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From editors

The second demographic transition¹ and the phenomenon of double aging² is shaping the new demographic structure of the world and regions for humanity. By improving our standards of living, thanks to the advancement of medicine, we live longer and our quality of life is better. The slogan “Add life to the years that have been added to life” is implemented through national public policy (social).

More and more research is being done on diagnoses, factors that optimize the successful aging. WHO (1999, 2012) presented a long list of them. There are recommendations for all generations, all spheres of human life. It emphasizes, among other things, the importance of daily physical activity, proper dietary habits, efforts to maintain good health.

The importance of integrating old people with the family, the local community, and the religious community has been highlighted. Social harmfulness of stereotypes of old age, ageism have been emphasized as well as the role of lifelong education and intergenerational dialogue. Modern analyzes of health relate to the holistic system, including mental well-being (mental and emotional), physical, social, spiritual and relate to opportunities for productive social and economic life.

Authors of texts in the current issue of the *Exlibris Social Gerontology Journal* consider these factors.

The volume begins with the text of Kate de Medeiros. An American scientist relates the stories of the lives of the elderly in the inner perspective of great and small narratives, setting the prospect for narrative gerontology in an interdisciplinary collection of science.

-
- 1 Surplus of deaths over number of births, strong correlation between declining fertility, decreasing mortality and aging of the population.
 - 2 Demographic terms, meaning dynamic, the fastest increase in the share of people over 85-year-old in the general population, the aging of the “top” of the pyramid age.

The topics of learning old age and in old age, taking care of personal health and intellectual health were taken by Jerzy Semków. He pointed to spiritual development as the main factor in the successful development of old age.

Anna Tylikowska and Kinga Tucholska have indicated a new topic of gerontological analysis – they referred to film therapy that can be applied in sociotherapy and psychotherapy of the elderly. They proposed a practical reference to group therapy using a particular film work.

Danuta Wolska drew attention to the difficult subject: intellectual disability in late adulthood. Thanks to advances in science, raised standards of care, people with intellectual disabilities live longer. Their humanity is irreducible, but in the population aged 43 years and older, regressive, involutional changes occur. These changes should be taken into account when planning the social and occupational activity of adults with intellectual disabilities and when planning care for them.

Trends of carnality are becoming more and more important in the culture of postmodernism, taking care of the body, its condition is becoming more and more common practice, also old people. The text of Karolina Talar contains an overview of the history of concern for health, the body, the physicality of man. It shows the transformations of humanity's relation to the question of one's own body. Describes the role of physical activity in extending life.

Marvin Formosa introduced the public policy of Malta to the elderly, its aims, directions and forms. The study is an interesting example of a well-thought-out strategy to support aging and old people in their health and development.

Nadia Lutsan dealt with a similar problem. She wrote about contemporary Ukraine, the needs of the elderly. She pointed to the basic problems of lack of qualified staff, lack of social and medical assistance for pensioners, poor financial situation and prejudicial social stereotypes. The author presents the main forms of state aid for Ukrainian pensioners.

Renata Konieczna-Woźniak presented a local policy of successful old age embedded in the space of a large Polish city: Poznań. Aging-friendly cities should pay special attention to space and buildings without barriers, friendly transport, housing adapted to the needs and capabilities of seniors. Social and civic participation of older people, respect and social inclusion are also serious challenges. The other challenges are communication and community support and health care.

Beata Bugajska, Rafał Iwański, Marta Giezek, Adam Ciemniak described the prosenioral institutional resources of Szczecin, another big Polish city. The areas and forms of help presented to the old inhabitants were presented. The text contains recommendations to optimize the social support provided by the city.

Volume is completed by: Joanna Wnęk-Gozdek's text on painting works of two Krakow's supercentenarians – in view of the expected "explosion of centenarians", information on the results of the research described in the doctoral dissertation of Łukasz Tomczyk and Katarzyna Sygulski's report of the International Scientific Conference

“Healthy ageing – multidisciplinary perspectives, life-span applications” (Krakow, Poland, March 23–25th, 2017).

I encourage you to read
Zofia Szarota

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ARTICLES

Part I
Studies and discourses

ARTICLES

Kate de Medeiros¹

Narrative Gerontology: Introducing the Field

DOI 10.24917/24500232.131.1

Key words: narrative gerontology, stories, autobiography, writing, interviews

Abstract

Narrative gerontology is a growing approach to understanding the experiences of later life. Narratives provide a type of raw material to gain an “insider’s perspective” on older age. The term “narrative” (coined in 1994) describes various types of stories that can range from a few sentences to a grand that covers a person’s lifetime. Depending on discipline (e.g., anthropology, medicine), narratives can be used in different ways (e.g., understanding perspectives within culture, understanding a patient’s perspective on an experience or condition). Key considerations regarding narrative gerontology include how best to elicit a story, the difference between big and small stories, analytical strategies, and issues of power, perspective and language. Overall, narrative gerontology isn’t limited to one single approach but instead encompasses many perspectives linked to putting experiences into words.

Interest in narrative methods in gerontology, the social sciences, medicine and others has increased dramatically over the past several years. Yet, many remain unclear on exactly what “narrative” entails including narrative as a mode of inquiry and/or research method and strategies for narrative analysis. This paper presents research on the historical use and theoretical development of narrative approaches and brings together a wealth of perspectives on narratives that will benefit researchers interested in considering incorporating narratives in their work.

In gerontology, the study of narratives plays an especially important role since narratives provide a type of raw material from which to gain an “insider’s perspective” on

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later life. As Kenyon, Clark and de Vries (2001) argue, “we age biographically as much as we age biologically, psychologically, and socially” (p. xx). Of course, we also age culturally. The types of stories we are given directly influence which experiences can be made known in a given situation. Narrative gerontology is therefore a broad term describing many ways that aging and older lives can be understood through stories (narratives). Narrative gerontology can be thought of as a framework to examine how people, cultures and societies come to know and reveal themselves to others through stories. It is also an approach to understand how stories, personal and public, mingle, change, and become co-authored by others.

What is Meant by “Narrative”?

In their classic work on narrative, Labov and Waletzky’s (1967) define narrative as any sequence of clauses that contains at least one temporal juncture. Narratives are about events or experiences that occur in time rather than random words or phrases having no time-based connection. Rather, narratives normally serve the function of personal interest from the point of the teller or speaker; the order of events disclosed cannot be changed without changing the inferred sequence of events. For Labov and Waletzky, the structural aspects of how the narrative unfolds is an important part of the story. Labov (2003) later updated the definition to include the following criteria that narratives must include reportable events, temporally ordered and centered around the narrator’s theory of causality. In other words, the narrator frames the story, including the details and order of events disclosed, around their central idea of what caused the event to occur in the first place. In addition, this revised definition grounds narrative in the experience and expressions of the teller/speaker and distinguishes narrative from story types such as stream-of-consciousness, or strictly imagined happenings unless they can be retold.

Other definitions of narratives include Donald Polkinghorne’s (1988) “the process of making a story, to the cognitive scheme of the story, or to the result of the process – also called ‘stories,’ ‘tales,’ or ‘histories’” (p. 13) or Gay Becker’s (1997) “the stories that people tell about themselves. Elliott Mishler (1986) takes a slightly different view suggesting that the most important part of a narrative is the quality of mind by the speaker/writer that is transmitted to the listener/reader through characterization, motivation, description, and commentary. For Mishler, it isn’t the way in which events are presented but rather the larger, deeper meaning that is at the heart of narrative.

Given these multiple, complex views of narrative, narrative in this paper will be simply defined as a telling some aspect of self through ordered symbols, whereby symbols can include language, images, movement, and other forms of expression (de Medeiros, 2013). This brief definition of narrative conveys the notion of temporality to some degree in that narratives have an ordered telling or plot. Events unfold in a way that the narrator hopes can be interpreted by the listener/reader. This definition

also speaks to Mishler's point of quality of mind in that some aspect of the narrator is being represented in the narrative. In other words, there is a point to the story that the narrator wants to be made known. It should be noted that although the focus in narrative is typically on stories told through language, stories are not restricted to language and can be told through other forms of expression (e.g., painting, dance.)

Some common terms used in conjunction within narrative are discourse, biography, autobiography, memoir, life story, and life review. Discourse is a broad term referring to expression through language (Labov, 2003); narratives are a type of discourse. The next three terms describe literary genres which are types of narratives. Biography is an account of a real person told by someone else with emphasis on capturing the subject's temperament and endeavors (Abrams & Harpham, 2011). Autobiography is a narrative written by a real person about him or herself an account autobiography with emphasis on his/her developing self over time (Eakin, 1999). Memoirs are similar to autobiographies except that the emphasis is on events rather than on the person (Abrams & Harpham, 2011). A life story describes stories people tell about their own lives and is generally in the form of narrative (Linde, 1993). Life stories can be oral or written. Finally, the life review is a purposeful reflection on past life events and their meaning. The life review is associated with psychiatrist Robert Butler, who coined the term in 1963, to describe people's need to revisit and come to terms with past conflict (Burnside, 1996; Butler, 1963). The life review doesn't necessarily take the form of narrative, although it can.

Brief History of Narrative Gerontology

James Birren, Hans Schroots, Gary Kenyon and Jan-Eric Ruth are among the scholars in gerontology credited with the development of narrative gerontology in the 1990s. Jan-Eric Ruth (1994) is cited as the person who coined the term. Kenyon and Ruth (1996) continued developing the concept, drawing from scholars in narrative psychology such as Jerome Bruner (1991). Kenyon and Randall (1999) describe narrative gerontology as a type of heuristic rather than a particular theory or method. Instead, it is lens through which to see aging, specifically through how experience is put into story form and what those stories say.

Another important feature of narrative gerontology is that it is not limited to stories alone or the use of stories as a form of data but also considers how various dimensions of stories (e.g., plot, word choices, themes, genre) can help build synergistic links of knowledge about growing older between and within disciplines (de Medeiros, 2011; Kenyon, Ruth, & Mader, 1999). As narrative gerontology has evolved in concept and scope, so have methods, analytical strategies, and interpretive stances. The next section explores some of the ways in which narratives have been used in various disciplines which focus on later life. Subsequent sections take a closer look at different analytical strategies.

Overview of Narrative in Research by Discipline

Given the multi-disciplinary nature of gerontology, how narratives are defined, obtained, and used can differ slightly. The following provides some examples of how narratives are used in different disciplines.

Anthropology. For anthropologists, “narrative” may focus on stories of and about cultures, including the culturally constructed self. This type of narrative research, therefore, extends beyond the story itself and instead encompasses the larger cultural factors (e.g., values, norms, ideals) that influence how narratives are told and what they mean. Such narratives may be analyzed for overarching themes, or presented in the form of case studies for a focus on particular participants. For example, Barbara Myerhoff’s (1980) well-known work about a retirement community in California was based on stories told by the informants about their experiences. Her goal was to understand the culture of the community through the stories people told. Other anthropologists have used narratives to understand cultural constructions of later life experiences such as being childless (Rubinstein, 1987), suffering (Black & Rubinstein, 2004), and generativity (Rubinstein, Girling, de Medeiros, Brazda, & Hannum, 2014). Narratives in this discipline are typically oral, obtained through one-on-one, semi-structured interviews over a series of time or multiple interviews.

Humanities. Scholars from the humanities may use narratives, fictional or otherwise, to consider the ways in which perceptions of self and reality are filtered through the complexity of language and genre (e.g., autobiography, letter). The story is the focus in this perspective. Often, the narratives are written (e.g., a novel), but not always. Ray (2000), for example, used narratives written in a life story writing class to better understand older women’s constructions of self.

Medicine and Nursing. Physician Rita Charon (2011) practices a type of narrative that she calls narrative medicine. She describes the “novelization of the body” in medicine or “the exposure of the body’s plot, form, voice, temporality, and governing images” (p. 47). For her, narratives unfold in clinical encounters between clinicians and patients. The role of the clinician is to elicit such narratives and, through careful listening, gain insight into what the patient is experiencing. The field of nursing has used narratives in a similar way (Burnside, 1996; Jones, 2003), sometimes combined with reminiscence or life review techniques. As with narrative medicine, the goal is to gain an understanding of the person and, as a clinician, to help address that person’s need in the best way possible.

Psychology. In slight contrast, narratives in psychology are often more linked to understanding the context of behaviors or emotions than on the story itself. The focus on narratives in this case is on the explanation they can provide for a given action or outcome as opposed to narratives acting as a way to better understand the cultural milieu. These narratives may be analyzed for specific details (e.g., names of people or events), for grammatical structure (e.g., use of passive voice) or other features that

provide insight into a person's inner world. Narratives have also been used to understand mental health issues such as depression (de Medeiros & Rubinstein, 2015) and as an intervention to improve memory performance and self-concept (Bluck & Levine, 1998; de Medeiros, Mosby, Hanley, Pedraza, & Brandt, 2011; Labov, 2003)

Public Policy. Narrative research in the realm of public policy explores how stories are strategically constructed and positioned to exert influence (Clark, 2007). In other words, using stories (e.g., experiences of older people with housing challenges) to create a larger narrative for action (e.g., increased government support for housing) is one way that narratives are used in policy. Another approach involves studying the way that policy arguments are made (i.e., the stories that they tell) to better position counter-arguments.

Sociology. Although sociology has long recognized the importance of personal narratives and individual lives (Elliott, 2005), many have pointed to tension between quantitative and qualitative approaches (Richardson, 1990). Sociologist Arthur Frank (1991), used his own experience with cancer to create an illness narrative. Using an approach he calls "thinking with stories," Frank (1998) argues that rather than acting on stories, as in the role of "expert" or analyst, people should let stories act on them (Frank, 2010). In other words, rather than coming to a narrative with a pre-formed idea of what the narrative should be or should express and a sense of professional distance from emotions, listeners/readers should open themselves up to emotional possibilities.

Interviews, Stories and Analysis

The past section discussed some of the ways that narratives are used in disciplines to understand experience. This section will provide more information on narratives can be elicited and analyzed. As mentioned earlier, narratives can be oral or written. How one obtains the narrative will greatly affect what is told through the narrative. Also important to consider are the many stories that occur within a story, the big stories and small stories. Finally, various analytical approaches can bring out different aspects of what's being told beyond the basic plot and action.

Eliciting a narrative. A question that invites a responder to tell a story (e.g., "tell me about a time when you were afraid") is different than a question that invites a responder to provide an answer (e.g., "Have you ever been afraid?"). In the first, the interviewer is asking for a story. In the second, the interviewer seems to be asking for a "yes" or "no" response and will likely not elicit a narrative. How a question is asked is very important when doing narrative work.

Eliciting a narrative can be as simple as asking, "Can you tell me a story about x." However, the interviewer (in the case of an oral interview) or listener/reader plays a significant role in shaping what stories are voiced. Consequently, stories may not represent some hidden "truth" about the responder but may simply serve to reconfirm what the interviewer had expected in the first place. Consider a questions by an in-

interviewer to a responder: “Tell me about a time when you were frightened about your health?” If the responder begins a story that is seemingly unrelated, (e.g., “Well, I come from a large family in the East”), the interviewer may be tempted to interrupt to keep the responder on track (e.g., “Could you just tell me about when you were frightened about your health?”). In this example, the resulting story may be one that the interviewer is interested in but not necessarily one that is important to the responder. The responder will quickly “learn” what the interviewer wants to hear and will alter his or her responses accordingly. It is therefore important to be aware of how the interviewer, questions, narrative type, or other considerations shape what stories are being told.

As mentioned earlier, genre or literary form can also shape what is told. Genres such as autobiography or traditional life story approaches, can also limit the types of stories that are told. Autobiography, for example, is a genre that developed based on the public accomplishments of men. Life stories, which often use a memoir format, also predispose the writer to highlight publically recognizable milestones in a person’s life, such as marriage, education, career. Although these may be important to some aspects of the person, other important experiences may be entirely omitted due to the limits of the genre. Often times, though, the potential of narrative is not realized because of limitations in how the narrative is obtained.

However, many times, researchers look for “spontaneous” stories or stories that occur as a result of another action or question. For example, researchers studying a topic such as pain in later life might want to know about the types of stories people tell in relation to their own pain. They may therefore ask to tell a story when pain was unbearable or when the person first became aware of pain. This will elicit a different response than simply asking if the person had experienced pain. Of course, stories about pain may emerge in a question asking about a life story. This latter example is the type of spontaneous story that can occur outside of the interview question.

Big stories and small stories

As mentioned earlier, there are roughly two types of narratives that one can study in the context of oral or written work: big stories and small stories. Bamberg (2006) and others distinguish between what they call big stories, or the fully developed, comprehensive narratives about our lives, and small stories which refer to types of narrative activities such as allusions to other stories or brief stories (in comparison to big stories) to include stories about events in the present and future as well as hypothetical events (Watson, 2007). Big stories are akin to over-arching narratives such as a complete story of one’s life or a full narrative on how one chose a career. Small stories are the “mini” stories that occur within the big story. For example, in a big story where a person tells about choosing a career, there are likely many small stories about friends, situations that came up during the process that challenged the career path, and other

seemingly small moments. To use an analogy, the big story is the chapter, the small story a few lines within the chapter.

Big stories are widely recognized as topics of research. For example, it is common in many gerontological research studies that use narrative to ask the responder to tell the story of his or her life or to tell a story about something, as was addressed in the previous section on eliciting narratives. However, what's often overlooked are the small stories that are embedded within the larger story. In the previous section, the example of a narrator who was seemingly getting sidetrack was used: Interviewer: "Tell me about a time when you were frightened about your health?" Responder: "Well, I come from a large family in the East". Although the response may at first seem off topic, it is actually a small story embedded within the larger story of becoming frightened about his or her health. These small stories can be analyzed on their own or juxtaposed to the larger story. Both approaches are discussed in the next section.

Analytical strategies. There are multiple analytical strategies one can use with oral or written narrative data. Much depends on the research question and the richness of the data available. This section will briefly describe eight strategies: 1) the entire story (Riessman, 1993); 2) bounded stories (Labov, 2003); 3) context of the story (Teun, 1997); 4) critical analysis (Clark, Kenyon, Bohlmeijer, & Randall, 2011); 5) indexicality and positioning (Watson, 2007); 6) temporal structure (Labov & Waletzky, 1967); and 7) thematic analysis and coding (Reissman, 2008). The first, the entire story, describes taking the big story at face value and considering questions such as what were the key events, what was the overall plot, and who were the main characters? In contrast, the bounded story (the second strategy) looks specifically at points in the text where there is a clear beginning, middle, and end. Bounded stories can be found in big stories and small stories. They can be a series of a few sentences or cover pages or minutes of talk. The third, context of the story, is described by Van Dijk (1997) as "the structure of those properties of the social situation that are systematically relevant for the discourse" (p. 11). These includes participants (to include not only the characters in the story but the salient characteristics of those characters such as gender, age, social position, and so on), setting, props and actions. Critical analysis involves questions such as: What genre is applied? Who is the author of the narrative? What are the constraints of the narrative? How might the narrative be different if told by someone else? What is the purpose? What type of language is being used?

Indexicality considers words, such as pronouns and other parts of speech that may have different meanings or referents depending on how or when they are used. Paying close attention to the actual word selection can provide new ways of interpreting a narrative. Positioning analysis examines the ways in which the speaker/writer alter their presentation based on either the response of the listener or the anticipated response of the reader (Davies & Harré, 1990). For example, in a narrative where a person is describing his or her age relative to another, the person may position him or herself as "old," "older," "younger," or some other category depending on who the listener or

anticipated reader is. The way in which the speaker/reader changes position, in relation to the listener/reader can provide insight into what perceived issues the speaker/writer is trying to address. In the case of positioning one's self as older or younger, the position that the speaker/writer takes says a lot about how he or she views him or herself in relation to others.

Temporal structure analysis examines the order in which events are unfolded in a narrative (Labov & Waletzky, 1967). As mentioned earlier, theorist such as Labov (2003) have argued that the order of events disclosed cannot be changed without changing the inferred sequence of events. Questions that one might consider in a temporal analysis are: Why are these events disclosed in this particular way? Are they chronologically based? If not, why? What does the speaker/writer hope to convey through the way in which events are ordered? Finally, thematic analysis looks at overarching patterns within the narrative (Riessman, 1993, 2007). Themes go beyond the structural aspects of the narratives themselves and instead speak to some larger meaning. This refers back to Mishler's (1986) perspective mentioned earlier which suggests that despite being limited by the ways in which a story can be told, narrators still work to convey a larger sense of meaning that exists beyond the structural aspects of the story itself. For example, in a narrative about moving from one home to another, an overarching theme might be something like "home as identity." In this respect, the analysis is not so concerned about the discrete patterns of speech used or events disclosed but rather is concerned with exploring some of the larger meaning units within the story. Overall, as with all research, the analytical method will depend on the research question and the data available.

Key Considerations Regarding Narratives and Narrative Data

Other key considerations related to narrative gerontology include issues of power, master narratives, the role of narrative forms, and language itself. Issues of power related to storytelling include which person or groups of people get to tell their story and which do not; what types of stories are privileged, and language as power. For example, stories by people with dementia are often not included in narrative work. Instead, their stories are "re-interpreted" and told by others. There is also very little narrative work involving ethnic and racial minorities, people who are economically or socially disadvantaged, and other marginalized groups. To understand the experience of older age, it is important to include the stories from all groups of older adults rather than focus on select groups.

Another consideration is the role of master narratives and counter stories (Nelson & Lindemann, 2001). For example, many narrative approaches (e.g., interviews, writing groups) are based on the assumption that the past is most relevant to an older person. It is common to ask about a person's past, where he/she worked, historical events that he/she may have witnessed, and so forth. This forms a master narrative of nostalgia,

thereby creating an expectation by both the speaker/writer and listener/reader that stories about the past are the most important stories for older people. This assumption may not allow stories about a person's hopes, plans and dreams for the future. Another example of a master cultural narrative can be found in the United States' ideal of "rags to riches." This master cultural narrative forms an expectation that anyone who works hard enough can succeed. It ignores social structures and inequalities that complicate this narrative. A counter narrative would be one that challenges this stereotype by describing an experience or situation whereby such a transition is not possible (e.g., a poor child who does not have access to quality education and is therefore severely disadvantaged in succeeding.) Recognizing master cultural narratives is important since they may be providing pre-established plotlines that do not reflect the person's experience.

Finally, language has been described as a tool of empowerment or disempowerment. Social constructionists have argued that language, as the vehicle for communicating social norms and realities, influences experience and perceptions of power. For example, regional accents that differ from the accents of the dominant group can cause one group to be perceived as less capable than other. As mentioned earlier, "language" also encompasses the repertoire of narrative forms that are available to the speaker/writer. Narrative researchers should therefore be aware of the array of contexts in which the narratives are produced.

Summary

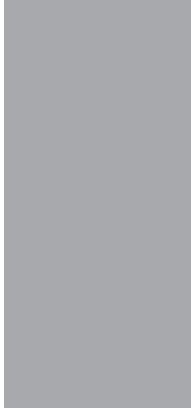
Overall, narrative gerontology is not limited to one perspective or approach but instead encompasses many perspectives linked to storying experience. Different specific disciplines may have particular ways in which they use narratives, but narrative gerontology is not bound to any one disciplinary perspective. Rather, approach will depend on what knowledge is being sought, what data are available, and what unique features emerge in the narratives obtained. Future developments in the field include the concept of narrative care, introduced by Gary Kenyon and William Randall, which describes narrative research and practice with respects to intervention. In this respect, narratives become more than ways to understand experience but instead become vehicles for change.

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Learning old age and learning in old age: an individual perspective

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Key words: Learning old age, personal experiences, Pierre Hadot, spiritual exercises, philosophy as a way of life

Abstract

Learning old age has an essentially individual character since it is dependent on many different factors. The first one, is the age of a person which, as I argue by referring to personal experiences, has a huge influence on our attitude towards seniors – from the acceptance and respect for old age, to its disavowal as a mark of a declining and decrepit lifeform. The second factor, nonetheless also important, is the experience of living in a multigenerational family in which the eldest members are deemed significant and entertaining respect. Another factor that shapes our perception of seniors is the level of environmental and widely societal awareness of the significance of aging processes and of their inevitability in the life of every human being. In that matter, we are still burdened with a feeling of inferiority as those who were bound to live on until the age of seventy, eighty, and ninety. Deeply ingrained, and stemming from a bad tradition, belief that leads one to commonly associate old age as the one “on which God had failed” is very slowly being eliminated from collective consciousness. The process is enhanced by a new opening of the last phase of life which as a result of constant lengthening acquires a new dimension, followed by a new meaning. Numerous examples of old people who take care of their psycho-physical condition and their social and spiritual development are gradually retrieving old age to its rightful place in human lifespan. In this process of change, a leading role seems to be played by a person’s spiritual development whose important component is spiritual practice wherein and thanks to which old age acquires the status of life’s period not worse than its previous stages.

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Introduction

Looking at the process of aging from the perspective of someone who is approaching eighty is sensible only in so far as this person, in the course of deepened reflection, attempts to uncover the truth about his attitude to old people beginning from his childhood and about the attitude of others towards himself being at an advanced age. Such a perspective is all the more important, given that after seventy-five the process of aging accelerates, therefore – as Hellen Bee argues – it may very well be that these are the last years during which the reflection upon learning old age and learning in old age is possible (Bee, 2004, p. 567–572). The idea of our learning to be old seems particularly interesting. Accompanying it, are questions: when does an old person become a source of knowledge and wisdom? At what age, specifically, and for whom can he or she be a teacher and a mentor and attest in this way to the value of the last stage of life?

Different Evaluations of Old Age in an Individual Lifespan

During my childhood people at advanced age (grandmother, grandfather) presented a positive image of old age, taking care of their grandchildren and indulging them in various ways. They embodied seriousness and at the same time resourcefulness. Old age which they represented seemed as a stage of life worthy of respect, understanding, and love. They would often manifest knowledge carried out of rural environments which in difficult situations proved to be indispensable². The knowledge of herbs, for instance, of human shortcomings, and the general knowledge of the world obtained in their youth had a valor of something new, unknown and thus arousing children's spontaneous interest. When they shared their experiences, nobody dared to interrupt them or in any way distract the telling of the story.

In the course of time, as the grandchildren matured, the role of old people diminished. The reason for it was the visible deterioration of their psycho-physical condition and the development of aging symptoms, such as illness and declining capability in various respects. This advancing, negative image of old age made the grandchildren aware, for the first time with such brute force, of the nature of aging processes and their inevitability in their own lifespan. Therein appeared the anxiety – the fear of one's own, imagined old age.

And so, as long the children were learning to comprehend old age basing on the examples of their closest relatives as important persons in the family's life, old age may have been deemed a desirable state owing to the status accompanying it. But the same people, when young and only maturing towards adulthood yet keeping vivid memories of the dark side of aging, would change their views on old age, negating its value and significance.

