Proposed discussion with His Holiness the Dalai Lama on the subject:

GROUP 1. Gains and Losses in old age:

This document is the result of various exchanges on the way aging is considered in the scientific interdisciplinary field of gerontology (an interdisciplinary field which includes physicians, biologists, psychologists, sociologists and social workers) in order to discuss this perspective with Her Holiness the Dalai Lama and his representatives.

1. Introduction : New frontiers in the life course ?

Worldwide, life expectancy at birth has more than doubled over the past two centuries, increasing from 25 to 65 years old for men and to 70 for women in developed countries. In the most industrialized countries these demographical changes were marked by two parallel phenomena: the decrease of fertility and the increase (or rectangularization) of life expectancy. These changes, have profoundly change the traditional pyramids of ages, and without migration fluxes, the population in industrialized countries would age even more rapidly.

In Switzerland, the number of octogenarians, nonagenarians and centenarians has greatly increased, notably since 1950. In 1900 there were 17'000 persons aged 80 and more (0.5% of the population). In 2000 they were about 300'000 composing 4% of the population. See also WHO reports.

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of the population. Internationally, Switzerland\(^4\) has the 3rd rank of life expectancy (80.6 years) with Japan in the first rank (81.9 years). The difference among countries (related notably to) are very large (see following figure, source Wikipedia) with the poorest countries far behind these wealthy countries.

Questions for discussion

How should we understand these trends in the cycle of lives? How should we understand an aging civilization? As a progress of medicine and wealth or as a sign of a declining civilization?

What is the meaning of these changes in life expectancy, mostly due to cultural factors, for humanity and the cycles of life?

\(^{4}\) To be updated…
New frontiers in the life course

The field of aging studies is an interdisciplinary endeavor as human development is the result of interaction among biological, psychological and cultural factors. Different theories of good or successful aging have been developed opposing two contrasted views of aging. On the one side we have a view of normal losses in the course of old age as insufficient. This is the influential perspective developed notably by Rowe & Kahn. They distinguish between two types of aging: one qualified of usual and the other of successful. The first includes individuals who are marked by the typical losses of old age. The second is characterized by individuals who avoid the usual decline with no or lower levels of losses. If some individuals escape to the usual diseases or losses of autonomy due to senescence, one should ask if losses are really related to age, or if there are factors who can explain a successful aging? In this optimistic perspective, successful aging is defined as a low probability of disease and incapacities, a preserved cognitive and functional capacity, and a strong commitment in social life (productivity and social relations). The crucial factor underlined by these authors is the past life style of individuals.

This perspective has been criticized by tenants of another view of successful aging who emphasize on the one side on the inevitability of losses in very old age and on the other side redefine the goal of aging, not as keeping a higher level of functionality in all domains, but as a functional cognitive adaptation to loss. If the first theory has the willingness to change life, the second relies more on the idea of accepting life as it is.

Critics to the Rowe and Kahn model underlined the lack of incorporation of social inequalities in the model leaving to the individual the responsibility to age successfully. Moreover this theory could lead public services to underestimate the future needs of the aging population in terms of housing and health care. And who decides what successful aging is? If we follow the indications of Rowe and Kahn, only a slight minority are successful. However, when people are asked about their aging, about half of them consider they age successfully!

The life course perspective distinguishes different (increasingly numerous) stages during the life course (notably: infancy, childhood, adolescence, young adulthood, middle adulthood, young old age and old old or very old age). Neugarten and later

