

EDUCATION AGAINST AGEISM, STEREOTYPES AND GERONTOPHOBIA ABOUT THE SEXUALITY OF OLDER ADULTS (DEVELOPMENT OF A MODEL FOR INTEGRATED PROMOTION OF SEXUAL LIFE OF OLDER ADULTS)

Accepted

10. 4. 2025

Revised

25. 6. 2025

Published

10. 10. 2025

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Abstract This study aims to develop an educational model and guidelines for promoting sexual health in older adults (55+), addressing ageism, stereotypes, and gerontophobia. Despite its significance for successful aging, sexual health in older adults is often neglected. The study involved 651 participants (aged 55-75) and used a quantitative approach, examining factors like health status, sexual activity, and education through an online survey. Key findings include a positive correlation between health and sexual satisfaction ($r = 0.2$ to 0.4 , $p < 0.001$) and the importance of sexual knowledge in life satisfaction ($F = 90.027$; $p < 0.001$). Results underline the need for tailored educational programs and open discussions on sexuality. The proposed model aims to improve sexual well-being and overall quality of life, promoting a holistic approach to sexual health care to older adults. These findings are relevant for shaping policies and interventions in Slovenia and globally.

Keywords

older adults,
sexuality,
stereotypes,
activity,
withdrawal,
satisfaction

1 Introduction

The proportion of older adults is increasing worldwide, outpacing all other age groups. Trends predict that by 2050, the number of people aged 60 and older is expected to increase to 2 billion. In Slovenia, the proportion of the population aged 65 and over is projected to increase from the current 21.1% to 32.1%. This raises important questions about how to support older adults so as to maintain their independence and activity levels, while also balancing health promotion policies to enhance their quality of life. Although sexual health is not always directly included in quality of life assessment tools, it is evident that sexual well-being significantly contributes to overall life satisfaction in many older adults (WHO, 2002). Promoting sexual health plays a vital role in improving their quality of life, positively influencing emotional and psychosocial well-being, and fostering intimacy and social connections. Sexuality is a normal and healthy part of life, and within this framework lies the issue of sexual health, which encompasses a wide range of interconnected mental, physical, and emotional factors (Breuner & Mattson, 2016). These factors reflect how well-being, illness, or specific challenges can affect an individual's sexuality, their family, relationships, work, hopes, and fears (Andrews, 2001; Breuner & Mattson, 2016).

Despite societal progress, we still struggle with prejudices, as sexuality remains a taboo topic, particularly pertaining to older adults. The belief that sexual activity is inappropriate or unseemly after a certain age is widespread. While we have come to understand that healthy eating, exercise, and caring for physical and mental health contribute to the overall well-being of older adults, it is equally essential to include the importance of healthy and safe sexuality. As a society, we must accept that sexuality is not bound by age, and that the upper age limit for sexual activities is determined by each individual based on their desires and abilities.

Sexual health, defined as a state of physical, emotional, mental, and social well-being related to sexuality, does not merely mean the absence of disease or disorders (WHO, 2006); it also encompasses sexual satisfaction, a complex and significant process (Miguel et al., 2024). Sexuality is an important and evolving aspect of health throughout one's lifespan. It is crucial that individuals do not shy away from their sexual desires, as this includes the right of all people to knowledge and the ability to

lead a safe and pleasurable sexual life (Starc et al., 2023), regardless of age. A satisfying sexual life provides individuals with a sense of vitality, as noted by Kastnebaum (1979) and Starc et al. (2023). Therefore, we should focus on helping older adults find the safest forms of sexual expression suited to their needs and circumstances (Aizenberg et al., 2003). Yan et al. (2011) view the maintenance of sexual life as a symbol of vitality and longevity, a perspective supported by Menard et al. (2015) and Starc et al. (2023), who further emphasize that sexual satisfaction should be regarded as a crucial aspect of sexual health, particularly for older adults. In this context, sexual satisfaction may become more significant than the frequency of sexual activity. Satisfaction with sexuality often involves emotional intimacy, affection, and mutual respect, elements that can be preserved or even strengthened despite age-related changes (Štulhofer et al., 2019). Therefore, focusing on sexual satisfaction is essential, as it allows for greater attention to the psychosocial and emotional dimensions of sexual health, which are just as vital as physical health in maintaining overall well-being. It is critical to shift the focus from merely physical sexual activity or function to a more holistic approach that incorporates sexual satisfaction as a key element of sexual health care (WHO, 2002). Menard et al. (2015) emphasize that sexuality is an integral part of healthy and positive aging (Starc et al., 2023).

The concept of satisfying sexuality is deeply connected to overall health, as it influences a person's well-being by promoting feelings of happiness, fulfillment, peace, and life satisfaction. It enhances the perception of the quality of one's sexual life and relationships (Pascoal et al., 2014). Conversely, the absence of satisfying sexuality can negatively impact well-being.

Uwagbai & Tyrrell (2018); Even-Zohar & Werner (2018); and Gewirtz Meydan et al. (2019) find that a lack of knowledge about health-related sexual issues hinders the ability to lead a satisfying sexual life, cope with changes in sexual function and identity, and manage expectations regarding the frequency of sexual activity.

As a critical element of sexual health, sexual satisfaction deserves attention in public health research as a key factor in successful aging and a potential correlate of various health indicators. This area should be systematically studied every few years.

While the number of studies addressing the sexuality of older adults is increasing, this study is the first in Slovenia to document the impact of knowledge and sexuality on successful aging among adults aged 55 and over. Although sexuality is a deeply personal subject, Gewirtz Meydan et al. (2019) argue that exploring sexuality is both normal and healthy. Supporting the sexual health of older adults presents numerous challenges, as noted by Chilton (2021). Maintaining the misconception that older adults are not sexually active leads to the neglect of their sexual health and contributes to discrimination against those aged 55 and older.

In recent years, various strategies and policies have been adopted to promote the health of older adults. However, gaps remain, particularly in the treatment of sexual health among this population. We find that the framework for sexual health education for older adults is inadequate, inconsistent, and ineffective in promoting their sexual well-being. Additionally, there is a lack of comprehensive information on sexual health, social issues, sexual behavior, intimate relationships, and life skills within the studied population.

The data from our research highlight the need to reduce age-related inequalities in sexual health and to implement measures to prevent discrimination against older adults (55+) regarding sexuality. Although the World Health Organization typically defines older adults as individuals aged 65 and over, we have included individuals aged 55 and over in our model. In Slovenia, reproductive health care programs are available for children, adolescents, and adults up to the age of 55. However, individuals over the age of 55 are not included in these programs, resulting in their sexual health needs being inadequately addressed. Furthermore, this article addresses the critical gap in sexual health care for older adults (55+), emphasizing the lack of research, education, and support systems that adequately meet the needs of this often-overlooked population. The results of our research, which explored the connection between sexuality and the quality of life in older adults, highlighted the influence of various factors, such as health status, frequency of sexual activity, upbringing, and education, on the significance of sexuality and sexual life satisfaction. Additionally, we analyzed differences based on gender, self-assessed health, attitudes towards sexuality in later life, and the educational content about sexuality that older adults expressed interest in receiving. This content would be tailored to their specific needs and preferences within the context of sexuality

education. We believe that proper education can dismantle stereotypes about older adults, revive forgotten values, and contribute to better self-acceptance, including the acceptance of age-related changes, particularly those related to sexuality.

2 Needs in Old Age

Aging can manifest implicitly or explicitly and be expressed at the micro, meso, or macro level. This definition is particularly relevant to the practice of sexuality, as it highlights well-established aspects in the literature, such as classical socio-psychological components—cognitive (stereotypes), affective (prejudices), and behavioral (discrimination)—as well as both conscious and unconscious dimensions. This underscores the individual, social, and institutional significance of the phenomenon. Consequently, the definition includes the following key dimensions:

- Three classical components (cognitive, affective, and behavioral),
- Positive/negative aspects (positive and negative aging),
- Conscious/unconscious aspects (implicit and explicit ageism), and
- Typological division (ageism at the micro, meso, and macro levels) (Iversen et al., 2009).

