AGEING AND SEXUALITIES

Interdisciplinary Perspectives

Edited by Elizabeth Peel and Rosie Harding

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For Martha and Jennie

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Interdisciplinary Perspectives

Edited by

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Routledge
Taylor & Francis Group
LONDON AND NEW YORK

First published 2016 by Ashgate Publishing

Published 2016 by Routledge
2 Park Square, Milton Park, Abingdon, Oxon OX14 4RN
711 Third Avenue, New York, NY 10017, USA

Routledge is an imprint of the Taylor & Francis Group, an informa business

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

The Library of Congress has cataloged the printed edition as follows:
Ageing and sexualities : interdisciplinary perspectives / [edited] by Elizabeth Peel and Rosie Harding.
pages cm
Includes bibliographical references and index.
ISBN 978-1-4724-3215-5 (hardback)
1. Older people--Sexual behavior. 2. Older gays--Sexual behavior. 3. Sex. 4. Aging.
I. Peel, Elizabeth, editor. II. Harding, Rosie, editor.
HQ30.A44 2016
306.7084'6--dc23

2015025289

ISBN 9781472432155 (hbk)

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Acknowledgements

The seed for this edited collection germinated in two symposia organized by Sue Westwood on LGBT ageing at the 2012 *British Society of Gerontology Conference* at Keele University, and we extend our grateful thanks to Sue Westwood for her significant contribution to this collection. We hope you enjoy this book which offers a range of social science perspectives on lesbian, gay, bisexual and heterosexual ageing in a non-heteronormative way. Thanks go to Neil Jordan at Ashgate. There have been highlights along the way; not least the contract coming through while Liz was a visiting research fellow at Flinders University and Rosie a visiting scholar at the University of Adelaide in September 2013.

We are very grateful to all the contributors, particularly to Chris Beasley for thinking it a 'lovely suggestion' to use some of her evocative portraits of older people on the cover, especially of her father who – after a longstanding focus on the life of the mind - is dealing with memory loss issues (Photography and design by Peter Hall). Liz would like to thank colleagues at the University of Worcester and beyond for supporting her endeavors, and colleagues in the BPS Psychology of Sexualities Section and those associated with PACE Health who keep sexualities related research and practice interesting. Thanks also to Badgers running club and Bramble for encouragement to engage in physical activity. Rosie would like to thank colleagues working in gender, sexuality and law at the University of Birmingham, in the ReValuing Care research network and more widely for continuing to create inspirational spaces for feminist inquiry. Thanks also must go to Frodo the cat for sitting on chapter drafts, sleeping on her keyboard and attacking her (computer) mouse.

Liz and Rosie

Introduction
Ageing and Sexualities

Rosie Harding and Elizabeth Peel[1]

Until quite recently, older age has been associated with asexuality. However, there is a growing interest in moving beyond the stereotype of older people as asexual (Gott, 2005) and developing a critical research agenda for ageing and sexuality (Marshall, 2011). Recent research has shown that sexuality remains relevant in older age (Carpenter and DeLamater, 2012) with many older people continuing to have fulfilling and meaningful sexual lives in later life (Lindau and Gavrilova, 2010), albeit understood through the much-critiqued lens of 'successful ageing' (e.g., Katz and Marshall, 2003).

This collection of original essays explores ageing sexualities from a range of social science disciplines and theoretical perspectives, located across several spatial and geographical contexts. It fills a gap in the burgeoning literature on ageing and sexuality by incorporating scholarship on, and interrogating, both lesbian, gay, bisexual (LGB) *and* heterosexual ageing. It seeks to locate ageing and sexuality in their normative frameworks, with the purpose of identifying and examining those frameworks and the norms upon which they are based. With contributions from leading authors in the field, the collection supports the exploration of the discursive production of sexuality and the spatial and temporal contingencies of sexuality performance, within the context of age and ageing. In doing so it complicates and innovates conceptualisations of ageing sexualities. In this introductory chapter, we firstly locate this collected volume in the context of existing research, then introduce each of the subsequent chapters, before identifying linking themes and a framework for the future research agenda in this field.

While the growing recognition that it is possible to be both older and sexually active has been lauded as an example of a decline in ageism, others have argued that it only serves to further marginalise the very old, the frail, the infirm, who are unable to keep up with these new 'sexy oldie' stereotypes and thus 'fail' to age successfully (Gilleard and Higgs, 2010). Ageing sexualities are not only nuanced by age itself, but also their intersection with other social and cultural locations, including ethnicity, class, and disability. Moreover, ageing is spatially located: the same spaces may be differently experienced, and different spaces occupied, according to age. As Paul Simpson (2012, 2013) has recently shown, for example, some middle aged gay men may choose to reject the commercial gay scene in

1 We would like to thank Sue Westwood for her contribution to this introduction.

preference for leisure spaces more commonly occupied by heterosexuals, where they can be free from the 'ageist gay gaze' (Simpson, 2012, p. 1) while still at the same time negotiating a heteronormative one. Heteronormativity is the assumption that heterosexuality is the norm; its counterpart, heterosexism, is the privileging of heterosexuality.

Lesbian, gay and bisexual ageing has been under-represented in authorship on both ageing (Cronin, 2006), sexuality in general (DeLamater, 2012) and LGB sexualities in particular (Pugh, 2002). However, there is now a growing body of work in this area (e.g., Herdt and De Vries, 2004; Ward, Rivers and Sutherland, 2012). While research on ageing heterosexuality has primarily focused on sex – desire, functioning, satisfaction, performance, health (Carpenter and DeLamater, 2012) – research on LGB sexualities has taken a wider approach, perhaps to compensate, in part, for the default heteronormativity of much of gerontology. Such research has addressed the lived experience of ageing sexualities (e.g., Kimmel, 2014), particularly among different generations and cohorts (De Vries, 2014); kinship formations, social networks and informal social support (Fokemma and Kuyper, 2009), mental and physical health and well-being (Fredriksen-Goldsen et al., 2013), and inequalities in regulatory contexts (Knauer, 2009). There is a particularly significant body of research on older lesbians and gay men's anxieties and concerns about older age care and accommodation (e.g., Hughes, 2009; Stein et al., 2010), which is perceived as a site of 'ignorance at least, homophobia at worst' (Guasp, 2011, p. 22), of disconnection from lesbian and gay support networks, and where many older lesbians and gay men may feel the need to (re-) conceal their sexual identities (Harrison and Riggs, 2006).

Most recently, there has been emergent interest in the temporal and spatial contingencies of the discursive and performative production of sexualities in general (Butler, 2008) and ageing sexualities more specifically (Binnie and Kleese, 2013). This body of work has tended to under-address issues of gender, older lesbians' experience (e.g., Averett, 2014), and also bisexuality (e.g., Dworkin, 2006). It has also not, as yet, been integrated into mainstream ageing sexualities discourse (Brown, 2009) which has remained 'resolutely heterosexist' (Clarke et al., 2010, p. 216).

With increasing recognition of LGB identities in law and society (Harding, 2011) and a new wave of openly visible LGB people now reaching older age, it is now time for their inclusion in discourse about ageing populations in general and ageing sexualities in particular. Doing so not only offers insights into the particularities and complexities of LGB ageing (Cronin and King, 2010), it can also serve to shine a light on heterosexual ageing and associated norms and normativities. In other words, how heterosexuality itself shapes the construction and experiences of ageing, and how heteronormativity can inform ageing policies (Heaphy and Yip, 2006) and provision (Ward, Pugh and Price, 2011) and who is privileged, and who is marginalised, in that process (Westwood, 2013). Moreover, it encourages us to move away from binary notions of sexuality and develop

more complex, subtle and nuanced understandings of sexuality, including in ageing contexts.

The central argument at the core of this collection is that sexuality informs lived experiences of, and processes of recognition and resourcing to, gendered ageing. In the findings of a UK survey of over 1,000 older LGB individuals and 1,000 older heterosexual individuals, for example, it was found that many older LGB and older heterosexual individuals shared similar concerns about ageing, relating to: needing care; independence; mobility; health; housing and mental health (Guasp, 2011, p. 7). However, the older LGB individuals were 'consistently more anxious' than their heterosexual peers about needing formal care provision (Guasp, 2011, p. 3). They were worried, in addition to the concerns shared with older heterosexual people, about sexuality-specific issues relating to lack of recognition and/or prejudice and discrimination. Because their social support networks are less likely to be intergenerational (due to the historical denial of access to parenthood for many older lesbians and gay men, see Hicks, 2005), older LGB individuals are also likely to be early and disproportionate users of those services about which they are so concerned (Heaphy, Yip and Thompson, 2004). In this way, we can see how sexuality can exacerbate ageing issues. Moreover, as women live longer than men, and single childless women in particular are most likely to spend their final years in residential care, this also disproportionately affects older lesbians compared with both older gay men and older heterosexual women (Westwood, 2014).

This edited collection showcases developments in theory, research and practice regarding sexuality and ageing. It considers the differences and similarities between, and among, ageing heterosexual and LGB older people. The collection addresses a significant gap in the burgeoning ageing sexualities field, and in so doing, identifies the key questions that will underpin social science research into the interactions of ageing and sexuality in the years to come. It includes authors from a range of disciplinary backgrounds (including social gerontology, sociology, cultural studies, medicine and health care, psychology and socio-legal studies) and different geographical (the UK, Australasia, Africa) contexts. The collection explores the importance of different forms of sexualities, particularly at their intersection with gender, and the significance of spatial-relational contexts, ranging from the individual, to residential care spaces to virtual spaces (i.e., internet dating). Several chapters compare and contrast heterosexual and same-sex experiences, others distinguish between experiences under the 'LGB/T ageing' umbrella, emphasising both shared and varied experiences in later life. By bringing together cutting-edge scholarship from these diverse veins of social science work on sexuality and ageing, this edited collection provides a coherent, integrated and comprehensive overview of the conceptual and practical challenges of understanding the complex interplay of ageing and sexuality in the twenty-first century.

Chapter Outlines

The chapters share, and yet are at the same time differentiated by, a number of central themes. Firstly: the representation and cultural constructions of ageing sexualities, still invisible in some spatial and cultural contexts, increasingly visible in others, with expanding diversification of that visibility. Secondly: the regulation of ageing sexualities, in political and socio-legal contexts. Thirdly, the diversifying spatial contexts of ageing sexualities: in public, private and virtual space. And, lastly, the embodied nature of ageing sexualities: embodied in the sense of experiencing an ageing body; embodied in the sense of being perceived as an ageing individual through bodily signs of ageing; embodied in relation to resistance to those markers of ageing, in various forms; and embodied because of the morbidity and mortality with which ageing, and very old age, are implicated. We shall now briefly outline each chapter in turn, tracing each of the themes through.

In Chapter 1, *Ageing and Sexuality in Western Societies: Changing Perspectives on Sexual Activity, Sexual Expression and the 'Sexy' Older Body*, Sharron Hinchliff and Merryn Gott chart the growing recognition of sexuality among older people in recent decades. From being regarded as asexual in Western cultures, older people have come under increasing pressure to age well, and part of that ageing well involves remaining sexually active. This is, of course, in the context of prevailing heteronormativity and heterosexism, primarily being heterosexually active. The majority of research on sexuality among older people has been conducted with heterosexual older people, sometimes explicitly, but more often unquestioningly. Hinchliff and Gott provide an informed, succinct and fluent overview of the current state of research. They caution that the 'sexy oldie' could become a new stereotype of ageing, one that will marginalise those who do not or cannot live up to its ideals.

In Chapter 2, *Ageing Sexualities in UK Regulatory Contexts*, Sue Westwood takes a socio-legal approach to consider ageing sexualities in the contemporary UK regulatory context. She argues that law and social policy privileges ageing heterosexual sexualities and marginalises ageing lesbian and gay sexualities and kinship forms. Using the concepts of nodes and flows, Westwood suggests that there is a four-tier privileging of relationship norms and forms in UK law and social policy affecting older people, which prioritises the conjugal couple, nuclear and biological family, over other relationship forms, particularly friendship. Westwood argues that this is both implicated in under-recognition and in relation to rights and entitlements, which in turn leads to uneven access to resources in later life. She concludes that ageing cannot only iterate sexuality inequalities but also exacerbate them, materially and socially.

In contrast to this narrative of emerging visibility of ageing sexualities in Chapter 3, *Inclusion and Representation of Older People and Sexual Health in Sub-Saharan Africa within Contemporary Population Health Research*, Gloria Chepngeno-Langat and Victoria Hosegood consider the under-representation of ageing sexualities in an African health research context. In their comprehensive review of the literature, they show how sexuality among older people has not been

addressed in sub-Saharan African public health strategies. This is of particular concern given the number of older people who are ageing with HIV. The focus on HIV prevention in public health strategies means that sex among older people can be constructed as 'dangerous' and something to be discouraged, rather than taking a broader, non-pathologising sexual safety approach, among people of all ages, including older people. Chepngeno-Langat and Hosegood argue that it is 'important' to understanding the sexual and health needs of older people in sub-Saharan Africa so that those needs can be better addressed.

The issue of lack of recognition is also central to Chapter 4, *Becoming Visible: De-Marginalising Older Lesbians in LGBT Ageing Discourse*, in which Jane Traies explores the lack of visibility of older lesbians. Traies argues that older lesbians are multiply marginalised by ageism, sexism and heteronormativity. Traies draws upon her recent research with over 400 older lesbians in the UK, to shine a light on their lives. In doing so she demonstrates how older women maintain, renew, discover and/or rediscover love and sexual intimacy with other women in later life. She highlights the close ties between older lesbians beyond those of sexual intimacy and friendship and how those ties sustain and support older lesbians in later life, and at the end of life. However, Traies also argues that a lack of visibility of the lives and relationships of older lesbians means that their particular needs and issues are less likely to be recognised and supported. As a result, older lesbians lives need to be made more visible.

In Chapter 5, *Sexual Identity Labels and their Implications in Later Life: The Case of Bisexuality*, Rebecca Jones explores how sexuality/ sexual identity labels are understood and socially (re-)produced from the perspective of bisexuality. She considers the implications for understanding the later life sexuality and retrospective sexual/relational history by analysing a vignette involving an older woman who has previously been in committed relationships with women and men. Jones' analysis highlights the potential problems inherent in the normative binary approach to sexuality classification, and the challenges that stem from seeking constancy in labelling/categorising an individual's sexuality/sexual identity. In older age, those who have more fluid sexual histories may find they are not only marginalised through ageism, but through this binarism which seeks to categorise an individual as either heterosexual or lesbian/gay. The risk is that this approach further marginalises those whose lives do not fit neatly into such simple categorisation leading to misrecognition and vulnerability.

Ageing is an embodied process, is experienced at an embodied level, and is perceived by others in an embodied way (i.e., the visual signalling of ageing). It is also an emplaced process, particularly when ageing bodies require high levels of personal care (often medicalised) and when that care takes place in residential care contexts for older people. In Chapter 6, *Older People and Sexuality in Residential Aged Care: Reconstructing Normality*, Michael Bauer, Linda McAuliffe and Deirdre Fetherstonhaugh consider how ageing sexualities are constructed and managed in formal care contexts. Their chapter provides an overview of current research, and the key issues relating to ageing sexualities in

residential care. Primarily focusing on heterosexual sexualities, they highlight the tensions between care cultures, organisational cultures, individual, family and staff norms values, and how this can lead to conflict about what is and what is not perceived as acceptable behaviour in residential care spaces. They highlight that these conflicting interests may place constraints on the personal rights and freedoms of an ageing, sexual, individual in residential care spaces.

The issues of both cultural visibility *and* value are addressed in Chapter 7, *"I am Getting Old and That Takes Some Getting Used To": Dimensions of Body Image for Older Men*. Here, Allan Tyler, Nuno Nodin, Elizabeth Peel and Ian Rivers report on a recent UK study which included experiences of and attitudes to health and wellbeing in LGBT and heterosexual people. Drawing on original questionnaire data exploring older men's perceptions of body image and embodied ageing, they explore how (hegemonic) masculinity and heteronormative gender roles inform how some men view themselves in later life and how they experience themselves as being regarded by others. Their chapter highlights the significance of the body as sexed, active, and medicalised in older age. Their analysis demonstrates the continued influence of heteronormative gender roles and expectations of hegemonic masculinities, as well as the youth-orientation of the traditional gay 'scene', in shaping how men see themselves in older age.

Developing the theme of recognition and context further, in Chapter 8, *Troubling Identities? Examining Older Lesbian, Gay and/or Bisexual People's Membership Categorisation Work and its Significance*, Andrew King takes a queer approach to the discursive (re-)production of sexuality. King explores how sexuality categories are reproduced in individual narratives and in interpersonal contexts. Drawing upon analysis of fragments of interview conversation, he argues that sexuality is negotiated, navigated and defined through and against normative heterosexuality. In other words ageing non-heterosexuality is understood as precisely that by lesbians and gay men, i.e. in terms of how, and in what way(s), an older lesbian or gay individual does not comply and/or conform to age-defined and/or heterosexist norms. King argues that in identifying the 'mechanisms by which these discourses are called upon and locked into place' it is then possible to make visible the normative assumptions upon which they are based and through and against which they are mobilised.

In Chapter 9, *Towards the Inquiry into Aged Care and Beyond: The Promise of New Era in LGBTI Ageing*, Mark Hughes addresses issues of rights and freedoms in older age care spaces in Australian contexts, with respect to LGB sexualities especially. Hughes traces the development of progressive new legislation which accords particular rights to older LGB individuals as a 'special needs' group, and shows how being assigned these rights then cascades into service provision and delivery, as well as funding for training to improve older age-related services. Hughes emphasises in particular the diversity of the ageing LGBT population and the importance of including the broadest spectrum of special interest groups in consultation processes of service design and delivery. This avoids the risk of

homogenised notions of older LGB people which might then lead to a under-recognition of the complexities of individuals lives, needs and interests.

Finally, in Chapter 10, *Internet Dating, Sexual Intimacy and Older People* Chris Beasley and Mary Holmes introduce a new way of conceptualising heterosexuality, heterodox heterosexuality, in the context of internet dating. Beasley and Holmes suggest that social media creates new spaces for later life (hetero-)sexual exploration and creativity which has potential to open up new opportunities for older women to express their sexual selves. Such new avenues, they argue, produce opportunities for different ways of being and doing heterosexuality away from, and in contrast to, heteronormative ways of living and being. They argue that heterodox heterosexualities offer space for divergent, transgressive and subversive sexual behaviours that depart from heteronormative understandings of gendered ageing.

In terms of inter-connecting themes, issues of representation and cultural construction of sexualities are present in each of the chapters. How we name sexualities, through and against which norms and normativities sexualities are discursively produced, how this in turn informs recognition and access to resources, particularly health and social care support, all speak to cultural visibility. As Jane Traies and Allan Tyler and colleagues show such cultural visibility is profoundly gendered. This cultural visibility is situated and contingent, interpersonally, discursively and in relation to a range of different regulatory contexts, in the context of this edited collection, Africa, Australia and the UK. This is also in relation to different spaces: the wide space of public health, the narrower space of interpersonal discourse, the imagined space with the observing other, the virtual space of the Internet. Yet across these spaces, including virtual spaces, there are issues of embodiment: how the sexed, gendered, ageing body is experienced, perceived and socially constructed; how ageist norms and normativities in relation to ageing sexualities are navigated, complied with and/or resisted; how ageing sexual bodies are subject to disciplining and normative control in residential care contexts. The chapters, separately and together, demonstrate the range, complexity and contingency of (ageing) sexuality performance, recognition, and social and cultural construction.

Setting a New Critical Research Agenda

The contents of this collection identify many of the key questions that should shape the focus of future research into ageing and sexuality. At its heart will be the critical interrogation of the constructs of ageing and sexuality themselves, and of gender, with which they are inevitably interwoven and implicated. As Sharron Hinchliff and Merryn Gott highlight, the notion of the sexy older person itself requires ongoing critique, particularly in relation to who is marginalised in that new ageing stereotype. Increasingly, ageing sexualities research will, if it is to reflect things as they are, release its traditional heteronormativity and address

ageing sexuality diversity. Similarly, research which is only about heterosexual ageing will need to identify itself as such and whatever generalisations made will need to be articulated as generalisations about ageing heterosexual women and men, not *all* ageing women and men.

Equally, research about lesbian, gay and bisexual ageing, will hopefully widen to more fully encompass bisexuality as well as other non-normative lives, e.g., those of older individuals who are asexual, intentionally chaste, single and sexual, queer and/or polyamorous (e.g., Barker and Langdridge, 2010), reducing the over-representation of 'sanitised' LGB lives and the marginalisation of the 'queer unwanted' (Casey, 2007). It remains to be seen to what extent women's voices will be equally represented in future research and, as Jane Traies argues, to what extent they may remain marginalised.

As Mark Hughes points out, the representation of older lesbian, gay, bisexual and queer individuals' concerns by advocacy and pressure groups requires further critical interrogation, particularly in relation to whose voices are being well-represented and whose are not (Westwood, 2014). As does the representation of the voices of older people in residential care contexts for older people, in relation to sexuality expression (as highlighted by Michael Bauer and his colleagues) and in terms of ensuring there is a range and choice of provision for older people across the sexuality spectrum.

The significance of spatiality, socio-cultural and regulatory contexts for the recognition and resourcing of ageing sexualities, as highlighted by Gloria Chepngeno-Langat and Victoria Hosegood and several other authors, is an area which warrants further investigation. In particular, how age informs spatial engagements and normative reproductions is an area which has considerable potential in the development of new knowledge and insights. So too does the area of ageing inequalities in the spatial contexts of domiciliary and residential care provision and, more broadly, in relation to social and cultural recognition. Chepngeno-Langat and Hosegood also flag the need for greater attention to be given to sexual health, and we would suggest this is not only in relation to physical, but also psychological, sexual health and well-being. There is still a great deal of work to be done in addressing cultural representations of ageing sexualities, and ensuring that commissioners and providers of ageing services are better informed about, and more attuned and responsive to, ageing sexuality diversity. As the following chapters demonstrate, the growing field of ageing sexualities offers rich opportunities to develop insights into the (re-)productive powers of the intersection of ageing, gender and sexuality in later life.

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Chapter 1
Ageing and Sexuality in Western Societies: Changing Perspectives on Sexual Activity, Sexual Expression and the 'Sexy' Older Body

Sharron Hinchliff and Merryn Gott

Introduction

In July 2013 *The Australian Women's Weekly* magazine contained an interview with Jane Fonda about her life as a Hollywood actor. The feature made reference to Fonda's many accolades, including the Oscars she had won (two, but nominated for more), her successful fight against breast cancer, the seven books she had authored, her status as a feminist icon of the 1970s, and her longevity in the 'fickle' Hollywood film industry. Clearly, the message went, this was a woman who had achieved a lot in her 75 years and was to be celebrated. But in the midst of this praise the feature took an interesting turn when it asserted that 'perhaps the most startling thing about the actress and L'Oreal ambassador is that, at 75, she is still having sex. Lots of it, apparently, and it's never been better'. The shock that comes from knowing that people (or is it just women?) are sexually active in their mid-seventies, and that they enjoy it, provides evidence of the persistence of the stereotype of an 'asexual old age'. This stereotype endures despite much evidence to the contrary (which we discuss later), indicating that it is grounded in social attitudes about ageing and gender rather than the life experiences of older adults themselves.

Historically, sexual activity and late adulthood have been incompatible in public discourses and this deeply entrenched view has been repeated and reinforced in a number of ways. For example, through the lens of medicine, ageing has been viewed predominantly in terms of disease and decline including sexual decline. And public policy has tended to promote ageism through enforced retirement and the neglect of older adults in key policy documents such as the UK *National Sexual Health Strategy* (Department of Health, 2001). Similarly, social attitudes that situate sex as the preserve of the young have been reinforced through media outlets where portrayals of sexuality have rarely included older adults (Gill, 2008; Vares, 2009). The combined force of such powerful discourses in Western societies has meant that later life sexuality has seldom been acknowledged and when it has, those expressions of sexuality have been stigmatised (e.g., the derogatory term 'dirty old man') or infantilised (e.g., the 'cute response' when old women and men

hold hands). Those working in the field of human sexuality have long asserted that sexuality should be approached from a life-course perspective (e.g., Rossi, 1994; Carpenter and DeLamater, 2012) but an examination of public discourses reveal that it has not typically been viewed in this way.

In line with a broader 'sexualisation of culture' however, changes began to be observed during the mid-1990s with regard to middle and old age sexuality. Representations of older adults as sexual beings were visible on television and in film as storylines depicted their intimate relationships (Vares, 2009). Around the same time there was a shift within the gerontological health circles as sexual activity came to be seen as important to the health and well-being of middle-aged and older adults. Sex in later life became a marker of successful ageing (Marshall, 2010), fuelled by the development of sexuopharmaceuticals (e.g., Viagra) which aimed to counter the negative effects of disease on sexual 'function'. Potts and Tiefer (2006) believe that the biomedicalisation of sexuality has fashioned new standards of sexual performance for women and men: a factor which has fed into the creation of a new myth around aged sexuality – the 'sexy oldie' (Gott, 2005). And today the message that sex is 'good' for ageing health sits alongside messages that treat sexuality in late adulthood with disdain. In this chapter we explore these arguments further, focusing on three key aspects of ageing sexuality: sexual activity; sexual expression; and the 'sexy' older body. We draw on social gerontology, gender studies, critical social psychology, and sociology literatures to examine the ways that public, medical and academic discourses have constructed and shaped understandings of middle and late adult sexualities. The process of ageing is understood in this chapter as something that cannot be disentangled from its social, cultural and historical contexts. And, following Weeks (2011, pp. 204–5), we see sexualities as the 'result of diverse social practices that give meaning to human activities, of social definitions and self-definitions, of struggles between those who have power to define and regulate, and those who resist'. Our first step, though, is to look at what we already know about sexual activity in middle and late adulthood, paying particular attention to frequency, difficulties and disease.

Sexual Activity

Evidence collected from surveys (e.g., Karraker, DeLamater and Schwartz, 2011; Mercer et al., 2013) confirms that people do not stop desiring sex or engaging in sexual acts just because they reach a certain age. We know that, as is the same for young adults, sexual activity levels are not homogeneous: some people are sexually active, some are not sexually active, and some resume sexual activity again after a long period of abstinence. A number of studies, the majority of which have been conducted within a heteronormative framework, have reported the rates of sexual activity of people in their 50s and older, demonstrating that older adults engage in sexual activity but that the frequency is reduced in comparison to younger cohorts. For example, when we look at recent data from the UK's largest

study on sexual behaviours, the *National Survey of Sexual Attitudes and Lifestyles* (NATSAL 3), of the sexual partners, practices and attitudes reported by men in the oldest age group (65–74 years), 37.2 per cent had vaginal intercourse and 33.1 per cent had engaged in masturbation with a female partner in the previous four weeks. In the past 12 months, 30.4 per cent had given or received oral sex and 2.9 per cent had anal sex, both with a female partner. With a male partner, 6.1 per cent reported any lifetime sexual experience or contact, 3.4 per cent any sexual experience with genital contact, and 0.9 per cent at least one male sexual partner in the last five years (Mercer et al., 2013). Of the sexual partners, practices and attitudes reported by women in the oldest age group (65–74 years), 23.1 per cent reported having vaginal sex and 10.3 per cent reported masturbation with a male partner in the previous four weeks, and in the last 12 months 19.0 per cent had given or received oral sex and 3.6 per cent reported having anal sex with a male partner. With a female partner, 2.6 per cent reported any sexual experience or contact, 0.8 per cent any sexual experience with genital contact, and 0.1 per cent at least one female sexual partner in the last 5 years (Mercer et al., 2013).[1]

Other UK studies of people aged 50 and older in the UK have found similar results. Two surveys commissioned by *Saga* in January 2013 (n=8989) and January 2014 (n=9685) revealed little difference regarding frequency of sexual activity. In 2013, 23 per cent reported sex at least once a week and 16 per cent once a fortnight, and in 2014, 23 per cent reported having sex once a week and 13 per cent reported once a fortnight. The 2013 results showed that the majority (82 per cent) reported a decline in sexual activity compared to when in their 20s and 30s, but 49 per cent reported their current sex life as more relaxing. However, while 28 per cent said they enjoyed sex more now, 36 per cent said they enjoyed sex less. (The sexual orientation of the respondents was not disclosed in the published reports from these studies.) When we compare the findings to studies conducted in other developed countries we see a parallel. Karraker, DeLamater and Schwartz (2011) reported the results of two nationally representative surveys of heterosexual sexual activity in the United States: the *National Health and Social Life Survey*; and the *National Social Life, Health, and Aging Project*. They found that 87.8 per cent of men and 71.9 per cent of women aged 44–59, and 72 per cent men and 45.5 per cent women aged 57–72, were sexually active. Reported frequency of sexual activity per month ranged from 6.18 per cent (men aged 44–59) to 1.74 per cent (women aged 57–72). Overall, men reported higher levels of sexual activity than women. Another nationally representative sample, the *Australian Longitudinal Study of Health and Relationships*, found that regular heterosexual activity was usual for participants aged 60–64 (n=635) who have a partner, with women and

1 Unfortunately, we cannot compare these findings to earlier NATSALs because NATSAL 1 only collected data from participants up to age 59 and NATSAL 2 from participants aged up to 44 years.

men reporting three sexual experiences on average a month (Ferris et al., 2008).[2] In response to the question 'An active sex life is important for sense of well-being', 78 per cent of women and 91 per cent of men agreed. Similarly, 56 per cent women and 81 per cent men agreed that 'Sex was very pleasurable', and 65 per cent women and 72 per cent men reported feeling very satisfied with their sexual relationship. Men were slightly more likely than women (86 per cent and 72 per cent respectively) to report that they found the sexual relationship 'very' emotionally satisfying (Ferris et al., 2008, p. 337).

A longitudinal study of Swedish 70 year olds carried out at four different time periods (1971–2, 1976–7, 1992–3, 2000–1; total sample n=1506) identified trends in heterosexual sexual activity (Beckman et al., 2008). The findings demonstrated that over this 30 year period, self-reported quality and quantity of sexual experiences improved. For example, the number of participants who reported that they were sexually active (defined as 'sexual contact between individuals most often with penetration' p. 2), that they had a positive attitude to sex, and that they believed sexuality was a positive factor in their lives, increased from the first to the last cohort. This was consistent for participants who were cohabiting, married and unmarried. There was also an increase across the 30 year time period in the number of participants who reported that they were sexually active at least once a week. Both women and men who reported high or very high sexual satisfaction increased over the 30 year period too. For women only, the proportion who reported low or no sexual satisfaction decreased, but the opposite was observed for men. The authors speculated that these changes could be connected to a number of factors: better socioeconomic status; higher educational levels; changes in relationships such as an increase in cohabitation and divorce; better health in the later born samples; societal shifts including attitudes towards sexuality; and legislative change, such as compulsory sex education in schools.

But we need to be mindful of the ways that research is carried out. It is clear that evidence regarding sexual activity amongst older (heterosexual) adults is largely derived from large-scale quantitative surveys which ask participants to specify the frequency with which they engage in specific sexual acts. The difficulties with extrapolating from this research to draw conclusions about sexuality and ageing are, however, numerous (Gott, 2005). For example, tools are typically not derived from qualitative research with older adults themselves which can lead to surveys not actually capturing what they intended to because nuances of language may be missed. Indeed, the language people use to describe all aspects of sexuality is very cohort specific. As Philip Larkin (1974) eloquently argued in *Annus Mirabilis*, each generation likes to believe that they invented sex. Therefore, without consultation with older adults themselves, it is possible that the survey is not capturing what the authors believe it is. There is also a tendency in such research to not be specific about the terms being used. For example, people are typically asked how often

2 Although the study included heterosexual and non-heterosexual participants, the data reported in this publication referred to heterosexuals only (Richters, 2014).

they 'have sex'. Our previous (qualitative) research with heterosexual older adults (Hinchliff and Gott, 2004) demonstrated that the term 'sex' can vary considerably in how it is defined at an individual level, and is subject to influence by both age and cohort. We found that for many older adults sex did not straightforwardly equate with intercourse, and could encompass activities that people in their 20s and 30s probably would not view as sexual (e.g., gardening together) (Hinchliff and Gott, 2004). However, the discussion of survey data, and sexuality and ageing more broadly, within most of the academic literature typically ignores these (very important) differences.

Another issue is that researchers do not sit outside the culture within which they study: they are part of it and thus the design of surveys can be problematic as they often reflect the assumptions that researchers bring to the whole area of sexuality and ageing. For example, some promote a romanticised notion of older age sex as something which occurs within the confines of (heterosexual) marriage. The *Saga* surveys make this preconception quite explicit by including data on sexual activity under a section in the 2013 report entitled *Valentine's Story* (2013) or specifically mentioning Valentine's Day under their section on sexual activity in the 2014 report. Surveys rarely mention sex as a potentially coercive activity, feeding into a generalised assumption that sex in later life is exclusively a 'good thing' (Gott, 2005). Most ignore the fact that some older adults have same sex partners, or that sexual practices and identities can change over the life course, and it is only recently been acknowledged that sexual risk-taking behaviour continues after middle age. We return to these issues in the following section.

The upsurge of interest in the frequency of sexual activity in the over-50s is, in our view, part of the backlash to the 'asexual old age' stereotype: it represents a desire to prove that older adults are indeed sexually active. However, the meaning of sexual activity can become broader with age, and the familiar saying that 'ageing changes sex rather than ends it' refers to the age-related health problems that can interfere with sexual activity but also the sexual problems that come with age. These include a longer refractory period (the recovery period after orgasm) for men as well as a decreased ability to delay ejaculation and an increased time to achieve an erection (Schlesinger, 1995). The changes women can experience include shorter and less intense orgasms, an increased time taken to become sexually excited (Schlesinger, 1995), and difficulties connected with reduced lubrication at menopause which can make penetrative sex painful. Lower levels of sexual desire can also affect older women and men but one study found that desire did not start to wane until around age 75 (DeLamater and Sill, 2007).[3] Interestingly, in their longitudinal study of 70 year old Swedish heterosexual women and men over a 30 year period, Beckman et al. (2008) found a decrease in the number of men reporting 'erectile dysfunction' (ED) and an increase in those reporting ejaculation

3 This study asked about the presence of a sexual partner but did not ask about sexual orientation. We do not know therefore if the results relate to older people who are heterosexual, gay or bisexual.

problems. The number of women who reported 'always' or 'usually' having an orgasm during intercourse increased, and the number of women who said they had never had an orgasm decreased. Over the 30 year period, male sexual problems were consistently reported as the reason why intercourse ended for those with a sexual partner. The findings from NATSAL 3 demonstrated lower levels of sexual 'function' (a combination of 'sexual response, sexual function in the relationship context and self-appraisal of sex life' p. 382) for sexually active women and men in the older age groups compared to younger cohorts (sexually active participants were defined as having at least one same sex or different sex sexual partner in the past year) (Mitchell et al., 2013). NATSAL 3 also found that the lowest recordings of recent sexual activities (vaginal, oral, anal, other genital contact) with members of a different sex were in the oldest age group (age 65–74) (Mercer et al., 2013).

But in spite of these needs, sexual well-being seems to be a difficult issue to address within healthcare settings and there is consistent evidence that health professionals do not routinely ask older clients about it. Mellor et al. (2013) explored health professionals' experiences of discussing sexual well-being with patients who had suffered a stroke and found that they tended not to raise the topic with patients, and that patients infrequently raised it themselves. The main obstacles that health professionals reported were their own lack of motivation and difficulties around communication skills and confidence. In our review of the literature (Hinchliff and Gott, 2011), we found that health professionals could experience significant barriers to asking about sex, which related to: assuming that sex was less important to older patients than it was to younger patients; inadequate training at medical school; and limited knowledge of later-life sexuality issues. We can expect these difficulties to be exacerbated when the older client has a same sex partner as our earlier research identified that health professionals experienced very similar obstacles around addressing the sexual health needs of lesbian and gay patients (Hinchliff, Gott and Galena, 2005).

STIs and HIV

Evidence for sexual risk-taking, defined here as unprotected vaginal, oral or anal intercourse, has also been found in the older age groups where rates of sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) have increased significantly over the past ten years, see also Chapter 3 this volume. Recent figures from *Public Health England* (2013) tell us that STIs in men aged 45–64 rose from 13,736 (in 2009) to 17,803 (in 2012), and for men aged 65+ they rose from 932 (2009) to 1355 (2012). The figures were lower for women but still showed an increase: from 4977 (in 2009) to 7267 (in 2012) for women aged 45–64, and from 130 (2009) to 232 (2012) for those aged 65+. We have broken down the rates for 2009–2013 by gender, age, STI and sexual orientation in Tables 1.1 and 1.2.

Table 1.1 Total number of STI diagnoses in women 2009–2013 (Public Health England, 2014a)

Sexual orientation	Age group	Gonorrhoea		Anogenital herpes		Syphilis		Anogenital warts	
		2009	2013	2009	2013	2009	2013	2009	2013
Heterosexual	45–64	122	239	1121	1878	26	30	1129	1606
	65+	3	2	40	97	1	6	39	84
WSW*	45–64	0	2	5	4	1	1	3	8
	65+	0	0	1	0	0	1	0	0

* Defined in the Public Health Report as women who reported being homosexual only.

It is clear from the data presented in Table 1.1 that women who identified as heterosexual were more likely to be diagnosed with a STI, and to show the highest increases in diagnoses, than Women who have Sex with Women (WSW). For men, the picture is very different. Table 1.2 shows incredibly large increases in gonorrhoea for Men who have Sex with Men (MSM) (both age groups), the highest increases for anogenital herpes in men aged 65+ (both heterosexual and MSM), the highest increases in syphilis for heterosexuals aged 65+ and MSM aged 45–65, and similar increases across age groups and sexual orientations for anogenital warts.

Table 1.2 Total number of STI diagnoses in men 2009–2013 (Public Health England, 2014a)

Sexual orientation	Age group	Gonorrhoea		Anogenital herpes		Syphilis		Anogenital warts	
		2009	2013	2009	2013	2009	2013	2009	2013
Heterosexual	45–64	424	594	882	1435	127	131	1995	2653
	65+	33	37	68	134	15	21	181	286
MSM*	45–64	397	1564	142	237	348	573	290	394
	65+	15	75	11	23	14	17	27	36

* Defined in the Public Health Report as men who reported being homosexual or bisexual.

Rises in STI diagnoses for the over 45 age groups reflect a trend across other developed countries. For example, in Australia STI rates among individuals aged 60+ increased by 58 per cent from 2007 to 2011 (The Kirby Institute, 2012). And, as Table 1.3 shows, the *Florida Department of Health* (2013a, 2013b, 2013c) reported significant increases for syphilis, chlamydia and gonorrhoea from 2003 to 2012 for people aged 45–54, 55–64 and 65+.

Table 1.3 Cases of STIs by year Florida 2003–2012

	Syphilis		Chlamydia		Gonorrhoea	
	2003	**2012**	**2003**	**2012**	**2003**	**2012**
Age 45–54	103	1602	334	7003	726	8077
Age 55–64	16	376	64	1634	173	2065
Age 65+	4	96	17	423	49	501

Increases in HIV in middle and late adulthood have also been observed over a similar time frame, with new diagnoses of HIV in the UK doubling from 2000–2009 (von Simson and Kulasegaram, 2012). More recent figures of new diagnoses among people aged 50+ continue to show this twofold increase: 990 diagnoses in 2012 compared to 500 in 2003 (Aghaizu et al., 2013). HIV diagnoses in the 50+ age groups are more likely to be made in men, and since 2005 approximately one third of new diagnoses were acquired through sexual contact *between* men (Public Health England, 2014b). The rise in new diagnoses, added to the cohort of people already ageing with HIV, has resulted in an escalation in the number of people aged 50 and older accessing HIV-related care: from 1 in 8 adults in 2003 to 1 in 4 adults in 2012 (Aghaizu et al., 2013). Again, this continues the trend from previous years where the over-50s who accessed care for HIV rose from 11 per cent in 2001 to 20 per cent in 2011 (von Simson and Kulasegaram, 2012). Almost three times more men aged 50+ than women accessed care for HIV in 2013 (Public Health England, 2014b).

Similar figures for new diagnoses of HIV in the over 50s have been recorded in other countries. We compared data from the *HIV and STI Australian Annual Surveillance Reports* on new diagnoses of HIV for 2008 and 2012. New cases increased in men aged 40–49 years from 4975 (2008) to 6256 (2012), and women aged 40–49 years from 261 (2008) to 364 (2012). Regarding the age group 50–59, reported cases in men rose from 1836 (2008) to 2411 (2012), and in women from 103 (2008) to 139. Of the oldest age group 60+, new cases for men increased from 645 (2008) to 865 (2012), and women from 87 (2008) to 92 (2012) (National Centre in HIV Epidemiology and Clinical Research, 2009; The Kirby Institute, 2013). Transmission of HIV in Australia continues to occur mainly in men who have unprotected anal intercourse with other men (The Kirby Institute, 2013). Data from the *HIV/AIDS Surveillance in Europe Report* (European Centre for Disease Prevention and Control, 2011), showing increases in new diagnoses of HIV across Europe for people over 50, have been presented in Table 1.4.

