

INTRODUCTION

The aging of the U.S. population is well-established, and psychologists are playing an increasingly prominent role in the care and well-being of older adults. The emergence of geropsychology as a subspecialty area of clinical practice is one of the most exciting developments in psychology during the past 25 years. This development is an important step in addressing the well-established shortage of geriatric mental health practitioners (American Psychological Association [APA], 2014c; Institute of Medicine, 2012). Between 5.6 million and 8 million older Americans have one or more mental health disorders. Because the number of adults age 65 and older is projected to rise from 40.3 million in 2010 to 72.1 million in 2030, the aging of America has profound implications for psychology and health care in general. Unfortunately, the number of psychologists working in or entering practice with older adults is disconcertingly small, and those who are competent to manage complex older adult cases are in short supply (Institute of

<http://dx.doi.org/10.1037/0000010-001>

Ethical Practice in Geropsychology, by S. S. Bush, R. S. Allen, and V. A. Molinari
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Medicine, 2012). Thus, geropsychology is still an underrepresented area of practice. Providing clinical services to older adults presents challenges that may be novel for those trained to work with younger adults. The following vignette illustrates some common issues a psychologist might encounter with an older client.¹

After suffering a recent stroke, Mrs. Jones presented with her daughter to the interdisciplinary primary care clinic in geriatric medicine at the local university teaching hospital. The daughter had made the appointment for Mrs. Jones because she was concerned about her mother's mental capacity for making decisions about important life issues, including living independently. Mrs. Jones and her daughter had a difference of opinion regarding the safety of Mrs. Jones's current living situation; they shared their concerns with the geropsychologists and other members of the geriatric care team, which included a geriatrician, nurse, pharmacist, and psychology and social work trainees. Mrs. Jones clearly and emphatically stated her preference for continuing to live in her home of 56 years, the home that she had shared with her late husband and currently shares with four cats and one dog. Her daughter, in contrast, offered that Mrs. Jones and one cat and the dog could live in the "granny flat" recently built onto her own house roughly 70 miles away.

How might the geropsychologist approach such a situation? What additional information does the geropsychologist need? What potential ethical and legal issues may arise in working with Mrs. Jones?

The primary goal of this book is to promote the development and maintenance of ethical competence in psychology trainees and practitioners working with older adults. To achieve this goal, we present common ethical and legal issues confronting geropsychologists and illustrate ways to identify and negotiate ethical issues and challenges through the use of vignettes covering a variety of practice contexts. By increasing awareness of such issues, psychologists may choose courses of behavior that are consistent with ethical practice, thereby promoting patient care and avoiding ethical misconduct. The book draws heavily from principle-based ethics (Beauchamp & Childress, 2013) and positive ethics (Knapp & VandeCreek, 2006, 2012) in the practical application of the *Ethical Principles of Psychologists and Code of Conduct* (hereinafter referred to as the Ethics Code; APA, 2010) and related professional guidelines and resources to geropsychology.

¹Proper steps were taken to protect the confidentiality of all individuals mentioned in the case examples throughout this book.

THE HISTORY OF GEROPSYCHOLOGY

Psychology as a discipline dates to the 19th century, when Wilhelm Wundt founded the first psychological research laboratory in Leipzig in 1879 and Francis Galton collected reaction time data at the first large health exhibit in London in 1884 (Birren & Schroots, 2001). APA was founded in 1892 with 31 members and G. Stanley Hall as its first president. According to Birren and Schroots (2001), however, 1950 may arbitrarily delineate the beginnings of organized university research and education in geropsychology. The Gerontological Society of America was founded in 1946, and Division 20 (Adult Development and Aging) of APA was founded in 1947.

Perhaps the strongest demarcation of the rise of clinical practice focused on the issues of aging was the establishment of the Society of Clinical Geropsychology, Division 12 Section II of APA in 1993. More recently, geropsychology was recognized as a specialty area by APA in 2011, and as of December 2014 those competent in geropsychology can now be certified by the American Board of Professional Psychology. Individuals seeking to be board certified in geropsychology must demonstrate adequate training and competence in foundational (theoretical and empirical) and functional (assessment, intervention, consultation) knowledge and skills relevant for the ethical practice of geropsychology.

