By now, demographic projections of the aging population are familiar to most people, and media-generated phrases such as "the graying of America" have begun to sound trite and overused. Older people account for an ever-increasing percentage of the total U.S. population. By the year 2020, people 65 years of age or older will outnumber teenagers in this country by 2 to 1. The oldest old (people 80 years of age or older) are the fastest growing component of the elderly population. To be even more precise, centenarians (i.e., people who have reached their 100th birthdays) constitute the most rapidly growing age group in the United States.

Thousands of occupational therapists and occupational therapy assistants work with older people. In the 1986 AOTA Member Survey (OT News, 1987), 14.8% of therapists and 22.4% of therapy assistants specified older adults (65 years of age or older) as their primary population of care. Another 30% in each professional category work with adults between 19 and 64 years of age, and yet another 22% work with people of mixed ages. Many of these therapists and therapy assistants are members of the Gerontology Special Interest Section, but many are not. The following questions arise: When does working with older people constitute a practice area of professional identity and specialization? If not by age alone, then by what is the practice of occupational therapy in gerontology defined?

Geriatric Occupational Therapy

A person who is 80 years old is both the same as and different from the person that he or she was at age 40. At 80 years of age, a person is experiencing life within a unique developmental context of age-related physical and psychosocial changes, such as sensory losses and family transitions. The context of their occupational behavior includes changing proportions of time spent in work, play, and self-care; different person/environment relationships; and changes in the meaning of daily activity. Their health context consists of a complex intermingling of wellness, acute illness, and chronic illness, which are superimposed on normal age-related changes.

And what about health care? Presently, the 12% of the population who are older people account for approximately 30% of all health care expenditures. Forty-two percent of all hospital days of care are used by the elderly. Twenty-two percent of all people over 85 years of age live in nursing homes, and almost 25% of elderly people living in the community...
have health-related difficulties with personal care and home management activities.

Therapists who recognize the uniqueness of the context of aging for their clients and patients and who are aware of occupational therapy's potential to enhance the quality of life in this developmental stage are most apt to identify themselves as specialists in gerontology. These therapists will be experiencing professional growth, excitement, and challenge for themselves while contributing creative ideas for practice and research to the field at large.

But many therapists and therapy assistants who work with older people do not recognize the special developmental, health, and occupational contexts of their clients. The practice of such therapists is indistinguishable from occupational therapy with all other adults. Perhaps these therapists did not have the benefit of special training in gerontology as a dynamic area of practice, or perhaps they practice in settings that do not acknowledge the special concerns of older clients. Perhaps they still hold to the belief that human development is a process that stops at puberty. Or perhaps they are working in gerontology, but their hearts and interests lie in another area of practice in which no positions are available. The clients, the work settings, and the occupational therapy practitioners all lose in these cases; the uniqueness of practice in gerontology is never realized or developed, and the client is deprived of services directed specifically to his or her contextual needs.

Paradoxically, although many therapists who work with older people do not think of their practice as an area of specialization, the profession does label it as such. This professional designation promotes the development of geriatric occupational therapy, but it can also result in disincentives to enter geriatric practice. The reluctance of educational programs to use long-term-care facilities for the mandatory Level II fieldwork assignments is a case in point. The image of specialization seems to obscure the fact that clients in long-term care present a very broad spectrum of occupational therapy concerns. These concerns may include postsurgical care, restorative rehabilitation for physical disabilities, independent living skills, meaningful interests and daily activities, mental health treatment, and community reintegration. All of the core areas of practice in occupational therapy are present in these settings.

Is geriatric fieldwork considered optional as a Level II experience because it is perceived as not providing the desirable age range for these experiences? Yet older adults are not a single age set. The age range of older people in any given facility will almost assuredly span 30 to 40 years. This span of years among mature adults produces a highly diverse population of people composed of many subgroups and of individuals with very different needs.

Is therapeutic nihilism at work? Depression is cited as running as high as 40% to 50% in long-term-care facilities. Ten percent to 15% of all people over 65 years of age have clinically significant depression, and twice that number are estimated to have mild depression. Is it because we believe this is not remediable that so few behavioral health treatment programs are developed for this group? In truth, depression in older age is one of the most treatment-responsive behavioral health impairments. Opportunities abound for the development of model programs in institutions and in the community.

Since evidence suggests that the fieldwork experience strongly influences the new therapist's ultimate choice of a practice area, and since the demand for health workers in gerontology keeps growing, this reluctance to use long-term-care facilities for Level II fieldwork works against the best interests of both the profession and the older population. The multidimensionality of the health concerns of aging people coupled with the inherent interdisciplinary nature of geriatric health care can yield one of the richest clinical experiences a student could ever have. The fact that people in these settings tend to be older and thus have unique contextual needs should not eclipse the fact that occupational therapy in these settings incorporates the depth and breadth of basic practice. The long-term-care settings that provide geriatric health care (e.g., adult day care, home health care, and nursing home care) all have the potential to provide this rich tapestry of clinical experience.

