



AMERICAN
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Guidelines for Psychological Practice with Older Adults

Introduction

The “Guidelines for Psychological Practice with Older Adults” are intended to assist psychologists in evaluating their own readiness for working with older adults, as well as seeking and using appropriate education and training to increase their knowledge, skills, and experience relevant to this area of practice. Although “older adults” typically refers to persons 60-65 years of age and older, gerontological researchers and policy makers increasingly recognize that this demarcation is socially constructed, encompasses younger-old (“third age”) and older-old (“fourth age”) individuals, and is linked to many socio-cultural referents, including family status and health conditions that vary widely across generational cohorts and socioeconomic and cultural groups (Baltes & Smith, 2003; Diehl et al., 2020; World Health Organization [WHO], 2017b). It is notable that adults over age 50 with problems such as serious mental illness or human immunodeficiency virus (HIV), and those who are sexual and gender minorities (SGM) are often considered “older adults” given their experience of increased incidence of multiple chronic conditions, sometimes shorter expected lifespan, and similar challenges to those faced by adults age 65 and older (Brennan-Ing et al., 2014; Chan et al., 2022; High et al., 2012; Olfson et al., 2015). We use “older adults” in this document since it is commonly used by geropsychologists and is the recommended term in American Psychological Association publications (American Psychological Association [APA], 2010a). The specific goals of these professional practice guidelines are to provide practitioners with (a) a frame of reference for engaging in clinical work with older adults; and (b) basic information and further references in the areas of attitudes, general aspects of aging and broad impacts of intersectionality, clinical issues, assessment, intervention, consultation, professional issues, and continuing education and training relevant to practice with this group. The guidelines recognize and appreciate that there are numerous methods and pathways whereby psychologists may gain expertise and/or seek training in working with older adults. This document is designed to offer recommendations on those areas of awareness, knowledge and clinical skills considered as applicable to this work, rather than prescribing specific training methods to be followed (see Hinrichsen et al., 2018 and Hinrichsen & Emery-Tiburcio, 2022 for more guidance). The guidelines also recognize that some psychologists will specialize in the provision of services to older adults and may therefore seek more extensive training consistent with practicing within the formally recognized specialty of Professional Geropsychology (APA, 2010b, 2008a), at the doctoral, internship, postdoctoral, or post-licensure levels (Council of Professional Geropsychology Training Programs [CoPGTP], 2022; American Board of Geropsychology [ABGERO], 2022).

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

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

Need

A revision of the guidelines is warranted at this time as psychological science and practice in the area of psychology and aging have evolved rapidly. Clinicians and researchers have made impressive strides toward identifying the unique aspects of knowledge that facilitate the accurate psychological assessment and effective treatment of older adults as the psychological literature in this area has burgeoned.

As noted in the 2013 Guidelines for Psychological Practice with Older Adults (APA, 2014a), professional psychology practice with older adults has been increasing, due both to the changing demography of the population, changes in service settings such as telehealth, and market forces. The inclusion of psychologists in Medicare in 1989 markedly expanded reimbursement options for psychological services to older adults. Today, psychologists provide care to older adults in a wide range of settings from home and community-based clinics, to telehealth, integrated primary care, and long-term care settings. Nonetheless, older adults with mental disorders are less likely than younger and middle-aged adults to receive mental health services and, when they do, are less likely to receive care from a mental health specialist than younger persons (Bogner et al., 2009; Choi et al., 2015; Institute of Medicine, 2012; Jacobs & Bamonti, 2022). Further, older adults who are Black, Indigenous and People of Color (BIPOC) are less likely to receive adequate mental health care (Chen et al, 2022; Jimenez et al., 2013).

Unquestionably, the demand for psychologists with a substantial understanding of later life wellness, cultural, and clinical issues will expand in future years as the older population grows

and becomes more diverse, and as cohorts of middle-aged and younger individuals who are receptive to psychological services move into old age (Carpenter et al., 2022; Karel et al., 2012). However, psychologist time devoted to care of older adults does not and likely will not meet the anticipated need (Hoge et al., 2015; Karel, et al., 2012; Moye et al., 2018; See also 2018 *APA: A Summary of Psychologist Workforce Projections*). Indeed, across professions, the geriatric mental health care workforce is not adequately trained to meet the health and mental health needs of the aging population (Hinrichsen et al., 2018; Hoge et al., 2015; Institute of Medicine, 2012).

Older adults are served by psychologists across subfields including clinical, counseling, family, geropsychology, health, industrial/organizational, neuropsychology, and rehabilitation. The 2018 APA Center for Workforce Studies survey found that 1% of respondents viewed older adults as their primary focus although 37% reported that they provide some type of psychological services to older adults (Moye et al., 2018). Relatively few psychologists, however, have received formal training in adult development and aging. Fewer than one third of APA member practicing psychologists who conducted some clinical work with older adults reported having had any graduate coursework in geropsychology, and fewer than one in four received any supervised practicum or internship experience with older adults (Qualls et al., 2002; Segal et al., 2012; Moye et al., 2018). Many psychologists may be reluctant to work with older adults, citing perceived low Medicare reimbursement rates, or because they feel they do not possess the requisite knowledge and skills. In the practitioner survey conducted by Qualls and colleagues (2002), a high proportion of the respondents (58%) reported that they needed further training in professional work with older adults, and 70% said that they were interested in attending specialized education programs in clinical geropsychology. In the APA Workforce study, there was strong interest in further training in aging among all psychologists (Moye et al., 2018).

Compatibility

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

The guidelines are also consistent with the efforts that psychology has exerted over the past two decades to focus greater attention on the strengths and needs of older adults, and to develop a workforce competent in working with older adults. Building on the adoption of the Guidelines for Psychological Practice with Older Adults (APA, 2004), The National Conference on Training in Professional Geropsychology was held in 2006 (funded in part by APA) and resulted in the development of the Pikes Peak Model for Training in Professional Geropsychology at the doctoral, internship, postdoctoral, and post-licensure levels (Knight et al., 2009). That same year,

the Council of Professional Geropsychology Training Programs (CoPGTP) was established “to promote state-of-the-art education and training in geropsychology among its members, to provide a forum for sharing resources and advancements in and among training programs, and to support activities that prepare psychologists for competent and ethical geropsychology practice” (CoPGTP, 2022). This organization has developed geropsychology training taxonomy guidelines at the predoctoral, internship, and postdoctoral levels (APA, 2020c). In 2010, the APA Commission on the Recognition of Specialties and Proficiencies in Professional Psychology recognized Professional Geropsychology as a specialty in professional psychology. In 2014, the American Board of Professional Psychology Geropsychology launched board certification in geropsychology (ABPP; ABGERO, 2022). There are now multiple paths for psychologists to gain geropsychology competencies and have these certified by well-recognized credentialing bodies (<https://gerocentral.org/training-career/seminarsce/>). For example, the E4 Center of Excellence for Behavioral Health Disparities in Aging and CATCH-ON Geriatric Workforce Enhancement Program have created an online certificate program in the Foundational Competencies for Older Adult Mental Health that is certified by the Council of Professional Geropsychology Training Programs (<https://e4center.org/training-and-technical-assistance/foundational-competencies-in-older-adult-mental-health-certificate-program/>).

Recognizing that there will never be enough geropsychologists to meet the mental health and substance use needs of older adults, a workgroup of the Council of Professional Geropsychology Training Programs (CoPGTP) led by Hinrichsen and colleagues (2018) surveyed geropsychologists to determine which of the Pikes Peak competencies were critical for generalists to develop basic competency. Results indicated weighting of each of the competencies in a 14-hour exposure-level training. Subsequently, a special issue of *Clinical Psychology: Science and Practice* (see Hinrichsen & Emery-Tiburcio, 2022) was devoted to delineating these basic competencies with foundational knowledge for all psychologists.

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

Development Process

In 2021, the APA Policy and Planning Board (P&P) in accordance with Association Rule 30-8.4, provided notice to Division 20, Division 12-Section II, and the Aging Portfolio that on December 31, 2023, the APA Guidelines for Psychological Practice with Older Adults would expire. The

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

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

These guidelines have been re-organized into six sections to be consistent with the Pikes Peak competencies (Knight et al., 2009): (a) Attitudes; (b) General Knowledge about Adult Development, Aging, and the Older Adult Population; (c) Foundations of Professional Geropsychology Practice; (d) Assessment; (e) Intervention; and (f) Consultation. Efforts were made to identify the best fit for each guideline, with recognition that some guidelines may span multiple Pikes Peak competencies. Reorganization of the guidelines was based upon consensus of workgroup members and informed by subject matter experts. Additionally, it is notable that two significant revisions were made to the structure of the 2013 guidelines. First, the original Guideline 11 was deemed to be redundant with other guidelines, and thus was removed. Second, given increased technology and telehealth use, an additional guideline was developed to provide recommendations for psychologists in the provision of telehealth care to older adults. Consideration was given to including telehealth in Guideline 8, which focuses on settings of care. The Task Force determined that the significant emergence of telehealth in recent years, along with common misperceptions about older adult use of telehealth, warranted the development of its own guideline.

Attitudes

Guideline 1. Psychologists are encouraged to work with older adults within their scope of competence. Training in professional psychology provides general skills that can be applied for

the potential benefit of older adults. Many older adults have presenting issues similar to those of other ages and generally respond to the repertoire of skills and techniques possessed by all professional psychologists. For example, psychologists are often called upon to evaluate and/or assist older adults with life stress or crisis (Brown et al., 2012) and adaptation to late life issues (e.g., chronic medical problems affecting daily functioning, caregiver stress; Moye et al., 2019). Psychologists play an equally important role facilitating the maintenance of healthy functioning, accomplishment of new life-cycle developmental tasks, and/or achievement of positive psychological growth in the later years (O'Rourke et al., 2018). Given some commonalities across age groups, considerably more psychologists may want to work with older adults, as many of their already existing skills can be effective with these clients (Karel et al., 2012; Moye et al., 2018).

However, other problems may be more prevalent among older adults than younger adults (e.g., sleep disorders, dementia, delirium), may manifest differently across the lifespan (e.g., anxiety, depression, loneliness, substance use), or may require modifications to treatment approaches (Jacobs & Bamonti, 2022; Ong et al., 2016; Yardley et al., 2015). In some circumstances, special skills and knowledge may be essential for assessing and treating certain problems in the context of later life (Segal et al., 2018; Qualls, 2022).

Clinical work with older adults may involve a complex interplay of factors, including developmental issues specific to later life, cohort (generational) perspectives and beliefs (e.g., family obligations, perceptions of mental disorders), comorbid physical illnesses, the potential for and effects of polypharmacy, cognitive or sensory impairments, a history of medical or mental disorders, and psychosocial issues such as social isolation and loneliness, or financial insecurity (Donovan & Blazer, 2020; Pharr et al., 2014; Raposo et al., 2014; Thompson et al., 2016; Wastesson et al., 2018). The potential interaction of these factors makes the field highly challenging and calls for psychologists to skillfully apply psychological knowledge and methods. Education and training in the biopsychosocial processes of aging along with an appreciation for and understanding of cohort factors can help ascertain the nature of the older adult's clinical issues. Additionally, consideration of the client's age, gender identity and expression, sexual orientation, cultural background, immigration status or history, degree of health literacy, prior experience with mental health providers, resiliencies, and usual means of coping with life problems inform interventions (Clauss-Ehlers et al., 2019; Layland et al., 2020; Musich et al., 2018). Thus, psychologists working with older adults can benefit from specific preparation for clinical work with this population.

Although it would be ideal for all practice-oriented psychologists to have completed courses relating to the aging process and older adulthood as part of their clinical training (Karel et al., 2010), this is not the case for most, and psychologists who frequently work with older adults desire further training in gerontology (Moye et al., 2018). Having reviewed these guidelines, psychologists can match the extent and types of their work with their scope of competence (APA 2017) and can seek consultation or make appropriate referrals when the problems encountered lie outside of their expertise. The guidelines also may help psychologists who wish to further expand their knowledge base in this area through continuing education and self-study. Further, the Council of Professional Geropsychology Training Programs (CoPGTP) published

recommendations for foundational competencies all psychologists should attain in working with older adults (Hinrichsen et al., 2018).

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

Guideline 2. Psychologists are encouraged to recognize 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, 2016) urges psychologists to respect the rights, dignity, and welfare of all people and eliminate the effect of cultural and sociodemographic stereotypes and biases (including ageism) on their work. The APA Council of Representatives recently passed an update to their 2002 resolution opposing ageism and continued to commit the Association to its elimination as a matter of APA policy (APA, 2020a). Ageism has been recognized as an important public health issue, which was starkly illustrated by the response to the COVID-19 pandemic regarding older adults based on negative stereotypes of this population's health and functioning, the notion that COVID was only an issue affecting older people, and the woefully inadequate response of long-term care facilities to protect residents from infection, hospitalization, and death (Ehni & Wahl, 2020; Fraser et al., 2020). We recognize that older adults represent an extremely vibrant group that demonstrate a multitude of strengths including enhanced resilience and coping abilities, especially seen during the COVID-19 pandemic (Fuller et al., 2021; Chen et al., 2018). Thus, this guideline attempts to provide an overview of ageism, its clinical impact, and efforts to combat its effects.

Ageism, a term first coined by Butler (1969), refers to prejudice toward, stereotyping of, and/or discrimination against people simply because they are perceived or defined as "old." Since its inception, the concept of ageism has been refined and expanded beyond the level of personal attitudes and prejudice to conceptualizing it as a "form of oppression deeply embedded in social structures" (Krekula et al., 2018, p. 33). Ageism operates on multiple levels: intra/interpersonal (micro level), within social networks and communities (meso level), and through institutional policies and cultural traditions (macro level; Iversen et al., 2009). Ageist attitudes can also operate discreetly and without intentional malice (i.e., implicit biases; Nelson, 2005). Further, the targets of these negative attitudes can be other-directed (e.g., what we think about other older adults) or self-directed (e.g., possessing negative feelings regarding one's own aging; Ayalon & Tesch-Romer, 2017).