Ramovš (2003, p. 90) argues that human needs are the driving force that helps individuals maintain a quality life. These needs trigger specific behaviors that help achieve bodily balance and are linked to the motivations that encourage activity. Physiological needs regulate bodily functions (e.g., the need for food, rest, excretion, sexuality, etc.), while psychosocial needs express desires for safety, love, belonging, respect, health, and learning. Both physiological and psychosocial needs are interconnected and evolve over time throughout the aging process, in accordance with norms, values, and attitudes, as noted by Maslow (1943), Ramovš (2004), and Roljić and Kobentar (2017). Goriup & Lahe (2018) also observe that aging is a dynamic, evolutionary developmental process in which individuals continuously develop, adapt, and change. Avis & Green (2011) add that, as the human sexual response cycle changes with age, sexuality may not be the same as it was at twenty (Hyde, 2010), but it can still be fulfilling (Karraker et al., 2011).

Youngkin (2004) and Steinke (2005) note that intimacy is often understood in the context of sexual performance, though it encompasses far more than just "bare" sexuality. Intimacy includes key components of a relationship such as:

- Commitment,
- Emotional intimacy,
- Cognitive intimacy,
- Physical intimacy, and
- Interdependence.

All these aspects of intimate life are closely tied to the context of aging, along with other influences that contribute to a meaningful life, as Youngkin (2004) points out.

While the need for intimacy and sexuality evolves over time, Yilkan et al. (2024) found that these needs remain crucial to healthy aging and should not be overlooked, as emphasized by Bagheri et al. (2024). However, even the best fulfillment of certain needs, when other important needs are neglected, can disrupt life satisfaction, undermining the fulfillment derived from already-met needs. Understanding and addressing all human needs is, as Ramovš (2003) emphasizes, essential for meaningful work with and for people. Bagheri et al. (2024) further stress that the denial of needs and neglect of health dimensions in sexuality are also driven by a lack of knowledge, making the development of effective educational programs in this area vital.

3 Ageism and the Sexuality of Older Adults

There are numerous and varied definitions of ageism, but they all share a common theme: discrimination against specific age groups. Various sources indicate that while some experts describe ageism as discrimination against older individuals, others highlight that it can also affect all age groups, particularly the young. Ageism consists of three main components:

- Prejudice against age, aging, and older people;
- Discrimination against older adults, especially in the workplace and social environments;

- Institutional policies and procedures that perpetuate stereotypical beliefs about older adults, limiting opportunities for fulfilling lives and diminishing their personal dignity (Butler, 1980).

Ageism, in relation to aging, is so widely accepted and embedded in our perceptions of aging that it has become socially "taken for granted," as noted by Sanchez Izquierdo et al. (2022). We often forget that aging is a process that affects every one of us (Goriup & Lahe, 2018). Holstein & Minkler (2003) further argue that ageism impacts all individuals, shaping society's attitudes toward older adults and our understanding of the aging process, while reinforcing structural inequalities. In its most extreme form, ageism involves intentional neglect, harassment, and abuse of older individuals (Butler, 2008).

Table 1: Taxonomy of Ageism

	DISCRIMINATION	PREJUDICE
CHRONOLOGICAL AGE	age barrier (e.g., insurance is only available to adults up to the age of 65)	statistical weighting (e.g., by including age in calculating priorities)
OLDER BODY	formal rejection of (e.g., older adults as advertising models)	withdrawal (e.g., avoiding contact with older adults at social events)

Source: Bytheway (2005).

Thornton (2002) notes that age-related prejudices most often refer to progressive physical and mental decline, social isolation, and asexual behavior. Biggs (2005) agrees, further highlighting that ageism, when linked to the connection between age and wisdom, works in favor of age, whereas the opposite is true regarding sexuality. Older adults are often subjected to the stereotype that they are no longer capable of sexual pleasure due to their age and that sexuality is, by default, assumed to be reserved solely for the young (Kastenbaum, 1979; Thompson et al., 2014). Emphasizing reproduction as the primary purpose of sexuality in the biomedical model reinforces the belief that when fertility declines, sexual desire and pleasure also disappear. This limited view overlooks broader aspects of sexuality, such as intimacy, affection, and emotional connection, which remain significant throughout the lifespan (Thompson et al., 2014). The notion that sexuality is important solely in terms of reproduction contributes to the marginalization of sexuality in older adults,

reinforcing stereotypes and potentially hindering access to the care and support they need to maintain sexual health in later life.

As a result of frequent exposure to these prejudices, older individuals often deny their own sexual needs, as noted by Olatayo et al. (2015). The loss of certain physical abilities, coupled with the development of negative attitudes toward older adults and the focus on their limitations or negative characteristics associated with aging, often leads older adults to withdraw from society (Cumming & Henry, 1961). Bagheri et al. (2024) further point out that this can result in mutual social isolation.

McAuliffe et al. (2007), Kirkman et al. (2015), and Haesler et al. (2016) emphasize that stereotypes stemming from ageism and irrational fears are primarily due to a lack of knowledge, denial of the importance of sexual well-being, and infringement on older adults' rights to sexual expression. Preventing and combating discrimination against older adults is challenging because ageism is ingrained in people's ways of thinking, behavior, and culture (Hošnjak & Goriup, 2023). Discriminatory attitudes and beliefs about the sexual activity of older adults due to their age often manifest in behavior, resulting in discrimination and social exclusion, which in turn negatively affects their well-being and quality of life (Corrigan, 2004). This is linked to increased anxiety, depression, and suicidal thoughts, all of which diminish the quality of life for those affected (Ha & Kim, 2021).

The negative perception of aging, particularly regarding sexuality in the third and fourth stages of life, is intensifying, especially in Western postmodern societies where media and entertainment frequently depict youthful images, while older adults are portrayed as physically, cognitively, and sexually inadequate (Zebrowitz & Montepare, 2000). Although aging is often associated with loss, particularly in the domain of sexuality, Wada et. al (2015) argue the opposite, highlighting that the development of PDE5 inhibitors, such as Viagra, and aesthetic procedures aimed at "aging gracefully" reflect an idealization of aging that is rooted in ageist norms and beliefs. These trends suggest that older adults are expected to maintain a youthful appearance and sexual vitality, which can increase societal pressure to ignore aging rather than accept it. In this regard, both extreme approaches-depicting older individuals as sexually inactive and pressuring them to preserve a youthful look-reflect ageist stereotypes, but in different ways.

Therefore, recognizing ageism in relation to the sexuality of older adults is crucial to ensuring they have equal opportunities to express their sexuality, just like younger adults. Additionally, there is a need to provide proper educational support, access to health information, and healthcare services to enable older individuals to lead healthy and fulfilling sexual lives in their later years.

4 The Influence of Knowledge on Older Adults' Sexual Satisfaction

A widespread stereotype is that "being old means being sick." While there is some legitimacy to the assumption that chronological age is associated with health decline and reduced functioning, the causal relationship between this decline and the sexual activity of older adults may be overestimated. Research has shown that knowledge and attitudes about sexuality are closely linked, and that the level of knowledge about sexuality among older adults is generally lower in those with a high degree of prejudice (Allan & Johnson, 2008; Funderburk et al., 2006). DeLamater (2012) also notes that the sexuality of older adults is a neglected topic, which fosters a one-sided perspective (Pavliha, 2009) and stereotypical thinking that older adults are not entitled to sexuality (Anderson, 2013).