The maturing of professions and specialties is reflected in the need for, and development of, guidelines, based on shared values and ideas about appropriate professional behavior, that guide members of the profession in their decisions about professional activities. With the APA (2010) Ethics Code as one primary resource, geropsychology scholars, informed by general bioethical principles, have generated additional professional guidelines that advise practitioners on best practices in geropsychology. Overviews of the application of professional ethics to geropsychology have also been published (see, e.g., Bush, 2012; Hays & Jennings, 2015; Karel, 2011), as have many articles and chapters on the ethical issues of specific aspects of practice and research with older adults. Reviewing, synthesizing, and extending these prior scholarly works on ethical practice in geropsychology in one volume marks another step in the maturation of the specialty. Although books on closely related topics such as ethical issues in geriatric mental health (Bush, 2009; Mezey et al., 2002) have been published previously, we identified the need for an ethics book specific to psychological practice with older adults to help practitioners identify ethical issues, recognize challenges, and promote ethical practice specifically from a psychological perspective that is informed by psychological ethics and resources.

The Pikes Peak model for training in geropsychology presented aspirational guidelines for the competent practice of geropsychology (Knight et al.,

2009), and Karel and colleagues (Karel, Emery, Molinari, & the CoPGTP Task Force on the Assessment of Geropsychology Competencies, 2010) used the Pikes Peak model to develop a self-assessment tool for determining practitioner competencies in assessment, intervention, consultation, research, supervision training, and management administration. Four broad aspects of training underlie this model and define geropsychology as a distinctive practice area: (a) knowledge of life span developmental theory; (b) knowledge of and skills relevant to late-life psychopathologies including dementia; (c) knowledge of medical comorbidities; and (d) knowledge of age-specific environmental contexts, including family, residential, health care, and community systems. Molinari (2012) provided further detailed suggestions for meeting the knowledge- and skills-based competencies delineated in the Pikes Peak training model by presenting tables that outline the content of the behavioral anchors of the competencies. Professional competence provides the foundation for ethical practice in geropsychology, and competence in ethical and legal aspects of practice is a component of such competent practice. That is, knowledge of ethical and legal aspects of practice is a core competency in geropsychology. Effective practice of geropsychology requires knowledge and understanding of the ethical and legal issues and challenges commonly encountered when working with older adults. Thus, geropsychology competence and ethical competence are inextricably linked.

UNIQUE ISSUES IN GEROPSYCHOLOGICAL PRACTICE

As reflected in the opening vignette, psychologists who work with older adults must address a host of unique issues not encountered with younger clients. The differences in presenting problems, involvement of others, clinical settings, and referral questions have ethical and legal implications for practitioners.

Presenting Problems

Many psychiatric disorders have a higher prevalence in later life (e.g., dementias), and some psychopathologies that occur throughout adulthood (e.g., depression, anxiety, substance abuse, psychotic symptoms) manifest in different ways or emerge for different reasons with older adults (Knight et al., 2009). Chronic medical problems are more common in late life and often are comorbid with emotional difficulties. Medications can have adverse cognitive, psychological, or behavioral effects that require the attention of geropsychologists, and polypharmacy is more frequently a problem for older

adults. Loss is a common theme in late life and can be experienced in many ways, such as the loss of one's physical abilities, professional identity and finances, family members and social supports, and independence. Such losses often negatively affect psychological functioning. However, in contrast to difficulties and disorders, health promotion has garnered relatively less attention but is becoming an increasingly important area of research interest in older adults even for those who have no disorders, and geropsychologists play an important role in fostering physical and emotional well-being.

Involved Parties and Unique Settings

The involvement of family members (typically spouses or adult children) and other caregivers in psychological assessment and treatment is more common with older adults than younger adults. Such involvement can be essential, but it can also pose unique challenges for patients, families, and clinicians. Geropsychologists are likely to confront competing expectations from the consumers of services, including patients, their families or caregivers, other health care professionals, and the institutions in which many older adults are evaluated and treated. Successfully negotiating conflicting interests and expectations is required to meet the needs of patients and other stakeholders and for competent professional practice.

Treatment of older adults occurs in a wide range of settings, including the same settings as with younger adults. Older adults are also more commonly evaluated and treated in their homes, rehabilitation settings, long-term care settings, and palliative care contexts. Care providers serve older adults through education, recommendations, environmental management, and support services; helping them do so is often an important role for geropsychologists. Geropsychologists also often work closely with interdisciplinary teams, which include the patients, families, care providers, and clergy, sometimes at the request of the institutions in which older adults are receiving care. Understanding the ethical issues that emerge in such contexts promotes quality care.

Referral Questions and Services

Geropsychologists have the knowledge and skills needed to assess and address cognitive, emotional, behavioral, and social problems experienced by older adults and those involved in the lives of older adults, such as family members or other care providers. Geropsychologists provide numerous services, including individual, couples, and family treatment; group therapy; behavior management consultation; environmental design; safety recommendations; staff education; and a variety of related services. Each of the issues

addressed and services provided offer opportunities for both ethical missteps and sound ethical decision-making.

