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Research Article

Age-Related Sexual Myths and Attitudes Toward Ageism Among Turkish Youth

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Abstract

Background: The aim of this study was to examine age-related sexual myths and attitudes toward ageism among Turkish youth.
Methods: The sample of this descriptive study consisted of 387 students studying at a university in Turkey. Data for the study were collected using a Personal Information Form, the Ageism Attitude Scale (AAS), and the Sexual Myths Scale (SMS) focusing on "Age and Sexuality" subscale. Descriptive analyses, Student's t-test, One-way ANOVA, and Pearson correlation test were utilized for data evaluation.
Results: The AAS mean score was 81.78 ± 3.14, and the SMS "Age and Sexuality" subscale mean score was 10.68 ± 3.10. The significant negative relationship was observed between participants' age and the SMS "Age and Sexuality" subscale score. Female and married participants had lower scores on the SMS subscale. Additionally, those living in rural areas, and those whose mothers had no formal education had higher scores on the AAS "positive ageism" subscale. A negative significant relationship was also found between the SMS "Age and Sexuality" subscale and all AAS scores.
Conclusion: Enhancing societal awareness through health education is crucial for eliminating myths about sexuality in old age and fostering positive ageism, which in turn can significantly improve the mental health and overall well-being of older adults.

1. Introduction

In almost every country around the world, there is an increase in both the number and proportion of the elderly population [1, 2]. According to the report of the United Nations [3], there are 703 million people aged 65 and over (9% of the total population) globally. It is expected that this number will double to 1.5 billion (16% of the total population) by the year 2050 [3]. In Turkey, as of 2020, the population aged 65 and over has reached approximately 8 million (9.5% of the total population) [4]. The increase in life expectancy and the growing proportion of the elderly population within the total population are closely related to improvements in science, technology, and environmental conditions, as well as decreases in fertility rates and morbidity and mortality rates [5, 6]. Although aging is a physiological process, it is a period that limits individuals' vital activities and functions, making elderly individuals socially and physically dependent to varying degrees [7]. While aging is an inevitable stage of human life, issues of ageism and social isolation during this period significantly affect the rights and quality of life of the elderly. Ageism, defined as attitudes, prejudices, and behaviors that cause unequal opportunities in social, economic, and health areas solely based on a person's age [8], can lead to negative mental health outcomes, including anxiety, depression, and feelings of worthlessness among the elderly. This connection between ageism and mental health emphasizes the need for a holistic approach in geriatric care, one that integrates both physical and psychological well-being.

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Ageism manifests in various ways in the delivery of healthcare services. For instance, while health issues in old age are often addressed through chronic conditions (such as diabetes and cardiovascular diseases), neurological conditions (such as dementia and Alzheimer's), and mental illnesses (such as depression and anxiety disorders), the sexuality and sexual health of the elderly are frequently overlooked. Few studies on sexuality and sexual health focus on assessing the sexuality and determining the needs of elderly individuals [9–11]. This neglect and dismissal contribute to the invisibility of elderly individuals in various areas of society [12]. However, just like young adults (18-59 years old), elderly individuals also have sexual thoughts, desires, fantasies, and ways of expressing their sexuality. Similar to younger adults, the elderly consider sexuality an important part of their lives, maintain sexual desires, and express a desire to engage in sexual activity. A study conducted on individuals aged 65-95 found that 52% of men and 30% of women were sexually active [13]. Another study by the National Council on Aging revealed that 71% of men in their 60s and 51% of women engaged in sexual activity at least once a month, while 50% of 80-year-old men and 58% of women remained sexually active [14]. According to the Elderly and Sexuality Survey in Turkey, 55% of men and 35% of women aged 65 and over expressed that their sexual desires and expectations continued despite aging [15]. Therefore, regardless of gender, sexual needs persist throughout life, although they may change in quality and quantity with advancing age [16, 17]. Satisfying sexual needs in old age positively affects individuals' quality of life, self-esteem, and physical and mental health until the end of life [18–22].

