
Guidelines for Psychological Practice With Older Adults

American Psychological Association

The “Guidelines for Psychological Practice With Older Adults” are intended to assist psychologists in evaluating their own readiness for working with older adults and in seeking and using appropriate education and training to increase their knowledge, skills, and experience relevant to this area of practice. *Older adults* typically refers to persons 65 years of age and older and is widely used by gerontological researchers and policymakers. We use *older adults* in this document since it is commonly used by geropsychologists and is the recommended term in American Psychological Association (APA) publications (APA, 2010b). The specific goals of these professional practice guidelines are to provide practitioners with (a) a frame of reference for engaging in clinical work with older adults and (b) basic information and further references in the areas of attitudes, general aspects of aging, clinical issues, assessment, intervention, consultation, professional issues, and continuing education and training relative to work with this group. 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. 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 Professional Geropsychology (APA, 2010c).

These professional practice guidelines are an update of the “Guidelines for Psychological Practice With Older Adults” originally developed by the Division 12, Section II (Society of Clinical Geropsychology) and Division 20 (Adult Development and Aging) Interdivisional Task Force on Practice in Clinical Geropsychology and approved as APA policy by the Council of Representatives in August 2003. The term *guidelines* refers to pronouncements, statements, or declarations that suggest or recommend specific professional 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 are not intended to be manda-

tory or exhaustive and may not be applicable to every clinical situation.

They should not be construed as definitive and are not intended to take precedence over the judgment of psychologists. Professional practice guidelines essentially involve recommendations to professionals regarding their conduct and the issues to be considered in particular areas of psychological practice. Professional practice guidelines are consistent with current APA policy. It is also 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, 2002a, 2010a). These guidelines were developed for use in the United States but may be appropriate for adaptation in other countries.

Need for the Guidelines

A revision of the guidelines is warranted at this time as psychological science and practice in the area of psychology and aging have evolved rapidly. Clinicians and researchers have made impressive strides toward identifying

This revision of the 2003 “Guidelines for Psychological Practice With Older Adults” was completed by the Guidelines for Psychological Practice With Older Adults Revision Working Group and approved as APA policy by the APA Council of Representatives in August 2013. Members of the Guidelines for Psychological Practice With Older Adults Revision Working Group were Gregory A. Hinrichsen (chair), Icahn School of Medicine at Mount Sinai; Adam M. Brickman, Columbia University; Barry Edelstein, West Virginia University; Tammi Vacha-Haase, Colorado State University; Kimberly Hiroto, Puget Sound Health Care System, U.S. Department of Veterans Affairs; and Richard Zweig, Yeshiva University.

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The literature cited herein does not reflect a systematic meta-analysis or review of the literature but rather was selected by the working group to emphasize clinical best practices. Care was taken to avoid endorsing specific products, tools, or proprietary approaches.

These guidelines are scheduled to expire as APA policy in February 2023. After this date, users are encouraged to contact the Office on Aging, APA Public Interest Directorate to determine whether this document remains in effect.

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the unique aspects of knowledge that facilitate the accurate psychological assessment and effective treatment of older adults as the psychological literature in this area has burgeoned.

As noted in the previous “Guidelines for Psychological Practice With Older Adults” (APA, 2004), professional psychology practice with older adults has been increasing, due both to the changing demography of the population and to changes in service settings 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 settings to 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 (Bogner, de Vries, Maulik, & Unützer, 2009; Institute of Medicine, 2012; Karlin, Duffy, & Gleaves, 2008; Klap, Unroe, & Unützer, 2003; Wang et al., 2005).

Unquestionably, the demand for psychologists with a substantial understanding of later-life wellness, cultural, and clinical issues will expand in future years as the older population grows and becomes more diverse and as cohorts of middle-aged and younger individuals who are receptive to psychological services move into old age (Karel, Gatz, & Smyer, 2012). However, psychologist time devoted to care of older adults does not and likely will not meet the anticipated need (Karel, Gatz, & Smyer, 2012; Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002). Indeed, across professions, the geriatric mental health care workforce is not adequately trained to meet the health and mental health needs of the aging population (Institute of Medicine, 2012).

Older adults are served by psychologists across subfields including clinical, counseling, family, geropsychology, health, industrial/organizational, neuropsychology, rehabilitation, and others. The 2008 APA Survey of Psychology Health Service Providers found that 4.2% of respondents viewed older adults as their primary focus and 39% reported that they provided some type of psychological services to older adults (APA, Center for Workforce Studies, 2008). Relatively few psychologists, however, have received formal training in the psychology of aging. Fewer than one third of APA-member practicing psychologists who conducted some clinical work with older adults reported having had 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). Many psychologists may be reluctant to work with older adults because they feel they do not possess the requisite knowledge and skills. In the practitioner survey conducted by Qualls et al., 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 two small surveys of psychology students, over half of those surveyed desired further education and training in this area, and 90% expressed interest in providing clinical services to older adults (Hinrichsen, 2000; Zweig, Siegel, & Snyder, 2006).

Compatibility

These guidelines build upon APA’s Ethics Code (APA, 2002a, 2010a) and are consistent with the “Criteria for Practice Guideline Development and Evaluation” (APA, 2002b) and preexisting APA policies related to aging issues. These policies include but are not limited to the “Resolution on Ageism” (APA, 2002d), the *Blueprint for Change: Achieving Integrated Health Care for an Aging Population* (APA, Presidential Task Force on Integrated Health Care for an Aging Population, 2008), the “Resolution on Family Caregivers” (APA, 2011), and the “Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change” (APA, 2012b).

The guidelines are also consistent with the efforts that psychology has exerted over the past decade to focus greater attention on the strengths and needs of older adults and to develop a workforce competent 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 Professional 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, Karel, Hinrichsen, Qualls, & Duffy, 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” (<http://www.copgtp.org>, para. 2). In 2010, the APA Commission on the Recognition of Specialties and Proficiencies in Professional Psychology recognized Professional Geropsychology as a specialty in professional psychology. Currently an initiative is underway to develop a geropsychology specialty through the American Board of Professional Psychology (ABPP). This will be one means to identify competent professional geropsychologists by a well-recognized credentialing body.

Within APA, the Office on Aging and the Committee on Aging 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 postlicensure. In the past decade, aging has been a major focus of three APA presidential initiatives: Sharon Stephens Brehm’s Integrated Health Care for an Aging Population initiative (<http://www.apa.org/pi/aging/programs/integrated/index.aspx>), Alan

Kazdin's Psychology's Grand Challenges: Prolonging Vitality initiative (<http://www.apa.org/research/action/gc-prolonging-vitality.pdf>), and Carol Goodheart's Family Caregivers initiative (<http://www.apa.org/pi/about/publications/caregivers/index.aspx>). 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 interest groups on aging and other efforts directed toward practice with older adults.

Development Process

In February 2012, the APA Policy and Planning Board, in accordance with Association Rule 30-8.4, provided notice to Division 20, Division 12, Section II, and the Office on Aging that on December 31, 2013, the APA "Guidelines for Psychological Practice With Older Adults" (APA, 2004) would expire. The Board of Professional Affairs and the Committee on Professional Practice and Standards then conducted a review and recommended that the guidelines should not be allowed to expire and that revision was appropriate. Upon notice of the guidelines' imminent expiration, the presidents of Division 20 and Division 12, Section II and the chair of APA's Committee on Aging made recommendations for members of the Guidelines for Psychological Practice With Older Adults Revision Working Group who represented multiple, diverse, constituent groups in the areas of practice (including independent practice), science, and multicultural diversity as well as early career psychologists and psychologists with experience in guideline development. The Committee on Aging's parent board, the Board for the Advancement of Psychology in the Public Interest, 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 Gregory A. Hinrichsen (chair), Adam M. Brickman, Barry Edelstein, Kimberly Hiroto, Tammi Vacha-Haase, and Richard Zweig. Working group members considered the recent relevant background literature as well as the references contained in the initial guidelines for inclusion in this 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.

Financial support for this effort was provided by the APA Council of Representatives, by Division 12, Section II, and by Division 20. No other 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 are organized into six sections: (a) competence and attitudes; (b) general knowledge about adult development, aging, and older adults; (c) clinical issues; (d) assessment; (e) intervention, consultation, and

other service provision; and (f) professional issues and education.

Competence in and Attitudes Toward Working With Older Adults

Guideline 1. Psychologists are encouraged to work with older adults within their scope of competence.

Training in professional psychology provides general skills that can be applied for the potential benefit of older adults. Many 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. For example, psychologists are often called upon to evaluate and/or assist older adults with life stress or crisis (Brown, Gibson, & Elmore, 2012) and adaptation to late-life issues (e.g., chronic medical problems affecting daily functioning; Qualls & Benight, 2007). Psychologists play an equally important role in facilitating the maintenance of healthy functioning, accomplishment of new life-cycle developmental tasks, and/or achievement of positive psychological growth in the later years (King & Wynne, 2004). Given some commonalities across age groups, considerably more psychologists may want to work with older adults, as many of their already existing skills can be effective with these clients (Molinari et al., 2003).

However, other problems may be more prevalent among older adults than younger adults (e.g., dementia, delirium), may manifest differently across the life span (e.g., anxiety, depression), or may require modifications to treatment approaches (e.g., pace of therapy; Knight, 2009; Pachana, Laidlaw, & Knight, 2010). In some circumstances, special skills and knowledge may be essential for assessing and treating certain problems in the context of later life (Pachana et al., 2010; Segal, Qualls, & Smyer, 2011; Zarit & Zarit, 2011).

Clinical work with older adults may involve a complex interplay of factors, including developmental issues specific to late 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, and history of medical or mental disorders (Arnold, 2008; Knight & Sayegh, 2010; Robb, Haley, Becker, Polivka, & Chwa, 2003; Segal, Coolidge, Mincic, & O'Riley, 2005). The potential interaction of these factors makes the field highly challenging and calls for psychologists to skillfully apply psychological knowledge and methods. Education and training in the biopsychosocial processes of aging along with an appreciation for and understanding of cohort factors can help psychologists ascertain the nature of the older adult's clinical issues. Additionally, consideration of the client's age, gender, cultural background, degree of health literacy, prior experience with mental health providers, resiliencies, and usual means of coping with life problems should inform interventions (Wolf, Gazmararian, & Baker, 2005). Thus, psychologists working with older

adults can benefit from specific preparation for clinical work with this population.

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 (Knight et al., 2009), this is not the case for most (Qualls et al., 2002). Having reviewed these guidelines, psychologists can match the extent and types of their work with their scope of competence (APA Ethics Code; APA, 2000a, 2010a) 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.

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, 2007). 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 supervisee (Karel, Emery, Molinari, & CoPGTP Task Force on the Assessment of Geropsychology Competencies, 2010; Karel, Holley, et al., 2012). The following guidelines, particularly Guideline 21, direct the reader to resources for psychologists interested in furthering their knowledge of aging and older adults.

Guideline 2. Psychologists are encouraged to recognize how their attitudes and beliefs about aging and about older individuals may be relevant to their assessment and treatment of older adults, and to seek consultation or further education about these issues when indicated.

