

Beyond decline: challenging narratives of aging, prevention and elevating well-being

Abstract

The aging process is accompanied by numerous psychosocial changes that extend well beyond the biological ones. Declining sexual function, increased psychological burden, increasing physical dependency, and progressive social isolation collectively diminish quality of life and overall wellbeing across both genders. All these changes do not occur in isolation, they interact, accelerate and amplify one another, thus, producing compounded effects that individuals, clinicians and caregivers must be aware of and recognize holistically. This current editorial-expert opinion will briefly concentrate on only six changes as a start: sexual function, disease-related decline, disability, incontinence, anxiety and depression, and social isolation. Furthermore, a call to action is presented to promote better aging outcomes, a stronger sense of self-worth, sustained and elevated well-being.

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Miranda A Farage

Ph.D. DermatoSciences, Cincinnati, OH 45249, USA

Correspondence: Miranda A Farage, Ph.D. DermatoSciences, Cincinnati, OH 45249, USA**Received:** April 20, 2026 | **Published:** May 05, 2026

Some psychosocial changes

Sexual function and health decline

Loss of sexual function is among the most prevalent but under-reported psychosocial change in aging individuals. Studies show that approximately 34% of older adults report lack of sexual interest, 23% experience difficulty with arousal, and 11% report difficulty achieving orgasm.^{1,2} These percentages represent only part of a broader picture shaped by coexistent comorbidities conditions. Women who undergo mastectomy or breast-conserving therapy for early-stage breast cancer experience significant declines in sexual functioning, often combined with depression and altered body image.³ Similarly, diabetes presents independent risks. A systematic review and metaanalysis by Pontiroli and colleagues⁴ demonstrated a significant association between diabetes and sexual dysfunction, emphasizing the importance of managing metabolic health to maintain sexual well-being. Together, these findings highlight that sexual dysfunction in older adults is frequently multifactorial, demanding integrated clinical assessment regardless of gender.

Disability and loss of independence

Disability represents one of the most profound and psychologically devastating transition a person can face and experience in later life. The loss of independence, whether gradual or immediate, is strongly associated with depression and reduced engagement in meaningful life activities. Extensive data from the Women's Health Initiative study^{5,6} emphasize that aging well is not merely the absence of disease, but rather the preservation of functional capacity, social participation, and psychological resilience. When disability disrupts these pillars, the downtrend psychosocial impact, in both genders, can be shattering and long-lasting across all individuals.

Supporting these insights, one has to mention Reker's Successful Ageing Scale which offers an integrative framework bridging Rowe and Kahn's theory of successful ageing, Ryff's model of psychological wellbeing, Baltes and Baltes' selective optimization with compensation, and Schulz and Heckhausen's lifespan model to propose the three interconnected critical components leading to a successful aging. These three important components are: 1) healthy lifestyle (good nutrition and physical activities), 2) life engagement (staying socially active with meaningful activities), and

3) adaption coping (ability to develop resiliency in managing stress and life challenges).⁷ As important, aging well should be relevant and achievable for older individuals living with lifelong or later-emerging disabilities. Accessible environments, lifelong learning, supportive careers, and inclusive communities have been identified as central facilitators of ageing well in this population.⁸ Lived-experience studies among adults aging with mobility, vision, and hearing impairments demonstrate that targeted accessibility, adaptive technologies, and reliable transportation are essential to sustaining engagement, autonomy, and dignity in everyday life.⁹

Incontinence: physical and psychosocial consequences

Urinary and fecal incontinence carry a deep psychosocial burden relative to their clinical visibility. Across studies, rates of sexual impairment attributable to urinary incontinence range from 2% to 64%, and evidence confirms a direct correlation between incontinence severity and the degree of sexual dysfunction.^{1,2} Beyond sexual health, incontinence is associated with anxiety, depression, shame, and social withdrawal. Fecal incontinence intensifies this burden even further, with both intrinsic disease factors and external contributors including injury and physical restraint worsening the clinical appearance.^{10,11} Many older adults are reluctant and ashamed to disclose incontinence issues to healthcare providers, which in turn means that psychosocial consequences often go unaddressed for a prolonged period of time.

Anxiety, death anxiety, and depression

Anxiety is highly prevalent among older adults, whether in residential or institutional care settings. It manifests across multiple vicious varieties including generalized anxiety, health anxiety, and death anxiety, and is frequently associated with fatigue, depression, and insomnia.¹² Death anxiety in particular, carries gender-specific and racial patterns. Research by Assari and Moghani Lankarani¹³ found significant race and gender differences in its correlates, a reminder to clinicians that a standardized psychological approach might be insufficient and that care must be tailored to each individual.