One of the most notable developments to the concept of ageism has been the increased focus on the contextual and interrelated factors that influence this aspect of inequality (Lindland et al.,

2015). In order to foster a nuanced understanding of ageism and its outcomes, researchers have emphasized the importance of viewing ageism from an Intersectionality Perspective (Ayalon et al., 2018; Rocha et al., 2022). Intersectionality suggests that age, as one socially constructed aspect of identity, continually interacts with other categories of identity such as race, gender, class, sexual orientation, and/or other factors (Ayalon et al., 2018). The intersection of these categories influences social identities and power dynamics and creates overlapping and interdependent systems of discrimination and disadvantage (Krekula & Johansson, 2016; Nikander, 2009; Fineman, 2011). For example, Western attitudes toward older men and women differ in a manner that reflects the convergence of sexism and ageism (Kite & Wagner, 2002). The combination of patriarchal norms with a culture that prizes youth results in the differential treatment of older adults based on gender (Barrett & Naiman-Sessions, 2016; Calasanti & Slevin, 2001; Chrisler, 2007). The stark increase in violence against older-appearing Asian/Asian Americans following the COVID-19 pandemic reflects a convergence of ageism, structural violence and racism, and misogyny (Takamura et al., 2022).

There are many inaccurate stereotypes of older adults that can contribute to negative biases (Lamont et al., 2015) and affect the delivery of psychological services, such as providers being less willing to work with older adults or being skeptical of the efficacy of psychotherapy with this population (Ayalon & Tesch-Römer, 2018, Bodner et al., 2018; Knight, 2009). These stereotypes are enmeshed within society and characterize older adults as possessing homogeneous, often undesirable, traits. For example, stereotypes include the views that age invariably results in dementia or decline in general ability; older adults are unemployable due to their inefficiency; older adults are inflexible and stubborn; older adults are socially isolated or dependent; and older adults have no interest in sex or intimacy (Abrams et al., 2016; Lyons, 2009). These stereotypes are not accurate as research has found that the vast majority of older adults remain cognitively intact into later life, have lower rates of depression than younger persons (Fiske et al., 2009; Haigh et al., 2018), are adaptive and in good functional health (Bosnes et al., 2017; Depp & Jeste, 2006), and have meaningful interpersonal and sexual relationships (Carstensen et al., 2011; Hillman, 2012; Træen et al., 2017). Some researchers have also demonstrated associations between companies with higher numbers of older workers and increased productivity at the company level (Van Dalen et al., 2010). Further, most older adults adapt successfully to life transitions and continue to evidence personal and interpersonal growth (Hill, 2005; Aldwin & Igarashi, 2016).

Ageism and negative stereotypes have been evident among many health care providers and their trainees (Ben-Harush et al., 2017; Garrison et al., 2022; Rosowsky, 2005; Wang & Chonody, 2013). These negative stereotypes can become self-fulfilling prophecies and adversely affect health care providers' attitudes and behaviors toward older adult clients. For example, stereotypes can lead health care providers to misdiagnose disorders (Bodner et al., 2018; Mohlman et al., 2011), inappropriately lower their expectations for the improvement of older adult clients (so-called "therapeutic nihilism"; Lamberty & Bares, 2013; Makris et al., 2015), and delay preventive actions and treatment (Wurm et al., 2013; Levy & Myers, 2004). Providers may also misattribute older adults' report of treatable depressive symptoms (e.g., lethargy, decreased appetite, anhedonia) to aspects of normative aging. Some providers unfamiliar with facts about aging may assume that older adults are too old to change (Ben-Harush et al., 2017; Kane, 2004) or are less likely than younger adults to benefit from psychosocial therapies (Roseborough et al.,

2013). Stereotypes about older adults may also take on a more paternalistic pattern (i.e., Benevolent ageism), incorrectly assuming that increased age warrants special assistance regardless of actual need, and incorrectly experiencing adults as “warm but incompetent”). These biased beliefs may influence providers to decisions that undermine their patient’s autonomy and competence; predictors of well-being in old age (Neubauer et al., 2017). Some researchers suggest that what may seem like discriminatory behavior by some health providers toward older adults may be more a function of a lack of familiarity with aging issues than discrimination based solely on age (Garrison-Diehn et al., 2022).

Older adults themselves can also harbor negative age stereotypes (Levy, 2009) and these negative age stereotypes have been found to predict an array of adverse outcomes such as worse cognitive performance (Lamont et al., 2015; Robertson et al., 2016), poorer physical health and functioning (Jackson et al., 2019; Tovel et al., 2019), worse mental health (Freeman et al., 2016; Han & Richardson, 2015), poorer work performance (Naegele et al., 2018), reduced engagement in preventative health behaviors and in help seeking behaviors (Sargent-Cox & Anstey, 2015), reduced longevity (Sargent-Cox et al., 2014), and reduced will to live (Marques et al., 2014; Levy et al., 2020). Further, subgroups of older adults may hold culturally consistent beliefs about aging processes that are different from mainstream biomedical and Western conceptions of aging (Cole et al., 2009; Dilworth-Anderson & Gibson, 2002). For example, in Chinese culture dementia disorders may be viewed not as a consequence of a neurological disorder but as a result of fate, “wrong-doing,” or excess worry (Sun et al., 2012). It is helpful for psychologists to take into account these differences when addressing an individual’s specific needs (Gallagher-Thompson et al., 2003; Mehrotra et al., 2018).

As negative self-beliefs and stereotypes toward aging represent a significant risk to the health and well-being of older adults, psychologists would benefit from an individualized understanding of the beliefs and stereotypes held, and the impact of these beliefs on their health and behavior (Levy, 2022). Psychologists may also benefit from considering their own responses to working with older adults. Some health professionals may avoid serving older adults because such work evokes discomfort related to their own aging or relationships with parents or other older family members (Nelson, 2005; Terry, 2008). Additionally, working with older adults can increase professionals’ awareness of their own mortality, raise fears about their own future aging processes, and/or highlight discomfort discussing issues of death and dying (Darrell & Pyszczynski, 2016; Nelson, 2005; Yalom, 2008).

In examining efforts to reduce ageism and age biases across the lifespan, research has demonstrated positive results for education and intergenerational contact in younger adults (Burnes et al., 2019) and reframing interventions for adults of all ages (Busso et al., 2019). Increasing intergroup interactions provide opportunities for experiences that challenge preexisting stereotypes (Chopik et al., 2017). Further, reframing messages about aging may be helpful in decreasing implicit bias (Busso et al., 2019). For psychology trainees, specialized clinical exposure and training with older adults appears to be particularly important in fostering positive attitudes toward this population (Koder & Helmes, 2008; Karel et al., 2012).

There are also broader efforts to address ageism and implicit biases and improve care for older adults. The Reframing Aging Initiative, led by the Gerontological Society of America on behalf

of Leaders of Aging Organizations (LAO), is a social change initiative that seeks to improve the public understanding of aging and older adulthood (Gerontological Society of America [GSA], 2022a). Age-Friendly Health Systems is an initiative that seeks to improve how health care systems address the unique needs of older adults through the provision of evidence-based interventions and reliable implementation of the 4Ms framework of high-quality care: What Matters, Medication, Mentation, and Mobility (Fulmer, 2021).

The effects of ageism and negative biases can influence clinical outcomes, provision of care, research inclusion and equity, and contribute to the unjust exclusion of older adults from fully participating as members of society (WHO, 2017a, 2020a). In order to reduce biases that can impede their work with older adults, it is important for psychologists to develop more realistic perceptions of the capabilities, strengths, and vulnerabilities of this segment of the population. Psychologists are encouraged to expand their awareness and understanding of intersectionality to inform their treatment and assessment of older adults. It is also important for psychologists to examine their own attitudes toward aging and older adults. As ageism can operate on multiple levels, including those that are introspectively inaccessible (and may constitute “blind spots”), psychologists should seek consultation or further education when indicated. One helpful tool for this is the Harvard Implicit Bias test regarding aging (see <https://implicit.harvard.edu/implicit/takeatest.html>).

Guideline 3. Psychologists are encouraged to increase their knowledge, understanding, and skills with respect to working with older adults through training, supervision, consultation, and continuing education, and to apply their expertise in advocacy to support the psychological well-being of older adults. As the need for psychological services grows in the older population, additional health care providers will be required, especially those with knowledge and skills in working with older adults (Institute of Medicine, 2012; Moye et al., 2018). Practitioners often work competently with older adults who have issues similar to those of younger clients. With increasing complexity of older adult client problems, psychological practice benefits from the acquisition and application of specialized knowledge and skills (Hoge et al., 2015). For example, older adults can present with a range of unique, life-stage challenges including adjustment to retirement, aging with acquired and congenital disabilities, chronic illnesses, progressive cognitive impairment, and end-of-life issues that young and middle-aged adults tend to encounter less frequently (Karel et al., 2016).

A persistent call has been made for additional training in aging across all levels of professional development (Holtzer et al., 2012; Karel, Sakai, et al., 2016; Moye et al., 2018). Training recommendations to prepare psychologists to work with older adults have been offered at the graduate, internship, and postdoctoral levels (Hinrichsen et al., 2018; Hoge et al., 2015; Karel, Sakai, et al., 2016). The development of the Pikes Peak Model for training in professional geropsychology (Knight et al., 2009) recognized that entry into psychological practice with older adults can occur at different stages of a psychologist’s career with many pathways to achieve competency. These pathways include doctoral and re-specialization programs, internship, postdoctoral fellowships, continuing education activities (workshops, in-service training/seminars, distance learning), self-study and/or supervised self-study, or combinations of such alternatives.

The competencies described in the Pikes Peak Model are organized in three domains: attitudes (e.g., awareness of limits of competence, attitudes and beliefs about aging, awareness of diversity in older adults, continuing education and skills building regarding aging), knowledge (e.g., general knowledge of adult development, clinical practice, assessment, intervention and service provision), and skill competencies (foundational, assessment, intervention, consultation-training, service delivery; Knight et al., 2009). The Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel et al., 2010, 2012) is a structured self-evaluation of learning needs to assist psychologists in evaluating their own scope of competence for working with older adults. The tool is intended for use by professional psychologists who are currently working with older adults, as well as trainees and their supervisors to rate progress over the course of a training experience (Karel et al., 2012; Available at <https://copgtp.org/resources/online-resources/>). Psychologists can match the extent and types of their work with their competence and as needed, seek additional knowledge and skills.

Psychologists who see any older adults in clinical practice are encouraged to pursue continuing education to develop and enhance their competence in providing psychological services to older adults (Karel et al., 2010; Moye et al., 2018). Psychologists may also gain additional education and access useful materials through interactions with professional organizations, including APA Division 20 (<http://apadiv20.phhp.ufl.edu/>); Division 12-Section II, the Society for Clinical Geropsychology (<http://www.geropsychology.org/>); and the APA Aging Portfolio (<http://www.apa.org/pi/aging/index.aspx>) and Continuing Education (<http://www.apa.org/ed/ce/index.aspx>), as well as The Council of Professional Geropsychology Training Programs (<http://www.copgtp.org/>), Psychologists in Long-term care (PLTC; <http://www.pltcweb.org/index.php>), the Gerontological Society of America (GSA; <http://www.geron.org/>), and the American Society on Aging (ASA; <https://www.asaging.org/>).

Psychologists are encouraged to apply their competencies in geropsychology and experience working with older adults to advocate for improving the health care and psychological health of this population (Karel et al., 2012). While older adults may have a lower prevalence of certain mental health problems than younger adults, they are also less likely to seek mental health treatment (Karel et al., 2012), and this underutilization of psychological services is exacerbated among some populations such as sexual and gender minorities and older people of color (Fredriksen-Goldsen et al., 2014a, 2014b; Rastogi et al., 2012). Advocacy for older adults can be practiced in myriad contexts including care and service delivery settings, academic and research institutions, and at local, state, and federal levels of government.

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

Guideline 4. Psychologists strive to gain knowledge about theory and research in aging.

APA-supported training conferences have recommended that psychologists acquire familiarity with the biological, psychological, cultural, and social content and contexts associated with normal aging as part of their knowledge base for working clinically with older adults, (Diehl & Wahl, 2020; Knight, et al., 2009; Woodhead & Yochim, 2022). Most practicing psychologists will work with clients, family members, and caregivers of diverse ages. Therefore, a rounded preparatory education for anyone delivering services to older adults encompasses training with a lifespan-developmental perspective for which knowledge of a range of age groups including

older adults is very useful (Hinrichsen et al., 2018). APA accreditation criteria now require that students be exposed to the current body of knowledge in human development across the lifespan as well as didactic and experiential training on diversity factors including age (Commission on Accreditation Implementing Regulations, Section C: https://irp.cdn-website.com/a14f9462/files/uploaded/Section%20C_092421.pdf). It should be noted that the definition of human development is broad. As such, psychologists teaching courses on lifespan development strive to include adequate research on aging and older adulthood and address the diversity of the older population.

Over the past 50 years, a substantial scientific knowledge base has developed in the psychology of aging, as reflected in numerous scholarly publications. *The Psychology of Adult Development and Aging* (Eisdorfer & Lawton, 1973), published by APA, was a landmark publication that laid out the current status of substantive knowledge, theory, and methods in psychology and aging. It was followed by numerous overviews of advances in knowledge about normal aging as well as psychological assessment and intervention with older adults (e.g., Bengtson & Settersten, 2016; Lichtenberg et al., 2015a, 2015b; Pachana & Laidlaw, 2014; Pachana et al., 2015; Scogin & Shah, 2012). A 2022 publication by members of the Council of Professional Geropsychology Training Programs provides an overview of foundational competencies in geropsychology (Garrison-Diehn et al., 2022; Hinrichsen & Emery-Tiburcio, 2022; Jacobs & Bamonti, 2022; Lind et al., 2022; Mast et al., 2022; Woodhead, E. L., & Yochim, 2022). Extensive information on resource materials is now available for instructional coursework or self-study in geropsychology, including course syllabi, textbooks, videotapes, online modules, and literature references at various websites. A brief list of websites is presented at the end of this document.

