drug boxed warning with medication use and health outcomes in elderly patients with dementia. *JAMA Network Open, 3*(4), e203630–e203630. doi:10.1001/jamanetworkopen.2020.3630

Rutherford, B. R., Choi, C. J., Chrisanthopolous, M., Salzman, C., Zhu, C., Montes-Garcia, C., Liu, Y., Brown, P. J., Yehuda, R., Flory, J., Neria, Y., & Roose, S. P. (2020). The COVID-19 pandemic as a traumatic stressor: Mental health responses of older adults with chronic PTSD. *The American Journal of Geriatric Psychiatry, 29*(2), 105–114. https://doi.org/10.1016/j.jagp.2020.10.010

Sachdev, P. S., Blacker, D., Blazer, D. G., Ganguli, M., Jeste, D. V., Paulsen, J. S., & Petersen, R. C. (2014). Classifying neurocognitive disorders: the DSM-5 approach. *Nature Reviews Neurology, 10*(11), 634–642. https://doi.org/10.1038/nrneurol.2014.181

Saez, P., Rivera Mindt, M., Byrd, D., & Manly, J. (2010). Increasing culturally competent neuropsychological services for ethnic minority populations: A call to action. *The Clinical Neuropsychologist*, *24*(3), 429–453.

Salthouse, T. A. (2019). Trajectories of normal cognitive aging. *Psychology and Aging, 34*(1), 17. https://doi.org/10.1037/pag0000288

Sánchez, V. G., Taylor, I., & Bing-Jonsson, P. C. (2017). Ethics of smart house welfare technology for older adults: A systematic review. *International Journal of Technology Assessment in Health Care, 33*(6), 691–699. https://doi.org/10.1017/S0266462317000964

Sargent-Cox, K., & Anstey, K. J. (2015). The relationship between age stereotypes and health locus of control across adult age-groups. *Psychology & Health, 30*(6), 652– 670. http://dx.doi.org/10.1080/08870446.2014.974603

Sargent-Cox, K. A., Anstey, K. J., & Luszcz, M. A. (2014). Longitudinal change of self-perceptions of aging and mortality. *The Journals of Gerontology: Series B: Psychological Sciences and Social Sciences, 69*(2), 168–173. https://doi.org/10.1093/geronb/gbt005

Saunders, R., Buckman, J. E. J., Stott, J., Leibowitz, J., Aguirre, E., John, A., Lewis, G., Cape, J., & Pilling, S. (2021). Older adults respond better to psychological therapy than working-age adults: Evidence from a large sample of mental health service attendees. *Journal of Affective Disorders, 294*, 85–93. https://doi.org/10.1016/j.jad.2021.06.084

Saxon, S.V., Etten, M.J., & Perkins, E.A. (2022). *Physical change and aging: A guide for the helping professions* (7th ed.). Springer.

Schaie, K. W. (1990). The optimization of cognitive functioning in old age: Predictions based on cohort-sequential and longitudinal data. In P. B. Baltes & M. M. Baltes (Eds.), *Successful aging: Perspectives from the behavioral sciences* (pp. 94– 117). Cambridge University Press. https://doi.org/10.1017/CBO9780511665684.006

Schaie, K. W. (2011). Historical influences on aging and behavior. In K.W. Schaie & S.L. Willis (Eds.) *Handbook of the Psychology of Aging* (7th Ed., pp. 41–55). Elsevier Academic Press.

Scheibe, S., & Carstensen, L. L. (2010). Emotional aging: Recent findings and future trends. *The Journals of Gerontology: Series B, 65*(2), 135–144. https://doi.org/10.1093/geronb/gbp132

Schilling, O. K., Wahl, H. W., & Oswald, F. (2013). Change in life satisfaction under chronic physical multi-morbidity in advanced old age: Potential and limits of adaptation. *Journal of Happiness Studies, 14*(1), 19–36. https://doi.org/10.1007/S10902-011-9313-3

Schmutte, T. J., & Wilkinson, S. T. (2020). Suicide in older adults with and without known mental illness: Results from the National Violent Death Reporting System, 2003–2016. *American Journal of Preventive Medicine, 58*(4), 584–590. https://doi.org/10.1016/j.amepre.2019.11.001

Schulte, M. T., & Hser, Y. I. (2013). Substance use and associated health conditions throughout the lifespan. *Public Health Reviews, 35*(2). https://doi.org/10.1007/BF03391702

Schulz, R., Beach, S. R., Czaja, S. J., Martire, L. M., & Monin, J. K. (2020). Family caregiving for older adults. *Annual Review of Psychology*, *71*, 635–659.

