Research booklet

Stigma and the Built Environment

Growing old in an inclusive environment

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Growing old in an inclusive environment

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* Front page image made by author

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While the terms: elderly, old people, older adults, or seniors are used in this research, I do recognize that these terms bring stereotypes with it, something that is not encouraged. I would like to mention the wide difference between the people among this group and like to indicate that everyone who grows old will be part of this group, something we should accept and normalize.

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“Rethinking growing old”

Abstract

Stigma and assumptions over past care concepts influence care giving and age-exclusion, which create a misconception of the current state of care facilities. This misconception limits the possibility of an inclusive built environment for the elderly. The perception of age differs for each individual, culture, country, and gender, which is why this research focused on how stigma of growing old in the Netherlands can be decreased. This research uses quantitative data to examine how the built environment contributes to decrease stigma about aging in society? Stigma is a social problem which causes problems in health, social connections, and self-esteem. Social awareness, education, contact, a supportive environment, appropriate care systems, decreasing and acting against stigmatic behavior, encouraging empowerment, promoting greater understanding, and increasing experiences can lower stigma. Architecture defines the context in which social events take place and how care and social systems are organized. It can provide expectations as well as limiting or give access to information and functions towards specific stigmatic groups. Using thematic analysis 5 key design elements were discovered to decrease stigma using the built environment, namely by creating a positive or similar value as the surrounding, through empowering the stigmatized group, by providing the necessary needs and desires for the individual, by creating communities and by facilitating awareness.

#stigma #the elderly #growing-old #inclusive #stereotype

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Introduction

People grow older and stay longer healthier than before, but older people are also vulnerable to exclusion, marginalization, and discrimination (UNECE, 2009). The research of Sacker et al. (2017) reenforces the statement that when people grow older the chances are higher that they are being excluded from society. The Netherlands is becoming an aging society, meaning that more than a quarter of the Dutch population will be over 65 years old. This makes the elderly a critical part of society. But why are the older adults being excluded?

The musician Kenny Rogers said: “Growing older is not upsetting, being perceived as old is.” This is being reinforced by the research of Chopik, Bremner, Johnson and Giasson (2018), they state that individuals often associate growing old with weakness, resource waste and possible exposure to infectious diseases, this in its turn leads to higher levels of stigma. Older adults try to avoid being perceived as old which they might do by identifying with middle aged adults or directing their attention away from other older adults (Chopik et al., 2018). Because of this, they are pushing others and themselves in a situation that makes them feel less important because of their age.

There is a misperception that assisted living means losing your freedom, privacy, and independence by living in an institutional style nursing home (Podewitz, 2020). This could be a reason for elderly to be discouraged to move to nursing homes, as they do not want to be associated with this negative age stereotype. This might have been the case when this generation was young, which created a misconception of today’s assisted living communities (Podewitz, 2020). This is being confirmed in the Ted talk of Yvonne van Amerongen (2019). She mentions that traditional nursing homes looked like hospitals, with nurses and paramedics in uniform as the residents lived in wards. The people could not choose for themselves what to do. They wanted to go home, to live in a normal house instead of a hospital like environment.

Nursing homes were hospitals for chronic patients but differed in the level of medical service compared to regular hospitals. After two-third of the care homes failed the basic quality criteria in 2006, nursing and care homes started to put more emphasis on the residential aspect instead of the institutional hospital character of the past, (Mens & Wagenaar, 2010, p.290).

This was the case for the senior-housing complex “Hoeverstate,” in which we stayed for a week. The concept of the complex is independent living with care in the background. During our stay, we rarely noticed people that required heavily care, in interviews it came multiple times forward that people with the need of care stayed in their appartement and felt uncomfortable to attend activities downstairs. This care in the background could be lowering the assumption that a nursing or elderly home is an institutional care facility but could also have led to stigmatize people in need of care to feel unwanted.

Nowadays care and rehabilitation is given at home, as much as possible, as the new healthcare reform assumes that people prefer this, but this assumption neglects the diversity of personal needs, and the attachment people have to their home. It could have an impact on their recovery but also on their social, emotional, and physical aspects of daily life (Kylén et al., 2019). The build environment influences the outcome of a patient’s well-being and health, as it defines the context in which care processes and social interactions take place (Kylén et al., 2019).

This situation gives us the problem statement: Care giving, and age-exclusion is based on stigma and assumptions. The stigma of being old limits the possibility of an inclusive built environment for the elderly, while this is mostly based on misconception or old concepts that are reformed over time.

My hypothesis is that the lack of understanding of being old creates a division between the elderly and the rest of society. I believe that the built environment can create a context for social interaction and educate the society to form a better perception about growing old.

This research aims to get insight how to decrease the stigma about growing old and to create a bridge between generations. While there is much research about the effect of the surrounding on the health and functioning of elderly as well as research about the influence of stigma on people's behavior, there is almost no research about the connection between architecture and stigma. It is quite clear that the surrounding influences people's behavior and thoughts, but it is difficult to find how architecture, or the surrounding can help create or reshape a stigma.

The objective of this research is to develop a design strategy that is targeted at creating a built environment that reduces the marginalization and stigmatization of elderly.
This leads to the main question of this research:
"How can the built environment contribute to decrease stigma about aging in society?"

- Which methods can be used to decrease stigma about aging in the Netherlands?
- In which ways does the built environment influence and decrease stigma?
- What are the key elements of the built environment to decrease stigma about aging?

Theoretical Framework

Growing old is a difficult term to research because when is someone old? Old means that something existed, or someone lived for a long time, but then again what is a long time? The world health organization (WHO) writes:

"DEFINITIONS OF THE OLD, ELDERLY AGED AND AGEING ARE NEITHER STRAIGHTFORWARD NOR UNIVERSALLY APPLICABLE. OLD IS AN INDIVIDUAL-, CULTURE-, COUNTRY- AND GENDER-SPECIFIC TERM" (2001, p.10).

To understand the general point of view about old it is easier to analyze when people are considered part of the elderly.

The elderly and age

The United Nations provide records for both 60 and 65 years of age and older to be considered part of the elderly. The WHO uses categories starting at the age of 65 and 80 (WHO,2001). While the Dutch national institute for public health and the environment (*In Dutch: Rijksinstituut voor Volksgezondheid en Milieu (RIVM*)), considers people above the 65 years part of the elderly.
But the RIVM also possess research in which they state people above the age of 70 and older are considered elderly. Most often the age of 65 and above are considered as the elderly when the topic "vergrijzing" (the aging population in society) is mentioned, like the research of Zantinge et al. (2011). For this research, the term elderly means older adults with an age above 65. While we use this description in this research, we recognize the wide difference between people among this group, and that not every person above the age of 65 would fit in the category elderly considering physical and emotional characteristics. As when someone is old is relative to a person's mind and life state.

The research of Paul Taylor et al. (2009) indicates that people in America between 18 and 29 think a person becomes old at the age of 60, while middle-aged respondents consider more an age around 69 and 72. People of 65 and older responded with the answer of an age of 74. All though age is a one way to indicate growing old, most respondents of Paul Taylor et al. (2009) research agreed that different potential markers, like failing health, memory loss and inability to drive, are indicators of old age. As this information is based on American culture and country, it is unknown if the Dutch population considers the same. To understand when someone is considered old by the Dutch population further research will be needed in the form of a survey.

Stigma

These indicators of growing old could represent the difference between young and old, but in turn could lead to a stereotypic view of elderly and in worst cases stigma. Stigma is created out of fear, but also arises from lack of awareness, education, perception (Minichiello et al., 2000 p.259; NursingAnswers.net, 2020). Goffman (1963) defined stigma as an "attribute that is deeply discrediting" (p3). He considers three categories of stigma, one that focuses on physical deformities, another that focusses on mental disorders and dementia and lastly there is a category based on group membership, for example race, religion, or age.

Stigma can be caused in three different ways (Borenstein, 2020). Public stigma is discriminatory behavior of others. Institutional stigma is caused by government and/or organizations that intentionally or unintentionally limit the stigmatized group, for example inaccurate or misleading media. The last type is self-stigma, in which a person creates negative attitudes towards their own condition. Each of these categories is relevant for the elderly.

As most stigmatized groups, this prejudice against older adults originates from a stereotypic kind of view. Older people are often negatively stereotyped as unhealthy or sick, forgetful, wrinkled, sexless, miserable, lonesome, and excluded from society (Minichiello et al., 2000 p.259; NursingAnswers.net,

2020). The stereotype content model (Fiske et al., 2002) gives a unified view for understanding stereotypes. It details two key dimensions namely warmth and competence.

Data using the Stereotype Content model has shown that elderly have little power within society and are uncompetitive for resources, which makes them perceived as warm but incompetent (Fiske et al., 2002). This model together with the Behaviors from intergroup affect and stereotypes (BIAS) map explores how stereotype content influences behavioral outcomes (Cuddy et al., 2007).
This model predicts that elderly experience active help because people perceive them as warm targets, but as they are perceived as incompetent they are also being excluded. Active help seems positive or harmless, but overaccommodating or patronizing speech can have negative outcomes, like lowered self-esteem and communicating competence (Chasteen & Cary, 2015).

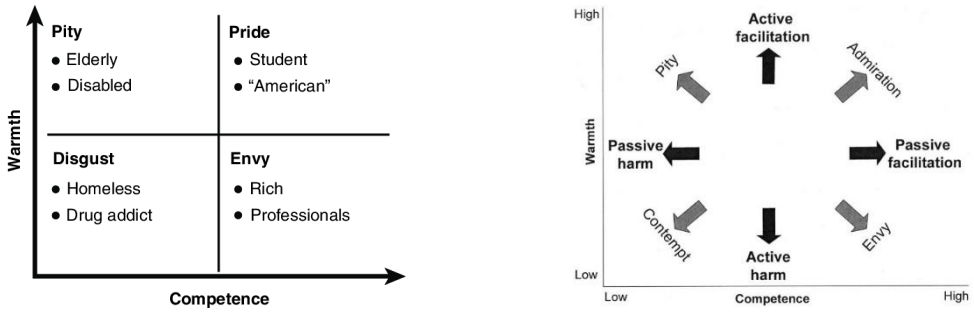


Figure 1: Stereotype Content model (Fiske et al., 2002) & the BIAS map (Cuddy et al.2007)

Built environment and stigma

In the article "Stigma and architecture of mental health facilities" by Jakub S. Bill (2016) the problems with stigma of mental illness are described, he also creates a connection between stigma and the built environment:

> *Stigma associated with mental illness is very common. Patients face prejudices, stereotypes, misunderstanding, discrimination, and self-stigma. They are afraid of being labelled. Another fear is the fear of mental health services, which makes patients avoid taking up treatment. Apprehension of treatment increases when a patient has to be treated in a psychiatric hospital. Fear of stigma associated with a facility appears. For many patients, hospitals become their home for weeks or months. Despite all improvements introduced to mental health facilities, they are still labelled and stigmatized (p499).*

He mentions that the perception of mental health architecture is closely related to the mental illness label, meaning that the poorly attitudes towards people with mental illness and to mental healthcare leads to low quality buildings. This in turn increases the discrimination of people with mental illness through the quality of the mental healthcare setting. Older people find themself in a comparable situation all through history. The vast majority the elderly lived in the worst and cheapest housing available until the late twentieth century (Mens & Wagenaar, 2010, p.27).

Care and architecture for elderly

The care of the elderly was contracted out by the poor boards, which decided to set up homes for the elderly around the sixteenth century. The first build environment in the Netherlands specifically for elderly were clusters of almshouses (hofjes) created from the thirteenth century. They formed small communities for the elderly, separated from the daily city life (Mens & Wagenaar, 2010, p.27).

In the 1920's a new type of housing for the elderly was created, these 'pensioentehuis' concentrated many apartments specifically designed for elderly and included communal facilities inside one

building. This typology was the forerunner of the later old people's home and would be referred as an institutional form of housing. Until the 1940's old age was synonymous with poverty for most people (Mens & Wagenaar, 2010, p.60), and in 1945, after World War II, it was concluded that the elderly formed a homogeneous group.

The only difference was made in the reliance on help. They were divided into two categories: Those who needed no or incidentally help, which formed 90 percent of the elderly, and the other 10 percent that could not manage without daily assistance. Because not everybody who needs care is ill or disabled, which divided the second category into two groups: valid or invalid. During this time, many housing typologies for elderly were created, such as the self-sufficient housing units, pensioentehuizen and the nursing homes. Other buildings combined aspects, like the self-sufficient housing units with communal facilities like service flats. Nursing homes were primarily for somatic patients, elderly with physical complaints. The minority of elderly people had a mental disorder, for which no specific facilities was provided. It was not until 1966 that the Central Council for public health recommended separating the two categories and that mental disorders required special homes. A problem with the elderly homes was the size and separation of the buildings, which had a negative effect on the living quality of the inhabitants as is written in "Health care architecture in the Netherlands" by Noor Mens and Cor Wagenaar (2010, p178):

> "WHAT HAD BEEN INTENDED TO CONTRIBUTE TO THE INTEGRATION OF THE ELDERLY IN EVERYDAY SOCIETY HAD LED TO THE OPPOSITE RESULT: CONCENTRATED IN BIG, HOSPITAL-LIKE BUILDINGS, THEY HAD BEEN LITERALLY ISOLATED."

In the beginning of the 1980's the idea of specific forms of housing for the elderly was abandoned. The nursing homes let go of the hospital concept and became more residential orientated with individual appartements with care given by an independent organization. The architecture of nursing homes started to look more like regular housing (Mens & Wagenaar, 2010, p.204). Not only nursing homes changed, but also the housing market received an interest in a potential market group. People preferred to still be able to live at home if they would become dependent on care. Because of this ordinary housing for elderly were developed by analyzing and renovating dwellings on the existing housing market based on accessibility, visitability and usability. This makes it possible for older adults to stay longer at home and it was also intended to increase the unpaid care by neighbors, acquaintances, and relatives (mantelzorg) by normalizing the housing for the elderly.

After 2006 nursing and care homes put more emphasis on the residential aspect instead of the institutional hospital character of the past (Mens & Wagenaar, 2010, p.290) as two-third of the care homes failed the basic quality criteria in 2006. This proved to be successful as nursing homes could remain open and became more desired to live in, it however required large scale renovations. New types of care facilities were formed, including a new care concept based on the commune model. Instead of care in one building, entire urban districts are being transformed into residential care or service zones *(in Dutch: woonzorgzone (wozozo))*. Instead of care residences, care centers function as a community service and take the role of community support points. Examples are the Garden Towns: Amsterdam, the AMC Amsterdam and the UMCG in Groningen.

Nursing homes and elderly housing have a long history in which they have been constantly changing. The ideas of how care should be given has been reformed over time. Although many characteristics of former care facilities may have changed, many characteristics could still be associated with care and the elderly. This research aims to evaluate how many people associate typical characteristics with elderly and nursing homes. This will contribute to existing literature by combining different data.

Research Methods

This research aims to answer the question "How can the built environment contribute to decrease stigma about aging in society?" As society and stigma is a broad topic and different in all geographical locations and time periods, more knowledge was needed about the connection between the build environment and the stigma in the Netherlands. This research used thematic analysis to identify common themes and generate patterns between the different subjects. This is done by analyzing qualitative data and quantitative data. While some information required fieldwork, most data is collected through secondary sources as literature about the different topics.

Most research questions required literature review to develop a broader understanding about the topic and to evaluate trends in the society. The selected literature was sourced through academic papers and by tracking down references or citations more documents were found which included terms that were found out to be key elements to decrease stigma. For the first sub question: *"Which methods can be used to decrease stigma about aging in the Netherlands?"* a survey was made to learn more about the current Dutch society and their perception about the topic. As perceptions of age could differ over time and would contribute to existing research to find if there is a different perception between regions and age groups.

While surveys are more quantitative to understand the general point of view of the population, interviews give more in-depth understanding of a topic. Interviews can give more insight but require more time and usually have a smaller target group. Surveys are easily done on a bigger scale, but the outcome requires more expertise to analyze. Because of the situation with the corona outbreak and the provided laws a digital survey was chosen to save time and to minimize risk of contamination.

The answer on the first question has given the conclusion if nowadays Dutch society has a negative perception about growing old and if a positive stigma of growing old is needed. It also concluded several aspects that would influence a person's perception and stigma. These aspects are being analyzed using case studies and literature of places and real-life events to answer the sub question: *"In which ways does the built environment influence and decrease stigma?"*

By analyzing the various aspects and their connection to the built environment, the influence of the built environment on societies stigma's is filtered out. This however does not provide a clear view how the environment can do it specifically. To answer this further research is done by using literature to analyze the requirements to provide for an inclusive environment for elderly. This provides an answer to the third sub question: *"What are the key elements of the built environment to decrease stigma about aging?"*

By answering these questions an overall evaluation is made to see if the built environment can create a context for social interaction and educate the society to form a more inclusive view about growing old. The evaluation leads to the conclusion and can answer the main question.