Training within a lifespan developmental perspective includes such topics as concepts of age and aging, longitudinal change and cross-sectional differences, cohort effects (differences between persons born during different historical periods of time), theories of aging, and research designs for adult development and aging (e.g., Zelinski et al., 2009; Fingerma et al., 2010; Pachana et al., 2014; Bengtson & Settersten, 2016; Segal et al., 2018). Understanding the benefits and limitations of different types of research designs and methods and the quality of the findings that are generated is important to practitioners in the application of empirical findings to their work. For example, longitudinal studies, in which individuals are followed over many years, permit observation of how individual trajectories of change unfold. Cross-sectional studies in which individuals of different ages are compared allow age groups to be examined. However, individuals are inextricably bound to their own time in history. That is, people are born, mature, and grow old within a given generational cohort. Therefore, it is useful to combine longitudinal and cross-sectional methods to differentiate which age-related characteristics reflect change over the lifespan and which reflect cohort differences due to historical time (Schaie & Parham, 1977; Schaie, 2011). For example, some older adults, especially those in rural areas, may have less access to technology or reliable internet connections. While older adults are more technologically literate than commonly assumed, others may be less practiced or fluent in their use of technology, impacting their ability to engage in telehealth as noted in Guideline 16 (Adams et al., 2020). Understanding the influence of an older adult's cohort aids in understanding the individual within their cultural context (see Guideline 5 and Guideline 11 for further discussion as well as Diehl & Wahl, 2020).

Psychologists strive to be aware of the components of “successful” or “healthy” late life development (e.g., Bundick, Yeager, King, & Damon, 2010; Liverman et al., 2015). The WHO (2020b) broadly defines healthy aging as “the process of developing and maintaining the functional ability that enables wellbeing in older age,” and considers the micro and macro factors in the older adult and their environment that contribute to overall wellbeing. Inevitably, aging includes the need to accommodate to physical changes, functional limitations, and other changes in psychological and social functioning, although there are significant individual differences in the onset, course, and severity of these changes. The majority of older adults adapt successfully to these changes and have resiliencies to assist in meeting these challenges (Manning et al., 2019; Ong et al., 2018). A related life-span developmental perspective is that despite biological decrements associated with aging, considerable potential exists for positive psychological growth and maturation in late life (Hill, 2005; Steverink, 2014). A life-span developmental perspective informs the work of practitioners as they draw upon psychological and social resilience built over the course of life to effectively address current late life problems (Pachana et al., 2015; Lichtenberg et al., 2015).

Guideline 5. Psychologists strive to be aware of the social/psychological dynamics of the aging process. As part of the broader developmental continuum of the life span, aging is a dynamic process that challenges the aging individual to make continuing behavioral adaptations (Carpentieri et al., 2017; Jeste et al., 2013; Tovel & Carmel, 2014). Just as younger individuals’ developmental pathways are shaped by their ability to adapt to anticipated early life transitions (Crockett & Beal, 2012), so are older individuals’ developmental trajectories molded by their ability to contend successfully with anticipated later life transitions such as retirement (Dawson & Sterns, 2012), residential relocations, changes in relationships with partners or in sexual functioning, bereavement, and widowhood (Bennett & Soulsby, 2012; Brennan-Ing et al., 2020; Hillman, 2012; Settersten & Thogmartin, 2018), as well as unanticipated experiences such as traumatic events (Heid et al., 2017; Whitehead & Torossian, 2021), or social isolation and loneliness. Clinicians who work with older adults strive to be knowledgeable of issues specific to later life, including grandparenting (Hayslip et al., 2019), adaptation to age-related physical changes as well as unanticipated health problems or disability (Lloyd et al., 2014; Schilling et al., 2013), or a need to integrate or come to terms with one’s personal lifetime of aspirations, achievements, and failures (Butler, 1969).

Most older adults contend successfully with myriad potential losses including persons, objects, animals, roles, belongings, independence, health, and financial well-being (Thumala Dockendorff, 2014). These losses may trigger problematic reactions, particularly in individuals predisposed to depression, anxiety, or other mental disorders (Neupert et al., 2017). Because these losses are often multiple, their effects may be synergistic (Calderón-Larrañaga et al., 2019; Viljanen et al., 2014). Nevertheless, many older adults challenged by loss find unique possibilities for achieving reconciliation, healing, or deeper wisdom (Howell & Peterson, 2020; Jeste & Lee, 2019). Moreover, the vast majority of older people maintain positive emotions, improve their affect regulation with age (Burr et al., 2021; Carstensen, 2021), and express enjoyment and high life satisfaction (Charles, 2011; Scheibe & Carstensen, 2010). It is similarly noteworthy that despite the aforementioned multiple stresses, older adults have a lower prevalence of psychological disorders (other than cognitive) and substance use disorders than do younger adults (Kessler et al., 2012; Schulte & Hser, 2013). In working

with older adults, psychologists may find it useful to remain cognizant of the strengths that many older people possess, the many commonalities they retain with younger adults, the continuity of their sense of self over time, and the opportunities for using skills and adaptations they developed over their lifespan for continued psychological growth in late life (Thumala Dockendorff, 2014).

Late life development is characterized by both stability and change (Baltes, 1997; Lang et al., 2011). For example, although personality traits demonstrate substantial stability across the lifespan (Bleidorn et al., 2021; Lodi-Smith et al., 2011), growing evidence suggests a greater degree of plasticity of personality across the second half of life than was previously believed (Costa & McCrae, 2010; Mroczek, 2014; Roberts et al., 2006). Of particular interest are mechanisms of continuity and change such as how a sense of well-being is maintained. For example, although people of all ages reminisce about the past, older adults are more likely to use reminiscence in psychologically intense ways to integrate experiences (Demiray et al., 2019; O'Rourke et al., 2011). Later-life family, intimate, friendship and other social relations (Blieszner & Roberto, 2012), and intergenerational relationships (Fingerman et al., 2011; Thomas et al., 2017) are integral to sustaining well-being in older adulthood.

There is considerable empirical evidence that aging typically brings a heightened awareness that one's remaining time and opportunities are limited (Carstensen et al., 1999). With this shortened time horizon, older adults are motivated to place increasing emphasis on emotionally meaningful goals. Older adults tend to prune social networks and selectively invest in proximal relationships that are emotionally satisfying, such as those with family and close associates, which promotes emotion regulation and enhances well-being (Carstensen, 2006; Carstensen et al., 2020; Carstensen, et al., 2011). Families and other support systems are thus critical in the lives of most older adults (Antonucci et al., 2011). Working with older adults often involves their families and other supports, while in some cases older adults are isolated and lack such supports (APA, Presidential Task Force on Integrated Health Care for An Aging Population, 2008; Brennan-Ing et al., 2017). Psychologists often appraise carefully older adults' social supports (Edelstein et al., 2012) and are mindful of the fact that the older adult's difficulties may have an impact on the well-being of involved family members (Adelman et al., 2014). With this information they may seek solutions to the older person's concerns that strike a balance between respecting their dignity and autonomy and recognizing the views of others about their need for care (see Guideline 10).

The individuals who care for older adults are often biological family members related by blood ties or marriage. Increasingly, psychologists may encounter complex and varied relationships including stepfamily members, fictive kin (unrelated significant others who are considered family members) who are important sources of support for many older people of color (Taylor et al., 2021), and chosen family, who play a prominent role in the social networks of sexual and gender minority individuals (Brennan-Ing et al., 2017; Cloyes et al., 2018; Knauer, 2016). All of these relationships are integral to older adults' patterns of intimacy, residence, and support. This document uses the term "family" broadly to include all such relationships and recognizes that continuing changes in the nature of families are likely in future generations. Awareness of and training in these issues can be useful to psychologists in dealing with older adults in matters of the diverse nature of family relationships and supports.

Guideline 6. Psychologists strive to understand diversity in the aging process, particularly how sociocultural factors such as sex, gender identity, race, ethnicity, socioeconomic status, immigration status, sexual orientation, disability status, religion, spirituality, and urban/rural residence may influence the experience and expression of health and of psychological problems in later life. The older adult population is highly diverse and is expected to become even more so in coming decades (Administration on Aging, 2011, U.S. Census, 2017). The heterogeneity among older adults surpasses that seen in other age groups (Cosentino et al., 2011; Liu et al., 2015). Psychological issues experienced by older adults may differ according to factors such as age cohort, gender identity, race, ethnicity and cultural background, sexual orientation, rural/urban environment, education and socioeconomic status, and religion. Psychologists should be aware of the intersectionality of these characteristics of diversity, and that the interplay of these factors may have multiplicative effects on the well-being of older adults (Crenshaw, 2017; Porter & Brennan-Ing, 2019). It should be noted that age may be a weaker predictor of outcomes than factors such as demographic characteristics, physical health, functional ability, or living situation (Lichtenberg, 2015b; Schaie, 1993). For example, clinical presentations of symptoms and syndromes may reflect interactions among these factors and type of clinical setting or living situation (Luhmann & Hawkey, 2016).

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

Sex, as a biological factor, has a strong association with the aging process. A striking demographic fact of late life is the preponderance of women surviving to older ages (See National Population Projections Tables:

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

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

In addition to biological sex, psychologists should strive to be aware of the diversity of gender identity. Gender identity refers to a person’s intrinsic sense of their gender as feminine or being a woman, masculine or being a man, or being some combination of male and female or some other gender (APA, 2015a). In many cultures, gender has been conceived along a binary, that is, either male or female. However, we now know that gender identity is better described along a continuum, with some people having gender identities with varying degrees of male and female attributes, or in some cases, having nonbinary identities that include neither male nor female aspects. People who are transgender have gender identities that do not align with their sex assigned at birth, while people whose gender identities do align with their sex assigned at birth are described as cisgender (APA, 2015a). For some people who are transgender, the misalignment of their gender identities with their sex assigned at birth can result in gender dysphoria. People who are transgender or gender diverse (TGD) may go through a process of social transitioning by adopting names, pronouns, and social presentations in line with their gender identities, or medical transitioning involving gender affirming treatment such as hormone therapies or surgery, so their appearance is more congruent with their gender identities. The degree of transitioning among people who are TGD is highly variable, and some people who are TGD may not undertake the transitioning process until late adulthood (APA; 2015; Porter et al, 2016; Services and Advocacy for GLBT Elders [SAGE] & National Center for Transgender Equality [NCTE], 2012). Guideline 9 of the “Guidelines for Psychological Practice with Transgender and Gender Nonconforming People” discusses the challenges faced by older adults who are TGD (APA, 2015a). Many older adults who are TGD have experienced lifetimes of

stigma, discrimination, and violence that may affect their mental health and willingness to access health care services (Fredriksen-Goldsen et al., 2014a; Witten, 2015). Further, many people who are TGD have had negative experiences with health care providers, and few mental health providers have had adequate training on gender diversity issues (McCann & Sharek, 2016). Psychologists working with older people who are TGD are encouraged to respect these clients by using the names and personal pronouns that affirm their gender identities (APA, 2015a; Hagen & Galupo, 2014; Porter et al, 2016).

Another aspect of diversity in later life is sexual orientation, including persons identifying as lesbian, gay, or bisexual (LGB; Fredriksen-Goldsen et al., 2013; Pereira et al, 2019). Minority sexual orientation is defined in terms of identity, attraction, or sexual behavior involving a person of the same biological sex (APA, 2021). While sexual orientation may involve attraction to different aspects of another person's gender, people who are lesbian, gay, bisexual or another sexual minority may possess a variety of gender identities (cisgender, transgender, non-binary, etc.), and psychologists should avoid conflating sexual orientation and gender identity (APA, 2021). It is important to be mindful that sexual orientation identity intersects with other aspects of identity (e.g., sex, gender identity, race, ethnicity, disability status). Older adults who are LGB have often suffered discrimination from the larger society for decades (APA, 2021), including the mental health professions, which previously labeled sexual variation as psychopathology and utilized psychological and biological treatments to try to alter sexual orientation. This past discrimination may make older LGB adults reluctant to access health and mental health care services resulting in unmet needs (Brennan-Ing et al., 2014; Pereira et al., 2019). As with other minority groups, these discriminatory life experiences can negatively result in health disparities (Fredriksen-Goldsen, 2017). APA's Guidelines for Psychological Practice with Sexual Minority Persons (2021) discusses particular challenges faced by older adults who are LGB.

It is critical also to consider the pervasive influence of cultural factors associated with race and ethnicity on the experience of aging (Hill et al., 2015; Tazeau, 2011; Westerhof et al., 2012; Whitfield, Thorpe, & Szanton, 2011). In the U.S., at present the population of older adults is predominantly non-Hispanic White but by the year 2050, people of color are expected to comprise 39% of the older population compared to 21% in 2012 (Ortman et al., 2014). Historical and cultural factors, such as the experience of bias and prejudice, may influence the identities of older adults of color and thereby affect their experience of aging and patterns of coping (Crewe, 2019; Wallace et al., 2016). The cumulative impact of experiences of racism and discrimination can result in the experience of race-based trauma, which may manifest with symptoms similar to post-traumatic stress disorder (Hemmings & Evans, 2018). Many older communities of color faced discrimination and were denied access to quality education, jobs, housing, health care, and other services. As a result, many older adults of color have fewer economic resources than non-Hispanic Whites although this may change in future generations (Assari, 2018). For example, non-Hispanic Blacks and Latinx older adults have faced greater economic insecurity over the life course compared with non-Hispanic Whites (Hacker et al., 2014). As a consequence of these and other factors (such as education and income disparities), older adults of color have more physical health problems than the older non-Hispanic Whites, and they often delay or refrain from accessing needed health and mental health services, which may be attributable, in part, to an historical mistrust of the mental health and larger healthcare system (Armstrong et al., 2013;

Cook et al., 2017; Luo et al., 2012; Powell et al., 2019). Being a person of color and being older is sometimes referred to as “double jeopardy” (Chatters et al., 2020; Crewe, 2019). Furthermore, one’s access to the opportunity structure earlier in the life course can perpetuate inequalities across individuals, families, and communities over time, a process known as cumulative disadvantage and advantage (Dannefer, 2020). Thus, psychologists should be aware that the health, income, and social inequalities experienced by their older clients may be rooted in a lifetime of disadvantage and deprivation. Psychologists may consult APA’s 2017 *Multicultural Guidelines: An Ecological Approach to Contest, Identity, and Intersectionality* for more guidance on practice with older adults of color (APA, 2017b). In order to provide culturally appropriate services and avoid a “one size fits all” approach, psychologists should also differentiate late life inequalities associated with cultural factors from those due to a history of poverty or low income which affect older adults of all cultural backgrounds (APA, 2019; Juntunen et al., 2022).