Table 1.4 New diagnoses of HIV in the age group 50+ across Europe

	2004		2010	
	Men	**Women**	**Men**	**Women**
West	2200	738	3025	874
Central	105	27	203	50
East	301	121	926	564

Clearly, Eastern Europe saw the highest increase in HIV diagnosis over this period, and the authors of the report inform us that the main mode of transmission was heterosexual sex followed closely by injecting drug use. They also warn that these figures include recently infected and those infected years ago, and are thus influenced by patterns of reporting, uptake of HIV testing and slow progression of HIV.

It is worrying that the over 50s are more likely to present late for HIV diagnosis when compared to younger groups in the UK (Aghaizu et al., 2013) because a late diagnosis is associated with poor outcomes for older adults (Davis et al., 2013), making them 'twice as likely to die' than their younger counterparts (von Simson and Kulasegaram, 2012, p. e688). What the STI and HIV figures seem to tell us is that the 'safer sex' messages of sex and relationship education are not reaching the older age groups or are not being heard. Sexual risk-taking in older adults is an under-researched area, and anecdotal evidence suggests that STIs continue to increase in older heterosexuals due to changing relationship structures (e.g., increasing divorce rates) as well as low perception of risk (e.g., because sexual health messages predominantly target younger people). As Minichiello, Hawkes and Pitts (2011) have argued, 'older adults are less likely to use condoms, possibly because they tend to view condoms primarily as a contraceptive measure, and women who no longer fear unwanted pregnancy may not insist on their use' (p. 183). Research that has been conducted in this area includes Lichtenstein (2012) who explored dating risks and sexual health issues for women who had resumed dating after the breakdown of a long-term relationship. She interviewed 22 women aged 35–66, four of who reported having sexual experiences with women and men. Age was a key theme when it came to condom use, and the women reported that older men were more likely to show resistance to wearing a condom whereas younger men were 'more welcoming' but did not initiate use. Overall, the men did not want to discuss safer sex and the women struggled with negotiating it as they were deemed 'too confrontational, awkward, or aggressive' (p. 191). Other reasons the women did not raise the issue of safer sex included being post-menopause or using birth control, thus associating condom use solely with pregnancy prevention. A similar generational difference was found by Kaighobadi et al. (2013) where older men who had sex with men held less positive attitudes towards using condoms, and consequently engaged in more sexual risk-taking, than younger cohorts. The authors gave two possible explanations for this: first,

that the men had developed habits and preferences that were resistant to change; and second, that their perception of risk was influenced by key social and political shifts within South African over the past 20 years, where HIV prevention targeted MSM differently to heterosexuals.

While STI campaigns continue to target young people – because the highest numbers of diagnoses are seen in these groups (e.g., the under 25s in the UK; Public Health Report, 2013) – a few have recognised the need to address older adults. In 2014 the *AIDS Community Research Initiative of America* (ACRIA) re-released their *When it Comes to Sex ... Age is not a Condom* campaign from 2012, which followed the 2012 *Safe Sex for Seniors* delivered by the organisation *Safer Sex for Seniors*, also US based. In 2012 we saw Australia's *Little Black Dress* campaign from *Family Planning New South Wales*. The UK also had its own campaign in 2010, *The Middle-Age Spread*, developed by the *Family Planning Association* (FPA).[4] High rates of STIs and HIV are public health concerns, yet the fact that these campaigns are developed and delivered by charities and not Government bodies gives a clear indication of the priority afforded to older adults. In the next section, we explore how unmet client need and the increases in STIs and HIV sit with the new emphasis on the benefits of sexual activity for ageing health and well-being.

Sex as Good for Health

Over the second half of the twentieth century, sex for pleasure rather than reproduction was transformed by sexologists from a behaviour previously considered morally suspect into one positively associated with health (Gott, 2005). Hawkes (1996, p. 6) described this shift in relation to the medicalisation of sex, in that sexual activity was 'dissected, explored, pronounced upon' by clinicians and sexual scientists (e.g., Kinsey et al., 1948, 1953) so much so that 'good sex' became 'synonymous with good health'. Indeed, this message was picked-up at the beginning of the twenty-first century by the UK National Health Service (NHS) which claimed that 'sexercise', which we assume refers to heterosexual, could reduce the risk of heart disease while the endorphins released during orgasm could stimulate the immune system and prevent cancer as well as limit the development of frown lines and wrinkles.[5] A direct relationship between sexual activity and increased life-expectancy or reduced facial wrinkles remains to be proven, although it has been argued that sexual activity *can* benefit health in line with moderate exercise (Brewer, 2004), and well-being through intimate connection with another person (Prager, 1995). And while the NHS continues to

4 For a selection of the posters and videos used in these campaigns, see http://sharronhinchliff.com/2014/01/26/sexually-transmitted-infections-and-hiv-in-the-over-50s-promoting-condom-use/

5 See http://news.bbc.co.uk/1/hi/4703166.stm

promote the health advantages of sex, it is now more cautious, making it clear that they are *potential* benefits and that celibacy does not infer ill health.[6]

Around the same time, a connection between sexual activity and good health in later life began to be promoted. In 2001, the UK Government's *National Director of Older People's Services* was quoted as saying that 'sexually active older people live longer and stay healthier than their celibate counterparts'.[7] We heard this message over 10 years later when, in 2013, a prominent leader in old age psychiatry asserted that sexual intercourse could improve life-expectancy and help older adults to look physically younger (Weeks, 2013). Marshall (2010) has noted comparable messages in Canada, which prompted her to argue that 'new agendas' are being developed which position sex and ageing as central to public health. In earlier work, she traced the cultural landscape to identify *how* sex came to be promoted as a 'healthy and necessary component of aging' and found that gerontology had been quick to follow sexology, and that various factors including the commercialisation of sex, had played a key role (Katz and Marshall, 2003, p. 3). The significance of this shift within the ageing field was noteworthy as it marked a move away from previous expert advice that people should accept changes in sexual capacity related to getting older, and consequently sexually retire.

Thus, in the context of a 'sexualisation of culture' and the backlash to the asexual old age, a new cultural representation of aged sexuality has emerged: the 'sexy oldie', which is based on the assumption that sex is always pleasurable and the ideal for all older adults (Gott, 2005). The medicalisation of sex has been significant here, and Hart and Wellings (2002) argued that the changes in sexual mores over the twentieth century could be understood in part to an 'over-medicalisation' of sex. Indeed, medicalisation normalises sexual intercourse at all stages of the adult life-course and consequently pathologises sexual abstinence, particularly within heterosexual relationships. According to Marshall (2010), this applies to the changes people can experience in their sex lives with 'normal' ageing as clinicians and doctors shape what we know about our ageing bodies. Clearly, an active sex life is now part of the ageing well agenda; an agenda that is underpinned by a focus on 'treating' sexual problems so that individuals can maintain sexual activity for as long as possibly.

Consequently, older adults are a key target for the development of biotechnologies that aim to enhance sexual 'function' and thus prevent sexual decline. Pharmaceutical interest in age-related sexual 'dysfunction' has been fuelled by the success of Viagra. With Viagra and other erection enhancing medications (EEMs), there is no excuse for men not to remain sexually active when sex is defined solely in terms of an erect penis. Indeed, it has been argued that EEMs reinforce this 'default male sexual script' (Potts and Tiefer, 2006), but this does not seem to be solely a heterosexual script. Jowett et al. (2012) found in their study of gay and bisexual men who had diabetes that the inability to achieve

6 See http://www.nhs.uk/Livewell/Goodsex/Pages/ValentinesDay.aspx

7 See http://news.bbc.co.uk/1/hi/health/1541706.stm

an erection was embarrassing and caused them to worry about losing their partner. The participants (average age 48.5 years) reported that an erect penis meant much more than the ability to penetrate as it signified sexual interest and arousal. The social construction of active, desiring, erection-focused masculinity has fuelled the pharmaceutical industry's attempt to create drug treatments for male sexual performance, hurried along by the clinicians who provide the treatment (Potts and Tiefer, 2006). But an issue here is that the target group is stereotyped as homogeneous, which is problematic as the drugs do not work for everyone, sexual activity may not be 'good' for the health of everyone, and the standards of sexual behaviour these developments are based upon may not suit older generations who take a broader view of sexual activity (e.g., Hinchliff and Gott, 2004).

The acknowledgement of sexual activity in middle and late adulthood by governments, academics and health professionals enables taboos to be broken and assumptions to be challenged. It can help to eliminate negative stereotypes of ageing and to support the appropriate targeting of health promotion messages. However, there are implications when sexual activity becomes a measure of successful ageing. In particular, remaining sexually active is presented as a personal responsibility, with the expectation that if adults are not sexually active then they are in some way not looking after their health. Additionally, sexual activity becomes something that should be monitored, checked for errors so that when identified they can be mended and successful ageing put back on track. Following Foucault (1978), the monitoring of sexual behaviour is part of the surveillance of sexuality; controlled and regulated by governing bodies and disciplinary institutions which 'inadvertently establish norms and standards for sexual behaviour against which people can measure themselves and be measured' (Hart and Wellings, 2002, p. 898).

Sexual Expression

It is perhaps not surprising then, that alongside the emphasis on sexual activity for ageing health and well-being, changes are being observed in the way that older sexuality is represented in contemporary media. Traditionally, when sexual content appeared in television programmes, films or adverts it featured young people, both reflecting and reinforcing the societal connection between young age and 'sexiness'. Older adults tended to be represented in gender stereotypical and asexual ways. But from the mid-1990s we began to see older heterosexual women and men depicted as sexual, albeit in a romantic rather than erotic way (Vares, 2009). According to Vares (2009, p. 505) these changes were located within a broader cultural shift where 'lifelong sexual function' had started to become a key component of successful ageing, as above. An interesting analysis of the way this shift was reflected in advertising is provided by Williams et al. (2007) who analysed the content of adverts for *Olivio* margarine where heterosexual older adults played the central characters. They found that over the years, from 1995

to 2002, romance and sexual attraction were foregrounded and the characters were depicted as 'playful'. Williams et al. argued that the advertisements were culturally significant because they used imagery and text normally associated with young people, such as slang terms for girlfriend and boyfriend, and thus challenged negative stereotypes of ageing sexuality. The authors also picked up on the influence of positive ageing, arguing that the ads tapped 'into consumer desire for a certain lifestyle' (Williams et al., 2007, p. 19). Indeed, the influence of positive ageing is important, as it emerged from the efforts of gerontologists, academics and practitioners to move away from the negative associations of ageing as decline (Bayer, 2005) and to recognise the value older adults make to society and their local communities.[8] Positive ageing has, in our view, fed into the representation of the 'sexy oldie' that is visible in popular media today.

But, as already indicated, tensions accompany the freedoms that are offered with new representations of 'sexiness'. Using the 'sexy midlifer' (Hinchliff, 2014) as an example, the sexy midlife woman is sexually agentic, desiring and desirable and is portrayed by the central female characters of television shows like *Cougar Town* (2009–present) and *Sex and the City* (1998–2004). Broad cultural shifts, and the increased visibility of heterosexual female 'sexiness' (Gill, 2008) and sexual pleasure (Atwood, 2005), have helped the 'sexy midlifer' to blossom. Shifts in gender relations have meant that she is not constrained to sex *only* within committed relationships, thus disconnecting sexuality from the traditional default female sexual script. But when the 'sexy midlifer' takes a younger male lover – the 'Cougar' – she does not escape unscathed. A recent study explored the views of heterosexual women (aged 30 to 68) towards the meaning of the label 'Cougar' and found that just over half of the sample (56 per cent) viewed the term negatively or with 'mixed emotion' on the basis that it categorised heterosexual women as 'sexual predators, reinforced double standards, or violated traditional gender norms'. However, 17 women viewed it positively because of its association with power and self-assurance, and because it drew attention to the value of relationships between older women and younger men (Montemurro and Siefken, 2014). The cougar label is part of and at the same time reinforces the sexualisation of 'older' women and as such the 'cougar' must meet specific standards of physical appearance. Like other 'sexy midlifers' she must be slim or curvy but not overweight, heterosexual, white and always abled-bodied.

And the media representation of the 'sexy midlifer' insists that she must always look younger then her age. Indeed, looking younger has been found to improve 'older' women's social and professional standing (Bayer, 2005), and investing in a youthful appearance has thus become a marker of successful ageing. There is anecdotal evidence that women seek plastic surgery to maintain status in the workplace on the basis that looking young for a fifty-something woman would

8 'Positive ageing' is often used interchangeably with 'successful ageing' or 'active ageing'; however, care must be taken when interpreting these terms as they tend to be used in very different ways.

increase her chances of retaining work or securing promotion (Shelly, 2014). In a cultural climate where it can be difficult for women to keep a sense of themselves as powerful as they get older, when looking old is viewed with disdain (Bayer, 2005), taking steps to look younger may be a meaningful choice from a pool of very limited options. Thus, freedoms (e.g., from the stereotype of asexuality) and opportunities (e.g., for new types of intimate relationships) but also restrictions (e.g., a continuation of the body project to conform to narrow beauty standards) are offered in this new representation of 'sexiness'.

The 'Sexy' Body

All of this demonstrates that the sexuality of women and men at middle and late adulthood sits in a contradictory position. On the one hand, representations of the active sexuality of older heterosexual adults are visible in film, television programmes and advertisements. Yet on the other, there is a clear aversion to naked old bodies. The naked bodies of older adults are not shown on screen or in magazines in the same way as naked young bodies. When it to comes to sex they remain partially covered, by clothes or bed sheets, and thus contrast sharply to the more revealing nude shots of young adults. In this highly visual culture, there is reluctance to present nudity unless the body fits the sexual ideal, and in this way naked older bodies remain hidden. Images of ageing sexuality conflict when sexuality is represented as able-bodied and smooth skinned, and ageing is represented in terms of decline, disability and illness. There is also a tendency, particularly in advertising, to mock older bodies and present them in derogatory ways. Recent examples include two advertisements for wall paint from the same French company: one had a black and white image of sagging female breasts drooping from the wall, the other a black and white image of a sagging male chest with paunch; both adverts had the strapline 'Your walls deserve a paint that will age well'. The message we receive from the visual images and the accompanying text is clear: to have an older body is to have a deteriorating body, and an old body is not appealing to the eye. The older female body was presented in a similar way in an advertisement for luggage, where a colourful photograph featured a close-up of the torso of an old woman wearing attractive underwear; the shot ended at her neck and groin, disconnecting her head and legs from the image. The text 'The old bag you'll actually love' accompanied the disembodied image (an 'old bag' is a Western slang term for a grumpy old woman).[9] Old bodies are thus objectified, and treating them primarily in terms of declining physical appearance works to reinforce the narrative that old bodies, the female body in particular, are undesirable (as suggested in the paint ads) or unloveable (as the luggage ad tells us). And given that the ads make a connection to women's sexuality (because the

9 These images can be viewed at: http://sharronhinchliff.com/2013/08/20/dump-the-old-bag-ageism-and-sexism-in-advertising/

images are of breasts or purple silk lingerie) they reinforce the message that older female sexuality is not something to be taken seriously. Such advertisements raise questions about age and sex prejudice in the societies which do not censor them. And while individuals may be bound by the values and ideas of the society within which they live, there are countless other ways of attracting attention to sell a product than by being offensive, sexist or out-and-out ageist.

In the *Double Standard of Aging*, Sontag (1978) drew attention to the way that the physical characteristics of older men were looked upon more favourably than those of older women. Almost 40 years on, the social construction of female beauty is still fixed on a youthful appearance. Visible signs of ageing tend to be seen as a weakness and as earlier research has found that both heterosexual and lesbian women can experience a 'loss' of social currency as they get older (Hurd Clarke, 2011, p. 4; Slevin, 2006). There is no doubt that women are disproportionately disadvantaged in comparison to men when it comes to ideas about what constitutes an attractive and 'sexy' body. Popular television programmes such as *Ten Years Younger* (2004–present) in the UK and *The Swan* (2004) in the US employ professional make-up artists, hairdressers and cosmetic surgeons to alter the 'grotesque' aged female body into a culturally acceptable younger version. This leaves the viewer in no doubt that the 'older' female body is abject, but it can be altered and improved through procedures that 'erase' or minimise the signs of age on a women's physical appearance. Orbach (2009) has drawn attention to the ways that altering the body to produce one that is more socially (or personally) 'acceptable' is presented to us through the rhetoric of choice. The message that women should be watchful of their bodies is conveyed through the diet, exercise, make-up and cosmetic surgery adverts and columns of many women's magazines. By remaking the body, the reader is told, women will feel better about themselves (Orbach, 2009). Women's bodies have long been the focus of critical scrutiny, but women today are ever more accountable for their bodies and judged by them, and in this way the body project has become a personal responsibility. That the television shows which encourage viewers to scrutinise the older female body occupy primetime slots exposes the value placed on women's physical appearance and conformity to the beauty ideal within Western societies.

By way of comparison, another representation of older women's sexuality has been presented over the past 20 years by artists who have celebrated older women and their bodies. For example, projects have been completed by Stephanie Diani who in *Dames: The Legends of Burlesque* photographed older women who had previously worked as burlesque dancers; the juxtaposition of an old body and burlesque clothing challenging the viewers' expectations of 'sexiness'. Jodi Bieber's *Real Beauty* captured women across the life-course, where bodily 'imperfections' such as wrinkles and cellulite were maintained in order to defy media depictions of female beauty. And Erwin Olaf's project *Mature* included semi-naked women aged 61–89 in various poses, countering the notion that beauty and active sexuality belonged only to young adults. More recently Edo Zollo's project *Beauty in Older Women*, was inspired by the mutually opposing

constructions of ageing as time of decline yet one of increased wisdom.[10] As a whole, this body of artistic work helps to produce a counter discourse to the dominant negative messages about older female bodies and ageing sexuality that are found in Western societies. As such, the projects come together as a much needed force of change.

Conclusion

In this chapter we have explored the shift that has seen older adults move from a position of asexuality to one where active sexuality is presented as a key ingredient of ageing well. Reconciling the asexual old age stereotype with a more contemporary understanding has not been a smooth process, nor is it likely to continue to be, as new representations of ageing sexuality combine with old forms of ageism and sexism. The significance attached to sexuality is cultural and historical, reflecting and reinforcing the dominant ideas and values about sexual activity, sexual attractiveness and sexual expression in any culture at a given time. Thus, it will never be static. Stuart-Hamilton (2000) made a valuable point when he argued that each generation of older adults has different demands and will reshape the future of health and social care as they refuse to accept ageist treatment.

> The first rock 'n' roll generation has now reached retirement age, and the flower power generation is in its fifties … older people of the future are unlikely to fit into the niches which have been established by societal expectations with quite the same willingness as previous cohorts. They have seen that conventions can be flouted and that protest can work. Accordingly, if younger generations do not change societal mores to better cater for older people, then older people are more likely to do it themselves. (Stuart-Hamilton, 2000, p. 210)

It is promising that research in the area of sexuality, sexual health and ageing is growing, and that large-scale important studies such as NATSAL 3 include older adults. Clearly, their sexual health and well-being needs are beginning to be taken seriously by academics, practitioners, policy makers and service providers. But we need to know more about how sexuality at middle and late adulthood is influenced by the intersections of ethnicity, sexual identity, socio-economic status and disability. And finally, in light of the focus on the health benefits of sexual activity as we age, we need to be sure that we are not creating a new stereotype that older adults *should* be sexually active if they are to age well.

10 A selection of the images can be viewed on Sharron's website: www.sharronhinchliff.com/tag/art

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Chapter 2
Ageing Sexualities in UK Regulatory Contexts

Sue Westwood

Introduction

With increasing recognition (and regulation) of the lives of lesbian, gay and bisexual (LGB) individuals (Harding, 2011) it would be understandable if people thought LGB inequality was a thing of the past, and that 'the world we have won' (Weeks, 2007) is one where LGB individuals and heterosexual individuals are now equal, in the eyes of the law at least. Unfortunately, this is not yet the case. There are enduring inequalities in UK law and social policy, which are particularly salient for older LGB individuals. This chapter explores how, and why this is, and considers the equality implications in relation to ageing and sexuality. I examine the regulatory contexts through, and against which, older LGB individuals experience and construct their lives. To do so, I analyse UK law and social policy affecting older people, from sexuality perspectives, and UK law and social policy relating to LGB individuals, from ageing perspectives. My analysis will demonstrate that in these regulatory contexts older LGB individuals are unevenly located, compared with older heterosexual individuals, in three main ways.

Firstly, there is now a four-tier system of relationship recognition in UK law, which disadvantages older LGB individuals and their relationships (Westwood, 2013), and this is particularly evident in terms of financial regulation. Secondly, UK social care law and social policy is constructed in ways that serve to privilege ageing heterosexual-identifying individuals and marginalise ageing LGB individuals. Thirdly, I shall argue that the Equality Act (EQA) 2010 disadvantages older LGB individuals in its construction of sexuality as a single strand 'orientation' and in its multi-faceted exclusions of protection from harassment on the grounds of sexual orientation, which particularly negatively affect older LGB individuals. The main direction of my argument across this chapter is that older LGB individuals are disadvantaged in comparison with both older heterosexual individuals and younger LGB individuals. In the conclusion, I consider the implications of this for ageing, sexuality and equality. In presenting my arguments I shall draw upon the concepts of 'nodes' and 'flows' to show how regulatory nodes shape uneven flows of recognition and resources to older LGB individuals. The rest of this chapter is organised as follows. Firstly, I shall provide a brief outline of the conceptual tools of 'nodes' and 'flows'. Then I use nodes and flows to analyse the four tier

relationship system in terms of financial regulation, social care law and policy and the Equality Act 2010. Lastly I consider the implications for ageing sexualities from an equalities perspective.

Analytical Framework: Nodes and Flows

In this chapter, I shall use the concepts of 'nodes' and 'flows' to demonstrate how regulatory frameworks shape access to recognition and resources in later life. Nodes, in the context of this chapter, refer to regulatory points which determine eligibility and entitlement in law. Flows refer to the nature and extent of the resources to which individuals are eligible/entitled in those regulatory contexts. The concepts of 'nodes' and 'flows' have so far been utilised in three key areas: social network analyses (Borgatti, 2009), including actor-network theory (Latour, 2007) and 'meshworks' (Escobar, 2001); global cultural flows (Appadurai, 2003); and nodal governance (Shearing and Wood, 2003). Social network analyses are predicated upon the notion that 'individuals are embedded in thick webs of social relations and interactions' (Borgatti, 2009, p. 892) and seek to understand different elements and aspects of them. Analyses have shifted, across 80 years of study, from mathematical and geometric mapping of nodes (individuals and/or groups) and flows (the connections between them) to analyses of nodes as structural positions (rather than people or groups). Social network analyses have moved, in recent years, beyond the structural and more towards the discursive production of social identities:

> Networks can be seen as apparatuses for the production of discourses and practices that connect nodes in discontinuous space; networks are not necessarily hierarchical but can in some cases be described as self-organizing, non-linear and non-hierarchical meshworks … they create flows that link sites which, operating more like fractal structures than fixed architectures, enable diverse couplings (structural, strategic, conjunctural) with other sites and networks. (Escobar, 2001, p. 174)

Nodal governance discourse seeks to analyse the mechanisms (the institutions, norms and practices) through which social systems are produced in more complex ways than simply through formal constitutions and laws. The concept of nodes is understood here as points on networks constituted by 'institutions with a set of technologies, mentalities and resources that mobilize the knowledge and capacity of members to manage the course of events' (Burris Drahos and Shearing, 2005, p. 35). Foucault's understanding of the disciplinary processes and productive nature of power and 'governmentality' – the practice of social control through normative power in institutions (Foucault, 1991 and 1994), – underpins this analysis, both against the backcloth of state regulation and the social landscapes which it shapes.

Global cultural flows analyses, have emerged from global network discourse (Castells, 2000) broadened from an analysis of the movement of peoples and cultures

in a global context to the movements of 'things', including ideas. These have been broadly classified by Appadurai (2003) under five main headings: 'ethnoscapes' (people who move between nations); 'technoscapes' (technology, linked to large multinational corporations); 'financescapes' (global economy); 'mediascapes' (electronic and new media) and 'ideoscapes' (official state ideologies and counter-ideologies) (Appadurai, 2003). Various other 'scapes' have been proposed as add-ons to those proposed by Appadurai. Of particular interest here are 'carescapes' (Milligan and Wiles, 2011) or 'landscapes of care' (Milligan, 2012). Some aspects of care are interwoven with the movement of people, as providers and receivers of care ('ethnoscapes'), and the movement of finance and technology relating to care ('financescapes' and 'technoscapes').

However the concept of carescapes also encompasses something more, in two main ways. Firstly care is a thing that is itself a flow (Raghuram, 2012), a flow of love, affection and support (Lynch, Baker and Lyons, 2009). As I shall show in this chapter, such of flows of care are directed in particular ways by nodes constituted by moments/points of governance. Secondly, carescapes also refer to the terrain of care itself: the mapping of care; the delineating of informal and formal care; the designation of care-givers and care-receivers; questions of who cares and how; the meaning(s) of care; in other words the (shifting) borders of care (McEwan and Goodman, 2010). These flows are unevenly distributed, directed by nodal governance which shapes the carescapes across which care and support flow. One of the major ways these nodes and flows operate are in terms of recognition of individuals and their needs, which in turn informs access to resources, in terms of those needs being met. Recognition is an entry point to possibilities of both social inclusion and exclusion (Young, 2000): without recognition there is no *possibility* of social inclusion.

Four-tier Privileging of Relationship Norms and Forms

There is now a four-tier relationship recognition system affecting both same sex and different sex couples in the UK (Westwood, 2013), reflected in different flows of finances, and health and social care provision, routed via nodes of relationship recognition and status. A key aspect of this is the privileging of the sexual couple and the nuclear family and the comparative lack of access to recognition and resources by non-sexual, non-biological/filial intimacies – the friends, ex-spouses, ex-partners, ex-lovers, occasional lovers, children of partners from previous relationships, children of ex-partners, children of friends, and so on (Roseneil, 2004). I shall deploy an acronym for these other relationship forms, not out of a wish to categorise in a reductionist sense, but for ease of analysis. I shall call them 'SLIFs' Supportive and Loving Intimate Friendships (SLIFs). The privileging of the sexual couple and nuclear family over SLIFs, disproportionately affects older same sex individuals whose kinship networks are more likely to include them (Westwood, 2013).

The four-tiers of recognition are depicted in Figure 2.1.

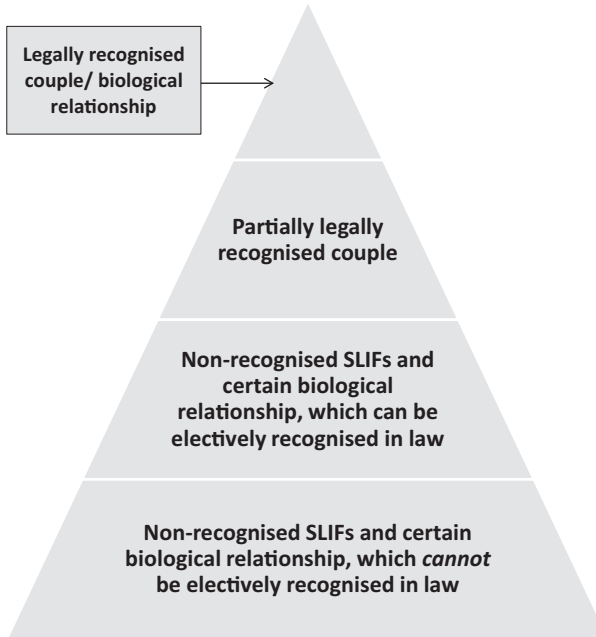

Figure 2.1 Four-tier hierarchy of relationship recognition

As can be seen in Figure 2.1, the four tiers are as follows:

1. At the first, most privileged, tier is the legally recognised civil partnership or married same sex couple, which now sits alongside the heterosexual spousal default mechanisms in tax, welfare benefits and pensions, inheritance law, housing policy and provision, and in health care decision making;
2. At the second, less privileged, tier is the partially legally recognised non-registered couple which has a degree of recognition, albeit less than the married/civil partnership couple, in various contexts which incur both privilege (e.g., some aspects of intestacy rules) and disadvantage (e.g., welfare benefits assessment), further nuanced by sex, with different sex couples afforded greater recognition than same sex couples;
3. At the third, even less privileged tier, are non-conjugal, non-biological/filial, intimate relationships, i.e., SLIF's, for which there is no formal legal provision and which are not automatically recognised in legal defaults, but for which partial recognition can be created through mobilising law (e.g., via nominations in private pensions, in Wills, Lasting Powers of Attorney, etc.); and
4. At the fourth, least privileged tier, are non-conjugal, non-biological/filial, intimate relationships, i.e., SLIF's, for which there is neither formal

> legal provision nor any means for remedying this through mobilising law. For example, non-recognition under mental health legislation 'Nearest Relative[1]' rules, no recognition of non-conjugal, non-biological relationships of care and support under intestacy rules, no tenancy rights upon death, etc.

Running in parallel to this are biological/filial family defaults in many areas of law, just behind the married/civil partnership couple, sometimes ahead of the conjugal couple, sometimes behind, according to different areas of law. The next section shows how this four-tier system operates in relation to the financial regulation of relevance in later life.

Financial Regulation

Later life finances (tax, welfare benefits, pensions, inheritance provision) have statutory flows across nodes structured upon heterosexist norms, privileging conjugal, biological and filial relationships, creating gaps where other relationship forms are located. The four tiers of regulatory relationship are clearly visible here. At the top tier is the legally recognised sexual couple, with spousal default mechanisms in tax, welfare benefits, pensions, and inheritance law. Civil and married partners are entitled to: a state pension on the basis of a partner's National Insurance Contributions; automatic access to a partner's occupational pension when they die;[2] the Married Couple's Allowance and tax benefits (enabling the transfer of savings to a partner who pays no tax or tax at a lower rate). Civil and married partners enjoy exemption from Inheritance Tax liability,[3] and are recognised under Intestacy Rules and Housing Tenancy succession rules. Each of these allowances and recognitions constitute nodes which direct flows of recognition, resources and entitlements towards the legally recognised couple.

At the second, lower, tier sits the non-registered sexual couple. Non-married and non-Civil Partnership Act 2004 (CPA) partners enjoy few of the above automatic benefits. Moreover, since the inception of the CPA, same gender couples on lower incomes have been penalised: previously assessed under welfare benefits means-testing as 'single persons' they are now assessed as if they are civil partners. In this way, nodes both direct flows of recognition, resources and entitlement away from non-legal sexual couples *and* recognition, penalties and obligation towards them. This is of particular significance to same gender partners who object to the legal recognition and regulation of relationships by

1 Section 26 Mental Health Act 1983 defines rights and responsibilities of the 'Nearest Relative'.

2 It is possible for anyone to be named as a beneficiary of a private pension upon death, but not for a state pension.

3 Sect. 18(1) *Inheritance Tax Act 1984*; *Tax and Civil Partnership Regulations 2005*.

the state (Rolfe and Peel, 2011) who are likely to be particularly represented by radical lesbian feminists resisting the patriarchal associations of state control of private life (Barker, 2012).

This also implicates class, gender and race/ethnicity. Just as the CPA (and now same sex marriage) itself has economically privileged winners (i.e., those in employment) and economically disadvantaged losers (i.e., those dependent upon state benefits) (Stychin, 2006), this too applies in older age. The more affluent with private pensions – not contingent on partnership status – being the winners and the less affluent reliant on state pensions – which are contingent on partnership status – being the losers. It also intersects with gender, privileging middle class men on relatively higher pensions than, for example, working class women more likely to be reliant on state benefits (Jackson, 2011). It further intersects with race and ethnicity: older people from ethnic minority communities, especially older women, are amongst the most socio-economically disadvantaged in the UK (Evandrou, 2000), meaning that older women from ethnic minority communities are more likely to be in the lower socioeconomic groups.

At the third, tier, further down, are those SLIF's which are not automatically recognised in any of the previously identified legal defaults, but for which partial legal recognition can be created through mobilising law i.e., via nominations in private pensions and in Wills. In this way law can be initially exclusionary, through an absence of nodes (determining entitlement) and yet also be mobilised to overcome certain exclusions, by initiating elective nodes. This 'opt out' option of will writing, is often used to argue against the significance of potentially discriminatory succession rules (Monk, 2011). However, disputed wills and discretionary awards under intestacy rules remain problematic for LGB individuals. This is partly because the court is required to be able to have the mindset of a LGB deceased individual (Anderson, 2011), which a predominantly heterosexual and heterosexist court is unlikely to be able to achieve (Hunter, 2010). Additionally, intestacy law is locked into a heteronormative family paradigm (Gallanis, 1999; Foster, 2001) and into norms and values which do not automatically prioritise actual love, care and support given to the person prior to death.

At the fourth, and lowest, tier are those SLIF's for which there is no formal legal provision and no legal mechanism to overcome their exclusion. For example, under intestacy rules there is no place for remuneration for relationships of care and support *provided* to the deceased before death. Dependents may claim, but providers cannot. Nodes here determine a lack of flows of recognition and resources for informal non-filial carers. Couples not married or in civil partnerships and SLIF's are also at greater risk of financial penalties and housing insecurity (if they have to sell their home to pay Inheritance Tax, for example). LGB individuals not in a conjugal/biological/filial relationship with the deceased but who were cohabiting with them in a rented property before their death are also at risk of losing their housing because, unlike partners and biological family, they have

no tenancy claim.[4] This includes those who provided care to the person before they died.

Through the nodal positioning of financial entitlement, then, the sexual couple and the biological/filial family remain dominant in automatic privilege and in defaults which can only be partially overridden. Through the different flows of privilege based on relationship status each of the three 'equalities of how' (Baker et al., 2009) are engaged: consistency (everyone being treated the same); opportunity (everyone having the same chances in life); and results (everyone having the same outcomes). In terms of 'sameness' not every older LGB individual is treated in the same way, contingent on relationship status, which produced uneven outcomes at times (e.g., tax privileges). Yet in other areas a failure to recognise difference, resulting in treating everyone the same way (e.g., married/civil partners and cohabiting partners in relation to welfare benefits) also produces uneven outcomes. Because of the contingencies of relationship recognition, all older LGB individuals do not enjoy the same opportunities or outcomes in terms of accessing relationship-linked material resources. Material benefits in later life, and upon death, flow to the sexual couple and biological/filial relationships and away from other relationships, including SLIFs. In this way the normativity of the sexual couple and the heterosexual family form are reinforced through nodes which direct flows of both legal recognition and material reward (Auchmuty, 2009; Wilkinson, 2013). Relationships involving the provision of care and support to the deceased before death receive no recognition or reward (Sloan, 2012) under intestacy rules, reiterating and reinforcing the under-valuing of care (Held, 2006) and the affective domain of equality (Lynch et al., 2009) in contemporary cultural norms.

Social Care Policy and Provision

At face value it might not be immediately obvious that UK social policy and provision relating to older people is shaped by sexuality, but on closer inspection, it becomes clear that it is. This is in three main areas relating to: carer recognition and support; community care policy; sheltered housing and residential care provision (Westwood, 2013).

4 Under tenancy rules in England and Wales, apart from spouse and civil partner, the only other people who have tenancy succession rights to council and housing association tenancies are other 'family members' (providing a spouse or civil partner is not living in the property, and the family member had been living there for over a year). 'Family members' comprise cohabiting partners, children, parents, siblings and most other 'close relatives', but not, significantly, 'friends'.

Carer Recognition and Support

Informal care and support is of particular importance in later life, when an ageing individual may need assistance with the practicalities of daily living, managing finances and/or personal care (Vincent, Phillipson and Downs, 2006). It can also be a vital emotional resource informing later life well-being and mental health, particularly for marginalised individuals, including older LGB individuals (Fredriksen-Goldsen et al., 2013). Support for carers is essential, both in their own right, and also because, with informal carer support, a person can often live for longer in their own home, and avoid needing formal domiciliary care provision and/or residential care (Glaser, 2009). Carer recognition (both by the carer themselves and by service and resource providers) is a fundamental part of carer support: without recognition carers will not be able to access information and support.

Most of carer discourse in UK social policy is generic, avoiding the use of specifics when referring to carers, including in relation to gender and sexuality. The problem with this 'all the same' approach is that it does nothing to override heteronormative defaults in provision and among providers. Carers of older LGB individuals, many of whom will be older LGB individuals themselves (Grossman, D'Augelli and Dragowski, 2007), are under-recognised in the UK (Willis, Ward and Fish, 2011). As I have argued elsewhere (Westwood, 2013, p. 356) this under-recognition is evident in four main ways:

1. in the use of the generic and genderless word carer in key legislative and social policy discourse, which fails to take into account carer diversity in general and LGB carers in particular;
2. in explicit heteronormative assumptions in the social construction of carers in wider government and voluntary sector discourse which again fails to take LGB carers into account, again excluding LGB carers;
3. in implicit heteronormative assumptions in older age carer discourse, e.g., dementia care;
4. in assumptions of heterogeneity in carer discourse which excludes wider relationship forms.

LGB women are particularly excluded by the 'spinster model' of care (Manthorpe and Price, 2005) whereby single women carers are assumed to be heterosexual. Gay and bisexual men may either only be recognised as carers for men with HIV/AIDS (Munro and Edward, 2010) or not recognised at all (Rosenfeld, Bartlam and Smith, 2012). LGB carers from Black and minority ethnic (BME) backgrounds are further marginalised by the under-recognition of BME carers (Katbamna et al., 2004). Bisexual women and men carers are likely to be 'read' as lesbian or gay if in same gender relationships or as heterosexual if in different gender relationships (Jones, 2010; Westwood et al., 2015). Polyamorous individuals (Barker, Heckert and Wilkinson, 2013), including LGB individuals, are unlikely

to be recognised at all. As Conaghan and Grabham (2007) have argued 'rights for carers require an intelligible model of the family that has no space for non-standard intimacies: polyamory, non-standard parental relationships, independent financial arrangements between partners, and close ties between friends' (p. 20).

Under-recognition of LGB carers means that they will not be provided with information about, nor be able to access the services to which they are entitled (Hash, 2006; Grossman, D'Augelli and Dragowski, 2007; Hash and Netting, 2009), increasing the risk of carer burnout and breakdown (Ward et al., 2005) and thereby disadvantaging not only the carer but the older LGB person to whom they are offering support. In this way heteronormative models of care and carers, predicated upon heterosexist nodes, directs flows of recognition and resources (financial and practical support) towards heterosexual carers and away from LGB carers, particularly those caring for older LGB individuals.

Community Care Policy

UK community care policy is predicated upon the notion that an older person will be in receipt of partner/local family/local community informal social support, and that only when that support is no longer sufficient will the state be required to intervene (Bernard and Phillips, 2000). This model includes the understanding that this family support will be intergenerational, i.e., that older people will have children and grandchildren. This model does not take into account the dynamics of the diverse composition of older LGB family forms (Westwood, 2013). Firstly, more older LGB individuals than heterosexual individuals are likely to be single and not have access to partner support (Guasp, 2011). Secondly, many older LGB individuals, especially the oldest old (Pugh, 2012) are likely to be estranged from their biological families due to historical and/or more recent tensions about their sexualities (Guasp, 2011). Thirdly, for many LGB individuals their personal communities are not local, but geographically dispersed, and in fact one of the challenges of ageing is maintaining physical links with communities when mobility may be restricted in later life (Heaphy, 2009), particularly for 'older older' LGB individuals who have limited IT skills and therefore restricted access to virtual communities. Even for those who are 'silver surfers', virtual communities, while a useful source of support (Peel and McDaid, 2015) cannot completely substitute the rewards of actual physical communities. And lastly, older LGB individuals (historically denied access to children through an absence of reproductive technologies, blocks on adoption, and even being excluded from parenting their own children, Wyland, 1997; Hicks, 2005) are less likely to have intergenerational support: 'just over a quarter of gay and bisexual men and half of lesbian and bisexual women have children compared to almost nine in ten heterosexual men and women' (Guasp, 2011, p. 3).

While many older LGB individuals have strong communities of support, including 'families of friends' (Roseneil and Budgeon, 2004), they are less likely to be intergenerational. This means that, in older age, friends may develop

heightened support needs at around the same time, meaning that they are no longer able to provide this extra help to one another:

> While 'families of choice' do provide social support, a key problem that older LGB people may face is that members of their 'family of choice' may be the same age as them and so this network of family/friends is likely to have age related problems at the same time and may not be as effective at providing the social support that may be necessary. (Musingarami, 2008, p. 4)

So the model of older individuals' personal communities, upon which UK community care policy is based, is constructed on heteronormative nodes which combine to construct a picture of flows of care and support which do not reflect those of older LGB individuals. This in turn means that community care modelling is not structured around the needs of older LGB individuals (Cronin et al., 2011). In particular it does not take into account the likelihood that they will be earlier and disproportionate users of formal social care provision than older heterosexual people (Heaphy, Yip and Thompson, 2004; Guasp, 2011; Ward, Pugh and Price, 2011) and so there is an absence of nodes directing flows of targeted support towards older LGB individuals.

