

**Guidelines for Psychological Practice  
with Older Adults**

**American Psychological Association**

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## **Guidelines for Psychological Practice with Older Adults**

In recent years, professional psychology practice with older adults has been increasing, due both to the changing demography of our population and changes in service settings and market forces. For instance, federal legislation contained in the 1987 Omnibus Budget and Reconciliation Act (OBRA, 1987) has led to increased accountability for some mental health issues. Psychologists' inclusion in Medicare has expanded reimbursement opportunities. For example, whereas in 1986 psychological practice in nursing homes was rare, by 1996 as many as a dozen large companies and numerous smaller organizations were providing psychological services in nursing homes. As well, clinicians and researchers have made impressive strides toward identifying the unique aspects of knowledge that facilitate the accurate psychological assessment and effective treatment of older adults, and the psychological literature in this area has been burgeoning. Unquestionably, the demand for psychologists with a substantial understanding of the clinical issues pertaining to older adults will expand in future years as the older population grows and service demands increase, and as cohorts of middle-aged and younger individuals who are attuned to psychological services move into old age (Gatz & Finkel, 1995; Koenig, George, & Schneider, 1994).

General practice psychologists as well as those specifically identified as geropsychologists are interested in this area of practice. Relatively few psychologists, however, have received formal training in the psychology of aging as part of their generic training in psychology. A recent survey of APA-member practicing psychologists indicated that the vast majority (69%) conduct some clinical work with older adults, at least occasionally, but that fewer than 30% report having had any graduate coursework in geropsychology, and fewer than 20% any supervised practicum or internship experience with older adults (Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002). Many psychologists may be reluctant to work with older adults, feeling ill prepared in knowledge and skills. In the above practitioner survey (Qualls et al., 2002), a high proportion of the respondents (58%) reported that they needed further training as a basis for their work with older adults, and 70% said that they were interested in attending specialized education programs in clinical geropsychology. In other research, over half of the psychology externs and interns studied desired further education and training in this area, and 90% expressed interest in providing clinical services to older adults (Hinrichsen, 2000). As

another indication of the perceived need for psychologists to acquire increased preparation for this area of practice, recent legislation in California has made graduate or continuing education coursework in aging and long-term care a prerequisite for psychology licensure (California State Senate Bill 953, 2002). In addition, the 2003 Congressional appropriation for the Graduate Psychology Education (GPE) program in the Health Resources and Services Administration's Bureau of Health Professions included funding specifically designated as support for training in Geropsychology as a public health shortage area ("Congress Triples Funding," 2003).

The present document is intended to assist psychologists in evaluating their own readiness for working clinically 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, when desired and appropriate. The specific goals of these 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, and continuing education and training relative to work with older adults. These guidelines build on, and are intended to be entirely consistent with, the APA's (2002) "Ethical Principles of Psychologists and Code of Conduct" and other APA policies.

The term *guidelines* refers to statements 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, these guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by psychologists in their work with older adults and their families. These guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional and clinical situation. They are not definitive and are not intended to take precedence over the judgment of psychologists. Federal and state statutes, when applicable, also supersede these guidelines.

These guidelines are intended for use by psychologists who work clinically with older adults. Because of increasing service needs, it is hoped that psychologists in general practice will work clinically with older adults and continue to seek education in support of their practice skills. The guidelines are intended to assist psychologists and facilitate their work with older adults,

rather than to restrict or exclude any psychologist from practicing in this area or to require specialized certification for this work. The guidelines also recognize that some psychologists will specialize in working clinically with older adults, and will therefore seek more extensive training consistent with practicing within the formally recognized proficiency/practice emphasis of Clinical Geropsychology<sup>†</sup>, identifying themselves as geropsychologists.

The guidelines further 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 knowledge and clinical skills considered as applicable to this work, rather than prescribing specific training methods to be followed.

### **Guidelines Development Process**

In 1992, APA organized a "National Conference on Clinical Training in Psychology: Improving Services for Older Adults," which recommended that APA not only "aid professionals seeking to specialize in clinical geropsychology," but also "develop criteria to define the expertise necessary for working with older adults and their families and for evaluating competencies at both the generalist and specialist levels" (Knight, Teri, Wohlford, & Santos, 1995; Teri, Storandt, Gatz, Smyer, & Stricker, 1992). Section II (Clinical Geropsychology) of APA Division 12 (Society of Clinical Psychology) and Division 20 (Adult Development and Aging) jointly followed up on this Training Conference recommendation by forming an Interdivisional Task Force on Practice in Clinical Geropsychology, charged to address the perceived need for guidance on appropriate preparation for clinical work with older adults. The Task Force included members with expertise and professional involvements in adult development and aging as applied to diverse areas within professional psychology; they represented not only the specialty formally designated as clinical psychology, but also clinical neuropsychology, health psychology, and counseling psychology, related areas of interest such as

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<sup>†</sup> In 1998, at the recommendation of the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP), the APA Council of Representatives formally recognized Clinical Geropsychology as "a proficiency in professional psychology concerned with helping older persons and their families maintain well-being, overcome problems, and achieve maximum potential during later life" (archival description available at <http://www.apa.org/crsppp/gero.html>).

rehabilitation psychology and community psychology, and licensed psychologists who engage in independent psychological practice with older adults and/or their families.

Consistent with its composition, the Task Force adopted an inclusive understanding and use of the term “clinical.” Thus, these guidelines use “clinical work” and its variants (e.g., working clinically) as generic terms meant to encompass the practice of professional psychology by licensed practitioners from a variety of psychological subdisciplines – including all those represented within the Task Force and, potentially, others. This usage is similar to that of the federal Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) which, under the Medicare program, recognizes as a clinical psychologist “an individual who (1) holds a doctoral degree in psychology; and (2) is licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive and therapeutic services directly to individuals.”

Task Force members considered the relevant background literature within their individual areas of expertise, as they saw fit. 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. The initial document went through multiple drafts, until a group consensus was reached, and suggested literature references were retained if they met with general consensus. The draft document was subsequently circulated broadly within APA several times in accordance with Association Rule 100-1.5 (governing review of divisionally generated guidelines documents). Comments were invited and received from APA boards, committees, divisions, state associations, directorates, offices, and individual psychologists with interests pertinent to this area of practice. At the time of their consideration of the document, both the Board of Directors and the Council of Representatives arranged for special reviews by guidelines consultants who made recommendations about content, formatting and wording. The Task Force carefully considered each round of comments, and incorporated revisions intended to be responsive to the suggestions.

Minor financial support for mailing expenses and the costs of other Task Force operations (e.g., conference calls) was provided by Division 12-Section II and Division 20. Prior drafts of the document were reviewed and formally endorsed by the executive boards of these organizations, as well as those of Division 12 and Division 17 (Society of Counseling

Psychology). No other financial support was received from any group or individual, and no financial benefit to the Task Force members or their sponsoring organizations is anticipated from approval or implementation of these guidelines.

These guidelines are organized into six sections: (a) 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) education.

## **Attitudes**

**Guideline 1. Psychologists are encouraged to work with older adults within their scope of competence, and to seek consultation or make appropriate referrals when indicated.** A balancing of considerations is useful in pursuing work with older adults, recognizing both that training in professional psychology provides general skills that can be applied to the potential benefit of older adults, and that special skills and knowledge may be essential for assessing and treating some older adults' problems. Psychologists have many skills that can be of benefit to and significantly increase the well-being of older adults. They are often called upon to evaluate and/or assist older adults with regard to serious illness, disability, stress or crisis. They also work with elders who seek psychological assistance to cope with adaptational issues; psychologists can help older adults in maintaining healthy function and adaptation, accomplishing new life-cycle developmental tasks, and/or achieving positive psychological growth in their later years. Some problems of older adults are essentially the same as those of other ages, and generally will respond to the same repertoire of skills and techniques in which all professional psychologists have generic training. Given such commonalities across age groups, considerably more psychologists may want to work with older adults, since many of their already existing skills can be effective with these clients.

On the other hand, because of the aging process and circumstances specific to later life, older adults may manifest their developmental struggles and health-related problems in distinctive ways, challenging psychologists to recognize and characterize these issues accurately and sensitively. In addition, other special clinical problems arise uniquely in old age, and may require additional diagnostic skills or intervention methods that can be applied, with appropriate adaptations, to the particular circumstances of older adults. Clinical work with older adults may

involve a complex interplay of factors, including developmental issues specific to late life, cohort (generational) perspectives and preferences, comorbid physical illness, the effects of taking multiple medications, cognitive or sensory impairments, and history of medical or mental disorders. This complex interplay makes the field highly challenging, and calls for clinicians to apply psychological knowledge and methods skillfully. Education and training in the aging process and associated difficulties can help ascertain the nature of the older adult's clinical issues. Thus, those psychologists who work with the aged can benefit from specific preparation for this work.