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

Aging is also a reflection of the interaction of the person with the environment (Wahl et al., 2012). For example, older adults residing in rural areas often have difficulty accessing aging-related resources (e.g., transportation, community centers, meal programs) and may experience low levels of social support and high levels of isolation (Arbore, 2019; Morthland & Scogin, 2011; Winterton et al., 2016). Older adults living in rural areas also have less access to community mental health services and to mental health specialists in nursing homes compared to those not residing in rural areas and may find seeking services for mental health to be stigmatizing (Averill, 2012; Brenes et al., 2015; Stewart et al., 2015). Recent models that draw upon standardized treatments (Gellis & Bruce, 2010), telehealth technologies (Dautovich et al., 2014), or utilize paraprofessionals to address provider shortages (Arbore, 2019) have begun to expand access to mental health care for homebound and rural older adults but confront issues of lower technology access in rural areas.

Guideline 7. Psychologists strive to be familiar with current information about biological and health-related aspects of aging. In working with older adults, psychologists are encouraged to be informed about the normal biological changes that accompany aging. Though there are considerable individual differences in these changes, with advancing age, the older adult almost inevitably experiences changes in sensory acuity, physical appearance and body composition, hormone levels, peak performance capacity of most body organ systems, and immunological responses and increased susceptibility to illness (Saxon et al., 2022). Disease accelerates age-related decline in sensory, motor, and cognitive functioning, while lifestyle and psychosocial factors may either mitigate or exacerbate the effects of aging on functioning (Aldwin et al., 2018). Such biological aging processes may have significant hereditary or genetic components

(Khan et al., 2017; Sierra, 2016) about which older adults and their families may have concerns. Adjusting to age-related physical change is a core task of normal psychological aging process (Saxon, et al., 2022). Fortunately, lifestyle changes, psychological interventions, the use of assistive devices, and addressing social determinants of health can lessen the burden of some of these changes.

It is useful for psychologists to be able to distinguish normative patterns of change from non-normative changes, and to determine the extent to which an older adult's presenting problems are symptoms of physical illness or represent the adverse consequences of medication. This information aids in devising appropriate interventions. The psychologist may help the older adult cope with physical changes, acute health crises, and chronic medical conditions (Niknejad et al., 2018; Zis et al., 2017). Most older adults have multiple chronic health conditions (Federal Interagency Forum on Aging-Related Statistics [FIFAS], 2020), each requiring medication and/or management. The most common chronic health conditions of late life include arthritis, hypertension, diabetes, cancer, chronic kidney disease, and heart disease (FIFAS, 2020; National Center for Chronic Disease Control and Health Promotion, 2022). Other common medical illnesses include osteoporosis, vascular diseases, neurological diseases (including stroke), and respiratory diseases (including asthma and COPD). Many of these physical conditions are associated with mental health and/or cognitive disorders (Denning, 2019; Feinkohl et al., 2018; Ohrnberger et al., 2017), either through direct physiological contributions (e.g., post-stroke depression; vascular cognitive impairment) or in reaction to disability, pain, or prognosis (Khan et al., 2016; Portacolone et al., 2018).

Because older adults frequently take medications for health problems, and polypharmacy is common in older adults, it is useful for psychologists to be knowledgeable about common pharmacological interventions for mental and physical disorders in later life. Knowledge of medications would include, for example, familiarity with prescription terminology (e.g., "prn" means "as needed"), brand and generic names of commonly used medications, common side effects of these medications, classes of medications (e.g., anticholinergic medications), common drug interactions, and age-related differences in the pharmacodynamics and pharmacokinetics of these medications (Arnold, 2015). It is also important for psychologists to be aware of high-risk medications for older adults included in the Beers Criteria (American Geriatrics Society, 2019). Many older adults with mental disorders who are seen for assessment or treatment by psychologists are prescribed psychotropic medications (Arnold, 2015; Ćurković et al., 2016). Although pharmacological treatment of older adults with mental disorders is a common and often effective treatment for depression (Lavretsky et al., 2020), anxiety (Wolitzky-Taylor et al., 2010), and psychosis (Chan et al., 2011), adverse side effects of these medications are common and potentially harmful. Adverse effects are particularly common for older adults with neurocognitive disorders. The Food and Drug Administration (FDA) issued a black box warning against prescribing antipsychotics to older adults with major neurocognitive disorders because they face increased risk of stroke and transient ischemic events with atypical antipsychotic use, and death with both atypical and conventional antipsychotic medications, but regulations to limit these medications have had mixed results in improving outcomes (Jin, et al., 2012; Rubino et al. 2020).

Multi-morbidity and polypharmacy are common in older adults, and result in increased complexity of care (Dahal & Bista, 2022). Thus, increased awareness and interventions aimed at reducing exposure and minimizing the risks associated with medications and their interactions in older adults are important in the community and especially in long-term care settings (Abrahamson et al., 2017; Bergman-Evans, 2020; Dahal & Bista, 2022; Halli-Tierney et al., 2019). Psychologists can play critical roles in identifying side effects and adverse events and discussing observations with prescribers, as well as discussing overall polypharmacy with prescribers who may be less familiar with the options for deprescribing.

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

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Guideline 8. Psychologists strive to be knowledgeable about psychopathology within the aging population and cognizant of the prevalence and nature of that psychopathology when providing services to older adults. Older adults have lower rates of depression, anxiety, schizophrenia, bipolar, and substance use disorders than do younger adults (Jacobs & Bamonti, 2022). Prevalence estimates suggest that approximately 20-22% of community-dwelling older adults may meet criteria for some form of mental disorder, including major neurocognitive disorder (Carpenter et al., 2022; Jeste et al., 1999; Karel et al., 2012). Among older adults, men have higher rates of substance use and personality disorders, whereas older women have higher rates of anxiety and depression (Reynolds et al., 2015), and rates vary across cultures and ethnicities (Jimenez et al., 2010). Differences across age, gender, and cultural groups may be due to cohort effects, differential mortality, diagnostic methods, and reporting biases due to stigma (Byers et al., 2010), as well as broader structural issues. For example, lower subjective well-being for older women compared to their male counterparts is most likely due to disadvantages older women experience in regard to health, SES, and widowhood (Byers et al., 2010; Piquart & Sörensen, 2001; Reynolds et al., 2015). For older adults living in a long-term care (LTC) setting, estimates of mental disorders are much higher, with two-thirds exhibiting cognitive impairment and 25% experiencing depression (Molinari et al., 2021).

Older adults may present a broad array of psychological issues for clinical attention, but may exhibit differences from younger adults in onset, presentation of symptoms, risk and protective factors, and comorbid mental disorders or health problems that are more common in later life (Jacobs & Bamonti, 2022). Some problems that rarely affect younger adults, notably major neurocognitive disorders due to degenerative brain diseases and stroke, are much more common in old age (see Guideline 7).

Among older adults seeking health services in clinical settings, depression and anxiety disorders, substance use, personality disorders and adjustment disorders are common, as well as problems related to chronic pain and insomnia (Byers et al., 2010; Jacobs & Bamonti, 2022; Reynolds et al., 2015). Suicide is a particular concern in conjunction with depression in late life, as suicide rates in older adults – particularly older white men living in rural areas -- are among the highest of any age group (Ehlman et al., 2020; see Guideline 20). The vast majority of older adults with mental health problems seek help in primary medical care settings, rather than in specialty mental health facilities, and prefer to receive behavioral health interventions such as psychotherapy rather than medication management (Areán & Gum, 2013).

Older adults may experience chronic or recurrent psychological disorders (“early onset”; Whitbourne & Meeks, 2011; Jacobs & Bamonti, 2022) or develop new problems (“late onset”) in the context of the unique stresses of old age or neuropathology. The majority of older adults who experience clinical depression, for example, have early onset depression which first occurred in earlier adulthood (Haigh et al., 2018). In those with early onset disorders, including serious mental illness or personality disorder, presenting symptoms may change in later life or become further complicated because of cognitive impairment, medical comorbidity, chronic pain, polypharmacy, and end-of-life issues (Balsis et al., 2015; Feldman & Periyakoil, 2006; King et al., 2005; Zis et al., 2017). Indeed, those older adults with serious mental illness, such as schizophrenia or bipolar disorder which most commonly has an early onset, present particular assessment and intervention challenges in part due to reduced social support that may result in housing instability, inappropriate admission to long-term care facilities, and early mortality (Jeste et al., 2011; Mausbach & Ho, 2015).

Older adults often have concurrent health and mental health problems. Mental disorders may co-exist with each other in older adults. For example, those with a mood disorder may also manifest concurrent anxiety, substance use disorders, personality disorders (Jacobs & Bamonti, 2022; Romirowsky et al., 2018; Substance Abuse and Mental Health Services Administration [SAMHSA], 2020), and those with major neurocognitive disorders typically evidence coexistent psychological symptoms, which may include depression, anxiety, paranoia, and behavioral disturbances, and these also may present as prodromal symptoms of dementia (Cohen-Mansfield, 2015). Additionally, behavioral disturbances such as hallucinations and delusions represent core clinical symptoms of some neurodegenerative disorders, such as Lewy Body dementia, making differential diagnosis complicated. Because chronic physical diseases are more prevalent in old age than in younger years, mental disorders are often comorbid and have reciprocal relationships with physical illnesses including cardiovascular disease and diabetes (Aldwin et al., 2007; Luo et al., 2020; Park & Reynolds, 2015). Being alert to comorbid physical and mental health problems and the presence of multiple comorbid conditions (multimorbidity) is a key concept in evaluating and treating older adults. Further complicating the clinical picture, many older adults take multiple medications (polypharmacy), and may be more sensitive to side effects of many medications. Further, older adults are more likely to have co-occurring sensory or motor impairments. All these factors may interact in ways that are difficult to disentangle diagnostically and challenge treatment planning. For example, sometimes depressive symptoms in older adults are caused by physical illnesses. At other times, depression is a response to the experience of physical illness (Luo et al., 2020). Depression may

augment functional impairment due to physical illness, increase the risk that physical illness will recur, reduce treatment adherence, or otherwise dampen the outcomes of medical care (Turan et al., 2014). Growing evidence links depression in older adults to increased mortality not attributable to suicide (Edelstein et al., 2015; Kozlov et al., 2019; Luo et al., 2020).

Some mental disorders such as depression and anxiety, especially when arising for the first time in late life, may be less common or have unique presentations in older adults, and are frequently comorbid with other mental disorders. For example, major depression, which is less prevalent in older adults than in younger adults, may have first onset in later life and coexist with a major neurocognitive disorder, a mild neurocognitive disorder that impairs executive functioning, or may be expressed in forms that lack overt manifestations of sadness (Fiske et al., 2009; Jacobs & Bamonti, 2022). It may thus be difficult to determine whether symptoms such as apathy and withdrawal are due to a primary mood disorder, a primary neurocognitive disorder, a medical or neurologic condition such as Parkinson's disease, or a combination of disorders. Generally, older adults' self-reports of depressive symptoms are similar to those described by DSM-5 criteria (Haigh et al., 2018), but age of onset may affect the experience of depression, as those with later onset depression tend to emphasize cognitive or somatic rather than affective symptoms (Edelstein et al., 2015). Furthermore, depressive symptoms may at times reflect older adults' confrontation with developmentally challenging aspects of aging, coming to terms with the existential reality of physical decline and death, loss of significant others, or spiritual crises (Aziz & Steffens, 2013).

Anxiety disorders, while less prevalent than in younger populations, are among the most commonly occurring mental health problems in older adults (Jacobs & Bamonti, 2022; Ramos & Stanley, 2018; Wolitzky-Taylor et al., 2010). Although older adults tend to present anxiety symptoms that are similar to those of younger adults, the content of older adults' fears and worries tends to be age-related (e.g., health and economic concerns; fears of falling; Lenze & Wetherell, 2011). Some have found that older adults who present with panic disorder and less avoidance symptoms for post-traumatic stress disorder (PTSD) tend to exhibit patterns of symptoms (e.g., fewer arousal symptoms, less avoidance, or more intrusive recollections) that differ from those of younger adults (Lauderdale et al., 2011; Rutherford et al., 2021). Further, while first onset of an anxiety disorder in older adulthood is uncommon, this may be true for some anxiety disorders (e.g., panic disorder; social anxiety disorder) more than others (e.g., generalized anxiety disorder; Ramos & Stanley, 2018; Wolitzky-Taylor et al., 2010). Anxiety symptoms in older persons often co-exist with and may be difficult to distinguish from symptoms attributable to co-existing depression, medical problems, medications, or cognitive decline. Reciprocal relationships are also observed; for example, when an anxiety problem (e.g., avoidance of walking due to a fear of falling) develops following a medical stressor, it may significantly complicate an older person's fall risk and physical rehabilitation. Further, recent research suggests that the common co-occurrence of anxiety with depression may slow treatment response for depressed older adults (Andreescu et al., 2009; Lenze & Wetherell, 2011), and that even sub-threshold levels of anxiety symptoms may be the fruitful focus of clinical efforts (Ramos & Stanley, 2018; Wolitzky-Taylor et al., 2010).

