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Building foundational knowledge competencies in professional geropsychology: Council of Professional Geropsychology Training Programs (CoPGTP) recommendations

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By 2050, the US older adult population will have doubled to 83.7 million people from earlier in this century, and the workforce is woefully underprepared to meet the mental health needs of this population. Professional geropsychology has developed comprehensive geropsychology competencies for specialists. Generalists are unlikely to attain full specialty geropsychology competency, however, and there has been little guidance on what core knowledge is key for those who treat a small number of older adults, or how much training is needed. Based on a survey of geropsychology experts, this article presents recommendations for foundational knowledge competencies at the basic "Exposure" level of training for any psychologist who serves older adults along with recommendations for continuing education training time allocation.

KEYWORDS
competency, education, geropsychology, older adults, training

1 | INTRODUCTION

The US Census Bureau estimates that by 2050, there will be 83.7 million people over the age of 65 in the United States (Ortman, Velkoff, & Hogan, 2014). This represents a doubling of the older adult population since the baby boomers started to turn 65 years of age in 2011. Although most adults turning 65 maintain stable health for years, 66% of Medicare beneficiaries had more than one chronic condition in 2015 and 36% had four or more chronic conditions (CMS, 2015). Chronic conditions are associated with geriatric syndromes such as falls, malnutrition, polypharmacy, and cognitive impairment (Vincent & Velkoff, 2010). These more complex health problems require increasing levels of family caregiving, community support services, and greater numbers of health-care providers skilled in addressing the needs of frail older adults. Specifically, although rates of mental health disorders are lower among older adults than younger adults in the general population (Reynolds, Pietrzak, El-Gabalawy, Mackenzie, & Sareen, 2015), rates among older adults with multiple chronic conditions are significantly higher (Huang, Dong, Lu, Yue, & Liu, 2010; Moussavi et al., 2007). Suicidal behavior also is associated with functional decline and numerous medical conditions (Fässberg, et al. 2016).

Two Institute of Medicine reports concluded that the health-care and mental health-care workforce with specialized skills in aging is inadequate (Institute of Medicine 2008, 2012). Further, the workforce is woefully underprepared to meet the mental health needs of older adults (Bartels & Naslund, 2013), such as familiarity with normative

In addition to named authors, the CoPGTP Workgroup includes Dolores Gallagher-Thompson, Andrew Heck, Michele Karel, Erlene Rosowsky, Susan Whitbourne, and Richard Zweig.

and abnormal cognitive changes, adjustment issues in retirement and beyond, and end of life care. Studies have found that from 39% (APA Center for Workforce Studies, 2010; N = 6,211 APA members) to 69% (Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002; N = 1,227 APA members) of doctoral-level psychologists report providing service to at least a few older adults. In the latter study, 37.1% reported providing services to older adults (ages 65–79) frequently or very frequently and 9.2% provided services to the oldest old adults (ages 80 +) frequently or very frequently (Qualls et al., 2002). However, most do so without any specialized training (Segal, Qualls, Grus, & DiGilio, 2012). In fact, only 3%–4% of psychologists have specialized training in geropsychology (APA Center for Workforce Studies, 2010; Qualls et al., 2002) and only 1% of respondents identified professional geropsychology as their primary specialty area, while 2% identified it as a secondary specialty area (APA, 2016).

Professional geropsychology has impressively defined itself in the last 20 years with the development of a geropsychology section (Society of Clinical Geropsychology) within the American Psychological Association's (APA) Division 12; promulgation of the Pikes Peak Model for Training in Professional Geropsychology (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009); development (APA, 2004) and revision (APA, 2014) of *APA Guidelines for Psychological Practice with Older Adults*; recognition in 2010 as a specialty within APA; development of a geropsychology training organization (CoPGTP) in 2007; and in 2014, development of a geropsychology specialty within the American Board of Professional Psychology (ABPP). The number of clinical geropsychology graduate programs has also grown in the last decade, but faculty positions sometimes go unfilled (R.S. Allen, personal communication, October 24, 2017), with few early career geropsychologists entering academia (Carpenter, Sakai, Karel, Molinari, & Moye, 2016). Further, there are not enough faculties in most clinical or counseling psychology programs with geriatric knowledge to substantively train students in this area and to offer geropsychology as a major area of study.