Principle E of the APA Ethics Code (APA, 2002a, 2010a) urges psychologists to respect the rights, dignity, and welfare of all people and eliminate the effect of cultural and sociodemographic stereotypes and biases (including ageism) on their work. In addition, the APA Council of Representatives passed a resolution opposing ageism and committing the Association to its elimination as a matter of APA policy (APA, 2002c).

Ageism, a term first coined by R. N. Butler (1969), refers to prejudice toward, stereotyping of, and/or discrimination against people simply because they are perceived or defined as “old” (International Longevity Center, Anti-Ageism Task Force, 2006; Nelson, 2002, 2005; Robb, Chen, & Haley, 2002). Ageism has been evident among most health care provider groups, including marriage and family therapists (Ivey, Wieling, & Harris, 2000), social workers (Curl, Simons, & Larkin, 2005;

Kane, 2004), clinical psychology graduate students (Lee, Volans, & Gregory, 2003; Rosowsky, 2005), and health care providers to adults with Alzheimer’s disease (Kane, 2002). Attitudes toward older men and women differ in a manner that reflects the convergence of sexism and ageism (Kite & Wagner, 2002) and differentially impact older adults based on gender (Calasanti & Slevin, 2001; Chrisler, 2007). For example, cultural standards of beauty may be magnified for older women (Clarke, 2011) and create pressure on them to maintain a certain body and appearance consistent with a youthful image (Calasanti & Slevin, 2001). Ageist biases can foster a higher recall of negative traits regarding older persons than of positive ones and encourage discriminatory practices (Perdue & Gurtman, 1990; Emlet, 2006). Moreover, ageist attitudes can take multiple forms, sometimes discreet and often without intentional malice (Nelson, 2005). Even persons with severe dementia respond with behavioral resistance when spoken to in an infantilizing manner (Williams, Herman, Gajewski, & Wilson, 2009; Williams, Kemper, & Hummert, 2004).

There are many inaccurate stereotypes of older adults that can contribute to negative biases (Cuddy, Norton, & Fiske, 2005) and affect the delivery of psychological services (Knight, 2004, 2009). For example, stereotypes include the views that (a) with age inevitably comes dementia; (b) older adults have high rates of mental illness, particularly depression; (c) older adults are inefficient in the workplace; (d) most older adults are frail and ill; (e) older adults are socially isolated; (f) older adults have no interest in sex or intimacy; and (g) older adults are inflexible and stubborn (Edelstein & Kalish, 1999). These stereotypes are not accurate, since research has found that the vast majority of older adults are cognitively intact, have lower rates of depression than younger persons (Fiske, Wetherell, & Gatz, 2009), are adaptive and in good functional health (Depp & Jeste, 2006; Rowe & Kahn, 1997), and have meaningful interpersonal and sexual relationships (Carstensen et al., 2011; Hillman, 2012). In fact, many older adults adapt successfully to life transitions and continue to evidence personal and interpersonal growth (Hill, 2005). Older adults themselves can also harbor negative age stereotypes (Levy, 2009), and these negative age stereotypes have been found to predict an array of adverse outcomes such as worse physical performance (Levy, Slade, & Kasl, 2002), worse memory performance (Levy, Zonderman, Slade, & Ferrucci, 2012), and reduced survival (Levy, Slade, Kunkel, & Kasl, 2002). Subgroups of older adults may hold culturally consistent beliefs about aging processes that are different from mainstream biomedical and Western conceptions of aging (Dilworth-Anderson & Gibson, 2002). It is helpful for psychologists to take into account these differences when addressing an individual’s specific needs (Gallagher-Thompson, Haley, et al., 2003).

Negative stereotypes can become self-fulfilling prophecies and adversely affect health care providers’ attitudes and behaviors toward older adult clients. For example, stereotypes can lead health care providers to misdiagnose disorders (Mohlman et al., 2011), inappropriately lower

their expectations for the improvement of older adult clients (so-called “therapeutic nihilism”; Lamberty & Bares, 2013), and delay preventive actions and treatment (Levy & Myers, 2004). Providers may also misattribute older adults’ report of treatable depressive symptoms (e.g., lethargy, decreased appetite, anhedonia) to aspects of normative aging. Some psychologists unfamiliar with facts about aging may assume that older adults are too old to change (Ivey et al., 2000; Kane, 2004) or are less likely than younger adults to benefit from psychosocial therapies (Gatz & Pearson, 1988). What may seem like discriminatory behavior by some health providers toward older adults may be more a function of lack of familiarity with aging issues than discrimination based solely on age (James & Haley, 1995). For example, many psychologists still believe that with aging, those with schizophrenia do not show symptom improvement. However, research on older adults with schizophrenia reveals that positive symptoms of schizophrenia do abate with age (Harvey, Reichenberg, & Bowie, 2006).

Psychologists may also benefit from considering their own responses to working with older adults. Some health professionals may avoid serving older adults because such work evokes discomfort related to their own aging or relationships with parents or other older family members (Nelson, 2005; Terry, 2008). Additionally, working with older adults can increase professionals’ awareness of their own mortality, raise fears about their own future aging processes, and/or highlight discomfort discussing issues of death and dying (Nelson, 2005; Yalom, 2008). As well, it is not uncommon for therapists to take a paternalistic role with older adult patients who manifest significant functional limitations, even if the limitations are unrelated to their abilities to benefit from interventions (Sprenkel, 1999). Paternalistic attitudes and behavior can potentially compromise the therapeutic relationship (Horvath & Bedi, 2002; Knight, 2004; Nelson, 2005; Newton & Jacobowitz, 1999), affect cognitive and physical performance (Levy & Leifheit-Limson, 2009), and reinforce dependency (Balsis & Carpenter, 2006; M. M. Baltes, 1996). Seemingly positive stereotypes about older adults (e.g., that they are “cute,” “childlike,” or “grandparent-like”) are often overlooked in discussions of age-related biases (Brown & Draper, 2003; Edelman & Kalish, 1999). However, they can also adversely affect assessment of, therapeutic processes with, and clinical outcomes with older adults (Kimerling, Zeiss, & Zeiss, 2000; Zarit & Zarit, 2007).

Psychologists are encouraged to develop more realistic perceptions of the capabilities and strengths as well as vulnerabilities of this segment of the population. To reduce biases that can impede their work with older adults, it is important for psychologists to examine their attitudes toward aging and older adults and (since some biases may constitute “blind spots”) to seek consultation from colleagues or others, preferably those experienced in working with older adults.

General Knowledge About Adult Development, Aging, and Older Adults

Guideline 3. Psychologists strive to gain knowledge about theory and research in aging.

APA-supported training conferences have recommended that psychologists acquire familiarity 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 (Knight et al., 2009; Knight, Teri, Wohlford, & Santos, 1995; Santos & VandenBos, 1982). Most practicing psychologists will work with clients, family members, and caregivers of diverse ages. Therefore, a rounded preparatory education for anyone delivering services to older adults encompasses training with a life-span developmental perspective for which knowledge of a range of age groups including older adults is very useful (Abeles et al., 1998). APA accreditation criteria now require that students be exposed to the current body of knowledge in human development across the life span (APA, Commission on Accreditation, 2008, Section C).

Over the past 40 years, a substantial scientific knowledge base has developed in the psychology of aging, as reflected in numerous scholarly publications. *The Psychology of Adult Development and Aging* (Eisdorfer & Lawton, 1973), published by APA, was a landmark publication that laid out the current status of substantive knowledge, theory, and methods in psychology and aging. It was followed by numerous scholarly publications that provided overviews of advances in knowledge about normal aging as well as psychological assessment and intervention with older adults (e.g., Bengtson, Gans, Putney, & Silverstein, 2008; Lichtenberg, 2010; Schaie & Willis, 2011; Scogin & Shah, 2012). Extensive information on resource materials is now available for instructional coursework or self-study in geropsychology, including course syllabi, textbooks, videotapes, and literature references at various websites, among them those of APA Division 20 (<http://apadiv20.php.ufl.edu/>), the Council of Professional Geropsychology Training Programs (<http://www.copgtp.org/>), GeroCentral(www.gerocentral.org), and the APA Office on Aging (<http://www.apa.org/pi/aging/index.aspx>).

Training within a life-span developmental perspective includes 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), and research designs for adult development and aging (e.g., P. B. Baltes, Reese, & Nesselroade, 1988; Fingerman, Berg, Smith, & Antonucci, 2010). Longitudinal studies, in which individuals are followed over many years, permit observation of how individual trajectories of change unfold. Cross-sectional studies in which individuals of different ages are compared allow age groups to be compared.

However, individuals are inextricably bound to their own time in history. That is, people are born, mature, and grow old within a given generational cohort. Therefore, it is useful to combine longitudinal and cross-sectional methods to differentiate which age-related characteristics reflect change over the life span and which reflect differences due to historical time (Schaie, 1977, 2011). For example, compared with young adults, some older adults may be less familiar with using technology, such as computerized testing. Understanding the influence of an older adult's cohort aids in understanding the individual within his or her cultural context (Knight, 2004; see Guideline 5 for further discussion, as well as Yeo, 2001, "Curriculum in Ethnogeriatrics").

There are a variety of conceptions of "successful" late adult development (see Bundick, Yeager, King, & Damon, 2010). Inevitably, aging includes the need to accommodate to physical changes, functional limitations, and other changes in psychological and social functioning, although there are significant individual differences in the onset, course, and severity of these changes. The majority of older adults adapt successfully to these changes. Several models that explain adaptation in later life have been proposed in recent years, with considerable empirical support for each (see Geldhof, Little, & Colombo, 2010; Staudinger & Bowen, 2010). A related life-span developmental perspective is that despite biological decrements associated with aging, the potential exists for positive psychological growth and maturation in late life (Gutmann, 1987; Hill, 2005). A life-span developmental perspective informs the work of practitioners as they draw upon psychological and social resilience built during the course of life to effectively address current late-life problems (Anderson, Goodman, & Schlossberg, 2012; Knight, 2004).

Guideline 4. Psychologists strive to be aware of the social/psychological dynamics of the aging process.

As part of the broader developmental continuum of the life span, aging is a dynamic process that challenges the aging individual to make continuing behavioral adaptations (Labouvie-Vief, Diehl, Jain, & Zhang, 2007). Just as younger individuals' developmental pathways are shaped by their ability to adapt to normative early life transitions, so are older individuals' developmental trajectories molded by their ability to contend successfully with normative later life transitions such as retirement (Sterns & Dawson, 2012), residential relocations, changes in relationships with partners or in sexual functioning (Hillman, 2012; Levenson, Carstensen, & Gottman, 1993; Matthias, Lubben, Atchison, & Schweitzer, 1999), and bereavement and widowhood (Kastenbaum, 1999), as well as non-normative experiences such as traumatic events (Cook & Elmore, 2009; Cook & O'Donnell, 2005) and social isolation and loneliness. Clinicians who work with older adults strive to be knowledgeable of issues specific to later life, including grandparenting (Hayslip & Kaminski, 2005), adaptation

to typical age-related physical changes such as health problems and disability (Aldwin, Park, & Spiro, 2007; Schulz & Heckhausen, 1996), and a need to integrate or come to terms with one's personal lifetime of aspirations, achievements, and failures (R. N. Butler, 1969).