Despite all this data, sexuality in old age is widely considered a "taboo" both globally and in Turkey, fostering negative attitudes toward elderly sexuality and perpetuating myths associated with sexuality in old age [10, 12, 23]. These negative attitudes, which persist across different cultures and age groups, have significant implications for the mental and emotional well-being of older adults. Discriminatory attitudes toward sexuality in old age and the prevalence of sexual myths are common, especially among younger populations. According to the literature, young people commonly believe in various sexual myths [24–29]. However, positive ageism has also been identified among young individuals [30–34]. Nevertheless, there is limited research examining the relationship between young individuals' attitudes toward ageism and their attitudes toward sexuality in old age. Studies indicate that, despite having positive attitudes toward age discrimination, young people may still hold misconceptions about sexuality in old age [35, 36]. At this point, interventions that encourage positive ageism and dispel myths about sexuality in old age, specifically targeting young individuals and society at large, become crucial. The aim of this study is to present new data on a topic with limited representation in the literature and to examine the relationship between young individuals' attitudes towards age-related sexual myths and ageism. The data obtained from this research, by addressing the intersection of age-related myths and ageism, will support broader efforts to promote mental well-being and quality of life across the lifespan. These insights will be essential for informing interventions and policies aimed at challenging societal stereotypes and fostering healthier attitudes toward aging and mental health in both younger and older populations.

2. Methodology

Data and sampling

This study is a descriptive and cross-sectional study conducted at a university in the Central Anatolia Region of Turkey from March 7 to June 30, 2022. The study population comprised 2,834 participants enrolled in 15 programs at the Health Services Vocational School of the university. The sample size was determined to be 338 using the formula for known populations (n=2834, p=0.50, q=0.50, d=0.05, t=1.96), which accounts for a 5% margin of error and a 95% confidence level. Participants were selected using stratified sampling, with programs at the vocational school serving as the stratification criterion. The disproportional stratified sampling method was employed, ensuring representation from each stratum. To account for potential data loss, a total of 387 participants were included in the final sample. This sample size accommodates an expected data loss of 10-15%, ensuring the robustness of the results.

Instruments and measurements

The data for the study were collected using the "Personal Information Form," "Ageism Attitude Scale," and "Sexual Myths Scale Age and Sexuality Subscale."

Personal Information Form: This form, prepared by the researchers, includes a total of 13 questions aimed at determining participants' demographic characteristics such as gender, age, academic department and class, place of residence, parental education, marital status, as well as assessing their attitudes towards the elderly (two questions) and evaluating their sexual knowledge levels (two questions).

Ageism Attitude Scale (AAS): Developed by Vefikuluçay-Yılmaz and Terzioğluin Turkey, the scale aims to determine individuals' attitudes toward ageism [37]. The scale is a 5-point Likert scale consisting of 23 items and three subscales. The "Restricting life of the elderly" subscale assesses society's beliefs and perceptions regarding restricting the social life of elderly individuals (items; 1, 5, 12, 14, 17, 19, 21, 22, 23). The maximum score that can be obtained from this subscale is "45," and the minimum score is "9." The "Positive ageism" subscale evaluates society's positive beliefs and perceptions towards the elderly (items; 2, 4, 6, 7, 8, 9, 13, 20). The maximum score for this subscale is "40," and the minimum score is "8." The "Negative ageism" subscale assesses society's negative beliefs and perceptions towards the elderly (items; 3, 10, 11, 15, 16, 18). The maximum score for this subscale is "30," and the minimum score is "6." The scale is scored as follows: 5=Strongly agree, 4=Agree, 3=Undecided, 2=Disagree, 1=Strongly disagree. Negative statements related to ageism (items; 1, 3, 5, 10, 11, 12, 14, 15, 16, 17, 18, 19, 21, 22) are scored negatively. The minimum and maximum scores that can be obtained from the scale are 23 and 115, respectively. The scale does not have a cutoff point. Higher scores on the scale indicate a positive ageism. Scores below the mean are considered negative, while scores above the mean are considered positive. The Cronbach's Alpha Reliability Coefficient of the scale is 0.80. In this study, the Cronbach's Alpha Reliability Coefficient of the scale was found to be 0.74.