2 Grandma used herbs to cure my inflamed middle ear.

One can thus say that old age became something undesired; the period of learning oldness occurred in its negative shape which resulted in dismissing the very thought of one's being old. One needs to remember, though, that fifty or sixty years ago, man after seventy and particularly after eighty was rarely to be seen and perhaps that was why he or she constituted an important point of reference for an adult person, representing for him/her a kind of *memento mori*.

We can see then, that the process of aging, in fact beginning in pre-school and school years as a way of preparing oneself to become a person of older age – someone serious and to be reckoned with – is debilitated in our youth period. Paying closer attention to the shortcomings of older people causes a peculiar mental negation of this condition especially with regard to one's own identity which often brings about a change in the behavior towards people in later periods of adulthood.

The posture of dismissing oldness intensifies as we mature to adulthood and once we enter the period of late adulthood. One's own old age seems such a distant stage of existence that the awareness of the necessity of learning to be old, for example by leading a healthy lifestyle, recedes into the background. Sure, health as an important value is for many adult people the object of care but only with regard to general well-being. It is not thought of in terms of something worth maintaining in late adulthood. Even though illness may appear from time to time and make one aware of the need to reform the lifestyle (or some of its elements, like smoking), for the majority of people it is not an incentive to motivate one to change hitherto kept habits. This situation changes radically when a serious illness in one's youth leaves lasting trace in one's system (eg. heart defect or living with only one kidney). Then the exigency to keep at least minimal comfort of living makes one prefer a more healthy lifestyle.

Old Age in the Face of Massive Tendencies to Rejuvenation

In general, old age – maybe except for cases of people having to care for old parents – disappears from the mind of adults (between twenty-two and fifty-five years old) who learn to postpone it ever forward. In the end, flooded by media images of “eternal youth” and alleged ways to achieve it, adults yield to this illusion and enter dangerous paths of combating the natural process of aging by surgical operations or the like rejuvenating endeavors. The power of the image of making oneself young again is so pervasive that paying no attention to its perils and costs, adults readily undergo medical, as well as para-medical treatments whose effects are not always beneficial.

At this point we seem to be touching the problem of the social tendency to keep one's psycho-physical and societal condition on the highest level throughout the whole human lifespan. Natural and understandable at first glance, this need, when realized permanently, does not guarantee our insusceptibility to the process of aging. Traditionally conceived oldness as the last stage of human existence is now looked upon as carrying a threat of losing that which is most valuable: health and the joy of life. But

is this grim vision correct and irrefutable? Doubtless, the lack of acceptance of old age is felt personally by every human being who passes its conventional threshold (sixty) and brings about psychical discomfort connected with the waning of one's belief in individual abilities in the face of the nearing end. We can add that this individual negative feeling is reinforced by the social perception of us, according to which we are old, not only in terms of age, but also with regard to our outlook and our behavior attributed to the late period of life. It must follow then, that our feeling of getting old is greatly influenced by other people's reaction to the whole sphere of our activities which naturally is subject to some limitations and sometimes even destruction.

The vision of old age sketched above, one which we fear the most: of old age unwanted, does not still exhaust all the possible versions of living through this stage of life and relating to its endowments and shortcomings. The new, more positive vision of old age can be built basing on the idea of learning to be old by deeper knowing and penetrating its mechanisms and specific features. The knowledge on this period of existence enhances its brighter image and helps to combat the dark vision of decrepitude awaiting us at the end of life. This rush towards learning to be of old age often appears at its threshold (Chopra 1995).

Old Age as the Subject of Spiritual Exercise (*exercitia spiritualia*)

The spiritual dimension of aging as a phenomenon, in a specific way ascribed to the last stage of human existence, carries in itself a mystery of human nature whose different aspects are subject to scientific reflection. The fear of death characteristic of the last phase of life, in the majority of cases brings to mind the feeling of loss and suffering. On the other hand, however, as Leo Buscaglia rightly argues – “it make us aware that we should live now, at this very moment, and that tomorrow is an illusion (and never comes forth)”. Death tells us that it “of no importance is how many days, hours and years we have before us, but in what way we shall use this given time” (Buscaglia, 2007, p. 126).

Why do so many people suffer because of the nearing life's end?

Beside indubitably worsening physical condition, when health problems herald for most of seventy, eighty and ninety year-olds the nearing end, of great importance is our spiritual condition, often marked by disorder and unawareness of what is lived at a given time.

It is reasonable at this point to recall the wisdom of all the classical philosophical schools which argued that “mankind's principal cause of suffering, disorder, and unconsciousness were the passions: that is, unregulated desires and exaggerated fears” (Hadot 1995, p. 83). The prevalence of anxiety and fear is, according to Cicero, an obstacle in achieving peaceful life which gains its true value only when we “get rid of our passions” (Friedmann, in: Hadot 1995, p. 83).

The period of late adulthood seems particularly fit for a human being, aware of his finitude, to undertake „spiritual exercises” (Hadot 1995) which could allow him to transform internally; in a sense rebuild his spiritual dimension along with his psychological condition. Spiritual exercises were well known in the Hellenistic and Roman era, and also in the Middle Ages they were the focus of philosophical schools. It will be helpful to cite a brief description of these exercises, as presented by Philo of Alexandria: “first attention, then meditations and ‘remembrances of good things’ then the more intellectual exercises: reading, listening, research, and investigation, and finally the more active exercises: self-mastery, accomplishment of duties, and indifference to indifferent things” (Hadot 1995, p. 84).

Attention (*prosoche*) is the fundamental Stoic spiritual attitude. It is a continuous vigilance and presence of mind, self-consciousness which never sleeps, and a constant tension of the spirit. Thanks to this attitude, the philosopher is fully aware of what he does at each instant, and he wills his actions fully. Thanks to his spiritual vigilance, the Stoic always has “at hand” (*procheiron*) the fundamental rule of life: that is, the distinction between what depends on us and what does not. (*ibidem*, p. 84.). Only thanks to constant vigilance are we able to concentrate on the moment that is. In this spiritual exercise mere knowledge is not what matters; we are dealing here with a “transformation of the whole personality” (*ibidem*, p. 85). The aim of meditation is to put in order our internal discourse; making it coherent and “arrange it around simple, universal principle: the distinction between what does and does not depend on us, or between freedom and nature” (*ibidem*, p. 85). Hadot goes on to argue that “We must confront life’s difficulties face to face, remembering that they are not evils, since they do not depend on us”.

At the risk of simplification, we could say that this philosophical attitude can be found today among the representatives of humanistic orientation who point out at the need to live “here and now”. F. Perls argues that present time, as the only reality we experience, is the only real one, therefore turning to the past which no longer is, or looking ahead into the future which is not yet there deprives us of the authenticity of fully participating in the world around us. Concentration on that which we currently live through does not naturally mean ridding our thoughts of any plans, dreams and memories. They cannot however function as substitutes for the present that block our conscious participation in the moment experienced “here and now” (Strumiska-Cylwik 2005, p. 73). Living at present is the necessary condition of experiencing the whole scale of feelings and perceptions which daily existence brings. It is also the condition of gaining knowledge indispensable for further existence in a world whose variability and mobility directly imposes on us the necessity of being lucid and vigilant. Only then do we have the chance to develop spiritually, especially during late adulthood, when – as it was shown – the specific aura that accompanies the last stage of life promotes spiritual exercise. According to Epicurean teachings, such exercises “are required for the healing of the soul” (Hadot 1995, p. 87). Let us remember: the source of human

unhappiness is fear of things which are not worth it, as well as desiring things which do not deserve our attention. Living a life overwhelmed by anxiety caused by unnecessary fears and desires unfulfilled, people are torn in the direction of the future which "hides from [them] the incomparable value of the simple fact of existing" (ibidem, p. 88). The return to the very pleasure of existence was one of the major stakes of Greek and Roman philosophy. Such relaxed existence allows one to better tackle the fears invading human consciousness which tends to concentrate on the past or on unpredictable future. Epicurus writes: "We are born once, and cannot be born twice, but for all time must be no more. But you, who are not master of tomorrow, postpone your happiness: life is wasted in procrastination and each one of us dies overwhelmed with cares" (Epicurus, *Gnomologium Vaticanum*, § 114, in: Hadot 1995, p. 88). This is the doctrine contained in Horace's famous saying: *carpe diem*:

Life ebbs as I speak:

so seize each day, and grant the next no credit

(Horace, *Odes*, I, 11, 7, in: Hadot 1995, p. 88).

Keeping a balance between these two attitudes seems to show a way of life which can ascertain the serenity so important for normal functioning and focusing on people and problems that fill the actual existence.

Max Scheler has also underscored human ability to self-creation. He thought human being was like a microcosm – a living creature filled with spirit: "a person in whom there is a spiritual factor unfound in other living creatures which testifies to his/her autonomy against vital and psychical causality" (Scheler 1987, p. 201). Self-creation then, as the result of the advancement of human spirituality, improves the quality of our existence in the world by making us independent on „vital and psychical causality”.

The genesis of human spirituality, his development towards a higher level of understanding his own nature, as well as the nature of the surrounding world, is also the object of other researchers' interest: philosophers, anthropologists, sociologists, psychologists and the representatives of the natural sciences. The rapid developments in biological sciences has brought about a tendency to analyze the spiritual dimension specific for human beings from the perspective of the evolutionary paradigm (Dyk 2008, p. 243).

Among the scholars who investigate the natural determinants of human spiritual evolution it is worth citing the opinion of Konrad Z. Lorenz who regards spiritual life as a new form of being, characteristic only to humans. Pointing out to the process of evolution, he distinguishes its two types: on the one hand we have a slowly advancing biological evolution, on the other, there is a fast-paced cultural evolution. Culture as a universal sphere is a peculiar „common matrix” of disparate manifestations of human spirit. Therefore, spiritual evolution is for Lorenz "identical with the cultural one" (Lorenz 2007, p. 287). Culture, just like human spirit, gains in its process of development a supra-individual dimension as a "totality of knowing, ability and desire"

(ibidem). Utilizing the concept of human soul, Lorenz sees it as a link between human biological heritage and his spiritual sphere, since it is shaped in a cultural environment as a natural effect of the adaptation of the biological nature of man to culture he has created. It is hard not to agree with the view that human spiritual life harnesses from rich resources of culture which, created by humans, specifically reflects their spiritual aspirations,

One can say that in spiritual exercise human being has to aptly reach for the goods of culture, utilizing their potential to transform his own personality by rendering it coherent – as the ancient philosophers pictured it. Man in the period of late adulthood while he possesses an undisturbed consciousness, has good chances of attaining the feeling of the accomplishment of a certain life mission. Referring to my own lifepath, it is easy to notice that aging process, although it marks itself in the sphere of psycho-physical abilities, motivates the search for the right lifestyle and the right posture towards ever new events and existential situations. In this context, the fear of death becomes the key to a reflexive analysis of the very nature of individual being.

There remains a question concerning the ways of defending oneself against those ego-crushing opinions that negate the value of our old age and trigger the feelings of resignation and lack of belief in one's own abilities.

It seems that it is necessary to rebuild and cultivate one's awareness that this inevitable phase of living in which we find ourselves is of equal value as the previous ones. Old age needs to be affirmed amongst its specific qualities which hitherto had been lacking. It is important to see old age as an opportunity to either use the interests and knowledge so far gathered, or to develop the ones which were silenced by the rush of humdrum duties of the professional and family life.

The basis to develop a positive thinking about late adulthood is:

1. Cultivation of physical fitness on the level our strengths can allow us; a strong will which enables to perform daily exercises independently on other physical activities.
2. Practicing intellectual activity, eg. by taking up again reading classical literature, cultivating knowing activities in the field that is close to us.
3. Cultivation, if possible, of professional activity, not only the one connected with the job we once had. It effectively enhances the betterment of psycho-social condition and is the source of belief in one's abilities, It also instigates one to act in two previously discussed fields (physical and intellectual activity).

Conclusion

Learning to be old has a greatly individualized character, since it is determined by many factors. The first one is the age of a person which – as I have shown referring to personal experiences – has a huge impact on the attitudes toward seniors; from acceptance and respect, to dismissal of oldness as a declining and decrepit form of life. The second factor, of no lesser importance, is the experience connected with living

in a multigenerational family in which the eldest members are regarded as significant and entertain respect. Another factor which influences the image of seniors and their presence in social life is the level of environmental and, put more widely, social awareness of the significance of aging process and their inevitability in every human being's life. In this respect, we are burdened by *odium* of being worse; of those who were destined to live on until seventy, eighty, or ninety. This view is firmly rooted but derives from an unfortunate tradition and invites the social imagination to think of old age commonly as the one "which was God's failure". Slowly, still, but visibly it is being eliminated from the collective (un)consciousness. The process is further encouraged by the new image of life's last phase which, as a result of its prolongation, acquires a whole new dimension and new meanings. Numerous examples of old people who take care of their psycho-physical condition and their social and spiritual development are gradually retrieving old age to its rightful place in human lifespan. In this process of change, a leading role seems to be played by a person's spiritual development whose important component is spiritual practice wherein and thanks to which old age acquires the status of life's period not worse than its previous stages.

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Cinematherapy possibilities: How to use films to solve psychological or social problems and enhance quality of life in the elderly?

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Keywords: cinematherapy, movietherapy, film, psychotherapeutic technique, psychological intervention in elderly

Abstract

Cinematherapy is a relatively new tool of the psychological change, having the potential to gain therapeutic, educational and developmental goals during individual or group meetings. This technique might be offered to persons on different stages of life, including the elderly. In the first part of the paper several definitions of cinematherapy, its purposes and explanatory mechanisms are presented and analyzed. The rules of the film selection and the methods of work based on films, with particular reference to the needs and typical problems of seniors are explained. The second part of the article provides some examples of films that might be effectively used in psychotherapy or sociotherapy of the elderly dealing with different issues. A ready-to-use scenario of group therapy session based on the one of recommended films is also proposed.

Introduction

Cinematherapy or movietherapy is a therapeutic technique recognized as a form of art therapy (Korbut, 2016) and used within a broader psychological intervention framework that aims at bringing in a change into the lives of people suffering from mental disorders or problems that lower the quality of their lives (see: Gregerson, 2010). Although therapeutic use of films was first reported in 1946 by Elias Katz, the technique is quite new; its first definition was formulated in 1990 by Linda Berg-

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Cross, Pamela Jennings and Rhoda Baruch (p. 135). According to them, cinematherapy “involves having the therapist select commercial films for the client to view alone or with specified others”. Conforming to Abby Calish (2001, p. 22), who prefers the term “videowork”, it is “a therapeutic process in which clients and therapists discuss themes and characters in popular films that relate to core issues of ongoing therapy”. Some definitions of cinematherapy underlie metaphorical aspects of films, which can give clients a new perspective of seeing their lives and problems (see: Hesley & Hesley, 2001; Heston & Kottman, 1997; Powell, Newgent & Lee, 2006; Wedding & Niemiec, 2003). Others emphasize the necessity of “follow-up processing” of client’s experiences resulting from watching a movie (Sharp, Smith & Cole, 2002, p. 270; see: Heston & Kottman, 1997; Marsick, 2010). Almost three decades of forming a theoretical framework of using films in therapy allow to shape its following general definition: it is “a technique of initiating, processing or reinforcing a therapeutic change, based on intentional psychological work on client’s experiences of watching film recommended by psychotherapist” (Tylikowska, 2016, p. 130).

A survey conducted by Georgios K. Lampropoulos, Nikolas Kazantzis, and Frank P. Deane (2004) demonstrated that sixty seven per cent of eight hundred twenty seven licensed practicing psychologists – members of American Psychological Association – were using films in different forms of therapy. Eighty eight per cent of them regarded the use of motion pictures as potentially beneficial in reaching therapeutic ends, and only one per cent considered it as possibly harmful. The survey showed that many psychotherapists, at least in America, include films in their practice to enhance its effectiveness. Films are used in the processes of raising awareness, moulding behavior and inspiring clients (Gregerson, 2010; Lampropoulos et al., 2004). Delivering comprehensive metaphors, they can serve “as a springboard to insight, and aid in therapeutic alliance building” (Powell, Newgent & Lee, 2006, p. 247). Films can provide clients with hope, encouraging them to take effort that could lead to positive change. They can modify clients’ view of their problems, making it easier to come up with solutions (Hesley & Hesley, 2001). Therapeutic use of films may result in changes of clients’ cognitive schemata, and thus – in forming more adaptive emotional and behavioral reactions (Tylikowska, 2016). Danny Wedding and Ryan M. Niemiec (2003, p. 207) claim that motion pictures can “enrich and expand psychotherapy”. They also may be a handy and universally available autotherapeutical tool, and a catalyst for personal growth (Raczek, 2014; Wolz, 2005).

This preliminary characteristic of cinematherapy outlines a wide range of its possible uses in various kinds of psychological interventions aimed at solving psychological and social problems of the elderly or enhancing the quality of their life. Movies may be used in the frames of individual, couple, family or group psychological work, conducted by psychotherapists, sociotherapists, social or medical workers, either in private or institutional environment (see: Gregerson, 2010; Tylikowska, 2016). After basic training the professionals can show the elderly how to use films not only as a

means of relaxation or entertainment, but also as instruments of disentangling everyday limitations and difficulties (e.g., personal or interpersonal conflicts), and thus provide them with a powerful self-help tool.

The article presents essential knowledge allowing of effective use of films in psychological work with seniors. It demonstrates a process of cinematherapy and psychological mechanisms engaged in the development of psychological change that may be stimulated by processing experiences that resulted from watching a film. The article offers guidelines for using movies in psychological or social work with the aged, sketching the possibilities and limitations of such work. Furthermore, it suggests utility areas of applying motion pictures in psychotherapy or sociotherapy of the elderly, recommends a list of movies that might be exceptionally suitable at work with them, and proposes a scenario of a group therapy session using one of the recommended films.

The process of cinematherapy

Cinematherapy is considered to be a technique or a supplemental therapy – i.e., not as a self-contained therapeutic procedure – for important reasons. A valid therapeutic use of films must be preceded by determining the needs and aims of a client or a group of clients, and followed by psychological processing of their watching experiences (see: Dermer & Hutchings, 2000; Sharp, Smith & Cole, 2002). The essence of cinematherapy lies in the appropriate selection of films and intentional working on thoughts and emotions activated by watching. The appropriate use of the technique demands applying many other therapeutic tools. In both institutional and self-help contexts, a plain plan of an expected outcome of potentially therapeutic film watching should be first established, and specific psychological interventions ought to be exercised after the screening (Tylikowska, 2015).

Shannon B. Dermer and Jennifer B. Hutchings (2000) distinguish three stages in the process of cinematherapy: assessment, implementation and debriefing.

1. Assessment is the first step of any effective psychological intervention. A therapist, along with a client or a group of clients, identifies her, his or their problems and objectives of the therapy. The therapist assesses client's strengths (i.e., functional cognitive schemata, interests, preferred activities), limitations (i.e., dysfunctional cognitive schemata, narrowed ability to understand content of films) and cultural context (i.e., socioeconomic status, gender). Assigning a movie to a specific client or clients demands recognition of the type of films which they typically enjoy (see: Hesley & Hesley, 1998; Tylikowska, 2016).

2. In group therapy or sociotherapy, a therapist usually watches a movie with clients (Powell, Newgent & Lee, 2006; Tylikowska, 2015). In individual, couple or family therapy, implementation typically means that the therapist recommends a movie to be seen after a session (Sharp, Smith & Cole, 2002; Wedding & Niemiec, 2003). In all cases, the therapist must know the film well and provide the client or clients with

reasons and goals for watching it. The therapist also gives the client or clients specific hints regarding movie characters or events that need be paid special attention to, or require taking notes, etc. (Tylikowska, 2016).

3. Debriefing is the processing of clients' thoughts and emotional reactions that arose during the screening of the movie. It usually includes a discussion about clients' global impression of the film and their thoughts about how it relates to their problems and how its content may be used to change their way of thinking, feeling or behaving (Dermer & Hutchings, 2000; Egeci & Gençöz, 2017; Powell, Newgent & Lee, 2006; Tylikowska, 2015, 2016).

Processing clients' movie watching experiences will vary, depending on therapist's approach, which can be cognitive-behavioral, psychodynamic, existential, humanistic, interpersonal, integrative, etc. These various approaches are based on very different conceptions of human mind and work on different psychological mechanisms.

How does cinematherapy work?

Although motion pictures are utilized in many psychotherapeutic approaches (Lampropoulos, Kazantzis & Deane, 2004), there are two main explanations of potential efficacy of its use: psychodynamic and socio-cognitive (Tylikowska, 2016).

Psychodynamic approach to cinematherapy

Psychodynamic explanations of working mechanisms behind possibly positive effects of cinematherapy refer to the idea of the unconscious. Films are seen as metaphors that may serve as "bridges, which indirectly foster open dialogue about subject matter that client tends to avoid when uncomfortable (Wedding & Niemiec, 2003), and improve exploration into the unconscious" (Powell, Newgent & Lee, 2006, p. 247). Motion pictures, like stories, myths, anecdotes and other narratives, captivate imagination by using metaphors to induce emotional and cognitive reactions, which allow them to entertain people. These reactions, if properly psychologically processed, may be utilized in therapy. Films "indirectly suggest new possibilities toward healing" and "encourage clients to journey into their emotional experience and personal narratives as indirect observers from a higher, meta-analytic plane" (Powell, Newgent & Lee, 2006, p. 247; see: Sharp, Smith & Cole, 2002; Wedding & Niemiec, 2003).

In psychodynamic approach, cinematherapy is usually conceptualized as an offshoot of bibliotherapy. Both techniques are based on "meaningful processing" (Sharp, Smith & Cole, 2002, p. 270) of a narrative material, representing characters coping with problems similar to clients' ones (see: Newton, 1995). Such processing involves three or four stages: identification, catharsis, insight and, optionally, universalization.

1. Identification stems from client's observations or feelings of her or his similarity to a fictional character. Such observations or feelings may encourage the client to explore the character's and his or her own emotions, motives and behaviors.

2. Involvement with character's emotions, life issues and their resolutions, or surfacing client's deep feelings and internal conflicts, may lead him or her to catharsis, that is to purification from negative emotions.

3. Through understanding a fictional character's emotions, motives or actions, the client may gain an insight, i.e., develop a new perspective of seeing her or his own problems or life situation (Morawski, 1997; Sharp, Smith & Cole, 2002).

4. Additionally, by observing and empathizing with fictional characters, the client may remark that others experience similar issues or situations, which can lower her or his sense of oneness, strangeness or isolation (Jeon, 1992; Sharp, Smith & Cole, 2002).

Psychodynamic approach, although quite popular, has at least one considerable flaw: its fundamental idea – the concept of deep unconsciousness, that is qualitatively different from consciousness – which has never been scientifically admitted (Bargh & Morsella, 2008). It seems that a skillful use of films as metaphors may give positive outcomes, as evidenced by some studies (Marsick, 2010; Powell, Newgent & Lee, 2006; Sharp, Smith & Cole, 2002), but actual working mechanisms of these outcomes stay vague. These mechanisms may differ from the ones that the psychodynamic psychologists postulate, e.g., they could be based on stimulating clients to self-distancing, that is to view their experiences from a distanced, third-person perspective, which has been recently discovered as a powerful therapeutic tool (Ayduk & Kross, 2010; Kross & Ayduk, 2011). They could also be based on experimentally well-grounded rules of socio-cognitive learning, which is based on using and processing the information from the observed role models.

Socio-cognitive approach to cinematherapy

According to John W. Hesley and Jan G. Hesley (2001), motion pictures can raise clients' hope for change, therefore promoting motivation necessary for therapeutic work. Films may help to reframe clients' problems, provide them with role models and improve their communication. Lampropoulos et al. (2004) claim that movies can enhance the ability to gather information and prepare clients for constructive actions, for many of them deal with important issues such as failed relationships, loss of work or health, physical or mental illness, dying and death, etc. Describing effectiveness of cinematherapy, Ha Gang Kim (2014) refers to modeling and vicarious learning, that is – to the mechanisms of social learning.

Albert Bandura's (1986, 2001) socio-cognitive theory is about people's ability to learn through observing others, who may be real life models as well as fictional characters presented in books, films or on the Internet. Social or observational learning, also named modeling, is the process of knowledge acquisition. It can be utilized in dealing with different situations, also problematic ones. Effective modeling engages a set of cognitive and behavioral processes, usually conceptualized as four phases: attention, retention, reproduction, and motivation. Their presentation below refers to general rules of social learning and, at the same time, to specificity of cinematherapy.

1. In order to learn, a person must first pay attention to a model (Bandura, 1977, 1986, 2001). Cinematherapy should be preceded by verifying if a client is interested in watching motion pictures. Then a therapist ought to choose a film accordingly to the client's preferences, which are determined, *inter alia*, by his or her generational belonging, gender, socioeconomic status and personal value system. The movie and its characters need to be in some way attractive to the client, otherwise learning would not occur. Modeled behaviors, emotional reactions, beliefs or skills should be exposed in the film in a way that is understandable to the client (so that he or she can cognitively process and remember them), and they should also meet positive outcomes. Before the screening, the therapist needs to activate client's attention by explaining the goals of cinematherapy. The therapist should also direct client's attention to specific movie characters, events or plots, that are related to therapeutic issues, and provide the client with necessary instructions, like replaying important excerpts or taking notes (Tylikowska, 2016).

2. Further use of observed behaviors or skills, revealing specific beliefs or emotional reactions, depends on a person's ability to remember them (Bandura, 1977, 1986, 2001). The therapist can reinforce client's memory of important information by discussing his or her movie watching experiences and pointing out the ones that are particularly significant or useful. The aim of reviewing of selected aspects of the movie during a therapeutic session (one or more, if necessary) is to make the client's cognitive schemata more flexible, to modify them, or to create new ones – so that she or he could think, feel, and behave in a more adaptive way (Tylikowska, 2016). Cognitive schemata include outcome and self-efficacy expectancies, which have well-proven impact on mental and physical health (Bandura, 1995).

3. Reproduction of observed and remembered information relies on individual ability to implement it (Bandura, 1977, 1986, 2001). If the person does not have required cognitive skills or sensorimotor capabilities, she or he would not be able to use the learned information. If information gathered by the client during watching and discussing the film is discordant with her or his cognitive schemata, then she or he will be reluctant to use them in everyday life. If the client does not verify acquired behaviors during therapeutic sessions, she or he may have difficulties with practicing them in real life situations. Thus, an important component of cinematherapy is the part when the therapist is testing the client's ability to use what she or he has learned, reinforcing new cognitive schemata or emotional reactions, and exercising new behaviors and skills. This may involve debating potential obstacles in using those behaviors and skills outside therapeutic sessions, as well as rehearsing or role playing them (Tylikowska, 2015, 2016).