While it would be ideal for all practice-oriented psychologists to have had some courses relating to the aging process and older adulthood as part of their clinical training (Teri et al., 1992), this is not the case for most practicing psychologists (Qualls et al., 2002). In the spirit of continuing education and self-study, psychologists already in practice can review the guidelines below and determine how these might apply to their own knowledge base or need for continuing education. Having evaluated their own scope of competence for working with older adults, psychologists can match the extent and types of their work with their competence, and can seek consultation or make appropriate referrals when the problems encountered lie outside their expertise. As well, they can use this information to shape their own learning program.

**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) urges psychologists to eliminate the effect of age-related biases on their work. In addition, the APA Council of Representatives in 2002 passed a resolution opposing ageism and committing the Association to its elimination as a matter of APA policy (APA, 2002b). Ageism refers to prejudice toward, stereotyping of, and/or discrimination against people simply because they are perceived or defined as "old" (Butler, 1969; Nelson, 2002; Schaie, 1993). Ageist biases can foster a higher recall of negative traits regarding older persons than of positive ones and encourage discriminatory practices (Perdue & Gurtman, 1990).

There are many inaccurate stereotypes of older adults that can contribute to negative biases and affect the delivery of psychological services (Abeles et al., 1998; Rodeheaver, 1990).

These include, for example, that: (1) with age inevitably comes senility; (2) older adults have increased rates of mental illness, particularly depression; (3) older adults are inefficient in the workplace; (4) most older adults are frail and ill; (5) older adults are socially isolated; (6) older adults have no interest in sex or intimacy; and (7) older adults are inflexible and stubborn (Edelstein & Kalish, 1999). Such views can become self-fulfilling prophecies, leading to misdiagnosis of disorders and inappropriately decreased expectations for improvement, so-called “therapeutic nihilism” (Goodstein, 1985; Perlick & Atkins, 1984; Settin, 1982), and to the lack of preventive actions and treatment (Dupree & Paterson, 1985). For example, complaints such as anxiety, tremors, fatigue, confusion, and irritability may be attributed to “old age” or “senility” (Goodstein, 1985). Likewise, older adults with treatable depression who report lethargy, decreased appetite, and lack of interest in activities may have these symptoms attributed to old age. Inaccurately informed therapists may assume that older adults are too old to change (Zarit, 1980) or less likely than younger adults to profit from psychosocial therapies (Gatz & Pearson, 1988), though discriminatory behavior by health providers toward older adults may be linked more to provider biases about physical health conditions associated with age than to ageism as such (Gatz & Pearson, 1988; James & Haley, 1995). Older people themselves can harbor ageist attitudes.

Some health professionals may avoid serving older adults because such work evokes discomfort related to their own aging or own relationships with parents or other older family members, a phenomenon sometimes termed “gerophobia” (Verwoerdt, 1976). 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, 1996; Newton & Jacobowitz, 1999) and reinforce dependency (Baltes, 1996).

Positive stereotypes (e.g., the viewpoint that older adults are “cute,” “childlike,” or “grandparentlike”), which are often overlooked in discussions of age-related biases (Edelstein & Kalish, 1999), can also adversely affect the assessment and therapeutic process and outcomes (Kimerling, Zeiss, & Zeiss, 2000; Zarit, 1980). Such biases due to sympathy or the desire to make allowances for shortcomings can result in inflated estimates of older adults’ skills or mental health and consequent failure to intervene appropriately (Braithwaite, 1986).

Psychologists are encouraged to develop more realistic perceptions of the capabilities and vulnerabilities of this segment of the population and to eliminate biases that can impede their work with older adults by examining their attitudes towards aging and older adults and (since some biases may constitute “blind spots”) by seeking consultation from colleagues or others, preferably from others who are 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 training conferences have recommended that, as part of their knowledge base for working clinically with older adults, psychologists acquire familiarity with the biological, psychological, and social content and contexts associated with normal aging (Knight et al., 1995; Santos & VandenBos, 1982). Moreover, given the likelihood that most practicing psychologists will deal with patients, family members, and caregivers of diverse ages, a rounded preparatory education encompasses training with a lifespan-developmental perspective that provides knowledge of a range of age groups, including older adults (Abeles et al., 1998). Over the past 30 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), printed 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 *Aging in the 1980s: Psychological Issues* (Poon, 1980), and more recently by *Psychology and the Aging Revolution* (Qualls & Abeles, 2000). The successive editions of the *Handbook of the Psychology of Aging* (Birren & Schaie, 1977; 1985; 1990; 1996; 2001) and various other compilations (e.g., Lawton & Salthouse, 1998) have provided an overview of advances in knowledge about normal aging as well as psychological assessment and intervention with older adults. On its home page, APA Division 20 presents extensive information on resource materials now available for instructional coursework or self-study in geropsychology, including course syllabi, textbooks, films and videotapes, and literature references (see <http://aging.ufl.edu/apadiv20/apadiv20.htm>).

Training within a lifespan-developmental perspective usually includes such topics as concepts of age and aging, stages of the life cycle, longitudinal change and cross-sectional

differences, cohort differences, and research designs for adult development and aging (e.g., Bengtson & Schaie, 1999; Cavanaugh & Whitbourne, 1999). Longitudinal studies, where individuals are followed over many years, permit observation of how individual trajectories of change unfold. Cross-sectional studies, where individuals of different ages are compared, allow age groups to be characterized. However, individuals are inextricably bound to their own time in history. People are born, mature, and grow old within a given generation (or “cohort” of persons born within a given period of historical time). Therefore, it is useful to combine longitudinal and cross-sectional methods in order to identify which age-related characteristics reflect change over the lifespan and which reflect differences in cohort or generation (Schaie, 1977). For example, older adults may be less familiar with using scantron answer sheets to respond to questionnaires or personality inventories, compared to college students of today. Rather than varying by stage of life, differing political attitudes may reflect various age cohorts’ different experiences with World War II, the Korean War, the war in Viet Nam, or the Gulf War. Appreciating an older adult’s cohort can be an integral aspect of understanding the individual within his or her cultural context (Knight, 1996).

There are a variety of conceptions of successful aging (Rowe & Kahn, 1998) and of positive mental health in older adults (e.g., Erikson, Erikson, & Kivnick, 1986). Inevitably, aging includes the need to accommodate to physical changes, functional limitations, and other losses. Baltes and Baltes (1990; Baltes, 1997) describe the behavioral strategies involved in such adaptation in terms of "selective optimization with compensation," in which older adults set priorities, selecting goals which they feel are most crucial or domains where they feel most competent, refine the means to achieve those goals, and use compensatory strategies to make up for aging-related losses. Another key aspect of a lifespan-developmental viewpoint is to emphasize that aging be seen not only according to a biologically based decrement model, but also as including positive aspects of psychological growth and maturation (Gutmann, 1994; Schaie, 1993) Such theories of the normal aging process have applicability for clinicians who strive to build a lifespan-developmental perspective into their interventions (Gatz, 1998; Staudinger, Marsiske, & Baltes, 1995).

**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 cycle, aging is a

dynamic process that challenges the aging individual to make continuing behavioral adaptations (Diehl, Coyle, & Labouvie-Vief, 1996). Many psychological issues in late life are similar in nature to difficulties at earlier life stages--coping with life transitions such as retirement (Sterns & Gray, 1999) or changes in residence, bereavement and widowhood (Kastenbaum, 1999), couples' problems or sexual difficulties (Levenson, Carstensen, & Gottman, 1993), social discrimination, traumatic events (Hyer & Sohnle, 2001), social isolation and loneliness, or issues of modifying one's self-concept and goals in light of altered life circumstances or continuing progression through the life cycle (Tobin, 1999). Other issues, however, may be more specific to late life, such as grandparenting problems (Robertson, 1995; Szinovacz, 1998), adapting to typical age-related physical changes, including health problems (Schulz & Heckhausen, 1996), or needs for integrating or coming to terms with one's personal lifetime of aspirations, achievements and failures (Butler, 1963). Older adults also routinely experience the effects of social attitudes toward the older population, including societal stereotypes about the aged (Kite & Wagner, 2002), and often are coping with particular economic and legal issues (Smyer, Schaie, & Kapp, 1996).