With the gap in geropsychology training options at the graduate level, the profession must rely on postlicensure psychologists to provide services to older adults despite the lack of specialized training. Unfortunately, as noted above, very few psychologists identify themselves as specialists in geropsychology or as practitioners whose professional practice is primarily devoted to delivery of services to older people (APA, 2016). A prior survey found that although most psychologists lacked formal training in professional geropsychology, many desired continuing education on the topic (Qualls et al., 2002). Although the Pikes Peak Model provides substantive guidance on the broad range of knowledge and skills needed for psychologists who work primarily with older adults (Knight et al., 2009), it does not identify which domains of knowledge would be most useful for those who do some work with older adults, or where to start in the learning process for postlicensure psychologists who would like to gain specialty skills.

Demand for geropsychology content at national conferences, including the American Psychological Association (APA) and Gerontological Society of America (GSA), suggests that increasing numbers of psychologists have interest in gaining at least minimal geropsychology training. Developers of these programs require explicit guidance based on geropsychology competencies to ensure quality training (Karel, Knight, Duffy, Hinrichsen, & Zeiss, 2010). Those who take part in these programs would benefit by knowing how the content of educational programs maps on to a consensus about core knowledge relevant to practice with older people.

To structure such training, we look to recent national specialty conferences that have reached general consensus on the use of consistent definitions for levels of training, with the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP), Council of Specialties (CoS), Association of State and Provincial Psychology Boards (ASPPB), and the American Board of Professional Psychology (ABPP) emphasizing the importance of standardized terminology to foster "truth in advertising" for consumers of training. In geropsychology, the Taxonomy Grid has been adopted and includes Exposure, Experience, Emphasis, and Major Area of Study for each level of training (doctoral, internship, postdoctoral, postlicensure). For postlicensure psychologists, CoS recommended training experiences, which are given in Table 1 (Council of Specialties in Professional Psychology, 2016). Given the need to identify core knowledge at the most basic "Exposure" level, CoPGTP constituted the *Building Foundational Knowledge in Geropsychology Workgroup*, which reviewed these issues to inform the development of a survey of geropsychologists based on the Pikes Peak Competencies.

TABLE 1 Council of specialties recommended training experiences in geropsychology for postlicense psychologists

	Hours of Gero CE	Hours of supervised Gero service
Exposure	15	0
Experience	25	500
Emphasis	50	1000
Major Area of Study	100	2000

Note. Supervised service = Must include at least 30% direct patient contact with older adults (e.g., assessment, treatment, consultation).
CE coursework = Must be approved by APA or by another major mental health organization.

2 | THE COPGTP BUILDING FOUNDATIONAL KNOWLEDGE IN GEROPSYCHOLOGY WORKGROUP

The chief purpose of the Building Foundational Knowledge in Geropsychology Workgroup (the "Workgroup") is to offer guidance to psychologists with little or no prior education or training related to professional geropsychology or adult development and aging who want to expand their professional work to include older adults, as well as to geropsychologists who seek to create training curricula. Each Workgroup member has at least 14 years of postlicensure experience in geropsychology and reflects diversity of geropsychology practice domains and settings. The student member at the time of the survey was an advanced doctoral clinical psychology student.

3 | METHOD

The Workgroup identified five key geropsychology attitude and knowledge domains from the Pikes Peak Model that were considered to be critical for all psychologists working with older adults to attain competency in the following: (1) attitudes about older adults and aging; (2) general knowledge of adult development, aging, and the older population; (3) knowledge of the foundations of clinical practice with older adults; (4) knowledge of the foundations of assessment of older adults; and (5) knowledge of intervention, consultation, and other service provision (Knight et al., 2009). Two other competencies were identified from the Pikes Peak Skills domain because they were viewed by the Workgroup as foundational. "Knowledge of assessment of risk (e.g., suicidality, self-neglect, elder abuse)" was added to Domain 4 (Assessment), and "knowledge of appropriate documentation, billing, and reimbursement procedures for geropsychological services in compliance with state and federal laws and regulations (especially regarding Medicare and Medicaid services), including assessment and documentation of medical necessity" was added to Domain 5 (Intervention, Consultation, and Other Service Provision).

