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# Training Program for Presarcopenic Elderly Patients

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**Keywords:** elderly, sarcopenia, strength, periodisation

## Abstract

*Purpose:* Our aim was to test a training program designed to decrease/reverse the deleterious effects of sarcopenia: a generalized and progressive loss of muscle mass and muscle strength and function. *Materials and methods*: An intervention group of 9 participants and a control group of 7 participants took part in the pilot study, aged 65+, and former patients of the Szent Rókus Hospital. We measured grip strength, functional capacity with the Timed Up and Go test, and the presence and severity of sarcopenia with the SARC-F questionnaire. A two-month training period followed, with biweekly workouts. After which we reassessed and used a paired samples T-Test in JASP 0.16.4.0.. A focus group interview was used to collect participants' thoughts and feelings regarding the training period. *Results:* The intervention group showed a positive, nonsignificant change in their SARC-F scores (p=0.080). Their functional capacity improved significantly (p=0.033). Their muscle strength also improved significantly (p=0.006). The control group's SARC-F scores decreased, (p=0.423), performed the TUG test slower (p=0.114) and their grip strength decreased (p=0.477). We received unanimously positive answers at the focus group interview. *Conclusion:* The exercise program improved the functional capacity and muscle strength of the participants; thus, it would be worthwhile for physiotherapists working with older people to familiarize themselves with principles used here and to utilize a similar program.

## Introduction

### *Sarcopenia definition*

Sarcopenia was first defined in 1980 as an age-related loss of muscle mass, mobility and self-care, and in 2010 the European Working Group on Sarcopenia (EWGSOP) added the loss of muscle function to the definition (Cruz-Jentoft & Sayer, 2019). In 2019, the EWGSOP updated the definition again, which was finally defined as follows: "sarcopenia is a progressive and generalized muscle disorder involving an accelerated deterioration of muscle volume and muscle quality, with an increased incidence of adverse events such as falls, stumbling and mortality" (Cruz-Jentoft et al., 2019). Although the focus of this paper is on skeletal muscle, sarcopenia affects not only skeletal muscle but also the heart and diaphragm, as it is a systemic disease (Pár et al., 2021).

In 2016, it was given a separate ICD code: M62. 84, classified as a muscle disease (Anker et al., 2016).

Sarcopenia should be distinguished from other similar conditions. These are cachexia, malnutrition and malaise, which may also contribute to lower muscle mass and muscle quality. According to the newer EWGSOP2 definition, which focuses on muscle function, reduced muscle mass but preserved muscle function may be associated with malnutrition, and reduced muscle mass also associated with reduced function may be associated with sarcopenia. Frailty is an age-related condition with increased vulnerability due to reduced performance (Chen et al., 2014). As it is a whole-body chronic inflammatory condition, such as sarcopenia, sarcopenia can be treated as a building block of frailty syndrome (Cruz-Jentoft & Sayer, 2019).

### *Basic training theory concepts*

The essential building blocks of any effective resistance training program are specificity, progressive overload, and variation (Kraemer & Ratamess, 2004).

*Specificity*: training adaptations correspond to the stimuli that elicit them, so that the specific stimuli that are applied in a training program determine the adaptations that we can expect and obtain. At the same time, if non-specific stimuli are applied in training, the training may even be counterproductive, i.e. the qualities to be increased may either not be increased or, in worse cases, can even regress (Sale & MacDougall, 1981). These adaptations may be developments in muscle size, muscle strength, changes in energy systems (anaerobic-aerobic), improvements in range of motion (ROM) or changes in the speed of a movement’s execution. While it is conceivable that there is some carry-over between adaptations, i.e. general fitness

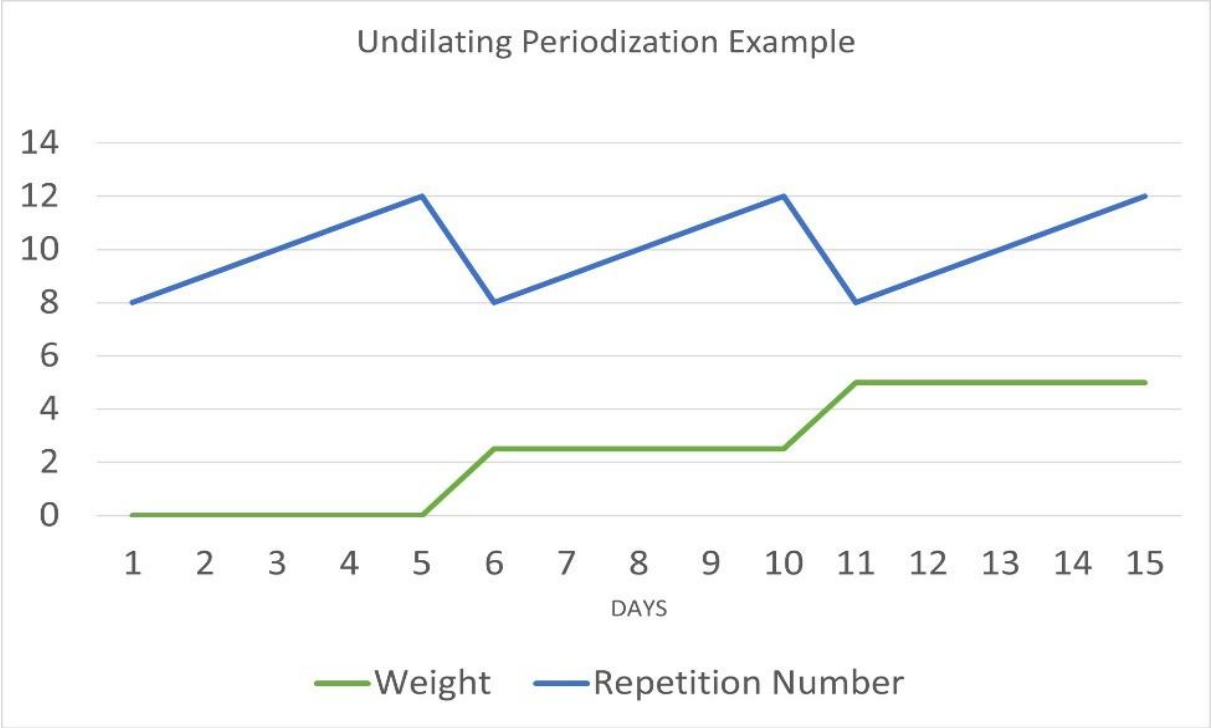
and performance can improve with almost any training modality, outstanding progression in specific domains can only be achieved with the right stimuli (American College of Sports Medicine [ACSM], 2009). However, specificity does not mean that only one domain can be developed, qualities considered to be in conflict with each other, such as maximal strength and endurance, cannot be developed simultaneously. In 1980, it was found that simultaneous strength and endurance development had a negative effect on strength development, reducing its effectiveness through the so-called "interference effect" (Hickson, 1980). Recent research, however, has shown that several domains can be developed simultaneously, as long as a well-designed and separated training program develops the two domains separately, in which case the principle of specificity is not compromised (Schumann et al., 2022).

*Progressive overload*: Progressive overload is a process whereby the body is subjected to progressively greater and greater loads. As the capacity of the individual increases, i.e. as tissues, organs and organ systems adapt to the stressors and stimuli they are exposed to (which in the case of this study, if we look only at the musculoskeletal system, is contraction against varying degrees of resistance, with a fixed number of sets and repetitions), an increasing amount of stimulus is required to reach the next capacity step. Put differently, if the body is only required to overcome the same amount of resistance continuously, then after a while that resistance becomes easy, but beyond a certain point no adaptation occurs. However, progressive overload can be enforced not only by increasing the resistance, i.e. the intensity, but also by increasing the number of repetitions for a given intensity, by determining the speed at which repetitions are performed, and by shortening the rest period between sets (ACSM, 2009).

*Variation*: variation in the context of exercise theory can be a variation of a particular exercise (bench press with a barbell vs. bench press with one-handed dumbbells) to achieve variations in ROM, relative and absolute intensity, or to focus on different muscles, and can also be a process of systematically changing the variables that build up the program (weight, number of repetitions, number of sets, rest time). As mentioned in the case of continuous overload, the body adapts to a certain type of stimulus, but it is not feasible to increase the weight alone each time, as this can quickly reach the individual's limit of development. By not changing the weight (or even decreasing it) but increasing the number of repetitions, a novel training stimulus can still be administered and the body can develop. Even without changing the weight or the number of repetitions, variation can be introduced by adding one more set to the previous number of sets. The proper use of variation is essential to trigger continuous adaptations during prolonged training periods. The second definition of variation in training design is periodization (ACSM, 2009; Stone et al., 2000).

*Periodization*: as mentioned in the section about variation; in order to maintain the adaptive response to training, changes can be made to the parameters that make up the training plan. Most often, the training volume (total work done, i.e. intensity x total number of repetitions (number of sets x number of repetitions); 100 kg 3x10 = 3000 kg), whether it is just the volume of a single training session, the volume of a micro- or macro-cycle, and the intensity are varied. There are several types of periodization, but since the study used "undulating periodization", we will only discuss it and the classical periodization. In classical periodization, also referred to in the literature as linear periodization, the initial high volume in the training program is accompanied by a lower intensity, and then as the volume decreases steadily, the intensity increases (Fleck, 1999). This type of periodization is very effective for the initial development of movement learning and for the initial development of core physical abilities that determine performance, such as endurance, strength-endurance and general strength (ACSM, 2009). This paper uses undulating periodization, i.e., fluctuating periodization. Undulating periodization, also referred to in the literature as non-linear periodization, uses more frequent changes in the composition of the load, which can occur on a daily, weekly or even bi-weekly basis. This means that the relationship between volume and intensity is constant for one day, one week or the desired duration, and changes occur thereafter (Evans, 2019). Taking the sit-to stand exercise as an example: in the first few sessions, only the patients' bodyweight was used as resistance, with the number of repetitions increasing every session. Then, after the first instance of external weight was introduced (in our case a 2,5 liter water bottle, weighing roughly 2,5 kilograms) the repetitions were decreased before a subsequent gradual increase. Again, as more external weight (a DIY sandbag weighing roughly 5 kilograms) was introduced, the repetitions were again lowered.

**1. Figure Undilating Periodization Example**




Research comparing exercise programs that use periodization and those that do not, has found that periodization is more effective in terms of the extent of adaptations induced. When comparing undulating periodization and classical periodization, undulating periodization has been shown to elicit better results, i.e. greater adaptation, than classical, linear periodization (Evans, 2019; Peterson et al., 2008; Stone et al., 2000). Moreover, given the limited resources at our disposal, a constant increase in weight (i.e. intensity) with a constant decrease in volume, would not have been possible. This adhering to undulating periodization is also a necessity.

## Materials and methods

### *Participants*

The initial survey was carried out at the St. Rokus Hospital, 2 Gyulai Pál Street, Budapest, and 16 people attended. A brief presentation was given on the nature of the pre-intervention surveys, followed by an introduction to the design, purpose and process of the research itself. A printed version of the patient information and consent form was then distributed. During recruitment and selection, any neurological condition requiring special treatment, i.e. recent brain event or disruption of temporal and spatial orientation, recent surgery, recent (within 6 weeks) hip/spinal prosthesis implantation, was considered as an

exclusion criterion. Cardiovascular diseases such as hypertension, anaemia and diabetes were not considered as exclusion criteria. After reading the document and giving their informed consent, surveys were conducted and then participants were divided into intervention and control groups according to their time schedule and motivation. After the allocation, an intervention group of 9 participants and a control group of 7 participants were formed. Of the 9 intervention group, 2 did not complete the training program and 1 did not show up to be tested again, thus after the two-month training period, 6 participants were retested. Out of the control group of 7, 2 persons disappeared from the register, 1 person could not be contacted for an appointment, 1 person did not respond to enquiries, and so 3 persons could be re-surveyed.

***Data Collection***

SARC-F questionnaire: the SARC-F Questionnaire, developed to assess the risk of sarcopenia, includes questions such as "How much difficulty do you have lifting and carrying a package weighing about five kilograms?" or "How many times have you fallen in the past year?", with three possible answers: no difficulty - 0 points, moderate difficulty - 1 point and great difficulty/unable to - 2 points (Vereckei et al., 2019). The cut-off point was 4 points or more. The mean score on the SARC-F questionnaire of the 16 subjects who appeared at the initial survey was 2.3 points, which was the same as the mean score of the 6 intervention group members who participated in the initial and subsequent measurements.

Timed up and Go walk test: in the TUG walk test, the participant sits on a chair, stands up on cue, walks 3 meters, turns around and sits back down again. Performance is timed in seconds, starting at the signal and stopping when the participant's back is again against the backrest. The participant is instructed to complete the walk as fast as he/she feels safe (Podsiadlo & Richardson, 1991). According to the European sarcopenia working group recommendation, 20 seconds is the threshold above which sarcopenia can be assumed to occur (Cruz-Jentoft & Sayer, 2019). The mean time for the 16 participants who attended the initial survey was 8.20 seconds, and the mean time of the participants who attended the sessions and were retested was 7.73 seconds.

Grip force measurement: manual grip force, is an effective measure of total body strength and indirectly, muscle mass (Wind et al., 2010). Measurements were performed using a CAMRY EH101 model. With the dominant side, elbow extended, and arm hanging next to the body, participants held the equipment in a pronation-supination mid-position. Two squeezes were performed and the higher value was recorded. The European sarcopenia working group gave 16kg as a range value, with results below this value suggesting sarcopenia (Cruz-Jentoft

& Sayer, 2019). The mean value of the 16 participants who attended the initial survey was 23.69kg, and the mean value of the participants who attended the sessions and were retested was 23.37kg.

Based on these results, the participants were considered presarcopenic.

***Description of Interventions***

Structure of the training program

A common denominator of intensity in exercise science is #RM, where RM stands for resistance maximum, and the number corresponds to the maximum number of repetitions performed. 1RM means one repetition maximum that is the highest amount of weight that is able to be performed once. Thus, 2-4-5 RMs show weights that can be lifted 2-4-5 times.

With respect to intensity, in previously untrained individuals, even very low intensities of 45-50% 1RM have been shown to induce muscle strength gains, but as individuals become stronger, higher intensities are required. It can be concluded that for beginners, an intensity of 50-60% is an optimal starting point, suitable to master the technique of performing the exercises and to get used to the specific form of training (ACSM, 2009). In terms of the number of sets of a given exercise, it can be said that training program using two, three, four, five and more than six sets are effective. Exercise programs using three sets were found to be more effective than programs using one or two sets (Schoenfeld & Grgic, 2018). For postmenopausal women, exercise programs using multiple sets were found to be more effective than those using one set. The former showed a strength increase of 3.5%-5.5%, while the latter showed a strength decrease of -1%-2% (Kemmler et al., 2004). In terms of weekly frequency, 2 to 3 training sessions per week is effective and necessary in the beginning to trigger adaptations, but in the later stages, 1 to 2 sessions may be sufficient to maintain the level. Although 3 training sessions per week show better results than 2 sessions per week, if the total volume is the same, similar levels of adaptations can be observed (ACSM, 2009).

An important consideration when sequencing exercises is that exercises that involve more joints, such as squats, push-ups, deadlifts, are more effective in eliciting adaptations in muscle strength, but also more fatiguing, Therefore, it is advisable to start with the most difficult, complex and fatiguing exercises, because if they are added later in the training session, the person will not be able to perform as well as at the beginning (Simão et al., 2007; Spreuwenberg et al., 2006).

Thus following the guidelines of the NSCA and the above mentioned rationales the training program had the following characteristics: Twice a week, 30-40 minutes in duration,

1-2 multi joint exercises per major muscle group with the most fatiguing at the beginning, 2-3 sets per exercise, adhering to progressive overload and at the correct intensity (65-85% 1RM, that is one repetition maximum, the highest weight a person can lift for one rep) (Fragala et al., 2019).

## RESULTS

Intervention group (N = 6)

**1. Table Results (Intervention group)**

**Paired Samples T-Test**

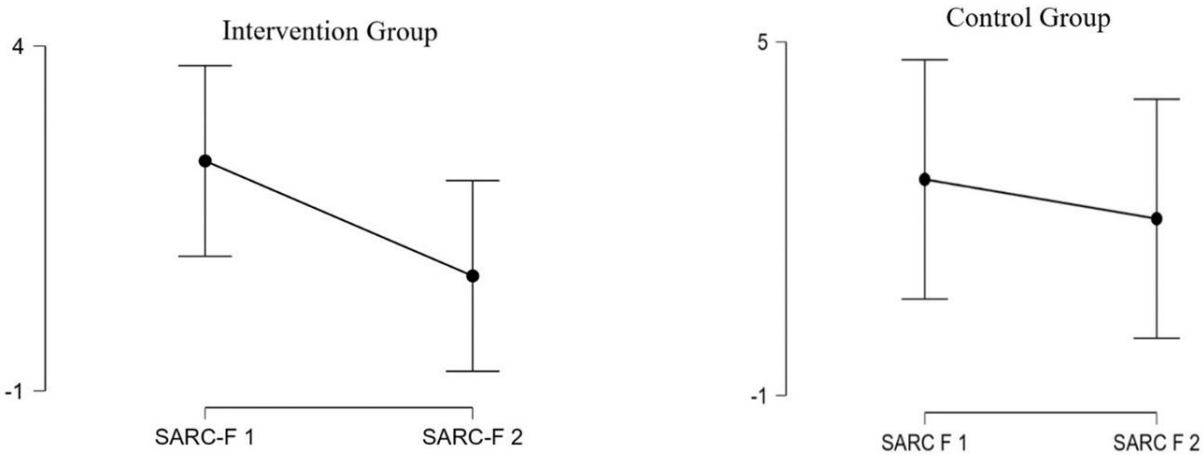
| Measure 1 | | Measure 2 | t | df | p | Cohen's d | SE Cohen's d |
|---|---|---|---|---|---|---|---|
| SARC-F 1 | - | SARC-F 2 | 2.193 | 5 | 0.080 | 0.895 | 0.514 |
| TUG 1 | - | TUG 2 | 2.915 | 5 | 0.033 | 1.190 | 0.283 |
| Grip 1 | - | Grip 2 | -4.563 | 5 | 0.006 | -1.863 | 0.218 |

**Descriptives**

| | N | Mean | SD | SE | Coefficient of variation |
|---|---|---|---|---|---|
| **SARC-F 1** | 6 | 2.333 | 2.066 | 0.843 | 0.885 |
| SARC-F 2 | 6 | 0.667 | 0.816 | 0.333 | 1.225 |
| TUG 1 | 6 | 7.727 | 1.989 | 0.812 | 0.257 |
| TUG 2 | 6 | 6.433 | 1.325 | 0.541 | 0.206 |
| Grip 1 | 6 | 23.367 | 3.638 | 1.485 | 0.156 |
| Grip 2 | 6 | 25.800 | 4.046 | 1.652 | 0.157 |

SARC-F questionnaire:

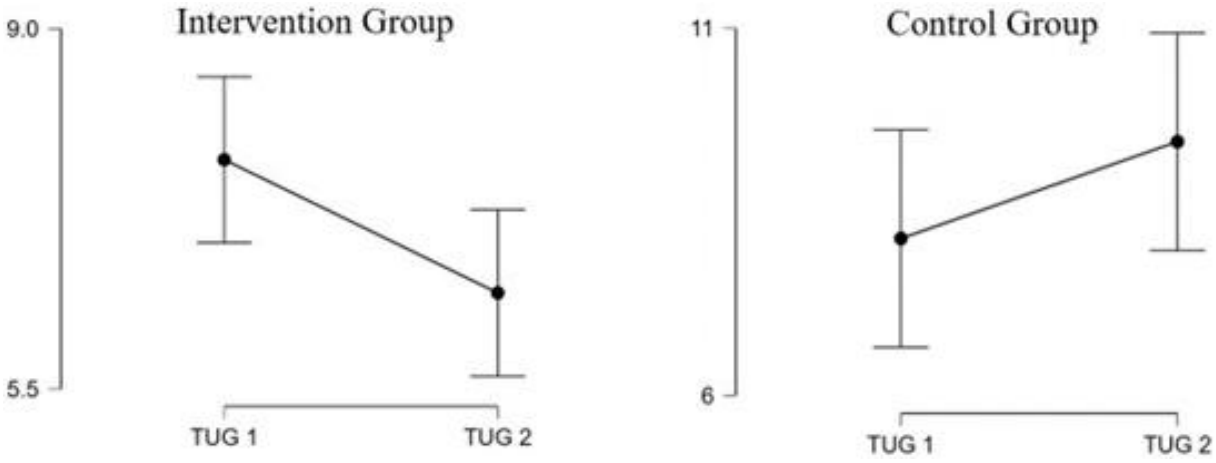
**2. Figure Sarcopenia questionnaire data, showing points achieved in the questionnaire**



The mean score on the SARC-F questionnaire for the 6 participants who took part in the intervention and were measured back was 2.333 (SD = 2.066) at baseline and 0.667 (SD = 0.816) at follow-up p = 0. 080.This p value does not show significance, but it does show a trend, and it is likely that the result would be significant with a higher number of participants.

Timed up and go test:

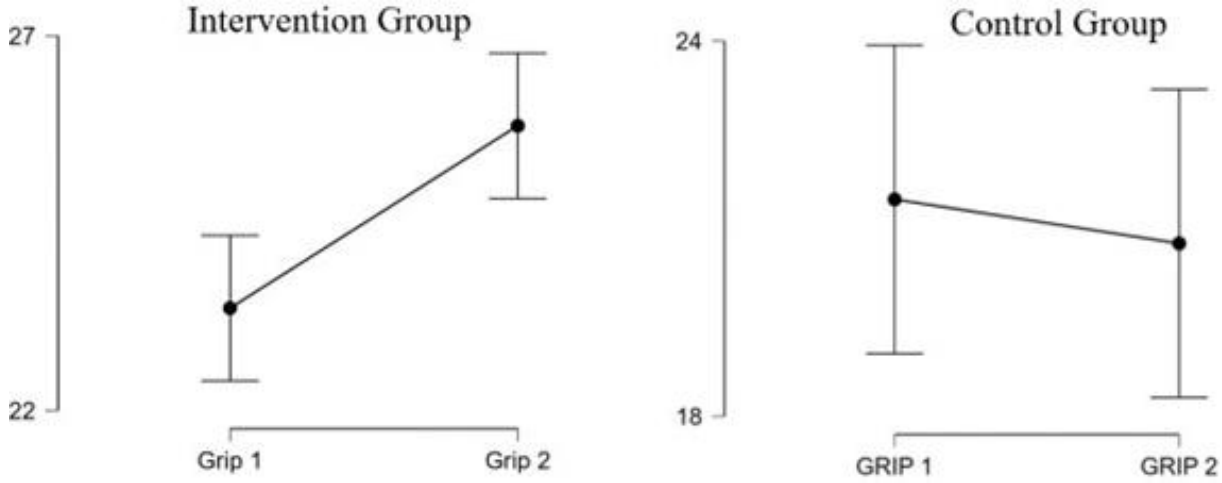
**3. Figure Timed Up and Go test data, in seconds**




The timed up and go test was completed in an average of 7.727 seconds (SD = 1.989) by the 6 intervention and 6.433 seconds (SD = 1.325) by the 6 intervention and retest participants, respectively, at baseline and retest, p = 0.033, indicating significance.

Grip strength:

**4. Figure Grip strength data, in kilograms**



On the manual clamp force measurement, the 6 intervention and back-measured participants averaged 23,367 (SD = 3,638) kilograms at baseline and 25,800 (SD = 4,046) kilograms at back-measurement, p = 0.006 indicating high significance.

Control group (N = 3):

**2. Table Result (Control group)**

**Paired Samples T-Test**

| Measure 1 | Measure 2 | t | df | p | Cohen's d | SE Cohen's d |
|---|---|---|---|---|---|---|
| SARC F 1 | - SARC F 2 | 1.000 | 2 | 0.423 | 0.577 | 0.000 |
| TUG 1 | - TUG 2 | -2.708 | 2 | 0.114 | -1.563 | 0.512 |
| GRIP 1 | - GRIP 2 | 0.869 | 2 | 0.477 | 0.502 | 0.092 |

**Descriptives**

| | N | Mean | SD | SE | Coefficient of variation |
|---|---|---|---|---|---|
| SARC F 1 | 3 | 2.667 | 0.577 | 0.333 | 0.217 |
| SARC F 2 | 3 | 2.000 | 1.732 | 1.000 | 0.866 |
| TUG 1 | 3 | 8.137 | 1.096 | 0.633 | 0.135 |
| TUG 2 | 3 | 9.453 | 0.335 | 0.193 | 0.035 |
| GRIP 1 | 3 | 21.467 | 1.901 | 1.097 | 0.089 |
| GRIP 2 | 3 | 20.763 | 3.253 | 1.878 | 0.157 |

SARC-F questionnaire:

The mean score on the SARC-F questionnaire for the 3 control participants was 2.667 (SD = 0.577) at baseline and 2.000 (SD = 1.732) at follow-up p = 0.423.

Timed up and go test:

The timed up and go test was completed by the 3 control participants in an average of 8.137 seconds (SD = 1.096) on the initial assessment and 9.453 (SD = 0.335) seconds on the retest, p = 0.114.

Grip strength:

On the manual grip strength measurement, the 3 control participants averaged 21.467 (SD = 1.901) kilograms at baseline, compared to 20.763 (SD = 3.253 kilograms, p = 0.477) at remeasurement.

**Discussion and conclusions**

The results suggest that resistance training is an effective antidote to sarcopenia and should be included in institutions' toolbox. Since the control group either stagnated or showed worse results in the follow-up retest, it can be assumed that the training programme triggered

positive adaptations. The increased muscle strength (and potential subsequent muscle mass gain) compensates for the muscle loss during sarcopenia and the imbalance in muscle protein synthesis and catabolism during anabolic resistance. The undesirable consequences of sarcopenia, such as reduced self-sufficiency and restricted living space, can also be overcome as the functional abilities of the participants in the training programme improved, as shown by the improvement in the timed up and go walking test. As there were no injuries during the 8-week training period, we can state that it is a safe way to improve strength in the geriatric population. It can be safely used in any environment.

It must be noted that very little, if any muscle tissue adaptations occurred during the two-month period, as these changes require more time. However, since the rate of muscle adaptation is similar to that of neurological changes (i.e. increases in strength performance); and those did occur, an assumption can be made that if the program would have continued, detectable muscle mass adaptations would have occurred.