Among the special stresses of old age are a variety of significant losses. Loss--whether of significant persons, objects, animals, roles, belongings, independence, health, or financial well-being--may trigger problematic reactions, particularly in individuals predisposed to depression, anxiety or other mental disorders. Among the elderly, losses are often multiple, and their effects cumulative. Nevertheless, confronting loss in the context of one's long life often offers unique possibilities for achieving reconciliation, healing, or deeper wisdom (Baltes & Staudinger, 2000; Sternberg & Lubart, 2001). Moreover, the vast majority of older people maintain positive outlooks and morale, and express enjoyment and high life satisfaction for the perspectives and experiences (including decreased social expectations) that accompany later life (Magai, 2001; Mroczek & Kolarz, 1998). Despite the multiple stresses and infirmities of old age, it is noteworthy that, other than for the dementias, older adults have a lower prevalence of psychological disorders than do younger adults. In working with older adults, psychologists have found it useful to remain cognizant of the strengths that many older people possess, the many commonalities they retain with younger adults and with themselves at earlier ages, and the opportunities for using skills developed over the lifespan for continued psychological growth in late life.

In older adults, there is both a great deal of continuity of personality traits (Costa, Yang, & McCrae, 1998; McCrae & Costa, 1990) and considerable subjective change across the second half of life (Ryff, Kwan, & Singer, 2001). Of particular interest is how 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, to maintain intimacy and to prepare for death (Webster, 1995). Dimensions of well-being that are useful for psychologists to consider include self-acceptance, autonomy, and sense of purpose in life (Ryff et al., 2001). Later-life family, intimate, friendship and other social relations (Blieszner & Bedford, 1995) and intergenerational issues (Bengtson, 2001) figure prominently in the aging process. One influential theoretical perspective suggests that aging typically brings a heightened awareness that one's remaining time and opportunities are limited, leading to increased selectivity in one's goals and social relationships and goals, and a growing concentration on those which are most emotionally satisfying (Carstensen, Isaacowitz, & Charles, 1999). For these and other reasons, older adults' voluntary social networks often shrink with age, showing a progressive focusing on interactions with family and close associates. Families and other support systems are critical aspects of the context for most older adults (Antonucci, 2001; Antonucci & Akiyama, 1995). Working with older adults often involves dealing with their families and other support or, not infrequently, their absence. Psychologists often appraise the social support context in detail (Abeles et al., 1998), and typically seek to find interventions and solutions to problems that strike a balance between respecting the dignity and autonomy of the older person and recognizing others' perspectives on the older individual's needs for care (see Guideline 19).

Though the individuals who care for older adults are usually family members related by blood ties or marriage, increasingly, psychologists may encounter complex, varied and nontraditional relationships 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 will be useful to psychologists in dealing with older adults manifesting diverse family relationships and forms of support.

**Guideline 5. Psychologists strive to understand diversity in the aging process, particularly how sociocultural factors such as gender, ethnicity, socioeconomic status,**

**sexual orientation, disability status, and urban/rural residence may influence the experience and expression of health and of psychological problems in later life.** The older adult population is highly diverse, including considerable sociocultural, socioeconomic, and demographic variation (U.S. Bureau of the Census, 2001). According to some research, the heterogeneity among older adults surpasses that seen in other age groups (Crowther & Zeiss, 2003; Nelson & Dannefer, 1992). The psychological problems experienced by older adults may differ according to such factors as age cohort, gender, ethnicity and cultural background, sexual orientation, rural/frontier living status, differences in education and socioeconomic status, religion, as well as transitions in social status and living situations. Clinical presentations of symptoms and syndromes in older individuals often reflect interactions among these factors and specifics of the clinical setting (such as the nursing home or the homebound living context). In addition, adults in the relatively earlier stages of their old age often differ considerably from the very old in physical health, functional abilities, living situations, or other characteristics.

An important factor to take into account when providing psychological services to older adults is the influence of cohort or generational issues. Each generation has unique historical circumstances that shape that generation's collective social and psychological perspectives throughout the lifespan. For the current group of American older adults, the economic depression of the 1930's and World War II were formative early life experiences that built a strong ethic of self-reliance (Elder, 1999; Elder & Hareven, 1994). Likewise, these individuals may have been socialized in communities in which negative attitudes toward mental health issues and professionals were prevalent. As a result, older adults may be more reluctant than younger adults to access mental health services and to accept a psychological frame for problems.

A striking demographic fact of late life is the preponderance of females surviving to older ages (Federal Interagency Forum on Aging-Related Statistics, 2000), which infuses aging with many gender-related issues (Huyck, 1990). Notably, because of the greater longevity of women, on average the older patient is more likely to be a woman than a man. This greater longevity has many repercussions. For example, it means that, as they age, most women will provide care to infirm husbands, experience widowhood, and be at increasing risk themselves for dementia and other health conditions associated with advanced age. Moreover, the current generation of older women was less likely to engage in competitive employment than the younger generation and therefore has fewer economic resources in later life than their male counterparts. Financial

instability may be particularly salient for the growing numbers of women grandparents raising grandchildren (Fuller-Thompson & Minkler, 2003). Women's issues frequently arise as concerns to be dealt with throughout the processes of assessing and treating older adults (Banks, Ackerman, & Clark, 1986; Trotman & Brody, 2002). Consideration of special issues affecting older men is similarly germane, though many of these have not been sufficiently researched (Bengtson, Rosenthal, & Burton, 1996).

It is critical also to consider the pervasive influence of crosscultural and minority factors on the experience of aging (Jackson, 1985; Miles, 1999). 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 (Gerontological Society of America Task Force on Minority Issues in Gerontology, 1994; U.S. Bureau of the Census, 1993). Earlier life experiences of older adults were often conditioned by racial or ethnic identity. Many older minority persons faced discrimination and were denied access to jobs, housing, healthcare, and other services. As a result, older minority persons have fewer economic resources than majority persons. For example, 47% of black women aged 65 to 74 years live in poverty. As a consequence of these and other factors, minority older adults have more physical health problems than the majority of older persons and they often delay or refrain from accessing needed health and mental health services (Abramson, Trejo, & Lai, 2002; Vasquez & Clavigo, 1995; Yeo & Hikoyeda, 1993).

In addition to ethnic and minority older adults, there are sexual minorities including gay, lesbian, bisexual, and transgendered persons (Kimmel, 1995; Reid, 1995). They have also suffered discrimination from the larger society, including the mental health professions, which previously labeled sexual variation as psychopathology and utilized psychological and biological treatments to try to alter sexual orientation. Guideline 12 of APA's Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients (2000) discusses particular challenges faced by older adults in this minority status.

Aging presents special issues for individuals with developmental and other longstanding disabilities (e.g., mental retardation, autism, cerebral palsy, seizure disorders, traumatic brain injury), as well as physical impairments such as blindness, deafness, and musculoskeletal impairments (Janicki & Dalton, 1999). Nowadays, given available supports, life expectancy for persons with serious disability may approach or equal that of the general population (Janicki, Dalton, Henderson, & Davidson, 1999). Many chronic impairments may affect risk for age-

associated changes (e.g., Zigman, Silverman, & Wisniewski, 1996), and/or may have implications for psychological assessment, diagnosis, and treatment of persons who are aging with these conditions.

Aging is also conditioned by a multiplicity of environmental and ecological factors (Scheidt & Windley, 1998; Wahl, 2001), including rural/frontier issues and relocation. Place of residence affects access to health services, and places obstacles to providers in delivering services. Older adults residing in rural areas often have problems accessing aging resources (e.g., transportation, community centers, meals programs) and as a consequence experience low levels of social support and high levels of isolation (Guralnick, Kemel, Stamm, & Greving, 2003; Russell, Cutrona, de la Mora, & Wallace, 1997). Rural elders also have less access to community mental health services and to mental health specialists in nursing homes compared to non-rural older adults (Burns, Wagner, Taube, Magaziner, Permutt, & Landerman, 1993; Coburn & Bolda, 1999). Homebound older adults also find it particularly difficult to obtain psychological services since there are few programs that bring such services to older adults' residences.