Given that CoS "Exposure" level of competency requires 15 hr of CE, the Workgroup sought to determine which topics should be prioritized in a basic two-day continuing education (CE) course in professional geropsychology (or 14 hr of training plus 1 hr for self-study) for an audience of generalist psychologists. The Workgroup designed a survey for professional geropsychologists. The goal of the survey was to reach broad consensus about the core foundational knowledge competencies drawn from the Pikes Peak Model needed by psychologists who are interested in serving older adults in clinical practice, or who have a practice that includes some older adults. The survey methods were deemed exempt from review by the Washington University in St. Louis Institutional Review Board.

By concretely framing questions around two-one-day workshops (typically not more than 7 hr per day), survey results were expected to be useful to those educators and trainers who wanted knowledge content delivered in this popular format. To complete the 15 hr required for "Exposure" level training, any hours not covered by a workshop were expected to be augmented by elective readings or webinars. There were two tasks in the survey: (1) allocate 14 CE hours across five knowledge/attitude domains and (2) rank the importance of the knowledge or attitude competencies within each of the five domains. A proportional weighted rank was calculated to determine how participants rated the importance of each competency. These rankings indicate the ranked importance of a topic as well as how participants as a whole ranked each topic in relation to other topics in each domain. Each rank was assigned a weighted score whereby the topics that were ranked first were given the highest priority, topics that were ranked second were given less priority, and so on. This scoring system allows for capturing the overall tendency of a topic to be near the top or bottom of the rankings. A request to participate in the survey was sent to geropsychology-relevant listservs (i.e., CoPGTP, APA's Society of Clinical Geropsychology, Psychologists in Long-Term Care, APA's Adult Development and Aging Division) with a link to Qualtrics, an online data collection service, for online completion.

4 | RESULTS

4.1 | Participants

As shown in Table 2, 149 geropsychologists responded to the survey. Most participants were female, mid-career, and clinical psychologists. Most had formal training and were working with older adults in a variety of settings at the time of the survey.

4.2 | Survey

In Task 1, respondents were asked this question: "If you were to allocate a total of 14 continuing education hours to the five domains listed below, how many hours would you allocate to each?" Participants allocated the most number of hours (Mean >3) to domains encompassing the foundations of clinical practice, assessment, and intervention and consultation; and the least number of hours (Mean = 1.42, $SD = 0.84$) to the domain encompassing attitudes about older adults and aging (see Table 3).

In Task 2, respondents were given the following instruction: "Please rank order the importance of each of the

TABLE 2 Sample characteristics, $N = 149$

Female, %	65.1
Years in practice, *M* (*SD*)	15.85 (12.15)
Primary graduate training focus, % endorsed	
Clinical	53.7
Neuropsychology	16.8
Geropsychology	14.1
Counseling	10.1
ABPP Board Certified in any specialty	16.1
Prior education relevant to older adults, % endorsed	
Academic courses/practice	45.6
One or more supervised clinical experiences following graduate school	34.2
CE credits, no courses	16.8
None	2.0
Prior/current professional experience with older adults, % endorsed	
Currently full time	45.0
Currently less than full time	46.3
Past work; none current	8.7
Primary work setting, % endorsed	
Physical health facility	25.5
Independent practice	18.8
College/university	14.8
Long-term care	14.1
Veterans Administration/Academic	12.1
Mental health facility	6.7
Other	6.0
Not currently working	2.0

issues listed within the five domains. A rank of 1 means the highest level of importance." Table 4 lists the topics in order of weighted rank (see Method section for further details), indicating several domains with flat distributions (i.e., Domain 1) and others with clearer preferences (i.e., Domain 2).