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8 A perspective closer to the lessons of the Nakula-Sutta ?
9 Is Tibetan Buddhism also an individualistic perspective in this regard ?
Lasslett have distinguished two life stages during old age commonly labeled third and fourth age or young- and old-old age. The increasing life expectancy in this perspective has not created the new category of the oldest old (the increasing number of nonagenarians and centenarians), but a new period of life notably characterized by functional autonomy, a disengagement of paid work (retirement), and self-development or leisure activities. In contrast fourth age is marked by high levels of losses. In summary, these authors divide old age in good news for the third age: increase in life expectancy (notably for women); substantial latent potential for better fitness (physical, mental) in old age; Successive cohorts (generations) show gains in physical and mental fitness; evidence of cognitive-emotional reserves of the aging mind; more and more people who age successfully; high levels of emotional and personal well-being (self-plasticity); effective strategies to master the gains and losses of late life. On the opposite bad news seems concentrated in older ages: Sizeable losses in cognitive potential and ability to learn; increase in chronic stress syndrome; sizeable prevalence of dementia (about 50% in 90.year olds); high levels of frailty, dysfunctionality and multimorbidity; Dying at older ages: with human dignity?

**Questions for discussion**

Can we define normatively (scientifically or in a dogmatic system) what is a successful aging process? Are there “bad” and “good” news about aging?

Do individuals know how they should or could age? Does science (and which one) or religion know?

Is the responsibility of a successful aging in the hands of the individuals or is it a collective responsibility?

What is the place and role across generations of mortality?

Is the idea of stages of life compatible with Buddhism?

**Diversity and continuity of trajectories in aging processes**

Another perspective comes from longitudinal studies of aging, an increasing tool used by researchers in order to describe and understand aging as a process and not only as a state (be it desirable or to avoid). Results of these studies in general teach us two important lessons. The first is that intra-individual change is often over-estimated in cross-sectional studies, whereas continuity is the most observed trajectory in most domains in longitudinal studies. The second general lesson is that diversity at the interindividual level should be acknowledged putting into question the idea of normal stages in the course of aging.

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In a longitudinal study on octogenarians, Lalive d'Epinay and Spini have shown that fragilization is a normative process in very old age. However frailty when it appears is a multidimensional concept and its definition is far from crystal clear15. When health trajectories are taken into account, diversity is observed. Some individuals remain independent for almost all their life, other (more or less half of the observations) express different forms of frailty which can worsen but not impede them to live an autonomous life, finally other live long episodes of dependence. Actually, all possible trajectories are observed across time (stability, decline, amelioration, death). Stability is the most frequent trajectory observed (with a time lag of about 12-18 months) during all the study (from 82 to 94 years old). The only noticeable change is the rarefication of amelioration trajectories with advanced age, but decline does not accelerate as could be expected. The lower potential for improvement or learning is also repeatedly found for domains like memory plasticity16.

When the last years of life are considered17, the same global conclusions hold. The trajectories leading to death show much diversity and as the authors conclude, the course of disability in the last years of life does not follow a predictable pattern and frailty is again the most frequent condition leading to death (27.9%), followed by organ failure (21.4%), cancer (19.3%), advanced dementia (13.8%).

Concerning well-being, the conclusion is more or less the same. Generally speaking, well-being remains fairly stable across old age and reaches its peak around 60 years old. In advanced old age, some dimensions of well-being seem to suffer from health decline even if it remains fairly resistant to change as underlined by the idea of a well-being paradox18 which sustains that well-being, even if it is correlated to health conditions, remains relatively more stable than health trajectories.

Questions for discussion

Is the idea of diversity of intra-individual relative stability and interindividual diversity in health trajectories interesting?

Do the concepts of frailty and fragilization as the main characterization of very old age bring anything to knowledge of the last years of life (in replacement of the opposition between independence/independence)?

How should we frame the question of autonomy/dependence, is this typically a question of a individualist society?

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Two models of frailty in old age: systemic and linear

Frailty\textsuperscript{19} is not yet defined in a consensual way. Definitions however agree on the conclusion that it is a multidimensional condition including dimensions like autonomy, cognitive difficulties, pain, sensorial problems (balance, vision, audition, etc.), and a general lack of energy. This last dimension appears central in many definitions of frailty. Frailty can be defined as a process in which risks of loss are relatively high, in which coping processes against chronic or event-related stress are altered and which results in losses of resources.