The UK personalisation agenda (Department of Health, 2006; 2007) enables older people to have personal budgets with which they can purchase care from their local communities. This is seen as a ways of enabling older LGB individuals to purchase care from their LGB 'communities' (CSCI, 2008) and has been envisioned as having great emancipatory potential:

> For older LGBT citizens, direct payments offers a new option for recruiting personal assistances through gay organizations and the gay press, enabling them to be supported from within their own community. Transferring the purchasing power directly into the hands of the service user in this way has the potential to revolutionize social care for gay people. (Concannon, 2009, p. 407)

This notion of the emancipatory potential of personal budgets is problematic in several ways. Firstly, as observed above, many older LGB individuals' personal communities are geographically dispersed, and so they may not have access to local networks from which they can purchase support. Secondly, many older LGB individuals, gay men in particular, feel excluded from the lesbian, gay, bisexual communities due to ageism (Simpson, 2013). Thirdly, as also observed above, many of the personal networks of older lesbians and gay men are likely to be intragenerational and so networks may experience heightened demands for care at the same time as there are reduced abilities to provide it. Lastly, the notion of 'community' is itself problematic. There is no single collective 'older LGB' or 'older LGBT' community. Bisexual women and men are often excluded due to biphobia (Barker et al., 2012); lesbians and gay men can have very little to do with one another, and tend to socialise in different ways (Pugh, 2002); and many LGB

people live life away from organised socialising (Heaphy, Yip and Thompson, 2004). In fact it is often socially isolated older LGB individuals, some of whom may have additional challenges, e.g., mental health problems, who are most likely to access formal networks (Knocker et al., 2012), especially those living in urban areas where such networks are more likely to be available. The nodal norms which are mobilised to construct a notion of an older LGB/LGB community, then, may be strategically useful to 'mobilise a constituency' (Bernstein, 2009, p. 267) in order to direct flows of recognition for campaigning purposes. However it can also be misleading, and particularly problematic in relation to care, by implying potential flows of resources which can be accessed to purchase care, when in reality they do not exist (Aronson and Neysmith, 2001, p. 143).

The alternative to purchasing care from local personal communities is to purchase care from formal agencies in the local area. However, many older LGB individuals are concerned that formal care providers are ill-equipped to meet their respective needs, being sites of 'ignorance at least, homophobia at worst' (Guasp, 2011, p. 22). Many would be uncomfortable being open about their sexualities to domiciliary care providers to the extent that some would rather avoid receiving support altogether, even if it is much needed (Guasp, 2011, p. 3). The lack of appropriate community support can produce profound disadvantages for older LGB individuals (Westwood, 2014):

> An older gay man with dementia decided to stop receiving services because of the homophobic reaction of care staff. This had led to him having to move into residential care earlier than necessary as his elderly partner had struggled to cope alone with caring responsibilities. (EHRC, 2011, p. 37)

Here we can see how insufficient carer support and inadequate home care provision produced both care breakdown and premature admission to residential care, which itself is a cause for concern in term of being able to meeting the needs of older LGB individuals (Price, 2010).

Sheltered Housing and Residential Care Provision

It is increasingly well recognised, internationally as well as in the UK, that sheltered housing and residential care provision is ill-equipped to meet the needs of older LGB people (Carr and Ross, 2010). Sexuality receives little attention in housing policy, particularly in relation to older people and even when there is relevant policy, there is often a lack of rigorous auditing procedures to monitor policy implementation (Fish, 2009).

Sheltered housing is often geared up to the identities of older heterosexual people and tends to replicate, and even magnify, the social divisions in mainstream society (Bernard et al., 2012). There is no specialist sheltered housing for older LGB people in the UK, despite increasing evidence of the wish among many older LGB individuals for this to be an option (Carr and Ross, 2013), particularly

among older lesbians (Traies, 2012; Westwood, 2014). Residential care provision is perceived as being a site of overwhelming heteronormativity and many older LGB individuals 'continue to live in fear and hide their identities' in care spaces (Harrison and Riggs, 2006, p. 49). There is a pressing need for a menu of choices in housing and residential care for older LGB individuals, both 'LGB/T friendly' provision and LGB/T specific provision, including lesbian/women only accommodation (with care if needed) for those LGB women who want it (Westwood, 2014). At the present time, there is no choice in the UK at all. This 'sexuality blind' approach to housing and residential care could be argued to be in breach of equality and human rights legislation in the UK (Cronin et al., 2011; Westwood 2014; 2015).

Approached with the conceptual tools of nodes and flows, sheltered housing and residential care provision for older people in the UK is positioned around standardised nodes based on a 'one size fits all' approach (Eaglesham, 2010) to the needs of older people which directs one type of flow of housing and one type of flow of residential care to all older people. A truly personalised approached would be indicated by a range of nodes, including optional, elective ones, triggering a range of different types of flows of accommodation/and care in older age. A lack of such diversity disadvantages many individuals from minoritised backgrounds, including older LGB individuals.

Equality Act

The Equality Act 2010 protects nine 'protected characteristics' (Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion and belief; Sex; and Sexual orientation) from indirect and direct discrimination, harassment and victimisation in a range of contexts, including work, housing and the provision of goods and services. When the Act was first passed into law, under a previous Labour government, it had an innovative section which afforded protection on the grounds of dual harassment, i.e., a person could claim they had been treated unfairly (under the Act) based on a combination two protected characteristics. So someone could claim that they had been discriminated against because they were old and a woman, for example, or old and gay (not old and a woman and lesbian, sadly, no triple discrimination claim was possible even then). However the subsequent coalition government decided not to enact this section of the Act, which means claims can only be made on the grounds of a single characteristic. So an older LGB individual, who feels they have been discriminated against because they are both older and LGB, will be unable to make a claim on this basis. In its current form, the Act is 'structurally antithetical to developing a nuanced recognition of intersectionality … .and to tackle more complex structural aspects of discrimination' (Squires, 2009, p. 506).

The Act also disadvantages older LGB individuals with specific reference to protection from harassment. The Act contains specific exclusions from protection

from harassment on the grounds of sexual orientation in: the provision of services (including goods) and public functions; the disposal, management and occupation of premises; education; and in associations.[5] These exclusions were introduced to protect anti-LGB religious proselytising from falling foul of the Act (Baird, 2009). The British Humanist Association recognised the unique position of older age care recipients in this regard, criticising the EQA's lack of protection from harassment in close care spaces (e.g., domiciliary care, residential care, hospices) referring to those spaces as being 'where service users are "captive" with limited choice and control over their environment'.[6] The Joint Committee on Human Rights (JCHR 2009) proposed special protections from harassment for those in 'closed' spaces (e.g., prisons, care homes, schools, etc.), but various faith organisations objected, and the government gave way. In effect this means that the only protection from harassment on the grounds of sexual orientation under the Act is in the workplace. It has particular implications for older LGB people living in care homes because it means they are less protected from harassment in those care spaces than their heterosexual peers. Moreover, given that homophobic harassment is defined as a form of elder abuse (Department of Health 2000, para 2.7) it means that they are also less well protected from some aspects of elder abuse than their heterosexual fellow-residents (SCIE, 2011). They are also less well protected from harassment than younger LGB adults who are less likely to be living in such closed care spaces and more likely to be in workplaces where they are protected.

Approached conceptually using nodes and flows, we can see how the Act has dormant nodes (in the form of dual discrimination) whose lack of enactment disadvantages those vulnerable to dual discrimination, including on the grounds of ageing and sexuality. The Act has nodes (protected characteristics; rights under the Act) which should afford flows of equal protection to all individuals identified within the Act. However, the harassment exclusions specifically *de-activate* certain nodes of protection, explicitly *redirecting* certain flows of protections (from harassment on the grounds of sexual orientation) away from individuals located in spaces other than the workplace, which particularly disadvantages older LGB individuals.

Conclusion

Utilising the conceptual tools of nodes and flows has highlighted a range of gaps in law and social policy affecting older LGB individuals, and an overarching promotion of coupledom and heteronormative family and community forms in contemporary UK regulatory contexts. Financial regulation in later life privileges the sexual couple, particularly the legally recognised sexual couple, and biological/filial relationships,

5 Equality Act 2010 S29(8); S33(6); S34(4); S35(4): S85(10) and S103(2).

6 JCHR (2009) Memorandum submitted by the British Humanist Association Ev 100–106.

disadvantaging other relationship forms, which may be of greater significance to older LGB individuals. In social care policy, flows of resource allocation are directed towards older people via nodes of heteronormativity, creating pockets of unmet need wherein older LGB individuals are positioned.

Flows of recognition and resources privilege, to varying degrees, conjugal, biological, and filial relationships over relationships of love, care and support, and younger, over older, LGB individuals. This in turn constrains older LGB individuals, and their more varied relationship forms, in terms of access to material, social and care resources in later life. This constrained access can only be partially resisted through the mobilisation of law, through formal processes of relationship recognition, including civil partnerships, marriage, the use of Wills, LPA's and so on. There is then unequal access of older LGB individuals' access to power (in the form of resources), in comparison to that of both older heterosexual-identifying individuals and younger LGB individuals.

I have demonstrated that LGB individuals' equality issues go beyond marriage, work, parenting, the sexual and the social; beyond urban-rural and commercial-non-commercial scene dichotomies; and beyond binary notions of heterosexual and non-heterosexual spaces (Valentine, 2007). They also include: ageing, death and dying; inheritance, pensions and welfare provision; retirement; caring for (often ageing) others; needing (older age) care and the range of care spaces, care providers and fellow care recipients that become engaged with as a consequence. The binary divides of home-space and public-space break down in older age, when home spaces can also become public spaces and vice-versa. Equality discourse becomes nuanced by issues of cognitive and/or physical frailty, by diminishing networks of resistance and support, and by a range of exclusionary processes involving the intersection of ageing and sexuality. In this way, ageing not only iterates and reinforces pre-existing inequalities associated with sexuality, it also introduces new ones as well.

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Chapter 3

Inclusion and Representation of Older People and Sexual Health in Sub-Saharan Africa within Contemporary Population Health Research

Gloria Chepngeno-Langat and Victoria Hosegood

Introduction

Research not only drives the discourse about, and opportunities for, better understandings of ageing, sexuality and sexual health, it also informs the social and medical interventions required to improve the wellbeing of older people. Additionally, the inclusion and representation of older people in sexual health research influences the types of discourse, negative or positive stereotypes and, visibility of sexuality in later life. This chapter undertakes a critical review of sexual health and public health literature in sub–Saharan Africa to examine the scope, rationale and the development of the representation and inclusion of older people in research over the past several decades. The review focuses on the population sciences or demography field and is also framed within a public health perspective. We also examine the methodological approaches used in these studies, and how the research methods and data availability determine the scope and extent to which older people are represented in sexual health and public health research. Thus, neglecting older people's right to sexual health and information is a denial of their human rights and can be considered a form of age discrimination. Furthermore, sexuality and sexual health are not only rights issues but sexuality in later life includes understanding the dynamics in relationships of older people structured around for example the traditional long-term relationships, but also including the increase in (re)partnering formations in old age and other forms of contemporary new age interactions occurring among older people (Hillman, 2012).

Sexual health has been defined by Cook, Dickens and Fathalla (2003, p. 14) as 'the ability to enjoy mutually fulfilling sexual relationships, freedom from sexual abuse, coercion or harassment and safety from sexually transmitted infections'. Whereas sexual health is conceptualised as the absence of disease or illness, sexual health is also considered a right that all persons should enjoy in accordance with international declarations and covenants on human rights in addition to other conventions on civil, social and cultural rights (Cook, Dickens

and Fathalla, 2003; Roseman and Reichenbach, 2009). Sexual health is thus a rights issue and the International Planned Parenthood Federation (IPPF), an advocate for sexual matters, represent sexual rights as encompassing sexual health and define this as 'human rights related to sexuality … that emanate from the rights to freedom, equality, privacy, autonomy, integrity and dignity of all people' (IPPF, 2008, p. iv).

Context of Sexuality and Sexual Health Research and Policy in Sub–Saharan Africa

Decades of concern about rapid population growth in sub-Saharan Africa have strongly influenced the age and gender-specific discourse and population policies in sub–Saharan Africa (The World Bank Group, 2014). Before the 1994 United Nations International Conference on Population and Development (ICPD) conference in Cairo this chimed with the widely held view that controlling population growth was necessary in order to achieve development, modernization and environmental sustainability (Seltzer, 2002; Rao, 2004; Eager, 2004). Given the emphasis of governmental and non-governmental agencies on the twin objectives of family planning and fertility control (Middleberg, 2003); little if any attention was given to sexuality, sexual or reproductive health in later-life. The 1994 ICPD conference was ground-breaking in redefining reproductive health and rights as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system', emphasising women and men's 'right to decide', and their right to 'satisfying and safe sex life' (Ashford, 2001). This definition was incorporated into the population policies of the developing countries and the rights of women in the reproductive ages took centre stage in the sexual health arena (Petchesky, 2001; Eager, 2004; Roseman and Reichenbach, 2009). Health policies on sexual health have focused mainly on meeting the needs of women in the reproduce age typically defined as 15–45 or 15–49 years (National Population Council, 2011; Johnson, Abderrahim and Rutstein, 2011). The final ICPD document includes the statement that 'older women and men have distinct reproductive and sexual health issues which are often inadequately addressed' (United Nations Population Information Network, 1994: Chapter VII 7.3). But no further details of these issues or what actions should be taken are included.

It is against this background of priorities in sexual and reproductive health that the severe HIV epidemic emerged in sub-Saharan Africa, leading in many countries to a shift in the research agenda from fertility to sexual health. In the next section, we will consider what impact the increasing focus on HIV has had on the inclusion of older people in sexuality and sexual health research conducted in sub-Saharan Africa.

Older People and Sexual Health in Sub-Saharan Africa: Review of the Literature

In this section, we summarise and appraise the existing literature addressing directly or indirectly aspects related to sexuality and sexual health in older men and women living in sub-Saharan Africa. A selective rather than an exhaustive review of the literature, our search was restricted to public health and social sciences disciplines. Searches were conducted using International Bibliography of the Social Sciences (IBSS), Web of Science and PubMed search engines. Only research papers published in the English language were reviewed. All types of academic literature written in English including journal papers based on empirical studies, descriptive studies, reviews, commentaries and opinion pieces, letters to editors and study reports were retrieved for analysis.

The keywords used were 'sexuality' 'sexual health OR sexual rights' 'reproductive health OR reproductive rights' and 'HIV' along with 'older people OR elderly OR older adults' AND 'Africa'. In order to retrieve all relevant literature, the search covered titles, abstracts and list of keywords. As the number of research papers initially identified was large, the first screening involved reading the abstracts and shortlisted papers were then read in detail to identify papers on older people. The searches were confined to the period January 1960 to December 2013 and divided into two phases: 1960–1993; and 1994–2013. Only six relevant papers on older people (3 per cent) were identified for the time period 1960–1993 with the search term 'sexual health OR sexual rights' returning no hits over this period. Overall, the majority of the relevant hits were returned for the keyword 'HIV' (75 per cent) followed by 'sexuality' (11 per cent) and 'reproductive health OR reproductive rights' (10 per cent).

A total of 179 research papers were selected for detailed review. The number of relevant research papers retrieved has increased markedly over a decade from a single paper in 1991 to 27 papers in 2011 (Figure 3.1). Most of the selected research papers focus on issues relating to HIV and AIDS (71 per cent) followed by studies on intergenerational sexual partnering (15 per cent) and on sexuality transmitted infections (4 per cent). Other issues covered are cervical cancer, changes in sexual norms, sexual behaviour, female genital mutilation, sexual violence and older people's general health including sexual health.

HIV Incidence and Prevalence in Older People

At the end of the 1990s and early 2000s, the increasing prevalence of HIV and AIDS led to efforts to complement estimates of HIV prevalence in clinic-based studies and sentinel surveillance with population-based HIV testing to estimate HIV prevalence through cross-sectional surveys. Examples of these surveys include the Demography and Health Surveys (DHS) series (ICF International. 2012), the national survey conducted in South Africa in 2002 by the Nelson Mandela Foundation in conjunction with the Human Sciences Research Council

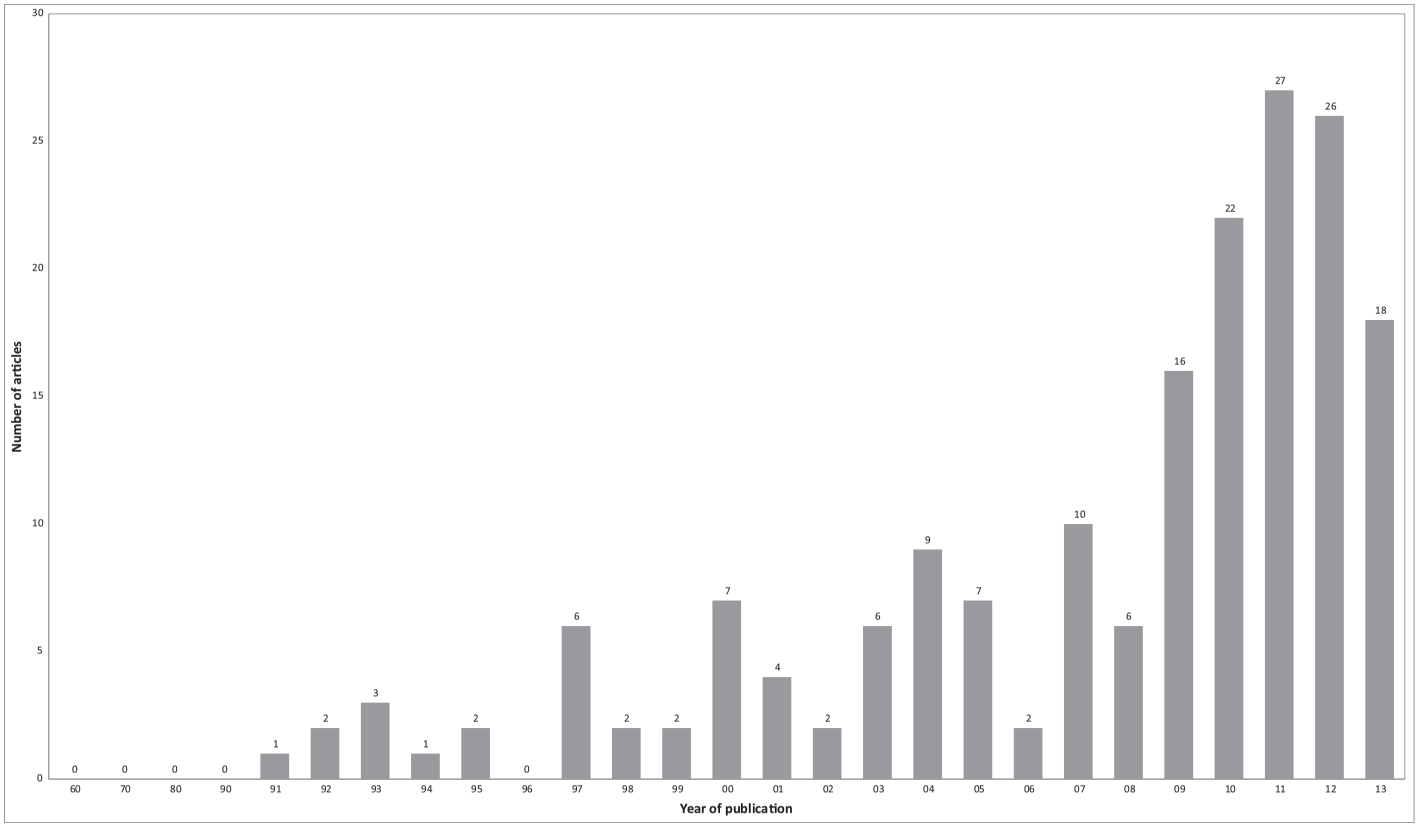

Figure 3.1 Number of retrieved research papers on sexuality and sexual health in sub-Saharan Africa (1960–2013)

(Shisana, Simbayi and HSRC, 2002) and, in a smaller number of longitudinal studies to measure HIV incidence such as the ALPHA network (ALPHA Network, 2015). The majority of HIV surveys started by restricting inclusion to men and women in a similar age range to those of reproductive and demographic health surveys e.g., approximately 15–49 years for women and 15–54 years for men. New infections were widely assumed to be low in people beyond the 'reproductive years'; consequently directly measured estimates of HIV prevalence and incidence in older age groups were unavailable in many populations. Increasing recognition that a) improvements in life expectancy accompanying the scale-up of public HIV treatment in sub-Saharan Africa would increase the number of HIV-infected people surviving into older ages and b) that HIV acquisition and transmission were occurring in older people, provided the impetus for some HIV surveys to offer HIV testing to older people.

The majority of the selected hits related to HIV/AIDS and older people (94 per cent) were published between 2000 and 2013. The coverage of these studies is however largely limited to South Africa, Kenya and Uganda, which account for two thirds of the selected studies (64 per cent). The concentration of studies in these three countries is mainly accounted for by the availability of cohort-based longitudinal empirical data encompassing entire populations within a delineated geographic area. Out of the 39 Demographic Surveillance Sites that collect longitudinal data, 11 sites are located in South Africa, Kenya and Uganda (INDEPTH Network, 2015).

HIV infection in older people

Improved life expectancy as a result of better management, and increased access to treatment has led to an ageing in the population of people living with HIV (PLHIV) (Kearney et al., 2010; Hontelez et al., 2012). Studies on the direct impact where older people themselves are infected or at risk of HIV infection increased over the review period with 70 per cent of papers we identified concentrated in the period 2009–2013. Earlier studies investigating HIV prevalence in older people were conducted in Uganda (Wawer et al., 1991) and Guinea-Bissau (Poulsen et al., 1997; Xiang et al., 1997). None of these earlier studies provided national or provincial level estimates of HIV prevalence among older people. The Guinea-Bissau studies benefited from epidemiological and demographic surveillance initiated in 1987 to mainly investigate the epidemiology of HIV-2 in the city of Bissau (Poulsen, et al., 1997). Other studies examining the prevalence of HIV on older people have been conducted in Kenya (Oyugi et al., 2009), South Africa (Chopra et al., 2009; Wallrauch, Barnighausen and Newell, 2010; Hontelez et al., 2011; Negin et al., 2012a), Tanzania (Mtei and Pallangyo, 2001), and Ghana (Duda et al., 2005; Sagoe et al., 2009). The reported HIV prevalence from these studies vary greatly ranging from a low of 1.1 per cent among women in a study in Accra Ghana (Duda et al., 2005) to 8.9 per cent among women in the rural area of KwaZulu-Natal in South Africa (Wallrauch, Barnighausen and Newell, 2010). HIV prevalence was substantially higher in studies of high risk groups such as

men who have sex with men (Chopra et al., 2009; Modi et al., 2011) and a study that examined HIV prevalence among older people attending a clinic in Tanzania where 77 per cent of those in the 50s were HIV positive (Mtei and Pallangyo, 2001). A projection modelling study using population-based data from rural population of KwaZulu-Natal in South Africa, predicts a near doubling of HIV prevalence by 2020 in older people 50 years and older. Whereas the prevalence in the 15–49 years age group is projected to decline over the same period (Hontelez et al., 2011).

A large proportion of the studies on the direct effect of HIV examine the risk of mortality associated with HIV infection (12 per cent) and on the level and pattern of morbidity in older people who are HIV positive (28 per cent). The studies on morbidity examine co-morbidity and how various diseases and conditions manifest among older people who are HIV positive. These also included sexual health diseases such as bacterial vaginosis (Sewankambo et al., 1997) and cervical cancer (Ononogbu et al., 2013) among women, AIDS was identified as a common cause of death among older people (Negin et al., 2010; Thorogood et al., 2011) and compared with younger age groups, older people with HIV had higher mortality due to faster disease progression (Lutalo et al., 2007; Van der Paal et al., 2007). On the other hand, older women with HIV were reported to have better survival rates compared with older men with HIV (Mills et al., 2011; Maskew et al., 2013). Three studies found that initiating antiretroviral treatment early improved the survival of older people with HIV (Mills et al., 2011; Mutevedzi et al., 2011; Kouanda et al., 2012).

Adequate knowledge on HIV and AIDS is to some extent important in influencing change in behaviour towards actions that minimise the risks of exposure to HIV (Helweg-Larsen and Collins, 1997; Ajzen et al., 2011). However, very few of the studies reviewed investigated the level of general knowledge about HIV among older people. Overall, out of the studies assessing the level of knowledge among older people, most highlighted low levels of general knowledge on risk factors and various aspects of HIV/AIDS (Kipp et al., 2009; Philip-Ephraim et al., 2010; Wagenaar, Sullivan and Stephenson, 2012; Negin et al., 2012b). One study found that older people were less likely to attend programs or interventions seeking to equip participants with skills to beneficially change their behaviour (Quigley et al., 2004). Inappropriate information and education can be a barrier to accessing information, as a study in Zimbabwe found HIV/AIDS material to be incomprehensible for older people. Although older people in this study acknowledged themselves as being at risk of HIV infection, the service providers interviewed had never attended to any older people in their facilities with some suspecting that older people may use proxies to collect or purchase contraceptives such as condoms (Gutsa, 2011). Among the studies retrieved, four were identified which assessed the extent of testing for HIV among older people. Interestingly, a study found a higher proportion of those over the age of 45 years being tested during home visits by health workers as opposed to testing in public venues (Maheswaran et al., 2012) and comparing men and women in Mpumalanga

Province in South Africa, men were more likely to test when they were older unlike women. This was attributed to women more likely to self-refer at a younger age because of pregnancy and during antenatal visits (Snow, Madalane and Poulsen, 2010).

Intergenerational sexual partnering

Age disparity between young people or adolescents and their sexual partners has been highlighted as one of the major risk factors that account for the disproportionately high HIV prevalence among young women 15–24 years compared to their male age counterparts (Miller, Clark and Moore, 1997; Vanoss Marin et al., 2000; Kelly et al., 2003), in addition to other negative sexual outcomes among young people such as teenage pregnancies and other sexuality transmitted infections. Approximately 15 per cent of the studies retrieved were on intergenerational sexual exchanges. The focus of the selected studies was mostly on young people with only five (Luke, 2003; Shisana et al., 2004; Thomas, 2007; Nobelius et al., 2011; Potgieter et al., 2012) out of the 26 studies on intergenerational sexual partnering including other age groups. These mixed studies included other age groups, mainly to investigate their opinion on intergenerational sexual relationships, or to provide suggestions on how to protect young people from the negative outcomes associated with these types of partnerships.

Whereas a large number of relevant hits on inter-generational sexual relationships were returned in the searches, most of these studies refer to relative age differences between young people usually adolescents and an older sex partners. The selected studies mostly report the sexual partner of the young person as 'older' with studies presenting the age difference between the young people and the older partner indicating an open-ended age gap particularly if the gap is over five years. For instance, in a study by Nobelius, et al. (2011, p. 255) using qualitative methodology to examine the sexual partners of out-of-school adolescents aged 13–19 years and their motivation for having sexual partners the word 'older women' appearing five times in the article and 'older men' almost 20 times. One section in the results titled 'older men' included phrases such as 'The most generous partners are usually older men … ' 'All female participants had been approached by older men offering gifts' 'older men … refuse condom use'. These and similar studies contribute to the very widely held view that 'sugar daddies' are one of the main factors for HIV acquisition in young women. This discourse reinforces negative stereotypes about older people's sexuality, in particular that of older men as a 'danger'. However, an inspection of a few studies that reported the exact age difference showed the difference between the young people usually 15–24 years and their older partners to range from five to ten years (MacPhail, Williams and Campbell, 2002; Luke, 2005; Chapman et al., 2010). And sexual relationships between young women and considerably older sexual partners are relatively rare even in communities with very high levels of HIV prevalence and HIV incidence (Luke, 2005; Ott et al., 2011).

Other Sexual Health Issues

The selected research papers that did not focus on HIV centred mostly on other sexuality transmitted infection among older people (14 per cent) including syphilis (Kassu et al., 2004), genital ulcer disease (Leichliter et al., 2011) and andropause[1] (Fatusi et al., 2003; Fatusi et al., 2004). One study estimates an increase in the prevalence of STIs among people aged 50 years and older in sub-Saharan Africa basing the estimation on the high HIV prevalence among older people for instance in Kenya, Botswana and Uganda where HIV prevalence is higher or similar to the younger age groups (Minichiello et al., 2012). Four studies on sexual health were identified which examined cervical cancer and included older people in the sample (Claeys et al., 2003; Gatune and Nyamongo, 2005; Taylor et al., 2010; Mingo et al., 2012). The suitability of integrating family planning services and cervical screening was examined in one study in Kenya assessed and the authors concluded that such an approach would not reach out to the population of women most at risk for example women outside the reproductive age (Claeys et al., 2003). A similar study in Kenya examining the understanding of the causes of cervical cancer among rural women aged between 20 and 50 years also found that lack of knowledge limited utilization of screening services (Gatune and Nyamongo, 2005).

Other distinct studies that were retrieved include a study in Somalia that explored the role and the views of older women regarding female genital mutilation (Ntiri, 1993) while another study which is a review article examined the potential role of older women in Africa as educators for young people on sexual matters (Annon, 1992). Sexual violence features as a topic of concern in two studies, one assessing the association between sexual violence and HIV status among discordant couples in Uganda (Shuaib et al., 2012) and the other study conducted in South Africa examined the consequences of intimate partner violence on mental health (Peltzer et al., 2013). A study conducted in Nigeria in 2012 investigated sexuality exclusively among older people, exploring the sexual health concerns of the study participants, socio-cultural beliefs on sex in later life and practices to enhance sexual functioning in old age (Agunbiade and Ayotunde, 2012).

The Unintended Subjects: Older People in Study Samples

It is evident from our review that older people are not usually the targeted research group for investigation, with only 38 per cent of the studies focusing exclusively on older people. The recruitment strategy for selecting participants and the criteria set for inclusion largely determine the chance that older people would fall within

1 Men from the late 40s or early 50s may experience symptoms such as loss of sex drive, erectile dysfunction, tiredness or lethargy due to a decline in androgen hormones in the body (Morales, Heaton and Carson III, 2000).

the bracket of the selected sample. Studies that rely on convenience samples or respondent-driven recruitment did end up having older people among the study participants, particularly if they did not have an age restriction as criteria for participation. Most of these studies where older people make up part of the sample recruited participants from clinics, especially HIV testing or treatment clinics and other health facilities (35 per cent), or other convenient places like workplace (6 per cent). For instance, a study of sexual behaviour linked to clinical trials of vaginal microbicides recruited women aged between 16 to 54 years in a small town in rural Tanzania. However, three quarters of the participants were under the age of 35 years and only nine out of the 465 participants were in the age group 45–54 (Tassiopoulos et al., 2009; Darj, Mirembe and Rassjo, 2010).

The number of older people included in studies varies greatly and this substantially influences the level of detail in the analysis and whether the sample size permits disaggregation by age groups. Out of the studies with mixed age groups, the largest proportion of older people 55 years or older was a study (Wojcicki et al., 2003) on the co-infection with Kaposi's sarcoma-associated herpes virus among cancer patients in South Africa (51 per cent) followed by a study with 48 per cent in Guinea-Bissau investigating the prevalence of the HIV2 strain (Poulsen et al., 1997). The lowest proportion of people aged over 50 years comprised 4 per cent of the sample, and were studies investigating herpes zoster in Tanzania (Naburi and Leppard, 2000) and the use of herbal remedies to enhance sexual experience in Zambia (Mbikusita-Lewanika, Stephen and Thomas, 2009). There is little consistency in the age groups in which older people are included. A study investigating the cervical cancer risk among women with HIV in Nigeria grouped women 40 years or older in a single age group (Ononogbu et al., 2013). Another study assessing the HIV risk factors among men 18 to 56 years who have sex with men in Lesotho, grouped all men aged 25 years and older as one age group (Baral et al., 2011).

Literature Focusing Exclusively on Sexuality or Sexual Health in Older Women and Men

The earliest publications among the research papers retrieved that only have people aged 50 years or older as participants were published from the year 2000. Prior to this period, one study investigated the risk factors for HIV-2 among older people in Guinea-Bissau (Poulsen et al., 1997), whereas the other paper examined the general health including sexual health of older people in one rural village in Botswana (Clausen et al., 2000). Only six of the 69 research papers that focused exclusively on older people were not solely on HIV (Naburi and Leppard, 2000; Kassu et al., 2004; Jobson, 2010; Agunbiade and Ayotunde, 2012; Chepngeno-Langat and Hosegood, 2012; Minichiello et al., 2012). Summaries of these articles are presented in Text Box 3.1.

TEXT BOX 3.1 – SUMMARY OF KEY ARTICLES

Clausen, F. et al., 2000. Morbidity and health care utilisation among elderly people in Mmankgodi village, Botswana. ***Journal of Epidemiology & Community Health*****, 54(1), 58–63**

Laboratory tests and a general medical examination of 337 older people were conducted to assess their vision, hearing, blood pressure and nutritional status. Women comprised 68 per cent of the study participants. The study also examined the utilisation of health facilities by the study participants in the month preceding the study and found that less than half (42 per cent) sought healthcare from a health facility for their concerns. Only one per cent reported a sexual health problem and none of the participants tested positive for HIV.

Minichiello, V. et al., 2012. STI epidemiology in the global older population: emerging challenges. ***Perspectives in Public Health*****, 132, 178–181**

This paper highlights a global rise of sexuality transmitted infections among older people by reviewing evidence from North America, Australia, China and Korea. The authors conclude by underscoring the lack of detailed epidemiological data on sexuality transmitted infections in the older population of Asia-Pacific and the Africa region and how this has led to the neglect of sexual health of older people and the lack of prevention, care and treatment programmes.

Agunbiade, O.M. and Ayotunde, T., 2012. Ageing, sexuality and enhancement among Yoruba people in south western Nigeria. ***Culture, Health & Sexuality*****, 14, 705–717**

This paper uses a qualitative approach by conducting ethnographic interviews with older people to explore the normative understand the value and importance of sexuality among older Yoruba people of Nigeria. A gendered meaning of the importance of sexuality in older where sexuality and medical measures to address sexual dysfunction among older men is encouraged whereas women who seek or express sexual desires are perceived not to conform to social expectations. Religion had a strong influence on their perceptions of sexuality in old age.

Kassu, A. et al., 2004. HIV and syphilis infection among elderly people in northwest Ethiopia. ***Japanese Journal of Infectious Diseases,*** **57(6), 264–267**

Patients visiting a health facility in Northwest Ethiopia for cataract surgery were recruited over a one year period for HIV and syphilis screening test. The participants 50 years or older numbering 706 had a median age of 65 years. The prevalence of HIV and syphilis in this population was 5 per cent or less. Higher prevalence of syphilis was reported among the older age groups with HIV mostly concentrated in 50–59 age group for men and 60–69 among the women. The study found very low co-infection of HIV and syphilis and the challenged the link between other sexually transmitted infections and the HIV virus.

Jobson, G., 2010. Changing masculinities: land-use, family communication and prospects for working with older men towards gender equality in a livelihoods intervention. *Culture, Health and Sexuality*, 12(3), 233–46
The authors recruited men 45–75 years whose spouses were participating in a land use intervention to understand the concerns facing men living in a community in KwaZulu-Natal South Africa against a backdrop of HIV and AIDS. The men in the study recognise the importance of changes in gender-roles and relations and a move towards gender equality. The authors conclude that livelihood interventions can provide an avenue of discussing sensitive gender issues and concerns.

Chepngeno-Langat, G. and Hosegood, V., 2012. Older people and sexuality: double jeopardy of ageism and sexism in youth-dominated societies. *Agenda*, 26(4), 93–9
This paper examines the factors that could explain the perception of sexuality in later life in sub-Saharan Africa. The gendered perception of sexuality in older ages where the sexuality of older men is generally accepted whereas the morality of women who display sexual interest in old age is put to question with the expectation that their desires should cease with childbearing.

With the exception of the qualitative study on sexuality conducted in Nigeria (Agunbiade and Ayotunde, 2012) studies on other dimensions of the interrelationships between sexuality, health and wellbeing of older people are virtually absent. Among the exceptions are social anthropological work in Ghana (van der Geest, 2001; van der Geest, 2006) and the more recent studies in Malawi (Freeman and Coast, 2013) and Uganda (Nyanzi, 2011) all of which were published since 2000. An advanced search on the International Bibliography of the Social Sciences (IBSS) database using the search terms 'Africa' AND 'sexual health' OR 'sexual rights' AND 'older people' OR 'elderly' OR 'ageing' OR 'aging' returned 13 hits with only five relevant research papers on older people out of which two were also retrieved from the Pubmed and Web of Science search engines (Munthree and Maharaj, 2010; Gutsa, 2011) and three relevant articles were new hits (Jobson, 2010; Christiansen, 2011; Chepngeno-Langat and Hosegood, 2012). Substituting the terms 'sexual health' OR 'sexual rights' with 'sexuality' returned six new hits but with no additional relevant research papers.

The medicalization of sexuality coupled with the approach toward sexuality as a problem to be addressed specifically within the medical or public health field (Bullough, 1975; Tiefer, 1996) can partly explain the lack of multidisciplinary research on sexuality and sexual health in sub-Saharan Africa. This may explain the lack of overlap in the research papers retrieved from the medical and the social sciences databases. Further, the papers presented in Text Box 3.1 are largely drawn from regional journals. Although the majority of HIV infection globally is concentrated in sub-Saharan Africa (UNAIDS, 2014), journals with a specific African regional focus may not be included in the mainstream search engines

possibly because of low/no impact factor, or because their focus is regional rather than disciplinary.

Indirect Impact of HIV and AIDS

The last and large theme – about 28 per cent of the selected research papers on HIV and AIDS – focuses on the indirect rather than direct impact of HIV on older people, with older women over-represented as the primary subject of interest. Older people have been affected indirectly by HIV in their role as caregivers to persons with AIDS, as carers of children orphaned as a result of one or both parents dying from AIDS, or indirectly through losing social, economic and instrumental support as a result of family or kin succumbing to AIDS (Knodel, Watkins and VanLandingham, 2003). Studies investigating the effects of caring for people with AIDS or caring for orphaned children dominate reported research on the indirect effect of HIV on older people (31 out of 35). These studies were largely consistent in highlighting the negative social, health and economic consequences for older people, based on self-reporting. However, two studies (Ice et al., 2010; Ice et al., 2012) that analysed biometric indicators to assess the effect of caregiving on the health of older people found contrasting results where caregivers reported better health outcomes compared with older people not providing care which was attributed to better socio-economic and wealth status among the caregivers. A number of studies examined the dynamics of living arrangement of older people as a result of mortality of a person with AIDS which impacts on the size and composition of households or families (Hosegood and Timaeus, 2005; Ssengonzi, 2009). One study that assessed a different aspect of the indirect effect of HIV on older people analysed the consequences of widowhood and found that unlike younger widows, older people were less likely to migrate from their matrimonial home or to remarry following the death of a spouse. Widowers were also more likely to remarry than widows (Ntozi, 1997).

Discussion

The key finding from this review is that research on sexuality and sexual health of older people in sub-Saharan Africa has largely been a result of awareness about the consequences and changing epidemiology of HIV and AIDS. In the field of public health, sexual behaviour and sexual health in this age group has consequently been viewed through the lens of epidemiology and clinical studies. Much less research attention has been given to other dimensions of the interrelationships between sexuality, health and wellbeing. The question we aimed to answer is to what extent are older people represented in sexual and public health research in sub-Saharan Africa?

This chapter highlights that the 1994 ICPD Program of Action, which advocated for reinforcement of reproductive health and rights is still guiding

population policies today. Adolescent sexual and reproductive health has been one of the additional sexual health emphases since this influential conference. Further, reducing maternal and child morbidity and mortality was reemphasised following the introduction of the Millennium Development goals in the year 2000 (Eager, 2004). The Millennium Development Goals (MDGs), HIV/AIDS and global health are currently at the forefront of the regions policies on population and health. Although the MGDs now include maternal, child and reproductive health goals and targets, healthy sexuality is omitted (Zeidenstein, 2009). An expert group meeting convened by the Ford Foundation and International Planned Parenthood recommended that sexuality be disentangled from reproductive health and identified two goals for attainment of sexual health and rights across the life course: 'healthy sexuality free from violence and discrimination' and, 'the highest possible standard of sexual and reproductive health and rights' (Kaufman, 2009, p. 77). However, while attention is given to early childhood and adolescence, the experience of men and women in later life is not explicitly noted (Tsui, Wasserheit and Haaga, 1997).

Availability of Data on Older People

The lack of attention on the sexual behaviour and sexual health of older people by researchers is also driven by the lack of data on which to conduct analysis. Only 39 per cent of the research papers reviewed focus exclusively on older people as the primary subject while for most of the studies (61 per cent), older people are included among other adults especially for studies with no upper limit on the cut–off age for eligibility. The dearth of data on older age groups is in marked contrast to the availability of data and knowledge about sexual behaviours and sexuality of people of reproductive age in sub-Saharan Africa, particularly women drawing from the interest in population control and the concern on uncontrolled rapid population growth (Taylor and Berelson, 1971; Ringheim, 2011). Nationally representative population and health surveys such as World Fertility Surveys (WFS), Contraceptive Prevalence Surveys and Demographic and Health Surveys (DHS) have been implemented in sub-Saharan Africa since the 1970s. The DHS are funded by the United States Agency for International Development (USAID), and between 1984 and 2010 around 236 surveys have been conducted out of which about half were implemented in sub-Saharan Africa (Short, Choi and Bird, 2012). These surveys generally restrict questions about sexual health to women aged 15–49 years and some surveys also include men with a slightly higher upper age limit, typically 54 years (Boerma and Sommerfelt, 1993; Curtis and Sutherland, 2004). The surveys were initially designed to monitor fertility and for evaluating family planning programs. Subsequently they have included a wide range of population and health topics. For instance, sexual behaviour, domestic violence and HIV/AIDS knowledge were added as major research components. However the studies are still largely restricted to the reproductive age group of 15–49 years for women and 15–54 years for men (Short, Choi and Bird, 2012).

