Attitude, Knowledge, and Skill Competencies for Practice in Professional Geropsychology: Implications for Training and Building a Geropsychology Workforce

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Professional geropsychology is a growing area of practice and training. To meet the mental health needs of an aging population, increasing numbers of psychologists need to develop competence to work with older adults, their families, and related care systems. The Pikes Peak model for geropsychology training (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009) delineates attitude, knowledge, and skill competencies for professional geropsychology practice and makes recommendations for training. In this paper, we define and illustrate the Pikes Peak geropsychology practice competencies through a case example. In the case, an older man with complex needs seeks care through a generalist psychologist in an outpatient setting. The attitudes, knowledge, and skills that the psychologist needs to consider, and implications for training, are reviewed. Training recommendations and resources are provided, with a focus on the training needs of psychologists who wish to expand their practices to include older adults.

Keywords: geropsychology, older adults, competencies, training, continuing education

To build a workforce of psychologists prepared to meet the mental health needs of an aging population, it is important to define competencies for geropsychology practice and explore and implement a wide range of training opportunities in the field. The Pikes Peak model for professional geropsychology training (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009) defines the core attitude, knowledge, and skill competencies for geropsychology practice, and makes recommendations about didactic, experiential, and supervisory experiences important for developing geropsychology competence. For this paper and the others in this special section, the focus is on explicating the Pikes Peak model to educators involved in the training of psychologists who wish to provide training to future geropsychologists. Not only can the Pikes Peak recommendations be used to guide formal training

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opportunities in doctoral programs (Qualls, Scogin, Zweig, & Whitbourne, 2010) and internship and postdoctoral programs (Hinrichsen, Zeiss, Karel, & Molinari, 2010), but they can inform the development of opportunities for education and training for postlicensure psychologists who wish to become competent in professional geropsychology.

In this paper, the attitude, knowledge, and skill competencies recommended for practice with older adults are summarized and illustrated through a case discussion. The full list of the Pikes Peaks competencies can be found in the 2009 American Psychologist article by Knight and colleagues (Knight et al., 2009). Implications for training and practice across a psychologist’s career are considered. In particular, training recommendations and resources are summarized with a focus on the postlicensure psychologist who wishes to develop geropsychology practice competencies to build on already established general competence in professional psychology.

Background: Professional Geropsychology

Growing Need for Geropsychology Services

The health care workforce is not prepared to meet the health and mental health care needs of our aging population (Center for Health Workforce Studies, 2005; Institute of Medicine, 2008). Across disciplines, most health care professionals receive relatively little training in geriatric care and Medicare reimbursement policies may pose financial disincentives for care of older adults. Mental health care needs are expected to rise for the older population, given both the increasing numbers of adults over the age of 65, and the fact that the baby boom cohort, now entering old age, has higher rates of mental disorders, and greater receptivity to mental health services, than the current cohort of older adults (He, Sengupta, Velkoff, & DeBarros, 2005; Koenig, George, & Schneider, 1994). In addition, the rapid growth of the “oldest-old” population will require specialized care related to chronic illness, dementia, long-term care, and end-of-life care (Gatz & Smyer, 2001; Jeste et al., 1999; Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002).

A survey of American Psychological Association (APA) members in 1999 (Qualls et al., 2002) found that psychologists had little formal training in aging and the majority of respondents (58%) felt they needed further training to work competently with older adults. Projections based on this sample’s responses suggest that psychologists are meeting only about half of the current need for geropsychology services, and do not include future needs.

Growth of Professional Geropsychology

The past 30 years have seen the coming of age of professional geropsychology, in the areas of research, practice, and training. A solid research base now informs geriatric mental health practice, and multiple-scientific journals are devoted to sharing research related to geriatric care. Increased training opportunities are available and multiple-professional organizations contribute to organized policy advocacy efforts, training, research, and practice in the field. The APA created the Office on Aging in 1998 (http://www.apa.org/pi/aging/).

During the past three decades, three conferences have convened with the aim of defining the scope of geropsychology practice and models of training for the field. The “Older Boulder” conference, held in Boulder, Colorado in 1981, focused on graduate education in geropsychology (Santos & VandenBos, 1982). The “Older Boulder II” conference, held in Washington, DC in 1992, worked to define the knowledge base for professional geropsychology practice and outlined three levels of geropsychology competence: exposure, experience, and expertise (Knight, Teri, Wohlford, & Santos, 1995). A task force spawned at the 1992 conference drafted a report that was later adopted by APA and published as the “Guidelines for Psychological Practice with Older Adults” (APA, 2004). The National Conference on Training in Professional Geropsychology was held in Colorado Springs, Colorado in 2006, and produced the Pikes Peak model for geropsychology training (Knight et al., 2009).