There are different types of models that describe frailty in the process of aging. We will focus on two distinct, but not exclusive models of this process: the linear and the cyclical (or systemic) model. The linear model has many variants, but most descriptions describe a more or less irreversible declining process that starts from autonomy and which can go to impairments, disabilities and finally death. The linear model is usually deterministic and assumes a causal or unidirectional chain of relationships related to age. Studies describe a large number of possible short- and long-term factors which could be associated to frailty and its various outcomes. Consistent with a life course perspective, diverse long-term biographic antecedents of frailty are identified. These may be related to genetic factors, as well as cumulative processes of (dis)advantages\textsuperscript{20} related to behaviors (professions for example) and social status (birth weight, risky behaviors, obesity, childhood adversity, etc.)\textsuperscript{21}. These risk factors may be conceptualized at the individual level, but also at the collective level, as some events like epidemics, wars, socio-economic conditions, and cultural changes have potentially a more important impact.

On a short-term basis frailty can also be explained by a large number of biomedical and psychosocial factors. These factors include pas negative or declining health statuses (illness, stroke, chronic diseases, depression, dementia, weight loss, etc.), disruptive or traumatic events (falls, loss of partner, hospitalization, etc.), psychological processes regulating stress (emotions, motivation, optimism, control beliefs, coping strategies, religiosity, etc.) and various social factors (poor finances, availability of services, etc.).

Finally this model also considers outputs of frailty (which can be also considered as resources and causal factors in the models...). Frailty can impact on various outcomes such as: health (physical or functional health, etc.), well-being (satisfaction, happiness, positive or negative affect, etc.), activities (daily, productive, leisure, cultural, etc.), the frequency and quality of relationships (cohabitants, friends, family, neighbors, professionals, etc.), and exchanges (help, care, visits, etc.).

One of the main issues related to the linear model is the difficulty of defining the essential features of frailty and of separating antecedents and outcomes of frailty. Cyclical or systemic models can complement this causal or linear view. The main assumption of cyclical models is that the process of frailty is generally due to senescence, but is often hidden before some trigger event (like a hip fracture, an illness, a hospitalization, etc.) can make it observable. A general feature of this model


\textsuperscript{20} See also the concept of allostatic load in biology which is closely related

\textsuperscript{21} Check literature : Ferraro….. Dannefer… etc.
is that frailty can be set in motion by a change (usually a loss of a given resource) in different subsystems of the organism (physiological, psychological, behavioral, etc.). The physiological dimension has been studied in greater details. There is evidence for a general decline with the advance in age of a number of physiological resources (including creatinine clearance, forces expiratory volume, nerve conduction velocity, insulin sensitivity, muscle mass, strength and maximum oxygen uptake). This process of senescence appears to accelerate after 70 years old and progressively erodes the reserves of resources in different subsystems of the individual. When reserves reach a given low value (some argue that there would be a general rule of 30% of reserves necessary to recovery), the organism would lose the capacity to adapt or recover previous states of functionality, which can be usually observed clinically. Over the life span, the individual is resilient to most stresses; therefore damages to the organism are in most cases reversible and can be successfully overcome. A lack of resilience is a key feature of frailty. The subsystems of the organism are related to one another, which constitutes a basic assumption of the cyclical model of frailty. Deficiencies in several functions may accumulate because of their underlying linkages. For example, if mobility is problematic, inactivity can lead to a loss of appetite and insufficient food intake may result in malnutrition. This in turn can give rise to muscular dysfunctions and further deceased inactivity.

**Questions for discussion**

What kind of life experiences or behavior may favor robustness across the life course and in particular in old age?

How should we define concepts like autonomy, independence, dependence? These are question of a whole life, should we define these concepts differently at different periods of life?

Functional health has been for a longtime the cornerstone of health evaluations in gerontology, what about the other dimensions?

How should we conceive frailty, or more generally, human vulnerability?

