

AgeWise Handbook

*Capacitating Young Adult Educators and Health
Carers on Gender, Sexuality and Diversity in the
Third Age*





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Introduction to the AgeWise Handbook

About the Never Gets Old Project

Never Gets Old – Inter-Generational Gender and Sexuality Education is a two-year Erasmus+ Cooperation Partnership in Adult Education bringing together organisations from Germany, Romania, France, Portugal and Cyprus. The project responds to a significant but often overlooked issue in adult education, healthcare and social care: the persistence of ageism, stigma and exclusion surrounding sexuality, gender and intimacy in later life.

Across Europe, older adults continue to experience stereotypes that portray ageing as incompatible with sexuality, intimacy, emotional connection or gender diversity. These assumptions may negatively influence healthcare practices, educational approaches, institutional environments and the self-perception of older adults themselves. Many professionals working with older adults report limited training and uncertainty when addressing sexuality, intimacy, relationships or LGBTQ+ issues in later life. At the same time, older adults themselves may internalise age-related stigma, leading to silence, shame or reduced access to appropriate support and information.

The Never Gets Old project was developed to address these gaps by promoting inclusive, respectful and person-centred approaches to sexuality and gender diversity in older adulthood. Through research activities, intergenerational dialogue, educational development, the partnership aims to strengthen professional competences while also contributing to greater dignity, visibility and wellbeing for older adults across diverse social and cultural contexts.

The AgeWise Handbook represents one of the central educational outputs of the project.

Purpose of the Handbook

The AgeWise Handbook was developed as a practical and educational resource designed to support professionals and organisations working with older adults in addressing sexuality, intimacy, gender and relationships in later life in a respectful, informed and inclusive manner.

The handbook combines theoretical knowledge, reflective approaches and practical educational tools. It aims to support professionals in:

- understanding the multidimensional nature of sexuality in later life;
- recognising the impact of ageism, stigma and social norms;
- approaching sexuality and intimacy as components of health, wellbeing and human dignity;
- developing person-centred communication skills;
- creating safer and more inclusive educational, healthcare and community environments.

Rather than presenting sexuality solely from a medical perspective, the handbook adopts a holistic understanding of sexual wellbeing that includes biological, emotional, relational, psychological, social and cultural dimensions. Particular attention is also given to diversity in ageing experiences, including LGBTQ+ perspectives, relationship diversity, autonomy, consent and ethical considerations in later life.

The handbook seeks not only to increase knowledge, but also to support reflection, dialogue and professional confidence when engaging with topics that are often considered sensitive or insufficiently addressed in adult education and care contexts.

Handbook structure

The AgeWise Handbook is organised into two complementary sections:

- **Theoretical section** - provides the conceptual and informational foundation of the eight handbook modules, addressing key topics related to sexuality, gender, intimacy and ageing.
- **Practical Tools section** - includes lesson plans, case studies, role-play activities, reflection exercises and facilitation guidance associated with each module.



In addition, **PowerPoint presentations** accompanying each module are available on the project's [website](http://www.nevergetsold.eu) and can be used to support workshops, staff training sessions and educational activities.

Intended Users

The AgeWise Handbook was developed primarily for:

- adult educators and trainers;
- healthcare professionals;
- psychologists and counsellors;
- social workers and care staff;
- organisations working with older adults;
- community educators and facilitators;
- professionals involved in inclusion, diversity and wellbeing initiatives.

The materials may be used in a variety of contexts, including:

- adult education programmes;
- professional development and staff training;
- healthcare and care facility settings;
- community workshops;
- intergenerational learning activities;
- awareness-raising and inclusion initiatives.

The handbook was intentionally designed to remain adaptable to different professional backgrounds, national contexts and levels of previous experience with the topics addressed.

How Project Activities Informed the Handbook

The content of the AgeWise Handbook was developed through collaborative activities carried out during the Never Gets Old project across partner countries. The handbook reflects insights gathered through:

- consultation and exchange activities with older adults, adult educators, healthcare professionals and care staff;
- intergenerational dialogue activities;
- piloting and feedback activities.

In this sense, the AgeWise Handbook represents a collaborative European educational resource developed through dialogue, shared experiences and practical engagement with professionals and communities working with older adults.

MODULE 1

Ageing Population and Positive Approaches to Ageing

Developed by:

Elisa Klein-Peters

Proportional Message



Overview

Europe is currently facing a profound demographic transformation characterised by a significant increase in life expectancy over recent decades (European Commission, 2024). This shift has led to a growing proportion of older adults within the population, presenting both challenges and opportunities to rethink how ageing is understood, experienced and supported (Rudnicka et al., 2020). By 2050, it is projected that there will be 43 people aged 65 and over for every 100 people of working age in the region (De Gobbi et al., 2025).

This module introduces demographic trends in Europe and presents some positive frameworks such as *healthy ageing*, *active ageing* and *quality of life*. It therefore challenges ageist narratives that frame later life as a period of inevitable decline, dependence or asexuality. Instead, the module emphasises ageing as a dynamic life phase shaped by identity, relationships, desire and intimacy.

Findings from the Never Gets Old focus groups (WP2) revealed that sexuality and identity in later life are frequently ignored or dismissed as irrelevant by both professionals and older adults. Participants highlighted the persistence of harmful stereotypes, silence around intimacy, and significant professional discomfort when addressing these topics. Module 1 responds to these insights by situating identity and sexuality as integral components of wellbeing across the entire lifespan and part of positive Ageing Frameworks.

By engaging with this module, professionals will gain a more nuanced understanding of demographic ageing, reflect on their own implicit assumptions, learn about three different positive ageing frameworks and in this way strengthen their capacity to support older adults in a more holistic manner.

Learning Outcomes Module 1

Desired Results: What will learners know or be able to do?	Evidence: How will we know they met the goals?
Structural Awareness: Explain the impact of demographic shifts in Europe.	Learners can explain the <i>Demographic Drag</i> in simple English and its implications for their workload.
Framework Integration: Differentiate between Healthy Ageing, Active Ageing, and Quality of Life models.	Learners can correctly categorise a set of care scenarios under the appropriate theoretical framework.
Subjective Assessment: Use validated tools (CASP-19/WHOQOL) to measure wellbeing beyond clinical health.	Practical demonstration of a Quality-of-Life interview using the provided questionnaire links.
Holistic Application: Apply a <i>Gender and Culture lens</i> to identify barriers faced by older adults.	Case study analysis where learners identify how gender and culture influence older people's or professionals attitudes and behaviour.
Professional Ethics: Balance the <i>Dignity of Risk</i> (Autonomy) against <i>institutional safety</i> (Beneficence).	Reviewing "Do's and Don'ts" and group debates on specific ethical and professional dilemmas (e.g., intimacy in care).



Key Concepts & Definitions

Ageism: Refers to the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age (WHO, 2025).

Old-age Dependency Ratio: A demographic indicator measuring the ratio of older dependents, typically those aged 65+, to the working-age population, usually 15-64 years (Eurostat, 2024).

Healthy Ageing: The process of developing and maintaining the functional ability that enables wellbeing in older age (to be and do what they have reason to value) (WHO, 2020).

Active Ageing: The process of optimising opportunities for health, participation and security to enhance quality of life as people age (WHO, 2002).

Quality of Life: An individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHOQOL, 1998).

Gender Lens: A perspective that considers how social statuses, traditional roles, and biological differences affect the wellbeing and opportunities of men, women, and gender-diverse individuals (WHO, 2002).

Holistic Framework in Gerontology: An approach that views ageing not merely as a series of medical symptoms or biological declines but acknowledges the interconnectedness of various aspects of a person's life, including their mental and emotional states, relationships, cultural background, and personal preferences (Hello Leaders, 2024).



Understanding the Topic

Ageing: Demographic Data

According to the 2024 ageing report by the European Commission, the EU population is projected to start falling in the coming years while the number of older people is rising, especially relative to the number of people at working age. This means that the size of the older age groups keeps continuously growing, while the younger age brackets would shrink.

This demographic transition toward an older society is not only a statistical change; it represents a fundamental shift in the social and economic fabric of Europe. As the proportion of older adults increases while the working-age population declines, the demand for high-quality care, inclusive support services, and specialised health interventions is expected to grow significantly. This shift places increasing pressure on already limited professional resources, making it essential for health and social care systems to adapt to a more diverse and ageing population. The data presented below provide empirical evidence supporting this demographic trend and highlight the scale of the challenge and the urgency of developing professionals who can provide holistic, respectful care.

The old-age dependency ratio is the ratio of the old-age population in the EU related to the working-age population and gives an idea about the shift between potential retirees and potential workers and thus of how an ageing population alters the balance between beneficiaries and contributors. The old-age dependency ratio for the EU was 33.9% on 1 January 2024 (see table below), with just over 3

persons of working age for every person aged 65 years and over. The old-age dependency ratio across the EU countries ranged from lows of 21.7% in Luxembourg and 23.6% in Ireland, with almost 5 working age persons for every person aged 65 years and over, to highs of 38.4% in Italy, 38.2% in Bulgaria and 38.2% in Portugal, where there were fewer than 3 working age persons for every person aged 65 years and over (Eurostat, 2024).

According to collected data, the old-age dependency ratio would rise further to 59.0 in 2070, with most of the increase expected already by 2045. This means, that the EU would go from having nearly thirty people aged 20-64 for every ten people aged over 65 years in 2022, to having less than twenty people by 2045 (European Commission, 2024).

Country	Population 1 January 2024	Old-age dependency ratio* 2024	Median age in years 2024	Increase of persons aged 65+ between 2014 and 2024
Germany	83.4 million 19% of EU total	35.2	45.5	20.9% to 22.4%
France	68.4 million 15% of EU total	34.8	42.6	18.0% to 21.4%
Romania	19.07 million	31.2	43.8	13.9% to 17.7%
Cyprus	934 000 0.2% of EU total	26.5	40.6	16.5% to 20.0%
Portugal	10.64 million of EU total	38.2	47.1	20.0% – 24.1%
Europe	449.31 million	33.9	44.7	18.7% to 21.6%

Data source: Eurostat (2024) *The age-dependency ratio is given by the number of young and elderly people at an age when both groups are generally economically inactive (i.e. under 15 years of age and aged 65+), compared to the number of people of working age (i.e. 15-64 years).

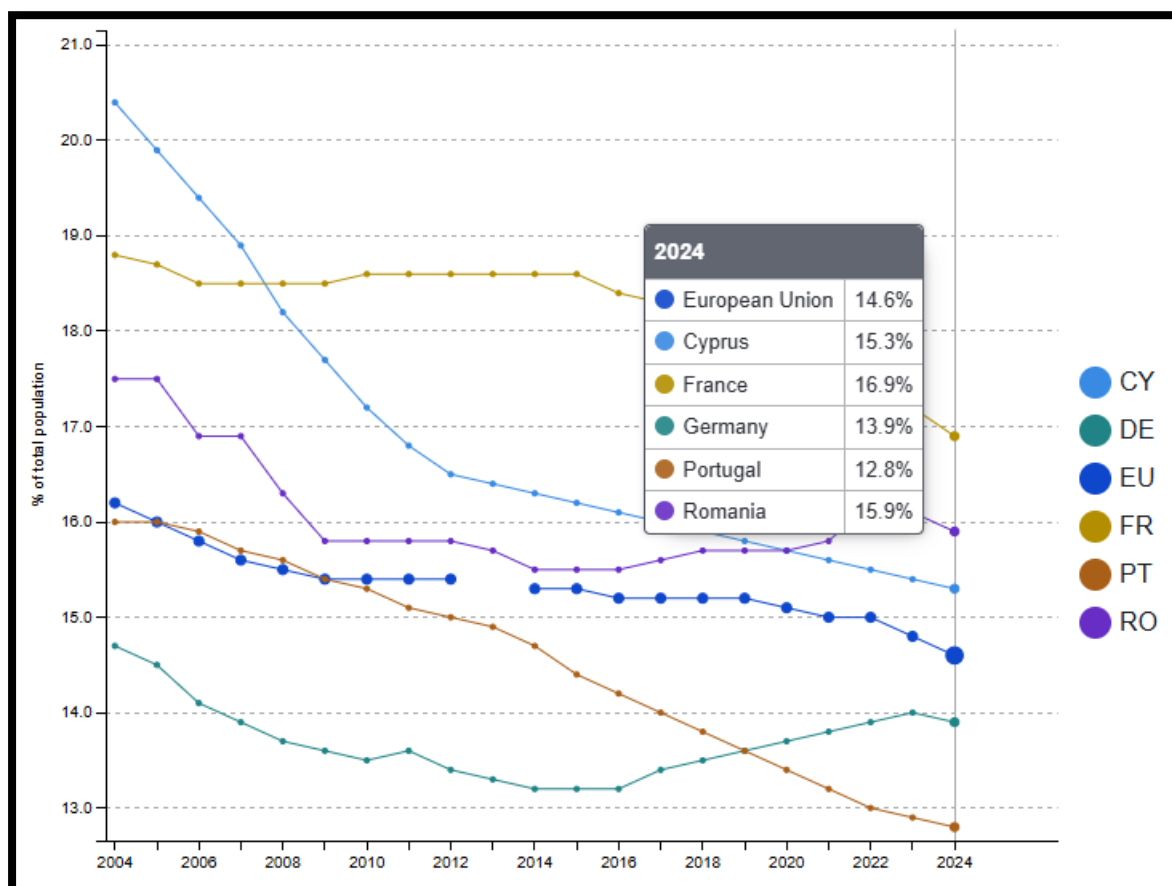


Figure 1 - Population aged less than 15 years as % of total population (Eurostat, 2024)

Within the Never Gets Old consortium, the partner countries represent a diverse spectrum of the European demographic shift. Portugal, alongside Italy and Greece, currently records one of the highest old-age dependency ratios in the EU (estimated at over 38%), with its median age increasing at one of the fastest rates in the region (Eurostat, 2024). In contrast, Germany has recently experienced a slight stabilisation or decrease in median age, a phenomenon primarily attributed to the influx of a younger migrant workforce. France continues to maintain one of the largest and most resilient populations; however, it is not immune to the "greying" trend prevalent across Western Europe, which has shifted national policy focus toward the long-term sustainability of social care systems.

The Eastern and Mediterranean partners face different structural pressures: Romania has undergone one of the EU's most significant relative population decreases (approximately -11% since 2004), largely driven by the emigration of the working-age population, which has accelerated a "top-heavy" ageing process. Conversely, Cyprus has recorded the highest relative population growth in the bloc (29% since 2004), yet it paradoxically faces a shrinking proportion of children, signalling that its future demographic health remains fragile.

The data provided by the 2024 Ageing Report underscores a transition from a period of demographic *bonus* (a country has a large, young working population) to one of demographic *drag*. Demographic drag occurs when a shrinking workforce and a growing elderly population slow down a country's economic growth. This happens because there are fewer workers paying taxes to support the rising costs of for example pensions, healthcare, and social services for older citizens. In other words: We can no longer rely on having a huge group of young workers to power the economy; instead, we must find new ways to support a much older society. For the Never Gets Old project, these numbers confirm

that the care and social sectors will face a dual pressure: a shrinking pool of professional caregivers and a rising demand for person-centred support. The projected spike in the dependency ratio by 2045 suggests that the window for implementing *Positive Ageing* frameworks is narrowing. Consequently, moving beyond clinical care to address holistic wellbeing, including the often-overlooked aspects of identity and intimacy, is no longer just an ethical choice, but a structural necessity to ensure the sustainability and dignity of European ageing societies.

Myths versus Realities in Later-Life Sexuality

Societal perceptions of ageing are often clouded by *sexual ageism*, a systemic bias that dismisses or pathologises the sexual lives of older adults and represents social expectations that older people do not or should not engage in sexual relationships. While demographic trends show an increase in life expectancy and a growing population of older adults, public and professional discourse often lags behind this reality, continuing to reflect ageist assumptions about later life and sexuality (Gewirtz-Meydan & Ayalon, 2020).

When thinking of stereotypes, a pervasive myth is that older adults are inherently asexual, "beyond" desire, or that sexual interest naturally vanishes with age. However, the reality is that sexuality is a dynamic life phase that continues across the entire lifespan. While physical functioning may change, research indicates that many older adults view sex as a vital component of quality of life, often shifting their focus from purely physical acts to deeper emotional intimacy and "complete" connection (Gewirtz-Meydan & Ayalon, 2020).

Another common myth frames later-life sexuality as ridiculous or inappropriate, yet studies show that it is the internalisation of these very stereotypes, not age itself, that most frequently hinders sexual expression (Gewirtz-Meydan et al., 2018).

These misconceptions have profound implications for services and wellbeing. When professionals operate under the myth of asexuality, they may overlook sexual health needs, fail to provide privacy in care settings, or ignore the specific concerns of vulnerable groups, such as LGBTQI+ adults who face "double invisibility" (Gewirtz-Meydan et al., 2018). Effective ageing frameworks must therefore move away from a strictly biomedical decline-model and adopt a holistic and more inclusive perspective. This includes acknowledging that sexuality is a fundamental human right and an indicator of successful ageing. By dismantling these myths, professionals can create a supportive environment where older adults feel empowered to express their identity and desire with dignity.

To delve deeper into the roots of ageist stereotypes and the societal prejudices that affect intimacy in later life, we encourage you to consult Module 2 of the AgeWise Handbook: [Ageism and Misconceptions about the Elders.](#)

Positive Ageing Frameworks

As the European and global population undergoes a significant demographic shift, the focus of gerontology and social policy has moved from a deficit-based model, which views ageing primarily as a period of inevitable decline or illness, toward positive ageing frameworks, which views ageing as a continued period of growth, development, and potential. A framework provides a way of understanding and can be a tool for organising programmes or services for seniors. For example, if different adult education organisations are all using the same framework to help think about and communicate their work, service gaps can be identified and help make it easier for seniors to access

the services they need, where and when they need them. The following frameworks provide different theoretical roadmaps for supporting older adults not just to live longer, but to thrive.

Healthy Ageing: A Functional Approach

Healthy ageing is about more than just maintaining our physical health over time. It is also about our mental and emotional health; our independence and quality of life; and our housing and financial security. It is about our ability to make connections with people, stay engaged in our communities, and feel like valued participants in society. Healthy ageing is about our ability to be resilient in the face of the increased frailty, decreased autonomy, and changing circumstances that are the realities many people face as we grow older.

The World Health Organisation (WHO) defines Healthy Ageing as the process of developing and maintaining the functional ability that enables wellbeing in older age. Unlike older medical models that focused solely on the absence of disease, Healthy Ageing emphasises the interaction between an individual's intrinsic capacity (physical and mental) and the environments they inhabit (WHO, 2020). It shifts the goal from *cure* to *functionality*. Even individuals with chronic conditions can age healthily if their environment (social, political, and physical) supports their ability to do what they value.

Functional ability is having the capabilities to enable people to be and do what they value (Beard et al., 2016). It is referred to as the ability:

- to meet their basic needs,
- to learn, grow and make decisions,
- to be mobile,
- to build and maintain relationships, and
- to contribute to society.

A systemic review by Abud et al. (2022), regarding a clear framework of healthy ageing, identified different determinants of healthy ageing on different dimensions:

- **Physical well-being:** Physical activity, exercise, healthy diet/nutrition, proactive lifestyle choices, medication management, alternative therapies to support the body's functions;
- **Mental/cognitive well-being:** Self-awareness, positive outlook/attitude (future-oriented mindset), sense of purpose, life-long learning, hobbies, faith/religion and spirituality;
- **Social well-being:** Social support and relationships with family, friends and even healthcare providers, financial security, community engagement/volunteering;
- **Independence** across all three dimensions.

Independence seems to be the golden thread connecting physical, mental, and social domains. It refers to the ability to live without constant support, remain self-reliant, and stay financially autonomous. The perception of independence is highly individual; for those with chronic conditions, it may focus on physical capability; for others, it is defined by the freedom to make their own choices.

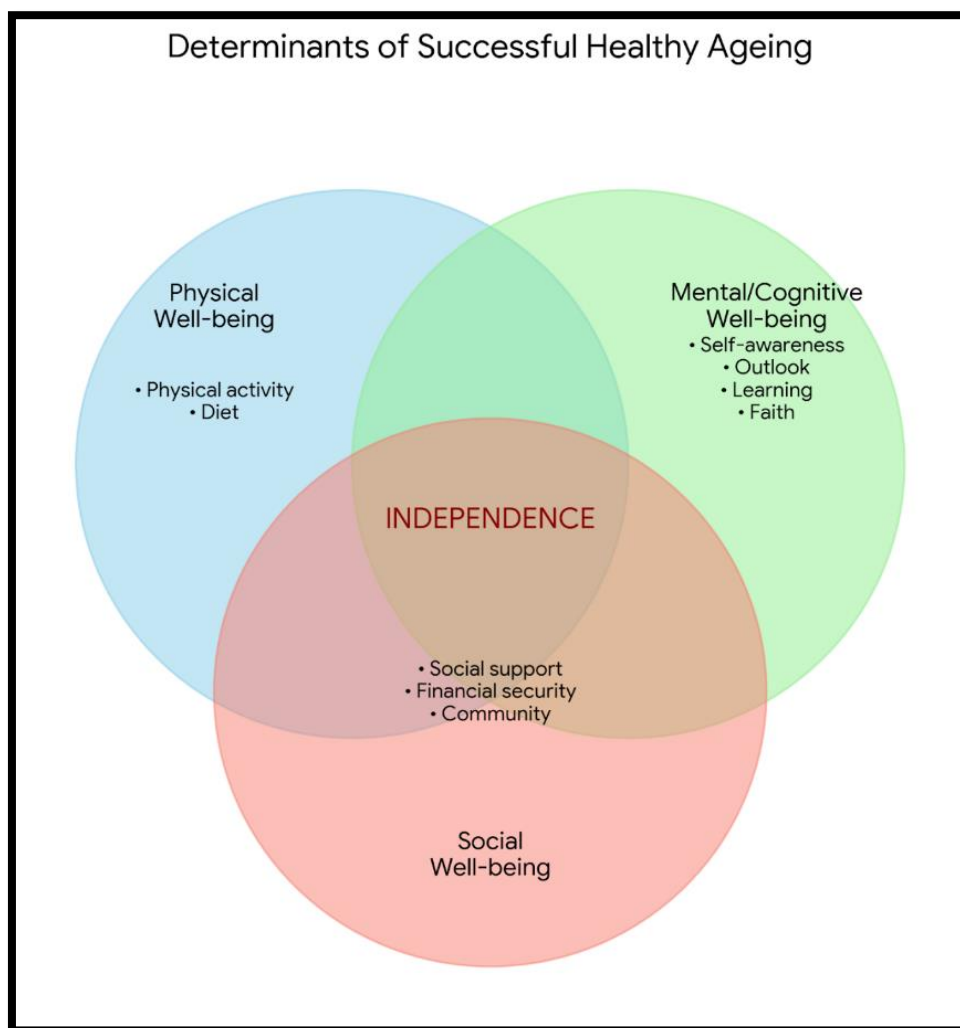


Figure 2 - Data based on Abud et al., 2022.

Examples of Healthy Ageing



*Images created/sourced via Canva (2026)

- **Age-Friendly Urban Infrastructure:** In a city that prioritises this framework, a resident with declining mobility can still do their own grocery shopping because the municipality has installed signage, widened pavements, and extended the timing of pedestrian crossing lights. By removing physical barriers, the environment compensates for a decrease in the individual's intrinsic physical capacity, allowing them to remain more independent.
- **Nutritional Security and Preventive Health:** Consider an older adult who participates in a community-supported agriculture programme that provides fresh, local produce. By maintaining a nutrient-dense diet rich in proteins and vitamins, they support their immune system and muscle mass (preventing sarcopenia). This proactive approach to nutrition reduces the risk of falls and hospitalisations, directly contributing to long-term functional stability.
- **Self-Management and Health Advocacy:** An individual who works collaboratively with their family doctor to manage a condition like hypertension. By monitoring their own blood pressure and understanding their medication, they demonstrate high "self-awareness" and agency and shift from being a passive patient to an active health advocate.

Active Ageing: Optimising Opportunities

The *Active Ageing framework* was adopted by the WHO in the early 2000s to convey a more inclusive message than *Healthy Ageing*. During the world summit on population taking place in Madrid in April 2002, the WHO approved active ageing as the main objective of health and social policies for older people (Paúl et al., 2012). The word *active* refers to continuing participation in social, economic, cultural, spiritual, and civic affairs, not just the ability to be physically active or participate in the labour force. It rests on three pillars: Health, Participation, and Security (WHO, 2002).

The profile of active ageing is expected to vary between contexts and cultures and can be used to guide specific community and individually based interventions in local environments. Research shows

that there are subjective variables contributing to active ageing (Paúl et al., 2012). According to the WHO, the Active Ageing framework encompasses six groups of determinants, each one enabling societal and environmental conditions for active ageing:

1. **Health and Social Services:** Health promotion, disease prevention, long-term care, and mental health services.
2. **Behavioural Determinants:** Smoking cessation, physical activity, healthy eating, oral health, alcohol consumption, and medication adherence.
3. **Personal Determinants:** Biology, genetics, and psychological factors.
4. **Physical Environment:** Ensuring age-friendly surroundings, safe housing, fall prevention, and the absence of pollution (clean water, air, and safe food).
5. **Social Determinants:** Social support, preventing violence and abuse, and fostering education and literacy.
6. **Economic Determinants:** Monitoring income, social protection, and financial security.

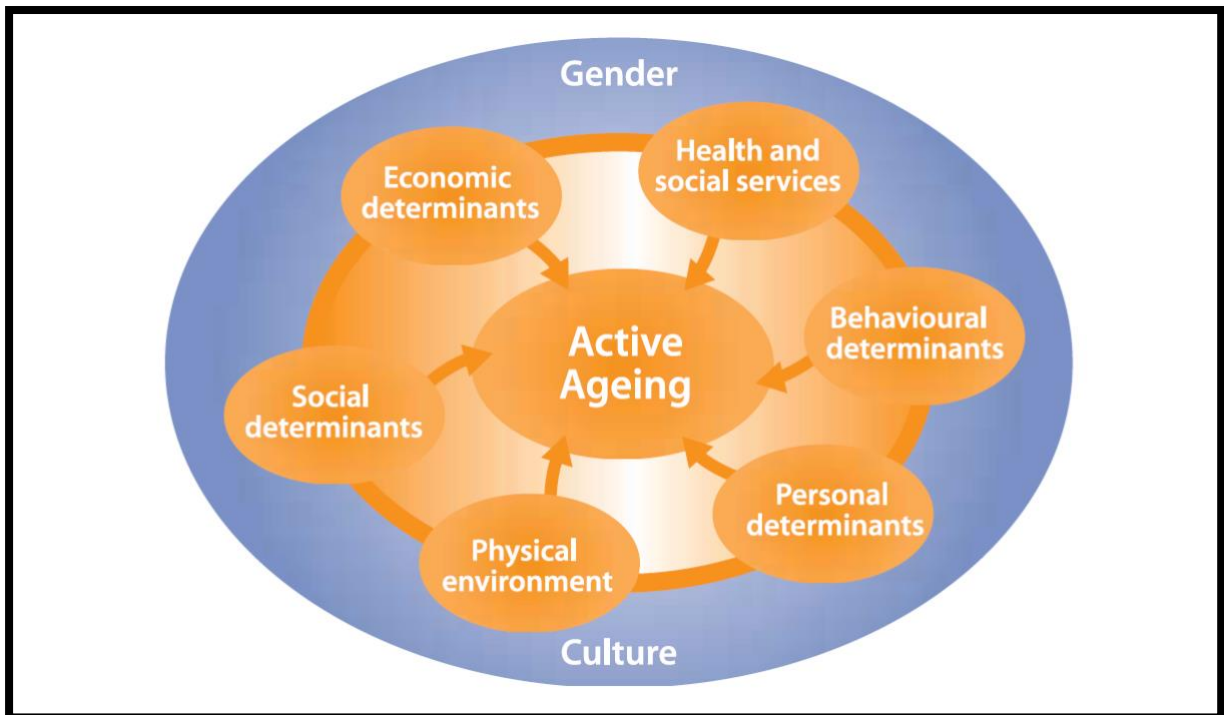


Figure 3 - The determinants of Active Ageing (WHO, 2002)

Culture and Gender are classified as cross-cutting determinants because they do not exist in isolation; instead, they act as fundamental factors that shape and influence every other factor of the active ageing framework.

Culture serves as the overarching environment for individuals, dictating societal views on the ageing process, health-seeking behaviours, and living arrangements, such as the preference for multigenerational households.

Gender, meanwhile, functions as a critical lens for policy appropriateness, highlighting how disparate social statuses and traditional roles lead to unique risks: women often face increased poverty due to lifelong unpaid caregiving, while men are statistically more susceptible to occupational hazards and

risk-taking behaviours. Together, these determinants ensure that ageing is understood not just as a biological process, but as a complex social and personal experience (WHO, 2002).

Some key aspects of Active Ageing are:

- **Autonomy:** the perceived ability to control, cope with, and make personal decisions about how one lives on a day-to-day basis;
- **Independence:** the ability to perform functions related to daily living - the capacity of living independently in the community with no and/or little help from others;
- **Quality of life:** *"an individual's perception of his or her position in life in the context of the culture and value system where they live, and in relation to their goals, expectations, standards, and concerns"* (THE WHOQOL GROUP, 1998).
- **Healthy life expectancy:** is commonly used as a synonym for "disability-free life expectancy".

Examples of Active Ageing



*Images created/sourced via Canva (2026)

- **Intergenerational Mentoring:** An older professional, though retired from full-time work, participates in a "knowledge transfer" scheme at a local business. By mentoring younger staff, they stay "active" in the civic and economic sense, ensuring their skills remain valued by society.
- **Lifelong Political Advocacy:** Engaging in local council meetings for senior rights. This ensures the "security" pillar is met by allowing older adults to have a voice in the policies that affect their lives and the environment they live in.
- **Senior University:** Enrolling in a "University of the Third Age" to learn a new language or history. This represents the commitment to "lifelong learning," keeping the mind engaged and social circles expanding.

Quality of Life: The Subjective Experience

While Healthy and Active Ageing frameworks often focus on functional capacity and societal participation, the Quality-of-Life framework centres on the individual's subjective experience of their own existence. The World Health Organisation defines Quality of Life as an individual's perception of their position in life within the context of the culture and value systems in which they live, and in relation to their goals, expectations, and concerns (The WHOQOL Group, 1998). This framework is multidimensional, moving beyond traditional medical markers to incorporate psychological health, social relationships, and personal beliefs.

In the context of an ageing population, Quality of Life serves as a vital indicator of well-being that persists even when physical health declines. Research suggests that for older adults, Quality of Life is closely tied to the concepts of autonomy (the ability to make one's own choices) and control over daily routines (Wiggins et al., 2004). Unlike certain standards of living, which focuses on income and material assets, Quality of Life measures how satisfied a person feels with their social connections, their sense of dignity, and their ability to pursue self-realisation in later life. Therefore, for many older adults, Quality of Life is more closely linked to autonomy (the ability to make decisions) and relatedness (connection to others) than to the absence of physical pain.

For professionals, the Quality-of-Life framework requires a shift in perspective: from asking "*What is the diagnosis?*" to asking "*What makes life worth living for this person?*" By prioritising an individual's personal values, including their need for intimacy, privacy, and identity, care providers can support a dignified life phase that is defined by the person living it, rather than by their clinical limitations.

Examples of Quality of Life

		
Maintaining Personal Style and Identity	Privacy and Intimacy	Autonomy in Small Decisions

*Images created/sourced via Canva (2026)

- **Maintaining Personal Style and Identity:** An older adult in a residential care home continues to dress in their preferred style and wear their favorite perfume/aftershave. This subjective sense of "self-expression" is a major component of psychological Quality of Life.

- **Privacy and Intimacy:** Having the autonomy to spend private time with a partner or close friend without interruption. For many, Quality of Life is defined by the freedom to maintain intimate relationships.
- **Autonomy in Small Decisions:** The ability to choose one's own mealtimes, what to watch on TV, or when to go for a walk. In gerontology, the perception of "control" over daily life is one of the strongest predictors of high Quality of Life.

Measurement of Quality of Life

To measure the subjective experience of ageing, researchers and practitioners typically rely on validated, evidence-based tools that capture the multidimensional nature of well-being. Two of the most globally recognised frameworks for assessing Quality of Life are the **WHOQOL-BREF** and the **CASP-19** (see also toolkit activities in annex).

The WHOQOL-BREF, developed by the WHO, is a 26-item questionnaire and is available for download in over 40 languages here: <https://www.who.int/tools/whoqol/whoqol-bref>

The CASP-19 is designed for older populations, moving away from health-related indicators to focus on *thriving* in later life. It is available in numerous languages to support international research and practice: <https://casp19.com/casp-translations/>

For more practical information and to learn how to use these tools, see the structured [lesson plan](#) for Module 1 and [exercise 2](#).

Utilising these tools allows professionals to move beyond clinical observations and gain a direct, person-centred understanding of an individual's wellbeing across the lifespan.

Situating Sexuality and Identity within Holistic Wellbeing

A truly holistic approach to these frameworks must acknowledge that sexuality and identity are integral to wellbeing and do not expire at a certain chronological age. Within the Active Ageing and Quality of Life models, sexuality is not merely a biological function but a fundamental expression of identity, relationship, and agency. The realities of later life involve the continuation of desire, the need for touch, and the maintenance of a sexual self-concept, all of which contribute significantly to psychological resilience.

When professionals ignore sexuality or treat it as irrelevant, they undermine the autonomy and self-realisation pillars of Quality of Life. Holistic support requires a shift in perspective: recognising that for many, a dignified life involves the freedom to express their gender identity and sexual orientation, and to pursue intimacy and connection throughout the entire lifespan. Integrating sexuality into positive ageing frameworks ensures that we are supporting the whole person, rather than a clinical version of "older age".

Synergies with Never Gets Old Focus Groups

The theoretical frameworks explored in Module 1 provide ideas for interpreting the lived experiences shared by participants in our national focus groups. Throughout the discussions, presented frameworks were mirrored and participants defined their daily needs; they often moved beyond concerns of clinical health to emphasise the importance of autonomy and the subjective feelings of getting older.

“Nobody wants to get old. I don't want to. [...] I don't think anyone likes it. This is a very internal process, and you must know how to grow old. And knowing how to grow old isn't easy for everyone [...].” – Participant Portugal.

The nature of gender and culture was also reflected in the group dynamics, as cultural expectations regarding family care or gendered norms shape how individuals discuss their identities.

“I think people still hold back a lot. For example, my grandmother was widowed at an early age. However, it was unthinkable to find another life. Never in her life. In her mind, it didn't make sense [...].” – Participant Portugal

“As a lesbian pensioner, I am 'outside' twice.” – German Participant

Furthermore, the determinants of Active Ageing, specifically social support emerged as practical barriers or facilitators in their lives.

“After her second husband died, she organised a sort of club at her home... and socialises every day.” – Participants Romania

“I think this transgenerational work thing is spectacular, because I think I have a lot to learn. It's not that I wasn't young before, but I was young at a different time [...].” – Participant Portugal

By situating these focus group insights within these established frameworks, we can see that the demographic change is not just a statistical challenge, but also a personal experience where the maintenance of independence and sexuality across the lifespan remains central to a person-centred model of care.

Professional Challenges

Translating positive ageing frameworks into daily practice can present challenges for healthcare and social service professionals. Often, practitioners are caught between the biomedical model, which prioritises safety and risk management, and the Quality-of-Life framework, which emphasises autonomy and the right to take dignified risks.

For example, supporting an older adult's sexual identity or need for intimacy in a residential setting may conflict with rigid institutional protocols or outdated professional boundaries. Furthermore, it is a challenge for professionals to always deliver person-centred care within systems, while they are increasingly strained by staff shortages and limited resources. Bridging this gap requires a shift in professional mindset, from being protectors of the elderly to being facilitators of their continued agency and self-expression.

For tips, how to support older adults better and deliver a more person-centred approach, see the following section: [Guidance for Educators and Professionals](#) or have a look at the [lesson plan](#) for Module 1 and [exercise 3](#).

Vulnerable Groups and Intersectionality

While frameworks like Active Ageing provide a universal ideal, they are not experienced equally by everyone. An intersectional approach is necessary to understand how various identities, such as

ethnicity, disability, socio-economic status, sexual orientation, and gender identity, overlap to create unique barriers to wellbeing.

For instance, LGBTQI+ elders may face double invisibility, fearing that their sexual identity will not be respected in traditional care environments, leading them to hide significant parts of their lives. Similarly, older migrants may navigate a cultural disconnect where mainstream health services fail to account for their specific traditions regarding family and care.

Recognising these overlapping vulnerabilities ensures that positive ageing is not a “one-size-fits-all” concept, but a flexible support system that protects the rights and dignity of every individual, regardless of their background.

Guidance for Educators and Professionals

Transitioning from theory to practice requires a shift in how we engage with older adults. The following guidance is designed to help professionals implement positive ageing frameworks while maintaining ethical standards and sensitivity.

Communication Recommendations

Validate, Don't Infantilise: Avoid "elderspeak" (using high-pitched tones or overly simplified language). Treat older adults as the autonomous peers they are.

Active Listening for Identity: Listen for cues regarding a person's identity, past roles, and current desires. Sexuality and intimacy are often discussed in "shades of grey", subtle hints that require a sensitive, non-judgemental response.

Do's and Don'ts

Do	Don't
Use person-first language and speak to the individual as an equal, regardless of their physical or cognitive status.	Don't use Elderspeak (baby talk, high-pitched tones, or collective terms like <i>we</i>) which diminishes a person's dignity.
Encourage shared decision-making, allowing the individual to lead the conversation about their care and daily routines.	Don't make assumptions about what a person can or cannot do only based on their age or medical diagnosis.
Provide private spaces for the expression of intimacy and gender identity (e.g. knock and wait for a response before entering the room).	Don't pathologise or ignore an older adult's sexual health or identity or treat it as inappropriate or a symptom.
Look at the "whole person," considering their cultural background, spiritual needs, and life history alongside clinical health.	Don't treat the person as a "case" or a list of medical symptoms; avoid focusing exclusively on biological decline.

Support the "dignity of risk," allowing individuals to make choices that enhance their joy, even if they carry minor risks.	Don't prioritise institutional safety so heavily that it results in the "social death" or total restriction of the individual.
Ask open-ended questions: "What does 'independence' look like for you today?"	Don't assume asexuality: Never dismiss a resident's request for privacy or their expression of gender identity as inappropriate.

Ethical Considerations

The primary ethical tension in ageing care is the balance between Beneficence (acting in the person's best interest) and Autonomy (respecting their right to choose). Professionals should adopt the *Dignity of Risk* principle whenever possible, acknowledging that a life without risk is a life without freedom. Ensuring that an older adult can express their sexuality and identity is a fundamental human rights issue, not a clinical luxury.



Summary and Key Messages

Module 1 establishes that ageing is a dynamic and multidimensional process rather than a narrative of inevitable decline. The core takeaway is that Positive Ageing is achieved through the synergy of Healthy Ageing (functional ability), Active Ageing (participation and security), and Quality of Life (subjective satisfaction). We have seen that while demographic changes across Europe present economic challenges, the primary focus for professionals must remain on the individual's independence and autonomy.

Key messages include the recognition of Culture and Gender as cross-cutting lenses that dictate how individuals experience ageing and access care. Furthermore, we must acknowledge that identity and sexuality continue across the lifespan; they are vital components of wellbeing that require professional recognition and support. By moving toward a holistic, person-centred approach, we can ensure that the *Never Gets Old* philosophy is reflected in every interaction, honouring the dignity of every older adult regardless of their background or physical status.



Practical Tools

Lesson Plan Module 1

The lesson plan is a structured guide which provides instructions for trainers or professionals on how to implement Module 1 in a group setting. It provides a structure for a training duration of 2.5 hours with a correspondent PowerPoint presentation, lists learning outcomes and a preparation checklist, and describes three exercises (see below).

- **Lesson Plan Module 1** - Demographic Change & Positive Ageing Frameworks, including exercise instructions.

- **Presentation Module 1** - Ageing Population and Positive Approaches to Ageing.

Exercise 1 – World Café

Objective: Connect the EU data to the learners' specific regional and professional reality using the Word Café Methodology (see instructions in lesson plan).

- [World Café Station Names](#)

Exercise 2 – Measuring Quality of Life

Objective: To gain practice in using the WHOQOL-BREF and CASP-19 tools using role play scenarios (see instructions in lesson plan).

- [Role Play Persona Cards](#) – for *Practitioners* and *Older Adults*.
- [Questionnaire WHOQOL-BREF](#).

Exercise 3 – Analysing Case Studies and Creating a 3-Step Action Plan

Objective: To apply *Gender and Culture Lenses* and solve ethical dilemmas using case study work and creating 3-Step Actions Plans (see instructions in lesson plan).

- [Case Study Cards](#).
- [3-Step Action Plan Worksheet](#).

References

- Abud, T., Kounidas, G., Martin, K. R., Werth, M., Cooper, K., & Myint, P. K. (2022). Determinants of healthy ageing: a systematic review of contemporary literature. *Aging clinical and experimental research*, 34(6), 1215-1223.
- Beard, J. R., Officer, A., De Carvalho, I. A., Sadana, R., Pot, A. M., Michel, J. P., ... & Chatterji, S. (2016). The World report on ageing and health: a policy framework for healthy ageing. *The lancet*, 387(10033), 2145-2154.
- De Gobbi, M. S., Kühn, S., Heins, G., & Malikova, Z. (2025). Demographic change in Europe and Central Asia: Addressing the issue of a shrinking and ageing labour force (No. 139). ILO Working Paper. <https://www.econstor.eu/bitstream/10419/324229/1/1929162480.pdf>
- European Commission. (2024). The 2024 Ageing Report: Economic and Budgetary Projections for the EU Member States (2022–2070) (Institutional Paper 279). Publications Office of the European Union. <https://doi.org/10.2765/049223>
- European Commission. (2021). Green paper on ageing: Fostering solidarity and responsibility between generations. https://commission.europa.eu/system/files/2021-06/green_paper_ageing_2021_en.pdf
- Eurostat. (2024, September). Population structure and ageing. European Commission. https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Population_structure_and_ageing
- Eurostat. (2025). Demography of Europe – 2025 edition. Interactive publication. <https://ec.europa.eu/eurostat/web/interactive-publications/demography-2025>
- Gewirtz-Meydan, A., & Ayalon, L. (2020). "Shades of grey": Exploring public opinion about later-life sexuality. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, 39(4), 647-661. <https://doi.org/10.1017/s071498081900062x>
- Gewirtz-Meydan, A., Hafford-Letchfield, T., Benyamini, Y., Phelan, A., Jackson, J. and Ayalon, L. (2018) 'Ageism and Sexuality', in Ayalon, L. & Tesch-Römer, C. (eds.) *Contemporary Perspectives on Ageism*. Cham: Springer International Publishing, pp. 149-162. doi:10.1007/978-3-319-73820-8_10. <https://cora.ucc.ie/bitstreams/7f056dc8-2801-4587-9aec-87a10ad79796/download>
- Hello Leaders. (2024, March 13). Holistic care: A comprehensive approach to well-being in the aged care sector. <https://helloleaders.com.au/article/holistic-care-a-comprehensive-approach-to-well-being-in-the-aged-care-sector>
- Paúl, C., Ribeiro, O., & Teixeira, L. (2012). Active ageing: An empirical approach to the WHO model. *Current Gerontology and Geriatrics Research*, 2012, 1–10. <https://doi.org/10.1155/2012/382972>
- Ribeiro, M. G. (2025, June 26). Active ageing: European frameworks and progress. European Association for the Education of Adults. <https://eaea.org/2025/06/26/active-ageing-european-frameworks-and-progress/>
- Rudnicka, E., Napierała, P., Podfigurna, A., Męczekalski, B., Smolarczyk, R., & Grymowicz, M. (2020). The World Health Organization (WHO) approach to healthy ageing. *Maturitas*, 139, 6-11. <https://doi.org/10.1016/j.maturitas.2020.05.018>

THE WHOQOL GROUP. (1998). Development of the World Health Organization WHOQOL-BREF Quality of Life Assessment. *Psychological Medicine*, 28(3), 551–558. doi:10.1017/S0033291798006667

Wiggins, R. D., Netuveli, G., Hyde, M., Higgs, P., & Blane, D. (2004). The Casp-19 scale of quality of life in old age: its measurement properties, reliability and validity. *Ageing & Society*, 24(5), 693–706.

World Health Organization. (2025, April 28). Ageing: Ageism. <https://www.who.int/news-room/questions-and-answers/item/ageing-ageism>

World Health Organization. (2020). Decade of healthy ageing: Baseline report. <https://www.who.int/publications/i/item/9789240017900>

World Health Organization. (2002). Active ageing: A policy framework (No. WHO/NMH/NPH/02.8). World Health Organization.

MODULE 2

Ageism and Misconceptions About the Elders

Developed by:

Elisa Klein-Peters

Proportional Message



Overview

This module examines how stereotypes, prejudice, and discrimination based on age create systemic barriers for older adults. We move beyond general ageism to look specifically at *Sexual Ageism*, the assumption that older adults are asexual, and the subsequent dismissal of their relational and identity-related needs.

In the context of sexuality and diversity, ageism acts as a *silent* agent. When professionals hold ageist biases, they overlook the sexual health, gender identity, and intimate needs of older adults. This can lead to a lower quality of life, increased social isolation, and medical errors where sexual health issues are misdiagnosed as just a part of getting old.

Findings from the Never Gets Old focus groups (WP2) highlighted a significant knowledge and comfort gap. While professionals value the idea of holistic care, many reported that discussing sexuality with older adults seems inappropriate and very often not a priority. WP2 data shows that institutional practices often prioritise safety and hygiene over intimacy, effectively "de-sexualising" older adults to suit the institution's comfort.

By completing this module, professionals will develop *bias-literacy*, the ability to recognise ageist triggers in themselves and their institutions. They will gain the vocabulary to advocate for the sexual rights of older adults and the tools to dismantle myths that hinder inclusive care.

Learning Outcomes Module 2

Desired Results: What will learners know or be able to do?	Evidence: How will we know they met the goals?
Identify and define the three levels of ageism (Institutional, Interpersonal, Internalised) and their systemic impact.	Learners successfully match real-world scenarios to the correct myths and correctly identify the specific level of ageism involved in each (exercise 1).
Recognise the gap between explicit professional approval of sexual rights and implicit personal biases or discomfort.	Learners can identify the 5 Major Research Themes found by Gewirtz-Meydan and Ayalon (2020) in staff reactions and propose inclusive alternative response (exercise 2).
Understand how gender, culture, and cognitive status overlap to create unique barriers to intimacy.	With the "Shades of Grey" discussions, learners can articulate why a <i>one-size-fits-all</i> care plan fails LGBTQI+ elders or women facing gendered beauty standards.
Challenge the <i>Asexual Stereotype</i> and the prioritisation of safety over the adult right to privacy.	Successful creation of an Anti-Ageist Campaign that includes respectful language and a concrete <i>Call to Action</i> (exercise 3).



Key Concepts & Definitions

Ageism: Refers to the **stereotypes** (how we think), **prejudice** (how we feel) and **discrimination** (how we act) towards others or oneself based on age (WHO, 2025).

Stereotypes: Cognitive structures that store our thoughts, beliefs and expectations about the characteristics of members of social groups. In the case of ageism, age stereotypes are used to make inferences about, and guide behaviour towards, people of a given age group (WHO, 2021).

Prejudice: An affective reaction or feeling that is directed towards an individual who belongs to a specific social group. In the case of ageism, prejudice is directed towards individuals perceived to belong to a specific age group, regardless of whether they actually belong to that group (WHO, 2021).

Discrimination: Any actions, practices, laws or policies that are applied to people based on their perceived or real membership in a socially salient group and that impose some form of direct or indirect disadvantage (negative discrimination) or advantage (positive discrimination) on them. In the case of age-based discrimination, these actions, practices and policies are directed at people perceived to belong to a specific age group (WHO, 2010).

Institutional Ageism: Laws, rules, norms, policies and practices of institutions – and the ideologies that are fostered to justify them – that unfairly restrict opportunities, and systematically disadvantage individuals based on their age (WHO, 2021).

Interpersonal Ageism: Ageism occurring during interactions between two or more individuals. In interpersonal ageism, the perpetrator is distinguished from the target of ageism (WHO, 2021).

Internalised Ageism / Self-directed Ageism: Ageism turned against oneself. People internalise biases based on age from the surrounding culture after being repeatedly exposed to them, and they then apply the biases to themselves (WHO, 2021).

Explicit ageism: Ageism that is consciously and intentionally engaged in by a person. It is often contrasted with implicit ageism, which operates largely outside of conscious awareness (WHO, 2021).

Implicit ageism: Ageism that is engaged in by a person without conscious awareness and intention (WHO, 2021).

Sexual Ageism: The specific belief that older people are, or should be, asexual, that sexual interest in old age is abnormal and not capable of having sex or enjoying a sex life like they did when they were young (Surles, 2023).

Elderspeak: Adjustments to speech patterns that are sometimes made by younger people when communicating with older adults, such as speaking more slowly or more loudly, shortening sentences or using limited or less complex vocabulary. These simplified speech patterns are implicitly based on the assumption that older adults are cognitively impaired or incapable of understanding normal speech (WHO, 2021).

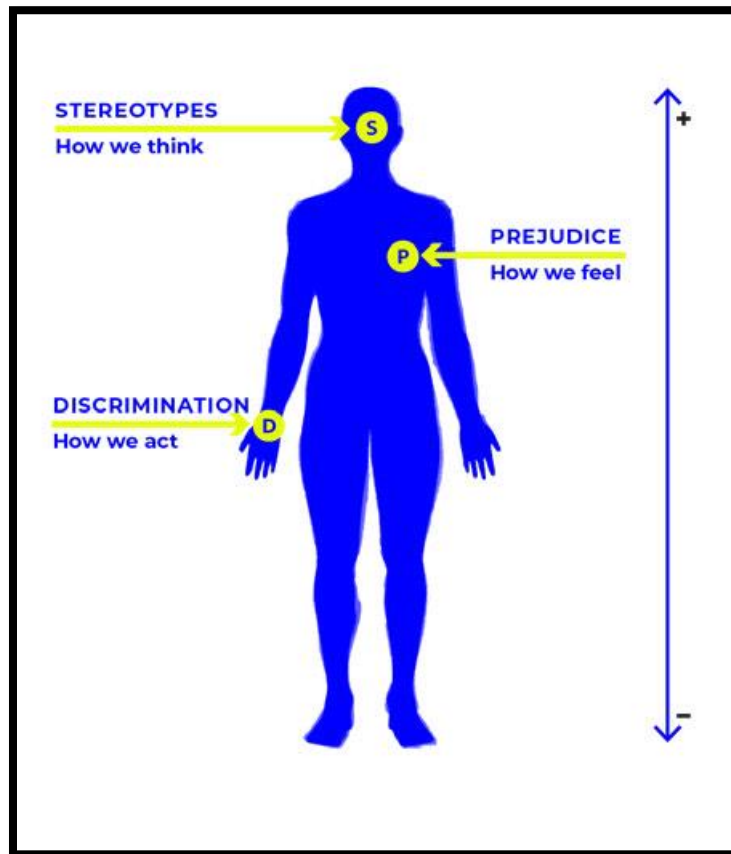


Figure 4 - The three dimensions of ageism, including stereotypes, prejudice and discrimination (WHO, 2021).

Understanding the Topic

Effects of Ageism

From the pressure to dye away every grey hair to anti-aging products, the message is clear: Youth seem to be the standard of value and being old is something to avoid. Never mind that these stereotypes create a world that will be less welcoming to everyone when arriving there.

Sexual health, identities, and intimacy are essential to older adults' quality of life, yet many beliefs and misconceptions exist within societies regarding sexuality in older age. Ageism is often described as the *last socially acceptable prejudice* (Abrams, 2023). In other words, while our society has worked hard to stop discrimination based on things like race or gender, prejudice against older people is still often ignored or even seen as "normal".

Ageism refers to the stereotypes, how we think, prejudice, how we feel, and discrimination, how we act, towards others or oneself based on age (WHO, 2025). While explicit ageism is consciously and intentionally, implicit ageism operates largely outside of conscious awareness and conscious intention.

It is important to recognise that age-based bias is a universal phenomenon that can affect individuals at any stage of life. Ageism occurs whenever stereotypes, prejudice, or discrimination are directed toward people based on their age. A Note on Focus: While ageism impacts all generations, Module 2

focuses specifically on ageism directed toward older adults. This alignment ensures that our training directly supports the mission of the *Never Gets Old* project, addressing the unique systemic barriers and taboos that hinder the sexual rights and holistic well-being of the elderly population.

Ageism is known to affect older people's lives in terms of their health and well-being. It is associated with poorer physical health and mental health (Lyons et al., 2018; Robb et al., 2002), leads to a poorer quality of life (Bodner & Cohen-Fridel, 2019) and higher rates of loneliness and social isolation (Donizzetti & Lagacé, 2022). Therefore, it represents a big obstacle to healthy ageing. Generally, research showed that experiences of ageism are greater among those without a partner, unemployed participants, those with lower incomes and poorer self-rated health (Heywood et al, 2019).

In the following part, we will explore different perspectives of ageism.

Three Levels of Ageism

To truly understand ageism, we must look beyond individual comments. Ageism is a multi-layered phenomenon that occurs on different levels; it exists in the laws of our countries, the interactions in our hallways, and even the quiet thoughts in our own heads. Ageism is not just a personal feeling; it is built into our systems and can be categorised into three distinct levels: Institutional, Interpersonal, and Internalised.

