Geriatric Occupational Therapy: The Uncertain Ideology of Long-Term Care

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Key Words: nursing homes • rehabilitation • role expectation

Survey data from 1995 have revealed that 38% of all registered occupational therapists and 62% of all certified occupational therapy assistants work primarily with older clients (Stancilff, 1996), yet the role of an occupational therapist in geriatrics is still being defined. Therapists in geriatrics have been characterized both as generalists and specialists (Davis & Kirkland, 1986; Dunn & Rask, 1989; Hasselkus & Kiernat, 1989; Rogers, 1981). The traditional rehabilitation ideologies of recovery and functional improvement found in many areas of practice demand a redefinition in geriatric practice. Somers (1991) has challenged the occupational therapy profession to continue to define its role as “an essential component of long-term care” (p. 635).

The lived experience of occupational therapy—the nature and meaning of doing our work—has recently been the focus of research that has been contributing to the definition of our practice. For example, Hasselkus and Dickie (1994) sought to understand therapists’ experiences in general practice, whereas Jacobs (1994) sought the same understanding in physical rehabilitation; Niehues, Bundy, Mattingly, and Lawlor (1991) studied the experience of therapists in school systems; and Lyons and Ziviani (1995) researched students’ experiences in mental health fieldwork. The present study extends and focuses these research findings on the nature of therapists’ experiences in geriatric practice. We used Tuan’s (1986) concept of the good life as it relates to therapists and older clients as a framework for analysis and discussion of the data. One major theme of the good life is activity, that is, what persons do or the occupations that bring “deep satisfaction to human beings” (Tuan, 1986, p. 4). The essence of this theme, within the context of doing occupational therapy in geriatrics, is the focus of this study.

The present study’s data consisted of a subset of interviews drawn from a nationwide study of occupational therapists in all areas of practice (Hasselkus & Dickie, 1994). In the original study, we conducted mail surveys and telephone interviews, asking respondents to think back over their practice and describe especially satisfying and dissatisfying experiences. The interviews were phenomenological (Van Manen, 1990) in that we were eliciting narratives about the lived experiences of therapy. Phenomenological studies are based on a narrative theory of human existence, that is, the theoretical proposition that the meaning of everyday activity is revealed in the narratives we create about those experiences (Bruner, 1986; Polkinghorne, 1988).

Better understandings of the satisfactions and dissatisfactions related to occupational therapy in geriatric...
practice will hopefully help guide students and therapists into making career choices that are realistic and appropriate. Additionally, these insights may assist therapists already practicing in geriatrics to develop strategies for maximizing satisfying experiences and minimizing dissatisfying experiences. In these ways, therapists can help to achieve the good life for themselves and for their clients.

Method

Sample

Of the 148 therapist respondents in the original study (Hasselkus & Dickie, 1994), 34 described experiences in geriatric practice (i.e., respondents stated that their clients’ ages were 60 years or older, referred to their clients as elderly, identified the practice setting as geriatric). These responses included 19 narratives of satisfying experiences and 20 narratives of dissatisfying experiences. The nature of the larger study’s phenomenological question led to narratives of experiences that were exceptional rather than to those that were ordinary; thus, the data of the geriatric subset may not capture the whole of geriatrics.

Of the 34 respondents in the geriatric subset, 33 were women. The respondents’ mean age was 38 years, with a range from 24 years to 69 years. The years of certification ranged from 1952 to 1990. Twenty-four respondents held bachelor’s degrees, and 10 held master’s degrees. The subsample, on average, was 2 years older than the total sample, had a ratio of women to men that was twice that of the total sample, and had a comparable percentage of respondents who held master’s degrees.