The experience of discrimination can be interpreted by the body as a social stressor, directly impacting health by activating the hypothalamic-pituitary-adrenal axis, leading to increased cortisol release and heightened systemic inflammation. Discrimination can also promote unhealthy sexual behavior, both intentionally and unintentionally, acting as a barrier to a healthy lifestyle (Jackson, Hackett, & Steptoe, 2019). If society taboos aging and we turn a blind eye to the natural aging process, older adults are marginalized on the social periphery (Anderson, 2013). Thus, aging is not only a biological phenomenon but also a social one. As Goriup and Lahe (2018) suggest, future perspectives on aging depend on current perceptions. Bagheri et al. (2024) and Rao et al. (2024) point out that all age groups in our society often misunderstand the aging process, frequently due to inadequate information.

Sexual health cannot be defined, understood, or applied without knowledge about sexuality, which is fundamental to behaviors and outcomes related to sexual health (WHO, 2006). Nappi & Lachowsky (2009) concur, noting that aging itself affects sexual functioning. However, they emphasize that sexual behavior in older adults is

strongly influenced by factors such as general physical and mental well-being, relationship quality, and life circumstances (Forbes et al., 2016). Although sexual function tends to decline with age, functionality is only one dimension of sexuality, which also includes emotional intimacy, sexual satisfaction, and overall sexual health, all of which are shaped by physical, psychological, and relational factors (Štulhofer et al. 2019). Braithwaite (2002) finds that an approach providing education and guidelines to improve quality of life at every stage of aging reduces the fear of aging, a view supported by Hamil-Luker & Uhlenberg (2002). Fear of aging affects individuals' attitudes and behaviors towards aging as well as their adaptation to their own aging process (Kinsella & Phillips, 2005), and this also extends to sexuality.

While acknowledging that the population is aging, society has not moved beyond merely recognizing this fact (Goriup & Lahe, 2018). Paunonen & Haggman Laitila (1990) highlight that the lack of information not only leads to misconceptions about older adults' sexuality but also impacts the later sexual lives of all generations. Over time, perceptions of age can change with sufficient information, leading to a better understanding of sexuality's dimensions and more effective interventions for sexual health (Bagheri et al., 2024; Yilkan et al., 2024). Instead of perceiving older adults as sexually incapable, we should offer them opportunities to learn and acquire new knowledge and skills, allowing aging to become a time of growth, fulfillment, and new opportunities—including in the realm of sexuality.

5 Methods

5.1 Study Design and Participants

The study utilized a quantitative, cross-sectional research design within a positivist framework to examine the relationship between sexuality and the quality of life in older adults. It also analyzed how various factors, such as health status, frequency of sexual activity, upbringing, and education, are associated with the perceived importance of and satisfaction with sexual life. The study sample included individuals aged 55 and older; however, for the purposes of the study, the age group was limited to between 55 and 75 years, using a purposive and opportunistic sampling approach. Data were collected through an online survey questionnaire, initially reaching a sample size of 1,050 older adults. However, questionnaires with

missing responses and those completed by participants aged over 75 were excluded, as individuals over the age of 75 are generally presumed to be less sexually active. Additionally, questionnaires with incomplete data were removed. The final sample thus included 651 participants.

In our study, we designed a questionnaire to collect relevant data on the needs and attitudes of older adults regarding sexuality in later life, focusing on knowledge, attitudes, and preferences for educational content. The research aimed to gather data on key areas essential for improving sexual health within this population. The survey questionnaire consists of five sections, through which we identified the relationships between attitudes towards aging and one's own sexuality, successful aging in relation to sexuality, and the need for educational content about sexuality.

To measure knowledge, respondents were asked to respond to statements about sexuality in older age using a three-point scale (yes, no, don't know), where lower scores indicated greater knowledge. The second section assessed attitudes toward sexuality in older adults, where participants expressed their level of agreement with statements on a five-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Additionally, we included a section to assess the sense of well-being or successful aging, specifically in relation to sexual health. This section also used a five-point Likert scale, where participants indicated their level of agreement with various statements about aging and sexual health. Finally, we gathered information on the types of educational content that participants would like to receive in sexual health programs for older adults. Participants expressed their opinions using a three-point scale (agree, unsure, disagree) and a five-point Likert scale, allowing them to rate their level of agreement with each statement. This questionnaire was designed to collect relevant data on the needs and attitudes of older adults regarding sexual health education, which will help to develop more effective educational programs aimed at improving sexual health in this demographic group.

5.2 Ethics

All participants were provided with access to the survey, which they completed online. The sample was purposive, selected to focus on individuals aged 55 and older, which was in line with the study's objectives. The survey was conducted

anonymously to ensure the confidentiality of respondents' identities. Participants were informed that their involvement was entirely voluntary and that they could withdraw from the survey at any time without providing a reason. If they completed the survey, they were considered to have given their informed consent to participate. We applied the principles of the Declaration of Helsinki to conduct the research. The ethics committee of the Health Centre Velenje approved the implementation of the research (Ref. No. 1749/2023).

5.3 Statistics

The collected data were first organized using Microsoft Office Excel 2018 and then statistically analyzed using the IBM SPSS Statistics for Windows, Version 29.0 (IBM Corp., New York) software. In the study, we employed explanatory factor analysis to extract dependent variables. We assessed the suitability of our data for performing factor analysis using the Kaiser-Meyer-Olkin (KMO) measure and Bartlett's test of sphericity.

An exploratory factor analysis (EFA) was conducted using the maximum likelihood extraction method (Promax rotation). The first analysis showed data suitability (KMO = 0.844; Bartlett's test, $p = 0.000$), identifying 34 variables with communalities below 0.4, which were excluded. A second analysis confirmed better suitability (KMO = 0.849; Bartlett's test, $p < 0.001$), with all communalities above 0.4. The final EFA identified seven factors, explaining 54.59% of the variance. The first factor explained 23.09%, the second 8.35%, and the third 10.97%, with the remaining factors contributing progressively less. Factor loadings were rotated using Promax, and Cronbach's alpha was calculated for each factor.

The factors were named as follows:

Factor 1 - "Coping with Age" (13 variables, Cronbach's alpha = 0.942)

Factor 2 - "Stereotypes about Older Adults' Sexuality" (7 variables, Cronbach's alpha = 0.871)

Factor 3 - "Attitudes towards Sexuality" (11 variables, Cronbach's alpha = 0.710)

Factor 4 - "Satisfaction with Sexual Life" (4 variables, Cronbach's alpha = 0.802)

Factor 5 - "Permissive Attitude towards Sexuality" (3 variables, Cronbach's alpha = 0.727)

Factor 6 - "Knowledge about Sexuality" (4 variables, Cronbach's alpha = 0.728)

Factor 7 - "Perception of One's Own Body" (2 variables, Cronbach's alpha = 0.680).

Using the Kolmogorov-Smirnov test, we determined that the individual factors/new variables were not normally distributed. Therefore, we employed non-parametric tests.

The Mann-Whitney U test was used to calculate differences in extracted factors and some other key variables by gender. The chi-square test was used to calculate the importance of sexuality by education. A linear regression was used to calculate associations about the importance of sexuality and sexual well-being. A P-value of less than 0.05 was considered to be significant.

6 Results

The final sample thus comprised 651 older adults (55+), representing 61.90% of valid questionnaires, comprising 237 (36.4%) men and 414 (63.6%) women. The mean age of the respondents was 64, with the majority coming from the Savinja region, followed by respondents from Carinthia, and the fewest from the Littoral–Inner Carniola and Lower Sava regions. This likely reflects greater promotion of the study in the Savinja region.

