Vocational Rehabilitation of the Older Worker

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Work is an important social role. A disability can interfere with a person’s work abilities and opportunities at any age. Unfortunately, the older population has received disproportionately little attention in rehabilitation, particularly in vocational rehabilitation. This is true, in spite of the fact that there is a growing population of older persons, with a high prevalence of disability. When returning an older disabled person to work, consideration of his or her particular physical, psychological, and social characteristics is required. This paper discusses the involvement of occupational therapists in the returning of older persons to work.

Work is one of the most important social roles a person fulfills in a lifetime. Work provides economic security, intellectual or physical challenge, and friendships and also helps to promote life satisfaction. Except for sleep, work consumes more time over the life span than any other single activity. The importance of work to an individual does not diminish as he or she grows older, as evidenced by the many persons who remain in productive roles after retirement.

A disability, whether it happens at a younger or an older age, often interferes with a person’s work ability and vocational opportunities. The major challenge for younger disabled persons is to enter the world of work. For these disabled persons, work is also important for gaining entrance into society, and employment is often seen as a sign of success in overcoming the limiting effects of a disability. Over the past several decades, the younger disabled population has enjoyed a fairly high degree of success in gaining employment. Much of this gain was achieved with the assistance of state departments of rehabilitation, schools, private insurance companies, and nonprofit rehabilitation facilities (e.g., Goodwill Industries).

Unfortunately, older disabled persons have not enjoyed the same degree of success. For this population, chances of returning to work after a disability in the later years are dramatically diminished. The vocational service, research, and training needs of the older disabled population have been relatively neglected during the past 50 years. The primary focus of services, even in a progressive field such as rehabilitation, has been on the younger person. Yet there are a number of reasons for focusing vocational (as well as physical) rehabilitation efforts on people 55 years old and older.

One reason is national economics: the Social Security system is rapidly going broke. When it was enacted in 1935, there were approximately 150 workers for every 100 retired persons. However, by the year 1990 there will be 116 nonworkers for every 100 workers (1), if most people retire at age 65 (and the trend is toward earlier retirement). Also, people today are living longer than they were in

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People also work for personal economic reasons. Many older persons simply cannot survive on the limited income from Social Security. One in four persons more than 65 years old already is near the poverty level (2). Industry also has a need to retain skilled workers (skills increase with age), and the shortage of skilled persons in some areas is becoming critical. Finally, premature and involuntary withdrawal from work because of a disability aggravates an older person’s physical health problems and adds to personal unhappiness; this further increases social costs and reduces the quality of life.

During the last 50 years, the age characteristics of the population have been changing rapidly, both with regard to normal aging and to disability. In 1900, the average life expectancy was 47 years, and only 2% of the population lived beyond age 65. Today, the older population (more than 60 years old) makes up about 12% of the population, and life expectancy is about 76 years (3). By the year 2020, that percentage should increase to about 17%. In the year 2030, one person in three will be more than 55 years old (4). This dramatic change is due to the control of childhood illnesses, the advent of antibiotics and other medicines, and the availability of better primary health care and improved public health.

The chance of becoming disabled increases substantially in later life, that is, from 3.1% for those less than 45 years old to 18.5% for the 55- to 64-year-old group (5). The activity-limiting disability rate increases further to about 56% for the more than 75-year-old group (6). Another way to view the relationship between age and disability is to note that about 40% of all disabled persons in the United States are now more than 60 years old (7). When older persons become disabled by a chronic health problem, they are usually more limited by it than younger persons (5). This is due to both the greater severity of the physical condition and to the presence of other chronic ailments (most of them musculoskeletal, cardiovascular, respiratory, and metabolic). Interestingly, older persons have fewer acute conditions than younger persons (5).

Also, the number of disabled persons who acquired their disabilities in younger life and who are now aging is rising. This includes people with early onsets of polio, spinal cord injury, arthritis, mental retardation, mental illness, and brain injuries. They are the first generation to live to a late age. Many of these persons are beginning to show what might be called “premature aging” of certain organ systems, a condition that is threatening their physical health and their work capacity (8). The very process of their successfully adjusting to their disabilities and pursuing a career may be speeding up their aging.

It is appalling, then, that although the prevalence of disability increases with age, the number of rehabilitation services available to the older population appears to decrease. The Rehabilitation Services Administration reports that in 1979, 97.5% of rehabilitated persons were younger and only 2.5% were older people. Even in physical rehabilitation, it is estimated that perhaps only 30% of the older disabled persons who could benefit from rehabilitation actually receive it (9, 10). Part of the problem is that older persons are simply not referred for rehabilitation services as frequently as younger persons. Far more older persons are excluded as “infeasible for rehabilitation.” Also, even if accepted, older persons are offered fewer vocational rehabilitation services (11). Thus, a wide disparity exists between the number of older persons who need rehabilitation assistance and the number who actually receive it.