4. Last but not least, the use of the information, including new behaviors or skills, depends on individual motivation, which is shaped not only by client's expectations, internal standards, and other cognitive schemata, but also by environmental factors, such as positive and negative reinforcements (Bandura, 1977, 1986, 2001). Therefore,

the therapist should monitor client's everyday practice of new attitudes, emotional reactions, and actions during sessions following proper cinematherapy, giving her or him constructive feedback, helping to overcome potential social hindrances, and strengthening positive change.

Socio-cognitive approach to cinematherapy brings forth the importance of diligent selection of motion pictures, which should take into account not only clients' intelligence and emotionality, but also her or his criteria of attractiveness of films and characters depicted in them (Tylikowska, 2016). The approach justifies the necessity of detailed discussion on clients' film watching experience and encourages extensive testing of learned knowledge, behaviors and skills, during and after therapeutic sessions. It underlines the requirement of adjusting clients' cinematherapy acquisitions to clients' previous cognitive schemata and to environmental factors. Although socio-cognitive approach reveals cinematherapy as a demanding technique (for therapists), it also discloses the technique's potential contribution to the process of clients' positive change as hard to overrate, for "movie characters can essentially act as cotherapists for clients" (Lampropoulos, Kazantzis & Deane, 2004, p. 535; see: Wedding, 2010).

Guidelines for using cinematherapy

The above presented information allows to formulate a set of basic instructions for using cinematherapy in different therapeutic modes. In individual, couple, family or group psychotherapy, and in sociotherapy, a therapist aiming to use motion pictures effectively should:

1. Decide if cinematherapy is an appropriate technique to work with particular client or clients. The use of it is advised against not only in the case of clients' unwillingness to watch movies, but also in the case of her or his inability to differentiate between fiction and reality, as in the case of some brain dysfunctions (that might be associated with age; Korsakova, 1997; see: Lampropoulos, Kazantzis & Deane, 2004).
2. Select a film carefully, taking into account many factors, such as clients' ability to understand motion pictures, their personal preferences and sociocultural background, as well as the overall goals of the therapy (Berg-Cross, Jennings & Baruch, 1990; Dermer & Hutchings, 2000).
3. Watch a film at least twice before assigning it to a client or clients and clearly define the purpose of watching it (Dermer & Hutchings, 2000; Hesley & Hesley, 2001).
4. Provide the client or clients with an explanation regarding the reason for watching the film and give them specific directions, i.e., to be mindful, pay attention to a certain character or a solution of a problem, etc. If a movie includes scenes or plots that might be disturbing (such as bursts of aggression, aching loss or dying), they ought to be discussed with the client or group of clients before the screening (Hesley & Hesley, 2001; Heston & Kottman, 1997; Tylikowska, 2015, 2016).

5. Arrange a skillful follow-up to process the film. Psychological elaboration of clients' movie watching experiences and acquired information are crucial elements of cinematherapy (Eğeci & Gençöz, 2017; Hesley & Hesley, 2001; Heston & Kottman, 1997; Marsick, 2010; Powell, Newgent & Lee, 2006; Sharp, Smith & Cole, 2002). It is important to keep in mind that integrating clients' newly gained knowledge with their cognitive schemata and everyday life conditions may be the most important part of the whole task (Tylikowska, 2016).

6. Remember that cinematherapy is one of potentially useful instruments of change, and not a therapy itself. It is a part of a broader therapeutic framework, and should be assisted with other techniques, such as Socratic dialogue and reality testing (in cognitive-behavioral approach), therapeutic circle or group discussion (in group mode), or other art therapy tools, i.e., drawing pictures, playing roles and creating alternative scenarios (in sociotherapy; Tylikowska, 2015).

7. Work with one film at the time of therapy to avoid excess of information and emotions (Hesley & Hesley, 2001; Lampropoulos, Kazantzis & Deane, 2004).

Applied cinematherapy with the elderly

There are hundreds of aging related films with the power to help older adults, families, communities and professionals deal with aging³. Table 1. shows the list of some documentaries that have been chosen on the account of their capacity to increase awareness, provide education, training, support, and inspiration to seniors. All of the documentaries mentioned here are available in open Internet access and might constitute the base of cinematherapy interventions. Their topics are quite varied – they show different aspects of the ageing process and the old age, and creative manners of adapting to this stage of life. They also concern challenges and typical problems of seniors, including physiological issues (eg., the declining physical fitness, age-related diseases), psychological issues (eg., symptoms of cognitive decline, loneliness, dependence), social issues (eg., isolation, ageism, abuse, neglect) and financial issues (lower income, health care costs) (see: Fuchs, 2001; Rehman & Mohyuddin, 2015; Streiner, Cairney & Veldhuizen, 2006; Steuden, 2011).

3 There are several web pages presenting documentaries on aging, elderly individuals and groups, for example: <http://www.programsforelderly.com>, <http://www.lib.berkeley.edu/MRC/aging.html>, <http://www.legacyfilmfestivalonaging.org/>, <http://www.grayingofaids.org/documentary-films-on-aging/>.

Table 1. Documentary films which may be used during cinematherapy sessions with seniors⁴

Inspirational Seniors
<i>The Art of Aging</i> (dir. Leaping Media) <i>Lives Well Lived</i> (dir. Sky Bergman) <i>Greedy for Life</i> (dir. Laurie Schur) <i>My 93 Year Old Flat Mate</i> (dir. Meggie Palmer and Bernadine Lim) <i>The Elders</i> (dir. Nathaniel Hansen) <i>Hip Hop-eration</i> (dir. Bryn Evans) <i>The Lady In Number 6: Music Saved My Life</i> (dir. Malcolm Clarke)
Love and Sexuality of the Elderly
<i>The Age of Love</i> (dir. Steven Loring) <i>Still Doing It – The Intimate Lives of Women Over 65</i> (dir. Deirdre Fishel) <i>Liberty 3 Stories about Life and Death</i> (dir. Pam Walton) <i>Silent Pioneers: Gay and Lesbian Elders</i> (dir. Pat Snyder, Lucy Winter, Harvey Marks, and Paula de Koenigsberg)
Activities & Hobby in the Old Age
<i>The 82 Year Old Sky Diver</i> (dir. James Callum and Alex Knowles) <i>The 77 Year Old Kite Surfer</i> (dir. James Callum and Alex Knowles) <i>Fabulous Fashionistas</i> (dir. Sue Bourne) <i>Age of Champions</i> (dir. Christopher Rufo)
The Elderly's Abuse
<i>Fleeced: Speaking Out Against Senior Financial Abuse</i> (produced by: National Community Reinvestment Coalition (NCRC) and WFYI Public Media, Atlantic Philanthropies) <i>Saving Our Parents</i> (produced by: Jeff MacIntyre, Debby Bitticks, Ken Bitticks, Lynn Benson, Dorothy Breininger)
Economic Issues
<i>All of Our Lives</i> (dir. Laura Sky) <i>Can't Afford to Grow Old</i> (dir. Roger Weisberg)
Ageism
<i>Ageless</i> (dir. Heater Gwaltney) <i>Cut Back: Facing Ageism</i> (dir. Patricia Sahertian) <i>Advanced Style</i> (dir. Lina Plioplyte)
Varia: Challenges of Aging
<i>The Invisible Years</i> (dir. Gideon Boaz) <i>In Search of Memory</i> (dir. Petra Seeger) <i>I Remember Better When I Paint</i> (dir. Eric Ellena and Berna Huebner) <i>Getting Around – Alternatives for Seniors Who No Longer Drive</i> (produced by: The AAA Foundation for Traffic Safety. Wiland-Bell Productions) <i>Aging Without Children - Who Provides Care?</i> (produced by: Trading Places, NBC News)

⁴ The titles of the films specified in this article are followed by the names of their directors or producers (provided in parentheses).

A positive movie experience can leave an older person in a better mood and more apt to engage in social contact with others. It can stir positive memories, inspire good feelings and induce to think over some matters. Watching a feature film as a part of therapeutic work can give the therapist an extra edge, increasing the therapy's benefits and their long-lasting (Kim, 2014; Yazici et.al., 2014; Danina & Kiselnikova, 2015). Table 2. provides examples of some movies that might be suitable for therapeutic work especially with the aged. To introduce some order we propose several categories. Although possibly disputable, the selection was not random. They combine two extensive realms: that of cinematic productions and that of knowledge from the field of social sciences, related to main psychological problems that seniors face. Most films mentioned here fit into more than one category they were arbitrarily classified as belonging to; that is, they may be classified differently.

Table 2. Feature movies that can be adapted for cinematherapy of seniors dealing with diverse psychological issues

Family Issues
<i>The Straight Story</i> (dir. David Lynch) <i>Little Miss Sunshine</i> (dir. Jonathan Dayton, Valerie Faris) <i>Marvin's Room</i> (dir. Jerry Zaks) <i>Olive Kitteridge</i> (dir. Lisa Cholodenko) <i>Terms of Endearment</i> (dir. James L. Brooks) <i>August: Osage County</i> (dir. John Wells)
Relationships & Love
<i>Harold and Maude</i> (dir. Hal Ashby) <i>Hope Springs</i> (dir. David Frankel) <i>Something's Gotta Give</i> (dir. Nancy Meyers) <i>The Bridges of Madison County</i> (dir. Clint Eastwood)
Grief, Loss, Death & Transformation
<i>A Single Man</i> (dir. Tom Ford) <i>Frida</i> (dir. Julie Taymor) <i>Steel Magnolias</i> (dir. Herbert Ross) <i>Up</i> (dir. Pete Docter, Bob Peterson)
Transition to Retirement
<i>Gran Torino</i> (dir. Clint Eastwood) <i>Harry and Tonto</i> (dir. Paul Mazursky) <i>On Golden Pond</i> (dir. Mark Rydell) <i>Quartet</i> (dir. Dustin Hoffman) <i>About Schmidt</i> (dir. Alexander Payne)
Health Issues
<i>The Hours</i> (dir. Stephen Daldry) <i>Intouchables</i> (dir. Olivier Nakache, Eric Toledano) <i>The Notebook</i> (dir. Nick Cassavetes)

Inspiration and Hope
<i>Gandhi</i> (dir. Richard Attenborough) <i>Lord of the Rings</i> (dir. Peter Jackson) <i>Bagdad Cafe</i> (dir. Percy Adlon) <i>Fried Green Tomatoes</i> (dir. Jon Avnet) <i>The Old Man and the Sea</i> (dir. Jud Taylor)
Anger and Forgiveness
<i>The Straight Story</i> (dir. David Lynch) <i>An Unfinished Life</i> (dir. Lasse Hallstrom) <i>Gandhi</i> (dir. Richard Attenborough) <i>Magnolia</i> (dir. Paul Tomas Anderson)
Spirituality and Religion
<i>The Apostle</i> (dir. Robert Duvall) <i>Brother Sun, Sister Moon</i> (dir. Franco Zeffirelli) <i>Contact</i> (dir. Robert Zemeckis) <i>City of Angels</i> (dir. Brad Silberling) <i>It's a Wonderful Life</i> (dir. Frank Capra) <i>Jonathan Livingston Seagull</i> (dir. Hall Bartlett)
Aging & End of Life
<i>Away From Her</i> (dir. Sarah Polley) <i>The Best Exotic Marigold Hotel</i> (dir. John Madden) <i>The Bucket List</i> (dir. Rob Reiner) <i>Cocoon</i> (dir. Ron Howard) <i>Curious Case of Benjamin Button</i> (dir. David Fincher) <i>Driving Miss Daisy</i> (dir. Bruce Beresford) <i>Time to Die</i> (dir. Dorota Kędzierawska)

The presented below scenario of a group session (prepared by the authors) proposes some activities related to one of the above listed American comedy-dramas *The Bucket List* (dir. Rob Reiner). It shows in detail how a film can be used to facilitate therapeutic group work. This scenario might be also easily adapted for an individual session.

Scenario 1. Group session work schedule related to the feature film *The Bucket List*

Theme: THE BUCKET LIST

Objectives:

- Induce the reflection on life purpose and joy.
- Bring into attention what may be done in order to achieve or maintain a sense of fulfillment.
- Focus on the link between present and future time perspectives.
- Enhance hope and well-being.

Keywords: list of wishes, purpose of life, joy in life, running time

Materials:

- Paper and pen, board.
- Film: *The Bucket List* (dir. Rob Reiner). Synopsis: Corporate billionaire Edward Cole and working class mechanic Carter Chambers have nothing in common except for their terminal illnesses. While sharing a hospital room together, they decide to leave it and do all the things

they have ever wanted to do before they die according to their bucket list. In the process, both of them heal each other, become unlikely friends, and ultimately find joy in life (source: <http://www.imdb.com>).

Plan:

1. Write the theme of the meeting ("THE BUCKET LIST") on the board and ask the group how they define this expression. Give a simple explanation: A number of experiences or achievements that a person hopes to have or accomplish during his/her lifetime; a list of things (goals, dreams and wishes) that one has not done before but wants to do before the end of life.
2. Ask the following questions to facilitate discussion in the group: What is the difference between a bucket list and a to-do list? Can you see any differences between a wish and a goal? Why create a bucket list? Why not? Have you ever made your own bucket list?
3. Propose individual work: Create your own bucket list. Start writing down what comes to mind as you hear these questions:
 - What do you wish you could do before the end of your life?
 - What would you do if you had unlimited time, money and resources?
 - What have you always wanted to do but have not done yet?
 - What experiences do you want to have?
 - Are there any special moments you want to witness?
 - What activities or skills do you want to learn or try out?
 - What are the most important things you can ever do?
 - What would you like to say/do together with other people? People you love? Family? Friends?
 - Are there any specific people you want to meet in person?
 - What do you need to do to lead a life of the greatest meaning?
4. Ask the group about feelings and thoughts which occur during this work (therapeutic circle).
5. Arrange the discussion in pairs about their personal bucket lists.
6. Inform the participants that they are going to watch a film entitled *The Bucket List*. Remind them to be mindful and to pay attention to (1) what was on the bucket lists made by Edward and Carter, (2) how they reacted when they accomplished or couldn't accomplish their goals and wishes.
7. After watching the film ask some of the following questions to induce self-reflection, self-revealing in the comments about the film, and facilitate group discussion:
 - What are your associations with the 'picture' you have seen?
 - What are you experiencing right now?
 - Why are you experiencing this feeling? What kind of thoughts do you have?
 - What does this feeling tell you about what's really important to you in your life?
 - Do you remember whether your breathing changed throughout the film? Could this be an indication that something threw you off balance?
 - What did you like and what you didn't like or even hated about the film? Which characters or actions seemed especially attractive or unattractive to you?
 - Did you identify with one or several characters? Did they develop certain strengths or other abilities that you would like to develop as well? How would you use them in your life?
8. Refer to bucket lists that participants have made before watching the film. Ask if they would like to add something to their bucket lists right now.
9. Table the following question: what is the first thing from your bucket list you are going to plan? Encourage and help at least two persons (volunteers) to make – in front of the group – a detailed plan (What? For what? When? Where? With whom? *etc.*) of pursuing

one wish or goal from her/his bucket list. Make sure it is realistic and feasible, taking into account possible obstacles and the ways to manage them (promote creating alternative plans to achieve one goal).

10. **Write the following sentence on the blackboard: 'GOAL WITHOUT A PLAN IS JUST A WISH'. Assign homework: make a plan of pursuing at least one item from your own bucket list.**
11. At the end of the meeting, leave participants with the open question: in the reference to all the things on your lists of wishes – what is the best way for you to allocate your time today?

Conclusions

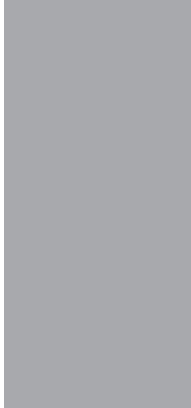
Recently cinematherapy, which uses documentary and feature films as therapeutic technique, has become a pervasive tool in the counseling field as its effectiveness has been demonstrated. Watching movies as a part of therapy significantly decreases clients' defensiveness and resistance toward therapy. It gives clients the opportunity to discuss their problems from the perspective of outsiders. It also makes them less guarded in discussions which helps in analyzing the situations and behaviors they experience (Danina & Kiselnikova, 2015; Yazici et.al., 2014). This approach seems to be especially helpful as a part of group therapy, seniors being no exception (Kim, 2014). Therefore, the authors have proposed to look at the problems of older adults through the lens of a film camera and to use documentary or feature films in the process of cinematherapy of the elderly. Several activities linked to conscious film watching, which can be effectively employed in psychotherapy or sociotherapy sessions to address and improve seniors' well-being, were also suggested. It is authors' hope that the scenario drafted in the second part of the article will inspire to adapt some cinematherapeutic techniques in psychological and educational interventions, make them more interesting to the beneficiaries, and, in the end – increase the therapy's efficacy.

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Life of people with severe intellectual disability – from adulthood to old age

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Keywords: a person with intellectual disability, adulthood, senility

Abstract

The psychology of development of human throughout his life developing worldwide after 1970 strongly emphasizes the interest in human in all phases of his life. The holistic attitude of the life-span psychology – manifested in the approach to human as a person – a multidimensional, but irreducible being, who functions in many areas, but always in a holistic way, and also a being that develops in a customized manner and without exception at every stage of life - helped to formulate many new detailed research problems. The scope of these research interests has also been extended to people with intellectual disabilities who increasingly take on social roles that are assigned to adults and perform developmental tasks assigned to a particular phase of life. Also, they increasingly reach late maturity, as the time of their dying gradually progresses.

The life of an adult is not homogeneous. It is created by the phases of life in which an adult functions, the life tasks that he or she undertakes, and the social roles that he or she performs. It is also difficult to clearly define the limits of adulthood, as it is not determined by the age, but the social and biological maturity. It manifests itself, first of all, in the ability to lead one's own life and to undertake and persistently strive for realizing development tasks, despite physical, social, and psychological obstacles encountered by every human being. Commitments, at this stage, are made in two spheres: family, which includes, in particular, procreation, choosing a life partner, setting up a family, birth and education of children, and professional, that mainly involves paid work of a fixed income, enabling to achieve financial independence (Gur-

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ba, 2000). The same situation applies to people with intellectual disabilities, although their life situation is slightly different. First of all, due to intellectual limitations, they are unable to carry out all the development tasks envisaged for this phase of life. This greatly limits their ability to achieve full autonomy and self-reliance. According to the DSM-V classification, *intellectual disability is a disorder beginning in the period of development and includes deficits in both intellectual and adaptive functioning in the areas of conceptual understanding, social functioning, and practical fields* (APA, 2015, p. 15). According to this definition, all three of the following criteria must be met, when it comes to intellectual disability:

- Criterion A concerning deficits in intellectual functioning, e.g. planning, problem solving, and abstract thinking. In the case of intellectual disability, there must be a decrease in intellectual efficiency by two or more standard deviations in the quotient of intelligence.

- Criterion B concerning overall deficits in adaptive behaviour by limits in one or more aspects of everyday life: participation in social life, communication, functioning at work and school, as well as home and community independence. Intellectual disability is characterized by significant disorders in adaptive functioning.

- Criterion C assuming that the onset of the disorder occurrence has been in the period of development.

The current classification distinguishes four types of disability: mild, moderate, significant, and profound (Morrison, 2016, pp. 26-27).

People with mild intellectual disabilities, entering adult life, take up most of the roles envisaged for this phase of life. On the other hand, preparing the more intellectually disabled for adulthood and its tasks requires work in the course of their whole life: at school, in the family home, or in rehabilitation centres for adults. Adulthood of people with intellectual disabilities, until recently, has not been of interest to researchers. Currently, there is a growing interest in the issue of adulthood of people with intellectual disabilities. This is due to an increase in the elderly population with disabilities (Cytowska, 2011). The environment should be maturely and appropriately treat them, properly select responsibilities and allow them to perform independently. Infantilisation of people with intellectual disabilities, lack of consent for their own actions or interference with their activity may lead to a slowdown in the development of their autonomy. Often, parents do not realize that their job is to help their child to become an adult, because the level of life skills he or she acquires will allow him or her to take up social roles envisaged for this phase of life. Jarosław Bąbka (2014, p. 14) points out that *people with disabilities are exposed to a variety of difficulties in functioning as adults due to poor education, not finding themselves on the labour market in times of intense social and economic change*.

After the period of early adulthood, there is a phase called middle adulthood. It involves the following tasks: getting a job, maintaining it and satisfaction with it, tak-

ing care of ageing parents, taking up the role of an uncle or aunt, and helping with housework. People with severe intellectual disability, properly prepared, are able to cope. In the middle adulthood phase, the first signs of ageing can be observed: first appearance of grey hair and wrinkles. These changes occur gradually and slowly, and often, for a long time, are not even noticeable. In addition, the moment of their start is dynamic and different. These first involutionary changes that occur in an adult human being are an indication of impending old age. They are proof that old age is an inevitable stage in every person's life. The changes are multidirectional, including both physical and mental changes.

They can lead to worsening of human functioning, which is often the cause of emotional crisis and lack of joy of life. The situation becomes even more difficult when people do not know that changes may occur, do not understand them, and often cannot deal with them by themselves. This is what the people with intellectual disabilities have to face. The dysfunctions resulting from the disability overlap with the person's individual pace of ageing, which complicates his or her already difficult life situation. Taking into account the way that people with intellectual disabilities function, there can be said that their ageing is slightly different. It is therefore very important to prepare people with severe intellectual disabilities for entering late adulthood. Parents, therapists and friends should take up this task earlier, as the changes may be incomprehensible for people with disabilities. They may cause irritation, annoyance, and even aggressive behaviour.

According to Ryszard Pichalski (2003), adulthood is a lifelong value, which means that a person is not fully mature, and therefore is not an adult, but constantly becomes adult, grows up to his or her own vision of the world and his or her place in it to his or her last moments of life. Almost every human being, as the years go by, more and more often thinks about his or her own old age, but also avoids this kind of thinking, fearing decrepitude, dependence on the family, loneliness, not wanting to accept the feeling of insecurity. He or she is frightened by the prospect of searching for support in social care. The author also points out that old age does not have to be a period of alienation, seclusion, total passivity. Old age - like childhood, youth, or maturity - takes something, but also gives something. The beginning of old age is not strictly defined, because it does not come overnight. There is a time to prepare for it. That is why everyone's job is to lead such a life so that old age is no surprise. One should take care of health condition and fitness better, which will translate into psychological well-being. The source of satisfaction for old age may be the feeling that life has not been wasted and it has not been squandered for trivial and unnecessary matters. Old age is characterized by a significant decrease in vital functions in terms of physical, mental, and social functioning. Old age also poses some challenges for the man, who, despite the difficulties, should tackle them. The most important tasks of this stage include accepting one's own life, taking up new roles and activities, and developing an attitude to death.

Expected life expectancy for the disabled is significantly lower than for the non-disabled. This is particularly true for people with severe disability and Down syndrome. Tadeusz Pietras, Andrzej Witusik, Marcin Panek, Piotr Kuna, Paweł Górski (2012, p. 377) cite research showing that the average life expectancy of people with Down syndrome is 55.8 years. In the 1930s, the average age of disabled people with intellectual disabilities increased to 15 for men and 22 for women. The mean median for the expected life expectancy of people with intellectual disability is 68.7 years. It is important to emphasize variety with regard to the degree of disability: for mild disability it is 74 years, moderate – 67.6 years, profound – 58.6 years. For people with a normal quotient of intelligence, the average life expectancy was 75.6 years for men and 81.2 years for women. The authors, analysing results of medical researches, indicate that the most common causes of death in people with intellectual disabilities are respiratory disorders, posture disorders' complications, gastrointestinal disorders, cardiovascular diseases, as well as oesophageal, stomach, and gall bladder tumours. The profile of the mortality structure differs from the population of healthy people, where cardiovascular diseases are the first, and on the second place there are tumours, with lung tumours as prevalent. In Down syndrome, the life-limiting factor is progressing stupor.

Effective adaptation to old age is the ability to cope with everyday problems by exercising personal control over one's own vision of ageing and quality of life under conditions of experiencing the loss of the most important values. Stanisława Steuden (2014, p. 8) emphasizes that *the complexity of human life, the richness of experience and the difference in the way of living is an individualized and person-specific manner of adjusting to old age*. Adapting to old age has a significant impact on the quality of life of people in this phase. Quality of life also depends on the course of previous stages, that is, from conception to old age. Old age is an inevitable and the most diverse phase of human life. *Disability has many names, but old age also has different faces* (Zych A.A., Kaleta-Witusiak, 2008).

According to Barbara Harwas-Napierała (2000), the support for development of adults with intellectual disabilities involves any (more or less conscious) measures manifested either by the individual (to himself or herself) or by other people to him or her in order to facilitate her developmental process. They should include:

- Assistance in accepting and adjusting to changes that occur in the social and family environment (retirement of parents, the need to support them in old age, preparation for passing away of the loved ones), and in oneself (involutionary changes, worsening of health).
- Consent of parents and therapists to make one's own decisions and to bear the consequences.
- Providing one's own activity related to family, professional, and social roles (Fornalik, 2008).

It depends to a great extent on the environment in which people with intellectual disabilities function whether they will have the opportunity to experience old age in all its aspects. It is the closest environment that should take care of their dignified old age.

People are increasingly interested in the issues of the elderly, as a result of many social changes that we face today. These include changes related to the situation on the labour market, the demographic situation or social policy of the state (Wrótniak, 2015). The author believes that old age is a static term - it occurs after adulthood; while the ageing process is dynamic and progressive. Ageing of the body is a set of anatomical and physiological changes that progress over time. They lead to reduction in the reserves and limiting of the ability to maintain homeostasis in stressful situations. These changes affect functioning of each cell, so they concern all tissues and systems. They are a natural stage of the body transformation, and therefore an inevitable part of every human life. Although they do not lead to illness or disability, they significantly increase their probability (Zasadzka, Wieczorowska-Tobis, 2014). The involuntary changes start around the age of 30 and deepen over time. Their progress is peculiar, which contributes to significant differences between people in old, the same, age. The ageing process is very fluid, it goes through stages (Wieczorowska-Tobis, Stogowski, 2014). Initially, there occurs social ageing, and then physical ageing. This process is also related to the conditions and the way of life, and is different depending on sex or place of residence. The process of ageing and old age are of interest to many sciences, including biology, geriatrics, medicine, philosophy, sociology, pedagogy, and psychology. Each of these areas has a different approach to ageing and old age. It is therefore very difficult to define these concepts in a way that would suit all researchers. The primary science related to ageing is gerontology. This is a field that involves the phenomena of late age. It seeks to understand the specificity of old people in the best possible way so that it can find ways to solve many of the problems faced by people in this age group. The goal of gerontology is to improve the quality of life for the elderly by rebuilding their authority, identifying their appropriate role in society and in the family, improving health, motivating for development, improving efficiency, and stimulating activity. (Krzysztofiak, 2016). To say that a human is already biologically, socially, and psychologically old, is, in fact, a question of convention that is ruling at a certain time, in a particular historical system, in a given culture and social sphere. In this view, in principle, it is the society who decides how old age is defined and perceived, because it is, in a certain way, a social destiny (Krzysztofiak, 2016). At present, ageing and old age appear in the field of pedagogy, whose aim is to raise to old age. This involves preparing people for old age by making them aware of the consequences of this stage in every sphere of life. The pedagogy of old age is to introduce the specificity of old age, and also to inspire and motivate older people to be active. Its purpose is to make that this group of people develop their interests and are socially active; as a result, it will enable these people to accept their age, to pass through this phase of life in a smoother way, as well as to avoid isolation and loneliness. The process of raising into old age should take place throughout the human life so that the desired habits can be appropriately established. The pedagogy of old age should also have an impact beyond seniors; it should also influence the people who help them, and even the whole society. It should develop an appropriate attitude, eliminate stereotypes

and prejudices against old people. On the other hand, help for people with intellectual disabilities entering adulthood and ageing should include:

- support of the family and providing financial help necessary for adults with intellectual disabilities to become independent,
- introduction of protected housing as a systematic solution contributing to the independence of people with intellectual disabilities,
- promoting universal health care programs and health programs,
- involving people with intellectual disabilities in social activities (Kijak, 2013).