Among the special stresses of later adulthood are a variety of losses ranging from those of persons, objects, animals, roles, belongings, independence, health, and financial well-being. These losses may trigger problematic reactions, particularly in individuals predisposed to depression, anxiety, or other mental disorders. Because these losses are often multiple, their effects can be cumulative. Nevertheless, many older adults challenged by loss find unique possibilities for achieving reconciliation, healing, or deeper wisdom (P. B. Baltes & Staudinger, 2000; Bonanno, Wortman, & Nesse, 2004; Sternberg & Lubart, 2001). Moreover, the vast majority of older people maintain positive emotions, improve their affect regulation with age (Charles & Carstensen, 2010), and express enjoyment and high life satisfaction (Charles, 2011; Scheibe & Carstensen, 2010). It is similarly noteworthy that despite the aforementioned multiple stresses, older adults have a lower prevalence of psychological disorders (other than cognitive disorders) than do younger adults (Gum, King-Kallimanis, & Kohn, 2009). In working with older adults, psychologists may find it useful to remain cognizant of the strengths that many older people possess, the many commonalities they retain with younger adults, the continuity of their senses of self over time, and the opportunities for using skills and adaptations they developed over their life spans for continued psychological growth in late life.

Late-life development is characterized by both stability and change (P. B. Baltes, 1997). For example, although personality traits demonstrate substantial stability across the life span (Lodi-Smith, Turiano, & Mroczek, 2011; McCrae et al., 2000), growing evidence suggests that there is a greater degree of plasticity of personality across the second half of life than was previously believed (Costa & McCrae, 2011; Roberts, Walton, & Viechtbauer, 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 (O'Rourke, Cappeliez, & Claxton, 2011; Webster, 1995). Later-life family, intimate, friendship, and other social relations (Blieszner & Roberto, 2012) and intergenerational relationships (Bengtson, 2001; Fingerma, Brown, & Blieszner, 2011) are integral to sustaining well-being in older adulthood.

There is considerable empirical evidence that aging typically brings a heightened awareness that one's remaining time and opportunities are limited (Carstensen, Isaacowitz, & Charles, 1999). With this shortened time horizon, older adults are motivated to place increasing emphasis on emotionally meaningful goals. 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., 2011). Families and other support systems are thus critical in the lives of most older adults (Antonucci, Birdett, & Ajrouch, 2011). Working with older adults often involves their families and other supports—or sometimes their absence (APA, Presidential Task Force on Integrated Health Care for an Aging Population, 2008). Psychologists often appraise carefully older adults' social supports (Edelstein, Martin, & Gerolimatos, 2012; Hinrichsen & Emery, 2005) and are mindful of the fact that the older adult's difficulties may have an impact on the well-being of involved family members. With this information they may seek solutions to the older person's concerns that strike a balance between respecting their dignity and autonomy and recognizing the views of others about their need for care (see Guideline 19).

Though the individuals who care for older adults are often family members related by blood ties or marriage, increasingly psychologists may encounter complex, varied, and nontraditional relationships including lesbian, gay, bisexual and transgender partners, step-family members, and fictive kin as part of older adults' patterns of intimacy, residence, and support. This document uses the term *family* broadly to include all such relationships and recognizes that continuing changes in this context are likely in future generations. Awareness of and training in these issues can be useful to psychologists in dealing with older adults with diverse family relationships and supports.

Guideline 5. Psychologists strive to understand diversity in the aging process, particularly how sociocultural factors such as gender, race, ethnicity, socioeconomic status, sexual orientation, disability status, and urban/rural residence may influence the experience and expression of health and of psychological problems in later life.

The older adult population is highly diverse and is expected to become even more so in coming decades (Administration on Aging, 2011). The heterogeneity among older adults surpasses that seen in other age groups (Cosentino, Brickman, & Manly, 2011; Crowther & Zeiss, 2003). Psychological issues experienced by older adults may differ according to factors such as age cohort, gender, race, ethnicity and cultural background, sexual orientation, rural/frontier living status, education and socioeconomic status, and religion. 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, 2010). For example, clinical presentations of symptoms and syndromes may reflect interactions among these factors and type of clinical setting or living situation (Gatz, 1998; Knight & Lee, 2008).

As noted in Guideline 3, an important factor to take into account when providing psychological services to older adults is the influence of cohort or generational is-

ues. Each generation has unique historical circumstances that shape that generation's collective social and psychological perspectives throughout the life span. For example, generations that came of age during the first half of the 20th century may hold values of self-reliance (Elder, Clipp, Brown, Martin, & Friedman, 2009; Elder, Johnson, & Crosnoe, 2003) more strongly than later cohorts. These formative values may influence attitudes toward mental health issues and professionals. As a result, 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, Gatz, & Smyer, 2012). Emerging cohorts of older adults (e.g., "baby boomers") are likely to 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 (Knight & Lee, 2008).

A striking demographic fact of late life is the preponderance of women surviving to older ages (Administration on Aging, 2011; Kinsella & Wan, 2009), which infuses aging with gender-related issues (Laidlaw & Pachana, 2009). Notably, because of the greater longevity of women, the older client is more likely to be a woman than a man. This greater longevity has many ramifications. For example, it means that 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, 2007b). 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 their male counterparts (Whitbourne & Whitbourne, 2012). Financial instability may be particularly salient for the growing numbers of female grandparents raising grandchildren (Fuller-Thompson & Minkler, 2003).

Older men may have an experience of aging that is different from that of women (Vacha-Haase, Wester, & Christianson, 2010). For example, due to social norms prevalent during their youth, some men may want to appear strong and in control, and 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, London, & Parker, 2010). These issues have practice implications, as older men may be less willing to seek help for mental health challenges (Mackenzie, Gekoski, & Knox, 2006) and more reluctant to participate in treatment. Therefore, awareness of issues germane both to older women (Trotman & Brody, 2002) and older men (Vacha-Haase et al., 2010) enhances the process of assessing and treating them.

It is critical also to consider the pervasive influence of cultural factors on the experience of aging (Tazeau, 2011; Tsai & Carstensen, 1996; Whitfield, Thorpe, & Szanton, 2011; Yeo & Gallagher-Thompson, 2006). The population

of older adults today is predominantly White, but by the year 2050, non-White minorities will represent one third of all older adults in the United States (Administration on Aging, 2011). Historical and cultural factors, such as the experience of bias and prejudice, may influence the identities of minority older adults and thereby affect their experience of aging and patterns of coping. Many older minority persons faced discrimination and were denied access to quality education, jobs, housing, health care, and other services. As a result, many older minority persons have fewer economic resources than older majority persons, although this may change in future generations. For example, more than half of African American and Latino older adults are economically insecure (Meschede, Sullivan, & Shapiro, 2011). Being a member of a minority and being older is sometimes referred to as “double jeopardy” (Ferraro & Farmer, 1996). As a consequence of these and other factors (such as education and income disparities), minority older adults have more physical health problems than do majority-group older adults, and they often delay or refrain from accessing needed health and mental health services, which may in part be attributable to a historical mistrust of the mental health and larger health care system (APA, Committee on Aging Working Group on Multicultural Competency in Geropsychology, 2009; Iwasaki, Tazeau, Kimmel, Baker, & McCallum, 2009; Kelley-Moore & Ferraro, 2004; President’s New Freedom Commission on Mental Health, 2003). Other factors tied to older minority group status, including degree of health literacy, satisfaction with and attitudes toward health care, and adherence to medical regimens, are associated with differential health outcomes (APA, 2007a).

In addition to ethnic and minority older adults, there are older adults who are members of sexual minorities, including persons identifying as lesbian, gay, bisexual, and transgender (LGBT; David & Cernin, 2008; Fassinger & Arseneau, 2007; Kimmel, Rose, & David, 2006). It is important to be mindful that identity as a sexual minority intersects with other aspects of identity (e.g., gender, race, ethnicity, disability status). LGBT persons have often suffered discrimination from the larger society (David & Knight, 2008), including the mental health professions, which previously labeled sexual variation as psychopathology and utilized psychological and biological treatments to try to alter sexual orientation. As with other minority groups, discriminatory life experiences can negatively result in health disparities. Guideline 13 of APA’s “Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Clients” (APA, 2012c) discusses particular challenges faced by older adults of this minority status.

Aging presents special issues for individuals with developmental or acquired disabilities (e.g., mental retardation, autism, cerebral palsy, seizure disorders, spinal cord injury, traumatic brain injury) as well as physical impairments such as blindness, deafness, and musculoskeletal impairments (APA, 2012a; Janicki & Dalton, 1999; Rose, 2012). Given available supports, life expectancy for persons with serious disability may approach or equal that of the general population (Davidson, Prasher, & Janicki,

2008; McCallion & Kolomer, 2008). Many chronic impairments may affect risk for and presentation of psychological problems in late life (Tsiouris, Prasher, Janicki, Fernando, & Service, 2011; Urv, Zigman, & Silverman, 2008) and/or may have implications for psychological assessment, diagnosis, and treatment of persons who are aging with these conditions (APA, 2012a).

Aging is also a reflection of the interaction of the person with the environment (Wahl, Fange, Oswald, Gitlin, & Iwarsson, 2009; Wahl, Iwarsson, & Oswald, 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 (Guralnick, Kemele, Stamm, & Greiving, 2003; Morthland & Scogin, 2011). Older adults living in rural areas also have less access to community mental health services and to mental health specialists in nursing homes compared with those not residing in rural areas (Averill, 2012; Coburn & Bolda, 1999). Recent models that draw upon standardized treatments (Gellis & Bruce, 2010) and telehealth technologies (Richardson, Frueh, Grubaugh, Egede, & Elhai, 2009) have begun to expand access to mental health care for homebound and rural older adults.

Guideline 6. Psychologists strive to be familiar with current information about biological and health-related aspects of aging.

In working with older adults, psychologists are encouraged to be informed about the normal biological changes that accompany aging. Though there are considerable individual differences in these changes, with advancing age the older adult almost inevitably experiences changes in sensory acuity, physical appearance and body composition, hormone levels, peak performance capacity of most body organ systems, and immunological responses and increased susceptibility to illness (Masoro & Austad, 2010; Saxon, Etten, & Perkins, 2010). Disease accelerates age-related decline in sensory, motor, and cognitive functioning, whereas lifestyle factors may mitigate or moderate the effects of aging on functioning. Such biological aging processes may have significant hereditary or genetic components (McClearn & Vogler, 2001) about which older adults and their families may have concerns. Adjusting to age-related physical change is a core task of the normal psychological aging process (Saxon et al., 2010). Fortunately, lifestyle changes, psychological interventions, and the use of assistive devices can often lessen the burden of some of these changes. When older clients discuss concerns about their physical health, most often they involve memory impairment, vision, hearing, sleep, continence, and energy levels or fatigability.

It is useful for the psychologist 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.