1. Institutional Ageism (The Systemic Level)

Institutional ageism refers to the laws, rules, social norms, and practices of organisations that limit opportunities or disadvantage individuals based on their age (WHO, 2021). This is often the most invisible form because it is baked into the way society functions.

A primary example is the age cap on certain screenings in the health care system. In many regions, routine sexual health screenings or reproductive health checks are automatically stopped once a patient hits 65, under the ageist assumption that they are no longer sexually active or at risk for STIs. This creates a systemic blind spot where older adults receive lower-quality preventative care than younger adults, simply because of a number on a chart.

Regarding the labour sector, another example would be ageism manifested through systemic barriers, such as discriminatory hiring practices that favour younger candidates or mandatory retirement ages that force skilled professionals out of their roles regardless of their actual competence.

2. Interpersonal Ageism (The Social Level)

This level occurs in the daily interactions between people. It involves the stereotypes and prejudices that emerge when one person interacts with another (WHO, 2021).

In professional care for example, this often manifests as microaggressions or dismissive behaviour. For instance, when staff members make jokes about two residents starting a new romantic relationship, they are practicing interpersonal ageism. Even if intended as harmless fun, these comments signal to the older adult that their desire for intimacy is a source of amusement rather than a valid human need. This creates a culture of shame and discourages residents from seeking the social connections they need for their well-being.

Another example would be, when we adopt an overly accommodating tone or simplified vocabulary with older adults, a practice known as elderspeak, we infantilise older adults, reinforcing a social perception of incompetence that often leads to disrespectful or dismissive treatment.

3. Internalised Ageism (The Personal Level)

Internalised ageism (also known as self-directed ageism) happens when older adults take the negative stereotypes they have heard throughout their lives and turn them inwards. Therefore, sexual self-ageism is directed toward oneself and manifests through the internalisation of external stereotypes and prejudice (Kerssies et al., 2025). Older adults begin to believe that the myths about ageing are actually true for them.

For example, consider an older woman who experiences physical discomfort, such as vaginal dryness, or feels a desire for a new partner. If she has internalised the message that she is “too old” to be attractive, she may never seek medical treatment or pursue a relationship. This is perhaps the most damaging level because it leads to *self-exclusion*. The individual stops themselves from accessing joy or health because they feel they no longer qualified for those experiences due to their age.

Self-directed ageism also impacts the young; for instance, individuals in their twenties may internalise the belief that they lack sufficient life experience for a role or work position, leading them to prematurely disqualify themselves from career opportunities.

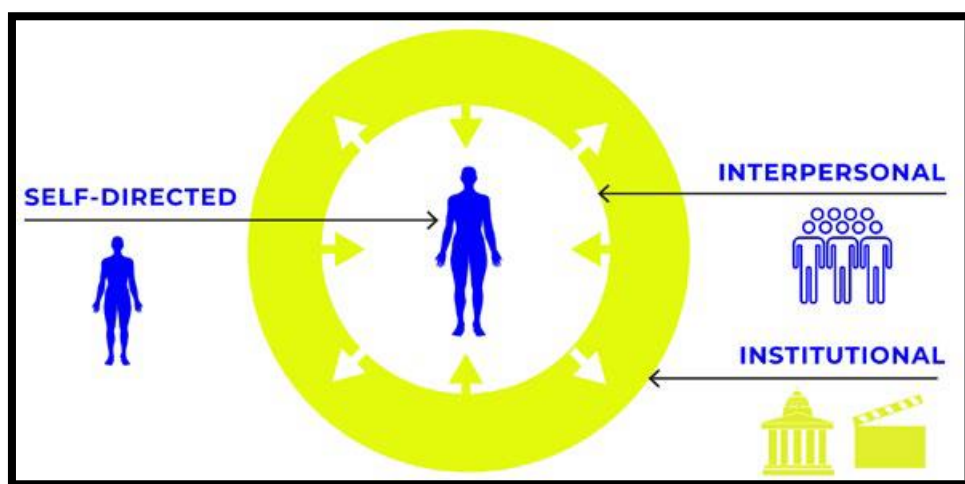


Figure 5 - The three levels of ageism (WHO, 2021).

These three levels do not exist in isolation; they feed into one another. **Institutional** lack of sexual health focus reinforces the **Interpersonal** idea that seniors aren't sexual, which eventually leads to the **Internalised** belief that one shouldn't even ask for help. Breaking the cycle requires professionals to intervene at all three levels simultaneously.

To learn more about how to identify levels of ageism with the help of 12 mini case studies and myths related to growing older, please consult [Exercise 1](#), based on *Demystifying the Myths of Ageing* (WHO, 2013).

Negative Societal Beliefs and Taboos surrounding Sexuality in Later Life

In many cultures, the intersection of *old age* and *sexuality* creates a profound social discomfort. This discomfort is rooted in several societal beliefs that professionals must learn to identify and challenge. Sexual Ageism is the belief that older people are, or should be, asexual, that sexual interest in old age is abnormal. It occurs when older people are stereotyped as being non-sexual, not capable of having sex or enjoying a sex life like they did when they were young (Surles, 2023).

The "Asexual" Assumption

The most pervasive belief is that sexual desire naturally expires at a certain age. This taboo suggests that once an individual passes reproductive age or faces physical health declines, they become asexual. When older adults do express sexual interest, society often reacts with shock or ridicule (the "dirty old man" or "predatory grandmother" images), effectively pathologising normal human desire. This taboo prevents older adults from discussing sexual health with doctors, fearing they will be judged as inappropriate.

The Sacredness of the Delicate Body

There is a societal tendency to view the aging body through a lens of fragility that is incompatible with sex. We often see older adults exclusively as grandparents or patients. These roles are culturally *de-sexualized*. In institutional settings, this taboo manifests as a certain attitude: staff may feel they are protecting a resident's dignity by ignoring their sexual identity, when they are actually stripping away their agency.

The Double Standard of Ageing and Gender

Societal taboos around sexuality are heavily gendered. Men are often allowed a longer sexual runway in the public eye, while women face a *double standard* where aging is equated with a loss of sexual value. This is reinforced by a multi-billion-euro anti-aging industry that labels the natural signs of a life lived, wrinkles, grey hair, changing body shapes, as *problems to be fixed*, further entrenching the belief that only youthful bodies are sexually valid.

The Silence of the Closet

For LGBTQI+ elders, these taboos are doubled. Many lived through eras where their identities were criminalised or pathologised. Societal taboos were created that forces many older LGBTQIA+ adults back into the closet when entering aged care. This silence is not a lack of identity; it is a survival mechanism against a society that refuses to see diversity in old age.

Many LGBTQIA+ elders who are living with HIV feel compelled to 'return to the closet' upon entering residential care. This self-concealment is often driven by a lack of specialised knowledge among medical staff and fellow residents regarding modern HIV treatments and transmissibility. The social stigma and fear surrounding the illness, remnants of the early epidemic, compound this isolation. After a lifetime of navigating systemic violence and discrimination, many individuals choose to conceal their identity once again to avoid further prejudice in the unfamiliar and often heteronormative environment of a nursing home.

These taboos create a circle of silence:

- The older adult stays silent to avoid being seen as *gross* or *difficult*.
- The professional stays silent to avoid awkwardness or disrespect.
- The family stays silent to maintain a specific image of their parent.

To break these taboos, professionals must move from a *safety-first model* to a *rights-based model*. Recognising that sexuality is not a youthful phase, but a lifelong right is the first step in dismantling the negative societal beliefs that isolate older adults.

Some Myths and Realities

Myth	Reality
"Older people don't have sex."	National surveys show that a significant percentage of adults aged 70+ remain sexually active and value intimacy. At the same time, sexual satisfaction often increases or stays stable with age. While the <i>mechanics</i> may change, the emotional intimacy and confidence often deepen.
"Older bodies are unattractive and non-sexual."	Beauty is a social construct. Attractiveness in later life is often tied to vitality and connection rather than "flawless" skin.
"If they can't have intercourse, their sex life is over."	This is the <i>Hegemony of Penetration</i> . Sexuality includes touch, kissing, masturbation, and emotional closeness. These remain vital even if physical disabilities occur.
"Sex is dangerous for the heart."	Sexual activity is no more strenuous than walking up two flights of stairs; for most, it is a safe, healthy exercise.
"Dementia makes you asexual."	The need for touch and connection is one of the last things to fade. Sexuality remains a core part of identity even with cognitive decline.
"STIs aren't a concern for people over 65."	Because of the <i>Asexual Myth</i> , older adults are less likely to use protection or be tested. Rates of STIs in older populations have risen significantly because doctors fail to discuss safe sex with them.
"LGBTQI+ seniors go back in the closet."	While many do out of fear, this is a failure of the institution's culture, not a choice by the individual.

A study by Gewirtz-Meydan and Ayalon (2020) is a landmark piece of qualitative research that moves beyond simple yes/no questions about ageism. It specifically explores the *shades of grey* - the complex, often contradictory ways the public views sexuality in later life.

Most studies on ageism use quantitative scales (ranking agreement from 1 to 5), which often suffer from desirability bias, which means that people answer what they think is the polite thing to say. Gewirtz-Meydan and Ayalon instead used an open-ended qualitative approach. They asked 135 participants to freely describe how they believe *sexuality changes in old age*, allowing for more honest, complex, and sometimes raw opinions to emerge.

The study identified five major themes that illustrate the spectrum of public opinion, ranging from negative to hopeful and transformative. The researchers found that while explicit ageism is declining, sexual ageism remains deeply rooted in the public's imagination.

1. **The Decline Narrative - "The World Belongs to the Young":** A significant portion of respondents viewed later-life sexuality purely through a lens of loss and decline. They

assumed that desire naturally vanishes and that older bodies are less attractive or less capable.

2. **The Asexual Stereotype:** Some participants struggled to even imagine older adults as sexual beings. They described sex in later life as rare, non-existent, or boring, often linking it only to biological functions (like hormones) rather than emotional connection.
3. **Quantity to Quality:** On a more positive note, many respondents believed that while the frequency of sex might decrease, the emotional depth increases. They viewed later-life sexuality as more complete, mature, and meaningful compared to the more physical sex of youth.
4. **The Hegemony of Penetration:** The study found that the public still narrowly defines sex as penetrative intercourse. Because aging can bring physical changes (like erectile dysfunction or vaginal dryness) that make penetration difficult, the public often assumes that if penetration stops, the sex life is over.
5. **Ambivalence and Contradiction:** The *Shades of Grey* title refers to the fact that many people hold conflicting views. They might say they support older adults' right to have sex (explicitly) yet still find the idea distasteful or "weird" when confronted with it in reality (implicitly).

To delve deeper into the different major themes, see [Exercise 2](#). This exercise will help professionals recognise gaps between their explicit (conscious/polite) beliefs and their implicit (unconscious/gut) reactions.

Bias Impact on Healthcare, Education and Institutional Settings

Bias against older adults is not just an attitude; it is a systemic force that shapes the quality of care and education. In healthcare, ageist biases often lead to therapeutic nihilism, the belief that treating an older person's condition is a waste of resources because "they are going to die soon anyway." This results in the under-diagnosis of treatable conditions, such as depression or sexual dysfunction, which are dismissed as "normal" ageing.

In educational and institutional settings, older adults are frequently excluded from modern curricula or technological training due to the *digital ageism myth*; the assumption that they cannot or will not learn new skills. This creates a cycle of exclusion: institutions don't provide the tools for engagement, and the resulting lack of engagement is used as proof that older adults are incompetent. When institutions prioritise safety and management over autonomy and identity, they effectively strip older adults of their adulthood, treating them as passive recipients of care rather than active participants in life.

Synergies with Never Gets Old Focus Groups

The findings from the WP2 Never Gets Old Focus Groups act as a bridge between theory and the lived reality of older adults. The voices of participants from partner countries mirror the core themes of Module 2, specifically the presence of sexual ageism, the gendered double standard, and the desperate need for institutional privacy.

"I think our culture and society needs to invest more in this theme; To show people that this is not evil. It's not a sin. That this is a natural thing." – Participant Portugal

A recurring theme in focus groups was the perception of sexuality as sinful when associated with older age. This quote supports our discussion on Negative Societal Beliefs and highlights that ageism is not just a lack of information, but a moral judgment that frames natural human needs as taboo.

Focus groups also addressed the *Double Standard of Ageing*. Participants noted that for women, the biological transition of menopause is often treated as a social expiry date for their sexuality.

“Especially after the menopause, people think that life is over, [...] it even seems ugly to talk about it.” – Participant, Portugal

This reinforces the module's section on Intersectional Perspectives, showing how women must fight both ageism and sexism to maintain their right to be viewed as sexual beings.

Participants in Germany highlighted how *Internalised Ageism* forces sexuality into the shadows. When the surrounding culture views older sex as ugly, the individual hides their identity. When people feel judged, they withdraw, which can lead to the social isolation and loneliness discussed earlier in the module.

“[...] often reflected in our self-image and in relation to sexuality, which tends to be lived less transparently [...] it is much more hidden, i.e. in the secret.” – Participant, Germany

Mirroring the findings of the *Shades of Grey* study (Gewirtz-Meydan & Ayalon, 2020), participants described a reality that contradicts the *Decline Narrative*. This confirms the reality that ageing can improve the emotional quality of sex, moving away from performance and toward trust and “getting in tune with each other”.

“[...] from my own experience of sexuality, it's simply much more relaxed, it's much calmer, actually also more trusting.” – Participant, Germany

Finally, focus groups provided concrete evidence for the Guidance for Professionals section regarding institutional boundaries and the *Dignity of Risk*.

“To knock in a care home before you go in [...] And if a person is in the process of pleasuring themselves... maybe just leave the room quietly and unobtrusively.” – Participant, Germany

This quote is an argument against *Institutional Ageism*. It highlights that the most impactful thing a professional can do is simple: respect the resident as an adult with a right to private, completely fine sexual expression

Professional Challenges: Navigating the Protector's Paradox

Professionals in aged care and social services often face a unique set of ethical and practical hurdles when confronting sexual ageism. The most significant is the *Protector's Paradox*: a practitioner may feel that by ignoring or discouraging a resident's sexual expression, they are protecting them from falls, STIs, or family disapproval. In reality, this protection often violates the individual's right to self-determination.

Other common challenges include:

- **The Family Conflict:** Managing adult children who may be uncomfortable with their parent's new romantic interest or gender transition.
- **The Confidence Gap:** Feeling of not being equipped to discuss sexual health or LGBTQI+ identities because these topics were never covered in their professional training.

- **The Institutional Expectations:** Rigid schedules for feeding, cleaning, and medicating that leave no room for private time or the "messy" reality of human relationships.

Vulnerable Groups and Intersectionality

To understand the impact of ageism, we must recognise that *Older Adults* is not a monolithic group. Intersectionality is the framework that helps us see how different forms of discrimination (like racism, homophobia, and ageism) overlap to create unique experiences of marginalisation.

LGBTQI+ Elders: Many have spent decades surviving in a world that pathologised their identities. When they enter aged care, they often face double invisibility. They are invisible as sexual beings because they are old, and invisible as queer beings because they are in an environment that assumes everyone is heterosexual.

People with Dementia: This group is particularly vulnerable to sexual infantilisation. Staff may view any expression of intimacy as a behavioural symptom to be suppressed rather than a human need for connection. Ethical care here requires a delicate balance of assessing capacity without defaulting to a total ban on touch.

A more intersectional perspective also reveals that the experience of ageing can be profoundly shaped by one's social position:

The Feminine Beauty Standard: Older women often navigate a social landscape that equates femininity with youth. They face a harsher standard of aesthetic ageing and may internalise the belief that they are no longer sexually valid once they no longer meet youthful beauty ideals. This can lead to self-silencing and a hesitation to seek treatment for physical intimacy issues.

Masculinity and Illness: For many older men, identity is traditionally tied to strength, autonomy, and sexual performance. Chronic illness or physical changes (such as erectile dysfunction or prostate issues) can be experienced not just as health problems, but as a profound loss of masculinity. This can lead to withdrawal, depression, or a refusal to discuss sexual health due to a sense of shame.

Class and Economy: Those with fewer financial resources (often women due to the gender pay gap) have less access to private spaces and high-quality sexual health resources, making their intimate lives more subject to institutional surveillance.

Culture: In some cultures, discussing sexuality is a deep taboo that is a strictly private matter or belongs in the family home rather than it is part of an individual health issue. For professionals, this makes intervention a delicate task. An overly direct approach might be perceived as intrusive or disrespectful, causing the older adult to shut down. Practitioners must move with cultural humility, recognising that while sexual rights are universal, the language and boundaries used to discuss them must be adapted to the individual's cultural comfort zone. The goal is to create a safe space where the person feels their privacy is respected while their rights are upheld.

To empower learners to create counter-narratives that challenge ageist media content and promote the sexual rights and diversity of older adults, see [Exercise 3](#).

Guidance for Educators and Professionals

Implicit Ageism is more dangerous because it is unconscious. It is the gut feeling of awkwardness you might feel when seeing an older couple kiss. To combat this, we must practice bias-literacy, which means constantly questioning why we feel uncomfortable in these moments.

Bias-literacy is the ability to recognise ageist triggers in real-time. Before acting, ask yourself: "*Would I react this same way if this person were 30 years old?*" If the answer is no, your reaction is likely shaped by ageism.

The Family Conflict: One of the hardest challenges is when a resident's family objects to their romantic life.

- Remind families that their parent remains an adult with the right to privacy and self-determination.
- If a daughter says, "*It's embarrassing that Dad is dating at 85,*" a professional should respond: "*We understand this is a change for the family, but your father's emotional well-being and his right to form connections are our priority here.*"

Do's and Don'ts

Do	Don't
Use the person's preferred name, e.g. " <i>John</i> ". "Mr." and "Mrs." may be problematic for some transgender individuals, as it can presume a person's gender based solely on appearance.	Don't use Elderspeak or diminutive terms (e.g., " <i>Sweetie</i> ," " <i>Honey</i> ," " <i>Young man</i> ").
Do maintain professional neutrality. Document a new relationship as a " <i>positive social connection</i> ."	Don't react with shock, disgust, or nervous laughter if you witness an older couple being physically affectionate.
Use open questions: " <i>Who are the important people in your life right now?</i> "	Never assume someone is heterosexual or past having sexual needs.
If a resident comes from a culture where sexuality is a deep taboo, focus on comfort and privacy.	If a resident comes from a culture where sexuality is a deep taboo, do not force a western clinical conversation.
Normalise the conversation and include sexual health questions in routine assessments. If the professional treats it as normal, the resident will feel safe.	Don't skip questions about sexual health or STIs because the patient is "too old" for it to be relevant.
Do use gender-neutral language: " <i>Did you have a partner or a significant person in your life?</i> "	Don't assume a widowed resident is heterosexual. Avoid asking " <i>What was your husband's name?</i> "

Do distinguish between inappropriate behaviour and an unmet need for connection. Look for ways to provide safe, consensual touch or sensory comfort.

Don't assume a person with dementia has lost the need for touch.

How to Avoid Stereotypes:

Challenge the Grandparent Label: While someone may be a grandparent, that is not their only identity. Treat them as an individual with a history, gender, and a sexual identity.

Audit your Jokes: If you hear a colleague making a joke about grandpa's new girlfriend, gently intervene: "*Actually, it's great to see him so happy; connection is important at any age.*"

The Permission-Giving Statement: When doing health checks, say: "*Many people find that their sexual needs change as they get older. Is there anything in that area you'd like to talk about?*" This lowers the barrier for the older adult to speak.

Your role is not to be a moral gatekeeper but a facilitator of dignity. By checking your bias, respecting privacy, and using adult language, you create an environment where older adults feel safe enough to be their whole selves.



Summary & Key Messages

Module 2 has explored the pervasive nature of ageism, identifying it as a multi-dimensional barrier that systematically de-sexualises older adults. We moved beyond simple prejudice to examine the three structural levels of ageism: *Institutional* (policies that exclude), *Interpersonal* (daily interactions and "elderspeak"), and *Internalised* (the harmful beliefs older adults turn toward themselves).

By examining the *Shades of Grey* in public opinion and the specific *Sexual Ageism* that assumes older age is a period of asexuality, this module highlighted how myths regarding attractiveness and capability lead to poorer health outcomes and social isolation. Finally, we applied an intersectional lens, acknowledging that the experience of ageism is compounded by gender, culture, and LGBTQI+ identities, requiring professionals to move beyond a one-size-fits-all approach regarding older adults.

Key Messages for Professionals

- **Ageism is a Clinical and Social Risk:** Ageism is not just unkind, it can lead to medical errors, missed diagnoses, and the violation of human rights. Recognising bias is a fundamental professional competency.
- **The Asexual Myth is a Choice, not a Fact:** Research consistently shows that intimacy and sexual interest remain vital components of quality of life well into the 80s and 90s. The end of a sex life is often a result of societal stigma rather than biological necessity.
- **Privacy is a Right, not a Privilege:** In institutional settings, privacy is the prerequisite for dignity. Professionals must transition from *gatekeepers* who monitor behaviour to *facilitators* who protect a resident's private space.

- **Intersectionality Defines the Experience**: We cannot support older adults effectively without acknowledging their diverse backgrounds. A person's history, whether they are an LGBTQI+ elder, a person with dementia, or someone from a traditional cultural background, dictates how they perceive and express their intimate needs.
- **Bias-Literacy Requires Constant Practice**: Combatting ageism is an ongoing process of self-reflection. By auditing our language (eliminating Elderspeak) and our reactions, we create a culture where older adults can age with their identities intact.

Final Thought: If we have the good fortune to live a long life, the ageist stereotypes we challenge today are the very ones that would have harmed us tomorrow. Inclusive care is an investment in our collective future.

Practical Tools

Lesson Plan Module 2

The lesson plan is a structured guide which provides instructions for trainers or professionals on how to implement Module 2 in a group setting. It provides a structure for a training duration of 2.5 hours with a correspondent PowerPoint presentation, lists learning outcomes and a preparation checklist, and describes three exercises (see below).

- **Lesson Plan Module 2** – Effects & Levels of Ageism, including exercise instructions.
- **Presentation Module 2** – Ageism and Misconceptions about the Elders.

Exercise 1 – The Ageism Puzzle

Objective: Learners will identify how 12 Myths of Ageing (WHO, 2013) manifest across *Institutional*, *Interpersonal*, and *Internalised* levels of ageism through real-world scenarios (see instructions in lesson plan).

Resources:

- **12 Case Situation Cards**.
- **12 Myth Cards**.
- **Worksheet: A Master Key for facilitators to check pairings**.

Exercise 2 – Shades of Grey

Objective: To help professionals recognise gaps between their explicit (conscious/polite) beliefs and their implicit (unconscious/gut) reactions using 5 major research themes (see instructions in lesson plan).

Resources:

- **5 Major Theme Cards**.

Exercise 3 – Reimagining the Narrative: A Media Campaign Workshop

Objective: To empower learners to create counter-narratives that challenge ageist media content and promote the sexual rights and diversity of older adults. (see instructions in lesson plan).

Resources:

- [Campaign Worksheets.](#)

References

- Abrams, Z. (2023, March 1). A new concept of aging. *Monitor on Psychology*, 54(2). <https://www.apa.org/monitor/2023/03/cover-new-concept-of-aging>
- Bodner, E.; Cohen-Fridel, S. Relations between Attachment Styles, Ageism and Quality of Life in Late Life. *Int. Psychogeriatr.* 2010, 22, 1353–1361.
- Donizzetti, A.R.; Lagacé, M. COVID-19 and the Elderly's Mental Illness: The Role of Risk Perception, Social Isolation, Loneliness and Ageism. *Int. J. Environ. Res. Public Health* 2022, 19, 4513.
- Gewirtz-Meydan, A., & Ayalon, L. (2020). "Shades of grey": Exploring public opinion about later-life sexuality. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, 39(4), 647-661. <https://doi.org/10.1017/s071498081900062x>
- Gewirtz-Meydan, A., Hafford-Letchfield, T., Benyamini, Y., Phelan, A., Jackson, J. and Ayalon, L. (2018) 'Ageism and Sexuality', in Ayalon, L. & Tesch-Römer, C. (eds.) *Contemporary Perspectives on Ageism*. Cham: Springer International Publishing, pp. 149-162. doi:10.1007/978-3-319-73820-8_10. <https://cora.ucc.ie/bitstreams/7f056dc8-2801-4587-9aec-87a10ad79796/download>
- Heywood, w., Minichiello, v., Lyons, a., Fileborn, b., Hussain, r., Hinchliff, s., ... Dow, b. (2019). The impact of experiences of ageism on sexual activity and interest in later life. *Ageing and Society*, 39(4), 795–814. doi:10.1017/S0144686X17001222
- Kerssies, J., Huijg, J. M., Messelis, E., Abma, T. A., & Bendien, E. (2025). Transforming sexual (self-) ageism: A tailored participatory action research approach for collaborative learning among older adults. *Educational Gerontology*, 51(12), 1340-1352.
- Lyons, A., Alba, B., Heywood, W., Fileborn, B., Minichiello, V., Barrett, C., ... Dow, B. (2018). Experiences of ageism and the mental health of older adults. *Aging & Mental Health*, 22(11), 1456–1464. <https://doi.org/10.1080/13607863.2017.1364347>
- Moore, A., & Reynolds, P. (2016). Against the ugliness of age: Towards an erotics of the aging sexual body. *InterAlia: Pismo poświęcone studiom queer*, (11a). <https://doi.org/10.51897/interalia/lrjz7417>
- Robb, C., Chen, H. & Haley, W.E. Ageism in Mental Health and Health Care: A Critical Review. *Journal of Clinical Geropsychology* 8, 1–12 (2002). <https://doi.org/10.1023/A:1013013322947>
- Surles, T. (2023, February 1). Fight sexual ageism and boost your sexual self-confidence. Next Avenue. <https://www.nextavenue.org/fight-sexual-ageism-boost-your-self-confidence/>
- World Health Organization. (2025, April 28). Ageing: Ageism. <https://www.who.int/news-room/questions-and-answers/item/ageing-ageism>
- World Health Organization. (2021). *Global report on ageism*. <https://www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/ageism/global-report-on-ageism>
- World Health Organization. (2013). *Demystifying the myths of ageing*. WHO Regional Office for Europe. <https://iris.who.int/bitstreams/27967758-3b6e-47cf-9242-e5961ddd3252/download>

MODULE 3

Sexuality, Gender and Diversity

Developed by:

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Overview

Why This Module Exists

Despite significant advances in LGBTQIAP+ rights across Europe, one population remains largely invisible in both public discourse and professional practice: LGBTQIAP+ elders. When was the last time you saw an openly lesbian or gay older couple in a training video? When did you last discuss the specific needs of an aging trans person in a care setting? For most of us, the answer is never.

This silence is not an accident. It is the result of a profound intersection of invisibilities: ageism, which desexualizes and infantilizes older people; heteronormativity, which assumes everyone is heterosexual; cisnormativity, which erases trans and non-binary experiences; and the lasting legacy of decades of criminalization, pathologization, and social stigma.

The Weight of History

LGBTQIAP+ elders alive today have lived through extraordinary historical changes. In France, homosexuality was partially decriminalized in 1791 but the age of consent remained unequal until 1982. In Germany, older gay men may carry the trauma of Nazi-era Paragraph 175, not fully repealed until 1994. In Romania, homosexuality was a criminal offense until 2001. Trans identities were classified as mental illnesses well into the 21st century. The AIDS epidemic of the 1980s and 1990s decimated networks of friends and chosen family, leaving deep scars of grief and survivor's guilt.

This is not ancient history. It is the lived experience of people now in their 70s, 80s, and 90s. They learned to hide who they were, to distrust institutions, to expect rejection. These survival mechanisms do not disappear with legal progress. They resurface when a person faces new vulnerabilities: loss of autonomy, entry into a care facility, dependence on others.

The “Return to the Closet”

One of the most heartbreaking phenomena documented by Grey Pride and by Le Girofard's own focus groups is the "return to the closet." An elder who has lived openly for decades may, upon entering a care facility, feel compelled to hide their identity again. They remove photos of their partner. They fall silent about entire decades of their life. Why? Because institutions are not perceived as safe. Because staff are not trained. Because the price of visibility, when you are vulnerable, feels too high.

What This Module Offers

This module invites professionals to:

- Understand the historical context that shaped LGBTQIAP+ elders' lives.
- Recognize specific barriers they face in accessing dignified care.
- Identify ageism within LGBTQIAP+ communities, a painful reality from our intergenerational dialogues.
- Learn from inspiring alternatives: the Maison de la Diversité, Lebensort Vielfalt, Grey Pride's “*Bienvenue*” label.

- Develop practical skills for creating environments where every elder feels seen, safe, and respected.

Ultimately, this module affirms that dignity in aging means the right to be fully oneself, without concealment or fear. It is about building a future where no elder has to choose between safety and identity.

Learning Outcomes Module 3

By the end of this module, participants will be able to:

- Distinguish between the concepts of sexual orientation, gender identity, gender expression and biological sex, and explain why these distinctions matter when supporting seniors.
- Describe the specific life experiences of LGBTQIAP+ seniors: socialization in a context of criminalization, impact of HIV/AIDS, “going back into the closet” in institutions.
- Analyze how age, sexual orientation and gender identity intersect to create unique situations of vulnerability.
- Identify manifestations of ageism within LGBTQIAP+ communities themselves and their consequences on the isolation of older individuals.
- Cite inspiring initiatives (Maison de la Diversité, Lebensort Vielfalt, Grey Pride's “*Bienvenue*” label) and draw inspiration from them in their professional practice.
- Use language and adopt a posture that does not presuppose the heterosexuality or cisidentity of the people they support.



Key Concepts & Definitions

Sexual orientation: Umbrella term describing the gender(s) towards which a person may feel emotional, romantic and/or sexual attraction (lesbian, gay, bisexual, pansexual, asexual, heterosexual).

Gender identity: A person's deep internal sense of being male, female, both, neither, or somewhere else on the spectrum. May differ from sex assigned at birth.

Cisgender: A person whose gender identity aligns with the sex they were assigned at birth.

Transgender/Trans: A person whose gender identity differs from the sex they were assigned at birth.

Non-binary: Term describing gender identities that do not fit exclusively within the man/woman binary.

Queer: Umbrella term for people whose sexual orientation or gender identity differs from dominant norms. Once pejorative, it has been reclaimed, but some older adults may still perceive it negatively.

Heteronormativity: The systemic assumption that heterosexuality is the norm. Concrete example: an admission form offering only “Married” or “Widowed” options.

Cisnormativity: The assumption that everyone's gender identity necessarily matches their sex assigned at birth.

“Going back into the closet”: Phenomenon where LGBTQIAP+ seniors hide their identity upon entering an institution, for fear of judgment or discrimination.

Minority stress: Concept by Ilan H. Meyer (1995) describing the physical and mental health problems linked to discrimination experienced by minorities.



Understanding the Topic

1. Why a Specific Module on LGBTQIAP+ Seniors?

This module is not a “diversity add-on”. It is fundamentally necessary because LGBTQIAP+ elders have lived through the 20th century in a radically different way than their heterosexual and cisgender peers. Understanding this history is not optional—it is essential for providing competent, dignified care.

1.1. A Contrasting Legal and Cultural Legacy Across Europe

The rights of LGBTQIAP+ people evolved at very different rates across European countries. This past is not ancient history—it directly shaped the life paths of today's elders. The table below illustrates these differences:

Country	Decriminalization	Marriage	Impact on Seniors
France	1982	2013	Seniors who experienced criminalization, then belated recognition.
Germany	1969 (FRG) / 1988 (GDR)	2017	Generations marked by paragraph 175 (Nazi criminalization).
Romania	2001	Prohibited	Persistent stigmatization, lack of legal recognition.
Cyprus	1998	Prohibited / Civil Cohabitation since 2015	Lack of social security, pensions, inheritance and medical protections

Portugal	1982	2010	Years of waiting for social and state recognition
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In France and Germany, despite legislative progress, many elders grew up in contexts where their identities were pathologized, criminalized, or hidden. This has created deep-seated patterns of concealment, shame, and distrust of institutions—patterns that do not disappear with age or legal change.

“I lived with my ‘friend’ for decades. Everyone knew, but we never held hands. Now people do it openly, and it makes me uneasy.”

(Focus group participant, 70+)

This quote illustrates the dilemma of older generations: they learned to hide to survive, and this habit does not disappear with evolving laws. It remains embedded, and can resurface in care environments where vulnerability is high.

1.2. The Weight of Institutions: A Life Spent Fearing Them

For many LGBTQIAP+ elders, institutions have never been safe places. Brett, a 72-year-old trans man from Lyon, carries this history in his body:

“I’ve been in institutions most of my life. It never scared me. But I won’t get to be in a nursing home like my mom was.”

Brett spent his teenage years in foster homes and group homes, estranged from his family. Unlike his mother, who could enter a nursing home expecting basic dignity and recognition, Brett knows his experience will be different. He has a full beard, a low voice, and has had his breasts removed. But he never had gender-affirming surgery, meaning that his transgender status would become instantly obvious to any caregiver tasked with bathing or dressing him.

This fear is not abstract. It is rooted in a lifetime of navigating institutions that were not designed for people like him. For Brett, and for countless other LGBTQIAP+ elders, entering a care facility is not a neutral transition—it is a potential return to a lifetime of vulnerability, exposure, and the constant need to justify one’s very existence.

1.3. The Impact of HIV/AIDS on a Generation

The AIDS epidemic of the 1980s and 1990s was a cataclysm for gay and bisexual communities. It decimated entire networks of friends, partners, and chosen family, creating deep generational trauma that continues to affect survivors today.

Key data:

- 30% of HIV diagnoses in France now involve people over 50
- Over 50,000 people living with HIV in France are over 50
- Many survivors experience what is called “Lazarus syndrome” - PTSD-like symptoms from surviving the epidemic while watching friends die

This history directly influences how older LGBTQIAP+ people relate to aging and institutions:

- Distrust of medical establishments that once pathologized them or failed them during the AIDS crisis
- Fragile support networks—chosen families were often decimated, leaving survivors isolated
- Fear of dependence—anxiety about losing autonomy and ending up at the mercy of potentially judgmental caregivers

As Grey Pride warns: “Care and nursing staff have received no training on HIV. We risk seeing the same fear and rejection we experienced in hospitals in the 1980s.”

1.4. The Weight of Silence: Invisibility in Media and Society

LGBTQIAP+ elders are almost entirely absent from media representations, training materials, and public discourse. As Francis Carrier, president of Grey Pride, notes:

“At present, it is almost impossible to find in French LGBT iconography positive images of older LGBT couples, as if sexual orientation and gender identity were reserved for youth.”

This invisibility is a form of violence. It sends a message that people like Brett do not exist, do not matter, and do not deserve to be seen. It contributes directly to isolation and self-censorship.

2. The Specific Challenges of LGBTQIAP+ Elders

2.1. The Body as a Site of Vulnerability: Trans Elders in Care Settings

For trans elders, the body itself becomes a site of potential exposure and vulnerability. Brett's situation illustrates this with painful clarity. To the outside world, he is a man. His beard, his voice, his clothing all align with his gender identity. But his body tells a more complex story—one that a nursing home aide might unexpectedly discover while helping him bathe.

This moment of discovery is fraught with risk. Will the aide react with professional calm, having been trained to understand diverse trans bodies? Or will there be shock, awkwardness, whispered conversations in the hallway? Brett's fear is not hypothetical—it is based on a lifetime of navigating spaces where his body was seen as “wrong”, “confusing”, or “deviant”.

Key challenges for trans elders in care settings:

- Involuntary disclosure of trans status during intimate care
- Lack of staff training on the diversity of trans bodies and transitions
- Absence of protocols for respectful intimate care
- Fear of harassment from other residents
- Potential misgendering after staff becomes aware of trans history

2.2. The "Return to the Closet" Phenomenon

One of the most heartbreaking findings from research and practice is the “return to the closet”. An elder who has lived openly for decades may, upon entering a care facility, feel compelled to hide their identity again.

Why does this happen?

- Fear of discrimination from staff or other residents
- Lack of visible signs of safety (rainbow stickers, inclusive posters)
- Previous negative experiences with healthcare providers
- Assumption that "people like me" aren't welcome here

Key data:

- 90% of LGBTQIAP+ elders have no children (INSEE)
- Only 12% of nursing homes in France train their staff on LGBTQIAP+ issues (Grey Pride, 2024)
- In labeled facilities ("Bienvenue" label), 30% more residents disclose their LGBTQIAP+ identity

2.3. Ageism Within LGBTQIAP+ Communities

One of the most striking findings from Le Girofard's intergenerational dialogue sessions is the reality of ageism within queer communities themselves.

Manifestations of intra-community ageism:

- In nightlife and cultural spaces: a pervasive “cult of youth” in gay bars, clubs, and drag scenes
- On dating apps: explicit rejection based on age (“too old”, “pass”)
- In activism: younger generations sometimes perceived as “overly theoretical” or disconnected from historical struggles; older generations sometimes made to feel their contributions are no longer relevant

- Social pressure to maintain a youthful appearance and energy, especially in social and dating contexts

This reality is particularly painful because it affects people already marginalized by mainstream society. It underscores the need for intentionally created intergenerational spaces where age diversity is seen as a strength, not a barrier.

2.4. The Persistent Taboo of Elder Sexuality

Beyond LGBTQIAP+ communities, society maintains a deep discomfort regarding the sexuality of older people.

The manifestations of this taboo:

- The myth of asexuality: the belief that sexual desire naturally expires at a certain age
- The aged body as a “non-sexual” body: elders are seen only as grandparents or patients—culturally desexualized roles
- The silence of institutions: in care settings, staff may think they are “protecting” residents by ignoring their intimate lives, when they are actually stripping away their agency

“Not talking about desire is removing an essential part of the individual.”

(Grey Pride campaign)

“Sexuality exists in tenderness... but not necessarily in sexual intercourse.”

(Focus group participant)

For trans elders, this taboo is compounded. Their body, already marked as “different” by societal norms, is further desexualized by age. The possibility of intimacy, of touch, of being seen as a desiring and desirable being, becomes almost unimaginable within the institutional gaze.

This taboo creates a vicious circle of silence:

- The elder stays silent to avoid being seen as inappropriate
- The professional stays silent due to lack of training or fear of awkwardness
- The family stays silent to preserve a certain image of their aging parent

2.5. Isolation: A Structural Issue

Isolation affects many elders, but for LGBTQIAP+ elders, it is often intensified by specific factors.

Specific Isolation Factors	Key Data
Lack of children	90% of LGBTQIAP+ elders have no children (INSEE). "Chosen families" are crucial but may be fragile.
Lack of inclusive facilities	Only 12% of nursing homes train staff on LGBTQIAP+ issues (Grey Pride, 2024).
Economic insecurity	40% of queer elders have pensions under €1000/month, linked to careers disrupted by discrimination.
Family rejection	Many experienced rejection from families of origin, leaving them without traditional support networks.
Geographic isolation	In rural areas, opportunities to connect with other LGBTQIAP+ people are extremely limited.

"LGBT elders suffer even more from isolation and poverty than other older people."

2.6. Healthcare Access: A Minefield

Access to respectful, competent healthcare remains a major challenge for LGBTQIAP+ elders.

Key data:

- 72% of doctors never ask older patients about their sexual orientation
- More than half of LGBT people do not discuss their sexual orientation during medical visits
- 67% of LGBT people over 50 believe they have poorer access to healthcare
- 65% fear they will be subjected to violence in care settings

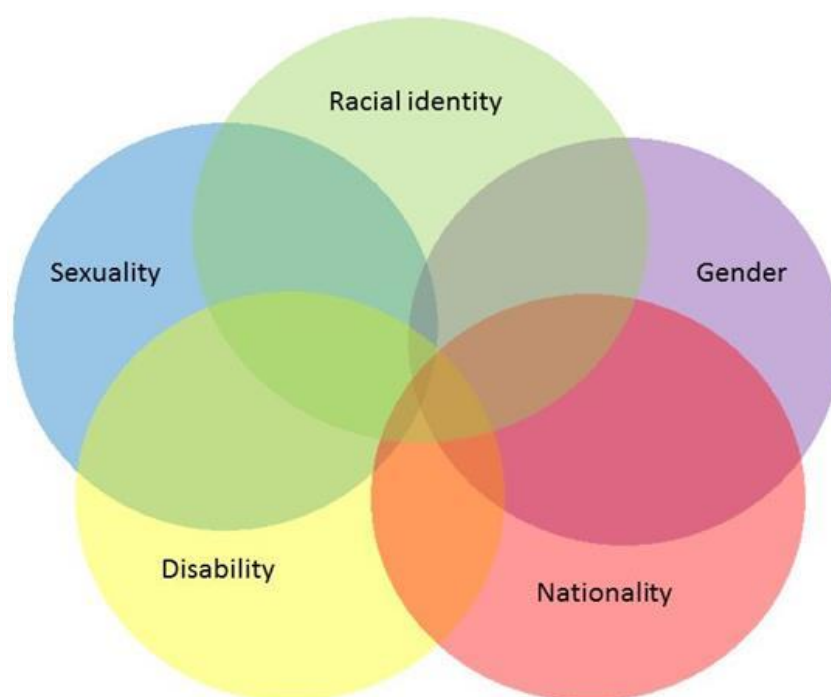
Specific barriers:

- Invisibility in medical practices: the silence rests on the erroneous assumption that sexual orientation is either obvious (heterosexuality presumed) or irrelevant
- Lack of knowledge about specific needs: staff are rarely trained on the needs of trans elders (hormone therapy continuity) or older gay men (sexual health, HIV)
- Fear of discrimination: many delay seeking care or avoid disclosing important information

"The impossibility of talking about one's identity leads to greater isolation and precariousness."

3. Intersectionality in Practice: Understanding Complex Situations

Intersectionality is not an abstract concept—it is a practical tool for analyzing situations and adapting care. Here are case studies drawn from research and focus groups.



Case Study 1: Barry, 72, trans man (inspired by The Atlantic article)

Barry is a 72-year-old trans man living in Lyon. He has a full beard, a low voice, and has had his breasts removed. However, he never had gender-affirming surgery. His body therefore bears the marks of a unique transition journey, different from the standardized paths often imagined by caregivers.

After a career in education and a life marked by complex family relationships (he spent his teenage years in foster homes), Barry lives alone. Recently, a fall and the onset of heart problems have led him to reluctantly consider entering a nursing home.

During a pre-admission visit, the director addresses him as "Mister" he feels recognized. But when the nurse coordinator raises the question of personal care and daily assistance, he senses discomfort. He knows that one day, perhaps soon, a caregiver will discover his naked body, and with it, a story that his external appearance does not tell. He dreads the questions, the stares, the whispers. He dreads having to justify who he is, once again.

Key challenges:

- Involuntary disclosure of trans status during intimate care
- Lack of staff training on diverse trans bodies and transitions
- Absence of institutional protocols for respectful intimate care
- Fear of isolation and discrimination from other residents
- The weight of a lifetime of institutional distrust

Questions for reflection:

- What assumptions might influence staff reactions when they discover Brett's body?
- What are the risks if the institution ignores the situation and puts nothing in place beforehand?
- What would a respectful, person-centered response look like?

Case Study 2: Simone, 78, lesbian

Simone lived with her partner for 40 years before she passed away. She is now entering a nursing home. On the surface: an elderly, widowed lady. But behind this apparent simplicity lies a much more complex reality:

- Ageism: no one talks to her about her emotional life anymore. It is assumed that at her age, “these questions” no longer arise.
- Sexism: as an older woman, she faces the “double standard of aging” - her social value and desirability decrease with age, unlike men's.
- Lesbophobia/invisibility: no one ever asks if the important person in her life was a woman. The wedding photo on the dresser? She doesn't have one. Her grief is completely ignored.

Intersectionality means understanding that these three dimensions combine to create a unique situation of vulnerability and invisibility. An inclusive approach must address all of them.

Case Study 3: Fatima, 68, lesbian and racialized

Fatima is a lesbian woman of North African origin living in a small town, considering moving to assisted living.

- Racism and lesbophobia: she faces potential discrimination related to both her origins and her sexual orientation, layered on ageism.
- Double invisibility in representation: media and culture almost never show older, racialized, lesbian women. She is represented nowhere.

- Specific stereotypes: she may face stereotypes like the “masculine lesbian” or the hypersexualization of racialized women.
- Healthcare access barriers: structural inequalities in healthcare access for racialized people compound with reluctance to discuss LGBTQIAP+ topics.

These examples show that it is impossible to properly support a person without considering the totality of their identity. Inclusion is not treating everyone “the same way” - it is adapting one's approach to the uniqueness of each life path.

4. Understanding the Research: What Studies Tell Us

Recent research provides valuable insights into the experiences and needs of LGBTQIAP+ elders.

4.1. The LEAP Study (2025-2027)

The LEAP study (LGBTQ+ Inclusive Home Provision for older people), a major UK-based research project launching in June 2025, aims to understand how prepared home care workers are to support older LGBTQ+ people.

Key findings from previous research that inform this study:

- Care workers lack skills, knowledge, and confidence to support older LGBTQ+ people
- Studies have focused on care homes, but home care remains under-researched
- Many LGBTQ+ adults worry about receiving hostile or discriminatory treatment in social care
- Some report fears about having to “de-gay” their own homes to protect themselves from anticipated homophobia or transphobia

Brett's story illustrates this perfectly. The fear is not about the home he might leave, but about the institution he might enter—a place where he may lose control over his own narrative.

4.2. The Insider-Outsider Status

Research on LGBT residents in mainstream housing schemes reveals an “insider-outsider status” - they experience partial visibility while also encountering exclusionary pressures that locate them as “the other”.

Key findings from a UK study (2019-22) with 15 LGBT residents aged 55-79:

- LGBT residents navigate a complex social position—visible yet marginalized
- Exclusionary practices by other residents reinforce boundaries of sexual and gender “normalcy”
- Maintaining external social connections outside the scheme becomes crucially important

This research challenges the assumption that housing schemes automatically provide “safe, secure spaces to grow old”. For LGBTQIAP+ elders, safety cannot be assumed—it must be actively created.

4.3. The Concept of “Chosen Family” and Its Limits

The importance of “families of choice” alongside families of origin is well documented. However, research also reveals the fragility of these networks:

- Proximity matters: friends may not live nearby or may face their own age-related mobility issues
- Friends may be the same age and experiencing similar health declines
- Networks decimated by the AIDS crisis left lasting gaps in support

This is why intentional community-building and inclusive institutional support are essential—chosen families cannot always provide the care that institutions should be offering.

5. Inspiring Initiatives for Action

It is not enough to identify problems. Concrete solutions exist across Europe, proving that another way is possible.

5.1. The Maison de la Diversité (Lyon, France)

Led by Les Audacieuses & Les Audacieux, this inclusive and participatory housing project responds to the social isolation of LGBTI+ elders and people living with HIV.

The concept: individual housing units + shared collective spaces + intergenerational living (including student housing), based on a project of mutual aid and solidarity around “aging well”.

Core values:

- Social connection as the key to aging well and maintaining autonomy
- Inclusive housing as a supportive, anti-speculative way of life
- Intergenerational solidarity as a source of inspiration and richness
- Openness to the surrounding neighborhood

This project is directly inspired by Lebensort Vielfalt in Berlin, a European pioneer since 2013.

5.2. Grey Pride and the “Bienvenue” Label (France)

Grey Pride combines advocacy with concrete tools for professionals. Relationships, sexuality or identity are some of the subjects that could be impacted in elder LGBTQI+ persons arriving in carehouses. This label is made to put forward these themes in taking care gestures.

Key actions:

- National helpline for isolated elders (01 44 93 74 03, Tuesdays and Thursdays 4-6pm)
- Qualiopi-certified training in nursing homes for all staff (caregivers, administration, management)

“*Bienvenue*” label: strict criteria for inclusive facilities:

- Trained staff
- Anti-discrimination charter
- Non-gendered spaces
- Regular audits with LGBTQIAP+ associations
- Partnerships with HIV-specialist physicians

Key data: In “*Bienvenue*”-labeled facilities, 30% more residents disclose their LGBTQIAP+ identity.

“Beyond the label, through training and awareness-raising in both private and public sectors: we must work towards recognition of gender identities in senior facilities.”

For Brett, a “*Bienvenue*”-labeled facility would send an immediate signal: here, staff have been trained. Here, my body will not be a source of scandal. Here, I might be able to age in peace.

5.3. Lebensort Vielfalt (Berlin, Germany)

A pioneering residence opened in 2013 by Schwulen Beratung Berlin, with 24 housing units for autonomous LGBT elders. With a waiting list of 400 people, two additional facilities have since opened, specializing in neurodegenerative diseases and psychological disorders.

Strengths:

- Chosen diversity: 60% gay men / 20% young people (under 55) / 20% women
- Small specialized care unit for those losing autonomy
- Openness to the neighborhood and cultural life

5.4. Tonic @Bankhouse (London, UK)

The UK's first LGBT+ affirming retirement community, opened in 2021 and fully occupied by the end of 2024.

Key features:

- 26 residents in a mix of shared ownership and rented apartments
- A “Community Agreement” signed by all staff and residents committing to inclusion
- Residents organize their own outings, communal meals, and gatherings—fostering “chosen family”
- Support through end-of-life experiences, shared grief, and legacy reflection

“At Tonic, people find a chosen family, a supportive network where they can be their authentic selves.”

“Why should we only have to be accepted? Accepted is almost like tolerated. But affirmative is: you don't have to explain anything, you're part of us.”

(Tonic resident)

This distinction - between “accepted” and “affirmed” - is crucial.

5.5. Key Lessons from These Initiatives

Lesson	Implication
Inclusion is not tolerance	“Accepted is almost like tolerated. Affirmative means you don't have to explain anything.”
Chosen families need support	Institutions must recognize and support these networks, not ignore them.
Training must be comprehensive	All staff—not just caregivers—need training.
Visible signs of safety matter	Rainbow stickers, inclusive posters, non-gendered spaces send powerful messages.
Co-creation is essential	Elders must be involved in designing the spaces and services meant for them.

These examples show that inclusion is not an abstract concept—it is a set of concrete choices: choices about housing, training, community-building, and labeling virtuous practices

6. The Intergenerational Dialogue Sessions: Key Findings

Le Girofard's intergenerational dialogue session in Bordeaux (October 22, 2025) brought together 23 participants aged 19-82 and revealed crucial insights.

Key themes that emerged:

1. Ageism and exclusion within LGBTQIAP+ communities

- Multiple participants described a “cult of youth” in queer spaces
- Older gay men reported feeling invisible in bars and clubs

- Some were told they were “too old” for certain events or spaces

2. Redefining sexuality in later life

- Participants defined sexuality broadly: tenderness, affection, sensuality, emotional connection
- Reduced emphasis on penetrative sex with age
- Importance of self-pleasure and solo sexuality acknowledged

3. Deep distrust of institutional care (EHPADs)

- Widespread fear of having to “go back into the closet”
- Concerns about heteronormative and cisnormative environments
- Lack of staff training on LGBTQIAP+ issues

"My challenge would be to avoid retirement homes at all costs. What happens there is truly appalling."

4. Strong desire for community-based alternatives

- Intergenerational co-housing projects
- LGBTQIAP+-specific senior residences
- Community-based care networks
- “Aging in place” with community support

"I'd like to be in a shared house... I think there are projects starting to be set up, shared housing for older people. »"

5. Intergenerational learning is valued—and needed

- Younger participants learning about historical struggles (AIDS crisis, legal battles)

- Older participants learning about evolving terminology and identity concepts
- Strong desire for more regular intergenerational exchanges

7. Implications for Professional Practice

What do all these findings mean for educators, caregivers, and institutions?

For training and education:

- Include modules specifically addressing intra-community ageism
- Develop case studies based on real experiences
- Address practical concerns about care facilities and healthcare access
- Use intergenerational dialogue as a core methodology
- Train staff specifically on trans aging and the diversity of trans bodies

For institutional practice:

- Develop clear protocols for intimate care that respect resident autonomy and dignity
- Visible signs of safety (rainbow stickers, inclusive posters) are essential, not optional
- Staff training must be comprehensive and ongoing
- Anti-discrimination policies must be actively enforced, not just displayed
- Partnerships with LGBTQIAP+ organizations provide essential expertise and credibility

For policy and advocacy:

- Support the development of LGBTQIAP+-affirming housing options
- Fund research on the specific needs of LGBTQIAP+ elders
- Require cultural competency training in all publicly funded elder care
- Recognize and resource community-led initiatives

For every professional who might encounter a LGBT+ elder:

- Remember that you may be the first person who has ever asked him the right question
- Remember that your reaction to his body will echo through his entire experience of care
- Remember that dignity is not a gift you bestow—it is a right you must protect
- Remember that they have been facing institutional violence their whole life. Your job is to make this one different.



Guidance for Educators and Professionals

Essential Reflexes to Develop

Language, the primary tool for inclusion:

- ✓ Replace “Do you have a husband/wife?” with “Is there an important person in your life?”
- ✓ Ask: “What pronouns would you like me to use?”
- ✓ Use neutral terms like “partner”.
- ✓ On forms, replace “Mr./Mrs.” with “First name”, “Last name”, and add an “Other” option.

What to avoid:

- ✗ “Elderspeak” or infantilizing diminutives (“young lady”, “young man”, “dear”, “sweetie”).
- ✗ Assuming heterosexuality (“How old was your husband when he passed?”).
- ✗ Laughing or making “discreet” comments about a relationship between two older people.

Creating a Welcoming Environment

- Visible signs: a small rainbow sticker, a “Everyone is welcome here” poster are strong signals.
- Documentation: display contact information for associations like Grey Pride.
- Non-gendered spaces: toilets accessible to all genders.
- Activities: offer diverse events, not just traditionally gendered activities.