Scogin, F., & Shah, A. (2012). *Making evidence-based psychological treatment work with older adults*. American Psychological Association.

Segal, D. L., Coolidge, F. L., & Rosowsky, E. (2006). *Personality disorders and older adults: Diagnosis, assessment, and treatment*. John Wiley & Sons.

Segal, D. L., Qualls, S. H., Grus, C., & DiGilio, D. (2012, August). The APA survey of professional geropsychology training and experience. *UNHCR Emergency Handbook: Older Persons.* https://emergency.unhcr.org/entry/43935/olderpersons.

Segal, D. L., Qualls, S. H., & Smyer, M. A. (2018). *Aging and mental health*. John Wiley & Sons.

Segal, D. L., Granier, K. L., Pifer, M. A., & Stone, L. E. (2020). Mental health in older adults: An introduction for integrated care professionals. *Clinics in Integrated Care, 2*. https://doi.org/10.1016/j.intcar.2020.100015

Seidel, L., Karpiak, S. E., & Brennan-Ing, M. (2017). Training senior service providers about HIV and aging: Evaluation of a multiyear, multicity initiative. *Gerontology & Geriatrics Education*, *38*(2), 188–203.

Services and Advocacy for GLBT Elders (SAGE) & National Center for Transgender Equality (NCTE). (2012). *Improving the lives of transgender older adults.* http://transequality.org/Resources/TransAgingPolicyReportFull.pdf

Settersten Jr, R. A., & Thogmartin, A. (2018). Flux: Insights into the social aspects of life transitions. *Research in Human Development, 15*(3-4), 360–373. https://doi.org/10.1080/15427609.2018.1513779

Shaw, C., Williams, K.N., & Perkhounkova, Y. (2018). Educating nursing home staff in dementia sensitive communication: Impact on antipsychotic medication use. *Journal of the American Medical Directors Association, 19*(12), 1129–1132. https://doi:10.1016/j.jamda.2018.09.030

Shear, M. K. (2015). Complicated grief. *New England Journal of Medicine, 372*(2), 153160. https://doi:10.1056/NEJMcp1315618

Shin, S. H., Kim, G., & Park, S. (2018). Widowhood status as a risk factor for cognitive decline among older adults. *The American Journal of Geriatric Psychiatry*, *26*(7), 778–787.

Sierra, F. (2016). The emergence of geroscience as an interdisciplinary approach to the enhancement of health span and life span. *Cold Spring Harbor Perspectives in Medicine,6*(4). https://doi.org/10.1101/cshperspect.a025163

Sinković, M., & Towler, L. (2019). Sexual aging: A systematic review of qualitative research on the sexuality and sexual health of older adults. *Qualitative Health Research*, *29*(9), 1239–1254.

Sisco, S., Gross, A. L., Shih, R. A., Sachs, B. C., Glymour, M. M., Bangen, K. J., ... & Manly, J. J. (2015). The role of early-life educational quality and literacy in explaining racial disparities in cognition in late life. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *70*(4), 557–567.

Smith, G.E., & Bondi, M.W. (2013). *Mild cognitive impairment and dementia: Definitions, diagnosis, and treatment*. Oxford University Press.