TABLE 3 Survey Task 2: Allocate hours by domain

Domain	Mean (*SD*)
Attitudes about older adults and aging	1.42 (0.84)
General knowledge about adult development, aging, and the older adult population	2.37 (1.19)
Knowledge of the foundations of clinical practice with older adults	3.08 (1.04)
Knowledge of the foundations of assessment of older adults	3.58 (1.16)
Knowledge of the foundations of intervention, consultation, and other service provision	3.58 (1.49)

In Domain 1, there is no clear preference for any of the four topics with respect to priority. In Domain 2, "normal aging and development" is favored in content over the remaining three topics. In Domain 3, "psychopathology," "neuroscience of aging," and "functional changes" are favored over the other topics. In Domain 4, "theory and research of assessment" and "assessment of risk" are favored over the other topics. In Domain 5, "theory, research, and practice of interventions," "health, illness, and pharmacology," and "knowledge of ethical and legal standards" are favored over the other topics.

5 | RECOMMENDATIONS

For psychologists with no or limited knowledge of geropsychology who are interested in building foundational knowledge competencies in geropsychology, the following are recommendations for basic curricula content. The findings are informed by the results of our survey and recommendations from CoS for postlicensure psychologists interested in obtaining "Exposure" to geropsychology. It is important to note that these recommendations do not encompass formal and complete training in the provision of professional services to older adults. Formal acquisition of skills in geropsychology would be needed for those psychologists who are interested in obtaining Experience, Emphasis, and Major Area of Study intensity levels of training as outlined in the CoS taxonomy noted earlier.

5.1 | Recommendation 1: Obtained hours of continuing education

Consistent with recommendations from the Geropsychology Specialty Council, postlicensure psychologists with interest in "Exposure" to geropsychology should obtain 15 accredited CE hours relevant to professional geropsychology.

5.2 | Recommendation 2: Allocation of hours

It is recommended that hours for the Pikes Peak Model Competencies at the "Exposure" level be allocated in the following way:

- Attitudes about older adults and aging: 1.5 hr.
- General knowledge about adult development and aging: 2.5 hr.
- Knowledge of the foundations of clinical practice with older adults: 3.0 hr.
- Knowledge of the foundations of assessment of older adults: 3.5 hr.
- Knowledge of the foundations of intervention, consultation, and other service provision: 3.5 hr.

TABLE 4 Results for Survey Task 2: Participant rankings of topics in each Pikes Peak Competency domain

Domain/topic	Proportional weighted rank (%)[a]
Domain 1: Attitudes about older adults and aging	
Increase knowledge, understanding, and skills with respect to working with older adults through continuing education, training, supervision, and consultation	29
Expand their awareness of how individual diversity in all of its manifestations (including gender, age, cohort, ethnicity, language, religion, socioeconomic status, sexual orientation, gender identity, disability status, and urban or rural residence) interacts with attitudes and beliefs about aging, to use this awareness to inform their assessment and treatment of older adults, and to seek consultation or further education when indicated	25
Work with older adults within their scope of competence; seek consultation or make appropriate referrals when indicated	24
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	21
Domain 2: General knowledge of adult development, aging, and the older population	
Normal or "usual" aging including the following: (a) biological and health-related aspects of aging and mind–body interactions; (b) psychology of aging including normative continuity and change in the domains of sensory processes, cognition, personality, and emotions; (c) social dynamics of the aging process, including issues such as work and retirement, friendships, roles, and family relationships	63
Theoretical models and research methodologies for understanding the processes of aging, including the life span developmental perspective, conception of positive or successful aging, and methodological issues in conducting or evaluating research on aging	16
Awareness of diversity in the aging process, particularly how sociocultural factors such as gender, age, cohort, ethnicity, language, religion, socioeconomic status, and urban–rural residence may influence the experience and expression of health and psychological problems in later life and how this knowledge may inform the assessment and treatment of older adults	15
Demographics of aging including where to obtain current knowledge on changes in population dynamics	6
Domain 3: Knowledge of the foundations of clinical practice with older adults	
Psychopathology in middle and later adulthood, including differences in the prevalence, etiology, presentation, associated features, comorbidity, and course of mental disorder in older adults, as well as the health-related consequences of treated and untreated psychological disorder in late life	34
The neuroscience of aging, its applications to changes in cognition, and its implications for clinical interventions with older adults	25
Knowledge of the salience of functional changes in later adulthood, including resulting problems in daily living	17
Knowledge of common acute, chronic, and terminal medical illnesses in late life	12
Awareness of the concept of person–environment interaction and the implications of this concept for adaptation in late life	11
Domain 4: Knowledge of the foundations of assessment of older adults	
Theory and research informing psychological assessment of older adults, including the broad array of assessment domains, methods, and instruments that are psychometrically suitable for assessing older adults	35
Knowledge of assessment of risk (e.g., suicidality, self-neglect, elder abuse)[b]	28
Knowledge of contextual issues in the assessment of older adults, including the system or environment in which the elder functions, and the impact on assessment process and outcomes	21
Issues in the limits of using assessment instruments created for younger persons with older adults without adequate standardization	15
Domain 5: Knowledge of interventions, consultation, and other service provision	
Theory, research, and practice of various methods of intervention with older adults, including current research evidence about their efficacy and effectiveness as applied to diverse groups within the older adult population	22
Health, illness, and pharmacology as related to assessment and treatment of late-life mental health problems, including awareness of medical or medication factors that may affect treatment outcomes (e.g., illness, medication side effects, polypharmacy)	22