It is important to assist people with intellectual disabilities in recognizing the positive aspects of ageing and eliminating the fear associated with arrival of this stage of life. It is also necessary to create a model of active ageing with a focus on development tasks. The positive reception of old age does not appear from nowhere – it is rather a result of good, wise preparation and raising to old age (Wolska, 2014). Good education to old age should be an essential element of modern education, free from prejudice and non-acceptance, and should be universal – referring to the needs and values, as well as preferences of the elderly (Kijak, 2013, p. 106).

Thanks to the *Scale of observation of involutionary changes in the development of mentally retarded people* by Lambert (in translating and modification by W. Pilecka, D. Wolska), I have obtained data concerning changes observed by parents or carers and occupational therapists in people with intellectual disabilities in the following areas: physical appearance, life activity, stereotyped and ritualistic behaviours, speaking and thinking, perception, memory, orientation in time and space, attention, nature and mood, and self-evaluation of changes (Wolska, 2014). The study included 300 adults living in a family of origin or in social care homes that were at least 40 years old.

Major regression changes were noted in the physical appearance of the subjects examined. They concern: *slowing the movements in the march, slowing the movements of the most important parts of the body, and manual difficulties*. Their intensity increased with the age of the subjects. The involutionary changes associated with life activity are: *lack of interest in external appearance, reluctance to engage in professional activity, and lack of interest in entertainment*. All stereotyped and ritual behaviours occur more frequently in the population of people over the age of 43 and concern: *the occurrence of stereotyped movements, stereotyped movements of hands, and ritual behaviours before falling asleep*. In the study group of adults with intellectual disabilities, the observed involutionary changes were also related to thinking: *slowing of train of thought, loss of thread during conversation*, as well as *reduced concentration* are the most common difficulties signalled by significant people. Rarely, there were difficulties with the severity of speech disorders: *less fluent language, difficulty in maintaining conversation, and loss of vocabulary*. All of the aforementioned changes had an upward trend in the group of over 43-year-olds. The change in perceptions observed by parents and therapists was mainly related to *wrong interpretation of events*. The *visual and auditory hallucinations* were minor. An involuntary change, which occurs most often in the population and is associated with

functioning of memory, is *forgetting where they leave their belongings, forgetting the names of known people, and losing memories of recent events*. In over 43-year-olds, there is a growing group of people *who do not remember from day to day*. Regression in terms of time and space orientation in the examined group of disabled people is not very serious and concerns: *confusing weekdays and hours of day, as well as forgetting the date and time*. The involutionary changes related to attention are evident when playing a *well-known game, the need to repeat well one routine that has been “mastered” so far and loss of the ability to track TV programs*, even though that before, watching TV filled almost all of the free time of the subjects. The involutionary changes in nature and humour are intensive in the study group. These include: *irritability, global changes of humour without cause, suspicion of people, feeling of persecution* and depressive symptoms: *no interest in the environment, general apathy and lack of cooperation*. A relatively small number of people with intellectual disabilities are unaware that their functioning has changed due to involutionary changes that have occurred in their lives. This is confirmed by the fact that self-assessments of people with intellectual disabilities who function well in the environment and are aware of their strengths and weaknesses – are right.

The above analysis clearly indicates that with age, the skills of people with intellectual disabilities developed during education and in activity centres change under the influence of emerging involutional changes. Therefore, these changes need to be taken into account when planning professional or social activity of adults with intellectual disability. The study enables to state that involution changes occurs more frequently when a person with disability lives in a social welfare home. Also, the lack of professional activity promotes intensification of involutionary changes.

At the end of the discussion on the most frequent involution changes in people with intellectual disabilities, I would like to propose a model of good old age that takes into account the independent variables influencing involutionary changes.

In the interest of good old age for people with intellectual disabilities, it is necessary to introduce systemic aid solutions. Older people emphasize the importance of the fact that the social worker is interested in their needs, views, and health. They appreciate the fact that they are still important members of society and that the state is taking action in support of people in old age. Employees who provide preventive home help should assist in small household chores. Sometimes it is enough to walk with the worker, to do shopping or to have a tea or a conversation together. Susan Gustafsson, Kajsa Eklund, Katarin Wilhelmson, Anna Karina Edberg, Boo Johansson, Greta Kronlof, Gunilla Gosman-Hedstrom, Synneve Dahlin-Ivanoff (2012) research indicates that in the elderly who have systematically benefited from this type of support, involutionary changes have considerably slowed. I think that in families with intellectually disabled, the workers would have to be prepared to talk about the possibilities and limitations of the disability. In Poland, families and people with intellectual disabilities can benefit from the services provided by social welfare facilities, but in order to make them available, there must be met a number of conditions. The preventive home visits would require only one criterion – of age.

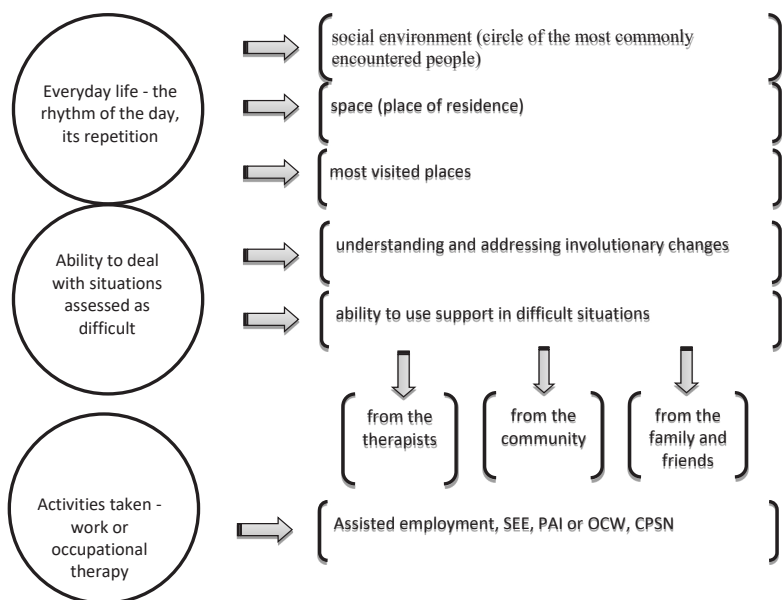


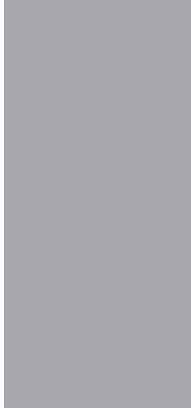
Chart 1. Model of good old age of a person with intellectual disability

I would like my considerations to help people with intellectual disabilities, their parents, therapists, and friends to consider old age as a phase of human life, with its tasks, difficulties and joys. I would like to convince them that it is worth trying to make it possible for them to experience full adulthood and old age. A person with intellectual disability at this time will need family and professional support to understand involutionary changes, to try to delay them and then, to accept it.

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Progress in physical activity of elderly people in hygienic and health aspect

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Keywords: senescence, history, physical activity, elderly, hygiene, health

Abstract

Physical activity of the elderly provides maintenance of efficiency, health for many years of life. It affects also on the extension of independence and is the cure on many maladies of old age. We can observe the effects of the coming old-age in the second half of life, middle aged, when we are getting older and occurs slow reduction of physical and psychical capacity of organism. „We run to die healthy” - who among us doesn't imagine how to be efficiency to the end of life in good sport condition? Physical efficiency allows us to achieve optimal quality of life everyday and the performance of motion activities, necessary for health of elderly people.

The sole goal of this article is to show how shaped by the views from the past on physical activity of elderly and views of doctors and activists of physical culture on seniors efficiency. The issue physical activity of the elderly is little known because we always pay attention on progress the children and the teenagers, what confirm many pedagogical works. We have not much science publications which encourage the elderly to active and healthy lifestyle. During the research following methods were used: source materials search, source amassing, combining those materials, analysing and interpreting the source materials, also explaining some of the historical facts with reference to reality of that times. The research covers elaborations about physical activities, medicine and history of physical culture field literature, and the recreation of elderly. Furthermore the method of individual observation was used. The article shows the role of the elderly people physical activity in hygienic aspect and his influence on extension of life. A very important role plays also family, their help, care on senior and mutual support and social awareness, which allows to actively participate the elderly in physical culture, whose aim is to maintain the efficiency to the end of life.

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Introduction

Physical activity of the elderly through health care, diet and hygiene promotes bodily fitness, prolongs youth, prevents loneliness and emptiness. Movement becomes a cure for many ailments. Physical activity in an older age is extremely important for health, allowing it to maintain fitness and independence for longer, and to improve mental health. Taking care of the physical condition, we care about the nervous system, which maintains the activity and health of seniors.

When we get older, „we run to die healthy”, in the sport form looking forward of a decent age and be fit until end in life. Physical inactivity is a dynamic aging of the body, a gradual decrease in mental and physical fitness of the body is a sign of coming old age. It starts in the second half of life, and its effects can be seen in middle age or elderly, therefore we exercise for health, pleasure, to maintain a good condition and well-being. The role of physical activity is to be a healthy and happy person, socially beneficial. It is an invaluable way to have a successful personal and professional life through health and sport - these are the values that accompany and should accompany us in the 21st century. A man should learn to grow old and how to maintain dignity in his life, physical activity is the main element of a healthy and hygienic lifestyle. Old age is the wisdom of the past life and the joy of living in preserved health.

Materials and methods

The sole goal of this article is to show how shaped by the views from the past on physical activity of elderly and views of doctors and activists of physical culture on seniors efficiency.

The issue physical activity of the elderly is little known because we always pay attention on progress the children and the teenagers, what confirm many pedagogical works. We have not much science publications which encourage the elderly to active and healthy lifestyle.

During the research following methods were used: source materials search, source amassing, combining those materials (Toporowicz 1996, p. 123), analysing and interpreting the source materials, also explaining some of the historical facts with reference to reality of that times. The research covers elaborations about physical activities, medicine and history of physical culture field literature, and the recreation of elderly. Furthermore the method of individual observation was used. The article shows the role of the elderly people physical activity in hygienic aspect and his influence on extension of life. A very important role plays also family, their help, care on senior and mutual support and social awareness, which allows to actively participate the elderly in physical culture, whose aim is to maintain the efficiency to the end of life.

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Interest in the efficiency of the elderly was accompanied by people from the dawn of history, their physical activity was defined as the strength and condition necessary for work and survival. Through work, tooling, and experience, man gained and learned motor skills from his ancestors; this work was done only by the power of human muscles. Dexterity, endurance and speed were the hallmarks of human motor skills. Motor fitness was to serve life and health.

From the beginning of its existence, man had to deal with illnesses and already in the stone age existed traumatic surgery, based on the “doctor” institution, when connected broken bones, overlap dressings wound and stitched wound healing, which served to improve health.

In the Neolithic period, attempts were made to treat patients with complicated surgical procedures such as trepanation of skull, use of laxatives, laxatives, and pain relievers (hemp, opium). Blood was letting by the opening the veins, cupping therapy, and other methods were used. Experimental medicine came to an end when a man began to wonder about the cause of illness. Prehistoric people attributed their longevity to higher powers or their ancestors. At favorable times, when the tribe had enough of food, and there was some survival when there was no danger, the old man was in a decent position, surrounded by the aura of supernatural authority by longevity. He was surrounded by honor and respect, and he played an important social role, namely, he was a guide between the temporal world and the supernatural – the sorcerer or the priest.

According to the African proverb ... *When the old man dies, the whole library get burns down* (Minois 1995, p. 20), the old man as the principal source of knowledge and memory of the tribe was an educator, judge, associated with his wisdom and experience. At primitive peoples, bearded and gray-haired men held power as the Council of Elders, which was the most respectable institution in civilizations of spoken tradition. The old man, depending on the circumstances, was surrounded with respect or contempt, worshiped or condemned to death, was a source of wisdom, and at the same time infirm, impotent, unnecessary, threatening the existence of the group. People was faced with the problem of old age have created all sorts of solutions: respect, rejection, indifference, care - these attitudes brutally was express fear, misunderstanding and powerlessness in the face of aging. Every society tried to live and survive, feared the powerlessness and sterile that old age was carrying. The fact that the man lived 70–80 years was an extraordinary feat that could be achieved through the help and care of the gods.

Ptah – a hotep who, after complaining for physical infirmity, boasted himself that the gods to bestow him grace, wishing his son to live to see to the same age as him, 110 years. Long life was the reward the gods admits the righteous.

Physical activity of primitive people was a time of adaptation to the natural environment, of mastering life skills, of opposing the threats of reality and of benefiting from

it, consisting in the existence of primitive man. Later, the development of bodily and physical fitness, necessary for survival in a difficult environment, developed. Physical exercises played a very important instinctive role, due to external hazards and to maintain the physical fitness of adults, who improved their vital functions while raising their hunting skills (Lipoński 2012, p. 23).

The care of a good body in Chinese and Indian culture were recognized since the earliest times, these were the oldest civilizations of the world, so despite differences I decided to combine them and describe them together.

Indian society attached great importance to hygiene and cleanliness, physical exercise conditioned by the country's defense requirements (Wroczyński 1979, p. 32). Sports that have been cultivated were mainly wrestling where they have achieved great physical fitness thanks to special massage (athletic, healing and hygienic). They used water baths to maintain high body hygiene. The most important religious system was yoga, which included physical exercise and was intended to control the body through the will of man.

The purpose of these exercises was to strive for the perfection of body and spirit through concentration, meditation, respiratory exercises, bans, and injunctions. In India, physical exercise were used as a means of maintaining and improving health. In the sacred books of the Vedas – Ayur Vedanta were recommendations for the hygiene of medical gymnastics (Wilk 1985, p.6). The two most prominent Indian physicians, Charaks (beginning of AD) and Sushruta (6th century BC), recommended exercising in the treatment of many diseases, exchanging a number of advantages of physical activity according to their age and health. They recommended systematic exercise.

Buddhism, which originated in India, has had a great impact on the spiritual life of China and Tibet. Chinese society especially cared about the elderly and recognized the family as the basis for social order, ancestor worship and the main source of wisdom (Wroczyński 1979, p. 21). Confucius (551–479 BC), a Chinese philosopher, wrote in Book Li that young people were taught six virtues, six activities and six teachings. **Virtues:** wisdom, charity, justice, fidelity, goodness, consensus. **Actions:** respect for parents, friendship to the brothers, cordiality to the relatives of the wife, friendship for the neighbors, compassion for misfortune and harm. **Sciences:** ceremonial court life, music, archery, car driving, writing, math.

Many of the activities carried out by Chinese society were cultivated until the late ages, ex. archery, which was the best way to social, moral and character education. The Chinese society knew *Kong Fu* gymnastics, which served to improve the body and support its immunity, grown by the elderly. On the other hand, the *taj - tsy* system defined the order of movements and the rhythmicity with which one passed from one attitude to another had a therapeutic significance (Wilk 1985, p. 5). *Nej Tsing (Book on Internal Life)*, written in the 3rd century AD, is the meaning of physical training for human health. It is the ancient Chinese *medicine canon of the yellow cesar Huang-Ti* (Minois 1995, p. 27). *Szenga* – a system of gymnastic exercises for the elderly, performed in

the sitting and lying position, also used a massage that stimulated muscular activity, as a therapeutic and preventive method has a positive influence on the respiratory and circulatory system, alleviated pain (Wilk 1985, p. 6). The masseur used his hands, elbows, feet and nails. It was combined with acupuncture – it is a puncture treatment with needles. There are over 693 vital points in the human body.

The first hygienic indications were created in China, India and Egypt, which concerned prevention and health protection, based on practical habits and customs as well as religious indications to protect human life and health. This practice was based on the experience of generations and drew conclusions and hygienic indications on proper nutrition, cleanliness, sleep, rest, and is used today. Over time, magical rituals have given birth to scientific medicine in China 4000 years ago, this knowledge has been written down on bamboo tablets containing the patient's symptoms, appropriate remedies, recipes, dosage and ways of using it in herbal medicine. Old-fashioned medicine is a philosophy of life, taking care of the physical and mental health of man.

The development of hygiene in Egypt has affected life expectancy, and health care has supported hygienic practices commonly used. Homes had bathrooms and toilets, ashes were used, clay, soda, mouth rinsed with salt water. Depilatory treatments were applied: manicures and pedicures, as well as ointments. The ancient Egyptians developed the cult of beauty and physical fitness (Wroczyński 1979, p. 28).

Herodotus (484–425 BC), describing the *Longevity Ethiopians* and seeking the mysterious source of longevity, wrote about the physical fitness of the elderly, presented the Egyptians and the Lebanese as the healthiest people of all who have “the highest in the world” physical fitness (Minois 1995, p.31). The family in ancient Egypt was a sacred institution. It was in the family that the principles of hygiene and health were taught. Herodotus argued that Egyptian elders should not leave their own fate, because according to the custom, daughters are obliged to keep their parents.

The fate of the old without children had to be regrettable; the lonely old man was placed on a par with the poor, the sick, the handicapped - there was a hospice for the poor in whom they found shelter most in need in Nippur in Mesopotamia. The old man and the old woman were treated with respect. The oldest image of the old man – the statue of Ebih-Ila, the administrator of the city of Mari – from 2700 BC with a bald, bearded figure was emanated a great dignity, reminding us that in this society every older man was in contact with the god. The old people were respected all the more so because they were so few in the world where the art of writing was rare, they were living archives and a code of laws, and their experience was immortal and useful in an environment that did not worship physical beauty but was valued for wisdom.

Since the dawn of history, man has been endeavoring for health and longevity through hygienic living. “Hygiene” (from Greek *hygieinos* – from Hygiei Greek goddess Hygiei) was engaged in research and observation of factors influencing health (Korczak 1982, p. 17). Already in Antiquity Hippocrates (460–370 BC) has developed new foundations of medical thought and knowledge, hygienic and health indica-

tions and regulations for the protection of health and life, *first harmless* (Wilk 1985). Through Humorous Theory, consisting of four elements such as cold, heat, dryness and humidity, he believed that the illness affected the human environment, he used climate treatment, baths, diets, gymnastics, walking, running, boxing and wrestling.

The most important state decisions belonged to the Council of Elders, they were called *gerousia* (*geron* – old) (Burda et al., 2002, p. 86). Council members may be meritorious citizens, must be over 60 and still be selected for life.

In *The Age of Cicero* (106–43 BC) he talked about active and cheerful, well-to-do lives, interest and exercise in virtues, remaining a useful mind, advice and experience for young children. Cicero's work is a beautiful praise of old age. The old man spoke beautiful, taught the youths about old age, which gentle and quiet, she came after life in good health, noble and beautiful. The good meaning of old age is the result of the inner attitude of man. The wisdom is to follow the nature in which old age and death are irrevocable. Cicero looked at the problem of old age from the perspective of an old man who had survived his life and could pass on his message to others.

Weapons against the old age is consciousness well-being of life, intellectual interests and continuous exercise themselves in virtue. Cicero presents four disadvantages and origins of old age:

- old age is considered unhappiness, because it receding the man away from active life,
- makes that body is physically unable,
- deprives sense pleasure,
- brings closer man to death.

The Ciceronian Katon overthrows all these accusations of old age, demonstrating that he serves fellow citizens with advice, mind and experience – old council. *Lack of prudence is a feature of youth, common sense comes with age. Respect for people is an ornament of old age. Neither gray hair nor wrinkles will cause people to start suddenly respect us. The mature fruit of human respect seems only a lifetime of reasonable* (Ciceron 1995, p. 43). It can be said that the fruit of old age is the memory and abundance of accumulated merit and experience passed on to the next generations.

Galen (130–210 r. n.), as the most prominent reformer and physician, organized exercises of healing gymnastics, and through the physical nature of constancy he preached unity to the processes of growth and twilight of man (Kałamacka 2003, p. 27). Our body is growing, aging, weakening and dying. Galen believed that old age was not a disease, emphasizing that older people need the same amount of physical exercise as young people, but their intensity should be less (Wilk 1985, p. 12). In addition, after exercising for massage, bathing and eating, they should sleep – these are privileges for the elderly. Ancient Rome broadcast dignity to the old.

In the field of medicine and hygiene in the Middle Ages, the physician played an important role: Awicenna (980–1037 AD), who presented the issues of hygiene of housing, clothing and nutrition in the *The Canon of Medicine*. He was a proponent

of physical exercise in the treatment and prophylaxis of the elderly, advising them moderate exercise. He showed the possibility of developing diseases through soil and drinking water.

In Europe, in the Middle Ages, hygiene has disappeared. Religious point of view: Asceticism, habits and hygienic lifestyles, so developed in Greece and Rome failed. *Palestrica diaboli negotium* – bodily exercises are the work of the devil (Osterloff 1976, p. 64), these were the words of Tertullian (160–220 AD), the so-called African father of the Church. His writings were ascetical - ethical content and his negative views on science and reason and on human nature. He condemned everything bodily, he saw only the material and the sensuous being; There was nothing in the body (Tatarkiewicz 1988, p. 190). This has led to the development of serious epidemics: plague, typhus, cholera and others. The average life expectancy was very low, about 20–23 years, and in England in the 14th century it was even 17–20 years.

Progress in the field of hygiene has been modest, we can talk about the regression of the theory and practice of hygiene. St. Augustine (354–430) as a saint and Doctor of the Church, played an important role in the development of modern thought, has designated six periods in human life: cradle, childhood, adolescence, youth, adulthood and old age – the last one starting around the sixties year. St. Augustine found signs of wisdom in the old man (gray hair), and also manifestations of sin (skin flaccid), the virtue counted for him, not the age. Old age in itself, imperfect, not necessarily bring wisdom.

The old man who turned into a human wreck should think of his salvation, he was a symbol of the vanity of the earthly world and repulsive ugliness, as well as the image of sin (old age and sickness), lived in misery, ugliness and suffering. St. Augustine argued that *physical exercise is the wheel in which the devil stands*. He appealed to *exercitio sacro* - holiest spiritual exercises (Głuszek et al. 1976, p. 290).

Improving living and hygiene in the Age of Enlightenment fostered progress in science and medicine. Great contribution of the Commission for National Education in Poland and teaching in health. Commission law recommended personal hygiene and hardening of the body, but they were not implemented in life, because the rakish gentry preferred feasting and hunting from other forms of activity.

In the eighteenth century doctors did not know much about old age. There was gratitude, tenderness and respect for old people; It was a time of cordiality for the family and the society: good old people, grandmas reading fairy tales, old people were not saints, or mythical grumblers, we were just starting to like them, and with this sympathy old age became more important (Bois 1996, p. 183).

In the eighteenth and nineteenth centuries there was a development and a revival in the field of hygiene issues *Utopia* and Tomasso Campanella (1568–1639) *The City of the Sun* contributed to the discussion of general hygiene. In the eighteenth century the work of Bernardin Ramazzini (1633–1714) *About the illnesses of craftsmen* and Christophe W. Hufeland (1762–1836) was published *The macrobiotic as the art of*

extending human life. At the beginning of the nineteenth century, Johann Peter Frank (1745–1821) in the *General Medical Police System* presented new ideas and directions of action, particularly important for human hygiene, on the threshold of the industrial revolution of the nineteenth century, emphasizing that the primitive man, which was closer to nature, was more healthy and happy, and life in cities made him less resistant to illness, less healthily and less happy.

In the development of hygiene and medicine in the nineteenth century, epidemics that threatened life and health of humans were of great importance, requiring them to be remedied; new research methods, physical, chemical and microbiological methods were introduced for this purpose – Max von Pettenkofer (1818–1901) Named hygiene father who drew attention to the environment in which a person lives (Korczak 1982, p. 24). He contributed to the development of the scientific basis of environmental hygiene. Joseph Pasteur (1822–1895), Joseph Lister (1827–1912) and Robert Koch (1843–1910), developed the bacteriological development of the bacterium, and led to the explanation of the role of germs in infectious diseases and the development of epidemiology, as well as the ways and means of the spread of germs in the human body.

The development of hygiene, hygiene and family medicine encouraged the use of toilet cleaners, hygiene nutritionists - nutritionists and orderly lifestyles. The physician, who cares about his patients, recommends physical exercise, travel, air change, spa and sanatoria. Water cure developed thanks to the Silesian peasant Wincenty Priessnitz (1799–1851). It has given rise to the development of hydrotherapy and balneology, to this day in many countries the word “shower” comes from its name and means shower. Jędrzej Śniadecki (1768–1838) introduced in Poland in the 19th century new methods of physical education, recommending physical exercises in the form of treatment.

Physical activity at the end of the 19th century served as organized movement of the health as a factor to compensate for many hours of work. Around the densely populated cities, attention was paid to the balance in creating areas for games, play, walks, ice rinks and bathing areas, which were also used by older people. An interesting phenomenon was the recreation of outdoor recreation, he was modeled on the United States and created in Krakow the park dr. Henryk Jordan (1842–1907). This project aimed to promote physical activity among adults in Cracow. In the Czech Republic (1862), the *Sokol*² Gymnastic Association was established. It was to be a physical education organization, educating the physical strength of the liberation struggle, whose membership was about 100,000. Its founder was Miroslav Tyrš (1832–1884) – the manager, ideologist, and also Jindrich Fügner, patron of this association, active doing fencing and rowing.

The body of the association was the *Sokol* script. The association developed in the Polish lands in Galicia in Lviv in 1867 as the Gymnastic Society, and in 1869 it adopted the name in accordance with the Statutes of the *Sokol* Gymnastic Society, which aimed at nurturing gymnastics, hygiene and educational in the field of physical culture. As a form

2 Falcon [ZS].

of physical activity, it initiated a gymnastic movement that involved also adults (Orlewicz-Musiał 2007, p. 4). He provided health, joy, physical development, morally and spiritually. This organization has become very popular for all people, dealing with hygiene education, printing publications, brochures, calendars, songbooks, health and exercise magazines that reached the elderly. Sokół has contributed to the development of physical culture in Poland, through gymnastics and outdoor activities (Kalamacka 1997, p. 46).