Solem, P., Syste, A., Furunes, T., Mykletun, R., De Lange, A., Schauffeli, W., & Ilmarinen, J. (2016). To leave or not to leave: Retirement intentions and retirement behaviour. *Ageing and Society, 36*(2), 259–281. https://doi:10.1017/S0144686X14001135

Sperling, R. A., Aisen, P. S., Beckett, L. A., Bennett, D. A., Craft, S., Fagan, A. M., Iwatsubo, T., Jack, C. R., Jr., Kaye, J., Montine, T. J., Park, D. C., Reiman, E. M.,

Rowe, C. C., Siemers, E., Stern, Y., Yaffe, K., Carrillo, M. C., Thies, B., Morrison-

Bogorad, M., Wagster, M. V., Phelps, C. H. (2011). Toward defining the preclinical stages of

Alzheimer's disease: Recommendations from the National Institute on Aging Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. *Alzheimer's & Dementia: The Journal of the Alzheimer's Association, 7*(3), 280–292. https://doi.org/10.1016/j.jalz.2011.03.003

Stacey, L., & Wislar, W. (2023). Physical and mental health disparities at the intersection of sexual and gender minority statuses: Evidence from population-level data. *Demography*, *60*(3), 731–760. https://doi.org/10.1215/00703370107085592

Stanziani, M., Cox, J., Bownes, E., Carden, K. D., & DeMatteo, D. S. (2020). Marking the progress of a "maturing" society: Madison v. Alabama and competency for execution evaluations. *Psychology, Public Policy, and Law, 26*(2), 145–153. https://doi.org/10.1037/law0000228

Steffen, A. M. & Schmidt, N. E. (2022). The CBTs in Later Life. In G. Asmundson (Ed.), *Comprehensive clinical psychology* (2nd ed). Elsevier.

Steffen, A.M., Thompson, L. W., & Gallagher-Thompson, D. (2022a). Skills for living with loss. In *Treating later-life depression: A cognitive-behavioral therapy approach, clinician guide* (2nd ed., pp. 255–271). Oxford University Press.

Steffen, A. M. & Zeiss, A. M. (2017). Interprofessional health care teams in geriatrics. *Reference Module in Neuroscience and Biobehavioral Psychology*. Elsevier. https://doi.org/10.1016/B978-0-12-809324-5.05142-7

Steffen, A. M., Zeiss, A. M., & Karel, M. J. (2014). Interprofessional geriatric healthcare: Competencies and resources for teamwork. In N.A. Pachana & K. Laidlaw (Eds.), *The Oxford handbook of clinical geropsychology*. Oxford Academic. https://doi.org/10.1093/oxfordhb/9780199663170.013.021

Steverink, N. (2014). Successful development and ageing theory and intervention: Theory and intervention. In N.A. Pachana & K. Laidlaw (Eds.), *The Oxford handbook of clinical geropsychology*. Oxford Academic. https://doi.org/10.1093/oxfordhb/9780199663170.013.028

Stewart, H., Jameson, J. P., & Curtin, L. (2015). The relationship between stigma and self-reported willingness to use mental health services among rural and urban older adults. *Psychological Services, 12*(2), 141. https://doi.org/10.1037/a0038651

Strong, J.V., Allen, R.S., Tighe, C., Jacobs, M.L., Dorman, H., & Mast, B. (2021). What geropsychology trainees think geropsychologists do and what we actually do: A mixed-methods study. *Gerontology & Geriatrics Education, 42*(2), 277–296.

Substance Abuse and Mental Health Services Administration. (2021). *Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health* (HHS Publication No. PEP21-07-01003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/

Sun, F., Ong, R., & Burnette, D. (2012). The influence of ethnicity and culture on dementia caregiving: A review of empirical studies on Chinese Americans. *American Journal of Alzheimer's Disease & Other Dementias, 27*(1), 13-22. https://doi.org/10.1177/1533317512438224

Sweet, C.M.C., Urizar, G. G., Miller, K., Saldaña, K. S., Garovoy, N., & King, A. C. (2021). Effects of health behavior interventions on psychosocial outcomes and cortisol regulation among chronically stressed midlife and older adults. *International Journal of Behavioral Medicine*, *28*(5), 627–640. https://doi.org/10.1007/s12529-021-09957-1

Tannou, T., Koeberlé, S., Aubry, R., & Haffen, E. (2020). How does decisional capacity evolve with normal cognitive aging: Systematic review of the literature. *European geriatric medicine, 11*(1), 117–129. https://doi.org/10.1007/s41999-019-00251-8

Tavares, L. R., & Barbosa, M. R. (2018). Efficacy of group psychotherapy for geriatric depression: A systematic review. *Archives of Gerontology and Geriatrics*, *78*, 7180.