What is the status of “energy” in frailty and human development? How can we conceive it in an interdisciplinary way?

**Overcoming frailty: individual and collective resources**

*Age in Western societies: an identity threat?*

Age, as sex and other phenotypic traits of individuals, is a basic social marker that shapes our identity and perception and attitudes towards others (Cuddy & Fiske, 2002; Montepare & Zebrowitz, 1998). Nonetheless, age is a special social category (compared to more impermeable social categories as sex or social class for example), as the majority of individuals in industrial societies are more or less “condemned” to become very old, especially if they have a high social status and are women (Arber & Ginn, 1993). Another important aspect that makes age a special social category is that we will, if our lives are long enough, grow into this category (Levy, 2003). Whereas individual characteristics such as ethnicity are fixed and thus...

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22 This part is based on excerpts of a paper by Spini & Jopp (in press). *Old age and its challenges to Identity.*
allow individuals to build up strategies to handle discrimination and distress related to their membership in a particular ethnic group, individuals build up (oftentimes negative) attitudes about the old very early in life even as they invariably progress toward becoming part of this group themselves (Levy, 2009). Besides these specific aspects concerning the role of the age category at the individual level, life course theorists have repeatedly argued that society is deeply structured by age, and that the life course (Riley & Riley, 1994) is a central institution of society (Kohli, 1986).

In Western societies, old age stereotypes are ambivalent. Elderly stereotypes have been thoroughly studied and the traits associated with advanced age are mostly negative and related to physical decline, cognitive deterioration, and social isolation or exclusion (Kite & Johnson, 1988; Palmore, 1990). This focus on losses has also been a reality in the first studies on old old age. At the same time, positive stereotypes have also been repeatedly found with respect to characteristics such as wisdom and dignity (Heckhausen, Dixon, & Baltes, 1989) or certain "young old" characteristics such as specific activity patterns and/or friendliness (Hummert, Gartska, Shaner, & Strahm, 1994). This ambivalence can also be found in the results presented by Cuddy and Fiske (2002) regarding the two classical dimensions of warmth and competence (Asch, 1946): elderly individuals were perceived as high on warmth, but low on competence. Also of interest is the fact that the two groups who were categorized as "alike" were individuals with mental and physical disability. As can be concluded by these studies, the stereotypes about old people are a powerful cultural environment which gives a standard to judge self and others.

As proposed by Greenberg, Schimel, and Martens (2002) the negative attributes of old age are also threatening for the self because they are associated with our fear of mortality and irreversible declines. For many, old age is linked with losing social roles, physical and cognitive decline. There is empirical evidence that indeed age stereotypes are threatening and have substantial negative effects on cognitive performance, health, and even survival (Desrichard & Kopetz, 2005; Hess, Auman, Colcombe, & Rahhal, 2003; Levy, 1996; Levy & Meyers, 2005; Levy, Slade, Kunkel, & Kasl, 2002; Tettamanti, Ryser, & Spini, 2009). In order to avoid one's assimilation into a category associated to threats to identity, older adults tend see themselves as being different from their age category (Greenberg, et al., 2002; Martens, Goldenberg, & Greenberg, 2005).

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It is also a well-known fact that individuals of all ages tend to declare a younger subjective age or age identity than their chronological age (Westerhof, 2008). Moreover, this tendency increases with advancing age and is particularly pronounced for older adults (Barak & Stern, 1986; Kleinspehn-Ammerlahn, Kotter-Grühn, & Smith, 2008; Montepare & Lachman, 1989). Moreover, a younger subjective age was found to be associated with a higher well-being (Barak & Stern, 1986; Filipp & Ferring, 1989; Steverink & Timmer, 2001). This positive effect of the discrepancy between chronological and subjective age is usually interpreted in the sense that people contrast themselves from the negative aging stereotype or expectancies associated with older individuals or groups, representing a self-enhancing strategy (Westerhof, 2008). However, this discrepancy may also reveal that individuals tend not to feel old. In interviews conducted by Hummel (1998) individuals reported that as long as their cognitive capacities are intact, they would not become old. This statement matches that individuals may not feel that they are getting older when they refer to their inner subjective experience, which Kaufman (1986) called "the ageless self", an expression developed on the basis of interviews.
about the personal experiences of aging. When asked what helped them to reach their very advanced age, even centenarians indicated that they were 100 “all of a sudden”, as documented in a film portrait by Michel (2010), indicating that they had experienced their aging as a continuous process despite all obvious qualitative changes in terms of losing health and loved ones, and being no longer able to pursue valued activities. Indeed identity is founded on continuity as a central principal!

