

## Rehabilitation of Older Persons Disabled by Cancer, Stroke, and Heart Disease

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### **Abstract:**

Rehabilitation of older persons disabled by cancer, stroke, or heart disease is discussed. Aspects of each disability are described, and the importance of timely and appropriate intervention with older persons is emphasized. Barriers generally faced by older disabled persons are briefly outlined.

### **Article:**

Rehabilitation counselors possess a unique combination of skills and knowledge that can make them invaluable resources in current and future efforts to address the needs of older adults. The current growth in the population of older adults can be expected to continue both in absolute numbers and relative proportion of the total population (Blake & Peterson, 1979). According to the Chartbook on Aging in America prepared for the 1981 White House Conference on Aging, in 1900 there were only 3.1 million people over 65 in the United States, and they constituted 4% of the population. By 1980, 11% of the population, a total of 25 million, was over 65, and 46 million persons were over 55. By the year 2000, it is expected that 54 million persons will be over 55, and 12% of the population, or 32 million, will exceed the age of 65. During the first two decades of the next century the ranks of the 55-and-over population will continue to swell as the "baby boom" generation grows older. This population shift, combined with economic factors that probably will delay retirement and lead to extended involvement in the work force, has profound implications for the delivery of rehabilitation services to older clients.

Older persons generally tend to have more chronic illnesses than do younger adults, and they often have multiple health problems (Blake, 1981; Myers 1983), Brotman (1982) pointed out that persons over 65 have twice as many disabilities and four times as many limitations in activities as younger persons. Heart disease, stroke, and cancer are among the most prevalent conditions, It has been documented that 85% of "older," White, male adults died of one of these diseases. The comparable figure for White women was 70%, and it was slightly less for Blacks. Heart ailments accounted for the largest number of deaths, approximately 64% for men and 50% for women. Furthermore, Butler and Gastel (1979) have reported that one-half of all cancers, the second leading cause of death, occurs in persons who are over 65.

Jernigan (1981) asserted that although individuals between 60 and 75 years of age tend to have serious health problems, many of these difficulties are preventable, including heart attacks, strokes, and cancer. He also pointed out that there are many survivors of such health conditions who are left with chronic disabilities. Jernigan stated that early efforts at rehabilitation with this group can do much to prevent progression of disability, and he added that restoration often has a reasonable chance of success. As increased attention is paid to expenditure of health care dollars, it is expected that there will be greater emphasis on a rehabilitation-oriented approach before acute hospitalization is needed (Brummel-Smith & Kemp, 1984).

Although many older people with identifiable physical problems could be helped by rehabilitation services, frequently these services are not provided. In 1979, only 2.4% of service recipients of state vocational rehabilitation agencies were over 65 (Blake, 1981), yet older persons constituted 11% of the population. Ironically, the rehabilitation system is particularly suited for helping older persons live more satisfying, productive, and healthy lives (Barry, 1981; Barry & Bozarth, 1980). Bias against older persons may be as

critical as feasibility of vocational goals in determining whether services are provided. As Benedict and Ganikos (1981) pointed out, older disabled persons are subjected simultaneously to the stigmas of ageism and handicapism. When rehabilitation considerations are discussed, the interrelatedness of these various factors must be considered.

## **BARRIERS TO REHABILITATION OF OLDER PERSONS**

Barriers to rehabilitation of older persons may be encountered in several interrelated areas. These include societal attitudes and behavior of rehabilitation and medical professionals and programs.