This organization is still active today in Sokół Senior Clubs, seniors thanks to gymnastics remain efficiency for a longer period of time, characterized by spontaneity, temperament and humor.

Both in Poland and in Europe in the 19th century brought great changes in all areas of life. The progress achieved in medicine and physical culture has had a huge impact on the interest in therapeutic gymnastics and other therapies. Europe did not like older people, but the aging of the population was a problem of the 19th century.

This has prompted many observers to draw conclusions for the future: that health and efficiency are useful values from which we can enjoy pleasure and serene of old age. The rise in the number of elderly people and their prolonged life, acceptance of old age, have contributed to the study of physicians, nursing and treatment. Old age was the image of the whole course of life, the dream of every human being. Cheerful aging was a reward for life in which a man should prepare himself through a hygienic, temperate way of life.

The nineteenth century was the period when the elders exercised their rule, were priests, were the leaders of nations, and the symbolic value of old age was respected. Thanks to medicine, it has become a natural phenomenon, aimed at explaining the process of aging, recognizing and curing old age.

The novelty of the twentieth century was the spread of physical activity, attention was paid to appearance, state of mind and body – to feel good in his skin.

Occured struggle with old age, and in order to delay the irreversible effects of aging, with old age, it was necessary to take care of hygiene, nutrition and physical culture as well as cosmetology. Clinics have been created offering miraculous rejuvenation treatments, surgical procedures, lifting – to look young, reject old age; Care for the body and health. Appeared new nursing homes for seniors. Very important for the doctors was the good of the elderly and to enable them to be calm old age through rehabilitation and mobility (Duby 2000, p. 111).

In modern times, family plays an important role in the lives of older people; as A.A. Zych (1995, p. 57) writes: *older people can convey to young people the difficult life experience gained, the wisdom of the past*, while the young can give older people the joy and optimism to live. *Old age is the luggage of many experiences, thoughts*. Youth is hope of the future, *young people facing the future want to live differently than parents and grandparents, do not want to make the same mistakes*. Seniors and juniors are mutually necessary for each other, this position includes the intergenerational bonds of family life, grandparents and grandmothers are life teachers, wise educators and carers.

The older generation needs a close, young man who expects warmth and concern, and through telling stories can give him the wisdom of survived years.

Conclusions

According to A. A. Zych (1995, p. 85), the highest value, valued by old people, is health; With age, the health of seniors is deteriorating. From the needs of an aging person such as *peace, family, happiness, friendship, love and attachment, kindness and goodness*, security, care and support, family is the greatest element of social identity. The task of every person is to prolong the period of physical activity, to maintain health, to shift old age to later, because each person is aging uniquely and individually.

One of the most important qualities of life at the turn of the old age is activity, which is the basis of good health and well-being (Żukowska 2012, p. 91). *Physical activity and longevity go together hand in hand*, actively optimistic look at the world, it's connected with mental health. Aging is very complex, because aging is a natural process, so do not fight with old age, you should prepare for it. Physical activity decreases the rate of aging, *one must live optimistically and humanistically, be human and live in a dignified way, and respect the others* – the idea of respect for man is derived from the philosopher Immanuel Kant (1724–1804).

The aging man should seek the solution of the purpose and the meaning of life, while old age should be considered as another vital task to be accomplished. *Life is only one and unrepeatable, too precious to destroy them mindlessly*, so you must live creatively, learn at every age of difficult art of life and create the art of living and live it in value way *so that old age becomes dignity and not a social burden* (Zych 1995, p. 130). A man who is over his adulthood must count on the fact that he will lose health every year, and his fitness and mental condition will be greatly reduced, he may run out of a life partner, family, home, what is involved with loneliness and dependency for others. Because be human means voluntarily giving something to the existence of another person, while respecting his pain and suffering and helping, when possible in overcoming this suffering.

Seniors should be calm, free from anxiety, old age, should occupy honorable place in society, care and respect for which they deserved through the work of life; *old man has the right to life* (Zych 1995, p. 130). Physical culture is *the care of the psyche of the body* – as the Polish philosopher Władysław Tatarkiewicz wrote (1886–1980), it is a feature of human life, through physical activity conditions the health, life, development and permanently efficient senior man. Motion is a medicine that does not cost anything.

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ARTICLES

Part II

Social policy – age-friendly friendship



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National policies for healthy ageing: the Maltese experience

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Abstract

Public policy in Malta is strongly geared towards improving the levels of healthy ageing of present and incoming cohorts of older persons. Ageing policy in Malta follows the European Commission's document Guiding Principles for Active Ageing and Solidarity between Generations which underlined how societies must not be solely content with a remarkable increase in life expectancy, but must also strive to extend healthy life years, and then to provide opportunities for physical and mental activities that are adapted to the capacities of older individuals. The government of Malta employs 14 consultant geriatricians who work mainly in the public rehabilitation hospital and residential/nursing homes, concentrating on frail elders, and in specialty clinics – for example, on memory, falls, and continence. This means that there is a consultant geriatrician for every 7,948 persons aged 60-plus, which compares well to other European Union nations such as Germany (7,496), Spain (7,701), United Kingdom (8,871), and Switzerland (9,250). At the same time, the Maltese government has launched the National Strategic Policy for Active Ageing, National Dementia Strategy, and the Minimum Standards for Care Homes in Malta all of which include a range of recommendations that aim to lead older persons towards higher levels of healthy ageing.

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Introduction

Transforming society's perception of ageing from one of an expectation of dependency and decline to that of an opportunity to actively participate in the labour market and society requires a paradigm shift that enables higher levels of healthy ageing. Respecting the rights of older persons to lead a life of dignity and independence, and to participate in social and cultural life, Maltese national policy caters for the creation of the necessary conditions that allow older persons to remain full contributing members of society rather than assuming a role of dependency. Ageing policy in Malta follows the European Commission's (2012a) document *Guiding Principles for Active Ageing and Solidarity between Generations* which underlines how societies must not be solely content with a remarkable increase in life expectancy, but must also strive to extend healthy life years by providing opportunities for physical and mental activities that are adapted to the capacities of older individuals. Strengthening measures of health promotion, care and protection, as well as disease and injury prevention at all ages enables older persons to lower their probability of illness and disability, whilst aiding them to ensure high physical and mental functioning that fosters independent living. This paper presents key developments in Maltese public policy related to healthy ageing. Following this brief introduction, the subsequent section highlights the range of public geriatric services. The third to fifth sections focus on policies which were launched and implemented precisely to improve the levels of health ageing amongst present and incoming cohorts of older persons in Malta, and presents the *National Strategic Policy for Active Ageing*, *National Dementia Strategy*, and the *Minimum Standards for Care Homes in Malta*. The final brief section brings the paper to a close by forwarding proposals for the future of healthy ageing policy in Malta.

Ageing transitions in Malta

Over the 20th Century the population of Malta has doubled, from 211,564 in 1911 to 434,403 in 2015 (National Statistics Office, 2016). However, the growth in the Maltese population was not evenly distributed amongst the various age cohorts. Whilst in 1901, 5.4 per cent of Malta's population was situated in the 65-plus cohort, in subsequent years this age group increased substantially to reach as much as 19.0 per cent respectively in the year 2016 (ibid.). As a result of such demographic developments, the Maltese population has evolved out of a traditional pyramidal shape to an even-shaped block distribution of equal numbers at each cohort except at the top.

At end of 2015, more than a quarter of the total population, 26.6 per cent, equivalent to 111,281, were 60 years old and over (National Statistics Office, 2016). The largest share of the older population is made up of women, with 53.8 per cent of the total. In fact, the sex ratios for cohorts aged 80- and 90-plus numbered 63.7 and 70.6 respectively, which means that amongst the oldest cohorts there is more than twice the number of older women than men. Such fluctuations were largely the result of

a declining birth rate, together with an increasing life expectation for both men and women. Whilst at the beginning of the 20th Century life expectancy in Malta was around 43 years for men and 46 years females, in 2013 these figures reached 79.6 and 84.0 years respectively (ibid., 2015). Malta also registers excellent and record results in health life years which is designated to monitor whether the extra years of life are lived in good health. A recent research publication concluded that whilst “on average across European Union member states health life years at birth was 61.8 years for women and 61.4 years for men”, it was “highest in Malta and Sweden for both women and men (above 70 years)” (Organisation for Economic Co-operation and Development & European Union, 2016: 56).

The population of Malta is expected to reach 468,900 and 480,700 persons by 2050 and 2070 respectively (National Statistics Office, 2015). Although the annual number of births is projected to fall over this period, the annual number of deaths is projected to continue rising at much faster rates. In fact, by 2050 the population of persons aged 65 years and over is projected to increase to around 124,000 – an increase of 51 per cent when compared to this segment of the population during 2015 which numbered 82,200. By 2070, this cohort will continue to increase 136,700 – an increase of 66 per cent compared to 2015 (ibid.).

Geriatric services

In 2000, the World Health Organization classified Malta as the 5th best performing health system from a total of 191 countries (Azzopardi, 2011). This is primarily due to the fact that health care in Malta boasts exceptional levels of equity as it is available to all citizens, irrespective of income. As far as geriatric services are concerned, Malta has come a long way in the past quarter of a century. As it was recently reported,

Geriatric medicine has been established in Malta since the year 1989 when the first consultant geriatrician post was advertised and filled in the state-run health services... the post of lecturer in Geriatrics at the University of Malta was created and the subject taught to medical students...A postgraduate training programme in Geriatrics was set up in...2008. (Ekdahl et al., 2012)

The past 25 years also witnessed the opening of an assessment and rehabilitation hospital specifically for older persons with an emphasis on enabling them to return back into the community, and the introduction of modules on geriatric medicine for medical students. The University of Malta also established Department of Gerontology to run a Postgraduate Diploma, Master Degree and Doctorate in Gerontology and Geriatrics. Presently, geriatric medicine is recognised as a separate specialty, with the government of Malta employing 14 consultant geriatricians who work mainly in the public rehabilitation hospital and residential/nursing homes, concentrating on frail elders, and in specialty clinics – for example, on memory, falls, and continence. This means that there is a consultant geriatrician for every 7,948 persons aged 60-plus (2015

figures) – which compares well to other European Union nations such as Germany (7,496), Spain (7,701), United Kingdom (8,871), and Switzerland (9,250) (Ekdahl et al., 2012). Geriatricians also teach university students following medicine, whilst also conducting clinical research. The Office of the Prime Minister (2013) reported that in 2012 the Department of Geriatrics provided a clinical service mainly on the following sites: Rehabilitation Hospital Karen Grech (249 beds), St. Vincent de Paul Long-Term Facility, Mount Carmel Hospital, Mater Dei Hospital (assessing referred patients), and state-run community homes and public-private beds (assessing referred patients). In addition, the department occupied a key role in specialised clinics related to memory, continence, movement disorders, falls, ophthalmic and tuberculosis/pulmonary disorders.

National Strategic Policy for Active Ageing

In its drive to improve the levels of health ageing, one of the first national policies launched by the Government of Malta to work towards such an objective included the *National Strategic Policy for Active Ageing: Malta 2014–2020* (Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing, 2013). Including a total of 75 policy recommendations, as much as one third of them focus on healthy ageing, with the remaining two themes being active participation in the labour market and social participation. The *National Strategic Policy* underlined that society should not be content solely with a remarkable increased life expectancy, but must also strive to extend healthy life years. Strengthening measures of health promotion, care and protection, as well as disease and injury prevention at all ages enables older persons to lower their probability of illness and disability, whilst aiding them to ensure high physical and mental functioning that fosters independent living. This entails the opportunity to live in age-friendly and accessible housing that are sensitive to the needs and services sought by older individuals, and that provide accessible transportation for independent living. The policy's recommendations that are related to healthy ageing included in table 1.

Table 1: National Strategic Policy for Active Ageing: Recommendations for Healthy Ageing**Health prevention and promotion**

- Ensuring that health promotion and disease prevention campaigns adopt a life course perspective.
- Targeting falls in older adults through the creation of falls prevention programmes.
- Creating and auditing strategies to ensure medication safety for older adults.

Acute and geriatric rehabilitation

- Targeting older adults to become informed consumers of health care through better information.
- Strengthening community health and rehabilitation services in order to allow a seamless transition between hospital-based and community services or other settings.
- Integrating acute geriatric care and rehabilitation within the acute public hospital.

Mental health and well-being

- Increasing health literacy and decreasing stigma on mental health and well-being in older adults through education strategies targeting both the general public and health care providers.
- Integrating mental health services within acute public hospital systems so as to address the complex needs of older persons and to contribute to decrease the stigma associated with mental illness.
- Strengthening the current geriatric mental health services, and expanding such services to meet the needs of older persons in the community.

Community care services

- Facilitating access to community care through a variety of access points across primary and acute care sectors, as well as a coordinated pathway to professional assessment.
- Ensuring alternative community care settings to cater for the needs of older persons.
- Guaranteeing that beneficiaries of community care services have the opportunity to participate in both service planning and provision, with consumer feedback being present at all levels.

Maximising autonomy in long-term care

- Promoting the autonomy of older adults in their decision-making process to enter a long-term care.
- Establishing procedures supporting the autonomy of older adults in their decision-making process including access to appropriate medical, legal, and community services.
- Implementing measureable national minimal standards for long-term care.

Protection from abuse

- Raising the recognition of elder abuse and neglect as a social reality through research, public education, and training of persons working in the social and health care sectors.
- Developing and implementing a strategy that empowers older adults to report abuse.
- Creating the necessary legal amendments to protect older adults from abuse and neglect.

End-of-life Care

- Improving the training opportunities in end-of-life and palliative care for persons working in the social and health care sectors.
- Creating legislation to introduce advance directives for health care.
- Developing and implementing policies and procedures in health care facilities concerning end-of-life issues, including but not restricted to artificial feeding and resuscitation.

National Dementia Strategy

Alzheimer's Disease International (2015) estimated that there were 46.8 million people living with dementia worldwide in 2015. This number will almost double every 20 years, reaching 74 million in 2030 and 131 million in 2050. The global costs of dementia have increased from US\$ 604 billion in 2010 to US\$ 818 billion in 2015, an increase of 35.4 per cent. The current estimate of US\$ 818 billion represents 1.09 per cent of global gross domestic product, an increase from the 2010 estimate of 1.01 per cent (*ibid.*). Excluding informal care costs, total direct costs account for 0.65 per cent of global gross domestic product. Cost estimates have increased for all world regions, but especially the African and in East Asia regions

The past decade witnessed an increasing interest on dementia from academic researchers. A decade ago, Abela and colleagues (2007) utilised figures based on the EURODEM project (which analysed the results of a population-based systematic review of published studies on the global prevalence of dementia from 1980 to 2004) to estimate that there were 4,072 individuals with dementia in the Maltese islands in the year 2005, mostly females and older adults aged 75-plus. This study also projected the number of persons experiencing dementia up to 2050, with figures indicate a near doubling in the number of individuals suffering from dementia during this period, so as to reach an estimated total number of 6,369 in 2050 2.00 per cent of total population). However, Scerri and Scerri's (2012) recent publication provided larger estimates. Drawing on data in another European funded project – the EUROCODE project, whose objective was to develop consensual European age and gender specific prevalence rates that would be acceptable for all countries – Scerri and Scerri (*ibid.*) estimated the number of Maltese people over 60 years of age who experienced dementia in 2010 was 5,198. This constitutes a significant increase on the previous projected data by Abela and colleagues (2007). The authors project that the number of Maltese people over 60 years of age who will experience dementia in 2030 will reach some 10,000 persons or 2.3 per cent of the total Maltese population (table 5.7 and 5.8). In other words, when one uses these revised estimates, it results that the 2 per cent prevalence rate of dementia among the local population is expected to be reached by 2025 – as much as twenty-five years prior to what was previously expected.

The importance of addressing dementia care did not pass unnoticed by the government, and the Malta Dementia Strategy Group was set up in 2009 to present a series of recommendations to the Ministry of Health that should establish high-quality dementia care. As Scerri (2012: 154) outlined, the “aim of this working group was that of devising a number of recommendations that would enhance dementia services and address local shortfalls in dementia care” so as to “advise and recommend the planning and development of services that provide high-quality care for individuals with dementia in the Maltese Islands”. Work followed a two-stage process: first, by analysing in detail the services currently available for individuals with dementia and their carers,

and secondly, a wide consultation process with stakeholders working in the field of dementia and the public in general. This threw light on how the

...services available for individuals with dementia showed considerable lack of support for these patients and for those who care for them. This is coupled by the lack of staff trained in patient-centred dementia care. Services that are provided by the various government departments are not tailored for the needs of these individuals especially if the patient is still relatively young... In the community, training of carers is only provided by the Malta Dementia Society through a series of organized talks and seminars. (Scerri, 2012: 155)

The findings were incorporated in a *National Dementia Strategy 2020* that included a number of recommendations, presented to the health authorities in January 2010 (Formosa, 2015). Recommendations included (i) improving awareness on dementia in the community and in relevant professional and non-professional fields, (ii) improving early diagnosis and intervention, (iii) providing good-quality information at the point of diagnosis and beyond, (iv) providing financial support to individuals with dementia in obtaining anti-dementia medication, (v) increasing knowledge on services that are already available for individuals with dementia, their relatives and carers, (vi) improving the quality of care in acute and long-term settings for individuals with dementia, both in state and private medical structures, (vii) improving support services within the community, (viii) improving end-of-life support services, and (ix), strengthening legal and ethical issues regarding individuals with dementia (Scerri, 2012).

Such a state of affairs led to the launch of the eagerly anticipated *National Dementia Strategy: Malta 2015–2023* (Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing, 2015a). The strategy makes Malta the 21st country to have a nine-year plan aimed at enhancing the quality of life of persons with dementia and her carers. The *National Dementia Strategy* included the following key objectives:

Increasing awareness and understanding of dementia. One fundamental aspect of this strategy is to increase awareness and understanding of dementia among the general public and healthcare professionals in order to reduce stigma and misconceptions about the condition.

Timely diagnosis and intervention. Early symptom recognition and interventions through appropriate referral pathways together with the necessary pharmacological, psychological and psychosocial support offer the best possible management and care for individuals with dementia. This strategy also encourages the development of advanced care directives.

Workforce development. Good quality care will be ensured through the provision of training and educational programmes for staff in direct contact with individuals with dementia giving particular importance to challenging behaviour and palliative care. Caregivers and family members who are responsible for the daily care of individuals

with dementia will also be provided with adequate training in order to offer the best quality care and help them cope with new challenges.

Improving dementia management and care. A holistic approach in service provision for individuals with dementia, their caregivers and family members will be adopted. Apart from providing all pharmacotherapeutic options to Alzheimer's disease patients, individuals receiving a diagnosis of dementia will have care plans developed by a multidisciplinary team specialised in dementia management and care. These will address activities of daily living that maximise independent activity, adapt and develop skills and minimise the need for support.

Ethical approach to dementia management and care. This strategy aims to promote an ethical approach to dementia management and care and provide individuals with dementia and their caregivers with the necessary psychological support needed in making important decisions regarding their health and welfare.

Research. Information regarding epidemiology of dementia in Malta, patterns of detection and diagnosis, and delivery of care are needed for proper planning and allocation of health and social care funds and for outcome evaluation. Since the delivery of care is context specific, the strategy aims to promote and support epidemiological research in the field of dementia in different care settings in Malta. Other research initiatives in the dementia field, through the collaboration with other research entities, will be strongly encouraged.

Minimum Standards for Care Homes for Older Persons

For many years, long-term care for older persons was the sole responsibility of religious authorities, and it was only in recent centuries that the state started to provide residential/nursing care to frail elders. In 2013, the total number of licensed care homes for older people – run by the private sector, the Church and the public sector – numbered 38. The total number of licensed beds reached 4,307 at the end of 2013 – that is, 4.2 per cent of the total 60-plus population. A Eurobarometer survey (European Commission, 2012b) advanced thought-provoking information on the perceptions of Maltese citizens on long-term care. One question queried whether the quality of LTC services in Malta is 'very good', 'fairly good', 'fairly bad', or 'bad', with 77 per cent (European Union average: 44 per cent) of respondents answering 'very good' and 'fairly good', whilst another 13 per cent replied 'fairly bad' or 'bad'. The remaining 10 per cent replied 'don't know'. Another question queried whether the affordability of long-term care services in Malta is 'affordable' or 'not affordable', with 18 per cent of respondents answering 'affordable'. The Eurobarometer also posited the following question: 'imagine an elderly father or mother who lives alone and can no longer manage to live without help because of her or his physical mental health conditions, in your opinion what would be the best option for them?' As much as 60 per cent of Maltese respondents answered that 'they should move to a nursing home

or sheltered housing' only second to Denmark (both 74 per cent). This demonstrated that in recent years the Maltese seem to be more ready to accept the settlement of one's relatives into residential and nursing care which is problematic when one considers that population projections show an increasing future demand and costs for long-term care.

In response to such a state of circumstances, the Government of Malta launched in 2015 the *Minimum Standards for Care Homes for Older Persons* (Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing, 2015b). The Standards acknowledge the unique and complex needs of older people residing in a care home. They stipulate the minimum requirements for the facility to operate as a care home as well as the required knowledge, skills and competencies needed by management and staff to ensure care homes deliver individually tailored, comprehensive and quality services. The Standards are applicable to all operations for which registration and annual licensing as a 'care home for older people' are required. All the minimum Standards are intended to be immediately applicable to all homes seeking registration and a license as of the date of promulgation of these Standards, whilst a number of the Standards are intended to be phased in gradually for care homes already operating as of this date. In order that these Standards be implemented by care homes, they have been endorsed by Parliament as a Legal Notice. An autonomous Authority will be set up to manage roles that are related to the sector. This authority will be responsible for the licensing of each home, both those that are in function already and also those that will be set-up in the future. The Authority will issue fines on irregularities as well as fines for each day that the fine quoted for by the authority is not paid within the due date given.

The Standards are based upon the principles of **person-centred care, dignity, privacy, physical and mental wellbeing self-fulfilment**, autonomy/empowerment, equality, and the right to complain and right to legal recourse. They advocate care homes to promote a culture of active ageing in the care home that is consistent with Malta's *National Strategic Policy for Active Ageing* (Parliamentary Secretariat for Rights of Persons with Disability and Active Ageing, 2013). The mission of care homes should go beyond the traditional concept of 'elderly care', and enable residents to realize their full potential for physical, social, and mental wellbeing. Moreover, care homes shall provide an environment where residents are enabled to engage in productive activities, and a healthy, independent and secure lifestyle. The licensee shall also undertake to promote a culture that encourages independence in activities of daily living including, but not restricted to, policies and procedures that promote (a) continence and independent personal care to the fullest extent possible, (b) mobility, (c) falls prevention, (d) prevention of pressure sores, and (e) prevention of the use of physical or chemical restraints. The Standards include 38 policy recommendations:

Standards 1 to 5 concern the *home's obligations*. Each care home shall provide a written and comprehensive Guide for Residents, which sets out the statement of purpose,

the range of facilities, and the terms and conditions on which all services are provided in the contract with each resident. All prospective residents and/or legally-appointed representatives shall thereby be able to make informed choices about whether or not the home is able to meet the individual's particular needs. The statement of purpose and the contractual arrangements entered into with each resident shall enable inspectors to assess how far the home is fulfilling its obligations to meet residents' requirements and expectations that are informed by regularly updated individual plan of care. Standards 6 to 10 relate to *health and personal care*. Residents' health and personal care shall be based on their specific individual needs and wishes within reason. Therefore, the assessment process and the individual's plan of care are seen as crucial in maintaining standards. The results of the initial and ongoing assessments shall be the basis of the plan of care, which then becomes the yardstick for the audit of the delivery of care. The care plan is a dynamic document, which must be reviewed and may be changed regularly according to the assessed needs of the resident.

Standards 11 to 15 concern *daily life and social activities*. Older individuals continue to have social, cultural, spiritual, and recreational needs and interests, and therefore should enter a care homes with a wide variety of expectations and preferences. The way in which social life is organized in the home, along with the range of activities available, must be set out in the home's statement of purpose and guide for residents so that prospective residents, their family and/or their representatives must have a clear idea of what is on offer. Standards 16 to 18 focus on *complaints and protection* by addressing the matter of how residents and/or their relatives and representatives can make complaints about anything that goes on in the home, both in terms of the treatment and care provided by staff and/or the facilities that are available. These standards deals with complaints procedures within the home relating to matters between the resident and the registered proprietor/manager. Complaints may also be made directly to the Regulator.

Standards 19 to 26 concern the *environment*. All new homes shall be constructed such that the living space suits all residents' needs. They shall provide single and double rooms with accessible en-suite showers and toilets as long as residents' safety is not thereby compromised. Moreover, all new homes shall also be constructed in such a way as to provide a homely environment - rather than an institutional setting, and should always be well maintained, tidy, attractive and clean. Standards 27 to 30 focus on staffing issues. In determining appropriate staffing contingents in all care homes (and in those that provide nursing and dementia care in particular), the regulatory requirement that staffing levels and skills mix are adequate to meet the assessed and recorded needs of the residents at all times in the particular home must be met. Each home is to determine the appropriate staffing levels and skills to meet the assessed needs of its own particular residents at all times, which will then be approved by the Regulator.

Standards 31 to 38 relate to *management and administration* issues by clarifying the qualities and qualifications required of the persons in day-to-day control of the delivery

of care, and how they should exercise their responsibilities. The standards highlight the importance of consulting residents about their health and personal care, interests and preferences. A key requirement of care homes is that residents are surveyed for their opinions and that results are published.

The Standards acknowledge the unique and complex needs of each individual residing in a care home; as such they stipulate the minimum requirements for the facility to operate a care home as well as the required knowledge, skills and competencies needed by management and staff to ensure care homes deliver individually tailored, comprehensive and quality services. Each Standard has an achievable outcome for the residents. Although the Standards are qualitative, they are also measurable: they provide a useable instrument for the independent regulator to assess the degree to which the Standards are being met through: regular communication with residents, family and close friends, staff, managers and others; observation of daily life and management of the home; audit of written policies, procedures and records; and scheduled and *ad hoc* inspections.

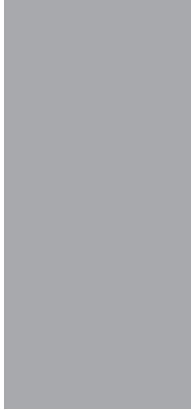
Conclusion

In achieving better levels of healthy ageing – that is, the process of optimizing opportunities for physical, social and mental wellbeing to enable older people to enjoy an independent and good quality of life – Maltese public policy needs to pay greater attention to how health care policies may improve individual well-being. However, healthy ageing is not just about prolonging life. It concerns learning, the exchange of good practice and the development of strategies and policies designed to promote older people's individual wellbeing and personal growth.

