RECREATIONAL THERAPY
FOR OLDER ADULTS

Nancy E. Richeson
Betsy Kemeny
I would like to dedicate this book to my dear friend and mentor, Dr. Linda Buettner. I met Linda at an ATRA conference, and when I sat next to her at a luncheon, we became fast friends. She always encouraged and supported my work and made research and professional activities engaging, and most importantly fun! Linda, thanks for all you did for the profession of recreational therapy.

–Nancy Richeson

I would like to dedicate this book to my sister, Nancy Bagwell Jones, who has been the primary caregiver for my mother, Irene, for many years. I give tremendous kudos to my sister who, as a caregiver, gracefully embraced the challenges related to aging described in this book. In the baby boomer generation herself, she cared for our mother at home. Later, she experienced all the levels of care and transitions through the health care system. Nancy, thank you for your compassion and determination to promote a better quality of life for mom.

–Betsy Kemeny
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Introduction

The purpose of the book, *Recreational Therapy for Older Adults* is to provide a comprehensive textbook for any college or university teaching an undergraduate or graduate course in recreational therapy or therapeutic recreation for older adults within their curriculum. A textbook that provides information that connects to health and human service competencies in the field of geriatric, gerontology, and interprofessional practice is desperately needed. Therefore, the textbook will provide an overview of gerontology and geriatric topics in addition to best practices in recreational therapy. Currently there are no textbooks in existence for teaching this course. This textbook will be key to providing a workforce that is qualified to provide services to an aging world. In addition, the approximately 30% of the CTRSs who work with older adults will want to purchase this book for their professional libraries.

Textbook Organization

Each chapter will include objectives, key words, an introduction, specific content for each chapter, conclusion, reading comprehension questions, suggested classroom activities, test questions, and references. In addition, many chapters will provide case studies and text boxes highlighting best practices.

Chapter Highlights

Chapter 1 will provide an overview of recreational therapy services for older adults, federal laws impacting older adult services, and definitions of old, including chronological vs. biological age, frisky, fragile, frail, young-old, old-old, and the oldest of the old. In addition, terminology surrounding the study of older adults such as geriatrics, gerontology, ageism, culture change, National Council for Therapeutic Recreation Certification (NCTRC) data, and global aging will be addressed.

Chapter 2 covers demographics, health disparities, social security, Medicaid, Medicare reimbursement, and the Center for Medicare and Medicaid Federal tags (CMS F-tags) that effect recreational therapy practice. Furthermore, information on the recreational therapy process, non-drug approaches to care, and care transitions will be discussed.

Chapter 3 highlights biological aging and reviews typical processes of aging by the body systems. An overview of chronicity, including the compression of morbidity is discussed. A comprehensive section on healthy aging is provided that includes access to health care and supportive services, age-friendly communities, aging in place, brain health, caregiver quality of life, care coordination and transitions, nutrition, physical activity, obesity, self-management strategies, and social engagement.

Chapter 4 discusses the biological factors and theories of aging and longevity. Concepts such as life span, life expectancy, and healthy life expectancy are reviewed.
Moreover, a variety of biological and environmental theories of aging are presented. Lastly, the anti-aging medical movement and blue zones are debated and discussed.

Chapter 5 focuses on chronic and acute conditions and geriatric syndromes. The top five chronic health conditions (heart disease, cancer, stroke, diabetes, chronic respiratory disease) and common acute illnesses (pneumonia, influenza, common cold, acute bronchitis, urinary tract infections, diarrhea, shingles), along with many geriatric syndromes (dementia, delirium, incontinence, falls, osteoporosis, weight loss) are presented.

Chapter 6 helps the recreational therapist understand the psychological perspectives, including mental health and mental disorders experienced by older adults. Creativity, wisdom, intelligence, and memory are presented, and mental disorders such as neurocognitive disorders, delirium, depression and anxiety disorders, major depression, dysthymia, and minor depression are discussed. Rounding out the chapter is an overview of psychoactive medications and the use of non-drug approaches to care are provided.