Geropsychology Competencies in Context

Competencies in professional psychology. Consistent with other health care professions (Accreditation Council for Graduate Medical Education and American Board of Medical Specialties, 2000; Epstein & Hundert, 2002), professional psychology has moved toward competency-based education, training, and credentialing (APA, 2008b; Kaslow, 2004; Kaslow et al., 2004; Rodolfa et al., 2005; Rubin et al., 2007). The 2002 Competencies Conference produced the “cube model” conceptual framework for considering the development of both foundational and functional competencies across a psychologist’s training career (Rodolfa et al., 2005). Foundational competencies are the underlying “building blocks” informing all professional psychology activity (e.g., ethical–legal standards, individual–cultural diversity), and comprise one axis of the cube. Along another axis of the cube are the six functional competencies of psychological practice: assessment–diagnosis–case conceptualization, intervention, consultation, research–evaluation, supervision–teaching, and management–administration. Finally, the third axis represents stages of professional development, including doctoral education, internship, postdoctoral training, and continuing education.

The cube model helped to inform the framework for the Pikes Peak training conference. First, geropsychology entails the application of the foundational and functional competencies for psychology practice to the special needs of older adults. Second, the cube model emphasizes the development of competence during training and over the course of one’s career. The Pikes Peak geropsychology training model emphasizes that competencies are developed incrementally and can be acquired through multiple-training pathways. Finally, the cube model highlights the importance of the assessment of competence, including ongoing self-assessment by professionals to assure maintenance of competence (Kaslow et al., 2007; Leigh et al., 2007). Likewise, the Pikes Peak model presumes that psychologists will have the interest to reflect on their individual competencies for providing care for older adults.

Competencies in geriatric health care. In addition to competencies for professional psychology practice, geropsychology competencies are informed by work done across professions to define competencies for geriatric care. For example, the John A. Hartford Foundation has supported these developments in both
Geriatric nursing (American Association of Colleges of Nursing & The John A. Hartford Foundation Institute for Geriatric Nursing, 2000) and geriatric social work (Damron-Rodriguez, Lawrance, Barnett, & Simmons, 2006). Within psychiatry, core competencies have been proposed for subspecialty training in geriatric psychiatry (Lief, Kirwin, & Colenda, 2005). Within the field of geriatrics, core competencies for multicultural geriatric care have been elaborated (Xakellis et al., 2004). Likewise, the field of palliative care has defined competencies for practice, which are relevant for psychologists who work with older adults with advanced illness (Morrison et al., 2007). Training in professional geropsychology therefore is informed primarily by models of training within professional psychology but also by team training models for geriatric health care (Heinemann & Zeiss, 2002; Seigler, Myer, Fulmer, & Mazey, 1998).

Geropsychology Practice Competencies: To Whom Do They Apply?

The Pikes Peak competencies for professional geropsychology practice (Knight et al., 2009) are aspirational. Possession of the competencies is seen as important for solid professional practice with older adults, especially when the psychologist practices extensively with older adults, across a wide range of care settings and/or provides services to older adults with complex clinical problems. Although geropsychologists sometimes play important roles in developing wellness programs to promote positive aging (e.g., Hill, 2006), the Pikes Peak competencies primarily address geropsychological practice in the realm of health and mental health care for older adults struggling with, or at risk for, health or mental health concerns. The competencies were developed with the newly trained, entry-level geropsychologist in mind, rather than an “expert” in the field. A newly gerocompetent psychologist would know enough about the field and his or her own competence to know when expert consultation was necessary. Not all psychologists who see some older adults in their practice would need to develop the full complement of competencies, particularly when the older clients are similar to younger clients seen in clinical practice. Needed knowledge and skill competencies would vary to some extent across settings of care (e.g., nursing home vs. outpatient independent practice) and primary professional functions (e.g., assessment, psychotherapy, consultation).

Method: Delineation of Competencies for Professional Geropsychology Practice

The competencies detailed in this paper are one outcome of the Pikes Peak Conference on Training in Professional Geropsychology (Knight et al., 2009). The 49 organizational and at-large delegates to the 2.5 day working conference were provided a rough draft of knowledge and skill competencies, compiled by the conference planning committee, to serve as a starting point for the conference work. The knowledge competency domains were taken directly from the “APA Guidelines for Psychological Practice with Older Adults” (APA, 2004), and the skill domains included professional functioning (or, foundational competencies per the cube model), assessment, intervention, consultation/training, research/evaluation, supervision/teaching, and skills for delivery of services in different care settings. Conference participants agreed that the skill competencies related to research, training, and administration would not be included in the fundamental competencies recommended for professional geropsychology practice. For a description of the conference methodology, see Knight et al. (2009).