1. Societal attitudes: Ageism—myths and stereotypes, Myers (1980) identified several myths that reflect negative cultural stereotypes and keep employers from hiring older disabled workers, Older workers are believed to be slow, more frequently absent, unable to meet job demands, inflexible, rigid, and unable to learn new skills. Butler (1975) has coined the term ageism to denote the negative beliefs held about an older person solely on the basis of age. As Myers (1980) pointed out, "age, in and of itself, does not have to be a job handicap" (p. 39). Society itself erects the attitudinal barriers that must be overcome.
2. Program and policy barriers. D.J. Dunn (1981) pointed out programming factors that work against the older disabled worker within the state-federal vocational rehabilitation program. Because the number of years an older person can work after rehabilitation are likely to be fewer than for younger clients, the rationale for providing case service funds is weakened. In some states, clients over 45 are considered "less feasible," and administrators may require extra justification before authorizing services. In addition, chronic aspects of conditions presented by older persons may be perceived as more difficult to manage, and older persons can be seen as less suitable prospects for rehabilitation than younger workers. The three disabilities in question, heart disease, cancer, and stroke, have their own additional barriers within the rehabilitation system. Other related systems, such as Social Security ceilings on earnings, also present obstacles to successful attainment of rehabilitation goals. Age discrimination in employment may be encountered as well (Myers, 1980).
3. Attitudes of medical and rehabilitation professionals. Attitudinal barriers among service providers can be highly detrimental to the older person seeking services. Negative beliefs held by medical and rehabilitation professionals can have a potentially tremendous impact on the older person, particularly if these beliefs are internalized by the client and his or her family. In addition, the attitudes of the service provider will affect his or her behavior and the delivery of service. It is critical for rehabilitation professionals to examine their own perceptions and beliefs and to acquire accurate information to counteract any negative stereotypes that they might have.

Because as many as 86% of all non-institutionalized older persons are believed to have at least one chronic health problem (Brotman, 1976), rehabilitation counselors can expect to see more older clients for whom such a chronic condition results in a disability. Older persons are more vulnerable to the three critical health problems that are the focus of this article: heart disease, stroke, and cancer. In this article we identify factors that can have an impact on the rehabilitation of older persons with these particular disabilities and outline strategies for achieving the maximum effectiveness of rehabilitation efforts.

## **HEART DISEASE**

According to Brotman (1982), 27.4% of non-institutionalized persons over 65 years of age report heart disease. Although all chronic heart conditions do not necessarily constitute a disability, a substantial number of older persons are disabled by heart disease.

Cardiovascular disease is disabling both psychologically and physiologically (Goldenson, 1978). The physical limitations that accompany heart disease have been studied extensively. Only recently has the condition of cardiac neurosis been defined as the debilitating fear of incapacity and death that causes many cardiac patients to perceive themselves as far more severely handicapped than their physical symptoms alone imply (Brammell, McDaniel, Niccoli, Darnell, & Roberson, 1979).

Successful rehabilitation of individuals with cardiac disease certainly is possible regardless of the patient's age and functional capacities. Providing early rehabilitation services seems to be the most critical factor because individuals may adjust more quickly if they can return to work as soon as possible (Fitzgerald, McGowan, Kutner, & Wenger, 1982). An estimated 70% to 90% of all persons having myocardial infarctions can return to work. Three-fourths of them are able to return to their former work, although as many as one-third will require some modifications of preexisting job tasks. The likelihood of a return to work decreases after 6 months and approaches zero after 1 year or if the client was not working at the time of the attack (Goldenson, 1978).

Return to work is most probable when appropriate treatment is provided, including counseling (Sanne, 1979). It is best for the client to return to work as soon as possible, usually within 6 to 14 weeks after myocardial infarction, initially on a part-time basis, with a gradual return to full-time. It is, however, sometimes necessary for persons with cardiovascular disease to change jobs. Extremely physically demanding jobs, such as construction, labor, or lumberjacking, often are precluded (Goldenson, 1978). Sheppard and Rix (1977) found that older unskilled and manual workers are four times as likely to stop working for health reasons as are persons of the same age in technical or professional jobs.