Most respondents were married or living in a cohabiting relationship (49.2%), 20% were widows, and 31.3% lived alone or with a partner (30.0%), while the least lived with others (0.5%). About 39.6% of the respondents experienced authoritarian upbringing or lived in a non-violent family, followed by authoritarian (violent) families (27.2%) and democratic (empathetic) families (26.9%). The results indicated that sexuality was more important to respondents who experienced a non-violent

and democratic upbringing (26.4%) and least important to those who had violent upbringing (4.5%). The majority of respondents had a secondary education (27.5%).

Regarding religious beliefs, 62.5% identified as Roman Catholic, followed by respondents who described themselves as atheists (9.8%), Orthodox (8.0%), and Muslims (6.8%); 4.0% of respondents chose not to specify their religious affiliation. Respondents raised in non-violent or democratic environments perceive sexuality as more important (26.4%). Individuals from violent or authoritarian families perceive sexuality as less important (4.5%).

The majority of respondents (46.9%) assessed their current state of health as moderately good, followed by respondents who assessed their state of health as very good (30.8%) and excellent (14.1%). The fewest respondents described their state of health as very bad (0.8%).

The majority of respondents (45.8%) have sexual intercourse 1 to 3 times per month, while the fewest (18.1%) reported never having intercourse in a month. According to gender, women are more often sexually active 1-3 times a month (48.1%) compared to men (41.8%), while men more often (40.5%) have sexual intercourse more than 3 times per month compared to women (33.6%). We found that the importance of sexuality differed statistically significantly based on the respondents' education level (chi-square = 97.325; $p < 0.001$). The importance increases with higher education, as (51.9%) respondents with a university degree, (57.9%) with a master's degree, and (88.9%) with a doctoral degree rated sexuality as important.

The majority of respondents ($N = 237$; 36.5%) indicated that sexuality was unimportant to them, while the fewest ($N = 28$; 4.3%) stated that sexuality was very important. Respondents who were sexually active rated the importance of sexuality with an average score of 2.67 ± 1.02 , while female respondents rated it with an average score of 2.45 ± 1.14 . The result of the Mann-Whitney U test ($U = 29,130.000$; $p = 0.020$) showed that there are statistically significant differences between genders in the perception of the importance of sexuality—sexuality is, on average, more important to male respondents than to female.

The results of the analysis indicated that religious affiliation influences how individuals assess the importance of various aspects of sexuality in intimate relationships. All observed differences were statistically significant, meaning they were not due to chance. For example, the importance of caressing, pleasure, tenderness, touching, and fidelity varied significantly across different religious groups. This suggests that religious affiliation has a tangible impact on how individuals perceive these aspects of sexuality.

Table 2 shows the importance of individual factors in interpersonal partner relationships related to sexuality. Respect is considered the most important factor by the respondents ($M = 4.36$; $SD = 0.87$), while sexual intercourse is rated as the least important ($M = 3.02$; $SD = 1.38$). The results of the Mann-Whitney U test revealed statistically significant differences between genders in seven out of eight factors related to sexuality, namely in penetrative activities (sex), trust, respect, caressing, pleasure, expression of tenderness, and fidelity.

Table 2: Descriptive Statistics on Key Aspects of Intimate Relationships and Their Importance in Sexuality-Related Partner Interactions Among Older Adults (N=651)

	M	SD
Sexual intercourse	3.2	1.3
Trust	4.21	0.99
Respect	4.36	0.87
Caressing	4.14	1.03
Pleasure	3.02	1.38
Showing tenderness	4.07	1.03
Touching	4.05	1.07
Loyalty	4.29	1.02

Legend: N = number of responses, Min = minimum, Max = maximum, M = mean, SD = standard deviation, (1 - "strongly disagree" to 5 - "strongly agree").

Source: Own.

Table 3 shows that respondents most strongly agree with the statements that satisfying sexuality contributes to a healthy life at any age ($M = 3.83$; $SD = 0.95$), that knowledge enhances the safety of sexual life ($M = 3.77$; $SD = 0.88$), and that older adults need information about sexuality in later life stages ($M = 3.77$; $SD = 0.89$). On the other hand, they agree the least with the idea that understanding sexuality in older adults helps them express the moral and ethical aspects of interpersonal relationships ($M = 3.43$; $SD = 0.94$).

Table 3: Descriptive statistics on the perceived impact of sexuality education and knowledge on the well-being of older adults (N=651)

	M	SD
Learning to express moral and ethical dimensions of interpersonal relationships.	3.4	0.9
Through knowledge, positive moral and ethical concepts are developed.	3.6	0.9
Older adults need information about sexuality in later life.	3.75	0.89
Satisfying sexuality at any age contributes to a healthy life.	3.83	0.95
Acceptance and understanding of the aging process.	3.73	0.87
Understanding sexuality alleviates and reduces loneliness among older adults.	3.66	0.89
Intimate relationships improve.	3.72	0.87
Cooperation between older adults and healthcare professionals strengthens.	3.51	0.88
Sexual safety improves.	3.77	0.80

Legend: N = number of responses, Min = minimum, Max = maximum, M = mean, SD = standard deviation (1 - "strongly disagree" to 5 - "strongly agree").

Source: Own.

Tabel 4: Gender Differences in Health Status, Sexuality-related Factors, and Sexual Life Satisfaction among Older Adults

	Gender	N	PV	SO	U	p
Current health status (self-assessment)	Men	237	3.5	0.8	48830.000	0.915
	Women	414	3.4	0.8		
F1: Coping with aging.	Men	237	3.9	0.6	47913.500	0.619
	Women	414	3.89	0.71		
F2: Stereotypes about sexuality in older adults.	Men	237	2.94	0.94	46876.500	0.344
	Women	414	2.98	0.98		
F3: Attitudes towards sexuality.	Men	237	3.19	0.35	42168.500	0.003
	Women	414	3.05	0.34		
F4: Sexual life satisfaction.	Men	237	3.82	0.87	43766.000	0.021
	Women	414	3.64	0.89		
F5: Permissive attitude towards sexuality (obligation and guilt associated with feelings related to sexuality).	Men	237	3.69	0.99	43604.500	0.018
	Women	414	3.49	1.04		
F6: Knowledge about sexuality.	Men	237	3.30	0.92	47634.500	0.535
	Women	414	3.40	0.80		
F7: Perception of one's body.	Men	237	4.13	0.77	47005.000	0.361
	Women	414	4.09	0.73		
Importance of sexuality.	Men	237	2.54	1.05	45712.000	0.132
	Women	414	2.42	1.12		

Legend: N = number of responses, M = mean value, SD = standard deviation; U = Mann-Whitney test; p < 0.05, ** p<0.01 (1 - "strongly disagree" to 5 - "strongly agree").

Source: Own.

Table 4 presents the results of a comparison of various aspects of sexual life and sexual satisfaction between men and women. The comparison involves the mean scores (M), standard deviations (SD), and the results of the Mann-Whitney U tests (U) with associated p-values (p). The items in the table focus on different factors such as health status, attitudes toward aging, stereotypes, sexual life satisfaction, permissive attitudes, knowledge, body perception, and the importance of sexuality. The p-value is much higher than 0.05, meaning there is no statistically significant difference between men and women regarding self-assessed health status. There is a statistically significant difference between men and women, with men having a slightly more positive attitude towards sexuality. Men report not only a slightly higher sexual life satisfaction, and the difference is statistically significant ($p < 0.05$), but also a more permissive attitude towards sexuality, and this difference is also statistically significant. The main findings of this table suggest that there are statistically significant gender differences in attitudes towards sexuality, sexual life satisfaction, and permissive attitudes towards sexuality, with men reporting more positive outcomes in these areas. However, there are no significant gender differences in the other factors measured, including current health status, coping with aging, stereotypes about sexuality, knowledge about sexuality, body perception, and the importance of sexuality. These results suggest that while men and women may have different experiences and views related to sexuality in certain aspects, in many areas, there are no significant gender-based differences.