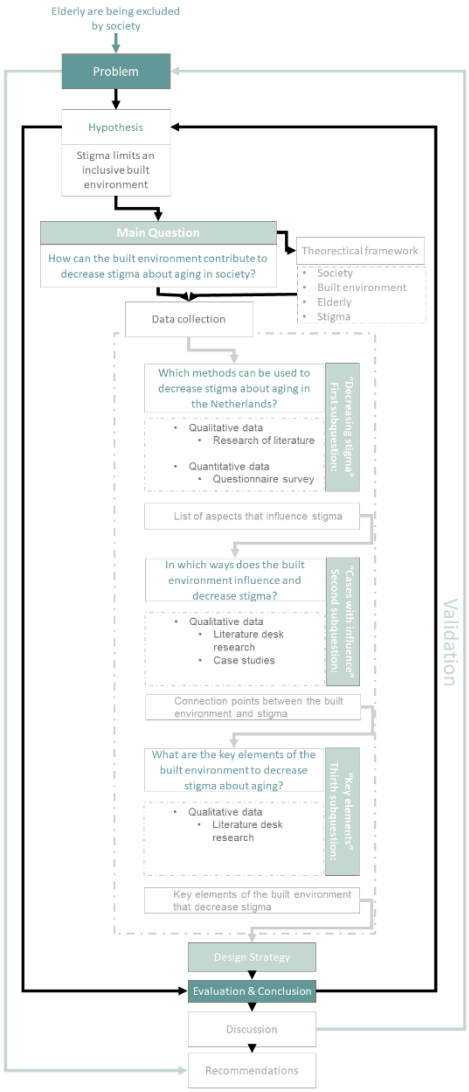


Figure 2: Diagram of research design, made by author (2021)

Results

Ch1. The influence of stigma

Stigma was briefly explained in the theoretical framework, in this chapter the creation of stigma is further researched and the question: "Which methods can be used to decrease stigma about aging in the Netherlands?" is being investigated.

As already mentioned, stigma can be the result of fear, lack of education, lack of contact, lack of awareness and negative experiences. These aspects can result in ignorance, prejudice, and discrimination, which in turn may lead to negative attitudes, rejection, and avoidance (World Health Organization & World Psychiatric Association, 2002). In the research "stigma of addiction and mental illness in healthcare" by Brondani et al. (2017) stigma is more conceptualized, as can be seen in the figure below (Figure 3). They discuss that someone is being stigmatized when he or she experiences being labeled, stereotyped, socially excluded, and discriminated against. Especially feeling powerless against those who exercising stigma.

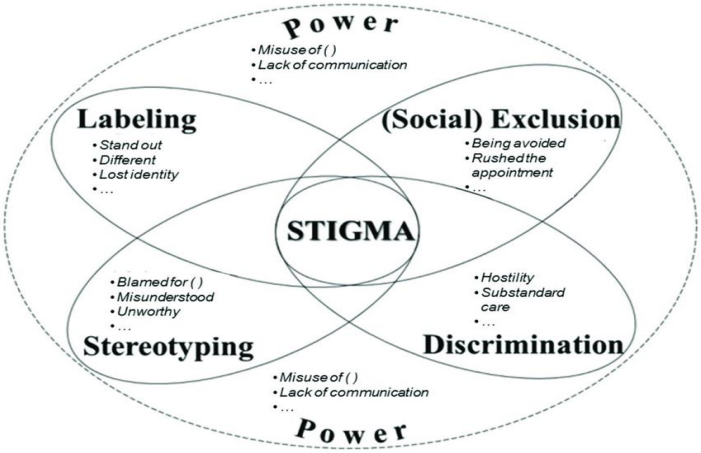


Figure 3: A visual representation of stigma (domains and their respective themes) (Brondani et al., 2017)

While the term stigma is more used in combination with mental illness, research has indicated that there is as well stigma about age. Mental disorders in old age are also quite common, a massive burden and represents important costs for societies (World Health Organization & World Psychiatric Association, 2002). This means that older adults with behavioral health problems must deal with a double stigma (Sundeen, 2019).

Problems of Stigma

The president and CEO of the Brain & Behavior Research Foundation, Borenstein (2020) acknowledges that the harmful effects of stigma include among other things: loss of hope, a lower self-esteem, increase of symptoms and difficulties with social relationships. Stigma can cause different problems, most importantly it can contribute to the worsening of symptoms (Dionigi, 2015) as well as affecting the attitudes of the stigmatizing person, the stigmatized person as well as the people in their surroundings (Robinson & Thompson, 1999; Borenstein, 2020).

While different media and research suggest that the older generation would not seek help as they grew up in an age in which the use of mental health services was uncommon, but this was proven wrong for the Canadian population by the research of Mackenzie et al. (2019). They noticed that older adults have a more positive attitude for seeking help than younger adults, but that those who endorsed public stigma likely internalized it as self-stigma.

The difficulty with this conclusion is that stigma and stereotypes are based on social and cultural constructs as well as individually interpretation. These aspects are shaped differently over time and place (Dionigi, 2015). This means the result of Mackenzie's research might not be similar in other parts of the world or during other time periods, as their research only included people from Canada from that specific period.

Survey results

To research the stigma in the Netherlands a survey **(Appendix A)** was made to indicate how people perceive aging and which aspects are associated with old age. Older people are defined in this research as people with the age of 65 years and older. However, it should be noted that the age at which an individual is perceived as 'old' varies across different cultures. Part of the questionnaire was dedicated to stigma of a nursing home. The last questions were about self-perception, how the respondent would like to grow old and if they already considered what happens when they grow old. The summary of the results can be seen in the survey report **(Appendix B)**.

According to 86% of the respondents, old age will come naturally. Most respondents have thought a bit about what happens when they are older, but not that much. When they are old, the majority want to stay in the area where they have lived most of their lives and enjoy being with others or to travel around, cycling or walking. Most people believe that independent living is best for the elderly and themselves, but that care should be available. If it is necessary, they would move to a life-resistant environment or a nursing home. Most people find nursing homes to be functional and convenient but find that there is much room for improvement. Both in care and the focus on the humane side of living. Several people say they find nursing homes a sad situation or that they would never want to live there.

The characteristics that people mainly associate with old age are: 'white/grey hair, wrinkles, difficulty adapting to change and lack of mobility'. When answering whether there are other characteristics that link people with the elderly, experience and wisdom were a positive characteristic, but also longer recovery time of the body and dementia were mentioned. Most respondents claimed that these characteristics do not only occur in the elderly and that not all elderly people have these characteristics. One of the respondents said during the survey, that he did not associate bad eyesight with growing old as he uses a friend with terrible eyesight as a reference.

In the survey one question requested at what age the respondent perceives someone as old. This question was to find the average age people considered as old. Some people commented that the age also depends on the person, as one person could be "old" at 40, while another could still be perceived as "young" at an age of 75. This answer would mean that the association of "old" has not so much to do with age, but more with behavior, knowledge/experience, or appearance.

People associate becoming old more with characteristics than with age. Even though people notice that not everyone ages the same way and will not have the same characteristics, specific generalizations are made, in general, negative aspects, like poor adaptability, lack of mobility and longer recovery time, were described as symptoms of old age. While most respondents do not experience any negativity with elderly and growing old, many of the respondents did not want to do activities with older adults, even though there are no limitation for them to do so.

The majority of the respondents suggest that in order to create a more age friendly environment for the elderly society should become more inclusive with more interest towards each other. Social activities and getaways should be organized for the elderly and the environment should have more meeting places. Other aspects were more seating and improvements to the infrastructure like broad pavements for easier walkability and wheelchair access. Nursing homes could increase visits by

adding mixed functions, but friends and family will remain the main purpose of visiting the area. Improvements for the nursing homes to live there differs among the respondents, from diversity in residents and a lively atmosphere to independence and better care facilities.

Decreasing stigma

Ageism in the Netherlands might be low in the Netherlands, considering the answers of the survey. But in some answers, stigma can still be noticed. As Edmond Chiu, the chairman of WPA section of Old Age Psychiatry, says: “Reducing stigma and discrimination will help people enjoy a better quality of life” (World Health Organization & World Psychiatric Association, 2002).

Approach to decrease stigma

By looking at different methods of decreasing stigma, it seems a strategy can be made to decrease the stigma of growing old. Greenstein (2017) and Borenstein (2020) gives different methods to fight mental health stigma, as well as chapter 4 of the book: “Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change” by National Academies of Sciences, Engineering, and Medicine (2016). The papers from de Mendonça Lima (2004) and Holm et al. (2014) give some advice how to solve stigma and the importance of decreasing stigma

The key aspects can be summarized in different points, namely:

- The increase of social awareness about growing old.
- To educate others and make the topic more approachable to discuss
- To increase contact with the elderly to decrease ignorance
- Create a supportive environment for the elderly and stop exclusion.
  Show compassion and be conscious of language
- Ensure that appropriate health and social care systems are in place that meet the needs of the elderly with educated and trained staff.
- Decreasing stereotypic aspects or behavior as well as acting against stigmatic behavior
- Encouraging equality and empowerment (to lower self-stigma)
- Promote a greater understanding.
  Acknowledge and to be honest, instead of hiding or excluding factors that are unwanted.
- By increasing positive experiences and decrease negative experiences.

Social Stigma

Stigma is a social problem which can cause problems in different fields like health, social connections, and self-esteem. This makes it difficult to translate it directly into architecture. But most methods of decreasing stigma are based on communication and social aspects in which architecture can contribute. Architecture defines the context in which social events take place and organizes the spaces in which health care and social systems are given. As can be concluded from the survey better circumstances are needed for the elderly in care-facilities.

The questions of the survey help spread awareness about growing old as well as decreasing ignorance by giving facts and knowledge about various aspects of aging and the stigma that comes with it. While it might be a start to decrease stigma, the focus of the survey was to indicate which factors are the most influentially connected with growing old. While the respondents associate negative characteristics with growing old, they also associate positive characteristics with elderly. These factors can be used to answer how the built environment can lower these negative associations with age and create a space that is more inclusive for the elderly and focusses on the positive side of aging.

Ch2. The connection of the built environment with stigma

In the first chapter the problems of stigma and methods of decreasing stigma were discussed. In this chapter the connection between the built environment and the influence of it on stigma are further analyzed. To analyze the effect of architecture on the social structure that defines stigma, case-studies and design techniques are being analyzed. During these paragraphs answers will be given on the question: "In which ways does the built environment influence and decrease stigma?"
The built environment has a significant role in society, it does not only influence organizational factors it also acts as a representation of society (Vangelatos, 2019). It is the location where most contact and social behavior take place, next to that it also influences our social and physical health. Architecture resonates with emotions, create a feeling of connection or a feeling of belonging. Stigma is based on social structures and assumptions, meaning that the influence of architecture and the built environment could influence stigma by providing a clear representation of society and by creating a feeling of connection between the different users of the built environment.

Stimulating behavior

In the past mentally ill, elderly and inform, development disabled, or criminal were being isolated from society, this was done by housing these groups outside the urban area (Robinson & Thompson, 1999). While in some places large institutional settings are maintained for such groups, they are no longer considered appropriate for people (Robinson & Thompson, 1999). Research showed that both resident and staff are affected by the residential setting in which people with development disabilities are situated. Residents of more institutional housing got more stereotypic repetitive behaviors and fewer independently generated behaviors than those in homelike housing (Robinson & Thompson, 1999). The findings of that research showed that the symbolic environment works in tandem with the instrumental environment which affects people's behavior because of expectations and the expectations of others. Robinson and Thompson (1999, p.254) suggest that access to non-stigmatized settings may benefit many kinds of people who are presently stigmatized. The access for these groups should not be designed with a negative value but created to convey a neutral or a positive value for the location.

Exclusion and discrimination

Other stigmatic groups based on racial differences, wealth, gender, or sexual interest have had a bigger impact on the built environment, as can be read in the article of Sarah B. Schindler (2015). She writes about the discrimination and segregation using physical design of the built environment in New York. She gives three examples, the first being the design of low bridges above the roadways towards the public park at Jones Beach. This was built intentionally low so that buses could not pass under them. The second example is about the opposition against the expansion of the subway system into the neighborhoods of the of wealthy, mostly white residents of the northern Atlanta suburbs. Both design decisions were based on decreasing access using public transport, which was primarily relied on by people of color and poor people (Schindler, 2015).

The third example is about the closing of a street that connected an all-white neighborhood to a primarily black one at the request of white resident in the city of Memphis. This would reduce traffic and noise, additionally it would promote safety, suggesting the 'undesirable traffic' of the Black residents of the city. Schindler points out the exclusionary urban design tactics like the street grid design, one-way streets, the absence of sidewalks and crosswalks, the location of roads and transit stops and even residential parking permits, which all isolate, often unintentionally, a neighborhood from its surrounding (Schindler, 2015).

By looking at examples of other stigmatized social groups, a theory can be made to make a place of that decreases the stigma for the elderly in the built environment. Since the 1950s and 1960s the United States has been interested in reducing stigma after the civil rights movement, which focused on racial discrimination.

House of care in Ballroom society

One of these groups were the underground ballroom society.
The Ballroom communities were formed by people, mainly from African American and Latin American members of the LGBTQ+ community, in defiance of laws which banned individuals from wearing clothes associated with the opposite gender (M. M. Bailey, 2011).
To cope and fight against this discrimination the Ballroom communities created an atmosphere that critiques and revises the dominant notions of gender, sexuality, family, and community using a kinship structure (Bailey, 2021). The ballroom scenes are a competitive environment to express and celebrate the very same characteristics that are being oppressed (Berman, 2021). It´s an act of expressing as well as creating value to undervalued characteristics by society.

Figure 4: Crystal LaBeija, the mother of ballroom, photo from Marlow La Fantastique (Berman, 2021)

According to Bailey (2021) the LGBTQ+ people of color do not have the luxury of safe, permanent, and reliable spaces in which to congregate and socialize, such as bars and clubs in gay districts. Therefor "houses" were established, with 'the House of LaBeija' being the first.

A "house" is an alternative family formation. The houses of Ballroom culture were a space of refuge and care for people who had nowhere to go. In these houses members of the ballroom community could experience cultural belonging and support that they did not receive in their own families and communities of origin (Bailey, 2021). The houses function as a place of shelter but also a place of freedom and expression of the individuality. That there is a necessity for a location where people can be themselves can be noticed by the growth of ballroom scenes all over the world (AT5, 2019).

	"Houses"
By:	The ballroom culture
Focus:	A source of family nurturing for people who do not get it at home
Type of project:	A social structure
Method:	Combining different people with a similar background and experience to create an understanding relationship and function as a place of acceptance.

Inclusive through design

Another country that deals a lot with stigma is South Africa. South Africa has a culture ingrained with inequality, with architecture playing a huge part in keeping the two races divided (Quirk, 2017). There is a stigma within informal housing in South Africa that 'real' buildings are constructed from masonry, which is not available for the poor (Quirk, 2017). At the Design Indaba Conference 2012 H. Wolff (2017), Y Tsai (2017) and Fibra Design (2020) talk about the use of architecture and design as a tool for social change. They explain that using color and spatial design can influence an area and the perspective of society. Design Indaba originated with the vision that creativity and design can create an economic revolution in South Africa and to develop a better future for the coming generations. H. Wolff (2017) and Y Tsai (2017) give examples of projects in Cape Town where design can help contribute to society without being explicit for the wealthy.

South Africa: container projects

The Safmarine container project is a community committed development by Safmarine, a shipping company of South Africa offering container and break-bulk shipping services (Bizcommunity, 2013). The company was given the South African Maritime Industry's Commitment to CSI Award for its containers-in-the-community program for uplifting, empowering and skill South African Citizens. Because the containers have a ten years of market use and are constructed to last twenty years, the company requested to recycle them into sustainable structures, functional for the community (Grieco, 2012; AJOT, 2008). Two of these buildings are the Safmarine sports center and the Vissershok primary school by Tsai Design Studio.

The Safmarine sports center brings pride into an industrial byproduct and a disadvantaged community and shows how sustainable architecture can be inexpensive using recycled materials and smart design choices. The sports center is multifunctional building to maximize the use with a double roof to isolate the interior from heat and direct sunlight and giving shade for spectators. On the other side the structure folds down, giving space for advertising as a possible source of income. The screen can be turned into an outdoor movie theater for the community.

Figure 5: Safmarine container sports centre design (Grieco, 2012)

The Vissershok primary school is attended by 25 children of farm workers and underprivileged families and was awarded the silver Loerie of 2013 (Tsai Design Studio, 2013). The design was realized based on a sketch of the student Marshaarn Brink (age 15) who won the competition "making the difference through design" (Rosenfield, 2017). Tsai Design Studio evolved the idea with limited means and budget optimizing the site conditions and environment. The school has a multifunctional design, made of an old shipping container with an outdoor jungle gym and a raised roof against direct sunlight and to reduce heat. The sloping site gave space for an assembly area.

Figure 6: Vissershok atmosphere (Tsai Design Studio, 2013; Rosenfield, 2017)

	Container projects
By:	Tsai Design studio
Focus:	Showing possibilities
Type of project:	Community facilities
Method:	By creating functional community facilities made by cheap local available materials the companies show that a 'real' building does not need to be made from bricks, which fights against the stigma of informal housing.

Slovo Park

The South African government made promises to provide resources and services to construct homes to the community of Slovo Park, an informal settlement close to Soweta in Johannesburg, but most of all the government promised them to recognize them as a legitimate formal community. But after the promises fell flat under mismanagement and a corruption scandal, the community members were blamed for the fault (Quirk, 2017). It was not until 2016 that Slovo Park was provided The Upgrading of Informal Settlements Programme (UISP) by the Gauteng High Court (Ebrahim, 2020).

"The Slovo Park upgrading experience offers important insights into engagement in the built environment between government, community-based organizations and civil society."