Analysis

We read each of the 39 interviews line by line and coded chunks of experiential data into three dimensions of occupational therapy practice as identified in the original study. These dimensions were Change (the ability or inability to help a client gain new capabilities or regain former capabilities and lifestyle); Community (a sense of harmony or disharmony in relationships with clients, family members, and coworkers); and Craft (feeling or not feeling a sense of enjoyment and skill in carrying out therapeutic tasks). As the data in each dimension expanded with more and more coded text, subdimensions emerged. For example, within the Change dimension, we created the Getting Back subdimension, which included descriptions of getting a client back home, helping a client gain back self-esteem, and persuading a client to go back to her painting.

After we organized the data into subdimensions, we examined them reflexively to identify the geriatric nature of these experiential themes. For example, the strong theme of helping a client get back home contained elements of getting the person out of and away from a nursing home. The implicit meanings attached to the nursing home as it related to older clients (e.g., dependency, loss of ‘place,’ disruption of lifelong patterns of activity, the beginning of the end) were what contributed to its geriatric nature. The meaning of home for older clients and therapists and the idea of continuity in the clients’ lives also implicitly contributed to the geriatric nature of this subdimension.

Throughout our analysis, we (the first and third authors) carried out individual parallel analyses and met weekly to discuss emerging subdimensions and experiential themes. This process of consensus building, which is akin to the concept of peer debriefing (Lincoln & Guba, 1986), was used to strengthen the authenticity of the interpretations. The final analysis and findings reported in this article are the result of collaboration and consensus between the first and second authors.

The Nature of the Experience

To understand the experience of occupational therapy in geriatric practice, each dimension—Change, Community, and Craft—was examined in depth. The questions addressed were: What is the nature of Change, Community, and Craft in these geriatric narratives, and how does this compare with occupational therapy practice in general?

Change

Change is the dimension of doing occupational therapy that encompasses modification within a client or in a client’s life context (Hasselkus & Dickie, 1994). Bringing about change is often the crux of whether a therapist believes that he or she has made a difference. The subdimensions of Change derived from these narratives were generated from themes that emphasized getting the client back to a previous lifestyle, helping the client regain hope for the future, and bringing about more independent function.

Getting Back. This subdimension encompasses a client’s return to a previous state of being. Prominent in this category were data that described helping a client to “go back home.” Enabling an older client to go home seemed to represent an accomplishment par excellence, and the respondents saw themselves as key in bringing this about, for example:

I was working with a woman who was, I guess, clinically depressed with some delusional kinds of features along with some paranoia. She was an older woman, probably about 60s. And she also had trouble moving around and used a walker. . . . The team wasn’t sure
that she expected to experience from getting home. In another narrative, the respondent was depressed to return home after a stroke and then finding institutionalization in a nursing home. To
the respondent himself or herself did not see a future for the client. For example, in a narrative about a 102-year-old
client who was referred after a hip fracture for lower-extremity dressing techniques and hip precautions, the respondent stated:
Although he was able to increase the level of his independence, I had a real problem with my role... like what were we trying to achieve there as occupational therapists? Maybe we were trying to improve their independence for a limited time, and maybe that was realistic... For my own well-being, I needed tangible goals. I didn't find [that] I could get those as easily from the terminal or very, very elderly patients.

The usual occupational therapy goal of increased independence had been achieved, yet the experience was dissatisfying to the respondent. To her, the situation seemed incompatible with the basic purpose of occupational therapy when she asked, “What were we trying to achieve there as occupational therapists?” Thus, age itself may contribute to a truncated view of the future for both therapists and clients.

Independent Function. This subdimension focuses on changes in a client’s level of independence in the performance of activities of daily living (ADL). In these narratives, we found much of what Mattingly (1991) calls chart talk (i.e., references to range of motion, transfer techniques, splinting, feeding, hemi-dressing). In the next narrative, the client was a woman who had experienced a stroke. The occupational therapy took place in a nursing home, and in this case, the client did not return home. Nevertheless, the respondent stated that “it ended up being a happy story”:

There was a particular case who had right CVA [cerebrovascular accident] with left hemiplegia. When she first came to us, she was really max or mod-max assistance for all ADL and transfers....Communication was really, really difficult, but as we kept working together, we really established a rapport with each other... We did a lot of functional transfer training, hemi-dressing techniques, the whole bit. Did a lot of Bobath techniques with her. Mat exercises with all the rolling and supine to sit... getting her to establish her sitting balance and from there standing balance. She really just progressed very nicely... She later progressed to probably about a stand-by assist/mini assist level, at least a level where she was doing things for herself... it ended up being a happy story.