Chapter 7 informs recreational therapy practice by highlighting theoretical concepts. A review of health promotion models such as the health belief model, the transtheoretical model, and the international classification of functioning, disability, and health is provided. Many social and psychological theories are presented that can guide practice. Examples include, but are not limited to role theory, activity theory, successful aging, optimizing health and well-being through therapeutic recreation, positive psychology, person-directed care, and gerotranscendence.

Chapter 8 provides the reader with a comprehensive review of assessment in recreational therapy for older adults. A discussion on why practitioners need to conduct assessments, the communication skills required along with useful and practical comprehensive assessment information. You will find assessments on cognition, physical function, screening techniques, mood, anxiety, delirium, pain, quality of life, federal assessment (MDS 3.0), and the Buettner Assessment of Needs, Diagnoses, and Interested in Recreational Therapy in Long-Term Care (BANDI-RT).

Chapter 9 offers numerous recreational therapy interventions for older adults. An overview of the Dementia Practice Guidelines is provided along with interventions that support behavior management, cognition, falls, healthy aging, hospice, palliative, and comfort care, depression, pain management, and physical interventions.

Chapter 10 encourages the reader to consider the many roles of the recreational therapist. The chapter highlights the role the Ombudsmen Reconciliation Act (OBRA) has played in clinical practice, the differences between recreational therapy and activities professionals, and the many roles of the recreational therapist. For example, how we can affect an older adult's quality of life and the role of the recreational therapist in culture change. In addition, a discussion on the recreational therapist's many roles such as the expert clinician, trainer and educator, and consumer of evidence.

Chapter 11 reviews the many job settings a recreational therapist may work. There are many more job opportunities to work with older adults besides long-term
care and skilled nursing facilities. Examples include, but are not limited to; home care, PACE programs, Hospital Elder Life Programs (HELP), mental health services, and palliative and hospice services. An appendix is provided to the reader that includes work the authors and their colleagues have done over the many years they have worked in recreational therapy.
About the Authors

Nancy E. Richeson is a recreational therapist and gerontologist with 38 years of professional experience. She is a professor emeritus from the University of Southern Maine and is currently the Director of Therapeutic Recreation at the University of Wisconsin—La Crosse. She is the editor-in-chief of the American Journal of Recreational Therapy (AJRT) and a fellow, distinguished in recreational therapy with the National Association of Recreational Therapy (NART). She has a Ph.D. from the University of Nebraska in Gerontology, a Certificate in Gerontology from the University of Nebraska at Omaha, and has been a Certified Therapeutic Recreation Specialist since 1982. She has served on the board of directors for the American Therapeutic Recreation Association (ATRA) and the National Council for Therapeutic Recreation Certification (NCTRC). Dr. Richeson was also the Older Adult Section leader for ATRA for many years. She has had numerous publications and presentations in the field of recreational therapy and gerontology.

Betsy Kemeny is Certified Therapeutic Recreation Specialist and Certified Professional Gerontologist with 29 years of professional experience. Her work experiences have included outpatient rehabilitation, adult day, assisted living, hospice, and long-term care. Dr. Kemeny has presented more than 30 times and published seven peer-reviewed works on the topic of older adults. She is currently an assistant professor in the Recreational Therapy program at Slippery Rock University and is a fellow, distinguished in recreational therapy with the National Academy of Recreational Therapy. Dr. Kemeny received her bachelor's degree in Sociology at Wake Forest University, her master's degree from the University of North Carolina at Chapel Hill, and her Ph.D. from Indiana University of Pennsylvania. Since 2014, Dr. Kemeny has served on the board of directors for the American Therapeutic Recreation Association and is currently the secretary. Dr. Kemeny served as the co-chair of the Older Adult Section for ATRA from 2003-2006.
Introduction to Recreational Therapy and Older Adults

Betsy Kemeny

Objectives

The reader will be able to do the following:

- Define recreational therapy services for older adults
- Describe OBRA 1987 and its implications for recreational therapy
- Explain the difference between young-old, old-old, and oldest of the old
- Define geriatrics, gerontology, elder, senior citizen, older person
- Explain the implications of ageism and what recreational therapists should do
- Describe the culture change movement
- Explain why recreational therapists need to study aging

Key Words

Ageism, biological age, culture change, chronological age, elder, fragile, frail, frisky, geriatrics, gerontology, global aging, long-term care, OBRA 1987, old, old-old, oldest of the old, recreational therapist, senior, young

Introduction: Recreational Therapists Should Study Aging

Recreational therapists work on interdisciplinary teams in various health care settings that serve older adults. OBRA 1987 was legislation that specifically addressed the quality of long-term care for older adults. This chapter will describe the reasons for recreational therapy students to learn more about older adults. In order to better understand services for older adults, it is helpful to understand the difference between chronological and biological age, geriatrics and gerontology, as well as the various names that people call older adults. Ageism represents stereotypical views based upon a person’s age. These misperceptions actually hurt older adults for
a number of reasons. Recreational therapists should advocate for a balanced view of aging.

**Recreational Therapy Services for Older Adults**

In order to provide services to older adults, recreational therapists work on the interdisciplinary team in various health care settings throughout the community. Based on the level of care needed, the recreational therapist’s role with the older adult may vary based on a wide variety of factors. Older adults may live independently in the community in their own home, with their family members, in a continuing care retirement community (CCRC) or HUD-sponsored senior apartments. Older adults may reside in assisted living, personal care boarding homes, skilled nursing facilities, hospice or group homes. Recreational therapists also work with older adults in acute care settings such as hospitals and rehabilitation hospitals (ATRA, Older Adult Section, 2017).

Although the recreational therapist may be given the title “activities director” in some facilities, the role of a CTRS** is not merely focused on planning activities in long-term care. Recreational therapists “treat and maintain the physical, cognitive, and emotional well-being of their clients” (CMS, p. A-18). According to the Centers for Medicare and Medicaid Services (CMS), the role of the CTRS** is to “reduce depression, stress and anxiety, recover basic motor functioning and reasoning abilities; build confidence; and socialize effectively” (CMS, p. 1-18).

According to ATRA, “Recreational therapy is a systematic process that utilizes recreation and other activity-based interventions to address the assessed needs of individuals with illnesses and/or disabling conditions, as a means to psychological and physical health, recovery, and well-being. Further, recreational therapy is a treatment service designed to restore, remEDIATE, and rehabilitate a person’s level of functioning and independence in life activities, to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participating in life situations, caused by illness or disabling condition” (ATRA, 2015).

In long-term care, assisted living, and retirement communities, recreational therapists provide services and therapy interventions to maintain or improve a person’s functional abilities to the highest practical level, while enhancing an individual’s quality of life. Individuals served in these settings may live with chronic medical conditions, severe pain, permanent disabilities, and dementia or Alzheimer’s, as well as requiring ongoing assistance with activities of daily living or need for some type of support or supervision. In physical rehabilitation and sub-acute/step down units, Recreational therapists provide medically necessary therapy services, under the direction of a physician designed to improve or enhance an individual’s functioning and return to life activities. These services may be provided in rehabilitation after a hospital stay, upon recovery from an illness, injury or surgery. In community-based settings and services, recreational therapists provide interventions to maintain or improve a person’s functional abilities to enable them to live in the community for as long as possible. This may include, but is not limited to: exercise, balance and oth-
er physical interventions; cognitive skills training and stimulation; recreational and social activities to promote engagement or interaction; coping and support groups; educational programs related to aging, health, finances, and community resources; and promoting community involvement and engagement.

