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Ethical Issues in Geropsychology: Clinical and Forensic Perspectives

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Abstract Ethical practice and decision making in geropsychology require an awareness and understanding of the ethical issues and challenges that are commonly encountered when working with older adults in clinical and forensic contexts. Although multiple resources are available to assist practitioners with identifying common ethical issues and challenges, experienced colleagues often serve as one of the richest sources of information. The purpose of this article was to tap the ethical knowledge of psychologists who have considerable experience working with older adults. Three board certified geropsychologists were each asked to respond to five questions about ethical issues. Their responses are presented in this article. Although multiple resources are typically necessary for addressing complex ethical issues, the experiences and advice of senior colleagues provide one important perspective to help clinicians anticipate, avoid, and address ethical challenges.

Keywords Ethics · Geropsychology · Interview · Competence · Resources · Colleagues · Decision making

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In the provision of clinical and forensic services to older adults, ethical practice and decision making require an awareness and understanding of the ethical issues and challenges which tend to be encountered more commonly when evaluating and treating older adults than with younger patient populations. For example, compared to some patient populations, assessment and treatment of older adults tends to involve more (a) cognitive and sensory deficits, (b) consultation with interdisciplinary teams, (c) involvement of family members and formal caregivers, (d) medical problems and medications, (e) care across a wide continuum of inpatient and outpatient settings, and (f) cohort differences (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009). These issues, alone and in combination, require an emphasis on some ethical issues more than others.

Many resources are available to inform professionals who work with older adults about ethical aspects of practice (e.g., Bush, 2009, 2012; Bush, Allen, & Molinari, in press; Bush, Connell, & Denney, 2006; Fins & Miller, 2000; Hays & Jennings, 2015; Karel, 2011; Post & Whitehouse, 1995). While familiarity with the American Psychological Association's (2010) Ethical Principles of Psychologists and Code of Conduct , other professional guidelines, and scholarly publications is necessary, the thoughts and suggestions of knowledgeable colleagues offer practitioners valuable perspectives that link the ethics literature to the nuances of clinical and forensic practice and facilitate ethical decision making (Bush, 2009). Experienced colleagues often serve as one of the richest sources of information on ethical practice. Such colleagues are commonly able to describe aspects of practice, in specific settings and with particular older adult subgroups, that require attention from an ethics perspective and can offer solutions that have been helpful in addressing past dilemmas. Experienced colleagues who are active in the profession are also well positioned to identify ethical issues and challenges that are still on the horizon. The purpose of this article is to

present ethical issues that are highly relevant in ethical practice with older adults from the perspectives of three geropsychologists who have considerable experience addressing, reflecting on, and advising on ethical matters.

Methods

Participants

The lead author (Bush) selected three board certified geropsychologists (Allen, Heck, and Moye) to contribute to the present article. The interviewees selected have the following experiences: Serving on ethics committees and institutional review boards, providing ethics education, publishing ethics-related articles and chapters, generating ethics vignettes for the American Board of Professional Psychology's (ABPP's) Geropsychology specialty board (ABGERO) oral examinations, and/or conducting the ethics oral examinations for board certification in geropsychology. The first author (Bush), also meeting these criteria, served as the interviewer. All authors have at least 15 years of experience, maintain direct practice with older adults, engage in scholarly work on topics related to aging and geropsychology, and are involved in geropsychology education and/or training.

Procedures

First, Drs. Allen, Heck, and Moye were each provided five questions about issues that are important to ethical practice in geropsychology. The questions were generated by the interviewer based on previous publications (e.g., Bush, 2009; Hays & Jennings, 2015; Holstein & McCurdy, 1999; Karel, 2011) that described aspects of geropsychology practice that have the potential for ethical challenges and decision making (see Table 1 for the list of questions). In addition to describing their personal experiences and opinions, the interviewees were asked to provide supporting references when applicable. The questions were emailed to the interviewees, and their responses were received via email.