Importantly, late-life depression has distinct neurobiological foundation that differentiate it from depression in younger adults. Alexopoulos¹⁴ describes the involvement of arteriosclerosis, inflammatory and endocrine changes, compromised neural pathway integrity, and alterations in the amygdala and hippocampus as

contributing to aberrant thoughts and mood dysregulation in older populations. Depression is most prevalent among those dealing with the highest burden of chronic illnesses which then creates a downhill vicious cycle which may contribute to a shortened lifespan.¹⁵

Social isolation: a silent and serious crisis

Social isolation among older adults is an emerging and serious public health issue affecting both men and women alike. Some key contributing factors include the loss of a spouse, health disability, reduced social networks, transportation limitations, and the general reduction of social opportunities that accompanies advanced age.¹⁶ Social isolation is not simply a quality-of-life concern but evidence shows a strong association between isolation, loneliness, and a quick decline path to all-cause mortality in older adults of all genders.¹⁵ Poor health increases the risk of isolation and is exacerbated by it, forming a vicious cycle that is extremely difficult to interrupt without systemic intervention.

For many people, one profoundly underappreciated and ignored driver of social isolation is the loss of professional identity. For many older adults, a significant part of their sense of self-worth, purpose, and social connection is anchored in their working life. When organizations push older employees out, whether it is done through forced redundancy, mandatory retirement, or the quiet marginalization of those deemed past their productive peak, the psychological damage can be extremely severe and shocking. The loss of a professional role is not simply just the loss of a job, it is the loss of one's own status, life purpose, routine, peer relationships, and the fundamental sense of being valued and needed. This hit to one's self-pride, belonging, dignity and own identity is a direct driver of social withdrawal, depression, and accelerated spiral decline. It is a consequence too often dismissed as a normal feature of aging, when in fact, it really reflects a systemic failure that demands urgent recognition, reparation and fixation.

A call to action for elevating aging well-being

The evidence presented in this brief editorial, demands more than clinical acknowledgement. It calls for a fundamental shift in how individuals, societies, and health systems approach the psychosocial dimensions of aging. These challenges are not confined to one gender, they are universal human experiences that require a committed, genuine and good faith response from all. Four immediate priorities stand out as a starting point.

Prevention should begin early and must continue through every life stage

One should not wait until symptoms emerge. Otherwise, it will definitely be a failed strategy. Prevention must and should begin early, with health literacy rooted with education from childhood onwards. Young people of all genders must be equipped with an understanding of how lifestyle choices, nutrition, mental health, and social connectedness today shape their well-being decades from now. This early foundation is not optional; it is actually the single most cost-effective investment a society can make in the long-term health of its aging population.

Yet, prevention cannot stop at youth. Every individual must be empowered, through every stage of life, to take active ownership, and control of their physical and psychosocial health. This means cultivating a culture of routine self-advocacy, being proactive, engaging with healthcare providers well before challenges escalate into crises. Open, normalized conversations about sexual health,

mental health, and aging must become part of how we live, not how we later ought to react. Prevention, understood this way, is not a clinical checkbox but a lifelong commitment, one that belongs equally to individuals, healthcare systems, educators, and policymakers.

Society must fundamentally rethink its relationship with the elderly

Undeniably, Western societies have unfortunately failed older adults. Aging is too often framed as a decline, and the elderly too often become invisible, institutionalized, disregarded, and/or disrespected. This stands in sharp contrast to Eastern and some other societies, where deep-rooted cultural traditions place older adults at the center of family and community life, surrounding them with respect, inclusion, care, love, and a continued sense of purpose. The psychosocial consequences of isolation and disengagement are not abstract, they are measurable and come hand by hand in rates of depression, cognitive decline, and mortality. Western societies must critically look at these cultural contrasts and aim to pursue structural changes, especially in how communities are designed, how intergenerational relationships are nurtured, and how value is assigned to older people as essential continuous contributors to society rather than consider them burdens. This effort must also address gender disparities in aging, where older men are rewarded greater respect and social status than older women.