Adapting Your Practice

- With a trans person: respect their chosen name and pronouns, ensure continuity of hormone therapy, do not ask intrusive questions.
- With a person living with HIV: do not stigmatize, maintain medical follow-up, be aware of specialized resources.
- With a person from a different cultural background: practice cultural humility, ask about their own words and reference points.



Summary & Key Messages

- Inclusion of LGBTQIAP+ seniors is not an option, it is an ethical and professional obligation to guarantee equal access to care and dignity.
- History matters. The experience of stigmatization among LGBTQIAP+ seniors influences their relationship with institutions. Ignoring this history means reproducing violence.
- Ageism also exists within communities. We must be aware of this and create truly intergenerational spaces.
- Alternative models exist and work (inclusive housing, labels, training). They prove that an inclusive society for all ages is possible.
- Action starts with language and posture. As a professional, you have the power to create safe spaces simply through your way of being and speaking.



Practical Tools & Resources

Lesson Plan Module 3

The [lesson plan](#) is a structured guide which provides instructions for trainers or professionals on how to implement Module 3 in a group setting. It provides a structure for a training duration of 2.5 hours with a correspondent PowerPoint presentation, lists learning outcomes and a preparation checklist, and describes three exercises (see below).

Exercise 1 – The Vocabulary of Inclusion

Objective: To understand and appropriate key LGBTQIAP+ terminology and its importance in professional practice with older adults (see instructions in lesson plan).

[Scenario Cards](#) – The Vocabulary of Inclusion.

Exercise 2 – Case Study Analysis

Objective: To analyse concrete situations of LGBTI+ elder and collectively build an appropriate, person-centred response (see instructions in lesson plan).

[Case Study Card](#).

[Case Study Discussion Questions](#).

Exercise 3 – Reimagining the Institution

Objective: To design concrete actions for making an institution more inclusive for LGBTQIAP+ elders across three domains: training, physical environment, and policies/protocols (see instructions in lesson plan).

[Institution Cards](#) – EHPAD / Home Care Service / Hospital / Assisted Living Residence.

3 Domain Action Plan Worksheet.



References

Grey Pride & French Initiatives

Association Grey Pride. (2023-2024). Guide "Accueillir les seniors LGBTQIAP+", Label "Bienvenue" – Critères et données d'impact, Ligne d'écoute nationale.

<https://greypride.fr/>

<https://greypride.fr/label-bienvenue/>

France Inter / Radio France. (2023, June 15). Deux Ehpad parisiens récompensés du label "Grey Pride" pour leur accueil des seniors LGBT.

<https://www.radiofrance.fr/franceinter/deux-ehpad-parisiens-recompenses-du-label-grey-pride-pour-leur-accueil-des-seniors-lgbt-1402454>

20 Minutes. (2023, June 19). Paris : Des Ehpad labellisés LGBT pour accueillir toutes les sexualités.

<https://www.20minutes.fr/paris/4041985-20230620-paris-ehpad-labellises-lgbt-accueillir-toutes-sexualites>

Les Audacieuses & Les Audacieux. (2024). Le projet Maison de la Diversité.

<https://audacieusement.org/le-projet-maison-de-la-diversite/>

International Initiatives

Schwulen Beratung Berlin. (2013). Lebensort Vielfalt – Ein Wohnprojekt für ältere Lesben, Schwule und Transgender.

<https://schwulenberatungberlin.de/lebensort-vielfalt/>

Tonic Housing. (2024). Tonic @ Bankhouse – UK's first LGBT+ affirming retirement community. Precarious Lives: Research on LGBT+ elders in housing.

<https://tonichousing.org.uk/>

<https://tonichousing.org.uk/our-impact/>

Trans Aging

The Atlantic. (2015, August 12). The Challenge of Being Transgender in a Nursing Home.

<https://www.theatlantic.com/health/archive/2015/08/transgender-nursing-home-aging/400580/>

Siverskog, A. (2021). Ageing bodies that matter: Age, gender and embodiment in older transgender people's life stories. *Journal of Aging Studies*, 58, 100951.

<https://www.sciencedirect.com/journal/journal-of-aging-studies>

Witten, T. M. (2017). Transgender and gender non-conforming aging: A review of the literature. *Journal of Aging Studies*, 43, 1-8.

<https://www.sciencedirect.com/journal/journal-of-aging-studies>

Bockting, W., Coleman, E., & De Cuypere, G. (2011). Care of transsexual persons. *New England Journal of Medicine*, 364(26), 2559-2560.

<https://pubmed.ncbi.nlm.nih.gov/21714669/>

Key Research & Data

Ezhova, I., Savidge, L., Bonnett, C., Cassidy, J., Okwuokei, A., & Dickinson, T. (2020). Barriers to older adults seeking sexual health advice and treatment: A scoping review. *International Journal of*

Nursing Studies, 107, 103566.

<https://pubmed.ncbi.nlm.nih.gov/32380261/>

Flesia, L., Monaro, M., Jannini, E. A., & Limoncin, E. (2023). "I'm Too Old for That": The Role of Ageism and Sexual Dysfunctional Beliefs in Sexual Health in a Sample of Heterosexual and LGB Older Adults. *Healthcare*, 11(4), 459.

<https://pubmed.ncbi.nlm.nih.gov/36832993/>

Fredriksen-Goldsen, K. I., et al. (2011). The Aging and Health Report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults. Institute for Multigenerational Health.

<https://stagebeta.scispace.com/papers/resilience-and-disparities-among-lesbian-gay-bisexual-and-46a7zc9ai4>

Institute of Medicine (US). (2011). The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding. National Academies Press.

<https://www.ncbi.nlm.nih.gov/books/NBK64800/>

Simpson, P., Horne, M., Brown, L. J. E., Wilson, C. B., Dickinson, T., & Torkington, K. (2018). The experiences of older lesbian, gay, bisexual and transgender people in care homes: A systematic review. *Ageing & Society*, 38(11), 2217-2240.

<https://www.cambridge.org/core/journals/ageing-and-society>

de Vries, B., & Croghan, C. F. (2014). LGBT Aging: The Contributions of Community-Based Research. *Journal of Homosexuality*, 61(1), 1-20.

<https://www.semanticscholar.org/paper/LGBT-Aging%3A-The-Contributions-of-Community-Based-Vries-Croghan/19ea7944dd8f48449926c0e147d9ebe23512ba83>

French Data & Reports

INSEE. (2023). Enquête Famille et logements – Données sur la composition des ménages.

<https://www.insee.fr/fr/statistiques>

Les Petits Frères des Pauvres. (2022). Rapport sur l'isolement social des personnes âgées.

<https://www.petitsfreresdespauvres.fr/informer/nos-publications/rapports>

Glossaries & Terminology

Chase, B., & Ressler, P. (2009). An LGBT/Queer Glossary. *The English Journal*, 98(4), 23–24.

<https://eric.ed.gov/?id=EJ832256>

Zeyen, T. L., Brunnett, R., Lottmann, R., & Kiegelmann, M. (2020). *LSBTIQ und Alter(n): ein Lehrbuch für Pflege und soziale Arbeit*.* Göttingen: Vandenhoeck & Ruprecht.

World Health Organization

World Health Organization. (2021). Global report on ageism.

<https://www.who.int/teams/social-determinants-of-health/demographic-change-and-healthy-ageing/ageism/global-report-on-ageism>

World Health Organization. (2019). Sexual health and rights.

<https://www.who.int/health-topics/sexual-health>

MODULE 4

The History of Social Norms of Gender and Sexuality in Europe

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Overview

Age and sexuality are still closely linked to stereotypical ideas, normative attributions, invisibility and taboos. This is also shown by the results so far of the "Never gets old" project (2024-2026), in which surveys of attitudes towards sexuality and age are being carried out in five European countries. Older people are often considered asexual, i.e. without any need for sexuality or primarily functional with regard to family structures and roles (grandparents). This happens both in everyday discourses and in media and institutional structures, such as in geriatric care facilities, which we have included in our project.

However, social norms of 'gender and sexuality' are not a static structure, but the result of historical negotiation processes. In Europe, they have been shaped over thousands of years by religion, law, medicine, economics and political power – and have been questioned again and again. Our ideas of gender, age and sexuality have thus grown historically and shape the self-image of older and younger people, family expectations and the actions of professionals in nursing, counselling and adult education.

The interviews and group discussions from the 2nd work package of the project show that the topic of sexuality in old age is strongly taboo in a wide variety of contexts: in families, in institutions and especially in nursing homes and between generations. In the discussions, the experience was mainly shared that sexuality surprises younger people in old age. This is how a teacher for nursing professions describes from her everyday life:

"I notice boundaries insofar as the student body sometimes shows me so often when it comes to sex in old age, [...] from 40 it is over. I reflect on this again and again and there is great amazement."

The reactions to pictures she shows in class also illustrate internalized stereotypical ideas:

"And the reactions to pictures that I show with hugs from people over 60 are: Wow, I can't even look, does it have to be like this? Or holding hands (...) oh, that's cute".

It has long been researched and described that sexuality is not a privilege of youth and that sexuality in old age is not a marginal phenomenon, but part of lifelong identity formation. Our perception of sexuality is influenced by norms, narratives (cultural narrative structures) and media images. These are then also incorporated into the concrete implementation of care, counselling and educational work.

The aim of this module is to show that social norms on gender and sexuality have changed again and again in the course of our history and that the respective validities shape our social human interaction with each other and influence our own self-image. By critically questioning the mechanisms for adopting values, norms and roles, the possibility is opened up to recognize stereotypes, question taboos and promote a self-determined way of life for older people.

The module is intended to support professionals in reflecting on their own assumptions, designing professional scope of action safely and consciously addressing normative expectations. Participants are given methods and spaces to recognize social norms, to examine their own attitudes and to react reflectively to age- and sexuality-specific questions.

The aim of this thesis is therefore to show the historical, cultural and media mechanisms that shape social norms on age and sexuality, and to derive methodological approaches for practice-oriented educational work.

Learning outcomes in Module 4

Target group	Gaining knowledge
Participants learn:	Standards have grown historically - What is considered "normal" today used to be different – and will continue to change. One's own convictions are socially shaped - Irritations and discomfort have cultural causes and are not individual deficits. Sexuality in old age is not a special case - but part of lifelong identity development.
Benefits for adult educators	Adult educators benefit because they: - be able to moderate more sensitively, - recognize their own implicit norms, - create learning spaces without embarrassment, - Understanding conflicts between generations better.
Benefits for skilled workers	Professionals (nursing, social work, counselling) benefit because they: - deal more professionally with closeness, intimacy and boundaries, - take the needs of older people seriously, - critically reflect on institutional rules, - act more ethically.



Understanding the Topic

1. Theoretical Frame of Reference: Social Norms, Identity and Age

Social norms are basic rules and agreements that structure the behaviour of individuals within a society. They define what is considered appropriate, expected or deviant, and have both a regulating and guiding effect (cf. Dimbath, 2025). Norms relating to gender, sexuality and age are of particular importance, as these areas are closely linked to questions of morality and taboos. They thus strongly influence the individual understanding and acceptance of sexual orientations and identities that deviate from the norm. In the social sciences, the terms gender and sexuality are not understood exclusively as biological givens, but as social constructions that arise in historical, cultural, and institutional contexts (Feldmann et.al. 2025). For example, the term *gender* refers to the socially produced roles, expectations and attributions that are linked to bodies and identities. In the sense of social science, *old age* is also understood not only as a biological process, but also as a socially structured phase of life that is associated with certain role models, rights and duties in the respective social context. The consideration of sexuality is also *subject* to social change processes and is shaped by norms, language, knowledge and institutions. There are forms of sexuality that are legitimized, others are marginalized or tabooed. Social norms are not only repressive, but also productive (cf. Dimbath 2025) by producing certain identities and ways of life in the first place. For example, a "gay identity" is closely linked to the historical persecution of homosexual men and the "gay movement" that grew out of it.

A short theoretical framework is helpful for understanding sexuality in old age. In social discussions, sexuality in older people is often given little consideration or completely ignored. Instead, there is often the assumption that sexual needs will also disappear with increasing age. However, this idea is not natural, but the result of historically grown social norms. The examination of this perspective forms the basis for the following historical analysis.

2. Historical Development of Social Norms of Age and Sexuality

Today's social ideas of sexuality in old age can only be understood against the background of historical developments. The following is a historical overview with some central normative shifts in relation to sexuality, gender and age.

2.1 *Pre-Modern Societies: Morality, Religion and Social Order*

In pre-modern societies, sexuality was strongly embedded in religious and moral systems. It was primarily considered functional for reproduction. Although gender in this era was thought of in binary terms – male and female – sexuality was defined less by identity than by social role. It was not the gender of the partner that was decisive, but the position in the power structure: active versus passive, free versus unfree or enslaved. Relationships between adult men and adolescent boys (pederasty) were socially accepted as long as they followed certain norms.

As for old age, it was often associated with withdrawal, wisdom or spiritual devotion. Sexual activity beyond reproductive purposes, especially in old age, was considered rather inappropriate or morally questionable. These normative ideas had an effect not only individually, but also structurally: deviations could result in social sanctions. Sexuality in old age was not so much invisible as morally disqualified. However, it must also be noted that there were very few old or very old people. Most people died at an age that corresponds to today's "Bestagers".

With the spread of Christianity in the Middle Ages (ca. 9th to 15th century), the view of gender and sexuality in Europe changed fundamentally. Sexuality was increasingly moralized and associated with sin. Legitimate sex was limited to marriage and was intended for procreation. Lust was considered

dangerous or was understood as a sin. In patriarchal thinking, the woman was seen as the "seductress" of the man, unless she was regarded as a "virgin" pure from all sin - i.e. sexuality. This dichotomy can still be found today in the Christian idea of the "Virgin Mary", who at the same time becomes a mother – but without the sex associated with sin.

2.2 Early Modern Period: Disciplining and Science

Between the 16th and 18th centuries, state and church control over the body and sexuality intensified, and married life was subject to stronger regulations. In the Catholic Church, celibacy for priests was introduced. At the same time, medicine began to systematically research gender. During this period (around 1800), the so-called "two-gender model" became increasingly prevalent in Europe, thus displacing the idea that women were "incomplete men". It was now postulated that women and men were fundamental, biologically based opposites. Social roles (e.g. housewife, breadwinner) were then derived from this, which were now considered "natural".

Sexuality was increasingly seen as an individual act that had to be monitored, classified, and standardized. Deviations were no longer considered just a sin, but were increasingly classified as an illness or even a crime. The ideas went so far that even masturbation was considered dangerous to health. This myth survived into the 20th century and can still be found in some societies and milieus.

2.3 Modernity: Medical and Scientific Normalization

From the 18th century onwards, with modernity and the emergence of scientific ways of thinking, the view of sexuality described above became established. The biological classification led to the consolidation of the idea of two clearly separated sexes with "natural" characteristics. Sexuality was increasingly viewed from a medical and biological point of view. Along with this, the idea of clearly distinguishable *phases of life* with specific functions also solidified in the biological role consideration. Age was now often assessed as a deficit phase, characterized by physical decline and loss of function. Sexuality in old age was no longer primarily morally condemned, but pathologized as no longer "age-appropriate" or assessed as a medical problem because it was perceived as inappropriate for old people. A "healthy", appropriate sexuality was increasingly granted only to young people in connection with the option of reproduction.

This perspective contributed to the consolidation of the assumption that sexuality is tied to youth, health and productivity. Parallel to this development, the first social movements emerged, such as the early women's movement, which questioned these attributions.

2.4 19th century: Bourgeoisness, pathologization and identity

The 19th century brought profound changes. Bourgeois society elevated the nuclear family to a moral ideal, and sexual fidelity in marriage became even more firmly established as the norm. Gender roles were sharply separated: the man belonged in the public sphere and gainful employment, the woman in the household, where her central task was motherhood (cf. Beck-Gernsheim 1980). However, this model was only viable for middle-class women. Female workers had to take care of the household and their children as well as pursue gainful employment.

At the same time, modern sexology emerged. Terms such as "homosexuality" were coined – initially as a medical diagnosis. This was the first time that same-sex desire was understood as a stable identity, but mostly as deviation or degeneration.

This new categorization had ambivalent consequences: it enabled and promoted visibility and self-description, but also led to stigmatization because it was associated with "illness".

Those affected, in turn, tried to avoid the latter by unsuccessful treatment attempts, which were prescribed to them by some psychiatrists. However, if homosexuality was recognized as an immutable

characteristic of a person, there was also the opportunity to take political action against the criminalization of same-sex acts. Even according to the legal opinion of the time, only those who were responsible for their actions could be punished. Karl-Heinrich Ulrichs was the first to try to demand the abolition of criminal liability with this justification at the German Jurists' Congress in 1867. However, he failed. This is surprising because homosexual acts were already exempt from punishment in some German states before the founding of the German Empire in 1871. In the new criminal code of the German Reich, however, § 143 of the Prussian Criminal Code was adopted as § 175, which made "unnatural fornication" between men a punishable offence.

2.5 20th century: ruptures, violence and liberation

The 20th century was marked by extreme contrasts. In Germany, industrialization, urbanization and the First World War led to the disintegration of traditional role models. The war in particular meant that women had to take over the tasks of men who were in the field. After the end of the war, many women did not want to go back to their "old role". They were helped by the fact that with the end of the German Empire, women were also given the right to vote. In Berlin in particular, a pronounced gay/lesbian subculture developed in the more liberal society, which was unique in the world. The National Socialist regime put an end to this development of dealing with homosexuality and once again solidified rigid gender norms and role models. In order to facilitate the prosecution of homosexual men, § 175 was tightened in 1935 in such a way that even suggestive glances could trigger prosecution. A distinction was made between men who had only been seduced and manifest homosexuals. Same-sex acts were no longer interpreted as part of the personality, but again as culpable misconduct. However, it was no longer about moral ideas, but about the accusation that homosexual men would refuse to reproduce. Women, on the other hand, were perceived as purely "passive" beings, as in the German Empire. Accordingly, §175 was not extended to them in 1935. Nevertheless, lesbian women were persecuted when they appeared openly. An indictment for violation of morality then became possible.

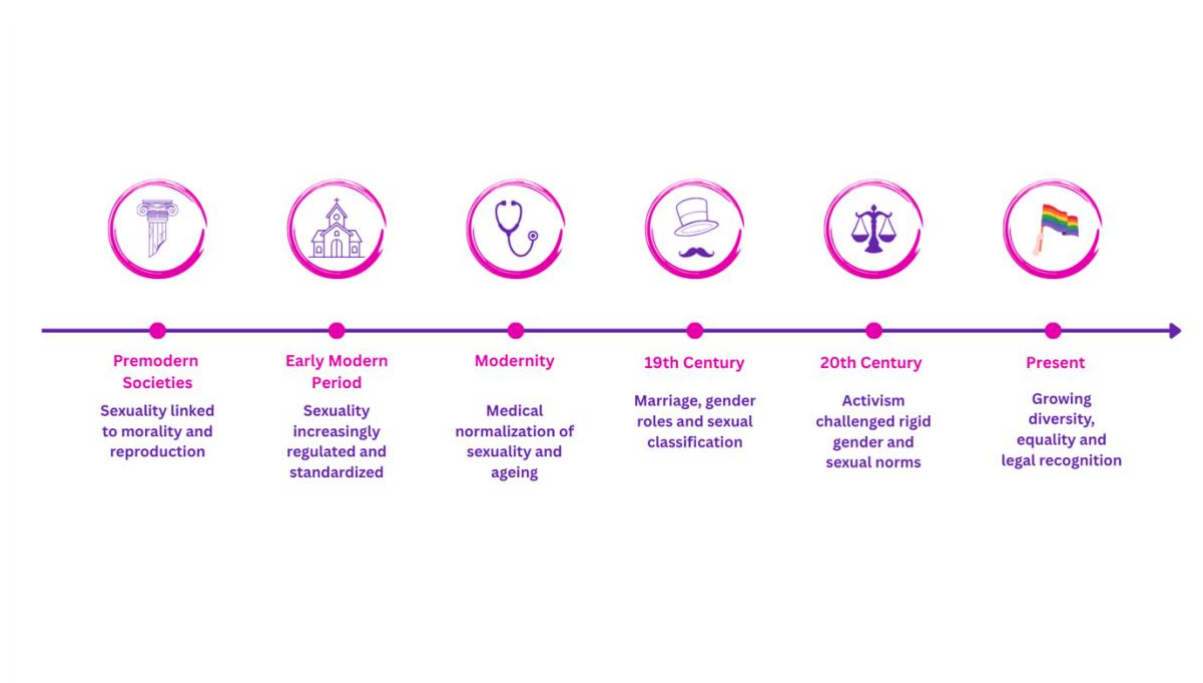


Figure 1. Image created in Canva (2026)

If we look at the EU countries in our project, the **Cypriot gay rights movement (AKOK)** emerged sometime later than in Germany. On the initiative of the well-known activist Alecos Modinos, together

with 16 gay men and a lesbian woman, it was officially founded in December 1987. The foundation took place at a time when same-sex relationships between men were also punishable in Cyprus and homosexuality was hardly discussed in public. As the first organized advocacy group for LGBT people on the island, AKOK was primarily committed to the decriminalization of male homosexuality.

Portugal joined a growing number of European countries in the 1980s in increasing their efforts to recognise and protect sexual rights. Although decriminalisation did not immediately eliminate existing stigmatisation and discrimination, it represented a fundamental structural step towards recognising the rights and dignity of LGBTIQ+ people. The reform brought the country into line with other European states that had already decriminalized homosexuality and laid the foundation for further action in the area of legal equality.

In France, full legal equality was completed in August 1982 in the sense of the decriminalization of homosexual acts. The change in the law meant that same-sex relationships between consensual adults were no longer treated differently from heterosexual relationships under criminal law. This strengthened an important legal principle of equality. At the same time, social acceptance remained limited, and many LGBTIQ+ people continued to face prejudice and discrimination in everyday life. Nevertheless, the reform represented a central step towards legal normalisation and was an important point of reference for subsequent gender equality developments in Europe.

In Romania, in 2001, in the course of the EU accession process, the government ended the criminal prosecution and legal discrimination of LGBTQ people by means of an emergency decree. The reform was closely linked to the requirements of European integration, but went beyond a purely formal adaptation. The abolition of the article represented an important symbolic turning point, as it for the first time placed greater emphasis on the right to privacy and the dignity of homosexual citizens. Even though the measure was initially primarily in the context of the EU accession criteria, it marked a fundamental step towards legal equality.

After the end of the Second World War, the prosecution of homosexual men in the Federal Republic of Germany initially continued unchanged and men convicted under § 175 of National Socialism remained in prison. As a result, most convictions under § 175 fall in the 1950s. This was made possible, among other things, by a ruling of the BVG in 1957, which did not classify § 175 as National Socialist law. In addition, the court found that the different treatment of men and women in § 175 did not violate the principle of equality in the Basic Law, because the sexuality of men and women would be fundamentally different.

The sexual revolution of the 1960s and 1970s then questioned marriage, heteronormativity and patriarchal gender orders. Feminist movements fought for reproductive rights, sexual self-determination and equality.

Lesbian, gay, and later trans* and inter* movements demanded social recognition. Gender and sexuality were increasingly understood as social constructions, not just biological facts. In recent years, "queer" has become the generic term for non-"heteronormative people", which then also includes people whose sexual desire is not fixed on one gender or who feel neither male nor female.

2.6 Present: Pluralization and Conflict

Greater equality and a diversity of lifestyles characterise today's Europe. For example, **in 2016, the right to adoption for married same-sex couples** was enshrined in law in Portugal. Previously, the legal situation was much more restricted: Although same-sex couples – regardless of whether they were married or living in a registered partnership – could adopt in certain cases, usually only one partner could take over legal parenthood. This often created legal inequality within the family, as one parent was not fully recognized and children had limited legal protection from both caregivers. The 2016 reform eliminated these differences and allowed for both joint adoption and so-called stepchild

adoption. The amendment brought Portuguese family law more in line with international human rights standards and at the same time took into account the lived reality of many LGBTIQ+ families.

The right to joint adoption for married same-sex couples in **Germany was introduced with the introduction of "marriage for all" on October 1, 2017**. Since that date, same-sex couples have been able to marry and adopt children together, putting them on an equal footing with heterosexual married couples.

In 2018, Portugal's then President Marcelo Rebelo de Sousa announced the **Law on the Self-Determination of Gender**. It introduces the right to change one's official name and gender at the age of 16 and with appropriate support, thus reducing bureaucratic and discriminatory obstacles.

In May **2020, Cyprus introduced a comprehensive ban on so-called conversion therapies**. This prohibited all psychological, medical, religious or other practices aimed at changing or suppressing a person's sexual orientation or gender identity. Violations can be punished with imprisonment of up to five years as well as fines.

The legislative initiative was significantly supported by the organization Accept–LGBT Cyprus and is in line with recommendations of the European Union.

The regulation follows on from earlier developments such as the decriminalization of homosexual acts and the introduction of registered civil partnerships. By classifying these practices as a form of domestic violence, the law also creates legal opportunities for those affected to demand protection and justice through reporting systems and legal proceedings. Despite some ongoing social reservations, Cyprus is thus considered a pioneer in the region in the field of legal protection for LGBTIQ+ people.

In Germany, the Law on Protection against Conversion Treatments came into force **on June 24, 2020**, and **France bans conversion therapies** and practices aimed at changing a person's sexual orientation or gender identity in January **2022**.

Same-sex marriages, the legal recognition of trans* people in Germany since 2024 and debates about non-binary genders stand for a profound change in social norms.

At the same time, these developments are not universally desired and accepted, and pluralistic concepts of gender and sexuality are being questioned by religious, conservative and nationalist movements. It becomes clear that norms are never final, but an expression of ongoing struggles for power and interpretation.

3. Factors influencing images of old age

3.1 Cultural narratives about aging and "appropriateness"

Cultural narratives have various functions: they serve to impart information, communicate, build community, pass on knowledge or simply entertain (cf. Matuszkiewicz 2017). These cultural narratives are also referred to as narratives and structure social ideas. They convey implicit expectations and define what is considered "normal" or "deviant".

With regard to old age, narratives exist in our Western society that link aging with withdrawal, rest and need reduction. A need for active participation in events, especially events for younger generations, may then cause astonishment. For example, one participant in the focus group in Germany describes how she perceives a social boundary in terms of age and participation opportunities despite the softening stereotypical images of age:

"What I experience is that 60 is such a sound barrier. I have the impression that if something is desired, please should not be older than 60. I hear that more often. "

In these narratives, sexuality is often at odds with expectations of "appropriate" aging. Older people are primarily portrayed in roles such as grandparents, people in need of care or wise advisors, while their physicality and sexuality are faded out. This creates the image of an asexual phase of life.

These narratives have an effect on several levels: they influence the self-image of older people, shape family expectations and structure institutional framework conditions. Sexuality in old age is not openly rejected, but often tacitly excluded. This silence increases insecurity and self-censorship.

The construction of appropriateness thus functions as a social regulator. It does not so much determine what is forbidden as what is not addressed. In this sense, cultural narratives are a central link between historically evolved norms and current practices – and thus a key to understanding the continuing taboo on sexuality in old age.

3.2 Media representations of age and sexuality: visibility, stereotypes and invisibility

The media play a central role in communicating and stabilizing social norms. They function as cultural resonance spaces in which social ideas about the body, gender, sexuality and age are reproduced, condensed or even questioned. With regard to sexuality in old age, there is a striking discrepancy between real life practice and media representation.

Older people appear comparatively rarely as sexual subjects in both traditional and digital media. When sexuality in old age is discussed, it often happens in specific forms of representation: as a humorous deviation, as a medical or psychological problem, or as a morally irritating event. These representations contribute to the reproduction of stereotypical images in which sexual desires of older people are either ridiculed, problematized or completely negated.

A central feature of media representations is **invisibility**, which is also described and criticized by a participant in the focus group from Germany:

"This applies in particular to sexuality – it is practically invisible. Although we live in a society steeped in sexualized images and cues, they almost never affect older people. It's always about the young – because older people assume that nothing is going on anymore."

The widespread lack of realistic, diverse representations of sexuality in old age creates the impression that it is a marginal phenomenon or something socially irrelevant. Invisibility has a normative effect: what is not shown does not appear to be intended. As a result, sexuality is implicitly linked to youth, attractiveness and physical performance.

At the same time, however, the media also contributes to the codification of normative body images. Aging bodies are often portrayed as deficient, sick or in need of care, which means that they remain excluded from dominant sexuality discourses. This logic of representation influences not only social attitudes, but also professional contexts, for example in nursing, counselling or adult education, in which media images can be adopted without reflection.

The effect of media stereotypes is not limited to individual perceptions. They shape family expectations, institutional routines and political discourses. Sexuality in old age is not explicitly prohibited in this way, but structurally marginalized. The media thus make a significant contribution to the maintenance of social norms that construct aging and sexuality as contradictory.

A critical examination of media representations is therefore a central component of norm-reflexive educational work. It makes it possible to deconstruct dominant images, to make invisibility visible and to open up alternative narratives that recognize sexuality in old age as a natural part of human lives.

3.3 Taboos, Silence and Institutional Practice

Sexuality in old age is a **double taboo subject** in many societies. It encounters social norms that generally link sexuality with youth, attractiveness and performance, and age-related ideas of seclusion, wisdom or moral appropriateness. The result is often silence – both in families and in institutional contexts. This silence does not lead to neutrality, but to uncertainty, discomfort and structural marginalization.

In family contexts, the taboo often expresses itself in subtle signals: desires, intimacy needs or sexual experiences of older people are not addressed or tacitly devalued. Professionals in nursing, counselling or social work often experience this spiral of silence as a challenge. They have to weigh up professional restraint, ethical responsibility and the need of those affected for recognition of the reality of their lives. A lack of education and training on this topic increases uncertainty and inhibitions.

Institutionally, taboos are reinforced by structures and rules. Institutions such as nursing homes or counselling centres often do not have clear guidelines for dealing with sexuality in older people. There is a lack of spaces, resources or guidelines for thematic integration into education or care services. As a result, it can lead to stagnation, normative self-censorship or even inappropriate reactions to the needs of older people.

The analysis of such taboo patterns shows that silence does not arise by chance, but is stabilized by **social, historical, and institutional mechanisms**. Education and training modules can play a key role here: By reflecting on their own attitudes, deconstructing dominant narratives and discussing case studies, participants are enabled to consciously address taboos. They learn to name uncertainties, critically question normative expectations and develop action-oriented strategies that meet the needs of older people.

Dealing with taboos is therefore not only a theoretical task, but has immediate practical relevance: It enables adult educators and professionals to create learning and working spaces in which sexuality in old age can be visible, respected and professionally addressed.



Guidelines for educators and professionals

In the following, some guidelines are formulated to support professionals and participants in dealing with the topic of age and sexuality in a reflective, sensitive and professional way, both in seminars and in their own organizations.

Communication recommendations

A respectful approach to the topic begins with language. Communication should therefore be appreciative and open, i.e.

- The attitude is characterized by the basic assumption: sexuality in old age is possible.
- Open questions that allow a wide range of answers are favourable in dialogue. These should be value-free.
- Leading questions should be avoided.
- Pauses, uncertainties and silence may be allowed and endured.
- How a person defines themselves should be respected and not questioned.

Key principles:

1. Describe instead of evaluate

- Separating observations from interpretations.
- Avoid labels (e.g. "inappropriate"); instead, remain specific and as neutral as possible → *"I noticed that..."*.

2. Use I-messages

- Make your own perceptions, feelings and needs transparent.
- No generalizations or recriminations.
"I'm irritated because I would have understood our approach differently" instead of *"You don't do it that way"*.

3. Openness to different perspectives

- Accept that there is no one right point of view.
- Asking instead of insinuating. *"How did you experience the situation?"*

4. No implicit norms or "man messages"

- Avoid statements such as:
 - "That's the way it should be".
 - "You should..."
- Instead: name your own values without making them absolute.

5. Respect autonomy

- Offers instead of instructions: *"Would it be helpful if we looked for another solution?"*.

6. Acknowledgment of feelings – without judgment

- Accept feelings, even if you don't share them.
"That sounds frustrating to you" (not: *"There's no reason for that"*).

7. Use language in an inclusive and precise way

- No generalizations about groups or people.

- Sensitivity to power relations and roles (e.g. teacher - student, caregiver - resident, manager - employee).

8. Goal: Understand, not correct

- Understanding communication as a joint clarification process.
- Not: "Correct" but focus on relationship and understanding.

Do's and Don'ts

Do's	Don'ts
Actively reflect on your own assumptions	Ignoring or trivializing sexuality in old age
Recognizing diversity of life plans	Using humor at the expense of the elderly
Consciously making one's own language inclusive	Making normative statements ("At that age it's ...")
Openly name uncertainties ("This is a sensitive topic...")	Addressing intimate topics without consent
Use further education and training	Generalizing cultural or religious attributions

Risks and avoidance strategies

A central risk that can stand in the way of reflective and inclusive educational work is the unconscious reproduction of age and sexuality stereotypes. Unintentionally, for example, in educational work, simplistic representations are shown or humorous comments are made, but which ultimately mark sexuality in old age as a deviation. If moralizing attitudes and statements are added ("but you shouldn't do that at that age"), the autonomy and self-determination of older people are restricted or ignored.

The medicalization of the sexual needs of older people is also problematic, i.e. sexuality in old age is primarily considered from a medical point of view and understood as a functional problem, while subjective meanings and needs, relationship experiences and social contexts are ignored.

To avoid these risks, continuous self-reflection by professional professionals is key. The conscious examination of one's own norms, uncertainties and cultural imprints contributes to recognizing unreflected attributions. Collegial exchange formats, case discussions and the use of multi-perspective materials that make diversity visible have a supportive effect. A separation between personal values and the professional role makes it possible to act sensitively and respectfully, even in situations of normative ambivalence. In this way, educational and practical work can help to avoid the consolidation of stereotypes and to promote an open, dignified approach to sexuality in old age.



Summary & Key Messages

The history of social norms of gender and sexuality in Europe is a history of control and liberation, of invisibility and visibility. It makes it clear that what seems to us to be "natural" has always grown historically – and is therefore changeable. The historical development thus does not show linear liberalization, but an ambivalence between the opening and persistence of normative exclusions. This ambivalence shapes current cultural narratives about aging and sexuality.

Main messages

- **Today's norms are neither self-evident nor immutable, but the result of social developments.**
- **Concepts are thus changeable.**
Practical impulse: Critically question your own assumptions and standards again and again.
- **Cultural narratives shape our perceptions and actions:** Narratives about "appropriate aging" or "natural sexuality" influence our attitudes.
Practical impulse: in pedagogical work, these narratives can be made visible, questioned, and alternative perspectives can be offered.
- **Ambivalences in perception and change:** Progress in the visibility of sexuality in old age exists alongside persistent exclusions.
Practical impulse: Acknowledge contradictions and address them in a methodically reflected way – e.g. in discussions, case studies or group work.
- **Professional reflection is key:** Ambivalences and taboos require professionals to actively reflect on their own values, insecurities and assumptions.
Practical impulse: Use supervision, collegial exchange and further training to act in a norm-critical manner.



Practical Tools

Through an appropriate inclusive methodological implementation of the module, the participants are to be enabled to achieve learning goals at different levels.

Learning objectives of the training module

After completing the module, participants should have achieved the following goals:

Knowledge Objectives

- They can relate social norms in relation to gender roles, sexuality and age in historical development.
- They know central historical and current narratives about aging and sexuality,
- They understand mechanisms of the connections between social taboos in relation to sexuality.

Reflexive Objectives

- They are able to reflect on their own attitudes and insecurities.
- They know their own values and can distinguish social norms from personal value judgments.

Competence to act

- They know the criteria of appreciative, unprejudiced communication and can apply them.
- They know how to sensitively question stereotypical attributions and address people in an appreciative way instead of avoiding them and conversations about sexuality.

Lesson Plan Module 4

The lesson plan is a structured guideline for the implementation of the module in educational work. It offers trainers or experts a structured orientation for a training duration of approx. 2.5 hours. He provides a PowerPoint presentation as well as a preparation checklist and describes expected learning outcomes and three exercises (see below).

Lesson Plan Module 4 – *The History of Societal Norms of Gender and Sexuality in Europe*

Presentation Module 4

Exercise 1 – "Position Barometer: Sexuality in Old Age"

Objectives:

- Attunement of the participants to the seminar topic.
- An initial assessment of the current situation and creation of a basis for discussion.
- Promoting the openness of participants to plenary discussions.

Resources:

Three prepared sheets or moderation cards, each with a statement 1. "That doesn't apply to me at all", 2: "Sometimes that's the way it is with me", 3: "Yes, I totally agree with that".

Exercise 2 – "Images of Age and Sexuality"

Objectives:

The participants

- recognize that their ideas are shaped by social images
- distinguish between personal associations and social visibility
- understand that norms are historically variable
- reflect on how invisibility and stereotypes arise
- develop initial approaches to question their own images.

Resources: Presentation materials, flipchart, pin board.

Exercise 3 – Self-Reflection: Sexuality in Old Age – Norms, Values and Taboos

Objectives:

- An in-depth examination of one's own assumptions
- Insight into how attitudes towards social norms are shaped
- Reflection on social norms and brainstorming to avoid stereotypes

Resources:

Prepared worksheets with the guiding questions for the individual work and subsequent discussion in the small group and in the plenary.



References

- Ariès, P. (1988). History of private life. Frankfurt a. M.: Fischer.
- Beck-Gernsheim, E. (1980): Das halbierte Leben: Männerwelt Beruf, Frauenwelt Familie. Frankfurt a.M.
- Berger, P. L., & Luckmann, T. (2016). The social construction of reality. Frankfurt a. M.
- Butler, J. (1991). The discomfort of the sexes. Frankfurt a. M.
- Dimbath, O. (2025): Social Norm. In: <https://www.socialnet.de/lexikon/Soziale-Norm>
- Fealy, G., McNamara, M., Treacy, M. P., & Lyons, I. (2012). Constructing ageing and age identities: A case study of newspaper discourse. Ageing & Society, 32(1), 85–102.
- Feldmann, M., Wazinski, K., Wanka, A. (2025): Intersectional Perspectives on Age(ing) and Gender in Social Work
- Foucault, M. (1999). The will to know. Sexuality and Truth 1.
- Goffman, E. (1977). Stigma. On Techniques of Coping with Damaged Identity. Frankfurt a. M.
- Honneth, A. (2010). The I in the We. Berlin
- Matuszkiewicz, K. (2017): "Who Creates History? Media and Personal Narrations in Digital Games". In: Maren Conrad, Theresa Schmidtke and Martin Stobbe (eds.): Digital Contexts. Literature and Computer Games in Contemporary Society. Special issue # 2 of Textpraxis. Digital Journal of Philology (2.2017). URL: <http://www.uni-muenster.de/Textpraxis/kai-matuszkiewicz-wer-erzeugt-die-geschichte>, DOI: <http://dx.doi.org/10.17879/61269492200>.
- Plummer, K. (1995). Telling Sexual Stories. London: Routledge.
- Somers, M. R. (1994). The Narrative Constitution of Identity. Theory and Society, 23(5), 605–649.
- Woodward, K. (2006). Aging and Its Discontents. Bloomington: Indiana University Press.

MODULE 5

Sexuality in the Third Age and Health Indicators

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Overview

This module explores sexuality in later life as a multidimensional aspect of health, wellbeing and human dignity. Moving beyond stereotypes that associate ageing with a loss of intimacy or desire, the module presents sexual wellbeing as an integral component of healthy ageing, shaped by biological, psychological, relational and social factors. The aim is to support educators, healthcare professionals and other practitioners in understanding how sexual expression and intimate needs may evolve in older adulthood while remaining meaningful and relevant to quality of life.

The module begins by outlining medical and physiological changes associated with ageing in both men and women, emphasising variability rather than decline as the defining feature of later-life sexuality. It then examines how chronic illness and medication can influence sexual functioning through physical symptoms, treatment effects and overall health burden. Building on this foundation, the module highlights the importance of mental health, body image and relational wellbeing, recognising that emotional security, companionship and self-perception often shape sexual experience as strongly as physiological factors.

Further sections address sexual health risks and protective strategies, including the under-recognised presence of sexually transmitted infections in older populations and the importance of prevention, education and routine clinical dialogue. The module concludes by focusing on ethical, person-centred communication in healthcare settings, offering practical guidance for initiating respectful conversations about sexuality and responding to expressed needs. Together, these components provide a holistic framework that integrates knowledge, ethical awareness and practical communication skills to support sexual wellbeing in later life.

This module is also informed by insights emerging from the Focus Group and Intergenerational Dialogue Sessions conducted within the project, where older adults shared personal reflections on intimacy, loneliness, emotional connection and the meaning of sexuality in later life. These discussions highlighted that sexuality is often understood by older persons not only in physiological terms, but as a broader experience of affection, communication, dignity and relational belonging. Participants also emphasised the impact of loneliness, social isolation and changing life circumstances on wellbeing, reinforcing the importance of addressing sexuality within a holistic, person-centred framework. Integrating these lived experiences alongside medical and psychosocial knowledge strengthens the relevance of the module and ensures that professional guidance remains grounded in the real needs and voices of older adults involved in the project.



Key Concepts & Definitions

Medical and physiological change

Ageing involves gradual endocrine, vascular, neurological and musculoskeletal changes that may influence sexual desire, arousal, comfort and response. These processes vary widely between individuals and do not inevitably prevent satisfying or meaningful intimate relationships.

Chronic illness and medication effects

Common chronic conditions in later life—such as cardiovascular disease, diabetes, arthritis or cancer—and their treatments may affect sexual functioning through fatigue, pain, vascular or neurological impairment, hormonal changes or medication side effects. Recognising modifiable contributors, including pharmacological influences, is essential for person-centred care.

Polypharmacy

Polypharmacy refers to the concurrent use of multiple medications, common in older populations. It may influence sexual functioning through side effects affecting libido, arousal, lubrication, erectile function or overall energy and mood.

Mental health, body image and relational wellbeing

Emotional wellbeing, self-perception and relationship quality strongly influence sexual expression in later life. Depression, anxiety, loneliness or bereavement may reduce desire and intimacy, while companionship, emotional safety and positive body image can support continued connection and satisfaction.

Sexual health risk and protection

Older adults remain susceptible to sexually transmitted infections and other sexual health concerns, particularly when prevention, screening and education are limited. Protective approaches include routine dialogue, safer-sex practices, access to information and integration of sexual health into general healthcare.

Person-centred communication

Person-centred communication recognises sexuality as a legitimate aspect of dignity, autonomy and identity across the lifespan. It involves respectful, inclusive dialogue, shared decision-making, attention to emotional and relational needs, and adaptation to individual cultural and social contexts.

Sexual response cycle

The sexual response cycle refers to the sequence of physiological and psychological processes associated with sexual arousal and satisfaction, commonly described as desire, arousal, plateau, orgasm and resolution.



Understanding the Topic

Medical & physiological changes in later-life sexuality

As people age, they undergo changes in their mental, emotional, physical, biological and social functioning. From a biological perspective, ageing-related changes occur in every multicellular organism that reaches reproductive maturity, affect all members of a species and share a common

molecular basis (Hayflick, 2007). However, the ageing process shows considerable individual variability, particularly between women and men. Women generally live longer than men but may experience greater frailty in advanced age, while men often face an earlier onset of cardiovascular and metabolic risk factors that can influence sexual functioning. These distinctions highlight the importance of personalised, gender-sensitive approaches to sexual health in later life. In the context of sexuality, age-related physiological changes may influence sexual expression, but they do not prevent the possibility of meaningful and satisfying intimate relationships.

Understanding these broader ageing processes provides an essential foundation for examining the specific physiological changes that may influence sexual functioning in later life.

“After the age of 60–65, people do not lose the joy of life; rather, the way they access life’s joys changes.”

(Focus Group participant, Romania)

In men, the ageing process involves gradual modifications in endocrine, vascular and neurological systems that shape the sexual response. Circulating testosterone levels typically decline progressively with advancing age, and this hormonal shift can contribute to reductions in sexual desire in some individuals. Importantly, changes in sexual desire are not uniform, and many older men do not experience predictable declines in libido despite age-related hormonal changes. Vascular changes, including decreased arterial compliance and endothelial function, can slow the onset of erection and reduce rigidity, often necessitating greater physical stimulation for arousal. Although sperm count often changes only minimally with age, the proportion of functionally viable sperm and the likelihood of conception may decline. Neurological alterations may attenuate sensory feedback, and the post-orgasmic refractory period typically lengthens, all of which may change the pattern of sexual response. In addition, the sense of urgency typically associated with the plateau phase may become diminished in later life (Meston, 1997; Steffens & Zdanys, 2022).

In women, menopause represents the most significant physiological shift affecting sexual functioning. The decline in oestrogen and other sex steroids contributes to changes in genital tissues, including thinning and reduced elasticity of the vaginal epithelium and decreased natural lubrication. These changes may lead to vaginal dryness, discomfort or dyspareunia during intercourse. Ageing may also be associated with shortening and narrowing of the vaginal canal, together with reduced blood supply to the pelvic region. Ageing also alters genital blood flow and arousal responses, which may be slower or less intense, and the number or intensity of muscular contractions during orgasm may diminish (Meston, 1997; Steffens & Zdanys, 2022).

Research on sexual physiology and sexual wellbeing in older transgender and gender diverse (TGD) adults remains limited, and much of the existing clinical guidance is still based on studies conducted in younger cohorts. As a result, the long-term interaction between ageing processes and gender-affirming medical interventions is not yet fully understood (Institute of Medicine, 2011; Iwamoto et al., 2023). Available evidence indicates substantial individual variability in sexual functioning across

the lifespan. Factors such as long-term gender-affirming hormone therapy, surgical history, and the physiological effects of ageing may interact in complex ways to influence sexual desire, arousal, comfort during intimacy, and overall sexual wellbeing (Ceolin et al., 2024).

For example, studies report that approximately 25–75% of transfeminine individuals may experience some form of sexual dysfunction after vaginoplasty, while around 54% of transmasculine individuals report sexual functioning concerns following procedures such as hysterectomy or phalloplasty. Pelvic floor–related symptoms have also been described, including urinary incontinence (reported in up to 15% of transfeminine individuals and up to 50% of transmasculine individuals in some studies) as well as irritative urinary symptoms and discomfort that may affect sexual activity (Dominoni et al., 2024). But the available literature remains limited and heterogeneous, with many studies relying on small samples and relatively short follow-up periods. As a result, long-term outcomes are still not fully understood.

Regarding gender-affirming hormone therapy, the onset and intensity of sexual function effects vary considerably between individuals, and the available evidence remains limited for many long-term outcomes. For example, estrogen combined with antiandrogen therapy in transfeminine individuals is commonly associated with decreased sexual desire, reduced spontaneous erections and progressive testicular atrophy, changes that may occur within the first months of treatment. In contrast, testosterone therapy in transmasculine individuals often leads to increased sexual desire, clitoral enlargement and cessation of menses, while vaginal atrophy may sometimes contribute to discomfort during sexual activity (Hembree et al., 2017).

Beyond physiological processes and sex-specific endocrine shifts, sexual wellbeing in later life is also shaped by chronic illness, medication use and broader health conditions, which are explored in the following section.

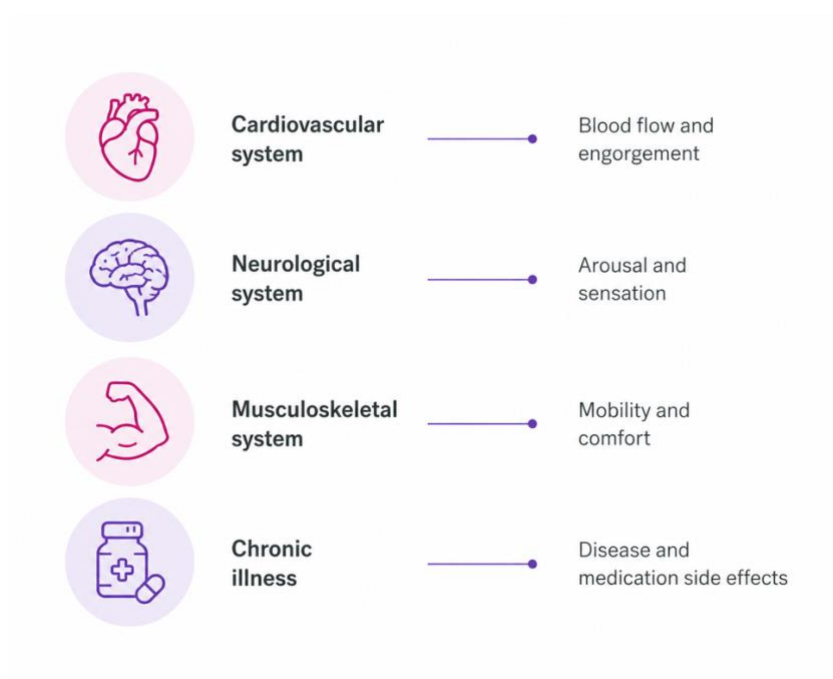


Figure 1. AI-generated infographic

Chronic illness, medication & sexual functioning

Evidence from a narrative review indicates that chronic conditions can shape sexual functioning in later life through distinct physiological mechanisms and symptom burdens (Merghati-Khoei et al., 2016).

- Cardiovascular disease may impair genital blood flow and reduce arousal or erectile capacity.
- Diabetes is frequently associated with neuropathy, vascular damage and hormonal changes that can affect desire, erection or lubrication.
- Chronic respiratory disorders may limit physical endurance and increase fatigue during intimacy.
- Musculoskeletal diseases such as arthritis can cause pain, stiffness and restricted mobility that interfere with comfortable sexual positioning.
- Cancer and its treatments may further alter body image, hormonal balance and energy levels, contributing to changes in sexual interest or responsiveness.

Together, these examples illustrate how the functional impact of chronic illness on sexuality often reflects the interaction between disease mechanisms, treatment effects and the individual's overall physical condition in later life.

Medication use constitutes an additional and frequently under-recognised contributor to sexual dysfunction in older adults. Many pharmacological treatments prescribed for chronic conditions—such as antihypertensives, antidepressants, antipsychotics, sedatives and some hormonal therapies—may influence libido, arousal, lubrication, erectile function or orgasmic response.

In clinical practice, sexual changes are sometimes attributed solely to ageing or disease progression, when they may instead relate to modifiable medication effects. Careful medication review and open discussion with healthcare professionals can therefore play an important role in identifying reversible contributors to sexual difficulties. These considerations highlight the importance of routinely acknowledging sexual health within chronic disease management and later-life care.

Mental health and relational wellbeing

Sexual wellbeing in later life is closely connected to mental health, emotional experience and the quality of interpersonal relationships. Research in geriatric mental health indicates that depression, anxiety, loneliness and experiences of loss or bereavement are associated with reduced sexual desire, diminished motivation for intimacy and withdrawal from relational closeness in older adulthood (DeLamater, 2012). Conversely, emotional security, companionship and a sense of belonging may support continued interest in affection and intimate connection even in the presence of physical health changes.

“Sexuality is not limited to the sexual act alone; it encompasses much more—it is a broader umbrella.”

(Focus Group participant, Romania)

Ageing is also accompanied by transformations in body image that can influence how older adults perceive their attractiveness, desirability and entitlement to intimacy. Visible bodily changes, illness-related limitations and internalised ageist beliefs may lead some individuals to view sexuality as inappropriate or unattainable in later life. Evidence suggests that these self-perceptions can shape sexual expression as strongly as physiological changes themselves, underscoring the importance of addressing emotional wellbeing and self-image alongside physical health (DeLamater & Koepsel, 2015).

Relational contexts play a central role in shaping sexual experience in older adulthood. Long-term partnerships may evolve as roles shift due to caregiving, illness or changing functional capacities, while individuals without partners may experience loneliness or reduced opportunities for intimacy. Intimacy in later life is therefore often redefined to include affection, touch, emotional closeness and companionship rather than sexual intercourse alone, with supportive relationships acting as protective factors for both mental health and overall wellbeing in older age (Fileborn et al., 2017).

“At a certain stage of life, loneliness can become a factor of psychological decompensation.”

(Focus Group participant, Romania)

In addition to individual psychological and relational factors, broader social contexts may also influence sexual wellbeing in later life. Psychosocial determinants such as minority stress, experiences of discrimination, access to supportive communities and relationship recognition can shape sexual health outcomes among older adults, particularly for those belonging to sexual or gender minority groups. These experiences may affect both opportunities for intimacy and willingness to seek support for sexual health concerns (Iwamoto et al., 2023).

Taken together, mental health, body image and relational wellbeing represent essential dimensions of sexuality in later life. Supporting sexual wellbeing therefore requires attention not only to physiological function, but also to emotional resilience, self-perception and the relational environments in which older adults live and connect.

Sexual health risks & protection in later life

While sexual activity and interest often continue into later life for many older adults, there are specific sexual health risks that warrant attention in clinical and educational settings. One major concern is the under-recognised burden of sexually transmitted infections (STIs) among older adults. Epidemiological evidence shows that STIs such as chlamydia, gonorrhoea and syphilis have increased in adults aged 50 and older in recent years, in part because this age group is often excluded from conventional sexual health education, screening and prevention programmes. Older adults may also underestimate their risk of infection and use protection less consistently, having come of age before widespread HIV education and condom promotion (Kumar, 2025).

Physiological changes associated with ageing — including thinner mucosal tissues, reduced genital lubrication and altered immune responses — can increase susceptibility to infection and complication once exposure occurs (Kumar, 2025). In addition, chronic conditions that are more prevalent with age, such as diabetes and cardiovascular disease, may impair tissue healing and immune function, sometimes exacerbating the impact of an infection or injury. These factors underscore the importance of routine sexual health assessment, risk reduction counselling and age-appropriate STI screening in older populations.