Taylor, R., Chatters, L., Cross, C. J., & Mouzon, D. (2021). Fictive kin networks among African Americans, Black Caribbeans, and non-Latino Whites. *Journal of Family Issues, 43*(1), 1-27. https://doi.org/10.1177/0192513X21993188

Tazeau, Y. N. (2011). Individual and cultural diversity considerations in geropsychology. In V. Molinari (Ed.), *Specialty Competencies in Geropsychology* (pp. 103-114). Oxford Academic Press.

Teri, L., Logsdon, R. G., McCurry, S. M., Pike, K. C., & McGough, E. L. (2020). Translating an evidence-based multicomponent intervention for older adults with dementia and caregivers. *The Gerontologist*, *60*(3), 548–557.

Thomas, P. A., Liu, H., & Umberson, D. (2017). Family relationships and well-being. *Innovation in Aging, 1*(3). https://doi.org/10.1093/geroni/igx025

Thompson, A. E., Anisimowicz, Y., Miedema, B., Hogg, W., Wodchis, W. P., & Aubrey Bassler, K. (2016). The influence of gender and other patient characteristics on health care-seeking behaviour: A QUALICOPC study. *BMC Family Practice, 17*(1), 1–7. https://doi.org/10.1186/s12875-016-0440-0

Thorp, S. R., Glassman, L. H., Wells, S. Y., Walter, K. H., Gebhardt, H., Twamley, E., ... & Wetherell, J. (2019). A randomized controlled trial of prolonged exposure therapy versus relaxation training for older veterans with military-related PTSD. *Journal of Anxiety Disorders*, *64*, 45–54.

Thumala Dockendorff, D. C. (2014). Healthy ways of coping with losses related to the aging process. *Educational Gerontology, 40*(5), 363–384. https://doi.org/10.1080/03601277.2013.822203

Tillman, J.L., & Mark, H.D. (2015). HIV and STI testing in older adults: An integrative review. *Journal of Nursing, 24*(15–16), 2074–2095.

Tolppanen, A. M., Solomon, A., Kulmala, J., Kåreholt, I., Ngandu, T., Rusanen, M.,

Laatikainen, T., Soininen, H., & Kivipelto, M. (2015). Leisure-time physical activity from mid- to late life, body mass index, and risk of dementia. *Alzheimer's & Dementia, 11*, 434–443. https://doi.org/10.1016/j.jalz.2014.01.008

Tovel, H., & Carmel, S. (2014). Maintaining successful aging: The role of coping patterns and resources. *Journal of Happiness Studies, 15*(2), 255–270. https://doi.org/10.1007/s10902-013-9420-4

Tovel, H., Carmel, S., & Raveis, V. H. (2019). Relationships among self-perception of aging, physical functioning, and self-efficacy in late life. *The Journals of Gerontology: Series B, 74*(2), 212–221. https://doi.org/10.1093/geronb/gbx056

Træen, B., Carvalheira, A., Kvalem, I. L., Štulhofer, A., Janssen, E., Graham, C. A., Hald, G.M., & Enzlin, P. (2017). Sexuality in older adults (65+) – an overview of the recent literature, part 2: Body image and sexual satisfaction. *International Journal of Sexual Health, 29*(1), 11-21. https://doi.org/10.1080/19317611.2016.1227012

Tsiouris, J. A., Prasher, V. P., Janicki, M. P., Fernando, A., & Service, K. P. (2011). The aging patient with intellectual disabilities. In M. E. Agronin & G. J. Maletta (Eds.), *Principles and practice of geriatric psychiatry* (2nd ed., pp. 627–648). Lippincott, Williams & Wilkins.