Second, responses were collated and combined, with some responses edited for length by the lead author. Examples from professional practice, when provided as part of the responses, use altered details to protect the identity of the older adult. Third, interviewees reviewed the combined content and raised questions to one another, with each interviewee providing further edits. Finally, all contributed to drafting the final manuscript. In this article, each question is listed, followed by the three colleagues' answers.

Table 1 Questions about ethical issues in geropsychology

1. What do you consider to be the primary ethical issues and dilemmas in the practice of geropsychology and how can they be addressed?
2. Which aspects of geropsychology practice, training, or research, if any, have ethical issues or challenges that have yet to be adequately addressed by the field? Do you have any suggestions to help address the problem?
3. What is a good path for education and training in geropsychology ethics that promotes sound ethical decision making and high standards of practice?
4. In your work with interdisciplinary colleagues, what ethical problems or misconduct have you observed and how did you address the matter?
5. When working with family members or formal caregivers of older adults, have you confronted ethical problems? If so, please explain.

Geropsychology Ethics Questions

1. What do you consider to be the primary ethical issues and dilemmas in the practice of geropsychology and how can they be addressed?

Dr. Allen

The foremost ethical dilemma facing geropsychology practice is the balance between respect for patient autonomy and beneficence (Beauchamp & Childress, 2012). Honoring the ethical principal of respect for autonomy within the context of increased chronic illness, potential cognitive and physical decline, and life within supervised living settings associated with aging presents unique challenges. In essence, geropsychologists are frequently asked to determine if an older adult possesses the decision-making capacity to provide an autonomous, voluntary plan of action in response to questions regarding living arrangements, finances, medical treatments, legal matters, and sexual activity, in addition to other circumstances. Accordingly, some authors have suggested the involvement of family members in supported capacity models when an older adult's individual capacity for autonomous informed consent may be in question (Allen & Shuster, 2002; King, Kim, & Conwell, 2000). One of the primary drivers of attention to this ethical conflict is the increased focus on patient-centered care throughout the continuum of long-term care from home health to skilled and hospice care settings. In care settings such as assisted living facilities and nursing homes operating under traditional medical care models, resident autonomy may sometimes be compromised due to increased staff and regulatory focus on beneficent responsibility for resident safety. The ethic of respect for autonomy guides geropsychologists to consider needs for balance in honoring the choices of older individuals with diminished capacity and providing appropriate protections to enhance their safety and well-being (American Bar Association & American Psychological Association [ABA & APA], 2008).

Dr. Heck

Many ethical dilemmas encountered in geropsychology surround striking a balance between the principles of *autonomy*

(situated within the APA Code of Ethics under General Principle E, Respect for People's Rights and Dignity) and *beneficence* (APA General Principle A, Beneficence and Nonmaleficence) (APA, 2010). The conflict between an individual's right to self-direction and the need to be protected or cared for manifests itself in numerous and varied ways across individuals and their specific circumstances. Western culture places a premium on the ability of people to govern themselves. As a result, ethical conflict can occur when a person's cognitive capabilities to govern him/herself deteriorate due to disease or injury. In such situations, there is often a need for interventions that maximize physical wellbeing while sacrificing independence, but the person wants to preserve his/her independence even at risk to him/herself. The point at which a person can no longer make independent decisions without causing harm to him/herself can be difficult to determine, especially in cases of early progressive dementia or mental illness with a fluctuating course (e.g., bipolar disorder). Removing a person's prerogative to self-manage is a very intrusive course of action that requires sound ethical justification, which is dependent upon the results of sound clinical practice or forensic assessment. When making a determination of decision-making capacity, the geropsychologist is, in effect, taking a position on how the balance between autonomy and beneficence is best struck in a given case. Practitioners who address this dilemma, because of the high moral consequences of the decision, are obligated to be well-versed in the key concepts of theory and practice of capacity assessment.