The medical community must lead with earlier awareness and identification

Psychosocial deterioration is usually a silent condition, rarely announcing itself aloud. Sexual dysfunction, social withdrawal, anxiety, and early depression are frequently missed or even labelled as inevitable features of aging. Healthcare providers across all disciplines must be equipped to recognize these trends earlier, be proactive and ask more focused questions of patients of all genders. Routine and private psychosocial screening should become standard practice in primary care, not an afterthought reserved for acute presentations. Medical curricula and continuing professional development must integrate the evidence base on aging, sexual and physical health, and mental well-being. Early awareness is the foundation for timely rescue, help, intervention and most importantly prevention.

Investing in interventions, programs, culture change and support is essential

Awareness without tangible actions is insufficient. Governments, health systems, communities, schools and colleges must invest meaningfully in programs that address the full spectrum of psychosocial need in aging adults of all genders, but equally important is the thoughtful work of shifting cultural attitudes toward aging itself. Culture shapes how societies treat their older members, and without deeply challenging long-held beliefs and stigmas around aging, gender, and self-worth, structural investments alone will likely fail or fall short.

This includes accessible mental health services, community-based social inclusion initiatives, peer support networks, workplace transition support, physical strengthening programs, and caregiver education. It also means fostering cultures that normalize conversations about aging, challenge ageist and gendered stereotypes, and actively celebrate the contributions of every older adult. Most importantly, it means cherishing older people with the dignity and respect they have spent a lifetime-earning.

Some concrete strategic examples of these efforts already exist on both sides of the Atlantic. In Europe, the active ageing policy

framework promotes meaningful engagement, preventative health, intergenerational solidarity, and respect for population diversity, while initiatives such as Ageing Well in Wales target age-friendly communities, fall prevention, dementia-supportive environments, and loneliness reduction. In the United State of America (USA), state-level plans, including the Aging Texas Well Strategic Plan, prioritize physical health alongside accessible community-based services and social and recreation opportunities. Equally important is the integration of spirituality into clinical and community care, through brief spiritual screening, meaning-centered conversations, and value-based advance care planning, all have been associated with reductions in anxiety and depression, lead to increase in hope, resilience, and quality of life, and greater dignity in serious illness.¹⁷ Meta-analytic evidence further confirms that spiritual interventions such as meditation, prayer, mindfulness, and compassionate care produce meaningful achievements in anxiety reduction, quality of life, and chronic disease symptom management, with patient satisfaction rates always exceeding 80%, particularly among older adults and those living with chronic illness.¹⁸

Conclusion

The psychosocial changes accompanying aging are clinically significant, interconnected, and frequently underestimated across all genders. Sexual dysfunction, disability-related loss of independence, incontinence, anxiety, depression, and social isolation, including the profound impact of losing one's professional identity and sense of worth, each carry substantial individual burden. However, together they represent a compounding challenge to human well-being. Effective clinical management requires a holistic, patient-centered approach that integrates routine psychosocial screening alongside conventional medical care. Critically, a meaningful change cannot begin at the time and point of crisis. Prevention must start early from childhood and youth onwards, embedding health literacy, self-advocacy, and open conversations about physical, spiritual and psychosocial health into education and culture long before symptoms emerge, and it must be sustained as an active, personal commitment throughout every stage of life.

Greater investment in community support structures, mental health access, physical strengthening activities, better nutrition and education is essential to meaningfully address these challenges at a population level. However, medicine and policy alone cannot carry this work. Culture is perhaps the most powerful and under-utilized force available to us. The way a society speaks about aging, portrays and treats older adults, and empowers value to lived experience shapes everything from individual self-perception to institutional priorities. Cultures that idolize their elders, as seen across many Eastern and indigenous societies, demonstrate that aging need not be synonymous with invisibility, loneliness, or decline. These examples are not relics; they are models worth learning from, adapting, and consistently practicing. A strong true change movement must therefore be cultural at its core and heart. It must challenge ageist narratives, celebrate the wisdom and resilience that come with age, and build communities where older adults are seen, heard, valued, appreciated and given the opportunity to keep contributing fully and actively to society. When culture shifts, attitudes follow, and when attitudes follow, policy, funding, role-modeling, and care all begin to positively change with them. The goal is not simply to manage aging better, but to reimagine what it means to grow old with dignity, independence, purpose, fulfillment, happiness, and a sense of self and belonging. Elevating human well-being in later life is not a choice, it is a moral obligation and a measure of the kind of society we choose and thrive to be.

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Conflicts of interest

The author declares no conflict of interest.

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