**Table 1.1**
Areas of Focus for Recreational Therapy with Older Adults (Adapted from ATRA website)

<table>
<thead>
<tr>
<th>Area of Focus</th>
</tr>
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<tbody>
<tr>
<td>Reducing depression, stress, and anxiety</td>
</tr>
<tr>
<td>Improving motor functioning</td>
</tr>
<tr>
<td>Increasing cognitive skills</td>
</tr>
<tr>
<td>Assisting to establish routines</td>
</tr>
<tr>
<td>Increasing tolerance and endurance for participation in life and social activities</td>
</tr>
<tr>
<td>Improving social interaction and skills</td>
</tr>
<tr>
<td>Enhancing coping skills</td>
</tr>
<tr>
<td>Maintaining strength, balance, and endurance</td>
</tr>
<tr>
<td>Assisting with community integration after an illness or disabling condition</td>
</tr>
<tr>
<td>Promoting active aging, wellness, and healthy living</td>
</tr>
</tbody>
</table>

**Federal Law Impacting Older Adult Services**

The Omnibus Reconciliation Act (OBRA) of 1987 and the Nursing Home Reform Act created standards for how nursing home care should be provided. In addition, it specifies the rights of residents in facilities. In order to receive Medicare or Medicaid funding, the long-term care facility must provide services so that each resident can “attain and maintain her highest practicable physical, mental, and psychosocial well-being” (CMS, 2017).

As a federal law, OBRA states that an activity department must be directed by a “qualified professional.” A CTRS® is considered a qualified professional. In addition, qualified professional for a long-term care facility includes activity professionals certified by the National Certification Council of Activity Professionals (NCCAP), Occupational Therapists (OTR/L), and Occupational Therapy Assistants (COTA). Moreover, some individuals who take a state approved training course can be considered a “qualified professional.” If a person is not a CTRS®, OTR/L, or COTA, to obtain certification as an activity professional for long-term care, a person must have a high school education (NCCAP, 2017). The individual must also take two 90-hour on-line modules and 30 hours of continuing education (NCCAP, 2017).

OBRA specifies what long-term care facilities are required to provide in terms of activities. The federal regulations, updated in 2017, are detailed in Chapter 3.
Defining “Old”

Chronological vs. Biological Age

A distinction exists between chronological and biological age. Chronological age refers to the years that a person has lived. Biological age more closely relates to how a person is functioning (Tuttle & Maier, 2018). While aging typically happens gradually, each individual ages at a different rate. Disease and functional impairment contribute most significantly to the variation. In other words, one 80-year-old woman may be completely able to live independently and work or volunteer every day. On the other hand, a different 80-year-old woman may require 24-hour care due to functional limitations. Biomedical, social, and environmental factors influence aging in an individual. Therefore, it is important to conceptualize age as multidimensional definition that captures how an individual functions and feels (Tuttle & Maier, 2018). As a CTRS**, it is not appropriate to make placement or programmatic decisions based only upon a person's age. Biological or functional age is more helpful for decision-making. Within these boundaries, the literature on older adults establishes categories for the aging population. While limited by individual differences in biological age, these generic categories provide insight that all adults over 65 should not be lumped together.

Frisky, Fragile, Frail

One categorization of older adults that captures biological age rather than chronological age is that of “Frisky, Fragile, and Frail.” With increasing age, there is an increased risk of frailty. The definition of frailty has multiple aspects that include weight loss, lack of physical activity, and lack of strength (Puts et al., 2017).
In addition to the physical construct or phenotype, some definitions of frailty include psychological, social, cognitive, and environmental problems that make the older adult vulnerable to decline (Dury et al., 2018). The prevalence of frailty in community-dwelling older people is approximately 10% (Collard, Boter, Schoevers, & Oude, 2012).