Attitude, Knowledge, and Skill Competencies for Practice in Professional Geropsychology

Case Illustration

In this section of the paper, a case example is presented to illustrate the relevance and application of the geropsychology competencies and their implications for training. The case is a synthesis of many cases but represents a typical, complex case of an older adult seen in an outpatient mental health clinic setting. After briefly introducing the therapist and the older adult client, the case is then considered in the context of the Pikes Peak model attitude, knowledge, and skill competencies. Geropsychology attitudes and knowledge base are each defined succinctly, and geropsychology skills are summarized in four categories: (1) foundational geropsychology competencies, and the functional competencies of (2) assessment, (3) intervention, and (4) consultation. Case illustration and training implications are then considered within each of these competency domains.

Case Introduction

Imagine that Dr. Maria Lopez is a psychologist working as part of a mental health group practice that includes psychologists and psychiatrists. The practice is known to several primary care medical practices in the community. Dr. Lopez specializes in treating depression and anxiety in adults, and is fairly comfortable addressing a range of concerns in the lives of adults from young through recently retired older people. Dr. Lopez is a 35-year-old female, Latina psychologist who completed postdoctoral training 5 years previously, and works in an urban/suburban community serving an ethnically and socioeconomically diverse population.

Dr. Lopez receives a referral from a local primary care physician for an 83-year-old, Italian American, Catholic man, John Florio, who became depressed some time ago while caring for his wife with dementia. His wife moved to a nursing home last month, after a hip fracture and declining physical and mental capacities. Mr. Florio’s primary care physician prescribed citalopram a few months ago, which has been of some benefit. However since his wife’s admission to the nursing home, Mr. Florio has continued to be depressed, anxious, and demonstrating decreased self-care. When his doctor suggested a mental health referral, he wasn’t eager but respected his doctor’s advice and allowed the doctor to send a referral to Dr. Lopez.

Dr. Lopez telephones Mr. Florio at home, to schedule an initial visit. He picks up the telephone, and has trouble hearing her because the TV is blaring in the background. She repeats herself loudly several times, and he does appear to understand why she is calling. He knows his wife’s admission to the nursing home, Mr. Florio has continued to be depressed, anxious, and demonstrating decreased self-care. When his doctor suggested a mental health referral, he wasn’t eager but respected his doctor’s advice and allowed the doctor to send a referral to Dr. Lopez.

Dr. Lopez telephones Mr. Florio at home, to schedule an initial visit. He picks up the telephone, and has trouble hearing her because the TV is blaring in the background. She repeats herself loudly several times, and he does appear to understand why she is calling. He knows his doctor just talked with him about getting some counseling. He says he’s not sure if he really needs to come in. “Wouldn’t you be depressed if your wife was in a nursing home? Isn’t that normal?” he asks. Reluctantly he agrees to schedule an appointment.

Attitudes

Definition. The “APA Guidelines for Psychological Practice with Older Adults” (APA, 2004) specifies core attitudes for work-
ing with older adults. These attitudes include awareness of one’s scope of competence and willingness to seek consultation or make referrals when unable to competently address the needs of an older client. A core issue for practice with older adults is to be aware of one’s own attitudes and beliefs about aging and older adults, and how one’s personal reactions may affect one’s practice. For example, extreme respect for elders or a tendency to infantilize them will interfere with appropriate assessment and treatment. Likewise, feelings of helplessness or protectiveness; doubts that long standing behaviors and attitudes of older clients can be changed; or discomfort with issues such as sexuality, substance abuse, or death/dying may lead to ineffective care. The APA Guidelines also emphasize the importance of continued development of competencies through continuing education, training, supervision, and consultation.

In addition to these core attitudes, the Pikes Peak model emphasizes awareness of individual diversity in all of its manifestations and, in particular, how attitudes and beliefs about gender, ethnicity, sexual orientation and other aspects of diversity interact with attitudes and beliefs about aging. An understanding of and appreciation for the interactions between age/cohort and other aspects of individual diversity, and one’s personal responses to these aspects of diversity, enhance effective psychological assessment, intervention, and consultation with a diverse aging population.

Case discussion. How might Dr. Lopez react when she receives the above described referral from the primary care doctor? What thoughts and feelings might she have as she talks with Mr. Florio over the phone? What might it be like for her to negotiate his hearing loss and apparent ambivalence about this referral to see a psychologist (does he know what a psychologist is?)? Might she be feeling hopeful or discouraged about her ability to help him?

These questions are critically important to consider. Each individual has different life experiences related to aging, illness, family caregiving, and varying degree of personal or professional comfort interacting with older adults. How might Dr. Lopez’s (or any other psychologist’s) age, gender, cultural background, life experience, and training background influence her comfort and confidence in working with an older, White, Italian American man who is very distressed, and whose wife of more than 50 years may be nearing the end of her life? For example, what are her experiences with aging of her parents or grandparents? Has anyone close to her lived with and died from progressive dementia? What might it be like to work with someone old enough to be her grandfather?