Dr. Moye

I find that in the everyday practice of geropsychology, the most commonly encountered ethical dilemma is the balance of respecting patient autonomy versus protection of patient welfare (i.e., beneficence) in the context of individual history, values, social situation, and health. As with most clinical and scientific issues in geropsychology, ethical issues are best approached with a lifespan perspective. This issue does not suddenly "flip on" as someone crosses over some threshold into "old age" but is encountered across all ages. In older adults, when this ethical conflict presents itself, consideration of the individual's history and current biopsychosocial context informs our judgment. Clinical judgment, with all its accompanying benefits and limitations, determines the course of ethical action. The geropsychologist weighs verbal statements, clinical indicators, scientific knowledge, and their own professional experience, working collaboratively with patients and their family members and/or formal caregivers when possible, in making sound decisions.

2. Which aspects of geropsychology practice, training, or research, if any, have ethical issues or challenges that have yet to be adequately addressed by the field? Do you have any suggestions to help address the problem?

Dr. Allen

Specific challenges that have yet to be adequately addressed by the field include questions concerning capacity for independent living or consent to sexual activities. These issues require further research attention and development of culturally appropriate interventions for geropsychologists and for the informal and formal caregivers of older adults with diminished capacity (Moye, Marson, & Edelstein, 2013). Further research is required specifically with regard to differences in decision-making models and treatment preferences among individuals self-identifying as members of racial/ethnic or sexual/gender identity minority groups. For example, recent research suggests that some structured interviews that may be used in capacity evaluations might be influenced by racial/ethnic identity and health literacy. Additionally, research attention to variation in decision-making models and treatment preferences among individuals self-identifying as members of sexual/gender minority groups is particularly lacking, and this limits the quality and evidence base of culturally appropriate interventions (DiNapoli, Breland, & Allen, 2013). Individuals identifying as members of such minority groups may face greater discrimination and stigma in treatment settings that practice traditional care delivery models and deemphasize patient-centered care, as well as in some forensic settings.

Additionally, determining the appropriate level of involvement of trainees in capacity assessments or therapeutic interventions can be challenging in specific cases, given their varying levels of experience and knowledge. Within our training program, the use of a specified model of training which is linked to evaluation, such as the Pikes Peak training model (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009; Wharton, Shah, Scogin, & Allen, 2013) and the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel et al., 2010), helps guide such training decisions with graduate students. The Pikes Peak training model and assessment tool covers the foundational and functional competencies expected of geropsychologists and provides a rating scale for clinician to rate their own competencies and those of trainees, helping to identify areas of strength and weakness. Increased training opportunities in geropsychology are needed at all levels of professional development, including predoctoral and graduate education and training, postdoctoral training, and post licensure.

I anticipate that two issues will grow in importance and require greater research and clinical attention in the coming years: (a) the death with dignity movement (http://www.deathwithdignity.org/) and decisions regarding capacity to choose legalized physician-assisted death; and (b) aging within the prison system, including decisions regarding compassionate release and the constitutionality of the death penalty for aged prisoners with diminished capacity. With regard to the death with dignity movement, four states have now

legislated death with dignity acts (Oregon in 1997, Washington in 2008, Vermont in 2013, and New Jersey in 2014), and one state (Montana) supports physician-assisted death through common law. Additional states are considering such legislation (http://www.deathwithdignity.org/advocates/national). In no other domain does the ethical balance between respect for personal autonomy and beneficence involve more personal values and ethical considerations than in evaluating one's right to choose end-of-life treatments including physician-assisted death. As the baby boomers age, however, greater research, clinical effort, and media attention focus on the need for informed and shared decision making, potentially involving family members or health care advocates, in addition to individuals and health care providers, in decisions regarding end-of-life medical care.

With regard to the increasing population of aging prisoners, research has shown that the expectation of parole influences inmates' end-of-life treatment preferences such that inmates may prefer life-sustaining treatments if they believe they may live to be released from prison (Phillips et al., 2011). However, compassionate release is rarely granted by state or federal courts. Moreover, to date, the United States Supreme Court has declined to hear any case that addresses the constitutionality of the death penalty for aged prisoners, though such a case was brought to the Court in 2006 (i.e., Allen v. Ornoski), and the court has established that individuals who lack the capacity to understand the nature of their crimes cannot be put to death because such action would constitute cruel and unusual punishment. Geropsychologists are likely to become more actively involved in such criminal forensic cases.

