

INTRODUCTION

My first real job out of college was as a social services outreach worker to older residents of the Fenway neighborhood of Boston. The Fenway—perhaps best known as home of the Boston Red Sox baseball team—was not in good shape: Urban renewal efforts had dislocated residents, a rash of arsons had occurred, and street crime was common. Members of the community gathered to figure out what could be done. One big concern was with Fenway's longtime older residents who seemed to bear the brunt of the neighborhood's problems. A community task force was formed, and from it emerged a proposal for door-to-door social services outreach to all residents 62 years of age and older. The proposal was funded, and I was one of the three outreach workers. We met with older residents in their homes to assess for a range of social services, housing, benefits, and health and mental health problems, and then as needed, made referrals.

I presumed I would meet many beleaguered older people struggling to survive. In reality, it was quite the opposite. I met extraordinary older people, including a sizable group of never married career women who lived in the neighborhood because it was close to downtown Boston, where they

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Assessment and Treatment of Older Adults: A Guide for Mental Health Professionals,
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worked. I learned my first lesson in gerontology: Most older adults are resilient, adaptive, reasonably happy, and have meaningful social connections. There were, of course, older residents with problems, and I directly observed what poverty, mental illness, chronic health problems, housing insecurity, and financial stresses looked like.

I was guided in this effort by experienced geriatric social workers from whom I learned much. I admired their commitment to and care for older people. Sensing my growing enthusiasm about aging, they asked if I might have interest in a career in aging. I replied that I intended to become a psychologist. “Are there psychologists who specialize in aging?” I asked. They knew psychologists who did research on aging but not any who were engaged in professional practice with older people. They said, however, that the population of the United States was aging and, undoubtedly in the future, all professional fields, including psychology, would develop aging-knowledgeable workforces. The year was 1976, and people 65 years of age and older constituted 10% of the U.S. population.

THE FUTURE AGING OF AMERICA ARRIVES

What my social worker colleagues had not advised me was that the lion’s share of the growth of the aging population would arrive when I was an older adult. In 2007, the first members of the 75 million baby boomer population began to turn 65. In 2030, the percentage of the U.S. population 65 years and older will be 20%. Ten thousand baby boomers turn 65 *every single day*. My social work colleagues were overly optimistic about how the health and mental health professions would build an aging-knowledgeable workforce.

Just as the first group of aging baby boomers began to turn 65, the Institute of Medicine (2008) published a report that essentially said that the United States had not done a good job of planning for an aging society and had a woefully inadequate workforce to serve that population. There were not enough aging specialists and never would be, according to the report. A later report from the same institute further documented that the mental health and substance use workforce for older adults was thin (Institute of Medicine, 2012). In the end, the report concluded, older adults would receive health and mental health services from individuals who had little or no training related to aging. The challenge then would be to build foundational knowledge and competencies in the existing workforce so it could do a better job of serving older Americans.

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OFF TO GRADUATE SCHOOL AND ON TO A CAREER IN AGING

I finished my job as an outreach worker, went to graduate school in New York, and was fortunate to have an academic mentor who was a psychologist who specialized in aging. I worked with her on a study of how older adults cope with chronic illness and other projects. I returned to the Fenway to gather dissertation data on how different residential environments impacted older residents' emotional and social well-being. There, I reconnected with my geriatric social work colleagues and some older residents whom I had first met when doing the outreach. A clinical psychology internship at Hillside Hospital, Long Island Jewish Medical Center, in New York included a year-long placement in a geriatric outpatient mental health clinic. Hillside Hospital became my professional home for 25 years, during which I saw older clients, did research on late-life depression and dementia, and created internship and postdoctoral training opportunities in geropsychology. I could not have imagined as a young social services outreach worker that the field of aging would bring me such varied and interesting professional opportunities.

Later in my career, through an American Psychological Association (APA) congressional fellowship, I was responsible for the aging legislative portfolio in the office of U.S. Senator Ron Wyden of Oregon. I then worked for the national mental health office of the U.S. Department of Veterans Affairs. Currently, I am on faculty in the Department of Geriatrics and Palliative Medicine at the Icahn School of Medicine at Mount Sinai and the Department of Counseling and Clinical Psychology at Teachers College, Columbia University, in New York City.