(Continues)

TABLE 4 (Continued)

Domain/topic	Proportional weighted rank (%)[a]
Knowledge of ethical and legal standards related to psychological intervention with older adults and care systems, with particular attention to aging-specific issues of informed consent, confidentiality, substitute or end-of-life decision-making and potential conflicts of interest, capacity and competency, and elder abuse and neglect	16
Models and methods of interdisciplinary collaboration, including an understanding of the varied components, roles, and contexts of interdisciplinary treatment of late-life mental disorders	8
Issues pertaining to the provision of services in the specific settings in which older adults typically live or seek treatment	7
Awareness of the broad array of potential clients (e.g., family members, other caregivers, health care professionals, and organizations) for psychological consultation and intervention and appropriate intervention strategies in these contexts	6
Prevention and health promotion services and their relevance for middle-aged and older adults at risk of mental disorders	6
Knowledge of aging services in the local community (e.g., day care, transportation, residential) and how to refer clients to these services	6
Knowledge of appropriate documentation, billing, and reimbursement procedures for geropsychological services in compliance with state and federal laws and regulations (especially regarding Medicare and Medicaid services), including assessment and documentation of medical necessity[c]	6

Note. [a]Proportional ranks indicate the relative importance participants awarded each topic. Ranks were calculated by weighting each participant's preferences for prioritizing topics, such that topics that were ranked first were given the highest priority, topics that were ranked second were given less priority, and so on. Proportional ranking takes into account the overall distribution of responses within each domain, ensuring balance between each respondent's preference and any tendency of the entire sample to prioritize certain items over others. Some domains sum to 99 due to rounding.

[b]This competency comes from Pikes Peak Model's "III. Skills: Assessment," item 6.

[c]This competency comes from Pikes Peak Model's "III. Skills: Professional Geropsychology Functioning," item 7.

- It is recommended that an additional hour be devoted to a topic within one of the five Pikes Peak domains with special relevance to the subpopulation of older adults or the setting in which the psychologist provides professional services.

The Pikes Peak Competencies document (Karel, Knight et al., 2010) provides detail about the content in each of these areas and is available from the Online Resources section of the CoPGTP.org web site. An online self-assessment tool for the Pikes Peak Competencies (Karel, Emery, & Molinari, 2010) is available in the Competencies section of the GeroCentral.org web site.

5.3 | Recommendation 3: Ranking of information within each of the five Pikes Peak domains

The suggested amount of time devoted to each of the competencies broadly reflects the proportional weighted rank of each competency from the survey, reflecting participants' preferences regarding the relative importance of each topic.

Domain 1: Attitudes about older adults and aging: Equal time (20–30 min) should be devoted to each of the four competency areas (scope of competence; attitudes and beliefs; diversity; and increasing knowledge).