Dr. Heck

Ethical issues in need of further attention include models used for ethical decision making and genetic testing for dementia risk. As with clinical decision making, ethical decision making that is evidence based provides clinicians with a solid foundation for their choices (Bartels et al., 2003; Halpern, 2005; Kim, 2004). The field could benefit from broader discussions of *specific models* of practice-related ethical decision making. Many such models exist, including an instrumental/pragmatic approach espoused by John Dewey (clinical pragmatism; Fins & Miller, 2000), a positive ethics approach (Bush, 2009; Knapp & Vandecreek, 2006), and even a neurocognitive approach (Reynolds, 2006). Most models consist of information-gathering, problem formulation and "diagnosis", solution application, and evaluation phases. Differences between models often consist of the overall philosophy of the approach (e.g., utilitarianism versus deontology) and the delineated process steps. How practitioners arrive at ethically acceptable solutions merits at least as much attention as the principles and standards those solutions are based upon. In geropsychology training, more overt focus on ethical problem-solving methodology would complement existing case/scenario-based ethics exercises by adding a layer of justification to chosen solutions that extends beyond the often arbitrary weighing of competing ethical principles. Practice and credentialing organizations' overt endorsement of the inclusion of the study of methodology within expected ethics training would enhance the quality, scope, and defensibility of geropsychologists' ethical practice and consultation.

In addition to further examination of ethical problem-solving methodology, the ethical issues surrounding genetic testing for the risk of developing Alzheimer's disease (AD) will grow in complexity and merit additional consideration. Genetic testing has become increasingly present in the public consciousness, and despite a slow start in the commercial sector, experts predict increased consumer interest in genetic testing in the next few years (Pollack, 2010). Although geropsychologists do not conduct genetic testing, scientific developments in genetics are likely to present ethical issues with which geropsychologists are likely to have to contend. We will need to continue to be knowledgeable about scientific and applied aspects of genetic testing and balance the risks and benefits of recommending the use of genetic technology on a patient-by-patient basis, given the state of the art and the individual's overall medical, psychological, and life context.

Dr. Moye

I anticipate two challenges will continue to demand our attention: the geropsychology workforce shortage (American Geriatrics Society, 2008; Institute of Medicine, 2012) and the benefits and limitations of the growing emphasis on evidence-based psychotherapy (Spring, 2007; Westen & Bradley, 2005). Across all disciplines, there are not enough health care professionals trained to work with older adults more generally and within geropsychology, raising the issue of distributive justice. A relatively small cadre of geropsychologists has and continues to labor to address the workforce shortage, but we remain woefully behind. Demographic and societal trends will only worsen the shortage as the aging population continues to grow and the demand for psychological services grows in response, despite potential cohort differences (Bartels & Naslund, 2013).

As I have begun my clinical work with the "baby boomers", I have certainly found these clients as a group to be more knowledgeable about psychotherapy and more willing to accept it, and in fact seek it, compared to prior older adult cohorts. If we have a limited number of psychologists trained or interested to work with this population, how do we select who will receive psychological services? Enter the challenges of distributive justice—how do we ethically allocate the scarce resource of competent intervention in a manner that equalizes outcomes across groups, and who decides? Ideally, we might distribute resources based on scientific evidence. For example, do older adults with dementia and their caregivers respond equally well to 4-, 12-, and 16-session interventions to address the behavioral, emotional, cognitive, and social challenges of dementia? The need for comparative

effectiveness research leads to a second ethical challenge for our field, namely, the benefits and limitations of the growing emphasis on evidence-based treatments (Bartels, Dums, Oxman, Schneider, Areán, Alexopoulos, & Jeste, 2003). The relationship of science to practice is reflected generally in our principles of beneficence and nonmaleficence, integrity, and responsibility.