Quote 1: Insight into Slovo Parks connections (Ebrahim, 2020)

The site was initially referred to as Nancefield Township, but after the death of Joe Slovo (the first Minster of Housing in post-apartheid South Africa) the community renamed the settlement Slovo Park in May 1995 (Slovo-park, 2010). The 4000 residents of Slovo Park founded the Slovo Park Community Development Forum (SPDCF) to combat the stigmas surrounding them as well as forcing the outside world to recognize them as a legitimate humane community (Quirk, 2017).

*Figure 7: Slovo Park Community Center plans (Quirk, 2017) *on the left <*

*Figure 8: Slovo Hall 2012 (1tot1 Agency of Engagement, 2021) *on the right >*

In 2010 a group of architecture students began working with the SPDCF to design and build as part of their post-graduate projects. Together with the community a design was made which existed of a meeting hall and a square allowing for adaptations and additions in the long term. Because of this collaboration of co-designing and co-building the 1to1 Agency of Engagement was born, a non-profit entity that provides spatial design solutions to residents of poor or unsafe neighborhoods in South Africa (Quirk, 2017; 1to1 Agency of Engagement, 2021).

"We hope to one day live in a South Africa where our cities are, and continue to be, spatially equitable, while all who live have equal spatial opportunities."

Quote 2: Slogan of 1to1 (1to1 Agency of Engagement, 2021)

	Slovo Park
By:	1to1 Agency of Engagement
Focus:	Empowering the locals
Type of project:	Community facilities
Method:	Including the community in the design and build process of the neighborhood and empowering them with information how to develop a legitimate looking living environment

The melting plot by Katarzyna Lejk is a social, architectural experiment that aims to integrate the residents of the city of Gdansk with minorities (Lejk, 2020).

The projects' goal was to create a friendly place designed to establish human connections. Many activities are undertaken in Gdansk to help integrate minorities as it is a place where people migrate to with different views and origins.

The project is designed as a pavilion to not only integrate into society, but also restore a neglected area of the city. The main reason for the project was the discrimination of the Polish population to ethnic origin. Lejk mentions that places that provide reliable information is highly desired. Lejk tries to let her design show that the ethnic variety can be a forceful positive factor in society by providing visual interaction, education, and contact spaces into a space close to society.

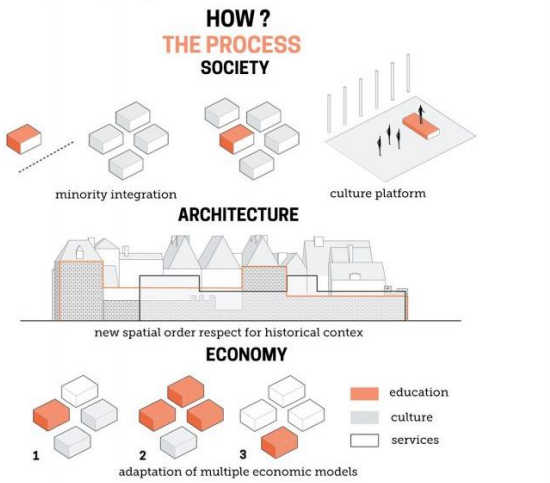


Figure 9: The result (Lejk, 2020)

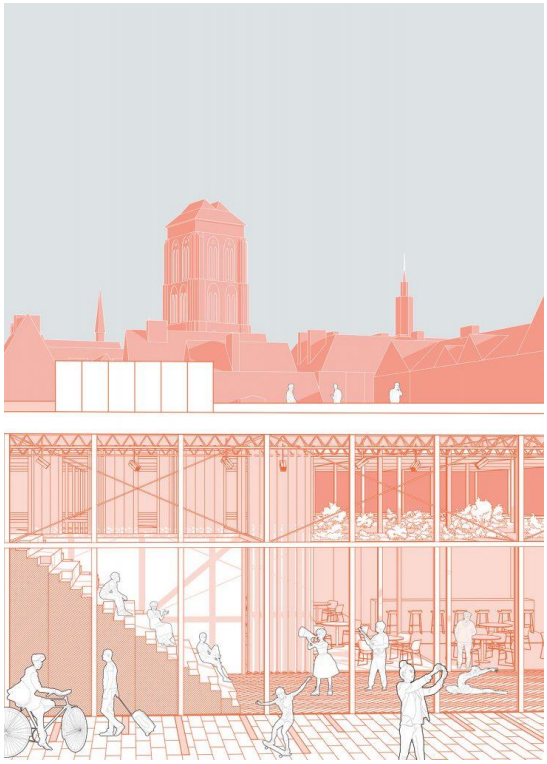


Figure 11: atmosphere Melting plot (Lejk, 2020)

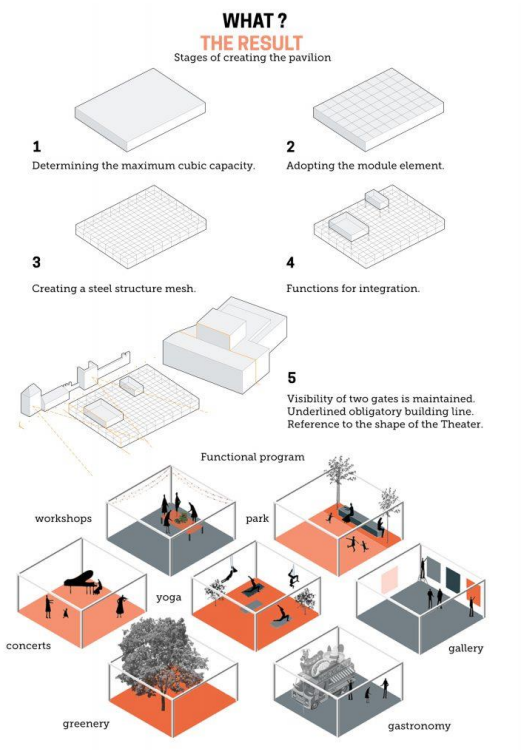


Figure 10: The Result (Lejk, 2020)

	Melting plot
By:	Katarzyna Lejk
Focus:	Integrating minorities in society
Type of project:	Pavilion
Method:	Addressing the problematics of society, architecture, and economy. By using adaptability the space should evolve and change in accordance with the social and cultural context and their needs. Using exhibition spaces, relaxation and offer contact spaces to educate.

Contributing to life

Lejk provides a space for minorities close to society and by letting it contribute to life. One aspect of life is care, everyone requires care. This means that the architecture of care facilities should be accessible for everyone and a safe spot for those being stigmatized. The key element is to facilitate care in a setting that is appropriate and to the liking of the person who requires care.

Figure 12: De hogeweyk (Be advice, 2020)

Vivium de Hogeweyk

For example, having the handicap of dementia should not and does not mean that the person's accommodation should not provide the wishes for their interior and surrounding of their daily life (burokade, n.d.). Hogeweyk is the first village where people with Alzheimer can live in a normal living situation inside a safe environment. Instead of a specific place that facilitate care, they integrated care into the living environment of the patients. To create a normal life, the plot is designed with four different lifestyles in mind: traditional domestic, urban, Gooisch (based on the local area), and cultural. Each house is dedicated to a lifestyle in which people with the same norms and values live and is situated in a matching surrounding. An aspect of normal living is independently moving at home and outside (burokade, n.d.). To provide this freedom the plot has multiple facilities that the residents and visitors can use, namely a restaurant, a café, a supermarket, a theater, an agency, various club rooms and a hairdresser & beautician (Be advice, 2020).

It started with a vision in 1993 and was realized in 2009 (Be advice, 2020). The care organization Vivium Zorggroep (n.d.) mentions while providing care, their main principle is the well-being of the patient. They describe it that instead of a traditional nursing home, they give a new home with a pleasant life where care is provided. The care-facility looks and feels like an ordinary neighborhood and became known as the first dementia village of the world. While the founders are glad about the fame and the awareness of their project, they are less happy with the label of a 'dementia village' (Be advice, 2020). The term focusses more on the disease then on their concept: the focus is not on dementia, but on people and a normal life.

Figure 13: Drawing and maquette of De Hogeweyk (burokade, n.d.)

"Be concerns everybody. Be yourself, be free, be strong, be proud, be together. Just be. Be advises on innovative care concepts for elderly people living with dementia and support their creation and implementation all over the world. A home to be at home."

Quote 3: The origin of Be (Be advice, 2020)

	Vivium de Hogeweyk
By:	Burokade
Focus:	Providing care and safety while maintaining the freedom of lifestyle
Type of project:	A village complex for people with dementia to live in
Method:	Providing facilities for different lifestyles in a safe environment

The elderly is often labeled as 'old and frail' and are disconnected from society (van der Velde, 2021). In the article of van der Plas (2020) is stated that because of the corona crisis the image of the elderly as a vulnerable and lonely population group became stronger, many aspects that gave joy and meaning to the elderly were not available anymore: visits of family, activities or even going outside were no longer an option. Jody van der Velde started a photo series to decrease these labels and show the passion and the stories of the elderly to the world.

> *It started with an elderly man of 91 years, Willem, he was stuck inside his wheelchair. He preferred to die then to be a burden for his younger wife. They started talking about his passion of the 'Nijmeegse vierdagen' (Nijmeegse four days) and Willem started to shine again. He joined the four days marches sixty times, and he would have sacrificed ten years of his life to experience this walk another time.*

The photo series show the diversity in the elderly, and that old is not who the individual elderly is, they are much more. They all have and had a different life and different passions. As van der Velden (2021) states: "The 'hidden passion' resurfaces and new energy and lifeforce is flowing again. This has made it clear to me that seeing people (again) is particularly good for their self-esteem."
The photo session was not only good for the elderly themselves; it also strengthened the bonds with their family members and their caregivers.

Figure 14: 'Passie in beeld' photo's by Peter van Beek (Kennemerhart, 2020)

	Passie in Beeld
By:	Jody van der Velde
Focus:	Decreasing the label and improving self-esteem
Type of project:	A photo series with elderly and their individual passion in one frame
Method:	Providing the opportunity for elderly to relive their passions as well as showing the world the individuality and difference in elderly.

Awareness

The photo-series of Jody van der Velde is an example of creating awareness and lowering ignorance. It shows the stigmatized group in a different view many would not associate with the people at the first glance. Another organization that focuses on creating awareness and lowering ignorance is 'Alzheimer Nederland.' They work towards a better quality of life for people with dementia and their loved ones. They support scientific research through financial support using donations. But their main concept is to provide information and educate about dementia, offer support, and advocate better care for those with the disease and the people around them (Alzheimer Nederland, n.d.).

Het Alzheimer café

Het Alzheimer Café is one of the projects by Alzheimer Nederland for people to meet others in the same situation, but also to educate about the situation in an informal way (Alzheimer Nederland, n.d.). Just like Alzheimer trefpunt (meeting point) or theehuis (Teahouse), the Alzheimer café is organized once a month in different cities and villages which makes it approachable for anyone who is interested.

Figure 15: Dementievriendelijk "Het hart van Weesp" (Weespernieuws, 2017)

They do not own specific buildings but use existing facilities as a meeting point. For example, in Weesp the Alzheimer café is organized inside the hotel: "Het hart van Weesp."

	Het Alzheimer Café
By:	Alzheimer Nederland
Focus:	Creating awareness
Type of project:	A meeting place in an informal surrounding
Method:	Using contact with others and by providing a situation in which experts help to educate. They use informal ways like watching a theatrical play, participating in games, and having drinks together to make the topic more approachable.

Amaris Schoonoord

The environment can help to facilitate functions that help understand and educate people, but equipment and building elements can aid as well with the care and health of patients and caregivers. This is being shown in the care-facility Amaris Schoonoord.

Amaris Schoonoord is a care-facility from Habion and Amaris Zorggroep, designed by OOK architecten (Slokker, 2019). Just like the Hogewyek the housing is central, and care needs to be as free and self-directed as possible (Habion, n.d.). The location uses modern technology to provide as much independency and safety to the resident as possible (Amaris Zorggroep, n.d.). It exists out of three villas containing fifty spacious appartements, three living rooms, the learning café 'het zorg innovatie huis' and a restaurant. The surrounding is adapted to allow self-direction and freedom for the residents with a park-like environment. The wide clinker path allows a large degree of mobility and a smaller side path with different textures can help people learn to cope with their mobility aid (P. Boerenfijn, personal communication, 10 September 2021).

Figure 16: Amaris Schoonoord (Habion, n.d.)

Het zorg innovatie huis

The learning café combines the three elements: care, housing, and innovation. It teaches staff, residents and others who are interested how to use domotica. Domotica is the integration of technology and innovative functions to create a better quality of living and life (Stichting smart homes).

Merlijn Sonneveld tells in Spot on Talk (2021) that some might consider that the innovations will take over their jobs as caretakers, the organization tries to show that the innovations are a support tool for the existing care and can help provide better quality care by letting clients be able to do more things independently.

Figure 17: Het Zorg Innovatie Huis (Waardigheid en trots, 2021)

The house is accessible to everyone, if the door is open people can walk in to ask about the products (Waardigheid en trots, 2021). The zorg innovatie huis is designed as normal appartement with domotico products focused on care, the products can be reserved and borrowed by anyone.

	Amaris Schoonoord
By:	OOK Architecten
Focus:	Providing care through education and technology
Type of project:	Elderly home
Method:	Education in a recognizable and comfortable surrounding by showing an example of technology to provide aid for living and care.

The environment

All these case studies show different ways how to deal with stigma. An institutional environment increases stigmatic behavior, while a homelike environment can help residents and staff to receive more independently generated behavior. An inclusive designed access for stigmatized people into a non-stigmatized context helps to decrease stigma, but architecture can also increase stigma by excluding or undervaluing access points for people that are stigmatized. The environment can exclude a part of society is shown by the example of the United States, but it can also include social groups into a community indicated by the development in South Africa and the Melting plot.

To lower stigma the environment needs to be accessible and inclusive for the people being stigmatized, instead of excluding people with specific characteristics. This was done in the past in New York using infrastructure to excluded unwanted people in particular neighborhoods. An environment should help create a community in which people feel safe to be themselves, this can be a social structure like the ballroom culture, but also through a space that integrates the specific requirements into a normal setting, like the Hogeweyk.

The ballroom culture and the nick name of the Dementia village for the Hogeweyk are labels or names which can help create awareness but can also lead to labeling and stereotyping an area and its residents for a specific characteristic. Providing correct information and making people aware of their behavior can help against discrimination. Architecture can accommodate functions that create awareness, educate about situations, and facilitate the needs to lower stigma.

People who are being stigmatized want to be provided and given the same value as other members of the society, to be part of a loving community. They want to have a normal life without being oppressed by their characteristics or their disadvantage, something their environment should accommodate. Instead, they should be feeling empowered by their characteristics as an individual. This can be done by letting them decide for themselves and provide possibilities and options that are in line with their passions and lifestyles.

The environment should be inclusive and normalize the stigmatizing features. Awareness can be created for their situation and show that the people are more than just a label, this can be done through contact with the stigmatized group and by showing the differences between individuals and accepting the different lifestyles, passions, and the needs of the stigmatized groups.

The built environment and stigma are connected by the value towards the stigmatized group of the surrounding, by including the stigmatized group in the development of their living situation and showing different possibilities. The way access to non-stigmatized settings is realized. the possibility of social and care structures within a community inside and outside their living situation.

Ch3. Adapting the environment

While in the first chapter stigma is conceptualized and in the second chapter the connection between stigma and the built environment is analyzed. In this chapter a strategy is made in which the elements of the second chapter will be discussed to make an environment which helps decrease the stigma of age. This chapter will answer the question: *"What are the key elements of the built environment to decrease stigma about aging?"*

This chapter will be the biggest part of the research as it will go further into detail what influences the stigma of growing old.

The value of environment

In chapter 2 different projects were analyzed to see how the environment can influence stigma. Of all the stigmatized groups, the older adult age group is the only group that every person will join, assuming a non-premature death, and it is likely to include the people whom we love and care about. As the percentage of elderly is growing each year the importance of an environment that lowers the stigma of elderly becomes more necessary, in 2021 19,8% of the Dutch population are 65 years or older, which is around 3.457.535 people, with currently 2.536 persons aged 100 or older (CBS, 2021).