This imbalance has been caused by the following factors: a) a lack of preparedness for this demographic change, b) a lack of understanding of the older person’s unique needs, c) a societal “ageism” (a prejudice against older persons), d) a system that has made it easier for older disabled persons to retire rather than to be returned to work, and e) the physical and psychological characteristics of the older persons. It should be evident that this problem can no longer be ignored.

Special Needs of the Older Person

If older persons are to return to work after a disability, their unique

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needs and characteristics must be addressed. Older persons are not simply young persons who have lived longer. Significant physiological, psychological, and social changes have occurred during the aging process. These changes often interact with changes brought about by the disability. Thus, to maximally assist the older person, it is necessary to have an understanding of both aging and the disabilities. For our purposes, the most critical age range is 55 to 70 years. However, with the growing number of older persons and the trend in rehabilitation to measure success in terms of independent living, the need to understand the more than 70-year-old population (the fastest growing group) will also increase.

The normal physiological changes that accompany aging are substantial. Normal changes include a gradual decrease in function and cell integrity in all organ systems at the rate of about 1% per year after the age of 20 years (12). By advanced age, this decreased function can affect physiological or behavioral functioning. For example, the average 70-year-old person’s kidney functions at about 40%. This reduction in function can in turn affect the excretion of many medicines, thus causing side effects. Because cells no longer divide in the aging person, the immune, cardiovascular, nervous, and musculoskeletal systems seem to serve as “pacemakers.” The integrity and adaptive capacities of each organ system thus determine the “rate of aging” in the mature person. Luckily, each organ system has surplus reserves, so that seriously impaired health does not occur unless there are multiple impairments or a capacity has been reduced to less than about 20%.

Older persons metabolize medicines quite differently because their bodies exhibit increased fat content, decreased water content, decreased albumin levels, decreased kidney and liver functioning, and altered functioning at the drug receptor site (12). The net effect of these differences is that for older persons a) dosages must be altered, b) some drugs are inappropriate altogether, and c) the likelihood of side effects (especially affecting performance) increases dramatically.

Sensory changes also occur in many older persons. Once they are 45 to 50 years old, most people need some corrective lenses. The ability to recover from a bright light decreases with age. Dark adaptation also decreases. By age 60, most people have decreased hearing ability, especially above 4,000 Hz.

Physical deconditioning is widespread among older persons. The average 55-year-old person is at 40% of vital capacity and physical stamina compared with a 20-year-old person. These physical differences can play a pivotal role in a person’s return to work after a disability, even if the differences are not directly caused by the disability.

The normal psychological changes that occur in later age are not major. Most people maintain their intellectual abilities until late in life, their personalities remain intact, and their interpersonal relations tend to remain the same (13). Even learned skills, such as those used on the job, remain fairly constant. Skill and productivity vary only slightly during the normal life span. Only tasks that are highly speeded, combine speed and complexity or agility, or are labor-intensive show large age differences. Even these differences are not substantial until about age 65 (14, 15). When Grumman Aerospace cut back its work force and used performance as the only selection criterion, the average age of its work force increased from 37 to 45 years (16). Even work injuries do not increase with age; they are proportionally higher for workers in the 20- to 34-year-old group (17). Also, older workers are rated as more stable, and more cooperative and reliable; and they use less sick leave, especially on Mondays and Fridays (18).

However, in the presence of a disability, the older person appears to be more handicapped than a younger counterpart, as measured by the likelihood of returning to work (11). This increased handicap is a product of physical, psychological, and socioeconomic factors.

The older disabled person is more likely to have multiple physical disabilities. Often, it is only the work-related disability that is called to the attention of the employer. Older persons are also more likely to develop secondary disabilities (e.g., deconditioning, infections, bed sores) while in rehabilitation than are younger persons, and they generally take a little longer to achieve the same degree of benefit in rehabilitation (19). More important, the psychological and socioeconomic problems of older persons are usually not given enough attention, and these problems play a large role in vocational rehabilitation. While normal psychological changes with age are minimal, the disability-related changes are immense. At least four psychological characteristics are important with older persons in vocational rehabilitation. First, older persons are more likely to become discouraged about returning to work (20, 21). Second, older persons with a disability are about three times more likely to develop a depression or a...
severe dysphonic state than are their younger counterparts (22). Depression or dysphoria in the presence of a disability is prevalent in nearly 20% of older persons. These problems often go unnoticed because they are displayed differently in later life. Instead of displaying the typical symptoms of sadness, crying, guilt, and expressed hopelessness, the older person is more likely to report memory problems, vague aches and pains, sleep disturbance, and anxiety. Older people tend to focus on physical problems and find it difficult to admit their psychological difficulties to a (usually younger) doctor. Depression, of course, will hinder any rehabilitation attempts. Third, older persons are more likely to believe that they are expected to retire when they have a disability in later life. Finally, older persons are more likely to make irreversible decisions about retirement (11). Once they decide to retire, it is hard to have them reconsider.