Sexual Myths Scale (SMS): Developed by Gölbaşı et al. in Turkey, the scale aims to determine individuals' sexual myths [38]. The scale is a 5-point Likert scale consisting of 26 items and eight subscales. In this study, the "Age and Sexuality" subscale (15, 16, 17, and 18 items) of the scale was used. The scale is scored as follows: 5=Strongly agree, 4=Partly agree, 3=Undecided, 2=Disagree, 1=Never agree. There are no negatively scored items in the scale. The minimum and maximum scores that can be obtained from the scale are 5 to 20, respectively. In this study, the Cronbach's Alpha Reliability Coefficient of the "Age and Sexuality" subscale was found to be 0.75.

Table 1: Distribution of scale total and subscale score means.

Scale and Subscales	$\bar{x}$±sd	Study min-max	Scale min-max
AAS Total	81.78±3.14	57-108	23-115
Restricting life of the elderly	36.27±3.54	22-45	9-45
Positive ageism	28.8±4.29	17-40	8-40
Negative ageism	16.6±3.14	8-30	6-30
SMS			
Age and Sexuality	10.68±3.10	5-20	5-20

Abbreviations: AAS: Ageism Attıtude Scale; SMS: Sexual Myths Scale; $\bar{x}$: mean; sd:standart deviation

Ethical considerations

Before starting the research, permission was obtained from the University Social and Human Sciences Ethics Committee (Decision Date: 25.02.2022, Decision No: 2022-148) and the institution where the research was conducted. Permission was also secured via email from the authors of the two scales used in the study. Participants were informed by the researchers about the purpose, content, and significance of the research. Those who agreed to participate provided consent through online forms. Data collection was carried out using Google Forms. Participants' identity information was not recorded during the completion of the data collection tools, ensuring anonymity. At every stage of the research, the principles of the Helsinki Declaration were adhered to, maintaining the ethical standards for research involving human subjects.

Statistical analysis

For all statistical procedures, the SPSS for Windows 22.0 (IBM Corp. 2013) computer statistics package will be utilized. In the evaluation of the data, descriptive statistical analyses (Mean, Standard Deviation, Minimum, Maximum) were employed, along with the Student t-test, One-Way ANOVA Test, and Pearson correlation test. The statistical significance level was considered $p < 0.05$.

3. Results

Sample characteristics

The participants have an mean age of 20.18 ± 2.11 (min: 17-max: 40), with 80.4% being female. About 76.0% of them live in the city center, and only 2.1% are married. Regarding family type, 22.5% of participants come from extended families, while 5.4% have mothers and 11.1% have fathers with a university degree or higher. Approximately 53.7% of participants have lived with an elderly person aged 65 or above at some point in their lives. In terms of education, 35.4% have received training on sexuality and sexual health, and 33.1% consider their knowledge level on the subject to be sufficient.

Distribution of scale total and subscale score means

The participants have a mean total score of 81.78 ± 3.14 (range: 23 to 115) on the AAS. The subscale mean scores for the AAS are as follows: "Restricting Life of the Elderly" is 36.27 ± 3.54, "Positive Ageism" is 28.8 ± 4.29, and "Negative Ageism" is 16.6 ± 3.14. Additionally, the participants have a mean score of 10.68 ± 3.10 (range: 5 to 20) on the "Age and Sexuality" subscale of the SMS Table 1.