This warrants two distinct pathways in healthy ageing policy. First, the prevention and reduction of the burden of excess disabilities, chronic disease and premature mortality by setting measurable targets for improvements in health status and in the reduction of chronic diseases, disabilities and premature mortality, making screening services that are proven to be effective, available and affordable to older persons, creating age-friendly health care centres and standards that help prevent the onset or worsening of disabilities, and finally, developing barrier-free housing options that are accessible to all people. Secondly, reducing risk factors associated with major diseases and increase factors that protect health by taking comprehensive action to control the marketing and use of tobacco products, developing appropriate guidelines on physical activity for older adults, ensuring that national nutrition policies and action plans recognise older persons as a potentially vulnerable group, promoting oral health among older people and encouraging women and men to retain their natural teeth for as long as possible, and finally, determining the extent of the use of alcohol, drugs and medication by people as they age and putting policies in place to reduce misuse and abuse.

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Needs and development opportunities of pensioners in Ukraine

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Key words: the needs, old age, ageing, social protection

Abstract

The article highlights the problems and needs of advanced age people. Their relevance is due to the progressive ageing and changes in socio-demographic structure of the population. The structure of social services is analyzed in the article. The author describes the main conditions and approaches of the advanced age people's needs solution; people's at an advanced age formal and informal support network of the needs in modern Ukraine is characterized.

Introduction

Today Ukrainian society is going through a difficult socio economic crisis, which entails a catastrophic drop of the population living standard (Луман, 2002). Particularly acute this problem is in relation to socially vulnerable layers of the population, namely the *aged people*.

The problem of the assistance to the aged people is recognized at the international level. Ukraine starts working in this direction following the recommendations of the Madrid International Plan of Action on Ageing in the framework of the United Nations Population Fund (www.un.org/russian/document/declarat/ageing_program_ch1.html). However, there are more problems than achievements: the lack of qualified personnel, finance, the absence of the medical-social assistance state program to the pensioners.

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Ukraine belongs to the group of the countries in which the population ageing will take place (Осауленко, Новікова, 2003, p. 40).

The studies that conducted in different countries of the world over the last decade, state the problem of global aging. Today in the world about 600 million people are over 60 years old, and by 2050 they will be about 2 billion, every month more than a million inhabitants of the planet cross over the threshold of their 60th anniversary. Today every tenth inhabitant of our planet have more then 60 years.

According to the classification of the World Health Organization (WHO) the persons aged from 60 to 74 years belong to the category of the aged people, from 75 to 89 years belong to the old people, and from 90 years and older belong to the centenarians (<http://www.who.int/ru/>).

In Ukraine the concept «the person at an advanced age» is consistently associated with the onset of the retirement age (60 years for men and women) (<http://zakon.rada.gov.ua/laws/show/1788-12>). Often uses the term «aged people», which in most cases has the same meaning as «the people at an advanced age» (<http://zakon4.rada.gov.ua/laws/show/3721-12>).

Every fifth Ukrainian is a person of advanced age. According to the State Statistics Service, in 2014, in Ukraine the share of the population aged of 60 years and older accounted 21.4% (<http://www.ukrstat.gov.ua/>).

According to forecast assumptions, in 2025 yr. their number will increase to 25%, and by 2050 yr. their number can increase up to 38%. It is quite high. According to ageing rating (share of population over 65 yrs old) Ukraine now occupies the 25th place in the world and has entered to the 30 oldest countries in the world (Kompleksnyy demohrafichnyy prohnoz...).

The progressive ageing of the population

Scientist, gerontologist I. V. Davydovskyi shared the concepts “old age” and “ageing”, and he emphasized that there are no specific definite dates of ageing, and the person’s calendar age and biological age may not coincide (Давыдовский, 1966, p. 302).

The majority of authors (M. Aleksandrov, O. Krasnov, E. Kholostov) come to the idea that the ageing process of different people occurs in different ways and depends on a number of factors – biological, physiological, psychological, environmental, social; lifestyle and standard of living; working conditions and recovery; family situation; personal relationships to age-related changes and the like.

In developed countries today is popularizing the concept of “successful ageing”, the main components that must accompany ageing according to this concept are: low probability of disease or disability; high learning opportunities and physical activities; active participation in society life.

The implementation of this concept due to the general situation in the country (the level of socio-economic development, political system, ecological conditions, tradi-

tions, mentality, etc.); and depends on each specific person (individual characteristics, lifestyle, past experiences, position in life, the willingness/unwillingness to maintain social connections with persons in the younger age groups).

The situation that exists now in Ukraine, is not conducive for implementation of the “successful ageing” concept’s main provisions. Of course, some of its elements partially implemented: for example, the persons of older-age contingent, as the rest of the population, have the opportunity to take an active part in the political life of society, to defend their social position. At the same time, there is no civil associations of the aged people in Ukraine which would provide them this opportunity.

Social policy is aimed at implementing of the aged people’s constitutional rights to social protection. One of the strategic goals for the nearest future is to achieve not only a tangible improvement in the material situation and living conditions for aged citizens, but enable them to live fully as long as possible for the benefit of society.

Analysis of the ageing persons and older persons’ conducted by Ukrainian scholars (Vlasyuk, Dzyuba, Shchets) situation suggests that they are the most socially unprotected categories of the population that requires special attention from the state (Дзюба, 2004, p. 68–73).

Aged people’s life in the modern difficult conditions in Ukrainian society has certain features. So we can speak confidently about the low material support of the aged person, which with retirement almost lose the opportunity of continued employment. With the transition to the category of elderly people, pensioners are often radically changed not only the relationship between man and society, but also such values as the meaning of life, happiness, good and evil, and so on. With age, the value hierarchy of self-esteem changes. Older people pay less attention to their appearance, but more – to the internal and physical condition.

Changes in the organization of social services and economic approaches associated with a significant increase in the proportion of elderly people in the structure of the population of Ukraine are inevitable. Already today, the system of social assistance and social work, working at maximum loads, is unable to fully meet the needs of the elderly, and about 7.5% of pensioners remain outside the scope of their attention and activities (Новікова, 2011, p. 136–140).

A special place among the problems of the older people in the aspect of social work is also the problem of discrimination and cruelty of the representatives of this age group from some members of society. The concept of “ageism” was introduced by American scientist Robert Neil Butler. Ageism assumes the perception of elderly people as intellectually insolvent, old-fashioned in their views, characterized by contempt of young and strong to the old and the weak. At the heart of this thought is the fear of a young woman before old age and death.

According to the world-famous American scientist Grace Kraiga, the association of all elderly people in one group leads not only to ignoring individual characteristics, but also does not take into account the state of physical health, factors of aging and

age-related regulatory factors. This is the cause of the occurrence of ageism, that is, a social setting in which unjustified highly appreciated youth and discriminates old age (Амосов, 2003, p. 130).

Ukrainian society is full of negative stereotypes of old age, and negative attitude to the aged people. According to a very popular belief, the people at advanced age cause irritation and contempt. Annoying the disturbing image of own future and the one who seems to have lost all that is usually considered valuable: strength, health, wealth, beauty, ability to care for themselves causes contempt. Breaking ties with the generations is an extremely important issue for our societies: it isolates advanced age people and impoverishes the human experience. The advanced age people are not a burden to the society, they can be the chance to improve the standard of living in the country, and the powerful factor of the society humanization.

According to the WHO, Ukraine takes the first place among the CIS (Commonwealth of Independent States) countries and the eleventh in the world for the spread of depression, especially among the aged people. This is a very scary statistic (Рибалко, 2008, p. 17–21).

Social protection of the aged people

At the present stage social protection of the aged people is carried out in two main directions – social support (social services; organization of the pension support) and social assistance (assistance of a single character) (Титаренко 2008).

Social institutions' network for the aged people who need constant care is functioning now in Ukraine. In particular these are: local centers for single disabled aged people; nursing homes of the public profile for aged citizens and disabled; geriatric pensions, special pensions for veterans of war and labor (Лукашевич, 2011, p. 368).

In recent years, the main trend is in the development of social services in the hospital became the new types institutions and today has already formed the network of mini-homes with a small number of residents, videlicet 334 in-patient units at regional centers. This gives the opportunity to bring the stationary social services for aged and disabled people who need them, and leave them in a familiar environment.

A new form of social services providing is the establishment of the specialized houses for single veterans of war and work, pensioners and disabled people in the regions, with the group of the social and medical services.

Today seven such houses operates in Ukraine, with the population of almost five hundred people (in Kyiv and Odessa, Donetsk and Lviv regions) (Рибалко, 2008, p. 17–21).

In view of the globalization to domestic social services sphere have been widely introduced foreign models of social services, which are more focused on the individual needs of the aged people.

It should be noted the penetration of international organizations on this market services, videlicet “Caritas”, “Doctors without Borders”, “Salvation Army” and others.

However, despite the existence the whole network of institutions, organizations and services that provide a range of services for the aged people in Ukraine, social work with this category of the population requires further improvement based on the experience of various countries around the world.

Needs of pensioners

Turning to the conclusions of the dissertation study by N. Ermak, we can identify the specific needs inherent in the elderly and divide them into two components: objective - material needs and subjective - spiritual (Єрмак, 2009, p. 95).

Considering the needs’ balancing problem and possibilities of their satisfaction for the aged people in Ukraine, we divided them into two components: the objective needs – physical ones and subjective spiritual needs.

In turn, the physical needs includes three components like: *physiological needs* (need for food, breath, physical activity and health); *needs in comfort environment* (desicion of the housing and environmental needs), *physical and social needs* (the need for labor, the satisfaction of the economic needs).

Spiritual needs include two blocks: *the interpersonal communication* (the need for belonging to a social group, in society, friendship, love, success, demand respect and recognition) and *self-actualization* (the need for self-realization, cognition, development, education, information, creativity).

The problem of self-realization in old age is not only scientifically relevant, but also vitally significant, because traditionally old age is perceived as the age of loss, sadness and loneliness.

In this regard, there is a constant search for new forms, methods and technologies of social work with the category aged people as possible in order to address problems of social adaptation and integration more effectively.

Needs assessment is seen as a foundation on which a successful policy of the national level or regional program is built.

In the Madrid International Plan of Action on Ageing proposed the ways of getting information that is organized according to three priority directions: the participation of the aged persons in the society development; health and well supporting; the creation of favorable conditions for individual development of the person throughout life. Such planning can serve as a basis for information gathering in the needs assessment process, regardless of what methods of needs assessment are selected (<https://www.un.org/development/desa/ageing/madrid-plan-of-action-and-its-implementation.html>).

Today in Ukraine the aged people require non-standard forms of employment. Therefore, in Ukraine since 2011 yr. is implemented the project “University of the third age”, which has one goal “Education throughout life”.

And informal education which helps to get new information through a variety of courses, hobby groups, clubs and other activities.

Education of the aged people is a structural element of lifelong education and has its own conceptual principles that require to consider of the personal physiological changes at optimally positive ageing.

Such changes include slowing of reactions in larger and more rapid fatigue and deterioration of the capacity for perception, narrowing the scope and reducing duration of attention concentration, difficulties of distribution and switching of attention, reduced ability to concentrate, increased sensitivity to foreign interference, some reduction of the memory possibilities, the weakening of the tendency to "automatic" remembering, the difficulty of reproduction of the received information.

Due to these features it is necessary to structurize the curriculum and take to attention psycho-pedagogical conditions of the learning process' organization for aged people

Conclusions

In the new socioeconomic realities of the society, the problem of targeted and differentiated approach to the organization of social services' work and providing support for the aged people becomes even more important.

The level of attention to the people at advanced age is an important indicator of the civilization level whole society.

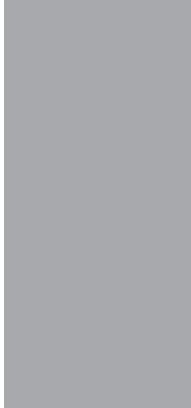
Among the perspective directions of scientific and pedagogical search is the creation and expansion of the network of adult education centres on the basis of the higher educational institutions and other educational institutions, and centers of informal education for different categories of adults, cooperation with universities of the third age, the development of scientific and methodological support of adult education in Ukraine.

The definition of this problem specificity with taking into account characteristics and needs of the aged people in an ageing society conditions can be a direction for further research.

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Invitation for seniors' activity – age friendly city

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Key words: age-friendly city, senior citizens' activity, public and private space, healthy ageing

Abstract

Human's life space usually decreases along with their age. Thanks to certain global and local solutions it may remain broader and serve healthy ageing and maintaining quality of life.

Life space of the seniors is a crucial issue of the social gerontology. This article refers to the problems of the city space that may stimulate or devitalise active, healthy lives of older people and their propitious old age. According to the agreements of the World Health Organisation a hospitable city for old people is the city that takes care of the following for its seniors: public space, transportation, accommodation, social participation, integration, employment, communication and information, support of the environment and health care. A serious threat for the quality of life of the growing urban population is shrinking of the public space and growing of the private space. The city space should not favour any of the age groups as everybody ages, irrespective of their age. The space must support building the relations between generations. In Poland many cities try to join the global network of the places open for older people. In 2016 Poznań: joined this network. This is a very prestigious distinction but also a liability for the city.

City space – contemporary trends

The space as a scientific category has recently become an important and frequently undertaken subject by the specialists of various areas, including social gerontologists. In particular, public and private space have been discussed, relations between

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them and social and communicative meaning of the space, but there are also other perspectives of its overview.

Stella Grotowska fitting into the discussion concerning the place for today's seniors in social life (a defined space), referring to various sources, stresses out after Yi-Fu Tuan that the space differs from the place associated with freedom. The place is a closed and limited space, a safe shelter for the established values. It is very important to distinguish public and private space. Private space, as S. Grotowska emphasizes, is in charge of an individual, whereas public space should be accessible and open to everyone, although today it does not always fulfil the criteria (Grotowska, 2011, p. 31–34)².

Considering problems of ageing and old people in the context of space seems to be fully justified as with age, the space: physical, public, social and even private one where people function, often decreases. Declining vital forces limit possibilities to remain active and mobile and thus the last years of life may lead to limit the space only to the private space, a flat or even one room, sometimes shared with other people. Then a doubt arises whether such space or a place, as it was called before, still is a safe, free and satisfactory one for old people.

Yet it is worth to add that apart from the specified spaces that may shrink along with ageing, although they would not have to, the space of an old person's spirit life may remain broad, free and unlimited.

It may even grow. The theory of gerotranscendence of Lars Tornstam (Erikson, 2012, p. 145–152; Malec, 2012)³ shows the exemplification of this phenomena.

This paper refers to spaces of cities, communities, and particularly of the city of Poznań, which according to the assumptions of the idea of the age-friendly city fostering life of all citizens, has realized concrete practices in the area for last few years.

In 2009 the United Nations informed that for the first time in the world's history, the number of urban dwellers exceeded the number of rural dwellers and they underlined that it will be a strongly growing tendency. More and more cities are expanding, creating metropolises and thus they are absorbing villages and towns around them increasing their physical space. That way, the character of the village, the place of living of the people who used to be engaged in farming, is changing. Physical space of the village is absorbed by the cities that transmit their lifestyle and other habits and ideas for professional and private activity to the rural inhabitants. The problems of contemporary cities are varied but for the further part of this article some of them, particularly those of social-cultural aspect brought up by sociologists, have to be mentioned.

An important part of the city is its social space that, according to Bohdan Jałowicki and Marek Szczepański, must be understood in few ways:

2 S. Grotowska, in her original work presents the role of the seniors in the space of communities, associations and catholic movements (Grotowska, 2011).

3 A person's internal, spiritual space is not a subject of this article and thus, despite the author's opinion that the issue ought to be at least mentioned in the discussion on old people's space, the problem was not elaborated on in this text.

- physical dispersion of people of defined features in a specified area (e.g. better and worse districts by their inhabitants' wealthiness)
- space created by a person, that its shaped by natural, social and cultural factors and in the process of their creation people are connected by specific relations of power and exchange
- social space is characterized by specific kinds of peoples' activities that create spaces: work, leisure, consumption
- space constitutes a specific value for people: economic, symbolic (Jałowiecki, Szczepański, 2009, p. 316–319, after: Szatan, 2012, p. 92–93).

For the city dwellers, its important part is a public space that is a space that belongs to all citizens. It is composed of: streets, squares, parks, etc. (Jałowiecki, Szczepański, 2009, p. 316–319, after: Szatan 2012, p. 93). The public space serves to make contacts between people and to build further relations between them. Unfortunately, nowadays it is becoming narrower due to its privatization, and sometimes is disappears completely which may adversely affect its communicative function. Communicative function of the public space is realized through: possibility of meetings and exchange of opinions, to express identity, communicate certain content, disperse elements of space (physical barriers- walls, gates or lack of them), to transform the space for its inhabitants which creates possibilities for social dialogue (Miciukiewicz, 2006, p. 213–232).

The public space requires its inclusive design. Marek Wysocki following Ron Mace, lists his seven rules: usefulness for people of differing abilities, flexibility in use, simple and intuitive usage, clear information, tolerance for mistakes, comfortable usage without effort, size and space suitable for access and usage. By invoking other authors and United Nations Convent, M. Wysocki also adds the rule of equality perception which allows for feeling in the space the same as all other inhabitants (Wysocki, 2017).

Similar criteria of inclusive streets design are promoted by Elizabeth Burton and Lynne Mitchell: familiarity- urban buildings should be intuitive for older people, distinctiveness- unique character of particular streets, facilitating their localization, safety and comfort- feeling the space as attractive, accessibility- satisfactory usage of streets regardless of physical, sensual or mental limitations of specific users, legibility- supporting special orientation using proper guidance (A. Bujacz, N. Skrzypska, A.M. Zielińska, 2012⁴, Frysztański, 2005, p. 151–158).

Besides its physical and material dimension, the public space should also have, as mentioned above, its social character, that is it should be socially accepted and provide the feeling of physical and emotional safety. For older people very often many places become inaccessible due to organization of the space that does not meet the criteria listed above.

4 A. Bujacz, N. Skrzypska, A.M. Zielińska, 2012, *Public urban space towards seniors' needs. Example of city of Poznań*, „Gerontologia Polska”, 2012, volume 20, no 2. The authors of this article, on the basis of the specified criteria, developed and carried out surveys among the citizens of Poznań.

M. Wysocki underlines one more important issue as regards basic principles of the policy towards old people, related to the space - the principle of locality that is "ageing in place". It means life in local community considering individual needs of older people. Only in such community, the real needs of its inhabitants may be determined and on their basis it is possible to establish goals leading to integration of community and actions to increase their activity, cooperation of all groups of inhabitants as locality is the key for social participation (M. Wysocki, 2017). Surely it is an important challenge as leaving seniors in their life environment as long as possible (preferably to the end of their lives), both private one that is the flat and social, allows to fulfil the needs of: intimacy, safety, belonging and participating in the group.

Why is it worth to be an active senior?

Human's activity is their psychic property (Gurycka 1977, p. 97). It is the way to learn about the reality that surrounds us and it expresses in physical and intellectual activities determined by personality factors (Zych 2001, p. 19). Antonina Gurycka similarly specifies, personality determinants originating from the individual themselves (limitations- health condition, level of physical fitness; mental- attitude, expectations, system of own values, conviction that the actions taken are purposeful), but also suprapersonal- (social- related to personal interactions; physical surrounding- climate, season of the year, air temperature (Gurycka 1977, p. 18–23). Life activity is something daily and natural and thanks to this activity people satisfy their needs and realize themselves in social roles.

The activity is shared into various areas but in the discussions on activity of older people, the following are specified most often: educational, social, cultural, professional, in the area of new technologies (Fabiś, Wawrzyniak, Chabior, 2015, p. 171–139; Szarota, 2010, p. 127–165; Fabiś (eds.), 2008). Professional activity and using the newest technologies belong to "the youngest" spaces of activity in older age, although professional activity has been shared by a small number of old people for long time but it depended on the work nature and its conditions. XXI century has intensified actions promoting seniors' activity. Since 2012, the European Year of Active Ageing and Solidarity Between Generations, it may be assumed that active ageing has become a special value. Specialists working on old age and ageing, in particular gerontologists and geriatricians foster to remain active, in various forms, as long as possible. There may be many justifications for motivating to be active but the basic ones seem to be: increasing life expectancy, dynamically growing population of older people, necessity to find seniors' own place in the changing world. It is important to stay fit, self-sufficient and engaged as long as possible. Nowadays these are the qualities promoted from the early age. However, their level may decrease with age as a result of natural lowering of vitality or unexpected disease. Everyone desires to maintain life independence as long as possible. But one needs to realize that it may be lost at any moment of life

and at the same time one would be forced to learn to accept help. In adult life we give help more often and thus accepting help is one of the challenges that is of particular importance with age. Many barriers occur in accepting help and according to Robert Hill they arise from few convictions: you should not accept help from strangers, it is better to give than to take, you should count on yourself and cope with life. Such attitude is a barrier in positive ageing that does not exclude regressive changes that are possible in late adulthood, but it assumes their acceptance and adjustment to them (Hill, 2008, p. 96). The price for increasing life expectancy often is a need to receive help and support from others. So activity is a value but it requires flexible reaction to the changes in the activity itself that may occur with age. It is worth to be active but in a reasonable, wise way suitable to health condition, possibilities and stage of life. Old peoples' activity is important not only for them but also for other age groups. It allows for being competent in changing life, according to the competence theory that was popularized in Poland in social gerontology by Jerzy Halicki (Halicki, 2000, p. 9–21).

Older people's activity that may seem to be an expression of competences but also lead to them, is inseparably linked with gerontological prevention. Social policy in Poland as regards seniors, was realized in a reactive, interventionist way for a quite long time. It is a definitely better idea to have a proactive⁵ approach. Possibility of preventive actions concerning physiological ageing were described in the dynamic model of gerontological prevention by Zbigniew Woźniak. In this model it is crucial to take care of: health and lifestyle (eating, activity, shape, condition), cognitive activity (memory, problems solving, education, strategies), social support (personal bonds, informal support, formal support, social activity), mental health (identity, emotions, self-respect, life satisfaction), seeking meanings (spirituality, religiousness, life goals), future planning (expenses, assets management, adaptation to lifestyle, personal issues, management of own time and life) (Woźniak, 2011). All areas of preventive activities aim to slow down ageing processes and to counteract pathological ageing. They need mobilization of the subject, activation in those areas to maintain psychosocial and health condition as long as possible.

In the discussion concerning activity in older age, it needs to be taken under consideration that activity of the Polish seniors in the measurements of several years ago, took the 27th place compared to other European countries. The following four areas were analysed back then: employment, social activity, independence and health and safety in life, readiness and preparation of the surrounding to use broadly understood resources of the ageing society⁶. Jolanta Perek-Białas and Elżbieta Mysińska carried out similar analyses in Poland, using the same domains but with the division of Poland into

5 For information see: The Strategy of Social Policy for Greater Poland Province until 2020; <http://rops.poznan.pl/wp-content/uploads/2016/01/strategia-polityki-spoleczenej.pdf> [20.03.2017].

6 For information see: <http://www1.unece.org/stat/platform/display/AAI/Active+Ageing+Index+Home>.

provinces. That way a rank of 16 Polish areas occurred. Further part of this article refers to age- friendly city. Poznań has been recognized as an age-friendly city and that is why it is worth here to recall results concerning the province, whose capital city is Poznań. In the area of employment the province took 9th place, when social activity came on 8th place, independence, health and safety took the second place and it was the best result among the domains. Ability and readiness of the surrounding to use the potential of the ageing society took distant 11th place in the rank (Perek-Białas, Mysińska, 2013; Pawlina, 2015). Polish research show that resources of all Greater Poland province, apart from independence, health and safety are still not very impressive for the realization of the idea of active ageing. Nevertheless, poor results is a great motivation to improve.

To sum up the discussion regarding activity of the older people it may be concluded that it is a value itself for seniors, but it is also very important for functioning of all society. Taking care of older people's activity is an investment in the future that may be longer, healthier and fuller then. The gerontological prevention, activity for old people, successful or positive ageing, are the categories that are not identical but they share the consciousness of choices made by older people. These choices refer mainly to their lifestyles that aim to: remain independent as long as possible, to deal with problems and challenges, to react to changes flexibly, that are framed in the process of ageing and old age.

Age-friendly city – good practices of Poznań

Big cities have this advantage over villages or small towns that people in big cities live longer. The reports concerning distribution of people worldwide show that now more people live in cities, that is 54% than in villages and the trend is growing, as according to the estimations in 2050 two thirds of the world population shall be living in cities. In XXI century cities have become the area of researches and the lifestyle of cities appeared to be favourite one not only for the citizens themselves but also for inhabitants of small towns or villages visiting them. The example here may be visits at shopping centres, entertainment parks, sports centres, multiplexes, restaurants or cultural institutions.

Life in the cities, especially in metropolises is exposed to a number of occurrences that may be inconvenient for older people. Some of them have been already mentioned before but it is needed to stress the ones usually referred to by the specialists.

They include: expansion of cities, depopulation of downtown, modern architecture, that creates the distance, mutual observation of the people creating illusive closeness, yet leading to isolation, degradation of public space- closed housing estates, spaces cut off people, culture of fear of strangers, processes of gentrification, disappearance of neighbourhoods, commercialization of space, moving around by cars that results in fewer opportunities to establish interpersonal contacts, crowding and noise, pollution or, recently increasing threat of terrorism.

Various organizations and associations, and the local authorities themselves try to mitigate and solve the city life problems mentioned above. For example, attempts to cope with the negative processes of life in metropolises have been taken by: WHO Healthy Cities Network (Healthy Cities)⁷, slow cities network (Slow Cities)⁸, or programs for ecology of cities (Urban Ecology), or important for this article net of age-friendly cities and communities, that are also friendly for all citizens, irrespective of their age (Age-friendly Cities and Communities). Requirements for age-friendly cities and communities have been established on the basis of the surveys carried out among seniors in 33 countries of the world and they include 8 areas described in the special guide that was also translated into Polish: Age-friendly cities. A guide. (Żakowska (eds.), 2016; Wysocki, 2015).

A space of a city may stimulate or weaken healthy functioning of the seniors. According to the findings of the WHO a city that is considered to be friendly for the seniors and also for other generations takes care of: outdoor spaces and buildings, transportation, housing, social and civic participation, integration, employment, communication and information, community support and health care. The space should not favour any of the age group and it must support building intergeneration relations. Many cities in Poland are trying to join the global network of the places open for older people. On 18 July Poznań joined this network⁹. The first Polish city that joined the network was Gdynia and in 2017, the third city – Ostrów Wielkopolski that has received this great distinction.