FORMAT AND VIGNETTES

Part I of the book provides an overview of foundational competencies in geropsychology, with an emphasis on ethical issues and decision making. This section provides a review of the integration of psychology and geropsychology, covers the establishment and maintenance of professional competence in geropsychology, describes common ethical issues and challenges in geropsychology, and presents an ethical decision-making model to assist geropsychologists in the prevention and successful resolution of ethical dilemmas. Applying the model to each case is likely to help achieve good outcomes. When a working knowledge of the model has been achieved, the individual steps can often be addressed implicitly under conceptually integrated categories. For the cases presented in this book, we often collapse steps in the model for a more fluid discussion of the salient issues. The importance of striving to understand individual, cultural, and cohort differences is considered an essential aspect of ethical decision making and is relevant across cases and settings.

Part II covers the ethical issues often associated with the undertaking of the functional competencies expected of geropsychologists. Separate chapters address geropsychology competencies in assessment; intervention; consultation, administration, and business aspects of practice; education, training, and research; and advocacy. Vignettes present ethical issues and challenges commonly encountered in various practice settings. An attempt was made to select settings that are either more commonly encountered in the treatment of older adults compared to younger populations or are becoming increasingly important practice settings for geropsychologists. We hope that the approach used to identify ethical issues, challenges, and solutions in the contexts described will transfer to the many other practice contexts in which geropsychologists provide services that are not directly addressed herein.

For each chapter, we provide an overview of the competency, identify the professional tasks that reflect competent behavior in this domain, and provide representative examples to illustrate the ethical issues and tensions being covered. For example, the clinical and ethical tension that often emerges from the clinician's desire to both promote patient autonomy (e.g., ability to continue living independently) and maximize patient safety (e.g., recommend placement in a supervised living setting because of significant cognitive deficits) is a primary tension encountered by geropsychologists that must be anticipated, understood, and addressed. The vignettes in this book

demonstrate the practical application of ethical principles and professional guidelines across a wide spectrum of geropsychology contexts. They are fictitious cases based on our combined experiences and are designed to provide a broad sample of the types of ethical issues and challenges geropsychologists experience. It is understood that the specific details of geropsychological practice can vary across the types of settings in which services are provided and across rural–urban or geographic regions of the country; thus, some aspects of the vignettes may seem atypical to readers as a result of such differences. Such details are typically less important than the underlying principles being presented. Because several good solutions to ethical challenges might be identified, we expect readers to identify different decisions that could have been made or varied courses of action that could be taken. Each vignette highlights only certain principles, although others may well be operative. We hope that the vignettes will stimulate thought and discussion.

IMPORTANT TERMINOLOGY

The Ethics Code comprises the Introduction and Applicability section, the Preamble, five General Principles, 10 Ethical Standards, and the 2010 Amendments. All references to the Ethics Code throughout the book refer to the 2010 APA Ethics Code unless otherwise specified. References to principles from other resources are accompanied by citations for the resources being referenced.

Older adults are referred to by different terms depending on the settings in which services are provided. For example, in skilled nursing facilities, the term *resident* is often used; in acute medical settings, the term *patient* is commonly used; and in private practice contexts, older adults may be referred to as *clients*. Similarly, the terms *inmate*, *litigant*, *defendant*, *plaintiff*, and *insured* are commonly used in forensic contexts. The term *client* is sometimes employed when services are provided to an individual involved in the older adult's life, such as a family member, and when services are provided to institutions or have been retained by an attorney. Rather than selecting one term and attempting to use it throughout the book, we use the term that seems most applicable to the issue being covered or the vignette being presented, with an understanding that others may prefer different terms. Additionally, unless otherwise specified, the term *geropsychologist* as used throughout the book is defined broadly to include all psychologists who provide clinical, research, teaching, supervision, or administrative services to older adults, their families, or the institutions that serve older adults. Similarly, the term *geropsychology trainee* refers to all psychology trainees who provide services to older adults.

NOTE REGARDING BOARD CERTIFICATION

Board certification in geropsychology through the American Board of Professional Psychology (ABGERO) involves a formal peer review of foundational and functional competencies in geropsychology. Examination of candidates' knowledge of ethical issues and ability to apply that knowledge to clinical cases is an important part of the examination process. We believe that a thorough understanding of the principles discussed in this book will be helpful to ABGERO candidates regarding their description of the details of the ethics materials they submit and their examination of ethical dilemmas in the vignettes presented to them. However, the book is not intended to be an ABGERO exam preparation manual, even though the issues and principles presented in this book may help geropsychologists prepare for the ethics portion of the ABGERO board certification examination.