When the older adult is dealing with physical health problems, the practitioner may help the older adult cope with physical changes and manage chronic disease (Knight, 2004). Most older adults have multiple chronic health conditions (Federal Interagency Forum on Aging-Related Statistics, 2012), each requiring medication and/or management. The most common chronic health conditions of late life include arthritis, hypertension, hearing impairments, heart disease, and cataracts (Federal Interagency Forum on Aging-Related Statistics, 2012). Other common medical illnesses include diabetes, osteoporosis, vascular diseases, neurological diseases (including stroke), and respiratory diseases. Many of these physical conditions have associated mental health problems (C. Butler & Zeman, 2005; Frazer, Leicht, & Baker, 1996; Lyketsos, Rabins, Lipsey, & Slavney, 2008), either through physiological contributions (e.g., poststroke depression) or in reaction to disability, pain, or prognosis (Frazer et al., 1996).

Because older adults frequently take medications for health problems, it is useful to have knowledge about common pharmacological interventions for mental and physical disorders in later life. Knowledge of the medications would include, for example, familiarity with prescription terminology (e.g., “prn”), brand and generic names of commonly used medications, common side effects of these medications, classes of medications, drug interactions, and age-related differences in the pharmacodynamics and pharmacokinetics of these medications (Koch, Gloth, & Nay, 2010). Many older adults with mental disorders who are seen for assessment or treatment by psychologists are prescribed psychotropic medications (Mojtabai & Olfson, 2008; Olfson & Marcus, 2009). Although pharmacological treatment of older adults with mental disorders is a common and often effective treatment for depression (Beyer, 2007), anxiety (Wolitzky-Taylor, Castriotta, Lenze, Stanley, & Craske, 2010), and psychosis (Chan, Lam, & Chen, 2011), adverse side effects of these medications are common and potentially harmful. Adverse effects are particularly common for older adults with dementia. For example, safety concerns have been raised in recent years about prescribing antipsychotic medications to older adults with dementia because they face increased risk of stroke and transient ischemic events with atypical antipsychotic use and of death with both atypical and conventional antipsychotic medications (Huybrechts, Rothman, Silliman, Brookhart, & Schneeweiss, 2011; Jin et al., 2013).

According to the National Center for Health Statistics (2011), 18% of older adults reported use of prescription pain relievers, and 12% of older women and 7% of older men reported taking antianxiety medications, hypnotics, and prescription sedatives during the past month. Older women are at greater risk of misusing antianxiety medications (including benzodiazepines) as well as of using them for longer periods of time than are older men. Long-term use of these medications is not recommended, particularly for older people (Blazer, Hybels, Simonsick, & Hanlon, 2000; Gray, Eggen, Blough, Buchner, & LaCroix, 2003). Given that adults 60 years of age and older fill more than a dozen prescriptions per year (Wilson et al., 2007), sig-

nificant problems can develop from use of multiple medications (Arnold, 2008). Increased awareness and interventions aimed at reducing exposure and minimizing the risks associated with medications and their interactions in older adults are important, especially in long-term care settings (Hines & Murphy, 2011).

Psychologists may help older adults with lifestyle and behavioral issues in maintenance or improvement of health, such as nutrition, diet, and exercise (Aldwin, Park, & Spiro, 2007) and the treatment of sleep disorders (McCurry, Logsdon, Teri, & Vitiello, 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, Yancura, & Boeninger, 2007). Other health-related issues include prevention of falls and associated injury (World Health Organization, 2007) and management of incontinence (Markland, Vaughan, Johnson, Burgio, & Goode, 2011). Older adults struggling to cope with terminal illness can also benefit from psychological interventions (Doka, 2008). Clinical health psychology approaches have great potential for contributing to effective and humane geriatric health care and improving older adults' functional status and health-related quality of life (Aldwin, Park, & Spiro, 2007).

A related issue is that while many older adults experience some changes in sleep, it is often difficult to determine whether these are age-related or stem from physical health problems, mental health problems, or other causes (Trevorrow, 2010). Sleep can often be improved by implementing simple sleep hygiene procedures and by behavioral treatment, including relaxation, cognitive restructuring, and stimulus control instructions (Ancoli-Israel & Ayalon, 2006; Dillon, Wetzler, & Lichstein, 2012).

Clinical Issues

Guideline 7. Psychologists strive to be familiar with current knowledge about cognitive changes in older adults.

Numerous reference volumes offer comprehensive coverage of research on cognitive aging (e.g., Craik & Salthouse, 2007; Park & Schwarz, 2000; Salthouse, 2010; Schaie & Willis, 2011). 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 an underlying neurodegenerative condition versus normal developmental changes. Further, several moderating and mediating factors contribute to age-associated cognitive changes within and across individuals.

For most older adults, age-associated changes in cognition are mild and do not significantly interfere with daily functioning. 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 and vocabulary, wisdom, reasoning, and other skills that rely primarily on stored information and knowledge (P. B. Baltes, 1993). Older

adults remain capable of new learning, though typically at a somewhat slower pace than younger individuals.

However, many older adults do experience change in cognitive abilities. There is evidence that executive abilities (e.g., planning and organizing information) show a greater amount of change relative to other domains (West, 1996). Psychomotor slowing, reduction in overall speed of information processing, and a reduction in motor control abilities are other changes commonly associated with normal aging (Salthouse, 1996; Sliwinski & Buschke, 1999). The changes likely reflect subtle nonspecific, widespread cortical and subcortical dysfunction. Attention is also affected, particularly the ability to divide attention, shift focus rapidly, and deal with complex situations (Glisky, 2007). Memory functioning refers to implicit or explicit recall of recently and distantly encoded information. Several aspects of memory show decline with normal aging (Brickman & Stern, 2009). 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 in which the response to a probe has been influenced by a previous exposure to a stimulus).

Many factors influence cognition and patterns of maintenance or decline in intellectual performance in old age, including genetic, health, sensory, personality, poverty, discrimination and oppression, affective, and other variables. Sensory deficits, particularly vision and hearing impairments, often impede and limit older adults' cognitive functioning (Glisky, 2007). Cardiovascular disease may impair cognitive functioning, as may certain medications used to treat illnesses common in later life (Bäckman et al., 2003; Waldstein, 2000). 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, psychological factors may influence older adults' cognition. Examples include affective state, sense of control and self-efficacy (Fuller-Iglesias, Smith, & Antonucci, 2009), active use of information-processing strategies, and continued practice of existing mental skills (Schooler, Mulatu, & Oates, 1999).

In recent years, there has been an increased recognition that lifestyle factors can impact cognition in late life. Maintenance of vascular health has a clearly established impact on physical well-being and has been found to affect cognitive health as well. High blood pressure, diabetes, a history of smoking, heart disease, and obesity have each been linked with suboptimal cognitive aging and to increased risk for neurodegenerative conditions such as Alzheimer's disease (Barnes & Yaffe, 2011). On the other hand, engagement in aerobic exercise, engagement in cognitively stimulating activities, and adherence to a Mediterranean-style diet (Scarmeas et al., 2009;

Wilson et al., 2002) may have benefits for cognitive aging.

An appreciable minority of older adults suffers significantly impaired cognition that impacts functional abilities. Under current clinical conceptualization (*Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision; American Psychiatric Association, 2000; McKhann et al., 1984), a diagnosis of dementia is made when cognitive impairment develops and is severe enough to impact basic or instrumental activities of daily living. The prevalence of dementia increases dramatically with age, with approximately 5% of the population between ages 71 and 79 years and 37% of the population above age 90 suffering with this condition (Plassman et al., 2007). The most common causes of dementia are Alzheimer's disease and cerebrovascular disease. Alzheimer's disease refers to the presence of characteristic brain pathology (i.e., plaques and tangles) that ultimately results in dementia. While impairment in delayed recall is a hallmark of the cognitive symptoms of Alzheimer's disease, the illness can present quite variably, and other neurodegenerative disorders may have similar symptoms. Among individuals with mild impairment, disproportionate deficits in visuospatial or executive functions may indicate other etiologies. Dementia due to Lewy bodies, Parkinson's disease, and multiple sclerosis is also relatively common. Less common causes of dementia include frontotemporal lobe degeneration, progressive supranuclear palsy, cortico-basal degeneration, Creutzfeldt Jakob disease, chronic traumatic encephalopathy, and others. The current clinical standard is to diagnose Alzheimer's disease syndromically: Individuals with progressive cognitive impairment in memory functioning and at least one other cognitive domain coupled with functional impairment and the absence of other pathologic features that can fully explain the syndrome meet diagnostic criteria (McKhann et al., 1984). Based on decades of research into the biology of Alzheimer's disease, there has been a greater appreciation of the cascade of biological changes that may be responsible for the dementia syndrome associated with the disease (Jack et al., 2010). In 2012 the U.S. Food and Drug Administration approved the use of amyloid positron emission tomography (PET) imaging for use in Alzheimer's disease diagnosis (Garber, 2012). Psychologists strive to understand the biological changes related to Alzheimer's disease and other causes of dementia and their associated neuropsychological and neuropsychiatric symptoms.

Some older adults experience significant cognitive decline that is greater than what would be expected for normal aging but is not severe enough to impact functional abilities. The term *mild cognitive impairment* (MCI) is typically applied to describe these individuals. MCI can be subdivided into various subtypes (e.g., amnesic versus nonamnesic, single vs. multiple domains affected) that may have some prognostic utility with respect to future cognitive decline and underlying etiology (Winblad et al., 2004). There also are numerous

biological and psychological causes of cognitive impairment in old age that may be reversible (e.g., medications, thyroid disorders, vitamin B12 deficiency, depression, systemic inflammatory disorders; Ladika & Gurevitz, 2011). Similarly, acute confusional states (delirium) 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 (Inouye, 2006).

Cognitively impaired older adults require considerable assistance from family members; and it is well established that those family members are often highly stressed and require ongoing support and access to community resources (APA, 2011; APA, Presidential Task Force on Caregivers, 2011).

Guideline 8. Psychologists strive to understand the functional capacity of older adults in the social and physical environment.

Most older adults maintain high levels of functioning, suggesting that factors related to health, lifestyle, and the match between functional abilities and environmental demands more powerfully determine performance than does age (P. B. Baltes, Lindenberger, & Staudinger, 2006; Lichtenberg, 2010). Functional ability and related factors weigh heavily in decisions older adults 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 (Sterns & Dawson, 2012). However, the accumulation of health problems and their effect on functioning may make that difficult for some older adults. Changes in functional abilities may impact other aspects of older adults' lives. Intimate relationships may become strained by the presence of health problems in one or both partners. Discord among adult children may be precipitated or exacerbated because of differing expectations about how much care each child should provide to the impaired parent (Qualls & Noecker, 2009). Increasing needs for health care can be frustrating for older adults because of demands on time, finances, transportation, and lack of communication among care providers.

The degree to which the older individual retains or does not retain "everyday competence" (i.e., the ability to function independently vs. rely on others for basic self-care; Knight & Losada, 2011; Smith & Baltes, 2007) determines the need for supports in the living environment. In adding supports in the older adult's 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 indicate the need for home health care. Some 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 should be provided, racial and cultural differ-

ences between care provider and recipient, or beliefs that family members are the only acceptable caregivers. Theoretical perspectives on person–environment fit (Wahl et al., 2009) have considerable applicability when an older adult evidences functional decline. For example, some older adults with mild cognitive or functional impairment successfully adapt to environments that impose few demands on them. As an older adult's functional ability declines, the environment becomes increasingly important in maximizing their functioning and maintaining their quality of life (Lawton, 1989; Wahl et al., 2012).