Thus, when going home was not a realistic goal for a geriatric client, some respondents felt satisfaction from gains in functional independence per se. Discharge of an older client from an acute care setting to a rehabilitation facility was also clearly regarded as a sign of major functional improvement as well as hope for the future and perhaps eventual discharge home.

Narratives of dissatisfying experiences in this subdimension largely described the many ways that the therapy goals for increased independence function were thwarted. These barriers to therapy were the same as those found in general practice, such as lack of carryover by staff members or family members, ineffective reimbursement systems, and a client’s refusal to carry out ADL indepen-
dissatisfaction arising when progress made in therapy was rendered futile by the client’s sudden death. When this happened, the respondent’s hopes and sense of future for the client were abruptly destroyed, and he or she struggled with the resulting disappointment. As one respondent said:

So many times you feel you’re having some success with someone or you see a lot of progress, and then they die...they are at the stage of their life when there isn’t that much left, and so you do what you can to make that as good as possible for them...and then all of a sudden overnight, they’re gone.

The future that has been envisioned for the client has suddenly been taken away, and the functional progress being made in therapy loses all meaning. The situation is more jarring than the loss that is felt when progress is undone by other factors; there is no second chance when the client dies.

Community

The dimension of Community encompasses the interpersonal relationship aspects of occupational therapy practice (Hassellkus & Dickie, 1994). In the subsample, the respondents weave a story of interactions and relationships within the geriatric context. Satisfactions and dissatisfactions are derived from the presence or absence of mutuality and a sense of being appreciated.

Mutuality. Mutualiy includes all the expressions of shared beliefs, empathy, and working together among the persons in the narrative. For the respondents, the best of all possible worlds existed when the therapist, client, family members, and other staff members shared enthusiasm for the therapy and beliefs about the possibilities for the future. If the client was not initially a “believer,” the respondents described devoting energies to attempting to persuade the client that the therapy and its goals were important. As one respondent illustrated, it was especially pleasing to witness a client’s shift from hopelessness and indifference to belief in the value of the therapy:

I had one client that wasn’t really sure if anything could really help her...She had a CVA and hemiparesis on the right side, which was her dominant side. She was getting some return, but that didn’t seem to excite her because it wasn’t like it used to be...[W]orking with her directly on return in that side and...on learning to do a few things herself...was a real slow process, but it was very rewarding because as she finally acknowledged there was some progress going on and things were coming back, she was delighted....What was most satisfying to me was that we could come away with an agreement; that I could see changes, but she couldn’t see them; and she would allow me to continue coming and then began to get excited or acknowledge that these things were happening...she could decide [that], yes, she could maintain her living in her own home with some help....And so it became a mutual goal from someone that had really no goal except to give up.

To persuade this client to believe that what could be accomplished in therapy would make a difference to her future was clearly very satisfying to this respondent. The subdimension of mutuality is the heart of this narrative—being able to “come away with an agreement.”

Mutuality was also important among staff members. One respondent described a 71-year-old client who had sustained brain damage secondary to a heart attack. Within 6 weeks of therapy, he had progressed to making “phenomenal progress” in ADL. The respondent stated:

The part of it that was very exciting to me wasn’t just the progress. I’m used to having patients make progress, but...that I was able to change some of the attitudes of the facility staff...the staff was really surprised to find that this patient was able to progress. He got to the point...[where] we were able to send him home.