Resistance training is an effective way to increase muscle strength and muscle mass, the two physical characteristics that are most impaired in the elderly with scrapie. Our aim in this research was to put together an effective training programme that requires few tools, is consistent with exercise theory principles and is effective in protecting against sarcopenia.

During the training programme, a group of 6 women aged 65 and over trained twice a week for 30-40 minutes for 8 weeks. Before and after the training period, their muscular strength was assessed using a manual grip strength test, their functional status using the timed up and go walking test, and the extent of any sarcopenia using the SARC-F questionnaire. The same tests were also performed on a control group. A pooled samples T-test was performed on the data and analysed using JASP 0.16.4.0. A significant difference was $p<0.05$.

In conclusion, the 8-week training period was effective in increasing participants' muscle strength, muscle mass and functional capacity: they increased their grip strength, scored better on the SARC-F test and completed the walking test in less time.

*Ethical approval*: This study was conducted in accordance with the 2008 revision of the 1975 Declaration of Helsinki.

*Authors' Contribution:* MR performed the literature search and analysis, compiled the testing methods, wrote the training program and supervised every training session, carried out the statistical analysis conducted the initial and follow-up tests with the help of ML and LP. GD provided consultation throughout the study period.

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# Behavioural Techniques in Work with Seniors

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## Abstract

This article explores the application of storytelling as a cognitive-behavioural therapy (CBT) tool for older adults, emphasizing its effectiveness in illustrating the role of avoidance and exposure in anxiety recovery. Integrating a complete theoretical introduction and narrative case example with conceptual support from psychoeducational materials, the article demonstrates how storytelling facilitates therapeutic insight and engagement, particularly in older populations.

## Introduction

Older adults frequently encounter life events that threaten their autonomy, security, or sense of identity such as bereavement, falls, serious medical diagnoses, or relocation to assisted living. These events, while often unavoidable, can precipitate significant psychological challenges. In clinical practice, older clients frequently attribute their emotional distress or loss of functioning to such life events. However, Cognitive-Behavioural Therapy (CBT) offers a different lens: psychological problems are not caused directly by the events themselves, but by how individuals respond to them (Blenkiron, 2005; Otto, 2000).

This manuscript explores the integration of storytelling as a psychoeducational method in CBT with older adults. Storytelling provides a powerful, developmentally attuned medium for conveying core CBT principles such as avoidance, exposure, and the anxiety maintenance cycle. Older adults often benefit from therapeutic methods that are structured, emotionally resonant, and grounded in meaning-making - characteristics inherent in narrative approaches (Laidlaw & Chellingsworth, 2016; Westerhof & Bohlmeijer, 2012).

Narrative-based interventions such as narrative group therapy have been shown to improve aging perceptions and reduce death anxiety in older adults, further supporting the value of storytelling in promoting psychological well-being in late life (Nozari et al., 2019). These approaches align with the cognitive and emotional tasks of aging - such as integrating past experiences, finding meaning in adversity, and maintaining a sense of agency. By embedding CBT mechanisms within a structured story, clinicians can offer older clients a therapeutic tool that is not only theoretically sound, but also experientially accessible. This paper introduces such a narrative model and explores its utility in helping older adults understand and modify maladaptive avoidance patterns.

## Methodology

This study employed a narrative integration method grounded in clinical psychoeducation and informed by principles of cognitive–behavioural therapy (CBT). The therapeutic educational story - The Story of Two Worlds - was originally developed as a teaching tool for students of social work and psychology, with the aim of illustrating the mechanisms through which avoidance maintains psychological distress and demonstrating how gradual exposure facilitates recovery. It was subsequently applied in clinical practice as part of client education, conceptualised as a composite of multiple clinical cases observed in CBT work

with older adults, and iteratively refined through therapeutic use, collegial feedback, and observed client responses.

The development process involved integrating theoretical concepts from CBT psychoeducation (e.g., the anxiety cycle, avoidance and exposure, normalization) into a structured narrative format designed for use in geriatric clinical settings. The story aligns with principles of narrative therapy, particularly externalization and re-authoring, by enabling clients to explore maladaptive patterns from a safe, symbolic distance (Laidlaw & Chellingsworth, 2016; Dulwich Centre Foundation, 2023).

The narrative was used in clinical sessions as a psychoeducational tool to facilitate insight and promote client engagement, especially among older adults who may prefer concrete, relatable examples over abstract psychological models. The structure allows therapists to pause at key moments to engage clients in discussion, reflection, or cognitive restructuring exercises, anchoring core CBT interventions within a meaningful narrative context.

The approach reflects a practice-based methodology - combining narrative therapy insights with CBT psychoeducation - tailored for older adults in clinical care.

## Results

### *Theoretical Background*

In the initial stages of CBT, psychoeducation plays a crucial role. Many clients - particularly older adults - enter therapy believing their psychological difficulties are direct consequences of negative life events. CBT reframes this: it is not the event, but the response, that determines whether a problem develops and persists (Blenkiron, 2005; Otto et al., 2000).

To convey this principle, a narrative-based technique has been developed. It vividly illustrates the fundamental mechanisms by which psychological problems such as anxiety, avoidance, and loss of functioning are maintained. This is particularly relevant in work with older adults, who often face challenges related to competence, social support, or autonomy (Secker, Kazantzis, & Pachana, 2004).

The technique utilizes parallel stories - two individuals in identical circumstances whose differing responses following a traumatic event lead to markedly different long-term outcomes. The story illustrates the basic model of the anxiety cycle:

Trigger → Anxiety → Avoidance → Immediate Relief → Long-term Worsening (Erickson et al., 2022).

Avoidance, while initially experienced as adaptive, prevents emotional recovery. Older adults frequently demonstrate this pattern after loss, medical setbacks, or trauma: withdrawing from meaningful activities to avoid discomfort, thus reinforcing anxiety. The narrative method shows that "the discomfort one allows oneself to experience is the path toward regaining function" (Davis et al., 2021).

A key element is normalisation - demonstrating that even supportive behaviours (e.g., offering to help) may unintentionally reinforce avoidance. The aim is not to label such behaviour as "wrong," but to clarify its long-term consequences:

"Taking the bus is not the problem—unless it becomes an escape from the steering wheel."

Thus, the goal is to support older clients in understanding that change does not mean returning to the past, but choosing to stop reinforcing fear. Discomfort, as in physical rehabilitation, is often a prerequisite for long-term improvement (Otto et al., 2000; Buur et al., 2025).

***Clinical Illustration: Story of Two Worlds***

In two parallel universes lived two men who led completely identical lives. They had the same primary family, education, job, secondary family - everything. The two universes were entirely identical. One day, due to a moment of inattention, both men caused a traffic accident in which they nearly hit a cyclist. Fortunately, both managed to swerve at the last moment; the car overturned and landed off the road. Miraculously, no one was injured, although the car was completely wrecked. After a hospital check-up, they were discharged with the remark that all their guardian angels must have been watching over them.

Upon returning home, the man kept thinking about what had happened - how he could have made such a mistake. Among many other thoughts, he wondered how he would get to work the next day, since the car was destroyed. He thought of asking his wife if he could borrow her car. But just imagining sitting behind the wheel made his stomach tighten, his hands tremble, and he felt intense anxiety. Despite this, he asked his wife, “Could I borrow your car tomorrow?”

At this moment, the two parallel worlds split.

In the first universe, his wife replied, “Of course, feel free to take it.” He responded, “I’m not sure I’ll manage it tomorrow… when I imagine myself driving, I start shaking, my stomach hurts, and I feel really scared.” His wife replied, “Well, that’s perfectly normal. You had an accident today - it’s only natural to feel afraid.”

The whole evening, he felt anxious, couldn't eat properly, slept poorly, and woke up tense. He barely managed to eat breakfast. When he got into the car, the anxiety surged - he trembled, drove very cautiously, arrived at work drenched in sweat, and couldn't concentrate. He worried all day about how he would manage the drive home. The return journey was also difficult, especially as he passed the site of the accident.

That evening, he told his wife, "Today was awful. I thought I wouldn't make it - it was terribly hard." She replied, "That's completely understandable. You had an accident yesterday - of course you're afraid."

The next day, it was slightly better. And better the day after that. After a few weeks, he decided to buy a new car. Driving the new vehicle became more enjoyable, and gradually, the fear faded. After about six months, his driving resembled how it was before the accident - not quite the same, but almost identical.

In the second universe, when he asked if he could borrow her car, his wife replied, "Unfortunately not tomorrow - I need it. But I can drive you to work." He said, "That would be great. When I thought about driving tomorrow, I started shaking, my stomach hurt, and I was really scared." She responded, "That's perfectly normal. You had an accident today - it's only natural to feel afraid."

Because he didn't have to drive, he calmed down, ate well, and slept fine. In the morning, he had breakfast and was driven to work by his wife. In the afternoon, she rang to say she could also pick him up - he happily accepted. This routine continued for several days.

After a few days, his wife said, "I can't take you tomorrow - but you can borrow my car." He froze - his hands trembled, stomach tightened, and heart raced. "I'm shaking… I don't think I can do it." She replied, "That's perfectly normal - it's been less than a week. Don't stress - you can take the bus. It stops right near your workplace." He said, "That's a great idea - and cheaper than driving too."

So he began taking the bus. As the weather warmed up, he said, "I might start cycling. It's more eco-friendly, and I'll get some exercise." His wife replied, "That's a great idea. Why stress yourself with driving?"

And so it continued - for several years.

Three years later, the parallel worlds met again. Both men lost their jobs. As they were skilled and experienced, they quickly found new roles - but the new jobs required driving.

For the first man, that wasn't a problem.

The second man, however, sought help from a therapist. He said, "I need help with driving. I feel an overwhelming fear when I even think about getting into a car."

The therapist asked, “Do you have any idea what might be causing this?” He replied, “Oh yes. I know exactly. I had a serious accident three years ago. Miraculously, no one was hurt - but since then, I haven’t been able to drive. It’s because of that accident.”

### *Psychoeducational Foundations from CBT*

The accompanying psychoeducational material reinforces the message that responses, not events, maintain anxiety (Blenkiron, 2005; Otto et al., 2000). Avoidance offers immediate relief but reinforces fear. Exposure entails short-term discomfort but enables long-term recovery. This is especially important in geriatric therapy, where fear-driven withdrawal can rapidly lead to loss of function and autonomy (Secker et al., 2004).

An additional metaphor likens recovery to rehabilitating a broken arm. Resting feels good, but without painful movement, function never returns. As the teaching story notes: "Sometimes things must hurt more before they can hurt less."

## Discussion

For therapists working with older adults, storytelling offers a powerful educational and therapeutic method that resonates with developmental, cultural, and cognitive aspects of aging. The story presented in this paper - universal in its structure - mirrors many challenges faced in later life, such as the aftermath of traumatic events, medical setbacks, or functional decline. In clinical settings, these often present as fear-driven avoidance: older adults may withdraw from walking after a fall, resist social contact following bereavement, or avoid medical care after a distressing diagnosis. These patterns, if left unaddressed, can accelerate functional loss and reduce quality of life.

Storytelling provides a developmentally appropriate way to illustrate how these patterns are maintained and how change becomes possible. Older adults often hold rich autobiographical memories and benefit from interventions that engage identity, life meaning, and narrative coherence (Westerhof & Bohlmeijer, 2012). Therapeutic stories support this process by enabling symbolic reflection on internal experiences, externalizing problems, and allowing clients to imagine alternative responses.

Moreover, research suggests that many older clients may struggle with abstract models or unfamiliar therapeutic language. Storytelling provides a cognitively accessible bridge to key CBT principles, such as the anxiety maintenance cycle, avoidance, and exposure (Laidlaw & Chellingsworth, 2016). Narratives offer emotional immediacy, normalize discomfort, and model adaptive coping without pathologizing distress. This is especially relevant in late life,

where emotional resilience often coexists with complex grief, trauma histories, or chronic illness.

As demonstrated in the narrative method described here, storytelling can also support re-authoring processes - enabling clients to view their responses not as fixed, but as open to change. The narrative context allows therapists to guide clients toward insight and motivation for behavioural change, while remaining grounded in lived experience and cultural understanding. This makes storytelling not only a clinical tool but also a means of enhancing agency and psychological flexibility in older adults.

## Conclusion

Storytelling constitutes a clinically valuable and conceptually robust adjunct to Cognitive Behavioural Therapy (CBT) when working with older adults. As illustrated by the narrative method presented in this paper, therapeutic stories can effectively demonstrate how psychological distress is maintained through avoidance behaviours, while also conveying the mechanisms by which gradual exposure facilitates functional and emotional recovery. This approach is particularly pertinent in gerontological contexts, where older individuals frequently experience fear-related withdrawal following life events such as bereavement, illness, or loss of autonomy.

By embedding CBT principles within a developmentally appropriate and emotionally resonant narrative framework, practitioners may enhance psychoeducational engagement and improve the accessibility of cognitive restructuring. Narrative methods align with the cognitive and psychosocial characteristics of later life, supporting reflective integration, identity continuity, and emotional processing. Furthermore, storytelling fosters therapeutic insight and facilitates client agency through the re-authoring of maladaptive patterns. When used alongside standard CBT interventions, narrative approaches offer a meaningful and culturally attuned means of empowering older adults to participate actively in their therapeutic process.

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# New Perspective in Elderly Care

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## Abstract

The aging of European societies requires new perspectives on old adults care that move beyond traditional medical approaches. This paper examines multidimensional frameworks supporting the well-being of older adults, based on comparative demographic data from Poland, Hungary, and the European Union. The analysis highlights both similarities and differences in life expectancy, health, and living conditions among people aged 65 and over. Empirical studies demonstrate that physical, psychological, social, and environmental dimensions of well-being are strongly interrelated. Psychological resources such as optimism, resilience, and positive beliefs about aging have measurable biological and behavioral effects. Equally vital are social participation and age-friendly environments that promote autonomy and dignity.

The paper as a conceptual paper argues for a holistic, interdisciplinary, and participatory model of care in late adulthood that integrates medical, psychological, and social perspectives. Such an approach offers a sustainable path toward healthy, meaningful, and dignified aging in contemporary European societies.

## Introduction

The aging of societies across the continent is a widespread phenomenon affecting almost all European countries. Data from Eurostat and the European Commission indicate that, as of January 1, 2024, the share of the population aged 65 and over in the European Union was 21.6% of the total population (Eurostat, 2025). This means that more than one-fifth of the EU population belongs to the senior age group.

The health condition and well-being of older adults are not solely the result of individual choices. Their formation also depends on systemic factors — including health policy, the availability of care services, housing policy, transportation systems, and the labor market, as well as initiatives aimed at social integration and the prevention of exclusion.

This paper examines the multidimensional concept of well-being among older adults and identifies factors that may support or threaten its maintenance. In the context of an aging society, the issue of quality of life in later adulthood is gaining increasing importance — not only from an individual perspective but also as a challenge for social policy, the healthcare system, and local communities. The purpose of this paper is to present the significance of the multidimensional concept of well-being among older adults and to identify factors that may either support or threaten its maintenance. To this end, the literature review was conducted. Furthermore, the article introduces an original model, called 4A, for studying changes and interventions among older adults, their families, and caregivers.

To illustrate that the quality of old age is not solely an outcome of individual choices, a comparative analysis was conducted between two countries—Poland and Hungary—focusing on the number of people under the age of 66, median age, life expectancy, and the living conditions of individuals aged 65 and over.

## A Brief Comparison of Poland and Hungary in the Context of the European Union Key Indicators and Trends

The demographic structures of Poland and Hungary show both similarities and distinctive national characteristics, which have important policy implications. Both Poland and Hungary are aging at a pace comparable to the EU average, yet life expectancy in both countries remains below the EU average, particularly in Hungary.

In Poland, the share of people aged 65+ at the end of 2024 was close to 20.5% of the total population, while in Hungary it stood at approximately 20.7% (Eurostat, 2024). Both populations are aging at a rate comparable to the European average. However, specific details

(e.g., the rate of change in median age, migration patterns, and differences in life expectancy) give the demographic challenges in each country a distinct national character (Trading Economics, 2025).

In Poland, this share was slightly lower - around 20.5% of the population at the end of 2024 -while in Hungary it reached approximately 20.7% (Trading Economics, 2025). These differences are relatively small, which allows both countries to be considered representative of the Central European model of demographic aging. Both Poland and Hungary remain close to the EU average; however, in both cases, a clear upward trend in the proportion of people aged 65+ is visible over the decade 2014–2024 (European Commission, 2024).

Indicators of median age also confirm the advancing aging of population structures. In 2024, the median age in the European Union reached 44.7 years, an increase of more than two years compared with 2014 (European Commission, 2024). In Poland, a significant rise in median age has been observed, comparable to the pace recorded in the Czech Republic and Slovakia. This indicates that the country's demographic structure is rapidly shifting toward an aging population. A similar, though slightly slower, trend can be seen in Hungary (European Commission, 2024).

Life expectancy indicators show that both Poland and Hungary remain below the EU average. In 2023, life expectancy at birth in the EU averaged 81.4 years (European Commission, 2024). In Poland, it stood at approximately 78.5 years (World Bank, 2024), while in Hungary it was around 76.8 years (OECD, 2023). This means that although the share of people aged 65+ is similar, citizens of Poland and Hungary live on average shorter lives than those in Western Europe, with important implications for the planning of health and social care policies for older adults (European Commission, 2024; OECD, 2023).

To highlight the most relevant indicators and facilitate comparison with the European Union average, Table 1 consolidates key demographic data for 2024 (Eurostat, 2024; Trading Economics, 2025; European Commission, 2024; OECD, 2023).

**Table 1: Key Demographic Indicators for Poland, Hungary, and the European Union in 2024**

| Indicator | Poland | Hungary | EU Average |
|---|---|---|---|
| **Population aged 65+ (%)** | 20.5 | 20.7 | 20.6 |
| **Median age (years)** | 43.9 | 43.1 | 44.7 |
| **Life expectancy at birth (years)** | 78.5 | 76.8 | 81.4 |

Differences in demographic trends are also shaped by socio-economic and health-related factors. First, migration plays a significant role in shaping age structures. Between 2010 and 2020, Poland experienced substantial migration flows both labor emigration and, after 2014, increasing immigration which contributed to a reduction in the working-age population and accelerated the aging process. Second, the population's health status remains an important differentiating factor. According to the OECD (2023), Hungary faces higher rates of chronic diseases and lower life expectancy than the EU average. Poland, despite slightly better indicators, also struggles with public health challenges typical of the region (e.g., high mortality due to cardiovascular diseases).

Both Poland and Hungary are aging at a rate close to the EU average but are characterized by poorer health indicators than the EU as a whole. These differences highlight the need for differentiated policy interventions in the areas of health, social care, and active aging, taking into account regional contexts.

## Late Adulthood as a Stage in Life Span

The process of aging represents a complex and multidimensional phenomenon encompassing biological, psychological, and social changes that occur continuously and dynamically throughout the entire life cycle (Baltes & Baltes, 1990; Rowe & Kahn, 1997). In gerontological literature, three major stages of this process are distinguished: early old age (60–74 years), late old age (75–84 years), and advanced old age (85+), each characterized by a distinct range of needs and developmental tasks (WHO, 2015). During early old age, individuals typically face the need to adapt to new social roles, redefine their identity after retirement, and maintain physical and cognitive activity (Baltes & Smith, 2003). Late old age involves striving to preserve autonomy, accept health limitations, and strengthen psychological resilience in the face of loss and change (Ryff & Singer, 1998). In advanced old age, social relationships, interdisciplinary care, and the preservation of dignity and meaning in life gain particular importance (Tornstam, 2005).

According to the World Health Organization (2015), *healthy aging* refers to maintaining functional abilities that enable individuals to do what they value in life.

**Multidimensional definition of well-being in late adulthood**

The analysis of older adults' well-being is grounded in Urie Bronfenbrenner's ecological model of human development (1979), which posits that an individual's functioning results from the dynamic interaction between the person and their environment. From this perspective, an individual's well-being is shaped by reciprocal influences across different levels of social systems — from the immediate environment (family, neighborhood, interpersonal relationships) to broader institutional and cultural structures (social policy, cultural norms, health care systems). In that understanding, well-being concerns four dimensions and areas of functioning: the body, relationships, achievements, meaning, imagination, and intuition. Thus, well-being in late adulthood is not solely the outcome of individual traits or choices but largely depends on the quality of interactions with the social and physical environment. For example, limited access to public transport (a physical constraint) — for instance, when travelling to a library that hosts senior meetings — may lead to social isolation (by restricting social contacts) and to reduced opportunities for achievement (lack of new stimuli and tasks offered by the library). Consequently, this can lower psychological and physical well-being across other dimensions.

When considered this way, areas of support or risk form an ecological model (analogous to Bronfenbrenner's model, 1979) and emphasize the multi-level nature of well-being, which encompasses both the individual level (e.g., health, competencies, motivation) and the environmental level (e.g., infrastructure, social norms, public policies). Within this framework, the psychological dimension of well-being acquires particular importance as a buffer against stress and developmental losses. The research shows that older adults who maintain positive social relationships, a sense of autonomy, and a sense of meaning in life report higher life satisfaction and better mental health (Diener, Lucas, & Oishi, 2009; Ryff & Keyes, 1995). Scholars also note that a high level in one dimension does not compensate for serious deficits in others — a holistic approach is necessary for a reliable assessment of functioning and for planning therapeutic or counselling interventions.

## Framework of Well-Being Dimensions in Older Adults

In the framework proposed in this article, following the World Health Organization (WHO, 2015, 2021), well-being in older adults is understood as a complex construct encompassing three interrelated dimensions:

- Physical well-being, related to somatic health, functional fitness, and the ability to live independently;
- Psychological well-being, including emotional balance, a sense of meaning in life, autonomy, and self-esteem, social relationships;
- Environmental well-being refers to living conditions, access to social support, health care, infrastructure, and a culture that promotes dignified ageing.

## Interrelations and Synergy Between Domains of Well-Being

In exploring the transformations associated with aging and the concept of well-being, a comprehensive literature review was undertaken. The literature was identified and selected according to key words: well - being and aging. The source of articles were in the databases: Google and Medfile.

The analysis focused on understanding how changes in old age relate to the influence and activity of individuals experiencing illness, as well as the role played by their surrounding social environment.

### 1. The Physical Domain of well-being

Epel et al. (2004) demonstrated that chronic psychological stress leads to the shortening of telomeres the terminal segments of chromosomes responsible for protecting DNA integrity. Women caring for chronically ill children were found to have shorter telomeres and lower telomerase activity, which biologically corresponded to an “accelerated cellular age” of approximately 10 years. Shorter telomeres are associated with an increased risk of heart disease, diabetes, osteoporosis, and cancer.

According to Fredrickson’s (2000) *broaden-and-build theory*, positive emotions expand the repertoire of adaptive behaviors and foster the development of psychological and physical resources, thereby enhancing resilience to stress and disease. Positive emotions contribute to lower cortisol levels, reduced inflammation, and improved immune functioning (Steptoe et al., 2009). As noted by Taylor et al. (2000), a positive psychological attitude is associated with greater physical activity, healthier eating habits, and fewer risky behaviors. Individuals with

higher levels of psychological well-being are more likely to engage in preventive, educational, and activating activities, which promote both longevity and improved quality of life.

According to the study in United Kingdom (McPhee, and all., 2016) the evidence shows that regular physical activity is safe for healthy and for frail older people and the risks of developing major cardiovascular and metabolic diseases, obesity, falls, cognitive impairments, osteoporosis and muscular weakness are decreased by regularly completing activities ranging from low intensity walking through to more vigorous sports and resistance exercises.

## 2. The psychological domain of well-being

The process of aging is often accompanied by greater emotional variability as well as enhanced ability to cope with negative affect, particularly when older adults maintain strong social ties (Carstensen et al., 2011). However, the loss of loved ones or deteriorating health may increase feelings of loneliness and sadness. Depression constitutes one of the key risk factors for accelerated aging. Kiecolt-Glaser et al. (2003) found that depression is associated with elevated inflammatory markers (CRP, IL-6), impaired immunity, and accelerated biological aging.

Social relationships are among the strongest predictors of both longevity and quality of life. Holt-Lunstad et al. (2010), in a meta-analysis including over 300,000 participants, demonstrated that strong social bonds reduce the risk of mortality by as much as 50%. Conversely, loneliness and social isolation increase the likelihood of depression, cardiovascular disease, weakened immunity, and premature death.

Levy et al. (2002) showed that positive beliefs about ageing can extend life expectancy by an average of 7.5 years. Similarly, Hill and Turiano (2014) found that a strong sense of purpose in life reduces mortality risk, regardless of age or health status.

Importantly, most studies indicate the existence of interactions and both positive and negative synergies among the different domains of well-being. For instance, research conducted by Hertzog and colleagues demonstrates that maintaining mental and physical activity, as well as a healthy lifestyle, can slow the processes of cognitive ageing (Hertzog et al., 2008). Other studies show that psychological factors such as a sense of meaning and social engagement support neuroplasticity and cognitive processes in later life (Wilson et al., 2007).

Research by Ryff and Singer (1998) reveals that individuals with a strong sense of purpose and autonomy exhibit better physical health, lower cortisol levels, and higher immune resilience. Similarly, Wilson et al. (2007) report that a strong sense of purpose serves as a protective factor against the development of Alzheimer’s disease.

Windle (2011) emphasizes that psychological resilience is one of the key predictors of quality of life and healthy aging. Individuals with high resilience are more likely to engage in social and physical activities, which helps prevent isolation. Likewise, optimism and a positive self-concept are associated with a lower risk of cardiovascular disease (Kubzansky et al., 2001) and a higher likelihood of adopting health-promoting behaviors (Taylor et al., 2000).

Optimism, a sense of purpose, and psychological resilience all contribute to maintaining health and independence. Individuals with a positive attributional style tend to perceive negative events as temporary and external, which enhances their adaptability and readiness to engage in health-promoting behaviors (Taylor et al., 2000). Moreover, optimists are more likely to take care of their health, participate in social activities, and report greater life satisfaction (Kubzansky et al., 2001).