Changes in functional capacity may prompt changes in social roles and may place an emotional strain on both the individual and the family members involved in his or her care (Qualls & Zarit, 2009; Schulz & Martire, 2004). Older adults and their family members often confront difficult decisions about whether the older person with waning cognitive ability can manage finances, drive, live independently, manage medications, and many other issues (Marson, Hebert, & Solomon, 2011). Caregivers often experience high levels of stress and are at increased risk for depression, anxiety, anger, and frustration (APA, 2011; Gallagher-Thompson, Coon, et al., 2003), as well as compromised immune system function (Fagundes, Gillie, Derry, Bennett, & Kiecolt-Glaser, 2012), although research suggests certain cultural values and beliefs may decrease perceived caregiver burden (Aranda & Knight, 1997). Similarly, older adults who are responsible for others (e.g., aging parents of adult offspring with longstanding disabilities or severe mental disorders) may need to arrange for their dependents' future care (Davidson et al., 2008). Older grandparents who assume primary responsibility for raising their grandchildren face the strains (as well as potential rewards) of late-life parenting (Fuller-Thomson, Minkler, & Driver, 1997; Hayslip & Goodman, 2008).

Even older adults who remain in relatively good cognitive and physical health are witness to a changing social world as older family members and friends experience health declines (Fingerman & Birditt, 2011). Relationships change, access to friends and family becomes more difficult, and demands to provide care to others increase. Many individuals subject to caregiving responsibilities and stresses are themselves older adults, who may be contending with physical health problems and psychological adjustment to aging. The death of friends and older family members is something many older people experience (Ramsey, 2012). The oldest old (those 85 years and older) sometimes find they are the only surviving members of the age peers they have known. These older people must deal not only with the emotional ramifications of these losses but also with the practical challenges of how to reconstitute a meaningful social world. For some older adults, spirituality and other belief systems may be especially important in contending with these losses (McFadden, 2010; Ramsey, 2012).

Guideline 9. 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.

Most older people have good mental health. However, prevalence estimates suggest that approximately 20%–22% of older adults may meet criteria for some form of mental disorder, including dementia (Jeste et al., 1999; Karel, Gatz, & Smyer, 2012). Older women have higher rates of certain mental disorders (e.g., depression) than do men (Norton et al., 2006), with research continuing to support a slightly lower subjective well-being for older women when compared to their male counterparts, most likely due to disadvantages older women experience in regard to health, socioeconomic status, and widowhood (Pinquart & Sörensen, 2001). For those living in a long-term care setting during their later years, estimates are much higher, with almost 80% suffering from some form of mental disorder (Conn, Herrmann, Kaye, Rewilak, & Schogt, 2007). Older adults may present a broad array of psychological issues for clinical attention. These issues include almost all of the problems that affect younger adults. In addition, older adults may seek or benefit from psychological services when they experience challenges specific to late life, including developmental issues and social changes. Some problems that rarely affect younger adults, notably, dementias due to degenerative brain diseases and stroke, are much more common in old age (see Guideline 7).

Older adults may suffer recurrences of psychological disorders they experienced when younger (Hyer & Sohnle, 2001; Whitbourne & Meeks, 2011) or develop new problems because of the unique stresses of old age or neuropathology. Other older persons have histories of chronic mental illness or personality disorder, the presentation of which may change or become further complicated because of cognitive impairment, medical comorbidity, polypharmacy, and end-of-life issues (Feldman & Periyakoil, 2006; King, Heisel, & Lyness, 2005; Zweig & Agronin, 2011). Indeed, those older adults with serious mental illness present particular assessment and intervention challenges in part due to reduced social support in their later years that may result in homelessness and inappropriate admission to long-term care facilities (Depp, Loughran, Vahia, & Molinari, 2010; Harvey, 2005). Among older adults seeking health services, depression and anxiety disorders are common, as are adjustment disorders and problems stemming from inadvertent misuse of prescription medications (Gum et al., 2009; Reynolds & Charney, 2002; Wetherell, Lenze, & Stanley, 2005). Suicide is a particular concern in conjunction with depression in late life, as suicide rates in older adults—particularly, older White males—are among the highest of any age group (Heisel & Duberstein, 2005; Kochanek, Xu, Murphy, Miniño, & Kung, 2012; see Guideline 16). As noted earlier, cogni-

tive disorders including Alzheimer's disease are also commonly seen among older adults who come to clinical attention. The vast majority of older adults with mental health problems seek help from primary medical care settings, rather than in specialty mental health facilities (Areán et al., 2005; Gum et al., 2006).

Older adults often have concurrent health and mental health problems. Mental disorders may coexist with each other in older adults (e.g., those with a mood disorder who also manifest concurrent substance abuse or personality pathology; Segal, Zweig, & Molinari, 2012). Likewise, older adults suffering from dementia typically evidence coexistent psychological symptoms, which may include depression, anxiety, paranoia, and behavioral disturbances. Because chronic diseases are more prevalent in old age than in younger years, mental disorders are often comorbid and interactive with physical illness (Aldwin, Park, & Spiro, 2007; Karel, Gatz, & Smyer, 2012). Being alert to comorbid physical and mental health problems is a key concept in evaluating older adults. Further complicating the clinical picture, many older adults receive multiple medications and have sensory or motor impairments. All of these factors may interact in ways that are difficult to disentangle diagnostically. For example, sometimes depressive symptoms in older adults are caused by physical illnesses (Frazer et al., 1996; Weintraub, Furlan, & Katz, 2002). At other times, depression is a response to the experience of physical illness. Depression may increase the risk that physical illness will recur and reduce treatment adherence or otherwise dampen the outcomes of medical care. Growing evidence links depression in older adults to increased mortality not attributable to suicide (Schulz, Martire, Beach, & Scherer, 2000).

Some mental disorders such as depression and anxiety may have unique presentations in older adults and are frequently comorbid with other mental disorders. For example, late-life depression may coexist with cognitive impairment and other symptoms of dementia or may be expressed in forms that lack overt manifestations of sadness (Fiske et al., 2009). 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, or a combination of disorders. 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, or spiritual crises.

Anxiety disorders, while relatively common in older adults, are less prevalent than in younger populations and are not part of normal aging (Wolitzky-Taylor et al., 2010). Although older adults tend to present anxiety symptoms that are similar to those of younger adults, the content of older adults' fears and worries tends to be age-related (e.g., health concerns; Stanley & Beck, 2000). Some have found that older adults who present with panic disorder or post-traumatic stress disorder tend to exhibit patterns of symptoms (e.g., fewer arousal symptoms or more intrusive recollections, respectively) that differ from those of younger

adults (Lauderdale, Cassidy-Eagle, Nguyen, & Sheikh, 2011). Further, while first onset of an anxiety disorder in older adulthood is uncommon, this may be true for some anxiety disorders (e.g., panic disorder, social phobia) more than others (e.g., generalized anxiety disorder, posttraumatic stress disorder; Stanley & Beck, 2000; Wolitzky-Taylor et al., 2010). As is the case with depression, anxiety symptoms in older persons often coexist with and may be difficult to distinguish from symptoms attributable to coexisting 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 physical recovery. Further, recent research suggests that the common co-occurrence of anxiety with depression may slow treatment response for depressed older adults (Andrescu et al., 2009) and that even subthreshold levels of anxiety symptoms may be the fruitful focus of clinical efforts (Wolitzky-Taylor et al., 2010).

Substance abuse is an issue that often comes to clinical attention in work with older adults (Blow, Oslin, & Barry, 2002; Institute of Medicine, 2012). Almost half of all older adults drink alcohol, and 3.8% of older adults living in the community report binge drinking (Institute of Medicine, 2012). All older adults are at increased risk for alcohol-related problems due to age-related physiological changes; however, women at all ages tend to be more susceptible than men to the physical effects of alcohol (Blow & Barry, 2002; Epstein, Fischer-Elber, & Al-Otaiba, 2007). Approximately 2.2% of older men and 1.4% of older women report using illicit drugs such as cocaine, heroin, and marijuana in the past year, and this rate is expected to increase as the baby boomers age (Institute of Medicine, 2012).

Other issues seen in older adult clients include complicated grief (Frank, Prigerson, Shear, & Reynolds, 1997; Lichtenthal, Cruess, & Prigerson, 2004), insomnia (McCurry et al., 2007), sexual dysfunction, psychotic disorders, including schizophrenia and delusional disorders (Palmer, Folsom, Bartels, & Jeste, 2002), personality disorders (Segal, Coolidge, & Rosowsky, 2006), and disruptive behaviors (e.g., wandering, aggressive behavior), which can be present in individuals suffering from dementia or other cognitive impairment (Cohen-Mansfield & Martin, 2010). 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. Many comprehensive reference volumes are available as resources for clinicians with respect to late-life mental disorders (e.g., Laidlaw & Knight, 2008; Pachana & Laidlaw, in press; Pachana et al., 2010; Segal et al., 2011; Whitbourne, 2000; Zarit & Zarit, 2007), and the literature in this area is rapidly expanding.

Assessment

Guideline 10. 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.

Relevant methods for assessment of older adults may include clinical interviewing, use of self-report measures, cognitive performance testing, direct behavioral observation, role play, psychophysiological techniques, neuroimaging, and use of informant data. Psychologists should aspire to have familiarity with contemporary biological approaches for differential diagnosis or disease characterization and with how this information can contribute to the assessment process and outcome, even if they do not apply these techniques themselves.

A thorough geriatric assessment is preferably an interdisciplinary one, focusing on both strengths and weaknesses, determining how problems interrelate, and taking account of contributing factors. In evaluating older adults it is useful to ascertain the possible influence of medications and medical disorders, since, for example, medical disorders sometimes mimic psychological disorders. Other possible influences to review include immediate environmental factors on the presenting problem(s) and the nature and extent of the individual's familial or other social support. 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, decision-making capacity, and the management of behavior problems associated with these and other disorders.

Developing knowledge and skill with respect to standardized measures involves understanding psychometric theory, test standardization, and the importance of using assessment instruments that have been shown to be reliable and valid with older adults (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education [AERA, APA, & NCME], 1999). This effort includes an understanding of the importance of appropriate content and age norms. When no instruments for measuring a particular assessment domain (e.g., personality, psychopathology) has been developed for older adults specifically, clinicians are encouraged to rely upon assessment instruments developed with young adults for which normative data are available and for which there is validity and reliability evidence to support their use with older adults.

The practitioner strives to understand the limitations of using such instruments, 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. Various resources are available (e.g., Edelstein et al., 2008; Lichtenberg, 2010) that provide discussions of the

assessment of various older adult disorders and problems. Gaining an understanding of the presenting clinical problem also may be aided by assessments of other persistent maladaptive behavior patterns (e.g., excess dependency) and/or contextual factors (such as family interaction patterns, degree of social support, and interactions with other residents and staff if working in a long-term care setting).