It is obvious that the narratives of mutuality, as with other subdimensions, often include the theme of going home. Enabling an older client to go home provides the linchpin for many of the stories, giving meaning to other parts of the experiences. Not only did the client make progress and the staff members’ attitudes change, but also “we were able to send him home.”

Feeling Appreciated. Knowing that what they were doing was appreciated was another source of satisfaction to the respondents. The clients themselves were one source for this feeling, such as the 92-year-old nursing home resident who was “just more than grateful” when the respondent helped her go home. A sense of feeling appreciated also came from family members and other nursing home residents, sometimes indirectly through their regard for a client’s accomplishments in occupational therapy. For example, the woman who returned to her oil painting gained recognition from her family members, staff members, and other residents in the nursing home (“there’s various people in the facility that are looking [paintings] from her”), and the man who returned to his whittling became a much happier person and was “much more liked on the unit.”

Alternatively, the community of people in a nursing home could become an opposing force to a therapist’s efforts. One respondent had devised a seating arrangement for a client to help her sit upright:

She looked great in it but she hated it...and she got everyone to agree that she didn’t need it and she didn’t want it. So they went along with her, and she didn’t use the seating insert at all. And she continues to be really slumped, practically falling out of her chair. So I was really upset because I went through a lot of work.

To have one’s hard work and product rejected in this way, not only by the client, but also by peer professionals, is very dissatisfying.

Craft

The Craft dimension of general practice consisted of the
narratives about what the occupational therapist did and the enjoyment or disappointment that he or she experienced in the act of doing therapy (Hasselkus & Dickie, 1994). Many geriatric narratives within the Craft dimension included data similar to those of general practice, such as descriptions of splinting or other treatment techniques. Yet, other parts of the Craft dimension stories were uniquely geriatric, reflecting skills and therapeutic approaches derived from this specific context.

Doing in Geriatrics. Much of the doing in geriatric occupational therapy emphasized the techniques that were used to help clients get back home. The respondents seemed to view evaluation of the home itself as a unique occupational therapy activity, one that enabled them to bring back privileged knowledge about a client's ability to go home and to use that knowledge to make recommendations. One respondent related the following:

We would leave the unit for the afternoon and go home via a taxi and just look, you know, go through the routine of her getting into her building and up to the second floor where she lived, and into the apartment. And I actually did an assessment as far as seeing if she could bathe herself, use the bathroom appropriately and safely, and...resume cooking for herself.

The pattern of thinking and acting alone, with minimal involvement of other professionals, is strongly evident in these data. The respondent just quoted conveyed an image of a therapist working alone with a client out in the community. Other respondents spoke of being the only one who acknowledged that a nursing home resident wanted to go home or the only one who took the time to find out what a client's interests were. Respondents spoke of working to bring about functional improvement when the rest of the staff members thought a client would be "better off dead" or "would only be a vegetable." Only one respondent made the team itself a central part of the story as she described working in a nursing home with a client with stroke.

In Flow. In the original study of general occupational therapy practice, certain stories within the Craft dimension described a deeper level of skill in multiple contexts accompanied by an orchestration of a complex series of interventions. We likened these experiences to Csikszentmihalyi's (1988) concept of flow where there is an optimal match between the challenges of a situation and a therapist's skills.

An attempt to institute a new program in a nursing home provided a paradigm example of flow in a geriatric experience that drew deeply and holistically on one respondent's training: "I entered a lot of residents in the city flower show, and they ended up winning 'The Best of Show!' They were all pretty excited about that...And [the nursing home] continued that program." But the story didn't end there. The respondent had a wheelchair-accessible home that she helped design for her husband who has a disability. After the flower show, she invited 33 residents to her home to celebrate. She described the experience as follows:

I think the most satisfying experience I've had as a therapist is seeing the benefit of my training and education. Here we had 33 elderly people, walkers, wheelchairs, you name it, and everybody was fine in their varying levels of independence. There were some people who were swimming in the pool for the first time in 25 years. It felt like a scene from the movie Cocoon. I think for me, instead of seeing, "Okay, well they've achieved functional level, they can be discharged from therapy," I was seeing them in a naturalized environment or...outside of their therapeutic setting and seeing them doing real things and hearing them say that they felt like real people. What I had given them was hope back and...something to really cherish. That's why I wanted to get into geriatrics in the first place.