Data gaps also exist in studies and surveys focusing specifically on the health and wellbeing of older people in sub-Saharan Africa. The WHO Study on Global AGEing and Adult Health (SAGE) surveys introduced in 2006–7 in four countries (Ghana; South Africa; Kenya; and Tanzania) collect detailed longitudinal data on the health and wellbeing of older people. One of the aims of the surveys is to explore the experiences of ageing in Africa. However, the topic of sexual health was not included (World Health Organization, 2012). A question on sexual drive and interest in sex was asked only of individuals reporting to have been diagnosed with depression (World Health Organization, 2006).

Demographic Surveillance Systems (DSS) are longitudinal and monitor the entire population of a defined geographical area provide platforms for conducting surveys and studies on older people. There are 32 such DSS sites in sub-Saharan Africa, located in 13 countries. About a quarter of the studies retrieved for review used data from a DSS and as highlighted in the results section, 56 per cent of the studies reviewed were conducted in South Africa, Uganda and Kenya which are countries with at least two DSS sites. The disadvantage of DSS, however, is that they cover a small geographical area and are mainly located in remote rural areas, and therefore are not representative of the general population at the sub-national and national level (Ye et al., 2012).

The types of quantitative empirical data available dictate the feasibility and the nature and scope of sexuality and sexual health research available on older people. Therefore, the limited sources of these types of data in addition to the assumption that sexuality is not important in shaping the lives of older people in sub-Saharan Africa may perpetuate the continued omission and missed opportunities for research (Nyanzi, 2011; Okiria, 2014). Ethnographic studies on sexuality in older ages also highlight the influence of religion particularly Abrahamic religions shaping the attitudes towards older people's sexual activity and sexuality (Agunbiade and Ayotunde, 2012; van der Geest, S., 2001). Sexuality in older ages is also genderd with that of older men encouraged whereas older women's sexuality is discouraged and also internalised by older people themselves (Chepngeno-Langat and Hosegood, 2012; Nyanzi, 2011).

Conclusions and Recommendations

This review of public health and social science literature shows that the sexuality and sexual health of older people in sub-Saharan Africa has been the subject of little detailed and in-depth analyses. The focus on fertility and reproductive aspects of sexuality imply that older people are omitted in favour of young and reproductive individuals. With life expectancy continuing to improve in sub-Saharan Africa and, with the current and future numbers of older people, addressing and understanding the sexual and health needs of older people becomes increasingly imperative. This review underscores the need to improve the evidence base by increasing the availability of detailed, high quality data on sexual health and sexuality in older

ages. Impetus to improve the evidence base, as well as including older people in sexual health research and health provision, is given particular urgency by the HIV epidemic in sub-Saharan Africa. A growing number of older people are living with HIV as a result of increased availability of treatment and the survival of people infected at younger ages (Hontelez et al., 2011) and new HIV infections are being acquired in later life (Wallrauch, Barnighausen and Newell, 2010; Mutevedzi and Newell, 2011). HIV-related studies have been the main contribution to African health literature on sexual behaviour in older life in the last decade. While these new data are welcome there is a need to recognise the impact that HIV research has in shaping the image of sexuality in older Africans locally and internationally. An image that is strongly framed by a sense of danger leading public health agencies to 'warn' women of the risks of acquiring HIV through sexual relationships with older men, and in which research attention on the patterns of sexual behaviour of older people is prompted by their acquisition or transmission of an STI and its attendant effects on ill health and treatment needs.

Our review also highlights the value of including older people outside the conventional reproductive age range when collecting sexual data in demographic and health surveys and population-based studies. But our review also highlights the 'silence' in the literature of accounts from older men and women about their own lives and health. There is a profound absence of literature describing how older men and women in contemporary sub-Saharan Africa understand their sexuality and sexual health. There is also a dearth of research that explores and responds to the intersection between ageing, sexuality and health for older women and men in the ethnically, socially, demographically and economically diverse populations across the region.

A more thorough evidence base on older people can be achieved by mainstreaming data on sexual health through eliminating the upper age limit set on studies collected to assess and monitor sexual behaviour and health in sub-Saharan Africa. The bias against older people can also be reduced by delinking sexual health from reproductive health and child bearing to also encompass non-fertility aspects of sexuality. Such avenues include the ongoing cross-sectional series of Demographic and Health Surveys and the Demographic Surveillance System, which also provide opportunities for panel or cohort studies. Whereas most of the studies we reviewed are descriptive, authors were unanimous in suggesting the need for interventions to address the health needs of older people. Therefore, other forms of evidence missing from the review are studies on evaluation and monitoring of interventions on sexual health and sexuality of older people. Implementation of interventions should be supported with data that is relevant and representative of the social and physical context, and the sexual and sexuality experiences of older people. For instance, the piloting of age- and context- sensitive interventions that incorporate policy-driven research in consultation with older people, would provide pertinent evidence base on later-life sexuality in sub-Saharan Africa. Research drawing on the voices and perspectives of older people themselves would also raise awareness of sexuality

and sexual health needs of older people. Sexual health of older people in sub-Saharan Africa should be prioritised along with other age-onset diseases and health conditions and one way is through multidisciplinary research bridging medical and social sciences practitioners and researchers.

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Chapter 4

Becoming Visible: De-Marginalising Older Lesbians in LGBT Ageing Discourse

Jane Traies

Introduction

The absence of older lesbians from LGBT ageing research (Heaphy, Yip and Thompson, 2003; Barker, 2004; Archibald, 2010; Traies, 2014) reflects a wider cultural invisibility (Kehoe, 1988; Neild and Pearson, 1992; Traies, 2009). This chapter uses data from a large-scale survey of the lives and experiences of lesbian-identified UK women over 60 to address that marginalisation and to challenge some prevailing cultural assumptions about older women, sex and relationships. Using a cultural studies perspective, the chapter begins by describing the wide diversity of lesbian partnerships beyond 60, including sexual relationships and older lesbian attitudes to sex. I then discuss the social context of older lesbian lives, including 'chosen families' and social networks. I conclude by considering what might result from making older lesbians more visible, and call for wider recognition of the importance of non-traditional affective bonds in older LGBT people's lives.

The study on which this chapter is based was carried out between 2009 and 2011, and collected a combination of quantitative data from a questionnaire survey and qualitative data from life history interviews and autobiographical writings. One of the interviews was with a woman whom, for the purposes of this chapter, I shall call Joan. She was born in London in 1930, became a secondary school teacher and, in her early twenties, married a fellow teacher. It was, she says, 'a very happy marriage'. Her husband was more than 20 years older than Joan, and died when their children were still of school age. After his death Joan went back to full-time work and, although she had many good friends, never met anyone else she wanted to marry. Joan's life was in many ways a conventional one: her career culminated in promotion to Deputy Headteacher, she was active in the Guide movement and in her local church, where she eventually became both a lay preacher and senior church steward. Nothing in this life prepared her for what happened when a new woman minister was appointed to the church. Working together on committees and a major development project, Joan and the minister became good friends and eventually, to Joan's surprise, lovers.

Up to then Joan would, if she had thought about it, have described herself as entirely heterosexual. In that respect her story is not exceptional: the large majority of women in my study – all of whom now identify as lesbians – had a

life-course trajectory which began in (more or less) contented heterosexuality and slipped, sooner or later, into same sex relationships. More than three quarters of lesbians report having had heterosexual intercourse at some point in their lives (Garnets and Peplau, 2006, p. 73). Fifty-two per cent of my survey respondents had been married, some for many years; what is unusual about Joan's story is that at the beginning of her first lesbian relationship she was 76 years old. I interviewed her four years later, just after her eightieth birthday, when she said, 'To be quite honest, it's still growing. It's still something very beautiful, for both of us' (Joan, born 1930).

This story, like any discussion of the sexuality of older women, presents many challenges to prevailing cultural assumptions (Traies, 2012). There are still 'huge cultural roadblocks' (Barker, 2004, p. 53) to the idea of older people, even heterosexual ones, as sexually active. Bildtgard (1998), for instance, has shown that to an overwhelming degree, the elderly are culturally depicted as having no sexual life at all, with sexuality being replaced by a need for tenderness and warmth. Because 'lesbian' is culturally constructed as a sexual identity and 'old' (particularly 'old woman') as an asexual identity, it is still difficult to situate older lesbian sexuality within any existing discourse other than the deviant or the pornographic. The (always heteronormative) stereotypes of old age allow no room for alternative sexualities: in a culture where every old woman automatically becomes a 'granny' – and therefore heterosexual by default (Neild and Pearson, 1992) – old lesbians cannot be imagined.

Healey (1994) noted that the 'lethal synergy' of ageism and heterosexism that makes older LGBT people forgettable is exacerbated by the sexism that makes old women invisible. Monika Kehoe (1986) also memorably described older lesbians as a 'triply invisible' minority, hidden from view by the intersection of these three oppressive discourses. The invisibility of older lesbians is complicated further if the people we are trying to see are not only hidden, but hiding. The fact that so many older lesbians are still wholly or partially 'in the closet' is often given as the reason why so little research into this group exists and why gay men are still more likely to be the subject of non-heterosexual ageing research.

The research project on which this chapter is based was designed to redress this imbalance in LGBT ageing research by producing a wide-ranging study of the lives and experiences of lesbians over 60 in the UK. The call for participation was initially emailed to several hundred people and organisations, including personal contacts, the mailing lists of lesbian organisations, national and regional lesbian social groups, organisations for the elderly and a variety of media contacts including local radio stations and the lesbian and gay press. I also distributed leaflets and postcards describing the project and giving contact details at various lesbian venues and at Prides. Because older lesbians have generally been thought to be reluctant to participate in research, every effort was made to emphasise confidentiality and, in the majority of cases, anonymity. My own identity as an older lesbian was made clear from the start. This strategy, together with others I employed, such as involving participants in the research design and feeding the

results back to them, have recently been recommended by Averett et al. (2014) as the most effective methods for research with older lesbians.

To encourage participation across the widest possible demographic, I made the questionnaire available both in hard copy (including a large print version) and online. A project website gave information about the research, several different methods of contacting me and a direct link to the online questionnaire. The questionnaire was also available by post or email. For those who did not want to write or could not email, I set up a dedicated confidential phone line (with a reassuring recorded greeting) for enquiries, questions and offers of participation.

The response was immediate and overwhelming, producing nearly 100 responses in the first week and 300 in the first two months. After six months there were nearly 400 completed questionnaires from all regions of the UK, as well as numerous offers of interviews. Time and resource constraints meant that not everyone who volunteered could be interviewed, so the remaining volunteers were offered the chance to write or record their life-stories, using a prompt sheet based on the guide I had devised for the semi-structured interviews. The final data-set comprised 372 completed questionnaires, 34 interviews and 11 autobiographies, making this the largest study of older lesbians to date.

The participants came from all regions of the UK, from towns and cities, suburbs and the countryside. Although the majority (83 per cent) described themselves as 'middle class', nearly half were born into working-class families. They had had a wide variety of jobs and careers. In these respects the sample could be said to have been fairly representative of the British population, as well as demonstrating the heterogeneous nature of the older lesbian community. The majority of the participants were in their sixties; however 12 per cent were aged 70 or over, and nine of these were over 80, making a significant contribution to a research field in which the 'oldest old' have been so thinly represented. Half of the women had been married; four out of ten had children.[1]

The overall aim of the project was to de-marginalise the lives of older lesbians within the wider context of non-heterosexual ageing studies. The data produced were wide-ranging, covering a variety of aspects of older lesbian life including physical and emotional health (Traies and Munt, 2014) and attitudes towards services for older people (Traies, 2012) and lesbian community (Traies, 2015). The present chapter is based on those subsets of the data which explored intimate relationships, sexuality and friendship.

Long Term Relationships

Just over half (55 per cent) of the survey participants were in intimate relationships with other women at the time of the survey (although only 42 per cent were living with a partner). The relationships varied greatly in the length of time partners had

1 A more detailed demographic analysis of the dataset can be found in Traies (2014).

been together. Fifteen per cent of participants had been with their present partners for more than 25 years; the longest current relationship reported was 43 years. For instance, Milly and Heather had been together over 30 years, as had Sylvia and her partner; Aine and Merle had recently passed their 20th anniversary. When I met Leo, she was grieving the recent death of the woman with whom she had shared life and work for 44 years. Their relationship had begun in the 1960s, in a time and place where they could tell no-one about it, and when social expectations might well have driven two women apart; but, Leo said, 'there was no question about anybody else, once we'd met. […] That was it' (Leo, born 1932).

A successful long-term partnership can nourish other people as well as the couple themselves. Irene, whose partner died after more than 30 years together, described them as 'lovers, companions and members of a "team" which concentrated on doing things for others'. She wrote about the way in which they:

> settled into a pleasing and satisfying routine, and over the 32 years we were together we gave friends and family – and ourselves – a really good time. We fostered cats, fed and watered the homeless, organised charity fairs, church sales and prayer groups and for nine years ran a group for Catholic (and other) lesbians (Irene, born 1929).

Andrea, 20 years younger than either Leo or Irene, had a different attitude to a long-term committed relationship:

> When my long-term partner and I got together, we mostly, almost always, eschewed being thought of as a couple; partly because when we were younger I think we looked towards older lesbians and (probably quite unkindly in some senses) thought 'We don't want to end up as a couple of old dykes like those are, two comfortable old people!' […] I think we still regarded ourselves as independent people who had chosen to live together (Andrea, born 1946).

Not all long-term partnerships lasted as well as Leo's. Irene's relationship grew difficult towards the end:

> Something got out of gear and matters between us began to deteriorate – very slightly and very slowly we had begun to drift apart while still retaining a genuine personal affection and a deep need for each other. In my case, I suppose it was the impulse which dogged every relationship I've ever had: the need for real independence and for time and space to call my own; no commitment and no ties. I just wanted my life to myself. It was an unspoken need, and it did not take into account what my partner wanted and needed. This was, probably, as I reached my 70s, and although extremely active felt less and less like travelling as my partner wanted to, and sex had become rather routine; she wanted other friends and different things to do outside the home. I ought to have seen it, and we ought to have talked about it – but we didn't. We began to go our separate

> ways, without ever separating; we loved our home and both of us wanted to stay together in it (Irene, born 1929).

Andrea also talked about the way in which a long-term relationship can become restrictive:

> One of the things I think is interesting these days about growing old in a relationship with somebody, is that you – I mean, we're all living so much longer, and so relationships are longer, and barring nasty unseens, we're mostly living through them – is that one of the things that I think I've rediscovered is the wish to come across as different to different and new people. And one of the things I've found most annoying is when my long-term partner will say things like, 'But you don't like yellow!', or 'But you don't do X, or you don't like Y'. […] I think it makes it very difficult for people to re-invent themselves in a good way as they grow older. […] And it's not necessarily that you want a new person in your life – maybe you want to *be* a new person in your own life, and your current life is stopping you! (Andrea, born 1946).

The diversity of experiences and attitudes reflected here shows that lesbian relationships vary as much in length, intensity and quality as heterosexual ones, and share many of the same challenges. The greatest difference, at the time of this research, was that it had not been possible for these partners to marry. Some of those in relationships had, however, registered a civil partnership.

Civil Partnership

Although over half the women in the survey were in a relationship with another woman, fewer than half of those had formed civil partnerships. Since civil partnership first became available in December 2005, older lesbians have been consistently less likely to register their partnerships than either older gay men or younger lesbians (Office for National Statistics, 2013). In 2005–6 the number of men over 60 entering partnerships was 5,319 as opposed to 1,944 women in the same age groups (ONS, 2013). At this time many older couples who had been together for a long time took the opportunity to register their partnerships; the average age at registration has dropped steadily ever since. The difference between the numbers of men and women registering has decreased over those years; numbers of male and female civil partnerships converged in 2009/10. However the statistics (Office for National Statistics, 2013) show that the discrepancy between men and women in the over-60 age groups persists year on year, with far fewer women than men over 60 entering into civil partnerships: in 2012 the figure was 778 men and 261 women.

My qualitative data suggest some explanations for these statistics, offering a variety of reasons why older women in committed lesbian relationships might,

or might not, want to register their partnerships. Rolfe and Peel (2011) have suggested that a major source of ambivalence for lesbians is that they support equal rights but want to resist dominant heteronormative cultural frameworks. Lesbian couples tend to be more critical than gay men of the heteropatriarchal associations of marriage (Peel, 2015), and of the potential of legalised same-sex unions to reinforce heteronormativity (Robson, 2009; Barker, 2012). Several interviewees expressed such reservations about civil partnership: Tamsin, for instance, saw it as a step on the road to a heteronormative assimilation of lesbian and gay people reminiscent of the 'legitimisation' that Vaid (1995) distinguishes from true 'liberation':

> I'm actually rather worried that all the focus on civil partnership – good as this has been – is defining us again as being 'just like everyone else, only same sex' – and actually we're not, necessarily (Tamsin, born 1947).

Fran dismissed the idea of civil partnership for several reasons, of which disapproval of 'the great marriage thing' was only one:

> Fran: Twenty-odd years! Twenty-two, I think … it's a long time. But we won't have a civil ceremony or anything. […] I think a lot of people do it because of complications about wills, and things like that, and there ain't no complication for us! Because I haven't got any family, and when I die, I don't give a toss what happens.
>
> Interviewer: And you don't feel any desire to …
>
> Fran: Flaunt it?
>
> Interviewer: … have a partnership for any other reason?
>
> Fran: No. I'm not sure – I don't know – why I don't want to go down that path … I mean, I know a lot of people do, and I'm sure there are sound political reasons for doing it – to show people that their relationship is just as valid as the great marriage thing – but I feel our relationship is valid anyway, I don't need to validate it! I suppose it's a good excuse for a good party [laughter] …
>
> Interviewer: I think a lot of women do think of it in terms of marriage, and they have political issues with that …
>
> Fran: Yes, I do, yes. I just don't want to. And [partner] feels the same, luckily. I mean, if [she] said to me, Look, I really want to do this, well I'd do it, for her. But for me, I don't feel I need to do that, really.

Fran's use of the word 'flaunt' recalls Peel's (2015) finding that lesbians were generally more critical of the consumerism and materialism associated with public relationship celebration than gay men. Like Fran, some interviewees simply did not see public affirmation of their relationships by mainstream society as necessary. As Andrea (born 1946) said, 'We felt that we didn't need that sort of public declaration of togetherness that the Civil Partnership seems to proclaim'. This attitude could be connected with the fact that, prior to the availability of civil partnership, lesbians and gay men had already found other ways of validating their relationships. Many created their own, usually entirely private, rituals or commitment ceremonies. Aine described how she and Merle 'got married' 20 years ago:

> This was in the March, after meeting in the November previously. We decided that we'd get wedding rings then, so we went in to respective jewellers … because they didn't have the sizes that we needed, they had one in one shop and the other size in the other shop, fortunately. And we bought our two rings, and then – we probably should have made more of a ceremony out of it – but in the middle of [the] High Street, at three o'clock in the afternoon, I gave you the one from me and you gave me the one from you! [they both laugh] And we wore them, ever since, after that. Except we got new ones when we had our civil partnership.

As this account suggests, Merle and Aine saw their relationship as a marriage in all but name.

> I do equate it with the marriage that you'd have – if heterosexual couples can get married, then why shouldn't we? (Aine, born 1941).

Civil partnership offered same-sex couples the opportunity to claim that equality: for Marguerite (born 1946), it was about 'being able to say […] that we could be responsible for each other in the way that everybody else can'. Another important reason for choosing to register a partnership was to clarify inheritance issues:

> And we could feel safe that if one or other of us died, there was going to be absolutely no problem about what was going to happen to our assets and pensions and all the rest of it (Marguerite, born 1946).

> And also, it's something to do with […] being able to leave your money. Because I had a lot of trouble last time, with the death duties (Merle, born 1945).

Shipman and Smart (2007) found that the significance of entering into a civil partnership was not driven purely by such instrumental reasons but by other more personal considerations such as love and mutual responsibility; however

they also acknowledged that these priorities shift over the life course. Attitudes to same-sex marriage and civil partnership vary between generations (Heaphy, Smart and Einarsdottir, 2013) and for older lesbians and gay men, legal and financial considerations such as pensions and inheritance tax can have greater significance than making a ritual declaration of love. Even for a couple who prefer not to disclose their relationship in all contexts, there are moments when official acknowledgment can be important:

> Aine: Merle felt that you weren't regarded as family, you see.
>
> Merle: That's right.
>
> Aine: And so we wanted to say that we *are* family, and I'm her immediate next of kin, and Merle's mine. That was probably … the legal bits that go around it are important.
>
> Merle: And when you go into hospital, you can say you're next of kin.
>
> Aine: I always put Merle down. And our doctor knows. But we don't go shouting it from the rooftops …

When women had decided to become civil partners after a long time together, they often expressed surprise that they 'felt different' afterwards:

> Yes, I think to our surprise we did! I mean, we wrote our own things we wanted to say, and we used other people's words as well, and … yes, even after all the years, it was very real, and did affect us very much. You know, we just felt that somehow we were altogether [pause] kind of more legitimate, because in the eyes of the world we could be totally upfront. It's strange … (Marguerite, born 1946).

Like the couples interviewed by Shipman and Smart (2007) these women found that public recognition had changed their lives in a positive way. Sally wrote about that difference in terms of a new sense of legitimation and confidence:

> [We] had our civil partnership registration in February 2006 and although we convinced ourselves that this was primarily just for legal and financial reasons in reality it was a very significant day for us and I recall a real sense of legitimation of us as a couple. The registry office is in the Town Hall […] and we were so well treated by all the staff we encountered. Being civil partners did give me a stronger sense of confidence particularly in relation to such things as booking a double room in a hotel or in filling in official forms. The fact that we had a legal partnership made a much greater difference than I had anticipated on this sense

> of legitimacy, and entitlement to things that heterosexual people take for granted (Sally, born 1950).

Although registering a civil partnership implies a public declaration, some women managed to do it very discreetly, without the knowledge of anyone beyond the registrar and their witnesses. Leo and her partner thought that was what they were going to do; in the end, however, it meant 'coming out of the closet' in a way they had never expected:

> So we thought we would do it very quietly. We had a couple of friends coming down to stay […] and we thought, 'Well, when [they] are here, they can be our witnesses, so we'll have it on that day'. […] I mentioned it to my brother, who lives in Australia, just as a matter of news. And the next day he rang up and said, 'I'm coming'. So if you have one relation, you have to ask the others … And I thought, 'Well they won't come, you know, because it's mid-week, and they've got children and jobs' … They all came. And they made a wedding cake; and you know … The whole thing was rather taken out of our hands. And then, of course –
>
> Interviewer: You're pleased, really, aren't you?
>
> Leo: Well, it happened, and you have to be pleased with what happened. And you know the banns, or whatever, have to be posted up […] but it was a bit of a shock to discover that all of [town] and most of [the county] would then discover. […] And obviously [our neighbour] had been discussing us … Anyway, we didn't have any more chance to be in the closet. I mean, everybody was terribly discreet, and congratulatory, and very loving, and they all, dammit, turned up, and packed the place. I mean, we'd invited quite a lot of people, but there were quite a lot of free-range characters who just came – and we weren't prepared for this. I hadn't even washed the car. It was all frightfully kind of impromptu and amateur – but it was great fun, and everybody was terribly nice. […] And we didn't expect it to make us feel different, but we did feel different.
>
> Interviewer: Oh, that's interesting. In what way?
>
> Leo: Well, that's a question that I cannot answer you.
>
> Interviewer: But so many people have said that to me.
>
> Leo: Yes, but I bet they haven't been able to define exactly what it was. And I know a couple of male friends who were married recently, and one of them found it different, but the other one didn't know what he was talking about [laughter]. So perhaps not everybody does; but we felt different. But I can't say more than that.

Leo's comments underline the way in which people differ in their need for the recognition, affirmation and legitimacy conferred by civil partnership. Consequently it is no more possible to generalise about older lesbians' attitudes to civil partnership than it would be to generalise about the attitudes of heterosexual people to marriage. However, unlike heterosexual people of their generations, older LGBT people have lived most of their lives in a social climate which not only denied them that legitimation of their relationships, but actively stigmatised them. Their diverse attitudes to the socio-legal changes represented by civil partnership must be seen as, at least in part, determined by their past experience.

Some survey respondents, who had experienced the death of a partner before civil partnership was created, told tales of suffering and discrimination arising from their lack of legal status:

> She died when I was on holiday and the relatives arranged the funeral to take place before I returned.
>
> Could not disclose our relationship, as her family were unaware of it, so the grieving was lonely.
>
> Could not talk to my closest friends about my grief as they did not know I was gay.
>
> Her family contested the will … tried to pretend we weren't lovers … (Anonymous survey responses.)

Same sex couples who reject the formal legitimation of their relationships remain vulnerable to this kind of discrimination. In the light of such experiences, it is sobering to reflect on the strength of conviction that continued to keep some of the women in the survey in a position which could prove legally, financially and emotionally so disadvantageous.

'Living Apart Together'

Although five out of ten women in the survey had partners, only four out of ten (42 per cent) were living with them. One in ten of the participants was a 'LAT': 'living apart together' in what Levin (2004, p. 223) has called a 'historically new family form'. Stonewall (2011, p. 6) recorded a similar proportion of older lesbian, gay and bisexual people living apart from their partners: three times as great as the number of heterosexual older people in the same living arrangement. Because Joan and her partner are prominent members of a Christian congregation, this affected their decision about where to live when they became a couple:

> Joan: We decided quite categorically that we would not live together, because we thought that wouldn't be a good idea as far as the Church was concerned. They would look and say 'Ah, well, you know! They were very good friends!'
>
> Interviewer: How often do you see each other?
>
> Joan: Most days. […] We sleep in each other's houses most nights, but there's usually maybe one night when we don't – mainly because of what we're doing the next morning. Something of that sort. Or she's going to her daughter's, and stays overnight. So yes, I suppose most nights we're together. Very little during the day – we both do our own thing in the day. And if she goes to the family, or if I have family, then that's fine (Joan, born 1930).

Joan and her partner live apart because they feel they need to conceal the nature of their relationship. They are not unique in this decision. However, couples choose not to live together for a range of reasons (Heaphy, Yip and Thompson, 2003); for women, it is just as often a matter of preserving freedom and independence. Interviewee Barbara compared her own view to that of a woman in the television documentary *Women Like Us* (1990)[2]

> There was one in *Women Like Us*, who'd not broken up with her partner, but had broken up the housing relationship, saying, 'I'm 60, I don't want to live with someone else anymore'. And I thought, 'Yes that has a point' (Barbara, born 1936).

Some women enjoy a close relationship but had come to value their own space:

> I certainly don't want to live with anyone again. I don't want anyone to live here with me again. And that was good with [ex-partner], because she didn't want anyone to live with her, either! And she was only 20 minutes away (Crunchy, born 1939).

For Jen, the situation evolved over time, and was influenced by the fact that her partner had a child still living at home:

> We've both had dreams of living together, but they've never coincided. I wanted her to leave [husband] and come and live with me, and then she said, 'No, I need to live on my own, I have never lived on my own'. And actually she still had one son who was very attached to her, so she and [son] went to her house. Then she wanted us to live together, after [son] went to University, and I by this time had decided I rather liked how we were, so I said no! And then we developed

2 Broadcast as part of Channel 4's *Out on Tuesday* series, this rare media representation of a group of old lesbians was fondly remembered by many of the interviewees.

> this pattern of living on our own in the week and at her house at weekends. It was meant to be alternate, but it doesn't work at my house, it absolutely doesn't (Jen, born 1942).

Julia didn't expect to go on living on her own when she met Philippa:

> I think when our relationship started, my expectation would have been that we'd eventually live together, and it then became clear to me that that wasn't what Philippa did. And I had to have a bit of a tussle with myself about that, because I actually think it's more fun, and less strain in some ways, to live with somebody, in that you're kind of grounded in your unit, you know, you share expenses … I think it gives a more emotional togetherness … I think it's a more natural way of living.

She still has mixed feelings, but has come to see Philippa's point of view:

> Well, emotionally I'm still drawn towards the idea of living with a partner, but if I really think about it, I did that with all my previous partners, right up until [previous partner] died, but then I was five years on my own, and I had my own place … Then it's difficult, isn't it? You start thinking, 'Oh, I'd have to sell my property, I'd have to get rid of some of my possessions … ' And none of these things should be important, but […] as you get older … As much as I would like to have the emotional security of being in a property together, it's all very well when things are going well, but then what happens in a worst-case scenario? So, it's a difficult one … For me I think I'd have to say that living with someone is the ideal in my head, but would it work out? I don't know. And it certainly won't work out if the other person is not used to doing it, so one just has to be a bit realistic about it, I suppose (Julia, born 1948).

These alternative living arrangements are ways in which older lesbians can be seen as contributing to wider changes in 'the staging of everyday life' (Beck and Beck-Gernsheim, 2002, cited in Almack, Seymour and Bellamy, 2010, p. 810). The erosion of traditional constraints and conventions is a theme in current sociological debates about the increasing diversity of family lives; Roseneil and Budgeon (2004, p. 128) have suggested that 'visible, "out" same-sex relationships, and the related reordering of the sphere of sexuality' have contributed to a 'significant challenge' to the notion of the conventional family. Heaphy, Yip and Thompson (2003) see the lives of older non-heterosexuals as an indicator of experiences that increasingly cut across the homo/heterosexual dichotomy. In other words, heterosexuals are beginning to make families in ways that lesbians and gay men already know about. Giddens (1992, p. 135) called people in same-sex relationships 'prime everyday experimenters', because they have been at the forefront of these social changes.

Recently-formed Relationships

Not all the partnerships reflected in the data were as long-lasting as some of those described above. The shorter – and therefore newer – relationships were in some ways more remarkable than the long-term ones, because of the way in which they challenged prevailing stereotypes of the sexless older woman. Eleven per cent of the intimate relationships reported in the survey were two years old or less, and five per cent were less than a year old, showing that some lesbians go on finding new sexual partners well into their 60s and 70s. This means that they also go on experiencing the pain of relationships ending; more than one interviewee described a recent break-up.

> Interviewer: Because you must have been – what? – in your late 60s, when you got together with [ex-partner]?
>
> Crunchy: Yes, 69 I was. […] I'm going to a barbecue, not this weekend but the next … this woman who fancies me, but I don't fancy her at all […] And she's very attractive and everything else, but I don't fancy her. I still fancy [ex-partner], I expect, that's why. But I'm going to her barbecue, anyway. And she's always emailing me and ringing me, and stuff like that (Crunchy, born 1939).

Crunchy, speaking here in her early 70s, was not unique among the interviewees in telling a story which contained both the pain of recent parting and the possibility of a new relationship in the future.

Sex and Sexuality

There has been little or no life course research about lesbian sexuality, despite the fact that 'most women who are not heterosexual have a "coming out" story of sorts, which focuses entirely on sexuality over the lifespan' (Rothblum, 2000, p. 202). Nonetheless the small amount of data available (Kehoe, 1988; Adelman, 1991; Help and Care Development Ltd., 2006) show that lesbians over 65 do remain sexually interested and active, though evidence for those aged 70 or more is 'extremely skimpy' (Barker, 2004, p. 53). My survey confirmed these earlier findings and supplied new data for the oldest age groups.

The definition of 'intimate relationship' given to respondents was 'one which is both emotional and physical/sexual'. The percentage of women in the survey who were currently involved in an intimate relationship with another woman decreased with age: but four out of ten women over 70 and three out of ten of those over 80 reported being in such relationships. Respondents were also asked, 'Over the last year, how often were you physically sexual with another woman?' One in five women said monthly or more often; one in ten said once a week or more. Of course, these results beg the question of what counts as 'sex' to a lesbian

(Richardson, 1992). Rothblum (2000) has suggested that lesbian sex remains misunderstood because 'sexual behaviour is still defined in genital ways that may not accurately reflect the totality of women's sexual experiences' (p. 203). Garnets and Peplau (2000) make a similar point: 'Researchers and theorists who attempt to generalize about sexuality and sexual orientation in both men and women often take male experience as the norm and ignore unique aspects of women's lives' (p. 181).

Indeed Marilyn Frye (1991) sees the very terms 'sex' and 'having sex' as so ineradicably phallocentric in their cultural definition that they are inappropriate to describe that gamut of 'emotional intensity, excitement, bodily play, orgasm, passion, and relational adventure' that constitute the acting-out of lesbian desire. She pours scorn on the idea that it is possible to say how many 'times' lesbians have 'had sex', asking (1991, p. 2), 'What does he think he means, "times"? What will we count? What's to count?' Garnets and Peplau (2000) see the need to establish 'a new paradigm', one that 'recognises the great diversity of women's erotic experiences and the many sociocultural factors that shape women's sexuality and sexual orientation across the lifespan' (p. 181). Until that diversity is recognised and described, '[w]omen's sexuality is an area where we don't even know what most of the questions are, let alone the answers' (Rothblum, 2000, p. 203).

Framing the survey questions on this topic was therefore something of a challenge. In the end I decided, for the reasons above, to avoid the phrases 'having sex' and 'how many times?' and to borrow my wording from Kehoe (1988), who asked, 'How often in the past year were you physically sexual with another woman?' Even so, one respondent wrote: 'Not sure how you are defining physically sexual. If intercourse, a few times; if hugging, kissing and being close, all the time' – a response that in its turn raises the question of how this lesbian defines 'intercourse'. The comments in the 'Other' box for this question also included 'Cuddles and kisses' and 'Physical affection but not actually sexual'.

Whatever lesbian sex is, however, the survey data show that it happens a good deal after the age of 60, and remains a significant part of women's lives and identities. Asked about the importance of sex in a lesbian relationship, while eight out of ten women said it was the 'main part' or 'an important part' of a relationship when they were younger, six out of ten still rated sex as an important part of a lesbian relationship after the age of 60. These findings resonate closely with the data produced by Help and Care Development Ltd. (2006, p. 37), 76 per cent of whose participants said they still had sexual needs, while half said an active sex life was important to them.

Just under half of my survey respondents (47 per cent) had not been sexually active in the previous year. This was not always because they were single; one respondent described her situation as: 'living with partner but sex not featuring much at present'. Of the women in the survey who were not sexually active, four out of ten said it was not by their choice. Life writer Kathryn and her partner were in this situation; their relationship had not been sexual for the last five years. She wrote: 'One thing I miss now […] is to have sex again, and yes I would cheat

on her, as I need it, but I also love her in so many other ways, as one does in a complete committed relationship'. Kathryn saw her age as a barrier to meeting new sexual partners:

> But at my age although I feel very young and have a young outlook, where can one find women to have some fun? Most of the clubs are for young people and most of the adverts in *Diva* are the same. […] I don't want to leave my life partner, I just want some sex; unlike men, and the straight scene, there are no cruising grounds for women (Kathryn, born 1949).

Others, however, say they are content to be celibate now. Interviewee Chris said she was happy with her single state: 'I've been single for nearly five years, and I enjoy it! […] We all miss certain things obviously … the companionship side of it … but I've got some darned good friends from many years ago, most of my friends I've known for at least five or six years'. Even so, she hinted that she has not entirely ruled herself out of the dating game:

> But maybe one day, who knows? It's never too late … I'm very much visible, in as much as I do go out and about, I go to clubs and things. I still like my dancing. I can still show them how it's done, even if I can't get up off the floor again! [laughter] Yes. I still keep going (Chris, born 1946).

Before leaving the subject of older lesbian sexuality, it is worth noting that three of the participants had never had a sexual relationship with a woman, but still claimed a lesbian identity. As historians such as Jennings (2007), Doan (2001), and Doan and Garrity (2006) argue, lesbianism is a culturally-produced identity that embraces more than the physically sexual. The data strongly support the idea that 'being' lesbian involves not only a sexual but also a social and emotional life that is woman-centred.

Families of Choice

Older lesbians share the experiences of loneliness and isolation common to other old people, but are more likely to be childless and to live alone than either heterosexuals or gay men (Stonewall, 2011). Half of the survey respondents (49 per cent) lived alone; six out of ten (58 per cent) had never had children. For these reasons older lesbians may be more vulnerable to loneliness than other groups. However there is also much evidence in the data for the existence of strong social and support networks for among older lesbians. Groups of friends emerge as crucially important support structures in the lives of many of the participants. They appear in the data two overlapping forms – personal friendship networks (or 'families of choice') and organised or semi-organised lesbian social groups.

The idea of 'friends as family' is often associated with lesbian, gay and bisexual lives. Kehoe (1988), Weston (1991), Weeks, Heaphy and Donovan (2001), Barker (2004), Almack et al. (2010) and others have written about the importance to older lesbians and gay men of these 'families of choice' or 'chosen families'. An older lesbian's 'chosen family' will sometimes consist entirely of other lesbians and gay men; more often it will be 'a mix of social and biological family links, friendships and inter-generational connections' (Almack et al., 2010, p. 916). In the case of many older lesbians, ex-partners and the relatives of partners and ex-partners may be members of the family of choice. Very often a lesbian's previous partner or partners are her among her 'significant others'. One of the oldest interviewees, Monica, described her most important relationship like this: 'There were, like, two phases in our relationship, when we were together physically, and when we were together just as friends. So until she died, I was friends with her, and I used to go and see her, and go and stay with her' (Monica, born 1922). Becker (1988) theorised that the experiences of stigma that lesbians have shared means that even after parting they have more in common than other people:

> Because lesbians are a stigmatised minority group, lesbian ex-lovers are united to one another by a bond of sisterhood. As lovers, they have fought for acceptance and understanding from their nuclear families, their children, their colleagues, and their neighbours. Having grown up in a homophobic environment, they have shared a battle against internalised homophobia as well. […] Lesbian ex-lovers remained connected by an overriding common cause – that of combating negative stereotypes of themselves, their relationship, and their lifestyle (pp. 212–3).

Keeping in touch after parting can also leave the door open for the healing of old wounds, sometimes many years later. Interviewee Crunchy nursed an ex-partner who was dying of cancer. They had parted years before, but: 'I was so pleased that my life worked out that I was around to look after her. Because she wouldn't have wanted anybody else bathing her, and stuff like that. […] And it was lovely, really. It was sad, but it was lovely, you know?' (Crunchy, born 1939). Such stories illustrate the 'bond of sisterhood' (Becker, 1998) between women who have once been lovers and have remained close friends: relationships which are very important to many older lesbians but can be entirely unseen – and therefore unvalued – by those outside the LGBT community.

Older Lesbian Networks

Many older lesbians have a social circle which is almost exclusively lesbian: six out of ten survey respondents (57 per cent) said, 'Most of my closest friends are lesbians'. Eight out of ten (81 per cent) said, 'Most of my closest lesbian friends are within 10 years of my age' and nearly half (47 per cent) said that they saw their closest friends once a week or more often. Data from the interviews also

suggest that many older lesbian friendships operate within close-knit groups and have lasted for many years. Eight out of ten survey respondents (82 per cent) had belonged to a specifically lesbian social group at some time; more than four out of ten (45 per cent) still did. Many of these groups started at a time when lesbians led deeply closeted lives and there were limited opportunities to meet other women. They helped to build communities where a woman could develop and maintain a lesbian identity and lifestyle. Many groups still exercise a good deal of secrecy around their existence and the identities of their members. They operate mainly at a local level and are often highly organised, through newsletters, email groups, social media and so on. Participants often belonged to more than one group, so that the lines of communication, both formal and informal, between individuals and groups make up a far-reaching web of connections. The rapidity and geographical spread of the response to my survey (see above) suggested that such networks are not only numerous and widespread but also interconnected, so that older lesbian knowledge can be quickly and efficiently shared. This networking forms a community of identity for many older lesbians.

In spite of the persecution and oppression experienced over their life course, 78 per cent of survey respondents described themselves as happy and in good emotional health. Among the strategies they have developed over the life-course in order to achieve this resilience, the long-lasting and supportive friendships described here have been crucially important, and bear witness to the strength of bonds formed within a hidden and stigmatised community.

Conclusion: The Implications of Invisibility

If, as Dyer (2002) has asserted, how we are seen determines how we are treated, then those who are not culturally 'seen' will be treated as if they do not exist. In spite of the increasing visibility and social acceptance of the LGBT community in the UK, many older lesbians can, for all the reasons given at start of this chapter, remain invisible to the mainstream population. This has consequences not only for history (their stories are lost) but for themselves as human beings (their identities are erased). As they grow older and require the support of services for older people, important aspects of their identities will be invisible to service providers. Does that matter? I would argue that it does, and that it is necessary for the well-being of older lesbians, as for other people of alternative sexualities, that their experiences and significant relationships are recognised and understood.

The research data described here prompt questions that challenge cultural assumptions and demand acknowledgement of uncomfortable facts: that old women are still sexual beings and many are sexually active; that falling in and out of love are not the sole province of the young, or even the middle-aged; that some old women fall in love with other women. Such facts require that society in general, and service providers in particular, recognise and respect a wider range of significant personal relationships and their importance in the lives of LGBT

people approaching the end of life. These relationships include not just the ties that are recognised in law (birth- or adoptive family, marriage, civil partnership) but also those that might have been invisible until now: chosen families, life-long friends, ex-lovers who became 'family'. For older non-heterosexuals, such relationships are key to both well-being and identity. In particular, if these significant relationships are not understood by the providers of health and social services, older lesbian, gay and bisexual people run the risk of being deprived of emotional and social support at one of the most vulnerable times of their lives.