The intersection of age and cohort on one hand and cultural differences on the other can further complicate rapport with older adults. In this example, the interaction between a later born Puerto Rican therapist and an earlier born Italian client may raise both cultural and age related biases on either or both sides of the therapy room. For Dr. Lopez, she may come to her relationship with Mr. Florio with great respect for elders, based on her own cultural background and life experience, and may understand some of the struggles he has had taking on caring for a wife who he had expected would care for him, given his traditional cultural expectations. In some cases, young professionals who have been raised to respect their elders find that this respect can “get in the way” of offering professional psychological services. For example, Dr. Lopez may find it difficult to interrupt Mr. Florio, who really does need some help staying on topic, to ask him personal questions about his health and marriage, or to witness him break down in tears. Mr. Florio may well have long held stereotypes about the role of women or Puerto Ricans in his city, and have the tendency of earlier born cohorts to speak more openly about gender, race, and ethnicity. These are not insurmountable problems, but they differ from issues typically encountered with younger adult clients and require additional self-reflection, experiential learning, and rapport building skills on the part of the therapist.

Training implications. Dr. Lopez’s awareness of her need for greater competency in geropsychology will be based in her ability for reflective self-awareness with regard to potential ageist stereotypes (both positive and negative) and their influence on her rapport with Mr. Florio. If this awareness leads her to seek additional training to enhance her attitudinal competencies in geropsychology, she will benefit from increased experience with a wide range of older adults, including contact with normally and successfully aging persons in nonclinical settings. In addition, she will benefit from supervision/consultation on clinical cases with input from an experienced professional geropsychologist who can listen to recordings of sessions and advise about potential indicators of being influenced by stereotypical thinking about aging.

Knowledge

Definition. Guided by and consistent with the APA Guidelines (2004), the Pikes Peak model outlines the knowledge base for geropsychology practice across four domains: (1) general knowledge about adult development, aging, and the older adult population (e.g., demographics; normal adult biological, psychological, emotional, and social development; wide diversity in the aging process); (2) foundations of clinical practice with older adults (e.g., neuroscience of aging, functional changes, psychopathology in late life, common medical illnesses); (3) foundations of assessment of older adults (e.g., assessment domains, methods, and instruments suitable for assessing older adults; contextual issues in assessment of older adults); and (4) foundations of intervention, consultation, and other service provision (e.g., efficacy and effectiveness of psychological interventions with older adults; models and methods of interdisciplinary collaboration; knowledge of aging services in the community).

Case discussion.

For his initial interview with Dr. Lopez, Mr. Florio drives himself to her office. He is obese and walks slowly with some discomfort in his hip and knees. He brings his hearing aids, and shows Dr. Lopez the list of his medications he keeps in his wallet. He takes five medications (for hypertension, diabetes, arthritis, and depression). He tells long stories that go off on tangents, and it can be hard to interrupt him. He struggles sometimes to find the right words to express himself. He works hard to hold back tears. He tells the story of meeting his wife shortly after returning home from Navy service during World War II, and discusses his three children and eight grandchildren. His daughter who lives locally has health problems herself. His son who lives nearby is very busy. His daughter who lives out-of-state calls every day.

Mr. Florio is a retired plumber, has a decent pension, and worries about long-term care expenses for his wife. He has Medicare and a supplemental health insurance policy. He and his wife used to enjoy playing cards, going to church, and taking cruises before she got Alzheimer’s disease. He promised himself, and her, that he’d never
put her in a nursing home. He took care of her at home the last few years, when she’d previously been the one who took care of everything in the home. He was exhausted, irritable, impatient in his role as a caregiver, but was devoted to taking care of her. She fell at night 2 months ago, required hip surgery, developed pneumonia, and was very confused. She was discharged from the hospital to a nursing home. He is with her at the nursing home all the time now, feels useless and guilty and can’t imagine living without her. He’s having trouble sleeping and is putting himself to sleep with 1 to 2 glasses of wine.

What does Dr. Lopez need to know to plan ongoing assessment, develop a diagnostic impression/conceptualization, and formulate an initial treatment plan? For example, does she know what level of emotional, cognitive, and daily functioning are “normal” for an 83-year-old man of his educational, occupational, and cultural background, and in his current situation? Does she know what range of medical, neurological, psychiatric, and psychosocial issues may contribute to his presentation? Can she place his life experience in its sociohistorical context and understand the resulting strengths and vulnerabilities that influence his current coping? What social or community services may benefit him now or in the future? Dr. Lopez likely brings important and relevant knowledge to this case, but may need some additional education across the Pikes Peak knowledge domains.