The emphasis of this narrative on enabling older clients to do real things and be real persons makes a strong statement about the satisfaction the therapist gained when she offered meaningful everyday activity in her own home environment. The clients became persons once again, and what they were doing were real things, not therapy. The level of challenge in successfully planning and carrying out this complex therapeutic program contributed to the respondent's experience of flow.

Discussion

We used Tuan's (1986) framework of the good life to discuss the two questions examined in this study: What is the nature of satisfying and dissatisfying experiences in geriatric occupational therapy, and how do these experiences compare with other areas of practice? To Tuan, the good life is realized both in the mind and in the everyday experiences of work and play and caring for self and others: "For a life to be good it must contain joyful, comforting, and import-laden experiences" (p. 7). Tuan's focus on the quality of everyday life resonates with occupational therapists' use of human occupation to support health, life span development, and independent function. In this way of helping persons live the good life, many therapists hope to live the good life themselves.

The narratives of satisfying and dissatisfying experiences provide access to understandings about what constitutes the good life for occupational therapists in geriatric practice. The descriptions of therapeutic techniques, goals, and concerns as well as the details about clients' life contexts reveal the therapists' perceptions of the good life for older persons. We can reflectively compare these findings with other areas of practice.

The Uncertain Ideology

These data indicate that returning a person to a former level of function or a former place of residence is part of what occupational therapists consider the good life for
older clients. These sources of satisfaction reflect the basic rehabilitation ideology that it is important and good to restore independence and continuity in a person's life. Yet, the mantle of rehabilitation did not rest comfortably on the shoulders of many of these respondents.

Long-term-care facilities represent a variety of sometimes ambiguous health care philosophies and ideologies. Therapists feel their way to see what is acceptable and workable in each system. Aronson (1990) called this process “reconciling personal realities and ideology” (p. 69). Occupational therapists in geriatrics must reconcile the discrepancies between their realities of practice and the traditional ideological assumptions of rehabilitation. Such a reconciliation means defining the limits of their services; setting priorities; sorting through competing demands; deciding what norms, ideals, or other commitments to uphold; and determining what is justifiable and rational.

The narratives in this study suggest that some occupational therapists in geriatrics believe that the traditional rehabilitation model is constraining, especially when working with older clients who reside permanently in a nursing home. The reimbursement system and the rehabilitation ideology tie therapists to the need to document measurable progress in functional independence, often limiting the therapist to biomedical areas of practice. One respondent expressed these limitations in her nursing home setting this way:

You could teach [the clients] the skills to dress themselves or feed themselves, but they still weren't happy with themselves. What they really needed was more social interaction, and it was very frustrating not to be able to get payment to spend the time to do that. I could do rehab, but what they really needed was to be a whole person.

This respondent expressed a strong pull toward what Mattingly (1994) called the “phenomenological body” (p. 75) of her clients, that is, the meaning and lived experience of the whole person.

It was with a sense of freedom from such biomechanical constraints that one respondent threw a party, breaking the boundaries of her role as a therapist and the older persons’ roles as clients and enabling each person to be more whole. This therapist sorted through her priorities, ideals, and other commitments and was able to reconcile the discrepancies between her personal reality and the rehabilitation ideology of the nursing home by linking up with a flower show and having a pool party. By her account, it was a smashing success. She ended her narrative with the strongly affirming statement: “That’s why I wanted to get into geriatrics in the first place.” In Tuan’s (1986) framework, we might conclude that in this situation, the respondent was able to bring about the good life for the nursing home residents and for herself.