Within psychology, there has been a proliferation of evidence-based therapies and a proliferation of practice expectations that such therapies generate. Overall, the articulation of therapeutic approaches and the testing of these through scientific methods is of course an appropriate and vital component of ethical practice. However, for many therapies, we yet have an inadequate base of *effectiveness* data with complex older adults, particularly those with cognitive compromise. We need to further articulate how to best train for clinical judgment that allows for individual clinicians to critically and thoughtfully adapt existing therapies in a manner that is considered "evidence based" which passes the muster of insurers, peer reviewers, and most importantly the standard of best outcomes for older adults.

3. What is a good path for education and training in geropsychology ethics that promotes sound ethical decision making and high standards of practice?

Dr. Allen

Education and training in geropsychology ethics may be supported by encouraging self-assessment at all levels of training and practice using a structured knowledge and skill rating tool, such as Pikes Peak Geropsychology Knowledge and Skill Assessment Tool (Karel et al., 2010). This tool, at its base, will encourage familiarity with other documents necessary for demonstration of foundational and functional competencies in the practice of geropsychology (e.g., ABA & APA, 2008; APA, 2014). Infusion of some basic geropsychology content into all graduate training programs will facilitate the APA Commission on Accreditation's (COA) aspirational goal of broad and general training for all psychologists. Encouraging sound ethical decision making and high standards of practice may be enhanced through familiarity with ethics literature (Bush, 2009, 2012; Karel, 2011), ethical decision-making resources (see, for example, ABA & APA, 2008; APA, 2014; Bush, 2009; Karel, 2011; Karel et al., 2010), and ongoing self-monitoring with consultation when individual boundaries of competent practice are reached. At any stage of professional development, the practitioner must acknowledge that working with older adults is not just an extension of clinical or forensic practice with emerging, young, or middle-aged adults. Blogs, interactive webinars or training institutes, and distance mentoring/supervision offer opportunities for ethics education and may become more commonplace for practicing clinicians in the coming decades. Certainly, more geropsychology education and training opportunities are needed (Association of Directors of Geriatric Academic Programs, 2007).

Dr. Heck

The APA requires accredited doctoral programs to include coursework on ethics, and many states and other jurisdictions require ethics-specific continuing education for licensure maintenance. The required content of each educational offering (e.g., theoretical versus applied and practical versus conceptual), however, is often not very specific. In my opinion, the most valuable ethics education and training involve a distinctly applied component, preferably incorporating the clinical–ethical experiences of the trainee. The most effective examples of this I have experienced have been in the process of my own board certifications in Clinical Psychology and Geropsychology under ABPP. Each board examination required presentation and discussion of ethical dilemmas in a clinical context, with a substantial portion of the oral examination focused on discussion and sometimes defense of the ethical decisions I presented in submitted materials. I believe that periodic guided reflection on the ethical elements of one's own practice, such as that found in the board certification examination process, is the best path to build upon the standard ethics foundation laid in graduate training. Comprehensive training in ethical issues in geropsychology covers a variety of resources, such as the *Fairhill Guidelines on Ethics of the Care of People with Alzheimer's Disease* (Post & Whitehouse, 1995) and the papers on decision-making capacity assessment for attorneys, psychologists, and judges from the ABA and APA (2005, 2008). However, in my opinion, the most important resource in addressing an ethical dilemma is collegial consultation, whether formal or informal.

Dr. Moye

At the end of the day, ethical practice is not about knowledge of ethical principles, but application of these principles to practice. In our setting, trainees come to us with an excellent foundation in ethics, which they then get to apply in their internship and fellowship years as they negotiate practice challenges under the guidance of a supervisor and consultation in weekly team meetings and, when appropriate, consultation to the ethics advisory committee. A next step for the field might be to develop web-based case examples with stop and start points which mimic the experience of supervised practice experience. It will be most helpful if these case examples can be true to life; for example, the case discussion is complicated by some sensory challenges, cognitive changes, and/or the individual being compliant and likable—or not at all so—to enable rich discussion and learning of ethical dilemmas in practice.