Table 5: Associations about the importance of sexuality in older adults

	(B)	SE	t	P
Perception of one's body.	-0.426	0.058	-7.4	< 0.001
Satisfaction with sexual life.	0.110	0.051	2.1	0.031
Frequency of sexual intercourse /activities.	0.275	0.064	4.2	< 0.001

Legend: B = coefficient of correlation, SE = standard error, p = statistical significance, $R^2 = 0.098$

Source: Own.

Table 5 shows associations between body perception, sexual satisfaction, and frequency of sexual activities with the importance of sexuality in older adults. The results indicate that: Body perception has a significant negative impact ($B = -0.426$) on the importance of sexuality. Satisfaction with sexual life ($B = 0.110$) and frequency of sexual activities ($B = 0.275$) have a positive impact on the importance of sexuality. All three factors significantly influence the importance of sexuality, with p-values less than 0.05, indicating statistical significance.

Table 6: Associations about the sexual well-being

	(B)	SE	t	p
Knowledge of Sexuality	0.363	0.038	9.488	<0.001
Satisfaction with sexual life.	0.110	0.051	2.166	0.031

Legend: B = coefficient of correlation, SE = standard error, p = statistical significance, R² = 0.122
Source: Own.

Knowledge of sexuality is significantly positively associated with the dependent variable (B = 0.363, p < 0.001), indicating that as knowledge increases, the sexual well-being also increases. The association is reflected by a small standard error (SE = 0.038). Satisfaction with sexual life also has a positive relationship with the dependent variable (B = 0.110, p = 0.031), but this effect is weaker. The model in Table 5 explains 12.2% of the variance in the dependent variable (R² = 0.122), suggesting moderate explanatory power. Knowledge of sexuality statistically significantly and positively impacts sexual satisfaction, with higher knowledge of sexuality associated with increased sexual satisfaction. Consistent with these findings, Figure 1 emphasizes the importance of knowledge in addressing the challenges of aging and sexual well-being, further highlighting the significance of education in improving sexual health. In addition, 31.7% of respondents reported not confiding in anyone about their sexual concerns, indicating a reluctance to openly address these issues.

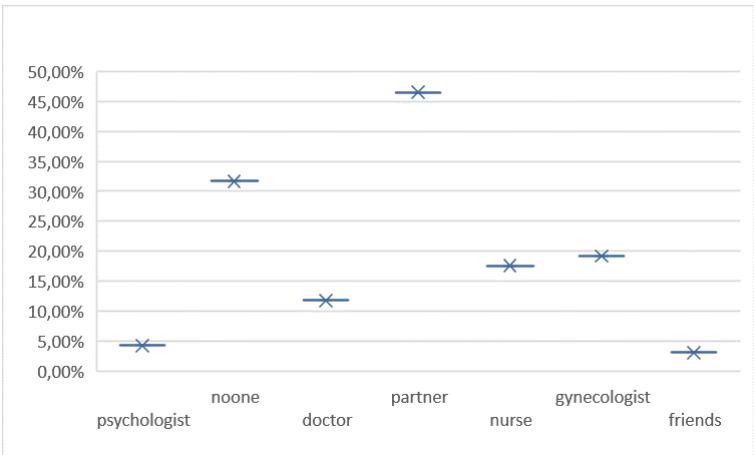


Figure 1: Distribution of who do respondents confide in about their sexual problems
Source: Own.

Since multiple responses were allowed, 31.7% of respondents indicated that they do not confide their sexual concerns to anyone, reflecting a reluctance to discuss the topic openly. However, 46.5% of participants reported that they would most likely trust their partner with such issues. Additionally, 19.2% expressed confidence in a gynecologist, and 17.6% in a nurse.

The majority of respondents (60.3%) also indicated that it would be beneficial to include topics on menopause and andropause in sexual education for older adults. In comparison, fewer (27.9%) felt it necessary to cover topics on sexually transmitted infections (STDs).

The results emphasize the need to create supportive environments and trusted relationships with healthcare professionals to promote sexual health and well-being in this often-overlooked population. They also provide a solid foundation for developing targeted interventions and educational strategies aimed at improving sexual health and quality of life among older adults, which are in alignment with the primary objectives of the study.

7 Discussion

7.1 Interpretation of Findings

The findings suggest that the significance of sexuality varies widely among older adults, influenced by factors such as upbringing, education, and religious affiliation. Those raised in non-violent or democratic environments tended to place more importance on sexuality, aligning with previous research by Bagheri et al. (2024) and DeLamater (2012), who found that social and familial contexts greatly influence sexual attitudes in later life.

Regarding education, we observed a significant correlation between higher education levels and the perceived importance of sexuality. This aligns with previous studies that show educated individuals tend to have more open and positive attitudes toward sexuality (Forbes et al., 2016). Gender differences were also evident, with men rating the importance of sexuality higher than women, reflecting findings by Kastenbaum (1979), who noted that older men generally report higher sexual satisfaction.

Religious affiliation played a substantial role in shaping sexual attitudes. Respondents identifying as Roman Catholic viewed aspects of sexuality, such as pleasure, tenderness, and caressing as more important, similar to findings from Goriup and Lahe (2018), who highlighted the influence of religious beliefs on sexual norms in later life.

Furthermore, the respondents indicated that sexuality education could improve their well-being, supporting prior research by Haesler et al. (2016), who stressed the need for sexual health education tailored to older adults. This is evident in respondents' high agreement with statements on the importance of sexuality education for older adults, particularly regarding menopause and andropause topics.

Statistical analyses revealed significant associations between body perception, sexual satisfaction, and frequency of sexual activity with the perceived importance of sexuality. As shown in Table 4, higher satisfaction with sexual life and more frequent sexual activity positively correlated with the importance placed on sexuality, echoing findings by Hyde et al. (2010) and Menard et al. (2015), who noted the centrality of sexual satisfaction for overall well-being in later life.

7.2 Implementing the Sexual Health Promotion Education Model for Older Adults (55+) in Practice

In conclusion, this study highlights key implications for healthcare professionals, therapists, and educational institutions in addressing the sexual health needs of older adults. A focus on holistic programs that cover both the physical and emotional aspects of sexuality in later life is necessary. Improving communication between older adults and healthcare providers is crucial, as only a small percentage of respondents discussed sexual concerns with healthcare professionals, indicating a reluctance to address the topic. This presents an opportunity for healthcare professionals to enhance their knowledge and actively promote sexual health among older adults.

Based on this, we have laid the groundwork for understanding the broader scope of sexual behavior in older adults, allowing us to develop an integral model of quality sexual health for older adults (55+). This model facilitates access to information

about the sexuality of older individuals, understanding the physical and hormonal changes brought about by aging, and the stereotypes related to the sexuality of older adults (55+). An environment that promotes a positive approach to older adults' sexual health allows them to live fully again, preventing them from being deprived of a satisfying sexual life.

The developed model is based on real needs and age-appropriate expectations that are essential for sexual satisfaction and the acceptance of aging limitations. This allows individuals to seek solutions and nurture intimacy into old age. The model encourages the development of a positive attitude toward sexuality, shaping perspectives, habits, and practices for satisfying sexual experiences while taking responsibility for one's sexual health and its impact on successful aging. It takes a broad view of sexuality, regardless of age, and facilitates access to services and education.

It includes complex factors divided into five thematic areas, with the possibility of expanding the content for a younger population:

- The functioning of the body and the emotional aspects of sexual health,
- Risk factors affecting sexual satisfaction,
- Mental and cognitive impacts on sexual health and satisfaction,
- The influence of hormones, STIs, and oncology on sexual health and satisfaction,
- Approaches to addressing current and potential sexual health issues.

These factors influence the overall awareness of all stakeholders in society, enabling a holistic approach to the sexual health of adults (55+) and shaping its conceptualization in society.