In their interviews with therapists in school-system settings, Niehues et al. (1991) identified a similar theme of ideological uncertainty and values conflict. Calling the school system an “indeterminate zone of practice” (p. 208) (a term credited to Schön, 1987), the authors described the mismatch between the medical context of the therapists’ training and the educational context of practice in the schools. The school-system therapists had to engage in reframing others’ views of their clients, that is, enabling teachers and parents to see these students in a more positive light. This reframing is analogous to the respondents in this study who described changing staff member or client attitudes from hopelessness to possibilities for the future. The school-system therapists worked to develop situatedness (Benner & Wrubel, 1989) in their positions to acquire knowledge about the cultural needs and expectations in that setting. The respondents working in the long-term-care settings also sought to understand the cultural parameters and expectations of their context. Like the school-system therapists, these respondents struggled with the ambiguity of their roles in practice, feeling the need to redefine real therapy in a context broader than direct, hands-on treatment (Niehues et al., 1991).

Thus, we come to understand that the rehabilitation ideology is not always a comfortable fit in long-term care. Sometimes occupational therapists may feel inappropriately constrained by the ideology; at other times, they may strive for the opportunity to incorporate the ideology to enhance the quality of life for their older clients. They seek to develop situatedness. The process of reconciliation between the therapist’s personal reality and the ideology of practice appears to be a strong contributor to the satisfactions and dissatisfactions of geriatric occupational therapy. The data in this study provide beginning insights into the nature of that process and point to the need for further research into the dynamics of this phenomenon.

The Lone Ranger

What is the meaning of the apparent soloistic nature of the practice of many of the respondents? Teamwork is another hallmark of the rehabilitation ideology, yet many respondents described their experiences in more individualistic terms. This “lone ranger” phenomenon might signify that other health professions are not as invested in geriatric rehabilitation as the occupational therapist, leaving the therapist to rely on himself or herself alone for practice. Alternatively, the setting for practice, with its uncertain ideology, may not lend itself to coordinated teamwork. Niehues et al. (1991) also described a phenomenon of uncoordinated teamwork in school-system practice. The lone ranger phenomenon can function as a constraint on therapy, creating an environment of limited
resources and a sense of isolation. In geriatric long-term care, however, it can also function as a sort of liberating agent, unencumbering the therapist from several layers of bureaucracy and enabling him or her to function with greater autonomy and freedom. As Tuan (1986) stated, “Freedom is an ambivalent value” (p. 164); it has advantages and disadvantages.

The Concept of Continuity

Tuan (1986) stated that the good life is one of stability and continuity. In geriatrics, continuity has been called the key to psychological well-being in old age (Maddox, 1968) and a major contributor to identity formulation in late life (Kaufman, 1986). Within the framework of continuity theory (Atchley, 1989), the term refers to coherence or consistency of life patterns over time.

Continuity is also a basic principle of the rehabilitation ideology. Within rehabilitation, illness is viewed as a disruption in the continuity of ongoing life processes. As occupational therapists, we work to reestablish the coherence and, thus, the continuity of a client’s life patterns. Mattingly (1994) described therapists as “transporters” (p. 84) because they help clients find their ways back to the real world. Therapists facilitate continuity through return to engagement in everyday life. This process of return has also been portrayed as a gradual convergence over time back to familiar daily patterns, phasing out the unusual and unfamiliar routines and activities engaged in during illness (Hasselkus, 1994).

These data of geriatric caregiving indicated that going home is seen as a major contributor to continuity for older clients. Enabling a person to go home is a triumph over adversity, a Gestalt-type symbol of a successful therapeutic ending. But there is a sense of oversimplification of the concept of home in the narratives, reducing it to an entity that is largely a physical space within which a person is able or not able to function at an acceptable level. In reality, home is more than this; it is “a very special space experience” (Van Manen, 1990, p. 102) that is related to our fundamental sense of being. Home is a source of identity, a place of safety and security, a symbol of order and control, and a refuge from the outside world (Csikszentmihalyi & Rochberg-Halton, 1981; Rowles, 1987). It is a setting that maximizes our sense of personal competence. Home is our point of reference from which we leave and to which we return as we carry out our everyday activities. Attachment to home transforms a dwelling place into “an extension of self and a repository of meaning” (Rowles, 1987, p. 336).