**Young-Old, Old-Old, Oldest of the Old**

Another categorization is based on chronological age. Ortman, Velkoff, and Hogan (2014) use U.S. Census data to divide the population into young-old, aged 65-74, old (75-85), and old-old (85+). More recently, oldest old category has been added to include old (aged 75-84), old-old (85-94), and oldest-old (95+) (Cohen-Mansfield, Blumsteing, Shorek, Eyal, & Hazan, 2013). When researchers compare individuals in these categories, a number of trends tend to surface. The oldest old use nursing and dentistry services more frequently and manifest a decline in function (IADI, ADL, cognitive function, and mobility). When comparing the cross-sectional age categories, the researchers found no difference in depression or loneliness. However, when the participants were tracked longitudinally (the same person over time), research indicates that depressed mood and loneliness did increase over time. Decline in subjective sense of well-being did not decline over time except when the person experienced institutionalization, lost their spouse, or had a change in health status.

**Terminology Surrounding the Study of Older Adults**

**Geriatrics**

Geriatrics is a branch of medicine that specifically focuses on older adults' medical conditions and disease processes. In order to be a Geriatrician, a person must first become a physician with three years of residency in internal medicine. After the residency, the physician pursues one- to two-year fellowship training in geriatrics. In addition, there is a specialty certification exam (American Medical Association, 2018). Geriatric psychiatry focuses on the impact of acute and chronic physical illness on mental health, and the pathology of primary psychiatric disturbances of older age. In their practice, they focus on preventing, diagnosis and treatment of mental and emotional disorders in older adults (American Psychiatric Association, 2018). Geriatric psychiatrists also pursue a geriatric fellowship for additional training after they have completed a residency in psychiatry. The American Board of Psychiatry offers a specialty certification in geriatric psychiatry.

**Gerontology**

Gerontology, on the other hand, is a multidisciplinary study of aging that focuses on promoting healthy aging. A wide variety of disciplines are represented in gerontology to include medical professionals (physician, nurse, social worker,
recreational therapy), economists, biologists, psychologists, and sociologists that are involved in the scientific study of aging (Gerontological Society of America, 2018).

**Preference in Terminology**

What do older people prefer to be called? There are a number of terms that are currently used, including *older adult, elder, senior,* and *elderly.* When National Public Radio conducted a poll, 43% of the older adults surveyed suggested that they preferred the term “older adult,” while about 30% preferred “elder,” and 30% preferred “senior” (Ericksonliving, 2018). In some connotations such as work and school, “senior” is a positive term that means holding a higher or authority position. The connotation of “elder,” a leader or person of high esteem, is also positive. However, when senior is paired with “citizen” or elder has an added “ly,” the connotation is more negative.

**Ageism**

Ageism is stereotypical views and discrimination based on a person’s age. Ageism can be an active bias against older adults, but an older adult can also buy into these beliefs about themselves. Ageism is not limited to older adults. Even when parents refer to the “terrible twos” or “tumultuous teens” to describe the behavior of a two year old or teen, the stereotyping based on a person’s age can be detrimental. The misconceptions or stereotypes about older adults involve an association between aging and inevitable decline that is not reversible. Another misconception is that of older adults being seen as “other” or not part of the community. Researchers found that older adults were perceived by some as an external group that is in competition for resources with other groups (Lindland, Fond, Haydon, & Kendall-Taylor, 2015).

Because of ageist stereotypes, older adults can suffer needlessly. Misperceptions of aging can block effective public policy and practices. Examples exist in the workforce and the current practice of medical treatment of older adults. The negative perceptions that decline is inevitable in older age can lead to a public perception
that nothing can be done to promote better outcomes for older adults (FrameWork, 2018). Even when they are capable of doing excellent work, older adults may be kept from being hired because of their chronological age (Neumark, Burn, & Button, 2017). With the aging of the population and decrease in hiring of older workers, this will add to the “dependency ratio,” or lack of workers who can provide services. When physicians categorize all older adults similarly, they may be overtreated or undertreated (Robbins, 2015). Moreover, although older adults may be viewed as vulnerable, there is a lack of public policy to protect older adults and their financial resources (Setzland & Watson, 2015).