Comparison of scale total and subscale scores with some characteristics

The scale total and subscale mean scores were compared among participants based on some demographic characteristics in the study Table 2. There is no statistically significant difference in the SMS "age and sexuality" subscale mean score among participants regarding grade, place of living, maternal education level, paternal education level, and family type ($p > 0.005$). However, a statistically significant difference was observed in the SMS "age and sexuality" subscale mean score among participants based on sex and marital status ($p < 0.05$). Female and married participants had lower mean scores in the age and sexuality subscale. Additionally, a negatively low-level significant relationship was found between participants' mean age and the SMS "age and sexuality" subscale mean score Table 2. There is no statistically significant difference in the AAS total mean score among participants based on sex, grade, place of living, marital status, maternal education level, and family type ($p > 0.05$). Additionally, there is no relationship between the mean age of participants and the AAS total, "positive ageism" and "negative ageism" subscale mean scores Table 2. However, participants whose fathers are not illiterate have higher AAS total scores compared to those whose fathers have middle / high school ($p < 0.05$). Female participants have statistically higher mean scores in the " restricting life of the elderly" subscale than males ($p < 0.05$). Participants studying in the second grade, residing in rural areas, and whose mothers are illiterate have higher mean scores in the "positive ageism" subscale than those studying in the first grade, living in urban areas, and whose mothers have higher education levels ($p < 0.05$). Participants whose fathers are illiterate and those living in nuclear families have higher mean scores in the "negative ageism" subscale compared to those with fathers with higher education levels and those living in extended families, respectively ($p < 0.05$; Table 2). There is no statistically significant difference in AAS total and subscale scores, as well as SMS "age and sexuality" subscale scores, based on participants' living with a person aged 65 and older, receiving information on sexuality and sexual health, and finding their knowledge sufficient ($p > 0.05$; Table 2).

Table 2: Comparison of scale total and subscale scores with some characteristics.

Characteristic	SMS		AAS		
	Age and Sexuality	**Restricting life of the elderly**	**Positive ageism**	**Negative ageism**	**Total**
	$\bar{x}$**±sd**	$\bar{x}$**±sd**	$\bar{x}$**±sd**	$\bar{x}$**±sd**	$\bar{x}$**±sd**
Sex					
Female (n=311)	10.49±2.96	36.50±3.46	28.78±4.23	16.68±3.22	81.96±7.77
Male (n=76)	11.47±3.52	35.32±3.73	29.13±4.59	16.55±2.84	81.01±8.27
t / p	-2.482 / **0.013**	2.613 / **0.009**	-0.605 / 0.546	0.345 / 0.731	0.947 / 0.344
Grade					
First grade (n=291)	10.73±3.11	36.25±3.37	28.61±4.16	16.70±3.05	81.57±7.62
Second grade (n=96)	10.55±3.08	36.34±4.02	29.57±4.64	16.50±3.42	82.41±8.60
t / p	0.492 / 0.623	-0.204 / 0.839	**-1.906 / 0.057**	0.560 / 0.576	-0.913 / 0.362
Place of living					
Urban (n=294)	10.61±3.04	36.27±3.59	28.61±4.28	16.81±3.13	81.70±7.95
Rural (n=93)	10.91±3.26	36.27±3.40	29.60±4.29	16.15±3.15	82.03±7.64
t / p	-0.808 / 0.420	0.188 / 0.986	0.760 / **0.053**	0.303 / 0.076	0.187 / 0.724
Marital status					
Married (n=8)	8.50±3.07	37.50±5.09	30.25±3.73	17.87±3.64	85.62±9.25
Single (n=379)	10.73±3.08	36.24±3.50	28.82±4.31	16.63±3.13	81.69±7.83
t / p	-2.024 / **0.044**	0.989 / 0.323	0.838 / 0.353	1.106 / 0.269	1.397 / 0.163
Family Type					
Nuclear family (n=300)	10.65±3.10	36.31±3.58	28.92±4.28	16.84±3.25	82.08±8.01
Extended family (n=87)	10.81±3.10	36.14±3.41	28.58±4.36	16.01±2.66	80.74±7.32
t / p	-0.439 / 0.661	0.372 / 0.710	0.650 / 0.516	2.179 / **0.030**	1.392 / 0.165
Maternal education level					
Not literate (n=38)	11.15±3.24	36.60±3.71	30.65±4.87	16.68±2.98	83.94±8.25
Literate / elementary school (n=209)	10.65±2.90	36.19±3.77	28.45±4.14	16.77±3.28	81.42±7.90
Middle / high school (n=119)	10.65±3.32	36.27±3.22	28.94±4.33	16.19±2.76	81.41±7.65
University and above (n=21)	10.38±3.61	36.47±2.58	29.00±3.86	18.04±3.58	83.52±7.82
F / p	0.372 / 0.773	0.170 / 0.916	2.898 / **0.035**	2.348 / 0.072	1.540 / 0.204
Paternal education level					
Not literate (n=9)	10.88±3.21	38.33±5.67	30.88±5.06	20.00±5.74	89.22±13.10
Literate / elementary school (n=151)	10.74±3.10	36.01±3.77	28.89±4.53	16.62±3.13	81.52±8.15
Middle / high school (n=184)	10.81±3.11	36.41±3.22	28.80±4.19	16.54±2.93	81.76±7.41
University and above (n=43)	9.88±2.97	36.16±3.44	28.44±3.71	16.55±3.15	81.16±6.91
F / p	1.100 / 0.349	1.399 / 0.243	0.813 / 0.487	**3.548 / 0.015**	2.858 / **0.037**
Living together with an elderly person					
Yes (n=208)	10.55±3.08	36.43±3.42	29.05±4.39	16.59±2.96	82.08±7.83
No (n=179)	10.83±3.11	36.08±3.67	28.61±4.18	16.73±3.35	81.43±7.92
t / p	-0.886 / 0.376	0.979 / 0.328	1.000 / 0.318	0.212 / 0.662	0.804 / 0.418
Sexuality education					
I received sexuality training (n=137)	10.72±3.41	35.97±3.81	28.80±4.43	16.26±3.38	81.04±8.40
I didn't receive sexuality education (n=250)	10.66±2.92	36.43±3.38	28.87±4.23	16.87±2.99	82.18±7.55
t / p	0.200 / 0.842	-1.216 / 0.225	-0.160 / 0.873	-1.825 / 0.069	-1.363 / 0.174
Own sexuality knowledge					
I think my knowledge is sufficient (n=128)	10.78±3.35	36.35±3.76	29.24±4.47	17.13±3.43	82.72±8.62
I think my knowledge is insufficient (n=105)	10.33±3.32	36.45±3.44	28.43±4.60	16.63±2.86	81.53±7.84
I'm undecided (n=154)	10.85±2.70	36.08±3.43	28.80±3.91	16.27±3.05	81.16±7.19
F / p	0.956 / 0.385	0.390 / 0.677	1.023 / 0.361	2.631 / 0.073	1.453 / 0.235
	r / p	**r / p**	**r / p**	**r / p**	**r / p**
Yaş	-0.157 / **0.002**	0.109 / **0.032**	0.034 / 0.501	0.021 / 0.675	0.076 / 0.134