Expectations

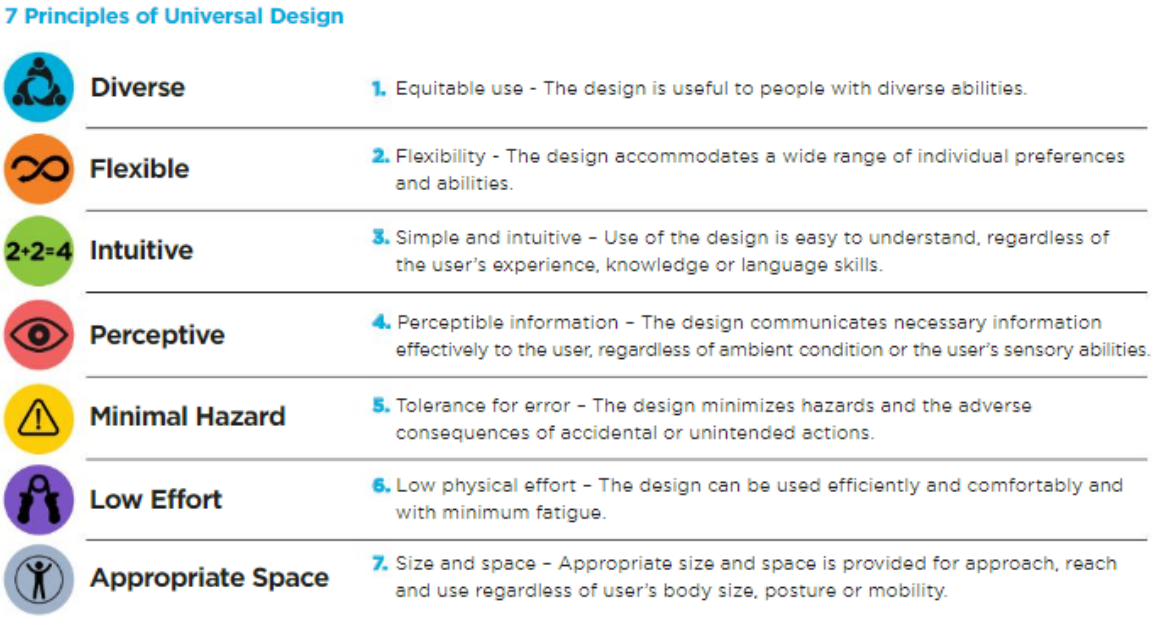
Stigma is affected by expectations and other evaluations, which is being influenced by the surrounding. Expectations and evaluations are being made on the idea of what is considered normal. Robinson and Thompson (1999) suggest that the physical alteration of the architecture of social settings can reinforce new ways of acting and perceiving, which could lead to eliminate stigma. They write that architecture is a medium that can eliminate or reduce the overt signs of stigma and alter the perception and values of society towards a devalued person or group. This is because the quality of architecture communicates a person's status to others but also directly and indirectly to themselves (Robinson & Thompson, 1999).

To reduce stigma the instrumental and symbolic effects of environment need to be considered. It is important to understand that stigma is a socially constructed concept, which involves what is defined as normal (Robinson & Thompson, 1999). The normalization principle tries to make everyday living conditions available to all people as close as possible to regular circumstances of society and ways of life (Nirje, 1985).

The normalization principles consider two key principles to reinforce normalization through architecture: 1. By creating a situation for all members of society that is as close as possible to societal norms, and 2. By balancing the negative value with neutral and positive value.
This means that by creating high value settings stigma can be reduced or prevented (Robinson & Thompson, 1999). Robinson and Thompson (1999) use the ramp as an example: while ramps were stigmatizing, they are currently accepted in public spaces. Ramps may even be seen as an economic advantage for property value when added to houses if they are designed properly with the right consideration of material, dimensions, appearance, and the situation/location of the built element.

Design value

An understanding how stigma and value are communicated through architecture is required to develop designs that support the lives of all people. One of these strategies is the universal design strategy. The universal design strategy focusses on making spaces accessible and usable for a wide range of people, considering the diverse physical and mental abilities people have (Preiser & Smith, 2010). The key element is not prioritizing a target group during the design process, but by approaching the project from the viewpoint of a range of users: those with special needs and those who are average (Preiser & Smith, 2010; Progressive AE, 2016). This can be done by recognizing the features and needs that could form barriers for some people and thinking inclusively about the complete range of impairments. By reviewing everything and finding a solution that fits all.



While universal design serves as many people as possible, it arrives at a single design solution, leaving out some users. Another strategy is inclusive design. The goal of inclusive design is to create designs that will not exclude or marginalize anyone, which could mean multiple solutions are provided to accommodate different users (Vinney, 2021). One of the biggest strategies of removing stigma is by not excluding the stigmatizing persons, creating an inclusive surrounding. By integrating the stigmatizing groups into the community, they are more likely to be accepted as normal members of society (Robinson & Thompson, 1999).

Empowering the elderly

Not only does multiple solutions allow for more inclusivity, but it also empowers people in choosing for themselves. Architects can use design and collaboration by providing the means and resources to empower communities and enrich their living conditions. In the article of Thomas (2021) five projects are being discussed that use different tactics in which architects can empower the users. These projects show the importance of landmarks, the creation of social cohesion and the interaction and collaboration with the community to increase empowerment among the people (Thomas, 2021).

Visual landmarks help a visual connection of the residents and signage helps people finding their way in the area, not only gives this safety but also a feeling of pride and identity. By letting the inhabitants interact with public spaces and how to use the space a feeling of ownership can be realized.

Often older adults are limited to accomplish their desires by regulations, resources, and tension in designed programs by what seems safest and healthiest by the professional vision (Glicksman, 2018), which goes against the importance of decision-making and life control for older adults as is established by the research of Tsubouchi et al. (2021).

According to the research of Tsubouchi et al. (2021) empowerment among older adults is a key concept for improving their health. They describe empowerment as "an important concept that promotes a paradigm shift in which care recipients and care providers must form a partnership and collaborate to solve problems, to demonstrate the individual's power, while respecting the rights and autonomy of the care recipient" (Tsubouchi et al., 2021). Empowering the elderly will help the people to create more self-worth and lowering self-stigma.

Tsubouchi et al. (2021) define the process of empowerment in five stages. The first two stages are welfare and access. Welfare involves meeting the basic needs and Access is about the ability to use a variety of power generating resources. The last three stages are about the role of the individual inside the community and the interactions with others. The third stage is about becoming aware of their own capabilities and self-worth. While the fourth stage involves proactive solutions and participation in decision making towards values and goals. The last stage is control by creating new relationships and to work together with others.

The elderly and their needs

The first stage of empowerment is supplying for the basic needs, but who are the elderly and what do they need? Many people believe the elderly are dependent of help, but 70% of the elderly do not experience any burden of their limitations (CBS, 2019) and 88% do not make use of elderly care (Vektis, 2019).
It´s true that in general as people get older, the more diverse services are required (Wang et al., 2019), but not all the older adults require the same.

Stereotypes, myths, and facts

There are stereotypes about the elderly that are incorrect. Some of these stereotypic characteristics are overgeneralizations that are based on individualized circumstances (Erber & Szuchman, 2014). Although there are some exceptions, stereotypic characteristics and myths about aging and older adulthood tend to be negative (anti-aging) rather than positive (pro-aging). A couple of characteristics of being old is mobility loss, loneliness, bad memory, and difficulties of adjusting to change. But also, positive characteristics like wise and the experience of life.

While not all stereotypes of ageing need the be negative, as mentioned in the research of Dionigi (2015), any kind of stereotypes can reinforce ageism and influencing a person's action, performance, decisions, attitudes, and their health. The difficulty with stereotypes is that they are social constructs, culturally and historically situated as well as individually interpreted (Diongi, 2015). But are these stereotypes true or false?

Mobility loss

When looking for a drawing of an elderly person, there will be a big chance that you will find an individual with grey hair, a cane or other walking aid. According to the National Institute on Aging (NIA, 2020) mobility loss is not a normal part of ageing and has more to do with risk factors, which includes muscle weakness, balance, gait problems or physical strength (NIA, 2020).

In the report of Zantinge et al. (2011) is stated that one of the five elderly uses mobility aids, with mostly older woman having limitations with mobility. Making it the biggest limitations among the elderly. CBS (2004) found out that in 2002 about 2% of the independent living elderly aged between

65 to 74 and 6% of the people over 75 uses a scooter or wheelchair. Out of the research of CBS (2004) the severe mobility limitations among the elderly in the Netherlands is declining since 1990, while there is not a real difference with the amount of elderly with physical limitations during the period of 1990-2007 (Zantinge et al., 2011). Meaning that other limitations like sight or hearing disabilities could have increased, but this does not mean that all elderly will have physical limitations, some are still physically fit until well in their 90's. Studies found out that 90% of the centenarians (people aged 100 or above) were still functional independent at the age of 92 (Zantinge et al., 2011).

All the elderly are the same

While it is a misconception there is not one type of elderly. The group is remarkably diverse. Think of the sporty couple who makes one bike trip after another, the elderly partner who takes care day and night of their frail husband or wife. Or the dementia resident of a nursing home waving to the people passing by. To give a perspective of how many Dutch elderly live in a nursing home, only 5% of the people over 65 live in nursing homes and only 15% of people over 85. Around 95%, the majority of the older adults with an age of 65 years and older live independently (Zantinge et al. 2011).

Housing needs

But what do the elderly want in their house? In the research of de Jong, Rouwendal, van Hattum and Brouwer (2012) the preferences of the older adults and the importance of housing attributes is being analyzed. They found out that there is a strong preference to stay put in their current residence, but that there is a difference in desired standards and the current housing situation (Jong et al., 2012).

Their results indicate that the majority do not want to live at the edge of the city, as they desire to have amenities as daily supplies, care facilities and public transport close to home. They would like to live with various kinds of households in the neighborhood, like single households, families, and older adults. Living among people of the same age becomes stronger by age. For the dwelling itself the older adults prefer apartments to non-detached housing either with or without a garden. Accessible by elevator, or at street level if it the person must climb stairs to access it.

They categorized their responses based on age, education level and motivation clusters to form a better understanding of the preferences of the elderly.

Differences in Age

Age does seem to influence the choices and shows preferences between three different age groups. The two older age groups, "young-elderly" (65-74 years) and "old-elderly" (75 years and older) do have a strong preference for rental dwellings with less maintenance, while the pre-elderly (55-64 years) prefer to have ownership of the dwelling. They also have a clear hierarchy in regard of the type of dwelling they prefer; detached housing is the most preferred dwelling type among the pre-elderly and non-detached housing is the least wanted type of housing for all age groups.

The neighborhood characteristics are more important for the younger age groups than the oldest age group (75+), while the role of the dwelling characteristics is more important for the old-elderly (75 years and older) compared to the other age groups. The young-elderly (65-74) are significantly more willing to pay for the luxury of domotics and to ability to choose the finishing of the rooms than the pre-elderly (55-64 years) and the old-elderly (75 years and older) would (Jong et al., 2012). The number of rooms does not seem to have a significant effect for each age group, except those aged of 75 and over without any children who do prefer a smaller dwelling.

Difference in Education level

There is a big preference by all elderly a dwelling with a living room, kitchen, bathroom and at least one bedroom on the same floor, but this does not necessarily mean they want to live smaller as they age. Higher educated adults do seem to prefer a house with multiple floors that is accessible at street level. While education show differences in desires, they are less visible than the difference in motivation clusters and age. The most prominent difference is that higher educated older adults also seem to prefer to have a say in the finishing of rooms and the use of domotics above those with a relative low education level (Jong et al., 2012). Those with a relative low education prefer a lower housing cost than to have a say in the finishing of the kitchen and bathroom.

Difference in personality

They identified five separate groups of older adults with the same view, motivation, and attitude towards housing. The first group can be described with the word Harmony and Security, the group consisted mostly out of older females with a relative low education level. They often live in neighborhoods with a mixture of single households, families, and older adults in rental apartments (Jong et al., 2012). This group has the strongest preference for their current dwelling and to live with other adults. They prefer to stay living in a neighborhood that is mixed and are the most willing to pay for choosing the finish in their dwelling compared to the other clusters.

The second cluster can be described with the word Harmony, and consists of couples, without children living at home, which tend to live in neighborhoods with predominantly other families. They show a preference for a bigger dwelling and a disliking to pay for luxurious and towards non-detached houses. They would prefer to live in an apartment within a mixed neighborhood (Jong et al., 2012). The third cluster consist mostly out of males with a relatively low educational level and can be described with the term security. They tend to live alone in a rental apartment that is accessible by a staircase. They possess a strong disliking towards domotics in their dwelling and would choose to stay living in a rental apartment, but one which is not only accessible by a staircase (Jong et al., 2012).

The fourth cluster consists of young and high educated females and can be described with the term vitality. The group is overrepresented with elderly living in a non-detached dwelling with garden, situated in a neighborhood inside the city of single households, families, and older adults. This cluster, in contrast to the other clusters, prefer to live in a detached dwelling with access on street level (Jong et al., 2012). The fifth and final cluster are highly educated couples with an active lifestyle, most of them are owners of a detached dwelling. They prefer a neighborhood with predominantly owner-occupied dwellings but would choose to live in an apartment instead of a detached dwelling. This group is willing to pay the most for having a say in the finish of their dwelling (Jong et al., 2012).

Elderly and care

In the research of Järvi et al. (2013) the elderly is segmented in three groups based on health, quality of life and functional ability to understand the service needs of the elderly. The well-coping group are independent elderly in which the three factors are perceived as good. They don´t require care but might need guidance to maintain their current health and ability to live independently.
The activity deficit elderly perceives slightly decreased health status but can enjoy and manage daily life. They need help with specific tasks and might be given the option to do activities in proximity but are independent if they are able to get there easily. The last segment is frail, in which there is a clear decline in perceived health, quality in life and the ability to function. The frail segments are dependent on others and specific care, which is why their time is mostly focused in managing their disease or disability.

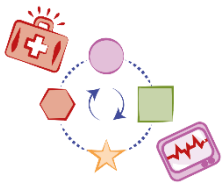
	Well-coping	*Activity deficit*	*Frail*
Primary needs	• Maintaining current health, spirit and functional ability	• Maintain current health • Prevent or alleviate future diseases	• Managing diseases • Preventing hospitalization
Secondary needs	• Live independently at home	• Having substance to life • Ease in everyday lives	• Creating substance to life
Core services	• Guidance and information • Errands • Health care /telehealth	• Supporting disease management • Alleviating functional decline	• All the health care services • Service supporting daily errands
Supporting services	• Easing daily errands • Increasing substance of life	• Time passing • Health care • Errands	• Time passing
Facilitating services	• Guidance of local service • Guidance on e-services • Support for administrative errands	• Guidance of local service • Guidance on e-services • Support for administrative errands	• Service guidance

Figure 18: Summary of needs and service content for elderly segments (Järvi et al., 2013)

In Figure 18 can be seen the result of their research of needs and services for the elderly segments. This analysis show that the elderly has different service needs, and one service package is not applicable for all. While the well-coping elderly need more alternative services, the frail segment benefits most of a specific service focused on particular problems depending on their situation (Järvi et al.,2013).

Aid and adaptation

Out of a survey made by Järvi et al. (2013) they found out that 48,7% of the elderly in Finland is well-coping and 41,5% is considered activity deficit, both segments are still very independent in most activities. Only 9,8% of the focus group was frail, those who required daily care.
Even those who are dependent on others prefer to be self-sufficient, but not all are able in the environment in which they life (NIA, 2020). People are met with barriers. These can be a physical barrier, like a staircase or a distance without a place to rest, or an emotional barrier, for example a person can feel the burden to ask for help or that the interior layout needs to be changed to make space for her wheelchair. Instead of going to the place she wants to, she might feel more comfortable staying at home. Requiring care can also be considered a barrier or a burden, like the situation of Willem that sparked the inspiration for ´van der Velden´ photo series.



Adaptations in the environment could help decrease these barriers. For example, handles, elevation stairs or smart home technology can help people who have limitations in strength and movement the ability to still live independently at home. This, however, doesn´t mean everyone has these requirements or want to invest in adaptations. The built environment should be able to provide, adapt or change accordingly to the needs and requirements of each person.

According to the research of Wang et al. (2019) the self-care ability and the economic status determines if the person is willing to invest in improving their health and to require medical service. Because of declining physiological functions and change in their social role and economic condition, the importance of social networks and self-awareness becomes crucial (Wang et al., 2019).
They also investigated the impact of social awareness and education. In their study they described social awareness as the internal ability to understand and sense one's abilities, problems and needs in a social setting. They found out that a strong social awareness can help elderly people to receive more medical services and achieve satisfaction. This concludes that the health status, financial ability, and social influence of an older person affects the service needs and service use.

Quality of life and loneliness

Two third of the independent living elderly in the Netherlands do not experience any physical limitations (Zantinge et al., 2011), although half of the independent living elderly live with one or more chronic diseases. From the age of 75, the risk of illness and limitations increases and the perceived health and physical quality of life decreases (Zantinge et al., 2011). 54% of the older adults between the age of 65 and 74 consider their physical quality of life as good, but only 30% of the adults over 75 do. This is low compared to the four of the five people in their twenties and thirties who experience a good physical quality of life. While the percentage of good psychological quality of life of older adults over 75 is almost the same as that of people under 65.

In the documentation of Gezondheidsmonitor Volwassenen en Ouderen of the GGD, CBS en RIVM (2020) is stated that 54,7% of the elderly feel lonely 65+ and 65,9% of the 85+, which shows an increase when people age. It also states that 50,1% of the population above 18 years feels lonely. While the stereotype of loneliness under the elderly might be true and that loneliness under the elderly is a significant issue, it is not only limited to the elderly. More than the half of the Dutch population feels alone, so creating awareness by showing all the information is a method to lower the ignorance as well as regarding the main issue: loneliness in society, instead of focusing on loneliness under the elderly.

Dementia and memory loss

According to Erber and Szuchman (2014) as well as the National institute of Aging (n.d.) one of the fears of ageing is that when you grow old you will get Dementia, with no prevention and no cure. But dementia is not a normal part of aging and not limited to age, 15.000 people in the Netherlands under 65+ have dementia (Alzheimer-Nederland, 2021). Dementia is a combination of symptoms of which the brains cannot process information properly. It is a collective name for different diseases that have to do with the loss of cognitive functioning, with Alzheimer being the most common form (alzheimer-nederland, 2021). 1 of the 5 people get dementia and it has the biggest impact on social and economic implications (WHO, 2021; alzheimer-nederland, 2021). Dementia is according to doctors and researchers the most common disease with the highest burden for patients and (informal) caregivers and has the highest healthcare costs (Alzheimer-Nederland, 2021).