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Chapter 5
Sexual Identity Labels and their Implications in Later Life: The Case of Bisexuality

Rebecca L. Jones

Narratives about sexuality, including those which involve sexual identity labels, are always historically, socially, politically and culturally located (Foucault, 1976; Giddens, 1992; Plummer, 1995; Weeks, 2007). In later life, any older person is likely to have lived through several changes in which sexual identity labels are widely known, which are favoured and which considered insulting. Sexual identity labels may also mean different things at different life stages and to different people signifying, for example, desire, performance, political affiliation or partner choice. The labels someone uses to describe their own sexuality may have changed over the course of their life. Indeed, labelling one's sexual identity at all may be a change – one consequence of the rise in the visibility of non-heterosexual sexualities has been an increased awareness of heterosexuality itself as a sexual identity (Katz, 2007). Over a long lifetime, someone's sexual preferences may also have changed, with or without change to any labels they use to describe their identity. This makes later life a particularly fruitful site for the consideration of sexual identity labels.

Debates as to the benefits and disadvantages of using sexual identity labels are well established in sociology, psychology and related disciplines (Fuss, 1991; Young and Meyer, 2005) especially around Queer Theory and other deconstructive approaches which argue for a radical destabilising of all identity categories (Butler, 1990, 1991; Seidman, 1997; Warner, 1991). This chapter does not aim to add to these arguments. Rather, it builds on Weeks' (1995) concept of 'necessary fictions' to argue that different approaches to sexual identity labels are appropriate for different contexts. Sexual identity labels are understood to be always oversimplifications but also often powerful and useful. This chapter uses the example of one relatively familiar sexual identity label, 'bisexual', to add to the growing debate about the use, limitations and implications of sexual identity labels in later life (Cronin and King, 2010; Cronin et al., 2011; Heaphy, 2005, 2007; King, 2014; MacKian and Goldring, 2010) and also in order to add to the very limited literature on bisexual ageing.

Definitions of bisexuality vary and have different implications. For example, one common definition 'attraction to both men and women' is argued to be problematic because it assumes binary gender (Barker, Yockney, et al., 2012; Bowes-Catton, 2007). This chapter defines bisexual as 'attraction to more than one gender or attraction regardless of gender'. This allows for more than two genders and also

includes people for whom gender has very little relevance to their attractions. 'Attraction regardless of gender' also carries the possibility of decentring gender as the organising system through which sexuality is understood, a project that may have particular relevance to bisexuality (Barker et al., 2008; Gurevich et al., 2007).

Studies of sexuality which privilege sexual identities over sexual behaviours or sexual attractions can be problematic for all sexualities, due to the often imperfect match between identities, behaviours and attractions (Jones and Ward, 2010) and the danger that those who claim particular sexual identities are seen as more central to a category or more authentic than those who do not. Privileging sexual identity is especially problematic for studies of bisexuality because there appear to be many more people who have sexual and romantic relationships with more than one gender than people who claim the identity of bisexual (Barker, Richards et al., 2012; Rodriguez-Rust, 2000).

While the numbers of people in their 50s and older who might tick a box marked 'bisexual' on a survey are thought to be very small, the numbers of those who, over the course of a relatively long life, may have had relationships with more than one gender are likely to be much higher. Life review in the context of an awareness of finitude, perhaps after the death of a long-term partner or around retirement, may cause people to reconfigure their past history (Ruth, Birren, and Polkinghorne, 1996). This reconfiguring might have a variety of results in terms of sexual identities, one of which might be to make the label of bisexuality seem personally applicable in a new way, although the common stigmatisation of bisexuality as an invalid and inauthentic sexuality (Gurevich et al., 2007; San Francisco Human Rights Commission, 2010) makes this relatively unlikely. However, this chapter argues that, notwithstanding the necessity to respect individuals' own choice of identity labels, there may be analytic scope to note bisexual behaviours over a life course in a way that makes bisexuality more visible as an act and a desire, particularly in an ageing context.

This chapter uses a vignette about an older woman whose sexual identity has changed several times over the course of her life to explore issues around the nature and functions of sexual identities across the life course. Vignettes have a long history of use in social science research (Finch, 1987) and have been used both to facilitate the collection of data and as a representation of already-collected data (Spalding and Phillips, 2007). Ely et al. (1997) taxonomise vignettes in qualitative research as 'snapshots', 'portraits' or 'composites'. The vignette presented here is a composite in that it does not represent a single event or individual, but instead represents the findings of a variety of research studies (e.g., Barker et al., 2008; Diamond, 2008; Klein, 1993; Rodriguez-Rust, 2000; Weinberg, Williams and Pryor, 2001) and also the shared understanding of members of a UK-based bisexual community. This vignette, alongside others which do not focus on ageing (see Jones, 2010), was composed initially by the author and then reviewed and refined by approximately 25 people who were active in a UK-wide bisexual community and by UK academics doing research into bisexuality. This review process took place partly online and partly during a workshop at a conference attended by

academics, practitioners and members of a bisexual community (BiReCon 2008[1]). These reviewers helped refine the vignettes and agreed that the final versions were plausible, authentic and realistic.

The vignette enables the discussion of some issues around the use of sexual identity labels across the life course and the distinctions between identities, behaviours and attractions. This adds to the scant literature on bisexuality and ageing (Dworkin, 2006; Firestein, 2007; Jones, 2011, 2012; Weinberg, Williams and Pryor, 2001). However, examining bisexuality from a late-life life course perspective is also useful to the study of sexuality more generally. There are practical implications for this, for older people's everyday lives and especially when they are using health and social care services, as well as more theoretical ones suggesting lines of future enquiry.

A Vignette: Muriel

In order to exemplify and make more concrete these theoretical issues, this paper draws throughout on the following vignette about an older woman living in the UK.

> Muriel is 78. When she was a girl she had a series of intense 'crushes' on older girls but she met her husband-to-be when she was 18 and quickly fell in love with him. They got married and had three children. When Muriel was in her early-30s, her husband divorced her.
>
> When she was in her late-30s Muriel joined a women's consciousness-raising group. In the group she came across the idea of lesbianism, which she had never heard discussed before and she met a woman, Pat, who already identified as a lesbian. Muriel was strongly attracted to her and before long they had started a relationship. After Muriel's children had left home, they lived together for several years, and became a familiar couple on the local lesbian scene. Pat developed breast cancer and, after many difficult months, she died. Muriel got a lot of support from her circle of lesbian friends and from a local voluntary organisation which supported lesbians and gay men who had been bereaved.
>
> Some months later, to her astonishment, she fell in love with a man, Colin. Her friends were very disapproving of her new relationship and gradually cut contact with her. The new relationship flourished, although Muriel recognised that she was still attracted to women too and missed her old circle of friends, especially as she was still grieving for Pat. She didn't feel able to keep using the bereavement service because she no longer seemed to count as a lesbian.
>
> In the mid 1980s, Muriel came across the idea of 'bisexuality' and started calling herself bisexual. After some years, the relationship with Colin ended amicably and Muriel met another woman, Joan, and went back to thinking of herself as lesbian because that was Joan's identity and she expected this to be the final relationship of her life.

1 See: https://bisexualresearch.wordpress.com/birecon/birecon-2008/

Last year Joan died and Muriel experienced some major health problems. She started receiving home care. She gets on well with one of her regular carers who asked her about the photos she had up around the house of her former partners. Muriel answers honestly but is horrified to discover later that her carer has spread malicious gossip among her colleagues about her past, saying that Muriel had been sexually predatory and promiscuous.

Source: first published in Jones (2010), reproduced with permission.

The vignette represented here is a fictional representation of many people's experiences, not genuinely 'Muriel's story'. However, as O'Dell et al. (2012) argue, the use of vignettes need not imply positivist epistemologies where the vignettes truthfulness or not is the key issue. Rather, as they argue, vignettes can be understood as inherently poly-vocal, allowing those who respond to them to make their own meanings. It is for this purpose that this vignette is included in this chapter, as a tool to help make visible the different implications of different theorisations of later life sexuality, and of bisexuality in particular.

Stories about sexuality, such as 'Muriel's', have often been used as a tool to explore the ways in which sexuality is socially constructed, and are argued to be a particularly persuasive and powerful form of culturally-recognisable sense-making (Crawley and Broad, 2004; Plummer, 1995; Saxey, 2008). Vignettes are also argued to be an effective means of exploring potentially unfamiliar and complex social issues, by making them more concrete and comprehensible (Northedge, 2002). They help what might otherwise appear abstract and rarefied become more relevant and applicable.

Sexual Identity Labels Across the Life Course

Which sexual identities are claimable and claimed is both historically and socially contingent. Historical studies have shown that the meanings and experiences of non-heterosexual sexual activity have varied hugely in different time periods (Bullough, 1997; Foucault, 1976; Norton, 2006). The language people use to describe and to think about their sexual desires is strongly affected, although not completely determined, by the time and place in which they live. Someone who, like Muriel, is now in their 80s in 2015 and lives in the UK, has lived through huge changes in the visibility of LGBTQ sexualities and also in the terminology that is used to discuss them. For example, the reclaimed term 'queer', which is favoured by some LGB&T people as an inclusive umbrella term, may not be acceptable to many older people because of their personal experiences of hearing it used as a pejorative term. Some of these changes in which sexual identities were claimable

in the UK in the twentieth and early twenty-first centuries can be seen in Muriel's story and can be represented in the following timeline:

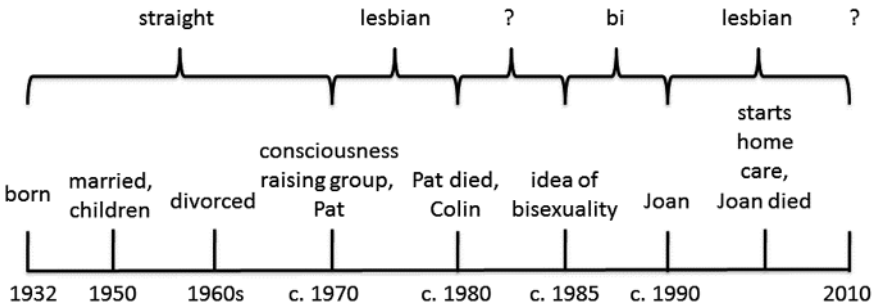

Figure 5.1 Timeline of Muriel's story

While there were women identifying as lesbians and even a few lesbian clubs in the UK in the 1940s and 50s (Gardiner, 2003), as well as a thriving publishing genre of lesbian pulp fiction (Foote, 2005), it was possible for someone like Muriel, following a conventional life course of marriage and children, not to have really encountered the possibility of lesbianism until she joined a consciousness-raising group. Consciousness-raising groups are of course also very much of their time and were a common route into identifying as a lesbian for many women who went on to claim that identity for the rest of their lives (Scicluna, 2013). However, for Muriel, that identity was challenged when she fell in love with Colin. The vignette states that she had a period of uncertainty about what sexual identity to claim until she encountered the notion of bisexuality. As this suggests, sexual identities and sexual practices may not be neatly aligned. However, this too did not prove to be a lasting identity for Muriel because she went back to identifying as a lesbian when she met Joan. The vignette does not reveal what, if any, sexual identity Muriel draws on in her current stage of life after Joan's death but it is clear that the fact that her past has been non-normative creates stigma.

Labelling oneself with a particular (non-heterosexual) sexual identity can carry psychological and material benefits for individuals. As the now-large genre of coming out stories attest (Herman, 2005; Saxey, 2008), finding a name to apply to your desires and experiences, and thereby a sense of community, can be hugely personally valuable. Muriel had identified as a lesbian for many years by the time Pat died and the vignette states that she and Pat were part of a local lesbian community. This good match between the sexual identity label that Muriel claimed and the gender of her partner (female), meant that Muriel was able to draw straightforwardly on the support of her friends in coping with Pat's death. It also meant that she was able to access a specialist bereavement service targeted at lesbians and gay men, an important benefit in a heteronormative world where the

loss of a same-sex partner may be misunderstood or treated less seriously than that of a different-sex partner (Dworkin and Kaufer, 1995).

Claiming a non-heterosexual sexual identity can also carry great benefits at a political and societal level. Work by LGB&T activists from the 1960s onwards has used shared identities to assert common experiences of discrimination and exclusion, and to press for, and achieve, significant legislative change (Eaglesham, 2010), which has materially and psychologically improved the lives of many LGBTQ people. Claiming non-heterosexual sexual identities has led to new possibilities for forms of sexual citizenships (Weeks, 2007).

However, claiming sexual identities can also be problematic. Individuals may dislike the connotations of particular identity labels, may feel that they misrepresent their own sexuality or may experience any attempt to categorise their sexuality as unwelcome (Barker, Richards, and Bowes-Catton, 2009; Ochs, 2007). Queer Theory (e.g., Butler, 1990, 1991; Seidman, 1997; Warner, 1991) argues that all identities, including those of sexual minorities, are performances of everyday life. It draws our attention to the differences that exist between people who claim a particular identity, such as 'woman', 'lesbian' or 'transsexual' and aims to destabilise apparently natural identity categories. A queer reading of the vignette about Muriel might focus on the mismatches between Muriel's sexual practices and attractions and the categories available to her. It might focus on the fluidity of her identities and experiences, in order to draw attention to the ways in which all sexual identities have regulatory effects. Muriel's story is certainly conducive to such a reading.

Importantly though, such an approach, emphasising difference and the instability of identity labels, can make it much more difficult to organise politically and to recognise common problems and needs (Jones and Ward, 2010). Analysing the vignette about Muriel in this way is not conducive to more practice or policy-focused tasks, such as increasing understanding of bisexuality in order to challenge the view of bisexuality as predatory and promiscuous that her home carer invokes. If the vignette about Muriel were being used in a workshop for home carers that aimed to deepen their knowledge of LGBTQ clients, an approach that treated her unproblematically as a bisexual person might be judged to be more useful than one that problematized all identity labels.

Weeks' (1995) concept of 'necessary fictions' can be a helpful way of reconciling these different approaches to identity. He argues that non-heterosexual sexual identities are necessary because the sense of belonging that they help create may be crucial to the lives and interests of LGBTQ people. But Weeks argues that these identities are also fictions because they are always an oversimplification – they are never able to fully convey the lived experience of sexuality. They are also products of their particular historical time and social context. Thus sexual identities matter immensely, but are also always provisional and an imperfect reflection of people's lives. In some contexts it may be appropriate to use identity categories as if they were relatively fixed and stable, in others it may not. King (2014) advocates a similarly provisional approach to the use of sexual identity

labels when he paraphrases Butler (1991, p. 14): 'one can appear under the sign "older LGB adult", but it should be permanently unclear what precisely that sign signifies'.

It is this approach that this chapter uses – sometimes identity labels such as 'lesbian', 'gay' and 'bisexual' are used as if they map fairly straightforwardly on to groups of people, in order to explore what might be distinctive about the experiences in later life of people who are attracted to more than one gender or experience attraction regardless of gender. However, at other points the terminology is problematized and a more complex understanding of sexuality is drawn on.

Vignettes themselves can be conceptualised as 'necessary fictions', just like sexual identities. They oversimplify the detail and complexity of real lives and appear to fix and solidify them into, for example, 400 carefully-chosen words. This is a further reason for the use of a vignette in this chapter.

Identities, Behaviours or Attractions?

Much sociological and psychological work on sexuality has focused on the formation and negotiation of identities (Crawley and Broad, 2004; Diamond, 1998, 2008; Fruhauf, Orel, and Jenkins, 2009; Herman, 2005; Plummer, 1995; Rivers and Gordon, 2010). Furthermore, much of the empirical literature is based on studies of people who self-identify as bisexual, lesbian or gay, partly because it is hard to access people who behave non-heterosexually but do not so identify (Jones and Ward, 2010). However, as has already been indicated, identity is not the only aspect of sexuality that can usefully be considered. Research that focuses only on identity, or recruits respondents only through these identity markers, risks missing whole groups of people. For example, researchers might be interested in how women who have lost a same-sex partner recover from their bereavement. If their recruitment literature called for lesbians to contact them, Muriel might not have felt that she fitted the criteria after she had met Colin, even though the researchers might have wanted to talk to her.

An alternative approach, most often found in sexual health work and with its roots in the HIV/AIDS crisis in the West in the 1980s, is to focus on sexual behaviours, setting aside questions of identity (Boellstorff, 2011). The terms 'MSM' (men who have sex with men) and the less commonly-used 'WSW' (women who have sex with women) represent attempts to do this (although there is also evidence that MSM is used by growing numbers of men as an identity label, see Boellstorff, 2011). The hope in relation to sexual health work is that using terminology that describes behaviours rather than identities will enable people who are in need of information or services around same-gender sexual practices but do not identify as gay, lesbian or bisexual to still access them (Young and Meyer, 2005). To return to the example about Muriel and the research study about loss of a same-sex partner, recruitment materials that asked for 'women who have lost a female partner', without naming such women as lesbians might have successfully recruited her to their study. The disadvantage

of behaviour-based approaches is that they may obscure the complexity of sexual behaviours, which may be intertwined with sexual identities, and may mask and depoliticise chosen sexual identities (Young and Meyer, 2005). They may also be less successful in recruiting to research studies people who do straightforwardly identify with a commonly used sexual identity label. Before Pat died, Muriel might have responded more readily to a call for participants in a study about lesbians' domestic practices than to one about women who lived together. The very terminology of common sexual identities speaks to potential research respondents and may increase feelings of ownership and the desire to participate for those who feel included in the terms.

A further alternative might be to focus on sexual attractions or desires, setting aside questions of whether and how people act on those feelings. In the vignette about Muriel, this might suggest focusing on her girlhood, perhaps reformulating 'crushes' as something more meaningful and significant. Such an approach might privilege desires over practices or identities. It is, however, seldom used in work around sexuality, perhaps because of the historic focus on sexual health issues. The rationale seems to be that if people are not acting on their same-sex attractions then there is no need to think about services for them. However, this is not necessarily the case, both because attractions may become practices and also because desires and attractions may have material effects on people's wellbeing (Barker, 2012; Firestein, 2007). A further benefit of focusing on attractions rather than practices or identities might be to reduce the apparent dominance of heterosexuality, by drawing attention to the prevalence of same-sex desires e.g., a large-scale US study found that 13 per cent of women and 6 per cent of men in the US reported attraction to more than one gender (Mosher, Chandra and Jones, 2005).

Bisexuality

One notable attempt to take attractions seriously alongside behaviours and identities is the grid developed by Klein (1993) which uses a Kinsey-like number (Kinsey, Pomeroy and Martin, 1948; Kinsey et al., 1953) to plot seven different aspects of sexual orientation in the past, present and future. 'Sexual attraction' and 'sexual fantasies' are two variables which are clearly to do with attraction and 'emotional preference' could also be argued to relate to attractions. It is not coincidental that Klein's work centred on bisexuality, since recognising the significance and differences between behaviour and attraction has particular salience to bisexuality, as is now discussed.

The proportion of people who identify, behave and are attracted bisexually could be represented as follows in Figure 5.2.

It is thought that many more people are attracted to people of different genders than behave bisexually, and that more people behave bisexually than identify as bisexual (Rodriguez-Rust, 2000). As the diagram suggests, there is also a small group of people who experience bisexual attractions and identify as bisexual but

do not act on those attractions. This might be because they are in a long-term monogamous relationship but want to give significance to their attractions as well as their practices, or because they do not want to be sexually active.

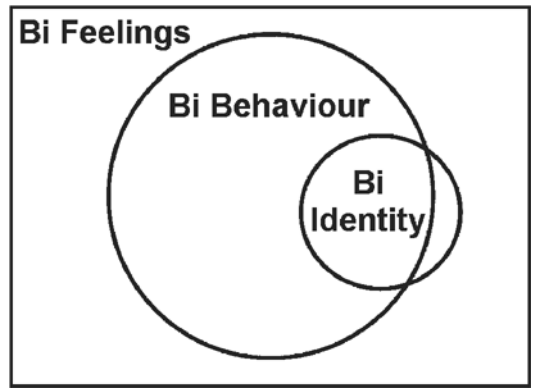

Figure 5.2 Bisexual identities, behaviours and attractions
Source: first published in Jones (2010), reproduced with permission.

Estimates of the percentage of the population who are bisexual crucially depend on whether attraction, behaviour or identity are taken as constituting 'bisexuality', with answers ranging from 'a majority' for attraction to as low as 0.5 per cent in some surveys of identity (Barker, Richards et al., 2012). Since the significance of studying LGBT issues is often asserted via claims as to the number of people involved, paying attention to whether what is being counted is behaviours, attractions or identities is particularly significant for bisexuality. Making claims for the significance of bisexuality on the basis of the numbers of people attracted to more than one gender is much easier than making claims on the basis of the use of identity labels.

While there are undoubtedly many commonalities between lesbians, gay men and bisexual people across the life course, grounded in their shared experiences of living in a heteronormative and heterosexist society (Hicks, 2008), it is also clear that bisexual people have some distinctive experiences. Evidence is building that bisexual people are more likely to experience mental health difficulties than lesbian, gay or heterosexual people (Jorm et al., 2002; King et al., 2003) including higher rates of depression, anxiety, self-harm and suicidality. Some researchers argue that 'biphobia' (negative attitudes and behaviours directed towards people who are attracted to more than one gender) contributes to these higher rates of mental distress (Barker, Richards et al., 2012)

One US report argues that the invisibility and erasure of bisexuality as a legitimate and authentic sexual identity is a particular problem, and a form of biphobia (San Francisco Human Rights Commission, 2010). There is a common

assumption that people are fundamentally attracted to only one gender (are 'monosexual'). That attraction might be to the same gender or to a different one, but the presumption remains that authentic attraction is gender-determined (Barker and Langdridge, 2008). Observers generally assume people's sexual identities on the basis of their current partner, if they have one. Thus, they see a woman with a female partner as a lesbian, and see a woman with a male partner as heterosexual, as seems to have been the case among Muriel's friends when she met Colin. However assuming sexuality on the basis of a known current partner's gender does harm to bisexual people. It erases bisexuality as a potential sexual identity, unless someone is publically known to have more than one partner at a time and those partners are different genders. While some bisexual people do have two concurrent partners of different genders, many do not. Those who do may not be known publically to have two partners, due to the stigma which surrounds multiple partners (Weitzman, 2007).

Assuming someone's sexuality on the basis of a known partner has some similarities with the situation in which a lesbian or gay person without a known partner is assumed to be heterosexual. However the difference is that, in many parts of the West today at least, lesbians and gay men are widely socially agreed to exist, even when they are subject to disapproval. Bisexuality is still subject to research which aims to discover whether it really exists (e.g., Rieger et al., 2005) and there are regular features in the media questioning whether bisexual attractions or behaviours are authentic (e.g., Burchill, 2012). Assuming someone's sexuality on the basis of their current partner also implies that people who have had relationships with more than one gender were, at best, searching for their authentic (monosexual) identity or, at worst, greedy and promiscuous.

Bisexual people report experiencing discrimination and prejudice from within ostensibly LGBT communities (Gurevich et al., 2007) and also report still-present tensions between bisexual women and lesbians in the light of lesbian separatism (Hartman, 2005). In our vignette, Muriel's group of lesbian friends, who may have been influenced by lesbian separatist ideas given that it was the early 1980s, did not continue to support her with her bereavement once her sexual behaviour had changed after meeting Colin. Similarly, she did not feel able to continue to use the specialist bereavement service, even though she was still struggling with the particular consequences of losing a same-sex partner. Services which explicitly support bisexual people are rare (Barker, Richards et al., 2012).

Understandings of bisexuality, including use or not of the self-description 'bisexual', vary across cultures, between parts of the world, across social and economic classes, between genders, and according to age cohorts. Some activists and authors reject all parts of the term 'LGBT' as inherently middle-class, metropolitan, white and western (Gosine, 2006). Empirical research focusing on bisexuality and non-white ethnicity is rare but what there is reports recurrent difficulties for non-white bisexuals in accessing organised bisexual communities, which are predominantly white and may be unwelcoming (Yuen Thompson, 2012). Some people use alternative terms, such as 'pansexual' and 'omnisexual',

often in an attempt to avoid some of the difficulties they see in the term 'bisexual' (Ochs, 2007). Debates about the benefits and pitfalls of claiming bisexual identities are found among community members as well as in academic texts (Barker et al., 2008; Barker, Richards and Bowes-Catton, 2009). Thus, the terminology researchers and practitioners use to discuss the experiences of people who are attracted to more than one gender is necessarily loaded and culturally specific. This chapter uses 'bisexuality' and 'bisexual' because these are most commonly used in the academic and practitioner literatures but this is not itself a neutral act – it is another 'necessary fiction'.

Bisexual Ageing

There has recently been a significant growth in the literature on sexuality in later life and in LGBT ageing in particular, as other chapters in this collection attest (for other recent collections, see Rowan and Giunta, 2014, and Ward et al., 2012). However, there remain significant knowledge gaps and there is barely any empirical research into the specific experiences of bisexual people as they age. Research studies tend to focus on lesbian and/or gay ageing but their findings cannot be applied straightforwardly to bisexual ageing (or indeed to trans ageing) since we know that bisexual people's experiences differ from those of lesbians and gay men in earlier life (Barker et al., 2012).

Although some studies may seem to promise information about bisexual (and trans) people's experiences of ageing, through their use of terms such as 'LGBT' or 'LGBTQ' in titles, introductory sections or conclusions, reading further often reveals little substantive bisexual content. Numbers of bisexual participants recruited to studies have often been very low (perhaps partly due to recruitment materials which use sexual identity labels, as already discussed), making generalised conclusions about the distinctiveness of bisexual ageing impossible to draw. Other studies analyse and present their findings by gender, obscuring any differences that might exist between gay and bisexual men or lesbians and bisexual women (e.g., Stonewall, 2011). For more discussion of the limitations of general LGBT surveys in identifying bisexual experiences and some good practice guidelines, see Barker et al. (2012).

There may be many reasons for these practices (for further discussion, see also Jones, 2010 and Jorm et al., 2002) but one effect is to obscure the fact that much more is known about older lesbians and gay men than is known about older bisexual and trans people. For example, rates of living alone, which is a key predictor of the need to access formal care services in later life, have long been known to be high among older lesbians and gay men (Cross and Brookdale Center on Aging of Hunter College, 1999) but there is no data on this for bisexual older people. Bereavement can be an important issue for older lesbians and gay men, who may lack social recognition of their loss as well as experiencing exclusion from formal processes surrounding a death such as the funeral (Dworkin and Kaufer, 1995).

There are no empirical studies characterising older bisexual people's experiences of bereavement.

To date, there have been extraordinarily few empirical studies on any aspect of bisexual ageing. A literature review found only two such studies – both are overviewed below. Both are small-scale qualitative studies which included substantial numbers of participants aged under 50 and neither included respondents in their 70s or older. Both focus on ageing as a lifelong process rather than the final decades of life. Neither paper extensively explores issues of difference between bisexuals, such as those of ethnicity, social class and economic situation.

Weinberg, Williams and Pryor's (2001) paper, which is part of a wider longitudinal study, examined the ways in which their 56 participants' experiences of their bisexuality had changed as they grew older (aged 35–67, mean age 50). Respondents were all white and middle-class and relatively highly educated. Their sexual practices had changed as they grew older but their identities as bisexual had remained constant. They were having less sex with fewer partners, which may partly have been to do with historical periods (before and after the AIDS crisis) but participants also attributed this to the effects of ageing, including life-stage effects such as being very busy with work and children. Participants were more likely to be having sex with only one gender and to be monogamous. They were less involved in organised bisexual communities and politics. However, many reported that their identity as bisexual was more stable and the researchers argue that they had 'obtained closure' on their identity. They based their identity as bisexual on their attractions rather than on their behaviours. The stability of their identity as bisexual as they grew older came from recognizing the long-standing nature of those attractions – this issue of later life perspectives on bisexuality is considered in more detail in the next section.

Jones' study focused on how bisexual-identified adults (aged 20–66, average age 37.5) imagined their own ageing and later life (Jones, 2011, 2012). Participants came from a range of countries and ethnic backgrounds although the majority were from the UK and identified as white. Nearly all of them were highly educated – 82 per cent had undergraduate degrees. A previous study of lesbians and gay men had found that the extent to which they could imagine positive ageing depended on the extent to which they imagined a traditional life course of settling down with one partner (albeit a same sex partner) and having children (Goltz, 2008). Many of the participants in Jones' study imagined very untraditional futures, such as having multiple partners, not having children, living in communes and so on but the futures they imagined were overwhelmingly positive and happy. Where participants specified which sexual identity labels they would use in later life, nearly all imagined that they would continue to identify as bisexual, whatever sexual practices they had in the future. This study is perhaps of most interest for suggesting ways in which people can be helped to envisage and plan for happy but non-traditional later lives.

In addition to these two empirical papers, there is a small literature making suggestions for issues that may arise in later life, written predominantly by

practitioners and academics with expertise in bisexuality (Dworkin, 2006; Firestein, 2007; Keppel, 2006). So far, this work is mostly located within disciplines such as psychology and psychotherapy. This literature does not discuss issues of intersectionality extensively but does suggest that common issues for bisexual older people may include: isolation and lack of supportive networks; personal and family effects if someone is coming out in later life; and biphobia and bisexual invisibility combining with ageism. This literature also includes good practice suggestions for ways to better support bisexually-identified and bisexually-behaving older people, for example, not assuming someone's sexuality on the basis of their current partner, identifying resources and information about community groups, and respecting individuals' use of pronouns and terminology (Keppel, 2006).

Bisexuality and Life Course Perspectives

There is a long tradition of life course perspectives within gerontology (Birren et al., 1996; Gubrium, 1997; Ruth et al., 1996; Ward et al., 2012). While there are sometimes hotly contested differences between different approaches (Bornat, 2001), all share a concern with seeing an older person's present situation and needs in the light of their past experiences. They suggest a focus on the whole life course, rather than just the current stage of life (Bengtson et al., 2005) and emphasise that this enables truly appropriate and personalised services and interventions to be offered to older people when they are needed.

This tradition of work is highly significant to the study of bisexuality and sexuality more widely. Taking a life course perspective makes the possibility of bisexuality much more obvious than a focus on a particular moment in time. Reading the account of Muriel's whole life, the descriptor 'bisexual' looks much more possible and appropriate than if a single point in time is considered. Since Muriel was always monogamous, a moment-in-time external perspective on her sexuality, based on the gender of her partner, would never have suggested bisexuality as a possible identity label. Indeed, moment-in-time perspectives make bisexuality seem almost impossible for monogamous people unless, perhaps, one person in the couple is currently transitioning between genders. A life course perspective, asking about someone's history in relation to sexuality, makes monogamous bisexuality visible. This is not to say that 'bisexual' is the correct identity descriptor for Muriel or for any other person with a history of attraction to more than one gender. Merely, it is to note that it is a candidate descriptor which is made visible by a life course perspective.

If Muriel herself had been asked to describe her sexual identity, Figure 5.1 suggests that there was only a period of about five years in which she would be likely to have given the answer 'bisexual'. The vignette does not reveal what label, if any, Muriel currently uses or what sense she makes of her experiences over the course of her life so far. Asking her directly and then using whatever term she chooses has much to recommend it in terms of individuals' rights to name and narrate their own

experiences. However the difficulty with this approach is that, as already discussed, the labels people use depend to some extent on the context and manner in which they are asked and on the rhetorical purpose of the speaker (Jones and Ward, 2010; King, in press; King, 2014). In the context of a social group for older lesbians, Muriel might happily tick a box on a monitoring form identifying herself as a lesbian but if giving an account of her relationship history, she might be more likely to label herself as bisexual. Furthermore, given the difficulties of claiming a bisexual identity when bisexuality is often seen as illegitimate, inauthentic or unviable (Gurevich et al., 2007; San Francisco Human Rights Commission, 2010), relying entirely on individual's own use of identity labels may do little to challenge conceptions of bisexuality or its erasure as a valid sexual identity.

This raises some interesting issues about the relative statuses of past and present identities. The proper concern to respect individual's right to name their own sexual identity has the effect of privileging present identities over past ones. Past identities that have now been discarded seem to be 'trumped' by currently claimed identities. This means that if someone has followed the relatively common identity trajectory heterosexual-bisexual-gay, those heterosexual and bisexual identities are often seen as invalid and inauthentic. Taking a life course perspective relatively late in a life course makes visible the fact that which moment-in-a-life a sexual identity is invoked may be significant. It raises the Queerer possibility that past selves might also have rights to stake a claim to label someone's sexual identity and that present selves might not always have the last word. This is tricky terrain but worthy of further consideration. It has particular relevance to the study of ageing and bisexuality but also for identities of all sorts that have changed over the course of someone's life, for example, other sexual identities, race or ethnic identities, class identities or gender identities.

Implications for Health and Social Care Services

This final substantive section of this chapter draws out some of the wider implications of these theoretical questions for the everyday lives of older people when they are using health and social care services. While some older people make no greater use of health and social care services than most younger people, increasing age does increase the likelihood that someone will use these services more extensively. It is for this reason that this section discusses the implications for health and social care services, not because being older and being an extensive user of health and social care services are considered synonymous.

Previous work on older LGB&T people's experiences of health and social care services has highlighted significant issues around heteronormative and heterosexist care and accommodation provision, and the consequence that many people choose to conceal their sexual identity (Cronin et al., 2011, Knocker, 2006). The case of bisexuality adds to this body of work by drawing attention to the complexity of all sexual identities – the distinctions between sexual attraction, sexual behaviour and

sexual identity are also important in working with lesbian, gay and heterosexual people. For example, people who do not identify as lesbian or gay but have same-sex attractions and behaviour are unlikely to pick up a leaflet offering services targeted at lesbian and gay elders, even if they might benefit from them. The case of bisexuality also helps to draw care workers' attention to the importance of using people's own identity labels, rather than ascribing them on the basis of either heterosexist assumptions or a current partner. There is a wide variation in older people's use of sexual and gender identity terms and using the wrong term can make services inappropriate and inaccessible (Alleyn and Jones, 2010).

Where older users of health and social care services have bisexual pasts, it is particularly important that care workers do not ascribe identity categories that clients do not use and do not assume that services for older lesbians and gay men will be acceptable or welcoming. Care workers also need to be alert to the possibility of biphobia, such as Muriel experienced when her home carer associated her bisexual past with being sexually predatory and promiscuous (for further examples of this, see Dobinson et al., 2005). Rigid thinking about sexual identity categories can have deleterious effects on care practices. If Muriel developed dementia and went to live in a progressive care home that identified her as a lesbian and aimed to support her lesbian identity, how might they respond to Colin coming to visit her and Muriel behaving sexually towards him? There is a danger that they might see her behaviour as evidence of cognitive decline and disinhibition, when in fact it was not. As Hicks (2008) also argues, a more nuanced and sophisticated understanding of sexuality would benefit care across the life course.

Gerontologists have long argued that researchers and care workers need to remain alert to the effects of historical periods on individual's lives (Bengtson et al., 2005). Stories such as Muriel's can contribute to this project. The services Muriel feels able to access in later life are fundamentally shaped by the times through which she lived and the ideas about sexuality to which she had access. A well-meaning care worker who was aware of Muriel's relationship with Joan might assume that she would welcome information about a local group for older lesbians. It is possible that she might feel able to attend such a group, because she had been thinking of herself as a lesbian in recent years, but it also possible that she would not feel able to attend because of her bisexual past and her previous experiences of rejection. Just as living through the Great Depression fundamentally marked the way people age (Elder, 1974), the history of sexual identity politics has effects on individuals as they age (see also Rosenfeld, 2003).

The UK charity 'Age UK' has produced a good practice guide for working with older lesbian, gay and bisexual people (Knocker, 2006). While this does not discuss bisexuality extensively, the general principles it suggests provide a practitioner-friendly introduction to the topic. In bi-specific form, these principles suggest that health and social care workers should: recognise their responsibilities to make explicit their bi-friendliness since silence is likely to be read as hostility or ignorance; realise that sexuality is not just about sex but about someone's social, cultural and relationship needs and thus an important part of any care plan and

any claim to provide person-centred care; recognise the increased salience of feelings of safety and security when people may have experienced discrimination and stigma throughout their lives (including from within LGBT communities), and especially when they are already vulnerable when using health and social care services.

Conclusions

This chapter has used the example of bisexuality to argue that research and practice around non-heterosexual ageing should pay closer attention to how sexual identity labels are used. The significance of the distinctions between identity, behaviour and attraction may be particularly clear in relation to bisexuality, but they are also important in work with lesbians, gay men and heterosexual people. Likewise, the significance of taking a life course perspective from relatively late in a life may have particular relevance to bisexuality, because this perspective may make visible otherwise invisible bisexuality, but it also has implications for lesbian and gay identities. As discussed, it may be politically necessary and personally supportive to accept someone's present-day claim to have 'always been gay really' but it is at least worth noting that this privileges present selves over past ones and that this is not inevitable.

The idea of vignettes as a form of necessary fiction helps to draw attention to what is achieved and what is obscured by the choice of a particular vignette. Muriel's story is, not coincidentally, well-suited to discussion of the distinctions between identity, behaviour and attraction, and the value of taking a later-life life course perspective. It says nothing of her sexual practices beyond her choice of partner and little of her attractions – a further attempt to decentre sexual identities could perhaps use a vignette which dealt with behaviours and attractions over a long life course much more fully. Muriel's life was relatively conventional and mainstream apart from her changes of sexual identity. A vignette about an older bisexual person who had multiple partners or a large number of partners, or one which talked about sexual practices such as BDSM might have lent itself better to discussion of couple-privilege or the stigmatisation and erasure of older people's sexual activity. A vignette about a long-married man, who briefly identified as bisexual before leaving his wife and coming out as gay would have been much more conducive to understandings of bisexuality as transitional and inauthentic. A story about someone who had identified as bisexual all their adult life but felt they had to go back into the closet when they entered a care home would have enabled a much more practice-centred discussion of sexual identities in residential settings for older people. To have used any of these putative vignettes to discuss the issues in this chapter might have been possible but they would have increased complexity in a way that reduced intelligibility and political utility.

It is clear that empirical data on the living situations, experiences and needs of older people with some relationship to the identity 'bisexual' is needed. Given

the distinctiveness of bisexual experiences earlier in life, we should anticipate that older bisexual people's experiences are likely to be significantly different from those of older lesbian and gay people. We need to be extremely cautious about applying findings from studies of generic LGBT ageing experience to bisexual (and trans) people, since these studies may have included very few, or no, bisexual (or trans) participants and may not have analysed their responses separately. Furthermore, given that most research into bisexuality has been conducted among white, middle-class, well-educated people, we need to be aware that older bisexual people from non-white, low-income, less educated or immigrant communities may experience ageing very differently.

The case of bisexuality highlights the importance of distinguishing between sexual identity, behaviour and attraction both in the design of research studies and in health and social care practice. If research studies elide identity and behaviour then findings may not be valid or generalizable. If care workers elide identity and behaviour then people who might benefit from services may not take them up. This is as true for lesbian, gay and trans people as for bisexual people. Thinking about bisexuality helps care services for older people with their wider project of conveying and responding to the heterogeneity of older people, whether LGBT or not. Taking a life course approach – looking at the whole of a person's life, not just their current situation – creates some interesting issues for the study of bisexuality and sexuality more widely, which seem worthy of further study.

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Chapter 6
Older People and Sexuality in Residential Aged Care: Reconstructing Normality

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Introduction

Older people living in residential aged care face numerous social, physical, attitudinal and structural challenges to one of the most basic human needs: sexual expression. The aim of this chapter is to provide a greater appreciation of these barriers and their causes, with reference to the latest social scientific research. The chapter begins with a brief discussion of the stereotypes that exist about older people and sexuality, before challenging these stereotypes with research evidence. Finally, we discuss older people and sexuality in residential aged care, including people living with dementia.

Older People and Sexuality: Stereotypes and Reality

For a long time, ageing and sexuality were viewed by western society as largely incompatible, with the older person considered to be asexual (Gott, 2005). Popular culture has perpetuated this myth, with a notable absence of sexual older adults portrayed in advertisements and in film (Vares, 2009, see Hinchliff and Gott, this volume). Very rarely do we see public images of older people showing wrinkled skin or grey hair. Even in TV and film, glimpses of older people who are naked or semi-naked are rare, and it is even more uncommon to see them portrayed in sexual relationships; furthermore, actions are usually suggestive rather than shown (Vares, 2009). The images we are presented with in the media are prolific and powerful and reinforce the stereotype that sexuality is associated with youth, physical health and vitality, while old age is associated with ugliness, sickness and decay (Gott, 2005).