Training implications. The aspirational intent of the Pikes Peak model is that geropsychologists acquire the knowledge base at least equivalent to taking a graduate course in adult development and aging and a graduate course in geriatric mental health. Clearly, taking such classes is the most efficient way to gain this knowledge base. When taking courses may not be practical for the postlicensure psychologist, self-directed readings on geropsychology practice and relevant research and didactic continuing education are other options. Continuing education (CE) offerings in geropsychology remain limited in number and scope, but are expanding. Both online distance and onsite continuing education opportunities are available (the latter are more readily available in some parts of the country than others). An informal survey of geropsychology CE offerings (Knight, 2008) suggested that many Pikes Peak knowledge domains were being addressed, but there were relatively limited offerings relevant to diversity and aging, medical, and functional changes in late life, interventions in specific settings, interdisciplinary team work, or prevention and health promotion with older adults.

Although Dr. Lopez would ideally seek continuing education opportunities to address gaps in her geropsychology knowledge base, much of her effort, at this point in time, will likely be self-study without access to fellow learners or an instructor for peer support, guidance in learning, or for answering her specific questions. Resources for geropsychology CE are described in detail later in this paper.

Skills

The Pikes Peak model specifies geropsychology skills in four broad domains: (1) professional geropsychology functioning (or, foundational competencies), (2) assessment, (3) intervention, and (4) consultation. In addition, the Pikes Peak model recommends that geropsychologists develop competency to work with older adults across a range of settings. Each of the four skill domains, as well as the issue of settings of care, is elaborated on and illustrated in this section. Rather than consider training implications for each skill domain, they are discussed at the end of this section.

Professional geropsychology functioning.

Definition. The Pikes Peak model adapts the foundational competencies of the cube model (e.g., ethical and legal issues, diversity, self-reflection, team functioning) to specify what is foundational to working with older adults. For example, the foundational geropsychology competencies for ethical and legal practice focus on common ethical and legal dilemmas faced in clinical work with older adults (e.g., informed consent, confidentiality, capacity/competency, end-of-life decision making, abuse and neglect in older patients). The Pikes Peak foundational competencies also include a competency for advocacy and care coordination, and one for appropriate business of practice (e.g., appropriate Medicare coding and billing).

Case discussion. Foundational issues for Dr. Lopez in working with Mr. Florio are likely to include: (1) building rapport and a therapeutic alliance with him; (2) appreciating his religious, cultural, and generational perspectives on marriage, gender roles, caregiving, end-of-life care, and expectations for help from others; (3) evaluating whether additional medical, neurological, psychiatric, or social service consultation would be informative; (4) determining whether to invite collaboration with his family, primary care, and or community providers into his treatment (with respect for confidentiality, consent, and appreciation of his capacities); (5) appreciating the research base that can inform evaluation and treatment with depressed older adults; and (6) appropriately documenting and billing Medicare for psychological services rendered.

Assessment.

Definition. Competencies for geropsychology assessment are guided by several core values and principles including: a recognition of the older adult’s strengths and compensatory strategies; as appropriate, the use of informant data; the ability to adapt assessments to the settings and subpopulations encountered in work with older clients; provision of practical recommendations to older adults, families, and teams; and appreciation of the ethical implications of geropsychology assessments. Assessment competencies include: the use of psychometrically sound screening tools for cognition, psychopathology, and personality, differential diagnosis of common late life conditions, evaluation of decision making and functional capacities, assessment of risk issues (e.g., suicidality, self-neglect, abuse of older patients), and communication of assessment results with relevant and practical recommendations.

Case discussion. Depending on initial data that have been gathered, a comprehensive geropsychological assessment (e.g., Lichtenberg, 1999; Lichtenberg, Murman, & Mellow, 2003; Zarit & Zarit, 2006) of Mr. Florio may include (1) interviewing one or more of his adult children (only with his consent) to get their perspectives on his functioning and their roles in helping him and their mother; (2) talking with his primary care doctor (only with his consent) to get a sense of the functional impact of, and his ability and motivation to manage, his chronic illnesses (e.g., taking medication, watching diet); (3) conducting a cognitive screening to determine the extent to which Mr. Florio’s cognitive abilities are consistent with his age and educational background, or appear impaired and in need of further neuropsychological evaluation; (4) considering whether comorbid mental health issues may affect Mr.
Florio’s functioning, such as possible posttraumatic stress disorder (PTSD) symptoms related to his World War II Navy combat, recent alcohol use, or longstanding personality characteristics; and (5) conducting a comprehensive risk assessment, including Mr. Florio’s thoughts of death, suicide, harm to others, access to weapons, reasons for living, and any signs of self-neglect or elder abuse/neglect.