To facilitate appropriate job placements for persons with cardiovascular disease, the American Heart Association has developed a scale to assess both functional capacity and its relationship to work capacity. The functional classification system developed by the New York Heart Association (see Brammell et al., 1979) is as follows:

1. No limitation—no symptoms with ordinary activity
2. Slight limitation—comfortable at rest; symptoms with ordinary activities
3. Marked limitation—comfortable at rest; symptoms with less than ordinary activity
4. Discomfort with any activity—may have symptoms at rest

In evaluating the work capacity of persons with cardiovascular disease, four factors should be considered (Brammell et al., 1979). First, the medical diagnosis, as determined by cardiac functional studies must be considered. Second, the physical demands that are made in the course of a day's work both on the job and going to and from work should be evaluated. Third, it is necessary to determine the amount of exertion involved in dealing with the social environment. Fourth, the extent to which unwarranted fear is a barrier must be examined and treated. The response to a heart attack or other cardiac problem is, of course, critical to rehabilitation outcome. Myer (1983) found that older clients were more accepting of their illness and had more positive feelings about having survived than did younger clients. Such an attitude may foster the rehabilitation process for those who experience it.

Counselors have a vital role to play in education and stress management because perceived stress can be decreased if clients are able to change and learn new ways of reacting to stressful events or life problems (Brammell et al., 1979). Siegler, Nowlin, and Blumenthal (1980) emphasized the importance of behavioral interventions to modify health-related risk factors among older adults. Stress or anxiety on the job may originate with the client, the employer, or the job itself and may necessitate a job change if appropriate intervention does not occur.

In working with older persons, one must realize that cardiac problems may be accompanied by other health problems that may compound the cardiac disability. Arthritis, depression, nutritional deficiencies, and infections are examples of such health problems that may be arrested through early detection and treatment (Jernigan, 1981). An older person's problems generally are multifaceted and require a multidisciplinary approach to rehabilitation.

It also is important to note that many older persons do not report cardiac problems. There can be difficulties with perception of pain so that an individual reports fatigue or indigestion when he or she actually is having an acute myocardial infarction. Other reasons for a person not reporting a condition include equating the disability with age, depression, or limited access to medical resources (Jernigan, 1981). There are needs for more aggressive cardiac rehabilitation programs and for improved screening methods to implement prevention programs. Community and patient education should complement early referral and intervention by rehabilitation professionals (Perlman, 1979).

When working with older adults, the scope of assessment should include social, environmental, and financial considerations in addition to medical factors (Person & Gatz, 1982) because all of these factors are interrelated and have an impact on rehabilitation outcome. Brummel-Smith and Kemp (1984) pointed out that "disability in all persons, but especially in older persons stems from the interaction of biological, psychological, social, economic, and political factors" (p. 5). This interrelatedness of factors has been seen in the rehabilitation of older persons with heart disease and can be seen in the following section on rehabilitation of older persons who have had strokes.

## **STROKE**

The average age of onset for cerebrovascular accidents is 60, although strokes may occur at any age (Anderson, 1981). A variety of incapacitating symptoms may occur, any of which may affect work capacity. These include motor weakness or paralysis; impairment of vision, eye muscle paralysis, and double or narrowed vision; occasional pain primarily due to contractures; impaired communication, both verbal and written; visual perceptual disturbances, impaired depth perception and spatial judgement; and, most commonly, depression (Rusk, 1977).

Residuals from a stroke can add to existing limitations that may occur with age. Verwoerd (1981) pointed out that general homeostatic capacity, recuperative ability, resilience, and energy gradually decline in older years. For this reason, stresses, both physiological and psychological, may have a greater impact than they did earlier in life. Dowd and Dowd (1981) asserted that physical illness may have a greater impact on the mental health of older persons than on younger persons. The rehabilitation counselor who is aware of the potential for depression can be prepared to provide needed counseling services. In working with older persons who have experienced a loss of some of their physical and mental abilities after a stroke, one must recognize the value attached to self-sufficiency and independence. Although the principle of retaining maximum client involvement in decision making and maintaining client autonomy is critical in work with all rehabilitation clients, it is especially important for older clients who have been independent for their entire adult lives. The client's success in maintaining a feeling of control over his or her life seems to be related to the maintenance of gains and, thus, to a successful rehabilitation outcome.