Juxtaposed with this view of the older person as asexual is the stereotype of the 'sexy oldie' (Gott, 2005; Vares, 2009). Since the 1990s, a new narrative has emerged where lifelong sexual function has become equated with successful ageing (Katz and Marshall, 2004; Vares, 2009), in what some have labelled the 'Viagra era' (Loe, 2004). At first glance it would appear that there has been a cultural shift, one that has resulted in the greater acceptability of the sexuality of older people. However, there are at least two major shortcomings with this

reconfiguration of ageing and sexuality. Firstly, defining lifelong sexual function as a necessary component of successful ageing implies that to not (for whatever reasons) continue to be sexually active into later life is a 'failure'. Secondly, while this new representation may challenge the invisibility of later life sexuality, some have argued it serves to reinforce its unwatchability. Portrayals of sexual older people in film are mostly limited to affectionate or romanticised relationships of the 'well preserved', with sex not actually shown but only hinted at (Bildtgard, 2000). As observed by Vares (2009), the representation of the asexual older person has been more or less reconstructed.

How do these stereotypes of the older person and sexuality compare with the reality? Since research into the sexual lives of older people first began in the 1950s, studies have repeatedly shown that many older people maintain sexual interest and remain sexually capable (Bretschneider and McCoy, 1988; Lindau et al., 2007). Studies in the USA (Lindau et al., 2007), Spain (Palacios-Ceňa et al., 2012), Sweden (Beckman et al., 2008), and Australia (Hyde et al., 2010; Ferris et al., 2008) have shown that many older people continue to be sexually active, even well into the later decades. When frequency of sexual activity declines sexual interest may persist (Kamel and Hajjar, 2003). This is not, of course, to say that sexuality is of high importance to all older people. We do not want to promote the stereotype of the 'sexy oldie' (Gott, 2005), nor the idea that all older people need be sexually demonstrative. What is needed however, is a recognition that sexuality does remain important for many older people. Furthermore, while the research literature often narrowly focuses on intercourse or oral sex (Gott 2005; Lindau et al., 2007), later life sexuality is multidimensional and may include intimacy, body image, self-esteem, romance, physical closeness, touch, cuddling, kissing, hugging, self-gratification and social relationships (Nay, 2004). This characterisation is echoed by the often cited definition provided by the World Health Organisation (2006): 'a central aspect of being human throughout life [that] encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction'.

The Challenge of Sexuality in Residential Aged Care

Older people are relatively free to express their sexuality in their own home in any way they see fit and for the most part what they 'do' passes under the radar. The prioritisation of the individual in western societies means that, in general, people's sexual behaviour is a matter of 'don't ask, don't tell'. However, when a person moves into a residential aged care facility, that is, a communal living space for older people where assistance with daily personal care needs is provided, things change. Assumptions are often made by health professionals, care staff and families alike, that the older person no longer has any interest in sexual expression, or indeed the physical or mental capacity for it. As such, sexual behaviour when it occurs is constructed as an aberration by staff, a problem or a disruption to the care

routine that needs to be managed and curtailed. Activities which were previously a private matter become public in an aged care facility.

Goffman's (1961) theory of the 'total institution' can lend some understanding to the problematisation of sexuality in an aged care facility. Many aged care facilities still have much in common with Goffman's total institutions. They continue to be an outgrowth of the medical model where the environment is characterised by a hierarchical staff structure with an emphasis on routine and efficiency (Bauer, 2006). Total institutions have authority over residents, restrict self-determination and autonomy and direct behaviour (Goffman, 1961). Residents in aged care facilities do not have complete freedom of action and the authority of the institution is manifested by regulations and the judgments of staff. Sexual interest and activity can continue in spite of physical or cognitive impairment (Kamel, 2001; Kamel and Hajjar, 2003), and this is no less true for people once they move into residential aged care (Ward et al., 2005). A study by Nay (2004) found that older people living in aged care homes engaged in a range of activities and behaviours including holding hands, cuddling, flirting, kissing, masturbation, intimate touch, talking 'dirty', intercourse, using sex aids and paying for sexual services. This list is not dissimilar to activities which have been reported in North America and the UK (Archibald, 1998; Bouman et al., 2006). An American study of nursing home residents found that sex was graded as moderately important to them, and more important than appetite; furthermore, they expressed positive attitudes towards more open discussion of sexual issues (Aizenberg et al., 2002). More recently, our research team (Bauer et al., 2013) interviewed older people with and without dementia between the ages of 79 and 101 living in a number of aged care facilities in two Australian states. We found that being able to express one's sexuality still mattered to residents. Older people interviewed in the study, irrespective of whether they had dementia, still wanted to look and feel attractive and, moreover, longed for companionship and affection. For some people sex was still important and where it was absent, its loss was lamented.

Aged care facilities are expected to provide a milieu which is supportive of older people living enriching and fulfilling lives (Australian Aged Care Quality Agency, 2014). However aged care facilities can also be regulated, medicalised and highly structured environments, governed by rules and routines (Doll, 2012). In this context, the identity of the older person can become reconfigured as vulnerable, frail, or unwell, particularly if they have a diagnosis of dementia. The older person's sexuality can be constructed as a 'problem', a 'hindrance' that gets in the way of staff providing care (Doll, 2012). Furthermore, when the resident's view of themselves or behaviour does not fit with how staff or families perceive them, or is diametrically opposed to the values of staff or families, conflict can occur. While the older person may experience their sexuality as active and healthy, staff and residents' families may interpret their behaviours as 'inappropriate' or even 'deviant' (Tarzia, Fetherstonhaugh and Bauer, 2012; Doll, 2012). The older person can then become constructed as 'difficult' or 'challenging', and this construction is harmful and can threaten their psychological and physical

wellbeing. Residents may withdraw from sexual expression fearing criticism or ridicule; or they may feel guilty, ashamed or embarrassed, thinking that their sexual desires are abnormal, unhealthy or immoral (Doll, 2012). This can create a context where older people are not entitled to, or permitted to express their sexuality, particularly in the residential aged care setting where older people need varying degrees of supportive care.

Dupuis, Wiersman and Loiselle (2012) have noted that long term care staff interpret and assign meaning to residents' behaviours (regardless of whether they have dementia or not), by filtering the behaviours through the 'lens of pathology'. For residents with dementia, the meaning of behaviours is therefore commonly associated with the disease in the brain and thus rarely contextualised biographically or historically as having a purpose or meaning.

To deal with residents' sexuality and sexual incidents staff often resort to the use of humour in the form of jokes, innuendo and witty replies (Bauer, 1999a). Humour can alleviate staff discomfort and embarrassment around sexuality, however joking about residents' sexual desires and activities can also be used as an effective smokescreen to conceal residents' needs. Humour about rather than humour with, can also be used to shame and stigmatise residents' needs and behaviours and can be used as a form of control whereby residents are coerced to conform to the values of staff, thereby denying them the freedom to express their sexuality (Bauer, 1999a).

Structural barriers inhibit intimacy in aged care facilities (McAuliffe et al., 2007) and residents are often denied access to privacy (Bauer, 1999). This is justified by prioritising other care needs over the expression of sexuality and the need for supervision and surveillance to reduce organisational risk and ensure resident safety (Cornelison and Doll, 2013). Lack of privacy has been consistently identified as an organisational barrier to residents being able to express their sexuality (Bauer et al., 2007; Hajjar and Kamel, 2003). Privacy can be compromised through such actions as staff not knocking on residents' doors before entering, or entering rooms before permission is given (Bauer, 1999; Bauer, 2014a). A less obvious breach of privacy takes the form of staff sharing residents' behaviours and other personal information with other staff, or with residents' families. While the impact of this may not be as apparent as the deprivation of space and/or time, information privacy is nonetheless also an important element in the maintenance of a resident's dignity (Bauer, 1999).

Sexuality, Well-being and Quality of Life

Giddens (1991) maintains that sexuality is a primary component of one's story of the self and the freedom to express one's sexuality is increasingly seen as important for self-identity (Foucault, 1978; Weeks, 1991). Because sexual expression is a determinant of self-rated health (Cott et al., 1999), it is considered integral to well-being and quality of life (Frankowski and Clark, 2009). It is imperative, therefore,

that sexual expression is considered a normal and accepted part of living in an aged care facility.

Despite the importance of sexuality to well-being and quality of life, the discourse, literature and on-site care practices by staff in the residential care setting have been slow to acknowledge its importance (Bauer et al., 2014). We have conducted numerous workshops on sexuality for aged care facilities in the state of Victoria (Australia) and have on many occasions found that care staff will (eventually) acknowledge that sexuality and feeling sexual are not age dependent (Bauer et al., 2013). However, when case studies involving residents in their seventies, eighties or nineties who express their sexuality are discussed, the situation becomes anathema and staff discomfort and negative attitudes often emerge.

The lack of acknowledgement of older people's sexuality further impacts on sexual health. When health professionals think of sexually transmitted infections (STIs) they do not often think of older people, and yet the risk of sexual infections does not diminish with age; in fact it is known to increase (Gott, 2004). Against a background of low condom use (Holden et al., 2005; Schick et al., 2010), the rates of sexually transmitted diseases such as chlamydia, gonorrhea and syphilis have doubled for people in their 50s, 60s and 70s in the past decade (von Simson and Kulasegaram, 2012). The number of people over the age of 50 years living with HIV is also increasing (Mahy et al., 2014).

A scoping review conducted by Kirkman, Kenny and Fox (2013) examining Australian federal, state and territory government health policy documents did not find any that were specific to older people's sexuality and sexual health. The authors note that this situation is not dissimilar to that in the USA and Canada where sexual health policies do not specifically refer to midlife and older adults. While the National Survey of Sexual Attitudes and Lifestyles in the UK now includes older people, data collection is limited by an unjustified upper age limit of 74 years. It needs to be considered that older people living in residential aged care facilities may not be as aware of the risk associated with the exchange of body fluids as younger generations and therefore be more susceptible to STIs.

Attitudes towards Sexuality and Older People in Aged Care

Health professionals have been found to share many of the inaccurate assumptions about sexuality and older people that permeate society generally, and this applies across cultures (Tsai, 2004). This is especially so for the very old and for those living in residential aged care (Gunderson et al., 2005). Health professionals as well as residents' families have been known to harbour conservative, (Bauer et al., 2014b; Mahieu et al., 2011) if not negative views, towards the issue of sex and older people (Bauer et al., 2013; Hinchliff and Gott, 2011) and many health professionals are not comfortable talking about sexuality (Dyer and das Nair, 2013). Expressions of sexuality by residents can often surprise staff, possibly because of the entrenched view that they are no longer capable or interested. This can evoke

a range of responses in staff including disgust, horror, disbelief, anger, confusion, denial, aversion and helplessness (Doll, 2012). While families may be supportive of hand-holding, kissing and hugging among residents, they react unfavourable to sexual intercourse (Bauer et al., 2014b). Conversations about this topic with older people who are recipients of care are largely considered taboo (Dyer and das Nair, 2013; McGrath and Lynch, 2014). Some studies have concluded that the attitudes of residential aged care facility staff are more negative when interactions are between same-sex couples (Di Napoli et al., 2013). The aged care industry continues to make assumptions of heteronormativity (Phillips and Marks, 2008, SAGE (Services and Advocacy for Gay Lesbian Bisexual and Transgender Elders, 2010) and older lesbian, gay bisexual and trans (LGBT) people are faced with the significant challenges of heterosexism (Tolley and Ranzijn, 2006) and the maintenance of their sexual identity.

Many older LGBT people in Australia lived through a time in history when they 'suffered stigma, discrimination, criminalisation, family rejection and social isolation' (Australian Government Department of Health and Ageing, 2012, p. 4). As Hughes (2009) notes, there are many concerns the LGBT community have with aged care services including: prejudice and discriminatory attitudes or behaviours towards them; the non-recognition of same-sex partners/relationships; a lack of awareness of LGBT issues; a lack of specific services; and the impact sexuality and/or gender identity may have on the quality of services provided.

Even at an organisational level, sexuality is not perceived to be a priority care need for residents as surveys of Australian facilities (Bauer et al., 2009; Shuttleworth et al., 2010) have found that the provision of information on this topic by facilities for residents or staff is very uncommon. A survey of all 806 aged care homes in the state of Victoria, Australia (Bauer et al., 2009) found that only 17 facilities (2 per cent of all facilities contacted) provided any written information to prospective residents that addressed the issue of love, sex or intimacy in residential aged care. Although the overall response rate to this survey was low, the findings nevertheless suggest a strong neglect of residents' sexuality.

Across categories of aged care staff and facilities, the evidence around attitudes towards sexuality is mixed. Managers of care homes have been found to be more permissive in their attitudes than nurses and care assistants (Bouman et al., 2007). Age and work experience have been suggested as possible attitudinal influences, with older staff and those with greater experience reporting more permissive attitudes (Bouman et al., 2007, however not all studies have found this to be the case (e.g., Bauer et al., 2013). The religiosity of a facility has been associated with more negative and restrictive staff attitudes (Gibson et al., 1999; Le Gall et al., 2002), however religiosity was not found to predict attitudes (neither positive nor negative) in another study (Bouman et al., 2007). Even when staff do hold favourable attitudes towards ageing and sexuality, many health professionals believe that talking about sex and sexuality would offend the older person (Lewis and Bor, 1994; Dyer and das Nair, 2013), even though there is literature to indicate

that older adults would welcome such discussion and believe it should be part of clinical care (Aizenberg et al., 2002; Hinchliff and Gott, 2011).

Many aged care staff are untrained in this area (McAuliffe et al., 2014) and in the absence of education aged care staff are likely to call upon their own attitudes and values (or those of the organisation in which they work) to guide their work practices. During our training workshops we have noted that, faced with sexual behaviour in the nursing home for the first time, an untrained staff member is likely to feel confronted and unsure how to proceed. A desire to protect residents' safety, avoid legal repercussions, appease families, and maintain institutional efficiency, is likely to influence the carer's response, with the rights of the resident given little if any consideration. Indeed, a grounded theory study of staff working in nursing homes in Australia and Sweden found staff perceptions towards resident sexual behaviour were influenced by their own degree of comfort with the issue, with the ethos of the organisation also found to be a contributing factor (Roach, 2004).

'Inappropriate' Sexual Behaviour

For those working at the coal-face of care delivery, encountering sexual behaviour of residents is not uncommon. Many aged care staff have not received education or training, and for those staff it can be very difficult to know how to respond and furthermore to distinguish what is a resident's normal sexual expression from inappropriate sexual behaviour caused by, for instance dementia, or the side effects of medication (Ozkan et al., 2008). Sexuality is not perceived by staff to be a priority care need in residential aged care facilities; there is a lack of education and guidelines on appropriate responses to sexual behaviour (Archibald, 2003) and the sexual assessment of residents is far from routine unless it is in response to what is perceived to be 'problem behaviour' (Ward et al., 2005), for example if staff perceive sexual behaviour as socially inappropriate, or threatening. Unfortunately, a resident's sexual behaviour is all too frequently labelled 'inappropriate' or 'disruptive', especially when the resident has a diagnosis of dementia (Roelofs, Luijkx, and Embregts, 2014). There are essentially two issues to discuss here. Firstly, what actually is an inappropriate sexual behaviour and secondly, if it is indeed an inappropriate sexual behaviour, how can it be managed.

While sexual identity/sexuality may be more in the public domain in that it can be observed by others (and open to censure) our sexual behaviour is usually a private matter and not something that we openly discuss with a host of other people. How we perceive what constitutes appropriate sexual behaviour can vary from one person to another and can be strongly influenced by our cultural, religious and societal views, our experiences and beliefs (Joller et al., 2013). Therefore, the labelling of a sexual behaviour as inappropriate is not only normative but can also be highly subjective and context contingent. The 'inappropriateness' of the behaviour may be more about the judgemental attitudes of observers rather than the behaviour itself (de Medeiros et al., 2008) and therefore it may be more fitting to describe the behaviour as sexually ambiguous (Alagiakrishnan et al., 2005).

The effect of labelling the behaviour, and the reaction of staff and family and other residents to the behaviour can have quite negative consequences for the person exhibiting the behaviour.

Examples of behaviours that are labelled or described as sexually inappropriate include lewd or sexual overtures and propositions, implied sexual acts (e.g., requesting unnecessary genital care), and overt sexual acts (e.g., touching, grabbing, or disrobing of self or others, public masturbation, viewing pornography in public) (Black et al., 2005; Joller et al., 2013; Ward and Manchip, 2013). While some of these behaviours may indeed be obviously sexual they may be a response to an unmet need that a person with dementia or other cognitive impairment, or someone with communication difficulties, cannot adequately express (Sanchez, 2011). The person may be in pain, have an itch, be hungry or thirsty, or even feeling hot (Joller et al., 2013; Sanchez, 2011). They may grab their groin because they are in discomfort as a result of a urinary tract infection, or need to go to the toilet, or they may be craving some physical 'skin' contact with someone else in an environment that is often devoid of human touch. Another consideration is that it may be that the sexual behaviour may be quite 'normal' in the privacy of one's room (i.e., masturbation) and it is the context in which it is exhibited that makes it inappropriate.

Data on sexual abuse in residential aged care are scant, it seems that many assaults are perpetrated by staff or uninvited visitors rather than other residents (Burgess, 2000). If however the behaviour is not the result of an unmet need, or that need cannot be identified and addressed, then it may indeed be described as sexually inappropriate and needs to be managed. According to Alkhalil et al. (2004, p. 231) sexual inappropriateness and hypersexuality exhibited by people with dementia can be defined as 'a vigorous sexual drive or other sexually related problems developing after the onset of dementia that interfere with normal activities of living or are pursued at inappropriate times with unwilling partners'. There are various estimates of between 1.8 per cent and 25 per cent of people with dementia exhibiting sexually inappropriate behaviour (Ward and Manchip, 2013), however the prevalence of inappropriate sexual behaviour in this population is relatively low (Alagiakrishnan et al., 2005).

Good management of a behaviour should start with a comprehensive assessment which takes into account the whole person and their needs (Ward and Manchip, 2013). When assessing a behaviour whether it be sexual or other, it is necessary to find out about the history of the behaviour, including the type of behaviour, how often it occurs, the duration of the behaviour, and the context in which it occurs (that is, the triggers or precipitants, with whom it is exhibited and what is happening at the time). Communication from care staff needs to be clear and unambiguous. Delivering messages such as 'we'll go and have a shower', 'let's get undressed', or 'it's time to hop into bed', can be confusing for a person with dementia. It is also important to acquire a sexual history including preferences, past behaviours and values and screen for other possible causes of the behaviour including 'psychiatric disorders such as hypomania or delusional

disorder, medications or substances misuse and delirium' (Ward and Manchip, 2013, p. 80). It is also critical to examine what the inherent problem with the behaviour is, whose problem the behaviour is, what risks if any are involved and importantly, the capacity of the participants to avoid exploitation.

There are two main approaches to the management of behaviours which have been assessed to be inappropriate; pharmacologic and psychosocial/ behavioural. These may be used separately or in combination and it is suggested that non-pharmacologic strategies should be attempted first (Joller et al., 2013). Behavioural interventions need to be tailored to the individual and can involve: removal of triggers or precipitating contributors (which may be another resident or staff member); distraction with other activities; redirection; environmental manipulation (i.e., rear closing clothing); and opportunities to relieve sexual urges (Joller et al., 2013). Strategies to address the resident's needs for love and intimacy, such as visits by spouses or partners, are of course also important and may actually prevent or minimise the incidence of inappropriate behaviours. Pharmacologic treatment can include: hormonal medications such as anti-androgens and oestrogens; antidepressants such as seratoninergics; and anticonvulsants such as gabapentin (Alkhalil et al., 2004; Joller et al., 2013). It must be said, however, that the use of hormonal medications raises some ethical issues especially around the ability of the person to give informed consent to drugs which can have side effects and create social stigma around their use, and which can be described as 'chemical castration'. As will be discussed later in this chapter, it is also vitally important to educate residential aged care staff and family carers as their attitudes and values, and how they react to behaviours, can have a huge impact on the person with dementia in terms of how they are treated and perceived.

Capacity and Consent

The most ethically contentious issue about the expression of sexuality of older people, and in particular, people diagnosed with dementia living in residential aged care, is around capacity and consent. Dementia, which causes a progressive decline in a person's mental functioning, is characterised by a loss of memory, intellect, rationality, social skills and normal emotional reactions and therefore has implications for a person diagnosed with the disease and their capacity to consent and make decisions about their life. The consent issue is particularly relevant as, in possibly all jurisdictions, sexual activity with someone who is unable to consent is a sexual offence. According to Tenenbaum (2009), even if a person with dementia 'is able to communicate their general desires regarding sexual interaction, the nature of their consent and nature of the interaction can be confusing' (p. 686).

There is no worldwide consensus around how to specifically determine the capacity to consent to engage in a sexual relationship and the criteria vary from one jurisdiction to another (Lyden, 2007; O'Neill and Peisah, 2011; White, 2010). Capacity determination in a residential aged care facility may be made on a case-by-case basis or through the use of a standardised test such as the Mini-Mental

State Examination (White, 2010, p. 150) but current practice seems to err on the side of caution, with paternalistic attitudes and fear of litigation and risk translating to over protection and prevention, or obstruction of sexual relationships in residential aged care (Tenenbaum, 2009). The main dilemma in residential care is that aged care facilities have a duty to protect their residents from sexual abuse and exploitation, but also a duty to support their residents' rights to make autonomous choices and to respect their private lives (Ward and Manchip, 2013). While mental capacity and competence are central to decision-making they should not be the only determinants in the life of a person with dementia in residential aged care (Kuhn, 2002). Beneficence is an ethical principle which prioritises the promotion of the good; in this situation, what is good for the person with dementia should also be of paramount importance.

Another contentious ethical issue around sexually activity and people with dementia is the question of whether there needs to be consistency between the person with dementia's present behavioural intents and their previously expressed values and beliefs (Loue, 2005). There is much disagreement about the 'now' self versus the 'then' self and which should take priority in decisions around best interests and the person with dementia. Dementia can significantly alter a person's behaviour, values and personality, and it is not uncommon to hear family members claiming that they are not the same person (Tarzia et al., 2012).

While advance care planning is about planning future care to ensure that a person's wishes are known for when they can no longer make decisions for themselves, it is unlikely that their wishes (or at least the intimate details) around sexual activity and possible future relationships will have been documented in a legally binding way or, that any legally appointed power of attorney will know all the details of the 'then' person's sexual preferences and previous behaviour. This is probably in part due to the fact that we do not, as a society, openly discuss our sexual lives with our families and it is often a family member, for example an adult child, who becomes the legally appointed power of attorney to make decisions on behalf of the person with dementia. The only knowledge this person may then have about another's 'then' self that would be used to foresee likely preference for future sexual activity, is that which has been publicly observed or witnessed within a family. This is particularly concerning when according to Tarzia et al., (2012), families are informed as a matter of course whenever residents with dementia express their sexuality. For the most part whether sexual relationships are discouraged, promoted, or ignored is a decision forged by the resident's family along with facility staff, often independent of the person with dementia's choices (Frankowski and Clark, 2009, p. 31).

It should always be presumed that a person has mental capacity and it is up to others to prove otherwise. Most assessments of capacity to consent involve ensuring that the person: can communicate a choice; understand and retain the information pertinent to the decision; is able to appreciate the situation and its consequences; and can display reasoning (e.g., Grisso and Appelbaum, 1998). Such capacity assessments however generally focus on high stake decisions such

as consent for medical treatment or participation in research and rely on logic, reasoning and awareness of implications (Tarzia et al., 2012). The question to ask is whether or not decisions about relationships and sexual intimacy are the same as these high stake decisions and therefore whether they require the same standard of capacity to consent. Lindsay (2010, p. 314) suggests that relationships 'do not necessarily form in a structured, logical manner … .sex is not a decision most people make after carefully weighing the pros and cons or the biological implications of their decision'.

There have been many guidelines and frameworks developed to assist aged care facilities in determining the decision-making capacity of a resident with dementia with regard to sexuality. These are mainly based on those proposed by Lichtenberg and Strzepek (1990), which ask a series of questions about the person with dementia's understanding of risks and consequences and relies on their ability to verbally communicate concepts and values (Tarzia et al., 2012). More recently O'Neill and Peisah (2011) suggest that when assessing capacity to consent to sexual relations there are several factors to take into consideration:

- What is the person's understanding about what is involved in sexual intercourse?
- What is their knowledge of the emotional obligations of romantic relationships in general and in relation to the specific object of their affections?
- Can they advocate for their interests and terminate the relationship if they choose?

Specifically when there might be a hint of abuse, harm or exploitation the following factors are important:

- What kind of relationship do they have? Is there a power imbalance or an element of coercion?
- Is there significant discrepancy between the two people's cognitive capacity?
- What pleasure (or otherwise) do they experience in the relationship? Are they willing or content for it to continue?

All of these frameworks/guidelines are quite restrictive, require a high standard for capacity to consent to sexual relations (possibly much higher than what is expected of people who do not have a diagnosis of dementia) and are particularly risk adverse. According to Tarzia et al. (2012):

> allowing persons with dementia to make autonomous decisions about their sexuality may indeed expose them to some elements of risk such as emotional distress if a relationship ends … these are risks that any sexually active person faces throughout his or her life, and we should not confuse a bad or unwise decision with incompetence. (p. 611)

Every effort should be made to ensure that people with dementia living in residential aged care are not put at risk of being forced to participate in unwanted sexual behaviour, contracting a sexually transmitted disease or any other harm, but we need to be careful that we are not being paternalistic and presuming that we know what is in the person's best interests.

Staff and Family Attitudes and Resident Wellbeing

Our recent study of all Australian residential aged care facilities found that assessment of sexual needs occurred most often in response to perceived 'disruptive behaviours'. Assessment of a resident's sexual needs on admission to the facility, or as part of the care planning process, was not common practice (McAuliffe et al., 2014). Lack of staff education about older adult sexuality and a failure of facilities to recognise and respect the residents' needs (for whatever reasons) therefore combine to help solidify inaccurate assumptions and stereotypes held by care staff about sexuality in older adults.

Addressing staff negative attitudes with respect to the sexuality of older people is important due to the impact they may have on the attitudes and behaviour of residents for whom they provide care. Indeed, one of the most significant barriers to sexual expression in the residential aged care setting is unsupportive staff attitudes (Hajjar and Kamel, 2003). Staff attitudes affect the environment in which they work, which is essentially the residents' home. If residents sense that staff are dismissive, unsupportive, patronising, or ridiculing of their sexuality, then they may be more likely to believe that their right to sexual freedom is unimportant and should refrain from sexual expression and therefore suppress their sexual needs.

Consistent with Goffman's (1961) view of total institutions, judgemental and restrictive staff attitudes can lead to staff adopting a paternalistic or parental approach and attempting to 'control' behaviour rather than supporting the autonomous choice of residents (Roach, 2004). In cases where two residents have formed a relationship and one or both have dementia, concern about potential abuse, or fear of disapproval or reprisal from the family who may see it as immoral or disloyal to a former partner, may lead staff to adopt a zero tolerance approach to such a relationship, even when the relationship may improve the residents' well-being and separation may cause residents some distress.

The attitudes of residents' families and their degree of comfort towards a parent's or spouse's/partner's need for intimacy, can also impact on staff responses and therefore the residents' autonomy and freedom of action. A significant barrier to the acceptance of a resident's sexuality by a resident's family member is similarly the stereotypical view that any display of sexualised behaviour by older people is abnormal or unimportant and needs to be discouraged. Many adult children find it difficult to accept that their ageing parents still have sexual needs (Heath, 2002) and moreover want to fulfil them. Families often expect to be kept informed of their relative's activities and behaviours and furthermore be involved in any

decisions that are made (Bauer et al., 2014b), even when dementia is not involved and the person has known capacity to make their own decisions. Not only does this breach the resident's privacy, but it further disempowers the resident because staff are likely to acquiesce to a family's demands (Frankowski and Clark, 2009) to intervene and stop a relationship or behaviour if the family are resentful and object. Sexuality remains a source of discomfort for many families, particularly when the resident has dementia and when its expression involves romance and erotic behaviour. While families may find holding hands, kissing, hugging and other expressions of affection acceptable for a resident, more intimate behaviours are considered to be too high risk and are not supported (Bauer et al., 2014b).

The Importance of Education about Sexuality and Older People

Research indicates that knowledge and attitudes (White and Catania, 1982; Livni, 1994; Walker and Harrington, 2002; Bauer, McAuliffe, Nay, and Chenco, 2013) and comfort levels (Weerakoon, Sitharthan and Skowronski, 2008) of care staff with respect to sexuality can, at least in the short term, be changed through education and training. Education is particularly important given that health professionals often have insufficient knowledge in this area on which to base their clinical practice (Gott et al., 2004b).

In the US, Walker and Harrington (2002) evaluated training materials designed to improve knowledge and attitudes about sexuality in long-term care staff. Training materials included videotapes that also examined staff responses to homosexuality. Using the Knowledge and Attitudes Toward Elderly Sexuality (KATES) survey developed by one of the authors, the pilot test of 109 staff found that training improved knowledge across three out of four program modules: need for sexuality and intimacy, sexuality and dementia, and sexuality and aging. The training did not significantly improve scores related to the family and personal issues module however, which was possibly due to the low number of participants that completed that module and was unlikely due to a ceiling effect.

In Australia, we evaluated an education program designed for residential aged care nurses to improve knowledge and attitudes towards sexuality in older adults (Bauer et al., 2013). Attitudes and beliefs towards older people expressing their sexuality were found to be more permissive in a sample of 112 nurses following the education, particularly attitudes towards same-sex couples and people with dementia. Our more recent study of sexuality and sexual health education and training in Australian residential aged care facilities was quite revealing (McAuliffe et al., 2014). Out of the thousand-plus facilities that responded to the study survey, almost half reported that their staff last attended education or training within the last 2 years; however, a staggering 40 per cent of facilities reported that their staff had never received education or training in the area. When education was offered, the topics most frequently covered were sexuality and normal ageing and sexuality and dementia, with discussions about sexual health, sexual policy, or

sexual needs assessment featuring far less frequently. Only five facilities reported that education had covered issues specific to LGB sexualities.

Clearly, education of staff in terms of frequency and content is far from ideal. The last few years have also seen the development of several other useful resources that may help address this gap in nursing knowledge and access to education. For instance, a publication developed by The Center on Ageing at Kansas State University entitled 'Pioneering change: Sexuality in Nursing Homes' provides an education module that may be reproduced for educational/ training activities. The module includes case studies in addition to a pre-test and post-test to help staff track improvements in knowledge. In the UK and Ireland, Dementia Care Matters have developed an education module on sexuality, intimacy and relationships. With the sub-heading 'A kiss is still a kiss', the module promotes an approach to sexuality and intimacy in dementia that focuses on well-being. An internet search will also reveal that online training modules exist, some of which attract professional development points or hours. In 2014, the Dementia Training Study Centres in Australia produced a free online 'Sexualities and Dementia Education Resource for Health Professionals' (www.dtsc.com.au/sexualities-dementia-resource/). This resource comes with a facilitator's guide and comprises four modules: 'Intimacy, sexuality and sexual behaviour'; 'Dementia and the expression of sexuality'; 'Ethical considerations: policy/guidelines development for sexualities and dementia in care settings' and 'Developing sexualities and dementia policy guidelines for care practice'.

There is little research around the education needs of families in aged care with regard to resident's sexuality but as with staff, a family's attitudes and decisions are also influenced by personal views, values and beliefs (Bauer et al., 2014b). It has been reported that spouses may be less tolerant than staff with respect to residents forming sexual relationships and engaging in sexual behaviours (Gibson et al., 1999), and our own work also suggests that many families may not be very accepting of sexual activity between residents (Bauer et al., 2014b). As such, education and support for families to help them to understand that the expression of sexuality is normal in old age and to assist them to come to terms with a resident's expression of sexuality may be of benefit.

Sexuality and Aged Care Facility Policy

Even when staff expresses positive views about the sexual rights of residents, few facilities have any formal policies or training programs in place. According to Shuttleworth and colleagues (2010) this lack of policy guidelines and training leads to inconsistent and uncertain practice, and points to the need for a national level approach to policy development. Our recent survey (McAuliffe et al., 2014) of all Australian residential aged care facilities provides further evidence of the policy gap in aged care. Less than a quarter of facilities that responded had policies covering sexuality, sexual health, or sexual behaviour. Furthermore, analysis of the

returned policies revealed that more often than not, policies focused predominantly on behaviour management, rather than how best to support residents' sexual expression and address residents' sexual needs.

International policy and guideline documents designed to assist aged care facilities to address residents' expression of their sexuality do exist however. These documents have all been developed in recent years, perhaps in response to warnings that the next generations of older people to enter care are likely to be more sexually liberated than their predecessors and more vocal about their sexual rights and needs. The Hebrew Home at Riverdale in the United States (www.hebrewhome.org) has frequently been acknowledged for leading the way with its progressive approach to sanctioning sexual expression among its residents by developing a sexual rights policy in 1995. The Atlanta Legal Aid Society (2004) has also published guidelines to assist staff and families of nursing homes to respond appropriately to sexual behaviours between residents (www.atlantalegalaid.org/fact20.htm). In the UK, the International Longevity Centre published 'The last taboo: A guide to dementia, sexuality, intimacy and sexual behaviour in care homes' and the Royal College of Nursing, a discussion and guidance document entitled 'Older people in care homes: sex, sexuality and intimate relationships'. In Canada, the Vancouver Coastal Health Authority has produced 'Supporting sexual health and intimacy in care facilities: Guidelines for supporting adults living in long-term care facilities and group homes in British Columbia, Canada' which includes information on how not to 'negatively label' residents and 'make moral judgements'. A group of professionals representing long term care in Ontario have also produced a document 'Intimacy, sexuality and sexual behaviour: How to develop practice guidelines and policy for long term care facilities'. In Australia GRAI and the Curtin Health Innovation Research Unit (2010) has also produced care guidelines to accommodate the needs of older LGBTI people in retirement and residential care homes. In 2012 the Australian government developed and endorsed a National LGBTI Ageing and Aged Care Strategy (http://lgbtihealth.org.au/ageing) to address the potential challenges for the growing numbers of LGBTI people who will be accessing aged care services in the future.

Residential aged care facilities in the process of developing their own policy on sexuality can also seek guidance from a comprehensive document that was recently developed to allow providers to audit their organisation and determine how supportive it is of the sexual expression of residents. The Sexuality Assessment Tool (SexAT)[1] for residential aged care facilities (Bauer et al., 2014a) addresses seven domains including policies, residents' needs, staff education and training, information and support for residents and families, the environment and safety and risk management. The tool is inclusive of people with dementia and those from culturally and linguistically diverse backgrounds and encompasses lesbian, gay, bisexual and heterosexual sexualities.

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1 See: http://www.dementiaresearch.org.au/images/dcrc/output-files/678-dcrc_formatted_sexat_jan_10_2014.pdf

Conclusion

Being able to express oneself sexually should not be taken away from someone just because they are old, and live in a residential aged care facility or have dementia. The dominant view within the aged care industry is still that older people are sexually invisible. This view is outdated, ageist and not defendable. The desire of older people to express their sexuality needs to be better understood by health professionals and families, and aged care staff and families must take older people's need for sexual expression seriously. Further research is needed to address the questions of whether improving staff knowledge and attitudes towards older adult sexuality actually translates into better practice, and whether there are other confounding factors that are preventing staff from addressing the issue with residents. As long as staff feel uncomfortable discussing and responding to residents' sexual expression, especially the sexual behaviours of older people with dementia, current practices make the expression of sexuality by residents in aged care facilities difficult if not impossible. Respecting the sexual needs of older people needs to be consciously acknowledged and addressed as a legitimate component of care by all residential aged care administrators. "Giving permission" for residents to do what consenting community dwelling adults do needs to gain widespread acceptance.

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Chapter 7
"I am Getting Old and That Takes Some Getting Used To": Dimensions of Body Image for Older Men

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Introduction: Diversities, Inequalities and Equities

This chapter focuses on how older gay, bisexual and heterosexual men talk about their bodies and body image, and foregrounds older men's experiences outside of a heteronormative lens – gay and bisexual, rather than heterosexual men are the primary focus. The way that people in general experience their bodies is undeniably intertwined with their social and psychological experiences. This concept of embodiment has been recognised within feminist literature (Weiss, 1999) and adopted within health discourse (e.g., Williams, Robertson and Hewison, 2009). Whilst embodiment and body image are distinct but interrelated concepts, health, psychology and sexualities literature sometimes fall short of examining how the two are mutually informing. Empirical research has largely aimed to quantify body satisfaction in terms that are not unlike the means we employ to measure the population's physical body (Cash and Pruzinsky, 2004). The bodies and images that are most often studied are those located in the discourses of women and young people, most often within heteronormative terms (Tylka and Andorka, 2012; Filiault and Drummond, 2009). The literature on older bodies, men's bodies and queer bodies[1] continues to develop, but often as discrete foci, and within a model that places ageing within a deficit model of advancing infirmity (cf. Blashill, 2011; Brennan et al., 2013; Jankowski et al., 2014).

This chapter builds on research and discourse on embodiment and body image, using data from 'The RaRE study: Risk and Resilience Explored', a mixed methods study conducted in England. Our aim in this chapter is to add to understandings in psychology, sociology and health about how men over 60 years old feel about their bodies by addressing the intersections of body image, gender, sexuality, and ageing. As the academic advisors and research co-ordinator of the RaRE study, we approach the data from a range of disciplines (e.g., clinical, health and social

1 By 'queer bodies' we mean those whose embodiment is positioned either explicitly or implicitly outside of the confines of (hetero)normativity, such as gender-queer, trans and intersex individuals.

psychology, education and sociology) and a range of theoretical perspectives (e.g., realism, social constructionism and queer theory). While our disciplinary and epistemic differences have strengthened the larger research project at design and analysis stages, we share a number of subject positions (including cisgender,[2] gay or lesbian, white, 'middle-aged') which invariably also impact on our approach to understanding older men's experiences.

In the following sections we define how we use the term 'body image' and how that definition is key to a critical reading of the existing literature and an inductive approach to data-analysis. We describe the RaRE study's overall aims, design, methodology and sample, before describing the sub-set of participants (n= 62) whose questionnaire data informs this chapter. We then interrogate three main themes: 'The Sexed Body' (hegemonic masculinities, cultural norms, feeling attractive), 'The Active Body' (sport and athletics in youth, keeping active in older age), and 'The Medicalised Body' (ordinary and extraordinary medical histories and holistic views of health and wellness). One super-ordinate theme, 'temporal constructions of men's bodies' is present throughout the analysis and is used as a framework to discuss how the three themes work together to advance our understandings of body image, older men, and sexuality.

Body Image

'Body image' is a synecdoche, a rhetorical trope used to describe a vast range of related but distinct ways of understanding the body (Cash and Pruzinsky, 2004), and 'body image' is also often understood as only a very narrow definition related to size and shape, particularly thinness and self-esteem amongst women and girls (Trollope and Turnbull Caton, 1995). Body image research has strong empirical and discursive ties with medicine and pathologised bodies. Much of the early research focused on disordered eating (Pruzinsky and Cash, 2004), and the distress that women and girls can experience related to thinness, media messages and social comparison (Tiggemann, 2004b; Striegel-Moore and Franko, 2004). Research with men and boys developed from models, theories and instruments that focused on women and girls (e.g., Stunkard, 2000) whilst ignoring some of the gendered physical and social differences between them (McCabe et al., 2010). Understanding the history and progression of body image research allows a more critical reading and clearer interpretation of results that can seem conflicting and counterintuitive, such as studies on body cathexis (satisfaction with particular areas of the body) that use instruments with the same assessment criteria and weighting for men and women. An assessment that men are satisfied with their

2 Cisgender refers to people who identify as the gender with which they were assigned at birth, in contrast to trans people who identify with gender other than the one assigned to them at birth.

arms because they do not want them to be thinner, for instance, ignores gendered ideals of size (Grogan and Richards, 2002).

Body image researchers may make specific reference to the sexual identity of participants/sample groups, for example reporting about gay men, but the majority of research on men's body image is with heterosexual men (Tylka and Andorka, 2012). The tension this creates is a reinforcement of differences between gay and heterosexual men, a homogenisation of men of different ages, and an erasure of bisexual men. Under-reporting of body image concerns (within research and within society, e.g., to doctors) has been noted as a reaction to a belief that body image issues are the preserve of women and girls (Pope et al., 2000). Furthermore, changes in social attitudes towards sexuality – from equal marriage legislation to sex education for young people, highlight how new research is required to explore shifts that can be seen in popular culture and the media (Filiault and Drummond, 2009).

New research continues to address difficulties with definitions, and redress epistemological limitations that have been identified, such as instruments that rely on culturally gendered ideals (Pruzinsky and Cash, 2004). For example, there has been a call to address 'mixed findings in relation to the impact of parents, peers, and the media on body image among males' (McCabe et al., 2010, p. 676) by: developing gender specific/ sensitive instruments (i.e., the types of questions posed), acknowledging diversity between age groups; and recognising distinctions between the overlapping but different symbolic meanings of size and shape (e.g., fat and muscularity). Further work including 'longitudinal studies, studies on older men, transnational studies, and studies on intra-group diversity' have specifically been identified as essential to adding nuance to our understanding of the intersectionality between gender, sexuality and body image (Filiault and Drummond, 2009, p. 320).

Much research with men continues to focus on extreme conditions and diagnosed pathologies, particularly relating to muscle dysmorphia and the 'drive for muscularity' (e.g., Hale et al., 2010; Smith et al., 2011). In contrast, within this study we have adopted an approach to address developing and undiagnosed stresses, and adopted an inclusive approach whereby clinical diagnosis of 'pathology' was not a criterion for participation.