Age does increase the probability of dementia and other diseases, but health and lifestyle are crucial factors to influence your chances on getting dementia (National Institute of Aging, 2021; Alzheimer-Nederland, 2021). Low mental activity, smoking, lack of movement and depression are some of the biggest factors that increase the chance of dementia.

Van der Voordt and Terpstra (1995) and the research of van Liempd et al. (2009) claim that intervening in the environment cannot stop the decline of dementia but can slow it down. While in most cases the underlying cause of dementia is still unknown (National Institute of Aging, 2021) and during developing environments for patients with dementia designers are confronted with a lack of knowledge about this target group (Alzheimer Architecture, 2010), there is scientific evidence that the environment can influence the growth of dementia.

Access to stimulation

Because of the disease, people with dementia are limited in their access to the need for stimulation as they are having little opportunities to engage in routine activities (Jakob & Collier, 2017). Sensory stimulation helps people with dementia to stay in the moment and interact with their current surrounding. Stimulation and meaningful activities are not only functional to pass time, but it also changes negative emotions and promote feelings of purpose and accomplishment (Jakob & Collier,

2017). Additionally, older people experience reduced acuity of senses, like hearing, vision, touch, smell, taste, and movement. Practicing their senses helps elderly to improve their cognitive symptoms and in their daily functioning. It was found out in the research of Mileski et al. (2018) that sensory training helped with improving communication, behavior, quality of life and improved functioning of the individual.

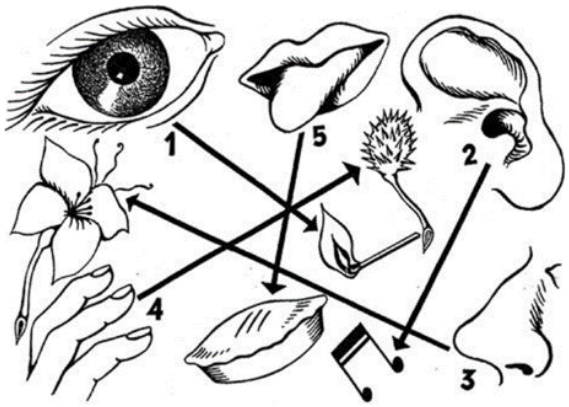


Figure 19: The order of senses according to Heilig's ranking (Spence, 2020)

Architecture influences our wellbeing, but mostly is designed for visual appearance and neglects the non-visual senses. To promote health and wellbeing buildings and environments should consider the impact of the various senses of the inhabitants and be aware in which way sensory atmospheric/environmental cues interact (Spence, 2020). The development of buildings and urban spaces with a multisensory approach will lead promoting our social, cognitive, and emotional development (spence, 2020).

Engaging older people in the use of technology or letting them participate in activities would help them keep up with cultural changes, but also helps keeping the brain active and improved memory (Erber & Szuchman, 2014; National Institute of Aging, n.d.). Approximately 58% of the older adults who live in institutional settings have some form of dementia, while most community-living older adults do not suffer from dementia (Erber & Szuchman, 2014).

The influence of change in lifestyle and community

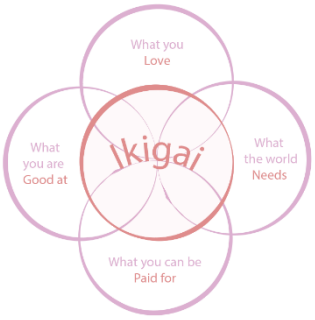
Community living is a principal factor for ageing healthy. Communities do not only help people engage in activities, but they also provide safety and give a purpose to many older adults. A strong community and social ties with family, friends or a spiritual community appears to be one of the key elements for longevity according to research into the blue zones (Garcia & Miralles, 2017). Medical studies of the centenarians of the blue zones note that the elderly in the blue zones have higher vitality and health than people of advanced age elsewhere, they suffer from fewer chronic illnesses and the rate of dementia is below the global average (Garcia & Miralles, 2017).

Blue zones

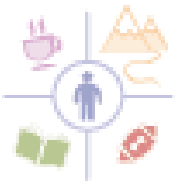
The blue zones are the geographic regions where people live the longest (Garcia & Miralles, 2017). 3 of the 5 blue zones are islands in which resources are scare and communities must help each other, these islands are Sardinia (Italy), Okinawa (Japan) and Icaria (Greece). The other two blue zones are Loma Linda (California), a religious group of Adventists with a specific diet and lifestyle, and the Nicoya peninsula (Costa Rica), a place where the older residents wake up early in the morning to work in the fields.

The blue zones have similar lifestyles and characteristics. Key factors for longevity include a healthy diet, exercising, having a purpose in life, and forming strong social ties. Other aspects are providing

the right environment and to have a positive outlook of live. These will promote healthy behavior and enough rest to lower stress. The diet of most blue zones exists mostly of vegetables and few animal proteins. They stop to eat when they are saturated, and do not eat until they are full, or if nothing is left. They exercise naturally with gardening or walking in their environment, and many believe drinking one or two glasses of wine a day helps to. It is important to have a goal to get out of bed, a purpose in life. The people of Okinawa call it an 'Ikigai,' while the people of Costa Rica call it a 'Plan de Vida.'
For many of the centenarians helping the community is their ikigai.



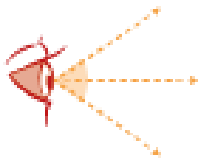
Lifestyles

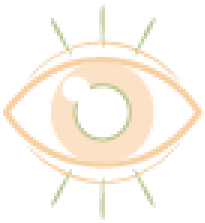


It should be kept in mind that there are no specific lifestyles of the elderly (Gorn & Claxton, 1985). Like in all societies, diversity among people increases with age and people are less similar in all aspects of life when they are old than when they were young adults or children. Lifestyle, income, age, and education influences the wishes and desires of an individual, which is being shaped over time. Future older adults can be expected to develop different lifestyles which will likely lead to preferences of diverse kinds of locations (Jong et al., 2012). This in turn will have an impact on spatial structures and architectural demands.

The importance of contact and education

Various research indicates that knowing or having contact with the target group that is being stigmatized reduces stigma (Richeson & Nicole Shelton, 2006; National Academies of Sciences, Engineering, and Medicine, 2016). Contact is not only direct communication with the stigmatizing group, but also visual interaction. Making the issue visible, showing the correct information, and giving insight onto the situation. Although architecture cannot force people to connect, just like architect Denise Scott Brown says: "it can plan the crossing points, provide sightlines, remove barriers and make meeting places useful and attractive." While architecture cannot control the outcome it can influence the fabric of the social culture (Cutieru, 2020).



Creating a community

An attractive and an open design can help make spaces more available for contact opportunities and can let a community come together (Zilliacus, 2017).
Increasing multifunctional usage in buildings can bring different social groups together. Programming for social intensity and by challenging spatial expectations of a location are one way to increase contact in an area, which have more to do with functionality than spatial design.
Social interactions are not only based on functions, but it also emerges at common grounds, like pathways or squares. Those are the places where different people cross each other and creates opportunities for people to bond. Combining pathways can create social hubs and increase the changes of social interaction (Zilliacus, 2017).

Experience and education

Many of the survey respondents **(Appendix B)** mention that they do not really experience any negative experiences with elderly.

Many acknowledged that a positive characteristic of the elderly is their life experience and advice. Most of them mention that they experience talking to elderly as positive. A place where people could meet and talk about their experience would be a positive influence for society, as well to create more awareness for the elderly and for life problems people could have. It is important that people recognize and address stigma, which can be done by educating oneself, but also by reframe the issue in a new light. By providing different interactions with the stigmatized group.

Discussion

What we can distinguish about these aspects is that the elderly is an extreme diverse group of people. Each individual is vastly different and has their own desires in life and their home. Not only desires but the required care is different for each person at every age. By being aware of adaptations and the differences in requirement of care a living environment can be adapted to the needs for each individual. The individuals should be challenged and stimulated to enact their passion, by increasing the opportunities for individuals to practice their passion and find new activities empowerment can be realized. Lastly, by making it visible for others that the elderly consists of different people with different passions and lifestyles the stereotype of one type of elderly can be lowered. The results demonstrate that there is a strong heterogeneity among the elderly, one that will be increasing in the future as people tend to develop different lifestyles and preferences.

The main goal for the built environment

Aging needs to be normalized in the society, by giving them a place of acceptance and a safe space where they can be themselves. The surrounding needs to show the diversity among the people and increase contact of different social groups with the elderly, not only to create social awareness but also to decrease loneliness as it is a genuine issue under the elderly, but in the entire Dutch population. Society should accept that care is required, but not let that exclude the elderly from their own lifestyles. It should provide multiple options and stimulate the senses to contribute to a welfare. The elderly must be able to exercise their passion and share their experiences with others, the build environment needs to put individuality in the spotlight and provide opportunities instead of barriers. This will lower self-stigma as well as empower the people themselves.

This supports that the hypothesis that the built environment can provide space for social interaction and education to form a better perception about growing old. But due to the lack of data about the division between elderly and the knowledge of the Dutch about growing old, it is unclear if the lack of understanding of being old creates a division between the elderly and the rest of society. Further research is needed to determine the relationship between the knowledge of growing old and the effect on stigma

The Dutch society do tend to have stereotypic view about what an elderly looks like but experience almost no negativity with the elderly and growing old. They do however indicate that the environment needs to be more age inclusive. This provides a new insight on how the Dutch experience aging and how the built environment can contribute to a better living situation for elderly. It shows a challenge for architects and the influence of architects on the social structure of society. Architects should design for society, and while architecture cannot solve the problems inside a society, architecture has the possibility to influence people's behavior. In the book "Scope of Total Architecture" by Walter Gropius is written that: "Good architecture should be a projection of life itself and that implies an intimate knowledge of biological, social, technical and artistic problems."

Conclusion

What can be conclude is that the built environment is of importance to decrease stigma, and 5 key design elements need to be considered to decrease stigma. These key elements are to design with similar or a higher value than the surrounding, by using design elements that empowers the stigmatized group, by providing areas and sightlines that increase contact, by including the needs and desires of each individual and by facilitating awareness.

The literature and survey seem to validate that care giving and age exclusion is based on assumptions of outdated care-concepts, but the case studies prove that there are already projects that discourage these assumptions and show the influence of the built environment in decreasing stigma.

The aim of the research was to indicate elements of the built environment that help decreasing stigma of ageing, but the broad subject of elderly and the diversity within it make it unclear which specific adaptations to the environment are needed to decrease stigma for this broad group. While the research gives clear insight about the diversity among the elderly, it also raises the question why we group all these different people together into one social group. Further research should consider the diversity among elderly and might want to focus on a specific segment of the elderly. For example, the elderly who are activity deficit or for elderly with specific care requirements instead of focusing on the total group of elderly.

Reflection

Introduction

The master track AR3AD110 Dwelling studio: Designing for Care in an Inclusive Environment (2021/22 Q1) is a course that focusses on the inclusiveness for elderly in an area.
This is done by researching the influence of design on the social requirements and needs of the elderly and how to include them in a society structure.

During my studies I focused on Architectural Engineering and complex projects, which focusses more on the techniques and materiality and large projects. I have chosen this course because I never got taught the social aspect of architecture and I expected by choosing this graduation studio to learn more about the spatial elements of architecture that influences the social structure of society.

At first, I wanted to research the topic dementia, because of my own experience and the ignorance my grandmother and her family had to go through because of the disease. During our stay at Habion's elderly complex Hoeverstaete, I experienced and found out a bigger problem, namely stigma and the assumptions people face being older adults.

This topic however was more difficult and complex to research than I at first anticipated. It gave me a lot of challenges, especially while designing.

In this reflection paper I will go through:

- The relationship between research and design
- The relationship between the graduation topic and the master program.
- The scientific relevance.
- The social relevance.
- The ethical issues I experienced.
- And lastly my own growth

My own experience with stigmatization of older adults.

I already experienced that the elderly met with discrimination, ignorance, and stereotyping.

My first interaction with stigma was the way my grandma was mistreated and excluded because of her disease. People who did not want to see her because they did not understand what was happening to her, the way she was ignored because she was different from before. This broke her but also my heart.

Of course, she was different because of the disease, she forgot many things and could not recognize people, even me, but she still was the same person who I loved and know. She was only in a different state of her life. While she was in the nursing home, I visited her regularly and loved to talk and walk with her as much as possible. The elderly at the nursing home were friendly, and I helped the staff with tasks if needed.

The course started with a field trip to an elderly home. I assumed that during my week at the elderly home Hoeverstate I would help elderly just like I did at the nursing home of my grandma.

I assumed the elderly required help, but those I met were independent and did not require or wanted any kind of assistance. During interviews we learned that those who required care preferred not to leave their appartement and felt uncomfortable to attend activities downstairs.

This brought up the questions: "Does society treat elderly different because of assumptions?" "How does the environment influence the way elderly are perceived" and "Does their environment influence how the elderly perceive themselves?"

This sparked the interest in the topic stigma.

1. The relationship between research and design

The research was the base for the design process. It started with anthological research at Hoeverstate in Alkmaar. Here we were introduced with the elderly, the different lifestyles each person has and the desires and needs each individual had.

This approach of meeting the target group is in my opinion the most important step a designer can make, as we design for people and their needs. This study focusses on the needs of the elderly and the fieldwork put emphasis on the individuality inside this social group to not generalize the term elderly. It does however focus on elderly who require care, giving us a limited, stereotypic view of the target group, as my research found out the elderly who require care is just a small fraction of the elderly.

Because of this I wanted my project to be a representation of the elderly, to create awareness for who truly this social group is and to decrease the stigma.

Stigma

To understand stigma, I did a theoretical framework on what stigma is and how it is influenced. During my fieldwork and pre-research, I found out that much of the care, design and perception of elderly is based on assumptions and stigma that are incorrect. This also is influenced by the context and the architecture in which the elderly resides.

Researching the history of elderly housing it was noted that elderly have been a stigmatized group since the beginning. Grouped together with the poor, sick and/or criminals, creating a negative attitude towards the elderly. This influenced perception on their living situation, with nursing homes being designed with the focus on care, not on the elderly that were residing inside.

My focus of the research was how to decrease stigma using the built environment. I researched topics and case studies that dealt with stigma in diverse ways. The diversity of techniques and cases thought me that there are a lot of stigmas and multiple ways to fight against them. This brought forth different elements required to decrease stigma and the first starting points for the design.

Choosing the location

One of the most important aspects was by creating a residential setting instead of an institutional setting that was the most common situation for elderly housing in the past. Of the three locations, Driebergen Rijsenburg was the project containing an institutional building excluded from the neighborhood. Already having two key factors of being a stigmatizing location.

Because of this I had chosen this location to transform it into a place that would be more residential and create a situation for all members of society that is as close as possible to societal norms as the normalization principle suggests.

Design goal

This translated my goal of the project to be: **"a representation of the elderly that is as close as possible to societal norms and open for everybody."**

I had a tough time to translate the theoretical information into the practical field. This is mostly because I found out that people aged 65 or older are no differently than other members of society.

And while my approached worked to find out the key-elements to decrease stigma, the problem was by making the goal of the project a representation of the elderly and by using universal design elements I prioritized a group of people. Creating a stigmatizing environment.

Until the P5 I will try to adapt my design to show better the atmosphere of the design and make slight changes that hopefully help destigmatize the area.

2. The graduation studio and the master track.

The master Program AUBS of TU Delft addresses technical, social, and spatial challenges. The master track in Architecture focusses on the design of innovative building projects that deal with these technical, social, and spatial challenges.

The graduation studio: Design for care towards an inclusive living environment focuses on the social aspect of architecture, mainly on the users and their needs. While most studios focus on the analytical part of research, Designing for Care brings the students in direct contact with the users.

This is particularly important for the education of architects as we should not forget for who we are designing. We are not designing buildings, we are designing a living environment for the users, for society.

I find this very appropriate as sometimes the focus is placed to much on the spatial and technical part of the building, and the users are being forgotten. Especially with stigmatized groups like elderly, who are forgotten, isolated or not considered because elderly housing is too expensive.

My graduation subject focuses on one of the social challenges that many times is overlooked inside the building sector, stigma.

3. Scientific relevance:

The research methodology of the studio is to go from anthropology to architecture. From observations and interviews to architectural solutions. The methodical line is human centered research, for this I participated in the life of elderly, observed diverse groups of people, and used a survey to learn how society thinks about the elderly and growing old.

All these research methods proved how diverse the elderly is and how strange it is that we, as a society, view elderly as one distinctive group. Generalizing and stereotyping a group of people that have just a small number of corresponding characteristics.

When researching elderly there should be a concrete description of what is considered being part of the elderly as this broad group of people can give assumptions to the reader and researcher in many ways.

4. Graduation project and the social framework:

The studio focusses on how we can involve the elderly in society, but it should also consider why the elderly are not part of society anymore?"

Many people forget that society influences the perception about elderly and how it influences their surroundings and our own perception as well. Architects design for the people and in a way shape society. Their idea of who their target group is influences their designs.
It is important for architects to learn who they are designing for and not generalize a person, or a group, based on a specific description or assumptions.

My graduation project tries to indicate that the elderly is not only the people in a nursing home, but also others that are overlooked when talking about elderly. The elderly who lives independently, those who require no care at all and the ones close to us, our grandparents, parents, and friends.