By the time they reach older adulthood, 50% to 90% of adults will have been exposed to a traumatic event (Monson et al., 2016; Moye et al., 2021). This is particularly true for older

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

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

Other problems or disorders seen in older adult clients that may differ from younger adults in regard to symptom presentation or late-life context include insomnia (Dzierzewski et al., 2018) psychotic disorders, including schizophrenia and delusional disorders (Jeste et al., 2011), personality disorders (Balsis et al., 2015; Segal et al., 2006), chronic pain (Hadjistavropoulos, 2015; Zis et al., 2017), sexual dysfunction (Hillman 2012, 2017), prolonged grief disorder (Shear, 2015), and disruptive behaviors (e.g., wandering, aggressive behavior) which can be present in individuals suffering from dementia or other cognitive impairment (Cohen-Mansfield, 2015). Familiarity with mental disorders in late life commonly seen in clinical settings, their presentations in older adults, and their relationship with physical health problems will facilitate accurate recognition of and appropriate therapeutic response to these syndromes. Many comprehensive reference volumes are available as resources for clinicians with respect to late-life mental disorders (e.g., Hinrichsen, 2019; Knight & Pachana, 2015; Lichtenberg et al., 2015a; Lichtenberg et al., 2015b; Pachana et al., 2021; Segal et al., 2018), and the literature in this area is rapidly expanding.

Guideline 9. Psychologists strive to be familiar with current knowledge about cognitive changes in older adults. Numerous seminal reference volumes offer comprehensive coverage of research on cognitive aging (e.g., Park & Festini, 2017; Schaie & Willis, 2011).

From a clinical perspective, one of the greatest challenges facing practitioners who work with older adults is knowing when to attribute subtle observed cognitive changes to an underlying neurodegenerative condition *versus* normal developmental changes. Further, several moderating and mediating factors contribute to, and confound age-associated cognitive changes within and across individuals. As discussed in Guideline 12, conducting cognitive screening routinely with older adults can help to clarify.

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

Many older adults do experience change in cognitive abilities. While there are multiple models proposed to explain cognitive changes with age, most studies agree that decline typically begins in early adulthood and is most prominent in the domains of processing speed, along with aspects of attention, working memory, and memory processing. Specifically, changes in more complex aspects of attention, such as divided attention and multitasking, in addition to executive functions and reasoning abilities, tend to be impacted more significantly than basic attention or vigilance abilities (Salthouse, 2019). The changes likely reflect subtle non-specific, widespread cortical and subcortical dysfunction. Attention is also affected, particularly the ability to divide attention, shift focus rapidly, and deal with complex situations. Memory functioning refers to implicit or explicit recall of recently and distantly encoded information. Several aspects of memory show decline with normal aging (Park & Schwarz, 2022). These include: working memory (retaining information while using it in performance of another mental task), episodic memory (the explicit recollection of events), source memory (the context in which information was learned), and short-term memory (the passive short-term storage of information). These changes in memory occur despite relatively preserved semantic memory (the recall of general or factual acquired knowledge), procedural memory (skill learning and recall) and priming (a type of implicit memory where the response to a probe has been influenced by a previous exposure to a stimulus).

Many factors influence cognition and patterns of maintenance or decline in intellectual performance in later life, including genetic, health and sensory variables, personality traits, affective state, and social determinants of health. Sensory deficits, particularly vision and hearing impairments, often impede and limit older adults' cognitive functioning (Glisky, 2007). Poorly controlled vascular disease in mid-and late-life (e.g., hypertension, heart disease, diabetes) may impair cognitive functioning as well as certain medications used to treat illnesses in older adults (Exalto et al., 2014). Cumulatively, such factors may account for much of the decline that older adults experience in cognitive functioning, as opposed to simply the normal aging process. In addition to sensory integrity and physical health factors, psychological and

life-course experiential factors may influence older adults' cognition. In recent years, certain personality traits, affective disorders, and experiences of poverty, discrimination and oppression have all been linked to cognitive functioning in late life (Aschwanden et al., 2021; Fuller-Iglesias et al., 2009; Zahodne, 2021).

Similarly, there also are numerous biological and psychological causes of cognitive impairment in later life that may be reversible if identified and treated (e.g., certain medications, polypharmacy, thyroid disorders, vitamin B12 deficiency, depression, infectious diseases; Ladika & Gurevitz, 2011). Acute confusional states (delirium) often signal underlying illness, infection processes, or toxic reactions to medications or drugs of abuse, which can be lethal if not treated but may be ameliorated or reversed with prompt medical attention (Hsieh et al., 2020). Screening tools are available to detect delirium, including identifying its characteristic waxing and waning symptoms (De & Ward, 2015).

Some older adults experience significant cognitive decline that is greater than what would be expected for normal aging, but not severe enough to substantially impact functional abilities. The term "mild cognitive impairment" (MCI) has historically been applied to describe these individuals, which is now captured under the terminology, "mild neurocognitive disorder" (MND) in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; APA, 2013). Of note, slightly different diagnostic frameworks exist for both MCI and various forms of dementia, and psychologists strive to familiarize themselves with these in addition to those in the DSM-5 (Albert et al., 2011; Sachdev et al., 2014; Sperling et al., 2011). MCI or minor neurocognitive disorder can be subdivided into various subtypes (e.g., amnesic versus non-amnesic, single versus multiple domains affected) which may have some prognostic utility with respect to future cognitive decline and underlying etiology, with amnesic subtypes more likely to progress to Alzheimer's dementia (AD) than others (Smith & Bondi, 2013; Winblad et al., 2004). While there is definite heterogeneity within groups of persons who are deemed to have MCI, there is evidence that it does indeed represent a risk state for the development of additional cognitive decline and dementia.

A minority of older adults experience significantly impaired cognition that impacts functional abilities. Major Neurocognitive Disorder is diagnosed when there is evidence of cognitive decline in one or more domains (memory, attention, executive functioning, language, perceptual, or social cognition) that is severe enough to impact basic or instrumental activities of daily living and is not better accounted for by another condition. The prevalence of MND increases dramatically with age; for example, 3% of people aged 65-74 years have Alzheimer's dementia (AD), the most common form of dementia, compared with 32% of people over the age of 85 (Herbert et al., 2013). The most common forms of MND are Alzheimer's disease, vascular dementia (VaD), frontotemporal dementia (FTD) and dementia with Lewy bodies (DLB); however, there is growing recognition that most cases of clinically diagnosed dementia syndromes reflect underlying mixed pathology (NIA, 2017); Corriveau et al., 2017). While a primary and early impairment in memory is a hallmark of the cognitive symptoms of AD, the illness can present quite variably, and other neurodegenerative disorders may have similar symptoms. However, early disproportionate deficits in visuospatial or executive functions may indicate other etiologies, such as dementia with Lewy bodies (DLB) or frontotemporal dementia (FTD) Less common causes include progressive supranuclear palsy (PSP), cortico-

basal syndrome (CBS), Creutzfeldt-Jakob disease (CJD), chronic traumatic encephalopathy (CTE), and others.

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

While no curative agents for MCI or dementia currently exist, there has been an exponential interest in, and increased recognition of modifiable lifestyle factors that can impact cognition in late life; psychologists make efforts to remain abreast of these developments. Maintenance of vascular health has a clearly established impact on physical wellbeing and has been found to affect cognitive health as well. High blood pressure, diabetes, history of smoking, heart disease, and obesity have each been linked with suboptimal cognitive aging and to increased risk for neurodegenerative conditions such as Alzheimer's disease (Norton et al., 2014). On the other hand, there is burgeoning evidence that optimal control of vascular disease, engagement in regular aerobic exercise, engagement in cognitively-stimulating activities, robust social support and engagement, and adherence to a "Mediterranean-style" or MIND diet (Kane et al., 2017; Livingston et al., 2020; Morris et al., 2015; Ngandu et al., 2015; Tolpannen et al., 2015) likely have benefits for cognitive aging. Moreover, these strategies are being viewed as possible primary prevention techniques for individuals in mid-life who may be at risk for dementia in older adulthood.

Guideline 10. Psychologists strive to understand and address issues pertaining to the provision of services in the specific settings in which older adults are typically located or encountered. Psychologists often work with older adults in a variety of settings, reflecting the continuum of care along which most services are delivered (Brink & Lichtenberg, 2014). These service delivery sites encompass multiple community settings older people engage with, including community-based and in-home care settings (e.g., senior centers, their own houses or apartments; see Yang et al., 2009 and Boland, 2019 for issues in provision of in-home services); outpatient settings (e.g., mental health or primary care clinics, independent practitioner offices, or outpatient group programs); day programs serving older adults with multiple or complex problems (e.g., adult day centers or psychiatric partial hospitalization programs); inpatient medical or psychiatric hospital settings, and long-term care settings (e.g., nursing homes, assisted

living, hospice and other congregate living sites). Psychologists seek to augment generalist competencies when working with interdisciplinary teams providing services to older adults in these settings (Labott, 2019; Moye, et al., 2019a). A set of specific practice guidelines is available for psychologists who provide services in long-term care settings (Molinari et al., 2021), as well as useful volumes and resources discussing various facets of such professional practice (O’Shea Carney & Norris, 2017; Long, 2014; see also *Psychological Services for Long-term care Resource Guide*, APA, 2013). Some psychologists provide services within the criminal justice system to the growing number of older adults who are or have been incarcerated (Fazel et al., 2016). Psychologists strive to develop the basic knowledge, skills, and setting-specific competencies to provide psychological services to older adults with psychological problems common to these varied settings (Lind et al., 2022; O’Shea Carney et al., 2015).

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

Guideline 11. Psychologists strive to be familiar with the application of telehealth practices and policies in assessing and treating older adults across settings and living situations.

Many older adults are becoming increasingly comfortable with technology (Alexandrakis, 2019; Anderson & Perrin, 2017). At least 75% of older adults are internet users, 61% own a smartphone, and differences between age groups regarding technology use are rapidly shrinking (Faverio, 2022). Rates of use vary by household income and educational level in addition to age (Anderson & Perrin, 2017). Although programs to improve access increased in availability during the pandemic (Waggoner & Dono, 2022), internet access is limited for many older adults, especially those in rural areas and with low socioeconomic status (Latulippe et al., 2017). Some of those who do have access lack the training to operate an internet-ready device (Latulippe et al., 2017; Wilson et al., 2021) and benefit from individual coaching (Wilson et al., 2021).

Technology can improve access to care via telehealth for older adults, especially for those who have transportation difficulties, live great distances from health care facilities, or have health issues or caregiving duties that make attending in-person appointments difficult (Choi et al., 2022). Research support for the effectiveness of telehealth among older adults is strong across a variety of settings and clinical activities (Doraiswamy et al., 2021; Gentry et al., 2019; Turgoose et al., 2018). Telehealth use among older adults increased rapidly during the Covid-19 pandemic – from 4.6% to 21.1% (Choi et al., 2022). Technology has also been effective in reducing social isolation and loneliness, thus decreasing risk for depression (Gorenko et al., 2021).

Barriers to effective use of technology for telehealth by older adults include user interface; physical, sensory, and cognitive deficits; internet access; socioeconomic status; digital literacy; and internalized ageism (Kottl et al., 2021). Screen, text, and image size on smaller screens with

poor optimization for vision changes are challenging for older adults with visual difficulties (Wilson, et al., 2021). Older adults with hearing loss may have difficulty with telehealth audio features (Foster & Sethares, 2014). Older adults with cognitive impairment may also struggle to utilize telehealth independently (Doraiswamy et al., 2021). Across the lifespan, internet access barriers may be particularly acute in rural or impoverished communities.

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

Guideline 12. In working with older adults, psychologists are encouraged to understand the importance of interfacing with other disciplines, and to make referrals to other disciplines and/or to work with them in collaborative teams and across a range of sites, as appropriate.

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

For effective collaboration with other professionals, whether through actual teamwork or referrals, it is useful for psychologists to be knowledgeable about services available from other disciplines and their potential contributions to care coordination. It is also useful for psychologists to develop an awareness of potential conflicts or ethical challenges that may arise when working in integrated care settings (Chenneville & Gabbidon, 2020). To make their particular contribution to such an effort, psychologists may often find it important to educate others as to the skills and role of the psychologist and to present both clinical and didactic

material in language understandable to other disciplines. The ability to communicate, educate, and coordinate with other concerned individuals (e.g., providers, family members) may often be a key element in providing effective psychological services to older adults (Steffen et al., 2014; Steffen et al., 2017; Areán & Gum, 2013) To provide psychological services in a particular setting, it is important to be familiar with the culture, institutional dynamics, and challenges of providing mental health services to older adults (Moye et al., 2019).

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

Guideline 13. Psychologists strive to understand the special ethical and/or legal issues entailed in providing services to older adults.

It is important for psychologists to strive to ensure the rights of older adults. Conflicts sometimes arise among family members, professional caregivers, and physically frail or cognitively impaired older adults because concerned individuals may believe that these older adults do not possess the capacity for self-determination on issues that affect their safety and well-being. Psychologists are sometimes called upon to evaluate one or more domains of capacity of older adults (e.g., medical decision-making, financial, contractual, testamentary, independent living, etc.; Moye et al., 2013; Moye, 2020). The publication, *Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists*, is one in a series of three handbooks published by the American Bar Association (ABA) and the Commission on Law and Aging and the American Psychological Association (APA) that provides guidance to psychologists on this important issue (ABA & APA, 2008). Psychologists working with older adults are encouraged to be prepared to work through difficult ethical dilemmas in ways that balance considerations of the ethical principles of beneficence and autonomy-- that is, guarding the older adult's safety and well-being as well as recognizing the individual's right to autonomy and to make their own decisions to the extent possible (Bush et al., 2017; Karel, 2011; Marson et al., 2011; Moye & Marson, 2007). This dilemma is especially relevant to older adults living in long-term care settings. The desire to live in less restrictive environments is optimally balanced against the obligations of family members and mental health practitioners to assure proper care for those who they believe may be unable to make their own decisions (Molinari et al., 2021).