**Guideline 6. Psychologists strive to be familiar with current information about biological and health-related aspects of aging.** In working with older adults, psychologists often find it useful to be informed about the normal biological changes that accompany aging. Though there are individual differences in rates of change, with advancing age the older individual inevitably experiences such changes as decreases in sensory acuity, alterations in physical appearance and body composition, hormonal changes, reductions in the peak performance capacity of most body organ systems, and weakened immunological responses and greater susceptibility to illness. Such biological aging processes may have significant hereditary or genetically related components (McClearn & Vogler, 2001), about which older adults and their families may often have keen interests or concerns. Adjusting to such physical changes with age is a core task of the normal psychological aging process (Whitbourne, 1996; 1998). When older clients discuss their physical health, most often their focus may be on changes with significant experiential components, such as changes in vision, hearing, sleep, continence, energy levels or fatigability, and the like. In such contexts, it is useful for the psychologist to be able to distinguish normative patterns of change from symptoms of serious illness, to recognize when

psychological symptoms might represent a side effect of medication or the consequence of a physical illness, and to provide informed help to older adults with respect to coping with physical changes and managing chronic disease (Frazer, 1995).

Over 80% of older adults have at least one chronic health condition, and most have multiple conditions, each requiring medication and/or management. The most commonly experienced chronic health conditions of late life include arthritis, hypertension, hearing impairments, heart disease, and cataracts (National Academy on an Aging Society, 1999). Other common medical problems include diabetes, osteoporosis, vascular diseases, neurological diseases, including stroke, and respiratory diseases (Segal, 1996). Many of these physical conditions have associated mental health conditions, either mediated physiologically (e.g., poststroke depression) or in reaction to disability, pain, or prognosis (Frazer, Leicht, & Baker, 1996).

Because older adults so commonly take medications for these conditions, it often is useful to have knowledge about various aspects of pharmacology. For example, pharmacokinetic and pharmacodynamic changes tied to aging affect older adults' metabolism of and sensitivity to medications, leading to consequent considerations about dosing. It is helpful to be familiar with medications typically used by older adults, including psychotropic medications, and potential interactions among them (Levy & Uncapher, 2000; Smyer & Downs, 1995). Numerous problems seen among older adults can stem from the multiplicity of medications they often are taking (so-called polypharmacy issues; Schneider, 1996).

Psychologists working with older adults may find behavioral medicine information useful in helping older adults with lifestyle and behavioral issues in maintaining or improving their health, such as nutrition, diet, and exercise (Bortz & Bortz, 1996). They can help older adults achieve pain control and manage their chronic illnesses and associated medications with greater compliance (Watkins, Shifrin, Park, & Morrell, 1999). Other health-related issues that are often encountered include preventive measures for dealing with the risk of falls and associated injury, management of incontinence (Burgio & Locher, 1996), and dealing with terminal illness (Kastenbaum, 1999). Behavioral medicine 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 (Siegler, Bastian, Steffens, Bosworth, & Costa, 2002).

For example, while many older adults experience some changes in sleep, it is often

difficult to determine whether these are inherent in the aging process or may stem from changes in physical health or other causes. Sleep complaints in older adults are sometimes dismissed as part of normal age-related change, but can also signal depression or other mental health problems (Bootzin, Epstein, Engle-Friedman, & Salvio, 1996). 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, Pat-Horenczyk, & Martin, 2001; *Older Adults and Insomnia Resource Guide*, 2001).

## 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., Blanchard-Fields & Hess, 1996; Craik & Salthouse, 2000; Park & Schwartz, 2000). For most older adults, the changes in cognition that occur with aging are mild in degree and do not significantly interfere with daily functioning (Abeles et al., 1998). While some decline in capacity and/or efficiency may be demonstrated in most cognitive domains, the vast majority of older adults continue to engage in their longstanding pursuits, interact intellectually with others, actively solve real-life problems, and achieve new learning.

Various cognitive abilities show differential rates and trajectories of change in normal aging (Schaie, 1994). Among the changes most commonly associated with normal aging are slowing in reaction times and the overall speed of information processing (Salthouse, 1996; Sliwinski & Buschke, 1999), and reduction in visuospatial and motor control abilities. Memory changes with age are also common, in particular those involving retrieval processes and so-called working memory (retaining information while using it in performance of another mental task) (Bäckman, Small, & Wahlin, 2001; Smith, 1996; Zacks, Hasher, & Li, 2000). Attention is also affected, particularly the ability to divide one's attention, to shift focus rapidly, and to deal with complex situations (Rogers & Fisk, 2001). Cognitive functions that are better preserved with age include learning, language and vocabulary skills, reasoning, and other skills that rely primarily on stored information and knowledge. Older adults remain capable of new learning, though typically at a somewhat slower pace than younger individuals. Changes in executive abilities, when they occur, tend to be quite predictive of functional disability (Royall, Chiodo, & Polk,

2000).

A large variety of factors influence both lifetime levels of cognitive achievement and patterns of maintenance or decline in intellectual performance in old age, including genetic, constitutional, health, sensory, affective and other variables. Sensory deficits, particularly when present in vision and hearing, often significantly impede and limit older adults' intellectual functioning and ability to interact with their environments, and may be linked in more fundamental ways with higher-order cognitive changes (Baltes and Lindenberger, 1997). Many of the illnesses and chronic physical conditions that are common in old age tend to have significant impacts on particular aspects of cognition, as do many of the medications used to treat them (Waldstein, 2000). Cumulatively, such factors may account for much of the decline that older adults experience in intellectual functioning, as opposed to simply the normal aging process in itself. In addition to sensory integrity and physical health, psychological factors such as affective state, sense of control and self-efficacy (Eizenman et al., 1997), as well as active use of information processing strategies and continued practice of existing mental skills (Schooler, Mulatu, & Oates, 1999) may influence older adults' level of cognitive performance.

At the same time, there is a relatively high prevalence of more serious cognitive disorders within the older adult population, and an appreciable minority of older adults suffers significantly impaired function and quality of life as a result. Advanced age is tied to increased risk of cognitive impairment, in varying forms and degrees. Population-based research has found that the prevalence of dementia increases dramatically with age, with various estimates indicating that as many as 25% to 50% of all those over age 85 suffer from this condition (Bachman et al., 1992; Evans et al., 1989). The most common types of dementia are Alzheimer's disease and vascular dementia; however, quite commonly, cognitive impairment in old age exists in milder forms that are not inevitably progressive and for which the etiology may not be clearly definable. Depression or anxiety sometimes triggers reversible cognitive impairments in older, vulnerable adults who had previously appeared normal in cognitive function (Butters et al., 2000). Reversible cognitive impairment or mental confusion can also result from medical conditions or side effects of medications. Acute confusional states (delirium) often signal underlying physical conditions or illness processes, which generally deserve prompt medical attention and sometimes may even be life-threatening (Dolan et al., 2000; Miller & Lipowski, 1991).

Largely as a consequence of the affected older adults' increased needs for assistance and

supervision, cognitively impairing disorders typically place great time demands and stress on caregiving family members as well as the affected individuals, and represent a very costly burden for society as a whole.

**Guideline 8. Psychologists strive to understand problems in daily living among older adults.** Older adults confront many of the problems in daily life that younger persons do. For example, increasingly, many older adults may remain in the work force, facing job pressures and decisions about retirement versus continued employment (Sterns & Gray, 1999). However, the increasing presence of acute or chronic health problems as persons age may exacerbate existing problems or create new difficulties. 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, 1999). Increasing use of health care can be frustrating for older adults because of demands on time, finances, transportation, and lack of communication among care providers.

It is important to understand how issues of daily living for many older adults center around the degree to which the individual retains “everyday competence” or the ability for independent function, or is disabled to such extent as having to depend on others for basic elements of self-care (Baltes, 1996; Diehl, 1998; Femia, Zarit, & Johansson, 2001). For example, for some older adults, health problems have an adverse effect on ability to complete activities of daily living, requiring the use of paid home health care assistants. 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 differences between care provider and recipient, or beliefs that family members are the only acceptable caregivers. Theoretical perspectives of person-environment fit or congruence (e.g., Kahana, Kahana, & Riley, 1989; Smyer & Allen-Burge, 1999; Wahl, 2001) have considerable applicability in such situations, and often are helpful in elucidating their remediable aspects. A useful general principle is the so-called “environmental docility” thesis, namely, that while behavior is a function of both person and environment, as older adults’ personal competence declines, environmental variables often play a correspondingly greater role in determining their level of functioning (Lawton, 1989).