When occupational therapists help a client go home, they are helping that person return to a place with all these meanings. Occupational therapists believe in the uniqueness and importance of their skills in this arena. They recognize that the spheres of continuity offered by a return home can be powerful and very positive; home is a symbol of the good life. Yet, this very meaningfulness of home can backfire on a client who is returning to his or her real world after an illness. The experience of home will not be the same if the body and mind (and capabilities) have changed. The level of competency and the senses of control, refuge, safety, and identity may all need readjusting as may the previously familiar routines within the home and neighborhood. Home is the place where we have always been able to be “what we are” (Van Manen, 1990, p. 102). It is at home that it will become obvious that what we are is now different.

Going home is the end of one phase in a person’s illness trajectory, but it is also the beginning of another phase. An occupational therapist can help an older client anticipate and plan for the new experience of home while also preserving the basic coherence and structure of the client’s life patterns. A therapist can facilitate the gradual convergence of daily activities back to the familiar routines of a former time. In this way, change is a part of continuity, and the continuity aspects of the experience of home can be strengthened while the discontinuity aspects are minimized.

The Uncertain Future


Uncertainty is a central feature of a chronic illness trajectory.... When chronic illness occurs late in life, uncertainty grows as serious questions arise about whether the individual will be able to weather the disruption and go on with daily life. (p. 166)

This quote raises our awareness of the concept of the uncertain future as an accompaniment to chronic illness in old age. Uncertain futures are attended by uncertain possibilities. Both of these uncertainties are present in geriatric practice.

In the geriatric narratives, descriptions of the respondents’ and clients’ views of the future and its possibilities range from denial of a future to messages of recovery and possible return home. Persuading a client to change his or her outlook from one of seeing no future to one of seeing possibilities was a source of satisfaction to the respondents. But incidents of ambivalence among therapists and other staff members about the rehabilitation potential of older clients were also described. It is an undisputable, actuarial fact that the older one is, the more likely one is to die. Therapists in geriatrics live with the knowledge that their clients are in the last stages of life. Such knowledge is bound to change a therapist’s temporal way of being in their world of work. Van Manen (1990) referred to a temporal way of being in the world as a “lived time” (p. 104).
The lived time of doing occupational therapy with older persons contributes to the uncertain ideology of geriatric rehabilitation. After all, rehabilitation is all about hope for the future and return to a continuing, meaningful life. Therapists in geriatrics, however, are brought face to face with the finiteness of life and must somehow reconcile their ideology with a future that is short. For the respondent with the 102-year-old client, her sense of future for this man led her to question whether there was an appropriate role for her in this situation. We might conclude from this scenario that, for some therapists, satisfaction is strongly linked to the client’s likelihood of enjoying a reasonably long future. When a therapist senses that time is short, the point of it all is missing. But for other respondents in this sample, great satisfaction and personal pride were derived from being the lone ranger who recognized and worked for continuing improvement, continuing quality of life, and returning the client home when others had given up.

Perhaps a fundamental task of the geriatric occupational therapist is reconciling the realities of the older client’s brief future with the traditional ideological hopes and dreams of rehabilitation. To be able to accept the older client’s movement toward death at the same time that we facilitate return to functional independence and continuity is no small feat. As Becker and Kaufman (1995) stated, rehabilitation for older persons with chronic illness “seesaws between hope and hopelessness” (p. 182). The therapists in our study who found satisfaction in geriatrics were not thrown off balance by the seesaw; instead they adapted their roles and had the ability to value the here and now without giving up hope for the future.

References