Eight national organizations (AARP, American Federation for Aging Research, the American Geriatrics Society, the American Society on Aging, the Gerontological Society of America, Grantmakers in Aging, the National Council on Aging, and the National Hispanic Council on Aging) have come together in the Reframing Aging Project in order to promote a better understanding of both the needs and contributions of older adults (Frameworks, 2018).

The strategy for changing public policy has four main communication goals: 1) Redefine the concept of aging itself so it is seen as any other stage in life with both challenges and benefits; 2) Change the public understanding that wellbeing in later life is impacted by social policy and structures; 3) Elevate an understanding that ageism exists; and 4) Create a sense of shared ownership for the needed change (FrameWorks, 2018). Recreational therapists can be positive change agents. The profession can support prevention to promote greater health and well-being for older adults. No matter what setting, CTRS** should try to promote the opportunity for older adults to be involved in civic and community life. In a long-term care setting, this might even mean more than trips. Residents should have the opportunity to be actively involved in community life. CTRS** should also be invested in the prevention of frailty.

**Culture Change**

In long-term care, there is a movement to transform older adult services in order to promote choice, dignity, respect, self-determination, and purposeful living. The culture change movement is based on person-directed values and practices to include the voices of older people and those working with them (Pioneer Network, 2018). Culture change or transformation involves all the disciplines in the long-term facility. However, recreational therapist may be leaders in culture change initiatives in the facility.

**Why Recreational Therapists Need to Study Aging**

**NCTRC Data**

According to NCTRC (2018), 29% of Certified Therapeutic Recreation Specialists (CTRS**) currently work with older adults. The fact that a third of the CTRS** work with older adults suggests a need to be prepared specifically to serve the older
population. Even in settings that are not typically thought of as “geriatric,” such as rehabilitation or acute care, there is a need to understand aging because of the amount of older adults who use these services. For example, 40% of the hospitalized patients are over 65 years old (Schmader & Auerbach, 2008). Other disciplines, such as physicians and nurses have noted the need for preparation to work with older adults as well.

**Global Aging**

Another compelling reason for recreational therapists to learn more about aging is that the overall population worldwide is growing older. Over the last 30 years, there have been dramatic changes in the percentage of individuals who are over 65 in the population. These changes have not only occurred in the United States but throughout the world at large. Other changes in the aging population, such the differences by sex and ethnic/racial status, are also important to understand. As the demographic changes, a higher percentage of occupations will be serving older adults. According to the Bureau of Labor Statistics (2018), the growth in health care occupations is mainly due to the increase in older adults in the population. In Chapter Two, the global aging phenomenon will be described in detail.

**Conclusion**

There is a need for specific education for recreational therapists in order to be prepared for the growth in the percentage of older adults in the population. Not only is the older population expanding, the oldest-old population is growing exponentially. Recreational therapy students who are going out into the workforce
in the future should be prepared to provide excellent care to older individuals. Recreational therapist may be serving older adults in a variety of settings, not only long-term care, but also in the community.

**Reading Comprehension Questions**

1. What are some of the settings in which recreational therapists work with older adults? What are two types of settings that you would like to learn more about?
2. What was the main focus of OBRA 87? How has it been updated in recent years?
3. What is the difference between chronological and biological age?
4. What is the difference between geriatrics and gerontology?
5. Explain the categories of young-old, old-old, and oldest of the old. Why is an understanding of the various categories of older people helpful in better understanding their needs?
6. Describe the categories of frisky, fragile, and frail and why these categorizations are important to better understand aging individuals.
7. What is the basis of ageism? How is ageism detrimental to older adults? How should CTRS’s try to advocate against ageism?
8. What is culture change and how might it impact long-term care in the future?
9. What are some reasons that recreational therapists should be well prepared with knowledge about older adults?