Research consistently demonstrates that the well-being of older adults is multidimensional and dynamic. Physical, psychological, social, and environmental factors interact continuously, and their balance determines both quality of life and the pace of ageing. Positive attitudes, psychological resilience, social support networks, and healthy behaviors create an *upward spiral* that reinforces well-being, whereas stress, isolation, and mental disorders may trigger a *downward spiral of* declining health and functioning.

Psychological well-being also benefits from a *positive feedback mechanism* — positive emotions generate positive experiences, which in turn strengthen one's sense of efficacy, competence, and meaning in life. As Fredrickson (2000) notes, positive emotions broaden one's repertoire of thought and action, fostering the development of long-term psychological and physical resources. As noted by Taylor et al. (2000), a positive psychological attitude is associated with higher levels of physical activity, healthier dietary habits, and fewer risky behaviors. Individuals with greater psychological well-being are also more likely to engage in preventive health behaviors, which contribute to both longevity and improved quality of life. It can therefore be argued that psychological factors—such as optimism, a sense of purpose, and meaningful relationships—not only enhance subjective well-being but also produce measurable biological effects. A concise summary of the literature review is presented in Table 2.

**Table 2: Dimensions of Well-Being Among Older Adults and Key Findings from Empirical Studies**

| Dimension of Well-Being | Key Findings from Empirical Studies | Authors (Year) | Practical Implications / Interpretation |
|---|---|---|---|
| **Physical (somatic and cognitive)** | With age, a slowdown in information processing and a decline in memory and executive functions are observed, influenced by biological and environmental factors. | Salthouse (2010) | Physical and cognitive activity may delay brain ageing. |
| | Intellectual and social engagement supports the maintenance of cognitive abilities and neuroplasticity. | Hertzog et al. (2008); Wilson et al. (2007) | Maintaining mental and social involvement supports brain health. |
| **Psychological (emotions, stress, beliefs, relationships, bonds)** | Depression increases levels of inflammatory markers (CRP, IL-6) and accelerates biological ageing. | Kiecolt-Glaser et al. (2003); Byers & Yaffe (2011) | Treating depression and promoting mental health are crucial for slowing ageing processes. |
| | Chronic psychological stress shortens telomeres and reduces telomerase activity, accelerating cellular ageing. | Epel et al. (2004) | Emotional support and stress reduction are essential for health prevention in old age. |
| | Positive beliefs about ageing extend life expectancy by an average of 7.5 years; positive emotions reduce cortisol levels and inflammation. | Levy et al. (2002); Steptoe et al. (2009); Fredrickson (2000) | Promoting positive perceptions of ageing supports longevity and mental health. |
| | A strong sense of purpose and autonomy is associated with lower stress levels and a reduced risk of neurodegenerative diseases. | Ryff & Singer (1998); Hill & Turiano (2014); Wilson et al. (2007) | Strengthening life purpose and engagement enhances psychological and cognitive resilience. |
| | Psychological resilience and optimism correlate with a lower risk of heart disease and a higher quality of life. | Windle (2011); Kubzansky et al. (2001); Taylor et al. (2000); Rossi et al. (2007) | Programs supporting resilience and healthy lifestyles enhance well-being in later adulthood. |
| | Strong social ties reduce mortality risk by 50%; isolation increases the risk of depression, heart disease, and premature death. | Holt-Lunstad et al. (2010) | Social support and integration of older adults are key to healthy ageing. |
| | Maintaining social connections improves mental and cognitive health and prevents loneliness. | Carstensen et al. (2011) | Intergenerational and community engagement programs are essential for older adults' well-being. |
| **Environmental** | Age-friendly environments with accessible infrastructure, transport, housing, and healthcare promote independence and quality of life. source: author's own work | WHO (2015); Wahl & Lang (2021) | Urban planning and public policy should promote age-friendly environments. |

Research confirms that stimulating activity, promoting engagement, and encouraging active participation lead to: an increase in positive emotions and a stronger sense of purpose, the strengthening of social bonds, the maintenance of cognitive and physical abilities, a delay in the loss of independence, and the preservation of dignity in the face of the inevitable changes associated with ageing. Dignity in old age signifies the right to autonomy, respect, and participation not merely access to medical care. As a brief conclusion, it is worth emphasizing that, in the author's view, only a systemic approach grounded in positive psychology, integrated services, and social participation can effectively support the well-being of aging populations.

**Late Adulthood in Society - Challenges**

As can be observed, research on psychological processes in old age rarely divides participants strictly according to chronological age. This is because, across all stages of ageing, several key dimensions remain essential — *acceptance, autonomy, activation, and activity*. These areas have been provisionally termed the 4A Model. It represents a holistic approach to the well-being of older adults, integrating physical, psychological, and social aspects of functioning. That idea is widely described and promoted by the United Nations Economic Commission for Europe (UNECE) and the Standing Working Group on Ageing (SWGA), which is an intergovernmental body that is subsidiary to the Executive Committee of UNECE. They created the Active Ageing Index (AAI). AAI is a tool to measure the untapped potential of older people for active and healthy ageing across countries. It measures the level to which older people live independent lives, participate in paid employment and social activities, and their capacity to age actively (UNECE, 2018).

This model aligns with the concept of *successful aging* (Rowe & Kahn, 1997) and the paradigm of positive psychology, which emphasizes developmental potential and the preservation of dignity in late adulthood (Seligman & Csikszentmihalyi, 2000). The model proposes a holistic perspective on aging by integrating *Activity, Acceptance, Autonomy,* and *Activation*—four interdependent domains that together offer a comprehensive and development-oriented framework.

- Physical health (medical) - Body (Activity) – engaging in physical, cognitive, and emotional activities adapted to one's abilities; maintaining bodily health and a diverse range of activities. Unlike traditional models that emphasize health status alone, Activity in the 4A Model includes diversity, adaptability, and personal meaning in everyday actions. It builds on the biomedical component of successful ageing but highlights the role of personalized, meaningful engagement rather than normative performance standards.

**Example of application**

A community health center implements individualized activity plans for older adults, combining light physical exercise, cognitive training, and interest-based workshops. Rather than focusing solely on fitness metrics, practitioners encourage participation that supports identity, enjoyment, and routine.

- Psychological health- Meaning and Sense (Acceptance) - personal acceptance of ageing as a natural stage of life and the creation of environments that acknowledge limitations while emphasizing opportunities at this stage. This dimension extends the psychological domain of the Active Ageing Index by emphasizing existential meaning-making and adaptive coping rather than only mental health outcomes.

**Example of application**

Counselors or therapists incorporate acceptance-based interventions (e.g., ACT, life-review therapy) to help older adults process transitions such as retirement or loss, while strengthening positive self-perceptions of aging.

- Behavioural (Autonomy) – sustaining the highest possible level of independence in decision-making and everyday functioning. Autonomy refers to maintaining the highest possible level of self-determination in everyday functioning—whether through independent living, participating in decisions about care, or preserving personal agency. This domain complements the “low probability of disease and disability” component of successful aging by arguing that supported autonomy (e.g., technological aids, environmental adaptations) is equally meaningful as full independence.

**Example of application**

Local governments implement age-friendly housing policies that provide assistive technologies and home adaptations, enabling older adults to make independent choices about daily routines and reduce reliance on institutional care.

- Social Relations (Activation) – fostering motivation to participate in social and educational life. That dimension extends the social engagement dimension of successful aging by highlighting not only participation itself but also the motivational and structural conditions that enable participation.

### Example of application

Municipalities collaborate with Universities of the Third Age, senior clubs, and NGOs to create flexible, low-barrier programs encouraging social involvement such as peer mentoring, intergenerational learning, or community volunteering.

To elucidate the distinct conceptual contribution and added value of the 4A Model, it is presented below in comparison with two dominant frameworks in the field of ageing research Successful Ageing (Rowe & Kahn, 1997) and the Active Ageing Index (UNECE & European Commission, 2019) which enables a more precise identification of the conceptual convergences, divergences, and practical implications of these approaches (see Table 3).

**Table 3: Comparison of the 4A Model, Successful Aging, and the Active Aging Index**

| Dimension | 4A Model | Successful Ageing (Rowe & Kahn, 1997) | Active Ageing Index (UNECE, 2018) |
|---|---|---|---|
| **Physical functioning** | Activity: adapted, meaningful physical, cognitive, and emotional engagement | Low disease probability; high physical and cognitive functioning | Health and capability indicators (e.g., physical functioning, life expectancy) |
| **Psychological well-being** | Acceptance: meaning, coping, resilience, emotional adaptation | Psychological and cognitive functioning | Mental well-being indirectly assessed through indicators of capability |
| **Autonomy / Control** | Autonomy: agency, decision-making, supported independence | Not a central component | Independent living; autonomy-related functional indicators |
| **Social participation** | Activation: motivation + participation in social, cultural, and educational life | Engagement with life | Social participation domain (volunteering, political participation, informal care) |
| **Particular Characteristic** | Psychological acceptance + motivational dynamics | Biomedical-functional perspective | Policy-oriented, comparative, quantitative measurement |
| **Typical application** | Clinical, counseling, and community programs | Health promotion, healthy lifestyle interventions | Public policy evaluation, international benchmarking |

In psychotherapeutic, educational, and counseling practice, the 4A Model can contribute to building family- and community-based support systems that integrate medical, psychological, and social care. By promoting active and fulfilling aging, it supports the well-being of older adults in the spirit of dignity and social participation, which is connected with trends to integrate healthcare and social support interventions (Wahl & Lang, 2021). Moreover, the model provides practitioners and policymakers with a clear, flexible structure for designing interventions that are individualized, culturally sensitive, and aligned with the values of late-life development.

## Summary and conclusions

Aging should not be perceived solely as a period of loss and dependency, but rather as a stage of life that when appropriately supported can be characterized by meaning, relationships, and dignity. Within this framework, aging becomes a meaningful period of continued growth, connection, engagement, and optimistic attitude, provided that society creates conditions that enable every older person to maintain dignity, autonomy, and the capacity for action.

It can be emphasized that the well-being of older adults is not solely the result of individual choices. Its formation depends on systemic factors uch as health policy, the availability of care services, housing and transport policies, labor market conditions, as well as initiatives promoting social inclusion and combating exclusion. Consequently, improving the well-being of seniors is a cross-sectoral task with direct implications for the stability of pension systems and the costs of long-term care (WHO, 2023). Key directions for intervention include:

- Promoting holistic medical and social care, based on collaboration within an interdisciplinary team (including physicians, nurses, physiotherapists, psychologists, dietitians, speech therapists, and social workers).
- Developing social activation programs, such as Universities of the Third Age, senior centers, and local volunteer clubs.
- Supporting families and caregivers through training, psychological counseling, and financial relief measures.
- Ensuring continuous access to rehabilitation, preventive healthcare, and sanatorium treatment, enabling the maintenance of physical fitness and independence.
- Providing health and psychological education that promotes autonomy, positive attitudes toward ageing, and effective stress management.

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# Modern Guidelines for Nutrition in Old Age: The Role of Preventive Diets in the Prevention of Chronic Diseases

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## Abstract

Increased life expectancy, coupled with declining fertility rates, is leading to a global demographic shift towards an ageing population. The number of older people (aged 60 and over) is expected to more than double by 2050 and more than triple by 2100. From an individual perspective, this is a positive development, but at the societal level it poses a number of challenges in terms of managing people's health, quality of life, and economic circumstances. Although life expectancy is increasing, for many people the quality of life is declining, which can have a negative impact on both health and social institutions. The nutritional needs of older people differ from those of younger people, mainly due to age-related physiological changes. Their calorie requirements may decrease due to slower metabolism and reduced physical activity, but their requirements for certain macro- and micronutrients may increase. With advancing age, the risk of chronic diseases such as cancer, metabolic and cardiovascular diseases increas, as does the risk of osteoporosis, cognitive decline, and disability. In order to maintain health in old age and prevent the development of cardiovascular and metabolic diseases, it is important to reduce the intake of simple carbohydrates (to a maximum of 10% of total carbohydrate intake) and saturated fatty acids (to a maximum of 20–25 g per day), while ensuring adequate protein intake (1.0–1.2 g per kg of body weight) and consuming at least 400 g of fruit and vegetables per day. The salt intake of Hungarian seniors also significantly exceeds the recommended level (instead of 2 g per day, men over 65 consume 6.2 g and women consume 4.7 g), and fluid intake is insufficient, too (the recommended amount is 35 ml per kg of body

weight). Among preventive strategies, nutrition is critical, yet it is currently underrepresented in the healthcare system and does not receive sufficient emphasis in care processes. A personalized healthy diet has significant benefits for older adults and can prevent, modify, or improve many age-related diseases and conditions. This review focuses on issues related to the nutrition and nutritional needs of older adults based on the latest guidelines. It also presents the most common complications resulting from poor nutrition and the possibilities for diet therapy.

## Introduction

Aging is one of the most significant risk factors for the development of non-communicable diseases, such as cardiovascular disease, diabetes, cancer, and neurodegenerative disorders (Shang et al., 2023). The expected doubling of the proportion of people over 60 years in the global population by 2050 will have serious health and economic consequences, especially in developing regions (WHO, 2025). In Hungary, the proportion of older people was 20.6% in 2022, which is expected to reach 26.9% by 2050. Further increasing the importance of appropriate nutritional strategies for the elderly population in both primary and secondary prevention (Kovács et al., 2025). The implementation of preventive nutritional strategies is key to long-term health sustainability and maintaining the quality of life of an aging population (Domínguez et al., 2023) (Chen et al., 2025). In addition, the unique nutritional needs of the aging body require special attention, as physiological changes with age affect nutrient absorption, metabolism, and requirements. These changes include a decrease in energy expenditure, a reduction in muscle mass and bone density, and a deterioration of the senses, such as taste and smell (Kovács et al., 2025).

In addition, a slowing of digestive functions, there is a decrease in stomach acid production, that can affect the absorption of certain vitamins and minerals, such as vitamin B12 and calcium, leading to deficiencies (Assmann et al., 2015). Upkeeping physical health and reducing the incidence of chronic diseases, proper nutrition also contributes to maintaining mental health and slowing cognitive decline, which further improves quality of life (Sun & Li, 2023). This is particularly relevant in Hungary, where less than 27% of older people consider themselves to be in good health, one of the lowest rates in the European Union, and where age-related chronic non-communicable diseases account for more than 75% of disability-adjusted life years (Ungvári et al., 2023). Based on the results of the latest National Nutrition and Nutritional Status Surveys from 2019, more than 70% of people over the age of 65 are overweight or obese in both sexes (Sepler et al., 2022), which poses a significant health risk regardless of age. Nevertheless, preventive nutrition is underrepresented in the healthcare system in Hungary today and does not receive sufficient emphasis in care processes. This is best demonstrated by the fact that, according to the latest domestic surveys, 49% of people over the age of 65 are at increased risk in terms of their nutritional habits (Susovits et al. 2022). A personalized healthy diet has significant benefits for older adults and can prevent, modify, or improve many age-related diseases and conditions.

## Materials and methods

The aim of this review is to summarize the most important and recent guidelines related to the nutrition of older adults and to present the most common complications resulting from poor nutrition and the possibilities for diet therapy. The Scopus, PubMed, and Web of Science databases were used to identify relevant literature, using keywords such as "old age," "nutrition," "guidelines," "prevention," "dietary manipulations," "quality of life," and "diet therapy." For greater transparency, the search results were summarized in a table showing the focus of the guidelines, their main findings, and the source.

## Results

Most of the international studies included in the review do not merely report individual research findings, but represent comprehensive position papers or clinical practice guidelines based on expert consensus, which are summarized in Table 1.

Volkert et al. (2019) and Riddle et al. (2024) primarily draw attention to the need for immediate and routine screening, particularly for malnutrition and dehydration. Screening is key to early identification of nutritional risk and initiation of targeted interventions. Due to the prevalence of dehydration, adequate fluid replacement is essential. General guidelines recommend 1.6 liters/day for women and 2.0 liters/day for men, but intake should be individualized, taking into account individual health status and environmental factors (Volkert et al., 2019; Dorrington et al., 2020; Lyons et al., 2022).

In order to maintain muscle mass and function, the recommendations pay particular attention to protein intake, which is higher than that of young adults. Based on the recommendations, this is 1.0–1.2 g/kilogram of body weight/day (kg/day). In cases of illness, acute stress, or an active lifestyle, the requirement may increase further, with 1.2–1.5 g/kg/day being recommended (Dorrington et al., 2020; Lyons et al., 2022; Bauer et al., 2013). Adequate protein intake is critical in preventing sarcopenia.

Micronutrient deficiencies are common in older adults, particularly vitamin D, vitamin B12, calcium, folate, iron, and zinc (Dorrington et al., 2020; Lyons et al., 2022; Zaragoza-Martí et al., 2020;). Adequate intake of these nutrients is essential for bone health, immune function, and cognitive function.

The diet should follow a nutrient-dense, balanced pattern: plenty of vegetables and fruits, whole grains, high-quality protein sources (e.g., lean meat, fish, dairy products, legumes), and low intake of saturated fat (max 20-25 g/day) and added sugar (maximum 10% of total

daily calories) is recommended (WHO, 2023b; Lyons et al., 2022; Govindaraju et al., 2018; Thorpe et al., 2016).

Nutritional interventions should be tailored to individual needs (e.g., chewing and swallowing difficulties, loss of appetite, chronic diseases) (Volkert et al., 2019; Riddle et al., 2024.) and should always be supplemented with regular physical activity to more effectively preserve muscle mass and function (Lorbergs et al., 2021; Bauer et al., 2013).

**Table 1: International nutritional recommendations for erderly people**

| Recommendation/guideline | Key points | References |
|---|---|---|
| **Regular screening for malnutrition** | All elderly people should be routinely screened for malnutrition and dehydration. | Volkert et al., 2019; Riddle et al., 2024. |
| **Protein intake** | 1.0–1.2 g/kg body weight/day, up to 1.2–1.5 g/kg body weight/day in case of illness or active lifestyle. | Dorrington et al., 2020; Lyons et al., 2022; Bauer et al., 2013. |
| **Fluid intake** | Women: 1.6 l/day, men: 2.0 l/day, but tailored to individual needs. | Volkert et al., 2019; Dorrington et al., 2020; Lyons et al., 2022. |
| **Micronutrients** | Vitamin D, B12, calcium, folate, iron, and zinc are particularly important; deficiencies are common. | Dorrington et al., 2020; Lyons et al., 2022; Zaragoza-Martí et al., 2020; 2023. |
| **Diet quality** | Fruits and vegetables, whole grains, high-quality protein, low saturated fat and sugar. | WHO, 2023a. Lyons et al., 2022; Govindaraju et al., 2018; Thorpe et al., 2016. |
| **Personalized advice** | Advice tailored to individual needs, led by a dietitian is recommended. | Volkert et al., 2019; Riddle et al., 2024; Lorbergs et al., 2021. |
| **Dietary supplements** | If necessary, vitamin D, B12, calcium supplements, but under medical supervision. | Dorrington et al., 2020; Lyons et al., 2022; Foote et al., 2000. |
| **Physical activity** | In addition to nutrition, regular exercise is important for maintaining muscle mass and function. | Lorbergs et al., 2021; Bauer et al., 2013. |

## Dietary recommendations for older adults in Hungary: main guidelines and characteristics

Based on the results of studies examining the nutritional habits and recommendations of older adults in Hungary, the primary goals are to improve diet quality, reduce salt and sugar consumption, increase fruit and vegetable intake (min 400 g/day), and prevent vitamin and mineral deficiencies (Table 2).

**Table 2: Summary of dietary recommendations and habits of Hungarian elderly people**

| Recommendation/guideline | Key points | References |
|---|---|---|
| **Reducing salt intake** | Salt consumption among older adults significantly exceeds the recommended level. According to the WHO, less than 5 g per day would be ideal, but the Hungarian average is 11 g/day. | Sarkadi-Nagy et al., 2021; Rurik & Antal, 2003; Ulambayar et al., 2025. |
| **Fruit and vegetable consumption** | The proportion of people consuming fruit and vegetables several times a day is very low (11.7% for fruit, 8.9% for vegetables). | Soós et al., 2024; Rurik & Antal, 2003. |
| **Fluid intake** | 36.3% of older adults drink only 1 liter per day, and 15.1% drink only half a liter, which is insufficient. | Soós et al., 2024; Ulambayar et al., 2025. |
| **Vitamin and mineral deficiencies** | Vitamin D, folic acid, biotin, and pantothenic acid intake is critically low, especially among the elderly. | Molnár et al., 2017; Guba et al. 2023; Soós et al., 2024. |
| **Traditional gastronomy** | Foods high in fat and carbohydrates, frequent use of fat, little fish, dairy products, vegetables. | Soós et al., 2024; Varga et al. 2022; Rurik & Antal, 2003; Ulambayar et al., 2025. |
| **Weight optimization** | Over 70% of older adults are overweight or obese, especially men. | Sepler et al., 2022; Soós et al., 2024; Ulambayar et al., 2025. |
| **Use of dietary supplements** | More than 40% of people over the age of 65 take some form of dietary supplement. | Horacsek, 2023; Soós et al., 2024; Rurik & Antal, 2003. |
| **Eating habits** | A minimum of three main meals a day is typical, with lunch being the most substantial; the number of meals increases with age. | KSH, 2019; Rurik & Antal, 2003 |

The salt and sugar consumption of Hungarian seniors significantly exceeds the recommended levels (instead of 2g/day, men over 65 consume 6.2g/day and women 4.7g/day), which contributes to the prevalence of high blood pressure and chronic diseases (Soós et al., 2024; Sarkadi-Nagy et al., 2021; Ulambayar et al., 2025). The consumption of vegetables, fruit, dairy products, and fish falls far short of international recommendations, which increases the risk of deficiencies and diseases (Soós et al., 2024; Rurik & Antal, 2003; Molnár et al., 2017). 48% of Hungarian women and 56% of men over the age of 65 consume less than 400 g of fruit and vegetables per day. This age group also has the lowest consumption of whole grains, at approximately 2.5 g per day. Low dietary fiber intake can be identified as a risk factor of cardiovascular and metabolic diseases and cancer in the elderly Hungarian population. (Zámbó et al. 2022). More than 80% of people over the age of 65 do not regularly eat fish , which significantly contributes to an unfavorable omega-3 to omega-6 fatty acid ratio. This can lead to cardiovascular and neurodegenerative diseases or worsen their prognosis (Varga et al. 2022). Deficiencies in vitamin D, folic acid, biotin, and pantothenic acid are particularly common, so

supplementation may be warranted (Molnár et al., 2017). Nearly 50% of women and men over the age of 65 take some form of dietary supplement (Horacsek, 2023). Low physical activity and the consumption of traditional, energy-dense foods further increase the risk of obesity and chronic diseases (Soós et al., 2024; Ulambayar et al., 2025; Rurik & Antal, 2003). Inadequate fluid intake (Soós et al., 2024; Ulambayar et al., 2025) increases the risk of dehydration. Dehydration is associated with increased hospitalisation, morbidity and mortality. Older adults are more susceptible to hypo/dehydration due to physiological and cognitive changes that occur with advancing age (Lacey et al. 2019; Mustofa 2023).

## Conclusion

Regular screening, a personalized, nutrient-rich diet, adequate protein and fluid intake, and advice from a dietitian are the most important factors in the nutrition of older adults. Optimizing micro- and macronutrients, improving diet quality, and taking individual needs into account are key to supporting healthy aging.

Dietary recommendations for older adults in Hungary focus on reducing salt and sugar consumption, increasing the consumption of vegetables, fruits, dairy products, and fish, and preventing vitamin and mineral deficiencies. In addition, it is important to optimize nutritional status in old age, as this is an essential condition for maintaining mental and physical health. In addition to traditional medicine, the implementation of targeted education on diet and lifestyle will be essential in the future to support healthy aging.

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# Growing Old and Being Gay or Lesbian in Malta: Anticipating Care in a Heteronormative Society

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## Abstract

Malta presents a unique paradox for sexual minority elders: it boasts some of the world's most progressive LGBTIQ+ legislation, yet retains a deeply rooted, religiously conservative social fabric. This article explores how this paradox shapes the ageing experiences and anticipated care needs of older gay men and lesbian women. Drawing on critical gerontology and utilising the Biographic-Narrative Interpretive Method (BNIM), to collect the data, using Thematic Analysis this study examins the life histories of participants aged 58 to 72. Findings reveal a pervasive fear of 're-closeting' upon entry into long-term care, driven by a lifetime of navigating heteronormativity. A distinct gendered divergence emerged: while male participants largely embraced a gay identity, female participants frequently rejected the 'lesbian' label, adopting strategies of protective silence. The study challenges normative models of 'successful ageing,' highlighting instead the resilience found in 'families of choice.' The article concludes that despite legal equality, the lack of culturally competent care creates a precarious future for Maltese sexual minorities, necessitating urgent policy interventions and affirmative staff training to support ageing in place.

## Introduction: The Background Context

Research on the intersection of sexuality, gender identity, and ageing is comparatively limited (Sussman et al., 2018). Scholarship regarding the multifaceted discrimination experienced by older adults—particularly where age intersects with gender, disability, sexual orientation, or migration status—remains sparse throughout the European Union. Given that the ageing population is highly diverse, possessing distinct needs and preferences, it is crucial to recognise these intersecting inequalities. A nuanced understanding of how these factors overlap is a prerequisite for developing robust policies that effectively protect the dignity of all older individuals (FRA, 2018).

Within gerontology, this lack of focus has historically rendered older Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer (LGBTIQ) persons socially invisible, particularly within formal support systems (Fredriksen-Goldsen & Muraco, 2010). Many service providers are unaware that LGBTIQ persons are potential users of their services (Hughes et al., cited in Fredriksen-Goldsen et al., 2014) or may not acknowledge the sexual orientation and partners of lesbian, gay, and bisexual (LGB) persons (Utamsingh et al., 2016).

This systemic invisibility is built upon a foundation of assumed heterosexuality and cisnormativity within health and social care systems (Caceres et al., 2020). Where heterosexuality is the default, individuals are less open to disclosing their sexual orientation to healthcare professionals (Rose et al., 2016). This has resulted in older LGBTIQ persons becoming medically underserved and facing a higher risk of health problems than their heterosexual counterparts (Erdley et al., 2014; Frimprong et al., 2020). As this growing demographic of sexual and gender minority (SGM) individuals increasingly requires long-term services and supports (LTSS), the development of culturally responsive care has progressed at a glacially slow pace (Rosser et al., 2024).