Further, Dr. Lopez will need to integrate information collected from various sources over time and then translate a clear conceptualization and recommendations to the patient, his family (if they have become involved), and potentially other care providers. Her biopsychosocial case conceptualization will then inform her treatment plan. For example, in terms of Mr. Florio’s cognitive functioning, she might find that his forgetfulness appears related mostly to his depression and sleep disruption or, she might find that, with additional evaluation or consultation, he himself appears to have early signs of dementia. Likewise, she might find his repeated statements that he can’t live without his wife to be a normative cultural expression of grief, or a sign of suicide risk after his wife dies.

**Intervention.**

**Definition.** Core values underlying geropsychology intervention include: therapeutic optimism, flexibility and clinical judgment, the use of evidence-based treatments when possible, and the importance of interfacing with systems and providing care coordination as needed. Intervention competencies include: applying individual, group, and family therapies to accommodate special needs of older adults; using late life interventions such as those focusing on life review, caregiving, and end-of-life care; using health enhancing interventions; intervening in settings serving older adults at appropriate levels of intervention (individual, family, environment, system).

**Case discussion.** Geropsychological interventions are often integrative (Hillman & Stricker, 2002; Knight & McCallum, 1998), and may shift over time. In Mr. Florio’s case, several evidence-based approaches might be effectively used to help him, including cognitive–behavioral, interpersonal, or family therapy interventions to address issues including depression, anxiety, sleep disruption, problem drinking, caregiving distress, and/or grief (Arean & Ayalon, 2005; Ayers, Sorrell, Thorp, & Wetherell, 2007; Gallagher-Thompson & Coon, 2007; Hinrichsen & Clougherty, 2006; Logsdon, McCurry, & Teri., 2007; McCurry, Logsdon, Teri, & Vitello, 2007; Qualls, 2000; Satre, Knight, & David, 2006; Scogin, Welsh, Hansson, Stump, & Coates, 2005; Sorocco & Ferrall, 2006). Mr. Florio might also benefit from community-based caregiver (e.g., through the Alzheimer’s Association) or bereavement (e.g., through a local hospice agency) support groups. In addition, collaboration with medical, psychiatric, and possibly neurology and neuropsychology providers may be helpful, to assure appropriate management of hypertension, diabetes, potential cognitive changes, as well as depression. One of the challenges Dr. Lopez will face in working with Mr. Florio is to prioritize areas for intervention, and to choose an intervention strategy most likely to match his problems, capabilities, and comfort level.

**Consultation/Training.**

**Definition.** A core value for geropsychology practice and training is that geropsychologists appreciate, learn from, help to educate, and participate in treatment planning, delivery, and program development with a wide range of geriatric care systems and teams. Consultation competencies are therefore central to geropsychology practice, and include the ability to: consult to families, other professionals, and a range of agencies and care systems; provide training to a range of professional and nonprofessional audiences; participate in interprofessional teams that serve older adults; design and participate in different models of aging services delivery; and collaborate and coordinate with other agencies that serve older adults (e.g., see APA, 2008a).

**Case discussion.** In working with Mr. Florio, Dr. Lopez will likely consult with his family and perhaps, a psychiatrist. Depending on various eventualities, she may also be called on to consult with his primary care physician, community providers (e.g., visiting nurse association, if he needs any care in his home), or assisted living facility staff should he have the need to transition to that level of care. Understanding and interfacing with these various care systems, and helping Mr. Florio and his family advocate and utilize available services as needed, can become part of her work as a psychologist. Further, if Dr. Lopez becomes interested in working more with people like Mr. Florio, she may decide to offer consultation and training to various physician practices and community groups.

**Delivery of services in different settings.**

**Definition.** Geropsychologists should be competent to provide services to older adults across a range of clinical, community, or residential settings and be aware of distinct issues that arise in these settings. The Pikes Peak model recommends that geropsychologists be able to deliver services in at least two of the following settings: outpatient mental health services; outpatient primary care/medical settings (Arean & Ayalon, 2005; Haley, 2005); inpatient medical service; inpatient psychiatric service; long-term care settings including nursing homes, assisted living facilities, home care, day programs (Lichtenberg et al., 1998; Molinari, 2000; Rosowsky, Casciani, & Arnold, 2008); rehabilitation settings (Lichtenberg, MacNeill, Frank, & Elliott, 2000; Lichtenburg & MacNeill, 2003); hospice (Haley, Larson, Kasl-Godley, Neimeyer, & Kwilosz, 2003); community-based programs (Bruce, Van Citters, & Bartels, 2005; Sullivan, Kessler, Le Clair, Stoel, & Berta, 2004); forensic settings (Moye, Karel, Armesto, & Goldstein, 2007; Moye, Wood, et al., 2007); home (Scogin et al., 2007; Steinman et al., 2007); and research settings (Arean, Alvidrez, Nery, Estes, & Linkins, 2003; Burns, Nichols, Martindale-Adams, Graney, & Lummus, 2003).