4. In your work with interdisciplinary colleagues, what ethical problems or misconduct have you observed and how did you address the matter?

Dr. Allen

One ethical dilemma that I faced and, in my opinion, dealt with less than optimally concerned respect for patient autonomy and informed consent with regard to disclosure of information in treatment. An interdisciplinary colleague chose to describe the need for a psychotropic medication to an older adult client as "taking vitamins" rather than taking a medication with mental health outcomes and risks. I was not present when this situation arose; rather, it was reported to me by a student. I addressed the ethical issue regarding disclosure, informed consent, and respect for patient autonomy directly with all of the students in training. We also had an interdisciplinary discussion about disclosure with the treatment team, including the practitioner in question. However, I did not directly address the different informed consent approaches from the perspective of geropsychology in relation to my colleague's discipline. In hindsight, clear communication about this clinical and ethical issue from one health care professional to another may have resulted in closer interdisciplinary ties and understanding for all clinical staff.

Dr. Heck

The most egregious instance of ethical misconduct I have witnessed involved a staff psychiatrist at a previous place of employment frankly advising a patient to behave in a manner that could get the patient's pending legal charges dropped. The patient had been admitted to our inpatient psychiatric facility from jail for restoration of competency to stand trial for a misdemeanor assault charge. In a team discussion with the patient, the psychiatrist directly informed the patient that if he was deemed incompetent to stand trial, then "the court would probably drop the charges" and "you can be found incompetent if you don't do well with your restoration work." I consulted with my supervisor at the time, and we agreed that it would be most appropriate for me to raise my concern directly to the psychiatrist. I explained to the psychiatrist that I perceived the action to be unethical on the basis of a violation of the principles of fidelity (professional roles and trust) and justice. I expressed that I believed that offering legal counsel was inappropriate, and encouraging the patient to manipulate the outcome of his course of treatment and subsequent evaluation(s) compounded the violation exponentially. The psychiatrist defended his actions by explaining that he believed putting the patient through an extensive legal process for a petty crime, for which he did not believe the patient should be held responsible, was unethical in and of itself, and that he had a responsibility to protect the patient's "best interests" by helping him out of the situation. With my supervisor's consultation and support, I took my concern to the facility's medical director, who agreed with my position and promptly re-assigned the patient to another psychiatrist. Ultimately, the patient was restored to competence, stood trial, was convicted of the minor offense, was sentenced only to time served, and was accepted by an assisted living facility.

Dr. Moye

Disagreements about the course of care and differing perspectives are quite common, but I have found these can be resolved with direct discussion, a skill that I have grown more comfortable with over the years. In my work within a large health care organization, I have rarely observed ethical problems or frank misconduct by colleagues. When ethical misconduct does occur, it is most often related to problems with boundaries that interfere with patient care. Boundaries can be particularly challenging within geriatric health care when we work in settings such as within an older adult's home and with multiple roles (e.g., the professional is assessor and therapist to patient and consultant to team). At times, even well-intentioned practitioners may be uncertain where the boundaries like concerning friendship, romantic, and/or financial relationships between employees, employees and patients, and staff who are both employees and patients. Our medical center has a robust ethics program which consists of responses to individual clinical cases (e.g., withdrawal of life sustaining treatment) and to employee or system issues. As such I have been fortunate to be part of a team that has a process of encouraging recognition and reporting, triage, delegation, investigation, and action. At times, that action is appropriately managed within the supervisory relationship or within extant human resources procedures. At other times, the investigation reveals a broader need. For example, concerning boundaries, the committee responded by developing a boundaries policy that clarified professional responsibilities and the pitfalls of dual roles, and then instituted system wide education about boundaries.

5. When working with family members or formal caregivers of older adults, have you confronted ethical problems? If so, please explain.