Rehabilitation should focus on independence rather than convalescence with therapy to improve coping skills and activities of daily living. Vocational evaluation to determine work skills is particularly valuable because of the complex nature of the limitations involved. In working with older stroke patients, it is important to observe the interaction of the effects of the stroke with possible effects of age (Birren, Woods, & Williams, 1980). For example, Benton (1977) found a significant interaction of age and brain damage on simple reaction time and that older people with brain damage had markedly slower reaction times.

Older persons also may require the rehabilitation counselor to modify various services. Adapting the retraining programs to the learning style of the older person can result in improved comprehension and outcome. It may be necessary, for example, to conduct shorter sessions, to wait after giving instructions to make sure the necessary information has been absorbed, and to structure carefully the training so the older person understands exactly what is expected.

Job changes are frequently necessary, requiring intensive vocational and personal counseling with the client who has suffered a stroke. Job changes may be accompanied by depression and frequently result in lowered

status and income. Sheltered workshop placements may be advisable and possible for stroke patients if severe impairments make competitive employment unfeasible because of the complex involvement of multiple physical and psychological factors. With less severe strokes, however, competitive vocational placements are feasible.

Several factors affect the prognosis for successful rehabilitation of older persons who have had strokes. In a study of 55 older workers, some of whom had suffered strokes, Morrison and Magel (1984) found that motivation to return to work was high for 84% of the sample. Of the 55 participants, 37 did return to work and most of these returned to their former jobs. The finding that severity of limitation and client motivation affect the success of rehabilitation for older disabled individuals is relevant in considering rehabilitation of older persons who have had strokes, and also for those with heart disease and cancer.

Because "older people with mild to moderate limitations can be rehabilitated and can often return to employment" (Morrison & Magel, p. 60), rehabilitation direction may depend on degree of impairment rather than age of client. Older disabled persons frequently have long job histories and high motivation to work. Morrison and Magel also found that for many older persons only limited rehabilitation services were required to move the individual toward reemployment.

Older disabled persons are more likely to have long work histories and frequently are highly motivated to work. A chronic condition may be complicated by the effects of age or by the existence of other illnesses. Thus, older persons may possess unique strengths along with a profile of limitations, and rehabilitation often is possible with the delivery of a limited number of services.

## **CANCER**

According to Goldberg and Habeck (1982), cancer has had poor visibility in the rehabilitation system until very recently. Even with numerous legislative and administrative changes, clients with cancer constituted only 0.6% of the total successful vocational rehabilitation closures in 1979. Numerous factors account for this low number, and fear and aversion to the word cancer may be part of the problem. Older persons with cancer may often be victims of the dual stigmas of "ageism" and cancer.

The American Cancer Society (1981) reported an estimated 805,000 new cases of cancer occurring each year. According to Goldberg and Habeck (1982), there are approximately 3 million Americans living today who have survived cancer, and it is estimated that one in four persons will eventually have cancer.

A marked increase in survival rates has occurred with the medical advances of recent years, and such improvements can be expected to continue. Uniformly negative assumptions about the course and outcome of cancer are outdated, and attitudes toward persons of all ages with this disability need to be appropriately modified. Research indicates that persons with cancer who have a strong work history are easier to rehabilitate than are other victims (Goldberg & Habeck, 1982). In view of the potentially substantial work history of the older person with cancer, the rehabilitation process may in fact require less vocational counseling, training, and work preparation than is necessary for younger cancer victims.

Many cancer patients return to their previous careers. Career change, however, may be necessary for some persons because of decreased physical capacities and cosmetic changes that result in withdrawal from occupational interaction. Career change requires attention to needs for realistic, long-range planning and for vocational counseling. Both are important for eliminating the development of feelings of despair and frustration and for restoring a sense of control over one's life. Personal counseling to foster self-esteem is critical to placement success and must include a realistic assessment of the course of the illness.

Persons with cancer often experience unique problems, including "living with the unpredictable nature of cancer, gaining a sense of control over the disease, handling a subtle form of social rejection, and undergoing lengthy rigorous treatment modalities such as chemotherapy" (Lebow, Maisiak, Sanders, Soong, & Cain, 1982,

p. 231), In working with older clients with cancer, one also must consider the additional problem of reduced reserve capacity, which may accrue with age (Macione, 1979). Early psychosocial assessment and intervention by a rehabilitation counselor can contribute to the client's successful return to work and community living (McCollum, Powell, & Gaiser, 1978).