When providing care to older persons, it is critical to consider their unique historical backgrounds (European Union, 2017) and how this history has shaped their identity (Fredriksen-Goldsen et al., 2019). Today’s older LGBTIQ adults came of age in eras where their identities were pathologised, criminalised, and heavily stigmatised (Pereira & Banerjee, 2021). Many lived their adulthood in constant fear of exposure, risking their housing, employment, and families (Haber, 2009; Knocker, 2012; Vella, 2013). Their environment often attempted to "normalise" them through psychological or medical treatment, physical and psychological abuse, and the denial of healthcare access (Witten, 2012).

These lifelong experiences of discrimination and victimisation, termed 'minority stress' (Meyer, 2003), have profound and cumulative effects on mental and physical health (Correro & Nielson, 2020). This fear persists into older age, manifesting as a deep distrust of mainstream institutions (Phan et al., 2023). Many older LGBTIQ adults anticipate prejudice from staff and residents in care facilities, leading them to conceal their identities (McMullen-Roach et al., 2025; Rosser et al., 2024). This 'retreating into the closet' is a protective mechanism that can lead to social isolation, poorer mental health, and a reluctance to seek necessary care (Pachankis et al., 2020). Data on LGBTIQ older persons in long-term care indicates that the care provided is often inadequate and damaging, forcing entire generations ‘back into the closet’ during a time of great need (Fasullo et al., 2022).

Malta presents a unique paradox for ageing sexual minorities. In legal terms, the country is a global leader in rights, having topped the ILGA-Europe Rainbow Map for ten consecutive years with a score of approximately 89% in legal and policy protection (ILGA-Europe, 2026). Yet, despite this status, the voice of the older LGBTIQ community has been largely absent from public and academic discourse. This legislative progress contrasts sharply with the lived reality of older generations who grew up in a deeply conservative, Catholic environment (Boissevain, 1993; Abela, 1994).

It is only recently that older LGBTIQ persons have been explicitly featured in key state frameworks, such as the National Ageing Policy (Ministry for Health and Active Ageing, 2023a), the National Dementia Strategy (Ministry for Health and Active Ageing, 2023b), and the National LGBTIQ Equality Action Plan (Human Rights Directorate, 2023).

However, the enduring impact of historical stigma remains visible in recent data. The 2021 national Census, which recorded sexual orientation for the first time (Table 1), revealed that within a total population of 447,456, only 2.5% of the Maltese population aged 16 and over identified as having a non-heterosexual orientation. This disparity is even more pronounced among older cohorts: of the 128,930 individuals aged 60 and over, only 645 (0.50%) identified as LGB or another minority sexuality (National Statistics Office Malta, 2024). This pattern mirrors international trends regarding the ‘statistical invisibility’ of older cohorts. For instance, data from the United Kingdom reveals that while roughly 3.2% of the general population identifies as LGB+, this figure drops significantly to approximately 0.8% for those aged 65 to 74 (Office for National Statistics [ONS], 2023). The similarity between the Maltese (0.50%) and UK figures suggests that these low self-identification rates are likely not a reflection of demographics, but of a shared generational hesitancy to disclose sexual orientation.

**Table 1: Maltese population aged 16 and over by sexual orientation, district and age**

| District and age | Straight/ Heterosexual | Gay or Lesbian | Bisexual | Other sexual orientation | Total |
|---|---|---|---|---|---|
| **Total** | **436,383** | **8,541** | **2,229** | **303** | **447,456** |
| **Malta** | **403,022** | **8,073** | **2,110** | **285** | **413,490** |
| **Gozo and Comino** | **33,361** | **468** | **119** | **18** | **33,966** |
| **Total** | **436,383** | **8,541** | **2,229** | **303** | **447,456** |
| 16-19 | 17,302 | 257 | 256 | 58 | 17,873 |
| 20-29 | 69,365 | 2,166 | 816 | 94 | 72,441 |
| 30-39 | 89,581 | 3,129 | 598 | 48 | 93,356 |
| 40-49 | 73,891 | 1,658 | 288 | 34 | 75,871 |
| 50-59 | 57,959 | 849 | 156 | 21 | 58,985 |
| 60-69 | 59,320 | 336 | 66 | 4 | 59,726 |
| 70-79 | 47,570 | 106 | 33 | 25 | 47,734 |
| Over 79 | 21,395 | 40 | 16 | 19 | 21,470 |

Source: National Statistics Office, 2024.

Local research focusing on older LGBTIQ persons has only begun to emerge over the past decade. As Vella and Hafford-Letchfield (2019: 59) observe, "whilst the gay community seems to have gained greater visibility, nevertheless little is known about those LGBT persons entering later life, and much needed policy and practice developments to enable a sense of continuity in keeping with the concept of active ageing". Their study further highlighted that equal rights provide a necessary level of safety, reassurance, and recognition within social care and housing, whilst also emphasising the critical importance of robust social networks.

Other local research into the experiences of older transgender persons has highlighted significant anxiety regarding the ageing process. Concerns particularly centred on the loss of youthful physical traits, which are often tied to their acceptance as women, and a lack of adequate healthcare, with few medical providers trained in the specific physiological and health needs of ageing trans women. Furthermore, the study identified issues of loneliness and social exclusion in later life, as well as anxiety surrounding admission to long-term care facilities due to fears of discrimination or neglect by staff and fellow residents. A profound sense of disconnection was also reported within the local LGBTIQ community; many older individuals felt sidelined and misunderstood, perceiving younger activists as prioritising visibility and media representation over the tangible support and care needs of the older generation (Cekic & Formosa, 2024).

Ultimately, much like feminism’s historical struggle to integrate the perspectives of older women, contemporary LGBTIQ activism in Malta appears to pay scant attention to its older members, prioritising instead the concerns of younger generations (Formosa, 2021).

Notwithstanding a growing acceptance of the LGBTIQ population, this is not sufficient to secure an environment free from negative attitudes, stigma, and discrimination (de Vries, 2015). When an individual reaches older age, a person-centred care approach demands that one cannot provide an adequate care plan if their history and future fears are disregarded (Pugh, 2012). This paper addresses this gap by giving voice to the stories of older gay men and lesbians in Malta, exploring how they experience older age and, specifically, how they perceive their future needs for health care and social support.

## Study Objectives

Given the scarcity of empirical data on sexual minority ageing in the Mediterranean region, this paper aims to bridge the gap between Malta's broad legislative progress and the individual lived reality of its older citizens. While situated within the wider discourse of LGBTIQ+ ageing, this research focuses specifically on the narratives of gay men and lesbian women.

In alignment with the exploratory nature of the Biographic-Narrative Interpretive Method (BNIM), the study pursues three primary objectives:

1. **To explore biographical pathways:** To document how older lesbian and gay individuals in Malta construct their life histories, specifically examining how they have navigated identity formation within a historically conservative and religious society.
2. **To examine the anticipation of care:** To investigate how past experiences of stigma or discrimination influence current perceptions and fears regarding future dependency, particularly the prospect of entering long-term care facilities (ageing in place vs. institutionalisation).
3. **To identify barriers to inclusive practice:** To analyse the disconnect between Malta's top-tier equality legislation and the 'on-the-ground' social reality, identifying specific gaps in service provision that may force older adults to 're-closet' themselves to access safe care.

## Methodology

This research adopted a qualitative methodology, which provides a deeper meaning and understanding of social phenomena (Braun & Clarke, 2013). Specifically, a narrative inquiry approach, that of the Biographic-Narrative Interpretive Method (BNIM), was utilised for data collection. This method allows for the exploration of lived experiences in the participants' own

words, capturing the complexities of their life stories (Wengraf, 2001). The procedure followed three distinct sub-sessions (Wengraf, 2001):

1. **Sub-session 1 (The Single Question):** Participants were asked a single overarching question: *' 'Can you please tell me your story of how today as an older adult identifying as lesbian/gay man, you have come to experience ageing, how you manage your everyday lifestyle now that you are of older age, keeping in mind your health care needs as well as social support. All the events and experiences which were important for you up to now. Start wherever you like. Please take the time you need. I'll listen first, I won't interrupt, I'll just take some notes for after you've finished telling me about your experiences.'* The interviewer did not interrupt, allowing the Gestalt of the participant's story to emerge.
2. **Subsession 2 (Narrative Follow-up):** Following a 15 minute break, the researcher asked follow-up questions based strictly on the notes taken in Sub-session 1, using the participant's own order and key words to elicit 'Particular Incident Narratives' (PINs).
3. **Sub-session 3 (Optional)**: This sub-session, which is considered optional was conducted after the preliminary analysis of both previous sub-sessions. Here a set of questions were developed, not restricted to sub-session one and two, but composed of questions about topics which may have not been mentioned in the narrative and more to do with the theory. Unlike the previous subsections the third sub-section is more structured (Wengraf, 2008).

The resulting narratives were analysed using Thematic Analysis.

Ethical approval was granted by the University of Malta Research Ethics Committee. Given the small size of the Maltese LGBTIQ community, anonymity was paramount. All participants were provided with information sheets and signed informed consent forms. To prevent deductive disclosure—a significant risk in small-island states (Damianakis & Woodford, 2012)—pseudonyms were assigned, and specific biographical markers (e.g., exact professions or village names) were obscured in the final transcripts.

**Participants**

The study originally set out to inquire into the lives of lesbian and gay men in Malta above the age of sixty-five. Despite the general accepted age bracket defining older person is 65 and above (World Health Organisation [WHO], 2026), which was achievable for gay men, it proved challenging for the lesbian group, possibly due to compounded invisibility, fear, or discomfort in being interviewed. This difficulty concurs with other gerontological research, which notes that lesbians can be more likely to hold reservations about their identity and are

often an ignored and invisible sub-population (Averett & Jenkins, 2012; Heaphy, Yip, & Thompson, 2004). Furthermore, critical gerontology suggests that 'social age' often accelerates for minority groups; due to 'minority stress' (Meyer, 2003) and the lack of heteronormative milestones (such as grandchildren), LGBTIQ individuals may anticipate ageing-related care needs earlier than their heterosexual peers.

Eventually, a total of six participants who identified as lesbian or gay, were over the age of fifty-eight, and were living in Malta were interviewed (see Table 2). The cohort included two women aged 58 and one aged 66, and three men aged 58, 67, and 73. The inclusion of the 58-year-old participants was deemed highly relevant as their narratives were deeply embedded with experiences and future concerns related to health care and social support.

**Table 2: Participant Demographics**

| Pseudo Name | Gender identity | Sexual Orientation | Age | Occupation |
|---|---|---|---|---|
| **Joseph** | Male | Gay | 73 | Sugar craft cake decorator (Retired) |
| **Karl** | Male | Gay | 67 | Activity coordinator (Retired) |
| **Peter** | Male | Gay | 58 | Hairdresser (Retired) |
| **Charlotte** | Female | Lesbian | 66 | Teacher (Semi-retired) |
| **Therese** | Female | Lesbian | 58 | Marketing officer |
| **Elisabeth** | Female | Lesbian | 58 | Accountant |

A striking divergence regarding identity labelling emerged during the interviews. While male participants were comfortable self-identifying as ‘gay’ and exhibited a strong affiliation of their identity, female participants expressed significant discomfort with the term ‘lesbian’. . One female participant felt more comfortable identifying as 'gay' rather than 'lesbian', while others avoided labels entirely, associating the term with negative connotations. This divergence underscore that, to avoid the error of treating older LGB adults as a monolithic group, care assessments must account for the intersection of sexual orientation with other key identity markers, such as gender, ethnicity, and physical ability (King & Cronin, 2013).

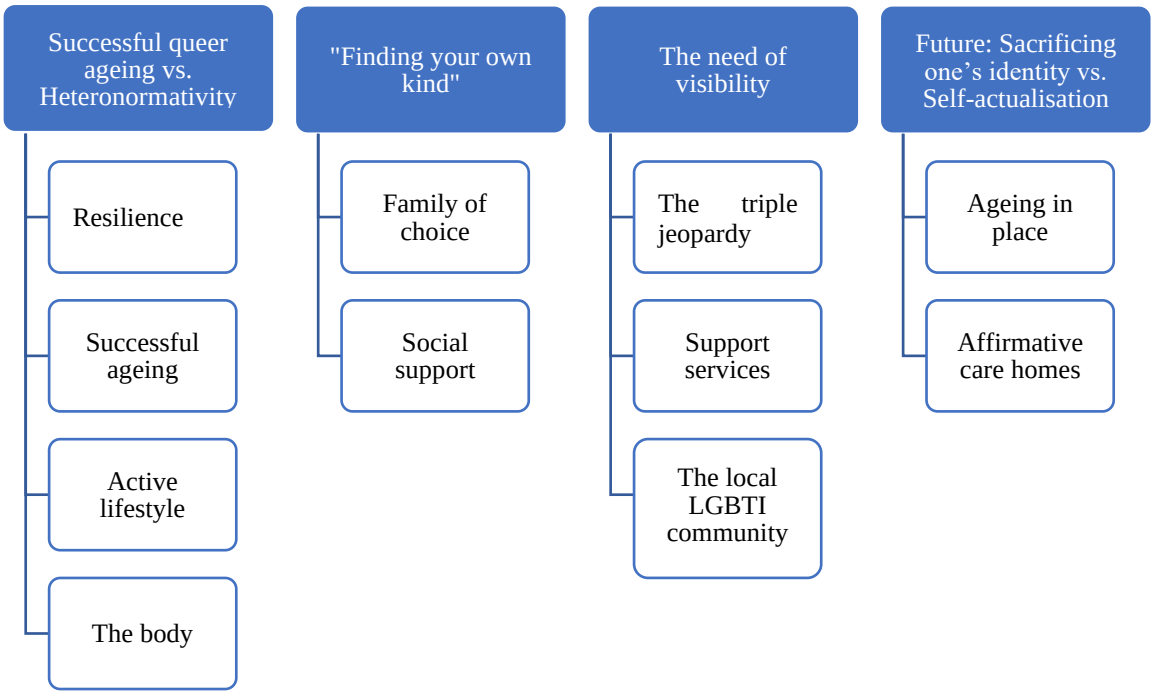
## Key Findings and Discussion

A rigorous thematic analysis of the participant narratives revealed an array of themes (Braun, & Clarke, 2006). These themes (see Diagram 1) illuminate the lived experiences of the participants and are discussed below, integrating findings from the broader literature to contextualise the Maltese experience.

Balance was considered during the design phase by securing an equal number of participants (3 men and 3 women). However, the analysis acknowledges that the lesbian sample

was harder to reach due to 'invisibility, fear and discomfort', resulting in a younger age profile for the female participants (mostly under 65). This composition shaped the results by highlighting a distinct contrast: while the male participants were 'gay affirmative,' the female participants were more 'private and reserved,' often rejecting the label of 'lesbian' entirely. To ensure lesbian experiences were equally represented despite this 'invisibility,' the findings incorporated specific themes such as 'The Triple Jeopardy' to address the intersectional economic and social challenges unique to the female participants.

**Diagram 1: Emerging Themes and Sub-themes**




## Successful Queer Ageing vs. Heteronormativity

All participants disclosed how, throughout their lives, they subscribed to the idea that the heteronormative culture and discourse were the socially appropriate and acceptable ways of life. Deviating from this norm was not an easy route. Some participants spoke of having to "escape the system" by leaving the island, while others, like Elisabeth, endured psychological distress due to sociocultural climate regarding homosexuality. She described attempting to convince herself that being gay was not a sin, stating: "I always said to myself that this was not a sin."This aligns with findings from Vella (2013) on the historical pressures faced by gay men in Malta. Such deviation resonates with the concept of queer temporalities, which embrace a 'messiness' that defies the pressure to act one's age or follow a linear progression (Brown, 2009; Sandberg, 2008).

Despite these historical challenges, a common trait that emerged was 'resilience'. Participants remained active within their sphere of life and demonstrated successful adaptation to older age. Therese spoke of anticipating the future role of acting as the primary caregiver for her parents, placing her within the heteronormative adult child-parent dynamic described by Muraco and Fredriksen-Goldsen (2014). This sense of duty aligns with Maltese cultural norms where family caregiving is considered an obligation (Bonnici, cited in Formosa, 2015). Similarly, Peter stated, "I do my share of volunteering despite my various conditions."

In the strict context of successful ageing, defined by Rowe and Kahn (1997) as high active engagement, high physical functioning, and low risk of disease -these participants appear to lead active lives. However, while Rowe and Kahn's model has been influential, it is increasingly criticised for its exclusionary nature. Rubinstein and de Medeiros (2015) argue that the model posits the individual as the sole locus of responsibility, ignoring the impact of biography and marginalisation. Similarly, Katz and Calasanti (2015) warn that this framework flattens the diversity of the ageing experience and overlooks intersecting social inequalities.

This critique is particularly relevant for individuals like Peter, whose engagement occurs alongside health conditions. For LGBTIQ elders, 'success' is rarely a linear trajectory of physical optimisation but rather a practice of 'crisis competence' (Kimmel, 1978). Consequently, this article pivots to a critical gerontological lens, viewing ageing not as a physiological test but as a complex navigation of a heteronormative care landscape (Sandberg, 2011).

The resilience demonstrated by the Maltese participants challenges the heteronormative lens of "successful ageing" —often depicted as heterosexual couples with grandchildren (Sandberg & Marshall, 2017)—by creating alternative narratives of success. Elisabeth further highlighted her strategy: "[My] Approach is to be as self-sufficient as possible, but to always keep friends close to you as much as possible" This "crisis competence" (Kimmel, 1978) is theorised to be a capacity cultivated from a lifetime of navigating adversity and stigma (Heaphy et al.,2004; Jurček et al., 2022).

In the context of active ageing, all women interviewed spoke of how they will continue to work, even though two are approaching retirement. However, a good part of the reason for remaining in paid work is also the financial motive, as all female participants stated how nowadays employment has become imperative to maintain a relatively good lifestyle. They acknowledged how important it is to remain part of the workforce, a point of view that is worthy of note as 76% of the general Maltese population view older persons as great contributors to the workplace (European commission, cited in Formosa, 2015). In this context, it is thus

imperative that workplaces remain safe places and that equal opportunities are provided, irrespective of one's sexual orientation.

While Fabbre (2015) outlines that the concept of successful ageing is built upon a heteronormative framework, this theory is contested by queer individuals who feel such a structure strips away the unique, non-conforming nature of their lived experience (Ramirez-Valles, 2016). This viewpoint was confirmed by the study participants, whose life stories demonstrated that a sense of successful ageing was achieved through unique experiences rather than conformity. Karl, for instance, refused to subscribe to heteronormative tenets, describing equal marriage, monogamy, and reproduction as merely replicating heterosexual norms.

However, Higgs and McGowan (2012) maintain that this popular culture has also rendered images of successful ageing as the ability to defer old age as much as possible, often by maintaining a fit body. This is a consumerist approach championed by the baby boomer generation, where biomedicine and bodily modifications—once primarily the domain of women—are increasingly consumed by men to remain sexually attractive (Leonard et al., 2012). Karl invests heavily in maintaining a good body image and monitoring his testosterone levels, particularly as he is attracted to younger men. As he states:

"I keep myself active through sports and make sure my testosterone levels are maintained. I keep a healthy diet."

This correlates with findings by Hajek (2014), who notes that many gay men over the age of 50 base their self-worth on body image, physical attraction, and sexual vitality. Consequently, this preoccupation with youth and sex suggests that for some within the gay culture, successful ageing is intrinsically linked to the manipulation of the body to delay the visible signs of ageing.

**"Finding Your Own Kind"**

This theme is a direct quote by Therese, highlighting the importance of a good support network was deemed imperative by all participants. This support consisted of two types: a close circle of friends and, ideally, a life partner. Having experienced a lifetime of misunderstanding from mainstream society, the participants have established strong ties of friendship that function as a 'family of choice' (Knauer, 2016).

Joseph explained how, even though he is legally married to his husband, his close circle of friends continues to be a great part of his life. These friendships are characterised by longevity, safety, intimacy, common values, trust, and reciprocity, fitting Gabrielson and

Holston’s (2014) definition of 'family of choice' as a support system that often replaces or supplements the roles of blood relatives.

Partnership was also highlighted as an ideal, conferring better overall health benefits (Goldsen et al., 2017). Joseph explained how his husband brought him peace of mind and security, stating: "Thank God for my husband, that is a great help to me as now I don’t work any more." This echoes Vella's (2013) earlier findings that such bonds bring a sense of security. Both Joseph and Peter legally formalised their relationships through marriage soon after it became law in Malta, seeing it as a way to gain the same rights and benefits as heterosexual couples and avoid the 'disenfranchisement'—a loss that cannot be publicly acknowledged or supported—that comes from an unrecognised relationship (Doka, 2002).

Therese described how her group of friends acts as a support system to one another by being in constant communication. She brought an example of how in the span of four years she lost five people and during the time of study another of her closest friends was battling for her life and further explained how such notions affect all her friends forming part of the group and how together they organised visits in making sure to be available and of support as best they can. This falls in line with Houghton, (2018) who stated that perhaps the most age-related concern faced by many older LG persons is the fear of not having adequate support as they further into age.

The Maltese participants' emphasis on 'families of choice' is a cornerstone of LGBTIQ ageing research. For older LGBTIQ adults, who are more likely to be single, live alone, and be estranged from biological families (Guasp, 2011; Houghton & Quartey, 2020), these chosen families are not ancillary but are the primary source of support, intimacy, and care (Hull & Ortyl, 2019). These networks are crucial for resilience, providing a space for identity expression and a sense of security (Knauer, 2016). The participants' move to legalise their unions demonstrates a desire to protect these vital relationships, particularly as they approach older age and anticipate future care needs.

**The Need of Visibility**

A significant gendered disparity emerged within the narratives regarding identity management and visibility. Although not all participants subscribe to the heteronormative culture, and are aware that they lead somewhat different lives to the norm, Charlotte and Elizabeth, in particular, did not want to stand out in any way or had to adhere to a particular label. In fact they refused to identify as lesbian due to the stigma and negative connotation it holds, with Elizabeth going a step further in stating that she did not need to identify as anything.

As highlighted by Westwood, (2013), in researching older lesbians this study also faced significant gendered disparity within the narratives regarding identity management and visibility. While the male participants generally embraced the label ‘gay’ and demonstrated a degree of comfort with public visibility, the female participants exhibited a distinct reticence, explicitly rejecting the term ‘lesbian’. This divergence must be theorised not merely as a personal preference, but as a reflection of the ‘double invisibility’ faced by older women who love women (Traies, 2016).

Averett and Jenkins (2012), highlighted how older lesbians are an invisible and ignored sub-population, which places them at a triple threat of marginalisation and oppression - that of being women, lesbian and of older age. Indeed, Charlotte only conveyed her acceptance to partake in this study because the researcher identified himself as a gay man, thus avoiding to“opening up” to a straight person - and addressed her partner as her friend “habibti”, when disclosing her narrative, thus denoting a certain fear. This aligns with Heaphy et al. (2004) who stated that lesbians are seen as being more ‘hidden’ as regards to how they manage their support networks, holding reservations about their identity in ‘going public’.

In the context of Malta’s historically patriarchal and Catholic society, women have traditionally been positioned as the guardians of family morality (Cutajar et al., 2023). Consequently, female sexual deviance has often been policed more rigorously—or silenced more effectively—than male homosexuality (Cassar, 2003). The rejection of the political identity ‘lesbian’ by the female participants can be understood through the lens of feminist gerontology as a strategy of protective silence (Fullmer et al, 1999). As Kitzinger (1987) argue, for older cohorts, the term ‘lesbian’ may hold multiple meanings for those who do not identify with it. Westwood (2013) elucidates that lesbian identity is not a monolith, but rather a spectrum defined by varying combinations of politics, performance, and desire.

By reframing their lives through narratives of ‘friendship’ or private companionship rather than public identity politics, these women navigate a care system that assumes heterosexuality (Rose, 2000). However, this invisibility is a double-edged sword; while it protects them from immediate discrimination, it renders their specific care needs—such as the recognition of a same-sex partner as next-of-kin—unseen by service providers. This finding underscores the necessity for care training that looks beyond identity labels to recognise the diverse forms of ‘families of choice’ that exist among older women (Dorfman et al, 1995; Fredriksen-Goldsen et al., 2023).

While legal rights have advanced, a sense of visibility was not equally felt. Lesbians, like other women, face income limitations due to historical career disparities (Orel, 2004),

which can impinge on health and leave care needs unmet (Heck et al., 2006). This places them at a 'triple jeopardy' of marginalisation based on age, gender, and sexual orientation (Averett & Jenkins, 2012), however Therese denotes a possible fourth intersection, that of being ‘single’. As she questions:

“…government policy[ies] they allow for single mums, married couples, tax rebates…they seem to help a lot of families but what happens to the people who are (single) fifty and older?”.

Therese further explained how social housing is a struggle for older single women, as preference is always given to women with children. She also mentioned that nowadays with the prices in rent always rising and the wages remaining the same, it is becoming nearly impossible to keep up with housing costs and daily struggles, "trying to live a healthy lifestyle comes at quite an expense," noting that basic necessities for a healthy diet have become expensive. This reflects the local context where older women are at a greater risk of poverty (Gialanzè, 2025), and poverty has a disabling effect, impacting nutrition and well-being (Formosa, 2015). She stated that there are other lesbians her age who are single, without kids and struggling, rendering also the reality of older single women deserves a seat at the table in policy discussions. Peter spoke of the need for more visibility and understanding of older lesbian and gay (LG) persons' needs from health and support services. While he opined that health services provided are generally good, they lack specific provisions for senior LGBTI care. This aligns with findings of the AARP1 survey (Houghton, 2018), with stressed that policies should cater to better access for LGBT-sensitive and specific care. Peter disclosed that he was discriminated against and denied a male carer. Initially, an employee informed him that since he was married, his partner was duty-bound to assist with his care needs, dismissing his specific context. Even though he was eligible for services as a person with disabilities requiring support for daily living activities, he was placed on a long waiting list. When he eventually found a male carer, the department rejected the solution. He was told that because he is gay, he was not allowed a male carer and would be paired with a female carer, despite his discomfort. As he stated:

“[The support service]… did not accept my request, since I am gay, and under no circumstances was I to have a male carer. That means that it has to be a woman who washes

[1] The AARP is an American charitable organisation dedicated to enhancing the quality of life for all. It leads positive social change and deliver value to those 50 and over with emphasis on those at social or economic risk.

me, it has to be a woman to help assist me with personal matters, an option which I could not accept".