Dr. Allen

In the past 18 months, my students and I have been involved with five ethically complex capacity evaluations with complicated family dynamics resulting from blended families Qualls' (2008). Caregiver Family Therapy model provides excellent guidelines and clinical examples about how to work with families and older adults to address referral questions from a family systems perspective. In three of these recent cases, we devised supervised spousal visitation plans on behalf of the "well" older adult client of the law clinic or community-based attorney that retained our services. In two of these three cases, the adult children of the spouse with diminished capacity were not in favor of spousal visitation. In the third, the legal guardian of the older adult with diminished capacity was not in favor of spousal visitation. The other two cases involved the awarding of guardianship to a specific member of a blended family; one of these occurred within the

context of financial exploitation of the older adult with diminished capacity. The ethical issues my students and I grappled with included: (a) cooperating with other professionals, including the attorney representing the other faction of the family system and the judge and (b) psychological services delivered to or through organizations and remembering that it was not the "well" older adult who retained our services but the attorney or law clinic representing that older individual within the context of complex blended family dynamics and civil capacity issues.

Dr. Heck

The issue I find most challenging in working with families and formal caregivers is when it is suspected that a designated surrogate decision-maker is making decisions based on his or her own values rather than on the patient's presumed or known premorbid values. Decisions about the use of over-objection medication, choice of facility or environment upon discharge, and disposition of finances or other resources arise frequently, and in some cases, a caregiver stands to benefit greatly from one course of action over another. I recall a case where a son was living in his mother's house for over 15 years while she was psychiatrically hospitalized. She had a longstanding diagnosis of schizoaffective disorder and was considerably psychiatrically and cognitively compromised. He resisted attempts to discharge his mother from the hospital at every turn; since he was her legal guardian, the hospital could not proceed to arrange a discharge placement without his consent. With each opportunity that arose for a viable discharge, he would cooperate initially, only to later sabotage the placement by, for instance, claiming that his mother "would never want to live in a place like that" or "she always hated living in the city." Hospital staff members were conflicted as to their recourse, as we had no evidence to counter the son's claims of his mother's values. It was only after years of seeing this pattern that we believed we had enough justification to legally challenge his status as his mother's guardian. The case fell victim to a considerable legal backlog (over 2 years), and his mother ended up dying under our care before we could successfully discharge her to a less restrictive environment.

Dr. Moye

Working with families and formal caregivers is very often core to ethically competent practice that considers the social context of the individual. In that manner, work within the social context does not in my view involve "ethical problems", but of course it requires ethical clarity in retaining your alliance to the individual older adult as your client, while exercising flexibility. As a small example, sometimes when we contact a veteran to make an appointment, a caregiver will state, "I handle his appointments." Immediately, and on the spot, the geropsychologist must determine how much can be disclosed to this individual. Given that the vast majority of older adults live with spouses or families, and the vast majority of caregiving is provided by families (Family Caregiver Alliance, 2005; Institute of Medicine, 2008), it is reasonable to assume that working with that person to schedule the appointment is appropriate. Work with families is often a core part of geropsychology practice and requires constant attention to potential dual relationships, flexibility, and on-your-feet thinking. In sum, the involvement of the family usually enriches the therapeutic work and is directed by the needs and choices of the older adult who is the client.

Discussion

Providing psychological services to older adults can be personally and professionally rewarding, with opportunities to engage in a variety of clinical and forensic activities that make meaningful contributions to patients, their families and care providers, triers of fact, and others involved in their lives. With the richness and diversity of the professional experiences come ethical considerations that can differ in important ways from those experienced by psychologists working with younger populations. Those ethical considerations and issues can become ethical challenges and dilemmas, particularly for those who have given little thought to common ethical issues or ways to avoid or address ethical challenges. Establishing competence in ethical aspects of practice is an important part of establishing professional competence in geropsychology. Experienced colleagues who are invested in promoting ethical standards of practice can be a valuable resource for psychologists new to this specialty, as well as for more senior professionals seeking clarification about ethical aspects of practice or simply seeking reassurance that they are "doing the right thing." The three experienced geropsychologists interviewed for the present article described what they consider to be primary ethical issues and their views on aspects of ethical practice in geropsychology.