Importantly, protective strategies exist that can enhance sexual health and safety in later life. Health promotion frameworks emphasise the need for comprehensive sexual health education that includes older adults, routine discussions between clinicians and patients about sexual activity and concerns, and encouragement of safer sex practices such as condom use for STI prevention (Stowell et al., 2023; Penhollow et al., 2024). Healthcare providers can also play a key role by normalising these conversations, offering tailored information about risk reduction, and facilitating access to screening, vaccines and treatment where appropriate.

Taken together, understanding and addressing sexual health risks in later life — including STI vulnerability, response problems and psychosocial influences — supports a holistic and person-centred approach to sexual wellbeing. Integrating sexual health promotion into routine care helps protect dignity, autonomy and quality of life for older adults.

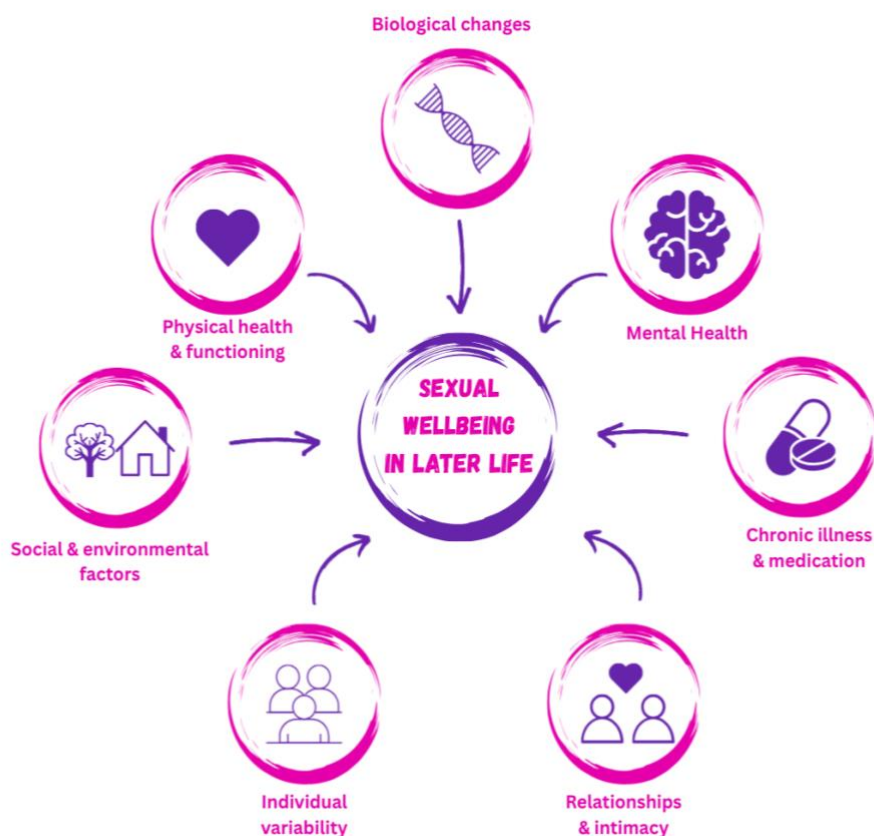


Figure 2. Image created in Canva (2026)

Communication in healthcare settings & person-centred approach

Open, respectful and person-centred communication is essential for supporting sexual wellbeing in later life. Despite the recognised importance of sexuality for quality of life, discussions about intimacy and sexual concerns are often absent from routine healthcare encounters with older adults. Research indicates that both healthcare professionals and patients may avoid these conversations due to discomfort, assumptions about asexuality in ageing, time constraints or uncertainty about professional boundaries, resulting in unmet needs and underrecognised distress (Fileborn et al., 2017; Gott & Hinchliff, 2003).

The World Health Organization's *World Report on Ageing and Health* emphasises the need for health and social care systems to move toward person-centred approaches that respect the values, preferences, functional abilities and life contexts of older adults (World Health Organization, 2015). Although these principles are articulated in relation to overall health and wellbeing rather than sexuality specifically, sexual health constitutes an integral dimension of quality of life and therefore falls within the scope of holistic, person-centred care. From this perspective, addressing sexuality in later life is not an optional or marginal aspect of practice, but part of supporting dignity, autonomy and meaningful participation in everyday life. Person-centred care in this context involves recognising the individuality of each older adult, engaging in shared decision-making, responding to emotional and relational as well as physical needs, and adapting communication and support to the person's cultural background, preferences and lived experience. Such an approach enables healthcare and social-care professionals to integrate sexual wellbeing into comprehensive care in a respectful, ethical and inclusive manner.

Communication about sexuality in later life should also acknowledge the diversity of experiences among older adults, including differences related to gender, sexual orientation, relationship status, disability, cognitive change and living environment. Inclusive communication practices—such as avoiding heteronormative assumptions, asking open-ended questions and validating emotional experiences—have been shown to improve trust, engagement and overall satisfaction with care (Hinchliff & Gott, 2011; Fileborn et al., 2017).

Principles for initiating conversations about sexuality in healthcare (based on Dukes, 2025)

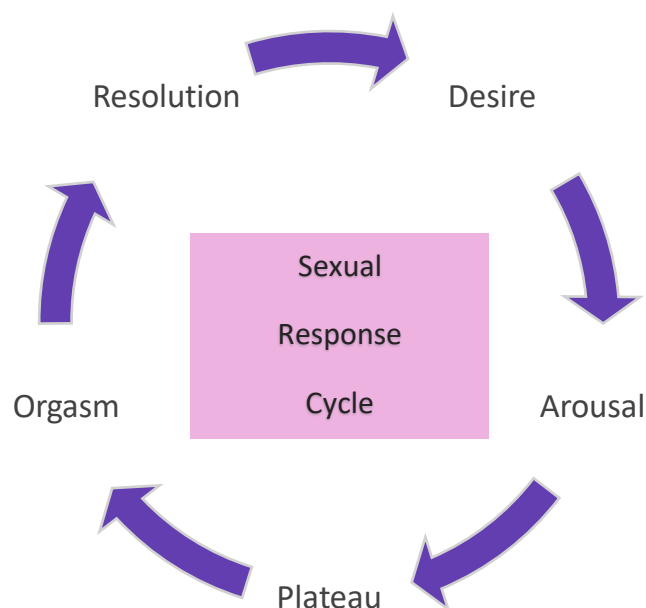
Principle	Practical meaning in clinical conversation	Example questions or phrases
Normalise the topic	Present sexual health as a routine and legitimate part of overall wellbeing, helping reduce stigma or embarrassment.	"I ask all my patients about sexual health because it is an important part of overall wellbeing."
Ensure comfort and consent	Create a safe, judgment-free space and explicitly give the patient permission to decline or skip questions.	"This is a confidential and judgment-free conversation. You can skip any question or stop at any time."
Use open, inclusive language	Avoid assumptions about orientation, partners or identity and invite sharing through neutral, open-ended wording.	"Is there anything about your sexuality or intimate relationships you would like to talk about?"
Start with a holistic framing	Introduce sexuality within the broader context of health and quality of life before asking specific details.	"Sometimes health changes or medications can affect intimacy or sexual wellbeing. Has this been relevant for you?"

Affirm sexuality as part of identity	Acknowledge that sexuality is a meaningful and valid dimension of a person's life, regardless of age.	"Sexuality and intimacy remain important parts of life for many people as they grow older."
Ask directly but sensitively	Once safety is established, explore specific concerns such as desire, pleasure, pain or relational changes.	"Have you noticed any changes in desire, comfort, or pleasure that you would like support with?"

Guidance for Educators and Professionals

Using the sexual response cycle as a conversational framework

For many professionals, initiating conversations about sexuality with older adults can feel uncomfortable or intrusive. However, avoiding the topic may leave important needs unrecognised and unaddressed. One helpful way to approach sexual wellbeing in a respectful and structured manner is to use the sexual response cycle as a conceptual guide for dialogue, rather than as a rigid clinical model. Framed sensitively, this perspective can support holistic assessment while maintaining dignity, privacy and emotional safety. Professionals may keep the stages of the sexual response cycle in mind as a practical guide when discussing sexual wellbeing, considering each stage in turn and the factors that may influence it in order to avoid overlooking important information about the person's experience.



In later life, the phases traditionally described within the sexual response cycle—such as desire, arousal, satisfaction and emotional resolution—may change in intensity, duration or meaning, but they do not disappear. Difficulties experienced in any of these areas may reflect underlying physical health conditions, medication effects, psychological distress, relational challenges or social isolation. Exploring these dimensions through gentle, open-ended questions allows professionals to understand the individual's experience without assuming dysfunction or imposing normative expectations.

Professionals can begin by focusing on interest and emotional closeness, for example by asking whether the person still feels a desire for intimacy, affection or companionship. Questions may then move toward physical comfort and bodily changes, including whether pain, fatigue, dryness or erectile difficulties influence intimate experiences. Discussion of satisfaction and emotional meaning can follow, exploring whether the person feels fulfilled, connected or understood within their relationships. Finally, reflecting on what intimacy represents at this stage of life can reveal important values related to identity, dignity and quality of life.

To support practical understanding, the table below outlines how different phases of the sexual response cycle may be influenced by common medical, psychological and relational factors in older adulthood.

Sexual response phase	Key influencing factors in older adults	Example questions
Desire	Hormonal decline (oestrogen, testosterone), depression or loneliness, relationship quality, chronic illness or fatigue, internalised ageist beliefs about sexuality.	“How important is physical intimacy or affection in your life at the moment?” “Have you noticed any changes in your interest in sexual activity or closeness over time?” “Sometimes stress, fatigue or health conditions can affect sexual desire. Has anything like this influenced you?” “Do you feel that emotional closeness with your partner influences your interest in intimacy?”
Arousal	Vascular and neurological conditions, vaginal dryness or erectile difficulties, medication effects, pain or reduced mobility, anxiety or body-image concerns.	“Some women experience vaginal dryness or discomfort during intimacy after menopause. Has this been something you’ve noticed or would like information about?” “Some people find that erections take longer or are less firm than before. If this is happening to you, we can discuss possible causes and options.” “Have you noticed any changes in lubrication,

		erection or physical comfort during intimacy?" "If intimacy has become uncomfortable, we can talk about ways to reduce pain and increase comfort."
Plateau	Reduced physical stamina, cardiovascular limitations, fatigue or comorbidity, relational tension, and lack of privacy in care environments.	"Do you sometimes find it difficult to maintain arousal during intimacy?" "Some people notice that they need more time or stimulation to stay comfortable during intimacy. Has that been your experience?" "Do fatigue, health conditions or environmental factors affect your ability to enjoy intimacy?" "Are there situations where privacy or living arrangements make intimacy more difficult?"
Orgasm	Diabetes, neurological or prostate conditions, hormonal changes, medication side effects, psychological inhibition or reduced relational connection.	"Have you noticed any changes in how easily you reach orgasm or in the intensity of sexual pleasure?" "Some medical conditions or medications can influence orgasm. Would you like to discuss whether this might apply to you?" "Do you feel satisfied with the level of pleasure you experience during intimacy?" "Are there any difficulties during sexual activity that you would like support with?"
Resolution	Emotional wellbeing, companionship or bereavement, cognitive changes affecting intimacy, and opportunities for dignity and affectionate contact in daily life.	"After intimate moments, do you usually feel relaxed and emotionally satisfied?"

		“Has the loss of a partner or changes in companionship affected your experience of intimacy?” “Do you have opportunities for affectionate contact, such as hugging or closeness?” “Are there ways in which your current environment supports or limits intimacy?”
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When to consider medical or specialist referral

Referral to a healthcare or mental health professional should be considered when sexual concerns are persistent, distressing, painful or associated with significant changes in physical, cognitive or emotional health. This may include suspected medication side effects, untreated depression or anxiety, chronic pain, hormonal or urogenital conditions, erectile difficulties, or emerging cognitive impairment affecting consent or behaviour. Timely referral supports comprehensive assessment, appropriate treatment and the protection of wellbeing, autonomy and safety in later life.

Common sexual health concerns expressed by older adults

Typical concern expressed	Possible professional response
“I don’t feel desire like I used to. Is that normal?”	Acknowledge that changes in sexual desire are common in later life. Explore possible contributing factors such as mood, fatigue, medication or relationship dynamics. If distressing or persistent, suggest discussing the issue with a healthcare professional who can assess hormonal, psychological or medical causes.
“My partner and I don’t have intercourse anymore.”	Normalise that intimacy may change with age and may include forms of closeness other than intercourse. Encourage open communication between partners and explore whether the change reflects preference, comfort, or possible health concerns.
Fear of being judged for wanting intimacy in a care facility	Reassure the person that intimacy and affection remain legitimate aspects of wellbeing in later life. Discuss rights to privacy and dignity in care settings and explore possible practical arrangements that support personal relationships.

Vaginal dryness or pain during intercourse	Explain that vaginal dryness after menopause is common. Encourage the person to consult a gynaecologist or primary care physician who can assess possible causes and discuss appropriate treatments such as lubricants, moisturisers or hormonal therapies.
Erectile difficulties	Acknowledge that erection changes are common with ageing but may also relate to cardiovascular health, diabetes or medication effects. Encourage consultation with a physician or urologist for proper assessment and management.
Body image concerns related to ageing	Validate emotional reactions to bodily changes and discuss how intimacy and attraction can evolve in later life. If concerns significantly affect wellbeing or relationships, suggest discussing them with a mental health professional or counsellor.
Shame or embarrassment about masturbation	Normalise self-stimulation as a common and healthy form of sexual expression across the lifespan. Reassure the person that it is a private matter and does not indicate a problem unless it causes distress.
Medication reducing arousal or orgasm	Acknowledge that some medications can influence sexual functioning. Encourage the person to discuss this with their prescribing physician, as adjustments or alternatives may sometimes be possible.



Summary & Key Messages

“Old age is not a limitation of rights.”

(Focus Group participant, Romania)

Sexuality in later life is neither absent nor uniform; it is a dynamic and deeply personal dimension of human experience shaped by health, relationships, identity and social context. Understanding this complexity is essential for professionals working with older adults, as sexual wellbeing contributes directly to quality of life, emotional resilience and dignity in ageing.

Biological ageing introduces physiological changes that may influence desire, arousal or comfort, yet these changes do not eliminate the possibility of meaningful intimacy. Instead, later-life sexuality reflects significant individual variability and adaptation. Chronic illness, medication effects and broader health conditions may further shape sexual functioning, highlighting the importance of holistic assessment and attention to potentially reversible contributors.

Equally important are the psychological and relational dimensions of sexuality. Mental health, body image, companionship and emotional security often determine whether intimacy remains accessible and fulfilling. Recognising diverse expressions of closeness—including affection, touch and emotional connection—supports more inclusive understandings of sexual wellbeing in older adulthood.

Sexual health risks, including vulnerability to sexually transmitted infections and unmet educational needs, demonstrate that sexuality remains a relevant clinical and public health concern in later life. Preventive education, routine screening and open dialogue are therefore essential components of comprehensive care.

At the centre of effective practice lies ethical, person-centred communication. Professionals play a crucial role in normalising conversations about sexuality, creating safe and respectful environments, and responding sensitively to expressed needs. Integrating sexual wellbeing into routine health and social care affirms autonomy, protects dignity and supports holistic healthy ageing.

Ultimately, supporting sexuality in the third age requires moving beyond stereotypes toward a compassionate, evidence-informed and person-centred approach that recognises intimacy as a lifelong human capacity.

Practical Tools

This module is supported by practical resources included in the AgeWise Toolkit, designed to help trainers and professionals translate theoretical knowledge on sexuality in later life into reflective and applied learning activities.

Lesson plan Module 2

Provides the structure, timing, learning objectives and facilitation guidance for delivering the module in training contexts.

Exercise 1

Sexual Response Cycle Application - [Case-based worksheet](#) - supports analysis of realistic later-life situations and encourages person-centred interpretation of sexual concerns.

Exercise 2

[Holistic Sexual Wellbeing Reflection Tool](#) - guides reflection across biological, psychological, relational and social dimensions of sexuality in later life.

Exercise 3

Communication and sexual response cycle - [Role-play activity](#) - enables participants to practise responding to sensitive sexual concerns and to explore sexual wellbeing through structured, person-centred dialogue using the sexual response cycle.

PowerPoint presentation

Facilitates clear, accessible and adaptable delivery of the module content.

How the tools can be used

- to plan and structure training sessions;
- to stimulate discussion and critical reflection;
- to apply theoretical knowledge to real-life scenarios;
- to strengthen ethical, inclusive and person-centred professional practice.

Together, these resources support the practical implementation of the module across educational, healthcare and community settings.

References

- Ceolin, C., Papa, M. V., Scala, A., Sergi, G., & Garolla, A. (2024). Getting old in the desired gender: a systematic review on aging diseases in transgender people. *Journal of Endocrinological Investigation*, 47(8), 1851–1862. <https://doi.org/10.1007/s40618-024-02353-y>
- DeLaMater J. (2012). Sexual expression in later life: a review and synthesis. *Journal of sex research*, 49(2-3), 125–141. <https://doi.org/10.1080/00224499.2011.603168>
- DeLaMater, J., & Koepsel, E. (2014). Relationships and sexual expression in later life: a biopsychosocial perspective. *Sexual & Relationship Therapy*, 30(1), 37–59. <https://doi.org/10.1080/14681994.2014.939506>
- Dominoni, M., Scatigno, A. L., Pasquali, M. F., Bergante, C., Gariboldi, F., & Gardella, B. (2024). Pelvic floor and sexual dysfunctions after genital gender-affirming surgery: a systematic review and meta-analysis. *The Journal of Sexual Medicine*, 22(1), 184–195. <https://doi.org/10.1093/jsxmed/qdae146>
- Dukes C. Talking about S-E-X in Healthcare Settings: Let's Get Clinical. *Dela J Public Health*. 2025 Jul 31;11(2):46-49. doi: 10.32481/djph.2025.07.12. PMID: 40786709; PMCID: PMC12333857.
- Fileborn, B., Lyons, A., Hinchliff, S., Brown, G., Heywood, W., Dow, B., Malta, S., & Minichiello, V. (2017). Improving the sexual lives of older Australians: Perspectives from a qualitative study. *Australasian journal on ageing*, 36(4), E36–E42. <https://doi.org/10.1111/ajag.12405>
- Gott, M., & Hinchliff, S. (2003). How important is sex in later life? The views of older people. *Social science & medicine (1982)*, 56(8), 1617–1628. [https://doi.org/10.1016/s0277-9536\(02\)00180-6](https://doi.org/10.1016/s0277-9536(02)00180-6)
- Hayflick, L. (2007). Biological aging is no longer an unsolved problem. *Annals of the New York Academy of Sciences*, 1100(1), 1–13. <https://doi.org/10.1196/annals.1395.001>
- Hembree, W. C., Cohen-Kettenis, P. T., Gooren, L., Hannema, S. E., Meyer, W. J., Murad, M. H., Rosenthal, S. M., Safer, J. D., Tangpricha, V., & T'Sjoen, G. G. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*, 102(11), 3869–3903. <https://doi.org/10.1210/jc.2017-01658>
- Hinchliff, S., & Gott, M. (2011). Seeking medical help for sexual concerns in mid- and later life: a review of the literature. *Journal of sex research*, 48(2-3), 106–117. <https://doi.org/10.1080/00224499.2010.548610>
- Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington (DC): National Academies Press (US); 2011. 6, Later Adulthood. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK64800/>
- Iwamoto, S. J., Defreyne, J., Kaoutzanis, C., Davies, R. D., Moreau, K. L., & Rothman, M. S. (2023). Gender-affirming hormone therapy, mental health, and surgical considerations for aging transgender and gender diverse adults. *Therapeutic Advances in Endocrinology and Metabolism*, 14, 20420188231166494. <https://doi.org/10.1177/20420188231166494>

Kumar B, Kaushal I, Narayanan B, Narang T. Sexually transmitted infections in the elderly: A growing concern in geriatric care. *Indian J Sex Transm Dis AIDS*. 2025 Jan-Jun;46(1):16-21. doi: 10.4103/ijstd.ijstd_108_24. Epub 2025 Jun 9. PMID: 40546355; PMCID: PMC12180883.

Merghati-Khoei, E., Pirak, A., Yazdkhasti, M., & Rezasoltani, P. (2016). Sexuality and elderly with chronic diseases: A review of the existing literature. *Journal of Research in Medical Sciences*, 21(1), 136. <https://doi.org/10.4103/1735-1995.196618>

Meston C. M. (1997). Aging and sexuality. *The Western journal of medicine*, 167(4), 285–290.

Penhollow T. M. (2024). Sexuality in Older Adults: Comprehensive Strategies for Clinicians and Patient-Centered Care. *American journal of lifestyle medicine*, 19(3), 392–402. <https://doi.org/10.1177/15598276241293100>

Steffens, D. C., & Zdanys, K. F. (2022). The American Psychiatric Association publishing Textbook of Geriatric Psychiatry. In *American Psychiatric Association Publishing eBooks*. <https://doi.org/10.1176/appi.books.9781615375196>

Stowell, M., Hall, A., Warwick, S., Richmond, C., Eastaugh, C. H., Hanratty, B., McDermott, J., Craig, D., & Spiers, G. F. (2023). Promoting sexual health in older adults: Findings from two rapid reviews. *Maturitas*, 177, 107795. <https://doi.org/10.1016/j.maturitas.2023.107795>

World Health Organization. (2015). *World report on ageing and health*. WHO Press.

MODULE 6

Otherisms in working with older and very elderly adults

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Overview

The term “otherism,” often referred to as “othering,” derives from the English terms “other” or “otherness,” which translate to “different” or “other.” Otherism describes a process in which individuals or groups (“us”) are distinguished from other individuals or groups (“the others”). In this social process, people or groups are thus constructed as “different.” In doing so, the non-self group is always categorized as “different” and “foreign” because it deviates from the “norm,” which serves as the justification for exclusion (see <https://diversity-arts-culture.berlin/dictionary/othering>).

It is important to recognize that older adults often face discrimination explicitly because of their age or are labelled as deficient or no longer capable (Butler, 1969; WHO, 2021). This module, “Otherisms,” broadens the focus beyond age-specific forms of discrimination to examine other forms of discrimination (“other-isms”) that can affect older adults. This is because they are often subject to multiple forms of stereotyping—due to their age, health limitations, dementia, their background or social status, or a non-heteronormative identity or life story.

Sexuality and identity in later life are particularly affected by such processes of othering. Older adults who express sexual needs or wish to engage in intimate relationships deviate from the social norm of “youthful sexuality” and are therefore often perceived as inappropriate or problematic. This perception frequently leads to the pathologization or moralization of their behaviour, particularly in institutional care settings.

Discrimination can become particularly acute in older age because dependencies increase: People are more reliant on professional support, institutional structures (nursing care, assistance, housing), and formalized regulations. Here, it is not only “support” that is organized, but also normality: Those perceived as “not fitting in” are given less space (literally and symbolically), less credibility, and less room to manoeuvre. This is particularly relevant in contexts where sexuality and intimacy are already socially taboo: norms then function not as an explicit prohibition, but as “not being intended” (Gagnon & Simon, 1973; Goffman, 1963).

An example from everyday life

In an inpatient facility, employees in the staff room talk about “the residents being difficult again today.” What does that mean? They are referring to several different individuals with unique needs. This collective term creates distance and obscures the specific causes of restlessness or dissatisfaction. This is where othering starts: a first, presumably unconscious, step has been taken toward “us caregivers” versus “these difficult residents,” who are viewed as a homogeneous group.

Reflective questions for your own work

- *In what situations do I use the terms “we” and “they” in this context (e.g., “the clients,” “the caregivers,” “those receiving care”)?*
- *How does this language affect our attitudes and actions?*
- *How could we describe the same situation in a more personalized and respectful way?*

It becomes clear that at the centre of “otherism” lies the division into “us” and “them.” This distinction is often made unconsciously, for example when professionals distance themselves from those in need of care or from people under their care, or when decisions are made exclusively within the team without involving the people affected. Psychologically, this often serves as a means of self-orientation and protection against emotional overload. And it often simplifies the work when everyone is treated

the same. Unfortunately, the reverse is also true: the more individual needs are addressed, the higher the expectations of those receiving care that these needs will be met. However, this is often simply not possible within the given work hours and budget constraints.

From a sociological perspective, this sweeping distinction between “us” and “them” therefore has the “advantage” of stabilizing the distribution of roles and power structures within care facilities. In this system, the “power” of the caregivers lies in providing the care recipients with the care services that have been defined as “standard” and in being “allowed” to set aside individual wishes. This relieves the caregivers both psychologically and in terms of their workload. The institution frees them from the “obligation” to respond to individual needs.

Nevertheless, it is worthwhile for both individuals and institutions to reflect on where we can support and avoid otherism. This paper examines key theoretical aspects of otherism, particularly in residential long-term care facilities for the elderly. Although sexuality and identity remain central components of human life throughout the entire lifecycle, these topics are often treated as taboo in old age. Furthermore, from a professional academic perspective, intersectional considerations—that is, overlapping dimensions of discrimination—must not be overlooked. Sexism, ableism, homophobia, transphobia, and social exclusion (e.g., poverty, loneliness, limited social networks, digital exclusion) remain relevant and potent.

Learning results in Module 4

This module is primarily intended for adult educators, professional nurses, instructors in nursing programs, and inpatient and outpatient care facilities. However, other healthcare professionals, as well as family caregivers who wish to address processes of stigmatization and critically reflect on their own attitudes and assumptions, will also find valuable insights:

- Starting points for recognizing “other-isms” as structural practices (not merely as individual attitudes),
- a deeper understanding of intersectionality and why aging gives rise to very different life realities,
- concrete guidelines for inclusive communication, the management of privacy, and ethical considerations (autonomy/protection/consent),
- Ideas and inspiration on how teams and organizations can implement anti-discrimination standards without exposing or shaming those affected.



Key Concepts and Definitions

Identity and Orientation

Identity describes the way in which people perceive and understand themselves based on their life history and through constant interaction with their social environment. Important factors that contribute to the formation of one’s identity include, for example, gender, age, and social background; ethnicity, nationality, and group affiliations; occupation and social status; as well as personal characteristics and competencies (Dorsch Encyclopedia of Psychology).

- Sexual orientation: Patterns of romantic/sexual attraction.
- Gender identity: A person’s internal sense of gender.
- Cis: Gender identity corresponds to the sex assigned at birth.

- Trans: Identity differs from the sex assigned at birth.

Self-determination

Self-determination means that every person has the right to decide for themselves how they wish to live. This freedom to determine one's own life is a human right in Europe that is also protected by our Constitution (Schneider et al. 2026).

Ageism

Discrimination or disadvantage based on age; in the context of sexuality, this often takes the form of **desexualisation** ("doesn't need that"), moralization ("inappropriate"), or is linked to sexual performance or youthfulness (Butler, 1969).

Sexism

Discrimination based on gender; in older adults, this is often linked to body norms, economic inequality, and gender-based expectations regarding "decency," caregiving, and relationship roles (Calasanti & Slevin, 2001; Sontag, 1972).

Ableism

The normalization of performance and autonomy as the standard; this leads to **desexualisation**, infantilization, overprotection, or blanket doubts about a person's capacity to give consent (Campbell, 2009; Goodley, 2014).

Homophobia / Transphobia

Discrimination, invisibilisation, or disadvantage based on sexual orientation and/or gender identity; often evident in heteronormative institutional practices (forms, assumptions, failure to recognize partnerships) or misgendering (Warner, 1991; Herek, 2000).

Social exclusion

Lack of resources and exclusion from participation (poverty, isolation, digital barriers, housing insecurity). Resources (spaces, mobility, networks, access to counseling) are often crucial for sexual self-determination (Levitas et al., 2007).

Stigma

A social label that can lead to shame, silence, withdrawal, or reduced access to care (Goffman, 1963; Link & Phelan, 2001).

Intersectionality

Inequalities do not operate in isolation from one another; rather, they are intertwined, thereby amplifying their impact: age × gender × disability × class × health × migration × queerness, etc. This gives rise to distinct, individual life circumstances, not merely additive "multiple problems" (Crenshaw, 1989; Collins & Bilge, 2016).

Consent

Consent is voluntary, informed, revocable, and context-dependent. In relationships of dependency (care/support), power imbalances and protective measures must be actively considered and

continually reflected upon. In cases of cognitive decline, individual assessments should take precedence over blanket prohibitions.

Mental capacity

Informed consent requires that a person understand the information, weigh the options, and give voluntary consent. In older adults, particularly those with cognitive impairments, decision-making capacity may vary. In such cases, a situational and relational assessment is necessary (Beauchamp & Childress, 2019).

Tokenism

Tokenism refers to a form of symbolic inclusion in which members of marginalized groups are visibly included but remain severely underrepresented in terms of numbers, and as a result face increased visibility, stereotyping, role assignment, and particular pressure to perform.

Professional Boundaries

Professional boundaries serve to protect both the people in care and the professionals. They define which forms of closeness, support, and communication are ethically acceptable and which constitute boundary violations.

Sexuality / Intimacy / sexual desire

Sexuality encompasses more than just sexual practices: it involves physicality, closeness, tenderness, desire, identity, self-image, relationship dynamics, and boundaries. It is always experienced and shaped individually. For example, intimacy can be sexualized or non-sexualized. In any case, sexuality remains significant throughout the entire lifespan. Theoretically, this can be understood through, among other things, Sexual Script Theory: sexuality is culturally learned, socially framed, and situation-dependent—not merely biological (Gagnon & Simon, 1973).



Understanding the Topic

1. Theoretical Framework

1.1 Sexuality in older age

Sexuality in older age is much more than physical sexuality. It includes intimacy, closeness, identity, sexual orientation, gender identity, and emotional bonds. Research shows that sexual experiences contribute to quality of life even in older age (WHO, 2015).

Nevertheless, aging is often experienced as a continuous sexual devaluation, accompanied by concerns about one's own attractiveness, declining sexual performance, and various illnesses and ailments. Women in particular are influenced by society's double standard of aging (see Ingrisch 2022), which means that women are perceived as unattractive, old, and asexual sooner than men. Social norms and images then lead aging people to describe themselves as asexual, even though they do not feel that way.

Furthermore, sexuality is often reduced to conventional coitus. The diverse needs and aspects of sexuality are ignored. Also ignored are the limited or absent opportunities for the exchange of tenderness, loving attention, physical contact, and intimate communication; especially in institutions

such as hospitals, nursing homes, and care facilities. This leads to misinterpretations of the sexual behaviours of older and sick people and to insufficient tolerance toward them. Older people sometimes experience their sexual needs as shameful and inappropriate (see Schultz-Zehden, B. 2013).

1.2 “Other-isms” become more prominent with age

Discrimination does not begin in old age—but its effects can accumulate and become institutionalized as people age. Two mechanisms are of particular importance in this regard:

- 1. Life-course accumulation:** Inequalities persist over years and decades (such as lower incomes, poorer access to health care, gaps in employment histories, and lower pensions) and become more apparent in old age (Dannefer, 2003; Levitas et al., 2007).
- 2. Institutional dependence:** As support systems expand, the rules, routines, and interpretive frameworks of institutions become the central “hub” of inclusion and exclusion (Goffman, 1961; Foucault, 1976).

1.3 Institutional Framework and Sexuality in Later Life

In the context of sexuality and intimacy, a third factor comes into play: **sexuality in old age** is often culturally taboo—as a result, social norms exert a particularly strong influence through silence, avoidance of the topic, and implicit boundaries of appropriateness (Goffman, 1963; Gagnon & Simon, 1973).

About how sexuality is handled in facilities, a basic pattern of “not being provided for” emerged from the focus group interviews conducted as part of the project. One participant in the interviews reported:

“Sexuality isn’t even discussed there [...] it’s a world away. They’re treated like little children who aren’t old enough to make their own decisions. Even the kids in kindergarten are allowed to do more.”

Focus Group Interview in Göttingen, March 2025

In institutional settings, sexuality is often not explicitly prohibited but is treated as “not intended”—as something that is symbolically “surrendered” upon entering care.

“And you leave your sexuality at the door. ... So whether it’s day care or a retirement home, a nursing home—whatever it is—you leave your sexuality at the door. You don’t have any. Under no circumstances. You also have no feelings, no emotions.”

Participant in the 2025 Expert Interview

These statements describe not just an individual taboo, but an institutional order of normality in which autonomy and adulthood are devalued—a typical intersection where ageism and ableism intertwine (Campbell, 2009; Goodley, 2014).

This synthesis is central to “Other-isms” because it demonstrates that exclusion arises not only from individual prejudices but also through institutional routines and status attributions (Goffman, 1961; Campbell, 2009).

1.4 Other-isms Mechanisms of the structuring of sexuality and intimacy

1.4.1 Invisibility

“Invisibilisation” means that needs are not identified, documented, or taken into account. As a result, “not addressed” quickly becomes “non-existent” (Link & Phelan, 2001; Goffman, 1963). This affects marginalized groups particularly severely because they already face stigma more frequently, and coming out (e.g., as queer or trans) can be risky (Spade, 2015).

The invisibility of queer life stories

Many older homosexual people still remember a time when homosexuality was a criminal offense and homosexuals were looked down upon by many of their contemporaries. Similarly, transgender people used to encounter little understanding. These experiences shape their sense of trust, feelings of shame, and how they approach openness about their own life stories.

Practical Example

Biographical surveys routinely ask about a “husband” or “wife.” Those who have remained unmarried are thus made to feel that “something” is missing from their lives. Older gay men, for instance, were unable to marry their life partners if they passed away before marriage was opened up to everyone in 2017. Another man came here as a guest worker and did not want to enter into an arranged marriage with a woman from his home country. However, prejudice prevented him from meeting a woman here. He is therefore unmarried against his will.

Questions for reflection

- *To what extent do our forms and consultations reflect gender and relationship diversity?*
- *Do we actively signal that different life choices are respected?*

But even for those who do not belong to marginalized groups, the connection between health and sexuality is often overlooked in medical history interviews. As one of the experts in our interviews describes:

“Family doctors, when seeing patients in their 60s or 70s ... don’t even think to ask, ‘How is your sex life?’ ... Because the assumption is that, well, there’s nothing left there.”

Participant in the 2025 Expert Interview

Key point: Silence or concealment is not neutrality. It reinforces the norm that “old age equals non-sexuality” and shifts the burden of proof onto those affected, forcing them to first “prove” their needs or to speak out “courageously” (Goffman, 1963; Link & Phelan, 2001).

1.4.2 Desexualisation & Infantilization (Ageism × Ableism)

Desexualisation is more than just “no sex”—it is a judgment of status: the person is no longer regarded as a legitimate subject of desire, intimacy, and self-determination. Ableism reinforces this judgment when the need for care or assistance is conflated with a lack of legal capacity (Campbell, 2009; Goodley, 2014).

The two quotes from the expert interviews mentioned above reflect this with the statements “You leave your sexuality at the door” and “They are treated like small, incapacitated children.”

Key point: This illustrates how care can tip over into incapacitation. This is less a matter of “individual misconduct” than a structural risk that arises when protection is universally prioritized over autonomy (Beauchamp & Childress, 2019).

1.4.3 Moral regulation (“appropriateness”) through defence, shaming, and trivialization

Moral regulation often manifests itself in the smallest of reactions (glances, jokes, looking away, trivialization) and produces shame (Goffman, 1963). Sexuality in old age thus clashes with cultural scripts in which sexuality is linked to youth, attractiveness, and sexual performance (Gagnon & Simon, 1973).

One of our experts describes the reaction of students when she shows photos of older people exchanging affection during a class at a geriatric nursing school:

“Wow, that’s cute!”

Participant in the 2025 Expert Interview

or

“Ugh, I can’t even look at that—do they really have to do that?”

Participant in the 2025 Expert Interview

Key point: Trivialization (“cute”) denies the seriousness of intimacy and shifts it into a childish register. Defensiveness (“is that really necessary?”) marks it as unacceptable. In both cases, exclusion occurs without an explicit prohibition.

1.4.4 Pathologization / Medicalization

When sexuality becomes apparent in old age, it is often viewed as a “problem”: as a dysfunction, a symptom, or a risk. This aligns with a modern logic of normalization and medical classification (Foucault, 1976; Link & Phelan, 2001). As one of our experts describes:

"Sexually transmitted infections among older adults [...] [are on the rise]. But in some cases, this goes completely undetected because, for example, general practitioners don't even think to ask their patients in their 60s or 70s about their sex lives. [They assume] [...] that there's nothing going on there anymore."

Participant in the 2025 Expert Interview

Key point: A dual logic is created: 1. Sexuality is considered "non-existent" → no space for discussion; 2. when it becomes visible → it is primarily framed as a risk or deviation. This often prevents a perspective focused on quality of life.

1.4.5 Overregulation driven by uncertainty ("just to be safe")

When guidelines are lacking, institutions often respond with blanket rules. These rules disproportionately affect marginalized individuals because they often have fewer social networks, face greater risks of stigma and exposure, and have less ability to advocate for themselves (Spade, 2015; Link & Phelan, 2001).

"So in nursing homes [...], [sexual activity] really doesn't happen at all."

Participant in the 2025 Expert Interview

Key point: If an issue is officially "not on the table," there are no professional avenues to address it in the event of a conflict. In such cases, informal norms (morality, shame, etc.) come into play—and that is precisely where "other-isms" are perpetuated.

2. Myths vs. Realities

Myth 1: "Treat equally = fair."

Reality: Equal treatment can reproduce barriers. Justice means designing conditions in such a way that different situations of life have real access (Crenshaw, 1989; Collins & Bilge, 2016).

Myth 2: "Sexuality in old age is rare, so it's not an issue."

Reality: Often, it is not a rarity that is the problem, but invisibility, shame, and lack of enablement (Goffman, 1963).

Myth 3: "Disability/care needs and sexuality don't go together."

Reality: This is an ableist model of normality. Assistance logic, privacy, protection, and self-determination are decisive (Campbell, 2009; Goodley, 2014).

Myth 4: "Queer issues are a youth issue."

Reality: LGBTQI+ people age - often with biographical stigma experience and specific safety needs (Herek, 2000; Stryker, 2008).

Myth 5: "Not addressing protects."

Reality: Silence is not neutral; it stabilizes stigmata (Goffman, 1963; Link & Phelan, 2001).

3. Intersectional Perspective: When Categories Overlap

Othering has a particularly strong effect when multiple characteristics converge. Older people are not just old—they may also have a history of migration, belong to a religious minority, be queer, live with a disability, or be socially disadvantaged. These overlaps (intersections) increase the risk of being overlooked, misunderstood, or treated stereotypically.

For example, an unmarried, lesbian resident with a Turkish family background will have experienced exclusion differently than a woman of German descent who has married her partner. The latter is likely to fit better into the facility's routines because the fact of being married is asked of everyone anyway. However, care cannot simply settle for adapting to what suits the majority. This is all the truer in an increasingly diverse society, where a single solution that fits everyone will become ever rarer. If society has now evolved to the point where, with the opening of marriage, same-sex oriented people are also "seen," then care must respond accordingly. A gay man who has experienced discrimination must no longer find himself in a situation where he feels he has to hide his identity in a nursing home out of fear of being rejected again. A resident with a refugee background may react sensitively to loud noises or situations of control—without this being immediately recognized as a biographically conditioned reaction.

Intersectional thinking means not reducing people to a single category, but recognising the complexity of their lived experiences and, in particular, acknowledging that where these categories overlap, the burdens they face can reinforce one another

- **Older LGBTQI+ people: Support groups vs. age norms**

The focus groups reveal a sense of ambivalence: the community can be a safe space – yet at the same time, 'new norms' exist.

„... in the queer scene ... it's the case that it doesn't matter how old you are.“

Participant of the Focus Group Discussion 2025, Göttingen

At the same time, the experience is made:

"In the club, only 'young standards' are always played - I don't fit in at all."

Participant of the Focus Group Discussion 2025, Göttingen

And:

"As a lesbian pensioner, I am 'outside' twice."

Participant of the Focus Group Discussion 2025, Göttingen

Key point: Intersectionality is not an abstract addition here, but describes concrete dynamics of recognition and participation (Crenshaw, 1989): Age × queerness changes how visibility and belonging are negotiated.

- **Biographical imprint: History of discrimination continues to have an effect**

"I still experienced paragraph 175 [...] that still has an impact today"

Participants of the Focus Group Discussion 2025, Göttingen

This points to risks and protective strategies rooted in one's life history (Herek, 2000): openness or silence are not a matter of 'character', but are often the result of a rational assessment of risk.

- **Sexism in Old Age: Double Standards and Reproduction as a Norm Framework**

Sexist images of old age have an effect, among other things, through body norms and the "double standard of aging" (Sontag, 1972; Calasanti & Slevin, 2001).

"So I could imagine that men are a bit more self-confident, while women are still internalized about it, this is the topic of having children [...] when this is completed at some point, so to speak, then it is already a certain change or change in such a phase of life, while the man could still theoretically become a father until old age, if he wanted to."

Participant in the individual interview 2025, Göttingen

- **Social exclusion: "You don't fit in here"**

"The fact that I don't have to be at this rave now at the age of 58 [...] You don't fit in here at all."

Participant in the Focus Group Discussion 2025, Göttingen

Social exclusion thus also affects the spaces in which flirtation, relationship, visibility and belonging take place.

Guidelines for educators and professionals

Educators and professionals have a special responsibility. Through further education and training, skilled workers can gain confidence in their actions and strengthen their professional attitude.

Fundamental aspects of working in the context of Othering are:

- Reflection on one's own values, norms and insecurities in dealing with sexuality in old age.
- Knowledge and imparting knowledge about legal and ethical principles.
- Fostering an open team culture where difficult situations can be discussed.
- Active protection of privacy, intimacy and self-determination.
- Inclusion of biography work for a better assessment of individual needs.

Central principles to counteract othering

Creating safe and respectful spaces

A central component is the establishment of spaces in which sexuality and identity can be talked about openly. This requires an appreciative attitude, discrimination-sensitive language and the active confrontation with one's own prejudices. Such a space is particularly crucial for LGBTQIA+ seniors, as they often have lifelong experiences of discrimination (Fredriksen-Goldsen et al., 2017).

Inclusive communication practices

Inclusive communication means shaping language and behavior in such a way that all people feel addressed and respected. This includes avoiding heteronormative assumptions ("Is your wife coming to visit you?"), using gender-neutral language, and using active listening in conversations. Professionals should not avoid conversations about sexuality, but accompany them sensitively and professionally.

Privacy and confidentiality

Privacy is a fundamental human right and is of particular importance in care contexts. In long-term care facilities, it is often limited by multi-bed rooms, organizational processes or staff shortages. Intimacy and opportunities for retreat must be actively protected, especially here, for example through lockable rooms, clear visiting regulations and confidential conversation settings.

Informed consent in case of fluctuating sanity

A particularly sensitive topic is the question of the ability to consent in people with dementia or other cognitive impairments. Current ethical approaches argue that consent should not be viewed exclusively as a static state, but as a dynamic process. Desires, nonverbal signals, and previous biographical statements should be included in the evaluation (Dewing, 2007).

Professional Relationships and Ethical Responsibility

Employees are often caught between support and professional distance. It is central that it is legitimate and necessary to acknowledge needs for closeness and intimacy without exploiting relationships of dependency or crossing boundaries. Regular supervision and ethical case discussions can have a supportive effect here.

Examples of challenges in practice

Religious, cultural and queer needs in everyday life

Otherism also arises when institutional processes tacitly proceed from a "norm biography": heterosexual, German-speaking, socialized in a Christian way.

Practical example

A same-sex partner is referred to as a "friend" in everyday life and is not taken seriously as a life partner. She is less naturally involved in visitation arrangements than the wives of men. Or: Religious rituals, eating habits or shame boundaries in personal hygiene are treated as "special requests" instead of as part of personal dignity.

Reflection Questions

- Which ways of life are implicitly considered "normal" in our country?
- Who has to adapt to our processes – and where could we be more flexible?
- How do we distinguish between organizational boundaries and mere habit?

Admission interviews/forms

These heteronormative assumptions ("husband/wife") are then also evident in the admission interviews and forms in institutions and make relationships invisible (Warner, 1991; Spade, 2015).

Privacy

Without privacy, intimacy is hardly possible - especially in shared spaces (Goffman, 1961).

"So the room or something, that's the private space, the privacy and so on, so that it is simply accepted and respected differently with regard to living out sexuality."

Participant in the individual interview 2025, Göttingen

Cultural practices

Trivialization, defensiveness, and humor are norm-setting (Goffman, 1963).

Family conflicts

Family norms vs. self-determination of the person (Beauchamp & Childress, 2019).

Uncertainty without guidelines

When sexuality "does not occur", ad hoc restrictions often arise in the event of conflict (Spade, 2015).

"The [sex life] doesn't really happen at all."

Participant in the individual interview 2025, Göttingen

Communication recommendations

Describing instead of evaluating: "I noticed ..." instead of "This is inappropriate".

Open-ended, non-judgmental questions: "What is important to you in terms of closeness/privacy/relationships?"

Do not assume: do not make assumptions about orientation, gender, relationship status, "family model" (Warner, 1991).

Language and cultural attributions

Practical example

A resident with a headscarf rejects certain foods. The team says: "They can't eat it." In fact, it is not a religious prohibition, but a personal aversion. The hasty cultural attribution replaces individual questioning.

Another example: An older man hardly talks about his private life. Employees suspect a lack of interest in social contacts. In fact, he has hidden his transgender nature for decades and is used to being careful because he doesn't always want to explain transsexuality to everyone.

Reflection Questions

- *When do we prematurely interpret behavior culturally or religiously?*
- *What questions could we ask instead of making assumptions?*
- *How openly do we talk about diverse lifestyles so that same-sex residents can also feel safe?*

Migration, language and power

Language is a central factor of Otherism. If older people do not speak German or speak it only to a limited extent, they are more quickly classified as "not oriented" or "not cooperative".

Practical example

A resident with little knowledge of German does not respond to care instructions. This is documented as a cognitive limitation. In fact, he does not understand the situation linguistically. A conversation in his first language shows that he is very well oriented.

Or: Relatives are automatically used as interpreters, even for sensitive topics. As a result, self-determination and privacy are lost and at the same time relatives are called upon, whose task is actually interpreting.

Reflection Questions

- *Where do we confuse language barriers with cognitive impairments?*
- *What options for professional language mediation do we know and use?*
- *How can we strengthen non-verbal communication and culturally sensitive care without reducing people to "culture"?*

Correct mistakes and misgendering briefly, take responsibility, don't dramatize.

Taboo-sensitive moderation

Don't "force" discussion spaces, but open them securely

One of the experts said in an interview:

"With the necessary tact. Don't just invite, let's talk about sex."

Participants in the individual interview 2025, Göttingen

Do's und Don'ts

Do's	Don'ts
Thinking about sexuality/relationships as part of quality of life, not only in the event of conflict	Interpreting silence as neutrality (Link & Phelan, 2001).
Actively enable privacy (knock-on rules, places of retreat, visiting options) (Goffman, 1961).	blanket prohibitions out of uncertainty ("to be sure") instead of individual case assessment (Beauchamp & Childress, 2019).
Intersectional Reflection: Identifying Barriers in Recognition/Access/Safety (Crenshaw, 1989).	Producing outing risks (questions in front of third parties, documentation without consent)
Standardizing Team Reflection: Stop Rules vs. Shameful Humor (Goffman, 1963).	Reproduce infantilizing care.

Risk Factors & Avoidance Strategies

Moral regulation

Reactions of professionals who are not neutral, but evaluate sexuality in old age or in queer people – e.g. as "unpleasant", "disgusting" or, conversely, childishly trivializing.

Examples:

- A nurse says: "At that age, it doesn't have to be anymore..."
- Giggling or derogatory looks at same-sex intimacy.
- Belittlement: "Oh, those two are as cute as teenagers".

Strategy: here it is advisable to formulate a **team standard**: "describe instead of evaluate" or **to use supervision** or establish **collegial case counseling**.

Ableist Logic of Protection

The sexuality of older people is restricted or even prevented with the argument of "protection"; especially in the case of cognitive impairments and often without a real test of self-determination

taking place. The problem here is that self-determination is restricted in favor of an exaggerated idea of protection.

Examples:

- A relationship is prevented because a person has dementia ("She can't decide that").
- Relatives or staff prohibit visits from a partner "for protection".
- Intimacy is generally rated as "dangerous".

Strategy: In this case, it is advisable to implement transparent **consent management**, structured **procedures and guidelines for action to ensure the protection** of vulnerable adults (children, adolescents) from any form of violence, abuse, exploitation or neglect (safeguarding pathways), good **documentation** and always the **individual case review** (Beauchamp & Childress, 2019).

Tokenism

Symbolic "inclusion", without real structural change. The problem is when this happens without further inclusive measures and an appropriate attitude. Then tokenism becomes pseudo-inclusion and real problems remain

Examples:

- Well-intentioned: the rainbow flag in the entrance area - but the staff is not trained.
- The mission statement mentions "diversity" - but complaints from LGBTQI+ people are ignored.
- There is a "queer contact person" - but he or she has no decision-making authority.

Strategy: Self-critical examination in the organization

- Language (do we use inclusive wording?)
- Rooms (e.g. do we have safe places to retreat?)
- Rules (are they sensitive to discrimination?)
- Complaint channels (for whom and how accessible and effective are they?)

Culturalization

A behavior or needs are hastily attributed to "culture" instead of seeing the individual perspective. This reduces people to stereotypes, which reinforces othering.

Examples:

- "It's taboo in your culture, isn't it?"
- Assumption that a person suppresses his sexuality because of his origin.
- Blanket attributions to "religious families".

Strategy:

- Ask individual questions instead of assuming or assuming without reflection.
- Orientation towards intersectional approaches (e.g. Patricia Hill Collins & Sirma Bilge).

Concrete examples of inclusive action

Forms/anamnesis: Use of neutral terms in forms ("partner", "reference person"), optional: pronouns/salutation.

Privacy by default: Respect room/private room, "Do Not Disturb" options, agree on clear call waiting rules.

Team culture: Establish a reflection routine ("What triggers us? Which norm is speaking here?"), instead of joke or defense (Goffman, 1963).

Health system: Sexual history as empowerment and prevention.

"That the family doctor sometimes asks it that way."

Participant in the individual interview 2025, Göttingen

Implementing aspects of culturally sensitive approaches

Person-centered questions

The focus is on the person's perspective, not norms or assumptions.

Examples:

- "What significance does closeness/relationship have for you at the moment?"
- "What can or should we pay attention to here so that you feel comfortable?"
- "How would you like to be addressed?"

Thinking about the security dimension

Taking into account that openness about identity can have risks (rejection, stigma, sanctions).

Examples:

- A person does not want to openly show their sexual orientation because relatives are dismissive.
- Fear of discrimination by roommates.
- Concern that the nursing staff will then be treated differently.

Strategy:

- Ensure confidentiality
- Offer options (e.g., discreet assistance)
- Handle information sensitively
- Reference to Stigma Theory (e.g., Bruce G. Link & Jo C. Phelan)

Ethical orientation

Everyday actions and decisions about them are not only based on institutional rules or are made according to one's own norms, but are based on ethical principles such as **autonomy, care, justice, non-harm**; in each case adapted to the individual lifeworld of the person (cf. Beauchamp & Childress, 2019). Ethical orientation thus ensures that culturally sensitive care is not only "polite", but is **systematically morally responsible, person-centred** and **fairly** implemented. It is the bridge between theory (ethical principles) and practice (dealing with diversity on a daily basis).



Summary & Key Messages

In summary, this chapter makes it clear that sexuality and identity are also essential aspects of human dignity and quality of life in later life. At the same time, the statements of the expert interviews and discussions within the framework of the Never gets old project show that sexuality in old age is often experienced as "not provided" in institutional contexts. Discrimination often works through invisibility, incapacitation, moral regulation, pathologization and overregulation (Goffman, 1963; Link & Phelan, 2001). Otherism becomes more complex when age interacts with migration experiences, experiences of racism, queer lifestyles or language barriers. A professional attitude in working with the elderly therefore also means thinking intersectionally: not to explain prematurely, but to remain curious, to ask biographical questions and to neither dramatize nor ignore differences. A diversity-sensitive, power-critical nursing practice strengthens dignity, security and belonging – especially for people who have already experienced exclusion in their lives.

For work with the elderly, dealing with Otherism thus means a change of perspective: away from deficit-oriented attributions, towards a power-sensitive, biography-oriented and diversity-conscious practice. The scientific basis helps to understand everyday situations not as isolated cases, but as part of larger social dynamics – and thus to act more professionally, reflectively and justly.

Inclusive practice means creating conditions so that diversity becomes possible in old age. This includes a safe and respectful environment, including communication, the protection of privacy and the sensitive handling of informed consent. These aspects form the basis of ethical practice. Especially in care contexts, it is necessary to critically question institutional structures and strengthen individual autonomy. The module thus provides important impulses for holistic, human rights-oriented care for older people.

Main messages

1. Othering is a central mechanism of social exclusion

- Older people, and especially LGBTQI+ people, often experience their identity, needs, and relationships being marked as "deviant."
- Othering happens subtly through language, normative expectations (heteronormativity, age norms, reproductive norms), and structural practices in organizations and institutions.

2. Other-isms seem intertwined

- Other-isms (sexism, ableism, homophobia/transphobia, social exclusion) often seem intertwined in old age and influence recognition, access and individual security.

3. Lifelong discrimination continues to have an effect

- Biographical experiences of discrimination, stigma and marginalisation influence behaviour, trust and needs in old age.
- Old people, who used to be excluded or pathologized, need sensitive handling and safe spaces.

4. Heteronormative and ableist assumptions reinforce othering

- Language, rituals and rules in care facilities often unconsciously presuppose heterosexual, reproductive and "normal" age roles.
- Blanket protective intentions or assumptions about abilities (e.g. in the case of cognitive impairments) can undermine self-determination.