**Resources to overcome frailty**

We just considered some elements of the societal context in western societies that give positive and negative meanings to aging and old age, with some evidence that becoming old may be somewhat threatening for the self and identity, even if most individuals find strategies to face this period of life. We will now focus on individual resources to face losses. Psychology (and sociology) has developed different models of self-regulation of stress.

Most scholars argue that self-regulation mechanisms are responsible for the stabilisation of self-esteem or well-being in the face of adverse conditions and age-related declines (P. B. Baltes & Baltes, 1990; Jopp & Rott, 2006; Jopp & Smith, 2006) and that they are available and well-functioning until very old age (Jopp & Rott, 2006; Jopp, Liu, Wozniak, & Rott, 2012). These self-regulatory mechanisms have been discussed under the term psychological strengths and include strategies (e.g., coping, life-management) as well as attitudes and beliefs (e.g., self-efficacy, optimism, meaning in life, will to live; Jopp, Rott, & Wozniak, 2010). Among the numerous self-regulation strategies (social comparison, temporal comparison, attribution), identity motives (continuity, distinctiveness, self-esteem, self-efficacy, meaning, etc.) or coping strategies (denial, facing, control, etc.)

Religiosity is also believed to be an effective resource, even if some contextual elements are to be taken into account.

The end-of-life stage in the developmental cycle poses another challenge. Following Breakwell (1986a), self-awareness and cognitive competencies are central components required for assimilation-accommodation process which is responsible for integrating new aspects into identity. According to identity process theory, this process is based on cognitive processes like “memory, learning, consciousness, and, probably, organized construal” (Breakwell, 1986a, p.26). In the same context, Breakwell also addresses what could happen if these cognitive processes are no longer available: “[...] without memory the whole process of assimilation-accommodation takes place in a vacuum [...]. The erosion of memory which often accompanies ageing is a central plank in the explanation of identity changes in the elderly.” (Breakwell, 1986a, p.26)

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23 This part is based on excerpts of a paper by Spini & Jopp (in press). Old age and its challenges to Identity.

24 See also Heckhausen & Schulz (1995), Spini & Girardin, …Breakwell 1986)

Does this mean that cognitive impairment, which is quite common in very old age, results in individuals losing their identity, are the processes essential to define and/or update one’s identity impaired or no longer functioning? What happens to identity, for example, when individuals’ short-term memory is impaired, as it is the case for patients with dementia or Alzheimer disease? And what are the consequences at an individual and a societal level?