5. Ethical issues:

My entire research focused on the ethical issue of societies assumptions about elderly. What I discovered is that the term elderly is very stereotypic, as it not only assuming someone's age but also their health or functionality.

As people are growing older and stay longer fit, society should rethink the term elderly and its meaning. Instead of people 65+ and older, maybe we should consider people above another age. Or loose the term in general and focus on a person's ability instead of the years they lived.

Personal reflection

If I look back to the entire process and with the added information I gained, I would have chosen a different topic or worked out the project in a different way. Instead of creating a new neighborhood, transforming an existing one would have been a better option.

While I was quite confident in my first design concept my mentors pointed out it lacked in a certain part. To investigate these aspects further I created multiple scenarios in which each concept has a different focus point.
As my mentors said I can´t keep changing and need to choose at some point. I did in the end choose one concept, but I´m not certain if the choice I made was the right one.

I got multiple times stuck in designing, found new ways to adapt and learned that my way of working is to go from extreme to extreme, to analyze how different situations could work, this tactic however requires time and a lot of changes during the design process.

The graduation process was a difficult one full of new experiences. I learned my own strengths and weaknesses. My strengths are in the technical part of architecture and by analyzing and creating different scenarios.

My weaknesses are in the spatial and social aspect of architecture as I am focus more on functionality and detailing instead of the emotional and social side of architecture.
Sadly, my expectations of what I would have learned from this studio didn´t came true, but I became better aware of my own design process, of myself and what I want to focus on in the future.

Definitions

Ageism:
The negative attitudes, stereotypes, and behaviors directed toward older adults based solely on their perceived age (Butler, 1969)

Old:
Having lived or existed for many years.

The elderly:
Old people considered as a group. In this research people above the age of 65+ are considered part of the elderly. (WHO & WPA, 2002). It should be noted that the age at which an individual is perceived as 'old' varies across cultures

Nursing home:
A place where old people live and can receive care, usually when they can no longer care for themselves.

Independent:
Not influenced or controlled in any way by other people, events, or things.

Society:
A large group of people who live together in an organized way, making decisions about how to do things and sharing the work that needs to be done.

Social group:
In social sciences it means two or more people who interact with one another, share similar characteristics, and collectively have a sense of unity.

Generations:
All the people around the same age within a society or within a particular family.

Individual:
A single person or thing, especially when compared to the group or set to which they belong.

Inclusive:
To include many different types of people and treat them all fairly and equally.

Exclusion:
The act of not allowing someone or something to take part in an activity or to enter a place.

Marginalization:
The act of treating someone or something as if they are not important.

Discrimination:
any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights (WHO & WPA, 2002).
For example, based on their skin color, sex, sexuality or age.

Stigma:
A process whereby certain individuals and groups are unjustifiably rendered shameful, excluded, and discriminated against (WHO & WPA, 2002).
Negative attitudes or discrimination against someone based on a distinguishing characteristic, like health condition, culture, gender, or race.

Perception:
A belief or opinion often held by many people and based on how things seem.

The built environment:
The human-made surroundings that provide the setting for human activities, ranging from interior, buildings and parks to neighborhoods and cities, including their supporting infrastructure such as water supply or energy networks.

Element:
One of the parts of something that makes it work or a quality that makes someone or something effective.

The elderly, old people, older adults, or seniors are terms which brings stereotypes with it. An aspect we do not encourage. While we use these terms in this research, we recognize the wide difference between people among this group.

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Appendix:

Appendix A: Survey

Appendix B: Survey Report

Perceptie van leeftijd

Consent This survey is for a research of a TU-delft master study, the purpose of this research is to indicate the perception of growing old in the current society.
The survey is voluntary, you can stop anytime you like and continue later on.
You may choose not to participate but participation is highly appreciated.
The questions will be about your own perception and experiences about the elderly, age and environmental factors. The survey will take around 10 - 20 minutes.

The results of this study will be used for scholarly purpose only and will not collect any identifying information, such as name, email-address or IP-address. All the answers are anonymous. At the end of the survey you can submit an email-address if you like to know more about the results and reason for questions, but this is not required.

The facts in between questions are based on numbers of the population of the Netherlands, but are representative for many countries over the world.

In case you have any questions about the study, please contact:
Mark Neuteboom, m.y.neuteboom@student.tudelft.nl.

By clicking the button below, you agree to answer the questions in this survey.

Q1 What is your age?

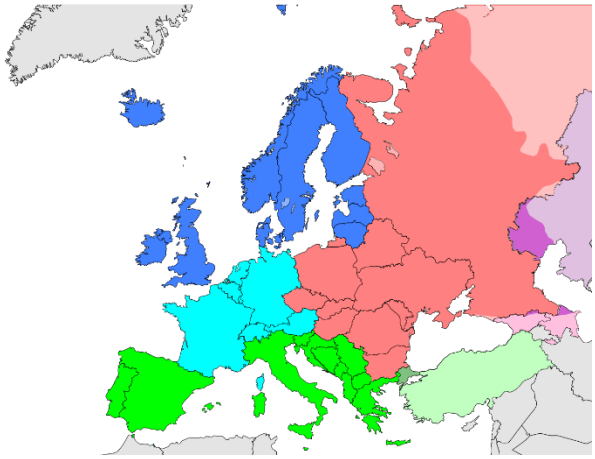
_____

Q2 What is your sex?

- ○ Male
- ○ Female
- ○ Other / do not wish to specify

Q3 What is your nationality?
based on the cultural background you identify by:

- ○ Dutch
- ○ West-European
  (France, Germany, Belgium) *light blue
- ○ East-European
  (Poland, Russia, Czech Republic) *red
- ○ North-European
  (England, Ireland, Finland) *dark blue
- ○ Mediterranean
  (Spain, Italy, Greece, Turkey) *green
- ○ Maroccan
- ○ African
- ○ Asian
- ○ Other:
  _____



Q4 In which province do you live?
In case you live in another country: Choose another country

- ○ Drenthe
- ○ Flevoland
- ○ Frieslans
- ○ Gelderland
- ○ Groningen
- ○ Limburg
- ○ North-Brabant
- ○ North-Holland
- ○ Overijssel
- ○ Utrecht
- ○ Zeeland
- ○ South-Holland
- ○ Another country _____

Q5 What is your highest/current education level?

- ○ WO/university (research-oriented education)
- ○ HBO (professional education by applied sciences)
- ○ MBO (Vocational Education and Training)
- ○ Voortgezet onderwijs: mavo, havo, vwo (secondary education)
- ○ basisschool (primary education)
- ○ Other ... _____
- ○ None

Q6 Do you celebrate your birthday?

- ○ Yes, as big as possible
- ○ Yes, but small and simple
- ○ Not really, I just buy a cake or something nice
- ○ No, not any more

Q7 Are you happy with you age?

- ○ Yes, I wouldn't want to be any other age.
- ○ Yes, but I would prefer to be ….
  _____
- ○ No, I prefer to be …. _____

Q8 Can you explain why you prefer this age?

- ○ My age doesn't really matter to me
- ○ At this age you are strong, handsome and successful
- ○ During this age I have fewer responsibilities (no work/expectations)
- ○ This age allows me to do certain activities such as...
  _____
- ○ Other reason .... _____

Q10 At what age do you think someone is old?
In this study, the term elderly or old people means people of this age and beyond. Elders can also be your grandparents, parents or friends/relatives if you consider them old.

_____

Q11 Which of these characteristics are descriptive of old people?
positive mindset / happy

- ○ negative mindset / grumpy
- ○ lonely
- ○ poor physical health
- ○ poor mental health
- ○ bad eyesight
- ○ bad memory
- ○ lack of mobility
- ○ unable to drive
- ○ white / grey hair
- ○ wrinkles
- ○ difficulty with adjusting to change(s)
- ○ unproductful
- ○ disconnected from society

Q12 Are there other characteristics that you associate with older people?

_____

Q13 Do all elderly people have these characteristics?

- ○ Yes
- ○ No

Q14 Are these features only specific for the elderly?

- ○ Yes
- ○ No

Q15 Do you have any disability?

- ○ None
- ○ Motor limitation: (amputation, spinal cord injury or walking problems)
- ○ Organic disability (Chronic): (diabetes, cancer, ashtma)
- ○ Vision: (blind / partially sighted)
- ○ Hearing: (deaf / hard of hearing)
- ○ Cognitive/Learning: (dyslexia, ADD/AHDH, Down syndrome)
- ○ Psychological (autism, depression, personality disorder)
- ○ Other.... _____

Q16 Do you use any human enhancers?

- ○ No
- ○ prosthetic/surgical limbs or appliances
- ○ mobility aids: wheelchair, walker, cane etc.
- ○ (reading-) glasses
- ○ hearing aids
- ○ assistance / service dogs
- ○ Other... _____

Q17 Would you use any human enhancers if you need them?

	Never	Depends on the situation / not certain	Yes ofcourse, if it helps
walking aid	○	○	○
hearing aid	○	○	○
(reading)glasses	○	○	○

Q18 Do you think of these enhancers or disabilities are comparable with the characteristics you mentioned before about elderly?

	Totally no	Both yes and no	Totally yes
Motor limitations (walking difficulties)	○	○	○
Hearing disabilities	○	○	○
Vision disabilities	○	○	○
Walking aid	○	○	○
Hearing aid	○	○	○
(reading)glasses	○	○	○

Did you know:

1 of the 5 people get dementia.
Dementia is not limited to age, 15.000 people under 65+ have dementia.

Age does increase the probability on dementia (and other diseases), but health and lifestyle are important factors to influence your chances on getting dementia.

(alzheimer-nederland, 2021)

Q20 Did you ever.....

	Never	The same as everybody	More than once a week
go through any discrimination or bad experience because of your age?			
go through any discrimination or bad experience because of your disabilities or your enhancers?			
make jokes about the age of others?			
make jokes about people their disabilities or their use of enhancers?			

Did you know:

9% of the Dutch population experiences ageism (discrimination based on age)
People who experience ageism, have a higher change on health problems
People refuse help or care out of the fear to be labeled

(Jackson et al., 2019) (Radar, 2021) (Mackenzie et al., 2019)

Q22 Where do you see the elderly most often:

- ○ On the street
- ○ In the park
- ○ At shops / shopping mall
- ○ In the supermarket / grocery stores
- ○ at parties / community events
- ○ During activities (golf course, painting lesson, etc.)
- ○ In a nursing home
- ○ Other places, namely ... _____

Q23 How often....
Grandparents, parents of friends/relatives can be part parent of the elderly, if they are 65 years of age if you give them as old.

	Never / once a year	Once a month	Once a week	Multiple times a week	Daily / always
do you see elderly?	○	○	○	○	○
do you help an old person find directions or cross the street?	○	○	○	○	○
do you help an old person with the groceries?	○	○	○	○	○
do you take a walk with the elderly?	○	○	○	○	○
do you play games or do activities with the elderly?	○	○	○	○	○

Q24 What is/would be your reason for helping the elderly?
Choose the reasoning that suits you the most.

- ○ I would help anyone in need
- ○ They require more attention
- ○ I like to do something for the community
- ○ They are a family member or a friend I feel responsible for
- ○ I do not help any elderly
- ○ other.... _____

Q25 Did you have had more negative or more positive experience with elderly ?

	1	2	3	4	5	
Negative experiences	○	○	○	○	○	Positive experiences

Q29 Were these experiences usually the result of:

- ○ The age of the elderly
- ○ bad memory
- ○ a disease or feeling unwell
- ○ the situation
- ○ their/your personality
- ○ other reason, namely... _____

Q27 Can you give an description of an experience?

_____

_____

_____

Q26 At which places were these experiences most often?

- ○ On the street
- ○ In the park
- ○ At shops / shopping mall
- ○ At the restaurant
- ○ At the nursing home
- ○ while visiting friends/family
- ○ Other... _____

Q72 Do you think your (built) environment is age-friendly?

- ○ Not at all
- ○ Both yes and no
- ○ Yeah, totally
- ○ I don't know

Q30 What could be improve to make it more friendly for the elderly?

_____

_____

_____

Did you know:

That around 20% of the Dutch population is above 65.
That in the Netherlands there are 2.536 elderly above 100 years old.
Women live usually longer than men

(CBS, 2021)

Q31 Which option do you think is best for the elderly to live in?

- ○ a nursinghome / home for the elderly with a care institution
- ○ living with relatives / family
- ○ living independently
- ○ Other ... _____

Q32 Have you visited a nursing home?

- ○ Yes, regularly
- ○ Yes, sometimes, but not often
- ○ Yes, but not anymore / long ago
- ○ No never

Q33 With which term do you associate a nursing home more?

	1	2	3	4	5	
The Elderly	○	○	○	○	○	Caregivers (nurses)
A hospital	○	○	○	○	○	An ordinary building
A care-facility	○	○	○	○	○	A living environment
Diseases	○	○	○	○	○	Health
Unpleasant	○	○	○	○	○	Pleasant

Q34 What do you think of a nursing home?

_____

Q35 Would you like to go to a nursing home when you get old?

- ○ Yes, that seems nice
- ○ That depends on the situation
- ○ No, I do not want to

Q36 Could you elaborate your reason?

_____

_____

_____

Q37 What does a nursing home need to have/change for you to visit it?

_____

Q38 What does a nursing home need to have/change for you to live in it?

_____

Did you know:

88% of the elderly don't make use of elderly care.
70% of the elderly don't experience any burden of limitations.

(CBS, 2019; Vektis, 2019)

Q40 Would you like to do more activities with the elderly?

- ○ No
- ○ Yes
- ○ Yes, but specifically activities such as...
  _____

Q41 What restricts you from meeting people over 65?

- ○ There are no limitations
- ○ I do not have the time
- ○ I don't know how to approach the elderly
- ○ I feel uncomfortable with the elderly
- ○ There is a social/cultural barrier (hearing/speaking/points of view)
- ○ The age difference
- ○ The distance between the location
- ○ I don't want to be associated with the elderly
- ○ Differently.... _____

Did you know:

54,7% of the people above 65+ feel lonely.
50,1% of the Dutch population above 18 years feels lonely

(GGD, CBS, & RIVM, 2020)

Q42 Have you already thought about what happens when you get old (over 65+)?

- ○ Yes
- ○ A bit, but not so much
- ○ No

Q43 What would you like to be able to do when you are old?

- ○ Gardening and/or cooking / baking
- ○ Being creative (painting, woodworking)
- ○ Do Exercise / sports, to play games
- ○ To travel / to go on walks / to cycle
- ○ To enjoy with the people
- ○ To learn new things
- ○ To relax
- ○ To still be working / do community service
- ○ Other.... _____

_____

Q44 Where would you like to live when you are old?

- ○ Near or in the middle of the city
- ○ In a nursing home with sufficient care facilities
- ○ In the same place I've lived all/most of my life
- ○ In a village where I know everyone
- ○ Quiet in nature, far from society
- ○ In another country, like I'm on a holiday
- ○ Somewhere different, namely....

_____

_____

Q46 Are you looking forward to growing old?

- ○ Yes
- ○ It wil come naturally
- ○ no

Q47 Can you explain your answer

_____

_____

_____

Q48 We are incredibly thankful for your answers!

In case you would like to know the result of the survey or the reason behind the questions, you can leave your email-address here:

e-mail: ….

_____

Q49 An email will be sent in the week of 10 - 16th of January, with the results and the explanations of this survey.

We wish you a wonderful day!

Bronnen over de feiten / Sources of the facts:

- *Alzheimer-nederland. (2021, February). Factsheet cijfers en feiten over dementie.* https://www.alzheimer-nederland.nl/factsheet-cijfers-en-feiten-over-dementie

- *GGD, CBS, & RIVM. (2020). Gezondheidsmonitor Volwassenen en Ouderen van GGD'en CBS en RIVM.* https://bronnen.zorggegevens.nl/Bron?naam=Gezondheidsmonitor-Volwassenen-en-Ouderen-van-GGD%E2%80%99en-CBS-en-RIVM

- *Jackson, S. E., Hackett, R. A., & Steptoe, A. (2019). Associations between age discrimination and health and wellbeing: cross-sectional and prospective analysis of the English Longitudinal Study of Ageing. The Lancet Public Health, 4(4), e200–e208.* https://doi.org/10.1016/s2468-2667(19)30035-0

- *Radar. (2021, February). Factsheet leeftijdsdiscriminatie. https://radar.nl/publicaties/factsheet-leeftijdsdiscriminatie/ Vektis. (2019, May 6). Feiten en cijfers over ouderenzorg. Retrieved 19 November 2021, from https://www.vektis.nl/intelligence/publicaties/factsheet-ouderenzorg Volksgezondheid. (2021, October). Infographic, ouderen samengevat. Volksgezondheidenzorg.Info. Retrieved 19 November 2021, from* https://www.volksgezondheidenzorg.info/verantwoording/infographics/overzicht-infographics#!node-ouderen-samengevat

- *Mackenzie, C. S., Heath, P. J., Vogel, D. L., & Chekay, R. (2019). Age differences in public stigma, self-stigma, and attitudes toward seeking help: A moderated mediation model. Journal of Clinical Psychology, 75(12), 2259–2272.* https://doi.org/10.1002/jclp.22845

Doel van de Enquete

Het hoofddoel van de enquete is om te kijken hoeveel stigma over ouderen en hun omgeving in Nederland aanwezig is. Daarnaast helpt deze enquete bewustwoording te creëren over de situatie van het ouder worden en het stereotypisch beeld van ouderen te verlagen.