5. Tokenism and symbolic inclusion are not enough

- Rainbow flags or "diversity-friendly mission statements" without real structural measures are not enough on their own and often seem superficial.
- Effective action usually requires adjustments and revisions of rules, implementation of inclusive complaint channels, training and concrete support services.

6. Culturally sensitive and person-centred approaches mitigate othering

- Individual needs, cultural backgrounds and personal meanings are actively queried.
- Ethical orientation (autonomy, care, justice, non-harm) is considered a basic guideline for transparent, responsible and respectful decisions in care.
- Security dimensions (stigma, institutional sanctions, family norms) must be taken into account.

7. Reflection on own standards and team processes are central

- Teams should regularly share their own assumptions, moral evaluations, and institutional norms (e.g., supervision, ethics meetings).
- "Describing instead of evaluating" in communication and documentation reduces subtle forms of othering.

Practical tools

The training tool is intended to provide participants with opportunities for self-reflection, to expand their competence to act in uncertain situations and subject areas, and to collect ideas for the implementation of their own educational offerings.

Learning objectives of the training module

1. Raising awareness and raising awareness: *Making "invisible" mechanisms visible*

- Participants recognize how othering arises in everyday care.

- They understand the impact on older people, especially LGBTQI+.
- They reflect on their own assumptions (e.g. heteronormativity, images of old age).

2. Strengthen reflection skills: professional self-reflection instead of unconscious reproduction of norms

- Questioning one's own values, attitudes and possible prejudices.
- Recognizing ambivalences.
- Establishment of an appreciative approach to uncertainty in the team.

3. Building practical skills for everyday life

Be able to apply concrete strategies, such as:

- Discrimination-sensitive language,
- "Describe instead of evaluate",
- Person-centred conversation.

4. Promote ethical decision-making skills

- Application of central principles: autonomy, care, non-harm, justice
- Dealing with dilemmas (e.g. ability to consent, protection concepts).

5. Strengthen culturally sensitive and inclusive practice and implement it in everyday life

- Understanding individual life realities instead of relying on stereotypical assumptions.
- Taking the dimension of safety into account (stigma, risks of discrimination).
- Promoting trust and creating safe spaces.

6. Initiate structural change

Critically analyse facilities with regard to:

- Language & Forms
- Rules & Routines
- Complaint structures
- Recognizing and avoiding tokenism

7. Reflection Questions for Teams

- What different life experiences can be behind seemingly "unusual" reactions?
- Where do we tend to reduce people to origin, religion, sexual orientation or gender identity?
- How can biography work and open-ended questions help to better understand individual backgrounds?

Target groups of the training

Primary Target Groups

- Nurses (inpatient & outpatient).
- Nursing assistants / caregivers.
- Social workers / social pedagogues.
- Adult educators.
- Therapeutic professions (ergotherapy, physiotherapy, psychotherapy).

Secondary Target Groups

Depending on the context, higher-level levels also benefit from the training. In terms of organizational development processes and structural changes, it makes sense to involve managers and QM.

Expanded Target Groups

In a broader sense, target groups that often play a central role indirectly in organizations also benefit, as they are indispensable and usually have greater everyday contact with residents, relatives and medical staff:

- Trainees in nursing and social professions.
- Housekeeping & service staff.
- Volunteers.
- Relatives (optional, depending on the setting).

Lesson Plan Module 6

A structured guideline is used to plan and implement this module in educational work. It is to be understood as a suggestion and offers trainers and experts a didactic and methodological orientation for a training duration of approx. 2.5 hours. He provides a PowerPoint presentation as well as a preparation checklist and describes expected learning outcomes and three exercises (see below).

Lesson Plan Module 6 – *Otherisms in Working with the Elderly and the Very Old*

Presentation Module 6

Exercise 1 – "Recognizing standard glasses"

Objectives:

- Making Othering and Normative Assumptions Visible
- Low-threshold introduction to the topic

Duration: 35 minutes

Resources: Prepared worksheets in the number of participants with "typical" statements in the nursing context.

Exercise 2 – ‘Case study’

Objectives Case 1

- Raising awareness of ableist protective logic
- Balancing self-determination and protection
- Applying ethical principles to concrete situations

Objectives Case 2

- Recognizing heteronormative exclusion
- Dealing with conflicts in the social sphere
- Development of inclusive action strategies

Objectives Case 3:

- Avoidance of stereotypical attributions
- Promotion of culturally sensitive, individual approach
- Strengthening communication skills

Objectives Case 4:

- Understanding Tokenism vs. True Inclusion
- Analysis of institutional structures
- Development of concrete approaches to change

Duration: 45 minutes

Resources: prepared worksheets, flipchart.

Exercise 3 – Train the Trainer- "Transfer to your own facility"

Objectives:

- The participants develop a concrete, realistic mini-intervention with which they can introduce the topic of *othering* into their own institution.
- Focus: Implementation instead of theory

Duration: 60 minutes

Resources: Prepared worksheets with the exact task instructions and guiding questions for the exercise.

References

- Arbeitskreis Medizinischer Ethikkommissionen in der Bundesrepublik Deutschland e.V. und Zurechnungsfähigkeit (2026): <https://www.akek.de/faq/6-informierte-einwilligung/> (letzter Aufruf: 05.02.2026).
- Beauchamp, T. L., & Childress, J. F. (2019). *Principles of Biomedical Ethics* (8. Aufl.). Oxford University Press.
- Butler, R. N. (1969). Age-ism: Another Form of Bigotry. *The Gerontologist*, 9(4, Part 1), 243 ff.
- Calasanti, T. M., & Slevin, K. F. (2001). *Gender, Social Inequalities, and Aging*. AltaMira Press.
- Campbell, F. K. (2009). *Contours of Ableism: The Production of Disability and Abledness*. Palgrave Macmillan.
- Collins, P. H., & Bilge, S. (2016). *Intersectionality*. Polity Press.
- Crenshaw, K. W. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *University of Chicago Legal Forum*, 1989, S. 139–167.
- Dannefer, D. (2003). Cumulative Advantage/Disadvantage and the Life Course: Cross-Fertilizing Age and Social Science Theory. *The Journals of Gerontology: Series B*, 58(6), S327–S337.
- Dewing, J. (2007). Participatory research: A method for process consent with persons who have dementia. *Dementia*, 6(1), S. 11–25.
- Dorsch Lexikon der Psychologie: <https://dorsch.hogrefe.com/stichwort/identitaet> (letzter Aufruf: 05.02.2026).
- Foucault, M. (1976). *Überwachen und Strafen: Die Geburt des Gefängnisses*. Frankfurt am Main: Suhrkamp.
- Foucault, M. (1983). *Sexualität und Wahrheit 1: Der Wille zum Wissen*. Frankfurt am Main: Suhrkamp.
- Fredriksen-Goldsen, K. I., Jen, S., Bryan, A. E. B., & Goldsen, J. (2017). Cognitive impairment, Alzheimer's disease, and other dementias in the lives of lesbian, gay, bisexual and transgender older adults and their caregivers. *Journal of Applied Gerontology*, 37(5), S. 545–569.
- Gagnon, J. H., & Simon, W. (1973). *Sexual Conduct: The Social Sources of Human Sexuality*. Aldine Publishing Company.
- Goffman, E. (1961). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Anchor Books.

- Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Prentice-Hall.
- Goodley, D.** (2014). *Dis/ability Studies: Theorising Disablism and Ableism*. Routledge.
- Herek, G. M. (2000). The Psychology of Sexual Prejudice. *Current Directions in Psychological Science*, 9(1), S. 19–22.
- Ingrisch, D. (2022): Es fängt schon an, wenn wir ganz jung sind. Aging and Aging Trouble. In: mdw- Webmagazin. <https://www.mdw.ac.at/magazin/2022/04/28/es-faengt-schon-an-wenn-wir-ganz-jung-sind/> (letzter Aufruf: 24.03.2026)
- Levitas, R., Pantazis, C., Fahmy, E., Gordon, D., Lloyd, E., & Patsios, D. (2007). *The Multi-Dimensional Analysis of Social Exclusion*. University of Bristol.
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, S. 27, S. 363–385.
- Schahrzad, Farrokhzad (2019): Empowerment junger Menschen mit (zugeschriebenem) Migrationshintergrund im Spannungsfeld von Othering und Selbstermächtigung. Hrsg. Informations- und Dokumentationszentrum für Antirassismusbearbeitung e.V. IDA. Düsseldorf. Link zur Publikation (letzter Aufruf: 10.11.2025).
- Schneider, G.; Toyka-Seid, C. (2026): Das junge Politik-Lexikon von www.hanisauland.de, Bonn: Bundeszentrale für politische Bildung. <https://www.bpb.de/kurz-knapp/lexika/das-junge-politik-lexikon/321117/selbstbestimmung/> (letzter Aufruf: 23.03.2026).
- Schultz-Zehden, B. (2013): Sexualität im Alter. In: Bundeszentrale für politische Bildung <https://www.bpb.de/shop/zeitschriften/apuz/153140/sexualitaet-im-alter/>
Lizenz CC BY-NC-ND 3.0 DE
- Serano, J. (2007). *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity*. Seal Press.
- Sontag, S. (1972, 23. September). The Double Standard of Aging. *The Saturday Review*, S. 29ff.
- Spade, D. (2015). *Normal Life: Administrative Violence, Critical Trans Politics, and the Limits of Law*. Duke University Press.
- Stryker, S. (2008). *Transgender History*. Seal Press.
- Warner, M. (1991). Introduction: Fear of a Queer Planet. *Social Text*, (29), S. 3–17.
- World Health Organization. (2021). *Global Report on Ageism*. World Health Organization.
- World Health Organization (WHO). (2015). *World report on ageing and health*. WHO Press. <https://iris.who.int/server/api/core/bitstreams/5174879e-b0dc-43fc-b3a8-b1db31c51d4c/content> (letzter Aufruf: 11.02.2026).
- Zusammenleben neu gestalten (2022): *Konfliktkultur!?! Anregungen zum Umgang mit Othering und Anfeindungen*. Hrsg. Zusammenleben neu gestalten. Angebote für das plurale

Gemeinwesen Prozessbegleitung. Impulse. Reflexionen. Frankfurt am Main. Link zur Publikation (letzter Aufruf: 10.11.2025).



MODULE 7

Inclusive Methodologies to Approach Sexuality, Gender and Diversity in the Third Age

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Overview

Why This Module Exists

Knowing what to do is not the same as knowing how to do it. Many professionals working with older adults understand, in principle, that sexuality, gender, and diversity matter. They have read the recommendations, signed the charters, and attended the awareness sessions. Yet when faced with a real situation—a resident who wants to talk about their intimate needs, a couple seeking privacy, a trans elder whose body tells a different story—they freeze. They lack the practical tools, the right words, the confidence to act.

This module exists to bridge that gap between intention and action. It moves beyond the "why" of inclusion to focus on the "how." It provides professionals with concrete, adaptable methodologies for creating environments where every older person can express their full humanity—their desires, their identity, their need for connection—without fear or shame.

From Silence to Dialogue

The most powerful tool a professional has is not a policy or a protocol—it is the ability to create a conversation. But how do you start a conversation about something so deeply personal, so culturally taboo? How do you ask an 85-year-old woman about her intimate life without being intrusive? How do you signal to a gay man that it is safe to mention his deceased partner's name? How do you support a person with dementia in expressing their need for tenderness?

These are not theoretical questions. They are the daily challenges of anyone working in gerontology, social work, healthcare, or community education. This module provides answers.

What This Module Offers

This module is a practical toolkit. It invites professionals to:

- Understand core principles: Learn the foundational elements of any inclusive methodology: respect, safety, consent, and cultural sensitivity.
- Develop communication skills: Acquire practical techniques for inclusive language, active listening, and creating conditions for safe dialogue.
- Use participatory strategies: Move beyond top-down approaches to co-create learning and care with older adults themselves.
- Adapt to diverse needs: Learn how to tailor methods for people with different cognitive abilities, emotional states, and social contexts.
- Navigate difficult conversations: Gain confidence in handling sensitive topics, from desire to grief to identity.

Ultimately, this module affirms that methodology is not a set of rigid techniques—it is a flexible, responsive, and deeply human approach to supporting the people in your care.

Learning Outcomes Module 3

By the end of this module, participants will be able to:

1. Explain why specific methodologies are necessary for addressing sexuality, gender, and diversity with older adults, moving beyond good intentions to effective practice.
2. Apply the four core principles of inclusive methodology—respect, safety, consent, and cultural sensitivity—in their professional interactions.
3. Use concrete communication techniques (inclusive questioning, active listening, non-verbal cues) to create safe spaces for dialogue.
4. Design and facilitate participatory, learner-centred activities that engage older adults as active partners in conversations about intimacy and identity.
5. Adapt their approach to meet the cognitive, emotional, and social needs of diverse older adults, including those with dementia, sensory impairments, or trauma histories.
6. Confidently navigate difficult conversations about sensitive topics such as desire, loss, identity, and consent.



Key Concepts & Definitions

Inclusive Methodology

An approach that actively ensures all participants feel seen, heard, and respected. It adapts to diverse needs, challenges assumptions, and creates conditions for full participation.

Learner-Centred Approach

A methodology that places the learner's needs, experiences, and perspectives at the center of the process. The professional acts as a facilitator rather than an expert, co-creating knowledge and meaning with participants.

Participatory Strategy

An approach that actively involves the target group in designing, implementing, and evaluating activities. Based on the principle “nothing about us without us”.

Psychological Safety

The shared belief that a space is safe for interpersonal risk-taking—for asking questions, expressing vulnerability, or sharing personal experiences without fear of embarrassment or punishment.

Active Listening

A communication technique requiring the listener to fully concentrate, understand, respond to, and remember what is being said. It involves both verbal and non-verbal signals of engagement.

Cultural Sensitivity

The awareness and respect for cultural differences in values, beliefs, and practices related to sexuality, gender, and intimacy. It requires humility and a willingness to learn from the other person's framework.

Trauma-Informed Approach

A methodology that recognizes the prevalence of trauma and actively avoids re-traumatization. It prioritizes safety, trustworthiness, choice, collaboration, and empowerment.



Understanding the Topic

1. Why Methodologies Matter: Beyond Good Intentions

Good intentions are not enough. In fact, without proper methodology, well-meaning professionals can inadvertently cause harm. This section explores why a deliberate, structured approach is essential.

1.1. The Risk of Unintentional Harm

Consider these common scenarios:

- A well-intentioned caregiver, wanting to be inclusive, asks a new resident: "So, do you have a husband or a wife?" The resident, a lesbian who lost her partner years ago, feels erased and unseen.
- A social worker, hoping to create an open dialogue, starts a group session by asking everyone to share "their experience with sexuality." The room falls silent. Participants feel exposed and vulnerable.
- An activity coordinator organizes a "romantic film night" for couples, inadvertently isolating all the single, widowed, or non-coupled residents.

In each case, the professional meant well. But without a methodology—without careful thought about language, safety, and inclusion—their actions caused harm. Methodology is not about bureaucracy; it is about intentionality. It is the difference between hoping to be inclusive and actually being inclusive.

1.2. The Power of the "Hidden Curriculum"

In any educational or care setting, there is a "hidden curriculum"—the unspoken norms, values, and assumptions that are communicated through actions, not words. When it comes to sexuality and gender, the hidden curriculum is often powerful and damaging:

- Silence teaches irrelevance: When professionals never mention intimacy or identity, they teach older adults that these topics are not important, not welcome.
- Assumptions teach invisibility: When forms only offer "Mr./Mrs.," when questions always assume heterosexuality, when activities are strictly gendered, professionals teach LGBTQIAP+ and gender-diverse people that they do not exist.
- Discomfort teaches danger: When a professional's body language shifts, when they change the subject quickly, when they avoid eye contact—they teach that this topic is dangerous, shameful.

Methodology gives us tools to examine and transform the hidden curriculum. It allows us to be intentional about what we teach through our actions.

1.3. The Need for Adaptability

There is no single "right way" to address sexuality, gender, and diversity with older adults. A methodology that works brilliantly with a group of cognitively healthy, socially engaged seniors may fail completely with individuals living with dementia. An approach that feels safe for a cisgender heterosexual woman may feel threatening for a trans man with a history of institutional violence.

This is why this module focuses on principles and adaptable strategies, not rigid techniques. True methodology is flexible; it bends to meet the person where they are, rather than forcing the person to fit the method.

2. Core Principles of Inclusive Methodology

All effective methodologies for addressing sensitive topics with older adults rest on four interconnected principles: Respect, Safety, Consent, and Cultural Sensitivity.

2.1. Respect: The Foundation of All Interaction

Respect is not just an attitude; it is a set of observable behaviors. In practice, respect means:

- Seeing the whole person: Recognizing that an older person is not just a patient or a resident, but a whole human being with a history, desires, and an identity.
- Preserving dignity: This means, for example, always knocking and waiting for a response before entering a private room. It means discussing intimate care needs discreetly, not in a loud voice in a common area.
- Using preferred names and pronouns: This is a fundamental act of recognition. It requires asking, not assuming.
- Avoiding infantilization: Never using terms like "sweetie," "dear," or "young lady" with older adults. Addressing them as the adults they are.
- Valuing experience: Recognizing that older adults have lived rich lives and have wisdom to share. They are experts on their own experience.

2.2. Safety: Creating Conditions for Vulnerability

For an older person to talk about intimacy, identity, or desire, they must feel safe. Creating psychological safety involves multiple layers:

Physical safety:

- Private, confidential spaces for conversation.
- Visible signs of inclusion (rainbow stickers, inclusive posters) that signal "this is a safe place."
- Clear protocols for reporting any discrimination or abuse.

Emotional safety:

- Predictable, consistent interactions that build trust.
- No judgment, no shock, no inappropriate questions.
- The right to pass—to choose not to answer or participate.
- Clear boundaries about what will be shared with whom (confidentiality).

Social safety:

- Group agreements that establish respect and confidentiality.
- Facilitation that ensures no one is targeted or made to feel different.
- Activities that build connection and mutual support among participants.

2.3. Consent: An Ongoing, Active Process

Consent is not a one-time checkbox. In the context of discussing sensitive topics, consent must be:

- Ongoing: Check in regularly. "Is it okay if we continue talking about this?" "Would you prefer to stop?"
- Active: Look for enthusiastic engagement, not just passive acceptance. Be alert to signs of discomfort—withdrawal, fidgeting, changes in tone.
- Specific: Consent to discuss one topic does not imply consent to discuss another.
- Revocable: Make it clear that the person can withdraw consent at any time, for any reason, without consequence.

For people with cognitive impairments, assessing consent requires particular skill. Look for assent—positive engagement through body language, tone, and affect. Be alert to signs of distress or withdrawal, which may indicate non-consent even if the person cannot verbalize it.

2.4. Cultural Sensitivity: Meeting People Where They Are

Cultural sensitivity does not mean knowing everything about every culture. It means:

- Practicing cultural humility: Approaching each person as the expert on their own cultural framework. Asking, "Can you help me understand what this means in your culture?"
- Avoiding assumptions: Not assuming that someone from a particular background holds certain beliefs. There is as much diversity within cultures as between them.
- Recognizing intersectionality: Understanding that a person's experience is shaped by the intersection of multiple identities—age, gender, sexuality, race, religion, disability.
- Adapting language and concepts: Being aware that words like "gay," "trans," or even "partner" may not resonate across all cultural contexts. Using the person's own language when possible.

3. Communication Approaches: Creating Safe Dialogue

Communication is the primary tool of any inclusive methodology. This section provides concrete techniques for creating dialogue that is safe, respectful, and productive.

3.1. The Power of Language

Language shapes reality. The words we choose can open doors or close them. Here are practical guidelines for inclusive communication:

Instead of...	Try...	Why
"Do you have a husband/wife?"	"Is there an important person in your life?" / "Tell me about your relationships."	Does not assume heterosexuality or marital status.
"Mr./Mrs. [Name]"	Use first name (if preferred) or ask: "How would you like to be addressed?"	Respects gender identity and personal preference.
"When you were young..."	"Throughout your life..."	Avoids framing the person's life as "over."
"You're so brave/young at heart!"	"Thank you for sharing that with me."	Avoids patronizing language.
"That must have been difficult for your husband."	"How did that affect the people close to you?"	Does not assume gender of partner.

3.2. Active Listening: Beyond Hearing Words

Active listening is a skill that can be developed. It involves:

Verbal techniques:

- Paraphrasing: "So what I'm hearing you say is that you felt hurt when..."
- Reflecting feelings: "It sounds like that experience was very painful for you."
- Asking open-ended questions: "Can you tell me more about that?" rather than "Did that make you sad?"
- Minimal encouragers: « Mm-hmm," "I see," "Tell me more »

Non-verbal techniques:

- Eye contact: Warm and attentive, not staring.
- Open posture: Arms uncrossed, body turned toward the speaker.

- Leaning in slightly: Shows interest and engagement.
- Nodding: Signals understanding and encouragement.
- Silence: Allowing space for the person to think and speak without rushing to fill the silence.

3.3. Creating Conditions for Dialogue

Sometimes the most important work happens before a single word is spoken. Creating conditions for dialogue means:

Preparing the space:

- Choose a private, comfortable location.
- Arrange seating to facilitate conversation (chairs at an angle, not across a desk).
- Remove physical barriers.
- Ensure the space is warm and inviting.

Setting the tone:

- Begin with a clear explanation of purpose and boundaries.
- Establish confidentiality: "What we discuss here is private. The only time I would need to share anything is if..."
- Emphasize the person's right to choose what to share.

Using visual cues:

- Display inclusive imagery (rainbow flags, diverse couples, people of all ages).
- Provide materials (books, brochures) that signal openness.
- Wear a pronoun pin or include pronouns in your introduction.

3.4. The Art of Asking Questions

Questions can invite sharing or shut it down. Here are guidelines for asking questions about sensitive topics:

Do Ask	Don't Ask
Open questions: "What was your experience of..."	Leading questions: "You must have found that difficult, right?"

Questions that normalize diversity: "Have you ever had a partner who was a different gender?"	Questions that assume pathology: "When did you realize you were different?"
Questions that offer choice: "Would you like to tell me about your relationships?"	Questions that demand disclosure: "Tell me about your sexual history."
Questions that follow the person's lead: "You mentioned your partner earlier. Would you like to talk more about that?"	Intrusive or pry questions : "And then what happened?"

4. Participatory and Learner-Centred Strategies

Traditional approaches to education and care are often top-down: the professional is the expert, the older person is the recipient. Participatory, learner-centred strategies flip this model. They recognize that older adults are the experts on their own lives and that meaningful learning and support happen through collaboration, not prescription.

4.1. The "Nothing About Us Without Us" Principle

This principle, born from disability rights activism, is fundamental to inclusive work with older adults. It means:

- Involving older adults in design: When creating a new program, activity, or policy, include older adults from the beginning. Ask them what they need, what they want, what has worked or not worked in the past.
- Co-creating content: Develop materials and activities with older adults, not just for them. Let them shape the agenda.
- Sharing power: Recognize that the professional's expertise is complementary to, not superior to, the older person's lived experience.

4.2. Practical Participatory Methods

Focus groups:

- Small, facilitated discussions with 6-8 participants.
- Used to explore experiences, needs, and ideas.
- Can be single-session or ongoing.
- Particularly useful for gathering diverse perspectives.

Co-design workshops:

- Structured sessions where professionals and older adults work together to design a solution (a program, a space, a resource).
- Use creative techniques (brainstorming, prototyping, role-play).

- Emphasize equal partnership and shared decision-making.

Peer facilitation:

- Train older adults to facilitate discussions or activities with their peers.
- Leverages the power of shared experience.
- Builds capacity and confidence within the community.

Community advisory groups:

- Establish an ongoing group of older adults who advise the organization on policies, programs, and practices.
- Ensure the group is diverse and representative.
- Compensate members for their time and expertise.

4.3. Learner-Centred Facilitation Techniques

In any group setting, the facilitator's role is to create conditions for learning, not to deliver content.

Key techniques include:

Starting where participants are:

- Begin by asking what participants already know, what they want to learn, what concerns they have.
- Adapt the agenda based on their responses.

Using experiential learning:

- Build activities around participants' own experiences.
- Use storytelling, case studies, and scenarios drawn from real life.
- Create opportunities for reflection and sharing.

Encouraging peer learning:

- Structure activities so participants learn from each other.
- Use small group discussions, pair shares, and whole-group synthesis.
- Validate and build on contributions from all participants.

Offering choice:

- Provide multiple ways to participate (speaking, writing, drawing, moving).
- Allow participants to choose their level of engagement.
- Respect the right to pass.

Closing the loop:

- Summarize what was learned.
- Ask participants what they will take away.
- Explain how their input will be used.

5. Adapting Methods to Diverse Needs

No single methodology works for everyone. Effective professionals adapt their approach to meet the unique needs of each individual or group. This section provides guidance for adapting methods across different cognitive, emotional, and social contexts.

5.1. Adapting for Cognitive Needs

For people with **dementia or cognitive impairments**:

- Simplify language: Use short, clear sentences. Avoid abstract concepts. Be concrete.
- Use multiple modalities: Combine words with images, objects, music, or movement.
- Focus on the present moment: Rather than asking about past experiences, focus on current feelings and needs.
- Look for non-verbal cues: Body language, facial expressions, and vocal tone are often more reliable than words.
- Validate emotions: Even if the person's words don't make sense, their feelings are real. Reflect and validate them. It refers to an approach focused on acknowledging and accepting the feelings and subjective reality of a person with dementia rather than correcting factual inaccuracies or confronting confusion.
- Create routines: Predictable structures reduce anxiety and create safety.

For people with **sensory impairments**:

- For hearing loss: Face the person, speak clearly, reduce background noise. Use written backup. Consider sign language interpreters.
- For vision loss: Describe visual materials verbally. Use tactile objects. Ensure good lighting.
- Provide materials in accessible formats: Large print, audio, braille, Easy Read.

For people with **aphasia or communication difficulties**:

- Give extra time: Allow the person to process and respond without rushing.
- Use communication supports: Pictures, writing, gestures, communication boards.
- Ask yes/no questions when appropriate: "Would you like to continue?" "Is this comfortable?"

- Check your understanding: "I think you're saying... Is that right? »

5.2. Adapting for Emotional Needs

For people with **trauma histories**:

- Use a trauma-informed approach: Prioritize safety, trustworthiness, choice, collaboration, and empowerment.
- Avoid triggering content: Be aware that certain topics (sexual violence, medical exams, certain types of touch) may be deeply triggering.
- Provide control: Emphasize that the person can stop at any time, can choose what to share.
- Watch for signs of distress: Withdrawal, agitation, dissociation. Be prepared to pause or stop.
- Have support resources available: Know how to refer to trauma-informed services if needed.

For people experiencing **grief or loss**:

- Acknowledge the loss: "I understand your partner passed away. That must be so hard."
- Follow the person's lead: Some people want to talk; others don't. Respect their pace.
- Create space for remembrance: Offer opportunities to honor loved ones if desired.
- Be present: Sometimes the most powerful support is simply being there, without words.

For people who are **anxious or shy**:

- Start slowly: Build trust gradually. Don't push.
- Offer alternatives: Some people prefer one-on-one conversations to groups. Some prefer writing to speaking.
- Normalize discomfort: "It's completely normal to feel a bit awkward talking about this."
- Use structured activities: Games, quizzes, or art projects can feel safer than open discussion.

5.3. Adapting for Social and Cultural Contexts

For people from **different cultural backgrounds**:

- Learn about cultural norms: But don't assume—ask.
- Use the person's own language when possible: Work with interpreters if needed.
- Be aware of family dynamics: In some cultures, family involvement in decisions is expected and desired.
- Respect different values: Even if they differ from your own.

- Avoid imposing Western concepts of sexuality and identity: Use the person's framework.

For people **in rural or isolated settings**:

- Use technology creatively: Video calls, phone support, online groups.
- Build on existing networks: Work with local community groups, faith organizations, or clubs.
- Be patient: Trust may take longer to build in close-knit communities where privacy is limited.

For people with **limited social support**:

- Be a consistent presence: Reliability builds trust.
- Connect to community resources: Help the person find groups, services, or activities.
- Recognize the role of "chosen family": Support connections with friends, neighbors, and other non-traditional supports.

6. Handling Sensitive Topics and Difficult Conversations

Even with the best preparation, conversations about sexuality, gender, and intimacy can be challenging. This section provides strategies for navigating difficult moments.

6.1. When a Person Discloses Something Unexpected

- Stay calm: Your reaction sets the tone. Breathe. Maintain a neutral, warm expression.
- Acknowledge the disclosure: "Thank you for trusting me enough to share that."
- Reflect back: "So what you're telling me is..."
- Ask what they need: "How can I best support you right now?" "What would be helpful?"
- Don't probe: You don't need to know all the details. Focus on the person's needs, not your curiosity.
- Know your limits: If the issue is beyond your expertise, say so and help connect to appropriate support.

6.2. When a Conversation Becomes Emotional

- Pause: "I can see this is bringing up some strong feelings. Would you like to take a moment?"
- Validate emotions: "It makes sense that you would feel that way."
- Offer choices: "Would you like to continue, or would you prefer to stop for now?"
- Use grounding techniques if needed: "Let's take a few deep breaths together." "Can you name three things you can see in this room?"

- Be present: Don't try to "fix" the emotion. Just stay with the person.

6.3. When a Person Says Something Inappropriate or Harmful

- Stay calm and professional: Do not shame or attack.
- Name the behavior, not the person: "That comment about [group] is hurtful. In this space, we treat everyone with respect."
- Use it as a learning opportunity: "Can you tell me more about why you said that?" "How do you think that might feel for someone who is [group]?"
- Reinforce group agreements: "Remember, we agreed to listen with an open mind."
- If the behavior continues, address it privately: "I'd like to talk with you about something that happened in the group earlier..."

6.4. When You Don't Know the Answer

- Be honest: "That's a really good question. I don't know the answer, but I can find out for you."
- Offer to research together: "Would you like to look into that together?"
- Connect to resources: "I know an organization that specializes in that. Would you like their contact information? »
- Follow up: If you promise to find information, do it.

7. Case Studies: Methodologies in Action

These case studies illustrate how the principles and techniques in this module can be applied in real situations.

Case Study 1: The Community Education Workshop

Context: A community center in a small town wants to offer a workshop on "Intimacy and Aging" for local seniors. They have never done this before and are unsure how to proceed.

Methodology in action:

1. Participatory design: Before designing the workshop, the organizers hold two focus groups with local seniors to understand their interests, concerns, and needs. They learn that participants want to talk about maintaining connection after loss, navigating new relationships, and dealing with family reactions. They explicitly do NOT want a "sex education" style presentation.
2. Co-creation: A planning committee of four seniors and two staff members is formed. Together, they design a four-session workshop series. The seniors suggest titles that feel comfortable ("Love and Connection at Any Age") and activities that feel safe (starting with general discussions before moving to personal sharing).

3. Creating safety: The first session focuses entirely on building trust and establishing group agreements. Participants co-create rules: confidentiality, the right to pass, no judgment, respectful listening. The facilitators model these principles throughout.
4. Learner-centred facilitation: Each session begins with a check-in and a question: "What do you want to talk about today?" The agenda adapts to participants' needs. When someone shares a personal experience, the facilitator invites others to reflect: "Has anyone else had a similar experience?"
5. Adapting to needs: One participant has early-stage dementia. The facilitator checks in with her regularly, uses simple language, and validates her contributions. When she becomes confused, the facilitator gently redirects or offers a break.
6. Closing the loop: At the final session, participants reflect on what they learned and what they will take away. Several express interest in continuing to meet. The center agrees to support an ongoing peer-led discussion group.

Case Study 2: The One-on-One Conversation

Context: A home care worker, Marie, visits 82-year-old Mr. Ahmed regularly. He has recently been widowed and seems increasingly withdrawn. Marie suspects he may be lonely and isolated.

Methodology in action:

1. Creating conditions: Marie ensures they have time for a private conversation. She sits in a comfortable chair near him, not across a table. She starts with general questions about how he's doing.
2. Active listening: When Mr. Ahmed mentions that he "misses the company," Marie doesn't rush to solutions. She reflects: "It sounds like you're feeling lonely since your wife passed." She allows silence for him to respond.
3. Asking open questions: "What was your marriage like?" she asks. Mr. Ahmed begins to talk about his wife, their life together. Marie listens without interrupting.
4. Following the lead: When Mr. Ahmed mentions that he sometimes thinks about "what comes next," Marie gently asks: "What do you mean by that?" This opens a conversation about whether he might want companionship again—something he has been afraid to even think about.
5. Respecting boundaries: When Mr. Ahmed becomes tearful, Marie pauses. "This is bringing up a lot of emotion. Would you like to continue, or would you prefer to stop?" He chooses to continue, but Marie's offer reinforces his control.
6. Offering support, not solutions: At the end, Marie doesn't tell him what to do. She asks: "What would be helpful for you now?" Mr. Ahmed says he might like to visit a local community center. Marie offers to help him find information.
7. Maintaining continuity: In subsequent visits, Marie gently checks in: "Have you thought more about the community center?" She doesn't push, but keeps the door open.

Case Study 3: The Institutional Response

Context: A nursing home realizes they have no protocol for supporting residents' intimate relationships. After two residents, both with dementia, begin a relationship, staff are divided on how to respond.

Methodology in action:

1. Multi-stakeholder consultation: The facility convenes a working group including staff from all levels, the residents' families, and—crucially—other residents themselves. An outside consultant with expertise in VIAS facilitates. ("VIAS" is being used as an analysis framework in project management or care ethics, a possible definition would be: V – Verify the facts and perceptions / I – Identify the core issue and ethical principles / A – Assess the risks and options / S – Strategise / Decide on a collective response).
2. Trauma-informed approach: The consultation begins by acknowledging that some residents and staff may have trauma histories related to sexuality. Ground rules are established for respectful dialogue.
3. Assessing needs and concerns: Through facilitated discussions, the group identifies key issues: lack of privacy, staff discomfort, family concerns, lack of clear policy, fear of abuse.
4. Co-creating solutions: The group brainstorms potential solutions: installing "Do Not Disturb" signs, creating a private visiting space, developing a staff training program, creating a simple protocol for assessing consent capacity.
5. Developing a draft policy: A smaller group drafts a policy based on the consultation. It includes clear principles (right to privacy, right to relationships, commitment to safety), practical guidelines, and a decision-making process for complex situations.
6. Piloting and feedback: The draft policy is piloted for three months. Staff and residents are invited to share feedback. Adjustments are made.
7. Implementation and ongoing review: The final policy is adopted. It includes a commitment to review annually and to continue involving residents in its implementation.



Guidance for Educators and Professionals

Essential Reflexes to Develop

Language:

- Replace closed, assuming questions with open, inclusive ones.
- Ask about pronouns and preferred forms of address.
- Use neutral terms like "partner" until you know otherwise.
- On forms, replace "Mr./Mrs." with "First name, Last name, Preferred pronouns."

Posture:

- Position yourself at the same level as the person you're speaking with.
- Maintain open, relaxed body language.
- Make warm eye contact without staring.
- Be present—put away phones and other distractions.

Environment:

- Ensure private spaces are truly private.
- Display visible signs of inclusion.
- Provide materials in accessible formats.
- Create opportunities for connection (social spaces, activities, events).

Practice:

- Always ask for consent before discussing sensitive topics.
- Follow the person's lead—they are the expert on their own life.
- When in doubt, ask: "What would be most helpful for you right now?"
- Know your limits and when to refer.

Common Pitfalls to Avoid

- Assuming rather than asking: Assuming heterosexuality, assuming comfort, assuming what the person needs.
- Rushing to solutions: Sometimes the most powerful thing is simply listening.

- Avoiding the topic altogether: Silence is not neutral—it communicates that the topic is taboo.
- Using jargon or complex language: Keep it simple and clear.
- Making it about you: "When I..." "I think..." Focus on the person.
- Pushing too hard: Respect the right to pass, the right to privacy, the right to say no.



Summary & Key Messages

- Methodology matters. Good intentions are not enough. Deliberate, thoughtful approaches are essential for creating truly inclusive environments.
- Start with principles. Respect, safety, consent, and cultural sensitivity are the foundation of all effective practice.
- Communication is key. The words we choose, the way we listen, the space we create—all shape whether dialogue is possible.
- Participatory approaches work. Older adults must be partners, not just recipients, in any process that concerns them.
- Adaptation is essential. No single method works for everyone. Tailor your approach to meet the unique cognitive, emotional, and social needs of each person.
- Difficult conversations are part of the work. With the right preparation and support, they can be navigated effectively.
- You are not alone. Use the resources, networks, and tools available. Collaborate with colleagues and community partners.



Practical Tools & Resources

Lesson Plan Module 7

The lesson plan is a structured guide which provides instructions for trainers or professionals on how to implement Module 7 in a group setting. It provides a structure for a training duration of 3 hours with a correspondent PowerPoint presentation, lists learning outcomes and a preparation checklist, and describes three exercises (see below).

Exercise 1 — Creating Inclusive Questions

Objective: To practice formulating open, inclusive questions for different situations.

Instructions: In pairs, take a "closed" or "assuming" question and transform it into an open, inclusive alternative. Discuss why the new formulation is more effective.

Exercise 2 — Adapting to Diverse Needs

Objective: To practice adapting a standard methodology to meet different cognitive, emotional, or social needs.

Instructions: In small groups, receive a scenario describing a participant with a specific need (e.g., early-stage dementia, trauma history, hearing impairment). Discuss how you would adapt a standard group discussion activity to ensure their full and safe participation.

Exercise 3 — Co-Designing a Workshop

Objective: To practice applying participatory design principles.

Instructions: In groups, imagine you are tasked with creating a workshop on "Intimacy and Aging" for seniors in your community. Using the "Nothing About Us Without Us" principle, outline a participatory design process. Who would you involve? What steps would you take? What challenges might arise and how would you address them?

References

French Sources

Haute Autorité de Santé. (2025). Accompagner la vie intime, affective et sexuelle des personnes en ESSMS. Volet 1 – Socle transversal. Saint-Denis La Plaine: HAS. Available at: www.has-sante.fr

Charte ISA. (2023). Charte internationale des droits à l'Intimité, la Sexualité et l'Autonomie en établissement. Available at: <https://charte-isa.com>

Petits Frères des Pauvres. (2022). Vie affective, intime et sexuelle des personnes âgées. Paris: Petits frères des pauvres. Available at: www.petitsfreresdespauvres.fr

Amnesty International Suisse. (2022). Guide de langage inclusif. Available at: <https://www.amnesty.ch/fr/le-lab/guides-et-outils/guide-de-langage-inclusif>

Direction générale de la cohésion sociale. (2021). *Circulaire n° DGCS/SD3B/2021/147 du 5 juillet 2021 relative au respect de l'intimité, des droits sexuels et reproductifs des personnes accompagnées dans les établissements et services médico-sociaux relevant du champ du handicap et de la lutte contre les violences.* Available at: www.legifrance.gouv.fr

International Sources

World Health Organization. (2006). Defining sexual health: Report of a technical consultation on sexual health, 28–31 January 2002. Geneva: WHO.

World Health Organization. (2021). Global report on ageism. Geneva: WHO. Available at: <https://www.who.int/publications/i/item/9789240016866>

Meyer, A., Rose, D. H., & Gordon, D. (2014). Universal design for learning: Theory and practice. CAST Professional Publishing.

Additional Resources

Grey Pride. (2024). Guide "Accueillir les seniors LGBTQIAP+" and Label "Bienvenue". Available at: <https://greypride.fr>

Les Audacieuses & Les Audacieux. (2024). Le projet Maison de la Diversité. Available at: <https://audacieusement.org/le-projet-maison-de-la-diversite/>

Schwulen Beratung Berlin. (2013). Lebensort Vielfalt - Ein Wohnprojekt für ältere Lesben, Schwule und Transgender. Available at: <https://schwulenberatungberlin.de/lebensort-vielfalt/>

Tonic Housing. (2024). Tonic @ Bankhouse - UK's first LGBT+ affirming retirement community. Available at: <https://tonichousing.org.uk/>

Kit à agir. Ressources pour l'animation et l'accompagnement. Available at: <https://kit-a-agir.fr>

Intimagir. Centres ressources sur la sexualité et la parentalité. Available at: <https://www.intimagir.fr>

MODULE 8

Dementia and Sexuality: Critical Points

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Overview

This module explores the complex relationship between dementia and sexuality, with particular attention to how cognitive changes can influence intimacy, sexual expression, consent and interpersonal relationships in later life. Changes associated with dementia, such as difficulties with memory, judgement, emotional regulation or social awareness, can affect how individuals experience and express sexuality. In everyday practice, these changes may lead to situations of misunderstanding, emotional distress or ethical uncertainty, both for people living with dementia and for those who support them.

Sexuality in later life, and especially in the context of dementia, is often surrounded by silence, discomfort and ageist assumptions. Older adults living with dementia are frequently perceived as asexual or incapable of meaningful intimacy, which can result in their needs being overlooked or actively restricted. At the same time, cognitive impairment can raise genuine concerns related to consent, vulnerability and protection from harm. Professionals are therefore often required to navigate difficult tensions between respecting autonomy and ensuring safety, without clear or consistent guidance.

This module responds to these challenges by adopting a rights-based and person-centred perspective. Rather than approaching sexuality in dementia as a problem to be managed, it encourages more nuanced, compassionate and ethically informed responses that recognise sexuality as an ongoing aspect of identity and wellbeing across the life course.

The content of the module builds on findings from WP2, which highlight how dementia intersects with factors such as gender, health status, cultural norms and social expectations. WP2 findings also point to a lack of training and clear frameworks for professionals, as well as to the emotional and ethical difficulties they encounter when responding to expressions of intimacy or sexual behaviour in people with cognitive decline.

By completing this module, professionals, educators and family caregivers will develop a clearer understanding of the ethical, social and practical issues related to sexuality and dementia. They will gain greater confidence in responding to sensitive situations, increased awareness of consent and safeguarding considerations, and practical communication strategies that support autonomy while maintaining safety, dignity and respect (World Health Organization, 2015; Alzheimer Europe, 2018).



Key Concepts & Definitions

This section introduces key concepts that are particularly relevant for understanding sexuality and intimacy in the context of dementia. Using clear and shared terminology helps support more consistent, ethical and sensitive practice, especially in situations that may be emotionally or morally complex.

Dementia

Dementia is a progressive neurocognitive condition characterised by a decline in memory, executive functioning, language, judgement and social awareness that interferes with daily functioning.

It includes different conditions such as Alzheimer's disease, frontotemporal dementia and vascular dementia, as well as mixed forms. In addition, there are reversible or secondary causes of cognitive impairment that may present with similar symptoms. These conditions may show distinct behavioural and emotional patterns. The associated neurological and cognitive changes can affect impulse control, emotional regulation, and interpersonal boundaries, which may in turn influence expressions of intimacy and sexuality.

Understanding dementia as a neurocognitive condition is essential to avoid moral interpretations of behaviour and to support clinically informed, proportionate responses.

Capacity

Capacity refers to a person's ability to make a specific decision at a specific time. It is not a global or permanent state but is decision-specific and may fluctuate.

A person is generally considered to have capacity if they can:

- understand relevant information
- retain that information long enough to make a decision
- weigh or evaluate the information
- communicate their decision

In the context of dementia, capacity may vary depending on the complexity of the decision. A person may lack capacity for financial decisions but retain capacity for relational or intimate decisions.

Consent

Consent is a central ethical concept in discussions of sexuality and dementia. It refers to the ability to understand, agree to and freely participate in intimate or sexual interactions. In the context of cognitive decline, consent should be understood as a dynamic and situation-specific process rather than a fixed capacity. Assessing consent involves attention to current abilities, verbal and non-verbal communication, emotional responses and the relational context. Safeguarding responsibilities must be carefully balanced with respect for autonomy and personhood. (World Health Organization, 2015; Syme & Cohn, 2016).

Intimacy

Intimacy refers to emotional, physical and relational closeness between people. It may involve trust, affection, mutual recognition and shared vulnerability, and does not necessarily imply sexual activity. For people living with dementia, expressions of intimacy may change over time, but the underlying need for closeness, reassurance and meaningful connection often remains. Viewing intimacy in this broader sense can help professionals respond more appropriately to behaviours that might otherwise be misinterpreted.

Hypersexuality and Sexual Disinhibition

Hypersexuality refers to increased or disinhibited sexual behaviours that may occur in certain forms of dementia, particularly frontotemporal dementia, due to impaired impulse control.

Sexual disinhibition may manifest as socially inappropriate comments, touching or behaviours. These behaviours are often neurological in origin and should not automatically be interpreted as intentional misconduct.

Apathy and Reduced Sexual Interest

Apathy is common in Alzheimer's disease and may reduce initiative, emotional engagement or sexual interest. Reduced desire should not automatically be interpreted as relational rejection.



Understanding the Topic

This section explores the key issues related to dementia and sexuality, drawing on research findings, ethical frameworks and professional practice. It addresses common misconceptions, highlights challenges faced by professionals, and considers the specific needs of vulnerable and diverse groups through an intersectional lens.

Dementia, Cognitive Change and Sexual Expression

Dementia (clinically referred to as major neurocognitive disorder) is a progressive condition that affects how the brain works. It is not a normal part of ageing. It involves a decline in memory, thinking, judgement and the ability to function independently in daily life.

There are several types of dementia. The most common types include:

- ✓ Alzheimer's disease, which mainly affects memory, orientation and language in the early stages.
- ✓ Frontotemporal dementia (FTD), which often affects behaviour, impulse control, empathy and social boundaries.
- ✓ Vascular dementia, which may affect attention, planning, speed of thinking and emotional stability.
- ✓ Lewy body dementia, which can involve fluctuations in attention, visual hallucinations and changes in movement.

Dementia can affect different cognitive areas, including:

- Memory (forgetting recent events or conversations)
- Executive functioning (planning, decision-making, impulse control)
- Language (difficulty finding words or understanding meaning)
- Social cognition (understanding social rules, empathy, recognising boundaries)
- Emotional regulation (managing emotions appropriately)

Because sexuality and intimacy depend on memory, emotional understanding, impulse control and social awareness, changes in these areas may influence how sexual behaviour is expressed.

Changes in sexual behaviour in dementia may vary. Some individuals may show reduced interest in intimacy (apathy), particularly in Alzheimer's disease. Others, especially those with frontotemporal dementia, may display increased or disinhibited sexual behaviours due to reduced impulse control.

Memory difficulties may lead to confusion about partners, forgetting previous sexual activity, or misinterpreting relational boundaries. In some cases, behaviours may appear socially inappropriate, such as undressing in public or masturbating without awareness of context.

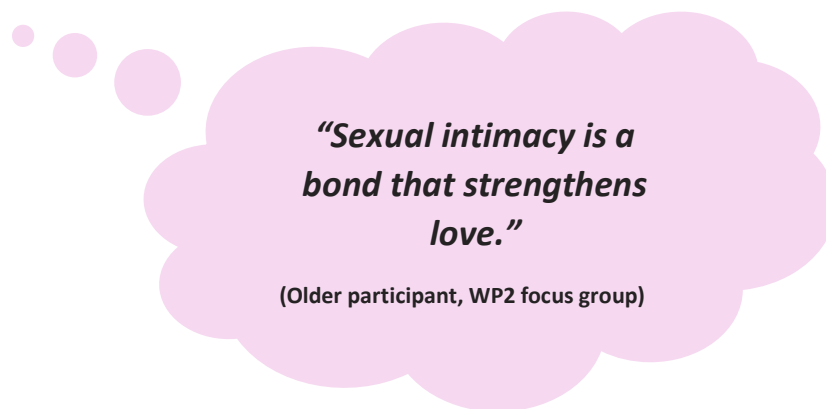
Several factors may contribute to these changes. Brain changes may reduce impulse control or empathy. Individuals may misinterpret needs for comfort, reassurance or closeness as sexual desire.

Loneliness, anxiety, pain or unmet emotional needs may also be expressed through sexualised behaviour. In addition, medication side effects, hormonal changes or psychiatric comorbidities may influence sexual expression.

Sudden changes in sexual behaviour should always prompt medical evaluation. In older adults, urinary tract infections, dehydration, electrolyte imbalances or other acute medical conditions can cause confusion or behavioural disinhibition. Assessing for underlying medical causes is therefore essential before assuming intentional behaviour.

Professionals and family caregivers should respond proportionately and contextually. Not all expressions of sexuality require restriction. Differentiating between low-risk behaviours (e.g., holding hands, seeking closeness) and high-risk behaviours (e.g., coercion, clear distress or inability to demonstrate understanding) supports balanced safeguarding that protects dignity while preventing harm.

While some forms of dementia, particularly frontotemporal dementia, may lead to impulsive or disinhibited sexual behaviours due to impaired executive functioning, it is important to distinguish these neurological manifestations from the relational meaning of sexuality itself. As one older participant expressed during WP2 discussion:



This perspective reminds us that sexual expression is closely linked to emotional connection. Although dementia can affect impulse control and social boundaries, it does not take away the underlying human need for attachment and intimacy.

Myths and Realities

Despite increasing awareness, many assumptions about dementia and sexuality continue to shape professional responses. These assumptions are often based on discomfort, fear or lack of training rather than on evidence or lived experience. Addressing common myths is an important step in preventing overly restrictive or stigmatizing practices.

Myth: People living with dementia are asexual or lose interest in intimacy.

Reality: Sexuality and the need for intimacy often persist, although they may be expressed differently.

Research with older adults in care settings also shows that intimacy and emotional closeness continue to matter for their wellbeing (Frankowski & Clark, 2021). Although stereotypes about ageing are still

common, older adults themselves remind us that sexuality and intimacy continue to matter throughout later life. As one participant shared during WP2 group discussion:

“Sexuality is more than genital sex. It is the need for affection, communication and tenderness, which we carry within us from birth until the end of life.”

(Older participant, WP2 group discussion)

This perspective challenges reductive understandings of sexuality and supports a broader, more inclusive view that recognises emotional closeness and relational needs as central to wellbeing in later life.

Myth: Any sexual behaviour in dementia is a symptom that must be controlled.

Reality: While some behaviours may require intervention, many expressions of intimacy are meaningful and appropriate when understood in context.

Myth: Protection and safeguarding require the restriction of all sexual expression.

Reality: Ethical practice involves balancing safeguarding with respect for autonomy, dignity and rights.

Challenging these myths is essential to avoid overly restrictive or paternalistic responses that may harm wellbeing and self-esteem.

Consent, Capacity and Ethical Complexity

Consent and capacity in dementia require balancing autonomy and safeguarding. A diagnosis of dementia does not automatically remove a person’s ability to consent. Decisions must be assessed situationally and proportionately.

Capacity refers to the ability to understand, weigh and communicate a specific decision. It is decision-specific and may fluctuate. Professional guidance also emphasises that capacity should be assessed in relation to each specific decision, particularly in the context of cognitive impairment (British Psychological Society, 2018). Consent refers to the voluntary agreement to engage in an interaction and requires basic understanding and absence of coercion.

A person may have fluctuating capacity but still demonstrate situational consent. These distinctions are particularly important in medico-legal contexts.

Professionals should distinguish between lower-risk intimacy (e.g., holding hands, hugging, kissing) and higher-risk sexual activity (e.g., genital contact, penetrative sex, or situations involving clear power

imbalance or distress). While lower-risk expressions of intimacy may require monitoring and support for privacy, higher-risk situations call for a more structured assessment.

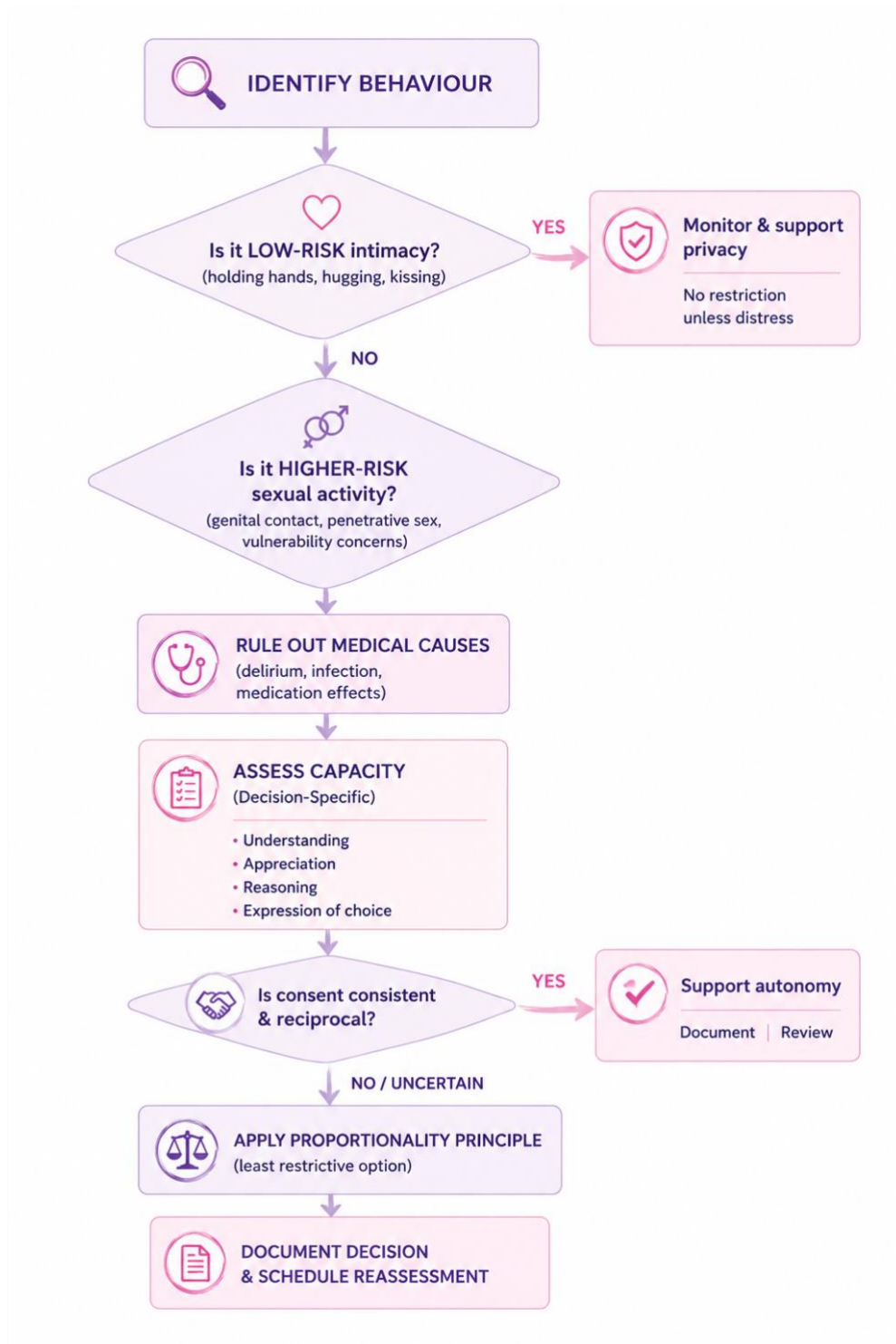


Figure 1. AI-generated image

When behaviour is identified, professionals should clarify the level of risk, assess decision-specific capacity if necessary, document the reasoning and apply the least restrictive option. In practice, this may involve offering psychological support, giving gentle reminders about boundaries, supporting safe and private interactions, or adjusting communication to help understanding. Involving a trusted person or checking for possible medical causes may also be helpful (e.g., delirium, infection, medication effects). More restrictive actions should only be used if there is a clear risk of harm, and should be regularly reviewed.