Turan, O., Yemez, B., & Itil, O. (2014). The effects of anxiety and depression symptoms on treatment adherence in COPD patients. *Primary Health Care Research & Development, 15*(3), 244–251. https://doi.org/10.1017/S1463423613000169

Turgoose, D., Ashwick, R., & Murphy, D. (2018). Systematic review of lessons learned from delivering tele-therapy to veterans with post-traumatic stress disorder. *Journal of Telemedicine and Telecare, 24*(9), 575–585. https://doi.org/10.1177/1357633X17730443

Turk, D. C., & Burwinkle, T. M. (2005). Clinical outcomes, cost-effectiveness, and the role of psychology in treatments for chronic pain sufferers. *Professional Psychology: Research and Practice, 36*(6), 602. https://doi.org/10.1037/07357028.36.6.602

United Nations (2022). *Old-age poverty has a woman's face.* https://www.un-ilibrary.org/content/papers/10.18356/27081990-142

United Nations (1991). *United Nations principles for older persons.* https://www.ohchr.org/sites/default/files/olderpersons.pdf

U.S. Census Bureau (2017). *2017 national population projections tables: Main series*. https://www.census.gov/data/tables/2017/demo/popproj/2017-summarytables.html

Vacha-Haase, T. (2011). Teaching, supervision, and the business of geropsychology. In V. Molinari (Ed.), *Specialty competencies in geropsychology*. Oxford University Press.

Vacha-Haase, T., Wester, S. R., & Christianson, H. F. (2011). *Psychotherapy with older men* (Vol. 8). Routledge.

Vale, M. T., Bisconti, T. L., & Sublett, J. F. (2020). Benevolent ageism: Attitudes of overaccommodative behavior toward older women. *The Journal of Social Psychology*, *160*(5), 548–558. https://doi.org/10.1080/00224545.2019.1695567

Van Orden, K. A., Lutz, J. (2020). Sadness and worry in older adults: Differentiating psychiatric illness from normative distress. *Medical Clinics*, *104*(5), 843–854.

Viljanen, A., Törmäkangas, T., Vestergaard, S., & Andersen-Ranberg, K. (2014). Dual sensory loss and social participation in older Europeans. *European Journal of Ageing, 11*(2), 155–167. https://doi.org/10.1007/s10433-013-029-7

Vinson, L. D., Crowther, M. R., Austin, A. D., & Guin, S. M. (2014). African Americans, mental health, and aging. *Clinical Gerontologist*, *37*(1), 4–17. https://doi.org/10.1080/07317115.2013.847515

Waggoner, J., & Dono, L. (2022, March). *High-speed internet discount program passes 10M enrollees*. AARP. https://www.aarp.org/home-family/personaltechnology/info-2021/fcc-subsidy-helps-broadband-internet-access.html

Wahl, H. W., Iwarsson, S., & Oswald, F. (2012). Aging well and the environment: Toward an integrative model and research agenda for the future. *The Gerontologist, 52*(3), 306-316. https://doi.org/10.1093/geront/gnr154

Wallace, S., Nazroo, J., & Bécares, L. (2016). Cumulative effect of racial discrimination on the mental health of ethnic minorities in the United Kingdom. *American Journal of Public Health, 106*(7), 1294-1300. https://doi.org/10.2105/AJPH.2016.303121

Walpert, M. J., Normando, E. M., Annus, T., Jennings, S. R., Wilson, L. R., Watson, P., Zaman, S. H., Cordeiro, M. F., & Holland, A. J. (2019). Age-related retinal thickness in Down's syndrome: A high-risk population for dementia. *Alzheimer's & Dementia (Amsterdam, Netherlands)*, *11*, 744–751. https://doi.org/10.1016/j.dadm.2019.08.007

Ward, E., & Shanks, D. (2018, December 20). *Implicit memory and cognitive aging*. Oxford Research Encyclopedia of Psychology. https://oxfordre.com/psychology/view/10.1093/acrefore/9780190236557.001.000 1/acrefore-9780190236557-e-378

Wastesson, J. W., Morin, L., Tan, E. C., & Johnell, K. (2018). An update on the clinical consequences of polypharmacy in older adults: A narrative review. *Expert Opinion on Drug Safety, 17*(12), 1185–1196. https://doi.org/10.1080/14740338.2018.1546841

Westerhof, G. J., Whitbourne, S. K., & Freeman, G. P. (2012). The aging self in a cultural context: The relation of conceptions of aging to identity processes and self-esteem in the United States and the Netherlands. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 67*(1), 52–60. https://doi.org/10.1093/geronb/gbr075

Westerhof, G. J., & Slatman, S. (2019). In search of the best evidence for life review therapy to reduce depressive symptoms in older adults: A meta-analysis of randomized controlled trials. *Clinical Psychology: Science and Practice*, *26*(4), e12301.