This sense of invisibility was also felt within the local LGBTIQ community itself. Almost all participants felt discriminated against on the basis of their age, noting that gay spaces and activities in Malta are geared towards the younger generation. As Karl expressed, "Don't expect me to just turn up, because if I don't find that the event appeals to me, I won't go." Therese further pointed out that "We are not a united gay and lesbian scene at all, and that's a shame!".

This corresponds with Heaphy 's (20120) findings, which state that gay men are subjected to ageism as they interact with younger members. The findings of Albo (2018) also denote the stereotype of the 'sad, old, lonely, bitter queen', and the overall idea of being 'old' is bad, and to be younger than one's chronological age is good, with such pressures to fit in and feel part of the gay community leading older gay man to take a covert route in "passing" as younger (Slevin & Linneman, 2010). Beyond ageism, a possible fear persists among older members of the LGBTIQ community living in a small island state, as Charlotte stated "In Malta I don't go for the fact that someone would bash you, Malta is too small".

The participants' feelings of invisibility are multi-layered. They face societal invisibility, where services are heteronormative, and also intra-community invisibility, where ageism within the LGBTIQ community alienates them from the very spaces meant for support (Willis et al., 2022). This 'minority within a minority' status can impact the formation of new relationships and increase isolation (Willis et al., 2019). The concern for sensitive and specific care (Hafford-Letchfield & Roberts, 2023; Sussman et al., 2018) is not just an abstract wish but a direct response to a lifetime of being overlooked by the very systems they will one day depend on.

**Future: Sacrificing One's Identity vs. Self-Actualisation**

The above theme denotes that, if the current climate of heteronormative culture in long-term care does not become more inclusive to all sexual identities, participants feel that they must sacrifice their true identity, whereas if the future proves otherwise, participants may continue to age and grow, reaching self-fulfilment in an affirmative manner with the possibility of reaching the final stage of Maslow's hierarchy of needs, that of self-actualisation. (McLeod, 2007).

When considering the future, all participants expressed that 'ageing in place'—remaining in their own homes, surrounded by partners and friends (Knocker, 2012)—was the

only viable option for retaining their sense of self and well-being. As expressed by Karl: “the future is one of my preoccupations, as to whether I will be able to remain living at home or not. I retrofitted the home when it went through the restoration process, so that I can remain in it”. While Therese was convinced that she would not enter into institutional care as she expressed: “Allow me to die here… bring me meals on wheels, whether I eat or not is not a problem… But I feel like I am going differently somehow.”

This preference was driven by a deep-seated fear of institutional care. Participants expressed helplessness and hopelessness at the thought of ending up in a nursing home, believing they would have to sacrifice their true selves. Karl conveyed that older LG persons end up "totally institutionalised, with no liberty of expressing their true selves". Peter elaborated on this fear: "...what concerns me is that you would not be able to talk about your life story. You would be living among people with a different mentality, those which maybe do not accept something like this.

This fear of retiring into a heteronormative residential setting re-awakens anxieties of their sexuality identity not being recognised, tolerated or accepted (Margolis, 2014), ending up being a target for humiliation or not feeling safe (Caceres et al., 2020; Leyerzapf et al., 2019; Margolis, 2014). This leads to the phenomenon of 're-closeting' to avoid hostility, and passing as heterosexual (Purvis, 2018; Ramirez-Valles, 2016; Willis et al., 2016).

When asked about alternatives, the idea of a 'gay affirmative care home' was raised as a way to live in a safe environment, free from judgement. Charlotte explained:

"I think the next thing is a home for these people who are ageing and would like to be together… They will be happy... and no one will be looking at them wondering about their sexual orientation... I think it’s about time that the government does this next step."

Therese also in agreement with Charlotte, further proposing that a wing will be allocated for LGBTIQ residents in St Vincent de Paul Residence SVPR, Malta’s largest state long-term facility:

“Definitely and the worst part of that is when you start to get old and you end up in an old people’s home. That scares the hell out of me, and it scares the hell out of a lot of us…So, it would be nice if there could be a little wing at SVP, for LG persons.”

The participants' profound fear of long-term care facilities is strongly supported by international literature. This fear is not irrational but is based on documented experiences of abuse, neglect, harassment, and discrimination in care settings (Justice in Ageing, 2015; Knocker, 2012; Stein et al., 2010). The assumption of heteronormativity and cisnormativity in care homes forces LGBTIQ residents to navigate a system that renders them invisible (Caceres

et al., 2020; Fasullo et al., 2022). The 'price' for this concealment is high, leading to isolation, depression, and a faster progression of cognitive decline (HCpro, 2017; McGovern, 2014).

Charlotte's call for an affirmative home aligns with research showing that older LGBTIQ persons would feel more comfortable if providers were specifically trained on their needs (Houghton, 2018). While some advocate for LGBTIQ-specific facilities, the broader call is for all mainstream services to become genuinely inclusive (Alzheimer Europe, 2022; Buczak-Stec et al., 2023). This requires more than simple non-discrimination policies; it demands proactive cultural change, visible signs of inclusion, and staff trained in affirmative practice (Cummings et al., 2021; Hafford-Letchfield et al., 2018).

## Conclusion and Implications

This collection of narratives provides a critical, in-depth look into the lives of older lesbian and gay individuals in Malta. The results delineate the importance of understanding their unique life histories, the societal factors that shaped them, and how this has impacted their outlook on social and health care support.

The 'gayby boomers'[2] have brought a new demographic to population ageing in Malta. From these six narratives, a sense of uncertainty emerges, revealing an unconscious conflict between living an affirmative LGBTIQ life and the inherent need to conform to heteronormativity to be adequately cared for. This fear becomes more pronounced when contemplating later life. The denial of one's true self is perceived as the potential price for entry into institutionalised care built around a heteronormative culture.

The findings from this Maltese study underscore a significant knowledge gap and, more importantly, a gap in service provision. What is known from the international literature is now confirmed within the Maltese context: older LGBTIQ persons fear for their future. They fear that the systems designed to care for them will instead strip them of their identity, their history, and their dignity.

The implications are clear. There is an urgent need for Maltese healthcare agencies, long-term care providers, and government bodies to move beyond simple tolerance. They must proactively adopt inclusive, person-centred care approaches for LGBTIQ residents. This includes:

1. **Policy and Visibility:** Implementing robust anti-discrimination policies that explicitly name sexual orientation and gender identity. This must be complemented by visible

[2] This term refers to LG persons who form part of the Baby boomer generation (Ramirez-Valles, 2016).

markers of inclusion, such as rainbow badges or affirmative posters, as highlighted in UK initiatives (Hafford-Letchfield et al., 2018).

2. **Staff Training:** Mandating comprehensive training for all staff (from management to frontline carers) on the unique histories, needs, and language relevant to older LGBTIQ adults. This training must move beyond a 'tick-box' exercise and aim for genuine cultural change (Westwood & Knocker, 2016).
3. **Affirmative Practice:** Updating intake forms to be inclusive of SOGI and 'families of choice'. Staff must be trained to use inclusive language, respect chosen family as legitimate decision-makers, and create an environment of trust that allows residents to share their biographies safely.
4. **Supporting 'Ageing in Place':** Recognising the strong preference for ageing in place, support services must be equipped to be LGBTIQ-affirmative in the community, ensuring home-care workers are trained and informal 'families of choice' are supported.

This study, while small in scale, opens the door to a critically under-researched area in Malta. It demonstrates that for older LGBTIQ Maltese, the fight for recognition does not end in old age; it merely shifts to a new, and perhaps most vulnerable, frontier: the care home.

## Intersectional Limitations

It must be acknowledged that the participants in this study represented a 'resource-rich' segment of the population—articulate, community-connected, and largely middle-class. This reflects a limitation in recruitment common to narrative inquiry. Consequently, the findings may inadvertently privilege a form of 'successful queer ageing' that is not accessible to those facing intersecting inequalities, such as those with disabilities, lower socioeconomic status, or those living in rural Gozo. Future research must specifically target these 'hard-to-reach' voices to avoid replicating the marginalisation found in mainstream gerontology.

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# Effectiveness of Self Compassion-Based Interventions on Elderly People: A Literature Review

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## Abstract

This review article is designed to evaluate the impact of self-compassion-based interventions on the physical, psychological, and social health of older adults. Recent studies support that high self-compassion enhances life satisfaction in older adults, strengthens resilience against physical and emotional challenges, and fosters a more positive adaptation to age-related changes. The evidence the impact of self-compassion-based interventions on the health of older adults shows that these approaches help elderly individuals better manage stress, control negative emotions, and reduce symptoms of depression, ultimately fostering greater resilience and life satisfaction. Integrating self-compassion with cognitive-behavioral or motor-based activities amplifies these effects, contributing to improved forgiveness, acceptance, and emotional adjustment. Furthermore, such interventions address important dimensions of mental health, including feelings of loneliness and the ability to form positive relationships, which are especially relevant for older individuals facing health challenges or living in residential care. Collectively, these findings underscore the value of self-compassion-focused programs in supporting successful aging and holistic mental health in later life. Given these findings, integrating self-compassion and mindfulness-based approaches into mental health programs for the elderly can offer valuable benefits.

## Introduction

Elderly people who practice self-compassion tend to experience better psychological well-being and cope more effectively with the challenges of aging, such as physical decline and emotional stress. Self-compassion in older adults involves treating oneself with kindness, recognizing the shared human experience of aging, and maintaining mindful awareness without harsh self-judgment. Research shows that higher self-compassion is linked to greater life satisfaction, less emotional distress, and a more positive attitude toward age-related changes. It also moderates the negative impact of poor physical health on subjective well-being, helping older adults maintain resilience despite health issues. Moreover, self-compassionate elderly individuals are more willing to seek and use assistance (e.g., using walkers or asking for help) without feeling bothered, which can promote better physical and cognitive functioning (Allen et al., 2012; Allen & Leary, 2014).

Research examining the relationship between self-compassion and psychological health in older adults shows that elderly individuals with higher levels of self-compassion are better able to cope with psychological issues such as depression, anxiety, and stress, and generally have higher psychological well-being (Othman et al., 2025; Tavares et al., 2023). For example, a systematic review found that self-compassion acts as a protective factor enhancing psychological health in older adults and is effective in managing depressive symptoms and anxiety (Moraes et al., 2021). Additionally, older adults with self-compassion are more successful in coping with negative emotions stemming from physical health problems, and self-compassion has positive effects on life satisfaction and psychological resilience (Allen et al., 2011; Herriot & Wrosch, 2021). Furthermore, self-compassion training for older adults leads to increased tendencies to be compassionate towards oneself and others, along with reductions in stress and anxiety (Büyükbayram Arslan & Çiçekoğlu Öztürk, 2025). These findings highlight self-compassion as an important personal resource for supporting psychological health in the elderly.

Studies investigating the relationship between self-compassion and physical health in older adults show that individuals with higher levels of self-compassion tend to have better outcomes regarding daily physical symptoms and chronic illnesses. Self-compassion plays a significant role in reducing daily physical symptoms and preventing the increase of chronic illnesses in late life (Herriot & Wrosch, 2021). Similarly, among elderly individuals with poor physical health, higher levels of self-compassion were associated with greater subjective well-being, whereas this effect was not observed in those with good physical health. Moreover, it is

reported that older adults with self-compassion approach themselves more kindly while coping with the negative effects caused by physical health problems, leading to higher quality of life as a result (Allen et al., 2012). These findings reveal that self-compassion is an important psychological resource that supports physical health and quality of life in older adults.

For these reasons, this article will present examples from intervention studies. The effects of self-compassion practices on older adults will be discussed based on the findings of existing research.

**Samples from interventions studies**

Table 1 presents examples of self-compassion-based intervention studies in the elderly. The aim of the study by Perez-Blasco et al. (2016) was to evaluate the effectiveness of a mindfulness and self-compassion-based intervention on enhancing the ability of older adults living in the community to adapt to stressful situations. The researchers randomized 45 non-institutionalized elderly individuals into either an intervention group or a waitlist control group and conducted pre- and post-intervention assessments using measures such as resilience, depression, anxiety, stress, and coping strategies. The results demonstrated that participants who received the mindfulness and self-compassion training showed significant improvements in resilience, increased use of positive reappraisal and avoidance coping strategies, and reductions in anxiety, problem-focused coping, negative self-focus, emotional expression, and religious coping when compared to the control group. These findings suggest that mindfulness and self-compassion interventions can enhance the capacity of community-dwelling older adults to cope with stress more adaptively.

The study by Kashmari et al. (2023) aimed to compare the effectiveness of cognitive-behavioral therapy (CBT) combined with self-compassion and cognitive-motor activities to cognitive-motor intervention alone in enhancing forgiveness and self-compassion among older adults. In this quasi-experimental research, 42 adults over the age of 60 were randomly assigned to either a group receiving CBT with self-compassion and cognitive-motor activities, a group receiving only cognitive-motor intervention, or a control group. Both intervention protocols lasted for 18 sessions over 9 weeks. The results showed that both intervention groups had significant improvements in forgiveness and self-compassion compared to the control group, but those who participated in the CBT and self-compassion program combined with cognitive-motor activities achieved greater improvements in self-compassion than the group with cognitive-motor activities alone. These gains were maintained at follow-up, suggesting

that integrating psychological and motor-based approaches can be particularly effective for promoting positive psychological traits in the elderly.

The aim of the study by Bijaeyeh et al. (2021) was to examine whether a self-compassion training program could enhance life satisfaction and resilience among elderly women. Using a semi-experimental design, the researchers selected elderly women from nursing homes and divided them into an intervention group, which received eight sessions of self-compassion training based on Gilbert's model, and a control group that did not receive any intervention. Assessments were conducted before, after, and at follow-up using validated scales for life satisfaction and resilience. The findings revealed that the intervention group experienced significant improvements in both life satisfaction and resilience compared to the control group, and these benefits were sustained during the follow-up period. The study concluded that self-compassion training could serve as an effective psychological intervention to promote greater well-being and adaptation in elderly women living in institutional settings.

The purpose of the study by Farokhzadian and Mirderekvand (2018) was to examine the impact of self-compassion focused therapy on psychological well-being and depression among the elderly. Using a quasi-experimental design, elderly participants were divided into an intervention group that received a series of self-compassion focused therapy sessions and a control group that did not receive any intervention. Standardized scales for psychological well-being and depression were administered before and after the intervention. The study found that participants who underwent self-compassion focused therapy experienced significant increases in psychological well-being as well as notable reductions in depressive symptoms compared to the control group. The authors concluded that self-compassion therapy can be implemented as an effective psychological intervention to improve mental health and reduce depression in older adults.

The study by Kazemi et al. (2020) aimed to examine whether self-compassion-based treatment could reduce feelings of loneliness and increase life expectancy in elderly women. Adopting a quasi-experimental design, the researchers selected elderly women for participation and divided them into an intervention group receiving self-compassion therapy and a control group. Validated scales were used to assess loneliness and life expectancy before and after the intervention. The results indicated that self-compassion therapy led to a significant decrease in loneliness and a notable improvement in life expectancy among participants compared to those who did not receive the intervention. These effects were also maintained at follow-up, demonstrating the potential of self-compassion-based interventions to support emotional well-being and optimistic outlook on life in older women.

The study conducted by Mohamed Abd-Elsalam Elhgry et al. (2020) aimed to evaluate the effect of a self-compassion-based intervention on self-compassion, life satisfaction, and psychological well-being among older adults living in a geriatric home. Utilizing a quasi-experimental pre-posttest design, the researchers recruited seventy elderly participants and administered structured sessions to introduce and cultivate self-compassion. Standardized assessment tools were used to measure self-compassion, life satisfaction, and psychological well-being before and after the intervention. The findings revealed that older adults who participated in the intervention demonstrated significant improvements in all three areas: their self-compassion, life satisfaction, and psychological well-being scores increased markedly after the program. The results underscored the value of self-compassion-focused interventions in fostering optimal psychological health and greater life satisfaction during late adulthood.

## Conclusion

Recent studies support that self-compassion and mindfulness-based interventions can play a crucial role in promoting the psychological well-being of older adults. The evidence shows that these approaches help elderly individuals better manage stress, control negative emotions, and reduce symptoms of depression, ultimately fostering greater resilience and life satisfaction. Integrating self-compassion with cognitive-behavioral or motor-based activities amplifies these effects, contributing to improved forgiveness, acceptance, and emotional adjustment. Furthermore, such interventions address important dimensions of mental health, including feelings of loneliness and the ability to form positive relationships, which are especially relevant for older individuals facing health challenges or living in residential care. Collectively, these findings underscore the value of self-compassion-focused programs in supporting successful aging and holistic mental health in later life.

## Recommendations

Given these findings, integrating self-compassion and mindfulness-based approaches into mental health programs for the elderly can offer valuable benefits. Tailoring interventions to include both psychological therapy and physical or cognitive activities may maximize outcomes. Nursing homes and community centers should consider structured self-compassion training to improve resilience and reduce loneliness. Moreover, healthcare providers working with chronically ill older adults should incorporate these practices to foster better acceptance and psychological adjustment, ultimately enhancing quality of life and possibly longevity.

**Table 1: Samples from interventions studies investigating the effects of self-compassion on elderly people**

| Authors | Aim | Conclusion |
|---|---|---|
| **Perez-Blasco et al., 2016** | To evaluate the effectiveness of a mindfulness and self-compassion-based intervention on enhancing the ability of older adults living in the community to adapt to stressful situations | The results demonstrated that both mindfulness and self-compassion significantly improved participants' capacity to cope with stress. Specifically, cultivating these qualities was associated with better emotional regulation, reduced stress levels, and increased psychological well-being. The study concluded that mindfulness and self-compassion practices can serve as effective interventions to help older adults manage stress and enhance their overall mental health. |
| **Kashmari et al., 2023** | To compare the effectiveness of cognitive-behavioral therapy (CBT) combined with self-compassion and cognitive-motor activities to cognitive-motor intervention alone in enhancing forgiveness and self-compassion among older adults | Both intervention methods (1) cognitive-behavioral therapy (CBT) combined with self-compassion and cognitive-motor activities, and (2) cognitive-motor intervention alone were effective in increasing levels of forgiveness and self-compassion among elderly participants. CBT combined with self-compassion and cognitive-motor activities was significantly more effective than cognitive-motor activities alone in enhancing self-compassion in the elderly. |
| **Bijaeyeh et al., 2021** | To examine whether a self-compassion training program could enhance life satisfaction and resilience among elderly women | The results suggest that self-compassion training is an effective therapeutic intervention to enhance psychological well-being and resilience in elderly women, and it can be effectively applied in nursing home settings |
| **Farokhzadian & Mirderekvand, 2018** | To examine the impact of self-compassion focused therapy on psychological well-being and depression among the elderly | Self-compassion-focused therapy significantly reduces cognitive vulnerability to depression and increases psychological well-being in elderly individuals. The research demonstrated statistically significant improvements in dysfunctional attitudes, self-esteem, and attribution styles related to negative events after eight sessions of therapy. |
| **Kazemi et al., 2020** | To examine whether self-compassion-based treatment could reduce feelings of loneliness and increase life expectancy in elderly women | Self-compassion-focused therapy significantly reduces loneliness and increases life expectancy among senior women. This indicates that the intervention not only helps elderly women feel less isolated but also has a positive impact on their overall longevity |
| **Mohamed Abd-Elsalam Elhgry et al., 2020** | To evaluate the effect of a self-compassion-based intervention on self-compassion, life satisfaction, and psychological well-being among older adults living in a geriatric home | A highly statistically significant increase in life satisfaction scores post-intervention. Elderly participants with chronic health problems showed notably higher self-compassion after the intervention, suggesting better acceptance and kind responses to their health difficulties. Positive increases were seen in psychological well-being subscales such as acceptance, autonomy, environment mastery, personal growth, positive relations, and purpose in life. |

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# The Role of Health Cooperation in Building Aggregate Demand for Health Services

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## Abstract

Working in a team greatly improves health cooperation and helps propose innovative solutions for health issues. Furthermore, a multidisciplinary team has more overlapping roles defined by communication and troubleshooting. However, Demand for health services is significant as it is related to the social aspect of citizens' health status in a country. Since it is significant, the current study focuses on a very important problem, which is the possibility of estimating the total social demand for health services through public-private sector cooperation in third-world countries, represented by Syria. Moreover, it endeavors to propose a model for estimating the total social demand for health services in the public and private sectors. The descriptive analytical approach was used, and the data were collected through cooperation between a team of health experts in various fields, depending on the available secondary data, interviews, and the observation and estimation of the primary data. The model design includes dividing the total demand into six dimensions, which are (demand for hospitals, demand for health centers, demand for medical clinics, demand for dental clinics, demand for pharmacies, and demand for laboratories). The study has the following result: Health collaboration plays an important role in designing the proposed model and getting the missing health data needed.

## Introduction

Elderly people who practice self-compassion tend to experience better psychological well-being and cope more effectively with the challenges of aging, such as physical decline and emotional stress. Self-compassion in older adults involves treating oneself with kindness, recognizing the shared human experience of aging, and maintaining mindful awareness without harsh self-judgment. Research shows that higher self-compassion is linked to greater life satisfaction, less emotional distress, and a more positive attitude toward age-related changes. It also moderates the negative impact of poor physical health on subjective well-being, helping older adults maintain resilience despite health issues. Moreover, self-compassionate elderly individuals are more willing to seek and use assistance (e.g., using walkers or asking for help) without feeling bothered, which can promote better physical and cognitive functioning (Allen et al., 2012; Allen & Leary, 2014).

Research examining the relationship between self-compassion and psychological health in older adults shows that elderly individuals with higher levels of self-compassion are better able to cope with psychological issues such as depression, anxiety, and stress, and generally have higher psychological well-being (Othman et al., 2025; Tavares et al., 2023). For example, a systematic review found that self-compassion acts as a protective factor enhancing psychological health in older adults and is effective in managing depressive symptoms and anxiety (Moraes et al., 2021). Additionally, older adults with self-compassion are more successful in coping with negative emotions stemming from physical health problems, and self-compassion has positive effects on life satisfaction and psychological resilience (Allen et al., 2011; Herriot & Wrosch, 2021). Furthermore, self-compassion training for older adults leads to increased tendencies to be compassionate towards oneself and others, along with reductions in stress and anxiety (Büyükbayram Arslan & Çiçekoğlu Öztürk, 2025). These findings highlight self-compassion as an important personal resource for supporting psychological health in the elderly.

Studies investigating the relationship between self-compassion and physical health in older adults show that individuals with higher levels of self-compassion tend to have better outcomes regarding daily physical symptoms and chronic illnesses. Self-compassion plays a significant role in reducing daily physical symptoms and preventing the increase of chronic illnesses in late life (Herriot & Wrosch, 2021). Similarly, among elderly individuals with poor physical health, higher levels of self-compassion were associated with greater subjective well-being, whereas this effect was not observed in those with good physical health. Moreover, it is

reported that older adults with self-compassion approach themselves more kindly while coping with the negative effects caused by physical health problems, leading to higher quality of life as a result (Allen et al., 2012). These findings reveal that self-compassion is an important psychological resource that supports physical health and quality of life in older adults.

For these reasons, this article will present examples from intervention studies. The effects of self-compassion practices on older adults will be discussed based on the findings of existing research.

**Samples from interventions studies**

Table 1 presents examples of self-compassion-based intervention studies in the elderly. The aim of the study by Perez-Blasco et al. (2016) was to evaluate the effectiveness of a mindfulness and self-compassion-based intervention on enhancing the ability of older adults living in the community to adapt to stressful situations. The researchers randomized 45 non-institutionalized elderly individuals into either an intervention group or a waitlist control group and conducted pre- and post-intervention assessments using measures such as resilience, depression, anxiety, stress, and coping strategies. The results demonstrated that participants who received the mindfulness and self-compassion training showed significant improvements in resilience, increased use of positive reappraisal and avoidance coping strategies, and reductions in anxiety, problem-focused coping, negative self-focus, emotional expression, and religious coping when compared to the control group. These findings suggest that mindfulness and self-compassion interventions can enhance the capacity of community-dwelling older adults to cope with stress more adaptively.

The study by Kashmari et al. (2023) aimed to compare the effectiveness of cognitive-behavioral therapy (CBT) combined with self-compassion and cognitive-motor activities to cognitive-motor intervention alone in enhancing forgiveness and self-compassion among older adults. In this quasi-experimental research, 42 adults over the age of 60 were randomly assigned to either a group receiving CBT with self-compassion and cognitive-motor activities, a group receiving only cognitive-motor intervention, or a control group. Both intervention protocols lasted for 18 sessions over 9 weeks. The results showed that both intervention groups had significant improvements in forgiveness and self-compassion compared to the control group, but those who participated in the CBT and self-compassion program combined with cognitive-motor activities achieved greater improvements in self-compassion than the group with cognitive-motor activities alone. These gains were maintained at follow-up, suggesting

that integrating psychological and motor-based approaches can be particularly effective for promoting positive psychological traits in the elderly.

The aim of the study by Bijaeyeh et al. (2021) was to examine whether a self-compassion training program could enhance life satisfaction and resilience among elderly women. Using a semi-experimental design, the researchers selected elderly women from nursing homes and divided them into an intervention group, which received eight sessions of self-compassion training based on Gilbert's model, and a control group that did not receive any intervention. Assessments were conducted before, after, and at follow-up using validated scales for life satisfaction and resilience. The findings revealed that the intervention group experienced significant improvements in both life satisfaction and resilience compared to the control group, and these benefits were sustained during the follow-up period. The study concluded that self-compassion training could serve as an effective psychological intervention to promote greater well-being and adaptation in elderly women living in institutional settings.

The purpose of the study by Farokhzadian and Mirderekvand (2018) was to examine the impact of self-compassion focused therapy on psychological well-being and depression among the elderly. Using a quasi-experimental design, elderly participants were divided into an intervention group that received a series of self-compassion focused therapy sessions and a control group that did not receive any intervention. Standardized scales for psychological well-being and depression were administered before and after the intervention. The study found that participants who underwent self-compassion focused therapy experienced significant increases in psychological well-being as well as notable reductions in depressive symptoms compared to the control group. The authors concluded that self-compassion therapy can be implemented as an effective psychological intervention to improve mental health and reduce depression in older adults.