The 'Risk and Resilience Explored' (RaRE) Study

In this chapter, we analyse and discuss data from 'The RaRE study: Risk and Resilience Explored', a mixed method comparative study developed to explore the risk and resilience factors relating to mental health and prevalent, potential, and/or perceived inequalities for LGBT people in England.[3] Three areas were identified

3 The funding parameters specified a focus on England. These data may have relevance to Wales, Scotland, Northern Ireland; however, we specifically refer to England because the data has not been collected and analysed from across the whole of the UK.

as especially salient and were the focus of the wider study: disproportionate rates of suicide and suicide attempt in LGBT young people, problematic use of alcohol by lesbians and bisexual women, and difficulties arising from, or signified by, body image problems for gay and bisexual men. See Nodin, Peel, Tyler and Rivers (2015) for a comprehensive overview of the broader study and overall findings.

Following University ethical approval, the data comprised semi-structured interviews (n=34) with LGBT participants. This initial qualitative phase informed the development of a comprehensive questionnaire (n=2078) completed by LGB (n=1378) and heterosexual (n=700) participants, of whom 1958 identified as cisgender and 120 identified as trans. This was followed-up by a second series of semi-structured interviews with LGBT participants (n=23) who were purposively sampled and recruited from the survey respondents, adding depth to findings from the previous phases and addressing contexts of risk and resilience. This chapter focuses solely on the questionnaire responses from men aged 60 years and above (n=62) as the interviewees did not include any older men.

The purpose of the questionnaire was to collect data for comparison of LGBT adults' (ages 18+) experiences of particular health inequities and the experiences of a comparative sample of cisgender people who identify as heterosexual. The questionnaire included quantitative (e.g., General Health Questionnaire, GHQ-12, Goldberg and Williams, 1988; Multidimensional Scale of Perceived Social Support, Zimet et al., 1988; and Rosenberg's Self-esteem Scale, Rosenberg, 1965) and qualitative components, including open-ended questions, and was completed in online and paper formats between June and November 2013. As well as the standardised measures, new instruments were developed to assess body image issues, alcohol abuse, self-harm and suicide. These were informed by an extensive literature review and initial analysis of the first interviews. To assess body image as a health concern across multiple sites of embodiment (aesthetics, physical competence, and experiences of the functioning body, Cash and Pruzinsky, 2004), a new instrument was developed. The 16-item, RaRE Body Satisfaction Scale (RBSS) – a forced-choice Likert rating scale from strongly disagree to strongly agree – asks participants to indicate how satisfied they are with various aspects of their bodies (e.g., their body shape, their genitals, etc.) and body-related behaviours (how much they eat or exercise). The 10-item, five point Body Image Social Influence (BISI) scale[4] was also developed to assess how participants' feelings about their bodies are influenced from different sources and groups of people (e.g., parents, childhood friends, medical professionals, people in the media).

The open-ended questions were included to capture additional detail and adapt instruments that might otherwise be exclusionary or restrictive for those with queer bodies or identities, e.g., outside normative (often binary) categories such as 'gay' or 'heterosexual'. In order to gather information about possible risk and resilience

4 The scale ranges from 'Had no influence at all' to 'Had a great influence', and includes a 'Not applicable' option.

factors, we asked broad follow up questions (e.g., 'What other things about your health and wellbeing would you like to tell us about?') and topic-focused questions (e.g., 'What do you think causes body image problems in LGBT people?', 'What do you think could prevent body image problems in LGBT people?'). None were phrased to ask about gay, bisexual or trans men specifically. The final draft of the survey was piloted on an independent panel of volunteers recruited for the purpose, with additional piloting after the survey had been constructed in Survey Monkey and the online and paper versions were aligned (Nodin et al., 2015).

Participants

Participants were recruited through multiple channels including social media, service providers, web advertising, flyers, posters, databases available from PACE, and word-of-mouth. During the later stages of the survey, purposive sampling was done to ensure adequate numbers from different sub-groups, for example bisexual men, Black and Minority Ethnic (BME) men, and older people. This chapter focuses on the RaRE study survey data from male survey participants aged 60–83 years (n = 62), with a mean age of 66.4 years (SD = 5.5).[5] These men make up 3 per cent of the total participants (n = 2,078) and 6.9 per cent of the total number of male survey respondents (n=902). There were 34 men who identified as gay, 18 who identified as heterosexual, and 10 who identified as bisexual. One gay man and one heterosexual man also identified as transgender.[6] All other participants in this sub-sample identified as cisgender. While the total number of male participants over 60 in each of the listed sexual identity categories is small comparatively, the existing body image literature emphasises the importance of understanding distinctions between men and women and their feelings and experiences (Blashill, 2010).

Most of the older male survey respondents identified themselves as White British (87.1 per cent). One participant identified himself as White Irish, and four men (6.5 per cent) identified as White Other (for example, American). In this age group, only three men (4.8 per cent) identified as having mixed/multiple ethnic identity, with none identifying with any other ethnic groups. Just over a quarter (25.8 per cent) of all the men over 60 were in a legally recognised relationship (i.e., married or civilly partnered). Nearly half (40.32 per cent) of the men were single. Men who had relationships that were not legally-recognised made up 19.4 per cent of participants, and an additional 14.5 per cent recorded the status of

5 Definitions of 'older' and classifications of the ages of 'older' participants are inconsistent across medical, psychology, sexualities and body image literature (Tiggemann, 2004a). In some research focused on gay men, 'older' is positioned as 30 years (Vincke, Bolton and Miller, 1997).

6 The gay participant was identified female at birth and identifies as a trans man. The heterosexual participant identifies as trans, specifying 'cross-dresser' and he identifies his gender as male.

their relationship as 'Other', including being a widower, long-term living with a long-standing friend, and having both a legally married partner as well as a long-term partner who is not legally-recognised (i.e., being polyamorous).

Analysis

First we analysed descriptive statistics from the quantitative sections of the large questionnaire. In order to recognise diversity within categories as well as across categories, we focused analytically on some of the variation, where very often people with diverging experiences and identities are regularly grouped together (such as 'LGBT people' or 'gay *and* bisexual men') and described in monolithic terms. We then explored the qualitative answers that were given to open-ended questions. We used thematic analysis to analyse the qualitative data (Braun and Clarke, 2006). All four of the authors familiarised themselves with the data. One (Tyler) coded the data using Microsoft Word and Excel software and pen-and-paper methods to develop groups of themes and sub-themes. From the quantitative data, we produced sets of descriptive statistics to describe demographic details as well as to indicate areas of similarity and difference between sub-groups. This data was then used to revisit the initial grouping of themes to refine the categories and map out directions for further exploration of the qualitative data where possible assumptions had been made and other relationships had not been identified. The revised themes were labelled and defined and a draft of the findings was produced. We identified three main themes: 'The Sexed Body'; 'The Active Body' and 'The Medicalised Body'. One super-ordinate theme, 'temporal constructions of men's bodies', was emphasised throughout. Temporality is introduced here simply as *explicitly* relating to and existing within (and across) a period of time. Used in this context, our findings build on the claim that 'there are significant resonances between queer subjectivity and the condition of old age. [T]he old are often, like queers, figured by the cultural imagination as being outside mainstream temporalities and standing in the way of, rather than contributing to, the promise of the future' (Port, 2012, p. 3). Notwithstanding a cross-sectional design, these men made sense of their bodies and body image through experiences, memories, and thoughts about the past, present, and future.

Sexed Bodies: Performative Masculinity as Worth

We identified 'The Sexed Body' as a theme about how older men understand their bodies through a gendered, cultural lens. Within this theme, these participants described their self-worth in relation to embodied performances of masculinity. They describe a hegemonic masculinity (Connell, 1995) that has been personally

and culturally reinforced through the media and, in the case of gay men, through social interaction within 'the gay scene'.[7]

Participants' responses indicate that these men view their bodies as symbolic markers of their performative selves, where hegemonic masculinity is a marker of esteem for a 'good' body and for being a 'good' boy or man. All participants were asked whether or not they had been considered a 'sissy', a 'tomboy', or just 'different' from others. Overall, 28 of the 62 men over 60 (45.2 per cent) responded 'yes' to this question, with gay men reporting the most 'yes' answers (18/34; 52.9 per cent). Over a quarter (5/18; 27.8 per cent) of heterosexual men also answered 'yes' to this question. Bisexual men answered 'yes' and 'no' in equal numbers. Participants were given two additional free-text fields to give details and expand on their answers. All who responded 'yes' provided additional responses, a few of which explained that their difference was not gender-related. For instance, one heterosexual man said he was unique because of the business his father ran; another gay man reported being singled out for having dark skin. These comments reinforce two points: first, identification with difference was not always remembered negatively by participants; second, we are reminded of intersectional identifications – where a person identifies or is identified as 'different' or 'other' to a group in early parts of their life and in more than one way, such as skin colour *and* sexuality (Riggs and das Nair, 2012).

More often, however, the 'differences' in this study were explained as being related to a non-hegemonic performance of masculinity. For some of the men, they described themselves as being 'effeminate' (Gay man, 72) or displaying 'latent gay presentation' (Gay man, 67). In 1967, the year that sex between men (aged 21 years and older) was decriminalised in England,[8] participants in this group were already between the ages of 14 and 37. Referring to their growing up, some used more euphemistic terms, echoing the derogatory nature with which their diversity was viewed. For instance, one gay man (aged 74) recounted 'At school, [I was] considered as a "Nance" but that was at school, not now'. Behaviours that were deemed to be feminine or not-masculine-enough were derided.

These respondents reported being judged and (de)valued based on the success or failure of performances of masculinity. This type of hegemonic regulation was not limited to gay men. Men who identified as heterosexual, but described themselves in terms like 'non macho' (Heterosexual man, 71) or 'bookish' (Heterosexual man, 63) also shared memories that accentuated disapproval from other men while they were growing up. One heterosexual respondent (aged 62)

7 We use 'the gay scene' as this was the language used by participants. However, we acknowledge the problematic erasure of the broader LBTQ population in queer community and commercial spaces when 'the gay scene' is the preferred language.

8 In 1967, sex between men was decriminalised in England, but the age of consent was set at 21 until it was lowered to 18 in 1993 and to 16 – equal with heterosex – in 2001. Sex between men was not decriminalised in other parts of the UK until the 1980s (Scotland and Northern Ireland) and the 1990s (Channel Islands and Isle of Man).

described himself as being considered different because he was artistic. He wrote '[I was] brought up in the 1950s and considered a nancy boy pansy by my father'. Across the stories, there is a conflation of quieter, artistic or academic pass-times with effeminacy and femininity. As one heterosexual man (aged 66) recounted '[I was] too bright; advanced ahead of my school colleagues all the time, going up to higher age classes twice. […] I came from a military family. I was definitely not welcome, and I left home at 16'.

Bodies are gendered at several stages throughout development and socialisation (Fausto-Sterling, 2000). The regulation of how masculinity and femininity are done, and by whom, has been shaped for older people in Britain throughout their lives (Segal, 1999; Weeks, 2007). In explaining how they were considered 'different', participants gave examples of how bodies were, and continue to be, signified as being good or bad, better or worse, valued or devalued and how their bodies were expected to move and sound, as well as look.

Attractive Bodies

Within the responses, there was an emphasis on attraction and attractiveness from gay and bisexual men; however, this was largely absent from the responses of the heterosexual men. Perhaps because of the wording of some of the questions about LGBT people and body image, only two of the heterosexual men made comments about the role of the body in sexual, romantic, or social attraction between people. Most heterosexually identified men replied that they did not know (n=5) or left the question blank (n=11).

Normative and idealised bodies were reported as being directed and produced throughout participants' adult years by two sources: the media and, in the case of gay men, 'the gay scene'. The survey data revealed a tension wherein only 16.1 per cent of all of the men in the 60 years and over group indicated that the people in the media had an influence on their own body image. However, in the qualitative responses, more than one third (n=16, 36.4 per cent) of gay and bisexual men explicitly identified images in the media as being either problematic and/or the way to improve issues of body image for individuals and as a mark of social health. Gay men talked about 'media representation' (Gay man, 68) and 'unrealistic images in the media – perfect teeth, airbrushed photos' (Gay man, 62) with a focus on 'perfect people' (Gay man, 65). This was identified as one of the key issues that added to problems with body image: 'I don't think the media helps – most people on TV and in the public eye are cool, sexy and look great – and most of the general population don't' (Gay man, 64). Men said that they did not see the same diversity in the media as they did in their lived experiences, and this related to seeing older bodies, and bodies that were 'ordinary', see also Hinchliff and Gott, this volume.

Some men said that the influence of unrealistic images and unrepresentative bodies was a problem across society generally, rather than being an issue for just LGBT people. As one gay man (aged 65) commented: 'I am not convinced that it

is a problem restricted to the LGBT community. I think that media advertisements and an over emphasis on "celebrities" and their lifestyles contributes to dissatisfaction'. Two of the heterosexual men rated the media as having a great influence on their own body image; however, again, none of the heterosexual men made any additional comment about attractiveness or the media. Whilst our initial impression was that this may be due to the wording of the study rather than a lack of reflexivity about how heterosexual men do or do not feel pressure about their bodies from the media, many of the women – across all sexual identities – expressed very clear and more emphatic views about how they felt the media impacts all people and perpetuates unrealistic ideals.

As well as the comments that the media influenced all people, gay and bisexual respondents noted 'the need to feel attractive to others' (Bisexual man, 60). Gay men made specific reference to how they felt they were impacted by idealised images and body stereotypes on 'the gay scene', particularly as older men. The concern that they expressed was that youth and muscularity are reinforced and reproduced as ideals, with few examples of older, queer role models. As one participant described:

> For gay men the cultural image of Peter Pan [causes body image problems], inasmuch that you're only attractive/worthwhile when young. The commercial scene that only presents one stereotype image of gay men, which excludes most, because the image is unobtainable (Gay man, 78).

When asked about what causes body image issues or could prevent them for LGBT people, gay men talked about the influence of mainstream media as well as media that is aimed at an audience of gay men. This included a recognition that 'gay media' exists within a commercial sub-culture and wider, mainstream commercial culture, and that both emphasise and perpetuate the equation of attractiveness with youth. The 'stereotype image of gay men' that is prevalent in much of the print and online media for gay men mythologises athletic, usually muscular, men. Whilst there has been some variation with fashion through the late twentieth and early part of the twenty-first century (Cole, 2000) including a queer 'Bear' movement to acknowledge (and valorise) bigger and 'furrier' bodies (Wright, 1997), the tall, white, mesomorphic body predominates the cultural imagination (Tylka, 2011). Older gay men risk feeling excluded from a social network where they cannot see themselves or others like them. For some, this social network includes, or has included, romantic and/or sexual possibilities.

Attraction and Competition

One of the surprising tensions that repeatedly stood out in the responses from gay men was the notion of competition *between* men for the attraction and attention of other men (or *another man*). Discourses about 'gay men', 'the gay community', 'the gay scene' and so forth reinforce the idea of a collective group:

'the challenge for modern advocates of community, therefore, is to imagine community without either neo-tribalism or self-immolation' (Weeks, 2011, p. 30). What the older participants in our study identified was the interaction *between* individuals and the individualistic feeling of the gay sub-culture that they had experienced: they attributed problems with body image to 'competition for sexual/romantic attraction' (Gay man, 60) and 'the competitive aspect of being in a gay community' (Gay man, 70). For some, feelings were not about competition *with* younger men, but had been experienced more so *as* younger men than in their current stage of life.

The role that sex plays for gay men was picked out by one participant as having multiple meanings, which can cause tension when this notion of individuation, bodily hierarchies and competition is applied: 'When you're younger, competition from your peer group [causes problems]. Having sex is a very close bonding type of experience for gay people, not just sex' (Gay man, 74).

What this illustrates are ideas about how gay men (and arguably many other people) may sometimes use sex as a form of intimacy or recreation. This fits within a broader shift in English social and personal attitudes towards sex through the twentieth century and to the present day (Weeks, 2007). For some gay men, these comments reveal a disconnection from a social network that accepted, valued, or reinforced the aspects of their gendered bodies and sexual bodies that they were told made them unacceptable outside of that network. Comparable data from heterosexual and bisexual men was not available.

Some participants acknowledged that significant changes have occurred in their lifetimes with regards to the acceptance, embracing or tolerance (depending on context) of sexual and gendered diversity. For instance, 'I grew up when to be gay was not acceptable and suffered all kinds of verbal abuse. It's very different now and gay people in their teens and 20s don't know how lucky they are. In fact I feel quite envious!' (Gay man, 72). With that, there was suggestion that a move away from *using sex* would benefit (gay and bisexual) men and a more holistic approach to the body-and-self would be helpful. In one comment, for example, a 60 year old bisexual man talks about the benefits of 'greater social acceptance, improved social integration' and how we should be 'encouraging less emphasis on sexual interaction as the primary means of self-validation' (Bisexual man, 60). This illustrates an advocacy for a very contemporary, holistic approach to well-being. What he summarises here are many of the men's comments that point to arriving at an understanding of the body as a symbol of value over the course of a lifetime of changes. This, in turn, contextualises their comments about sex as symbolic (of) belonging and as a way of interacting socially. For many, ageing may reinforce the experience of being 'queer' or 'other'; whilst for some – particularly heteronormative – men, the cultural devaluation of the ageing body might mark their initiation to an 'outsider' identity (Clarke et al., 2012).

At the crux of this can be the rejection and stigma from heteronormative culture and the emphasis placed on that alternative social network, having often taken the form of a commercial scene and/or a sexualised environment

(explicitly or implicitly). A paradox to this conundrum: men who are single may be more isolated *and* men who feel isolated maybe looking for romantic or sexual connection, *as well as* non-sexual, social connection. There may be a need for more compartmentalisation of different social and sexual aims by individuals, or a need for more attention to how single, older men can recreate and strengthen networks for companionship and intimacy later in life.

Active Bodies

The second major theme we identified in the qualitative data related to sport and active bodies. Within the group, the men emphasised and elaborated on two opposing sub-themes that were also divided diachronically. The first was that lack of ability and/*or* enjoyment of sports and athletic activities in youth were common amongst the men who reported feeling different as young people. The second was that men who talked about being active now – in their older years – indicated that this was interrelated with a positive outlook on physical, as well as social and mental health.

The stereotypical view that gay men lack the same ability or interest in sport as heterosexual men is one that has been challenged in recent years (Ziegler and Buzinski, 2007), but a gender hierarchy is maintained within a dominant repertoire that femininity in sport is incompatible or inferior. All these older men, regardless of sexual identity, who reported memories of being made to feel different or a 'sissy' made specific mention of the types of hobbies and activities that were associated with masculinity. When we asked men why they felt different, or to elaborate on why they were called a sissy in their youth, answers from one bisexual man and eight of the gay men included specific mention of sport. Examples include 'manly sport never interested me' (Gay man, 74) or just 'bad at sport' (Bisexual man, 77). Throughout, sport was explicitly denoted as a 'manly' pursuit: 'Heavier than others, less masculine, not at all interested in sports' (Trans* identified gay man, 62).

The body that did not participate in sports was an unsporting body, and equated with a sense of queerness: 'I was a clumsy, chubby boy with a pronounced lisp. No interest in sports' (Gay man, 60). Reading these accounts within a framework of queer theory, body fat, co-ordination and even speech are accounted as antithetical to a sporting interest. In other words, we can observe a pattern of *collocations* or associations between different words (Baker, 2003). The meaning of the body is (re)constructed when it is positioned within structures and hierarchies of gendered performance, body shape and sport, all of which are themselves reinforced as mutually informing and co-constructive as they are repeatedly remembered together. The body is 'othered' as an indexical signification of the social self. In another example, the syntagmatic association of intellect, personality, sexuality and gender are all set against sport as defining – and stigmatising – a man's identity: 'Because I was more intelligent, more sensitive, attracted […] to other

boys/men, a little effeminate, and not remotely interested in sports (compulsory at school, which I hated anyway)' (Gay man, 72).

The emphasis placed on sport as a part of defining the masculine body fits within the construct of hegemonic masculinity (Jarvis, 2006), but the emphasis that men placed upon it both within and across their responses marked it out as something that warranted further attention on its own. What made it even more interesting were the accounts of how sport was seen as an extremely positive part of other men's lives, particularly as they attributed it as central to continued good health.

'A Moving Target is Harder to Hit': Activity in Older Age

In contrast to the explicitly negative associations of sport that some of the gay men shared from their youth, continued sport and activity through older age were talked about as being closely related to a positive sense of self. Respondents gave us examples of their activities that included cycling, walking, swimming, and gardening.

> I'm now 78. I swim 6 [times per] week. I'm involved primarily with LGBT friends through being the facilitator of the [Name] Reading Group; attendance at the [Name] Lunch Club, and by playing an important part in the recently formed [Name] self-help group. I enjoy going with a close friend to the theatre, galleries, etc. (Gay man, 78).

In his response to our invitation to share details about his health and well-being, this participant details a very holistic approach to activity. Fewer than 15 per cent of adults over 75 years report exercise that lasts longer than 10 minutes (Fox et al., 2011), but he is physically very active, as well as socially, intellectually and culturally engaged and stimulated. His response indicates his interest in self-care, and the pleasure he derives from being active and involved in a friendship and a community that he actively maintains.

This association with the social aspect of physical activity was echoed by participants who were less mobile or more affected by pain. For these men, challenges to physical health or mobility had a knock-on effect by limiting the amount they could socialise, as well as undertake regular exercise. Physical health also affects their social and mental well-being. Physical problems perpetuate, compound and accentuate isolation, and provide barriers to regular social and physical activities. In this example, arthritis and a hip replacement had become obstacles.

> Dealing with physical problems in the last 2 years has had an impact on my ability to engage in all I would like to, including: socialising (for 3–4 months) cycling and gardening – my main forms of physical exercise (Gay man, 60).

The very active 78 year old swimmer in the earlier example described his atypical level of involvement and activity, and in the same answer described himself as medically 'typical' for his age group: 'As expected I take the usual medicines of other members of my age group as prescribed by my doctor' (Gay man, 78). Whilst men expressed feeling typical for their age, there were complexities in their answers.

> I am unable to work like everyone else – especially as I have very good mates who are all working. I am the 'odd man out' and although they are all very supportive of me I still feel inadequate. At my age and after being so super fit and completing voluntary Army service and getting injured in the process I feel that someone like me should not have to go through this debilitating nonsense (Bisexual man, 60).

Fitness and activity were discussed like this in comparison to others, but also with reference to past, present and future bodies. The meaning that men gave to their own, present body was constructed through the activities that they did or used to do and the activities of other men. They expressed their perception of the kind of man they were in terms of the types of activities that they could and could not do, or found challenging. When identifying physical challenges and limitations that they experienced with their bodies, some men described ways that they reflexively used activity to contribute to their continued sense of well-being.

> My eyesight limitations […] have had an impact on my life – but not the level of being registered as disabled. I am unable [to] see well enough not to be able to qualify for a driving licence. We have a dog – which means we get plenty of exercise (Heterosexual man, 68).

In this example, the man spoke collectively, implicitly including his wife when he wrote about walking the dog for exercise (Peel, Douglas, Parry and Lawton, 2010). He went on to describe keeping in touch with their children and their active participation in each other's lives. Again reinforcing the intersections of physical and social health, but also emphasising that a physical disability does not preclude an active, engaged life.

Some of the responses about being active in older age challenged a number of stereotypes. For example, one man described having lived with HIV since he was 37 in the 1980s: 'Having been HIV+ for 31 years I do try and do plenty of exercise and swim a lot. I have always believed a moving target is harder to hit' (Gay man, 68). As well as challenging stereotypes that would associate older men with inactivity generally, what he reported emphasises the narrative that men who have HIV (and not AIDS) have a higher awareness of health issues and medical concerns, yet they evaluate their fitness and health similarly to men who do not have HIV (Blashill and Vander Wal, 2011). His answer did not describe having HIV as unproblematic – indeed he described ongoing struggles with stigma and

self-esteem – but his story illustrates the dramatic social, medical and technological changes that he has witnessed in his life. As an active, older man living with HIV in England he can provide an affirmative example of how older men, people living with HIV, and older people living with intersectional challenges from illness or injury can sometimes be pro-active in adapting to their circumstances, and emphasise action for healthier living.

Medicalised Bodies: 'My GP Told Me that I was "Disgustingly Healthy"'

The third theme we found in these data from older men highlighted understanding about their bodies in medicalised terms. Because of the nature of the study, we specifically invited people to offer additional information about their health and wellness. As well as examples of health and wellness, some people described injury and illness. Older men indicated that their doctors and/or health professionals had some influence on how they felt about their bodies. Medical conditions and histories were detailed by a number of participants and included comparisons with peers as well as temporal comparisons, including comparisons with their past self *and* anticipation of their future self.

In response to a question about the people in their lives they felt had influenced their body image, these respondents indicated that doctors and health professionals had roughly an equal amount of influence as romantic partners, and more influence than for any of the other categories listed, such as parents, friends, or people they see in their leisure time. This finding was roughly the same for gay and heterosexual men, whereas bisexual men rated the influence of their doctor lower in comparison to romantic partners, friends and childhood friends; an issue unexplored in previous research with men across a general population (Tylka and Andorka, 2012).

The language that the men used to talk about their bodies revealed experience and rehearsal with a technical, medical vocabulary, including a number of shorthand abbreviations that would be unfamiliar to a cohort who have neither experience nor exposure with their particular diagnosis and treatment. For instance, terms such as 'recent angioplasty' (Heterosexual man, 68) and 'only had physical problems: OA [osteo-arthritis], Hip replacement, RA [rheumatoid arthritis], subacromial impingement [trapped tendons or tendonitis] and torn rotator cuff tendon, disc herniation' (Gay man, 60) were used. We read a number of detailed descriptions where men talked about physical as well as mental health.

In talking about their bodies in medical terms, we noted the complex intersectionality between age, sexuality, and a framework of temporality, 'in the sense of how time is experienced or perceived and in the sense of how available time might be filled' (Port, 2012, p. 5), or in cases like the participant below, nullified. Men referred to their health and bodies by talking about a past standard of health they had experienced as younger men. Some noted recent changes to their health. Others gave accounts of past or long-term illness, and some described

a compounding of health concerns where new conditions emerged in addition to on-going issues.

> I have been HIV positive since 2000 and was diagnosed when infected. Peer support groups at [Name] and elsewhere helped a great deal in my coming out at age 57. I had a soft tissue sarcoma removed from my [leg], with no side effects. I never stopped work until I retired in 2012 age 66. […] I have been [on] a 20mg a day dose of citalopram for depression for over 11 years, and the staying alive is not a priority (Gay man, 67).

Like the examples in earlier sections, this man goes on to write about his experiences with social and medical challenges together with accounts of resilience. In this abbreviated example, he gives an account that includes physical and mental health, interventions and continuation with ordinary routine, past and current illness and construction of his feelings about the future. In his longer, written answer, this same man also gave us details about his relationship with his children and grandchildren. These accounts, along with his medical history are framed within a narrative that reveals the acceptance, as well as the rejection and stigma, that he has experienced in relation to coming out as gay. The qualitative data is invaluable here, not just in revealing the detail and the contradictions, but also the shifting subject positions for a population who are commonly described – even within this chapter – in very categorical terms. From his answer, we also learn about the interrelationship of his medical history with his family and sexual history: that he came out as gay to his wife when he was diagnosed with HIV after which he experienced depression and considered ending his life. In this case, temporality explicitly frames the intersectionality and an imagined future is both challenged and challenging.

A quarter of people living with an HIV diagnosis in the UK are now aged 50 and over (Yin et al., 2014). Whilst the overall number of new infections of HIV in the UK has decreased slightly, both the proportion and number of diagnoses amongst older adults has increased (Yin et al., 2014). For example, in 2012, 26 per cent of heterosexual men who were diagnosed with HIV were aged 50 years or older; however, whilst most gay, bisexual and other men who have sex with men (MSM) do not have HIV, they continue to be disproportionately affected by HIV. In our sample, five of the men who identified as gay (15 per cent) talked about having HIV, but none of the men who identified as heterosexual or bisexual. This is significantly higher than the proportion of all gay, bisexual and other MSM living with HIV within the national population (5.88 per cent or 1/17,[9] Yin et al., 2014). This may be related to sampling for the RaRE study; however, the process of HIV diagnosis and 'coming out' to partners may also affect how MSM

9 This figure is for men aged 18–59 years. The 2014 report from Public Health England does not give figures for MSM aged 60 years and older. It notes that in the total population of MSM presenting for care for HIV, 30 per cent are aged 50 years and over.

identify their own sexuality to themselves and others. Older adults (over 50 years) have also been found less likely to disclose their HIV status than younger people (Emlet, 2006).

The time at which the men responding to our study were diagnosed with HIV ranged from three decades before to within the previous few years. What may disrupt dominant ideas about sex and sexual health amongst older men is exemplified by the man who was diagnosed with HIV in his retirement.

> I picked up HIV just as I retired and was going to look forward to a better future – understandably – many LGBT people (and straights as well of course) shy away from you as a result. I think it has made my lack of ability to make friends even worse and that has made me a bit depressed I think (Gay man, 64).

The idea that people in their sixties are at risk of HIV and other sexually transmitted infections runs contrary to the mythologised ideology of the heterosexual matrix (Rubin, 1993). Older people in England are discursively constructed as married and monogamous, and retirement infers a slowing down, not the kind of body that is at risk of HIV and STIs (see also Chepngeno-Langat and Hosegood, this volume). Yet, this adds to a relatively recent understanding that intimate life continues into and through our older years and changes to patterns of marriage, partnership, and divorce have played a role in exposing a generation who may be less aware of or feel able to manage their own risk. This man suggests he may have depression and expresses his feelings in a way that is typical of depression and common amongst people who have been diagnosed with many medical conditions, including HIV as described here (Blashill and Vander Wal, 2011). Stigma has been significantly associated with negative self-image, depression, poor mental health and increased disability (Fredriksen-Goldsen et al., 2012). This pattern of depression related to diagnosis with HIV intersects with depression related to other life changes that may or may not be directly or indirectly interrelated, such as a partner's reaction. In this man's account, he was previously married to a woman and his diagnosis prompted him to tell his wife. He talks about her reaction and their subsequent divorce. These experiences and changes in identity are invisible – or make false assumptions about causality – when research is designed to focus on sexual identities as being fixed through people's lives. The medicalised body is also the social body. The interplay of the physical, mental and social tripartite advocated in some models of understanding body image (Tylka and Andorka, 2012; Tylka, 2011) is brought forward in the participant's own words. In one of his answers, our oldest participant, aged 83 years, touched on all of the major themes: the sexed body, the active body, and the medicalised body, combined to construct the temporal body.

> Although I am over 80 years old I certainly don't feel it and I am regularly taken for being much younger probably because I am of quite slim build with no excess bodyweight (comes of being an athlete when I was younger and keeping

> up with a reasonable amount of exercise even in my later years). My GP told me when I had my annual "MOT" last month that I was "disgustingly healthy" for my age (whatever that may mean). I live alone (and have done since the break-up of a long-term relationship 8 years ago (after being together 24 years). The relationship did not end on a sour note and we have still remained friends it was just the age gap that was there interfered in things (I was much older). Both of our families were supportive of us and our relationship and both families have remained in touch in a caring way since the breakup. This has certainly been a great help to me in overcoming some of the difficulties that arise if one is living alone when you are older (Gay man, 84).

Another participant summarised the role of social expectancy with a list of ways that people could actively engage in self-care through their lives:

> Important to get HIV check-ups after risky sex, of any even small risk. Important to keep doing things. Important to role model gay people as contributors to the bigger picture. Energy paid out conveys health and youthfulness. Paying attention to how you look is very crucial, as is trying not to look your age (Gay man, 68).

Both of these examples bring together the ways that the ageing male body is talked about. The former speaks about his own health and wellness very personally and reflexively. The latter elides his own subject position as he provides advice about what will help LGBT people. Both men provide insight into how we can build on models of resilience, and in doing so, redress an emphasis on deficit models within a traditional psychological lens of advancing infirmity.

Conclusions: Contexts and Temporal Bodies

In our analysis of the data for this study, we found three themes about how our older male participants understand men's bodies and body image. We have described these as 'The Sexed Body'; 'The Active Body' and 'The Medicalised Body'. As we continue analysis across different subsets, we emphasise the development of one super-ordinate theme, 'The Temporal Body'.

Using a model that acknowledges physical, social and temporal factors to understand men's body image is helpful to address the provision and access of health services for older men (Tylka and Andorka, 2012). Including factors (or mediators) of body appearance, functional performance, *and* social influences offers a holistic perspective. It creates a space for dialogue and a recognition of the interconnectedness of physical, mental and social health and well-being. Expectations of (hegemonic) masculinity and heteronormative gender roles can continue to influence how men are viewed as they age and how they see themselves. Gender, gender roles, and sexuality 'scripts' inform the lives and experiences of

men as well as women, however they identify with heterosexual, bisexual, gay, trans* or cisgender. Rather than being ignored in the name of 'equality', men's gender and sexuality might better be acknowledged within practice and mainstream service provision, and used to redress structural and social inequities related to the social expectations of these scripts.

Many of the examples we have used as illustrations are from gay men by virtue of number and descriptiveness, but men of all sexual identities were proud advocates of rude health even in their late 70s and early 80s, which they attributed to maintaining or adopting an active lifestyle: sporting, cultural and social. They emphasised the interrelatedness of feeling physically and mentally well. In cases where men faced physical obstacles to mobility and activity, men expressed greater concern related to increasing or compounding existing feelings of isolation. Compounding age and health issues were a concern for these older men, sometimes related to health inequities. Changes in family and social structures were interrelated with changes in health. A sense of connection was related to how secure and supported men reported feeling.

As well as their 'romantic partners', older men attributed the most influence on the feelings they had about their bodies to their doctors or health professionals. The men used a medicalised language to talk about their bodies, describing detailed medical histories and using medical terminology and jargon. As well as describing their past bodies, again they contextualised their current health experiences in social terms.

Using thematic analysis to compare answers from different questions across the dataset from different men aged 60 and over allowed us to observe how participants gave answers that constructed past, present and future selves. Amidst a repertoire that emphasised youth, it was cheering to read about men in their 60s talk about when they *will be older* in a future tense and context. In constructing these temporal bodies, they emphasised the centrality of gendered scripts in their identities and the impact that continues to have. As older men, they are aware of comparisons with other (younger) men's bodies, as well as making comparisons with their own younger bodies. Gay men in particular expressed concern that ideals that have been portrayed and assimilated by men in 'the gay scene' – as well as across society – are not representative and exclude and erase older men's bodies. Many stressed that attraction to other men can also foster a sense of competition *between* men, which in turn can be alienating and serve to further exclude people from a social space where they have sought refuge and companionship from dictates of heteronormative oppression.

One man's view was that problems with body image for LGBT people were related to 'dress code and attitude' and that the solution was to 'dress and act as normal people do' (Heterosexual man, 67). Without further elaboration from him, we might read this as an example of continuing hegemonic regulation of how 'normal' bodies should look, dress and behave. In our aim to explore risk and resilience, we can identify continued tensions between social expectations of 'heteronormative' performativity and how all older people embody 'queer' to a greater or lesser degree (Port, 2012). Liberal ideologies are paradoxically restrictive

within repertoires of 'age-appropriateness', heteronormativity, homonormativity and biological determinism (Weber, 2012). Even as inequities based on sexuality are addressed and reduced, new hierarchies emerge. We must continue to explore the lived experiences of people with evermore individuated identities within the broad categories we address as heterosexual, gay and bisexual.

Acknowledgements

We express our gratitude to the many diverse research assistants and panel members who have co-produced this work along with the participants who volunteered their time to be interviewed or complete questionnaires. The RaRE study was funded by the Big Lottery Research Fund (2010–2015) and led by PACE – a leading London charity that provides mental health services to LGBT people.

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Chapter 8

Troubling Identities? Examining Older Lesbian, Gay and/or Bisexual People's Membership Categorisation Work and its Significance

Andrew King

Introduction

Over the past decade or so the lives of older people who identify as lesbian, gay and/or bisexual (LGB) have increasingly become the focus of research, emanating from academics, third-sector organisations and community-based projects. This population of older adults has also been identified in some forms of policy making and service provision as being in particular need of support. Moreover, writers have suggested that because current generations of older LGB people experienced a more draconian climate earlier in their lives, even if they did not necessarily identify as lesbian, gay and/or bisexual at the time, this legacy of stigma has endured (de Vries, 2014; Knauer, 2011). Cumulatively, therefore, older LGB people are identified as a distinct group of the ageing population with different life experiences and needs to their older heterosexual peers, which requires an institutional response.

In this chapter, I briefly consider some of the main findings of the aforementioned research and what it suggests about older LGB people. However, my central aim is to revisit and extend analyses and contentions I have developed previously (King and Cronin, 2010; King, 2014), to argue for a more nuanced approach to older LGB identities. I do this by drawing on Queer Theory, particularly as it is manifested in the work of Judith Butler (1993, 1999), bringing this into an analytic dialogue with Conversation Analysis, particularly a form of Conversation Analysis known as Membership Categorization Analysis (MCA). I will then use qualitative interview data drawn from research I conducted for a local government authority. I will analyse this with MCA to demonstrate that ageing sexualities, such as older lesbian, gay and/or bisexual sexualities, are constructed, situated accomplishments that rely on considerable identity categorisation work. I will argue that in the move to institutionalise these identities this work can be elided, something I reflect more upon in the conclusion to this chapter.

Older LGB People – A Troubling Story

Research emanating across a range of social science disciplines and organisational contexts tells a rather troubling story of LGB ageing and the lives of older LGB people. Survey research conducted in the UK for the LGBT charity Stonewall (Guasp, 2011), for instance, has compared LGB people and heterosexual people over 55 years of age across a range of issues and contexts. The research found that older LGB people were more likely to rely on friends rather than family for support later in life; be more reliant on public services; be more fearful of going into residential care and have less confidence that health and social care services would meet their needs (see also Westwood, this volume). Similar findings from social scientific research have documented the challenges and multiple forms of discrimination that older LGB people face in the areas of housing (Boggs et al., 2014; Johnson et al., 2005), health and social care (Willis et al., 2011), as well as end-of-life planning (Almack et al., 2010; Westwood, 2013).

There have also been a number of community-based projects, developmental work and forms of activism in the UK (Fenge, 2010; Newman and Price, 2012; River, 2006) and other Western contexts, including but not limited to the US and Australia (de Vries and Croghan, 2013; Cohler, 2005). These projects have sought to identify and challenge discrimination, particularly as it is ingrained into institutional structures, policies and services. Additionally, a range of equality legislation in the UK over the past ten years, recently combined into the Equality Act (2010) and Marriage (Same-Sex Couples) Act (2013) means that there is an increasing onus on institutions providing services to older people to take account of the needs of their LGB clients, to ensure that they are non-discriminatory on the grounds of sexual orientation. However, the picture that emerges from research indicates that older LGB people continue to be systematically disadvantaged when compared to their heterosexual peers.

The increasing focus on older LGB lives should be welcomed and it is good to see older LGB people's lives being taken seriously, although much work remains to be done. My concern in this chapter, however, is not to undermine or eschew previous research, which provides important, necessary and vital correctives to inequality and prejudice. Instead, I focus on the *constitution* of the subject and the recognition of difference based on ageing and sexuality, amongst other forms of identity, social division and inequality, that such developments are based. There are a growing number of studies that point towards intersectional differences within and between older lesbian, gay and/or bisexual people themselves, on the grounds of gender, ethnicity, social class, (dis)ability and health status, amongst others (Cronin and King, 2010; de Vries, 2014). Additionally, there is recognition that older LGB people might not have identified according to those sexual identity categories across their life course (Cronin, 2004; Jones, 2011; Jones, this volume; Traies, 2012). Yet there is little written about *how* such identities, particularly those related to ageing sexualities are constituted at an interactional, moment-by-moment level in specific contexts. There is an understandable motivation to make

things better, to decrease inequality and promote dignity, respect and rights. There is also, however, a tendency to overlook the tenets of influential perspectives – such as Queer Theory and Ethnomethodology and Conversation Analysis – that trouble the notion of a relatively stable subject to whom research, policy and practice can be directed. These perspectives, instead, point towards the instability and highly contextual and contingent nature of identities.

Troubling Identities

Queer Theory, with its focus on deconstruction and discourse (Valocchi, 2005) may seem rather abstracted from the lived experiences of older LGB people and their everyday interactions with institutions and service providers. Queer Theory developed in the 1990s, providing a critical counterpoint to work which sought to create sexual and other forms of equality through integration within existing, assimilationist paradigms (Gamson and Moon, 2004). Queer Theory, following its post-structuralist leanings, implies that such a move was impossible because it did not fully account for the power of institutionalised heteronormativity, the notion that heterosexuality is the dominant, normative sexuality from which others are judged and that this is a foundation of society. The task of Queer Theory, therefore, is to deconstruct heteronormativity, to show how it constructs difference and subjectivity and above all power relations; or as Fuss (1991) asserted: 'heterosexuality secures its self-identity and shores up its ontological boundaries by protecting itself from what it sees as the continual predatory encroachments of its contaminated other, homosexuality' (p. 2).