Abbreviations: AAS: Ageism Attıtude Scale; SMS: Sexual Myths; Scale; $\bar{x}$: mean; sd:standart deviation; t: independent samples t-test F: one-way analysis of variance; r: Pearson correlation coefficient

Table 3: The correlation between scale total and subscale mean scores.

AAS	SMS Age and Sexuality	
	r	**p**
AAS Total	*-0.267*	*0.000*
Restricting life of the elderly	*-0.331*	*0.000*
Positive ageism	*-0.033*	*0.517*
Negative ageism	*-0.249*	*0.000*

Abbreviations: AAS: Ageism Attıtude Scale; SMS: Sexual Myths Scale; r: Pearson correlation coefficient.

The correlation between scale total and subscale mean scores

The relationship between participants' AAS total and subscale scores and SMS "age and sexuality" subscale scores has been evaluated. A negative and low-level significant correlation has been found between SMS "age and sexuality" subscale and AAS total and all subscale scores ($p < 0.01$; Table 3).

4. Discussion

Socio-cultural myths, religious teachings, environmental factors, and individual differences contribute to the perception of "old age" and "sexuality" as generally unrelated phenomena, often shaped by negative ageism. However, associating old age with conditions such as dependency, illness, and disability leads to the acquisition of negative ageism and the perpetuation of myths that suggest asexuality in old age. This study aims to examine the relationship between young individuals' age-related sexual myths and ageism attitudes. The obtained data has been discussed in line with the relevant literature. In Turkish culture, elderly individuals are perceived as wise figures in society, and their advice, experiences, and life stories are highly valued. Showing respect to elderly family members, visiting them, and meeting their care needs are traditional practices in Turkish culture. This reflects an expression of respect and love for the elderly. Particularly in the process of raising children, parents nurture their children within the framework of these teachings, encouraging them to treat the elderly with respect and tolerance [38–40]. In this study, participants were found to have an above-mean positive ageism. This finding can be considered an expected outcome for young individuals raised in Turkish society. In our study, it was found that participants had below-mean beliefs related to age and sexuality; participants with fewer myths tended to have more positive ageism. This data can be considered quite promising. The composition of the study's sample, consisting of university students and individuals undergoing education in various fields related to the provision of healthcare services, may have influenced this result. Individuals with higher levels of education are generally more open-minded, and their likelihood of having myths about the inappropriateness of sexuality in old age may be lower. The theoretical knowledge provided during health-related professional courses could also have reduced or eliminated sexual myths about age.