Whitbourne, S. B., & Whitbourne, S. K. (2012). Demography of aging: Behavioral and social implications. In S. K. Whitbourne & M. J. Sliwinski (Eds.), *The Wiley-Blackwell handbook of adulthood and aging* (pp. 25–48). Wiley Blackwell. https://doi.org/10.1002/9781118392966.ch2

Whitbourne, S. K., & Martins, B. (2020). Psychotherapy with the underserved older adult population. *Bringing Psychotherapy to the Underserved: Challenges and Strategies*, 263.

Whitbourne, S. K., & Meeks, S. (2011). Psychopathology, bereavement, and aging. In K.W. Shaie & S.L. Willis (Eds.), *Handbook of the psychology of aging* (7th Ed., pp. 311–323). Elsevier Academic Press.

Whitehead, L., Jacob, E., Towell, A., Abu-Qamar, M., & Cole-Heath, A. (2018). The role of the family in supporting the self-management of chronic conditions: A qualitative systematic review. *Journal of Clinical Nursing, 27*(1–2), 22–30. https://doi.org/10.1111/jocn.13775

Whitehead, B. R., & Torossian, E. (2021). Older adults' experience of the COVID-19 pandemic: A mixed-methods analysis of stresses and joys. *The Gerontologist, 61*(1), 36–47. https://doi.org/10.1093/geront/gnaa126

Whitfield, K. E., Thorpe, R., & Szanton, S. (2011). Health disparities, social class, and aging. In K.W. Shaie & S.L. Willis (Eds.), *Handbook of the psychology of aging* (7th Ed., pp. 207–218). Elsevier Academic Press.

Whitson, H. E., Cronin-Golomb, A., Cruickshanks, K. J., Gilmore, G. C., Owsley, C., Peelle, J. E., Recanzone, G., Sharma, A., Swenor, B., Yaffe, K., & Lin, F. R. (2018). American Geriatrics Society and National Institute on Aging bench-to-bedside conference: Sensory impairment and cognitive decline in older adults. *Journal of the American Geriatrics Society*, *66*(11), 2052–2058.

Williamson, V., Stevelink, S. A. M., Greenberg, K., & Greenberg, N. (2018). Prevalence of mental health disorders in elderly U.S. military veterans: A meta-analysis and systematic review. *American Journal of Geriatric Psychiatry, 26*(5), 534–545. https://doi.org/10.1016/j.jagp.2017.11.001

Wilmoth, J. M., London, A. S., & Parker, W. M. (2010). Military service and men's health trajectories in later life. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 65*(6), 744–755. https://doi.org/10.1093/geronb/gbq072

Wilson, J., Heinsch, M., Betts, D., Booth, D., & Kay-Lambkin, F. (2021). Barriers and facilitators to the use of e-health by older adults: A scoping review. *BMC Public Health, 21*(1), 1556. https://doi.org/10.1186/s12889-021-11623-w

Winterrowd, E., Canetto, S. S., & Benoit, K. (2017). Permissive beliefs and attitudes about older adult suicide: A suicide enabling script? *Aging & Mental Health, 21,* 173-181. doi: 10.1080/13607863.2015.1099609

Winterton, R., Warburton, J., Keating, N., Petersen, M., Berg, T., & Wilson, J. (2016). Understanding the influence of community characteristics on wellness for rural older adults: A meta-synthesis. *Journal of Rural Studies, 45*, 320–327. https://doi.org/10.1016/j.jrurstud.2015.12.010

Witten, T. M. (2015). When my past returns: Loss of self and personhood – dementia and the trans-person. In S. Westwood, & E. Price (Eds.), *Lesbian, gay, bisexual and trans* individuals living with dementia: Theoretical, practical and rights-based perspectives.* Routledge Press.