Loss of mental abilities such as those found in Alzheimer's disease and other dementias and associated emotional and behavioral problems often have a significant impact on both older adults and family members (Schulz, O'Brien, Bookwala, & Fleissner, 1995). Older adults and family members confront difficult decisions about whether the older person with waning cognitive ability can manage finances, drive, live independently, or manage medications and make decisions about medical care. Older persons with dementia and their families must also deal with the financial and legal implications of the condition. Family members who experience caregiving stress are at increased risk for experiencing depression, anxiety, anger and frustration (Gallagher-Thompson & DeVries, 1994), and compromised immune system function (Cacioppo et al., 1998; Kiecolt-Glaser, Dura, Speicher, Trask, & Glaser, 1991). In addition, older adults who are responsible for others, such as the aging parents of adult offspring with longstanding disabilities or severe psychiatric disorders, may experience considerable duress in arranging for the future care or oversight of their dependents (Greenberg, Seltzer, & Greenley, 1993; Seltzer, Greenberg, Krauss, & Hong, 1997). Older grandparents who assume primary responsibilities for raising their grandchildren may face many similar problems and strains (Fuller-Thomson, Minkler, & Driver, 1997; Robertson, 1995; Szinovacz, DeViney, & Atkinson, 1999). Partly as a result of such tensions, mentally or physically frail older adults are at increased risk for abuse and neglect (Curry & Stone, 1995; *Elder Abuse and Neglect*, 1999; Wilber & McNeilly, 2001; Wolf, 1998).

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 (Myers, 1999). Relationships change, access to friends and family becomes more difficult, and demands to provide care to others increase. Of note, 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. Death of friends and older family members is something most older people experience (Kastenbaum, 1999). 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 not only deal with the emotional ramifications of these losses but also the practical challenges of how to reconstitute a meaningful social world.

**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.** Prevalence estimates suggest that approximately 20-22% of older adults may meet criteria for some form of mental disorder, including dementias (Administration on Aging, 2001; Gatz & Smyer, 2001; Jeste et al., 1999; Surgeon General, 1999). 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 (e.g., Bonwick & Morris, 1996; Hyer & Sohnle, 2001) 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 (Light & Lebowitz, 1991; Meeks & Murrell, 1997; Rosowsky, Abrams, & Zweig, 1999). 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 (Fisher & Noll, 1996; Gallo & Lebowitz, 1999; Reynolds & Charney, 2002). Suicide is a particular concern in conjunction with depression in late life, as suicide rates are higher among older adults than in other age groups (see Guideline 16). Dementing 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 (Phillips & Murrell, 1994).

Older adults often have multiple problems. Both mental and behavioral disorders may be evident in older adults (for example, those with Axis I disorders who also manifest concurrent substance abuse or Axis II personality disorders). Likewise, older adults suffering from progressive dementias typically evidence coexistent psychological symptoms, which may include depression, anxiety, paranoia, and behavioral disturbances. Because medical disorders are more prevalent in old age than in younger years, mental and behavioral problems are often comorbid with medical illness (Lebowitz & Niederehe, 1992). Being alert to comorbid physical and mental

health problems is a key concept in evaluating older adults. Further complicating the clinical picture, older adults often 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 medical conditions (Frazer, Leicht, & Baker, 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 compliance, 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 may have unique presentations in older adults. 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 (Gallo & Rabins, 1999). It may thus be difficult to determine whether symptoms such as apathy and withdrawal are caused by a depressive syndrome and/or impaired brain functioning (Lamberty & Bieliauskas, 1993). 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. Familiarity with the mental disorders of late life usually evident in clinical settings, their presentations in older adults, and relationship with physical health problems will facilitate accurate recognition of and appropriate therapeutic response to these syndromes.

Other issues that often come to clinical attention in older adults include substance abuse (Blow, Oslin, & Barry, 2002), complicated grief (Frank, Prigerson, Shear, & Reynolds, 1997), sexual dysfunction, psychotic disorders, including schizophrenia and delusional disorders (Palmer, Folsom, Bartels, & Jeste, 2002), and behavioral disturbances (e.g, wandering, aggressive behavior) in those suffering from dementia or other cognitive impairment (Cohen-Mansfield, Werner, Culpepper, Wolfson, & Bickel, 1996). Many comprehensive reference volumes are available as resources for clinicians with respect to late-life mental disorders (e.g., Butler, Lewis, & Sunderland, 1998; Edelstein, 2001; Kennedy, 2000; Smyer & Qualls, 1999; Whitbourne, 2000; Woods, 1999; Zarit & Zarit, 1998), 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 psychometrically suitable for use with them.** Relevant methods may include clinical interviewing; use of self-report measures; cognitive performance testing; direct behavioral observation; psychophysiological techniques; and use of informant data.

A thorough geriatric assessment is preferably an interdisciplinary one, determining how problems interrelate and taking account of contributing factors. In evaluating older adults it is, for example, almost always useful to ascertain the possible influence of medications on the presenting mental health or psychological picture, 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 for the presence of depression or other affective disorder, suicidal potential, psychotic symptoms, and like issues. As part of this process, in addition to employing clinical interview and behavioral observation techniques (Edelstein & Kalish, 1999; Edelstein & Semenchuk, 1996), psychologists may conduct various forms of standardized assessment.

Developing knowledge and skill with respect to standardized measures involves understanding the importance of using assessments that have been shown to be reliable and valid with older adults (e.g., Ivnik et al., 1992). For example, when assessing late-life issues in personality and characteristic patterns of behavior in relationship to older adults' clinical symptoms, psychologists frequently administer and interpret both symptom scales (such as those for depression or anxiety) and trait/personality measures (e.g., Costa & McCrae, 1988). Likewise, gaining an understanding of the clinical problem may require assessments of other persistent behavior patterns (e.g., assertiveness, dependency) and/or of contextual factors (such as family interaction patterns, degree of social support). Such assessments are likely to be most accurate and useful when based on measures designed for use with, or that have known psychometric properties relative to, older adults. The *Geropsychology Assessment Resource Guide* (1996) produced by the Veterans Administration and other resources (e.g., Lawton & Teresi, 1994; Poon et al. 1986) offer commentary on assessment instruments for use with

geriatric patients.

As well, behavioral assessment has many applications in working with older adults, particularly for psychologists working in hospital, rehabilitation, or other institutionalized settings (Fisher & Carstensen, 1990; Hersen & Van Hasselt, 1992; Lundervold & Lewin, 1992). Behavioral analysis (and associated intervention techniques) may often be useful with patients who show potentially harmful behavior such as wandering (Algaze, 2001) or assaultiveness (Fisher, Swingen, & Harsin, 2001), sexual disinhibition, or excess disability (i.e., impairment of function greater than that directly attributable to disease; Roberts, 1986). These techniques can also be valuable in determining elderly individuals' skills and weaknesses and targeting areas in which to strengthen adaptive behavior.

In assessing older adults, particularly those with cognitive impairments, psychologists may rely considerably on data provided by other informants. It is useful to be aware of empirical findings about effective ways of gathering such information, and general considerations about how to interpret it in relation to other data (e.g., Teri & Wagner, 1991). Likewise, evaluations of older adults may often be clarified by conducting repeated-measures assessments at more than a single time point. Such longitudinal assessment is useful particularly with respect to such matters as the older adult's affective state or functional capacities, and can help in examining the degree to which these are stable or vary according to situational factors, time of day, or the like.

Psychologists may do assessments for more than diagnostic purposes. They may also use them to help generate appropriate intervention strategies with the older patient, the family, other support providers, or professional caregivers, and to evaluate the outcomes of these interventions. For example, assessments may be used to appraise patient satisfaction with psychological interventions in nursing homes, to determine the key efficacious components of day care programs, or to evaluate the cost-benefit of respite care programs designed to help family caregivers maintain their demented relatives 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. Such program evaluations can lead to improved services for older adults.

**Guideline 11. Psychologists strive to understand the problems of using assessment instruments created for younger individuals when assessing older adults, and to develop**

**skill in tailoring assessments to accommodate older adults' specific characteristics and contexts.** When assessment tools appropriately validated and normed for use with this age group are not available, psychologists may find themselves in the position of using instruments imperfectly suited for the situation and exercising professional judgment to evaluate the probable impact of aging on test performance. At other times, the challenge may be to adapt the assessment procedures to accommodate the special frailties, impairments or living contexts of older adults (e.g., Hunt & Lindley, 1989). 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.