PSYCHOLOGY AND AGING

Unfortunately, my enthusiasm about aging has not been widely shared in psychology nor, for that matter, in most professional disciplines. Aging has been a hard sell, in part, I believe, because most individuals hold stereotypical and overly negative views of aging and older adults. Only 3% to 4% of psychologists have specialized training in aging (Hoge, Karel, Zeiss, Alegria, & Moye, 2015), which is not that different from other health and mental health professions (Bragg & Hansen, 2010). However, reflecting the growing U.S. population of older adults, almost 40% of psychologists now see some older adults in clinical practice (APA, 2016; Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002), despite that few of them have formal training related to aging.

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Only in the past 20 years has a field of geropsychology been substantively built. Therefore, until recently, few formal pathways have been available for those interested in becoming a geropsychologist. Similar challenges have existed for other mental health disciplines. When I entered psychology, a few clinical psychologists wrote of their work with older adults and expressed hope that the area would mature. The field of geropsychology—which has been variously known as “clinical aging,” “clinical geropsychology,” “applied aging,” and “professional geropsychology”—first built on the larger field of academic gerontology to inform its applied work.

Although the foundation of professional geropsychology sits on almost 100 years of the study of aging and the psychology of aging, it also rests on more recent efforts. Those efforts include three training conferences on how to prepare individuals to become geropsychologists (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009); APA (2014) guidelines on professional practice with older adults; APA’s designation of geropsychology as a specialty; a geropsychology specialty board within the American Board of Professional Psychology; the establishment of a number of geropsychology organizations within and outside of APA; and federal policy that includes psychiatry, psychology, social work, nursing, and others as eligible providers under Medicare, which pays the lion’s share of mental health services for older adults (Hinrichsen, 2010).

THE CHALLENGE OF BUILDING FOUNDATIONAL GEROPSYCHOLOGY AND AGING COMPETENCY FOR POSTLICENSURE PROFESSIONALS

Some professionals without training in aging who are seeing older adults in clinical practice would like to gain foundational knowledge in this area. The practical challenge is where to gain that knowledge. Psychologists have two key guiding documents: The Pikes Peak model for training in professional geropsychology (Knight et al., 2009) and the APA “Guidelines for Psychological Practice With Older Adults” (APA Guidelines; APA, 2014). I hasten to add that other disciplines have created those own professional statements about recommended areas for knowledge and skills for those who serve older adults alone or in collaboration with others (e.g., American Association of Colleges of Nursing, 2016; Association of Gerontology in Higher Education, 2014; Galambos, Greene, Kropf, & Cohen, 2018; Interprofessional Education Collaborative, 2016; Williams et al., 2010). The Pikes Peak model outlines three domains of competence that should inform training in

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geropsychology: attitudes, knowledge, and skills. The APA Guidelines outline similar content with which psychologists who practice with older adults are encouraged to be familiar. The practical question is: What is foundational among the many areas recommended in the Pikes Peak model and the APA Guidelines? In other words, where do you start? This issue became increasingly important as my colleagues and I created professional training workshops for psychologists, social workers, and other mental health professionals interested in building basic knowledge about aging.

To address this issue, my colleagues and I, who are members of the Council of Professional Geropsychology Training Programs (CoPGTP), created a survey. CoPGTP is an organization of programs that provide training in geropsychology consistent with the Pikes Peak model. CoPGTP includes programs on the educational continuum from graduate school to postlicensure education. We surveyed 149 geropsychologists and asked which competencies among the many in the Pikes Peak model were most important for a postlicensure psychologist new to the aging field to learn first in the equivalent of a 2-day continuing education workshop. Survey results included recommendations that these five competencies be included: (a) attitudes about older adults and aging; (b) general knowledge of adult development and aging; (c) knowledge of the foundations of clinical practice with older adults; (d) knowledge of the foundations of assessment; and (e) knowledge of intervention, consultation, and other service provision (Hinrichsen, Emery-Tiburcio, Gooblar, & Molinari, 2018). Our hope is that these recommendations will yield greater uniformity in how introductory workshops and other venues on mental health and aging are created as well as bring about practical guidance for individuals who seek to build knowledge in this area.