How do we address these problems? How do we generate enthusiasm and a drive toward self-education in those therapists who work with older clients (in any setting) but who are unenlightened concerning the specialized nature of geriatric occupational therapy? And how do we create an awareness in the profession at large that occupational therapy in geriatric settings provides diversity and exceptional opportunities for basic professional practice as well as for specialization?

**Education**

We must overcome our negative cultural and professional biases: Negative stereotypes are present in our views of older people and their "treatment potential," in our decisions about the care they should and should not receive, and in our views of geriatric care as an inadequate arena for fieldwork experiences. We must examine our own values and biases, individually and as a profession. Are we addressing gerontology only reluctantly because the demographics demand it, or are we taking it on eagerly because it represents a practice arena in which occupational therapy has much to offer? Does our present valuing of high technology, standardized testing, the medical model of practice, and the protection of occupational therapy territory preclude concomitant valuing of activities of everyday life, individualized assessment of basic function, nonmedical models of prevention, wellness and management of chronic illness, and interdisciplinary nonterritorial thinking? Can we, in fact, finally embrace gerontology because of the exciting opportunities it offers to occupational therapists for the enactment of the core of our practice and for leadership in health care services?

We must ensure that undergraduate and graduate curricula incorporate more dynamic content and a more positive image of geriatric practice through course work and fieldwork.
Textbooks published as recently as the mid-1980s are already out-of-date. Recent studies have dispelled long-held beliefs in the inevitable decrease in functions such as cardiac output and renal filtration rates and in the rise in blood pressure with age. That some physical changes with age are not inevitable kindles a tremendous sense of optimism and enthusiasm for working with older adults. What else is no longer held to be a truth? We must imbue our students and ourselves with a curiosity to challenge much of what is currently portrayed as normal aging or as irreversible. Our educational programs are ideal settings in which to inspire enthusiasm for this evolving, dynamic nature of geriatric practice.

Marketing Within the Profession

In recognition of the inescapable fact that demographics will to a large extent shape the future of our profession, can occupational therapists and the profession as a whole become more proactive toward geriatric health care concerns rather than continuing in a reactive mode? Can we expand our one-to-one clinician mindset to explore and develop roles as planners, administrators, and advocates in gerontology so that we can affect the system as well as the individual? Can we recognize, accept, and even nurture nontraditional models of occupational therapy that address service and reimbursement needs in restorative care and in prevention and maintenance?

As experts in the development and evaluation of activities programs, can we contribute to the pursuit of quality of life in long-term care facilities as urged by the Institute of Medicine's 1986 Report on Quality of Care? Can we develop a sense of community in geriatric facilities through the promotion of activities that enhance a feeling of belonging and an attachment to place?

Can we view the threats presently facing hospitals as opportunities for occupational therapy? The reduction in admissions causes a press for increased outpatient and community programs with revenue potential. The Medicare diagnosis-related group (DRG) system with its guidelines for length of stay increases the potential for rehospitalization without reimbursement because of the earlier discharges. Does this create an opportunity for occupational therapists to serve the family caregivers in posthospitalization programs, ensuring safety and performance in the home as patients resume functional activities?

Research

Proactivity and creditable leadership in gerontology may well depend on research. The conduct of research and the dissemination of research findings are the primary vehicles for communication within occupational therapy and across the many other disciplines that contribute to gerontology. If we are to reach for our rightful place in the sun, we must demonstrate creative and meaningful research productivity that has obvious significance to gerontology issues of practice. And we must share our research questions and results with audiences within the field of occupational therapy and with other disciplines.

It is important to stimulate the refinement and further development of geriatric occupational therapy. We must observe more critically the experience of well elderly in the community so that we may better understand how older persons learn to adapt and negotiate their environments to accomplish their daily living activities. We need to know much more about activity and the older person. Is disengagement really a form of emotional energy conservation as has been suggested by professionals outside our field? By far, the majority of older people are women. What are the cultural implications of this for our profession, which focuses on instrumental life tasks and social roles? How are the special needs of older women different from those of older men?

Great excitement exists for occupational therapists in gerontology because our practice focuses on the very heart of the profession—the balance of work and play and self-care and the interaction of these elements with the health of the person. There is a special satisfaction in being a specialist in geriatric occupational therapy and in bringing to gerontology the rehabilitation philosophy and the focus on function and independent living. Others may not know how to be a team member or may need to be reminded that function, not symptoms, should be the primary focus of work with older adults. These concepts come so naturally to us that we forget they are not given for other disciplines. They are derived from our professional socialization and from our professional culture. We can share that culture with others and provide leadership in interdisciplinary efforts. We can improve the quality of life for older people and, ultimately, for ourselves. And we can increase our profession’s visibility and maximize its potential ability to develop and provide quality treatment programs for elderly people.

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