Age is not the only potential limitation on the use of some diagnostic and standardized assessment instruments. Multicultural factors also can play a significant role in the process and outcome of assessment (see Guideline 5). It is important for psychologists to appreciate 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 understand the potential limitations of existing normative data and related ethical issues when assessing racially and culturally diverse older adults (e.g., Brickman, Cabo, & Manly, 2006). The content validity of assessment instruments can be compromised by cross-cultural differences in the experience and presentation of psychological disorders (e.g., depression; Futterman, Thompson, Gallagher-Thompson, & Ferris, 1997). Considerable within-group and between-group differences can be found among diverse cultures, and clinical presentations may vary through differences in degree of assimilation, educational experience, and acculturation (Edelstein, Drozdick, & Ciliberti, 2010). Response styles to test items can vary across cultural groups and affect the outcome of assessment. For example, Asian American individuals have a tendency to avoid the use of the extremes on rating scales (Sue, Cheng, Saad, & Chu, 2012). Finally, it is important that the psychologist synthesize assessment results with an eye to the cultural and linguistic characteristics of the person being assessed (AERA, APA, & NCME, 1999; APA, 2002c).

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 institutionalized settings (Dwyer-Moore & Dixon, 2007; Molinari & Edelstein, 2010; Zarit & Zarit, 2011). Functional analysis and assessment are often useful with individuals who exhibit problems such as wandering (Dwyer-Moore & Dixon, 2007; Hussian, 1981) and aggression and agitation (Cohen-Mansfield & Martin, 2010; Curyto, Trevino, Ogland-Hand, & Lichtenberg, 2012) by enabling the clinician to identify the variables underlying the problem behaviors. The combination of norm-based standardized testing and behavioral assessment also can be valuable. In assessing older adults, particularly those with significant cognitive impairment, psychologists may rely considerably on data provided by other informants. It is useful to be aware of effective ways of gathering such information and of general considerations about how to interpret it in relation to other data. Likewise, evaluations of older adults may often be clarified by conducting repeated assessments over time. Such repeated assessment over time is useful particularly with respect to such matters as the older adult's affective state, functional

capacities, or cognitive abilities 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 an intervention (Haynes, O'Brien, & Kaholokula, 2011).

Psychologists may also perform assessments for the purpose of program evaluation. For example, assessments may be used to appraise patient satisfaction with psychological interventions in nursing homes, determine the key efficacious components of day care programs, or evaluate the cost-benefit analysis of respite care programs designed to help family caregivers maintain their relatives with cognitive impairment at home. Assessments may thus play an important role in determining the therapeutic and programmatic efficacy and efficiency of interventions, whether made at individual, group, program, or systems levels.

Finally, balanced evaluations of older adults include attention not only to deficits but also to 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. Support from cultural, ethnic, and religious communities can help the client to further address issues of concern (APA, 2012b).

Guideline 11. Psychologists strive to develop skill in accommodating older adults' specific characteristics and the assessment contexts.

At times the practitioner may face the challenge of adapting assessment procedures to accommodate the particular impairments or living contexts of older adults (Edelstein et al., 2012). For example, with older adults who have sensory or communication problems, elements of the evaluation process may include assessing the extent of these impediments, modifying other assessments to work around such problems, and taking these modifications into account when interpreting the test findings. In particular, clinicians would not want to confuse cognitive impairment with sensory deficits.

The effects of vision deficits can be attenuated to some degree through oral presentation of assessment questions and encouragement of the use of corrective lenses, non-glare paper, and bright light in the testing environment. To be useful, self-administered assessment forms may have to be reprinted in a larger font (e.g., 16 point) or enlarged if administered by computer. The effects of hearing deficits can be attenuated through the use of hearing aids and other assistive listening devices (e.g., headset with amplifier). Hearing difficulties in older adults tend to be worse at higher frequencies, and thus it can be helpful for female psychologists, in particular, to lower the pitch of their voices. When making accommodations in the assessment process, psychologists strive to be knowledgeable about how such accommodations may influence/alter the specific cognitive demands of the task. To reduce the influence of sensory problems, it may also be useful to modify the assessment environment in various ways (e.g., avoid glaring lights, and lower the background noise, which may tend

to be especially distracting; National Institute on Deafness and Other Communication Disorders, 2010).

Aging individuals with developmental disabilities or preexisting physical or cognitive impairments may present unique challenges for psychological assessment. A number of relevant factors need to be taken into consideration. Sensitivity to these factors may demand exercising special care in selecting assessment methods and instruments appropriate for the individual and/or making adjustments in methods and diagnostic decision making (APA, 2012b; Burt & Aylward, 1999, 2000).

Psychologists who work with older adults are encouraged to consider their multicultural competence (APA, Committee on Aging Working Group on Multicultural Competence in Geropsychology, 2009) in the assessment of older adults. Multicultural competence includes explicit consideration of the older adult's ethnic, racial, and cultural background but also other factors, such as degree of health literacy and prior experience with mental health providers. Multicultural issues and aging are interwoven (Hinrichsen, 2006) and can collectively influence and complicate the assessment process and outcome. The intersection of aging and disability yields similar issues that require culturally competent assessment (Iwasaki et al., 2009). When selecting assessment instruments, psychologists are encouraged to be aware of the potential methodological problems that can plague the development of assessment instruments (e.g., participant selection, sampling, establishment of equivalence of measures) and of the consequences of inadequately developed instruments when cultural factors are not considered (Okazaki & Sue, 1995). Once tests are selected, cultural experience can differentially affect test performance and bias performance even when ethnic groups are matched on several demographic factors (Brickman et al., 2006). The entire assessment enterprise is best informed by specialized knowledge and guided by cultural competence.

The increasing availability of telehealth technology for adults with limited access to care has demonstrated efficacy across rural and urban adults (Buckwalter, Davis, Wakefield, Kienzle, & Murray, 2002; Grubaugh, Cain, Elhai, Patrick, & Frueh, 2008). Nonetheless, it behooves providers to consider older adults' prior experience with, expectations of, and hesitations about this relatively new assessment modality.

Guideline 12. Psychologists strive to develop skill at conducting and interpreting cognitive and functional ability evaluations.

Quite commonly, when evaluating older adults, psychologists may use specialized procedures to help determine the nature of and bases for cognitive difficulties, functional impairment, or behavioral disturbances (Attix & Welsh-Bohmer, 2006; Cosentino et al., 2011; Lichtenberg, 2010). Psychologists are often asked to characterize an older adult's current cognitive profile 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 issue, and/or other

causes (Morris & Brookes, 2013). Assessments can range from a brief cognitive screening to in-depth diagnostic evaluation. Cognitive screening typically involves use of brief instruments to identify global impairment with high sensitivity but with relatively low diagnostic specificity. Diagnostic evaluations include more comprehensive assessment than screening instruments and can be used to characterize the nature and extent of cognitive deficits. Assessment of cognition may be appropriate for older adults who are at risk for dementia or have suspected cognitive decline due to an underlying neurodegenerative disorder, mental disorder, or medical condition. Federal legislation provides for screening for cognitive impairment during annual wellness visits for Medicare beneficiaries (Patient Protection and Affordable Care Act, 2010).

Differentiating the factors contributing to cognitive impairment among older adults can be challenging and often requires a neuropsychological evaluation (APA, 2012b). A neuropsychological evaluation includes the integration of objective measures of cognitive performance with historical, neurological, psychiatric, medical, and other diagnostic information by a clinician with competency in neuropsychological assessment. By comparing standardized test performance with culturally and demographically (e.g., age and education) appropriate normative data, psychologists first determine whether the cognitive profile is consistent with normal aging or whether it represents a significant decline. Using profile analysis, psychologists examine the pattern of test performance to differentiate the sources of cognitive impairment (Lezak, Howieson, Bigler, & Tranel, 2012). Prompt evaluation of cognitive complaints may be useful in identifying potentially reversible causes of cognitive impairment (APA, 2012b). Repeated neuropsychological evaluation can help further characterize the nature and course of cognitive impairment. Consideration of practice or exposure effects is an important element of repeated assessment.

The ability to conduct valid assessments and make appropriate referrals in this area depends upon knowledge of normal and abnormal aging, including age-related changes in cognitive abilities. In conducting such assessments, psychologists rely upon their familiarity with age-related brain changes, diseases that affect the brain, tests of cognition, age- and culturally appropriate normative data on cognitive functioning, the client's premorbid cognitive abilities, and consideration of the quality of education in addition to the absolute number of years of education (Brickman et al., 2006; Manly & Echemendia, 2007; Manly, Jacobs, Touradji, Small, & Stern, 2002; Morris & Becker, 2004; Salthouse, 2010; Schaie & Willis, 2011). Brief cognitive screening tests do not substitute for a thorough evaluation, although some older adults may not be able to tolerate long assessment batteries due to frailty, severe cognitive impairment, or other reasons. Psychologists make referrals to clinical neuropsychologists (for comprehensive neuropsychological assessments), geropsychologists, rehabilitation psychologists, neurologists, or other specialists as appropriate. See the "Guidelines for the

Evaluation of Dementia and Age-Related Cognitive Change” (APA, 2012b) for more information.

Advances continue in the development of biological markers derived from blood or cerebrospinal fluid (Trojanowski et al., 2010) and in the identification of relevant genes (Bertram & Tanzi, 2012). Newly developed PET neuroimaging techniques can be used for the detection of one of the hallmark pathological changes of Alzheimer’s disease and have received approval from the U.S. Food and Drug Administration for clinical diagnosis (Yang, Rieves, & Ganley, 2012). However, at present these techniques are chiefly utilized for research. Psychologists conducting cognitive diagnostic assessments with older adults are encouraged to be informed of developments related to pathogenesis and diagnosis from the biological literature. As reliable biological markers continue to be developed for clinical use, cognitive and neuropsychological assessment will remain essential for characterization of disease course, determination of onset of symptoms, and tracking of treatment response.

In-person cognitive evaluation of older adults is often difficult because of mobility issues and access to health care professionals in certain geographical regions. Widespread availability of low-cost computers, high-definition digital cameras, and software for video conferencing has increased the option for conducting these evaluations remotely (Charness, Demiris, & Krupinski, 2011; Fortney, Burgess, Bosworth, Booth, & Kaboli, 2011). Much work is still required to develop valid and reliable remote evaluation protocols including ensuring that assessment procedures administered remotely are comparable to an in-person evaluation. Nonetheless, there is emerging evidence of comparability between remote and in-person assessment (Hyler, Gangure, & Batchelder, 2005).

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 independent activities of daily living (IADLs; e.g., managing finances, preparing meals, managing health). All of these abilities require a combination of cognitive and behavioral skills. In 2008, 14.5 million older adults reported having some level of disability, which was 37.8% of the older adult U.S. population (Centers for Disease Control and Prevention, 2008). In addition, increasingly psychologists are being asked to evaluate older adults’ decision-making capacity relevant to, for example, finances, driving, wills, living wills, durable powers of attorney, health care proxies, and independent living. (See Guideline 19.)

Disabilities among older adults are often due to age-related cognitive and physical changes (e.g., sensory system, cardiovascular system, musculoskeletal system; Saxon et al., 2010) and the direct and indirect effects of chronic diseases. 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. To make ecologically valid recommendations in these areas, the psychologist often integrates

the assessment results with clinical interview information gathered from both the older adult and collateral sources, direct observations of the older adult’s functional performance, along with other pertinent considerations (e.g., the immediate physical environment, available social supports, or local legal standards; see Guideline 19). Several approaches can be taken to assess functional abilities, ranging from questionnaires to performance-based evaluation.