Similar considerations regarding informed consent for treatment apply in work with older adults as in work with younger people. Ethical and legal issues may enter the picture when some degree of cognitive impairment is present, when the older individual lacks familiarity with treatment options, or when other conditions exist that suggest an older adult cannot provide valid consent. For example, some older adults may initially display an unwillingness to consent to participate in psychotherapy. However, once informed of what treatment entails, consent is often given. When older adults are brought in for therapy or assessment by family members, practitioners are encouraged to take steps to ensure that it is the older adult's decision whether to participate in the process or not, independent of the desires of the family. In fact, obtaining

the individual's consent and reminding the individual and the family about the confidentiality of the treatment or evaluation process may be an important part of building initial rapport with the older adult (Bush et al., 2017; Hays & Jennings, 2015).

A diagnosis of major neurocognitive disorder is not necessarily equivalent to lacking capacity in one or more areas. Even older adults with dementia often maintain the capacity to give or withhold consent well into illness progression (ABA & APA, 2008; Bush et al., 2015; Moye & Marson, 2007). The transitional period wherein a person with dementia progresses from having capacity to lacking capacity within one or more domains requires careful evaluation. Even after the older adult is assessed as lacking a specific capacity, the individual often remains capable of expressing core values and indicating assent with treatment decisions. Assessment of one or more domains of capacity requires an understanding of both clinical and legal models of diminished capacity, functional abilities linked to legal standards, and appropriate use of instruments to assess functional abilities, neurocognitive abilities, and psychiatric symptoms (Bush et al., 2015). An understanding of the person's long-held system of beliefs and values is also essential, as is an assessment of ways to potentially enhance capacity and maximize functional abilities. Often the psychologist may need to determine if a capacity assessment is warranted, or if the situation can be resolved through supportive decision making or in another manner. Knowledge of geriatric support services as well as legal tools and mechanisms for shared, supportive, or substitute decision making, such as powers of attorney, are critical (Hays & Jennings, 2015; Lind et al., 2022). Some individuals may have diminished capacity in one domain but not others. Because some domains of diminished capacity may improve over time, as can be the case with reversible or treatable causes of cognitive decline, reassessment of capacity may be required (ABA & APA, 2008). Older adults with apparent diminished capacity and who have few or no social connections are especially vulnerable and require careful evaluation and, as needed, advocacy on their behalf, such as the development of supportive decision-making agreements (Bush & Heck, 2018; Catlin et al., 2021; Stanziani et al., 2020). Recent guardianship law emphasizes "supported decision making" as a paradigm shift away from the concepts of diminished capacity and surrogate decision making (Moye & Wood, 2020). Supported decision making is a series of relationships and agreements, which may be more or less formal, designed to assist persons in making and communicating decisions to others. This emphasis on supported decision making is consistent with long-standing approaches in geropsychology which emphasize respect for persons and recognizing and including supportive others and supportive services in care plans, when it is consistent with the individual's values.

Psychologists working with older adults who are at risk due to diminished capacity may often encounter confidentiality issues in situations that involve families, interdisciplinary teams, long-term care settings, other support systems, or HIPAA protections regarding the electronic transfer of personal health information. A common ethical dilemma with regard to confidentiality involves older adults who are moderately to severely cognitively impaired and as a result may be in some danger of causing harm to themselves or others. Careful consideration is useful in view of these issues and consultation with other professionals may be especially helpful. In select situations, a careful balance of ethical considerations of beneficence and respect for autonomy includes tolerating some at-risk behavior (ABA & APA, 2008; Hays & Jennings, 2015; Lind et al., 2022).

In some settings (e.g., long-term care facilities) mental health services may be provided in the residence in which the older adult lives. In these settings, psychologists may be particularly challenged to protect client confidentiality. For example, it may be difficult to find a place to meet that is private. In addition, in such settings it is important to establish clear boundaries about what will and will not be shared with residence staff, both verbally and in written records (Karel, 2009; Molinari et al., 2021; Moye, 2020).

Psychologists working with older adults may at times experience pressure from family members or others involved to share information about the older person. Such information sharing may be justified in terms of the need to help the older adult, and collaboration with others may be very advantageous. Nonetheless, except in limited circumstances (e.g., elder abuse, presenting danger to self or others, guardianship), older adults in treatment relationships have as much right to full confidentiality as younger adults, and must provide documented consent to permit the sharing of information with others (Hays & Jennings, 2015).

Another set of ethical issues involves handling potential conflicts of interest between older adults and family members, particularly in situations of substitute decision making. Even when cognitive incapacity interferes with a person's ability to exercise autonomy in the present, it is often possible to ascertain what the individual's values are or have been in the past and act according to those values. When there is a substitute decision maker, there may be some risk that the surrogate will act for his or her own good rather than in the best interests of the older adult with dementia (ABA & APA, 2008; Moye, 2020). This potential for conflict of interest arises both with formally and legally appointed guardians as well as decision making by family members. Such conflict can also arise during decisions about end-of-life care for older family members (Carpenter & Merz, 2020). Because situations involving death and dying are more common in later life, psychologists who work with older adults may often find it useful to be well informed about legal concerns and professional ethics surrounding these matters (APA, 2017).

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

Since an estimated 10-14% of older adults experience elder abuse (Lachs & Pillemer, 2015; Yon et al., 2019) psychologists are likely to encounter situations in which it is suspected that older adults may be victims of psychological or verbal abuse, financial exploitation, physical or sexual abuse, abandonment, or neglect. Others are victims of investment fraud (DeLiema et al., 2020; Wood & Lichtenberg, 2017). Risk of elder abuse is higher among older adults who live with spouses or adult children, are socially isolated, have lower incomes, need more physical assistance, or who have compromised cognitive functioning (Lachs & Pillemer, 2015). Women are more likely than men to be victims of elder abuse, as the longer life expectancy of women increases the number of years in which they may have greater contact with potential abusers (Kreinert et al., 2009; National Committee for the Prevention of Elder Abuse & MetLife Mature Market Institute, 2012; Yon et al 2019). In addition, women are subjected to higher rates of

family violence across the lifespan, and researchers have shown that previous exposure to a traumatic life event (e.g., interpersonal and domestic violence) elevates an older adult's risk of late life mistreatment (Acierno et al., 2010).

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

Guideline 14: Psychologists strive to be knowledgeable about public policy, state and federal laws and regulations related to the provision of and reimbursement for psychological services to older adults and the business of practice. With a changing policy climate, the health care landscape continues to evolve. Psychologists who serve older adults are encouraged to be alert to changes in health care policy and practice that will impact their professional work including practice establishment, state laws that govern practice, potential for litigation, and reimbursement for services.

Medicare, the federal health insurance program for persons 65 years of age, and younger persons with disabilities, is a chief payer of mental health services for older adults. Psychologists were named as independent providers under Medicare in 1989 and the regulations that govern provision of services as well as reimbursement rules and regulations have evolved in the intervening years (Hinrichsen & Emery-Tiburcio, 2022). Therefore, it is important for those who provide psychological services to older adults to be knowledgeable of the structure of the Medicare program and the rules that govern provision of and reimbursement for services billed to Medicare (Norris, 2015). Medicare Advantage Plans, also known as “Part C” or “MA Plans,” have become increasingly popular in recent years. Medicare Advantage Plans are provided by private insurance companies approved by Medicare to follow Medicare rules. Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Private Fee-for-Service (PFFS), and Special Needs Plans (SNPs) are offered, and most include Part D, or medication coverage (“Medicare Advantage Plans,” n.d.). Some older adults also have insurance that supplements Medicare coverage called “Medigap” policies. Knowledge of Medicaid (the federal/state insurance program for low-income Americans) is also useful as some states provide reimbursement for mental health services for older adults who have both Medicare and Medicaid (“dual eligibles”). Some individuals with Medicare, Medicare Advantage, or Medicaid coverage may find it more difficult to find mental health providers because of reimbursement rates and program restrictions or requirements. Psychologists in the U.S. may also benefit by being knowledgeable about Social Security benefits, from which the vast majority of older adults receive payment as well as a broad range of services that are provided through the Older American's Act (Firman et al., 2019; O'Shaughnessey, 2011) and other sources. The business of psychological practice with older adults requires a practical knowledge of not only requirements for reimbursement but also office management, collaboration with other professionals, protection from potential litigation, and practice development (Hartman-Stein, 2006; Vacha-Haase, 2011). For those who provide services in hospital and long-term care settings, substantive knowledge of

institutional policies (e.g., reimbursement, documentation, protection of patient privacy) is highly desirable (Molinari et al, 2021).

Assessment

Guideline 15. Psychologists strive to understand the functional capacity of older adults in their own social and physical environment. Most older adults maintain high levels of functioning, suggesting that factors related to health, lifestyle, and the match between functional abilities and environmental demands more powerfully determine performance than does age (Abdi et al., 2019; Chatterji, et al., 2015). Attention to assessing functional capacity in the context of person-environment fit is a part of competent clinical practice with older adults. Older adults' level of cognitive and physical functioning weighs heavily in decisions they make about employment, health care, relationships, leisure activities, and living environment. For example, many older adults may wish or need to remain in the work force (Dawson & Sterns, 2012; Solem et al., 2016). However, the accumulation of health problems and their effect on functioning may make that difficult for some older adults. Changes in functional abilities may impact other aspects of older adults' lives. For example, intimate relationships may become strained by the presence of health problems in one or both partners (Syme & Cohn, 2021). Discord among adult children may be precipitated or exacerbated because of differing expectations about how much care each child should provide to the affected parent (Luichies et al., 2021). Increasing needs for health care can be frustrating for older adults because of demands on time, finances, transportation, and lack of communication among care providers. Attention to assessing functional capacity in the context of person-environment fit is a part of competent clinical practice with older adults.

The degree to which the older individual retains or does not retain the ability to function independently versus relying on others for basic self-care, determines the need for support in the living environment (Abdi et al., 2019). Theoretical perspectives on person-environment fit (Park et al., 2017) have considerable applicability when older adults evidence functional decline. For example, some older adults with mild cognitive or functional impairment successfully adapt to environments that impose few demands on them. As an older adult's functional abilities decline, the environment becomes increasingly important in maximizing their functioning and maintaining their quality of life (Abdi et al., 2019). Reablement, or enhanced home care, programs have demonstrated some success in improving functioning to increase opportunities to age in place (Flemming et al., 2021). Technological advances have also offered options for keeping older adults safe at home (Chiu et al., 2020) though ethical issues have arisen related to privacy and autonomy (Meiland et al., 2017; Sánchez et al., 2017). As such, psychologists working with older adults need to become familiar with processes for encouraging referrals to occupational therapy services; in-home assessments can lead to recommendations for home modifications that maximize person-environment fit and enhance daily functioning. In engaging the older adult in a conversation about adding supports to their living environment, it is important to balance the person's need for autonomy and quality of life with safety. For example, for some older adults, health problems make it difficult to engage in activities of daily living which may necessitate home health care. 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, beliefs that family members are

the only acceptable caregivers, or preference to not have anyone in their home for any reason (AP-NORC Center for Public Affairs Research, 2016).

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

Many older adults provide support for another as a caregiver or care partner. Caregivers often experience high levels of stress and are at increased risk for depression, anxiety, anger, and frustration (APA, 2011a; Miller et al., 2020; Woodford et al., 2018), as well as compromised immune system function during caregiving (Allen et al., 2017) and after the loss of the care recipient (Wilson et al., 2020). However, certain cultural values and beliefs may decrease perceived caregiver burden and increase resilience and growth (Teahan et al., 2018), and that dementia caregiving may be a protective factor in mortality (Leggett et al., 2020). Similarly, older adults who are responsible for others (e.g., aging parents of adult offspring with longstanding disabilities or severe mental disorders) may need to arrange for their dependents' future care (Sivakumar et al., 2020). Older grandparents who assume primary responsibility for raising their grandchildren face the strains and rewards of late life parenting (Hayslip et al., 2019).

Guideline 16. Psychologists strive to be familiar with the theory, research, and practice of various methods of assessment with older adults, and knowledgeable of assessment instruments that are culturally and psychometrically suitable for use with them. Relevant methods for assessment of older adults may include clinical interviewing, use of self-report measures, cognitive performance testing, direct behavioral observation, role play, psychophysiological techniques, neuroimaging, and use of family and/or informant data. Psychologists should aspire to have familiarity with contemporary information about biological etiologies and how they contribute to differential diagnosis and disease characterization, including but not limited to knowledge about genetic, neuroimaging, and neuropathologic features. Psychologists should further aspire to understand how this information can contribute to the assessment process and outcome, even if they do not apply these techniques themselves or directly utilize this data.

A thorough geriatric assessment is preferably an interdisciplinary one, focusing on both strengths and weaknesses, determining how problems interrelate and taking account of contributing factors. In evaluating older adults, it is important to ascertain the possible contributing or confounding influence of medications and medical disorders. Medications with anticholinergic

properties, for instance, span multiple medication classes including antihistamines and bladder control compounds, and can negatively impact cognition in older adults (American Geriatrics Society [AGS], 2019; Arnold, 2015). Similarly, medications such as steroids and opioids can commonly affect mood. Medical and neurologic disorders sometimes mimic psychological disorders. Other possible influences to assess include immediate environmental factors on the presenting problem(s), and the nature and extent of the individual's familial or other social support. In many contexts, particularly hospital and outpatient care settings, psychologists are frequently asked to evaluate older adults with regard to depression, anxiety, cognitive impairment, sleep disturbance, suicide risk factors, psychotic symptoms, various types of decision-making capacity, and the management of behavior problems associated with these and other disorders.