**Case discussion.** Dr. Lopez’s psychology services are provided to Mr. Florio on an outpatient basis. However, the more that she understands the culture of nursing home care and related systemic and funding issues, the better she can help Mr. Florio negotiate the long-term care system while his wife is receiving care there. And, as above, familiarity with the community context of services for older people and home care services, as well as senior residential options, assisted living and skilled nursing care systems, will inform her work with older adults like Mr. Florio if their care needs change over time. Dr. Lopez will do well to consult and collaborate with geriatric social work and care manager colleagues when clients like Mr. Florio need guidance about accessing various levels of care.

**Training implications.** As she considers this array of skill competencies in professional geropsychology, Dr. Lopez will need to evaluate the extent to which the generalist competencies she already has in assessment, intervention, and consultation are a
good match for Mr. Florio’s needs and identify the areas that are sufficiently distinct to require additional training. For example, she may conclude that her assessment skills are sufficient to assess his emotional distress (with attention to age specific norms) and his use of alcohol, but feel uncertain about her ability to assess his cognitive impairment and its likely causes. She may also feel uncertain about her skills in understanding the influence of his chronic illnesses and their treatments on his emotional status and his day-to-day functioning. Although the knowledge base for a better understanding of what to do could be acquired by reading, the skills are likely to require additional experiential training including some observed experience with a professional geropsychologist consultant. Similarly, if she concludes that his principal presenting problem is depression, Dr. Lopez may feel quite competent to use cognitive–behavioral therapy (CBT) to address the depression. She may then discover that her respect for older adults and her lifelong training to be polite and not interrupt her elders pose problems in directing the course of the therapy conversation and in responding to Mr. Florio’s failure to complete CBT homework assignments. These relational issues are likely to require some additional experiential training with a professional geropsychologist.

Dr. Lopez’s likelihood of finding such consultation may be quite limited at the present time. Although there are early efforts to establish a corps of geropsychologists interested and able to provide such consultation, it remains small (see APA Division 12, Section 2’s Website at www.geropsych.org). Some regions of the country have greater concentrations of geropsychologists (e.g., New York, Los Angeles), although other regions have very few if any geropsychologists who could play consultation roles. Therefore, the availability of postlicensure experiential training remains minimally available and needs to be a focus of future development in the field.

**Acquiring Geropsychology Practice Competencies: Recommendations for Training**

**Self-Guided Training**

The competence movement within professional psychology has addressed head-on the importance of continuing professional development over one’s career. The ability to know what one does and does not know, or “metacompetence,” is critical to ongoing professional development, and is a foundational skill—entailing self-awareness, self-reflection, and self-assessment that can and should be taught and practiced over the course of training (Barnett, Doll, Younggren, & Rubin, 2007; Falender & Shafranske, 2007). A mindful approach to continuing professional education ideally entails an ongoing assessment of one’s professional competencies, and which competencies need further development based on one’s professional responsibilities.

The Pikes Peak competencies provide a starting point for interested psychologists to consider the competency landscape for working with older adults and to seek training in new areas as needed. A Task Force of the Council of Professional Geropsychology Training Programs (CoPGTP) developed a geropsychology competency assessment tool that can be used by professional psychologists, or psychologists-in-training, to complete a self-evaluation of their training needs related to geropsychology practice (see CoPGTP Website at http://www.uccs.edu/~cpgtp/). Although the research literature suggests that professionals may not be very accurate at evaluating their own competencies (Eva & Regehr, 2005), the geropsychology competence assessment tool is quite detailed to help facilitate considered self-reflection to the extent possible. Dr. Lopez could benefit from a self-study using this tool, to help her clarify which geropsychology knowledge and skills she has already developed with confidence versus which she needs additional education and training to develop.

**Training Resources**

Psychologists like Dr. Lopez can now find increasing numbers of CE offerings on topics related to geropsychology practice, through workshops, online offerings, and home-study programs. Pre- and postconference workshops at the annual APA meeting and state conventions are often available, as are intensive workshops in some areas of the country (e.g., The University of Colorado at Colorado Springs National Clinical Geropsychology Conference, http://www.uccs.edu/~geropsy/), University or college academic credit courses (e.g., Psychology of Aging) are often available for nondegree seeking students. A list of geropsychology continuing education opportunities is being compiled and maintained at the CoPGTP Website (http://www.uccs.edu/~cpgtp/).