**Suggested Classroom Activities**

1. Using common magazines, each student will be asked to cut out various pictures of older adults and share with the class their picture(s). Facilitate a discussion about how older adults are presented in advertisements and feature stories. Encourage students to describe how the images in the media may differ from accurate representation.
2. Using a group of current advertisements on Youtube, ask each student to pick one that interests them. Facilitate a discussion about how older adults are presented in advertisements and feature stories. Encourage students to describe how the images in the media may differ from accurate representation.
3. Ask students to write a reflection in which they write simple answers to a series of questions about aging. Fill in the blanks A. When I am old, I.... B. Growing old means.... C. Growing old makes me feel... D. The older I become... E. Old people never... F. A person is considered old when... G. When I see someone old, I ..... 
4. Conduct a pre-test of using the AGHE competency standards. The post-test can be conducted at the end of the semester (See Appendix).
5. Assign students a demographic question about older adults (i.e., how many older adults live beyond 100 in America) and give them time in class to search these websites to figure out the answer.

**Age Data**
http://www.census.gov/population/www/socdemo/age.html

**Agency for Healthcare Research and Quality**
http://www.ahrq.gov/data

**A Profile of Older Americans**
http://www.aoa.gov/AoARoot/Aging_Statistics/Profile/index.aspx

**Statistics on the Aging Population**
http://www.aoa.gov/AoARoot/Aging_Statistics/index.aspx

6. Have the students complete the “myths of aging” quiz on their own. Follow it with a class discussion about why the answers are true or false. This is an excellent teaching tool for uncover unconscious bias toward older adults.

### Multiple Choice Questions

1. Geriatrics is
   a. the multidisciplinary study of aging that includes sociology and psychology and focuses on healthy aging.
   b. the branch of medicine that focuses on middle-aged adults.
   c. the branch of medicine that focuses on older adults.
   d. pursued only by those with a PhD in sociology.

2. Gerontology is
   a. the multidisciplinary study of aging that includes sociology and psychology and focuses on healthy aging.
   b. the branch of medicine that focuses on middle-aged adults.
   c. the branch of medicine that focuses on older adults.
   d. pursued only by those with a PhD in sociology.

3. According to the NCTRC,
   a. only a very small proportion of recreational therapists currently work with older adults.
   b. 61% of CTRS*s work with older adults.
   c. 29% of CTRS*s work with older adults.
   d. working with older adults does not fit within the scope of a CTRS*.

4. Culture change involves
   a. working with older adults in encouraging involvement with the fine arts.
   b. supporting individuals’ goals and objectives.
c. a movement to change the atmosphere of long-term care to promote respect.
d. is an effort by nursing to make the facility better for the residents.

5. Ageism involves
a. stereotypical views about people based on age alone.
b. what young people think about older people.
c. active discrimination against old people.
d. acknowledging young people are more important than old people.

6. What do the majority of older people prefer to be called?
   a. Older adult
   b. Elder
   c. Senior
   d. Senior citizen

7. Frailty
   a. refers to physical decline in an older adult.
   b. refers to the old-old population above 85 years old.
   c. includes physical decline and psychological, social, cognitive vulnerabilities.
   d. includes only emotional issues.

8. What is the purpose of FrameWorks?
   a. To reframe the discussion about culture change
   b. To reframe the discussion about poverty
   c. To launch a public relations campaign to better understand needs and contributions of older adults
   d. To frame portraits of older adults in a positive way

9. Chronological age is
   a. the age that the person feels or seems.
   b. the number of years that the person has lived.
   c. the most important marker to understand older adults.
   d. great help in determining goals and objectives.

10. What is the best way to divide the categories young-old, old-old, and oldest old?
   a. Young-old is 50-60, old-old is 60-80, and oldest old is 80+.
   b. Young-old is 65-75, old-old is 75-85, and oldest old is 85+.
   c. Young old is 65-74, old is 75-84, old-old is 85-94, and oldest old is 95+.
   d. Young old is 45-55, old is 55-65, old-old is 65-80, and oldest old is 80+.

Answers: 1. c, 2. a, 3. c, 4. c, 5. a, 6. a, 7. c, 8. c, 9. b, 10. c

References