It may be useful to modify the assessment environment in various ways in order to reduce the influence of sensory problems or other preexisting (e.g., motor or longstanding intellectual) impairments on test results. In particular, clinicians would not want to confuse cognitive impairment with sensory deficits. Hearing difficulties in older adults tend to be worse at higher frequencies, and background noise can be especially distracting (Vernon, 1989). Thus, it can be helpful for the clinician to minimize surrounding noise and for female psychologists, in particular, to lower the pitch of their voice. To be useful, self-administered assessment forms may have to be reprinted in larger type, and high-gloss paper is best avoided.

Aging individuals with developmental disabilities or other preexisting physical or cognitive impairments may present unique challenges for psychological assessment, as well as for intervention (Janicki, Heller, & Hogg, 1996). Often it is not useful to apply the same techniques as employed with nondisabled individuals. Sensitivity to these special circumstances may demand exercising special care in selecting assessment procedures appropriate for the individual, and/or making adjustments in methods and diagnostic decisionmaking (Burt & Aylward, 1999; Working Group for the Establishment of Criteria for the Diagnosis of Dementia, 2000).

Another common challenge in conducting assessments is taking account of the potential influence of both psychopharmacological and other medications, and other substance use (Blow, 2000; Blow et al., 2002). Substance abuse assessment, particularly with respect to alcohol use but spanning the full range of abused substances, is frequently very valuable in clinical work with older adults. Whereas work demands and legal problems make alcohol abuse more apparent in

younger adults, in older adults it is often more difficult to detect or may present itself via atypical symptoms. Also, because of the multiple medications that many older adults take, psychologists may frequently find it useful to evaluate prescription and over-the-counter medication misuse (whether inadvertent or not).

Other special challenges in assessing older adults include interpreting the significance of somatic complaints; appraising the nature and extent of familial and other social support; evaluating potential elder abuse or neglect; and identification of strengths and potential compensatory skills.

**Guideline 12. Psychologists strive to develop skill at recognizing cognitive changes in older adults, and in conducting and interpreting cognitive screening and functional ability evaluations.** Quite commonly, when evaluating geriatric patients, psychologists may use specialized procedures and tests to help determine the nature of and bases for an older adult's cognitive difficulties, functional impairment, or behavioral disturbances (*Geropsychology Assessment Resource Guide*, 1996; LaRue, 1992; Lichtenberg, 1999; Poon et al., 1986; Storandt & VandenBos, 1994). For example, the referral question may be whether the individual's impairments exceed the extent of change expected from age alone, or whether the observed problems stem from a dementing process, depression, and/or other causes (Kaszniak & Christenson, 1994; Lamberty & Bieliauskas, 1993). Differentiating cognitive deficits that reflect early dementia from those associated with normal aging, and mild dementia from depression can be diagnostically challenging (Butters, Salmon, & Butters, 1994; Kaszniak & Christenson, 1994; Spencer, Tompkins, & Schulz, 1997). Clarification is often provided by comprehensive neuropsychological studies and longitudinal, repeated-measures evaluation. While impairment in delayed recall is a hallmark of Alzheimer's disease, the illness can present quite variably, and other dementing disorders may also present with poor retention. Disproportionate deficits in visuospatial or executive functions may indicate other etiologies. Prompt evaluation of memory complaints may be useful in identifying potentially reversible causes of cognitive impairment (APA Presidential Task Force on the Assessment of Age-Consistent Memory Decline and Dementia, 1998), though such complaints are also influenced by mood and many other factors and in themselves are generally not reliable indices of objectively measured cognitive decline (Niederehe, 1998; Smith, Petersen, Ivnik, Malec, & Tangalos, 1996).

The ability to make accurate assessments and appropriate referrals in this area depends upon knowledge of normal and abnormal aging, including age-related changes in intellectual abilities. In conducting such assessments, psychologists rely upon their familiarity with age-related brain changes, diseases that affect the brain, tests of cognition, and age-appropriate normative data on cognitive functioning (Albert & Moss, 1988; Green, 2000; Ivnik et al., 1992; Nussbaum, 1997; Park, Zec, & Wilson, 1993), as well as upon knowledge of how performance can be influenced by preexisting impairments and individual differences in cognitive abilities. Brief cognitive screening tests do not substitute for more thorough evaluation in challenging cases. Psychologists make referrals to clinical neuropsychologists (for comprehensive neuropsychological assessments<sup>‡</sup>), neurologists, or other specialists as appropriate.

Psychologists sometimes do functional capacity assessments and consult on questions regarding an older person's functional abilities (Diehl, 1998; Willis et al., 1998). For example, they may be asked to assess the individual's abilities to make medical or legal decisions (Marson, Chatterjee, Ingram, & Harrell, 1996; Moye, 1999; Smyer, 1993; Smyer & Allen-Burge, 1999) or to exercise specific behavioral competencies, such as medication management (Park, Morrell, & Shifrin, 1999) or driving (Ball, 1997; Odenheimer et al., 1994). Other questions, including those of a forensic nature, may involve the elder's capacity for continued independent living, capacity for making advanced directives or a valid will, or need for legal guardianship (*Assessment of Competency and Capacity of the Older Adult*, 1997; Marson, 2002; Smyer, Schaie, & Kapp, 1996). In addressing questions in these areas, the psychologist typically evaluates cognitive skills, higher-order executive functioning (such as ability to plan, organize and implement complex behaviors), and other aspects of psychological function, using assessment procedures within their expertise and competence that have demonstrated validity concerning the referral questions. Furthermore, to make ecologically valid recommendations in these areas, he or she often integrates the assessment results with clinical interview information

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<sup>‡</sup> In 1996, at the recommendation of the Commission for Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP), the APA Council of Representatives formally recognized Clinical Neuropsychology as a “specialty that applies principles of assessment and intervention based upon the scientific study of human behavior as it relates to normal and abnormal functioning of the central nervous system” and that “is dedicated to enhancing the understanding of brain-behavior relationships and the application of such knowledge to human problems” (archival description available at <http://www.apa.org/crsppp/neuro.html>).

gathered from both the older adult and collateral sources, with direct observations of the older adult's functional performance, and with other pertinent considerations (such as the immediate physical environment, available social supports, or local legal standards).

### **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). As different theoretical approaches have emerged, each has been applied to older adults, e.g., psychoanalysis, behavior modification, cognitive therapy, and community mental health consultation. In addition, efforts have been made to use the knowledge base from research on developmental processes in later life in order to inform intervention efforts (e.g., Knight, 1996).

Increasing 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 (Pinquart & Soerensen, 2001; Zarit & Knight, 1996), though often responding somewhat more slowly. Cognitive-behavioral, psychodynamic, interpersonal and other approaches have shown utility in the treatment of specific problems among the aged (Gatz et al., 1998; Teri & McCurry, 1994). The problems for which efficacious psychological interventions have been demonstrated in older adults include depression (Areán & Cook, 2002; Niederehe & Schneider, 1998; Scogin & McElreath, 1994), anxiety (Stanley, Beck, & Glassco, 1996; Mohlman et al., 2003; Wetherell, 1998; 2002), sleep disturbance (Morin, Colecchi, Stone, Sood, & Brink, 1999; Morin, Kowatch, Barry, & Walton, 1993), and alcohol abuse (Blow, 2000). Cognitive training techniques, behavior modification strategies, and socio-environmental modifications may have particular relevance both for treating depression and improving functional abilities in cognitively impaired older adults (Burgio, 1996; Camp & McKitrick, 1992; Floyd & Scogin, 1997; Neely & Bäckman, 1995; Teri, Logsdon, Uomoto, & McCurry, 1997). Reminiscence or life review therapy has shown utility as a technique in various applications, including the treatment of depression (Areán et al., 1993) and post-traumatic stress disorder

(Maercker, 2002). The research knowledge base in treatment of late-life mental disorders is less adequate, however, with respect to establishing the efficacy of psychological interventions with ethnic minority older adults (Areán, 2003).

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 (Watkins et al., 1999) and behavioral aspects of urinary incontinence (Burgio, 1998). They also can provide valuable assistance to older adults in dealing with the developmental issues of later life (Gutmann, 1994; Tobin, 1999), adapting to changing life circumstances, improving interpersonal relationships, and the like (e.g., see *Aging and Human Sexuality Resource Guide*, 2000).

**Guideline 14. Psychologists strive to be familiar with and develop skill in applying 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 techniques, and may employ both methods used for direct patient care and others designed for working with older adults' families and caregivers. 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 (Zarit & Knight, 1996; Duffy, 1999a).