Intervention, Consultation, and Other Service Provision

Guideline 13. 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.

Psychologists have been adapting their treatments and doing psychological interventions with older adults over the entire history of psychotherapy (Knight, Kelly, & Gatz, 1992; Molinari, 2011). As different theoretical approaches have emerged, each has been applied to older adults, including psychodynamic psychotherapy, behavior modification, cognitive therapy, interpersonal psychotherapy, and problem-solving therapy. 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 built during the individual’s life span (Anderson et al., 2012; Knight, 2004).

Evidence documents that 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, 2012d; Piquart & Sørensen, 2001; Scogin, 2007; Zarit & Knight, 1996). Both individual and group psychotherapies have demonstrated efficacy in older adults (Burlingame, Fuhrman, & Mosier, 2003; Payne & Marcus, 2008). Cognitive-behavioral, psychodynamic, problem-solving, and other approaches have shown utility in the treatment of specific problems among older adults (Floyd, Scogin, McKendree-Smith, Floyd, & Rokke, 2004; Gatz, 1998; Scogin & Shah, 2012; Teri & McCurry, 1994).

The problems for which efficacious psychological interventions have been demonstrated in older adults include depression (Piquart, Duberstein, & Lyness, 2007; Scogin, Welsh, Hanson, Stump, & Coates, 2005), anxiety (Ayers, Sorrell, Thorp, & Wetherell, 2007), sleep disturbance (McCurry et al., 2007), and alcohol abuse (Blow & Barry, 2012). Behavior therapy and modification strategies, problem-solving therapy, socio-environmental modifications, and related interventions have been found useful in treating depression, reducing behavioral disturbance, and improving functional abilities in cognitively impaired older adults (Areán, Hegel, Vannoy, Fan, & Unutzer, 2008; Curyto et al., 2012; Logsdon, McCurry, & Teri, 2007).

Reminiscence or life review therapy has shown utility as a technique in various applications for the treatment of depression (Scogin et al., 2005). The clin-

ical utility of exposure-based therapies (prolonged exposure; cognitive processing therapy) for older adult trauma survivors demonstrates mixed results, with more research on the cumulative effect of trauma on older adults (Hiskey, Luckie, Davies & Brewin, 2008) and less on assessment of treatment efficacy (Clapp & Beck, 2012; Owens, Baker, Kasckow, Ciesla, & Mohamed, 2005). However, the research is more limited on the efficacy of psychological interventions with ethnic minority older adults as compared with majority older adults (APA, Committee on Aging Working Group on Multicultural Competence in Geropsychology, 2009; Areán, 2003; Hinrichsen, 2006; Tazeau, 2011; Yeo & Gallagher-Thompson, 2006).

Psychotherapies delivered as part of integrated care models have also been found to be effective in the treatment of depression in primary care settings (Skultety & Zeiss, 2006). 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 (Hadjistavropoulos & Fine, 2007; Morone & Greco, 2007) and behavioral aspects of urinary incontinence (Burgio, 1998). They also can provide valuable assistance to older adults adapting to changing life circumstances, improving interpersonal relationships, and/or experiencing sexual concerns, or other issues (APA, 2007a; Hinrichsen, 2008; Hillman, 2012). As with other age groups, practitioners are encouraged to use evidence-based practices with older adults (APA, Presidential Task Force on Evidence-Based Practice, 2006).

Guideline 14. Psychologists strive to be familiar with and develop skill in applying culturally sensitive, specific psychotherapeutic interventions and environmental modifications with older adults and their families, including adapting interventions for use with this age group.

Such interventions may include individual, group, couples, and family therapies. Examples of interventions that may be unique to older adults or that are very commonly used with this population include reminiscence and life review; grief therapy; psychotherapy focusing on developmental issues and behavioral adaptations in late life; expressive therapies for those with communication difficulties; methods for enhancing cognitive function in later years; and psychoeducational programs for older adults, family members, and other caregivers (APA, Presidential Task Force on Caregivers, 2011; Gallagher-Thompson & Coon, 2007; Qualls, 2008). No single modality of psychological intervention is preferable 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, gender, cultural background (Gum et al., 2006; Landreville, Landry, Baillargeon, Guerette, & Matteau, 2001), and place on

the continuum of care (for case examples, see Karel, Ogland-Hand, & Gatz, 2002; Knight, 2004; Pachana et al., 2010), and, as noted earlier, on the availability of an evidence-based practice. For example, community-dwelling older adults who are quite functional both physically and mentally may respond very well to forms of psychotherapy often delivered in outpatient settings (e.g., individual, group, family therapies). Given that many disorders of late life are chronic or recurrent rather than acute, clinical objectives often are focused on symptom management and rehabilitative maximization of function rather than cure (Knight & Satre, 1999).

The research literature provides evidence of the importance of specialized skills in working with the older adult population (Pinquart & Sörensen, 2001). A variety of special issues characterize work with older adults that may require that psychologists evidence sensitivity to age-related issues and sometimes utilize specialized intervention techniques (see *Psychotherapy and Older Adults Resource Guide*, APA, 2009b). For example, some older adults (including those in certain cultural groups) may view use of mental health services as stigmatizing, in which case practitioners often make active efforts to engage them and discuss their concerns. Culturally sensitive psychotherapy may incorporate aspects of the older adult's (in some cultures "elder" is the preferred term) indigenous spiritual beliefs or cultural practices and customs. In some clinical situations, intervention techniques developed particularly for use with older adults, such as reminiscence therapy, may be appropriate. Reminiscence is frequently used as a supportive therapeutic intervention to assist older adults in integrating their experiences (Scogin et al. 2005; Shah, Scogin, & Floyd, 2012).

Because physical health issues are so commonly present, psychological interventions with older adults frequently address the older adult's adaptation to medical problems (e.g., pain management or enhancing adherence with medical treatment; Hadjistavropoulos & Fine, 2007). When facing life-limiting health problems and the end of life, older adults may require assistance with managing this process, for which therapeutic models exist (Breitbart & Applebaum, 2011; Haley, Larson, Kasl-Godley, Neimeyer, & Kwilosz, 2003; Qualls & Kasl-Godley, 2010).

For some older adults, standard therapeutic approaches can be modified with respect to process or content (Frazer, Hinrichsen, & Jongasma, 2011). Examples of process change might include modifying the pace of therapy (Gallagher-Thompson & Thompson, 1996), accommodating sensory limitations by reducing ambient noise and glare, and speaking more slowly. 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 (Knight & Satre, 1999). It is also important to adapt interventions to the clinical setting (e.g., private office, home, hospital, or long-term care facility; see Guideline 15).

Often psychologists provide services to older adults as active participants in family, social, or institutional systems. Therefore, in working with older adults, practitioners 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 & Zarit, 2009). Or the psychologist may provide behavioral training and consultation on environmental modifications to long-term care staff for dementia-related problem behaviors (Qualls & Zarit, 2009).

Guideline 15. 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.

Psychologists often work with older adults in a variety of settings, reflecting the continuum of care along which most services are delivered (APA, Presidential Task Force on Integrated Health Care for an Aging Population, 2008). These service delivery sites encompass various community settings where older people are found, including community-based and in-home care settings (e.g., senior centers, their own homes or apartments; see Yang, Garis, Jackson, & McClure, 2009, 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 (such as adult day care centers, psychiatric partial hospitalization programs) serving older adults with multiple or complex problems; inpatient medical or psychiatric hospital settings; and long-term care settings (such as nursing homes, assisted living, hospice, and other congregate care sites). Some psychologists provide services within the criminal justice system to the growing number of older adults who are or have been incarcerated (Rikard & Rosenberg, 2007). Some institutions include a variety of care settings. For example, consultation in continuing care retirement communities may involve treating older adults in settings ranging from independent apartments, to assisted living settings, to skilled nursing facilities. 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.

A set of practice guidelines is available for psychologists who provide services in long-term care settings (Lichtenberg et al., 1998), as well as useful volumes discussing various facets of such professional practice (Hyer & Intrieri, 2006; Molinari, 2000; Norris, Molinari, & Oglund-Hand, 2002; Rosowsky, Casciani, & Arnold, 2009;

see also *Psychological Services in Long-Term Care Resource Guide*, APA, 2013).

Guideline 16. Psychologists strive to recognize and address issues related to the provision of prevention and health promotion services with older adults.

Psychologists may contribute to the health and well-being of older adults by helping to provide psychoeducational programs (e.g., Alvidrez, Areán, & Stewart, 2005) and by involvement in broader prevention efforts and other community-oriented interventions. Related efforts include advocacy within health care and political legal systems (Hartman-Stein, 1998; Hinrichsen, Kietzman, et al., 2010; Karel, Gatz, & Smyer, 2012; Norris, 2000). 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 (Cohen et al., 2006). Such work may entail becoming familiar with outreach, case finding, referral, and early intervention, as these relate to particular groups of at-risk older adults (Berman & Furst, 2011). 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, or the risk factors affecting the older adult group of concern. For example, if attempting to reduce isolation as a risk factor for depression, it might be pertinent to consider the availability of organized opportunities for older adult socialization and whether to increase these (Casado et al., 2012). 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 (www.cdc.gov/aging).

An area of particular concern for preventive efforts in the older adult population is that of suicide prevention (see *Depression and Suicide in Older Adults Resource Guide*, APA, 2009a; *Late Life Suicide Prevention Toolkit*, Canadian Coalition for Seniors' Mental Health, 2008; and *Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities, Substance Abuse and Mental Health Services Administration*, 2011). Older adults, especially older White men, are the age group at particularly high risk for suicide (Conwell, VanOrden, & Caine, 2011). Practitioners are encouraged to be vigilant about assessing suicide risk in older adults across a variety of settings (e.g., health, mental health, and long-term care; Reiss & Tishler, 2008). For example, the majority of older people who have died because of suicide have seen a physician within a month before death (Conwell, 2001). Therefore, it is important to enlist primary care physicians in efforts to prevent late-life suicide (Schulberg, Bruce, Lee, Williams, & Dietrich, 2004) through improved recognition of depressive symptoms and other risk factors (Huh et al., 2012; Scogin & Avani, 2006) and referral to appro-

appropriate treatment (Pearson & Brown, 2000). Treatment of depressive symptoms in older primary care patients has, in fact, been found to reduce suicidal ideation (Bruce et al., 2004).

Guideline 17. Psychologists strive to understand issues pertaining to the provision of consultation services in assisting older adults.

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 in the areas of social psychology, developmental psychology, diversity, group dynamics, communications, program design and evaluation, and others. Psychologists who work with older adults possess such knowledge and skills with specific relevance to the older adult age group (APA, Presidential Task Force on Integrated Health Care for an Aging Population, 2008). Psychologists frequently consult with family members of older relatives who have mental health problems, especially those with dementia. Given the anticipated dearth of aging specialists as the size of the older population rapidly grows, psychologists with aging expertise will likely play important roles in educating other professionals about aging (Institute of Medicine, 2012).