Developing knowledge and skill with respect to standardized measures involves a high level of training and experience in, including but not limited to, psychometric theory, principles of test development and standardization, and appropriate selection of test instruments and normative samples to which test performances are compared (American Educational Research Association [AERA], APA, & National Council on Measurement in Education [NCME], 2014). When possible, clinicians are encouraged to utilize instruments that have been developed and normed for older adults specifically (See <https://aria.ua.edu/measurement-archive/>; see also *Website Resources for Psychological Practice with Older Adults* below). When this is not feasible, clinicians are encouraged to rely upon assessment instruments developed with young adults for which older adult normative data are available, and for which there is validity and reliability evidence to support their use with this population. The practitioner strives to understand the limitations of using certain instruments, to consider that this approach leaves open the question of content validity (i.e., the age-relevant item content coverage for the construct being measured), and to interpret the assessment results accordingly, identifying any non-standardized approaches or limitations of their assessment. Multiple resources are available (e.g., Balsis et al, 2015; Edelstein et al., 2015; Lichtenberg, 2010).

Age is not the only potential factor to consider when utilizing diagnostic and standardized assessment instruments in older adult populations. Issues of culture, race, education, and language can also play a significant role in the process and outcome of assessment (see Guideline 5 for detailed discussion). It is important for psychologists to appreciate intersectionalities of age and culture and potential cultural influences on the psychometric characteristics of assessment instruments and to conduct culturally sensitive assessments. Culturally appropriate norms are not always available for assessment instruments, so it behooves the psychologist to be informed about which measures are most appropriate for diverse populations and to understand the potential limitations of using other normative data and related ethical issues when assessing racially, culturally, and linguistically diverse older adults (e.g., APA, 2017; Brickman et al., 2006; Fujii, 2016; Rivera-Mindt, Byrd, Saez et al., 2010; Sisko et al, 2015). This includes, but is not limited to, recent immigrants and refugees, first and second-generation Americans, and Americans from culturally or linguistically distinct regions of the U.S. (e.g., Appalachian, Creole, or Indigenous communities). Test items considered commonplace or benign in certain populations may be considered obscure or offensive to others, which can complicate interpretation of low scores on certain assessment measures.

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

In addition to diagnostic and other standardized assessment, behavioral assessment has many applications in working with older adults, particularly for psychologists working in hospital, rehabilitation, or other institutionalized settings (Dwyer-Moore & Dixon, 2007; Molinari & Edelstein, 2010; Zarit & Zarit, 2011). Functional analysis and assessment are often useful with individuals who exhibit problems such as wandering (Dwyer-Moore & Dixon, 2007; Hussian, 1981) and aggression and agitation (Cohen-Mansfield, 2015; Curyto et al., 2011) by enabling the clinician to identify the antecedents to problem behaviors. The combination of norm-based standardized testing and behavioral assessment also can be valuable. In assessing older adults, particularly those with advanced Major Neurocognitive Disorder, it is important that psychologists recognize the dimensionality of cognitive impairment and implement a flexible approach to assessment. This may mean choosing an assessment measure specifically developed for individuals with advanced disease or relying more heavily on data provided by other informants such as family, physicians, or other allied health staff. It is useful to be aware of effective ways of gathering such information, and general considerations about how to interpret it in relation to other data. Likewise, evaluations of older adults, particularly those with cognitive impairment, may often be clarified by conducting repeated assessments over time. Repeated assessment over time is likewise 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 contextual factors (e.g., time of day, activities, presence or absence of other individuals; Kazdin, 2003). Moreover, repeated assessment over time is useful when evaluating the effects of a medical intervention or rehabilitation (Haynes et al., 2011). Psychologists who conduct repeat assessments strive to be informed about possible practice effects that can occur with repeat administration of the same, or similar, assessment instruments (Chelune & Duff, 2019) and aspire to use reliable change estimates when available to help detect true and meaningful change over time (Hinton-Bayre & Kwapil, 2017).

As with assessing younger adults, balanced evaluations of older adults include not only attention to potential deficits, but also the identification of strengths (e.g., cognitive, functional, social) that can be garnered to aid in treatment or for the development of compensatory strategies to address deficits. Successful communication of these strengths and associated, targeted compensatory strategies is a critically important outcome of psychological assessments. This

information can aid the older adults themselves, as well as their family and loved ones as well as their medical and cultural communities in providing appropriate support and resources.

Guideline 17. Psychologists strive to develop skill at conducting and interpreting cognitive and functional ability evaluations. Quite commonly, when evaluating older adults, psychologists may use specialized procedures to help determine the individual's cognitive strengths and weaknesses, functional abilities, and to understand their behaviors (Attix & Welsh-Bohmer, 2006; Lichtenberg, 2010; Yochim & Mast 2019, 2011). Psychologists are often asked to characterize an older adult's current cognitive profile and determine whether it represents a significant change from an earlier time and, if so, whether the observed problems are due to a specific neurodegenerative process, a psychiatric or medical condition, and/or other causes (Morris & Brookes, 2013). Assessments can range from a brief cognitive screening to in-depth diagnostic evaluation. Cognitive screening typically involves the use of brief screening instruments to identify global impairment with high sensitivity but with relatively low diagnostic specificity. Diagnostic evaluations include more comprehensive assessment than screening instruments and can be used to characterize the nature and extent of cognitive deficits. While there is currently no evidence-based treatment for reversing cognitive impairment associated with neurodegenerative disease, brief cognitive screening may still be appropriate for older adults who are at risk for dementia or have suspected cognitive decline due to an underlying neurologic or medical condition, or a mental disorder. Identifying cognitive strengths and weaknesses can be helpful to generate compensatory strategies and target modifiable risk factors (e.g., increasing physical activity) to improve function and quality of life (Lisko et al., 2021). Federal legislation provides for screening for cognitive impairment during annual wellness visits for Medicare beneficiaries (Patient Protection and Affordable Care Act, 2010) and subsequent publications have provided recommendations to help clinicians operationalize methods of assessment in primary care (Liss et al., 2021).

Differentiating factors contributing to cognitive impairment among older adults can be challenging and most often require a neuropsychological evaluation conducted by clinicians with competency in neuropsychological assessment. See the *2021 APA Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change* for more information. A neuropsychological evaluation includes objective measurement of cognitive performance using standardized psychometric instruments that assess various cognitive domains. This is integrated with information obtained from family, friends, or staff that know the person well, in addition to historical, neurological, psychiatric, medical, and other diagnostic information. Psychologists with these competencies compare standardized test performance with culturally and demographically appropriate normative data in order to determine whether the cognitive profile is consistent with those known to occur in later life, or whether it represents a significant decline from the individual's baseline level of functioning. Using profile analysis, the pattern of test performance can help differentiate the possible sources of cognitive impairment. Prompt evaluation of cognitive complaints may be useful in identifying potentially reversible causes of cognitive impairment (e.g., metabolic abnormalities, vitamin deficiencies, medication side effects), and identifying cognitive impairment that may be due to factors such as depression or anxiety (APA, 2021). Repeated neuropsychological evaluation over time can help further characterize the nature and course of cognitive impairment. Consideration of practice or

exposure effects is an important element of repeated assessment (Hinton-Bayre & Kwapil, 2017).

The ability to ethically conduct valid assessments and make appropriate referrals and recommendations in this area depends, in part, upon knowledge of expected age-related changes in cognitive abilities (*See Guideline 8*). In conducting such assessments, clinicians rely upon their familiarity with age-related brain changes, conditions that affect the brain, psychometric properties of tests of cognition, demographically-appropriate normative data for tests of cognitive functioning, the client's premorbid cognitive abilities, and consideration of the quality of education in addition to the absolute number of years of education (Byrd, 2022; Fujii, 2016; Manly & Echemendia, 2007; Ravdin & Katzen, 2019; Salthouse, 2010; Schaie & Willis, 2021; Sisco et al., 2015). These clinicians also take into account observations of the person's behavior during cognitive testing, and measures of performance validity (Sweet et al., 2021). Brief cognitive screening tests do not substitute for a thorough evaluation, although some older adults may be unable to tolerate long assessment batteries due to frailty, severe cognitive impairment, or other reasons. Psychologists make referrals to clinical neuropsychologists (for comprehensive neuropsychological assessments), geropsychologists, rehabilitation psychologists, neurologists, geriatricians, or other specialists as appropriate. See the *APA Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change* (2021) for more information.

Research on the role of blood, cerebrospinal, and neuroimaging biomarkers in predicting, identifying, and treating neurodegenerative disease has grown exponentially in the past several years (Jack et al., 2018). The identification of relevant genes has shown similar progress (Takada, 2016). This is particularly true for Alzheimer's disease, which has, in part, shifted from a clinical diagnosis to a clinical-biologic diagnosis that involves both a clinical presentation and biologic evidence of amyloid, tau, and/or neurodegeneration (Dubois, 2021). While the assessment of biomarkers in routine clinical practice remains uncommon, cerebrospinal fluid tests for amyloid, tau and neurodegeneration are clinically available (Shaw, 2018). Positron emission tomography (PET) radioligands are available and FDA-approved for both amyloid and tau, but their use in clinical practice is also extremely limited at the current time. Psychologists conducting cognitive diagnostic assessments with older adults are encouraged to be informed of these recent developments related to pathogenesis and diagnosis of neurodegenerative diseases. As reliable biological markers continue to be developed for clinical use, cognitive and neuropsychological assessment will remain essential for characterization of disease course, determination of onset of symptoms, and to track treatment response

In addition to the evaluation of cognitive functioning, psychologists are often called upon to assess the functional abilities of older adults, which typically include the ability to perform activities of daily living (ADLs; e.g., bathing, eating, dressing) and instrumental activities of daily living (IADLs; e.g., managing finances, preparing meals, managing medications and appointments). All these abilities require a combination of cognitive and behavioral skills. In 2019, approximately 44% of the older adult U.S. population reported having one or more disabilities (CDC, 2019), though it is noteworthy that advancing age and functional decline are not necessarily linearly related (Lichtenberg, 2010). In addition, psychologists are increasingly being asked to evaluate older adults' decision-making capacity (*See Guideline 15*; also <https://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf>).

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

Intervention

Guideline 18. Psychologists strive to be familiar with the theory, research, and practice of various methods of intervention with older adults, particularly with current research evidence about their efficacy with this age group. Psychologists have been adapting their treatments and doing psychological interventions with older adults over the entire history of psychotherapy (Hinrichsen, 2020; Knight & Pachana, 2015; Molinari, 2011). As different theoretical approaches have emerged, each has been applied to older adults, including psychodynamic psychotherapy, behavior modification, cognitive behavioral therapy, interpersonal psychotherapy, problem-solving therapy, as well as emerging evidence for the “third wave” cognitive and behavioral therapies (e.g., Acceptance and Commitment Therapy [ACT], Dialectical Behavior Therapy [DBT], Metacognitive Therapy [MCT], and Mindfulness-Based Interventions [MBIs]). In addition, efforts have been made to use the knowledge base from research on adult development and aging to inform intervention efforts with older adults in a way that draws upon psychological and social capacities developed during the individual's lifespan (Anderson et al., 2012; Griffin et al., 2015; Hinrichsen, 2020).

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

The problems for which efficacious psychological interventions have been demonstrated in older adults (Scogin & Shah, 2012) include depression (Edelstein et al., 2015) anxiety (Goncalves & Byrne, 2012), insomnia (Hinrichsen & Leipzig, 2021) and alcohol misuse (Blow & Barry, 2012; Substance Abuse & Mental Health Services Administration, 2020). In addition, behavior therapy and modification strategies, problem-solving therapy, socio-environmental modifications, and related interventions have been found useful in treating depression, reducing behavioral disturbances, and improving functional abilities in cognitively impaired older adults (Cohen-Mansfield, 2015; Kirkham et al., 2012; Kiosses et al., 2015). Reminiscence or life review therapy has shown utility as a technique in various applications for the treatment of depression (Alquam, 2018; Westerhof & Slatman, 2019), including for those with cognitive impairment (Cuevas et al., 2020). Preliminary evidence suggests that exposure-based therapies (prolonged exposure [PE]; cognitive processing therapy; narrative exposure therapy) for older adult trauma survivors are effective (Böttche et al., 2016; Lely et al., 2019; Robjant & Fazel, 2010), with indication from the first randomized controlled trial of PE that older adults may benefit from longer than standard treatment (Thorpe et al., 2019). The research is more limited on efficacy of psychological interventions with older adults from communities of color as compared with non-Hispanic Whites, though tailored interventions for specific groups of older adults have been found to be effective (Chavez-Korell et al., 2012; Emery-Tiburcio et al., 2019; Iwamasa & Hays, 2018; Lau & Kinoshita, 2019; Pratap et al., 2018). The settings and scope of targets for psychotherapeutic interventions continue to grow. Psychotherapies delivered as part of integrated care models have also been found to be effective in the treatment of depression in primary care settings (Bruce & Sirey, 2019; Emery-Tiburcio et al., 2019). Psychological interventions are also effective in the behavioral medicine arena as adjunctive approaches for managing a variety of issues in care for those with primary medical conditions, such as managing pain (Niknejad et al., 2018) and behavioral aspects of urinary incontinence (Burgio, 2013). They also can provide valuable assistance to older adults experiencing prolonged grief disorder (Roberts et al., 2019), adapting to changing life circumstances, improving interpersonal relationships, and/or experiencing sexual concerns, or other issues (Hinrichsen, 2008; Hillman, 2012; Sinković & Towler, 2019). As with other age groups, practitioners are encouraged to use evidence-based practices with older adults (APA, 2021).

A related issue is that as many as 50% of older adults experience some changes in sleep or insomnia (Patel et al., 2018). These changes are not necessarily age-related and often stem from physical health problems (e.g., chronic pain), mental health problems, or other causes (Brewster et al., 2018; Dunietz et al., 2018). Cognitive behavioral therapy for insomnia (CBTi) has been found to be effective in treating insomnia in older adults by replacing maladaptive thoughts and sleep habits. It improves sleep hygiene by utilizing techniques like stimulus control, sleep restriction, relaxation techniques, cognitive restructuring and has shown to improve sleep outcomes (Brewster et al., 2018).