The main threat of aging that people report in interviews is to “lose one’s head.” If expectations concerning the physical health can be levelled and adjusted to some extent, maintaining one’s cognitive capacities represents the central battle of very old age. The main reason is the threat to lose self-awareness, which can be thought as going back to infancy or more extremely to losing one’s humanity (Kruse, 2009). This anxiety towards dementia can also be related to the fact that, as underlined by Breakwell (1986a), the memory system is a necessary framework for maintaining distinctiveness and continuity. Does this then mean that identity can totally disappear if the memory gets lost? To be sure, the damages to the self and identity can be dramatic as dementia progresses. However, there are more and more claims that some elements of the self (personality traits, memories), notably from the past, survive even into advanced dementia (Cohen-Mansfield, Golander, & Arnhem, 2000; Klein, Cosmides, & Costabile, 2003; Sabat & Harré, 1992). For instance, individuals with beginning stages of dementia show complex processing and adjustment to the diseases (Stechl, Lämmler, Steinhagen-Thiessen, & Flick, 2007). Individuals at later stages of dementia were furthermore found to be able to experience a variety of distinct emotions, including positive as well as negative affect, as assessed via coding of facial expressions (Re, 2003). It was also shown that daily situations of high emotional value can be identified for individuals with dementia via observation (Bär et al., 2006) and that the well-being of dementia patients can be enhanced by allowing them meaningful interactions with volunteer who trigger personally relevant situations through sensual experiences (e.g., looking at a book representing the landscape where a person grew up, by providing the food they used to like most; Ehret, 2009). Thus, there is substantial evidence that individuals living with dementia may have more access to everyday life stimuli and emotional experiences than previously thought.

Research addressing identity processes in the course of dementia and Alzheimer disease are still scarce. There is, for example, evidence that some aspects from the past remain, even in the context of a declining memory (Kitwood, 1993); several scholars claim that these remaining memories are a basis for establishing a continuity between the past and present, which is key in maintaining a coherent sense of the self.

At a more abstract level, these considerations also question the conception of identity in scientific research. George26 underlines the central role of self and identity in contemporary research on individual’s development and aging processes. Identity and self are viewed as cornerstones of well-being. There are indeed important links between the self and physical and mental health, role performance, the quality of interpersonal relationships and subjective well-being. If self-esteem and self-efficacy have been thoroughly studied, George defends the idea that these identity motivations should be complemented by another neglected motivation of self-

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enhancement: authenticity (the sense that our life, both private and public, reflects one's real self). Unfortunately research on authenticity is lacking, but one has to mention the promising developments about identity that Dambrun and Ricard27 brought in distinguishing between self-regulation (defensive nucleus of the individual) and a more Buddhist sense of self and happiness integrated in a network and more fluid.

Moreover, there is empirical evidence that patients with dementia can still learn and improve their well-being through group activities (Haslam Jetten, Haslam, & Knight, 2012). An individual's memory may not be the only source of identity. As claimed by the tenants of life-span psychology (Baltes, et al., 1998), despite the decline in biological resources in very old age, cultural resources may partially compensate for losses. Such cultural compensation may also apply to identity, given that it is a social representation composed of contents shared by individuals and groups whose value depends on social structures and communication systems (Breakwell, 1993; Doise, 1998). Although the social aspect is a recognized aspect of identity theory, most researchers have focused on individuals' cognitive definition of the self. For example, Vignoles et al. (2006, p. 309) acknowledge that “like all subjective meanings, identity is constructed through a complex interplay of cognitive, affective, and social interaction processes, occurring within particular cultural and local contexts.” However, their next sentence reaffirms the pre-eminence of the individualist cognitive framework of the original theory, that: “an important assumption of the current studies is that these processes are guided by particular motives or goals of the individual.” Is the individual's self-consciousness really the cornerstone of identity in a social system? Aren't there other processes based on the emotions, body, or collective practices that could strengthen other parts and processes of our identity as a process? Moreover, couldn’t we also define parts of an individual's identity in his or her environment?

In ancient Egypt, pharaohs used to inscribe their name in cartouches on every important building. This practice was meant to ensure immortality of individual's soul following the belief that if the name of the person survives his or her death, they would overcome death. Would it not be possible to think the same of identity? Identity is also constituted by social relations and interactions (Cooley, 1964; Sabat & Harré, 1992). Other individuals or the groups we belong to help to shape and maintain our self-image, contribute to experiencing continuity and distinctiveness, in their representations and communication. Most current theories of identity have an individualistic and atomistic view of identity. Future theories should also explore ways in which institutions, family and groups can socialize identities in order to empower patients (Haslam, et al., 2012). In the most extreme cases of dementia, institutions (families, nursing homes, hospitals) should have the duty of maintaining and developing individual's identity as a distinct and valuable person anchored in temporality within individual and in collective narratives and practices. In these later cases of dementia institutions may acknowledge identity discontinuity and adapt the environment to the person instead of stressing or neutralizing the person in order to behave “normally”. It may be a more philosophical or a priori statement at this stage, but we believe that researchers should go beyond an individual and cognitive