The APA Office on Aging Website offers many resources for psychologists interested in learning more about psychological practice with older adults (www.apa.org/pi/aging). The CoPGTP Website has a list of reading and Internet resources for psychologists and students interested in learning more about any of the particular Pikes Peak attitude, knowledge, or skill competencies. The APA video/DVD series has a number of programs on psychotherapy with older adults (http://www.apa.org/videos/), with expert geropsychologists demonstrating their work with older adults who are depressed, older couples, caregivers, late-life sexual issues, and other topics. The APA Committee on Aging typically sponsors full-day CE workshops at the annual convention, and has put together a web-based program as part of the APA Online Academy, entitled “What Psychologists Should Know About Working With Older Adults” (see http://www.apa.org/ce/).

Certainly, professional consultation with psychologists who work proficiently with older adults is an important way for psychologists to get input on challenging cases. As above, resources for such consultation remain limited but are likely to expand. Participation in professional list-serve groups can also be an avenue for professional consultation. For example, the Society of Clinical Geropsychology (www.geropsych.org) and Psychologists in Long Term Care (www.pltcweb.org) both have active email discussion groups. Often, psychologists or students will pose questions to the group, looking for feedback on challenging clinical cases or consultation dilemmas as well as for research or community resources. Likewise, other geriatric care professionals in one’s community can be important resources for consultation (e.g., geriatric social workers, physicians, psychiatrists).

**Recommendations and Future Directions**

Training and building a geropsychology workforce will require increased exposure to the field of aging at all levels of training (e.g., starting in high school and college), along with increased...
opportunities for education and training. Exposure to aging issues and older adults earlier in one’s career relates to increased interest in the field (Hinrichsen & McMeniman, 2002). In this issue, geropsychology training recommendations at graduate (Qualls et al., 2010) and internship and postdoctoral levels (Hinrichsen et al., 2010) address the importance of exposure to aging in didactic, research, and clinical training settings to facilitate growing numbers of psychologists prepared to serve the needs of an aging population. This paper addresses the reality that most psychologists who are currently in practice, or currently in training, are unlikely to have had opportunities for formal training in geropsychology (Qualls et al., 2002). To meet the growing demand for geriatric behavioral and mental health services, psychologists who have completed formal doctoral psychology, but not geropsychology, training will also need to pursue professional practice with older adults and, hopefully, continuing education to develop and enhance geropsychology competence.

Effective professional training in geropsychology will be best achieved when organized training sequences or curricula can be flexibly adjusted to the “starting point” of each psychologist. Organized and sequential learning is more easily achieved in predoctoral, internship, and postdoctoral fellowship programs with clearly defined learning goals and objectives, but is challenging in the postlicensure CE environment. CE offerings are typically developed and provided within a laissez faire free market approach. That is, trainers offer what they want to teach and what continues to attract paying attendees and trainees take what interests them. Although state licensing boards provide broad oversight of professional continuing education requirements, these requirements vary widely across states.

Postlicensure training in geropsychology could be organized to facilitate acquisition of the Pikes Peak competencies. Selection and sequencing of content of training should be tied to an individual learner’s didactic and experiential training needs (e.g., to address the needs of older adults in community vs. long-term care settings). The challenge is to organize and sequence postlicensure geropsychology training among disparate training entities including universities, state associations, APA, individual expert geropsychology trainers, nursing home psychology companies, and online continuing education companies. Supervised experiential training is the least developed and most difficult to organize aspect to be addressed by future training programs in postlicensure geropsychology. Given the geographic dispersion of both professionals and settings where they work (notably, urban vs. rural) and the many time demands on busy professionals, the Pikes Peak model acknowledges that distance education is necessary and useful. Ongoing developments in distance learning, consultation, and supervision for professional education will undoubtedly be adapted for professional geropsychology training (Murphy, Levant, Hall, & Glueckauf, 2007).

Psychologists have critical skills and knowledge to contribute to the well-being of an aging population, as well as to models of integrated and interdisciplinary health care that suit geriatric care so well. Both psychologists-in-training and psychologists-in-practice will benefit from increased training opportunities to help translate their knowledge and skills to work with older adults. The Pikes Peak model for training in professional geropsychology (Knight et al., 2009) provides a set of aspirational competencies that can guide trainers and educators in professional psychology who wish to add a training focus in geropsychology to their existing programs, or to develop new programs. The Council for Professional Geropsychology Training Programs is an organization that aims to provide information, consultation, and support for graduate, internship, postdoctoral, and postlicensure training programs; psychology students seeking information about training opportunities in the field; and, postlicensure psychologists looking to expand their practices to work with older adults. A challenge for training and education in professional psychology over the next decade will be to increase both interest in and training opportunities for psychological practice with older adults.

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