The vision of the model emphasizes principles and activities to support the sexual health and quality of life of older adults. It is also aimed at ensuring more humane practices in the planning of social policy and long-term care, including complex, holistic solutions that we aim to make available in primary healthcare, directly and without referrals, to the entire older population.

Recognizing that older adults respond differently to health education advice regarding sexual health—some with interest, others with discomfort—we can tactfully offer free choice of topics through the developed integral model of quality sexual health care for older adults (55+). By networking with other providers focused on preserving and promoting health and acquiring healthy lifestyle habits, we can facilitate easier access to other existing workshops in primary healthcare. Effective health education advice can significantly reduce risk factors affecting sexuality, thereby improving sexual activity and quality of life.

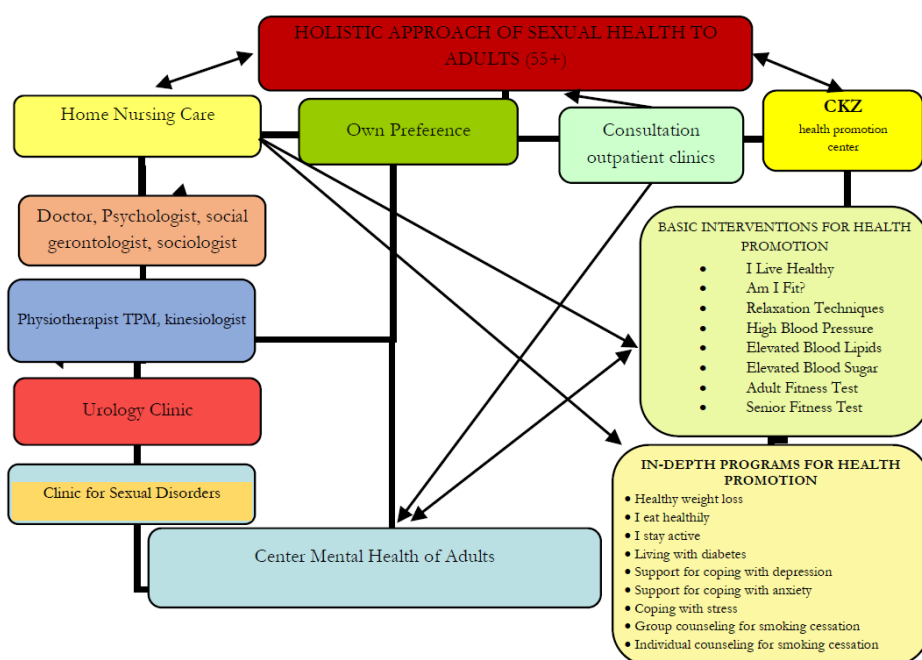


Figure 2: Organizational Chart of Multidisciplinary Collaboration within Healthcare

Source: Own.

The model enables the expansion of guidelines within primary care settings, including Reference Clinics, Health Promotion Centers, Adult Mental Health Centers, family medicine clinics, physiotherapy, home care, urology clinics, and sexual health clinics. By extending the model across the primary care network and later collaborating with an interdisciplinary team (including doctors, registered nurses, social gerontologists, physiotherapists, kinesiologists, dietitians,

psychologists, sociologists, and others), we can facilitate both individual and group interventions. These efforts help individuals gain insight into potential issues, encourage developing a positive outlook on sexuality, and guide them towards healthy lifestyle choices, thereby improving sexual health and well-being in the broader population.

The role and connections between stakeholders in the model facilitate the flow of information and productive collaboration for the benefit of older adults' sexual health. The stakeholders are interconnected in such a way that older adults can access various types of care – from physical and mental support to specialized clinics – without referrals and with greater accessibility within primary health care. Older adults are empowered to choose the topics or types of care they prefer (e.g., workshops at the Health Promotion Center, counseling at a reference clinic, or home care services) based on their desires and needs. Community support is also provided through mutual connections, guiding older adults to health-promoting workshops where they not only receive information about healthy lifestyles but also learn about sexuality and its connection to healthy and quality aging. The connections also enable specialized care. If the basic care identifies specific issues, older adults can be referred (or self-refer) to a urology clinic, sexual dysfunction clinic, or adult mental health center for further professional assistance.

Home Care Services operate in the field, where registered nurses provide direct support to older adults, helping to identify issues, offering counseling, and referring them to Health Promotion Center workshops or other specialists.

Reference Clinic - provides individualized counseling and health care, helps recognize risks, promotes healthy sexuality, and refers to Health Promotion Center workshops or other specialists.

Health Promotion Center (HPC) - a key partner in organizing health promotion workshops that can meaningfully include additional topics such as healthy aging, sexual health, the impact of healthy nutrition, and physical activity on sexual health. *Physiotherapy and Kinesiology (team-based health care)* - assist in addressing physical limitations affecting sexual health and activity, including sexual function.

Urology Clinic- provides specialized care for issues related to the entire sexual health, not just reproductive health, of older adults.

Sexual Dysfunction Clinics - offer specialized help for sexual function issues and counseling.

Adult Mental Health Center - addresses psychological issues related to intimacy, stigma, and self-esteem in older adults.

Personal Choice - the model emphasizes voluntary involvement of older adults based on their desires and needs, recognizing that older adults accept health advice differently – some with interest, others with discomfort.

This content can also serve as recommendations for changes in primary health care and the education of health professionals. Furthermore, it may provide a foundation for enhancing collaboration among public health institutions, educators, and policymakers in addressing the sexual health of older adults. It could also serve as a basis for developing an Action Plan to support the sexual health of older adults, promoting greater and faster progress toward achieving equality in the treatment of sexual health for the entire adult population.

7.3 Future Research

Future research can deepen the understanding of older adults' sexual needs and desires, contributing to the development of tailored support and services. Educational programs for older adults should focus on sexual health, with content adapted to various educational levels. Increased access to sexual health resources, such as workshops and counseling services is essential. Targeted interventions should be developed to foster positive attitudes towards sexuality, particularly among less educated groups.

Healthcare policies should be adjusted to offer more comprehensive sexual health education and support, especially for older adults. Lastly, additional analysis of regional and demographic trends in sexual health perception can guide interventions that address specific needs within different populations.

8 Limitations

Our study has both strengths and limitations. We focused on older adults aged 55 to 75 as the upper age limit, based on the assumption that adults beyond this age are less sexually active. Consequently, it is more challenging to describe the experiences of individuals in later life stages. Additionally, due to the sampling method, we did not include those residing in nursing homes or requiring daily medical care. This limitation not only affects assumptions about sexual activity but also about self-assessed health status, as older individuals are likely to experience more significant health issues. Thus, our findings may not be generalizable to individuals with severe health problems. Also, gender disparity in the sample may impact the generalizability of the results.

One of the open questions in the field of sexual health among older adults is the connection between mental, emotional, and cognitive health, the connection between aspects of sexual health, and how these relationships differ by gender. It is also possible that reduced sexual function may worsen an individual's mental health or vice versa, highlighting an area worth further exploration and future research. A limitation also includes the possibility that respondents may not answer truthfully or may fail to understand the questions.

The added value of the research lies in the fact that its results can serve as a starting point for improving collaboration between public health institutions, educators, and policy makers in efforts to address the sexual health of older adults. The content of this model may also serve as recommendations for changes in primary healthcare and the education of all healthcare professionals.

9 Conclusion

By promoting an inclusive understanding of sexuality in later life and addressing societal taboos, healthcare systems can improve sexual healthcare for older adults. Ensuring open communication, increasing access to resources, and addressing misconceptions will empower older individuals to lead fulfilling sexual lives, thereby enhancing their quality of life and successful aging. Further research, particularly longitudinal studies, could help clarify whether and how sexuality directly impacts

overall health and aging, providing stronger evidence for causal relationships. Intervention efforts should focus on reducing barriers to discussing sexual health and integrating it into broader health promotion strategies for aging populations.