definition of an individual’s identity and complement it with a social and institutional definition. Articulating different layers that form identity, spanning the person-specific aspects to institutional or societal aspects, is needed to complement the already well-developed study of the self within the so-called social cognition tradition.

Individual resources have limits in a lot of cases (isolation, dementia, dependence…). Thus, the role (possibilities and duties) of institutions and communities (the state, families, professionals, etc.) are of first importance. Family (and especially women, daughters notably) is clearly the first support and provides the largest amount of help to the needed. The policies of supporting the carers are now in the agenda of policy makers. Retirement policies and policies of care/institutionalization (hospitals, nursing homes, home care) are also well-developed in Western countries, but they represent a high cost that some countries have difficulties to assume. There remain though many possibilities to improve and innovate in helping the elderly when they become frail or dependent. Most research and development funds go in Western countries to medicine, pharmaceutics and biological research. There are also developments in advanced technologies (robotics for example). The social and human sciences also develop ideas and new practices, sometimes less visible and spectacular, but maybe more transferable in developing countries.

Let’s give two examples developed in the Swiss Romandie:

First, the integration and empowerment of community-dwellers by the project “Quartiers Solidaires” developed by Pro Senectute Vaud28 in collaboration with the Leenaards Fondation (since 2002).

This project is targeted towards old people from specific districts (2’000 to 12’000 people) in order to reestablish a sense of community and struggle against individualization and powerlessness which is often experienced by retired individuals who have difficulties to keep a societal role and remain integrated in the community (with sometimes a high level of subjective insecurity). Applied by a sociocultural worker from 3 to 5 years in the district, this methodology allows the new formed community of elders to be autonomous (in the sense of being able to describe their activities, goals and way to sustain them) not being dependent of the professionals anymore. The actual results (from 15 districts in 10 years) show that elder’s life’s quality (and also the others generations as well) benefit from this “empowerment” process.

In the canton of Valais, (on another scale) a new initiative called Dominos, develops studios in the community for the very old in parallel to nursing homes. This solution is cheaper, relies a lot on co-habitation and interpersonal support, and leaves the elderly within the community.

Indeed there are many ways to improve the condition of living of the elderly who are vulnerable and research should be also developed in this domain. The role of aged adults in society and their rights of participating to the different fields of the society (training, productive work, intergenerational relationships, etc.) could be thought in different ways and is thought in different ways across cultures, as well as the end of life. Something to be debated together, for sure!

Questions for discussion

Individuals are “naturally” very resistant to stress and losses, do we agree across disciplines and epistemologies that the “human mind” is the most powerful “tool of life” for individuals?

What are the main processes of development in old age, as biological forces are declining? Identity? Beliefs?

Are there universal motivations or end-states of development?

What is the view of Tibetan Buddhism on authenticity?

How can we define identity for people who become demented? Is an individual definition still of use? How do individuals and institutions (hospitals, family, nursing homes, religious representatives, etc.) around the aged person take their share of responsibility in maintaining the dignity and identity of the frail or dependent person?

What are the Tibetan/Buddhist views about intergenerational relationships and community responsibilities and exchanges?

What is the responsibility of the community and institutions towards aging people? What is the risk of an unbalanced investment in different ages (children, young adults, families, old age)? What are the possibilities of knowledge and practices transfers across societies/cultures and ideological/cultural/ethnic backgrounds?

Do all living systems have memory systems? What kind of memories do we carry with us and how do they transform?