Capacity to consent to sexual activity should be evaluated through four core questions:

- ♥ Does the person understand the relationship?
- ♥ Do they appreciate potential consequences?
- ♥ Can they explain their choice?
- ♥ Is consent consistent and free of distress?

Ethical decision-making in this context should be guided by four core principles:

- ♥ Autonomy – respect for the person’s self-determination and relational identity, for example by supporting their choices and preferences wherever possible.
- ♥ Beneficence – promoting emotional and psychological wellbeing, such as ensuring comfort, connection, and a sense of safety.
- ♥ Non-maleficence – preventing harm, exploitation or coercion, for instance by recognising signs of distress or vulnerability and responding appropriately.
- ♥ Justice – avoiding discrimination, including ageism, by ensuring fair and respectful treatment regardless of age or cognitive ability.

Dementia may alter expression, but it does not erase personhood (Beauchamp & Childress, 2019). Ethical decision-making is strengthened through transparency, documentation, reflection and shared responsibility within teams.

Beyond formal capacity assessments, consent in the context of dementia cannot be reduced to purely verbal confirmation or legal criteria. In many situations, particularly in moderate cognitive decline, relational and emotional indicators become central to ethical evaluation. As highlighted during the WP2 discussions:

“Consent is not always about words. Sometimes it is about calmness, familiarity, emotional comfort and the absence of distress.”

(Professional participant. WP2 group discussion)

This reflection draws attention to the importance of recognising non-verbal communication, emotional comfort and the absence of distress as meaningful signs of consent. It encourages an approach that considers not only the person's understanding, but also how they feel during the interaction. To avoid wrong or harmful decisions, it is important to take time, observe the person over time, and, when needed, ask for input from colleagues or family members. Decisions should be based on the person's usual behaviour, preferences and overall wellbeing.

Challenges Faced by Professionals

Professionals across health, social care and educational settings frequently describe feeling uncertain or unprepared when issues of sexuality arise in the context of dementia. This uncertainty is not necessarily due to lack of concern, but often reflects limited guidance, inconsistent policies and fear of making ethical or legal mistakes.

Common challenges include:

- ♥ Lack of clear organisational policies or guidance
- ♥ Fear of legal or professional consequences
- ♥ Conflicting expectations from families, institutions and individuals
- ♥ Personal values or cultural norms influencing responses

These challenges may lead to avoidance, inconsistent practice or overly restrictive responses. Knowledge and attitudes towards sexuality in later life can also shape how such situations are understood and managed (Mahieu et al., 2020).

Professionals also report that family reactions can significantly complicate responses to intimacy in later life. This tension is reflected in the lived experiences of older adults themselves. As one participant shared:

“My children were angry when I fell in love again. They thought it was ridiculous at my age, even though I was alone and needed companionship.”

(Older participant, WP2 interview)

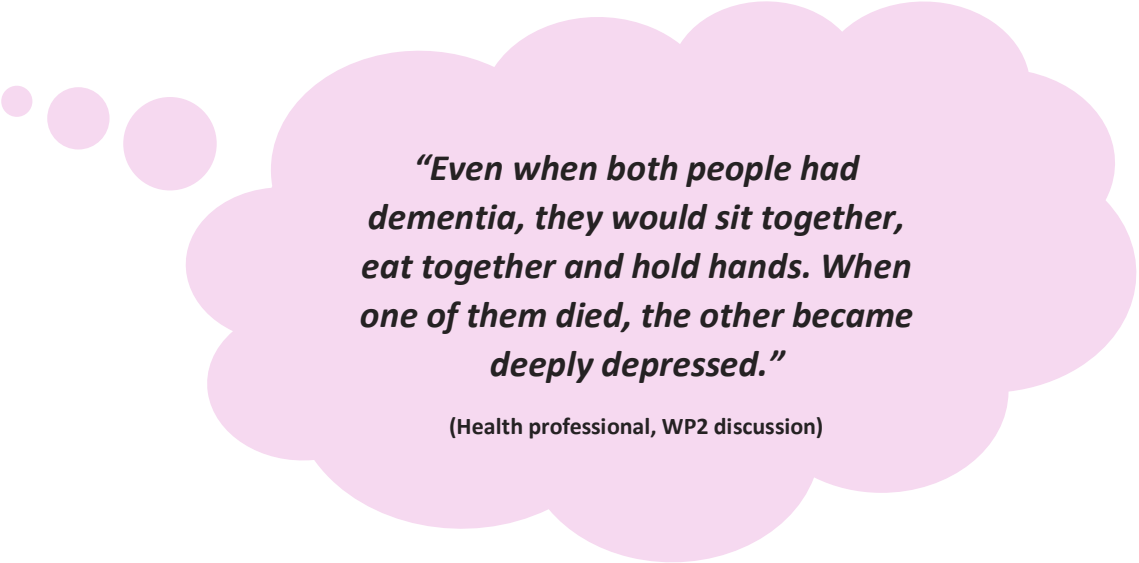
Such reactions illustrate how ageist assumptions can persist even within families, placing professionals in difficult positions when trying to respect autonomy while managing conflict and emotional distress.

These challenges may lead to avoidance, inconsistent practice or overly restrictive interventions. Training and reflective practice are therefore essential to support confident, ethical and compassionate responses.

Safeguarding Without Stigmatization

Safeguarding is a crucial responsibility, but it should not be implemented in ways that stigmatise or suppress sexuality. Risk assessments should be proportionate, transparent and focusing on preventing harm while preserving dignity and relational needs.

Observations from professional practice highlight the emotional significance of relationships, even in advanced cognitive decline. One health professional involved in WP2 reflected:



“Even when both people had dementia, they would sit together, eat together and hold hands. When one of them died, the other became deeply depressed.”

(Health professional, WP2 discussion)

This example demonstrates that affective bonds can persist beyond verbal communication and cognitive capacity, reinforcing the need for safeguarding approaches that do not automatically restrict relational closeness.

This requires:

- ♥ Clear communication within multidisciplinary teams;
- ♥ Involvement of the person living with dementia whenever possible;
- ♥ Respectful engagement with families and caregivers;
- ♥ Ongoing review rather than fixed assumptions. (Alzheimer Europe, 2018; World Health Organization, 2015).

By addressing these core issues, this section provides a foundation for understanding dementia and sexuality as a complex, ethically sensitive and deeply human area of professional practice.

Guidance for Educators and Professionals

Working with issues of sexuality and intimacy in the context of dementia can be emotionally challenging and ethically complex. Professionals may experience uncertainty, discomfort or fear of “getting it wrong”, particularly when clear institutional guidance is lacking. This section offers practical orientation to support thoughtful, respectful and person-centred practice.

First, it is important to approach sexuality in dementia with curiosity rather than assumption. Behaviours or expressions of intimacy should not be immediately categorised as problematic or inappropriate. Instead, professionals are encouraged to consider the person’s life history, relationships, cultural background and current emotional state. Asking “What might this behaviour be communicating?” can help shift responses from control to understanding.

Communication Recommendations

Effective communication is central when addressing sexuality and intimacy in the context of dementia. Professionals should use clear, simple and respectful language, adapted to the person’s cognitive abilities. Non-verbal communication, including tone of voice, facial expression and body language, plays a crucial role and should come across as calm and reassuring.

Table 1. Do’s and Don’ts in Professional Practice

Do	Don’t
✓ Acknowledge sexuality and intimacy as part of human wellbeing across the life course	✗ Assume that people living with dementia are asexual or incapable of intimacy
✓ Approach situations with openness and curiosity rather than judgement	✗ Automatically label expressions of sexuality as inappropriate or problematic
✓ Consider personal history, relationships and emotional needs	✗ Rely on blanket restrictions instead of individual assessment
✓ Involve the person living with dementia in decisions whenever possible	✗ Allow personal discomfort or moral beliefs to guide professional decisions
✓ Seek multidisciplinary input when ethical uncertainty arises	✗ Ignore or silence expressions of need for closeness and affection
✓ Assess consent using a decision-specific and relational approach	✗ Attribute all behavioural changes solely to dementia without medical evaluation
✓ Rule out reversible medical causes (e.g., delirium, infection, medication effects) when behaviours change	✗ Use punitive or shaming responses to sexualised behavior

✓ Review current treatments and consider side effects that may influence behaviour	✗ Override possible consent without structured assessment
✓ Take into account comorbidities (psychiatric conditions, neurological disorders, chronic pain) when evaluating sexual behaviour	
✓ Manage inappropriate behaviours proportionately, focusing on understanding triggers before applying restriction	

Taking time, slowing interactions and checking for understanding can reduce distress and help maintain dignity and trust.

Examples of Inclusive Behaviour

Inclusive practice may include recognising and respecting long-term intimate relationships, supporting appropriate expressions of affection, and ensuring that care environments allow for privacy and dignity. Using inclusive language and acknowledging diverse sexual identities and orientations, including those of LGBTQI+ older adults, are also essential components of respectful care.

Supporting Privacy and Intimacy in Care Environments

Care environments, including both institutional settings and private care arrangements, should actively support the right to intimacy and privacy for older adults living with dementia. The absence of private space can unintentionally restrict emotional expression, reinforce stigma, and negatively impact psychological wellbeing and sense of identity.

In many care settings, organisational routines, shared spaces, and risk-averse practices may limit opportunities for private interaction, even when there is no clear risk of harm. As a result, expressions of affection or intimacy may be discouraged, interrupted, or misinterpreted, leading to frustration, distress, or withdrawal.

To address these challenges, care environments should incorporate dedicated or adaptable spaces that allow for privacy, dignity and safe expression of intimacy. This may include access to private rooms, the possibility for couples to spend time together without interruption, and flexibility in visiting arrangements. Staff practices also play a crucial role, particularly in recognising when privacy is appropriate and in avoiding unnecessary intrusion.

Importantly, supporting intimacy should not be seen as incompatible with safeguarding. Creating environments that enable privacy is therefore not an optional aspect of care, but a key component of ethical, inclusive and dignity-based dementia care (World Health Organization, 2015; Alzheimer Europe, 2018; Mahieu & Gastmans, 2015).

During WP2 discussions, older participants clearly expressed this barrier:

“Some couples told us that the hardest part was not their condition, but the lack of privacy in care institutions.”

(Older participant, WP2 discussion)

Educators and professionals should therefore reflect on how organisational structures and routines can either support or undermine dignity, intimacy, and quality of life.

Risk Factors and How to Avoid Them

Common risk factors include reinforcing ageist stereotypes, focusing too much on risk without properly assessing the situation, and prioritising institutional convenience over individual rights. These issues can lead to overly cautious or restrictive responses that may affect a person’s dignity and autonomy. They are often linked to uncertainty, lack of clear guidance, or fear of making the wrong decision. Reducing these risks requires ongoing reflection, regular training, and clear organisational policies. It also means reviewing decisions over time and adapting them as situations change, rather than relying on fixed assumptions.

Culturally Sensitive Approaches

Professionals should be aware that cultural, religious and social norms, as well as a person’s life experiences, can influence how sexuality, intimacy and dementia are understood and expressed. For example, individuals who grew up at a time when homosexuality was stigmatised or criminalised may experience discomfort, fear or confusion when expressing their identity or forming intimate relationships. Others may have different expectations shaped by past relationships and social norms. Sensitive practice involves listening carefully, avoiding assumptions, and adapting responses to respect both cultural and personal backgrounds.

While these recommendations primarily address professional practice, similar principles are equally relevant in family and home contexts, where most day-to-day care takes place.

Guidance for Family Members and Caregivers (Psychoeducation at Home)

In everyday life, home is often where intimacy, emotional connection, and behavioural changes are most visible and need to be managed. Caregivers frequently feel unprepared or distressed when confronted with changes in sexual behaviour. Psychoeducation is therefore essential to support both the person living with dementia and the caregiver's confidence, wellbeing, and emotional resilience (Gitlin & Hodgson, 2015)

Understanding Behaviour: "What is this communicating?"

A shift from judgement to understanding is essential.

Sexual or intimacy-related behaviours often reflect unmet needs rather than intentional actions. These may include:

- need for comfort or closeness
- loneliness or fear
- confusion about identity or relationships
- physical or emotional discomfort
- reduced impulse control

Caregivers are encouraged to ask: "What might this behaviour mean?". This perspective supports more compassionate and effective responses (de Medeiros, 2013).

Practical Strategies for Everyday Situations

- **Closeness or affection**

Offer safe, appropriate alternatives (e.g., holding hands), provide reassurance, and avoid rejection or shaming.

- **Inappropriate behaviour (e.g., undressing, sexual comments)**

Remain calm, avoid confrontation, and use gentle redirection ("Let's go to your room", "Let's have some tea together"). Consider possible triggers such as discomfort, lack of privacy, or overstimulation.

- **Confusion about partners**

Avoid harsh correction ("That's not your spouse"). Use reassurance and focus on emotional security rather than factual accuracy. Use validation and emotional anchoring: "You are safe, I'm here with you".

- **Repetitive requests**

Recognise memory impairment, respond consistently, and redirect attention without frustration.

Boundaries, Consent and Safety at Home

Balancing protection and respect is essential. Not all expressions of intimacy are harmful. Caregivers should observe signs of comfort or distress, consider the person's level of understanding, and take into account the history of the relationship.

When uncertainty exists, professional advice should be sought, patterns of behaviour monitored, and restrictive responses avoided where possible (National Institute for Health and Care Excellence, 2018).

Emotional Impact on Family Members

Caregivers may experience discomfort, embarrassment, grief, jealousy, or moral conflict. These reactions are common but may affect care if unsupported.

Psychoeducation should encourage open discussion, access to support groups, and professional counselling when needed.

Communication Within the Family

Differences in beliefs are common, particularly between partners and adult children.

Focusing on the person's wellbeing, avoiding ageist assumptions, and involving professionals when needed can help reduce conflict.

Creating a Supportive Home Environment

A supportive environment can prevent many difficulties:

- ensure privacy and dignity
- reduce overstimulation
- maintain predictable routines
- adapt clothing if needed
- monitor physical comfort

When to Seek Professional Help

Support should be sought when behaviour changes suddenly, distress or risk is present, consent is unclear, or the caregiver feels overwhelmed. Medical causes should always be considered first (World Health Organization, 2017).

Key Message for Families

- Living with dementia does not remove the need for affection, closeness, emotional connection, and dignity.
- Supporting these needs requires understanding, patience, and flexibility—not control.

Sexual Behaviour in Family Context: Additional Considerations

In the family context, expressions of sexuality in dementia are shaped not only by cognitive changes, but also by existing relational roles and emotional histories. Behaviours that might be more easily contextualised in professional settings can become significantly more complex when they occur within close personal relationships, such as between spouses, or when directed towards adult children or informal caregivers. This relational proximity may intensify emotional responses, including discomfort, confusion or moral tension, particularly when behaviours challenge socially or culturally internalised boundaries.

Understanding these situations means looking beyond behaviour itself and trying to see what might be behind it. Changes in intimacy or sexual expression are often shaped by relationships, identity, and a person's life story. For this reason, supporting families is not just about managing behaviour. It is

also about helping caregivers make sense of what they are seeing, process their own reactions, and feel more confident responding in a way that is respectful and non-judgemental.

Small, thoughtful changes in how situations are approached - such as slowing down, paying attention to emotional cues, and focusing on connection rather than control - can make a meaningful difference in everyday care. At its core, this is about holding on to what makes us human: the need to feel close to others, to be understood, and to belong.



Summary & Key Messages

Sexuality and intimacy remain important aspects of human identity and wellbeing, even in the presence of dementia and cognitive decline. While dementia can change how sexuality is experienced and expressed, it does not eliminate the need for closeness, affection, recognition and dignity. This module has highlighted the importance of moving beyond ageist and stigmatizing assumptions that deny older adults their sexual and relational needs.

Addressing sexuality in the context of dementia requires professionals to navigate complex ethical, emotional and practical challenges. Central to this process is an understanding of consent as dynamic and context-dependent, alongside a commitment to safeguarding that does not rely on blanket restrictions or fear-based responses. Respecting autonomy while preventing harm is not a fixed rule, but an ongoing process of reflection, assessment and communication.

This module also reminds us to see each person as an individual. Factors such as gender, sexual orientation, culture, health, and life circumstances all shape how dementia and sexuality are experienced. Being aware of these differences helps professionals respond in ways that are more inclusive, respectful, and sensitive, especially for those who may already feel overlooked or marginalised.

For educators and professionals, confidence in addressing sexuality and dementia grows through knowledge, reflection and open dialogue. Clear guidance, multidisciplinary collaboration and organisational support are essential in creating environments where intimacy is acknowledged as part of holistic care rather than treated as a problem to be managed. While this represents an important goal, it may not always be easy to achieve in practice due to constraints related to time and available resources. However, even small steps towards more open and respectful approaches can make a meaningful difference.

Family members and informal caregivers also play a crucial role in supporting the emotional and relational needs of people living with dementia. With appropriate guidance and support, they can contribute to creating safe, respectful and meaningful opportunities for intimacy at home.



Practical Tools

This module is supported by a comprehensive set of practical tools included in the AgeWise Toolkit. These tools are designed to translate the ethical and theoretical content of the module into structured, applicable professional practice.

PowerPoint Presentation and Trainer Notes

A structured slide deck guiding the progression from awareness to applied ethical reasoning.

Lesson Plan Module 8

A structured 2 and a half hour training framework supporting facilitators in delivering the module through interactive discussion, case analysis and ethical reflection.

Exercise 1: Myth vs Reality

An interactive activity aimed at challenging ageist and stigma-based assumptions about sexuality and dementia.

Exercise 2: Consent and Capacity Reflection Tool

A structured framework supporting professionals in assessing consent in a context-specific and proportionate manner.

Exercise 3: Case Study Cards and 3-Step Action Plan Template

Practice-based scenarios that guide participants through ethical reasoning, safeguarding considerations and long-term planning.

Together, these tools help turn understanding into action when supporting people living with dementia in real-life situations.

References

- Alzheimer Europe. (2018). Dementia and intimacy. Alzheimer Europe.
- Bauer, M., Fetherstonhaugh, D., Tarzia, L., Nay, R., & Wellman, D. (2013). Supporting residents' expression of sexuality in aged care: The initial construction of a sexuality assessment tool. *Journal of Clinical Nursing*, 22(19–20), 3065–3076. <https://doi.org/10.1111/jocn.12180>
- Bauer, M., Nay, R., McAuliffe, L., & O'Donnell, L. (2021). Supporting sexuality for people living with dementia in residential aged care: A systematic review of policies. *International Psychogeriatrics*, 33(3), 249–263. <https://doi.org/10.1017/S1041610220001757>
- Beauchamp, T. L., & Childress, J. F. (2019). *Principles of biomedical ethics* (8th ed.). Oxford University Press.
- British Psychological Society. (2018). Guidance on consent and capacity in adults with cognitive impairment. British Psychological Society.
- de Medeiros, K. (2013). Sexuality and dementia: Review and implications for practice. *American Journal of Alzheimer's Disease & Other Dementias*, 28(2), 122–130. <https://doi.org/10.1177/1533317512471309>
- Frankowski, A. C., & Clark, L. J. (2021). Sexuality and intimacy in assisted living: Residents' perspectives and experiences. *Journal of Applied Gerontology*, 40(1), 18–26. <https://doi.org/10.1177/0733464819871607>
- Gitlin, L. N., & Hodgson, C. V. (2015). Caregivers as therapeutic agents in dementia care. *Annual Review of Gerontology and Geriatrics*, 35(1), 217–248. <https://doi.org/10.1891/0198-8794.35.217>
- Livingston, G., Sommerlad, A., Orgeta, V., Costafrada, S. G., Huntley, J., Ames, D., Ballard, C., Banerjee, S., Burns, A., Cohen-Mansfield, J., Cooper, C., Fox, N., Gitlin, L. N., Howard, R., Kales, H. C., Larson, E. B., Ritchie, K., Rockwood, K., Sampson, E. L., ... Mukadam, N. (2017). Dementia prevention, intervention, and care. *The Lancet*, 390(10113), 2673–2734. [https://doi.org/10.1016/S0140-6736\(17\)31363-6](https://doi.org/10.1016/S0140-6736(17)31363-6)
- Mahieu, L., & Gastmans, C. (2015). Sexuality in institutionalized elderly persons: A systematic review. *International Journal of Nursing Studies*, 52(12), 1891–1905. <https://doi.org/10.1016/j.ijnurstu.2015.07.007>
- Mahieu, L., de Casterlé, B. D., Acke, J., & Gastmans, C. (2020). Nurses' knowledge and attitudes toward aged sexuality in institutionalized elderly: A systematic review. *Journal of Advanced Nursing*, 76(6), 1449–1463. <https://doi.org/10.1111/jan.14321>
- National Institute for Health and Care Excellence. (2018). Dementia: Assessment, management and support for people living with dementia and their carers (NG97). NICE.
- Syme, M. L., & Cohn, T. J. (2016). Examining aging sexual stigma. *Journal of Gerontological Social Work*, 59(1), 1–17. <https://doi.org/10.1080/01634372.2015.1119426>
- World Health Organization. (2015). World report on ageing and health. WHO.
- World Health Organization. (2017). Global action plan on the public health response to dementia 2017–2025. WHO.

Practical Tools

Module 1



Lesson Plan

Module 1	Ageing Population and Positive Approaches to Ageing
Target Group	Adult educators, healthcare professionals, social workers, care staff
Duration	2.5 hours
Learning Outcomes	Learners will be able to: • Explain the impact of demographic shifts in Europe Structural Awareness • Differentiate between Healthy Ageing, Active Ageing, and Quality of Life models Framework Integration • Use validated tools (CASP-19/WHOQOL) to measure wellbeing beyond clinical health Subjective Assessment • Apply a Gender and Culture lens to identify barriers faced by older adults Holistic Application • Balance the Dignity of Risk (Autonomy) against institutional safety (Beneficence) Professional Ethics
Preparation	- Prepare room with chairs and tables, computers and a projector. Book it in advance, if necessary. - Organise projector, flipchart and markers. - Print necessary handouts, worksheets and questionnaires. - o Exercise 1: World Café station names. - o Exercise 2: Questionnaires WHOQOL-BREF and/or CASP-19. - o Exercise 2: Role Play Persona Cards. - o Exercise 3: Case Study Cards. - o Exercise 3: 3-Step Action Plan Worksheets. - Having put up the setup, inform participants about the purpose of the module, its objects and the agenda. - Provide any breaks when necessary.
Check List	Tech: PPTX & projector check Exercise 1: Three flipchart sheets & markers Exercise 2: Printed questionnaires & persona cards & clipboards Exercise 3: Case file cards & worksheets General: Name Tags & feedback forms

Lesson Plan | Face-to-Face

Topics & Activities	Duration in Minutes	Methods	Equipment & Materials
Opening and expectations – Presenting agenda and learning outcomes for module 1.	5 min	Presentation	Laptop, projector, PowerPoint presentation
Theoretical input on European demographic data.	15 min	Presentation	Laptop, projector, PowerPoint presentation
Exercise 1 - World Café Objective: Connect the EU data to the learners' specific regional and professional reality. Activity: Set up three "stations" (tables) with a large sheet of paper on each. <i>Station 1: Implications for Funding & Infrastructure in our community.</i> <i>Station 2: Implications for Staff & Personal Workload.</i> <i>Station 3: Implications for the Well-being of older adults.</i> Groups spend 5 minutes at each station adding their thoughts on paper sheets before rotating. After three rounds, points will be presented and discussed within the whole group. Example question for facilitator: Despite some differences in the numbers between countries, what is one challenge or trend that seems to be the same for all of us? How do these numbers explain what you are seeing every day in your facility or with your residents right now? If you had to pick just one piece of information from these papers to share with a colleague who wasn't	30 min	World Café (Rotating small group discussions), Group Presentation	Three separate tables or wall spaces labeled with station names (printed handout), three pieces of paper or flipchart sheets, markers, tape, timer

here today, which one would it be and why?			
Theoretical input on Positive Ageing Frameworks.	15 min	Presentation	Laptop, projector, PowerPoint presentation
Exercise 2 - Measuring Quality of Life Objective: To gain practice in using the WHOQOL-BREF and CASP-19 tools. Activity: Divide learners into pairs and hand out Role Play Persona Cards and printed questionnaires: one plays the <i>Practitioner</i> , the other the <i>Older Adult</i> . The Practitioner conducts a 10-minute interview using one of the two questionnaires. After the interviews, impressions, ideas and feedback will be discussed within the whole group.	20 min	Role-Play Simulation, Group Discussion	Handouts: printed copies of WHOQOL-BREF and CASP-19, printed (and laminated) Role Play Persona Cards, pens and clipboards for practitioners to take notes.
Theoretical input on Holistic Frameworks and Professional Challenges. Follow-up group brainstorming: “What are your challenges?”	15 min	Presentation, Group Discussion	Laptop, projector, PowerPoint presentation
Exercise 3 - Analysing Case Studies and Creating a 3-Step Action Plan Objective: To apply <i>Gender</i> and <i>Culture lenses</i> and solve ethical dilemmas. Activity: Divide participants into small groups. Each Group is given a Case File. They must complete a two-part task: 1) Identify how gender and culture are creating barriers in this specific story. 2) Draft a 3-step action plan to move from a <i>Deficit Model</i> to a <i>Positive Ageing approach</i> for this person. Afterwards, different cases will be presented to the group, including	30 min	Case-Study Work and Action Planning, Group Discussion	Handouts: Printed Case Study Cards, printed 3-Step Action Plan Worksheets

action plans. A group discussion will be facilitated.			
Theoretical input on guidance for educators and professionals, ethical considerations, Do's and Don'ts.	10 min	Presentation	Laptop, projector, PowerPoint presentation
Key messages & wrap-up – discussing final questions and feedback.	5 min	Presentation, Group Discussion	Laptop, projector, PowerPoint presentation, <i>optional</i> : Flipchart to document questions and feedback
Feedback form (<i>optional</i>)	5 min	Module evaluation	Printed feedback forms or QR-code to access online survey



Excercise 1

World Café

Implications for
Funding &
Infrastructure in our
community.

Implications for Staff
& Personal
Workload.



Implications for the Well-being of older adults.



Exercise 2

Measuring Quality of Life

APPENDIX 8- THE WHOQOL-BREF

ABOUT YOU

I.D. number

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Before you begin we would like to ask you to answer a few general questions about yourself: by circling the correct answer or by filling in the space provided.

What is your **gender**?

Male

Female

What is your **date of birth**?

____ / ____ / ____
Day / Month / Year

What is the highest **education** you received?

None at all

Primary school

Secondary school

Tertiary

What is your **marital status**?

Single

Separated

Married

Divorced

Living as married

Widowed

Are you currently **ill**?

Yes

No

If something is wrong with your health what do you think it is? _____

Instructions

This assessment asks how you feel about your quality of life, health, or other areas of your life. **Please answer all the questions.** If you are unsure about which response to give to a question, **please choose the one** that appears most appropriate. This can often be your first response.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life **in the last two weeks**. For example, thinking about the last two weeks, a question might ask:

	Not at all	Not much	Moderately	A great deal	Completely
Do you get the kind of support from others that you need?	1	2	3	4	5

You should circle the number that best fits how much support you got from others over the last two weeks. So you would circle the number 4 if you got a great deal of support from others as follows.

	Not at all	Not much	Moderately	A great deal	Completely
Do you get the kind of support from others that you need?	1	2	3	4	5

100

You would circle number 1 if you did not get any of the support that you needed from others in the last two weeks.
Please read each question, assess your feelings, and circle the number on the scale for each question that gives the best answer for you.

THE WHOQOL-BREF

		Very poor	Poor	Neither poor nor good	Good	Very good
1 (G1)	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2 (G4)	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the last two weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3 (F1.4)	To what extent do you feel that (physical) pain prevents you from doing what you need to do?	1	2	3	4	5
4 (F11.3)	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5 (F4.1)	How much do you enjoy life?	1	2	3	4	5
6 (F24.2)	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7 (F5.3)	How well are you able to concentrate?	1	2	3	4	5
8 (F16.1)	How safe do you feel in your daily life?	1	2	3	4	5
9 (F22.1)	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about **how completely** you experience or were able to do certain things in the last two weeks.

		Not at all	A little	Moderately	Mostly	Completely
10 (F2.1)	Do you have enough energy for everyday life?	1	2	3	4	5
11 (F7.1)	Are you able to accept your bodily appearance?	1	2	3	4	5
12	Have you enough money to meet your	1	2	3	4	5

(F18.1)	needs?					
13 (F20.1)	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14 (F21.1)	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15 (F9.1)	How well are you able to get around?	1	2	3	4	5

The following questions ask you to say how **good or satisfied** you have felt about various aspects of your life over the last two weeks.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16 (F3.3)	How satisfied are you with your sleep?	1	2	3	4	5
17 (F10.3)	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18 (F12.4)	How satisfied are you with your capacity for work?	1	2	3	4	5
19 (F6.3)	How satisfied are you with yourself?	1	2	3	4	5
20 (F13.3)	How satisfied are you with your personal relationships?	1	2	3	4	5
21 (F15.3)	How satisfied are you with your sex life?	1	2	3	4	5
22 (F14.4)	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23 (F17.3)	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24 (F19.3)	How satisfied are you with your access to health services?	1	2	3	4	5
25 (F23.3)	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to **how often** you have felt or experienced certain things in the last two weeks.

		Never	Seldom	Quite often	Very often	Always
26 (F8.1)	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

Did someone help you to fill out this form?.....

How long did it take to fill this form out?.....

SET 1

PRACTITIONER: YOUR GOAL IS TO USE THE QUESTIONNAIRE TO CHECK ON THE PERSON'S MENTAL HEALTH. YOU ARE FRIENDLY BUT FEEL PRESSURED BY TIME. TRY TO MOVE BEYOND "YES/NO" ANSWERS.

SET 1

OLDER ADULT (MARTA, 79): YOU MOVED INTO RESIDENTIAL CARE 3 MONTHS AGO. PHYSICALLY, YOU ARE FINE, BUT YOU FEEL INVISIBLE. YOU MISS YOUR GARDEN AND YOUR OLD DOG.

IF THE PRACTITIONER ASKS ABOUT YOUR HEALTH, TALK ABOUT YOUR MEDICATION. WAIT FOR THEM TO ASK SPECIFICALLY ABOUT YOUR FEELINGS OR HOBBIES BEFORE MENTIONING THE GARDEN.

SET 2

PRACTITIONER: YOU ARE A SENIOR NURSE. YOU ARE VERY FOCUSED ON SAFETY AND PREVENTING FALLS. YOUR GOAL IS TO ASSESS THE OLDER ADULT'S QUALITY OF LIFE USING THE QUESTIONNAIRE.

SET 2

OLDER ADULT (ARTHUR, 82): YOU LIVE AT HOME AND USE A WALKER. YOU ARE ANNOYED BECAUSE YOUR CHILDREN WANT YOU TO STOP COOKING FOR YOURSELF. YOU VALUE YOUR AUTONOMY. BE SLIGHTLY DEFENSIVE. IF THE PRACTITIONER FOCUSES TOO MUCH ON SAFETY, TELL THEM YOU'D RATHER TAKE A RISK AND BE HAPPY THAN BE SAFE AND BORED.

SET 3

PRACTITIONER: YOUR GOAL IS TO SEE IF THE ENVIRONMENT MEETS THE PERSON'S NEEDS. USE THE QUESTIONNAIRE. YOU WANT TO ENCOURAGE THEM TO JOIN LOCAL COMMUNITY GROUPS.

SET 3

OLDER ADULT (ADNAN, 75): YOU ARE A MIGRANT WHO WORKED IN CONSTRUCTION FOR 40 YEARS. YOUR NEIGHBORHOOD HAS CHANGED, AND YOU DON'T FEEL AT HOME OR THAT YOU "FIT IN". YOU FEEL THE SENIOR CENTERS ARE ONLY FOR PEOPLE WHO SPEAK THE LOCAL LANGUAGE PERFECTLY. SEE IF THE PRACTITIONER LOOKS FOR A CULTURALLY SENSITIVE SOLUTION.

SET 4

PRACTITIONER: YOU ARE A YOUNG STUDENT. YOU ARE A BIT NERVOUS ABOUT ASKING PERSONAL QUESTIONS. YOUR GOAL IS TO EXPLORE THE PLEASURE AND SELF-REALISATION SECTIONS OF THE QUESTIONNAIRE.

SET 4

OLDER ADULT (LUCIA, 71): YOU ARE VIBRANT AND RECENTLY STARTED DATING ANOTHER PERSON IN YOUR WALKING CLUB. YOU FEEL LIKE A TEENAGER AGAIN, BUT YOU ARE AFRAID PEOPLE WILL THINK YOU ARE SILLY AT YOUR AGE.

MENTION THAT YOU FELT NEW ENERGY. ONLY REVEAL THE DATING PART IF THE PRACTITIONER CREATES A VERY SAFE ATMOSPHERE.

SET 5

PRACTITIONER: YOU HAVE RECEIVED A COMPLAINT FROM A FAMILY MEMBER WHO SAW THEIR FATHER KISSING ANOTHER RESIDENT. ASSESS THE RESIDENT'S WELL-BEING USING THE QUESTIONNAIRE. YOU ARE WORRIED ABOUT CONSENT, BUT YOU WANT TO SUPPORT THEIR RIGHTS. DETERMINE IF THE RELATIONSHIP IS ENHANCING THE RESIDENT'S QUALITY OF LIFE.

SET 5

OLDER ADULT (HENRY, 81): YOU HAVE LIVED IN THE FACILITY FOR TWO YEARS. SINCE MEETING JANE, YOU FEEL HAPPIER THAN YOU HAVE IN A DECADE. YOU ARE FULLY AWARE OF WHAT YOU ARE DOING, BUT YOU FEEL THE STAFF WATCH YOU AND TREAT YOU LIKE A CHILD WHEN YOU ARE TOGETHER. IF THE PRACTITIONER BRINGS UP THE FAMILY'S COMPLAINT, EXPRESS YOUR FRUSTRATION.



Exercise 3

Analysing Case Studies and Creating a 3-Step Action Plan

STEP 1: The Lens Analysis

Which "lenses" are at play here?

Check all that apply: ☐ Gender ☐ Culture ☐ Ageism ☐ Institutional Safety.

Briefly describe the clash between the "Deficit Model" (what the system wants) and the "Positive Ageing Model" (what the person needs).

STEP 2: The Holistic Reframe

Looking at the Whole Person: What is one thing about this person's history, pride, or joy that is being ignored?

The Dignity of Risk: If we prioritise this person's autonomy, what is the "safe-enough" compromise?

STEP 3: The Implementation (3 Concrete Actions)

What can you say to the person or family today to validate them?

What change is needed in the care plan or staff behaviour?

How do we ensure this person's Quality of Life?

"Lens" References: Quick Definitions

1. The Gender Lens

This is a way of looking at a situation to see how social expectations of being a man or a woman affect an older adult's experience.

In practice it asks: "Is this person being treated, or are they behaving, this way because of traditional 'rules' about their gender?" (e.g., assuming a daughter will provide free care, or assuming an older man doesn't need emotional support).

2. The Culture Lens

This is a way of looking at care through the person's values, language, and heritage. It recognises that well-being means different things in different cultures.

In practice it asks: "Are we judging this person's behaviour based on our own cultural norms, or are we respecting their specific traditions regarding family, food, and authority?"

3. The Dignity of Risk

This is the ethical principle that every adult has the right to make choices and take reasonable risks that might lead to personal growth or happiness, even if those choices could result in a fall or injury.

In practice it asks: "Are we 'protecting' this person so much that we are taking away their freedom and joy?" It shifts the goal from *total safety* to *the best possible life*.

Case Study Files

1: THE INVISIBLE PATRIARCH (GENDER & CULTURE)

PERSONA: GIOVANNI (76), A TRADITIONAL ITALIAN IMMIGRANT. HE HAS EARLY-STAGE PARKINSON'S. HIS WIFE OF 50 YEARS RECENTLY PASSED AWAY.

DILEMMA: GIOVANNI REFUSES TO LET FEMALE NURSES HELP HIM WITH PERSONAL CARES BUT GETS ANGRY WHEN MALE STAFF AREN'T AVAILABLE. HE IS BECOMING ISOLATED BECAUSE HE BELIEVES MEN DON'T GO TO "COMMUNITY COFFEE MORNINGS".

CHALLENGE: HOW DO GENDER ROLES AND CULTURAL PRIDE CREATE A DEFICIT IN HIS CARE?

2: THE PROTECTING SON (ETHICS & AUTONOMY)

PERSONA: MARTHA (82), A RETIRED JOURNALIST WHO LOVES HER INDEPENDENCE. SHE HAS MINOR BALANCE ISSUES.

DILEMMA: MARTHA WANTS TO CONTINUE TAKING THE BUS TO THE CITY LIBRARY ALONE. HER SON HAS CALLED THE FACILITY DEMANDING THEY LOCK HER IN OR TAKE HER BUS PASS AWAY FOR HER SAFETY.

CHALLENGE: APPLY THE DIGNITY OF RISK. HOW DO YOU BALANCE THE SON'S FEAR (SAFETY) WITH MARTHA'S QUALITY OF LIFE (AUTONOMY)?

3: THE SILENT LANGUAGE (CULTURE & QUALITY OF LIFE)

PERSONA: SUN-HI (88), A KOREAN WOMAN LIVING IN A WESTERN CARE HOME. HER ENGLISH WAS FLUENT, BUT AS HER DEMENTIA PROGRESSES, SHE IS REVERTING TO HER NATIVE LANGUAGE.

DILEMMA: STAFF TREAT HER AS NON-VERBAL OR DIFFICULT BECAUSE SHE DOESN'T FOLLOW INSTRUCTIONS. SHE IS LOSING WEIGHT BECAUSE SHE DOESN'T RECOGNISE THE FOOD BEING SERVED.

CHALLENGE: USE THE CULTURE LENS. HOW IS THE SYSTEM FAILING TO SEE SUN-HI'S WHOLE PERSON BEYOND HER DIAGNOSIS?

4: THE "SILLY" ROMANCE (SEXUAL AGEISM)

PERSONA: DAVID (79) AND LILLIAN (81). BOTH ARE RESIDENTS WHO HAVE STARTED A ROMANTIC RELATIONSHIP.

DILEMMA: THEY WERE FOUND IN LILLIAN'S ROOM WITH THE DOOR LOCKED. THE STAFF ARE GOSSIPING, AND SOME ARE MAKING JOKES ABOUT "GRANDMA'S BOYFRIEND". A STAFF MEMBER SUGGESTS THEY SHOULD BE SUPERVISED DURING DATES.

CHALLENGE: IDENTIFY THE SEXUAL AGEISM. HOW DOES THIS GOSSIP IMPACT THEIR RIGHT TO INTIMACY AND SELF-ESTEEM?

5: THE GENDERED BURDEN (GENDER & POLICY)

PERSONA: SARAH (60), WHO IS A "YOUNG-OLD" ADULT HERSELF, IS THE PRIMARY CAREGIVER FOR HER MOTHER (89) AND FATHER (91).

DILEMMA: SARAH IS EXHAUSTED AND LOSING HER OWN HEALTH. WHEN SHE ASKS FOR HELP, THE SOCIAL WORKER SAYS, "IT'S SO WONDERFUL THAT THE FAMILY IS TAKING CARE OF THEM; DAUGHTERS ARE SO MUCH BETTER AT THIS."

CHALLENGE: APPLY THE GENDER LENS TO THE CAREGIVER. HOW DO SOCIETAL EXPECTATIONS OF WOMEN'S ROLES CONTRIBUTE TO THE *DEMOGRAPHIC DRAG* ON INDIVIDUALS?

Practical Tools

Module 2





Lesson Plan

Module 2	Ageism and Misconceptions About the Elders
Target Group	Adult educators, healthcare professionals, social workers, care staff
Duration	2.5 hours
Learning Outcomes	Learners will be able to: - Identify and define the three levels of ageism and their systemic impact. - Recognise the gap between explicit professional approval of sexual rights and implicit personal biases. - Understand how gender, culture, and cognitive status overlap to create unique barriers to intimacy. - Challenge the <i>Asexual Stereotype</i> and the prioritisation of safety over the adult right to privacy.
Preparation	- Prepare room with chairs and tables, computers and a projector. Book it in advance, if necessary. - Organise projector, flipchart and markers. - Print necessary handouts and worksheets. - Exercise 1: Case Situation Cards for each group. - Exercise 1: Myth Cards for each group. - Exercise 1: Key Worksheet for facilitator to check pairings. - Exercise 2: 5 Major Theme Cards. - Exercise 3: Campaign Worksheets for each group. - Having put up the setup, inform participants about the purpose of the module, its objects and the agenda. - Provide any breaks when necessary.
Check List	Tech: PPTX & projector check Exercise 1: Case & Myth Cards, Master Key for facilitator Exercise 2: 5 Major Theme Cards, Flipchart & Markers Exercise 3: Campaign Worksheets, Post-it Notes, Large Papers General: Name Tags & feedback forms

Lesson Plan | Face-to-Face

Topics & Activities	Duration in Minutes	Methods	Equipment & Materials
Opening and expectations – Presenting agenda and learning outcomes for module 2.	5 min	Presentation	Laptop, projector, PowerPoint presentation
Theoretical input on definitions, effects and levels of Ageism.	15 min	Presentation	Laptop, projector, PowerPoint presentation
Exercise 1 – The Ageism Puzzle Objective: Learners will identify how 12 Myths of Ageing (WHO, 2013) manifest across <i>Institutional</i> , <i>Interpersonal</i> , and <i>Internalised</i> levels of ageism through real-world scenarios. Activity: In small groups, read the following mini-case studies. Identify which level of ageism is present and which of the 12 WHO Myths are being reinforced.	25 min	Case Study Analysis, Group Matching Exercise, Comparative Discussion	12 Case Situation Cards, 12 Myth Cards, Worksheet: A <i>Master Key</i> for the facilitator to check the pairings. <i>Depending on number of small groups, print various packs of puzzle cards.</i>
Theoretical input on negative societal beliefs, myths, and taboos surrounding sexuality in older age,	15 min	Presentation	Laptop, projector, PowerPoint presentation
Exercise 2 – Shades of Grey Objective: To help professionals recognise gaps between their <i>explicit</i> (conscious/polite) beliefs and their <i>implicit</i> (unconscious/gut) reactions using 5 major research themes. Each group takes one theme card (1. Decline Narrative, 2. Asexual Stereotype, 3. Quantity to Quality, 4. Hegemony of Penetration, 5. Ambivalence). Groups will discuss: Where have we seen this in our facility? Anything comes to mind when connecting the theme to any explicit or implicit ageist act?	25 min	Focused Group Discussion, Reflective Storytelling, Brainstorming	5 Major Theme Cards, Flipchart & Markers

Theoretical input on bias impact on healthcare, education and institutional settings, vulnerable groups, intersectionality and professional challenges. Follow-up group brainstorming: <i>“What are your challenges?”</i>	15 min	Presentation, Group Discussion	Laptop, projector, PowerPoint presentation
Exercise 3 – Reimagining the Narrative: A Media Campaign Workshop Objective: To empower learners to create counter-narratives that challenge ageist media content and promote the sexual rights and diversity of older adults. Activity: Using the worksheet as a guide, groups move through a creative process: 1. Choose a thematic (e.g. a myth) 2. Select a powerful slogan to give their campaign a voice. 3. Describe a visual - what does the image look like? 4. Groups sketch a rough version of their poster or social media post on flipchart paper. Define a specific <i>Call to Action</i>: What is the one concrete thing you want a professional or a family member to do differently after seeing your campaign? 5. Each group pitches their campaign.	30 min	Creative Design, Collaborative Writing, Presentation	Campaign Worksheets, Post-it Notes, Large Papers
Theoretical input on guidance for educators and professionals, ethical considerations, Do’s and Don’ts.	10 min	Presentation	Laptop, projector, PowerPoint presentation
Key messages & wrap-up – discussing final questions and feedback.	5 min	Presentation, Group Discussion	Laptop, projector, PowerPoint presentation, <i>optional</i> : Flipchart to document questions and feedback
Feedback form (<i>optional</i>)	5 min	Module evaluation	Printed feedback forms or QR-code to access online survey



Exercise 1

The Ageism Puzzle Key: 12 Myths of Ageing

Myth	Case Situation for the Card	Level of Ageism
1. Mental & Physical Deterioration	A doctor ignores a 75-year-old's complaint of chronic joint pain, stating, <i>"At your age, you have to expect things to stop working; there's no point in further testing."</i>	Interpersonal
2. Similar Needs	A residential home provides only one type of leisure activity (Bingo) for all 200 residents.	Institutional
3. Creativity is for the Young	A local community center refuses to fund an innovative and new business idea: The "Senior Startup Incubator."	Institutional
4. Experience is Irrelevant	During a strategy meeting at a non-profit organisation, a younger coordinator interrupts a retired executive, saying, <i>"The world has changed too much for your 'old school' methods to work now."</i>	Interpersonal
5. Want Peace and Quiet	A care assistant discourages two residents from going to a late-night jazz club, telling them, <i>"You'd be much happier staying in your quiet room with a nice cup of tea."</i>	Interpersonal
6. Hospital Beds are the Issue	A city council focuses its entire senior budget on building more clinical ward-style rooms instead of accessible parks or social dance halls.	Institutional
7. Taking from the Young	A newspaper argues that pension increases should be frozen because every Euro spent on "the past" (seniors) is stolen from "the future" (school children).	Institutional
8. Spending is a Waste	A hospital ethics board debates whether to provide an expensive heart valve to a 80-year-old, questioning the <i>"Return on Investment"</i> given her remaining years to live.	Institutional

9. Unsited for Modern Work	A tech company's recruitment algorithm automatically filters out any applicant with more than 30 years of experience, assuming they can't handle a fast-paced environment.	Institutional
10. Can't Teach New Tricks	An 80-year-old woman stops herself from signing up for a coding class, thinking, " <i>My brain is too old to absorb new technology; I'll just stick to what I know.</i> "	Internalised
11. Expect to Move Aside	A senior volunteer resigns from a board she loves because she feels guilty for taking up a seat that she believes rightfully belongs to a younger person.	Internalised
12. Things Work Out Themselves	An aged care facility has no policy on sexual consent or intimacy, assuming that seniors don't have sexual lives and therefore no rules or protections are needed.	Institutional

Myth	Some Counterpoints for Reference (WHO, 2013)
1. Mental & Physical Deterioration	Much of the decline in vigour is not inevitable; it results from societal expectations and a lack of physical activity. Simple changes like increased exercise and improved diet can tackle many problems associated with age, such as muscle loss and aerobic capacity.
2. Similar Needs	Diversity actually increases with age. The oldest population segment is the least homogeneous, with needs varying wildly based on chronological, biological, and psychological age.
3. Creativity is for the Young	Creativity has no "sell-by date". Many influential figures, from Michelangelo to contemporary authors, produced their greatest work well after 70. Compulsory retirement is a social construct, not a biological limit on productivity.
4. Experience is Irrelevant	Older people possess stored knowledge and managerial skills that cannot be learned from books. They serve as vital transmitters of tradition and can mentor younger generations in disappearing skills like handicrafts or complex problem-solving.
5. Want Peace and Quiet	Most older people do not withdraw from social interaction unless forced by society. For example, community centers in Athens see high demand for parties, dances, and excursions.
6. Hospital Beds are the Issue	While medical care is important, the true issue is maintaining independence. Policies must focus on income, housing, and social networks to reduce the inappropriate and wasteful over-reliance on hospital beds.
7. Taking from the Young	Many improvements for older people benefit all ages. Safe road crossings, better street lighting, and low-floor buses help parents with strollers and people with shopping carts just as much as they help seniors.
8. Spending is a Waste	Appropriate spending actually saves money. Small investments in hearing aids, walking aids, or home maintenance keep people mobile and in their social networks, preventing the need for much more expensive long-term care.
9. Unsuitable for Modern Work	Older workers are often more consistent, reliable, and loyal than their younger counterparts. They excel in strategic thinking, deliberating complex issues, and taking a comprehensive perspective.
10. Can't Teach New Tricks	Older adults are often more motivated and persistent in training than younger students. The "trick" is the teaching method; when allowed to proceed at their own pace with practical applications, they learn as effectively as anyone.
11. Expect to Move Aside	Older people are becoming an increasingly vocal and influential "grey euro" in the marketplace. They are better informed about their health rights than ever and can make surprising contributions to community decision-making if given a seat at the table.
12. Things Work Out Themselves	Relying on chance is dangerous because of the rapid pace of modern change. Without active discussion and planning involving all generations, the specific needs of the most vulnerable older citizens will be ignored.

World Health Organization. (2013). *Demystifying the myths of ageing*. WHO Regional Office for Europe. <https://iris.who.int/bitstreams/27967758-3b6e-47cf-9242-e5961ddd3252/download>

Case Situations

<i>A doctor ignores a 75-year-old's complaint of chronic joint pain, stating, "At your age, you have to expect things to stop working; there's no point in further testing."</i>	<i>A residential home provides only one type of leisure activity (Bingo) for all 200 residents.</i>
<i>A local community center refuses to fund an innovative and new business idea: The "Senior Startup Incubator."</i>	<i>During a strategy meeting at a non-profit organisation, a younger coordinator interrupts a retired executive, saying, "The world has changed too much for your 'old school' methods to work now."</i>
<i>A care assistant discourages two residents from going to a late-night jazz club, telling them, "You'd be much happier staying in your quiet room with a nice cup of tea."</i>	<i>A city council focuses its entire senior budget on building more clinical ward-style rooms instead of accessible parks or social dance halls.</i>
<i>A newspaper argues that pension increases should be frozen because every Euro spent on "the past" (seniors) is stolen from "the future" (school children).</i>	<i>A hospital ethics board debates whether to provide an expensive heart valve to a 80-year-old, questioning the "Return on Investment" given her remaining years to live.</i>
<i>A tech company's recruitment algorithm automatically filters out any applicant with more than 30 years of experience, assuming they can't handle a fast-paced environment.</i>	<i>An 80-year-old woman stops herself from signing up for a coding class, thinking, "My brain is too old to absorb new technology; I'll just stick to what I know."</i>
<i>A senior volunteer resigns from a board she loves because she feels guilty for taking up a seat that she believes rightfully belongs to a younger person.</i>	<i>An aged care facility has no policy on sexual consent or intimacy, assuming that seniors don't have sexual lives and therefore no rules or protections are needed.</i>

Myths

MYTH 1: PEOPLE SHOULD EXPECT TO DETERIORATE MENTALLY AND PHYSICALLY.	MYTH 2: MOST OLDER PEOPLE HAVE SIMILAR NEEDS.
MYTH 3: CREATIVITY AND MAKING A CONTRIBUTION IS THE PROVINCE OF YOUNG PEOPLE.	MYTH 4: THE EXPERIENCE OF OLDER PEOPLE HAS LITTLE RELEVANCE IN MODERN SOCIETY.
MYTH 5: MANY OLDER PEOPLE WANT TO BE LEFT IN PEACE AND QUIET.	MYTH 6: HOSPITAL BEDS AND NURSES ARE THE MAIN ISSUE.
MYTH 7: PROVIDING FOR OLDER PEOPLE TAKES AWAY RESOURCES FROM YOUNG PEOPLE.	MYTH 7: PROVIDING FOR OLDER PEOPLE TAKES AWAY RESOURCES FROM YOUNG PEOPLE.
MYTH 9: OLDER PEOPLE ARE NOT SUITED TO MODERN WORKPLACES.	MYTH 10: YOU CAN'T TEACH AN OLD DOG NEW TRICKS.
MYTH 11: OLDER PEOPLE EXPECT TO MOVE ASIDE.	MYTH 12: THINGS WILL WORK OUT FOR THEMSELVES.



Exercise 2

Shades of Grey

1. The Decline Narrative - "*The World Belongs to the Young*"

A significant portion of respondents viewed later-life sexuality purely through a lens of **loss and decline**. They assumed that desire naturally vanishes and that older bodies are less attractive or less capable.