Stigma is een brandmerk dat aan een bepaald persoon, groep mensen of een zaak gekoppeld word, dit wordt meestal versterkt door negatieven vooroordelen en ervaringen die het stigma ondersteunen. Stigma kan ontstaan in een samenleving uit angst maar ook uit een gebrek aan bewustzijn, educatie of perceptie. Bewustwording van het probleem is de eerste stap om stigma te verlagen. Andere methodes zijn: contact met de doelgroep, onderwijzen over de situatie, openlijk praten over het probleem of communiceren door middel van media en het erkennen van het probleem.

Stigma kan in drie vormen ontstaan:

1. Publieke stigma;
   is het discriminerende gedrag van anderen in de samenleving.
2. Institutionale stigma;
   Wordt veroorzaakt door overheid en/of organisaties die de gestigmatiseerde groep beperken.
3. Zelf-stigma;
   is een negatieve houding van de persoon, die gestigmatiseerd wordt, ten opzichte van zijn eigen toestand.

Stigma kan zowel opzettelijk als onbewust gecreëerd worden.

Een situatieschets hiervan is:

" Mensen met gehoorproblemen of dementie hebben het moeilijker om mensen te verstaan. Een bedrijf speelt hier op in door aan te geven dat mensen rustiger en eenvoudiger moeten praten met personen met gehoorproblemen of dementie, daarvoor gebruiken ze een reclame met een voorbeeldscene waar een verwarde oudere vrouwen een jonge man niet kan verstaan totdat hij gebruik maakt van beperkte woordenschat en eenvoudige, korte zinnen en vertraagd spreekt met een overdreven intonatie (elderspeak)."

Hoewel het goed bedoeld is, kan het overkomen, doordat het bedrijf een oudere vrouw gebruikt, dat het probleem bij ouderen voortkomt ***(institutionale stigma)***
Mensen associeren dat ze eenvoudigere zinnen moeten gebruiken bij oudere volwassenen ***(stereotype)*** *en behandelen ouderen met elderspeak om ze te helpen* ***(publieke stigma)****.*
De oudere volwassenen die geen problemen hebben voelen zich benadeeld, maar verklaren dat het komt omdat ze ouder worden. Hierdoor krijgen ze een verlaagd zelf-beeld ***(zelf-stigma)****, waardoor ze minder praten met anderen wat hun spraakvaardigheden vermindert.*
Wanneer ze praten met anderen mensen hebben ze moeite met communiceren, waardoor het stereotypisch beeld dat ouderen hulp nodig hebben met communiceren wordt versterkt ***(ervaringen)****.*

Tijdsverschil

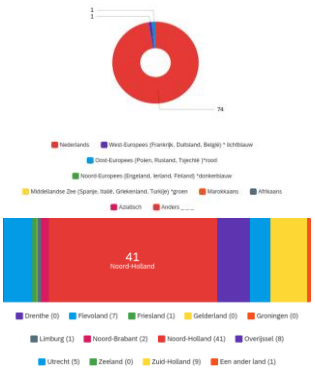
Er zijn 76 enquetes ingevuld, maar doordat alle vragen vrijwillig te beantwoorden zijn en geen vraag verplicht was om te beantwoorden, zijn sommige vragen niet beantwoord door alle respondenten.

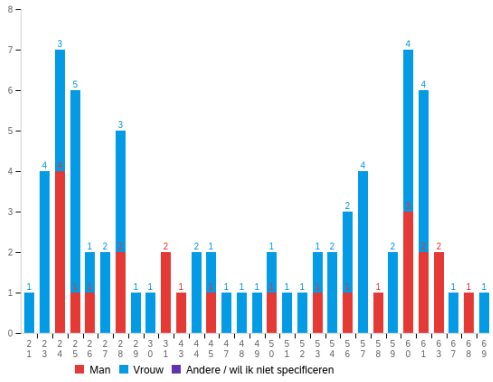
Gemiddeld zaten de mensen tussen de 7 minuten en 40 minuten.
Een persoon heeft er rond de 3 uur over gedaan.

Dit tijdsverschil kan te maken hebben met de vragen. Hoewel het geen moeilijke vragen zijn, zijn het persoonlijke vragen, wat betekend dat het voor iedereen anders is en een specifiek antwoord moeilijk te bepalen is. Het kan zijn dat het onderwerp nieuw is voor de respondent, of dat hij/zij er nog niet over nagedacht heeft, waardoor er meer denktijd nodig is. Een andere theorie is doordat er geen druk achter de enquete zat of een tijdslimiet dat de respondent tijdens de enquete andere activiteiten deed.

Respondenten

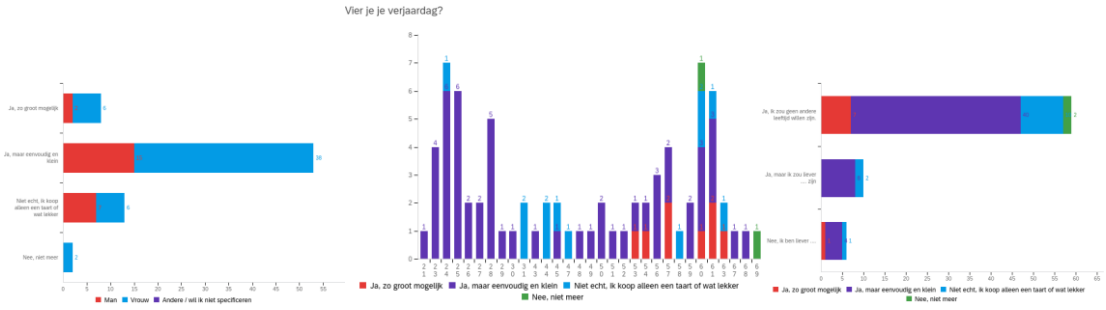
De eerste vragen zijn bedoeld om de respondenten te catagorizeren. Er zijn verschillende factoren die inspelen op stigma en perceptie. Voorbeelden zijn leeftijd, geslacht, cultuur en opleiding. Deze vier factoren waren leidend voor dit onderzoek om de respondenten te kunnen catogorizeren. Cultuur en opvoeding zijn belangrijke factoren op hoe wij als persoon, maar ook als onderdeel van de samenleving gedragen en denken. Het educatie niveau zou invloed kunnen hebben op stigma, om dit te testen hebben we deze factor meegenomen in de enquete.



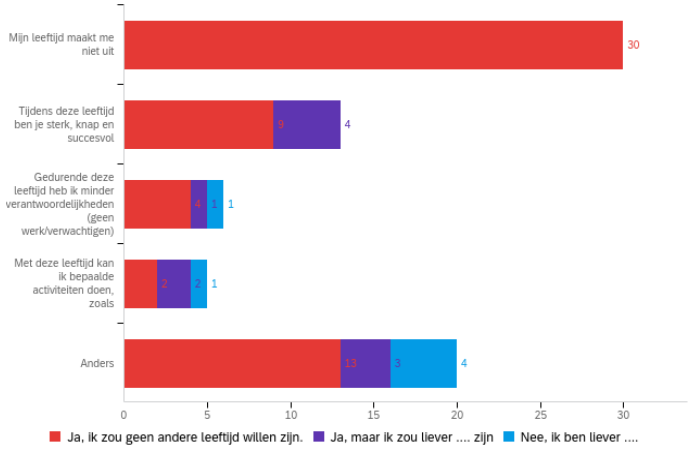


Leeftijd

Het vieren van je verjaardag zou een positiever beeld geven over ouder worden.
Deze vraag was net als de educatie niveau, om te testen of het vieren van je verjaardag effect heeft op je eigen perceptie op ouder worden. Dit blijkt niet het geval te zijn, de resultaten laten zien dat zowel mensen die hun verjaardag zo groot mogelijk vieren als mensen die het niet vieren dezelfde reacties hebben of ze liever een andere leeftijd hebben of niet.



De meeste respondenten maakt het niet uit welke leeftijd ze zijn, zoals paar respondenten antwoorden: “het gaat niet om de leeftijd, maar om de levenservaring en de groei van jezelf als een persoon. De mensen die liever een andere leeftijd zijn, zijn het liefst tussen de 20 en 35 zijn. Dit is vanwege het feit dat ze dan fysiek sterker zijn en nog een toekomst voorzich hebben.

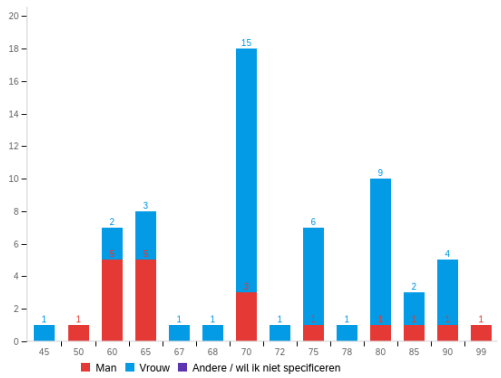


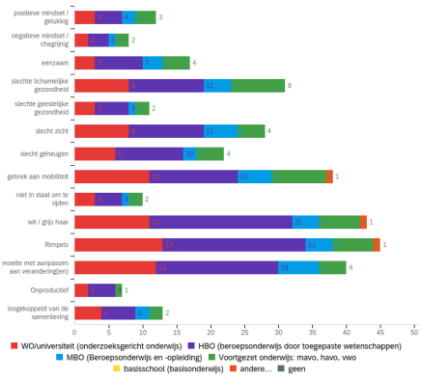
Paar voorbeelden van antwoorden:

- “Ik zou niet jonger of ouder willen zijn dan wat past bij het aantal jaren levenservaring dat ik heb.” (een man van 31 jaar)
- “Elke leeftijd heeft zo zijn mooie en mindere kanten. Op deze leeftijd zit ik in een mooie ontdekkingsfase waarbij ik veel kan leren.” (een vrouw van 23 jaar)
- “Ik heb graag de leeftijd die past bij de levenservaring die ik heb. Ongeacht mijn leeftijd, zou ik geen andere leeftijd willen hebben.”(man van 31 jaar)
- “Met deze leeftijd veel bereikt. Kan nu wat minder inspannen” (vrouw van 57)
- “Je leeftijd bepaald je levenshouding. Ik zou niet terug willen. Een ander verhaal is, dat je op deze leeftijd verplicht gepensioneerd wordt en dan automatisch niet meer bij de groep maatschappelijk nuttigen behoort.” (een vrouw van 67 jaar)

Oud

De respondenten associeerde rond de 70 en 80 jaar met oud. Sommige mensen merkten op dat de leeftijd ook afhangt van de persoon, aangezien de ene persoon op 40-jarige leeftijd "oud" kan zijn, terwijl een andere op 75-jarige leeftijd nog steeds als "jong" beschouwd kan worden. Een van de respondenten (28 jaar) vermelde dat zij zichzelf rond 40 oud zal noemen, maar anderen pas rond 65 oud beschouwt. Dit antwoord zou betekenen dat de associatie met 'oud' niet zozeer met leeftijd te maken heeft, maar meer met gedrag, kennis/ervaring of uiterlijk.

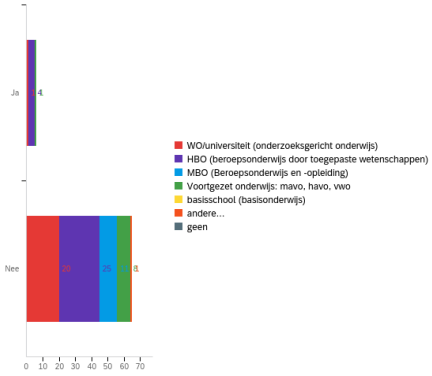




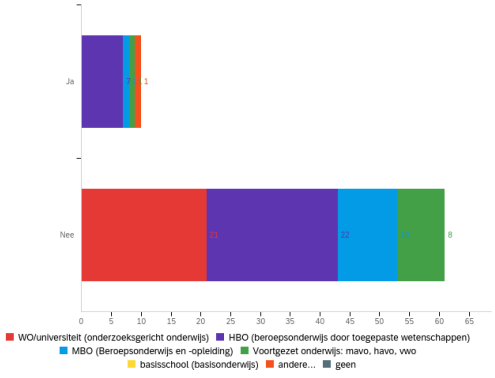
Omdat stigma voornamelijk over een negatief stereotypisch beeld gaat, werd de vraag gesteld ‘welke kenmerken er beschrijvend zijn voor oude mensen?’ met voornamelijk voorbeeld kenmerken die negatieve associaties. Een utopisch resultaat zou zijn dat geen kenmerken gekozen zouden worden, maar dat is natuurlijk een idealisch gedachte. Elk persoon is immers op een andere manier en een andere leeftijd oud, zoals voorheen gesteld werd.

De kenmerken die mensen voornamelijk met ouderdom associeeren zijn: ‘wit/grijs haar, rimpels, moeite met aanpassen aan veranderingen en gebrek aan mobiliteit’. Bij het antwoorden of er andere kenmerken zijn die mensen koppelen met ouderen was ervaring en wijsheid eem positieve kenmerk, maar ook langere hersteltijd van het lichaam en dementie werden genoemd.
De meerderheid van de mensen beweert dat deze kenmerken niet alleen bij ouderen voorkomt en dat niet alle ouderen met deze kenmerken te maken hebben.

Hebben alle ouderen deze kenmerken:



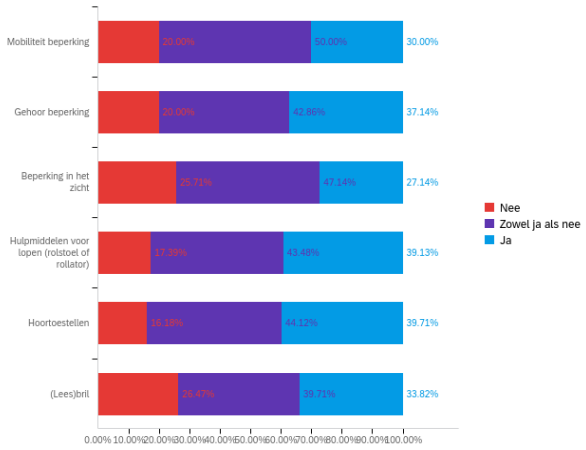
Zijn deze kenmerken alleen bij ouderen:



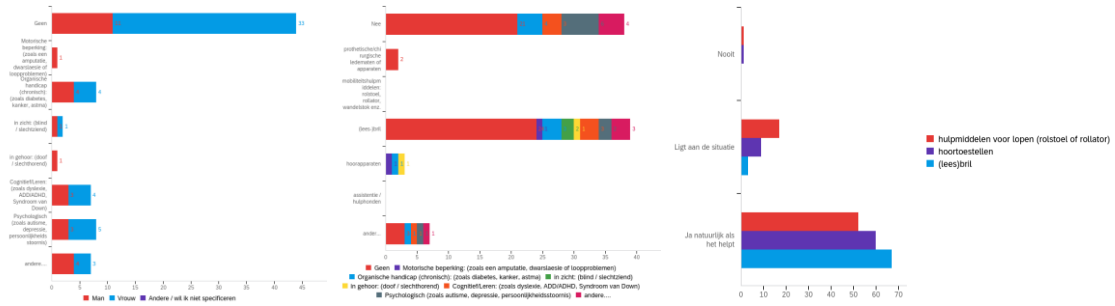
Beperkingen

Bij het afbeelden van ouderen worden vaak beperkingen of hulpmiddelen gebruikt, zoals een kromme rug, een bril of een wandelstok. Deze factoren helpt het publiek met het verbeelden van ouderen, maar kan ook een stereotypisch beelde creëeren. Een stereotypisch beeld kan ervoor zorgen dat mensen gedrag of andere personen vermijden om niet onder dit stereotypisch beeld te vallen.
Een oudere slechthoorende vrouw wilde bijvoorbeeld geen gehoorapparaat gebruiken, omdat ze nog jong was. Ze keek ook raar op toen haar schoonzoon aantoonde dat hij zelf een gehoorappaat droeg. De meeste mensen tonen aan dat een hulpmiddel gebruikt zal worden als ze het nodig hebben, maar beperkingen en hulpmiddelen worden over het algemeen wel met ouderdom geassocieerd.

Associatie is een belangrijk onderdeel van stereotypisch beeld en stigma. Een van de respondenten zei tijdens het onderzoek dat hij slecht gezichtsvermogen niet associeerde met oud worden, vanwege een vriend met een slecht gezichtsvermogen van 24 jaar die hij als referentie gebruikt.



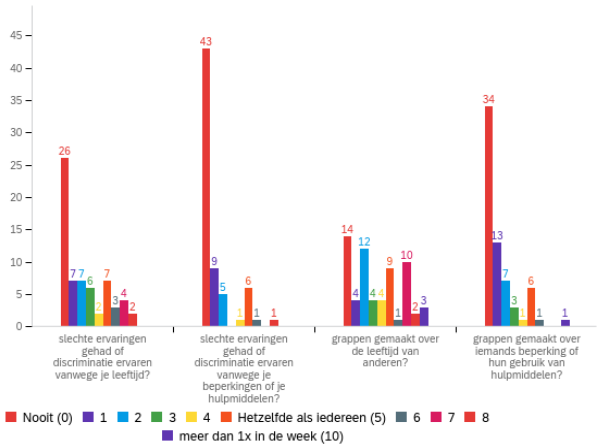
De vraag kwam naar voren of mensen met een beperking, beperkingen minder of totaal niet asocieren met ouderen. Dit blijkt niet het geval te zijn, vooral mensen die aantonen dat ze zelf geen beperking hebben associeren beperkingen en hulpmiddelen niet met ouderen.