The study by Kazemi et al. (2020) aimed to examine whether self-compassion-based treatment could reduce feelings of loneliness and increase life expectancy in elderly women. Adopting a quasi-experimental design, the researchers selected elderly women for participation and divided them into an intervention group receiving self-compassion therapy and a control group. Validated scales were used to assess loneliness and life expectancy before and after the intervention. The results indicated that self-compassion therapy led to a significant decrease in loneliness and a notable improvement in life expectancy among participants compared to those who did not receive the intervention. These effects were also maintained at follow-up, demonstrating the potential of self-compassion-based interventions to support emotional well-being and optimistic outlook on life in older women.

The study conducted by Mohamed Abd-Elsalam Elhgry et al. (2020) aimed to evaluate the effect of a self-compassion-based intervention on self-compassion, life satisfaction, and psychological well-being among older adults living in a geriatric home. Utilizing a quasi-experimental pre-posttest design, the researchers recruited seventy elderly participants and administered structured sessions to introduce and cultivate self-compassion. Standardized assessment tools were used to measure self-compassion, life satisfaction, and psychological well-being before and after the intervention. The findings revealed that older adults who participated in the intervention demonstrated significant improvements in all three areas: their self-compassion, life satisfaction, and psychological well-being scores increased markedly after the program. The results underscored the value of self-compassion-focused interventions in fostering optimal psychological health and greater life satisfaction during late adulthood.

## Conclusion

Recent studies support that self-compassion and mindfulness-based interventions can play a crucial role in promoting the psychological well-being of older adults. The evidence shows that these approaches help elderly individuals better manage stress, control negative emotions, and reduce symptoms of depression, ultimately fostering greater resilience and life satisfaction. Integrating self-compassion with cognitive-behavioral or motor-based activities amplifies these effects, contributing to improved forgiveness, acceptance, and emotional adjustment. Furthermore, such interventions address important dimensions of mental health, including feelings of loneliness and the ability to form positive relationships, which are especially relevant for older individuals facing health challenges or living in residential care. Collectively, these findings underscore the value of self-compassion-focused programs in supporting successful aging and holistic mental health in later life.

## Recommendations

Given these findings, integrating self-compassion and mindfulness-based approaches into mental health programs for the elderly can offer valuable benefits. Tailoring interventions to include both psychological therapy and physical or cognitive activities may maximize outcomes. Nursing homes and community centers should consider structured self-compassion training to improve resilience and reduce loneliness. Moreover, healthcare providers working with chronically ill older adults should incorporate these practices to foster better acceptance and psychological adjustment, ultimately enhancing quality of life and possibly longevity.

**Table 1: Samples from interventions studies investigating the effects of self-compassion on elderly people**

| Authors | Aim | Conclusion |
|---|---|---|
| **Perez-Blasco et al., 2016** | To evaluate the effectiveness of a mindfulness and self-compassion-based intervention on enhancing the ability of older adults living in the community to adapt to stressful situations | The results demonstrated that both mindfulness and self-compassion significantly improved participants' capacity to cope with stress. Specifically, cultivating these qualities was associated with better emotional regulation, reduced stress levels, and increased psychological well-being. The study concluded that mindfulness and self-compassion practices can serve as effective interventions to help older adults manage stress and enhance their overall mental health. |
| **Kashmari et al., 2023** | To compare the effectiveness of cognitive-behavioral therapy (CBT) combined with self-compassion and cognitive-motor activities to cognitive-motor intervention alone in enhancing forgiveness and self-compassion among older adults | Both intervention methods (1) cognitive-behavioral therapy (CBT) combined with self-compassion and cognitive-motor activities, and (2) cognitive-motor intervention alone were effective in increasing levels of forgiveness and self-compassion among elderly participants. CBT combined with self-compassion and cognitive-motor activities was significantly more effective than cognitive-motor activities alone in enhancing self-compassion in the elderly. |
| **Bijaeyeh et al., 2021** | To examine whether a self-compassion training program could enhance life satisfaction and resilience among elderly women | The results suggest that self-compassion training is an effective therapeutic intervention to enhance psychological well-being and resilience in elderly women, and it can be effectively applied in nursing home settings |
| **Farokhzadian & Mirderekvand, 2018** | To examine the impact of self-compassion focused therapy on psychological well-being and depression among the elderly | Self-compassion-focused therapy significantly reduces cognitive vulnerability to depression and increases psychological well-being in elderly individuals. The research demonstrated statistically significant improvements in dysfunctional attitudes, self-esteem, and attribution styles related to negative events after eight sessions of therapy. |
| **Kazemi et al., 2020** | To examine whether self-compassion-based treatment could reduce feelings of loneliness and increase life expectancy in elderly women | Self-compassion-focused therapy significantly reduces loneliness and increases life expectancy among senior women. This indicates that the intervention not only helps elderly women feel less isolated but also has a positive impact on their overall longevity |
| **Mohamed Abd-Elsalam Elhgry et al., 2020** | To evaluate the effect of a self-compassion-based intervention on self-compassion, life satisfaction, and psychological well-being among older adults living in a geriatric home | A highly statistically significant increase in life satisfaction scores post-intervention. Elderly participants with chronic health problems showed notably higher self-compassion after the intervention, suggesting better acceptance and kind responses to their health difficulties. Positive increases were seen in psychological well-being subscales such as acceptance, autonomy, environment mastery, personal growth, positive relations, and purpose in life. |

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# Digitális játékok és aktív idősödés: az online szabadidő pszichológiai, kognitív és szociális összefüggései időskorban

# Digital Games and Active Aging: The Psychological, Cognitive, and Social Aspects of Online Digital Leisure in Elderly Years

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**Kulcsszavak:** időskor, aktív idősödés, digitális szabadidő, videójátékok

## Absztrakt

A tanulmány az időskorúak digitális szabadidős tevékenységeit, különösen a videójáték-használatot vizsgálja az aktív idősödés és a digitális jóllét keretében. E tevékenységek komplex pszichológiai, szociális és egészségügyi hatásokkal járnak, amelyek az aktív idősödés modern értelmezésében kiemelt jelentőséggel bírnak. A tanulmány célja az idősek digitális játékhasználatának átfogó bemutatása, különös tekintettel a motivációkra, a részvételt segítő és gátló tényezőkre, ezek potenciális pozitív hatásaira és kockázataira, valamint a digitális játékok kognitív, érzelmi és társas működésre gyakorolt hatásaira. Az online játékok és a digitális játékterek, beleértve az e-sport kezdeményezéseket és a virtuális valóság alapú alkalmazásokat, új lehetőségeket kínálnak az idősek számára a rekreáció, a tanulás és a társas integráció területén. A tanulmány fő következtetése, hogy a digitális játékok megfelelő támogatás és felhasználóbarát tervezés mellett az aktív és minőségi idősödés fontos eszközei lehetnek.

**Keywords:** elderly individuals, active aging, digital leisure, video game

## Abstract

The study examines the digital leisure activities of older adults, especially video game use, in the context of active aging and digital well-being. These activities have complex psychological, social and health effects that are crucial in the modern interpretation of active aging. The aim of the study is to provide a comprehensive overview of digital game use among elderly

individuals with a specific focus on motivations, factors facilitating and hindering participation, their potential positive effects and risks, and the effects of digital games on cognitive, emotional and social functioning. Online games and digital game spaces, including e-sports and virtual reality-based applications, offer new opportunities for seniors in the areas of recreation, learning and social integration. The study highlights that digital games with adequate support and user-friendly design can be important tools for active and quality ageing.

## Bevezetés

Az elmúlt két évtizedben az időskor és a digitalizáció kapcsolata alapvetően átalakult: az online tér egyre inkább meghatározó része az idősödő és idős korosztályok mindennapjainak (United Nations Economic Commission for Europe, 2021). A technológiai eszközök terjedése, a szélessávú internet elérhetősége és a digitális szolgáltatások révén az idősek is egyre aktívabb szereplők a digitális világban. A növekvő online jelenlét és digitális aktivitás olyan praktikus funkciókkal szolgálhat számukra mint az információszerzés, kapcsolattartás vagy ügyintézés, továbbá szabadidős tevékenységnek és rekreációnak is lehetőséget biztosítanak (Charness & Boot, 2009; De Schutter, 2011; Kaufman & Zhang, 2015; Neves és mtsai., 2018). E tevékenységek a társas integrációra, a minőségi szabadidő és az aktív idősödés megélésére új útvonalakat nyithatnak az idősebb személyek számára (Kaufman és mtsai., 2016; Toril és mtsai., 2014). Mindezek a változások új kutatási irányokat és értelmezési kereteket követelnek meg. Jelen tanulmány célja, hogy átfogó képet adjon az idősek digitális szabadidőtöltéséről, különös tekintettel az online játékhasználatra és annak pszichológiai, társas és egészségügyi vonatkozásaira.

## Módszer

Jelen tanulmány narratív, tematikus szakirodalmi áttekintés formájában nyújt átfogó képet az időskorúak digitális szabadidőtöltéséről, kiemelt figyelmet szentelve a digitális játékhasználat pszichológiai, kognitív és szociális vonatkozásaira. A téma feldolgozásához illeszkedő források beazonosítása és kiválasztása a PRISMA 2020 irányelveinek az átláthatóságra irányuló ajánlásainak megfelelően történt (Page és mtsai., 2021).

Az irodalomgyűjtés során előbb nemzetközi adatbázisok segítségével (pl. PsycINFO, PubMed, Scopus, Web of Science), majd a Google Scholar felületével kiegészítve, valamint releváns gerontológiai és az időskort fókuszba állító folyóiratok áttekintésével azonosítottuk a releváns forrásokat. Elsősorban a 2000 után megjelent, lektorált tanulmányokra és áttekintő cikkekre fókuszáltunk, mivel az idősek digitális szabadidő-eltöltésének és játékhasználatának vizsgálata ebben az időszakban kezdett hangsúlyossá válni. Emellett néhány korábbi, az aktív idősödés és a kognitív tartalék elméleti keretét meghatározó klasszikus munkát is felhasználtunk.

A keresés során az „idős”, „időskor”, „idős személy”, „idősödés”, „elderly”, „older adults”, „aging”, „active aging” kulcsszavakat kombináltuk a „digital leisure”, „online leisure”, „video games”, „digital games”, „exergames”, „virtual reality”, „e-sport”, „digital well-being” kifejezésekkel, ragozott alakokkal. A találatokat először cím és absztrakt alapján tekintettük át:

azok a publikációk kerültek előszűrésre, amelyek az idősödő felnőtt vagy idős korosztály digitális szabadidős tevékenységeit, különösen a játékhasználatot vizsgálták, és amelyek pszichológiai, kognitív, szociális vagy egészségügyi kimenetekkel foglalkoztak. Ezt követően a potenciálisan releváns tanulmányokat teljes szövegükben is áttekintettük.

A beválasztási kritériumok az alábbiak voltak:

- a digitális játékokhoz vagy tágabban a digitális szabadidőhöz kapcsolódó tevékenységet vizsgáljon
- a minta legalább egy része időskorú személyekből álljon (vagy külön publikálásra kerüljenek az idősebb korosztály eredményei)
- számoljon be kognitív, érzelmi, társas vagy egészségügyi hatásokról
- elméleti keretet nyújtson az aktív idősödés, digitális jóllét és digitális játékhasználat összefüggéseihez.

Előnyt élveztek a peer reviewed és empirikus vizsgálatok, valamint a szisztematikus áttekintések. Nem vontuk be azokat a munkákat, amelyek kizárólag technológiai fejlesztést ismertettek empirikus vizsgálat nélkül, illetve amelyek kizárólag fiatal populációra vagy általános felnőtt mintára fókuszáltak.

A tematikus telítettség növelése érdekében hólabda-módszert is alkalmaztunk: a tanulmányok hivatkozásjegyzékét áttekintve további releváns forrásokat azonosítottunk, illetve a már bevont cikkekre hivatkozó újabb munkákat is megkerestük. Azokat a forrásokat emeltük be részletesebben, amelyek jól reprezentálják az időskori digitális játékhasználat fő motivációit, lehetőségeit, akadályait és kockázatait.

Az így kialakult irodalomkorpusz eredményeit narratív módon, tematikus blokkokba rendezve szintetizáltuk. A cikk fő fejezetei az idősek digitális részvételét, a digitális játékok motivációs hátterét, kognitív és érzelmi hatásait, az innovatív játéktereket (e-sport, virtuális valóság), valamint a digitális jóllét és az aktív idősödés összefüggéseit mutatják be. Tanulmányunk célja így a főbb tendenciák, visszatérő mintázatok és ellentmondások feltárása, amelyek további empirikus vizsgálatok számára jelölnek ki lehetséges irányokat.

## Az idős személyek és a digitális időtöltés

Korábban az idős személyek technológiai hátránya, a digitális szakadék, az alacsony eszközhasználati hajlandóság, a tanulási nehézségek, valamint az életkor, iskolázottság, jövedelem és egészségi állapot szerinti rétegzett technológiahasználat állt a kutatások középpontjában (Charness & Boot, 2009; Marston és mtsai., 2016; Schulz és mtsai., 2015), mára azonban egy új trend rajzolódik ki. A demográfiai változások következtében az európai

társadalmakban, így Magyarországon is, egyre nagyobb az idősebb korosztály aránya (European Commission, 2020). Napjaink idősödő társadalma abból a generációból kerül ki, akik aktív munkavállaló korukban már használhattak számítógépet, internetet és digitális eszközöket. Ebből következően az idősödő felnőtt és idős korosztály egyre inkább aktív online felhasználó. Nő a közösségi médiában töltött idejük, emelkedik az online tartalomfogyasztásuk mértéke (Macdonald & Hülür, 2020). Megfigyelhető részükről az érdeklődés a digitális játékok iránt is, legyen szó puzzle játékokról, online rejtvény- vagy stratégiai játékokról, videójátékokról, exergame-ekről (mozgásra ösztönző játék, a szó az angol exercise, mint testmozgás és game, mint játék szóösszetételből jön létre), vagy akár virtuális valóság-alapú megoldásokról (Allaire és mtsai., 2013; Anguera és mtsai., 2013; Baragash és mtsai., 2022; De Schutter, 2011; Kaufman és mtsai., 2016; Schell és mtsai., 2016). A COVID-19 idején különösen nagy szerep jutott a digitális tevékenységeknek, ami még inkább hozzájárult a digitális technológiáknak a mindennapokba történő integrációjához (Martins Van Jaarsveld, 2020).

A szabadidő digitális eltöltése egyre fontosabb erőforrássá válik, hiszen nem csupán szórakozási lehetőséget nyújt, hanem egy olyan aktív részvételt biztosít az idősek számára, amely hozzájárulhat az egészség fenntartásához, kompetenciaélményhez és autonómiához. Lehetővé teszi a folyamatos tanulást, a társas interakciókat, valamint a fizikai és kognitív aktivitás fenntartását, ezzel hozzásegítve a személyt az aktív, sikeres idősödéshez (Allaire és mtsai., 2013; Bleakley és mtsai., 2015; De Schutter, 2011; Maillot és mtsai., 2012; Zhang & Kaufman, 2016). Az online módon eltöltött szabadidő ezért egyre nagyobb teret kap az egyének életében: a szabadidő töltés hibriddé alakul, amelyben az online és offline tevékenységek, események és kölcsönhatásaik közösen hatnak az életminőségre és a jóllétre (Carnicelli és mtsai., 2016).

A digitális térben zajló szabadidőtöltés különböző tevékenységeket foglalhat magába, úgy mint a filmnézés, a beszélgetés és a társas kapcsolatok ápolása (Olecká és mtsai., 2022; Redhead, 2016; Silk és mtsai., 2016). Az így megvalósulható kikapcsolódási formák akkor válnak különösen jelentőssé, amikor a fizikai aktivitás vagy a hagyományos közösségi tevékenységek kevésbé elérhetők, például a korlátozott mobilitás vagy távolság miatt, amelyek az idős személyek esetében nagyobb nehézséget jelenthetnek (Bene és mtsai., 2020). Míg a korábbi kutatások a szabadidő eltöltésének passzív formáit emelték ki, újabb vizsgálatok rámutatnak, hogy a digitális rekreációs tevékenységek is lehetnek aktív jellegűek (Marston és mtsai., 2016; Marston & Kowert, 2020; Tutar & Turhan, 2023). Ha az egyének igényeikhez, szükségleteikhez igazodva, célirányosan válogatják ki a számukra megfelelő digitális tartalmakat, ezzel tevékeny résztvevőivé, irányítóivá válnak időtöltésüknek

A digitális részvételt nagyban meghatározza a digitális önbizalom és énhatékonyság (Choi & DiNitto, 2013; Ulfert-Blank & Schmidt, 2022), azaz, hogy egy idős személy mennyire érzi magát kompetensnek a médiahasználat során. Ezt az idősek életkori sajátosságai vagy kognitív képességei mellett a technológiához való viszonyuk, előzetes tapasztalatuk, motivációjuk, valamint a környezetük attitűdje is befolyásolja (Charness & Boot, 2009; Melenhorst és mtsai., 2006). Empirikus kutatások alapján, akik magasabb digitális énhatékonyságról számolnak be, nagyobb valószínűséggel próbálnak ki új alkalmazásokat, online játékokat és egyéb szolgáltatásokat (Kaufman és mtsai., 2016; Mohsin és mtsai., 2022).

Az idősebb korosztály digitális eszközökhöz való hozzáférése jelentősen javult (European Commission, 2020). Emellett továbbra is fennáll a képességbeli és attitűdbeli lemaradásuk a fiatalabb generációkhoz képest: alacsonyabb a technológiai jártasságuk, bizonytalanabbak az eszközhasználatban, emiatt több kudarc éri őket, szorongóbbak, és gyakoribb esetükben az elkerülő magatartás (Bene és mtsai., 2020; Charness & Boot, 2009; Friemel, 2016; Mitzner és mtsai., 2010; Nimrod, 2018). Eltéréseket tapasztalhatunk a digitáliseszköz-használatuk mintázatai és motivációi tekintetében is: az idősebb korosztály azokat az alkalmazásokat, digitális platformokat preferálja, amelyek tempójukban, felépítésükben és tematikájukban illeszkednek a korábbi analóg, offline tevékenységekhez és játékélményekhez, így ezek digitális adaptációi a legnépszerűbbek körükben (De Schutter, 2011; De Schutter és mtsai., 2015).

Digitális eszközhasználatukat többnyire instrumentális, szociális és rekreációs motivációk mozgatják: a kutatások gyakran említik a kikapcsolódást, a közös időtöltést, kihívás élményét, „kognitív edzést", illetve a magány csökkentését mint főbb tényezőket (De Schutter & Vanden Abeele, 2010; Marston, 2013; Zhang & Kaufman, 2015). Erős motivációnak tűnik a fiatalabb generációkkal, elsősorban az unokákkal való kapcsolódás: a közös játék, a digitális élmények együttes megélése, amelyek hozzájárulnak a társas kapcsolatok fenntartásához és a családi kapcsolatok erősítéséhez, elősegítik a kölcsön megértést és a támogató környezet online megtapasztalását is (Chua és mtsai., 2013; Osmanovic & Pecchioni, 2016; Pecchioni & Osmanovic, 2018; Zhang & Kaufman, 2015).

Számos vizsgálat azt mutatja, hogy a megfelelő támogató környezet, a gamifikált (játékosított) tanulási programok révén az idősek digitális kompetenciái jelentősen fejlődnek formális (tanfolyamok, idős akadémiák), nem-formális (közösségi programok, klubok) vagy informális közegben (családtagoktól, unokáktól való tanulás). Ezek mind csökkenthetik a generációk közötti digitális távolságot, növelhetik a technológia használatának élvezetét, és elősegíthetik a kreatív és szociális célú digitális aktivitásokat az idős korosztály körében (Allaire

és mtsai., 2013; Janssen és mtsai., 2023; Kaufman és mtsai., 2016; Marston és mtsai., 2016; Mayhorn és mtsai., 2016; Osmanovic & Pecchioni, 2016).

Az idősek online világba való bevonódása több, egymással összefonódó területen érhető tetten: a videójátékok, a sorozatdarálás (azaz filmek vagy sorozatrészek egymás utáni megtekintése, Starosta & Izydorczyk, 2020) és a közösségi médiahasználat mind olyan gyakorlatok, amelyek a mindennapi rutinuk részévé váltak. Ez számos pozitívumot hoz az életükbe: rendszerességet, közös beszédtémát, társas kapcsolódási lehetőséget, érzelmi bevonódást, a valahova való tartozás érzését. Továbbá az online közösségekben, játéktevékenységekben való részvétellel, a kognitívan stimuláló tartalmak fogyasztásával intellektuális aktivitásuk fenntartásáért is tesznek (Allaire és mtsai., 2013; Bleakley és mtsai., 2015; Kaufman és mtsai., 2016; Sharma és mtsai., 2022). Azok az idősebb felnőttek, akik rendszeres online tevékenységet folytatnak, magasabb szubjektív jóllétről, alacsonyabb depresszióról és fokozottabb társas támogatottságról számolnak be, mint nem online társaik (Allaire és mtsai., 2013; Kaufman és mtsai., 2016; Zhang & Kaufman, 2015). Ezen tevékenységek a WHO aktív idősödés modelljének dimenzióihoz is illeszkednek, mint például szociális és egészségügyi tényezők (Paúl és mtsai., 2012).

Ugyanakkor ezen tevékenységek időgazdálkodási, alvásminőségi kockázatokkal járhatnak. Kontrollálatlan használatuk ronthatja az életminőséget, csökkentheti a fizikai aktivitást, az alacsony szintű kompetenciaérzés vagy a bonyolult felhasználói felületek kellemetlen érzéseket, bosszúságot, frusztrációt válthatnak ki (Hargittai & Dobransky, 2017; Marston, 2013; Mohsin és mtsai., 2022). Az idősek sérülékenyebb felhasználók is, hiszen fokozottan ki vannak téve az online csalásoknak, adathalász kísérleteknek (Bene & Balázs, 2019; Burnes és mtsai., 2017; Carlson, 2006). Továbbá, ha a digitális aktivitás az offline társas kapcsolatok rovására történik, vagy az online kapcsolattartás okán felmentve érzik magukat a személyes találkozások alól, az elmagányosodáshoz, izolációhoz is vezethet (Bene és mtsai., 2020; Bleakley és mtsai., 2015; Kaufman és mtsai., 2016; Zhang & Kaufman, 2015). Az információs túlterhelés, azaz az interneten megjelenő nagy mennyiségű, gyakran ellentmondásos információk különösen megterhelőek lehetnek azon idős személyek számára, akik kevésbé jártasak ezen a területen (Hargittai & Dobransky, 2017; Zulman és mtsai., 2011), így növelhetik az egyén stressz és frusztráció szintjét.

Fontos tehát, hogy a digitális térben megvalósuló szabadidő eltöltésre vonatkozóan új szabályokat alakítsanak ki az egyének, amelyek hosszú távon olyan megoldást kínálnak, amik a feltöltődést szolgálják, és nem engedik, hogy a használat stresszforrássá váljon, vagy digitális függőséggé alakuljon (Aggarwal és mtsai., 2020; Andreassen, 2015). Ehhez új készségek

elsajátítása, valamint egy új egyensúly megteremtése is szükséges: a digitális felületeken való időtöltést tudatosan kell szabályozniuk. Ezáltal a személy a hedonikus és személyes növekedésre, önmegvalósításra irányuló élményeket is kontroll alatt tartva minimalizálhatja a lehetséges negatív hatásokat (Al-Mansoori és mtsai., 2023; Gui és mtsai., 2017; Vanden Abeele, 2021). Az online és offline tevékenységek közötti egyensúly megtalálása tehát nagy jelentőségű a modern társadalmak tagjai számára. Az idős személyek aktív és minőségi öregedéséhez is akkor tudnak hozzájárulni a digitális tevékenységek, ha azokat nem csupán az unalom vagy a magány előli menekülés, hanem a kognitív képességek frissen tartása, a közösségi kapcsolatok megőrzése, az új kihívások keresése motiválja (Allaire és mtsai., 2013; De Schutter, 2011; Kaufman és mtsai., 2016). Továbbá az is fontos, hogy ezek kiegészítői és nem helyettesítői lesznek a személyes társas érintkezéseknek, valós közösségi eseményeknek és fizikai aktivitásnak (Almourad és mtsai., 2021; Vanden Abeele, 2021).

**Digitális játékok időskorban – motivációk, lehetőségek és akadályok**

Az online időtöltés – ideértve a közösségi média használatát, az online kommunikációt, a digitális tartalomfogyasztást, valamint az online játékokat és videójátékokat – nem pusztán új kikapcsolódási forma, hanem komplex pszichológiai, szociális és egészségi következményekkel járó tevékenység. Az internet, a közösségi média és a digitális játékok az idős személyek életében olyan funkciókat töltenek be, amelyek korábban csak fizikai, társas vagy intézményes keretek között voltak elérhetők. Az életminőségükre gyakorolt hatásuk sokszínű, komplex. Ezért szükséges egyre több tudományterület (például a gerontológia, informatikatudomány, pszichológia vagy a szociológia) bevonása ezek vizsgálatára (Grates és mtsai., 2019). Kutatások szerint az online játékok és digitális platformok nemcsak társas kapcsolódást és érzelmi támogatást nyújtanak, hanem kognitív stimulációt, hangulatjavulást és stresszszint csökkentést is eredményezhetnek(Allaire és mtsai., 2013; Bleakley és mtsai., 2015; Zhang & Kaufman, 2015). Hozzájárulhatnak a kompetenciaérzés megéléséhez, valamint identitást erősítő funkciót is betölthetnek: az akció- és stratégiai játékok elsősorban a kognitív képességeket és végrehajtó funkciókat stimulálják, a szociális online játékok pedig a társas kapcsolatok bővítésében, a magány csökkentésében és a pszichológiai jóllét növelésében játszanak szerepet (Allaire és mtsai., 2013; Osmanovic & Pecchioni, 2016; Zhang & Kaufman, 2015, 2017).