Accession of Poznań to the network of ca. 360 age-friendly cities worldwide is a great honour for Poznań but also a great responsibility. How does the Poznań metropolis discharge of its task? This question made the author of this text to review the situation, in particular in the city of Poznań.

7 The Program of Healthy Cities came to Poland at the beginning of the 90-ties of XX century. The Healthy Cities Network was founded in Łódź in 1991, followed by the Polish Healthy Cities Association with its seat in Łódź. Healthy City should seek to ensure its citizens: clean, safe environment, significant share in taking and controlling decisions regarding the citizens, their health and good well-being, possibilities to provide basic needs of life (safe food and water, accommodation, work, safety), instant access to health care at proper level, conditions to improve physical and mental fitness, mutual support and peaceful life. Poznań joined the Network of Healthy Cities in 1993 and has been realizing the successive phases of the project. <http://www.poznan.pl/mim/ezdrowie/miedzynarodowa-siec-zdrowych-miast-swiatowej-organizacji-zdrowia-who,p,16623,16625,17035.html>; http://uml.lodz.pl/miasto/zdrowie/zdrowe_miasto/idea/.

8 The International Association of Cities Cittaslow is a non-profit organization. Its aim is to promote cultural and traditional variety of local products, protection of environment and improvement of life. <http://www.twojaeuropa.pl/3950/slow-city-powolne-miasta>.

9 For details see: <http://www.gazetasenior.pl/wp-content/uploads/2016/08/Gazeta-Senior-Pozna%C5%84-sie-wrze-2016.pdf> [access 17.01.2017].

Number of Poznań citizens now equals about 540 thousand. For last few years the population of the citizens in their retirement age has grown significantly and now it numbers about 26% of all citizens.

The possibility to be and to remain active as long as possible should be strongly supported by the closest family of the older person, but also by the solutions arising from the seniors policy of a local and global range.

What solutions does Poznań propose to its citizens for good ageing?

1. Age-friendly outdoor spaces and buildings. A healthy city is the one that has an access to rivers, lakes and water reservoirs, that is free of pollutions, green, properly distanced from the industrial spheres. Location by the Warta river has resulted in an interesting development of the river and its bed through adjusting it to the recreation needs of the citizens. 5 lakes of Poznań agglomeration, including 3 in the city of Poznań itself has been used in a similar way. Places for walks, relax, meetings and banquets have appeared along the river banks and the lakes have gained nicer beaches and opportunities to do water sports. Moreover, there are more and more places to do exercise, outdoor gyms often together with playgrounds for children. Another example is using the big square of the city hall for summer theatrical meetings, concerts and similar events. Many actions have been also taken to improve safety of the citizens. Directly in the places of residence, districts, housing estates, meetings of the police with the seniors are carried out in order to inform about threats and ways to react to them. In the city centre a Strefa Tempo (Tempo zone) has been introduced which is a speed limit for the vehicles and the traffic lights have been turned off and as a result the drivers are forced to drive more carefully. Also old, uneven pavements are being changed gradually for bike routes, although in this area there is still a lot to do. Number of toilets in the public places have increased and the seat on bus stops are being changed. In some shopping centres wheel chairs are available and in shops there are mixed-age teams that may match to serve the clients at different ages in a better way.

2. Transportation. Poznań together with neighbouring localities constitute a broad metropolis and that is why the integrated public transport is so important. Timetables are scheduled the way the passengers can coordinate the time of travel. Persons over 65 can buy yearly tickets for seniors for 50 zlotys and over 70 they can travel for free. Some cities and communities of metropolises have introduced their own benefits for seniors. In the city there are already a few easy access tram stops and yet another investments are planned. Some of the public transport vehicles are low floor ones. Also city bikes are available to hire. Parking spaces on pavements is still a problem as they obstruct walking.

3. Housing. The problem of creating a proper personal space, that is a place of living is equally important as others, however with progressing ageing and regressive changes in development accompanying old age, it seems to be one of the most critical ones. Along with age, the time spent at own home increases. Adjusting flats, houses to be active in them is a challenge for the city. The basic question is availability of

flats, low rent and possibility of modernization of current flats for seniors as well as building new flats without barriers. In 2009, 79 1–2 room flats and a new community centre were released for use of seniors. In plans there are other similar investments. In Poznań there are 5 24-hour care homes and more than ten day-care centres. Many private institutions of support and care for older people have been opened in recent years. At housing estates, ramps are built in old buildings and the persons who want to modernize their flats without barriers can apply for co-financing for modernization. It needs to be stressed that applications for such co-financing are worded very simply, they are easy to read, enriched with pictures. Housing still remains a serious challenge.

4. Social participation. For seniors in Poznań who are interested in social activity there is a broad offer of possibilities to realize it. For the participant the important things are: costs, location and information about the activities¹⁰. There are numerous ideas for activation as in the city we have: 3 Universities of the Third Age, 50 Senior's Clubs, 19 Pensioner's Clubs. Over 10 years ago, the first Polish Senior Citizens City Council was created in Poznań and a bit later, the Centre for Senior Citizens Initiatives that coordinate and moderate activation but also influence senior policy of the city. There are also many offers of social participation, engagement in voluntary work of older people. In the recent years, special care of places for physical activity has been taken. Among many projects brought to Poznań Civil Budget in 2017, the first place was taken by free sports activities: Housing Estate Trainer and Senior Trainer.

5. Respect and social inclusion. Current strong generation differences, especially between generations of Baby boomers and X (older ones) and between generation Y and Z (younger ones) may weaken or even eliminate intergeneration relations. (Dostatnia 2014, p. 36; Appelt, Wojciechowska 2016, p. 115). Inclusive actions directed to older people in life of cities and creating proper space for meetings with other generations are extremely important. Good practices include for example reading fairy tales to the youngest ones, in the recently opened Centre of Family Initiatives. There are also special phone numbers that seniors can call when they want to propose a civil initiative. Local TV and radio stations as well as the press promote older people's activity. Most spectacular example of the engagement of seniors in the city life is the aforementioned The Senior Citizens City Council.¹¹

6. Civic participation and employment. Employment does not always have to associate with professional activity, it may be replaced by voluntary works. The Centre for Senior Citizens Initiatives runs various types of voluntary works for the people 60+ but also younger ones. One can participate in voluntary works: competence (offering their own competences to others, teaching them, e.g. work with computer), informative (en-

10 Utterance of Zdzisław Szkutnik, Chairman of the Senior Citizens City Council in Poznań <https://www.mixcloud.com/ZdachuPoznania/zdzislaw-szkutnik-i-damian-dubina-25072016-audycja-z-dachu-poznania/law-szkutnik-i-damian-dubina-25072016-audycja-z-dachu-poznania/>.

11 <http://mrs.poznan.pl/>.

agement in getting to bigger and bigger number of seniors in the city and invite them to activities), artistic (inviting seniors to activities in literacy, painting, photography and others allowing for self-expression and that give joy to others), counselling (legal advice and in particular psychological), operational (help in organization of the Fairs Active 50+, Senior ones and similar cyclic and incidental events).¹² One can become a senior voluntary worker in many other parts of the city. Another important issue is a labour market for people who are 50+. Employment offices offer special trainings, activation and age management programs.

7. Communication and information. Creating age-friendly virtual space, in the era of the abundance of information, is a very important task and the skill of seeking the information is nowadays a crucial competency. Not all seniors joined the informative society. It is also good to use traditional means of information, invitations directly delivered so it is important to take care of readable bulletins, updated and delivered directly to older people. Such efforts are noticeable in the city.

8. Community support and health care. Health care system in Poland, particularly towards older people is not satisfactory. There are still not enough geriatricians, properly prepared nurses, units for special care over seniors, not suitable time of a medical visit for older people. These problems are discussed in Poznań during various conferences and they are lobbied by the Senior Citizens City Council on the meetings of the city and province authorities. Health, the primary value, in the ageing society, is left outside the area that above all should be supported by the prophylaxis. White Saturdays organized by the students of the Medical University in Poznań is one of many of those valuable practices and there should be more of them.

The city for everyone – challenges for Poznań

There are more and more new places of recreation, and even in the old parts of the city the amount of greenery is growing. The city centre is becoming a place for pedestrians, cyclists and urban transport, traffic, noise and pollution have been reduced. Until half 2017, almost 40 places were recognized as senior-friendly gaining a certificate of confirmation. But the city still lacks many actions that would allow all citizens for healthy, safe and satisfactory life. Described, selected good practices is just the beginning of changes that may lead to the comfort of life, regardless of age. In my opinion, the idea of social participation is the one that is best realized in Poznań. There are many offers for activation of seniors: physical, recreational, social, intellectual, artistic, etc. Yet, there is still a problem of seniors' participation. In the activating programs „younger seniors” prevail as are able to find offers addressed to them. Thus it is so important not to activate only those who already are active. Definitely the group of less active or even passive people is still more numerous. Comfort of life is above all connected with health and this is why it is important to intensify the

12 <https://www.google.pl/#q=centrum+inicjatyw+senioralnych&spf=1496864275544>.

actions aiming to get an access to health and care services, specialists and therapists. Despite good result obtained by Greater Poland province in the area of researches on activity, health prevention and medical services in Poland are not the strong side of supporting older people. It needs to be taken under consideration that the senior is not only an active, smiley, well-groomed person who has a problem what else they can choose to be more active and maybe even overactive. This model of activity is shaped as one of many (especially by media) and realized by some seniors who gave in to this persistent pressure of fighting to cheat their own time in at least two ways: strong “rejuvenating”, constant rush and life in continuous lack of time to keep pace with everything, not to lose a thing, as it was in other periods of their lives. Another challenge for the city is organization of its space the way to prevent processes of gentrification. Modern constructions are unavailable for many older people due to economical barrier. The space also may be discouraging with its futuristic solutions. In big shopping centres, restaurants, banks and offices there are still mostly young people. It is another challenge that does not only refer to organization of the space itself but also an offer, services, age and competences of the staff. Specialists of market research pay attention to the fact that older clients prefer older staff who understand their needs and use the same language etiquette. Another challenge is safety of seniors. Poznań is considered to be rather a peaceful and safe city however education on threats is still a task to realize but in a way so as not to create an excessive fear that would stop older people from leaving their houses.

At the end it is needed to specify the most difficult and most needed, in my opinion, challenge for age-friendly city that is taking care of the oldest seniors, often called people of the „fourth age”. In the area of supporting ageing there is also a senior who is sick, inactive, in need of help. Poznań tries to see also those citizens but surely, solution of the problems of this group of seniors is still far from their needs and expectations. It requires local and system solutions. An example of these attempts is a project of telecare for 100 citizens proposed to Poznań Civil Budget for 2018. The essence of the age-friendly city is also caring for possibilities to leave its citizens in their own flats as long as possible, preferably to the end of their lives so as they do not have to spend their last days in care homes or other care institutions. Using telecare, telemedicine in bringing help to the oldest citizens is becoming an important task. However if there is a need to put a senior away in one of aid institutions, the age-friendly city is obliged to create the best possible conditions also in care homes.

Surely it is worth to create more proposals joining generations, building a space for everyone, that is a space which wants to avoid separation, ghettoization of older people or even positive discrimination, based on laudable goals¹³ but still discrimination.

13 It is worth to underline that positive discrimination is needed as temporary support for disadvantaged people who face worse treatment because of their: sex, race, age, religion, features, etc.

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The optimization of elderly care in Szczecin – research report

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Key words: elderly people, long-term care, social care system, senior housing

Abstract

The aim of the research was the examination of the available solutions in the field of meeting the needs of dependent elderly people in Szczecin and indicating priority actions in terms of elderly care optimization, possible to implement in Szczecin, on the basis of the diagnosis of the needs as well as resource and financial analysis. The method of desk research, including statistical and financial data concerning the social care sector, was used in the article. On the basis of the collected data it is possible to state that investing in sheltered accommodation is an alternative solution for building a nursing home. It is a less expensive replacement, which provides dependent seniors with a higher standard of care and support.

Introduction

The process of the ageing of Polish population and growing demand for long-term care services provided to dependent elderly people point at the necessity of creating

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a consistent support system for the elderly, with the use of alternative, efficient and economically effective solutions (Iwański, 2016). A new approach concerning social care in terms of seigniorial policy departs from the traditional one, based on giving benefits or places in nursing homes to the dependent people, towards the development of the preventive, activating services and support in the living environment. The need of the deinstitutionalization of elderly care for the development of services in the living environment is specified also by the gerontological research (Fal, 2016, p. 22–26). At the bottom of the conducted research there are findings of the national Supreme Chamber of Control's inspection conducted in 2015, entitled "Elderly care support provided by communities and counties which pay attention to the necessity of creating alternative solutions, cheaper than nursing homes, using all the statutory means including day-long support forms in the place of living (Common European Guidelines on the Transition from Institutional to Community Based Care, 2012). It was agreed, according to the of Supreme Chamber of Control recommendations as well as in compliance with the modern vision of social care, that the twenty-four-hour institutional care is the ultimate form of supporting the elderly, used when all other forms of assistance turn out to be insufficient (*ibidem*). The most efficient form of elderly care are community support services provided in the place of living. It was established that the rules of dealing with the elderly, accepted by UN in 1991, such as independence, participation, care, self-fulfillment and dignity (ONZ, 2017), are fundamental for the seigniorial policy development. Realization of the elderly people's independence, care and dignity rule in accordance with the subject of the research is expressed in the right to live in the environment which is adapted to personal preferences and changing possibilities, opportunity to stay in one's own apartment as long as possible, and access to services sustaining elderly people's autonomy and giving sense of security. At the same time, the principle of subsidiarity is also important. In this principle, when it comes to elderly care, conditions allowing the use of family, neighbours and friends care potential first are created, and next, with the growing demand for care, other informal groups, non-governmental organizations and local institutions are introduced. Such a way of thinking is based on a hierarchical compensation model, according to which formal assistance is the ultimate form of help, when it cannot be provided by the family and neighbours (Szweda-Lewandowska, 2014, p. 215–224).

The aim of the research was the examination of the available solutions in the field of meeting the needs of dependent elderly people in Szczecin and indicating priority actions in terms of elderly care optimization, possible to implement in Szczecin, on the basis of the diagnosis of the needs as well as resource and financial analyses. It was agreed that the optimization of elderly care means increasing its quality by satisfying the needs of the elderly which are triggered by dependence, taking into account demographic forecasts and socio-cultural conditions as well as all statutory support

mechanisms, including support of the family in elderly care, with the use of economically rational solutions.

The need for elderly care in the context of demographic analysis

In 2016 Szczecin was inhabited by more than 405.000 people, of which 74.000 were 65 or more years old (BDL, 2016). Almost every fifth citizen of Szczecin was classified as a senior according to the demographic, economic, social, and civil rates. In classical scales of old age, population is described as old when the number of people over 65 exceeds 12% by Rosset, 15% by Klonowicz, and as very old, according to the latest UN scale, when the number of seniors reaches the level of 21% (Jurek, 2012). The demographic forecasts show that in the coming decade the population of Szczecin will exceed the updated UN old age scale.

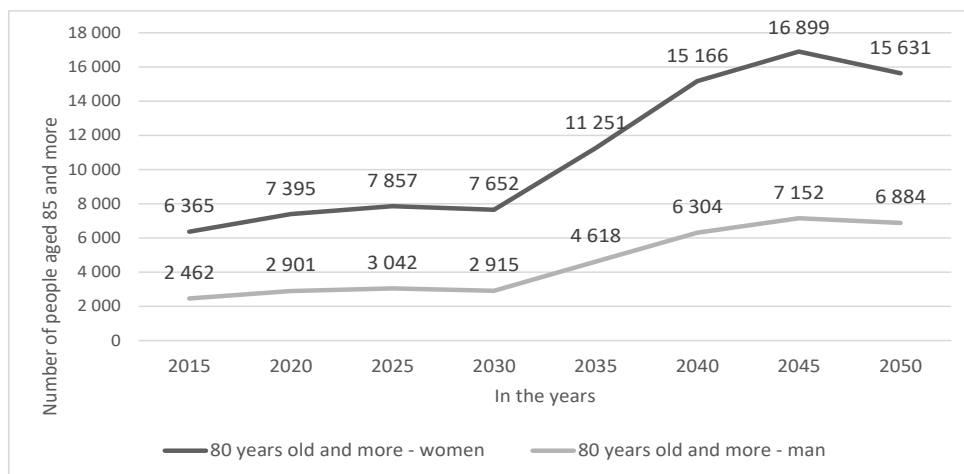
Table 1. Szczecin citizens aged 60 and more – status for 31 XII 2015

Sex	Years of living						
	60 and more	60–64	65–69	70–74	75–79	80–84	85 and more
Men	44.049	15.063	11.994	5.679	5.153	3.630	2.530
Women	63.304	18.277	15.163	7.908	8.434	6.979	6.543
Total	107.353	33.340	27.157	13.587	13.587	10.609	9.073

Source: Bank Danych Lokalnych, GUS 2016, www.bdl.stat.gov.pl [access 29.10.2016].

According to the GUS demographic forecast, till 2050 the number of people who are over 85, and are classified as very old, will almost triplicate. Along with age, the risk of dependency increases and the need of the elderly for assistance and support in everyday functioning grows. In 2030 more than 27.000 people aged 80 and more will live in Szczecin, and in 2050 the number will go up to 36.000 (GUS, 2014). Demographic forecasts point to the phenomenon of double ageing of the society. In a decade and a half, the number of young pensioners over the age of 60 and 65 will rise significantly, along with the increase of the number of people in advanced old age, entering “the fourth age”. The double ageing of the population leads to an increased demand for public forms of dependent elderly support and care. In families, help might be needed by two eldest generations at the same time. Taking into consideration that old age includes postwar age groups and, at the same time, migration trends of the population boom from the 70s and 80s of the 20th century, it can be assumed that part of the seniors won't receive support from children and grandchildren in the following years.

Picture 1. Demographic forecast – age category 85 and more for the city of Szczecin for years 2015–2020



Source: forecast for communes and cities with district rights and subregions for years 2014-2050, GUS 2014.

The time of advanced old age is also connected with feminization of the ageing process in these age categories. The average life expectancy of women is much more longer than of men, and in the next decades this trend will be maintained. As estimated, every second 80-year-old requires support and help in everyday functioning. The number of one-man households led by elderly people will also be growing. In the following decades the demand for community, stationary and semi-stationary care services will be increasing. Until 2045 the number of people aged 85 and more will triplicate, which will influence the dependent elderly care system.

The dependency ratio will be increasing with every decade systematically. Currently, for every 100 people in the working age there are 57 in the pre- and post- working age. In the following decades the ratio will be growing, in 2030 it will reach the level of 63, and till 2050 it will equal 79. The number of people in the working age will decrease from 256.000 in 2014 to 189.000 in 2050. The retention of the fertility rate at a low level, which will not guarantee substitutability of generations, will lead to the decline of the number of people in the pre-working age. However, the number of people in the post-working age will be rising significantly every year, from 86.000 in 2015 to 104.000 in 2050. The considerable growth of the percentage of elderly people in the population of Szczecin leads to taking actions aiming at minimizing the economic, social and civil costs connected with the increase of the demographic dependency ratio.

In conclusion, according to the demographic forecasts the ageing process of the population will be proceeding. At present, there are no premises which would indicate the possibility of diverting the demographic trends in terms of the fertility rate to a level which will ensure the substitutability of generations or changes in migration trends.

Remembering about the subject of the analysis we should distinguish three demographic aspects which have crucial influence on the security of dependent elderly people:

- Till 2010 the number of inhabitants of Szczecin aged 85 and more will almost triplicate.

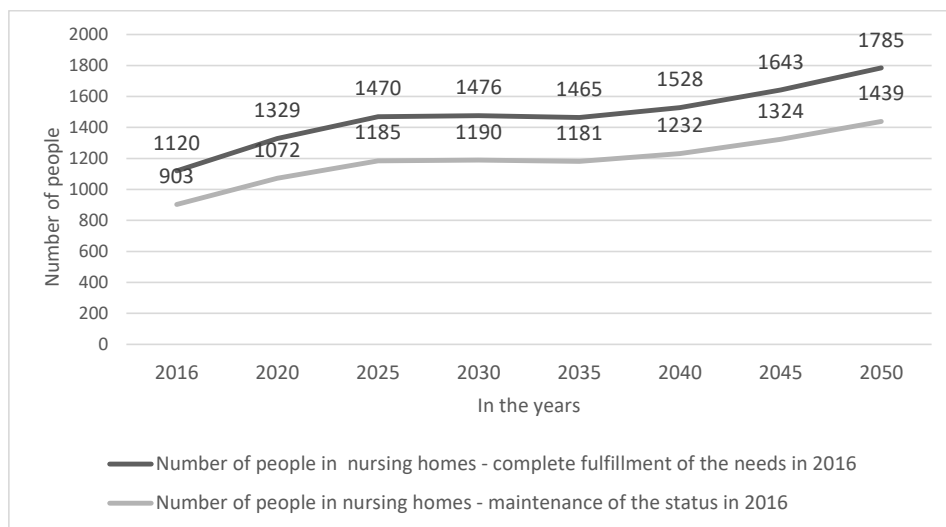
- Till 2030 the number of young pensioners over 60 and 65 will increase considerably, along with the growth of the number of people in the advanced old age, entering “the fourth age”

- With every decade the demographic dependency ratio will be growing systematically. The number of people in the working age will decrease.

The demand of elderly people for stationary care

Providing care to dependent elderly people from the commune of Szczecin city is carried out in the place of living and in nursing homes in form of day-long security of all the needs of seniors. In 2016, on a yearly basis, there were 903 chronically, somatically sick elderly people (MOPR Szczecin, 2016) in nursing homes, and 217 were waiting for a place for them (The strategy of solving social problems for the commune of Szczecin City for years 2015–2020, 2015). Securing care needs in the described year would require increasing the number of places by 24%, so opening, at current standards, at least 2 new institutions. In the following years, together with the increase of the demographic dependency ratio which will result in a lower care potential of the families, because of the migration trends of people in the working age, a multi-sectoral development of the elderly care system will be necessary.

Picture 2. The demand of elderly people for stationary care – deficient and optimal variant



Source: own elaboration.

In 2016 care in nursing homes was given to 1,22% of people over 65 living in Szczecin, including people who were given a place in institutions outside of Szczecin. Meeting the needs of all the people waiting for a place in care centers would rise the rate to the level of 1,52%. Private institutions providing 24-hour elderly care services were not included in the analysis. The offer of subjects in the market of stationary care services is directed into elderly people and families, who are able to cover all the costs of the given care, without the support of the commune. A monthly fare for a stay in such institutions varies from 2.200 to 7.000 PLN. Often enough it is necessary to pay extra for basic hygiene supplies and medicines. The private sector will be developing dynamically in the coming years, but without the system of co-funding the services from public means, the offer of this sector will not be aimed at people with low incomes from social transfers, which do not have any capital.

Therefore, taking two variants into consideration: loss-making – keeping the short-ages at current level, and predicting full satisfying of the needs like in 2016, till the second decade of the XXI century in Szczecin, extra places should be created: in the first variant – 169, and in the second one – 257 places for seniors requiring help. The demand was estimated on the basis of the growth of the number of people over 65 in the population of Szczecin. Considering current standards (Art. 6 pt. 1, Dz.U. 2012 poz. 964) in the field of the organization of stationary elderly care, assuming that we do not introduce alternative solutions, creating at least two new nursing homes would be necessary. Assuming the option of full fulfillment of the needs – on the basis of the presented estimates – creating three institutions would be necessary.

Along with the age, the risk of dementia increases, as estimated 50% connected with Alzheimer's disease. In the population of people aged over 65, 5 to 10% is endangered with the disease. The risk grows with age, for people over 80 can reach even 50% (Knapik-Czajka, 2010, p. 140). According to Polish studies, the frequency of occurrence of dementia in urban populations takes from 5,7 (Bidzan, Turczyński, Szaber, 2007, p. 181–188) (for population over 65 years old) to 10%. Nationwide the number of people with dementia amounts from 300.000 to 500.000 (Gabrylewicz, 2014, p. 17). Having Alzheimer's disease is in 85% sporadically coincidental, only 15% is genetically conditioned (Wojszel, Bień, 2002, p. 2–6). Because of the feminization process in the old age categories, Alzheimer's disease concerns mainly women. The illness requires providing long-term support, and in the last stage a senior with Alzheimer's disease needs stationary 24-hour care. In 2015, 74.000 people in the age of 65 or more lived in Szczecin. Taking into consideration the optimistic variant, assuming that this type of medical condition touches 5% of people aged 65–69, 10% aged 70–74, 15% aged 75–79, 20% aged 80–84 and 25% aged over 85, 9485 elderly people suffered from dementia diseases.

In the next decades the number of people over 85 will increase and the risk of dependency will rise considerably. In 2020 more than 10.000 elderly people requiring help because of dementia diseases will live in Szczecin. Till 2050 the number of seniors with this type of medical condition will go over 16.000. Assuming that currently 80% of

dependent elderly care is realized by informal care givers – family, in case of dementia diseases in the following years it will be necessary to create a system which will provide support for 2101 people in 2020 and 3269 in 2050, who will not receive support and care from family members.

Assessment of the resources of Szczecin City Commune in terms of providing care to elderly people in the context of included costs

In Szczecin there are two nursing homes offering 24-hour stationary care. “Dom Kombatanta” nursing home at no. 17 Krucza Street, can accommodate 241 people. “Dom Kombatanta I Pioniera Ziemi Szczecińskiej” nursing home offers places for 251 seniors. Moreover, Szczecin Commune provides seniors’ stay in supracommunal nursing homes outside of Szczecin (in 2016 – 302 people).

The basis to estimate the average monthly cost of stay in the nursing home is the cost of the functioning of the home in the previous year, excluding renovation and capital expenditure and taking into consideration the predicted consumer price index emerging from the budget act for the coming year multiplied by the actual population of the city. In 2014 the average cost of stay of one nursing home resident was 2822,38 PLN. In the analyzed period, the average cost of living of one person in the institution increased by 156 PLN and in 2016 was 2978,97 PLN. In the first place, the fee for the stay in a nursing home is covered by the senior, in the amount of 70% of the received pension. Next, the rest of the fee should be paid by the family. When the two main sources are not enough to cover the monthly cost of living in the nursing home, the rest is paid by the commune. In the researched period (2014–2016) the supplementary payment covered by the commune on a yearly basis increased from 17 million in 2014 to 18 million in 2016.

The next means of supporting seniors and their families are day-support centres, in which seniors spend time during the day, receive two meals a day, are provided with care and their free time is arranged. It is a form of support for those elderly people who do not need 24-hour maintenance, are capable of taking part in activities and can count on their families in the evenings, at nights and on holidays. In Szczecin there are six day-support centres, including two specializing in providing care to people suffering from Alzheimer’s disease and one functioning as part of the programme Senior+. Their support is used by 205 elderly people. The initial analysis of the costs stresses the possibility of lowering the costs by assigning their running to non-governmental organizations.