ABOUT THIS BOOK

Purpose

The content of this book reflects CoPGTP recommendations on foundational attitudes and knowledge competencies in geropsychology (Hinrichsen et al., 2018). I also believe that the content reflects aging-relevant content often recommended by other mental health disciplines. This book is a broad overview of what I and others consider to be critical information for those mental health practitioners without prior aging background who are serving some older adults in clinical practice. The book is a primer for those who want to learn the professional lay of the land in geropsychology. It is not

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intended to be exhaustive in its coverage. What I hope the book does, however, is pique the reader's interest in learning more about geropsychology and more generally about aging. The book is also informed by many years of experience in conducting introductory mental health and aging continuing education workshops for psychologists, social workers, and related disciplines. Postlicensure professionals often attend the workshops to gain continuing education credits and to learn more about this area of practice. Practitioners are busy people who want to learn information in a way that is clearly conveyed and that has practical utility. Workshop participants also want to know about my own and other presenters' experience in working with older adults: "What kind of problems do you usually see?" "What do you find that works best in addressing this problem?" "Can you give me a clinical example of that?" "What assessment measures do you find work best?" "What would you do differently now than you did in the past?" "How do I get paid for my services?" "What's a good book on this topic?"

To that end, I have integrated my own clinical observations and experience into this book. Another person writing this book would use different examples, likely provide different emphases, and recommend different preferred approaches. I hope, however, that with content guided by the CoPGTP recommendations on foundational attitude and knowledge competencies, we each would cover the same issues informed by contemporary research and professional practice, albeit in different ways. Another caveat is that although my more than 40 years in the field of aging has encompassed a wide range of experience with varied problems and subpopulations of older adults, it has not included the full range of settings and populations that exist. I have chiefly worked in outpatient mental health and primary care medical settings in urban areas. I have not worked in long-term care settings where some psychologists work. I have general familiarity with late-life cognitive issues but am not a neuropsychologist. Some mental health conditions I rarely treat and try to refer.

Structure

This book has seven chapters. The first two chapters examine attitudes toward aging and basic facts about and perspectives on the aging process. These chapters are not clinically focused, but I hope after you read them you will find them clinically relevant. Chapters 3 and 4 are general overviews of issues in assessment and treatment of older clients. Chapter 5 reviews assessment and treatment of depression and anxiety and Chapter 6 discusses assessment and treatment of cognitive impairment and problem alcohol use

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and prescription drug misuse. Why have I chosen to focus on these four problem areas and not others? These areas are most commonly encountered in clinical practice. As a primer, this book intends to address foundational issues, and I believe these four problem areas are critical to working with older people. Chapter 7 summarizes key themes of the book and offers practical recommendations for those interested in further building knowledge and skills relevant to geropsychology. I end with some personal reflections on aging.

At the beginning of each chapter, I note how the chapter covers foundational attitude and knowledge competencies recommended by CoPGTP (Hinrichsen et al., 2018) and reflects recommended content from the Pikes Peak model for training in professional geropsychology (Knight et al., 2009) and the APA Guidelines (APA, 2014). For some readers, this material may not be of interest because it “gets into the weeds” of specific content. Yet for those who are interested in developing continuing education workshops in the area or want more guidance on further professional development, this material should be helpful. For the record, material in this introduction reflects content from the Attitudes domain of the Pikes Peak model for training in professional geropsychology (Knight et al., 2009), including items 1 (Work with older adults within their scope of competence and to seek consultation to make appropriate referrals when indicated) and 4 (Increase knowledge, understanding, and skills with respect to working with older adults through continuing education, training, supervision, and consultation). It also reflects content of the APA Guidelines (APA, 2014), including Guideline 1 (Psychologists are encouraged to work with older adults within their scope of competence). A case example¹ illustrates each of the four mental health problems chosen as a focus in the book. I have tried to provide continuity in the book with one case, Mabel Brown, which is discussed in several chapters. I have also reiterated the theme “I wasn’t always this way,” which is derived from Mrs. Brown’s case throughout the book. It is a reminder that older adults seen in clinical practice have long and rich histories about which practitioners should be cognizant.

The volume includes two appendices. Appendix A summarizes resources listed by chapter. These resources include recommended books (“On My Bookshelf”), links to organizations or materials (“On My Favorite Links

¹In all case examples, names and clinical material have been altered to protect client confidentiality.

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Tab”), and a few scholarly articles (“An Article Worth Reading”). Appendix B includes a list of assessment instruments recommended in Chapters 3, 5, and 6 and provides information on how to obtain those instruments.

I loved writing this book. Throughout the writing, I was continually reminded of the contributions of my academic and practitioner colleagues who have built the field of aging, my many teachers, my open-hearted students, and the many extraordinary older adults I have met during my career. I hope that you will glean as much joy in professional work with older adults as I have.