Guideline 19. Psychologists strive to develop skills in adapting psychotherapeutic interventions, including environmental modification, in a manner sensitive to cultural and other individual differences among older adults. Some interventions, such as individual, group, couples, and family therapies, may be readily adapted to treat specific problems among older adults. Other interventions uniquely developed to address common problems in older adults or that are very commonly used with this population include reminiscence and life review

(Westerhof & Slatman, 2019); facilitation of normative grief reactions (Steffen et al., 2022b); complicated grief therapy (Roberts et al., 2019; Shear et al., 2014); psychotherapy focusing on role transitions, developmental issues and behavioral adaptations in late life (Knight & Pachana, 2015; Roseborough et al., 2013); treatments for depression in those with cognitive impairment (Kiosses et al., 2015), acute or chronic medical problems, or elevated suicide risk (Raue et al., 2017); methods for enhancing cognitive function in later years; and interventions and psychoeducational programs for older adults, family members and other caregivers (APA, 2011a, 2020b; Cheng et al., 2020; Karlin et al., 2017; Qualls, 2016; Schultz et al., 2020). No single modality of psychological intervention will be efficacious for all older adults. The selection of the most appropriate treatments and modes of delivery depends on the nature of the problem(s) involved, clinical goals, the immediate situation, and the individual patient's characteristics, preferences, reference group identities (Jimenez et al., 2012; Hillman & Hinrichsen, 2014; Kim et al., 2017; Vinson et al., 2014), place on the continuum of care settings (for case examples, see Karel et al., 2002; Knight, 2004; Pachana et al., 2010) and, as noted earlier, availability of an evidence-based practice. For example, community dwelling older adults who have high physical and mental functional ability may respond well to standard forms of psychotherapy that are often delivered in outpatient settings (e.g., individual, group, family therapies). It is the degree of functional impairment (physical, cognitive, and social), rather than age, that is the primary determinant of whether and how to modify standard treatments, and this forms the basis of careful evaluations of functioning.

The research literature provides evidence of the importance of specialized skills in working with older adults (Jacobs & Bamonti, 2022; Mast et al., 2022; Qualls, 2022). A variety of specific issues characterize work with older adults that may require sensitivity to age-related issues and utilization of specialized intervention techniques (see *Psychotherapy and Older Adults Resource Guide*, APA, 2009b). In addition, some older adults from historically marginalized groups (e.g., BIPOC, LGBTQ+, TGD) experienced healthcare institutions as untrustworthy due to past experiences or have been harmed by mental health services. Practitioners then take active efforts to engage them and discuss their concerns, and offer healing and corrective experiences (Jimenez et al., 2012; Hillman & Hinrichsen, 2014; Kim et al., 2017; Vinson, et al., 2014). Psychotherapy informed by “gero-diversity” may incorporate aspects of the older adult's reference group identities and corresponding values, beliefs, cultural practices, and customs in order to align interventions in a person-centered, culturally humble manner and decrease stigma (APA, 2017, 2018). 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 (Shah et al., 2012; Westerhof & Slatman, 2019).

Because physical health issues are so commonly present, psychological interventions with older adults frequently address the older adult's adaptation to medical problems, such as pain management or enhancing adherence with medical treatment (Hadjistavropoulos, 2015). When facing life limiting health problems and end of life, older adults may require assistance with managing this process for which therapeutic models exist (APA, 2017; Carpenter, 2015; Kasl-Godley et al., 2014).

For some older adults, standard therapeutic approaches can be modified with respect to process or content. Examples of process change might include modifying the pace of therapy, accommodating sensory limitations by reducing ambient noise and glare, speaking more slowly or closer to the ear of the older adult, encouraging the use of sound amplifiers (“pocketalkers”) or hearing aids, or involving a caregiver. Modification to the content of therapy may include more attention to physical illness, grief, cognitive decline, and stressful practical problems experienced by some older adults than is usually the case with younger adults (Lind et al., 2022; Steffen et al., 2022). It is also important to adapt interventions to the clinical setting such as private office, home, hospital, or long-term care facility; see Guideline 10 for more on this issue.

Often psychologists provide services to older adults as active participants in family, social, or institutional systems. Therefore, in working with older adults, psychologists may need to intervene at various levels of these systems. For example, psychologists may assist family members by providing education and/or emotional support, facilitating conceptualization of problems and potential solutions, and improving communication and the coordination of care (Qualls, 2016). Or the psychologist may provide behavioral training and consultation on environmental modifications to long-term care staff for dementia related problem behaviors (Cohen-Mansfield, 2015).

Consultation

Guideline 20. Psychologists strive to recognize and address issues related to the provision of prevention and health promotion services for older adults. Psychologists may contribute to the health and well-being of older adults by helping to provide psychoeducational programs (e.g., Reijnders et al., 2017) and through involvement in broader prevention efforts and other community-oriented interventions (Alegria et al., 2019; Hirst et al., 2013). Related efforts include advocacy within health care and political legal systems (Karel, et al., 2012; Monahan et al., 2020; Schulz et al., 2020). In such activities, psychologists integrate their knowledge of clinical problems and techniques with consultation skills, strategic interventions, and preventive community or organizational programming to benefit substantial numbers of older adults (Clark et al., 2012). Such work may entail becoming familiar with outreach, case finding, referral and early intervention, as these relate to specific groups of at-risk older adults (e.g., Fredriksen-Goldsen et al., 2014). An important aspect of these efforts is for psychologists to understand the strengths and limitations of local community resources relative to their domains of practice, or the risk factors affecting the older adult group of concern (Seidel et al., 2017). For example, if the aim is to reduce isolation as a risk factor for depression, it might be pertinent to consider the availability of organized opportunities for older adults to socialize and whether there should be an organized effort to increase these options (Casado et al., 2012). Similarly, relative to fostering older adults’ general sense of well-being, it might be useful to advocate for more health promotion activities designed to facilitate their participation in exercise, good nutrition, and healthy lifestyles (Alegria et al., 2019; Clark et al., 2012).

There are several areas of health promotion and prevention efforts relevant to psychologists working with older adults. Depression and concomitant risk of suicide is one area of particular concern (Schmutte & Wilkinson, 2020). Risk for depression in older adults is associated with female sex, chronic illness and functional impairment, cognitive impairment, social isolation, life event stress, and a history of depression (Kok & Reynolds,

2017). However, older men are at greater risk of suicide and suicidal ideation may be present in older adults who do not exhibit symptoms of depression (Raue et al., 2014). A variety of mechanisms including deficits in emotion regulation, social processing, and cognitive control may explain suicidal behavior in older adults (Kiosses et al., 2014). Therefore, practitioners are encouraged to be vigilant about assessing suicide risk in a variety of settings, including primary care. Further, it is important to enlist primary care physicians in efforts to recognize depressive symptoms and other risk factors for suicide (Huh et al., 2012) and provide referrals for appropriate treatment (Fiske et al., 2015).

Alcohol and substance misuse among older adults is a related topic of concern regarding health promotion and prevention efforts by psychologists. The use of alcohol and other substances that are considered unhealthy includes consuming more than the recommended amount of alcohol (i.e., more than three standard drinks on one occasion or more than seven drinks per week for adults aged 65 and older), use of tobacco products, use of illicit drugs, and misuse of prescription medications (Han & Moore, 2018). While older adults have typically used alcohol and other substances at lower rates than younger adults, this appears to be changing with the aging of the “Baby Boom” generation (Chhatre et al., 2017; Han & Moore, 2018; Shulte & Hser, 2013). In fact, rates of unhealthy substance use among older adults appear to be increasing in recent years. In the period between 2005/2006 and 2013/2014, binge drinking (≥ 5 drinks on one occasion) increased overall among older adults by 19.2% (21.5% of men and 9.1% of women), and alcohol use disorders increased by 23.3% during this time. Between 2000 and 2012, admissions for substance use treatment among older adults increased from 3.4% to 7.0%, and were primarily for alcohol (Chhatre et al., 2017). Misuse of alcohol and other substances in older adults is associated with poor physical and mental health and may be used to cope with stressful life events, life transitions such as retirement, and mental health issues like depression (Mauro et al., 2015; Shulte & Hser, 2013). Substance misuse among older adults is of concern given the greater sensitivity to the effects of alcohol and other substances with increased age (Shulte & Hser, 2013), as well as the increased morbidity and risk of falls associated with such use resulting from chronic disease and interactions with other medications (Han & Moore, 2018; Shulte & Hser, 2013). In addition to alcohol, psychologists must be aware of other substance use, including opioids. In fact, the number of opioid deaths increased by a factor of 20 from 1999 to 2019, and disproportionately affected older non-Hispanic Black men, whose rate of opioid deaths is four times that of the general population of older adults (Mason et al., 2022). Thus, psychologists working with older adults should be conscious of the potential for unhealthy substance use in this population and provide appropriate screenings and referrals (Han & Moore, 2018).

While most older adults are engaged in active and rewarding social relationships, some may experience feelings of loneliness, particularly those in their late 80s or older (Anderson & Thayer, 2018; Lee et al., 2021). Loneliness, the psychological perception of an absence of meaningful relationships, has been identified as an emerging public health issue for older adults given its associated risk for mortality comparable to tobacco use, physical inactivity, and obesity, as well as its association with increased health care utilization (Gerst-Emerson & Jayawardhana, 2015; Ong et al., 2016). Loneliness is distinct from, but may be related to, living alone, social isolation, and solitude (Ong et al., 2016). Some older adults may be

particularly vulnerable to loneliness due to losses in their social networks and social roles as they age (Cohen-Mansfield et al., 2016). Psychological factors associated with loneliness in older adults include impaired cognitive function, poor mental health, life event stress, and low perceived self-efficacy. Studies have found that approximately 25% to 40% of community-dwelling older adults endorse significant feelings of loneliness (Ong et al., 2016; Perissinotto et al., 2019), but these proportions are higher among some subpopulations of older adults such as those aging with HIV (Brennan-Ing et al., 2017). Since loneliness in older adults may not be readily apparent, psychologists working with this population should consider screening patients for loneliness, and if detected, make referrals to programs and interventions designed to increase social connectedness including psychotherapy and telephone support interventions (Perissinotto et al., 2019).

Guideline 21. Psychologists strive to understand issues pertaining to the provision of consultation services in assisting older adults. Psychologists who work with older adults are frequently asked to provide consultation on aging-related issues to a variety of groups and individuals. Many psychologists possess a complement of knowledge and skills that are especially valuable in the provision of consultation including social psychology, developmental psychology, diversity and inclusion, group dynamics, communications, program design and evaluation, and others. Psychologists who work with older adults strive to draw upon knowledge and skills with specific relevance to the older adult age group (Bensadon, 2015). For example, once consent is obtained, psychologists frequently consult with and provide psychoeducation for family members of older relatives who have been diagnosed with mental health or cognitive concerns, especially those with dementia, on how to best support these aging family members. Given the anticipated dearth of aging specialists as the size of the older population rapidly grows, psychologists with relevant expertise will likely play important roles in educating other professionals about aging (Institute of Medicine, 2012; Ward et al., 2018).

In consultation with other professionals, institutions, agencies, and community organizations psychologists may play key roles in training and educating staff who work directly with older adults in many different settings (Garzonis et al., 2015; Lee et al., 2020; Molinari et al., 2021; O’Shea Carney et al., 2015). In the staff training role, psychologists teach basic knowledge of normal aging and development, improved communication with older adults (GSA, 2012), appropriate management of cognitive and behavioral issues (Teri et al., 2020), and facilitate social engagement given the adverse consequences of social isolation (Van Orden et al., 2020). For example, many long-term care staff members recognize that they lack adequate knowledge of how to implement evidence-based non-psychopharmacological protocols to address the mental health needs of residents, particularly those with serious mental illness or major neurocognitive disorder (Karel, Teri, et al., 2016). More staff consultation and training in behavioral principles may result in a reduction in the over-use of psychoactive medications and improved quality of life for this vulnerable population (Arnold, 2015). Psychologists may contribute to program development, evaluation and quality assurance related to aging services (O’Shea Carney et al., 2017). When consulting with health care teams or organizations, psychologists can facilitate increased collaboration among members of interdisciplinary care teams especially those that have client populations with complex medical and psychosocial needs (Farrell et al., 2018; Geriatrics Interdisciplinary Advisory Group, 2006; McDaniel et al., 2014).

Conclusion

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

Website Resources for Psychological Practice with Older Adults

Name	Website
Alabama Research Institute on Aging – Measurement Archive	https://aria.ua.edu/measurement-archive/
American Board of Geropsychology	https://abgero.org
APA Aging Portfolio	http://www.apa.org/pi/aging/index.aspx
APA Center for Workforce Studies	https://www.apa.org/workforce
APA Division 20	http://apadiv20.phhp.ufl.edu/
APA Guidelines for Psychological Practice with Sexual Minority Persons	https://www.apa.org/about/policy/psychological-sexual-minority-persons.pdf
APA Guidelines for Psychological Practice with Transgender and Gender Nonconforming People	https://www.apa.org/practice/guidelines/transgender.pdf
Area Agencies on Aging	https://www.usaging.org
Caregiver Briefcase	http://www.apa.org/pi/about/publications/caregivers/index.aspx
Committee on Aging	https://www.apa.org/pi/aging/cona
Division 12-Section II, the Society for Clinical Geropsychology	http://www.geropsychology.org
E4 Center of Excellence for Behavioral Health Disparities in Aging	https://e4center.org/
GeroCentral	https://gerocentral.org/
Gerontological Society of America (GSA)	http://www.geron.org/
GSA KAER Toolkit, Fall 2020 Edition	https://www.geron.org/publications/kaer-toolkit

Integrated Health Care for an Aging Population	http://www.apa.org/pi/aging/programs/integrated/index.aspx
National Population Projections Tables	https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html
Project Implicit	https://implicit.harvard.edu/implicit/takeatest.html
Psychologist in Long-term Care	http://www.pltcweb.org/index.php
SAMHSA Treatment Improvement Protocol (TIP) 26 Treating Substance Use Disorder in Older Adults	https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-011%20PDF%20508c.pdf
The Administration for Community Living (ACL)	https://acl.gov
The American Society on Aging	https://www.asaging.org/

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