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, the clinical goals, the immediate situation, and the individual patient's characteristics, preferences and place on the continuum of care (for case examples, see Karel, Ogland-Hand, & Gatz, 2002; Knight, 1992). For example, community dwelling elders who are quite functional both physically and mentally may respond very well to outpatient forms of psychotherapy (individual, group, family, etc.). On the other hand, many disorders of late life are chronic or recurrent rather than acute, and the clinical objectives typically involve symptom management and rehabilitative maximization of function rather than cure (Knight & Satre, 1999).

Accordingly, frail elders who are cognitively impaired, bed-bound, and depressed may respond most positively to behavioral techniques or modified psychotherapeutic approaches, emphasizing interpersonal support and environmental modifications designed to maximize functional abilities (Lichtenberg & Hartman-Stein, 1997; Wisocki, 1991).

The research literature provides evidence of the importance of specialized skills in working with the older adult population (Pinquart & Soerensen, 2001). A variety of special issues characterize work with older adults that may require that psychologists show particular sensitivities or utilize specialized techniques of intervention (*Psychotherapy and Older Adults Resource Guide*, 2003). For example, because many older adults lack familiarity with psychological services or harbor negative attitudes toward mental health issues, therapists often take special steps to educate older patients about ways in which psychological intervention may be helpful. 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, both as an element of other therapies (e.g., Birren & Deutchman, 1991; Peake, 1998) and as a separate, special technique (Haight, 1991; Haight & Webster, 1995; Sherman, 1991).

Because the issues are so commonly present, psychological intervention with older adults frequently also incorporates ways of addressing medical and other forms of comorbidity (for example, pain management, or enhancing compliance with medical treatment; Park, Morrell, & Shrifin, 1999). When facing physical illness, older adults may require assistance with adjusting to disabilities, bringing awareness and autonomy to the dying process (Kastenbaum, 2000), or altering patterns of relationship to family members, friends or significant others.

Though the procedures and techniques of clinical psychology in general are useful in working with older adults, and helpful in facilitating continued psychological growth at this stage of the life cycle, the appropriate and effective application of these methods to older adults involves expertise in adapting and tailoring them to fit the specific needs and situations of this age group (Jongsma & Frazer, 1998). Various adaptations of therapies have been advocated. For example, the processes of problem-solving, new learning, and behavior change often unfold more slowly when working with older adults (Gallagher-Thompson & Thompson, 1996); and sometimes modifications may be helpful to make the therapy more "user friendly" for older

adults (Duffy, 1999a). These modifications may range from using larger print on forms for self-monitoring behavior or mood, to incorporating expressive techniques into the therapeutic interaction, to therapists' conducting home visits when mobility is impaired (Buschmann, Hollinger-Smith, & Peterson-Kokkas, 1999; Duffy, 1999b; Zeiss & Steffen, 1996).

Such changes may be prompted more by specific issues that older adults face (e.g., chronic illness and disability, grieving for loved ones, caregiving), the specific environments in which some older adults live or spend time (e.g., age-segregated social programs, skilled nursing facilities), or generational or cohort differences, than by clients' age per se (Knight, 1996). Many of the unique aspects of intervening with older adults thus may come from the content, rather than from the processes, of the therapy, where there is more attention to physical illness, grief, cognitive decline, and stressful practical problems associated with being old (Knight & Satre, 1999). It is also important to adapt interventions to fit the environmental context of the work, whether that be a private office, home, hospital or long-term care facility setting (see Guideline 15).

Furthermore, in addition to providing individual forms of treatment, many times psychologists deal with older adults as active participants in family or other social systems and work extensively with other interacting persons. Psychologists often assist family members or other care providers by providing education and/or emotional support, facilitating conceptualization of problems and potential solutions, and improving communication and the coordination of care (Qualls, 1995). While treating emotional and behavioral symptoms in older adults with progressive dementias generally involves attending to the affected older person as an individual (Kasl-Godley & Gatz, 2000), often families may also need help in understanding and coping with the behavioral problems that accompany dementia (Thompson & Gallagher-Thompson, 1996). Psychological interventions with family members who are providing care to older adults is a distinctive area of practice, with organized programs of intervention, training for providers, and evaluation of effectiveness (Coon, Gallagher-Thompson, & Thompson, 2003; Gallagher-Thompson & Steffen, 1994; Knight, Lutsky, & Macofsky-Urban, 1993; Mittelman et al., 1995; Teri et al., 1997).

**Guideline 15. Psychologists strive to understand the 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 (Gelfand, 1999; Scheidt & Windley, 1998). These service delivery sites encompass various community settings where older people are to be found, including community-based and in-home care settings (e.g., senior centers, their own homes or apartments); outpatient settings (e.g., mental health or primary care clinics, private practitioner offices, HMO settings, or outpatient group programs); "day" programs (such as day hospitals or health care centers, day care centers, psychiatric partial hospitalization programs) serving elders with multiple or more complex problems; inpatient medical or psychiatric hospital settings; and long term care settings (such as nursing homes, residential care, assisted living, hospice and other congregate care sites; see Smyer & Allen-Burge, 1999). Some institutions include a variety of care settings. For example, consultation in Continuing Care Retirement Communities may run the gamut from older adults living in independent apartments to assisted living settings to the skilled nursing facility (SNFs). 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 clinician will usually treat physically frail and/or cognitively impaired elders (Lichtenberg & Hartman-Stein, 1997).

Understanding the financing and reimbursement systems, such as Medicare and Medicaid, that govern the organization and operation of various facilities is an important aspect of professional function in these settings (Norris, 2000; Norris, Molinari, & Rosowsky, 1998).

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 (Lichtenberg, 1994; Molinari, 2000; Norris, Molinari, & Ogland-Hand, 2002; see also *Psychological Services for Long Term Care Resource Guide*, 2000).

**Guideline 16. Psychologists strive to recognize 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., Gallagher-Thompson & DeVries, 1994) and by involvement in broader prevention efforts and other community-oriented interventions, as well as by advocacy within health care and political-

legal systems (Gatz & Smyer, 2001; Hartman-Stein, 1998; 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. 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. An important aspect of this emphasis 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 (Fees, Martin, & Poon, 1999), it might be pertinent to consider the availability of organized opportunities for older adult socialization and whether to increase these. 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 (Bortz & Bortz, 1996; Rowe & Kahn, 1998).

An area of particular concern for preventive efforts in the older adult population is that of suicide prevention (*Depression and Suicide in Older Adults Resource Guide*, 2002; Pearson, 2002). Older adults, and especially older white males, are the age group at highest risk for suicide (Conwell & Duberstein, 2001). A large study conducted in Finland indicated that depression was a particularly common precursor among older women who attempted or committed suicide, whereas older men in this category were more likely to have financial or physical health difficulties or substance abuse problems (Suominen et al., 1996). According to such data, assessment for suicide risk and prevention interventions might be directed towards older adults with depression and/or substance abuse. An influential observation has been that 70 to 75% of older adults who commit suicide have seen a physician quite recently (Carney, Rich, Burke, & Fowler, 1994). Based on this logic, it is important to enlist primary care physicians in efforts to prevent late-life suicide, through improved recognition of depressive symptoms and other risk factors, and referral to appropriate treatment (Pearson & Brown, 2000).

**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 to families and other caregivers of older adults, as

well as to other professionals, self-help and support groups, institutions, agencies, and community organizations. In particular, they may often play key roles in providing training to staff who work directly with older adults in a variety of settings (Kramer & Smith, 2000), and in leading or contributing to program development, evaluation and quality assurance (Hartman-Stein, 1998; Knight & Kaskie, 1995). In the changing health care system, psychologists are increasingly likely to fill such consultative, supervisory, and educational roles in the organization and delivery of services to impaired older persons (e.g., particularly in nursing home settings; see Smyer, Cohn, & Brannon, 1988). If current trends continue, they may spend even more time than is already the case training and clinically supervising other health care providers for work with the aged.

**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 frequently may 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. Other disciplines typically involved in coordinated care, either as part of a team or to which referrals may be appropriate, include physicians, nurses and other associated health professionals, social workers, clergy, and lawyers. Psychologists can help a group of professionals become a team that is interdisciplinary in function, rather than merely multidisciplinary in structure, by generating effective strategies for integrating and coordinating the services provided by the various team members (Zeiss & Steffen, 1998).

For effective collaboration with other professionals, whether through actual teamwork or referrals, it is useful for psychologists to be knowledgeable about the services available from other disciplines and their potential contributions to a coordinated effort (e.g., see *Resource Directory for Older People*, 2001). 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 may often be a key element in providing effective psychological services to older adults.