In our study, it was determined that participants who were female and married had fewer myths related to age and sexuality. Similarly, there are many studies indicating that men have more sexual myths than women [27, 41]. In patriarchal societies, it can be considered that the privileges granted to men in terms of sexuality may lead them to believe in more myths. From a broad perspective, it can be said that patriarchy predominates in Turkey, the Middle East, and a large part of South and East Asia. Married individuals, on the other hand, have more experience with sexuality as they are part of a lifelong relationship. This experience can help them have accurate information about sexuality and be less exposed to sexual myths. A healthy sexual life among married couples can encourage open communication and social support. This communication can help reduce sexual myths. However, there are also studies contradicting our study, showing that married individuals have more sexual myths than singles [42, 43]. Although this study found that the participants' age did not have an impact on ageism attitude, it is worth noting that as age increases, it may positively influence ageism, fostering greater empathy and understanding towards the elderly. Additionally, in our study, it was observed that as participants' age increased, myths related to age and sexuality decreased. There are several studies in the literature indicating that as age increases, the level of knowledge about sexuality and sexual health also increases [44, 45]. According to the current data, it can be considered that the experience gained with age contributes to learning, increases awareness of recognizing and coping with myths related to age and sexuality. Deliberate efforts to turn to reliable sources of information and seek accurate knowledge may help reduce myths and negative ageism.

In our study, participants who have been residing in rural areas and whose mothers have low literacy levels were found to have higher scores in the "positive ageism" subscale ($p < 0.05$). A study conducted by Kaçan et al. also found that individuals with a rural residence ("village") had significantly higher positive ageism [46]. Kurtkapan identified that female participants had a more positive attitude compared to males [47]. Similar results were obtained by Köse Tosunöz and Güngör [48]. In countries with diverse social structures like Turkey, the influence of a mother's lack of education and rural residence on positive ageism can be complex. For instance, in Turkey, in rural areas, elderly care is often perceived as a responsibility attributed to women due to societal gender roles. Additionally, traditional family values are more pronounced in rural areas in Turkey. Therefore, uneducated women living in rural areas may be more inclined to develop a positive ageism, viewing positive ageism as part of their family structure and traditions. They may see their positive attitudes towards the elderly as a reflection of their upbringing within the framework of these teachings while raising their children.

5. Conclusıon

In this study, it was found that as the mean age decreases among young participants studying in various health-related fields, they have more sexual myths associated with "age and sexuality". Conversely, those with more positive attitudes towards ageism exhibited fewer sexual myths about aging and sexuality. These findings provide valuable insights into the interplay between ageism and sexual myths, highlighting

how misconceptions about aging and sexuality can impact mental health and overall well-being. Understanding these dynamics is crucial for developing educational programs that not only address and correct myths about sexuality in old age but also promote positive ageism. Such programs are essential for fostering a more inclusive and supportive environment for older adults, which can significantly enhance their mental health and quality of life. By addressing and challenging age-related prejudices and stereotypes, healthcare professionals can play a pivotal role in improving the mental well-being of older adults. Future research should continue to explore these themes within a broader social context to further unravel the complexities of how age-related sexual myths and ageism influence mental health outcomes.

Weaknesses of the Research

This study was conducted within a single vocational school at a university in one province of Turkey. As a result, the findings are limited in their generalizability to other regions of Turkey and to university students outside of this specific institution. The research sample consisted of individuals enrolled in health-related fields, which may influence their attitudes and knowledge about age and sexuality differently compared to students from other disciplines or institutions.

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