There was agreement among the colleagues that efforts to strike a balance between respect for patient autonomy (APA General Principle E, Respect for People's Rights and Dignity) and beneficence (APA General Principle A, Beneficence and Nonmaleficence) represent a primary goal for psychologists working with older adult clients. A tension commonly exists between the desire to support the rights of patients to make the decisions that govern their lives and the desire to promote patient welfare, when patients' decisions are seemingly inconsistent with their welfare. This issue is particularly complicated when patients' decision-making capacity is in question. Geropsychologists are well served by striving to understand patients' core personal values, while maintaining an awareness of their own beliefs and values regarding the balance between patient autonomy and welfare and considering the impact of their values on their clinical actions and decisions.

Despite considerable investment in advancing ethical practice, there remain many aspects of geropsychology practice that could benefit from additional focus, now, and in the future. The colleagues identified the following issues as being in need of additional focus: (a) determining decision-making capacity, (b) establishing culturally appropriate interventions, (c) education and participation of students/trainees in varied clinical activities, (d) ethical problem-solving methodology, (e) death with dignity movement and physician-assisted death, (f) compassionate release from prison, (g) death penalty for aged prisoners with diminished capacity, (h) genetic testing for risk of Alzheimer's disease or other forms of dementia, (i) distributing care in the context of a workforce shortage, and (j) delivering evidence-based care, particularly when the evidence has not yet been extended to complex older adults with cognitive compromise.

Compared to some mental health specialties, it is only relatively recently that guidelines for education, training, and practice in geropsychology have emerged, and geropsychology has only recently become a distinct specialty board of ABPP. Nevertheless, numerous resources exist to support evidence-based practices, help geropsychologists achieve and maintain competence in their clinical and forensic work with older adults, and promote ethical knowledge and decision making in geropsychology. Such resources include (a) position statements by professional organizations, particularly the APA (e.g., ABA & APA, 2005, 2008; APA, 2014); (b) scholarly works, such as ethics books, book chapters, and journal articles (e.g., Bush, 2009, 2012; Bush, Allen, & Molinari, in press; Hays & Jennings, 2015; Karel, 2011); (c) the APA Ethics Code; (d) collegial consultation, broadly defined to include ethics committees, interdisciplinary colleagues, and other geropsychologists working with older adult patients; (e) the Fairhill guidelines on ethics of the care of people with Alzheimer's disease (Post & Whitehouse, 1995); (f) advance directives; and (g) the Pikes Peak documents (Karel et al., 2010; Knight et al., 2009).

Collaboration with interdisciplinary colleagues can facilitate the care and wellbeing of older adults. However, ethical challenges can arise from the differing perspectives that professionals from different disciplines have on core ethical principles and the application of the principles to individual patients. The colleagues interviewed for this article identified a tendency for ethical challenges to arise from differing interdisciplinary perspectives about respect for patient autonomy, integrity, and justice, as well as what is in the "best interests" of patients. Challenges of this nature can be addressed through informal discussions with colleagues; more structured interdisciplinary exchange of information about ethics, such as ethics grand rounds; and formal reporting avenues, such as ethics committees and institutional review boards.

Involvement of family members is often a valuable and necessary component of psychological services with older adults, but such involvement can lead to ethical challenges for clinicians. Matters of confidentiality, fees and financial arrangements, and differences between the needs and values of patients and those of family members (or formal caregivers or surrogates) can result in ethical dilemmas, particularly if not anticipated and managed proactively. While the information imparted by experienced geropsychologists can promote an understanding of ethical matters of primary importance to geropsychologists and improve ethical competence, the ultimate foundation for ethical behavior and sound ethical decision making lies in the personal commitment of each practitioner to continually strive for high standards of ethical practice.

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