In terms of socioeconomics, it may be easier for many older persons to retire than to continue working. The media emphasize the pleasures of retirement, a spouse may be working to help provide an income, Social Security and other pension plans are offering more attractive earlier retirement plans, extended medical benefits are available, and the rehabilitation system, with its limited resources, centering on the younger person.

**The Occupational Therapist’s Role in the Rehabilitation of the Older Person**

Because of their background and training, occupational therapists are well qualified to deal with the complex problems encountered in the vocational rehabilitation of the older person. Together with vocational counselors, occupational therapists are the key persons that can help a disabled older person to return to work. Because of the therapist’s traditional involvement with work evaluation, hand function, and activities of daily living, he or she can help in the transition from “patient” to “worker.” Concurrently, occupational therapists can play a vital role in educating physicians, other allied health personnel, third-party payers, and employers about the unique problems of the older person, their unique advantages, and some of the positive things that can be done to improve employability.

As the above discussion suggests, work ability lies at the intersection of physical, psychological, and socioeconomic factors. The occupational therapist plays a unique role in that he or she can assist in all three areas. In addition to providing traditional therapy, the occupational therapist can aid in the vocational rehabilitation of the older person by a) constantly stressing that the patient’s ultimate success is heavily dependent on all three spheres, b) promoting early rehabilitative intervention to prevent discouragement and the development of deconditioning, c) understanding the unique physiological differences between the young and the old (e.g., drug metabolism, secondary disabilities, altered presentation of diseases), and d) establishing reasonable expectations of the length of time it will take an older person to return to work.

In the physical rehabilitation of older rehabilitants, the assessment of transferable skills is very important: Fewer older than younger persons are interested in retraining as a means of returning to work (25% vs. 60%) (23). Perhaps this is due to the fact that older people do not want to invest a great deal of time to returning to work or do not find school to be age-appropriate. Likewise, insurance carriers and state departments of rehabilitation are less inclined to support training programs for older workers, preferring on-the-job training or immediate placement on a job (23).

The occupational therapist should also perform an analysis of the job demands in relation to work capacities, develop assistive devices or methods to improve function, relate the results to the rehabilitation counselor, and attend to new or previously undetected problems that may affect the older disabled person in the work place.

The occupational therapist should also address the psychological needs of the older persons. First, the older person needs help with making a decision on whether or not to return to work. The therapist must evaluate whether the decision is based on realistic expectations and on accurate information (even older persons are susceptible to the myths on aging: “you can’t teach an old dog new tricks,” etc.). Second, programs must be set up to help older persons who become discouraged or even depressed...
while trying to return to their old job or while looking for a new one. “Mini goals” (steps toward employment) should be established and reinforced (e.g., writing a resume, making a list of possible job contacts). Group support in the search for employment helps create a sense of cohesion and comradery; however, individual counseling should be arranged to deal with feelings of discouragement that cannot be verbalized in a group. Third, it is vital to help the older person maintain a self-concept of “worker.” The therapist should relate as many of the therapeutic activities to work objectives as possible. Fourth, the involvement of the family is important, because families provide the bulk of ongoing care and support to older persons. A family’s support and understanding of the rehabilitation objective is particularly influential in the transition period between medical rehabilitation and early vocational efforts.

The occupational therapist is also skilled in vocational planning. Older persons need support in finding a new job or in returning to the old employer, especially in a different position. Most people need counseling about what they can realistically expect. Older persons usually have not had to search for a job for many years. Some may even have forgotten how they originally got their job. Few have had to “sell” themselves to an employer. Some may even feel that searching for a new job is demeaning or otherwise threatening and thus will want to abandon their efforts. For example, many older persons, if they return to work, will face a change in status, a change in location, a decrease in earnings, or a different supervisor. Because these experiences may involve feelings of loss, which normally increase in later years, they should be clarified before the person begins work.

Salmon (20) has discussed the counseling issues of loss with older persons. Intensive job placement assistance was shown to be more important for older persons than for younger persons (11). Some of the useful job placement techniques are courses on how to prepare a resume, videotaped “mock” interviews for feedback, “Job Club” approaches, which provide group support for placement efforts, and intensive “networking” training, which focuses on cultivating the personal contacts developed over the years that can be used for job leads.

The occupational therapist can work with insurance representatives and employers to help dispel the erroneous myths surrounding older persons and to point out the cost savings of retaining a skilled worker. Most employers respond favorably to hiring a person who can be shown to be a valuable employee.

Summary

The older person is faced with many serious obstacles in returning to work. These include physical, psychological, and socioeconomic differences. Older persons do, however, retain a wealth of work capabilities that make them suitable for employment. Occupational therapists can play an important role in this area by providing appropriate understanding of principal age changes, the unique psychological status of the older person and the different vocational needs of this group.

References