The rehabilitation counselor is potentially a valuable member of the cancer rehabilitation team for older clients. The rehabilitation counselor may provide skilled assessment and restoration services as well as emotional and educational support for the patient and his or her family. In addition, the counselor may coordinate services and make referrals to other agencies (Lebow et al., 1982). In working with older clients with cancer, counselors need to be aware of discriminatory practices that do occur and be prepared to assume an advocacy, role. In addition, an outreach effort may be necessary in delivering services to this group because older persons with cancer frequently do not know that they may be eligible for rehabilitation services (Mayo Comprehensive Cancer Center, 1977).

A variety of specific counseling approaches can be used with older individuals with cancer. Dolan, Allen, and Sawyer (1982) recommended that rehabilitation counselors use relaxation techniques to help their clients reduce the anxiety-based pain, nausea, and sleep disturbances that may accompany cancer. Such techniques may have need to be adapted if there are any sensory deficits present in the older individual, and it should be remembered that such techniques may seem strange to an older person. A logical explanation with clear information can help overcome this barrier.

Another area of counseling that may benefit older persons with cancer, or with the other disabilities described, is assertion or social skills training. Individuals who become disabled and return to work may require specific skills to manage the social aspects of a medical disorder or disability (M.E. Dunn & Herman, 1982). For example, an older person who returns to work after cancer treatment may need to address fear and aversion felt by co-workers or to correct misperceptions. An older person who has had a heart attack may need to learn how to set limits to minimize the stress or demands in his or her environment. The stroke patient may need to learn to ask for help without losing his or her feeling of self-confidence or may wish to learn to refuse help that is not required. Such skills can be useful for achieving the maximum potential of a variety of individuals.

As can be seen from this brief review, approaches to rehabilitation of older persons with cancer also may be applicable to other disability groups. Certain commonalities occur in the rehabilitation of older persons.

## **CONCLUSION**

A variety of approaches to the rehabilitation of older persons with heart disease, stroke, and cancer have been outlined. Certain similarities that exist through the general field of rehabilitation of older persons also appear repeatedly in this article. Rehabilitation of older persons is multidimensional and requires a multidisciplinary team approach. Generally, older persons who are disabled have more than one chronic condition, and the physical impairment interrelates with social, psychological, and economic factors. Previously held negative beliefs about the prognosis for rehabilitation are changing in light of current research (Morrison & Magel, 1984).

Rehabilitation of older clients is a process that requires specific knowledge and skills. Knowledge about the effects of aging and how age may interact with disability is essential to effective service delivery. Older disabled individuals may be highly motivated and excellent candidates for rehabilitation, and services delivered may require adaptation on the basis of the needs and goals of the older client.

Working with older persons is in some ways different from working with other age groups. The rehabilitation counselor can be an active advocate for older persons who have cardiovascular disease, stroke, or residuals of cancer but to do so effectively requires a positive, optimistic outlook, combined with a sincere interest in older clients and belief in their work potential. It is important to recognize that some older persons will have disabilities so severe as to preclude even part-time work. Independent living rehabilitation, however, may still

be feasible. Vocational and independent living rehabilitation need not be mutually exclusive alternatives. Measures of outcome may have to be adjusted to include such goals as achieving maximum independence, slowing or halting decline, or maintaining current level of functioning.

Rasch (1979) found that rehabilitation of the older age group is as economically feasible as it is for young age groups. Growick and McMahon (1983) pointed out that older persons may require different services on the basis of varying needs. For example, older persons are likely to spend more time receiving restoration services and less time in training. Growick and McMahon encouraged counselors to become more responsive to the needs of older persons, particularly as the number of older clients being served increases. In delivering services to this group, it is important to use specialized knowledge and skills to be more responsive to the needs of older clients. Rehabilitation counselors have tremendous potential to address the growing need for services among older persons who are disabled.

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