Wolitzky-Taylor, K. B., Castriotta, N., Lenze, E. J., Stanley, M. A., & Craske, M. G. (2010). Anxiety disorders in older adults: A comprehensive review. *Depression and Anxiety, 27*(2), 190–211. https://doi.org/10.1002/da.20653

Wood, S., & Lichtenberg, P. A. (2017). Financial capacity and financial exploitation of older adults: Research findings, policy recommendations and clinical implications. *Clinical Gerontologist, 40*(1), 3–13. https://doi.org/10.1080/07317115.2016.1203382

Woodhead, E. L., & Yochim, B. (2022). Adult development and aging: A foundational geropsychology knowledge competency. *Clinical Psychology: Science and Practice, 29*(1), 16–27. https://doi.org/10.1037/cps0000048

World Health Organization. (2008). *WHO global report on falls prevention in older age*.
World Health Organization. https://apps.who.int/iris/handle/10665/43811
World Health Organization. (2017a). *Developing an ethical framework for healthy ageing: Report of a WHO meeting*. https://www.who.int/teams/maternal-newbornchild-adolescent-health-and-ageing/ageing-and-health
World Health Organization. (2017b). *Mental health of older adults*. https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults
World Health Organization. (2020a). *Ageism*. https://www.who.int/health-topics/ageism
World Health Organization. (2020b). *Healthy ageing and functional ability*. https://www.who.int/news-room/questions-and-answers/item/healthy-ageing-andfunctional-ability
World Health Organization. (2021). *Ageing: Ageism*. https://www.who.int/newsroom/questions-and-answers/item/ageing-ageism
World Health Organization. (2021) *WHO's work on the UN Decade of Healthy Ageing 2021–2030*. https://www.who.int/initiatives/decade-of-healthy-ageing
Wright, S. L., & Canetto, S. S. (2009). Stereotypes of older lesbians and gay men. *Educational Gerontology, 35*, 424-452.
Yang, J. A., Garis, J., Jackson, C., & McClure, R. (2009). Providing psychotherapy to older adults in home: Benefits, challenges, and decision-making guidelines. *Clinical Gerontologist, 32*(4), 333–346. https://doi.org/10.1080/07317110902896356
Yarnell, S., Li, L., MacGrory, B., Trevisan, L., & Kirwin, P. (2020). Substance use disorders in later life: A review and synthesis of the literature of an emerging public health concern. *The American Journal of Geriatric Psychiatry, 28*(2), 226–236. https://doi.org/10.1016/j.jagp.2019.06.005
Yon, Y., Mikton, C., Gassoumis, Z. D., & Wilber, K. H. (2019). The prevalence of self-reported elder abuse among older women in community settings: A systematic review and meta-analysis. *Trauma, Violence, & Abuse, 20*(2), 245–259. https://doi.org/10.1177/1524838017697308
Zahodne, L. B., Sharifian, N., Kraal, A. Z., Zaheed, A. B., Sol, K., Morris, E. P., Schupf, N., Manly, J. J., & Brickman, A. M. (2021). Socioeconomic and psychosocial mechanisms underlying racial/ethnic disparities in cognition among older adults. *Neuropsychology, 35*(3), 265–275. https://doi.org/10.1037/neu0000720
Zheng, H. (2021). A new look at cohort trend and underlying mechanisms in cognitive functioning. *The Journals of Gerontology: Series B, 76*(8), 1652–1663. https://doi.org/10.1093/geronb/gbaa107
Zeiss, A. M., & Thompson, D. G. (2003). Providing interdisciplinary geriatric team care: What does it really take? *Clinical Psychology: Science and Practice, 10*(1), 115–119. https://doi.org/10.1093/clipsy.10.1.115
Zelinski, E. M., Kennison, R. F., Watts, A., & Lewis, K. L. (2009). Convergence between cross-sectional and longitudinal studies: Cohort matters. In H. B. Bosworth & C. Hertzog (Eds.), *Aging and cognition: Research methodologies and empirical advances* (pp. 101–118). American Psychological Association. https://doi.org/10.1037/11882-005
Zis, P., Daskalaki, A., Bountouni, I., Sykioti, P., Varrassi, G., & Paladini, A. (2017). Depression and chronic pain in the elderly: Links and management challenges. *Clinical Interventions in Aging, 12*, 709-720. https://doi.org/10.2147/CIA.S113576

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