Az online játszható kognitív jellegű játékok, mint például a puzzle, stratégiai vagy memóriajátékok, hozzájárulhatnak a kognitív képességek megtartásához: fenntartják és javíthatják a figyelmet, az információ feldolgozási sebességet, a munkamemóriát, a végrehajtó funkciókat, a reakcióidőt és a térbeli tájékozódási készségeket (Anguera és mtsai., 2013;

Ballesteros és mtsai., 2015; Basak és mtsai., 2008; Belchior és mtsai., 2013; Maillot és mtsai., 2012; Toril és mtsai., 2014). A kifejezetten kognitív funkciók fejlesztésére tervezett játékok célzottan edzik az előbbieket, és akár hat hónapig fennmaradó javulást is hozhatnak egy tréningen való részvételt követően (Anguera és mtsai., 2013).

A kooperatív játékok vagy társas interakciókra épülő videójátékok és a sokszereplős online szerepjátékok (MMORPG, Massively Multiplayer Online Role-Playing Game) hozzájárulnak a társas tőke növeléséhez, ami kedvezően hat a mentális egészségre, valamint a magányosság és depresszió csökkenésére (Genoe és mtsai., 2018; Zhang & Kaufman, 2015). Az ilyen jellegű játékok iránti érdeklődést több tényező is motiválja, így a szórakozás, a társas kapcsolatok kialakítása és fenntartása, továbbá kognitív kihívások keresése. Kvalitatív vizsgálatok alapján az idősek számára e játékok egyszerre jelentenek tanulási lehetőséget, kognitív stimulációt, szociális interakciót és önmegvalósítást (De Schutter, 2011; De Schutter & Vanden Abeele, 2010; Toril és mtsai., 2014; Zhang & Kaufman, 2016). E játékok olyan multimodális környezetet nyújtanak, amely egyidejűleg aktiválja az érzékszervi feldolgozást, a figyelmi kontrollt, és motoros válaszokra, valamint döntéshozásra készteti a játékost (Anguera és mtsai., 2013; Basak és mtsai., 2008). Az ilyen kooperatív és sokszereplős játékok által megélt sikerélmények, autonómia- és kompetenciaérzés, kontrollérzet, társas és rekreációs élmények ellensúlyozhatják az ezen időszakban más életterületeken megélt veszteségeket vagy korlátozottságot (Allaire és mtsai., 2013; Kaufman és mtsai., 2016).

Az idősek játékhasználata mögött tehát számos tényező állhat: kíváncsiság, társas kapcsolódás iránti igény, unalomcsökkentés, stresszoldás vagy éppen az önállóság és kompetencia megélésének vágya. A kutatások arra utalnak, hogy a játékok kipróbálását előbbiek közül elsősorban a belső motivációk, így a játékok élményszerű, érzelmi és esztétikai vonzereje, a flow érzése, a kompetencia megélése, a kihívások és a történetek megismerése vezérlik. Ugyanakkor azt is elmondhatjuk, hogy a társas támogatás – például családtagok, unokák bevonódása – erősen növeli a részvétel valószínűségét (Allaire és mtsai., 2013; Zhang & Kaufman, 2015). Sok idős személy felnőtt családtagok, unokák vagy más barátok hatására próbál ki egy-egy online játékot, tőlük tanulják meg ezek alapjait, ami így a társas tanulás és a közös élményszerzés egyik formája lesz. Ezen játékélmények megerősítik a társas kapcsolódás élményét, és növelik a biztonságérzetet is a digitális térben: a barátok, családtagok vagy online közösségek támogató jelenléte csökkenti a szorongást, és növeli a digitális eszközhasználattal kapcsolatos önbizalmat (Marston és mtsai., 2016; Osmanovic & Pecchioni, 2016).

A másokkal való közös játék hozzájárulhat ahhoz is, hogy új kapcsolatokat alakíthasson ki az idős személy, csatlakozhasson online társaságokhoz (klánok, céhek stb.), klubokhoz,

hozzáférhessen olyan társas hálózatokhoz, amelyek képesek lehetnek helyettesíteni is akár az offline társas érintkezéseket, növelhetik a társas tőkét, valamint csökkenthetik a magány érzését (Zhang & Kaufman, 2015, 2017). A kooperatív és többszereplős játékok különösképpen támogatják a társas interakciót, illetve a szorosabb, aktívabb közösségek, vagy csoportos közös játéktevékenységek során ezek a csoportok el is várhatják, hogy szöveges üzenetváltások mellett hangalapú csatornákon (pl. Discord, TeamSpeak, Mumble) is kommunikáljanak a tagok egymással – ezzel is szorosabbra fűzve a közöttük lévő kapcsolatot.

Az idősek körében népszerűek továbbá a könnyen tanulható online közösségi játékok, mint a közösségi média oldalakon játszható játékok, a logikai, puzzle vagy casual (azaz alkalmi, hétköznapi mobiljátékok. Ezek általában egyszerű mechanikájuk, rövid játékmenetük okán ideálisak azon idősek számára, akik kevés játéktapasztalattal, alacsonyabb digitális önbizalommal bírnak (Allaire és mtsai., 2013; De Schutter, 2011).

Az ilyen jellegű játékok tempója, azonnali visszajelzési rendszerei olyan környezetet biztosítanak, amelyben az idősek saját tempójukban próbálhatják ki magukat és új készségeiket, és gyors sikerélményt nyújtanak, erősítve ezzel a kontroll és autonómia érzését (Osmanovic & Pecchioni, 2016). Továbbá ezen játékokban sok esetben beépített társas funkciókat is találhatunk, például csoportos pontversenyek és kihívások, üzenetváltási lehetőségek, játékon belüli ajándékküldés formájában. E játékok a kutatások szerint pozitív hatással vannak a kognitív működésre, különösen a figyelmi folyamatokra, valamint pozitív érzelmi állapotokat idéznek elő (Maillot és mtsai., 2012; Toril és mtsai., 2014). A társas támogatás tehát nem csupán motivációs tényező, hanem a játékban való részvétel kulcsfontosságú fenntartója is. A videójátékosok közötti együttműködés, a közös problémamegoldás és a versengés mind olyan szociális élményeket kínálnak, amelyek hozzájárulnak az idős személyek társas beágyazódásához, valamint lehetőséget teremtenek arra, hogy úgy éljenek át társas élményeket, hogy közben fizikai korlátaik ne akadályozzák a részvételt.

Ugyanakkor a technológiai összetettség, a nagyrészt angol nyelvű felületek, az időhiány, a korábbi vagy kezdeti negatív attitűdök csökkenthetik a részvétel valószínűségét (Kaufman és mtsai., 2016). A megfelelő támogatás és felhasználóbarát tervezés esetén ugyanakkor az idősek képesek hatékonyan megtanulni és élvezni a digitális játékokat (Belchior és mtsai., 2013), és azok, akik rendszeres játékosok, jobb szubjektív jóllétről és alacsonyabb depressziószintről is számolnak be, mint a nem játékos kortársaik (Allaire és mtsai., 2013). Továbbá a videójáték-alapú tréningek ígéretesnek tűnnek a kognitív funkciók fenntartására, az enyhe kognitív zavarra és a korai demenciára irányuló intervenciók során (Mansor és mtsai., 2020; Saragih és mtsai., 2022).

A digitális játékok hatásait gyakran a kognitív tartalék és a neuroplaszticitás elméletével is összefüggésbe hozzák. A kognitív tartalék koncepciója szerint az intellektuálisan és szociálisan gazdag tevékenységek olyan környezetet teremtenek, amely támogatják a neuroplaszticitást, így ezek védőfaktorként működve növelhetik az agy ellenálló képességét az életkorhoz köthető, patológiás és neurodegeneratív megbetegedésekkel, például a demenciával szemben (Mansor és mtsai., 2020; Stern és mtsai., 2020). Gyakori játékhasználat során az idegrendszeri hálózatok adaptív módon átszerveződhetnek, ami viselkedéses szinten gyorsabb reakcióidőben, jobb szelektív és megosztott figyelemben, illetve hatékonyabb végrehajtó funkciókban jelenhetnek meg.

Ugyanakkor a videójátékok nem helyettesíthetik a klinikai prevenciós programokat, csupán kiegészítő eszközként tekinthetünk rájuk. A jelenlegi eredmények közvetett módon, a kognitív teljesítményjavuláson keresztül utalnak a kognitív tartalék növekedésére, nem pedig közvetlen neurobiológiai bizonyítékokra támaszkodnak (Mansor és mtsai., 2020; Saragih és mtsai., 2022; Toril és mtsai., 2014). A szakirodalomban számos kritikát is találunk a digitális játékok és kognitív tréningek kapcsán, mivel ezeknek a piaci marketingüzenetei jóval megelőzték a tudományos bizonyítékokat, és a jelenleg ismert kutatási eredmények is csupán rövid ideig tartó (maximum 12 hét), alacsony elemszámmal bíró, heterogén mérőeszközökkel rövid utánkövetési idejű, és sok esetben kontrollcsoport nélkül megvalósuló vizsgálatokból származnak (Bleakley és mtsai., 2015; Gates és mtsai., 2019; Mansor és mtsai., 2020; Simons és mtsai., 2016).

A javulás gyakran a „közeli transzferre” korlátozódik (azaz elsősorban ugyanazon kognitív területen, illetve a gyakorolt feladatokhoz hasonló tesztekben mutatkozik), miközben kevés olyan kutatási eredmény áll rendelkezésre arra vonatkozóan, hogy a mindennapi működésben, funkcionális kimenetekben is tartós változás jelenne meg (Kelly és mtsai., 2014). Ezért a digitális kognitív tréningekkel kapcsolatban indokolt a kritikus, „evidence-based” megközelítés: a játékok tekinthetők ígéretes kiegészítő eszközöknek az aktív idősödés támogatásában, de egyelőre nem állíthatjuk, hogy elegendő bizonyítékunk lenne arra, hogy e digitális kognitív tréningek az idős személyek mindegyikénél hasonló, kizárólag pozitív hatást váltana ki a kognitív működésben (Gates és mtsai., 2019).

Mindemellett a videójátékok és a játékos elemek nem csupán erőforrások, hanem kockázati tényezők is lehetnek (Czaja & Lee, 2007; Griffiths & Nuyens, 2017). A különböző jutalmazási rendszerek, a folyamatos kihívások, a ranglisták vagy a napi belépésért járó jutalmak, könnyen túlzott bevonódáshoz és időgazdálkodási problémákhoz vezethetnek, akár az alvás vagy a személyes kapcsolatok rovására mehetnek (King és mtsai., 2011; Peracchia & Curcio, 2018). Az összetett felhasználói felületek, a gyors reakcióidőt igénylő játékmechanikák és az idegen

nyelvű menük frusztrációt, inkompetencia-érzést válthatnak ki (Czaja & Lee, 2007; De La Hera és mtsai., 2017; Vaportzis és mtsai., 2017). Emellett a mikrotranzakciókra, extra jutalmakat ígérő ajándékdobozokra épülő üzleti modellek pénzügyi és függőségi kockázatot is jelenthetnek (Xiao, 2021; Zendle & Cairns, 2018), különösen azon idősek számára, akik kevésbé jártasak a digitális fogyasztóvédelemben (OECD, 2023). Mindezek arra utalnak, hogy e játékok csak akkor tekinthető egyértelműen kedvezőnek az időskorú személyek számára, ha a játékok tervezése és használata tudatosan figyelembe veszi a rájuk jellemző életkori sajátosságokat, és biztonságos, átlátható játékkörnyezeti feltételeket biztosít számukra (Keates & Clarkson, 2003; Xiao, 2021).

Ami viszont számos kutatásból kiolvasható, hogy sok idős számára ezek a játékok olyan élményeket kínálnak, amelyek számukra a mindennapokban már csak korlátozottan érhetők el: versengés, kihívás, sikerélmény, felfedezés vagy kreatív problémamegoldás.

**Innovatív digitális játékterek: e-sport és virtuális valóság**

Az utóbbi években megjelentek az idősebb korosztályt is célzó új digitális játékterek is, például az e-sport versenyek és a virtuális valóság (VR) alapú alkalmazások. Bár az e-sport főként a fiatal felnőtt korosztálynak szánt terep, vannak kezdeményezések idős amatőr játékosok, csapatok számára is versenyek szervezésére, amelyek nem csupán a casual játékokra korlátozódnak (Leung & Chu, 2023). Így például Japánban rendszeresen szervez a Care eSports Association nevű szervezet 60 és 90 év közötti idősek számára bajnokságokat különböző játékokban (pl. japán sakk, go táblajáték, Tekken8 akciójáték); a 60 év feletti korosztályba tartozók a Matagi Snipers e-sportcsapatba is csatlakozhatnak (pl. Counter-Strike és VALORANT belső nézetű lövöldözős játékokba). Malajziában az 50 évnél idősebb személyek a „Boomers2Gamers" kampányba kapcsolódhatnak be, és részt vehetnek különböző szenior e-sport csapattagként bajnokságokon (pl. a Counter-Strike 2 belső nézetű lövöldözős játékban). Svédországban a 65 év feletti idősek a versenyszerűen működő Silver Snipers e-sportcsapatba jelentkezhetnek, és vehetnek részt bajnokságokon (pl. Counter-Strike: Global Offensive belső nézetű lövöldözős játékban). Finnországban a „Grey Gunners" professzionális csoportba léphetnek be az idősek (pl. Counter-Strike: Global Offensive belső nézetű lövöldözős játékba). A kínai Innovációs és Technológiai Hivatal több különböző programot is elindított 2018-ban az időskorúak e-sport tevékenységének népszerűsítésére.

Bár az e-sport időskori űzése nem széles körben elérhető, inkább példamutató kezdeményezés, egyre több figyelmet kap, valamint egyre nagyobb népszerűségnek örvend, különösen az olyan e-sportágakban, amelyekben a versengés, a csapatjáték jelentős motivációs hatással bír az idős generációra. A szenior e-sportolók gyakran számolnak be olyan élményekről,

miszerint e digitális játékokban újra kompetensnek érzik magukat, önálló döntéseket hozhatnak, és valódi csapattagként kapcsolódhatnak egymáshoz (Przybylski és mtsai., 2010). Ezen tényezők, a kompetencia, az autonómia és a kötődés, az öndeterminációs elmélet alapján is univerzális, veleszületett pszichológiai szükségletek, amelyek teljesülésekor az egyén motiváltnak és boldognak érzi magát (Ryan & Deci, 2017). Ez számos tanulmány szerint alapvető a megfelelő egészségmagatartás és aktív életmód fenntartásához (Fortier és mtsai., 2012; Ng és mtsai., 2012). Az e-sportcsapatok közösségi aktivásai kapcsán az idős csapattagok előbbiek mellett a strukturált napirendet, a közös célokat és az erős csapatkohéziót emelik ki mint legfőbb pozitívumokat (Webster, 2017).

Hasonlóképpen a virtuális valóság is egyre elterjedtebb a rehabilitáció, a kognitív edzés és a mentális egészség támogatása terén az idős korosztályban. A VR-alapú mozgásos tréningek, memóriafejlesztő programok és játékok vagy relaxációs élmények, képesek olyan környezetet teremteni, amely fokozza a bevonódást, növeli a motivációt, és kompenzálja a valós környezet korlátait (Baragash és mtsai., 2022). A VR-alapú mozgásos programok javíthatják az egyensúlyérzéket, mobilitást, és gazdag szenzoros élményeket nyújtva serkenthetik az agyi és fizikai aktivitást is, valamint a depressziós tüneteket is csökkenthetik (Appel és mtsai., 2020; Chen és mtsai., 2023; Gao és mtsai., 2020; Maillot és mtsai., 2012; Pacheco és mtsai., 2020; Yen & Chiu, 2021). Így ezek a platformok vonzóak lehetnek azok számára, akiknek fizikai vagy szociális korlátozottság miatt nehezebb részt venniük hagyományos aktivitásokban, de mégis szeretnének egy élményszerű, biztonságos környezetben kognitív és mozgásos tevékenységeket folytatni.

A VR-alapú vezetett meditációról szóló kutatások eredményei is azt mutatják, hogy e módszer a hagyományos vezetett mediációknál hatékonyabban képes csökkenteni a szorongás- és stresszszintet, valamint képesek növelni a jóllétet is (Appel és mtsai., 2020; Corbel és mtsai., 2025).

A digitális játékok tehát nem csupán alternatív szabadidős lehetőséget jelentenek, hanem a modern idősödés egyik fontos alkotóelemeivé is válnak, amelyek a kognitív, érzelmi és társas funkciók fenntartását is támogathatják. A gamifikáció nem játékos tevékenységekbe való beépítése különösen ígéretes megközelítés lehet az idős személyek egészségmagatartásában és rehabilitációjában (Bleakley és mtsai., 2015). A gamifikált mozgásprogramok, rehabilitációs és memóriafejlesztő alkalmazások sikeresen növelik az idősek aktivitási szintjét, önhatékonyságát és tanulási motivációját (Maillot és mtsai., 2012). A játékosított környezetben a fokozatos nehézségi szint, a vizuális visszajelzés és a teljesítménykövetés olyan ösztönző tényezők, amelyek csökkentik a kudarcélményt és elősegítik a kompetencia és énhatékonyság érzését (Polo-

Peña és mtsai., 2021). Ezen felül a játékosítás társas elemei – például ranglisták vagy közös kihívások – elősegítik a közösségi kötődést is (Wang és mtsai., 2021).

Mindazonáltal a VR és az e-sport esetében is figyelembe kell venni a különböző akadályokat és kockázatokat: ezek magas költségei, a technikai kompetenciák szükségessége, a mozgásos tevékenységekből fakadó szédülés, dezorientáció vagy a túlzott bevonódás veszélyei időskorban is fennállhatnak (Appel és mtsai., 2020). Így a kutatók a biztonságot és hatékonyságot szem előtt tartva a VR-alapú exergame-ek esetében például a nem túl gyakori, de rendszeres részvételt javasolják közösségi, csoportos módon, szakemberek, fizikoterapeuták bevonásával (Peng és mtsai., 2024). Megjelenhet ezeken a felületeken is az ageizmus (az idős személyekkel szembeni negatív előítélet, hátrányos megkülönböztetés, Jászberényi, 2010), ami így tovább erősítheti a gátlásokat (Mariano és mtsai., 2022).

**Digitális jóllét és aktív idősödés**

A WHO aktív idősödés koncepciója három fő dimenzió, az egészség, részvétel és biztonság köré szerveződik, és azt hangsúlyozza, hogy az idős személyek életminőségét nemcsak az egészségi állapot, hanem a társadalmi részvétel és az egzisztenciális biztonság is meghatározza (World Health Organization, 2000). A digitális tér, beleértve a videójátékokat is, ma már ennek a keretnek a kiterjesztéseként is értelmezhető. Az egészség támogatásában az online környezet számos területen jelenhet meg: fizikai aktivitást, erőnlét javulást biztosíthatnak a mozgásra ösztönző VR játékok (például Maillot és mtsai., 2012). A végrehajtó funkciókat, a figyelmet és a reakcióidőt a stratégiai vagy gyors döntést igénylő játékok és kognitív tréningek javíthatják (például Anguera és mtsai., 2013). A részvétel dimenzióban a sokszereplős online szerepjátékok és online közösségi játékok teszik lehetővé a társas tőke építését (például Chua és mtsai., 2013). A biztonság szempontjából pedig a digitális fogyasztóvédelem, a családok és manipulatív játékmechanikák felismerése válik fontossá, valamint az, hogy az idősek megfelelő támogatást kapjanak az eszközök biztonságos használatához (például Peng és mtsai., 2024). Egészségpszichológiai nézőpontból tehát úgy tűnik, hogy a játékok egyaránt nyújtanak sikerélményt, kontrollérzést, kompetencia-élményt és autonómiát is, amelyek a pszichológiai jóllét és az aktív megküzdés bizonyítottan fontos összetevői (Allaire et al., 2013; Kaufman et al., 2016).

A digitális szabadidő és játékhasználat az idősödés modern megközelítésében integráló szerepet is játszhat azáltal, hogy lehetőséget teremt az önálló információszerzésre, a kulturális tartalmak fogyasztására és számos online közösséghez való kapcsolódásra, ezzel összekapcsolva az énhatékonyság megélését, a kognitív stimulációt, a rekreációt és a társas kapcsolódást (Allaire

és mtsai., 2013; Kaufman és mtsai., 2016). A nemzetközi gyakorlatban egyre több program célozza az idősek digitális jóllétének erősítését, gyakran kifejezetten játékos formában, például idősek otthonában, közösségi központokban megvalósítva. Azonban ahhoz, hogy hosszú távon fennmaradjon az idősek játékok iránti érdeklődése, úgy tűnik, nem elegendő egy játék önmagában, szükséges a közösség tagjaival való kapcsolódás, a belső motiváció, és a személyes segítségnyújtás is (Janssen és mtsai., 2023).

Mindezek alapján a digitális játékok az idősek számára nem csupán szórakoztatási funkciót töltenek be, hanem olyan komplex motivációs, társas és érzelmi erőforrások is lehetnek, amelyek az aktív idősödést támogató eszközként is azonosíthatók, amennyiben megfelelő támogatással és a saját igényeikhez igazított formában férnek hozzá ezekhez a lehetőségekhez az idős személyek (Basak és mtsai., 2008; Bleakley és mtsai., 2015; Toril és mtsai., 2014). A motivációk sokfélesége és a játékélményhez kapcsolódó pozitív pszichológiai folyamatok egyértelműen jelzik, hogy a digitális játékok és VR-alapú élmények az idősödés újszerű megközelítésében egyre inkább létező és értékes rekreációs formának tekinthetők, így mindenképpen érdemes lehet a jövőben ezeknek az egészségügybe és a szociális ellátásba való integrálását megfontolni.

## Következtetések

Jelen narratív szakirodalmi áttekintés az időskorúak digitális szabadidős tevékenységeit és a digitális játékhasználatát vizsgálta az aktív idősödés, valamint a digitális jóllét keretrendszerében. Az áttekintett eredmények alapján a digitális játékok időskorban nem csupán modern szórakozási formák, hanem olyan eszközök is lehetnek, amelyek kognitív stimulációt, érzelmi bevonódást és társas kapcsolódást is támogathatnak, amennyiben azok az idős személyek sajátosságaira is figyelmet fordítva kerültek megtervezésre. Ugyanakkor a szakirodalom következetesen jelzi, hogy a lehetséges hatások erősen függhetnek a játék típusától, a játékkörnyezet biztonságosságától, az egyéni készségektől, felhasználói kompetenciáktól, illetve a játékos szociális környezetétől, amelyek alapvetően befolyásolhatják azt, hogy a játékhasználat erőforrásként vagy kockázati tényezőként jelenik-e meg.

Ebből következően a digitális játékok időskori szerepének értékelésekor az lehet a legtermékenyebb, ha a felhasználó–játék–környezet hármas rendszerében gondolkodunk, mintsem magára a technológiára fókuszálunk. A kutatások alapján a digitális játékhasználat és a játékosítás az aktív idősödés több dimenziójához is kapcsolható és számos olyan lehetőséget kínál, amelyek kiegészítő jelleggel olyan egészségügyi célokhoz illeszthetők, mint a fizikai aktivitás ösztönzése, az életminőség támogatása, a motiváció fenntartása vagy a kognitív

stimuláció. Orvosi és klinikai vonatkozásban ugyanakkor fontos ezek alkalmazási módja: a játék nem helyettesítheti a már bizonyítottan hatásos kezeléseket, de strukturált, szakember által támogatott programban növelheti az együttműködést és a bevonódást, illetve csökkentheti a passzivitást.

Továbbá ezek a játékok közösségi aktivitásként különösen értékesek lehetnek: a közös célok, csoportos tevékenységek, kihívások és együttműködés társas kapcsolódást, beszédtémát és strukturált időtöltést adhatnak. Ugyanakkor a digitális játékok prevenciós szempontból akkor válhatnák igazán ígéretessé, ha ezek célja nem pusztán a „játékkal eltöltött idő”, hanem a kiegyensúlyozott, értelmes és társas értelemben is beágyazott digitális szabadidő. Ennek része az online-offline egyensúly, a tudatos időszabályozás és a pozitív hatásokkal, következményekkel járó rutinok kialakítása, különösen időskorban.

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# Az időskori szegénység társadalmi arcai Magyarországon

# The Social Faces of Elderly Poverty in Hungary

Talyigás Katalin

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**Kulcsszavak:** időskori szegénység, rejtőzködő szegénység, digitális kirekesztés, társadalmi kohézió, közösségi programok

## Absztrakt

Az időskori szegénység Magyarországon egyre fontosabb társadalmi kérdés, amely nem pusztán jövedelmi hiány, hanem többszörös depriváció: anyagi nélkülözés, egészségromlás, lakhatási bizonytalanság, digitális hátrányok, társas kapcsolatok gyengülése és elmagányosodás formájában jelenik meg, különösen a nők, vidéken élők, egyedülállók és alacsony iskolai végzettségűek körében.

A tanulmány célja bemutatni az időskori szegénység formáit, hozzájáruló társadalmi tényezőit (pl. rendszerváltás hatásai, életpálya-törések, családi támogatás csökkenése), valamint azt vizsgálni, hogy helyi, közösségi és szakmapolitikai beavatkozások hogyan mérsékelhetik a kockázatot, biztosítva a méltó, biztonságos és részvételre épülő időskort.

A vizsgálat elemző-deszkriptív módszerrel készült, hazai (KSH, 2024) és nemzetközi (Eurostat, 2024; Eurofound, 2022) statisztikák, szakirodalom (pl. Albert & Dávid, 2019; Walker & Zaidi, 2020) és esettanulmányok (pl. panelban élő idős hölgy mindennapi lemondásai) feldolgozásával, EU-jogi keretek (Alapjogi Charta) integrálásával.

A 65+ korosztály 20,3%-a szegénység- vagy kirekesztődéskockázatban (EU-átlag: 17,2%), súlyos depriváció 9% (EU: <5%), >430 ezer fő <140 ezer Ft/hó nyugdíjjal; alacsony digitális használat (35-40%, EU: 65%), egészségi mutatók (5,3-6,5 év egészségben); ezek halmozódva rejtőzködő szegénységet erősítenek: gyógyszerek halasztása, közösségi visszavonulás, stressz és izoláció.

A válaszok több szintűek: közösségi programok fejlesztése (klubok, önkéntes hálózatok), digitális kompetenciafejlesztés (tanfolyamok, segítői programok), célzott támogatások (lakhatás, rezsi), egészségmegőrzés (prevenció, age-friendly települések) és helyi adatgyűjtés szükséges a láthatatlan szegénység felismeréséhez és a társadalmi kohézió erősítéséhez.