Bij de antwoorden kwam ook naar voren dat sommige fysieke factoren niet onder beperking gezien worden, zo gaven verschillende respondenten aan dat ze geen beperking hadden maar wel gebruik maakte van een hulpmiddel, zoals het dragen van een bril bij slecht zicht of het gebruik van een prothetische/chirugische ledemaat of apparaat.

Heb je ooit...

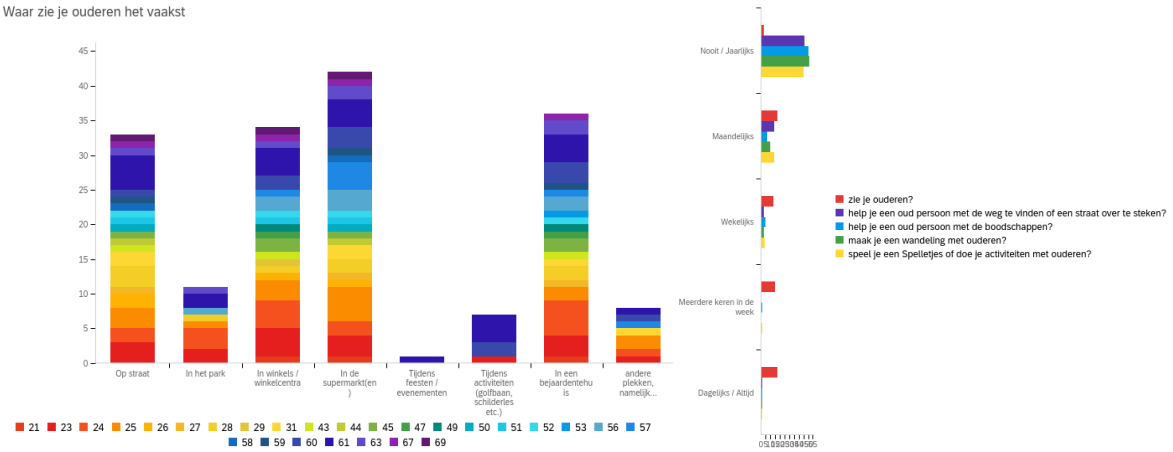
Deze vragen gingen over discriminatie over ouderdom en het stereotyperende beeld, ook werd hierbij gevraagd naar grappen maken over mensen hun leeftijd of beperkingen. De grappen zijn een verwijzing naar (onbedoelde) stigmatisch gedrag, wat als een onschuldig grapje bedoel is, kan een persoon ondervinden als een negatieve ervaring of discriminatie.



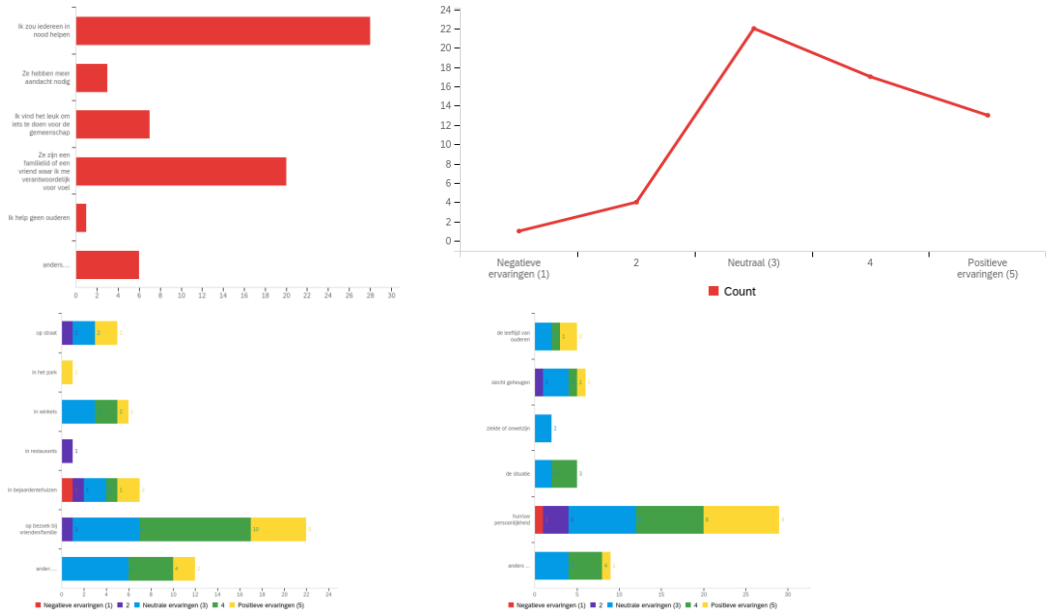
Over het algemeen hebben de respondenten geen negatieve ervaringen of discriminatie ondervonden. Mensen ondervonden wel meer discriminatie vanwege leeftijd dan vanwege beperkingen. De gegevens vermelden ook dat grappen over leeftijd vaker worden gemaakt door de respondenten dan grappen over beperkingen of hulpmiddelen, deze worden nauwlijks gemaakt.

Ontmoetingen en ervaring

Zoals al aangegeven cultuur is een belangrijke invloed op stigma, ontmoetingsplekken en hun omgeving zijn daardoor invloedrijke factoren op het beeld over ouderen. Deze vragen gingen over het aantal contactmomenten met ouderen en waar deze plaats vonden. Door deze vragen kan er een veronderstelling gemaakt worden waar de stigma kan worden onderbroken en meer contact met ouderen kan worden gecreerd. Contact met de doelgroep is een van de belangrijkste factoren om stigma te verlagen.



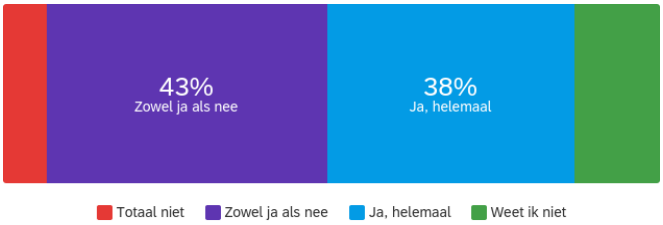
Contact kan zowel negatief als positief ervaren worden. Volgens de respondenten zijn hun ervaringen met ouderen vooral neutraal en positief. De vraag erna ging dieper in waarom deze ervaringen positief of negatief waren ervaren, dit antwoord kan aanduiden welke contact momenten versterkt kunnen worden om meer positieve ervaringen te creëren en negatieve ervaringen te verkleinen. Daarnaast zorgt deze vraag om na te denken over wat de reden is voor de ervaring,



De meeste ervaringen komen voort uit de persoonlijkheid van of de ouder, de respondent, of van beiden. Wat wel duidelijk gemaakt wordt is dat de situatie verschilt per persoon, en zoals een persoon duidelijk aangeeft: “Mijn ervaringen met ouderen zijn niet anders dan met andere mensen.” Dit is precies is wat deze enquete wilt bereiken, mensen onderwijzen dat: “Ouderen net als iedereen mensen zijn, ze zijn allemaal verschillend en worden oud op hun eigen manier. Er is geen ‘een type oudere’ dus we moeten ze ook niet als ‘een uniforme groep’ behandelen.”

Omgeving

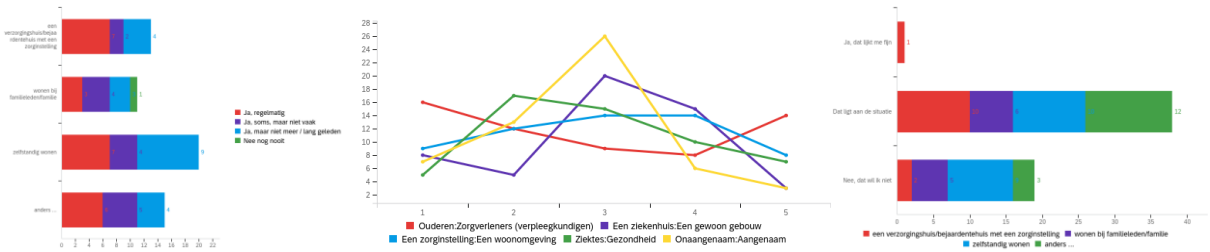
Deze twee vragen waren gesteld om te analyseren of de omgeving in Nederland wel geschikt is voor ouderen en welke onderdelen van de omgeving aangepast moeten worden vanuit de ogen van de medebewoners.



Over het algemeen hebben mensen wel een idee of de omgeving leeftijdsvriendelijk is of niet. Maar 13% van de ondervraagde antwoorden weet ik niet. De meeste vinden hun omgeving geschikt, maar dat het wel beter kan. Wat er verbeterd kan worden gaat vooral over een inclusieve maatschappij waarbij over elkaar wordt nagedacht en meer activiteiten en contact met elkaar gerealiseerd wordt. Andere aspecten gaan over het infrastructuur, zoals bankjes, toegankelijkheid, bredere paden en duidelijke richting aanwijzing.

Verzorgingshuis

Deze vragen gaan over hoe er over verzorginshuizen wordt nagedacht en wat het beste is voor ouderen om in te wonen. Verzorgingshuizen hebben zelf te maken met stigma, zo werd het in het verleden geassocieerd met een ziekenhuis of een gevangenis. Momenteel worden veel ouderencomplexen ontworpen als een leefomgeving met de zorg in de achtergrond. Dit is een oplossing om een fijnere woonsituatie te creëren, maar als de zorg verkeerd integreerd wordt kan het ook problemen opleveren.



De meeste mensen vinden dat zelfstandig wonen het beste is voor ouderen en hun zelf, maar dat zorg wel beschikbaar moet zijn, indien verhuizen naar een levensloopbestendige omgeving of een verzorgingshuis als het nodig is.
De meeste mensen vinden verzorgingshuizen functioneel en handig, maar veel vinden dat er veel verbetering voor zorg en focus kan op het humane. Verschillende mensen tonen aan dat ze liever er nooit willen wonen of dat het een trieste situatie is.

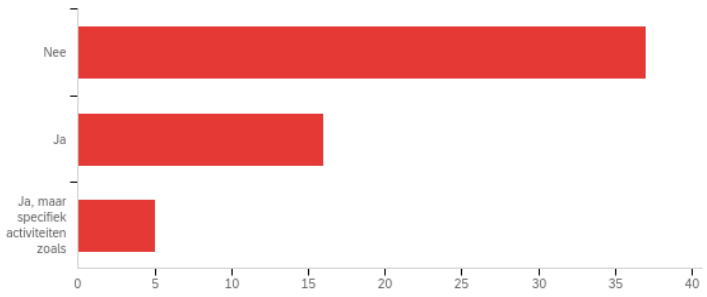
“Over het algemeen is het triest”
“Goede bedoelingen, maar teveel focus op ‘ouder zijn’ en beperkingen/zorg. Dat het ‘gewoon’ mensen zijn, allemaal anders, leek soms verder weg...”
“Ik vind het goed voor mensen die zorg nodig hebben of niet meer thuis kunnen wonen. Maar het zou beter zijn als mensen zolang mogelijk thuis kunnen wonen met zorg dichtbij.”
“Goed dat het bestaat. Er zijn veel ouderen die zich hier veel minder eenzaam voelen. Desondanks voelt niet elke oudere zich hier thuis. Het kan soms statisch zijn en er wonen alleen maar ouderen, waardoor de doelgroep erg wordt buitengesloten in onze maatschappij.”

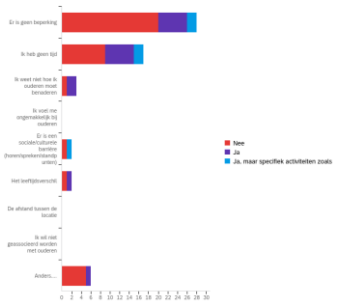
Activiteiten en eenzaamheid

Een respondent vermelden dat hij liever niet naar een verzorginshuis wilt omdat hij bij een verzorgingshuis het idee heeft dat je daar wordt verwaarloosd als oudere als je geen familie hebt die langskomt.

In het nieuws wordt besproken dat ouderen vaak eenzaam zijn, als je naar de gegevens kijkt zijn voelt ongeveer de helft van de samenleving zich eenzaam. Hierdoor valt de 54,7% boven de 65+ in vergelijkbaar met de 50,1% boven de 18+ eigenlijk wel mee. Het is wel zo hoe ouder iemand wordt hoe eenzaamer hij raakt, wat ook te maken heeft dat meer leeftijdsgenoten en vrienden ouder worden en overlijden. De nadruk op deze gegevens is dat eenzaamheid niet alleen voor ouderen een probleem is, maar dat eenzaamheid een maatschappelijk probleem is waar elke leeftijdsgroep mee te maken heeft.

Activiteiten met mensen en familieleden is dus van belang als je op jezelf woont of in een verzorgsinstelling komt. De meeste mensen ervaren geen beperkingen of hebben geen tijd om ouderen te ontmoeten, maar de meeste willen ook geen activiteiten doen met ouderen.
Dit kan te maken hebben vanwege het op deze wijze geforceerd voelt en niet noodzakelijk is in hun ogen. In het geval met ouderen bezoeken als ze familie zijn of om verhalen te delen met vrienden voelt dan al veel eenvoudiger aan.



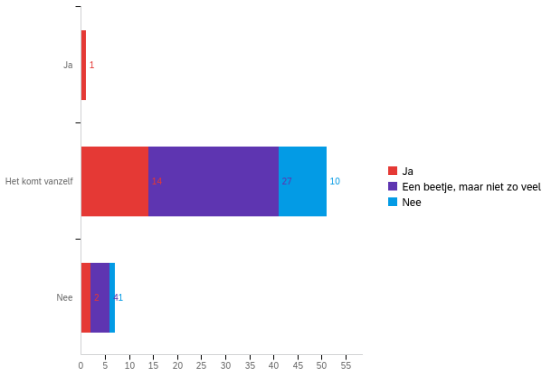


Een andere reden is de situatie waarin de respondent zich bevindt. Zoals een respondent beschrijft wilt hij momenteel geen activiteiten met ouderen doen omdat het te riskant is met de corona-pandemie, een ander beschrijft dat ze geen ouderen ontmoet, omdat ze vooral online of op school mensen leert kennen waar deze doelgroep zich niet bevindt.

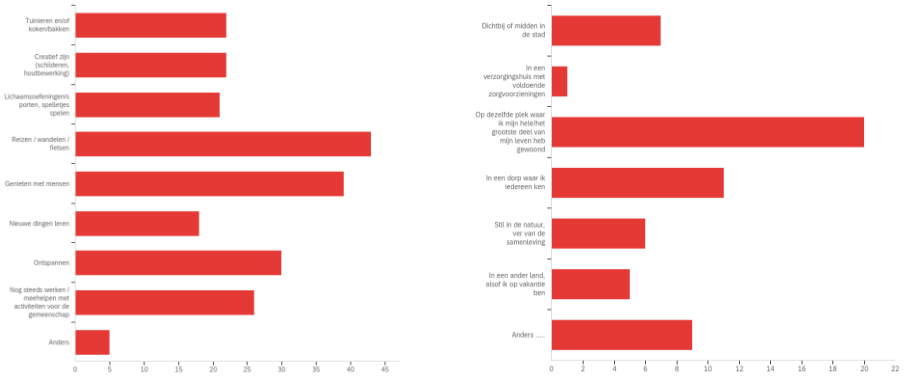
Zelf oud worden

Hoewel er veel wordt besproken over wat er gebeurt met je lichaam als je een tiener bent en wat voor beroep je wilt uitoefenen als je volwassen bent, er wordt bijna nooit gesproken over wat erna gebeurt, als we met pensioen gaan of als we met ouderdom te maken hebben. Ouderdom is misschien geen taboe om over te praten, maar er wordt weinig over de situatie openlijk gecommuniceerd.

De laatste vragen gaan erop in of mensen er al over nagedacht hebben en wat zij als persoon graag zouden willen doen en hebben als zij oud zijn. Dit kan natuurlijk veranderen over tijd, maar dit geeft wel een indicatie wat gewild is. Deze vragen zorgen er niet alleen voor dat mensen er al over nagaan denken en hoopt hopelijk ook ervoor dat het thema ouderdom meer open gesteld wordt voor gesprekken.



Volgens 86% van de respondenten komt ouderdom vanzelf wel. De meeste respondenten hebben een beetje nagedacht over wat er gebeurt als ze ouder zijn, maar niet veel. Als ze oud zijn wil de meerderheid wonen in de omgeving waar ze het grootste deel van hun leven gewoond hebben en genieten met anderen of reizen.



"Ik kan beter in het moment leven dan mij zorgen maken over de volgende dag. Ik heb vrienden en familie waarvan ik weet dat ik voor altijd op hen terug kan vallen. Zorgen voor morgen, vragen voor later."

"ik verheug me niet op de lichamelijke ongemakken en het krijgen van beperkingen, maar het is niet tegen te houden. Ik wil proberen zo actief en gezond mogelijk te blijven."

"Aan elke leeftijd zit zijn voor en nadelen, elke dag goed beleven en genieten"

“ik kijk uit naar de vrijheid van pensioen, maar zie op tegen het verliezen van dierbaren”