To provide psychological services in particular settings, it is important to learn how to collaborate in an interdisciplinary fashion with other disciplines operating in those environments. For this, it is useful to be familiar with the issues affecting particular service settings, such as age-related residential settings and services programs, and existing and emerging health care delivery systems, and to understand how various locales (e.g., in-home, outpatient, partial or day care, inpatient, extended care) fit into the broader continuum of care (see Guideline 15). It is also useful to understand entitlement programs for older adults (e.g., Social Security), provider reimbursement programs such as Medicare (see Administration on Aging, 2001; *Medicare Handbook: A Guide for Psychologists*, 2003; *Medicare Local Medical Review Policies Tool Kit*, 2003; Norris, 2000; Norris, Molinari & Rosowsky, 1998), and how entitlement and reimbursement issues affect each of the disciplines on the team.

Sometimes psychologists are not able to operate within a team approach because they work in a private practice setting or other clinical context that lacks close linkages with other professions. In such settings psychologists may often see older adults with treatable problems for which they are not receiving adequate or timely professional attention. In such cases, another important role for the psychologist is to be proactively involved in outreach and appropriate referral to other professionals. Once having assured that such older adults receive more comprehensive care (whether that be in terms of social services, medications or other forms of care), psychologists can take steps to improve overall coordination and management of the care. They can attempt to tailor their psychological services to fit into an integral care plan suitable for the older individual and work towards helping the other care providers understand how each professional service being offered may affect the patient's response to other aspects of ongoing care. Such coordination of services is often key in the care of older adults, even in the private practice setting.

**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 insure the safety of the older adults with whom they work but also to allow them to direct their own lives. Conflicts arise particularly with physically frail or cognitively impaired older adults

because their ability to exercise autonomy is presumed to be impaired. 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, 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, and to avoid adding their own value preferences to an already complex mix (Gilhooly, 1986; Yarhouse & DeVries, 1998).

Similar considerations regarding informed consent for treatment apply in work with older adults as in work with younger people. Special considerations tend to enter the picture to the degree that cognitive impairment (whether due to longstanding disabilities or age-associated changes) is present, or that the older individual may lack familiarity with the treatments that are being discussed as options. For example, while refusals of treatment always deserve to be respected, extra efforts may also be essential to assure that an older adult is making a treatment decision on an adequately informed basis. Older adults who may initially display an unwillingness to consent to participate in psychotherapy sometimes change this stance when informed that the therapy is short term, that it does not involve inpatient commitment, and that they will have the opportunity to decide their own treatment goals. As older adults are often brought in for therapy by family members, it is also important to assure that the older individual can make his or her own treatment decision independently of the desires of the family. Insistence on obtaining the individual's personal consent often may be an important part of building rapport with the older adult (Knight, 1996).

A diagnosis of dementia is not equivalent to incapacity. Even older adults with dementia often maintain the capacity to give or withhold consent until the illness has progressed to a point at which incapacity can be clearly established (Moye, 2000; Smyer & Allen-Burge, 1999). The particular point at which this occurs depends on the specific decision to be made. Even after incapacity becomes clear-cut, the individual often remains able to indicate assent to decisions.

Psychologists working with older adults may often encounter confidentiality issues in situations that involve families, multidisciplinary teams, long-term care settings, or other support systems. A common values conflict with regard to confidentiality involves older persons who are moderately to severely cognitively impaired and may be in some danger of causing harm to themselves or others as a result. Though it constitutes an exception to the general rules concerning confidentiality and deserves to be thought through with care, in such cases, it may be

allowable to contact and share information with others. At the same time, for some individuals, preserving the individual's continued freedom and autonomy may be worth tolerating some risk of self-injury or allowing them to remain in a substandard living environment (Norris, Molinari, & Ogland-Hand, 2002).

In some settings (e.g., nursing homes, board and 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 (Lichtenberg et al., 1998).

Psychologists working with older adults may at times experience pressure from family members or other helping professionals who are also involved to share information about the older person. Such information sharing is often justified in terms of the need to help the older adult, and the collaboration with others may be very advantageous. Nonetheless, older adults in treatment relationships have as much right to full confidentiality as younger adults, and deserve to be asked to consent (in writing, if possible) to the sharing of information as long as able to provide consent (Knight, 1996).

Another set of ethical issues involves handling potential conflicts of interest between older adults and family members, particularly in situations of substitute decision making (Smyer & Allen-Burge, 1999). Even when cognitive incapacity does interfere with a demented person's ability to exercise autonomy in the present, it may remain possible to ascertain what the individual's wishes have been in the past and act according to those wishes. The question arises as to who decides what is in the demented person's best interests: one or another family member, a professional person, the residential facility in which the demented person resides, the director of a research program and so on. In each instance, 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 demented older adult (Allen-Burge & Haley, 1997). This potential for conflict of interests arises both with formally and legally appointed guardians as well as with informal substitute decision making by family members.

Psychologists may experience role conflicts when working in nursing homes. 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 reserving uppermost priority for serving the best interests of the older adult, even when the psychologist has been hired by the facility (Abeles et al., 1998).

At times, psychologists may encounter situations in which it is suspected that older adults may be victims of abuse or neglect, and will be legally obligated to report these to appropriate authorities. Serving older adults well under these circumstances entails being knowledgeable about applicable statutory requirements as well as local community resources, and collaborating in arranging for the involvement of adult protective services (*Elder Abuse and Neglect*, 1999; Pollack & Weiner, 1995; Wolf, 1998). 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 regarding legal concerns and professional ethics surrounding these matters (APA Working Group on Assisted Suicide and End-of-Life Decisions, 2000).

## **Education**

**Guideline 20. Psychologists are encouraged to increase their knowledge, understanding and skills with respect to working with older adults through continuing education, training, supervision and consultation.** Psychologists can obtain training in working clinically with older adults through various pathways, including respecialization programs, postdoctoral fellowships, continuing education activities (workshops, in-service training/seminars, distance learning), self-study and/or supervised self-study, or combinations of such alternatives. Newly trained psychologists fortunate enough to be given supervised experience in clinical work with older adults as part of their graduate training most commonly receive it within clinical internships or postdoctoral fellowships, although some graduate programs may provide such training opportunities as part of clinical practicum course work. Those already in practice but unable to participate in concentrated, formal training programs may be able to accumulate continuing education credits. Many practicing psychologists perceive a need for and express interest in continuing education in clinical geropsychology (Qualls et al., 2002), and opportunities for obtaining continuing education in this area are expanding. Individuals in practice may also enroll over time for course work relating to the provision of services to the older adult, and gain consultation or supervised experience working with older

adults by arrangements with local clinical service organizations and/or individual psychologists who are already skilled in this area.

The research and practice literature relevant to working with older adults is available through various major professional journals, including a growing number of applied clinical journals. Research and practice developments are also disseminated to practitioners through various professional organizations. Within APA, both Division 20 (Adult Development and Aging), and Division 12-Section II (Clinical Geropsychology) have newsletters, email networks, and web sites offering information useful to practicing psychologists. For example, among its “Resources for Educators,” the Division 20 web site features extensive listings of relevant reference materials, including books, films and videotapes, sample syllabi for various undergraduate and graduate courses in the psychology of aging, and a guide to doctoral programs in adult development and aging, including clinical geropsychology (APA Division 20 Education Committee, 2002). The Division 12-Section II website features a directory of pre- and post-doctoral training opportunities in clinical work with older adults (Hinrichsen & Arnold, 2001). Likewise, the Office on Aging page on the main APA website provides access to a number of aging-related APA publications, some of them downloadable (see <http://www.apa.org/pi/aging>).

Psychologists in Long Term Care (PLTC) is an independent organization that convenes regularly in conjunction with APA Conventions and annual meetings of the Gerontological Society of America (GSA). PLTC frequently provides workshop training for psychologists interested in developing assessment, therapeutic and consultation skills in serving older adults in long term care settings. The GSA has a multidisciplinary membership and, as part of its annual meeting, promotes information sharing and networking among the health professions which serve older adults in sessions held by standing interest groups on numerous topics (e.g., mental health practice, end-of-life issues). Other special interest groups on aging have operated for varying periods of time and with variable intensity within the Association for Advancement of Behavior Therapy (AABT), and in additional practice-oriented APA Divisions, such as Division 17 (Counseling Psychology), Division 29 (Psychotherapy), Division 38 (Health Psychology), and Division 42 (Independent Practice).

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