**Keywords:** elderly poverty, hidden poverty, digital exclusion, social cohesion, community programs

**Abstract**

Elderly poverty in Hungary is an increasingly important social issue, extending far beyond income deficiency to encompass multiple deprivations: material deprivation, health deterioration, housing insecurity, digital disadvantages, weakening social connections, and loneliness, particularly affecting women, rural dwellers, singles, and those with low education levels.

The study aims to present the forms of elderly poverty, contributing social factors (e.g., effects of the regime change, life-course disruptions, declining family support), and to examine how local, community, and professional policy interventions can mitigate risks, ensuring a dignified, secure, and participation-based old age.

The analysis employs a descriptive-analytical approach, processing domestic (KSH, 2024) and international (Eurostat, 2024; Eurofound, 2022) statistics, literature (e.g., Albert & Dávid, 2019; Walker & Zaidi, 2020), and case studies (e.g., an elderly woman in a panel apartment making daily sacrifices), integrated with EU legal frameworks (Charter of Fundamental Rights).

20.3% of those aged 65+ face poverty or exclusion risk (EU average: 17.2%), severe deprivation at 9% (EU: <5%), over 430,000 receive <140,000 HUF/month pension; low digital usage (35-40%, EU: 65%), poor health indicators (5.3-6.5 healthy years); these accumulate to reinforce hidden poverty: deferred medications, social withdrawal, stress, and isolation.

Responses must be multi-level: developing community programs (clubs, volunteer networks), digital competency training (courses, helper programs), targeted supports (housing, utilities), health preservation (prevention, age-friendly settlements), and local data collection to recognize invisible poverty and strengthen social cohesion.

## Bevezetés

Az időskori szegénység egyre fontosabb társadalmi kérdés Magyarországon. Bár gyakran a nyugdíjak mértékével azonosítják, valójában jóval összetettebb jelenség: az anyagi nélkülözés az életminőség, az egészségi állapot, a lakhatási biztonság, a digitális hozzáférés és a társas kapcsolatok területén egyaránt megmutatkozik. Az időskori szegénység ezért nem pusztán jövedelmi hiány, hanem **többszörös, egymást erősítő depriváció**, amely egyszerre érinti az anyagi, a kapcsolati és az információs erőforrásokat (Eurofound, 2022).

A jelenség több okból is „láthatatlan". Az érintettek jelentős része életpályája során hozzászokott a takarékossághoz. A szegénység inkább az alkalmazkodásban, a lemondásokban, a mindennapi döntések kényszerű beszűkülésében jelenik meg. A társadalomtudományi kutatások is rámutatnak arra, hogy az időskorúak körében gyakori a rejtőzködő szegénység: kevesen kérnek segítséget, sokan szégyellik helyzetüket, és nem tekintik magukat rászorulónak (Albert & Dávid, 2019).

Ezt az „alacsony láthatóságot" erősíti, hogy a társadalmi közvélekedésben korábban élt az a kép, hogy az idősek helyzete stabilabb, kiszámíthatóbb, mint más korcsoportoké. A nemzetközi, és hazazai kutatások azonban egyértelműen mutatják, hogy a demográfiai, gazdasági és egészségügyi folyamatok gyors változása miatt az időskori szegénység kockázata sok országban növekszik, különösen a nők, a vidéken élők, az egyedülállók és az alacsony iskolai végzettségűek körében (Eurostat, 2024; Walker & Zaidi, 2020).

**Az elemzés célja**, hogy bemutassa, milyen formákban jelenik meg az időskori szegénység Magyarországon, milyen társadalmi tényezők járulnak hozzá fennmaradásához, és hogyan hatnak egymásra azok a folyamatok, amelyek a szegénységet összetett, többszereplős kockázattá teszik. A vizsgálat fókusza kiterjed az egészségi állapotra, a digitális hátrányokra, a társas kapcsolatok gyengülésére és az elmagányosodásra is.

**A tanulmány arra keres választ**, hogy a különböző szintű – helyi, közösségi és szakmapolitikai – beavatkozások miként járulhatnak hozzá az időskori szegénység mérsékléséhez. A hangsúly azon a kérdésen van, hogy milyen konkrét, a mindennapi élethelyzetekhez igazodó eszközökkel lehet támogatni az időseket abban, hogy méltó, biztonságos és részvételre épülő életet élhessenek.

**Az időskori szegénység különböző formái az egyéni élethelyzetekben mutatkoznak meg**, sokszor nehezen észrevehető módon. Időskorban a nélkülözés nem feltétlenül hangos panaszokban, hanem apró, mindennapi döntésekben jelenik meg: a fűtés visszafogásában, a gyógyszerek kiváltásának halasztásában, az élelmiszervásárlás szűkítésében vagy a közösségi

részvétel elmaradásában. A kutatások szerint ezek a látszólag „kis" lemondások egymást erősítve járulnak hozzá a hosszú távú depriváció hoz (O'Shea & Walsh, 2022; Daatland & Herlofson, 2020).

Egy idős hölgy példája jól mutatja ezt a folyamatot: panellakásban él, vásárláskor kizárólag az akciós termékeket keresi, gyógyszereit váltogatva szedi, mert nem tudja mindegyiket kiváltan, takarékoskodik a fűtéssel, évek óta nem újította meg ruhatárát, és közösségi rendezvényekre sem jár, mivel a belépők ára is gondot jelent. Bár kifelé azt mondja: „megvagyok", a csendes, mindennapi megküzdés tartós bizonytalanságot, stresszt és elszigetelődést eredményez.

A szegénység arcai gyakran a **halmozódó hátrányokból** állnak össze: a romló egészségi állapotból, az elmaradó kezelésekből, a társas kapcsolatok csökkenéséből, a fizikai környezet hanyatlásából. Ezek a tényezők időskorban különösen erősen hatnak, mert a veszteségek (egészségromlása, társ elvesztése, jövedelem csökkenése) felhalmozódnak és kevésbé pótolhatók (Holt-Lunstad, 2021).

Az idős emberek szegénységi helyzete így nem egyetlen dimenzióban, hanem mindennapi élethelyzeteik összességében válik láthatóvá:

– a lakhatás körülményeiben, a szűkülő mozgástérben,

– a szükséges gyógyszerek elmaradásában,

– a társas élet visszaszorulásában,

– és az önkéntelen elszigetelődésben.

Mindez arra mutat rá, hogy az időskori szegénység nemcsak anyagi, hanem társas és egészségi kockázatokkal jár együtt, amelyek egymást erősítve formálják az idős emberek életminőségét.

A hazai adatok egyértelműen jelzik, hogy az időskori szegénység jelentős társadalmi probléma. **A 65 év felettiek 20,3%-a** volt kitéve a szegénység vagy társadalmi kirekesztődés kockázatának 2024-ben (KSH, 2024), továbbra is az EU-átlag (17,2%) felett van (Eurostat, 2024). A relatív jövedelmi szegénység aránya az idősek körében **14–15% között stagnál**, ami hosszabb távon sem mutat érdemi javulást (Eurofound, 2022).

A súlyos anyagi és társadalmi depriváció aránya a 65+ korosztályban **9% körül alakult 2024-ben**, míg az EU-átlag 5% alatt volt. A mutató arra utal, hogy az idősek egy része nem képes fedezni még az alapvető szükségleteit sem. A szubjektív anyagi helyzetet vizsgáló felmérések is megerősítik, hogy az időskorú háztartások körében az anyagi nehézségek tartósnak tekinthetők (Eurofound, 2022).

Az alacsony összegű nyugdíjak elterjedtségét mutatja, hogy 2021-ben több mint **430 ezer ember kapott 140 000 forintnál alacsonyabb ellátást**, és ez a szám 2023–2024-re csak kis mértékben csökkent (mfor.hu, 2023; KSH, 2024). Mindez összefügg azzal, hogy a nyugdíjak értéke lassabban követi az inflációt és a megélhetési költségek emelkedését. A 2010-es évek elejéhez képest **mintegy két és félszeresére nőtt** a szegénységi küszöb alatt élő nyugdíjasok száma, ami egyértelműen a társadalmi egyenlőtlenségek növekedésére utal.

**Nemzetközi összevetésben** Magyarország továbbra is az OECD azon országai közé tartozik, ahol az időskorúak szegénységi rátája viszonylag magas, miközben a lakosság öngondoskodási képessége alacsony (OECD, 2023). A nyugdíjak helyettesítési rátája — vagyis hogy a korábbi kereset hány százalékát éri el a nyugdíj — hosszabb távon érezhetően csökkent.

A 65 éves korban várható egészségben eltöltött életévek száma Magyarországon **5,3 év a férfiaknál**, és **6,5 év a nőknél** (Eurostat, 2024). Ez az egyik legalacsonyabb érték az EU-ban. Ez azt jelenti, hogy a 65 év felettiek jelentős része **rossz egészségi állapotban** él, ami tovább növeli a kiadásokat, és szoros összefüggésben áll a szegénységi kockázattal.

A 65 év felettiek mindössze **35–40%-a** használ rendszeresen internetet Magyarországon (Eurostat ICT Survey, 2024).

Ez jóval az EU-átlag (≈65%) alatt van, és azt jelzi, hogy a digitális ügyintézés gyors terjedése mellett az idősek jelentős része információhoz és szolgáltatáshoz való hozzáférési hátrányban szenved. Ez az „új típusú depriváció” egyre meghatározóbb része az időskori szegénységnek.

## Az időskori szegénység kialakulásának okai: A rendszerváltás hatásai

A rendszerváltást követő gazdasági átalakulás különösen erősen sújtotta azokat a generációkat, akik az 1980-as és 1990-es években érték el pályájuk csúcspontját. A tömeges munkahely-megszűnések, a privatizáció, az ipari struktúraváltás és a közszféra leépítése tartós munkanélküliséget és életpálya-töréseket okozott. Ezek a megszakítások sokaknál csökkentették a nyugdíjjogosultsági időt, és hosszú távon járultak hozzá a ma tapasztalható alacsony nyugdíjakhoz (Hablicsek, 2004; Spéder, 2020).

A rendszerváltás generációja ma már időskorú, és helyzetüket tovább nehezíti a nyugdíjak reálértékének lassú csökkenése, különösen az inflációs időszakokban. Ez a korosztály gyakran tekint vissza stabilnak hitt életpályára, amelyet később a gazdasági szerkezetváltás „kiforgatott” a korábbi kötött pályákból. A társadalmi mobilitás beszűkülése és az újraiparosodás hiánya miatt sokan már nem tudták kompenzálni az életkorukat meghatározó veszteségeket.

## Életpálya és bérstruktúra

Az időskori anyagi biztonságot alapvetően meghatározza az egész életpályán át felhalmozott munkaerő-piaci pozíció, a keresetek szintje és azok stabilitása. A magyar munkaerőpiac sajátossága, hogy jelentős a szegmens, ahol tartósan alacsony bérezés, részmunkaidő vagy atipikus foglalkoztatás jellemző, különösen a nőknél, a gondozási feladatokat ellátóknál és a fizikai munkakörökben dolgozóknál. Ezek a pályák alacsony járulékbefizetést eredményeznek, amely a nyugdíjrendszerben később visszaköszön, és **strukturálisan építi be a szegénység kockázatát** az időskorba (OECD, 2023; Eurofound, 2022). Az elmúlt 15 évben a bérek növekedésével nem tart lépést a nyugdíjak emelése.

A nők életpályája különösen sérülékeny: a gondozási munkák miatti karrierszakadások, az alacsonyabb bérek és a részmunkaidős foglalkoztatás nagyobb arányban fordulnak elő. A nemzetközi szakirodalom ezt „gender pension gap”-ként írja le, amely Magyarországon is kimutatható, és időskorban jelentős egyenlőtlenségekhez vezet (Walker & Zaidi, 2020). A bizonytalan foglalkoztatási formák terjedése tovább súlyosbítja ezt, mivel a későbbi életkorokban a jövedelmi hátrány már nem korrigálható. Hosszú évek óta nem változik a minimál nyugdíj összege.

## Egészségi hátrányok

Az egészségi állapot és a szegénység közötti kapcsolat időskorban különösen erős. Magyarországon a krónikus betegségek előfordulása magas, miközben a 65 év felettiek jelentős része egyszerre több betegséggel él. A kezelések, a gyógyszerek, a magánorvosi vizsgálatok és a gyógyászati segédeszközök költségei gyakran meghaladják az idősek anyagi lehetőségeit, ami további szükségletek felhalmozódásához vezet (WHO, 2023; KSH, 2024).

A szegénység és az egészségi állapot kölcsönösen erősítik egymást: az alacsony jövedelmű idősek nagyobb valószínűséggel mondanak le kezelésekről, halasztanak gyógyszervásárlást, vagy későn fordulnak orvoshoz. Az Eurostat adatai szerint a 65 év felettiek körében a „halasztott orvosi ellátás anyagi okból” aránya az uniós átlag felett van. Ráadásul a 65 éves korban várható egészségben eltöltött életévek száma az egyik legalacsonyabb az EU-ban, ami tovább növeli a kiszolgáltatottságot és az egészségügyi kiadások súlyát (Eurostat, 2024).

## A családi támasz csökkenése

A családi kapcsolatok átalakulása az időskori szegénység egyik legfontosabb, mégis gyakran alulértékelt tényezője. A fiatalabb generációk mobilitása – a városba vagy külföldre

költözés, az ingázás, a kiszolgáltatott munkaerő-piaci pozíciók – jelentősen csökkenti az idősek körüli rendelkezésre álló érzelmi és gyakorlati segítség mennyiségét. Az egyedül élő idősek aránya a 65 év feletti népességben továbbra is magas, különösen a nők körében. A családi támogatás visszaszorulása anyagi következményekkel is jár: kevesebb a költségmegosztás, a mindennapi segítség, a gondozási feladatok gyakran fizetett szolgáltatásokra hárulnak, amelyek nagy terhet rónak a szűkös jövedelmű háztartásokra (Kovács, 2021).

A kapcsolathiány azonban nemcsak pénzügyi problémát jelent, hanem a társas támogatás csökkenésével az egészségi állapot romlását és az életminőség hanyatlását is előidézheti. A nemzetközi kutatások egyértelműen igazolják, hogy az időskori társas izoláció a depresszió, a szorongás, a kognitív hanyatlás és a korai halálozás kockázatát is növeli (Holt-Lunstad, 2021). A családi hálók gyengülése így többszörösen is hozzájárul a szegénység újratermelődéséhez: érzelmi, anyagi és egészségi szinten egyaránt.

**Digitális kirekesztettség**

A digitális hozzáférés hiánya az időskori szegénység egyik új, gyorsan növekvő formája. Bár a társadalmi digitalizáció felgyorsult, a 65 év felettiek körében az internethasználat aránya Magyarországon mindössze **35–40%**, messze elmaradva az EU-átlagtól. A digitális készségek hiánya azt eredményezi, hogy az idősek sokszor nem férnek hozzá azokhoz az információkhoz és szolgáltatásokhoz, amelyek alapvető fontosságúak lennének: banki ügyintézés, egészségügyi időpontfoglalás, közlekedési tájékoztatás, online támogatási kérelmek (Eurostat ICT, 2024).

A digitális kirekesztettség így nemcsak technológiai, hanem **társadalmi egyenlőtlenségi kérdés** is. Az információhoz való hozzáférés ma a szociális biztonság egyik feltétele: aki nem tud online ügyeket intézni, gyakran kimarad a számára elérhető támogatásokból, vagy másokra (családtagokra, szociális szolgálatokra) szorul. A digitális kizáródás tovább növelheti az elszigeteltséget is: az online kommunikáció hiánya miatt az idősek nehezebben tartják fenn társas kapcsolataikat, ami fokozza a magány és az információs hátrány kockázatát (Tóth, 2022; Seifert, 2021).

A digitális szakadék társadalmi következményeire a kutatások egyre gyakrabban alkalmazzák az „új szegénységi dimenzió” fogalmát, amely a technológiai, a jövedelmi és az információs egyenlőtlenségek összekapcsolódását jelzi. Azok az idősek, akik egyszerre élnek alacsony jövedelemből, rossz egészségi állapottal és digitális ellátatlansággal, különösen sérülékeny helyzetben vannak.

## A felismerés fontossága

A „rejtőzködő szegénység” veszélyes, mert éppen azok az emberek esnek ki a támogatási látótérből, akiknek a legnagyobb szükségük lenne segítségre. A felismerés ezért nemcsak szociálpolitikai, hanem társadalmi, közösségi és emberi jogi feladat is.

## Mert az emberi méltóság megőrzése alapjog

Az anyagi nélkülözés nem kizárólag jövedelmi kérdés: hat a döntési szabadságára, az önbecsülésre, a társadalmi részvételre is. Az idősek méltóságának és alapvető ellátáshoz való jogának védelme **eszmei és jogi értelemben is kiemelt európai elvárás**.

Az **EU Alapjogi Charta 25. cikke** rögzíti az idősek jogát a méltóságteljes, független életre és a társadalmi részvételre.

A **34. cikk** kimondja a szociális biztonsághoz és a szociális segítséghez való jogot, amely különösen fontos az időskori létbiztonság szempontjából.

Az Európai Bizottság **2012-es Zöld Könyve az idősödésről** hangsúlyozza, hogy a méltó időskornak **rendszers**zintű feltételei vannak: megfizethető lakhatás, hozzáférhető egészségügyi ellátás, társadalmi részvételi lehetőségek.

A **Fehér Könyv a nyugdíjak jövőjéről (2012)** pedig egyértelművé teszi, hogy az idősek megélhetés biztonsága nem kizárólag az egyének, hanem **állami rendszerek felelőssége** is.

A **2007-es Fehér Könyv az egészségügyi stratégia jövőjéről** az egészségegyenlőtlenségek csökkentését nevezi meg uniós célként, ami különösen releváns az időskori szegénység szempontjából.

## A hazai szabályozás és az EU-elvárások közötti ellentmondás

Magyarország Alaptörvénye egyfelől rögzíti az emberi méltóság sérthetetlenségét (II. cikk), másfelől viszont a **XVI. cikkben** a szülőtartásra épülő családi kötelezettséget hangsúlyozza. A Szociális törvény módosításai ezt a logikát tovább erősítik: a gondoskodás felelőssége **elsődlegesen az egyénre és a családra hárul**, míg az állam szerepe másodlagossá válik, és jellemzően csak akkor lép be, ha a családi támogatás nem megoldható.

Ez a felfogás **jelentős eltérést mutat** az EU alapdokumentumaiban megfogalmazott elvektől, amelyekben a méltó időskor **állami és rendszerszintű garanciaként** jelenik meg. Az uniós normák szerint a család fontos szereplő, de nem helyettesítője a közfeladatoknak.

A két megközelítés közötti feszültség arra mutat rá, hogy az időskori szegénység kezelése csak akkor lehet sikeres, ha a **családi, közösségi és állami felelősség**

**kiegyensúlyozott**, és a méltóság védelme nem szűkül le egyéni vagy családi teherként értelmezett kötelezettséggé.

### Mert a szegénység elszigetel és gyengíti a társadalmi kohéziót

A nélkülözés gyakran társas elszigetelődéssel jár: az idősek kevesebbet mozognak, ritkábban vesznek részt közösségekben, és sok esetben szégyellik anyagi helyzetüket. A társas izoláció azonban nemcsak érzelmi teher, hanem komoly egészségi kockázati tényező is, amely növeli a depresszió, a szorongás és a korai halálozás valószínűségét.

A láthatatlanság így nemcsak az egyének helyzetét rontja, hanem **a közösségek erejét is gyengíti**, csökkentve a társadalmi bizalmat és a generációk közötti együttműködés lehetőségét.

### Mert a generációk közötti szolidaritás a megértésen alapul

Az idősek helyzetének feltárása nélkül a társadalom fiatalabb tagjai nem látják át a nélkülözés, a kiszolgáltatottság és az egészségi hátrányok összefüggéseit. A szolidaritás azonban csak akkor erősödhet, ha a társadalom érzékeny és tájékozott az idősek valós szükségleteiről.

### Mert az időskor nem a lemondás, hanem a biztonság ideje kell legyen

Az idősödő társadalmak egyik alapvető célja, hogy a hosszabb élet nem több nélkülözéssel, hanem több eséllyel és részvétellel járjon. Az időskori szegénység viszont a lehetőségek beszűkülését, sokszor a reménytelen alkalmazkodást kényszeríti ki. A felismerés tehát annak a közös felelősségnek a része, hogy a későbbi életszakasz biztonságos és emberhez méltó legyen.

### Lehetséges válaszok és teendők

Az időskori szegénység összetett társadalmi probléma, ezért a válaszoknak is több szinten – egyéni, közösségi, helyi és országos szinten – kell megjelenniük. A megoldási lehetőségek nem kizárólag a szociális ellátórendszeren belül értelmezhetők: a közösségi kapcsolatok, a digitális és egészségügyi hozzáférés, a helyi szolgáltatások minősége és az önkormányzati szerepvállalás egyaránt meghatározza az idősek életminőségét.

### Közösségi programok fejlesztése

A közösségi programok olyan eszközök, amelyek egyszerre erősítik a társas kapcsolatokat, csökkentik az elszigetelődés kockázatát, és támogatják a fizikai-mentális jóllétet. Ide tartoznak az idősklubok, generációk közötti programok, közösségi házak, önkéntes segítőhálózatok. A kutatások egyértelműen mutatják, hogy a közösségi részvétel javítja az életminőséget, csökkenti a magányt és elősegíti a társadalmi integrációt (Daatland & Herlofson, 2020).

A jövőbeni fejlesztés célja nemcsak a kínálat bővítése, hanem **a részvétel minőségének javítása**: olyan programok támogatása, amelyekben az idősek aktív szereplőként, nem csupán résztvevőként vannak jelen. A helyi önkormányzatok és civil szervezetek együttműködése kulcsfontosságú, különösen kistelepüléseken, ahol kevés a formális szolgáltatás.

### Digitális kompetencia fejlesztés

A digitális kirekesztettség, mint ahogy azt állítottuk az időskorúak egyik legjelentősebb, újonnan kialakuló szegénységi kockázata. A digitális készségek fejlesztése – akár célzott tanfolyamokkal, egyéni mentorálással, akár közösségi internetpontok létrehozásával – elengedhetetlen a szolgáltatásokhoz és információkhoz való hozzáférés biztosításához. A „digitális segítő” programok jó gyakorlatként terjednek Európa-szerte: fiatal önkéntesek vagy digitálisan jártas idősek segítik társaikat az ügyintézésben és az alapvető technológiák használatában (Seifert, 2021).

A digitális eszközök hiánya is akadály: eszközkölcsönző rendszerek, tablet- vagy laptop-hozzáférést biztosító programok csökkenthetik ezt a hátrányt. A digitális bevonás nemcsak technikai képesség, hanem **szociális egyenlőség** kérdése is.

### Célzott szociális támogatási formák

A szociális ellátórendszer egyik legfontosabb feladata az időskori szegénység enyhítése, különösen a tartósan alacsony jövedelmű vagy egyedül élő idősek esetében. A célzott támogatások – lakhatási, gyógyszer- és rezsitámogatások – akkor hatékonyak, ha az egyéni élethelyzetre szabottak, és figyelembe veszik az egészségi, gondozási vagy digitális hátrányokat.

A helyi szociális szolgálatok kulcsszereplők a szükségletek felismerésében, a krízishelyzetek azonosításában, a támogatások eljuttatásában. A civil és karitatív szervezetekkel való együttműködés tovább erősítheti a rendszer rugalmasságát és reagálóképességét.

### Egészségmegőrző programok

Az egészségmegőrzés elősegítése – fizikai aktivitás, szűrések, életmód-tanácsadás, mentális egészség támogatása – az idősödő társadalmak egyik legfontosabb közpolitikai feladata. A prevenciós programok nemcsak az egyéni életminőséget javítják, hanem jelentősen csökkentik az egészségügyi ellátórendszer terheit (WHO, 2023).

Az „idősbarát település" és az „age-friendly city" típusú helyi programok azért hasznosak, mert integrált megközelítést alkalmaznak: a környezet, a mobilitás, a szolgáltatások és a közösségi részvétel egyaránt az idősek szükségleteihez igazodik.

### Rendszeres, helyi szintű adatgyűjtés és monitoring

A hatékony időspolitika alapja a megbízható, aktuális és rendszeresen gyűjtött helyi adatbázis. A települési önkormányzatok által végzett felmérések (pl. idősek élethelyzete, szolgáltatáshoz való hozzáférés, gondozási szükségletek, közlekedési akadályok) hozzájárulhatnak ahhoz, hogy az intézkedések célzottak, arányosak és fenntarthatók legyenek.

A helyi monitoring nemcsak a szolgáltatásfejlesztést segíti, hanem lehetőséget ad arra is, hogy a döntéshozók időben reagáljanak az új társadalmi kockázatokra – például az emelkedő energiaárak, a lakhatási terhek vagy az izoláció növekedésének hatásaira

## Összefoglalva

Az időskori szegénység nem csupán anyagi kérdés. Olyan összetett, egymást erősítő hátrányok rendszere, amely a mindennapi élet valamennyi területére kihat: a lakhatásra, az egészségre, a társas kapcsolatokra, a fizikai és digitális hozzáférésre, valamint a biztonságérzetre. Az időskorúak nagy része csendben viseli a nélkülözést, gyakran láthatatlan módon – és éppen ez a láthatatlanság teszi különösen veszélyessé.

A felismerés, az empátia és a cselekvés együttesen adnak választ arra a társadalmi felelősségre, hogy az időskor méltó életszakasz legyen, ne pedig lemondás és magány. Az idős emberek méltóságának, biztonságának és társadalmi részvételének biztosítása nem szűkíthető le kizárólag a család feladatára, de nem is kizárólag állami ügy: a közösségek, a helyi önkormányzatok, a szakmai szereplők és a társadalmi intézmények együttműködése szükséges.

A jövő időspolitikájának egyik kulcsa, hogy a hosszabb élet lehetőségét ne több nélkülözéssel, hanem több eséllyel, részvétellel és biztonsággal járó életszakasszá alakítsuk. Az idősek helyzetének megértése és a valós szükségletekhez igazodó válaszok kialakítása nemcsak társadalmi kötelesség: a közös jövő feltétele.

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