2. The Asexual Stereotype

Some participants struggled to even imagine older adults as sexual beings. They described sex in later life as **rare, non-existent, or boring** often linking it only to biological functions (like hormones) rather than emotional connection.

3. Quantity to Quality

Many respondents believed that while the frequency of sex might decrease, the **emotional depth** increases. They viewed later-life sexuality as more complete, mature, and meaningful compared to the more physical sex of youth.

4. The Hegemony of Penetration

The public still narrowly defines sex as **penetrative intercourse**. Because aging can bring physical changes (like erectile dysfunction or vaginal dryness) that make penetration difficult, the public often assumes that if penetration stops, the sex life is over.

5. Ambivalence and Contradiction

The *Shades of Grey* title refers to the fact that many people hold conflicting views. They might say they support older adults' right to have sex (**explicitly**) yet still find the idea distasteful or "weird" when confronted with it in reality (**implicitly**).



Exercise 3

Reimagining the Narrative: A Media Campaign Workshop

Step 1: Choosing a thematic

Choose a thematic for your campaign, for example choosing from the different myths we learned about. *Example: We are fighting Myth #3 (Creativity is for the young) or Theme #2 (The Asexual Stereotype).*

Our theme is:

Step 2: A powerful slogan

Write a punchy headline. Ensure it does **not** use infantilising language. Use adult, respectful, and empowering vocabulary.

Our slogan/slogan is:

Step 3: Sketching the visuals

Visuals in age-care often focus on *weakness* or *isolation*. Describe an image for your poster that shows **agency, diversity, or intimacy**. Consider: Who is in the picture? What are they doing? How do they look (clothing, posture, expression)?

Visual Description:

Step 4: The Call to Action

What is the one concrete thing you want a professional or a family member to **do differently** after seeing your campaign? *Example: "Ask, don't assume," "Knock and wait," or "Include sexual health in the care plan."*

Our Call to Action:

Practical Tools

Module 3





Lesson Plan

Module 3	Sexuality, Gender and Diversity
Target Group	Adult educators, healthcare professionals, social workers, care home staff
Duration	2.5 hours
Learning Outcomes	Learners will be able to: • Distinguish between sexual orientation, gender identity, gender expression and biological sex. • Describe the specific life experiences of LGBTQIAP+ elders (criminalization, HIV/AIDS, "return to the closet"). • Analyse how age, sexual orientation and gender identity intersect to create unique vulnerabilities. • Identify manifestations of ageism within LGBTQIAP+ communities themselves. • Cite inspiring initiatives (Maison de la Diversité, Grey Pride, Lebensort Vielfalt). • Use language and adopt a posture that does not assume heterosexuality or cisidentity.
Preparation	- Prepare room with chairs and tables, computers and a projector. - Organise projector, flipchart and markers. - Print necessary handouts and worksheets: - o Exercise 1: Scenario Cards for each group - o Exercise 2: Case Study Card for each group - o Exercise 2: Discussion Questions handout - o Exercise 3: Institution Cards for each group - o Exercise 3: 3-Domain Action Plan Worksheet for each group - Inform participants about the purpose of the module, its objectives and the agenda. - Provide any breaks when necessary.
Check List	☐ Tech: PPTX & projector check ☐ Exercise 1: Scenario Cards ☐ Exercise 2: Case Study Cards & Discussion Questions ☐ Exercise 3: Institution Cards, Action Plan Worksheets, Post-it Notes, Large Papers ☐ General: Name Tags & feedback forms

Lesson Plan | Face-to-Face

Topics & Activities	Duration	Methods	Equipment & Materials
Opening and expectations – Presenting agenda and learning outcomes for Module 3	5 min	Presentation	Laptop, projector, PowerPoint presentation
Theoretical input – Why a specific module? History, HIV/AIDS impact, specific challenges, inspiring initiatives	25 min	Presentation	Laptop, projector, PowerPoint presentation
Exercise 1 – The Vocabulary of Inclusion Objective: To understand and appropriate key LGBTQIAP+ terminology and its importance in professional practice. Activity: Participants work in small groups. Each group receives a set of scenario cards describing situations involving LGBTQIAP+ older adults. Participants identify the most relevant terminology, discuss why it is important in the situation, and reflect on how lack of knowledge may affect the quality of care. Groups share their conclusions in plenary, using the facilitator answer key to support discussion.	20 min	Small group discussion, plenary sharing	Scenario Cards (4 scenarios)
PAUSE 1	10 min	–	–
Theoretical input – Intersectionality in practice, case study introduction	10 min	Presentation	Laptop, projector, PowerPoint presentation

Exercise 2 – Case Study Analysis Objective: To analyse a concrete situation of a LGBTQ+ elder and collectively build an appropriate, person-centred response. Activity: Participants analyse a case study. Working in small groups, they discuss challenges for the individual, staff and institution, identify potential assumptions and biases, assess possible risks, and propose person-centred responses. Groups present their recommendations and discuss inclusive institutional practices in plenary.	25 min	Case study analysis, small group discussion, plenary sharing	Study Card, Discussion Questions handout
PAUSE 2	10 min	–	–
Exercise 3 – Reimagining the Institution Objective: To design concrete actions for making an institution more inclusive for LGBTQIAP+ elders across three domains. Activity: Each group receives an institution card describing a different care or community setting. Participants identify potential barriers related to age, sexuality and gender diversity and develop practical solutions across three domains: training, physical environment, and policies & protocols. Groups complete the Action Plan Worksheet and present their three priority actions to the plenary.	30 min	Creative design, collaborative writing, presentation	Institution Cards, 3-Domain Action Plan Worksheets, Post-it Notes, Large Papers
Theoretical input – Guidance for educators and professionals, Do's and Don'ts	10 min	Presentation	Laptop, projector, PowerPoint presentation

Key messages & wrap-up – discussing final questions and feedback	5 min	Presentation, Group Discussion	Laptop, projector, PowerPoint presentation
Feedback form	5 min	Module evaluation	Printed feedback forms or QR code



Exercise 1

Scenario A

You are admitting a new 82-year-old resident.
On the admission form, she checked
"Married" but you never see a husband. She
often talks about her "best friend" with whom
she lived for 40 years.

Question :

- What term from the glossary is most relevant here?
- Why is this term important in this situation ?
- How could a lack of knowledge about this term harm the quality of care ?

Facilitator's Answer Key

Lesbian, invisibility, chosen family

The system erased her relationship. Using inclusive language ("Is there an important person in your life?") would have allowed her to share her story.

Scenario B

A 75-year-old resident confides in you that he was married to a woman for 30 years, but always knew he was gay. He has never told anyone about this before.

Question :

- What term best describes this situation?
- Why might this person have stayed silent for so long?
- How should you respond to build trust?

Facilitator's Answer Key

Gay, late-life disclosure, minority stress

He has carried this secret for decades. This is a moment of immense trust. Respond with gratitude and normalisation, not shock.

Scenario C

You need to assist a new resident with personal care. The file identifies her as "Madame," but she has a pronounced Adam's apple and a deep voice. You are unsure how to proceed respectfully.

Question :

- What terms do you need to know to handle this situation well?
- What should you do before providing care?
- What should you absolutely avoid doing or saying?

Facilitator's Answer Key

Transgender, pronoun, cisnormativity

Never assume. Ask respectfully: "What pronouns do you use? How can I best support you with personal care?"

Scenario D

During a workshop, an 88-year-old resident says: "I don't understand all these new words, 'queer', 'non-binary'... In my day, we were just queers and we kept quiet."

Question :

- What does this statement teach us about the importance of history ?
- How can you acknowledge his experience while also introducing newer concepts ?
- What would be a respectful and educational response ?

Facilitator's Answer Key

Queer, generational differences, reappropriation

Acknowledge his history: "You're right, that word was used as an insult. Today, many people have reclaimed it proudly."



Exercise 2



BRETT, 72 year's old

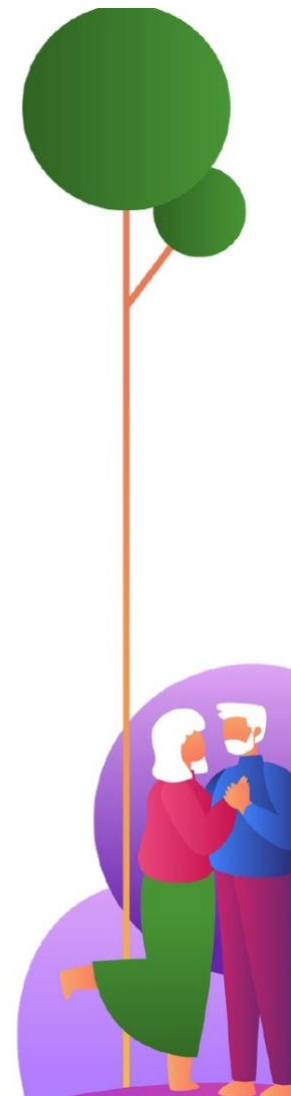
- Brett, 72, is a transgender man living in Lyon. He has a full beard, a low voice, and had chest surgery (mammectomy) several years ago. However, he never had gender-affirming surgery. His body therefore bears the marks of a unique transition journey.
- After a career in education and a life marked by complex family relationships (he spent his teenage years in foster homes), Brett lives alone. Recently, a fall and the onset of heart problems have led him to reluctantly consider entering a nursing home.
- During a pre-admission visit, the director addresses him as "Monsieur." Brett feels recognized. But when the nurse coordinator raises the question of personal care and daily assistance, Brett senses discomfort. He knows that one day, perhaps soon, a caregiver will discover his naked body, and with it, a story that his external appearance does not tell.
- "I've been in institutions most of my life. It never scared me. But I won't get to be in a nursing home like my mom was."

Source: Inspired by The Atlantic (2015), "The Challenge of Being Transgender in a Nursing Home"



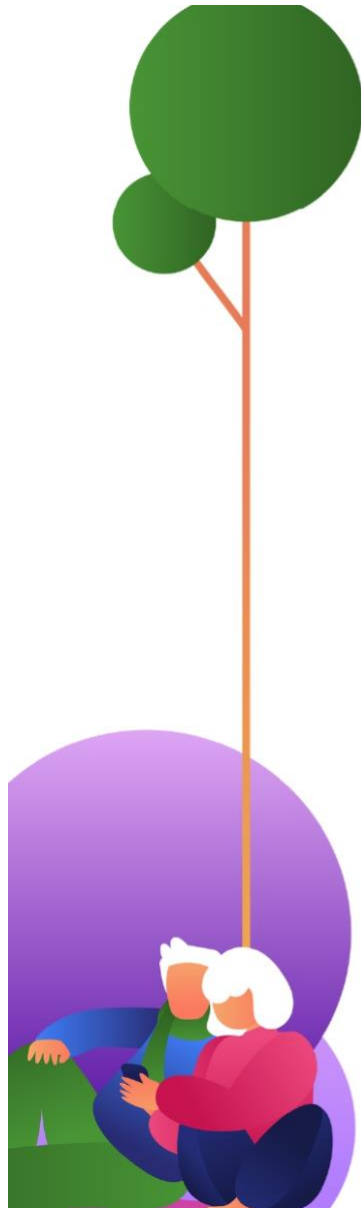








- For Brett himself ?
- For the care staff ?
- For the institution ?

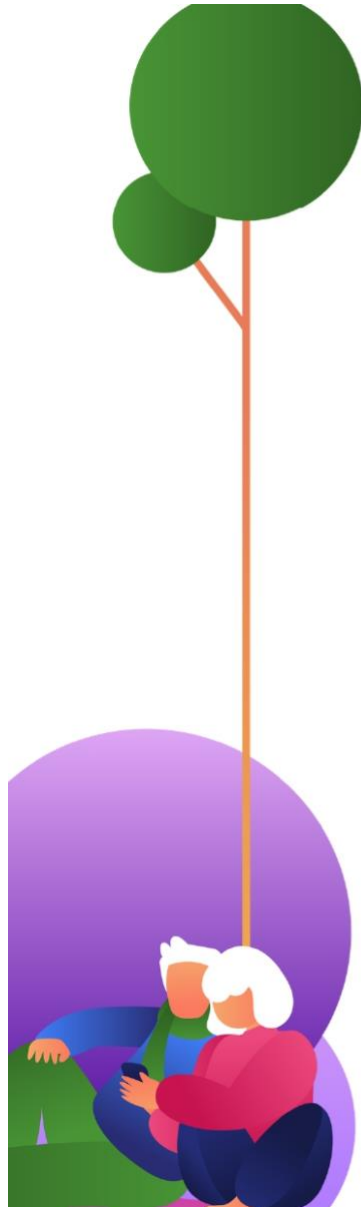


BRETT

What assumptions or biases might influence staff reactions when they discover Brett's body ?



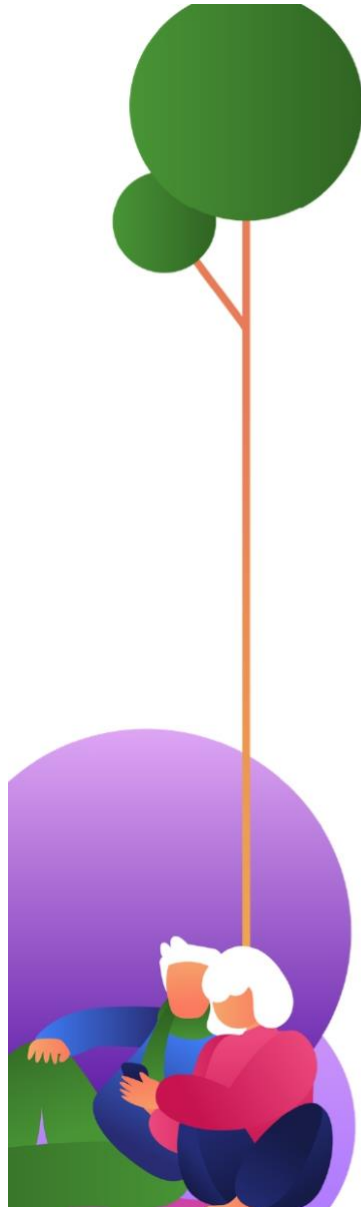
What are the risks if the institutions ignores the situation and puts nothings in place beforehand ?



BRETT

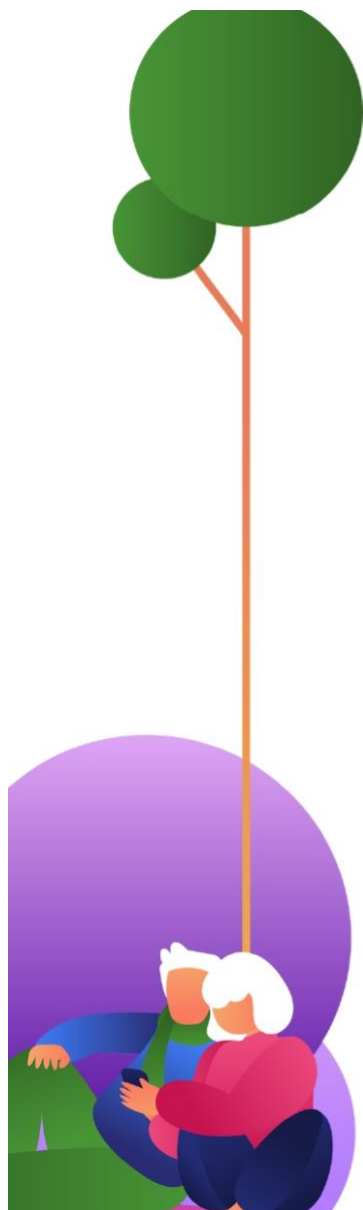
What would a respectful, person-centred response look like ?

- What should management do before Brett arrives ?
- What should the caregiver do in the moment ?
- What policies or protocols could help ?



BRETT

**What can the institution do so that Bratt doesn't have to
"explain who he is " one more time ?**



BRETT FACILITATOR'S NOTES

CHALLENGE	RECOMMENDED RESPONSE
• Involuntary disclosure during intimate care • Staff lack of training on trans bodies • Fear of other residents' reactions • Brett's lifetime of institutional distrust	• Develop a protocol: before first intimate care, a trusted staff member asks: "Is there anything about your body or your history that would help us support you better?" • Provide mandatory training on trans aging and the diversity of trans bodies before Brett's arrival. • Have a clear anti-discrimination policy. Consider a team meeting to prepare. Offer Brett the choice of a private room if available. • Assign a key contact person to build trust. Listen to his concerns without defensiveness.



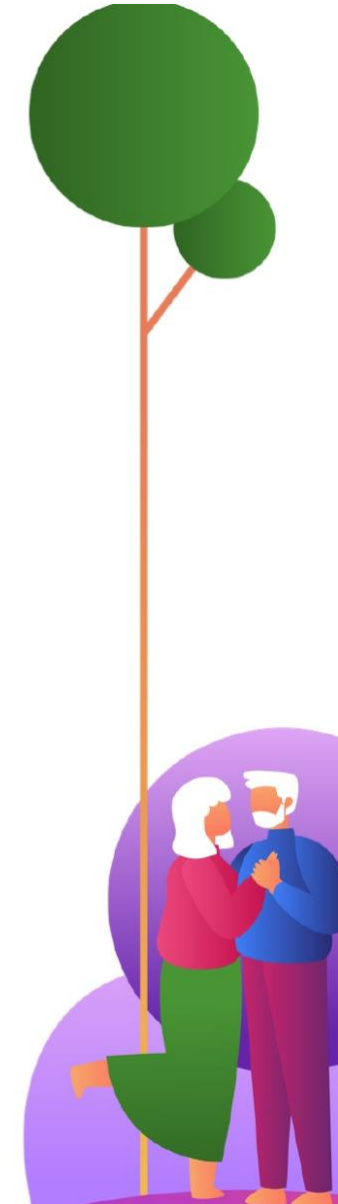
SIMONE, 78 year's old

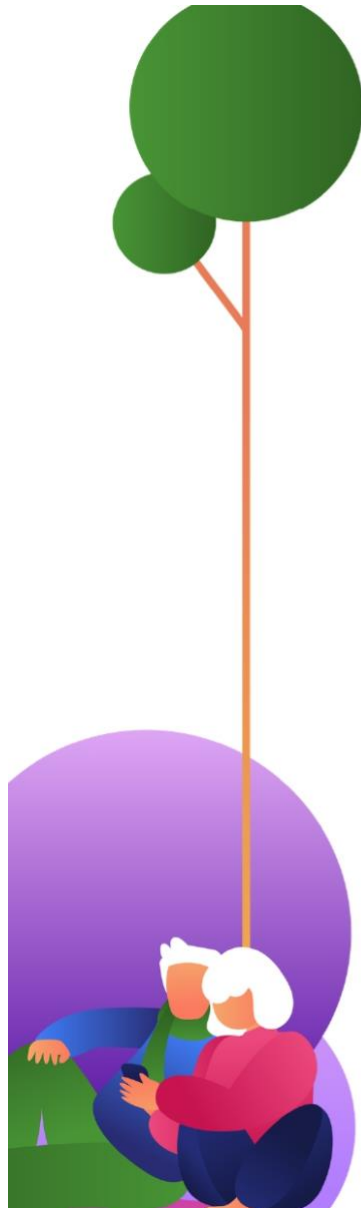
- Simone, 78, is a lesbian woman. She lived with her partner, Marie, for over 40 years. They met at a time when homosexuality was still highly stigmatized, and they never felt safe being open about their relationship. To the outside world, they were "two friends living together."
- Marie passed away five years ago. Simone is now entering a nursing home. On her admission form, she checked "Widowed" – there was no box for "partner" or "civil union." She never mentions Marie to the staff.
- During a care team meeting, a young nurse's aide mentions that Simone seems very sad and withdrawn. Another staff member says: "She's probably just lonely since her husband died."
- No one knows about Marie. No one has asked.







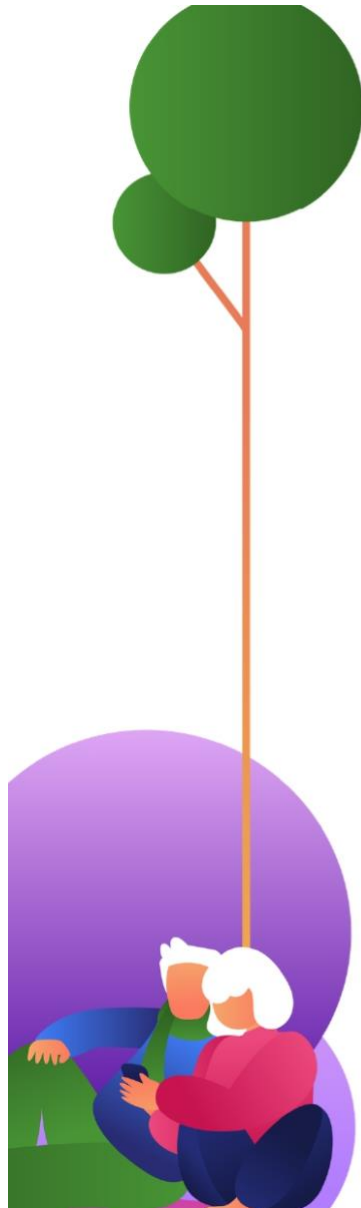




SIMONE

What are the main challenges in this situation ?

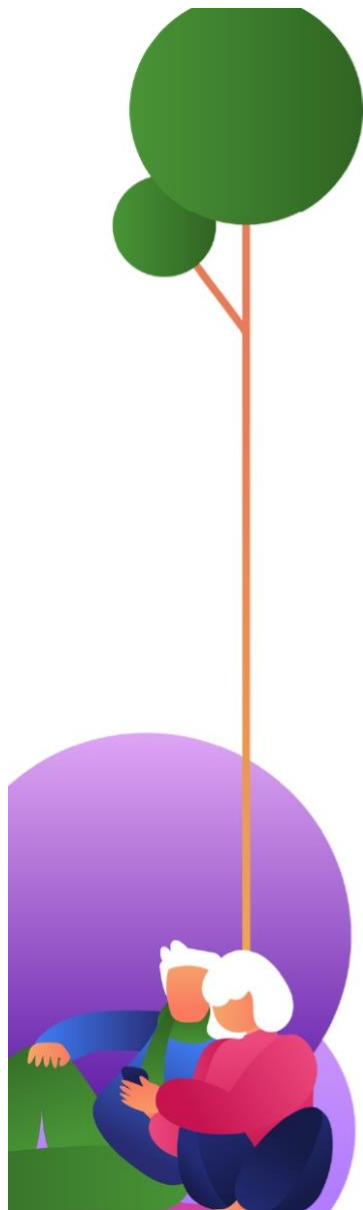
What forms of discrimination are intersecting here? (ageism, sexism, lesbophobia)



SIMONE

What hasn't Simone mentioned Marie to anyone ?

What historical context might explain her silence ?

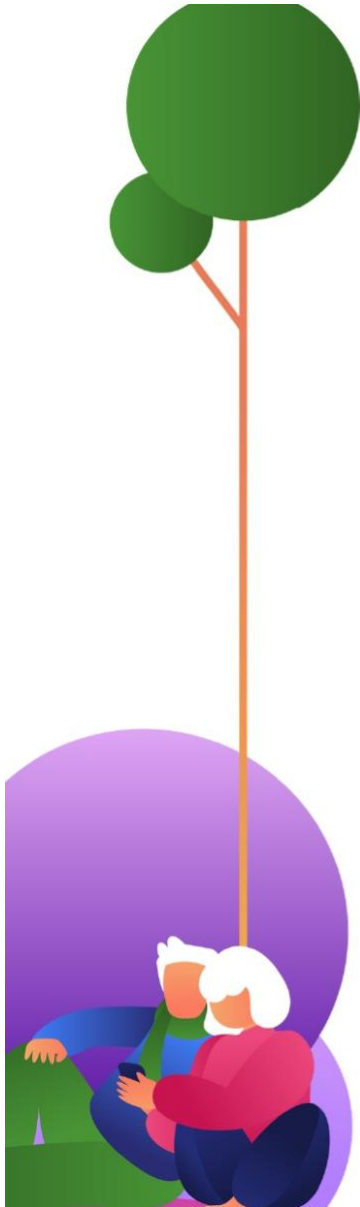


SIMONE

What are the consequences of this invisibility for Simone's well-being ?

How does it affect her grief ?

How does it affect her daily life in the institution ?



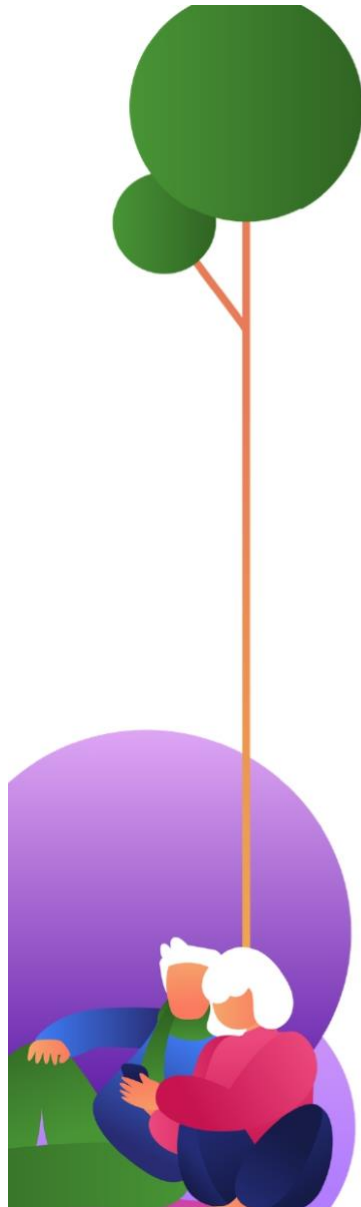
SIMONE

How could the institution have done things differently from the start ?

- What questions should have been asked at admission ?
- What would a more inclusive intake process look like ?



What can staff do now to create a safe space for Simone to share her story ?



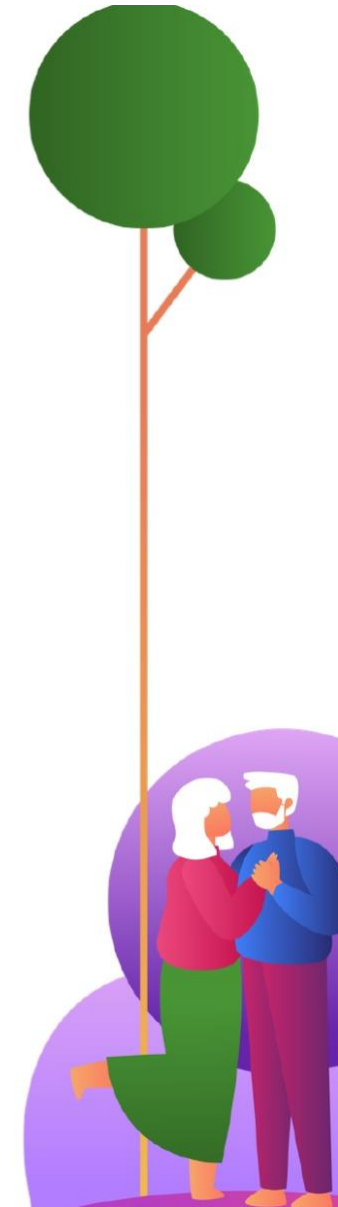
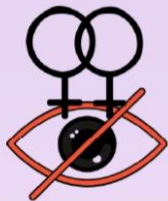
SIMONE FACILITATOR'S NOTES

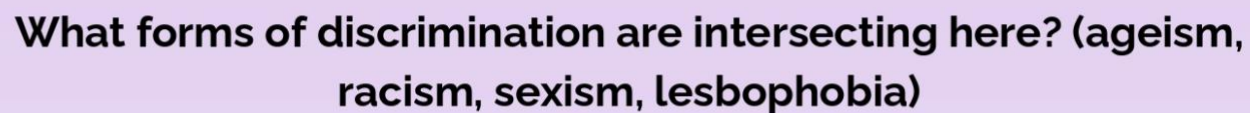
CHALLENGE	RECOMMENDED RESPONSE
• Invisibility of same-sex relationships • Historical trauma and silence • Unrecognized grief	• Review admission forms: add "partner," "civil union," "chosen family" options. Train staff to ask: "Is there an important person in your life?" • Understand that Simone learned to hide to survive. This is not resistance – it's protection. Build trust slowly, without pressure. • Her grief for Marie is real and unacknowledged. A simple statement can help: "Some of the most important people in our lives aren't always recognized on forms. If there's someone you'd like to talk about, we're here to listen."
• Isolation	• Invisibility leads to isolation. Creating visible signs of inclusion (rainbow stickers, inclusive posters) sends a signal that this might be a safe place.

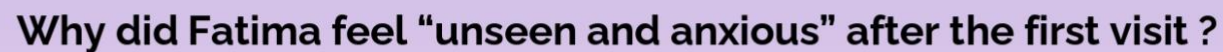


FATIMA 68 year's old

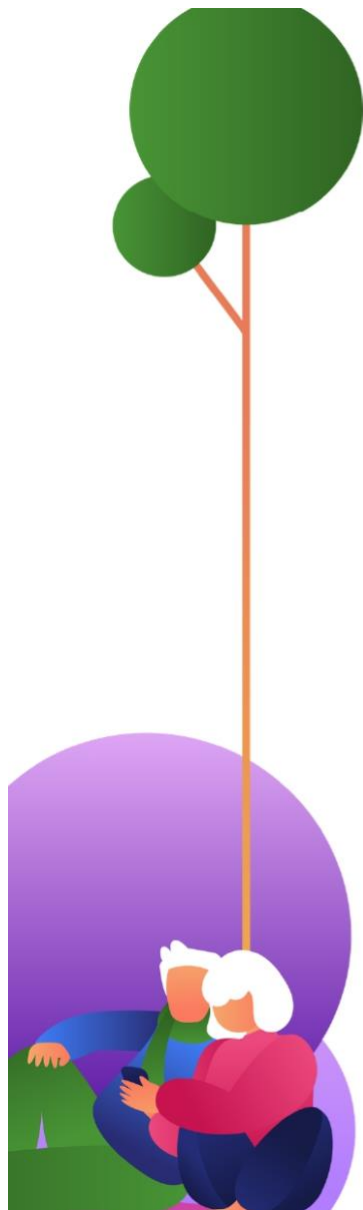
- Fatima, 68, is a lesbian woman of North African origin. She was born in France to immigrant parents and has lived her entire life in a medium-sized town in the south. She came out later in life, after a brief marriage to a man in her twenties that produced two children, now adults with whom she has a distant relationship.
- Fatima is beginning to experience health issues that make living alone difficult. She is considering moving to an assisted living residence. She has visited two residences in her area, but left both feeling unseen and anxious.
- At the first residence, the director enthusiastically showed her the activities: "We have knitting club, bingo, and our residents love the weekly sing-along!" Nothing reflected her interests, her culture, or her identity.
- At the second residence, she overheard two staff members talking about "the Arab woman who came to visit." She left without finishing the tour.
- Fatima wonders: Will there be anyone like me there? Will I have to explain myself constantly? Will I be visible at all?







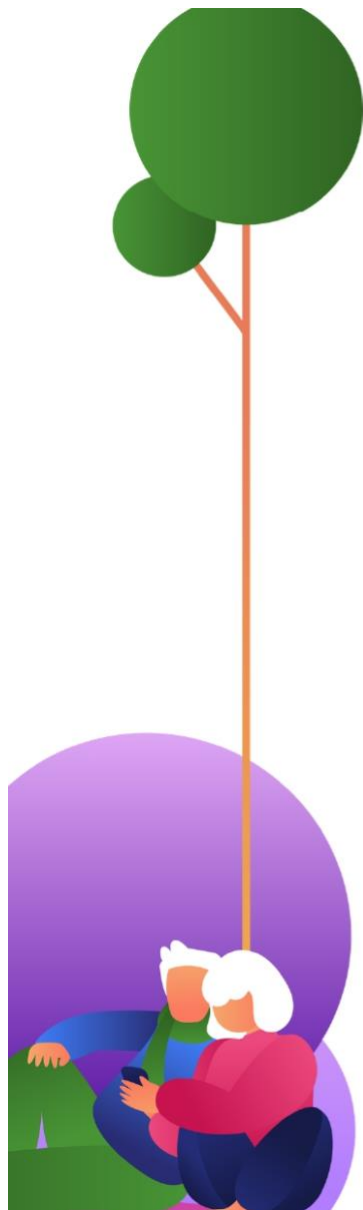
What was missing from director's presentation ?



FATIMA

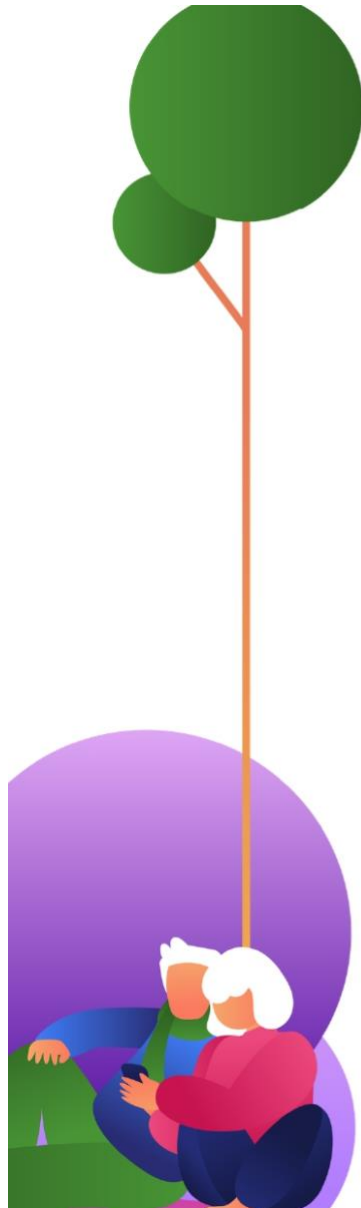
What impact did the staff comment (“the Arab woman”) likely have on Fatima ?

How does this kind of casual remark affect trust ?



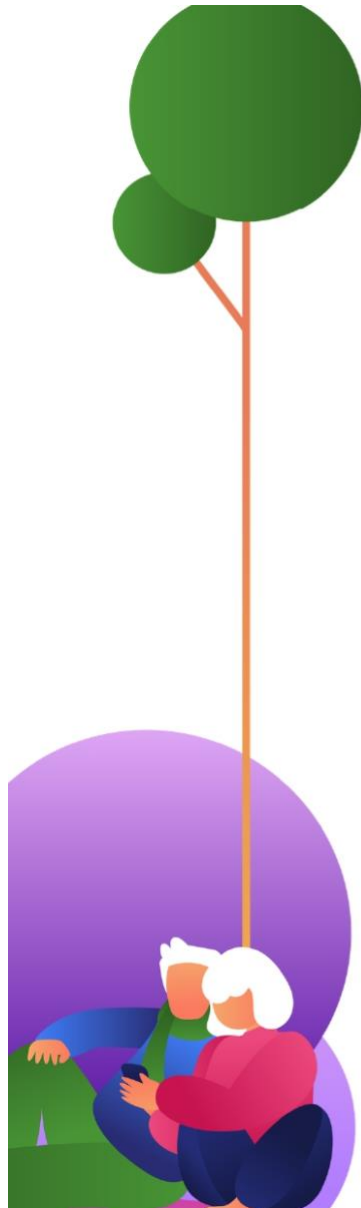
FATIMA

What would an inclusive residence need to offer to make Fatima feel welcome ? *Consider : activities, representation, staff training , physical environment



FATIMA

How can institutions move beyond "one-size-fits-all" approaches to inclusion?



SIMONE FACILITATOR'S NOTES

CHALLENGE	RECOMMENDED RESPONSE
• Triple invisibility (age + race + sexual orientation) • Cultural assumptions in activities • Casual racism from staff • Fear of having to explain	• Fatima is represented nowhere. Institutions must actively work to show diverse representations in their materials, posters, and activities. • Bingo and knitting are not universal. Ask residents what they want. Offer diverse activities: film screenings, discussion groups, music from different cultures. • The comment "the Arab woman" is a micro-aggression. Staff training must address racism and its impact. All staff must understand that every word matters. • Fatima doesn't want to be a "diversity ambassador." She wants to be a resident. Institutions must do the work of inclusion so she doesn't have to.

COMPARATIVE ANALYSIS – Facilitator's Guide				
Theme	BRETT	SIMONE	FATIMA	
• Invisibility	• His trans history will be discovered, not shared	• Her 40-year relationship is completely invisible	• She is invisible in activities, representation, and staff attitudes`	
• Fear of institutions	• Lifetime of institutional trauma	• Learned to hide to survive	• Heard casual racism from staff	
• What would help ?	• Protocols for intimate care, staff training	• Inclusive intake questions, visible signs of safety`	• Diverse activities, diverse representation, staff training on racism	
• The cost of silence	• Vulnerability during care, potential trauma	• Unrecognized grief, isolation	• Anxiety, withdrawal, potentially giving up on residential care	



Exercise 3

Institution Card Nursing / Care Home

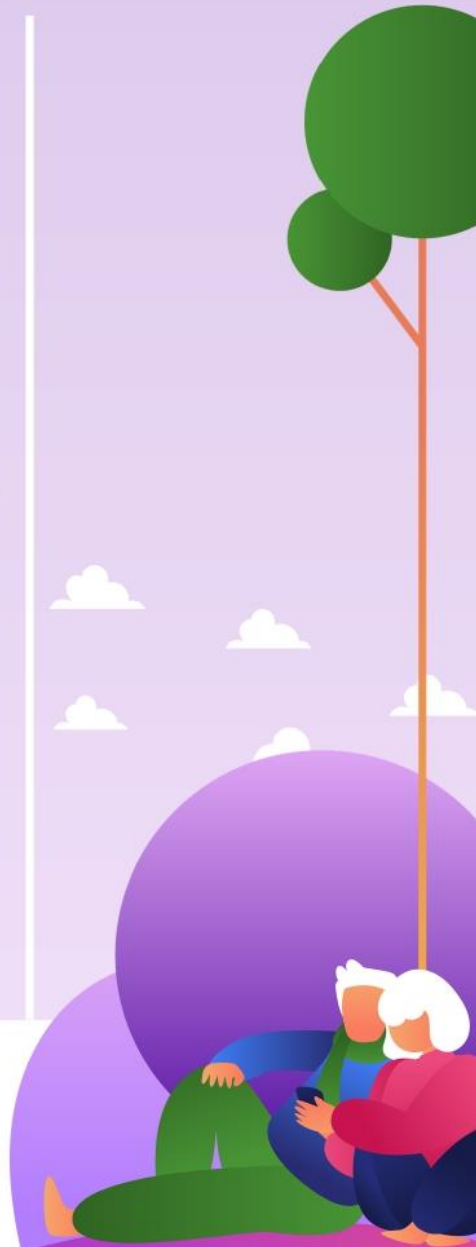
- You're the director of a nursing home composed
- A new person arrived in the nursing home, he/she feel lost and uncomfortable. He/she said to you that he/she has had bad experiences in the past with care older.
- This resident seems isolated from others. He/she leaves the dinning room earlier than other resident and don't participate to group activities.
- The person refuse to talk about his/her previous situation with care holders.
- No visits are organised by his/her family



Institution Card

Associative structure

- You are animator in an associative structure which organized activities linked to LGBTQIAP+ representation
- Most of participants are aged between 19 and 35 years old
- Older person approach the meeting with the desire to discover your associative structure
- Younger, without being hostile, passed over the presence of the new participants
- The older person came to you at the end of the activity to tell you that he/she don't think that he/she will come back



Institution Card

Independent Living Residence

- You are care holder in an independent living residence. Resident are able to manage their visit in and outside the structure
- One of them has declared an heavy treatment that do not have an impact in his/her mobility, without developing pathologies effects
- The person has a pill box coming from drugstore, and do not want you to prepare it, and flee the discussion about that. He/She tells you that "you could not understand"
- The resident has no family and rarely talk about his/her social relation in the past

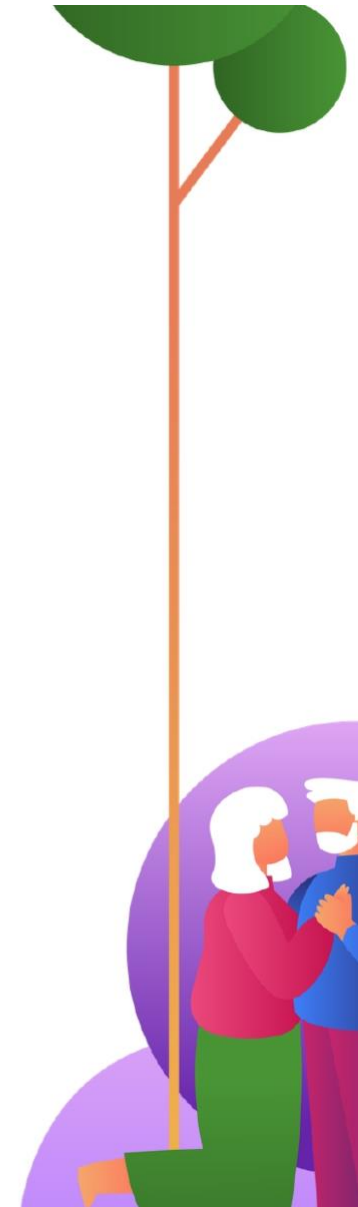


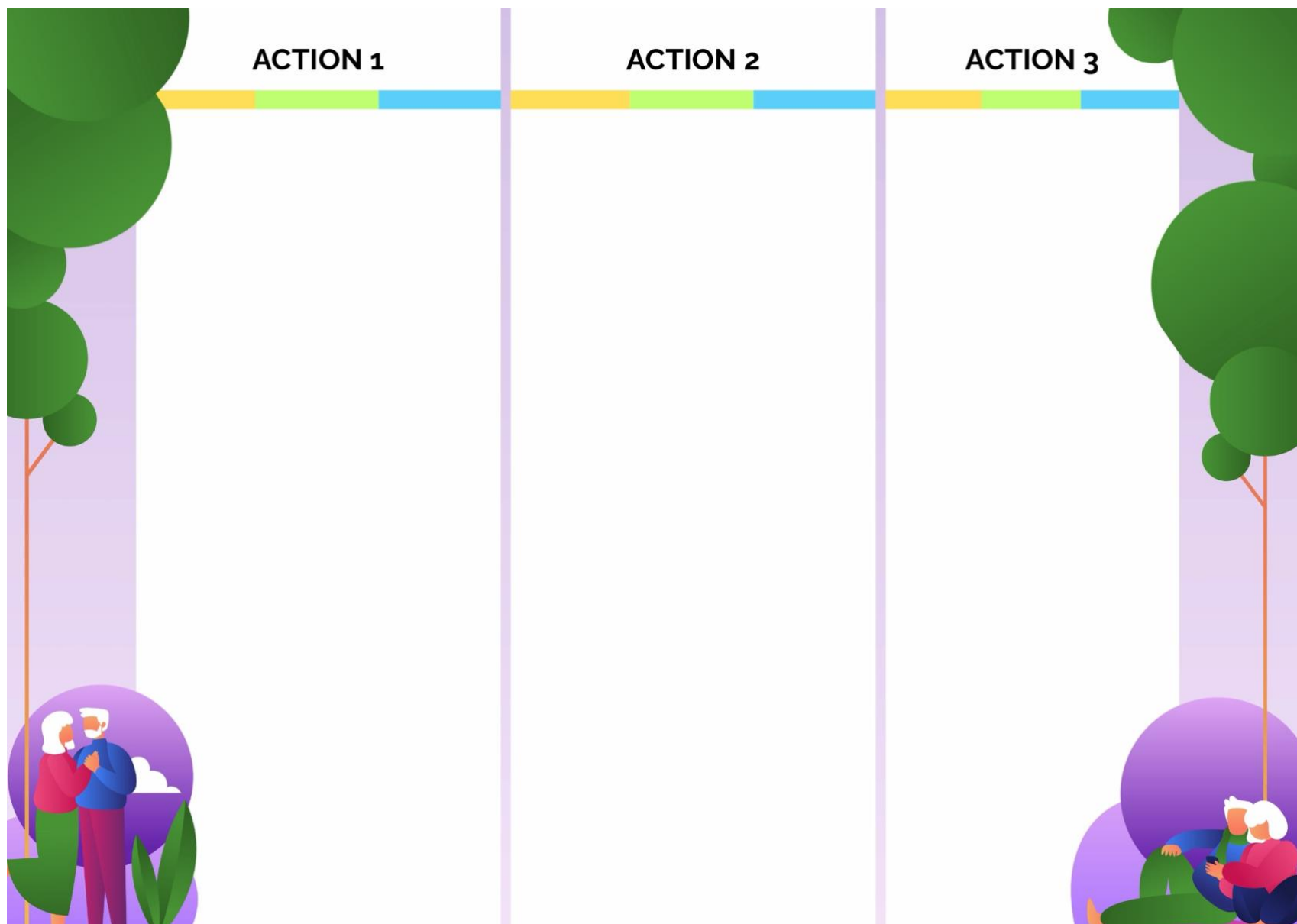
Domain Action Plan Rule's

- In the next board, you'll have to imagine actions to put in place to avoid discrimination linked to age, sexuality or gender in medical or social structure. These actions have must be split in three different categories

TRAINING	PHYSICAL ENVIRONMENT	POLICIES & PROTOCOLS
Who? What topics? How often? By whom?	Visible signs, spaces, documents, posters	Admission forms, intimate care protocols, anti-discrimination, partnerships

- Stick a piece of paper with the right colour in an chronological order to illustrate the application of your action planes
- Then, Prepare a 2-minute presentation of your 3 best ideas to share with the whole group**





Practical Tools

Module 4



Lesson Plan

Module 4	The History of Social Norms of Gender and Sexuality in Europe
Target Group	Adult educators, healthcare professionals, social workers, care staff
Duration	2.5 hours
Learning Outcomes	Participants • can place social norms relating to gender roles, sexuality and age in their historical context, • understand the mechanisms of social taboos relating to sexuality, • are able to reflect on their own attitudes and uncertainties, • are aware of their own values and can distinguish between social norms and personal judgements. • are familiar with the criteria for respectful, non-judgmental communication and can apply them, • know how to sensitively question stereotypical attributions and address people respectfully instead of avoiding them and conversations about sexuality.
Preparation	Organize • a room large enough for 12-18 people (book it in advance, if necessary). • a projector, laptop and flipchart with paper and a facilitator's toolbox. • possibly bring an adapter for your laptop. • Print the Worksheets. • Prepare evaluation forms or QR-code survey. • Prepare Name Tags Draft an invitation letter that provides information about the event, including details of the content and timing. On site • Arrange the chairs in a circle in the middle of the room and place any tables around the outside against the wall. • Technical and Presentation check. • Provide any breaks when necessary.
Check list	1. Invitation letter. 2. Moderation material. 3. Prepared and printed worksheets. 4. Prepared moderation cards.

Lesson Plan | Face-to-Face (minutes)

Topics & Activities	Duration in Minutes	Methods	Equipment & Materials
Opening and expectations – Present agenda and establish respectful discussion space.	10 min	Presentation	Laptop, Projector, PowerPoint presentation
Exercise 1: Einstiegsübung Brainstorming various statements on the topic of age and sexuality; short reflection on each position.	20 min	Sociometric Exercise	A worksheet with the various statements
Theoretical input: Historical overview of social norms.	10 min	Lecture	Laptop, Projector, PowerPoint presentation
Exercise 2 – "Images of Age and Sexuality"	35 min	Map query (Kartenabfrage) Discussion	Pin board, moderation material
Theoretical input: Visibility and invisibility.	15 min		Laptop, Projector, PowerPoint presentation
Exercise 3 – "Self-reflection": Sexuality in old age – norms, values and taboos.	25 min	Single reflection 10 min Small group exchange 15 min	Worksheet Exercise 3
Guidelines for educational work	10 Min	Presentation	PowerPoint
Perspectives for one's own educational work.	15 min	Discussion	
Key Messages & Farewell.	10 min	Discussion and summarising the results	Flipchart



Exercise 1

Worksheet - Statements for Constellation Work

Invite the participants:

"I read out different statements one after the other. *Please position yourself in terms of your agreement, conditional agreement, or disagreement with the statements. You are welcome to move a little between the individual statements" and read the statements one after the other. Point out that it is voluntary.*

Important: mark a ground anchor with a free map. Participants can position themselves here if they do not want to say anything about it.

- Talking about sexuality with people I don't know is foreign to me (unpleasant, unsettles me, embarrasses me, ...)
- Sexuality in old age is a completely normal need.
- I've never really dealt with the topic of sexuality in old age.
- When I see old people holding hands or kissing in public spaces, I notice it differently than I do with young people.
- Older people are also sexually active, I've often noticed that in various ways.
- I notice that the topic of sexuality is often still shameful for me.
- To be able to talk openly about sexuality, with people of all ages, would be a wish of mine.
- When I'm older, I want sexuality, intimacy and closeness to other people to be part of my everyday life.



Exercise 2

"Images of Age and Sexuality"

Duration: 35 minutes

Format: Individual and whole group

Materials required: presentation materials, flipchart, pin board

Learning objectives:

The participants,

- recognize that their ideas are shaped by social images
- distinguish between personal associations and social visibility
- understand that norms are historically variable
- reflect on how invisibility and stereotypes arise
- develop initial approaches to question their own images.

Procedure:

1. Introduction: Activation with associations (individual work, 5 minutes)

Introduction:

"When you think of *age and sexuality* – what images, scenes or associations come to mind? These can be concrete images, terms or situations. Important: It's about what comes to mind spontaneously, not about what you think is right."

Task:

- 2–3 tickets per person
- Terms or small sketches (both allowed)

2. Collection & first sighting (plenary, 5 minutes)

Moderator collects the cards and hangs them on the pin board in a disorderly and visible way.

Key question:

"What do you notice when you see it that way?"

Important: no reviews

3. Reflect on visibility (plenary, 10 minutes)

Introduction:

Where do we actually encounter these images?"

Guiding questions (have prepared for maps in advance):

- "Which of these images do we often see in the media or in public?"
- "Which ones rarely or not at all?"

Division on the pin board with two heading cards:

- "frequently visible" (**prepare heading cards**)
- "rarely visible" (**prepare heading cards**)

4. Historical Change of Perspective (plenary, 10 minutes)

Introduction:

"Imagine if we had asked the same question to your parents, grandparents or great-grandparents..."

Key questions:

- "What pictures would have been taken back then?"
- "What might not have been said at all?"
- "What would have been considered inappropriate?"
- Plenary discussion.

⇒ Optional: in groups of 2, then short feedback in the plenary.

5. Final reflection (plenary, 5 minutes)

Key questions:

- "What does that tell us about social norms?"
- "What seems self-evident today – but wasn't it always the case?"
- "What is perhaps completely missing?"

Conclusion:

- Images are created through repetition (media, culture).
- Visibility creates the impression of "normality".
- Invisibility does not mean non-existence.
- Norms change historically.
- one's own ideas are socially shaped, not individually "neutral".



Exercise 3

Self-Reflection: Sexuality in Old Age – Norms, Values and Taboos

Duration: 10 minutes of individual work, 15 minutes of exchange in a small group

Format: Individual work and subsequent exchange in small groups

Materials needed: Prepared worksheets with the questions

Learning objectives:

1. An in-depth examination of one's own assumptions
2. Insight into how attitudes towards social norms are shaped
3. Reflection on social norms and brainstorming to avoid stereotypes

Procedure:

In the individual work, the participants write down keywords for themselves on the following key questions:

1. What norms about sexuality do you think apply in our society?
2. What are your own assumptions about sexuality in old age? To what extent do they perhaps differ from the prevailing norms?
3. Do you have contact with old people? If so, to what extent can you also talk openly about topics such as sexuality, intimacy and closeness?
4. The topic of sexuality is still often taboo and shameful. Do you feel the same way? Where do you think this shame comes from?
5. How were you yourself socialized in terms of sexuality? What are messages about sex, intimacy, and physical closeness that you grew up with?
6. When you are old yourself, how do you want to live sexuality and physical intimacy? What are your wishes regarding this need?
7. In your opinion, what would be the prerequisites for being able to live your wishes?
8. What do you think it takes to ensure that the topic of sexuality in old age does not continue to be taboo in society?
9. What would you like to contribute more to this in your educational work in the future?

Result assurance:

Finally, the entire group comes together again and holds key findings on the question "What are our most important findings and what do they mean for us personally and our educational work?"

Attention: the questions can be very concerning. Question to the group: how did you feel about the questions? What is going through your head and stomach now? How do you feel? If necessary, offer an energizer after the exercise.



Worksheet – Self-Reflection: Sexuality in Old Age – Norms, Values and Taboos

Take 10 minutes to reflect on the following guiding questions. This reflection is only for you personally. You can jot down bullet points and then decide what you want to contribute to the small group discussion.

- What norms about sexuality do you think apply in our society? In what ways were they conveyed to you?

- What are your own assumptions about sexuality in old age? To what extent do they perhaps differ from the prevailing norms?

- Do you have contact with old people? If so, to what extent can you also talk openly about topics such as sexuality, intimacy and closeness?

- The topic of sexuality is still often taboo and shameful. Do you feel the same way? Where do you think this shame comes from?

- How were you yourself socialized in terms of sexuality? What are messages about sex, intimacy, and physical closeness that you grew up with?

-
- When you are old yourself, how do you want to live sexuality and physical intimacy? What are your wishes regarding this need?

- In your opinion, what would be the prerequisites for being able to live your wishes?

- What do you think it takes to ensure that the topic of sexuality in old age does not continue to be taboo in society?

- What would you like to contribute more to this in your educational work in the future?