Once implemented, this model will contribute to the development of age-appropriate educational resources and training for healthcare professionals, thus improving the quality of sexual health care for older adults. It is crucial to communicate to older adults that the desire for sexuality is normal and that maintaining this aspect of life is essential for their well-being, as long as there is a desire. A healthy perspective on sexuality goes beyond the taboos surrounding older adults' sexuality and facilitates open dialogue and understanding in this area. Finally, the model should also serve as a foundation for policy changes and collaboration between public health institutions, educators, and policymakers, which will enable the development of an action plan aimed at promoting the sexual health of older adults. By ensuring continuous access to information, professional assistance, and support, we can enable older adults to lead healthy and fulfilling sexual lives, thereby contributing to their overall well-being and successful aging.

Ethical Considerations and Conflict of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

Funding

The research was conducted as part of the author's own academic requirements and was not financially supported by any external entity.

Acknowledgment

I sincerely thank all respondents for their time, openness, and willingness to contribute to a better understanding of the often-overlooked topic of sexual health in later life.

Note

Talking about sexuality is neither wrong nor immoral; this research demonstrates that sexuality can be a positive and wonderful part of life, if we allow ourselves to embrace it. It is especially important to clearly communicate to older adults that sexual desire is normal and that maintaining this aspect of life is essential for their well-being, as long as the desire persists.

References

- Aizenberg, D., Weizman A. IN Barak, Y. (2003). Sildenafil for selective serotonin reuptake inhibitor-induced erectile dysfunction in elderly male depressed patients. *Journal of Sex & Marital Therapy*, 29(4), 297-303. <https://doi.org/10.1080/00926230390195533>
- Allan, L.J., Johnson, J.A., & Emerson, S.D. (2014). The Role of Individual Difference Variables in Ageism. *Personality and Individual Differences*, 59(March), 32–37.
- Andrews, G. (2001). *Women's Sexual Health* (2nd ed.). Bailliere Tindall.
- Andersson, J. (2013). Old bastard - rebellion against or a repetition of negative age codes?, *Sociologisk Forskning*, 50(3–4), 247–66.
- Avis, N.E. & Green, R. (2011). The perimenopause and sexual functioning. *Obstetrics and Gynecology Clinics*, 38(3), 587-594.
- Bagheri, R., Momtaz Y.A., Foroughan, M., & Shahboulaghi F.M. (2024). Women's Sexual Health in Old Age: Identification of Influencing Factors Using Focus Group Interviews Based on Socioecological Approach. *Sexuality and Disability*, 42(2), 295-316.
- Bytheway, B. (2005). Ageism and Age Categorization. *Journal of Social Issues*, 61(2), 361–374. Retrieved from: <https://doi.org/10.1111/j.1540-4560.2005.00410.x> (September 15, 2024).
- Biggs, S. (2005). Beyond appearances: perspectives on identity in later life and some implications for method. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*. 60(3), 118-128. <https://doi.org/10.1093/geronb/60.3.S118>
- Braithwaite, V. (2002). Reducing ageism. In T. Nelson (Ed.), *Ageism: Stereotyping and Prejudice against Older People* (pp. 311-337) MIT Press.
- Breuner, C.C., & Mattson, G. (2016). Sexuality Education for Children and Adolescents. *Pediatrics*, 138(2), e20161348. <https://doi.org/10.1542/peds.2016-1348>
- Butler, R.N. (1969). Age-ism: Another form of bigotry. *The Gerontologist*. 9(4), 243-246. https://doi.org/10.1093/geront/9.4_Part_1.243
- Butler, R.N. (2008). *The longevity revolution: the benefits and challenges of living a long life*. New York: Public Affairs.
- Chilton, R.L. (2021). *Addressing Occupational Therapy Practitioners' Knowledge and Attitudes about Older Adult Sexual Health and Sexual Activity through Continuing Education*. Retrieved from: https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1000&context=smhs_hs_caps_tones (August 12, 2025).
- Corrigan, P. (2004). How Stigma Interferes with Mental Health Care. *American Psychologist* 59(7), 614–25.
- Cummings, S.M., Kropf, N.P., & DeWeaver, K.L. (2000). Knowledge of and attitudes toward aging among non-elders: gender and race differences. *Journal of Women and Aging*, 12(1/2), 77 – 91.
- DeLamater, J. (2012). Sexual expression in later life: A review and synthesis. *Journal of sex research*, 49(2-3), 125-141.
- Even-Zohar, A., & Werner, S. (2018). Examining the attitudes and knowledge of social work and nursing students on later-life sexuality. *Canadian Journal on Aging*, 37(4), 377-389. <https://doi.org/10.1017/S0714980818000260>
- Forbes, M.K., Eaton, N.R., & Krueger, R.F. (2016). Sexual quality of life and aging: a prospective study of a nationally representative sample. *J. Sex. Res.* 54(2), 137–148. <https://doi.org/10.1080/00224499.2016.1233315>
- Funderburk, B., Damron-Rodriguez, J., Levy Storms, L., & Solomon, D.H. (2006). Endurance of Undergraduate Attitudes Toward Older Adults. *Educational Gerontology*, 32(6), 447–62. <https://doi.org/10.1080/03601270600685891>
- Gewirtz-Meydan, A., Levkovich, I., Moshe M., Gur, U., & Ayalon, L. (2019). Promoting a Discussion on Later Life Sexuality: Lessons from Sexologist Physicians. *Sexual and Relationship Therapy*, 34(2), 193–210. <https://doi.org/10.1080/14681994.2018.1437258>