In providing consultation to other professionals, institutions, agencies, and community organizations, psychologists may play key roles in the training and education of staff who work directly with older adults in many different settings (Haley et al., 2003; Kramer & Smith, 2000; Zarit & Zarit, 2007). In the staff training role, psychologists teach basic knowledge of normal aging and development, improved communication with older adults (Gerontological Society of America, 2012), appropriate management of problem behaviors (Logsdon & Teri, 2010), and facilitated social engagement (Meeks, Young, & Looney, 2007). 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 dementia (Molinari et al., 2008). More staff consultation and training in behavioral principles may result in a reduction in the overuse of psychoactive medications and improved quality of life for this vulnerable population (Camp, Cohen-Mansfield, & Capezuti, 2002). Psychologists may contribute to program development, evaluation, and quality assurance related to aging services (Hartman-Stein, 1998; Hyer, Carpenter, Bishmann, & Wu, 2005). When consulting with health care teams/organizations, psychologists can facilitate increased collaboration among members of interdisciplinary care teams, especially those that have client populations with complex medical and psychosocial needs (Geriatrics Interdisciplinary Advisory Group, 2006).

Guideline 18. 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.

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. As most older adults suffer from chronic health problems for which medications have been prescribed, coordination with the professionals prescribing them to the older adult is often very useful. Other disciplines typically involved in coordinated care, either as part of a team or to which referrals may be appropriate, include physicians, nurses, social workers, pharmacists, and associated others such as direct care workers, clergy, and lawyers. Psychologists can help a group of professionals become an interdisciplinary team rather than function as a multidisciplinary one by generating effective strategies for integration and coordination of services provided by the various team members (Zeiss, 2003; Zeiss & Karlin, 2008; see *Blueprint for Change: Achieving Integrated Healthcare for an Aging Population*, APA, Presidential Task Force on Integrated Health Care for an Aging Population, 2008).

For effective collaboration with other professionals, whether through actual teamwork or through referrals, it is useful for psychologists to be knowledgeable about services available from other disciplines and their potential contributions to a coordinated effort. 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 specific 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 (APA, Presidential Task Force on Integrated Health Care for an Aging Population, 2008). To provide psychological services in a particular setting, it is important to be familiar with the culture, institutional dynamics, and challenges of providing mental health services to older adults.

Sometimes psychologists in independent practice or in settings which lack close linkages with other disciplines have limited contact with those who provide care to the older adult. In such cases, practitioners are encouraged to be proactively involved in outreach to and coordination with the relevant professionals. To provide the most comprehensive care to older adults, practitioners are encouraged to familiarize themselves with aging-relevant resources in their communities (e.g., National Association of

Area Agencies on Aging, <http://www.n4a.org>) and to make appropriate referrals.

Guideline 19. Psychologists strive to understand the special ethical and/or legal issues entailed in providing services to older adults.

It is important for psychologists to strive to ensure the right of older adults with whom they work to direct their own lives. Conflicts sometimes arise among family members, formal caregivers, and physically frail or cognitively impaired older adults because some concerned individuals may believe that these older adults do not possess the ability to make decisions about their own lives that can affect their safety and well-being. Psychologists are sometimes called upon to evaluate one or more domains of capacity of older adults (e.g., medical, financial, contractual, testamentary, or independent living decision making; Moye, Marson, & Edelstein, 2013). The publication *Assessment of Older Adults With Diminished Capacity: A Handbook for Psychologists* (American Bar Association & American Psychological Association [ABA & APA], 2008) is one in a series of three handbooks published by the American Bar Association Commission on Law and Aging and the American Psychological Association. It provides guidance to psychologists on this important issue. 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, guarding the older adult's safety and well-being as well as recognizing the individual's right to make his or her own decisions to the extent possible (Karel, 2011; Marson et al., 2011; Moye & Marson, 2007). This dilemma is especially relevant to older adults with serious mental illness living in long-term care settings. Their desire to live in less restrictive environments is optimally balanced against the needs of family members and mental health practitioners to assure proper care for those who they believe may be unable to make their own decisions.

Similar considerations regarding informed consent for treatment apply in work with older adults and in work with younger people. Ethical and legal issues may enter the picture when some degree of cognitive impairment is present or when the older individual lacks familiarity with treatment options. For example, some older adults may initially display an unwillingness to consent to participate in psychotherapy. However, once informed of what treatment entails, they often give consent. When older adults are brought in for therapy by family members, practitioners are encouraged to take steps to ensure that it is the older adult's decision whether to participate in treatment 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 process may be an important part of building initial rapport with the older adult (Knight, 2004).

A diagnosis of dementia is not equivalent to lacking capacity in one or more areas. Even older adults with

dementia often maintain the capacity to give or withhold consent well into illness progression (ABA & APA, 2008; Moye & Marson, 2007; Qualls & Smyer, 2007). The particular point at which a transition occurs from having capacity to lacking capacity with respect to one or more areas requires careful evaluation. Even after the older adult is assessed as lacking a specific capacity, the individual often remains able to indicate assent to decisions. Assessment 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. Often the psychologist may need to determine if a capacity assessment is indicated or if the situation can be resolved in another manner. Knowledge of geriatric support services and mechanisms for shared or substitute decision making are critical. Some individuals may have diminished capacity in one domain but not others. Because some domains of diminished capacity may improve over time, reassessment of capacity may be required (Qualls & Smyer, 2007). Older adults with apparent diminished capacity who have few or no social connections are especially vulnerable and require careful evaluation and, as needed, advocacy on their behalf (Karp & Wood, 2003).

Psychologists working with older adults may often encounter confidentiality issues in situations that involve families, interdisciplinary teams, long-term care settings, or other support systems. A common values conflict with regard to confidentiality involves older adults who are moderately to severely cognitively impaired and who may be in some danger of causing harm to themselves or others as a result. Careful consideration is useful in view of these issues, and consultation with other professionals may be especially helpful. For some older adults, preservation of their autonomy may be worth tolerating some risk of self-harm (ABA & APA, 2008).

In some settings (e.g., long-term care facilities), mental health services may be provided in the residence in which the older adult lives. In these settings psychologists may be particularly challenged to protect client confidentiality. For example, it may be difficult to find a place to meet that is private. In addition, in such settings it is important to establish clear boundaries about what will and will not be shared with residence staff, both verbally and in written records (Karel, 2009; Knapp & Slattery, 2004; Lichtenberg et al., 1998).

Psychologists working with older adults may at times experience pressure from family members or other involved helping professionals to share information about the older person. Such information sharing is often justified in terms of the need to help the older adult, and collaboration with others may be very advantageous. Nonetheless, older adults in treatment relationships have as much right to full confidentiality as do younger adults and should provide documented consent to permit the sharing of information with others (Knight, 2004).

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 does interfere with a person's ability to exercise autonomy in the present, it may remain possible to ascertain what the individual's values are or have been in the past and to act according to those values. When there is a substitute decision maker, there may be some risk that the substitute decision maker will act for his or her own good rather than in the best interests of the older adult with dementia (ABA & APA, 2008). This potential for conflict of interests 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 (Haley et al., 2002).

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 (Rosowsky et al., 2009).

At times, psychologists may encounter situations in which it is suspected that older adults may be victims of abuse or neglect. Individuals over age 80 are more likely than older adults in younger age groups to be victims of elder abuse, as are those who need more physical assistance or who have compromised cognitive functioning. Women are more likely than men to be victims of elder abuse. In part this may be related to the longer life expectancy of women, which increases the number of years in which they may have greater contact with potential abusers (Krienert, Walsh, & Turner, 2009; National Committee for the Prevention of Elder Abuse & MetLife Mature Market Institute, 2012). In addition, women are subjected to higher rates of family violence across the life span, and researchers have shown that previous exposure to a traumatic life event (e.g., interpersonal and domestic violence) elevates an older adult's risk of late life mistreatment (Acierno et al., 2010).

In most states, practitioners are legally obligated to report suspected abuse and neglect to appropriate authorities. Serving older adults well 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 (see *Elder Abuse and Neglect: In Search of Solutions*, APA, Committee on Aging, 2012, and the National Center on Elder Abuse, <http://www.ncea.aoa.gov>). Likewise, because death and dying are age related, psychologists who work with the older adult population may often find it useful to be well informed about legal concerns and professional ethics surrounding these matters (APA, Working Group on Assisted Suicide and End-of-Life Decisions, 2000; Haley et al., 2002).

Professional Issues and Education

Guideline 20. Psychologists strive to be knowledgeable about public policy and state and federal laws and regulations related to the provision of and reimbursement for psychological services to older adults and the business of practice.

With the recent passage of the Affordable Care Act, the health care landscape continues to change. 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 older and for younger persons with disabilities) is a chief payer for 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, 2010). Therefore, 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 billed to Medicare (Hartman-Stein & Georgoulakis, 2008). Some older adults have insurance that supplements Medicare coverage (so-called "Medigap" policies). Knowledge of Medicaid (the federal/state insurance program for low-income Americans) is also useful; and some states provide reimbursement for mental health services for older adults who have both Medicare and Medicaid ("dual eligibles"). Some individuals with Medicaid coverage may find it more difficult to find mental health providers because of reimbursement rates and program restrictions or requirements. Psychologists may also benefit by being knowledgeable about Social Security, from which the vast majority of older adults receive payment, as well as about a broad range of services that are provided through the Older Americans Act (O'Shaughnessy, 2011) and other sources. 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 highly desirable.

Guideline 21. Psychologists are encouraged to increase their knowledge, understanding, and skills with respect to working with older adults through training, supervision, consultation, and continuing education.

As the need for psychological services grows in the older population, additional health care providers will be re-

quired, especially those with knowledge and skills in working with older adults (Institute of Medicine, 2012). Practitioners often work competently with older adults who have issues similar to those of younger clients. With increasing problem complexity, psychological practice with older adults benefits from the acquisition and application of specialized knowledge and skills (Knight et al., 2009). 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 most young and middle-aged adults encounter less frequently.

A persistent call has been made for additional training in aging across all levels of professional development (Holtzer, Zweig & Siegel, 2012; Zimmerman, Fiske, & Scogin, 2011). Training recommendations to prepare psychologists to work with older adults have been offered for graduate (Qualls, Scogin, Zweig, & Whitbourne, 2010) and internship and postdoctoral levels (Hinrichsen, Zeiss, Karel, & Molinari, 2010). 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. These pathways include doctoral and respecialization programs, internships, postdoctoral fellowships, continuing education activities (workshops, in-service training/seminars, distance learning), self-study and/or supervised self-study, or combinations of such alternatives. Psychologists who see some 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, Knight, Duffy, Hinrichsen, & Zeiss, 2010). Psychologists may also gain additional education and access useful materials through interactions with professional organizations, including APA Division 20 (<http://apadiv20.pphp.ufl.edu/>), APA Division 12, Section II (<http://www.geropsychology.org/>), and the APA Offices on Aging (<http://www.apa.org/pi/aging/index.aspx>) 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 (<http://www.pltweb.org/index.php>), and the Gerontological Society of America (<http://www.geron.org/>).

The Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel, Emery, et al., 2010) 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 by trainees and their supervisors to rate progress over the course of a training experience (Karel et al., 2012). Psychologists can match the extent and types of their work with their competence and, as needed, seek additional knowledge and skills.

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