Practical Tools

Module 5





Lesson Plan

Module 5	Sexuality in the Third Age and Health Indicators
Target Group	Adult educators, healthcare professionals, psychologists, social workers, care staff
Duration	2.5 hours
Learning Outcomes	Participants: • can describe key medical, physiological and psychosocial aspects of sexuality in later life, • understand how chronic illness, medication and mental health may influence sexual wellbeing, • can apply the sexual response cycle framework to later-life case scenarios, • are able to reflect on relational, emotional and ethical dimensions of intimacy in ageing, • can demonstrate person-centred and respectful communication when addressing sexual health concerns.
Preparation	Organize: • a room large enough for 12–20 participants (book it in advance if necessary), • a projector, laptop and flipchart with paper and facilitator materials, • printed Case Study worksheets, Role Play worksheets and Holistic Reflection Tools, • evaluation forms • name tags if appropriate. Facilitators should: • review Module 5 content, especially medical–physiological and psychosocial links, • select one or two case studies appropriate to participants’ professional background, • prepare a short introductory statement normalising sexuality as part of health and dignity in later life, • ensure a respectful, confidential and non-judgemental learning environment suitable for sensitive discussion. On site: • arrange chairs to support pair and group discussions,

	• conduct technical and presentation checks before the session, • provide breaks when needed, • ensure privacy and a comfortable atmosphere for reflective discussion.
Check list	1. PowerPoint presentation (Module 5). 2. Printed Case Study worksheets. 3. Printed Role Play worksheets. 4. Printed Holistic Sexual Wellbeing Reflection Tool. 5. Feedback forms 6. Pens and moderation materials. 7. Laptop, projector and timer/visible clock.

Session Plan (Timing and Activities)

Topic & Activities	Duration	Methods
Opening and Theoretical Input	40 minutes	✓ Welcome and brief framing of the topic within healthy ageing and quality of life; ✓ Short expectation round: one word describing participants' main concern or curiosity; ✓ Establish ground rules: confidentiality, respect, voluntary sharing; ✓ Facilitator presentation covering: • physiological changes and variability; • chronic illness and medication effects; • mental health and relational wellbeing; • sexual health risks; • principles of person-centred communication.
Case-based worksheet (sexual response cycle application)	30 minutes	✓ Participants work in small groups analysing a later-life scenario using the sexual response cycle framework; ✓ Groups identify: biological contributors, psychological/relational factors, possible professional responses; ✓ Short plenary sharing focused on practical implications for care.
Break	10 minutes	
Holistic Sexual Wellbeing Reflection Tool and Wrap-up	30 minutes	✓ Guided use of the Holistic Sexual Wellbeing Reflection Tool (individual or group reflection); ✓ Discussion: barriers and facilitators for addressing sexuality in professional settings;

		✓ Key takeaways: one insight and one action for practice; ✓ Facilitator summary linking reflection to person-centred care.
Communication and Sexual Response Cycle – Role-play Activity	30 minutes	✓ Participants work in pairs: one participant takes the role of the older adult and the other the role of the professional; ✓ Participants practice empathetic and respectful communication about sensitive concerns; ✓ The professional explores the situation using questions related to the sexual response cycle; ✓ Participants identify possible influencing factors; ✓ After approximately 7 minutes, participants switch roles using a different scenario; ✓ Short debrief discussion focused on communication challenges and person-centered approaches.



Exercise 1

Sexual Response Cycle Application - Case-based worksheet

1. Learning objectives

By the end of the activity, participants will be able to:

- ✓ recognise how different phases of sexual response may be affected in later life;
- ✓ distinguish between medical, psychological, relational and social influences on sexual wellbeing;
- ✓ formulate respectful and appropriate professional responses;
- ✓ reflect on personal attitudes and potential age-related assumptions.

2. Instructions

This activity is designed as a small-group case analysis exercise.

- Divide participants into small groups of 3-5 people.
- Assign one case scenario to each group.
- Ask participants to read the scenario carefully and discuss it together.

3. The Scenarios

Case 1

Maria is 72 and has been in a long-term relationship for over 40 years.

In recent years, she has begun to avoid sexual intimacy because intercourse has become painful and uncomfortable. She feels embarrassed discussing this with her partner and has never mentioned it to her doctor. Her partner interprets the avoidance as emotional rejection and tension has grown between them.

Case 2

John is 68 and lives with diabetes and hypertension.

Over the past year, he has experienced erectile difficulties and increasing fatigue. He feels ashamed and has gradually withdrawn from physical and emotional closeness with his partner, avoiding affectionate contact altogether. He has not discussed these changes with any healthcare professional.

Case 3

Helen is 75 and was widowed five years ago.

She has recently formed a close emotional relationship with a man she met at a community centre. Although she feels companionship and affection, she experiences anxiety about how her family and friends might judge a romantic relationship at her age. She is unsure how to navigate intimacy and worries about "what is appropriate."

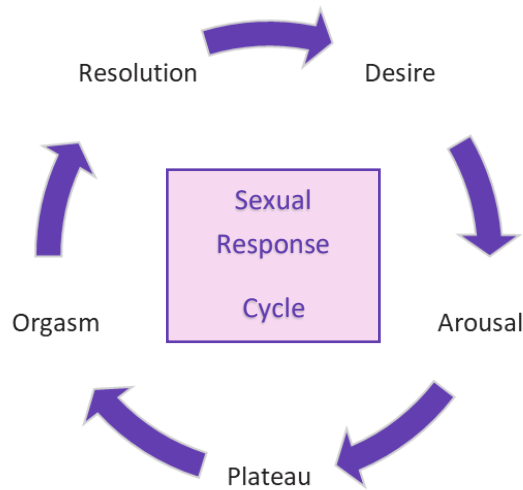
Case 4

George is 80 and has been diagnosed with mild cognitive impairment.

He has begun expressing increased physical affection toward another resident in his care facility. Staff members feel uncertain about how to respond, while his family is concerned that he may be

confused or vulnerable. No structured conversation about his emotional or relational needs has taken place.

4. Sexual Response Cycle Framework



5. Participant analysis questions

Each group discusses the assigned case using the following guiding questions:

1. Which phase or phases of sexual response may be affected?
(e.g., desire, arousal/comfort, satisfaction, emotional meaning)
2. What factors may contribute to the situation?
 - medical or physiological
 - psychological or emotional
 - relational
 - social or cultural
3. What would be an appropriate professional response?
Consider communication, assessment, reassurance, referral or environmental support.

6. Plenary reflection

After group discussions, invite each group to briefly share:

- the main issue identified;
- the factors influencing sexual wellbeing;
- one possible supportive professional action.

Facilitators should emphasise that multiple interpretations may coexist and that the aim is not to produce a single correct answer, but to develop reflective and person-centred thinking.

7. Key learning messages

- Sexual wellbeing remains a meaningful component of quality of life in later life.
- Difficulties in intimacy often reflect interacting biological, psychological and social factors, rather than a single cause.
- Open, respectful communication can significantly reduce distress and stigma.
- Professionals play an essential role in recognising needs, supporting autonomy and facilitating appropriate care.
- A holistic, person-centred perspective aligns with healthy ageing, dignity and inclusion.



Exercise 2

Holistic Sexual Wellbeing Reflection Tool

1. Objectives

This worksheet supports participants in:

- ✓ recognising the multidimensional nature of sexual wellbeing in later life;
- ✓ exploring biological, psychological, relational and social influences on intimacy;
- ✓ reflecting on personal assumptions and professional attitudes toward sexuality in ageing;
- ✓ strengthening person-centred and respectful approaches in practice.

2. Instructions

Read the reflection areas listed below.

1. Choose one real-life professional situation or a hypothetical older adult scenario from the list below.
2. Consider how each dimension of sexual wellbeing may be relevant in that situation.
3. Write brief notes individually or discuss your ideas in a small group.
4. Focus on understanding the person's experience rather than finding a single "correct" answer.

Case 1

Anna is 70 and lives alone since her husband died eight years ago. Recently she has begun a close friendship with a neighbour and they spend a lot of time together. She enjoys the companionship but feels uncertain about whether intimacy would be "appropriate" at her age. She also worries that her adult children might react negatively if they knew she was considering a romantic relationship again. At the same time, Anna has been experiencing low mood and occasional loneliness, particularly during the evenings.

Case 2

Peter is 73 and has been living with Parkinson's disease for several years. His mobility has gradually decreased and he often feels tired. He and his partner still care deeply about each other, but physical intimacy has become more difficult due to stiffness, fatigue and changes in coordination. Peter sometimes feels frustrated and worries that he is becoming a burden to his partner. They rarely talk openly about intimacy anymore.

Case 3

Elena is 67 and recently retired from her job as a teacher. Since retirement she has noticed changes in how she perceives her body and attractiveness. She has gained some weight and feels less confident about her appearance. Although her relationship with her partner remains supportive, she sometimes

avoids intimacy because she feels embarrassed about her body and worries that she is no longer attractive.

Case 4

Victor is 79 and lives in a residential care facility after the death of his spouse. He has recently developed a friendly and affectionate relationship with another resident. They often spend time together talking, holding hands and sitting close. However, the facility has limited private space, and some staff members feel uncomfortable with displays of affection between residents. Victor sometimes feels that his emotional and relational needs are not fully recognised within the institutional environment.

3. Tasks

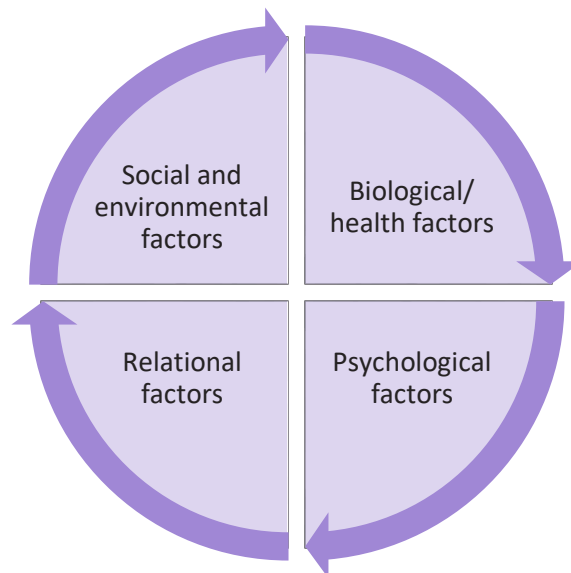
Step 1 – Identify the context

Briefly describe the older adult or situation you are reflecting on:

- Age range and living context (e.g., community, partner relationship, care setting):
- Relevant health or life changes:
- Main concern related to intimacy, sexuality or emotional closeness:

Step 2 – Explore holistic dimensions of sexual wellbeing

Reflect on each dimension and note possible influences.



Biological/ health factors (e.g., chronic illness, medication, pain, hormonal or functional change)	Notes:
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Psychological factors (e.g., mood, anxiety, body image, self-esteem, loneliness, past experiences)	Notes:
Relational factors (e.g., partner relationship, communication, loss, caregiving roles, emotional closeness)	Notes:
Social and environmental factors (e.g., privacy, cultural attitudes, institutional rules, family dynamics, stigma)	Notes:

Step 3 – Person-centred professional response

Based on the reflections above, consider:

- What needs or wishes might this person have?
- What would be a respectful first step in professional communication?

- Is there any support, referral or environmental change that could improve wellbeing?

4. Reflection Questions

1. Which dimension of sexual wellbeing is most often overlooked in your professional context?
2. What assumptions about ageing and sexuality might influence professional responses?
3. How can a person-centred approach change the way this situation is addressed?
4. What is one action you could apply in your practice after this reflection?

5. Trainer Notes (Facilitation Guidance – if considered)

- ✓ Allocate 20–30 minutes depending on group size and discussion depth.
- ✓ Emphasise that participants may use hypothetical cases to avoid personal disclosure.
- ✓ Maintain a non-judgemental and confidential atmosphere.
- ✓ During debrief, focus on learning insights and professional implications, not personal stories.
- ✓ Conclude by linking reflections to person-centred communication and holistic care in later life.



Exercise 3

Communication and sexual response cycle - Role-play activity

1. Objectives

This activity helps participants practise how to:

- ✓ respond empathetically to sensitive sexual concerns
- ✓ explore sexual wellbeing in a structured way using the sexual response cycle

2. Instructions

Participants work in pairs. One participant plays the older adult. One participant plays the professional (doctor, nurse, psychologist, social worker, caregiver).

The role-play has two steps:

Step 1 – Respond to the concern

The older adult introduces their situation.

The professional should:

- ✓ acknowledge the concern
- ✓ normalise discussion of sexuality
- ✓ respond respectfully.

Step 2 – Explore sexual wellbeing

The professional continues the conversation by exploring the person's experience using questions related to the sexual response cycle: desire, arousal, plateau, orgasm, emotional resolution.

Participants should try to identify possible influencing factors such as: health conditions, medication, emotional wellbeing, relationship dynamics, living environment.

After approximately 7 minutes, participants switch roles with a new scenario.

Scenario 1

You are 72 years old and have been married for over 40 years. Over the last few years, you have noticed that you rarely feel interested in sexual intimacy. Your partner sometimes interprets this as rejection, which has created tension between you.

Recently you have also felt more tired and less motivated in general. You are not sure whether these changes are “just ageing” or something else.

You have come to a routine medical consultation and hesitantly mention that intimacy has become difficult in your relationship.

Scenario 2

You are 68 years old and in a long-term relationship. Over the past year, sexual activity has become uncomfortable because of dryness and occasional pain during intercourse.

Because of this, you and your partner have started avoiding intimacy, even though emotional closeness is still important to you.

You feel embarrassed bringing up the topic, but you would like to understand whether anything can help improve comfort during intimacy.

Scenario 3

You are 74 years old and have recently been diagnosed with hypertension and type-2 diabetes. Over the last year you have noticed that erections take longer to occur and are sometimes difficult to maintain.

You are worried that something may be seriously wrong, and you feel frustrated because intimacy used to be an important part of your relationship.

You mention this during a medical visit but are unsure how openly you should talk about it.

Scenario 4

You are 80 years old and live in a residential care facility. Over the past months you have developed a close relationship with another resident.

You enjoy spending time together, holding hands and sitting close to each other, but you worry that staff or family members might judge you if the relationship becomes more intimate.

You feel uncertain about what is considered acceptable in this environment and would like reassurance.

3. Additional Guidance

During the role-play, the professional should:

1. Acknowledge the concern

Examples:

“Thank you for sharing this with me.”

“Many people experience similar changes in later life.”

“It’s completely appropriate to talk about intimacy and sexuality.”

2. Explore using the sexual response cycle

Example directions for questions:

Desire: interest in intimacy, emotional closeness, mood and motivation

Arousal: physical comfort, lubrication or erection, medication or health conditions

Plateau: stamina, fatigue, environmental barriers

Orgasm: satisfaction or changes in pleasure, medication effects

Resolution: emotional connection, feelings after intimacy, companionship and affection.

Practical Tools

Module 6



Lesson Plan

Module 6	Other-isms in working with the elderly and very old adults
Target Group	Adult educators, healthcare professionals, social workers, care staff, extended target groups such as trainees in nursing and social professions, housekeeping & service staff, volunteers, relatives (optional, depending on the setting).
Duration	2.5 hours
Learning Outcomes	Benefits for participants 1. Raising awareness: Making ‘invisible’ mechanisms visible. 2. Strengthening reflective skills: professional self-reflection rather than the unconscious reproduction of norms. 3. Building practical skills for everyday life. 4. Promoting ethical decision-making. 5. Strengthening culturally sensitive and inclusive practice and its implementation in everyday life. 6. Expanding skills to initiate structural change.
Preparation	Organize • a room large enough for 12-18 people (book it in advance, if necessary). • a projector, laptop and flipchart with paper and a facilitator's toolbox. • possibly bring an adapter for your laptop. • Print the Worksheets. • Prepare evaluation forms or QR-code survey. • Prepare Name Tags Draft an invitation letter that provides information about the event, including details of the content and timing. On site • Arrange the chairs in a circle in the middle of the room and place any tables around the outside against the wall. • Technical and Presentation check. • Provide any breaks when necessary.
Check list	1. Invitation letter. 2. Moderation material. 3. Prepared and printed worksheets. 4. Prepared moderation cards.

Lesson Plan Module 6 | Face-to-Face (minutes)

Topics & Activities	Duration in Minutes	Methods	Equipment & Materials
Opening and expectations – Present agenda and establish respectful discussion space.	10 min	Presentation	Laptop, Projector, PowerPoint presentation.
Exercise 1: "Recognizing standard glasses" Making Othering and Normative Assumptions Visible Low-threshold introduction to the topic	30 min	1. Individual work (5 min): 2. Small groups (10 min): 3. Plenum (10 Min): 4. Part 4: Reflection in the plenary (5)	Prepared worksheet 1 in number of participants, flipchart, pin board
Exercise 2: „Case Study“	30 min	Small group work (10 min) Plenary discussion (20 min)	Four worksheets, each with one case study
Theoretical Input	10 min	Lecture	Laptop, Projector, PowerPoint presentation.
Exercise 3: „Train the Trainer-Transfer into practice“	60 min	Small group work, presentation	Worksheet 3, pin board, flipchart, moderation material.
Key Messages & Farewell.	10 min	Discussion and safing Results	Flipchart.



Exercise 1

"Recognising standard glasses"

Duration: 35 minutes

Format: Part 1: Individual work, Part 2: Small groups, Part 3: Plenary discussion

Materials required: prepared worksheets, presentation materials, flipchart or pin board.

Learning objectives:

1. Making Othering and Normative Assumptions Visible
2. Low-threshold introduction to the topic

Procedure:

1. Individual work (5 min):

Evaluate statements (e.g.):

- "Do you have a husband?"
- "At that age, it's no longer important"
- "This is certainly only a phase"

2. Small groups (10 min):

- What is problematic about that?
- What is the norm behind this?
- Who does that exclude?

3. Plenary (10 min):

Collection under categories:

- Heteronormativity
- Alternative standards
- Moral evaluation

4. Reflection in plenary (5 min)

- What patterns stand out?
- What statements do you know from your everyday work?
- What does this mean for dealing with residents/patients?

If necessary, deepening: Select 2–3 statements and rephrase them sensitively and inclusively.

Example: Instead of: "Do you have a husband?" → "Would you like to tell me about important people in your life?"

If necessary, transfer question: "How would you do this exercise yourself with a team?"

Outcome: Participants recognize that seemingly everyday statements are not neutral, but normative (result: *"I listen differently now."*), they can name which norms are behind statements (result: *"I understand why this may be problematic."*), they become more sensitive to the effect on those affected (change of perspective), reflect on their own attitude and develop new linguistic skills (*"I know how to say it differently."*) and experience leadership competence in the exercise, which they can take with them into their organisation.

Worksheet- "Recognising standard glasses"

Part 1: Individual work (5 minutes)

Read the following statements and mark spontaneously:

1. ✓ = unproblematic
2. ? = uncertain
3. ! = problematic

Statements:

1. "Do you have a husband?"
2. "At your age, sexuality no longer plays a role."
3. "This is certainly only a phase."
4. "The two are cute together."
5. "Your daughter must come to visit you often, doesn't she?"
6. "You're already too old for such topics."
7. "We just want to protect you."
8. "That's rather unusual in your culture, isn't it?"
9. "You don't seem like a lesbian woman at all."
10. "This is not the right place for something like this."
11. "They don't have a family of their own."
12. "You don't mean that seriously."
13. "In the past, it wasn't all that complicated."
14. "We treat everyone equally here."
15. "We don't have to address that separately."

Part 2: Small group work (10 minutes)

Exchange ideas in your group.

Key questions:

1. Which statements have you marked as problematic – for what reason?
2. What norms or assumptions are behind this? (e.g. heteronormativity, age norms, cultural attributions)
3. Who could be excluded or hurt by these statements?
4. Which statements may seem "harmless" at first glance, but are still problematic?



Exercise 2

Case studies

Case 1: "We just want to protect them"

Situation:

Mrs. M. (82) lives in a nursing home and has incipient dementia. She has a close, also physically intimate relationship with a roommate. The team is unsure whether Ms. M. is "really capable of consenting". A nurse suggests that the two be spatially separated – "for their protection".

Work order:

Analyse the case in your group.

Key questions for reflection:

- Where does othering manifest itself?
- What assumptions about age, sexuality or cognitive impairment become visible?
- Which ethical principles are affected (autonomy, care, etc.)?
- How can consent be assessed responsibly here?
- What are the options for action?

Please note down a few bullet points for each.

The questions are intended as a suggestion. You don't have to answer them all in writing.

Choose a time guard and a person to write down bullet points.



After 15 minutes you will return to the

Plenary session.

Case 2: "This is not the right place"

Situation:

Mr. K. (76) receives regular visits from his long-time partner. Some roommates complain to the staff, which is "unpleasant" and "not appropriate". A nurse asks Mr. K. to "make such visits more discreet".

Work order:

Discuss how the team might respond appropriately.

Key questions for reflection:

- What forms of othering are recognizable?
- What role do heteronormative ideas play?

- Whose needs are prioritized here – and why?
- What could an inclusive approach look like?
- What structural solutions would be possible?

The questions are intended as a suggestion. You don't have to answer them all in writing.

Choose a time guard and a person to write down bullet points.

➡ After 15 minutes you will return to the
Plenary session.

Case 3: "It's different in your culture"

Situation

Mrs. A. (79) has a migration background. One caregiver avoids talking to her about partnership or sexuality on the grounds that "it's certainly taboo in her culture." However, Mrs. A. seems increasingly withdrawn.

Work order 15 minutes

Analyse the situation and develop alternative courses of action. Write down your ideas on cards; please one keyword per card.

Guiding questions for the discussion:

1. What is the problem here?
2. What does "culturalization" mean in this case?
3. What are the risks for Ms. A.?
4. How could one ask sensitively and openly?
5. What role does person-centred communication play?

The questions are intended as a suggestion. You don't have to answer them all in writing.

Choose a time guard and a person to write down bullet points.

➡ After 15 minutes you will return to the
Plenary session.

Case 4: "We're all right here"

Situation:

The mission statement of the institution says "We treat everyone equally". Nevertheless, there are no gender-neutral forms, and LGBTQI+ issues are not addressed in everyday life. One resident says that she feels "not seen".

Work order:

Evaluate the situation on a structural level.

Key questions for reflection:

1. What is meant by "equal treatment" here – and what is the problem?
2. Where does tokenism or invisibility manifest itself?
3. What structural barriers exist?
4. What specifically needs to be changed (language, rules, offers)?
5. How can real inclusion be implemented?

The questions are intended as a suggestion. You don't have to answer them all in writing.

Choose a time guard and a person to write down bullet points.

➡ After 15 minutes you will return to the
Plenary session.



Exercise 3

"Transfer to your own facility"

Aim of the exercise

The participants develop a **concrete, realistic mini-intervention** with which they can introduce the topic of *othering* into their own institution.

Focus: **Implementation instead of theory**

Step 1: Clarify the starting point (10 minutes)

Think about your own setup:

Key questions:

- Where do you experience situations in everyday life that have to do with othering? (e.g. language, dealing with residents, rules, uncertainties in the team)
- Which situations are typical or recurring?
- Where is there a need for clarification or reflection in the team?

Write down 1 specific situation:

Step 2: Select mini-intervention (10 minutes)

Choose a **suitable method** (you don't have to reinvent anything!):

- ☐ Reflecting on statements (as in exercise 1)
- ☐ Case discussion (as in exercise 2)
- ☐ Short impulse + discussion
- ☐ Change of perspective exercise ("How does it feel for those affected?")

What else can you think of?

Step 3: Schedule mini-training (20 minutes)

Plan a short session (10-15 minutes) for your team.

Structural aid:

- **Topic / goal of the unit:**
→ What should colleagues have understood afterwards?

- **Entry (2-3 minutes):**
→ How do you pick up the team? (e.g. statement, question, short case)
- **Main part (5-7 minutes):**
→ What should colleagues do specifically? (discuss, reflect, evaluate)
- **Conclusion (2-3 minutes):**
→ What is the central finding?

Step 4: Presentation of your schedule 5-10 minutes

Step 5: Feedback (5 minutes)

Key questions:

- What was understandable and easy to implement?
- What inspired reflection?
- Where was it unclear or too complex?
- Did the attitude seem appreciative and open?

If there is time for a practical unit:

In small groups:

- One person moderates the mini-session
- The others take on the role of the team

Aim of the exercise

The participants:

- transfer the topic **concretely to their own practice**
- develop **realistic, short interventions** for everyday work
- gain confidence in **leading groups**
- learn to **flexibly adapt existing methods**
- realize: Change often begins with **small impulses in the team**

Remember

You don't need to provide comprehensive training– a well-placed 10-minute impulse can already trigger change.

Transfer question

When and in what context could you implement your mini-intervention in concrete terms? (e.g. team meeting, handover, further training).

Practical Tools

Module 7



Lesson Plan

Lesson Plan | Face to face

Topics & Activities	Duration	Methods	Equipment & Materials
Opening and expectations – Presenting agenda and learning outcomes for Module 7	5 min	Presentation	Laptop, projector, PowerPoint presentation
Theoretical input – Why methodology matters? The principles of inclusive communication (language, posture, environment)	20 min	Presentation	Laptop, projector, PowerPoint presentation
Exercise 1 – Communication Do's and Don'ts Objective: To identify and practice inclusive communication techniques through real-life scenarios. Activity: Participants work in small groups using a set of communication cards. For each statement, they decide whether it represents inclusive professional practice (DO) or problematic communication (DON'T), explain their reasoning, and propose a more respectful alternative when appropriate. Groups discuss their responses and compare them with the facilitator answer key during plenary feedback.	25 min	Small group discussion, card sorting, role play	Communication Do's and Don'ts Cards, flipchart
PAUSE 1	10 min	–	–

Theoretical input – Creating safe spaces, adapting to different realities (cognitive decline, disability, cultural diversity)	15 min	Presentation	Laptop, projector, PowerPoint presentation
Exercise 2 – Complex Situation Analysis Objective: To analyse delicate situations (resident relationships, family opposition) and build a team-based response. Activity: Small groups analyse a complex case scenario involving intimacy, relationships, consent, family concerns or diversity in later life. Using the structured reflection worksheet, participants identify the key issues, stakeholders and ethical principles involved, and develop a step-by-step response plan. Groups present and discuss their recommendations in plenary.	25 min	Case study analysis, small group discussion, plenary sharing	Complex Situation Cards
PAUSE 2	10 min	–	–
Exercise 3 – Photo-Expression Facilitation Practice Objective: To experiment with the photo-expression tool and practice facilitating a short discussion on a sensitive topic. Activity: Participants work in small groups and take turns facilitating a short discussion using photo-expression images and facilitation scenario cards. One participant acts as facilitator, while others take the role of participants. Observers complete the Peer Observation Form and provide feedback on	30 min	Small group facilitation practice, peer observation	Photo-Expression image set, Facilitation Scenario Cards

communication style, questioning techniques, group management and handling of sensitive topics.			
Theoretical input – Guidance for educators and professionals, ethical considerations, working as a team	10 min	Presentation	Laptop, projector, PowerPoint presentation
Key messages & wrap-up – discussing final questions and feedback	5 min	Presentation, Group Discussion	Laptop, projector, PowerPoint presentation
Feedback form	5 min	Module evaluation	Printed feedback forms or QR code



Exercise 1

Do or Don't

1 "AT YOUR AGE, YOU SHOULDN'T WORRY ABOUT THAT KIND OF THING ANYMORE."

Explain why it's a do or a don't & find an alternative if don't

Do or Don't

2 "IS THERE AN IMPORTANT PERSON IN YOUR LIFE THAT YOU'D LIKE TO TALK ABOUT?"

Explain why it's a do or a don't & find an alternative if don't

Do or Don't

3 TO A RESIDENT WHO SEEMS SAD: "YOU'RE PROBABLY JUST LONELY SINCE YOUR HUSBAND DIED."

Explain why it's a do or a don't & find an alternative if don't

Do or Don't

4 "WHAT PRONOUNS DO YOU USE? I WANT TO MAKE SURE I ADDRESS YOU CORRECTLY."

Explain why it's a do or a don't & find an alternative if don't

Do or Don't

5 LAUGHING NERVOUSLY AND CHANGING THE SUBJECT WHEN A RESIDENT MENTIONS THEIR SEX LIFE.

Explain why it's a do or a don't & find an alternative if don't

"MANY PEOPLE FIND THAT THEIR INTIMATE NEEDS CHANGE AS THEY GET OLDER. IS THERE ANYTHING YOU'D LIKE TO DISCUSS?"

20

Explain why it's a do or a don't & find an alternative if don't

Do or Don't

Do or Don't

7 WALKING INTO A RESIDENT'S ROOM WITHOUT KNOCKING, EVEN IF THE DOOR IS CLOSED.

NEVER GETS OLD

Explain why it's a do or a don't & find an alternative if don't

Do or Don't

8 "WOULD YOU PREFER A MALE OR FEMALE CAREGIVER TO ASSIST YOU WITH PERSONAL CARE?"

NEVER GETS OLD

Explain why it's a do or a don't & find an alternative if don't

Do or Don't

9 "THAT'S SO CUTE THAT YOU TWO ARE HOLDING HANDS AT YOUR AGE!"

NEVER GETS OLD

Explain why it's a do or a don't & find an alternative if don't

Do or Don't

10 "I ASK ALL THE PEOPLE I SUPPORT ABOUT THEIR EMOTIONAL AND INTIMATE WELLBEING – IT'S PART OF OVERALL HEALTH."

NEVER GETS OLD

Explain why it's a do or a don't & find an alternative if don't

Do or Don't

11 ASKING A FEMALE : "WHAT WAS YOUR HUSBAND'S NAME?"

NEVER GETS OLD

Explain why it's a do or a don't & find an alternative if don't

Do or Don't

12 "I NOTICED YOU SEEM MORE WITHDRAWN LATELY. IS THERE SOMEONE YOU'RE MISSING OR SOMETHING ON YOUR MIND?"

NEVER GETS OLD

Explain why it's a do or a don't & find an alternative if don't

Card	DO/DON'T	Why	Better alternative
1	✗ DON'T	Dismissive, ageist, shuts down conversation	"Many people find that intimacy continues to be important. Is this something you'd like to talk about?"
2	✓ DO	Inclusive, open, allows for diverse relationships	
3	✗ DON'T	Assumes heterosexuality, assumes cause of sadness	"You seem sad. Would you like to talk about what's on your mind?"
4	✓ DO	Respectful, creates safety for trans and non-binary people	
5	✗ DON'T	Signals discomfort, shuts down trust, humiliates	Stay calm, listen, respond seriously: "Thank you for sharing that with me."
6	✓ DO	Normalises the topic, opens dialogue	
7	✗ DON'T	Violates privacy and dignity	
8	✓ DO	Respects preferences, especially important for trans residents	
9	✗ DON'T	Infantilising, dismissive of adult relationship	"It's wonderful to see you both so happy together."
10	✓ DO	Normalises, creates permission to speak	
11	✗ DON'T	Heteronormative, erases other possibilities	"Was there an important partner in your life?"
12	✓ DO	Open, caring, invites sharing without pressure	



Exercise 2

NEVER
GETS
OLD

SITUATION A

TWO RESIDENTS IN YOUR NURSING HOME, JEAN (82) AND MICHEL (79), HAVE BECOME VERY CLOSE OVER THE PAST FEW MONTHS. THEY EAT ALL THEIR MEALS TOGETHER, SPEND HOURS IN THE GARDEN HOLDING HANDS, AND STAFF HAVE NOTICED THAT MICHEL OFTEN VISITS JEAN'S ROOM LATE IN THE EVENING.

SOME STAFF MEMBERS THINK IT'S "SWEET." OTHERS ARE UNCOMFORTABLE AND HAVE STARTED MAKING JOKES. MICHEL'S DAUGHTER HAS COMPLAINED TO THE DIRECTOR: "MY FATHER IS VULNERABLE. I DON'T KNOW WHAT JEAN WANTS FROM HIM."

As a team, what do you do?

NEVER
GETS
OLD

SITUATION B

MONIQUE, 76, HAS BEEN LIVING IN YOUR ASSISTED LIVING RESIDENCE FOR TWO YEARS. SHE RECENTLY STARTED A RELATIONSHIP WITH ANOTHER RESIDENT, CLAIRE, 74. THEY SEEM VERY HAPPY TOGETHER – THEY GO TO ACTIVITIES TOGETHER, SHARE MEALS, AND HAVE BECOME EACH OTHER'S MAIN SOURCE OF SUPPORT.

MONIQUE'S SON HAS DEMANDED A MEETING WITH YOU. HE IS FURIOUS: "MY MOTHER WAS MARRIED TO MY FATHER FOR 40 YEARS. SHE'S NOT A LESBIAN. THIS WOMAN IS TAKING ADVANTAGE OF HER. I WANT YOU TO SEPARATE THEM." MONIQUE HAS TOLD YOU SHE HAS NEVER BEEN HAPPIER AND THAT CLAIRE IS "THE BEST THING THAT'S HAPPENED TO ME IN YEARS."

As a team, how do you handle this situation?

NEVER
GETS
OLD

SITUATION B

GINETTE, 88, LIVES IN YOUR NURSING HOME. SHE HAS MODERATE ALZHEIMER'S DISEASE. HER MEMORY COMES AND GOES – SOME DAYS SHE RECOGNISES HER CHILDREN, OTHER DAYS SHE DOESN'T.

GINETTE HAS BECOME VERY AFFECTIONATE WITH ANOTHER RESIDENT, ROBERT, 85, WHO ALSO HAS COGNITIVE IMPAIRMENT. STAFF HAVE OBSERVED THEM KISSING AND TOUCHING. BOTH SEEM HAPPY AND RELAXED IN EACH OTHER'S COMPANY. NEITHER SEEMS DISTRESSED OR UPSET.

HOWEVER, SOME STAFF ARE WORRIED: "CAN SHE REALLY CONSENT TO THIS? WHAT IF SHE DOESN'T UNDERSTAND WHAT'S HAPPENING? WHAT IF ROBERT DOESN'T UNDERSTAND?"

GINETTE'S DAUGHTER IS HORRIFIED AND WANTS THE RELATIONSHIP STOPPED IMMEDIATELY.

As a team, how do you assess the situation and respond?



SITUATION D

A NEW RESIDENT, ALEX, 70, IS JOINING YOUR NURSING HOME NEXT WEEK. ALEX IS A TRANSGENDER MAN. HE HAS A BEARD AND A DEEP VOICE, AND HIS FILE IDENTIFIES HIM AS "MR. ALEX DUBOIS."

DURING THE PRE-ADMISSION VISIT, ALEX MENTIONED TO THE DIRECTOR THAT HE HAD TOP SURGERY YEARS AGO BUT NEVER HAD LOWER SURGERY. HE SAID: "I'M TELLING YOU THIS BECAUSE I KNOW SOMEONE WILL EVENTUALLY NEED TO HELP ME WITH PERSONAL CARE. I DON'T WANT IT TO BE A SURPRISE. I DON'T WANT TO HAVE TO EXPLAIN MYSELF WHILE I'M NAKED AND VULNERABLE."

THE DIRECTOR HAS SHARED THIS INFORMATION WITH YOU, THE CARE TEAM. NONE OF YOU HAVE EVER RECEIVED TRAINING ON SUPPORTING TRANS RESIDENTS.

As a team, how do you prepare for Alex's arrival? What do you do when the moment for intimate care comes?



SITUATION E

YOU ARE A HOME CARE WORKER VISITING MRS. KAUR, 78, WHO IMMIGRATED FROM INDIA 40 YEARS AGO. SHE LIVES ALONE AND RECEIVES DAILY VISITS FOR PERSONAL CARE AND COMPANIONSHIP.

MRS. KAUR HAS NEVER DISCUSSED HER PERSONAL OR EMOTIONAL LIFE WITH YOU. WHEN YOU'VE GENTLY ASKED ABOUT HER FAMILY, SHE HAS SAID HER HUSBAND DIED MANY YEARS AGO AND SHE HAS NO CHILDREN.

RECENTLY, YOU'VE NOTICED SHE SEEMS WITHDRAWN AND SAD. YOU SUSPECT SHE MIGHT BE LONELY OR MISSING SOMEONE, BUT WHENEVER YOU TRY TO APPROACH THE SUBJECT, SHE BECOMES SILENT AND CHANGES THE TOPIC.

YOU KNOW THAT IN SOME CULTURES, DISCUSSING PERSONAL OR INTIMATE MATTERS OUTSIDE THE FAMILY IS DEEPLY TABOO. YOU DON'T WANT TO BE INTRUSIVE, BUT YOU'RE ALSO CONCERNED ABOUT HER WELLBEING.

How do you approach this situation with cultural humility while still fulfilling your duty of care?

Step	Questions	Your Team's Response
Step 1	What is the main issue here? What are the different perspectives involved?	
Step 2	Who needs to be involved in addressing this situation? (resident, family, staff, management, external experts?)	
Step 3	What ethical principles are at stake? (autonomy, dignity, safety, privacy, consent, family relationships?)	
Step 4	What actions should be taken, and in what order? (immediate steps, short-term, long-term)	
Step 5	How do you document and communicate the decision to everyone involved?	



Exercise 3

Peer Observation Form – Facilitation Practice

Facilitator's name: _____

Scenario: ☐ A ☐ B ☐ C ☐ D ☐ E

Observation Area	What worked well?	What could be improved?
Opening – Did the facilitator explain the topic clearly? Create a safe atmosphere?		
Use of images – Did the facilitator use the photo-expression tool effectively? Were the images helpful?		
Questioning – Did the facilitator ask open, inclusive questions? Did they listen actively?		
Managing the group – Did everyone get a chance to speak? Were silences respected?		
Handling sensitive moments – Did the facilitator respond well to any discomfort or emotion?		
Closing – Did the facilitator summarise or thank participants appropriately?		



SCENARIO A

Intimacy and Aging

TOPIC: "WHAT DOES INTIMACY MEAN TO YOU AS YOU GET OLDER?"

CONTEXT: YOU ARE FACILITATING A 10-MINUTE DISCUSSION WITH A SMALL GROUP OF CARE HOME RESIDENTS*. SOME RESIDENTS MAY HAVE COGNITIVE IMPAIRMENT.

USE THE PHOTO-EXPRESSION IMAGES TO HELP PEOPLE EXPRESS THEMSELVES.

Goal: Help participants share their thoughts and feelings about intimacy in later life.



SCENARIO B

Love and New Relationships

TOPIC: "IS IT POSSIBLE TO FALL IN LOVE AT ANY AGE?"

CONTEXT: YOU ARE FACILITATING A 10-MINUTE DISCUSSION WITH A SMALL GROUP OF OLDER ADULTS IN AN ASSISTED LIVING RESIDENCE. SOME HAVE LOST PARTNERS, SOME ARE SINGLE, SOME ARE IN NEW RELATIONSHIPS.

USE THE PHOTO-EXPRESSION IMAGES TO START THE CONVERSATION.

Goal: Create a safe, non-judgemental space where people can share their experiences and hopes.



SCENARIO C

Touch and Affection

TOPIC: "THE IMPORTANCE OF TOUCH AND AFFECTION AS WE AGE"

YOU ARE FACILITATING A 10-MINUTE DISCUSSION WITH CARE HOME STAFF (PLAYED BY OTHER PARTICIPANTS). THEY WANT TO BETTER UNDERSTAND RESIDENTS' NEEDS FOR TOUCH AND AFFECTION, BUT SOME FEEL UNCOMFORTABLE WITH THE TOPIC.

USE THE PHOTO-EXPRESSION IMAGES TO HELP PEOPLE EXPRESS THEMSELVES.

Goal: Help staff explore their own attitudes and understand residents perspectives



SCENARIO D

Diversity and Inclusion

TOPIC: 'FEELING SEEN AND RESPECTED FOR WHO YOU ARE'

CONTEXT: YOU ARE FACILITATING A 10-MINUTE DISCUSSION WITH A SMALL GROUP OF CARE HOME RESIDENTS*. SOME RESIDENTS MAY HAVE COGNITIVE IMPAIRMENT.

USE THE PHOTO-EXPRESSION IMAGES TO HELP PEOPLE EXPRESS THEMSELVES.

Goal: Help participants share their thoughts and feelings about intimacy in later life.



SCENARIO E

Love and New Relationships

TOPIC: "IS IT POSSIBLE TO FALL IN LOVE AT ANY AGE?"

CONTEXT: YOU ARE FACILITATING A 10-MINUTE DISCUSSION WITH CARE HOME STAFF AND MANAGEMENT (PLAYED BY OTHER PARTICIPANTS). YOUR RESIDENCE WANTS TO BECOME MORE INCLUSIVE OF LGBTQIAP+ RESIDENTS. USE THE PHOTO-EXPRESSION IMAGES TO HELP PEOPLE THINK ABOUT WHAT "FEELING SEEN" MEANS.

USE THE PHOTO-EXPRESSION IMAGES TO START THE CONVERSATION.

Goal: Encourage reflection on how the environment and practices can signal inclusion or exclusion.

Practical Tools

Module 8





Lesson Plan

Module 8	Dementia and Sexuality: Critical Points
Target Group	Adult educators, healthcare professionals, social workers, care staff. For optimal interaction, participants should work in small groups of 3-5 people. This allows for active participation, sharing perspectives and more effective discussion.
Duration	2.5 hours
Learning Outcomes	Learners will be able to: • Explain how dementia-related cognitive changes influence intimacy and sexual expression Structural Understanding • Differentiate between autonomy, safeguarding, beneficence and dignity of risk Ethical Literacy • Apply a context-specific and time-specific approach to consent assessment Consent Competence • Recognise intersectional vulnerabilities (gender, LGBTQI+, culture, health status) Inclusive Awareness • Develop a structured 3-Step Action Plan for complex ethical scenarios Professional Confidence
Preparation	- Prepare room with chairs and tables arranged for group work. - Organise projector, laptop and flipchart. - Print Myth vs Reality worksheets. - Prepare Consent Reflection Tool and Case Study Cards. - Print 3-Step Action Plan worksheets. - Prepare evaluation forms or QR-code survey.
Check List	Tech: PPTX & projector check Exercise 1: Three flipchart sheets & markers Exercise 2: Printed questionnaires & personal cards & clipboards Exercise 3: Case file cards & worksheets General: Name Tags & feedback forms

Lesson Plan | Face-to-Face (150 minutes)

Topics & Activities	Duration in Minutes	Methods	Equipment & Materials
Opening and expectations – Present agenda and establish respectful discussion space.	5 min	Presentation	Laptop, projector, PowerPoint presentation
Theoretical input: Sexuality, Ageism & Dementia Sexuality as lifelong identity; stigma; cognitive change and relational needs.	15 min	Presentation	PowerPoint presentation
Exercise 1 – Myth vs Reality Small group classification and plenary discussion	20 min	Group work + plenary	Printed worksheets, flipchart
Theoretical input : Consent & Ethical Complexity Context-specific consent; non-verbal indicators; dignity of risk.	20 min	Presentation	PowerPoint presentation
Exercise 2 – Consent in Practice Case analysis using Consent Reflection Tool and proportional response.	30 min	Case-study group work	Case cards, Consent Tool
Short Break – Participants take a short pause to rest and reflect before continuing.	10 min	Informal break	-
Exercise 3 – 3-Step Action Plan Immediate response; Ethical reasoning; Long-term strategy.	35 min	Group work + presentations	Case cards, Action Plan worksheet
Key Messages & Wrap-Up Shift from control-based responses to dignity-centred practice.	10 min	Plenary discussion	Flipchart
Evaluation Confidence scale + open reflection question.	5 min	Individual reflection	Feedback forms / QR code



Exercise 1

Myth vs Reality

Duration: 20 minutes

Format: Small group work (3–5 participants)

Materials needed: Printed worksheet, flipchart, marker

1. Purpose of the Exercise

This activity aims to:

- Challenge ageist and stigma-based assumptions regarding sexuality in dementia
- Strengthen participants' critical thinking skills
- Encourage evidence-based reflection rather than reactive judgement
- Prepare participants for deeper ethical analysis in subsequent activities

The exercise supports the shift from control-based responses to person-centred and rights-based practice.

2. Instructions for Participants

1. Work in small groups.
2. Read each statement carefully.
3. Decide whether the statement represents a Myth or a Reality.
4. Provide a short justification for your choice.
5. Be prepared to briefly share one example in plenary discussion.

3. Worksheet – Statements for Classification

For each statement, mark:

☐ Myth or ☐ Reality

- | | |
|----|---|
| 1. | People living with dementia lose all interest in intimacy. |
| 2. | Sexual expression in dementia is always inappropriate or pathological. |
| 3. | Capacity to consent must be assessed for each specific decision. |
| 4. | Safeguarding requires prohibiting intimate relationships in care institutions. |
| 5. | Hypersexual behaviour may result from neurological changes affecting impulse control. |

6.	If a person cannot verbally explain consent, this requires careful assessment, but it does not automatically mean that consent is absent.
7.	Emotional calmness and absence of distress may indicate situational consent.
8.	Sexuality in later life includes affection, tenderness and emotional closeness.
9.	Family disagreement automatically justifies stopping a relationship.
10.	Sudden sexual disinhibition may have medical causes that require evaluation.

4. Facilitator Debrief Guide

Correct classification:

- 1 → Myth
- 2 → Myth
- 3 → Reality
- 4 → Myth
- 5 → Reality
- 6 → Reality
- 7 → Reality
- 8 → Reality
- 9 → Myth
- 10 → Reality

Key discussion points

- Sexuality persists across the life course, although expression may change.
- Dementia does not automatically remove relational identity or the need for closeness.
- Safeguarding must be proportionate and not based solely on discomfort.
- Sudden behavioural change should prompt medical evaluation.

5. Reflection Questions (Plenary)

- Which statement generated the most debate?
- Which myth is most common in your professional context?
- How might these myths influence institutional practice?



Exercise 2

Consent and Capacity Reflection Tool

Duration: 30 minutes

Format: Small group case analysis

Materials needed: Case cards, Consent Reflection Tool worksheet, flipchart

1. Purpose of the Exercise

This activity aims to:

- Develop decision-specific consent assessment skills
- Strengthen understanding of fluctuating capacity
- Practise proportional safeguarding responses
- Integrate ethical reasoning into practical decision-making

The exercise supports the application of a structured, context-sensitive approach to consent.

2. Instructions for Participants

Participants work in small groups (3–5 members).

Each group receives one case scenario.

Using the Consent Reflection Tool, groups must:

1. Identify the type of behaviour (low-risk / moderate-risk / high-risk).
2. Assess whether capacity concerns are present.
3. Apply the four consent assessment questions.
4. Identify possible medical or contextual factors.
5. Propose a proportionate professional response.

Groups will present their conclusions briefly in plenary (3–5 minutes).

2. Case Scenarios

Case 1 – Emotional Relationship in Care Setting

Maria (79) has moderate Alzheimer's disease and lives in a residential care facility. She has formed a close relationship with Ion (82), another resident. They hold hands, sit together during meals, and occasionally kiss. Maria's daughter insists that the relationship must stop, arguing that her mother "does not understand what she is doing."

When staff speak with Maria, she says: “He makes me feel calm. I like being with him.”

She appears emotionally relaxed and does not show signs of distress.

Case 2 – Disinhibited Behaviour

Andrew (75) has been diagnosed with dementia. Over the past two weeks, he has begun making explicit sexual comments toward staff and once attempted to touch a caregiver inappropriately.

This behaviour is new. He appears impulsive and laughs when redirected.

Staff are concerned and unsure whether this reflects intentional misconduct or neurological change.

Case 3 – Gender Expression and Staff Discomfort

Alexander (76) is a resident with moderate dementia living in a care facility. Throughout their life, Alex occasionally expressed a non-conforming gender identity, although this was not openly discussed with family. Recently, Alexander has started asking to wear clothes traditionally associated with a different gender and has requested access to personal items such as makeup and jewellery.

Some staff feel uncomfortable and unsure how to respond, while others question whether this reflects Alex’s authentic identity or is a result of cognitive decline. Alex appears calm and becomes distressed when prevented from expressing these preferences.

Family members dismiss this behaviour as “confusion” and ask staff to discourage it. Staff are uncertain how to balance respect for identity, dignity and wellbeing with family expectations and professional boundaries.

How should staff respond in a way that respects identity, dignity and wellbeing?

4. Consent Reflection Tool (Participant Worksheet)

For your assigned case, discuss and complete

A. Behaviour Classification

- ☐ Low-risk (affection, holding hands, consensual closeness)
- ☐ Moderate-risk (unclear or fluctuating consent, unequal cognitive ability, behaviour causing possible discomfort, context not fully understood)
- ☐ High-risk (coercion, distress, power imbalance, genital contact without clarity)

Explain your reasoning:

B. Consent Assessment – Four Key Questions

1. Does the person understand the nature of the relationship or interaction?
2. Can the person appreciate potential consequences?
3. Can the person express a voluntary choice?
4. Is consent consistent and free from distress, coercion or fear?

C. Capacity Considerations

- Is capacity decision-specific in this situation?
- Could it fluctuate?
- Is formal assessment required?

D. Medical / Contextual Factors

E. Proportionate Professional Response

What is the least restrictive and ethically justified intervention?

5. Plenary Debrief (Facilitator Guide)

Case 1:

Assessment approach:

- Observe whether both individuals appear comfortable, relaxed and engaged.
- Look for signs of mutuality, consistency and absence of distress.
- Consider the stage of dementia and ability to understand the relationship.
- Avoid making assumptions based solely on family views.

Ethical reflection:

- Balance autonomy with safeguarding responsibilities.
- Avoid unnecessary restriction based on age or diagnosis.
- Recognise the importance of relational wellbeing.

Response

- Support the relationship if there is no indication of harm or coercion.
- Ensure privacy and dignity for both individuals.
- Communicate openly with the family, acknowledging their concerns
- Document observations and decisions clearly.

Case 2:

Assessment approach:

- Identify possible triggers (e.g., discomfort, confusion, overstimulation).
- Assess whether the behaviour is persistent or situational.
- Consider underlying medical causes (e.g., infection, medication effects).
- Observe whether others are experiencing distress or harm

Ethical reflection:

- Balance protection of others with respect for the individual.
- Avoid moral judgement and focus on understanding behaviour.
- Ensure responses are proportionate to the level of risk.

Response

- Use calm, non-confrontational communication.
- Redirect behaviour in a respectful way.
- Modify the environment if needed (e.g., privacy, reduced stimulation).
- Seek medical review if behaviour changes suddenly.
- Provide staff with guidance and support.

For case 3:

Assessment approach:

- Observe Alex's emotional state and consistency of preferences over time.
- Explore whether expressing gender identity brings comfort or reduces distress.
- Consider past identity, but prioritise present wellbeing and lived experience.
- Reflect on whether restrictions may cause harm or distress.

Ethical reflection:

- Balance autonomy and dignity with safeguarding responsibilities.
- Avoid assumptions based on personal values or discomfort.
- Recognise the risk of discrimination or invalidation of identity.

Response:

- Support Alex's choices where these do not cause harm.
- Ensure privacy and create a respectful environment.
- Provide staff with guidance and space to reflect on their own attitudes.
- Engage in sensitive communication with family, explaining the importance of dignity and wellbeing.



Exercise 3

Case Study Cards and 3-Step Action Plan Template

Duration: 35 minutes

Format: Small group work + plenary presentations

Materials needed: Case scenario sheet, 3-Step Action Plan worksheet, flipchart

1. Purpose of the Exercise

This activity aims to:

- Strengthen ethical decision-making skills in complex situations
- Apply autonomy, beneficence, non-maleficence and justice in practice
- Develop proportionate safeguarding responses
- Increase professional confidence in situations of uncertainty

2. Case Scenario

Maria (83) lives in a long-term care facility and has vascular dementia (moderate stage). She has formed an intimate relationship with Petru (85), who also lives in the same institution and presents mild-to-moderate cognitive impairment.

They spend significant time together, hold hands, and have been observed kissing. Staff report that both appear emotionally calm and comfortable in each other's presence.

However, their families disagree:

- Maria's daughter believes her mother "no longer understands relationships" and demands separation.
- Petru's son supports the relationship, stating that his father "deserves companionship."

The institution has no clear written policy regarding intimacy between residents.

Staff feel uncertain and concerned about legal and ethical consequences.

3. Instructions for Participants

Work in groups of 3–5 participants.

Using the 3-Step Action Plan Template, analyse the case and prepare a short presentation (5 minutes per group).

Focus on proportional, rights-based and ethically grounded responses.

4. 3-Step Action Plan Template (Participant Worksheet)

STEP 1 – Immediate Professional Response

Consider:

- Is there visible distress, coercion or imbalance of power?
- Are there signs of confusion or misunderstanding?
- Are reversible medical causes excluded?
- What level of risk is present (low / moderate / high)?

Write your assessment:

STEP 2 – Ethical Analysis

Tick the principles involved:

- ☐ Autonomy
- ☐ Beneficence
- ☐ Non-maleficence
- ☐ Justice

For each selected principle, briefly explain:

- Autonomy
- Beneficence
- Non-maleficence
- Justice (including ageism concerns)
- What is the core ethical tension in this case?

STEP 3 – Long-Term Strategy

Develop a proportionate response addressing:

- Capacity assessment (if needed)
- Documentation
- Family communication strategy
- Institutional policy clarification
- Privacy and dignity support
- Multidisciplinary consultation

Proposed structured plan:

5. Plenary Presentation

Each group presents:

1. Main ethical dilemma identified
2. Level of risk assessed
3. Proposed proportionate intervention

6. Facilitator Debrief Guide

Emphasise:

- A dementia diagnosis does not automatically remove relational autonomy.
- Family discomfort alone is not sufficient justification for restriction.
- Proportionate safeguarding requires structured assessment.
- Institutional uncertainty increases professional anxiety — policy development is part of ethical responsibility.
- The least restrictive option should always be considered first.



Thank you for supporting dignity, inclusion and sexual wellbeing in later life.