Domain 2: General knowledge about adult development and aging: About two-thirds of the time (~100 min) should be devoted to normal aging and development. The remainder of the time (~50 min) should include a discussion of models and methodologies; demographics of aging; and diversity.

Domain 3: Knowledge of the foundations of clinical practice with older adults: About half of the time (~90 min) should be devoted to material relevant to psychopathology of middle and later adulthood and functional changes in later adulthood; one-quarter time (~45 min) devoted to neuroscience of aging, with the remainder of the time (~45 min) focused on discussion of late-life illness and person–environment fit.

Domain 4: Knowledge of the foundations of assessment of older adults: About one-third of the time (~70 min) should be devoted to theory and research informing psychological assessment, and half of the time (~105 min) devoted to contextual issues in the assessment of older adults and assessment of risk. The remainder of the time (~35 min) should include discussion of the limitations of using assessment instruments.

Domain 5: Knowledge of intervention, consultation, and other service provision: About 40% of the time (~85 min) should be devoted to theory, research, and practice of various methods of intervention and health, illness, and pharmacology as related to assessment and treatment. About 20% of the time (~40 min) should be

devoted to knowledge of ethical and legal standards. The remaining time (~85 min) should include brief discussion of settings of care, aging services, prevention and health promotion, awareness of array of potential clients, interdisciplinary collaboration, and documentation and billing.

5.4 | Recommendation 4: Training modalities

Many CE venues exist from which an interested psychologist could obtain foundational competencies in professional geropsychology. It is recommended that these venues be accredited by APA or another reputable mental-health-relevant professional organization. The most preferred training vehicle would be two-one-day workshops or one-two-day workshop that covers the material recommended in this document (accredited hours of one-day CE workshops vary somewhat, from 6–7 hr). If hours total less than the recommended 15, the psychologist should obtain additional hours through webinar, online training, accredited reading, or other vehicles that offer CE credits.

5.5 | Recommendation 5: Resources

CoPGTP has created a document, *Recommended Resources Associated with the Pikes Peak Competencies,* which lists resources associated with each of the five Pikes Peak Competencies domains. These resources could help to guide creation of a curriculum for a geropsychology foundational knowledge competencies course or could be used as supplemental readings for those who have obtained the 15 hr of accredited CE. The document is in the Online Resources section of the CoPGTP.org web site.

5.6 | Recommendation 6: Augmentation of knowledge competency with skills competencies

It is recommended that psychologists who are interested in building geropsychology competency will obtain skills competencies in addition to knowledge competencies. Skills competencies are typically built by obtaining consultation on work with older adults from a psychologist with substantive knowledge and experience in working with older adults. The Society of Clinical Geropsychology and Psychologists in Long-Term Care both have mentoring programs that can connect interested psychologists with geropsychologists for this type of experience; membership in these organizations may be required. Evidence of specialized knowledge and skills in geropsychology is reflected in a substantive history of training in and delivery of mental health services to older adults, and by attaining a specialty credential in geropsychology from the American Board of Professional Psychology.

6 | CONCLUSION

Unprecedented in human history, older adults will constitute a sizeable proportion of the population of the United States as well as in many other developed countries. Only a small fraction of the health- and mental-health-care workforce has specialized training and skills to serve older adults. Therefore, older adults will rely on generalist health and mental health providers for care. Within psychology, a need exists for guidance to generalist psychologists on how to obtain substantive "Exposure"-level knowledge related to adult development and aging and geropsychology. This knowledge is the foundation upon which clinical skills can be developed. The recommendations from this CoPGTP survey offer useful guidance for program developers in geropsychology. Further, consistent with the APA push for greater uniformity in educational nomenclature within and across specialties, these CoPGTP recommendations have been endorsed by our sister psychology and aging organizations, including APA's Committee on Aging, Division of Adult Development and Aging, Society of Clinical Geropsychology, as well as by Psychologists in Long-Term Care.

CONFLICT OF INTERESTS

The authors have no conflict of interests to disclose.

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