- Goriup, J., & Lahe, D. (2018). *Poglavja iz socialne gerontologije* (Zbirka Znanstvene monografije) (1. natis). Maribor, AMEU - ECM, Alma Mater Press.
- Ha, J., & Kim, J. (2021). Ageism and the factors affecting ageism among Korean nursing students: A cross-sectional study. *International Journal of Environmental Research and Public Health*, 18(4), 1–10. <https://doi.org/10.3390/ijerph18041798>
- Haesler, E., Michael B., & Fetherstonhaugh, D. (2016). Sexuality, Sexual Health and Older People: A Systematic Review of Research on the Knowledge and Attitudes of Health Professionals. *Nurse Education Today*, 40, 57–71.
- Hamil-Luker, J. & Uhlenberg, P. (2002). Later life education in the 1990s: Increasing involvement and continuing disparity. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 57(6), 324–331.
- Holstein, M.B., & Minkler, M. (2003). Self, society and the new gerontology. *The Gerontologist*, 43, 787–796.
- Hošnjak, A.M. & Goriup, J. (2022). Development of a model for the prevention of ageism in nursing practice in a team with social gerontologist. *Proceedings of CBU in Medicine and Pharmacy*, 3, 1–5.
- Hyde, Z., Flicker, L., Hankey, G.J., Almeida, O.P., McCaul, K.A, S.A., Chubb, S.A.P., & Yeap, B.B. (2010). Prevalence of Sexual Activity and Associated Factors in Men Aged 75 to 95 Years A Cohort Study. *Annals of Internal Medicine*, 153(11), 693–702.
- Iversen, T.N., Larsen, L., & Solem, P.E. (2009). A Conceptual Analyses of Ageism. *Nordic Psychology*, 61(3), 4–22.
- Jackson, S.E., Hackett, R.A., & Steptoe, A. (2019). Associations between Age Discrimination and Health and Well-being: Cross-Sectional and Prospective Analysis of the English Longitudinal Study of Ageing. *The Lancet Public Health*, 4(4), e200–208.
- Karraker, A., DeLamater, J., & Schwartz, C.R. (2011). Sexual frequency decline from midlife to later life. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 66(4), 502–512.
- Kastenbaum, R. (1979). *Growing Old: Years of Fulfilment* (Life Cycle Series). Holland. Multimedia Publications Inc.
- Kinsella, K., & Phillips, D.R. (2005). Global aging: The challenge of success. *Population Bulletin*, 60(1), 3–40.
- Kirkman, L., Dickson-Swift, V., & Fox, C. (2015). Midlife relationship diversity, sexual fluidity, well-being and sexual health from a rural perspective. *Rural Society*, 24(3), 266–281.
- Maslow, A.H. (1970). *Motivation and Personality*. London: Harper and Row Publishers.
- McAuliffe, L., Bauer, M., & Nay, R. (2007). Barriers to the Expression of Sexuality in the Older Person: The Role of the Health Professional. *International Journal of Older People Nursing*, 2(1), 69–75.
- Menard, A.D., Kleinplatz, P.J., Rosen, L., Lawless, S., Paradis, N., Campbell, M., & Huber, J.D. (2015). Individual and Relational Contributors to Optimal Sexual Experiences in Older Men and Women. *Sexual and Relationship Therapy*, 30(1), 78–93.
- Miguel, I., von Humboldt, S., & Leal, I. (2024). Sexual well-being across the lifespan: Is sexual satisfaction related to adjustment to aging?, *Sexuality Research and Social Policy*, 1–12.
- Nappi, R.E., & Lachowsky, M. (2009). Menopause and sexuality: prevalence of symptoms and impact on quality of life. *Maturitas*, 63(2), 138–141.
- Olatayo, A.A., Kubwa, O.O., & Adekunle, A.E. (2015). Sexuality in Nigerian older adults. *The Pan African Medical Journal*, 22(390), 1–6.
- Paunonen, M., & Häggman-Laitila, A. (1990). Sexuality and the Satisfaction of Sexual Needs: A Study on the Attitudes of Aged Home-Nursing Clients. *Scandinavian journal of caring sciences* 4(4), 163–168.
- Pascoal, P.M., de Santa B.N., & Monteiro P.N. (2014). What is Sexual Satisfaction? Thematic Analysis of Lay People's Definitions. *Journal of Sex Research*, 51(1), 22–30.
- Pavliha, M. (2009). Aktivno staranje. IN U. Krevl (ed.), *Zbornik 8. Festival za tretje življenjsko obdobje* (pp. 6–12). Ljubljana: Inštitut Hevrek.

- Ramovš, J. (2003). *Kakovostna starost, Socialna gerontologija in gerontagogika*. Ljubljana: Inštitut Antona Trstenjaka.
- Rao, T.S.S., Tripathi, A., Manohar, S., & Tandon, A. (2024). Promoting sexual well-being. *Indian Journal of Psychiatry*, 66(2), S262-S271.
- Roljić, S., & Kobentar, R. (2017). Starost kot izziv: zdravje in oskrba. *Internogradio*. Ljubljana: Javni zavod Cene Štupar Center za izobraževanje Ljubljana.
- Sánchez-Izquierdo, M., García-Sánchez, R., & Fernández-Ballesteros, R. (2022). Anti-Ageism Social Actions: Lights and Shadows. *Land*, 11(2), 195. <https://doi.org/10.3390/land11020195>
- Starč, A., Gošnak Dahmane, R. & Gabrovec, B. (2023). *Dejavniki spolnega zadovoljstva v Sloveniji*. Ljubljana: Univerza v Ljubljani, Zdravstvena fakulteta.
- Steinke, E. (2005). Intimacy needs and chronic illness. *Journal of Gerontological Nursing*, 31(5), 40–50. <https://doi.org/10.3928/0098-9134-20050501-08>
- Štulhofer, A., Jurin, T., Graham, C., Enzlin, P. & Bente, T. (2019). Sexual well-being in older men and women: Construction and validation of a multi-dimensional measure in four European countries. *Journal of Happiness Studies*, 20(7), 2329–2350. <https://doi.org/10.1007/s10902-018-0049-1> (September 15, 2024).
- Thornton, J.E. (2002). Myths of aging or ageist stereotypes. *Educational Gerontology*, 28, 301-312.
- Thompson, A.E., O'Sullivan, L.F., Byers, E.S., & Shaughnessy, K. (2014). Young adults' implicit and explicit attitudes towards the sexuality of older adults. *Canadian Journal on Aging / Revue Canadienne Du Vieillessement*, 33(3), 259–270.
- Uwagbai, O., Tyrrell, C., & Falzgraf, S. (2018). Quality Improvement - Knowledge and Attitudes of Nursing Staff Towards Sexuality of Elderly Long-term Care Residents. *Journal of the American Geriatrics Society*, 66(April), S46–S47.
- Wada, M., Hurd Clarke, L., & Rozanova, J. (2015). Constructions of sexuality in later life: Analyses of Canadian magazine and newspaper portrayals of online dating. *Journal of Aging Studies*, 32, 40–49. <https://doi.org/10.1016/j.jaging.2014.12.002>
- World Health Organization (WHO). (2002). *Active ageing: A policy framework*. Geneva: World Health Organization. Retrieved from: <https://apps.who.int/iris/bitstream/handle/10665/67215/WHO?sequence=1> (September 15, 2024).
- World Health Organization (WHO). (2002). *World Health Organization quality of life (WHOQOL) – brief version*. Geneva: World Health Organization.
- World Health Organization, Regional Office for Europe. (2006). *Concepts for sexual health* (EUR/MCH 521). Copenhagen: WHO. Retrieved from: https://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/ (September 15, 2024).
- Zebrowitz, L.A., & Montepare, J.M. (2000). Too young, too old: Stigmatizing adolescents and elders. In T.F. Heatherton, R.E. Kleck, M.R. Hebl & J.G. Hull (Eds.), *The social psychology of stigma* (pp. 334–373). Guilford Press.
- Yılkan, I., Apak, E., & Artan, T. (2024). Opinions of the elderly on sexuality in old age: “I want but I can’t”. *Archives of Gerontology and Geriatrics Plus*, 1(1), 100004. <https://doi.org/10.1016/j.archger.2024.100004>
- Yan, E., Wu, A.M.S., Ho, P., & Pearson, V. (2011). Older Chinese men and women's experiences and understanding of sexuality. *Culture, Health & Sexuality*, 13(9), 983–999. <https://doi.org/10.1080/13691058.2011.605471>
- Youngkin, E.Q. (2004). The myths and truths of mature intimacy. *Advanced Nurse Practitioner*, 12(9), 45–48.

Povzetek v slovenskem jeziku

Ta študija si prizadeva razviti izobraževalni model in smernice za spodbujanje spolnega zdravja starejših odraslih (55+), pri čemer se osredotoča na vprašanja starizma, stereotipov in gerontofobije. Kljub njegovemu pomenu za uspešno staranje je spolno zdravje starejših pogosto zanemarjeno. V raziskavi je sodelovalo 651 udeležencev (starih od 55 do 75 let), uporabljena pa je bila kvantitativna metoda, ki je s spletno anketo proučevala dejavnike, kot so zdravstveno stanje, spolna aktivnost in izobrazba. Ključne ugotovitve vključujejo pozitivno korelacijo med zdravjem in spolnim zadovoljstvom ($r = 0,2$ do $0,4$; $p < 0,001$) ter pomen spolnega znanja za življenjsko zadovoljstvo ($F = 90,027$; $p < 0,001$). Rezultati poudarjajo potrebo po prilagojenih izobraževalnih programih in odprtih razpravah o spolnosti. Predlagani model je usmerjen v izboljšanje spolnega blagostanja in splošne kakovosti življenja ter spodbuja celostni pristop k spolnemu zdravju starejših. Ugotovitve so pomembne za oblikovanje politik in intervencij v Sloveniji in po svetu.