Apart from nursing homes – 24-hour and daytime, a system of sheltered and assisted housing for elderly people is built in Szczecin. It is aimed at elderly people who are at least 65 and require partial or complete support of others⁵.

5 The system is run created by Szczecińskie Towarzystwo Budownictwa Społecznego Sp. z o.o., Towarzystwo Budownictwa Społecznego Prawobrzeże Sp. z o.o., Zarząd Bu-

In sheltered apartments seniors are guaranteed round-the-clock care and nursing, meals and arranged free time. This option has its positive aspect also in the context of using big size apartments, which are difficult to sell or rent. Sheltered apartments are usually accommodated by 5–6 seniors. The venues have a living room with its integrative function, three double bedrooms, a kitchen and two bathrooms. Owing to the opportunity of putting 5–6 dependent people in one apartment it is possible to provide them with 24-hour care like in a nursing home. The cost of creating one sheltered apartment for 6 people based on the housing stock in the commune of Szczecin and subsidiaries was estimated on the basis of current experiences connected with the activation of five apartments for 28 elderly people in previous years. Having regard to the cost of renovation and fitting of the rooms, the cost of the creation of such a flat is on average 102.040 PLN. It is worth mentioning that the expenses are diversified according to particular residential substance. The amount includes the cost connected with equipping the apartment and renovating it. The average cost of the renovation stays at the level of more than 68.000 PLN, and the cost of equipment – 33.080 PLN.

The main ingredient of the cost of maintaining a sheltered flat are expenses connected with providing care and support, which is realized round-the-clock seven days a week. The care index, so the number of care takers for one care giver is not bigger than 6 people. It is a level impossible to achieve in nursing homes in the westpomeranian voivodship, where for one care giver there are 15 seniors during the day and even 60 at night (Iwański, 2016). In sheltered housing residents pay for the cost of living from their pensions. On a yearly basis, the expenses for this aim barely surpass 20.000 PLN. The rest of the expenditures (184 464 000 PLN yearly) are covered within care and support services given to every person, owing to which 24-hour maintenance is possible. The economic phenomenon of sheltered housing lies in the fact that putting 6 dependent people in one flat and securing them with 6 hours of care services a day guarantees round-the-clock care (together 36 hours of care a day) assuring two care givers in peak hours so at times of the morning and evening hygiene and during meals. Providing the same comfort to 6 people in their place of living is impossible from the perspective of the budget of the city.

In years 2015–2016, 5 sheltered apartments were activated in Szczecin and 28 people live in them. In 2017 4 apartments will be activated, and in years 2018–2020 – one apartment a year.

Assisted living is the complementation of the offer for people requiring limited support and assistance in everyday functioning. First venues of this type in Szczecin were put into service in July 2015 as part of the project entitled “Rewitalizacja RAZEM – Dom dla seniora”. There were 23 apartments, including 6 studio flats, 16 two-room flats and one three-room flat. In general, the so called “senioral quarter” is accom-

modated by 30 people. The programme is conducted by Szczecińskie Towarzystwo Budownictwa Społecznego (The Social Building Association of Szczecin) and the commune of the city of Szczecin. The social care over the residents is provided by Social Welfare Centre. The so called “quarter 23” is not only about assisted living, but also all the infrastructure allowing to have a self-reliant, independent and satisfying life even with some functional limitations. In the architectural and spatial aspect, those are apartments without barriers – easily accessible and designed to facilitate life to the disabled or endangered with disabilities, with huge common space encouraging to enhance neighbour bonds.

In years 2018–2020 STBS will prepare 45 apartments for the elderly. The apartments will have the access to the recreational, cultural and health offer owing to the surrounding venues offering activation of the elderly, there will be a geriatric health centre and a Local Activity Centre. The monthly cost of the maintenance of the sheltered flat, which includes the rent, management costs, utilities and renovation fund stands at the level of 650 PLN for an apartment of 40 m² and 750 for an apartment of 50m² (MOPR, 2016).

A crucial element in the systemic approach to elderly care is enabling them to function in the place of living. Because of this, specialist care services are provided in the place of living or current stay.

Table 2. Services in form of elderly care services in Szczecin

Care services	2016	
	Total	Including specialist care services
Number of people using support in form of care services	1 605	150
Number of services in hours	651 334	44 351
The cost of provided help	8 544 836	893 959
Average number of hours for one person - yearly	405,82 hours	295,67 hours
Average number of hours for one person - monthly	33,82 hours	24,61 hours
Average cost of one hour	13,12 PLN*	20,16 PLN¹

Źródło: MOPR Szczecin, 2016.

Every year the number of granted benefits to people over 61 increase together with the expenses in this field. In the analyzed period rise of the expenditures by 40% was noticed and in 2016 they reached the level of over 8,5 million PLN. The increase is

caused mainly by people from older age groups. 88% of beneficiaries of the services are women. The increase of the expenditures for care benefits realized in the environment is inevitable, but it is worth mentioning that it is the most common, accessible and economic form of helping seniors with limited self-reliance provided by social welfare institutions, allowing the elderly to stay in their environment. Care services are mainly provided to lonely elderly people. In 2016 84% of benefits were performed in one-person households.

Within environmental support for the elderly with limited self-reliance there are two pilotage programmes that have been implemented: "Przycisk życia" ("The button of life") – currently 50 people are involved, but till 2020 there will be 250 people using the programme; and "Gorący posiłek dla senior" ("Hot meal for the senior"). Additionally, "Srebrny Telefon dla Seniora" ("A silver phone for the senior") is functioning.

The analysis of the costs of the investment – creating 100 places in sheltered housing versus 100 places in nursing homes

The cost of creating one sheltered apartment for 6 people using the housing stock belonging to Szczecin commune and subsidiaries was counted on the basis of previous experiences connected with setting 5 apartments for 28 elderly people in former years. Taking into account renovation and fitting expenses, the cost of creating one apartment is 102 040 PLN. Securing 100 places for dependent elderly people requires creating 17 sheltered apartments, whose estimated cost equals 1 734 687 PLN. The estimated total cost of constructing a nursing home for 100 elderly people has been specified as 22 720 560 PLN. The main elements of the investment expenses are construction and development of the site with its equipment. Because of the dynamic situation on the marketplace the estimated cost of the investment can increase significantly⁶.

In conclusion, the cost of securing the needs of 100 dependent elderly people in a nursing home is 22 720 560 PLN. The cost of meeting the needs of 100 dependent seniors in sheltered housing is 1 734 687 PLN. There are a few arguments for sheltered accommodation apart from the lower cost of creating the places. The investment process in this case is shorter and brings smaller deviations in terms of the planned and actually borne investment costs. Building a nursing home requires a multi-stage investment and a number of investment procedures. Moreover, sheltered housing can be created in stages (e.g. 5 every year) which helps to stagger the costs in time. The

6 At the current stage there is no possibility of using the simplified calculation method, consisting of estimating the budget of the works as a sum of products of basic works and their individual prices. Therefore, for the valuation of the construction works the method of individual price net for 1 m² of total space was used. For the valuation of the fitting and some of the elements of the estimated budget, the method of market valuation was used, on the basis of the common knowledge accessible on the websites of BIP units of local government. The total area to value is: 3500 m², and the price net is 3000 PLN. The cost of the internal fitting was also estimated. It was assumed that the area for the investment belongs to the commune of Szczecin City.

time needed to activate a sheltered flat is much shorter than building a nursing home. Sheltered flats can be located in different parts of the city, which plays an important role in letting seniors stay in their environment and preventing the creation of the so called “social enclaves”.

Conclusions and recommendations

Demographic forecasts and the conducted research indicate the necessity of preparing solutions aiming at restricting the negative results of the process of the ageing of the population of Szczecin. The need for care services for the dependent elderly people will be growing systematically in the coming years. The extension of all the elements of the system of support, environmental, semi stationary and stationary forms is needed. We recommend especially:

I The development of forms of 24-hour care alternative for nursing homes, less costly and more acceptable by elderly people, particularly:

1. Intensification of the development of sheltered housing by increasing the number of sheltered apartments to 5 in every consecutive year, in years 2018–2030.
2. Development of the sheltered housing system.,
3. Creation of family nursing homes for elderly people.

II Creation of environmental support system:

1. Optimization of the functioning of daytime support centres through:
 - a) rationalization of costs
 - b) profiling the work of daytime support centres, especially taking into account supporting people with dementia, Alzheimer’s disease and disabilities (the blind, deaf and others);
 - c) assigning the conduction of the support centres to non-governmental organizations
 - d) extending the range of services of the centres in favour of people in the living environment;
 - e) development of voluntary care service, including people in the “third age” in favour of people in the “fourth age”.
2. Development of environmental services in cooperation with social organizations (e.g. transport services, adaptation of spaces, food delivery, shopping, small repairs) and schools (e.g. hot meal) enabling elderly people to function independently in their environment.
3. Extending environmental support for dependent seniors and members of their families, including respite care.
4. Development of the chain of senior clubs.

III Support for people with dementias

1. Creation of the urban plan of support for people with dementias, in cooperation with specialists and non-governmental organizations.

2. Adaptation of current resources of nursing homes to the needs of people leading a recumbent lifestyle, who are characterised by exiguous or zero independence.

IV Working out family support mechanisms in the process of elderly people care.

1. Preparing family care givers to provide care to dependent seniors in a safe way adequate to their needs. In many cases the health crisis of the senior is sudden (e.g. stroke, hip injury), the necessity of providing care the dependent elderly person is abrupt. Moreover, it is important to take care of psychological support for the family care givers, who, because of the difficulties it brings and its length (often counted in months) are endangered with a number of psychological crises (e.g. depression, caregiving burnout).

2. Consideration of legal, organizational and financial possibilities concerning introduction of “caring voucher”, thanks to which a supplementary payment to care services provided by private subjects in an environmental and stationary form would be possible.

V Creating a Senior’s Centre, in which could function such departments as: department of intervention, information, special counselling, judicature, family support, senior initiatives, equipment rental, etc.

The described recommendations refer to the indication of solutions which are vital for the improvement of elderly care within social welfare actions, in the light of the legal possibilities which are in force. An equally important role in building a coherent elderly care system belongs to the health sector, however, changes in this field are not included in the competences of commune/district self-government and require independent analysis.

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*Joanna Wnęk-Gozdek*¹

Colors of old age – passions of Crakow centenarians

As long as you paint,
you are always young...
youth has no end.²

Henryk Kozubski (106 years)

Key words: centenarians, education for old age, passion, painting

Abstract

The article presents the profiles of two Crakow centenarians whose passion is painting.

Since 2016, a team from Department of Andragogy and Social Pedagogy (editors of the Polish Social Gerontology Journal) has been conducting qualitative research among centenarians living in Krakow and its surroundings. In 2015, there were more than 4 thousand centenarians living in Poland (Ministry of the Interior and Administration 2015), and in 2016 Cracow district had 99 residents aged 100 years and more (ZUS 2017). The vast majority of this group were women. It is not easy to reach these respondents. Health condition and barriers keeping them from independent functioning limit their visible social activity, that is, all the activities people undertake outside their homes (Szukalski 2013, p. 35). The interview-based studies were conducted in a group of over a dozen of seniors. Each of these encounters was a unique experience, letting the researchers get to know a piece of “living” history of human-

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2 Quoted from the interview with Henryk Kozubski on 11 May 2017.

kind, and an opportunity to gain unique knowledge in the area of widely understood education for old age (Szarota 2015, pp. 22–35).

Among the respondents, there were two 100 year old artists who share an amazing passion for painting. Why is it so amazing? Because it has managed to overcome all limitations and difficulties. First of the artists, 101-year-old Stanisław Jakubczyk, was born in 1916 in Lubatowa, in Subcarpathia region. He studied at the Academy of Fine Arts in Krakow, in the Center for Pedagogical Studies and the Film School in Łódź. He is a member of Association of Polish Artists and Designers. He designed about 150 stained-glass windows and is the author of mosaics, altar sculptures and paintings in over a hundred churches in Poland and several ones abroad. His portfolio also includes many short movies awarded at national and foreign festivals and 12 poetry and prose publications (Jakubczyk, Dzieszyński 2003). Painter almost since his birth, he has been faithful to this art despite severe sight problems. As he himself says: “What kind of painting is that... magnifier must be huge, my nose on it and I put the brush under it (...) because I can’t see, the center of my vision if completely blurred, I can only see the edges. But I am stubborn. Once I start something, I do all I can to complete it, even if it costs me a lot of effort”³ (Jakubczyk 2017). The “fruit” of this tedious work are series of paintings that will be exhibited in November 2017 in the Krakow Palace of Arts. The exhibition of Stanisław’s works will be unique, as he notices, because: “I thought it would be good to show only the things I made when I was over a hundred years old” (ibidem). The series of abstract paintings titled “Fluencje” (*Fluencies*) will be presented. It is an attempt to capture the phenomenon of dispersion and mixing of dyes in spinning water. Another cycle, “Oratoria” (*Oratories*), is a symbolic presentation of selected Lord’s Prayer verses in a different prayer settings. A motive connecting four paintings are Latin word of the prayer, that refer to men: *Thy will be done, give us our daily bread, forgive our trespasses, do not lead us into temptation* and a white figure representing humanity. The oratories are: a basement, a temple, a prison cell and a theatre.

Another of the two seniors, 106-year-old Henryk Kozubski, was born in 1911 in Biecz where he spent his childhood and early adolescence. In 1926, his family moved to Wieliczka. He graduated from the Faculty of Agriculture at the Jagiellonian University in Krakow. He had worked in agriculture his whole life. When he retired, he engaged in social activities. He began to paint watercolors when he was 94. He explains his artistic and cultural activity with a belief: “If you [a senior] still have strength, you must work, and you have to work to have strength”⁴. During 12 years he has taken part in over 60 exhibitions, created more than 600 paintings, has been an active member of Art-Klub in Wieliczka and at present, he and a photographer Paweł Jędo work on a movie about his life, titled “The Painter of Life”. He speaks with humility about his own artistic work: “I have never thought that as an amateur, I would be showing my

3 Quoted from the interview with Stanisław Jakubczyk on 24 May 2017.

4 Quoted from the interview with Henryk Kozubski on 11 May 2017.

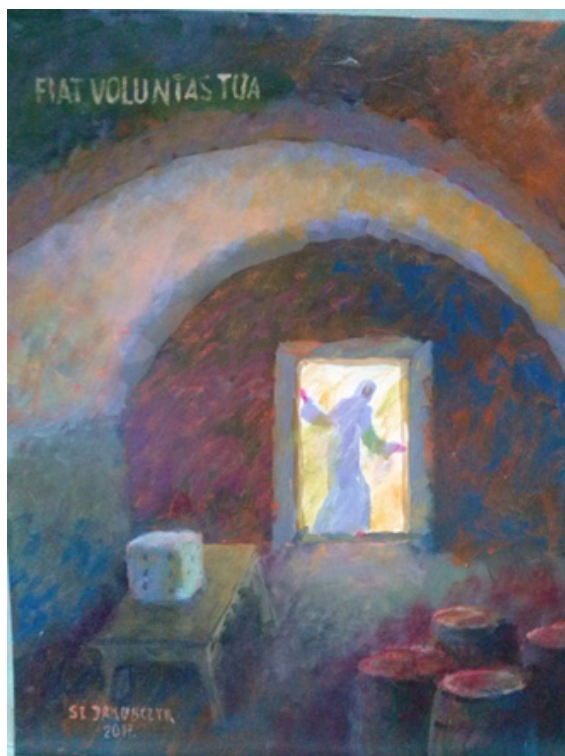
works. This is my life's biggest surprise" (Krzywda 2016). Henryk owes his success to hard work. Constructive critical evaluation he received one day from a professional artist, did not discourage him. "I decided to improve my skills. And I began to paint professionally" (Kozubski 2017). And next review was exceeded his expectations: "I was called a unique Chagall from Wieliczka" (ibidem). Paintings by Henryk Kozubski present watercolor landscapes, still nature and monuments of architecture. His works are displayed on the walls of his family house and shown in different public places, for example, in a mine, old tower or train carriages. He also organized exhibitions in neighboring villages. He wanted to give as many people as possible a free access to art. Henryk does not want to waste even a moment of his life, therefore he has precise plans: "I am not going to accept that I am old and frail, I am going to paint till the last day of my life" (ibidem).

The noble respondents, Stanisław and Henryk, every day paint they old age with new shades from a multi-color palette of life and do not give up on their dreams. Stanisław would like to finish his last book. He emphasizes: "Writing is another thing I am still able to do... Now, when I do not have many laps left until the finish line, I have to hurry up. Our present reality provokes, it does not let me stay silent, it forces me to speak" (Jakubczyk 2016, p. 10). Henryk has still many ideas. As he notices, there are still empty pages in his family chronicle. Both gentlemen, since they heard about each other, would like to meet in person. The University of the Third Age of Pedagogical University of Cracow will take all efforts to organize a meeting of both nestors with a wider audience.



Stanisław Jakubczyk with one of his paintings from "Oratories" series⁵.

⁵ Picture taken by the author during the interview with Stanisław Jakubczyk on 24 May 2017.



First painting from “Oratories” series by Stanisław Jakubczyk⁶.



Henryk Kozubski in his house presenting his family chronicle⁷

⁶ Ibidem.

⁷ Picture taken by the author during the interview with Henryk Kozubski on 11 May 2017.



Henryk Kozubski presenting his watercolor paintings⁸

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⁸ Picture taken by Gabriela Mruszczak during the interview in July 2017.

Lukasz Tomczyk¹

**Social forces in the process of digital inclusion of seniors
(based on the project Digital Poland of Equal Opportunities)²**

It is estimated that about 12 million Polish citizens have experienced digital exclusion (Batorski, 2015, p. 335). Such people are not able to take advantage of possibilities and resources that are hidden from them in the virtual space. A small part of this group uses some e-opportunities in a mediated way, thanks to help from other people. As for Poland, inability to participate in the virtual space is less and less connected with insufficient funds to buy digital equipment or pay for regular Internet access. Most often, it results from lack of motivation to use electronic media and inadequate level of digital competencies. Thus, e-inclusion of the digitally excluded seems to be one of the challenges of modern society based on information technologies. The use of ICT is noticeable in almost every area of life and it enables more comfortable, faster and – in many cases – more cost-effective management of daily tasks (Jasiewicz et al., 2015, p. 3). With these facts in mind, digital exclusion has been included as one of the objectives of social policy and considered as one of the priorities related to improvement of the level of human capital (Stawicka, 2015, p. 13).

It needs to be emphasized that attempts to minimize digital exclusion in Poland have been implemented for about 20 years. The first attempts at minimizing the phenomenon of digital division were introduced as far back as in the late 1990s. In this initial stage of information society development, most of them involved providing households and institutions of all kinds with computers and Internet access. Modeling digital competencies and encouraging to “be online” were secondary in this period. In the following years, there was a regular development of various institutional forms of education of the digitally excluded, among them: senior clubs, universities of the third age, libraries, foundations, culture centers, e-centers, Orange Academy, businesses and a range of non-governmental organizations involved in increasing the level of digital competencies and raising funds for this type of activities from external sources (see Bucholtz, et al., 2015, p. 4).

The example of Cities on the Internet Association (Stowarzyszenia Miasta w Internecie, SMwI) analyzed in the paper, a non-governmental body responsible for digital inclusion of generation 50+, presents new aspects and opportunities of civic engagement in social policy processes, development of human and social capital and, first of all, supporting active ageing and old age. Activities of several hundred volunteers-

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educators point to the significance of human and social potential to transform lives of disfavored individuals.

As emphasized by A. Naumiuk, social activity is a complex process and its multi-threaded and multi-dimensional analysis that included factors like: motivation among the beneficiaries, ideas supporting the activities and organizational aspect, provides an answer to questions about practical sphere of the phenomenon. In order to understand the phenomenon of voluntary work by Lighthouse Keepers of Digital Poland of Equal Opportunities (Latarnicy Polski Cyfrowej Równych Szans), we need to consider several layers of a complex social activity mechanisms connected with the process of engaging social forces to advance digital inclusion of people in their late adulthood (see Naumiuk, 2007, p. 71–74).

Due to the fact that social activities are still not very popular form of leisure activities and the effects of such work are not always visible in a local environment, the attitudes of Lighthouse Keepers of Digital Poland of Equal Opportunities should be particularly promoted. Thanks to stubbornness and consequence of these educators-activists, the number of digitally excluded in Poland decreases, and their social participation destroys the myth of impossibility of mass volunteer engagement in quick and effective response to civilizational changes (see Naumiuk, 2011, p. 108–109). Thus, Lighthouse Keepers contradict some common opinions about modern citizen not willing to get involved in social activities, seniors not being open to new technologies, lack of motivation in local communities to embrace changes and hermetic local resources not open to collaboration with other institutions or volunteers. Activity of Digital Poland of Equal Opportunities also sets new ways of social practices based on education, and points social educators towards deeper analysis of the key concepts in social pedagogy and andragogy, referring to modernization, social change and human capital.

Programs based on the concept of education in a local community are the answer to the needs of such communities and provide efficient and relatively cheap solution to problems in the area of social inequalities. In this case, education of the excluded takes on the form of social initiatives, support groups formed bottom-up as a response to the needs of disfavored groups (Jurgiel, 2007, p. 28).

Poland has a rich tradition of pro-social activities as well as non-formal and environmental education. This type of human and social capital requires that social policy creators on local, regional and national level consider, understand and appreciate such solutions as Digital Poland of Equal Opportunities program, if they want to continue with social transformation that would respond to general social needs – the needs determined by on-going technical, social cultural, administrative and economic changes.

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A report from the International Scientific Conference

**“Healthy ageing: multidisciplinary perspectives, life-span applications”,
Cracow, 23–25 March 2017**

The international scientific conference entitled “Healthy ageing: multidisciplinary perspectives, life-span applications” took place on March 23–25, 2017. The meeting was organised by the Faculty of Social Pedagogy and Andragogy (at the Institute of Educational Sciences) and the Faculty of Psychology of the Pedagogical University of Cracow. The purpose of the conference was the review of the latest knowledge about the optimal course of late adulthood and old age, the diagnosis of the practices supporting the human development and possibilities to maintain high quality of life during this period.

The meeting was organised in partnership with the City of Cracow, while the Magical Cracow was the media patron (Krakow.pl). The honorary patronage over the conference was taken by Rector of the Pedagogical University in Cracow. **The scientific patronage over the conference was held by the Association of Social Gerontologists.**

The conference was attended by 57 participants presenting papers. The speakers represented a total of 24 scientific units. The meeting was attended both by the Polish and foreign scientists – from the USA, Ukraine, Italy and Malta. The conference was multidisciplinary – invited guests represented such fields of education like: pedagogy, psychology, sociology, health sciences, speech language pathology and economics.

Not only students, researchers and practitioners were the listeners, but also participants of the University of the Third Age, operating at the Pedagogical University. The subject of health was treated holistically on the conference – the physical, mental and social aspects were included. The meeting was both theoretical and practical. The recipients were presented with the issue of various problems of the elderly, as well as forms of help and care for seniors. Thanks to the meeting, the participants got to know different faces of the old age.

The first plenary session was held on Thursday, which subject focused on the spiritual development of the elderly. This part addressed the issues of human development from the andragogical perspective, old age as a context for spiritual development, the proposal to expand the Erik Erikson’s theory, communication with seniors, sharing the life experience and narrative gerontology in theory and practice.

The next plenary session was held on the second day of the conference, on Friday. The presented papers focused on the opportunities and limitations in supporting the development of sessions (in the health perspective). In this part, the speakers talked about senior policy, active and healthy ageing, human sexuality, quality of life, as well as the incurable disease, which is an educational situation.

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On the same day, the third plenary session was held, which also referred to the opportunities and problems in supporting the development of the elderly, but in the perspective of social policy. The presented topics are: "The policy of healthy aging as an example of sub-policy of life", "Needs and opportunities for development of the elderly in Ukraine", "Our common senility, or how does the social policy shape the spaces that are friendly to seniors and is it really happening? On the example of Poland", "Senior in the institutional perspective of pro-senior policy of the country. Facts and myths.", "Helping the older inhabitants of Cracow search for the meaning of life – the systemic actions of the Cracow self-government".

Five parallel thematic sessions were held on the first day of the conference. The first one concerned the aging process in the geragogical perspective. This section analysed the issues, such as: wisdom and education of seniors, activity and interests of the elderly, as well as the roles they play.

The next session was called "Prevention, participation, protection, partnership". The speakers discussed, among others, the topic of proactive living space, senior support system, coping with difficulties. They talked about the physical activity of the elderly, problems in communicating with the sick and the quality of life.

The third thematic session referred to suffering and ways of dealing with it. The speeches focused on topics, such as: the course of life in intellectually disabled, geragogy, experiencing pain by patients with cancer, reinforcing hope in seniors, quality of life of the disabled elderly, successful aging and senior care.

The next part concerned the development potential of the person at the old age. This session was devoted to the following topics: "Narrative identity of the elderly", "The course of life – autobiographical narration in the context of developmental tasks of R.J. Havighurst", "How to become a tantric instead of a grumbler?", "Loneliness and solitude in the experiences and narratives of marriages with a great length of married life", "Implementation of development tasks in late adulthood and ways of measuring it", "Personal resources and implementation of development tasks by women in late adulthood", "Existence. Existential counselling for seniors in narrative perspectives. Selected issues" and "Critical events in the life of the elderly".

The last thematic session was focused on communicating the experience between generations. The following, among others, was discussed: good practices, the quality of life of the seniors in the intergenerational optics, family in the reflection of older people. The issues of learning from the experiences of others, the role of grandparents in the lives of grandchildren, the attractiveness of seniors, the education of older people, as well as the intergenerational transmission of values were discussed.

Three interesting workshops were also prepared for the conference participants, which attracted great interest. The first one was held on Friday, and concerned the narrative strategies in gerontological practice. The remaining workshops took place in parallel on the last day of the conference. One of them was called "Life as a Story.

Methodology of the memoir writing courses”, the second workshop was about film therapy for the elderly.

The conference has become a place for theoretical reflections and exchange of research experiences on aging and old age. The meeting resulted in interesting lectures, which have contributed to science. The conference was attended by valued academics from the country and abroad, practitioners dealing with seniors, as well as representatives of senior institutions. The high rating of the meeting is composed of: participation of gerontological authorities, a very rich program, the quality of speeches, creative discussions, interesting workshops, as well as the number of represented environments. The value of the event also results from the fact that the practical proposals of changes were presented, which can have a positive impact in the future.



JAK STARZEĆ SIĘ ZDROWO: multidyscyplinarne ujęcia, całościowe aplikacje

HEALTHY AGEING:

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