Queer Theory is not really a unified theoretical perspective, nor does it have a clear empirical/methodological programme that may be useful for researchers, organisations or advocates wishing to focus on the practices that it claims to uncover (Green, 2007; McIlvenny, 2002). Yet its relentless focus on the power of heteronormativity to manifest categories of identity, which shape and constrain lives, enabling subjectivities to become and be undone, is particularly important. This is especially so in the queer theoretical work of Judith Butler whose key insight is that categories of identity are performative, they are brought into being through discursive practices that constitute what they name (Butler, 1999). She illustrates this (Butler, 1993) in relation to gender:

> [gender] is thus not the product of choice, but the forcible citation of a norm, one whose complex historicity is indissociable from relations of discipline, regulation, punishment. Indeed, there is no 'one' who takes on a gender norm. On the contrary, *this citation of the gender norm is necessary in order to qualify as a 'one'*, to become viable as a 'one', where subject-formation is dependent on the prior operation of legitimating gender norms. (p. 232, my emphasis)

Butler is suggesting here that gender identity is constructed through the power of gender norms that people are compelled to *do*. Thus gender identity is not of one's own making. Indeed, one cannot 'be' gendered outside of a discourse of gender; identities are constituted in and through it and discourse regulates who one can be. To do gender differently is to risk being culturally unintelligible, to have one's personhood subject to erasure. Whilst Butler is referring here to gender, the same argument can be applied to other aspects of identity, such as sexuality and age. We are compelled to 'do' sexuality and age within normative limits and it is the doing of such identities that constitutes them socially.

Queer Theory regards all identities as created through social understandings and practices during specific historical eras; indeed, contemporary understandings of age, gender and sexuality emerged during the nineteenth century as part of the ongoing Enlightenment project (Foucault, 1978; Jordanova, 1989; Lesko, 2001). Queer Theory is useful for thinking through questions of power, identity and subjectivity and how certain identities are brought into being and indeed recognised by discursive practices of categorisation. However, although it certainly provides us with an analytical vocabulary, as I have noted above, it does not really illuminate the everyday lived experiences of either becoming and/or being a member of such an identity category, only that such categories are regulatory and constraining (Jackson and Scott, 2011). Within sociology, however, there are two other perspectives, in particular, which draw attention to practices of identification and the significance of 'doing' identity, but with a greater focus on *how* these are achieved in everyday life: Ethnomethodology and Conversation Analysis.

Ethnomethodology examines the methods that people use to make sense of the world around them and create social order (Garfinkel, 1967). In so doing, Ethnomethodology suggests people (or members in the perspectival parlance, because they are members within social, interactional contexts) offer accounts, or explanations of their understanding. This is particularly so if they are called upon to *account for* some aspect of their identity or behaviour. For instance, because homosexuality and bisexuality are different, or other, within heteronormativity, these identities are accountable – explainable – in certain contexts in ways that heterosexuality is not. In offering accounts, people will invariably use talk, and Conversation Analysis, which was developed by Harvey Sacks in the 1960s, drawing on an Ethnomethodological perspective, is the exploration of how sense making and accounting takes place through talk (Sacks, 1995).

Sacks developed two strands of Conversation Analysis (Silverman, 1998). The first and what has become the most widely used, is sequential analysis. This focuses on the structure of talk, how things are said in terms of turn-taking, pauses, overlaps, laughter and intonation. The second is categorisation analysis, which focuses on categories of people, places, events, objects that populate talk and the activities or attributes that are associated with them. According to Sacks, categories are grouped together into collections, or what he called membership categorisation devices (MCDs). For instance, the MCD or collection 'sexuality' has a number of categories, including: heterosexual (straight), homosexual (lesbian and gay),

bisexual (bi), amongst others. Some MCDs display what Sacks called 'duplicative organisation'; that is, they have certain team positions. Sexual identity categories, within heteronormativity are so organised, with heterosexuality assuming the dominant position. Furthermore, categories have certain features associated with them, what Sacks called 'category bound attributes' (CBAs). Thus, an attribute associated with homosexuality, as opposed to heterosexuality is to have desires for, or sex with, someone of the same, rather than a different sex. CBAs can be one way that people 'read off' someone's sexuality; often these are carried within cultural stereotypes: for example, a man whose sexuality is 'accountable' because he is a women's hairdresser (for a discussion of this example see Sacks, 1995). Yet categories, MCDs and CBAs are not law-like, or obdurate. They are culturally prescribed, subject to change and above all they are used by people in their everyday interactions in variable and complex ways. In short, people make sense of themselves and their social world partly through identity categorisation work.

The examination of identity categorisation work has been called the exploration of 'culture-in-action' (Baker, 2000) – it demonstrates 'how discourses are called on and how they are invoked in the mundane activities of talking, hearing, reading and writing' (p. 112). In her discussion of the applicability and critical application of CA and categorisation work to gender, Stokoe (2004) suggests that the concern with everyday interactions and their apparent mundaneness is exactly where gender is 'done', normatively, strategically and in ways that are transgressive. Gender is done, undone and redone through everyday categorisation practices. In Ethnomethodological and Conversation Analytic terms categories are used 'artfully', not in a mendacious way, but in terms of skill, of competence within a culture. We can see a link here between Queer Theory, with its notion of the performativity of discursive identity categories (such as heteronormativity and gender), the Ethnomethodological focus with how people use methods, such as accounting, to make sense of the social world and the form of Conversation Analysis that explores how categories contain social knowledge (discourses), but are always transformed in use, through accounting practices.

Membership categorisation analysis (MCA) is the term that has since been given to the examination of categories that started with Sacks. It is the method that I will use in the remainder of this chapter.

Methodology

Research Design and Sample

Ann Cronin (AC) and I were commissioned by managers at a local government authority (LGA) to undertake a scoping study regarding older LGB people in their Borough. The LGA were producing a sexuality equality scheme in response to recent equality legislation (Equality Act 2010) and the LGA's organisational policies concerning equality and diversity. They had already engaged in some wider

LGBT equality work, taking part in the Stonewall Equality Index and running events for LGBT History Month. In developing their sexuality equality scheme the managers at the LGA specifically wanted to make sure that older LGB people's voices and needs were included. The qualitative study included: interviews with older LGB people; a gay men's focus group; interviews with key older people's service providers; and interviews with a number of LGBT activists and advocates. In total 23 older LGB people were recruited via newspaper adverts, flyers in public settings, including LGBT specific spaces, and online LGBT forums: 11 gay men, one bisexual man and 11 lesbians aged between 50 and 78 years. Participants came from a range of socio-economic backgrounds, although just over half identified themselves as middle-class. All participants identified as White, apart from one gay man who identified as Mixed White/Black African-Caribbean.

Interviews with participants typically lasted up to 90 minutes and included questions about: sexual identity across their life course; their experiences of a variety of services; their feelings about their local area; and concerns and hopes about ageing as a lesbian, gay and/or bisexual person. All the interviews with the women were conducted by AC and I conducted most of the interviews with the gay and bisexual men. This was due to concerns about gendered power structures, particularly older lesbian and bisexual women being interviewed by a man, but also the researchers having 'insider' members' knowledge which could be useful for establishing rapport. The focus group – which covered similar topics to the interviews – lasted two hours and was conducted by AC with my support.

These data were first analysed using thematic and narrative analysis (Bryman, 2004) to facilitate a report suitable for the LGA with recommendations about how to improve services for older LGB people (see also King 2015; King and Cronin 2010).

Doing MCA

Ethnomethodology, Conversation Analysis and MCA are usually associated with so-called 'naturally occurring' talk i.e., talk which is not obtained via social scientific methods *per se*, such as interviews and focus groups. However, Baker (2002) and Stokoe and Smithson (2001) have argued that there is no reason why this kind of institutionalised talk i.e., that generated through research, cannot be analysed in this way. Yet Stokoe (2012) has suggested there have been very few systematic explanations concerning how to conduct an MCA, nor the level of conversation analytic detail that is necessary. I have used a restricted set of symbols from the full CA transcription system[1] in the extracts that follow. For strict adherents to CA this might be problematic because it does not illustrate the

1 This is a symbol laden notation system developed by Gail Jefferson for recording key features of talk in textual form: for example, pauses (in tenths of a second), intonation, pitch and amplitude, laughter, overlaps, interruptions, speed. For a good overview see Wooffitt (2005).

full panoply of talk-in-interactional features (e.g., Schegloff, 2007). But in his categorisation work Sacks (1995) very much focused on the categories themselves and their sequential unfolding, rather than focusing deeply on the surrounding 'mechanics' of the talk. Stokoe (2012) and others (Watson, 1997) have argued that tracing the sequential unfolding of categories, MCDs and attributes is important in order to explore how people manipulate and transform meanings across their accounts. So my use of some transcription symbols is oriented to this sequential unfolding, particularly the delivery of categories, MCDs and attributes, noting pauses, hesitations, overlapping talk, some intonation and laughter.

Using qualitative data analysis software (for a detailed overview of this method see King, 2010), I conducted a three step model of MCA, which was influenced by Stokoe (2004). This involved: identifying key categories, the collections, or MCDs from which they come, together with their associated attributes; mapping the sequence of these within each account and across the sample; and identifying how certain categories, MCDs and attributes were treated as anomalies or disruptions by the co-participants in the talk that required some form of explanation or repair.

In the remainder of this chapter I use this model of MCA to explore the complex identity categorisation work undertaken when participants were called to account for their ageing sexualities. I demonstrate that older LGB people's identities should not be treated as *a priori* entities, but as performative and discursively constructed, argued over and rejected within interactions.

Accounting for Ageing Sexualities through Categorisations

Troubling Sexualities?

Sometimes categories that can be associated with the MCD 'sexuality', such as gay, lesbian or bisexual were used by participants in response to a question posed by the interviewer concerning sexuality and sexual identity. In this section, I will discuss three examples that illustrate how participations responded. What is common to all three, however, is how gender is also made relevant to make sense of categories of sexuality.

Bisexuality is often represented as problematic within sexual minority communities; a form of sexual identity that is inauthentic, questionable and troublesome (e.g., Jones, 2011; Weinberg et al., 2001). Arguably, in Extract 1 (below) Graham's membership categorisation work can be heard as a form of clarification, for the interviewer, as to how he specifically views his bisexuality; in this case *he* draws attention to the gendered direction of his desire:

Extract 1

AK: what I'd like to do (.) er (.) to start with (.) is to talk a little bit about sexuality and sexual identity (0.2) we all (.) kind of (.) use different terms to

describe our er (.) sexuality (0.1) our sexual iden:tity so it would be really useful for me if you could describe your sexuality (.) your sexual identity.

G: (0.2) well I er (.) would describe myself as being bisexual (0.1) with a leaning towards the male er (.) gay side

AK: ok (0.3) and how long have you identified as bisexual

G: since er (.) since I was about 10 years old (0.1) I suppo::se

In this extract my interview question make's the MCD, or collection of categories, 'sexuality/sexual identity' relevant to the interaction. However, before addressing the actual categories I want to focus on the ways that categories are brought into play: how the question is delivered and how Graham initially responds. My question begins with a statement 'what I'd like to do'. It has a partially hesitant delivery (note the pauses; some very short (.), others longer). Graham initially responds thus: '(short pause) well I er'. As Schegloff and Lerner (2009) note, well responses to *wh*-questions preface a nonstraightforward response. Arguably, both the delivery of the question, with its reference to the MCD sexuality and Graham's hesitant 'well' response indicate 'trouble' i.e., that sexuality is being held 'accountable', something that needs to be substantiated in this context. Graham confirms his membership, his incumbency, of a recognisable category of sexuality, ('bisexual') for the purposes of this context. However, after a short pause, Graham follows this initial membership categorisation with an attribution ('a leaning towards') and the introduction of a gendered category ('male') and another category of sexuality, turned into an attribute 'gay side'. Thus, Graham can be heard as stating that he is bisexual (for categorical purposes), but clarifies how his membership of this category, to me, giving more specific information.

It is also interesting that despite this identity categorisation work, following my recognition token ('ok'), in the follow up question I did not add this degree of categorical sophistication, asking instead a question about longevity of bisexual categorical incumbency. There is, therefore, a form of erasure taking place here, an un-troubling of sexuality, on my part; a point I will return to in the conclusion when I discuss wider issues about categories in research, policy and service provision.

While Graham responds to the MCD sexuality by offering a recognisable category, which he then clarifies, other participants sought to distance themselves from sexual identity categories in a number of ways. One such way was the use of, but then rejection of, categories of sexuality. This can be seen more prominently in the categorisation work taking place in Extract 2 (below), conducted by AC with Abbey and Jean, a same-sex couple:

Extract 2

AC: so (.) can you tell me (.) how yud describe your sexualities

Abbey: gay women or lesbians (.) you know

AC: yeah

Abbey: I mean it's just (0.1) but (.) er (.) I mean we really don't label ourselves (.) do we

Jean: no (.) we don't really

Abbey: (0.1) a young fellow who lives ((nearby)) he just calls us the chicks from 56 (.) you know (.) duzn he

Jean: yes

Abbey: and er (.) he:z young enough to be our son (.) you know heh

AC: mmn

Abbey: so I think that is kinda nice we call ourselves chicks from 56 which is really nice you know

AC: mmh:mm

Abbey: because then it duznt make you feel too <u>old</u> (.) or past it

(.) or I think people just accept us for what we are don't the[y]

Jean: [ye]ah

we've had no bother (.) since we've been here

Once again, we can see how AC's question sets the categorical scenery for the response: the MCD 'sexualities' is deployed. Certainly, in her response, Abbey construct's their sexualities using two recognisable sexual identity categories from this MCD: 'gay women' and 'lesbians'. However, she then qualifies her use of these categories, noting that 'we really don't label ourselves do we'; an attribution, in the form of a question, that is affirmed by Jean: 'no we don't really'. Such a denial is potentially *troublesome*; indeed, it warrants a further account from Abbey concerning how they do categorise themselves. In CA terms, Abbey is offering a self-repair. In undertaking this, Abbey turns instead to another MCD made relevant in her previous response, 'gay *women*' i.e., gender. Here she gives an extended account, with affirmative interjections from Jean and AC, about a male neighbour who she says has given them a gendered epithet: 'the *chicks* from 56'. Yet it is clear from what follows in her talk that any latent sexism that could be associated

with this category, 'chicks' is sometimes used as a sexist description for women, does not appear to concern Abbey here. Thus, it seems that gender is deemed by Abbey and Jean to be more preferable than sexuality as a categoriser. However, yet again, Abbey challenges this presumption in her ongoing account: the reason she claims that they like the epithet is not simply associated with gender *per se*, but with age: it 'doesn't make you feel too old or past it'. These categorisations can be related to and accord with the view that women are disadvantaged by ageing, whatever their sexuality (Krekula, 2007). Hence, Abbey's statement 'people just accept us for what we are, don't they?' which is quickly affirmed by Jean to the point where their speech overlaps and followed by a statement that explicitly rejects any 'bother' in their specific geographical location, suggests that sexuality is the bother, the trouble, rather than ageing or gender. Hence, ageing and gender are preferable categorisers.

Extracts 3 and 4 are from the interview I conducted with Ernest. Like that of Abbey and Jean, the interview began with a question concerning sexuality. Here again it is possible to see Ernest's categorisation work troubling categories of sexuality:

> Extract 3
>
> AK: We all use different terms to describe our sexuality (.) so it would be helpful for me if you could tell me how you describe your sexual identity
>
> Ernest: Right (0.1) er well (.) I feel it's a very important issue (.) well it is for me I'm a gay man (.) but my gayness is not (.) what I would call my primary characteristic (.) er my primary characteristic is that I'm male (.) and er (.) I would do everything that I would expect an ordinary male to do except that when it comes to sex then I'm going to prefer to have sex with other men (.) but that's the only way I consider myself to be gay

My question again makes membership categories associated with the MCD 'sexuality' a relevant resource for Ernest to categorise himself. The question includes an extreme case formulation, 'we all' (Edwards, 2000), which serves to underscore the 'obviousness' of such categorisation work. This makes it difficult for Ernest to offer any other form of account, or even a brief account. This, of course, does not mean that Ernest will always categorise himself according to this MCD and in his response he makes it clear that his understanding of his sexuality is more complex, what could be described as 'doing' rather than 'being'. Initially he categorises himself as a 'gay man'; rather like Abbey and Graham, there is the invocation of a gendered, sexuality. However, rather than ending his description at this point, Ernest then turns this categorisation into an attribute, 'gayness' and in so doing makes his membership of this category notable. Ernest then re-emphasises his gender, asserting that 'male' is his 'primary characteristic'. Yet Ernest turns this into a positioned category. What distinguishes him from being an

'ordinary male' however is something he 'does': he 'has sex with other men'. It appears, to an extent, that the categorisation work that Ernest is undertaking here uses heteronormative and gendered understandings/assumptions: heterosexual men, men who don't have sex with other men, are 'ordinary'; conversely, gay is not ordinary. This appears to be confirmed when he subsequently provides an account of why 'gay' is not his primary characteristic:

Extract 4

Ernest: I've never lived erm (.) I've always been around other gay people but I've never lived in an exclusively gay community I've never been in an exclusively gay relationship although I've had quite a few fairly long-term gay relationships (.) but er (.) I wouldn't consider anything like a civil partnership or anything in a formalised way (.) I have been married but that was purely for erm immigration purposes while I lived briefly in America (0.3) and that didn't succeed at all hehhehh (0.5) it wasn't a very rewarding experience

Here Ernest is outlining what he associates with 'being gay' and this leads him to question his own categorical incumbency. For instance, he dissociates himself from certain attributes that he considers mark membership of this category: membership of a gay community, an exclusively gay relationship and civil partnerships. However, it is not possible to simply classify Ernest as 'closeted' from this statement, since he makes it clear he has always associated with gay people and has had 'long-term' gay relationships. Moreover, he explains that his attachment to the heteronormative activity, 'marriage' (the interview was conducted before the Marriage (Same-Sex Couples) Act 2013), was both instrumental and unrewarding, emphasised by his laughter (hehhehh).

Other writers assert that that older gay men, like Ernest, who grew up in an era when homosexuality was more socially proscribed, are more likely to attempt to 'pass' as heterosexual than those who are younger (Rosenfeld, 2002; Knauer, 2011). Whilst this could be an example of passing, it is also possible to view Ernest's categorisation work here as a more complex representation of self. In effect, Ernest subtly and skilfully situates himself as 'gay', but not 'typically' gay. This can be viewed as heteronormative, since he appears to suggest he passes as 'straight', but it also can be viewed as 'queer': Ernest is actively rejecting existing categorisations and situating himself as different. This may well be the result of a lifetime of passing. But it may also be a more subtle practice of transgression that having spent a lifetime of avoiding being categorised (and in some cases pathologized) is indicative of how Ernest views his sexuality – something he does rather than something he is. Thus, it is important to avoid simply categorising Ernest as 'gay', or for that matter as a 'man who has sex with men', since this would miss his more complex understanding.

Troubling Age Categories?

In the previous extracts that I have used in this chapter it is possible to see how in responding to a question from the interviewer about sexuality, several participants troubled and problematised the categories associated with this MCD. They have also, to an extent, partially rejected their membership of them, although arguably for different reasons. In effect, their responses meant that they did not unquestioningly accept sexuality as a) a single category which was wholly indicative of who they are, as a person; or b) as being applicable to them without some form of clarification and shaping, particularly without recourse to gender. From the perspective of Queer Theory such accounts are performative, they bring these identities into being, but not as identical copies. From an Ethnomethodological/Conversation Analytic/MCA perspective it is through these accounts that such categories are made understandable. In this section of the chapter I want to focus on what happened when categorisations of age were made relevant by the interviewer's questioning, focusing here on the categorisation/attribution work that troubles, or problematises, age categories.

As well as troubling and reshaping categories associated with their sexuality, as I implied earlier when discussing the interview AC conducted with Abbey and Jean, other participants also problematised being categorised by age. I am not claiming that this is something specific to LGB people; indeed, studies have examined the rejection and reconfiguration of age identities more broadly, regardless of a person's sexuality (Hurd, 1999; Krekula, 2007). Nonetheless, being aged, as a process of categorisation, is of significance within a LGBT culture that is said to valorise youth (Cronin and King, 2010; 2014), especially for gay men (Jones and Pugh, 2005) and a wider sexist and ageist culture that denigrates older women who are not in relationships (Price, 2011).

It was notable that Abbey (and Jean) did not want to be considered as 'past it' (Extract 2). Following on from that discussion attention had turned to bars, clubs and socialising. At this point, Jean qualified the use of the category 'older' invoked in the interviewer's question:

Extract 5

AC: do you er (.) think much about your age (.) or getting older

Jean: I think the only time I think about that is when we are surrounded by the younger lesbians (.) isn't it?

Abbey: mm:mn

Jean: when I was your age (.) you know (.) [you] find yourself thinking that

AC: [yes]

Jean: but no (0.1) I'm probably more comfortable now

Here Jean invokes the categorisation 'younger lesbians' as having an impact on her sense of an aged self. In other words, Jean turns 'lesbians' into a positioned category that has relevance for her (and including Abbey through her 'isn't it?' utterance). Thus 'lesbians' becomes a hearably age positioned category, as well as being associated with sexuality and gender. It is also notable that Jean temporises and contextualises this by making the age of AC relevant to this discussion: 'when I was your age'. Yet this is used as an exemplar to enable Jean to contrast ('but no') to how she feels now about ageing (in contradiction to her previous statement). Age is troubling, but manageable.

Whilst Jean troubles membership of an age categorisation, by recourse to others, but claims she is 'comfortable', in a later extract from Ernest's interview, he rejects his membership of the age categorisation 'older' when he is positioned as 'someone who can comment on services for older people':

Extract 6

AK: What about service provision for older people (.) do you think

Ernest: There again I have very rarely got myself involved (.) and not classifying myself as gay er (.) I don't classify myself as er old (0.1) I just don't think in terms of age

((additional talk removed here))

Ernest: so that's [his voluntary work] brought me much more in to focus the needs of older people and what older people talk about er (.)

which is mainly sitting around chatting about the old days hehhehh[eh]

AK: [m]mn

Ernest: it's not really my scene (.) but you know you listen (.) and you try and be as helpful as you can

AK: ye:ss

Ernest's response explicitly makes clear that the attribute 'older' is not applicable to him. This is despite the fact that he has already told the interviewer he is 73 years of age. Nonetheless, here he explains that age is not connected to chronology, but his voluntary work has made him 'think' about what older people need and their behaviours: their talk, 'chatting about the old days'. It is notable that Ernest laughs at this point. One effect of laughter in Conversation Analytic terms is to gain

recognition for something that might be potentially controversial or difficult (Holt, 2012). Indeed, Ernest's laughter receives a response from me (as an overlapping 'mmn'). We cannot assume that Ernest does not want to talk about the old days because they hold memories that are painful, but his subsequent suggestion that his role was to 'listen' and 'be helpful' again dissociates him from membership of the category 'older person'. Hence, although Ernest could be located as 'older' according to normative chronological models of ageing, here he skilfully positions himself as different. He is, in *queerer* terms, challenging and renegotiating the boundaries of ageing sexualities.

Discussion and Conclusion

I noted near the beginning of this chapter that there has been a growing interest in the lives of older LGB people over the past ten years. I am certainly not dismissing the value of research, policy, practice and/or activism that seeks to improve the lives of older LGB people, and indeed have undertaken work that has sought to do this myself (see for instance King, 2015).What I have been concerned with in this chapter, however, is *how* people come to identify or be identified as older lesbian, gay and/or bisexual people. Rather than seeing these identities as largely taken-for-granted, stable, trans-contextual and existing *a priori* to interactions, I have examined them as more emergent, contextual and performative. In this discussion and concluding section of the chapter I will explain this further, and then consider the ramifications of this for research, policy and practice.

The work of Queer Theorists, including Butler, suggests that identities are performative, brought into being by repeated acts that are understood through discursive norms. So, for instance, in the case of sexuality – participants in the study outlined above understand sexuality because there is a socially and historically specific discourse about it, which shapes and makes meaningful desires and actions (Weeks, 2012). Not only does this shape how people understand sexuality, it is imbued with power relations, as queer theorists have suggested (Fuss, 1991). But sexual 'others', those who stand outside the heteronormative sphere, also have power to take on an identity and reconstruct it. To be 'gay, lesbian and/or bisexual', therefore, is both to be situated as 'other', but it also affords the possibility of using that identity for productive purposes e.g., legislative rights, creating a community, being a service user with specific needs. It is arguable that other identities, including but not limited to gender and age, are similarly socially constructed and brought into being in and through power relations. Whilst this argument may be compelling philosophically, it doesn't tell us very much about how this process of categorisation occurs in everyday life: how such identities are performed, troubled and problematised and transformed.

I have turned to Ethnomethodology and Conversation Analysis in order to draw these insights together, particularly in my use of Membership Categorisation Analysis (MCA). The latter, which is a form of Conversation Analysis, influenced

by Ethnomethodology, explores how categories are used in talk. As Baker (2000) has noted, categories carry discourse – so categories of sexuality carry the discourse of sexuality, categories of gender carry the discourse of gender, categories of age carry the discourse of age – but not deterministically; people use and shape them, trouble and problematise them, they have agency.

In this chapter I have argued that identifying someone as an older lesbian, gay and/or bisexual person is not straightforward; it involves complex identity categorisation work, played out through the performative use of identity categories and their associated attributes within interactions. Yet policy-makers and service providers often work with rigid categories for the purposes of auditing equality in service delivery and to ensure inclusivity, something that others have noted can result in something of a 'tick-box' approach (Monro, 2006). Moreover, when issues of overcoming discrimination and creating inclusion are paramount the rather esoteric notion that identities are complex and contextually produced may seem rather immaterial. However, I think it is in such circumstances that questions of identity, categorisation and how people speak in their own terms, are of paramount importance. If we are to avoid repeating the myriad disempowerments of heteronormativity, then it is imperative that people's own identity work is not ignored or glossed over. For instance, if Ernest prefers not to be called 'gay' or indeed 'older', what effect would categorising him as such on an equality monitoring form be? Similarly, would Graham be allowed to fully explicate his understanding of bisexuality? Would Abbey and Jean allow others to refer to them as 'chicks'?

There are, therefore, considerable implications for service providers and policy-makers and indeed researchers wishing to take equality and diversity seriously, whilst at the same time trying to incorporate *difference*. Diversity, as I have argued elsewhere, does not always reference and take account of *difference* (Cronin and King, 2010). Yet taking difference seriously means actually engaging with differences on their own terms. I would concur therefore with the tenet of Butler's (1991) response to such a question about being identified as a lesbian:

> identity categories tend to be instruments of regulatory regimes, whether as the normalising categories of oppressive structures or as rallying points for a liberatory contestation of that very oppression. This is not to say that I will not appear at political occasions under the sign of a lesbian, but I would like to have it permanently unclear what precisely that sign means. (pp. 13–14)

While this inevitably introduces the problem of how identity categories are mobilised for political and rights based purposes, failing to take account of ageing sexualities *in interaction* does, in my view, lead to a position where heteronormative understandings of ageing sexualities can be reinscribed under another guise. To explore the emergence, use and problematisation of categories within talk-in-interaction is one way that we can ensure that it is indeed permanently unclear

what precisely those categories mean and, perhaps more importantly, examine what they mean to people themselves.

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Chapter 9

Towards the Inquiry into Aged Care and Beyond: The Promise and Challenge of a New Era in LGBTI Ageing

Mark Hughes

Introduction

In 2011, in a landmark move, Australia's Productivity Commission acknowledged the particular issues faced by sexually and gender diverse communities in the aged care system. It recommended the development of a national lesbian, gay, bisexual, transgender and intersex (LGBTI) ageing plan, the rollout of sensitivity training to aged care providers, and the resourcing of organisations to provide community aged care packages to LGBTI communities. This challenge was taken up by the Federal Labor Government, which launched the National LGBTI Ageing and Aged Care Strategy in 2012, as part of its Living Longer Living Better reform program.

While these reforms have been an undeniably positive development, it is argued in this chapter that their implications for the promotion of LGBTI ageing into the future are complex. Drawing on neo-institutional theory (DiMaggio and Powell, 1983), I argue that LGBTI ageing activism and the promotion of equitable service delivery by professional groups risk becoming co-opted by the state's focus on competition and consumerism. The more LGBTI community organisations and aged care providers compete for and acquire government grants and contracts, the greater the risk they will conform to the normative expectations of governments and funders and be restricted in their capacity to speak out. Included in this is a concern that narrow and essentialist conceptions of what it means to be LGBTI are elevated because they are politically understandable, expedient and socially appropriate (Cooper, 2006).

The discussion in this chapter is informed by my social work discipline, as well as by a sociological analysis of how organisational behaviour is shaped by wider social, political and cultural forces. While the specific focus is on Australia, the themes and implications extend to other countries, including the United Kingdom (UK) and United States of America (USA), where a mixed economy of welfare exists and where neoliberal trends have emphasised individual responsibility and laissez-faire market forces. The chapter begins by highlighting the contribution of neo-institutional theory for understanding the field of aged care. It then explains the aged care policy and service environment in Australia and the significance of

the Productivity Commission Inquiry and the subsequent reforms. This provides the context for tracing the emergence of three strands of LGBTI ageing promotion in Australia: activism, professionalisation, and institutionalisation. A series of hypotheses are then explored in relation to the implications of the institutionalising strand for the development of LGBTI ageing and aged care into the next decade.

The Contribution of Neo-institutional Theory

There are a range of ways of understanding the emergence of LGBTI ageing and aged care as issues of significance in Australia. Theories on social problem construction (e.g., Spector and Kituse, 1987) provide insight into how a private problem becomes reconceptualised as a public issue, and the various stages involved in gaining fully-fledged public legitimacy. New social movement theories (e.g., Habermas, 1981) examine the ways in which 'grass-roots' campaigns emerge in relation to human rights concerns. Neo-institutional theory (e.g., DiMaggio and Powell, 1983) can analyse how organisations develop and homogenise as they respond to a social issue or need. Each of these conceptual frames can help explain the emergence of and response to LGBTI ageing and aged care in Australia and elsewhere around the world.

In particular, neo-institutional theory provides some unique insights into current developments, because of its relevance to policy design and service delivery, within the context of particular government value and ideological priorities. As espoused by DiMaggio and Powell (1983), neo-institutional theory seeks to explain how organisations tend towards homogeneity in both their structures and practices, as more particular organisational fields develop and become established. An organisational field comprises those organisations 'that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and product consumers, regulatory agencies, and other organizations that produce similar services or products' (DiMaggio and Powell, 1983, p. 148); elsewhere it has been described as a sector (Scott, 2008). This approach developed in reaction to 'old' institutional theory, which focuses on internal organisational conflict and how political dynamics within organisations impact on rational organisational behaviour (Selznick, 1949). Whereas the 'new' approach locates the source of irrationality more within the organisation's wider environment: the organisational field (DiMaggio and Powell, 1991).

In Australia, both the not-for-profit sector (Warburton and McDonald, 2009) and the health care sector (Briggs et al., 2012) have been identified as reflecting the characteristics of organisational fields where increased homogeneity is observable. While located across the not-for-profit, public and private sectors, similarly it is possible to conceptualise community and residential aged care in Australia as an organisational field that comprises a series of institutions that bear remarkable resemblance to each other. This is not least because many compete for the same contracts and are constrained by the same regulatory systems. Despite

this, it would be a mistake to assume that this organisational field, like others, is not without its diversity and complexity (Scott, 2008).

The concern, as expressed by neo-institutional theorists, is that the innovative activities of organisations that improve performance (e.g., responsiveness to community need) may, over time, become legitimised to such an extent that they are adopted or replicated by other organisations without consideration to their ongoing benefit. Or, sometimes, in contradiction to their ongoing benefit. This is because organisations 'compete not just for resources and customers, but for political power and institutional legitimacy, for social as well as economic fitness' (DiMaggio and Powell, 1983, p. 150). This was conceptualised by DiMaggio and Powell as isomorphism – the convergence of different organisms into similar forms – which may occur through three different means. *Coercive isomorphism* occurs through political influence, such as through a direct political mandate or societal pressure to conform to certain standards. *Mimetic isomorphism* involves organisations modelling their behaviour on others when there is substantial uncertainty, for example in relation to environmental conditions or organisational goals. *Normative isomorphism* involves the increasing professionalisation of the field, resulting in increased emphasis placed on formal education and the proliferation of common models across organisations as a result of increased professional networks.

While DiMaggio and Powell's (1983) approach has been influential across a range of disciplines (Greenwood and Meyer, 2008), it is important to acknowledge points of critique. The delineation of their approach as neo-institutionalism (one among a number so framed), in contrast to 'old' institutionalism, is criticised by proponents of the latter. Selznick (1996) argued that both share a focus on rejecting behavioural and 'rational actor' approaches to understanding organisational life, and to reject the contribution of the 'old' institutionalism approach simply embraces 'pernicious dichotomies' (p. 275). For Suddaby (2010), there is a danger that neo-institutional theory is being inappropriately applied with too much focus given in research to the outcomes of institutionalisation, because they are easier to measure, than its processes. According to Clegg (2010), a key concern lies in the inadequate treatment of power in institutional approaches: that they 'downplay struggle and conflict' (p. 6). He argues that a third generation of institutional theory must take better account of power and agency. Recent blending of neo-institutional theory and governmentality (Schweber, 2014) suggests some potential in this regard, although this work is still at an early stage of development.

While acknowledging these limitations, I argue that neoinstitutional theory, as articulated by DiMaggio and Powell (1983) remains a valuable lens for examining developments in LGBTI ageing and aged care, particularly in exploring a possible drift towards isomorphism. Later in this chapter the potential for institutional isomorphic practices to emerge in the development of responses to LGBTI ageing and aged care are examined. The focus of this analysis is on the application of six hypotheses developed by DiMaggio and Powell (1983) that assess the risk of each dimension of isomorphism. First, though, I overview some key features of

Australia's aged care system and then explore the emergence of LGBTI ageing and aged care as an issue in this country.

Australia's Aged Care System and Recent Reforms

Like other western nations, Australia has been significantly influenced by the neoliberal values of increasing individuality, competition and consumerism. The Australian 'welfare state' comprises a mixed economy, involving governments (Federal, State and Local), not-for-profit organisations and private providers. As in the UK, the blurring between these types of organisations is increasing, for example through the rise of social enterprise agencies and practices. Of course, this is not a completely free market as governments take an active role in regulating the health and human services sectors, controlling and influencing both the entry and behaviour of service provider organisations (Davidson, 2011). Common regimes for the funding and regulating of human services include: competitive tendering and contracting, involving minimal consumer control; quasi-voucher licensing, whereby funding is allocated to consumers who can choose how to spend it; and a hybrid model, whereby the range of providers a consumer can choose from is limited to those approved through a competitive tendering process (Davidson, 2011, p. 226).

Australia's aged care system – comprising both community and residential aged care – reflects the above characteristics and trends. Following an earlier influential conceptualisation by Howe (1996, cited in the Productivity Commission, 2011), the Productivity Commission described older people's participation in the aged care system as a pyramid. At the bottom are the vast majority of people aged 65 and over who live with some limitations but otherwise independently, and at the top are the relatively few older people who receive intensive palliative care services. In between are people receiving a diversity of resources and support services designed to help them live at home independently or live in 'low care' residential facilities. These include Home and Community Care (HACC) services – funded through competitive tendering – such as day respite, meals services, transport assistance, domestic assistance, home modifications and community nursing. They also include Community Aged Care Packages (CACPs) – providing assistance with dressing, showering and occasional nursing care – which are funded through a hybrid model, with agencies being approved as a provider and then competing to tender for the relatively small number of packages available. Towards the top of the pyramid is the smaller number of people receiving high-care nursing services either at home, through an Extended Aged Care at Home (EACH) package, or in a residential aged care facility. It is important to note that the above characterisation is based on adults aged 65 and over and if an older population group (e.g., 85 and over) was selected then a much greater use of high-care nursing services (at home and in residential care) would be evident.

In 2010 the Federal Labor Government tasked the Productivity Commission to develop options for redesigning the aged care system so that it is able to meet the changes expected over the next few decades as a result of population ageing. It was also requested to consider changes in the context of the Government's social inclusion agenda, which included the reform of Federal legislation that discriminated against same-sex couples and their children (aside from the Marriage Act 1961). The use of the Productivity Commission for this purpose cemented the treatment of population ageing and aged care delivery not only as social issues but also as economic issues (Hughes, 2011). This is because the Productivity Commission, an independent agency, is charged with providing advice to Australian governments on microeconomic reform. Historically, it has drawn on neo-classical economic principles, utilising statistical modelling, to report on all parts of the economy, including the public, private and not-for-profit sectors (Banks, 2007). As might be expected, the Commission's agenda conforms to neoliberal trends of reducing government regulation, increasing competition within a mixed economy of welfare, and increasing consumer choice (Hughes, 2011).

The recommendations of the Inquiry, following an extensive period of community consultations that generated about 900 submissions in total, included changing the funding of aged care so that the system is more standardised, efficient and equitable. They also included: increasing the proportion of consumer contributions; removing limits on the availability of Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) packages; and introducing greater consumer choice over access to care services. These recommendations were relatively expected with Blake (2014) arguing:

> For some time now there has been a consistency or sameness about the reports and recommendations coming from the Commission. In fact you can now pretty well guess the content of a Commission report;
> If it's an issue about regulation – propose deregulation,
> If it's a government service – recommend privatisation,
> If it's about government service delivery – give consumers vouchers. (p. 17)

For Blake (2014), the neoliberal agenda of the Productivity Commission was clearly on display in its recommendations on aged care reform.

In terms of social inclusion, the Productivity Commission's recommendations appeared to be relatively progressive. Notably, for LGBTI seniors, the Commission went further in its recommendations than any public inquiry or government report ever has before. It recommended that accreditation standards for both community and residential aged care should cover sexual and gender diversity (Productivity Commission, 2011). Support and advocacy services for LGBTI seniors were also proposed, as were block-funding grants to organisations targeting services to LGBTI people. Notably, the Commission recommended the development of an LGBTI ageing plan and, most significantly, the inclusion of LGBTI seniors as a 'special needs group' under the Aged Care Act 1997 (one of eight groups, including

Aboriginal and Torres Strait Islander people, so designated). While the terminology may seem dated, this designation carries legal significance, as it requires providers of aged care services to consider and, where appropriate, address the needs of LGBTI consumers. Although arguably this categorisation reinforces a fixed notion of what it means to be LGBTI without scope for deconstruction, questioning or recognition of the diversity and fluidity of LGBTI identities, relationships and practices (Cooper, 2006).

Following further public consultations, the Labor Government released its 'Living Longer Living Better' program of reforms (Department of Health and Ageing, 2012a), which was subsequently adopted by the conservative Abbott Coalition Government (and is now simply called Aged Care Reform). The reforms included: nearly $1b in extra funding to enable people to stay at home longer – including an additional 40,000 home care packages (the new name for EACH and CACPs); $660m to fund better residential aged care; $80m to improve access to health, allied health and palliative care; and establishing a gateway agency (through a website called My Aged Care) as a single entry point to the aged care system. One of the most notable developments was the introduction of consumer-directed care, similar to the direct payments scheme in the UK, which aims for older people to have greater control over the choice of services and resources provided to them. This reflects a key shift in government funding priorities, as also reflected in the National Disability Insurance Scheme, towards quasi-voucher licensing, while also acknowledging the call for service users to have a greater say in how and what services are delivered to them (Davidson, 2011).

The recommendation by the Productivity Commission (2011) that LGBTI seniors be identified as a special needs group was also accepted, as was the development of a national plan. The National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy (Department of Health and Ageing, 2012b) was launched in 2012, following public consultations and a draft stage. Key initiatives included: the expansion of the Community Visitors Scheme (a program enabling volunteers to visit socially isolated older people) to include LGBTI people; revision of the aged care program guidelines to ensure service providers are aware of their responsibilities towards LGBTI people; the national rollout of LGBTI sensitivity training by contracted LGBTI community organisations to the aged care workforce; enabling LGBTI seniors to easily access aged care advocacy programs; and increasing research on LGBTI ageing (Department of Health and Ageing, 2012b). The commitment to sensitivity training was a key achievement, reflecting the call internationally for increased LGBTI 'cultural competence' among aged care providers (e.g., Gendron et al., 2013).

The development of this strategy was a real milestone in the promotion of LGBTI ageing as a social issue in Australia, but it did not happen by accident. While certain events came together fortuitously to create the conditions for the strategy, it was undeniably the product of concerted efforts by particular individuals and community groups over a number of years. Arguably it has provided the basis by which LGBTI people and organisations can move from the margins to the centre

of Australia's aged care system. Indeed, it promises a new era in LGBTI ageing in Australia. But with this, comes significant challenges. In the next section of the chapter I discuss the emerging strands of LGBTI promotion in Australia, and what the new 'post-inquiry' era may mean for them.

Strands of LGBTI Ageing Promotion

The emergence of LGBTI ageing promotion in Australia has been relatively late compared to other countries. For example, substantial and important debates occurred in the United States in relation to gay and lesbian gerontology in the 1980s and early 1990s, which were largely ignored by Australian researchers, policy makers and service providers. Most notable was the debate about successful ageing and adaptation, with a series of prominent US researchers (e.g., Kimmel, 1978; Friend, 1980) arguing that lesbians and gays are likely to age even more successfully than the general population because they have survived such a major life crisis as 'coming out' – referred to as 'crisis competence'. For the most part, it was mainly in the late 1990s and early 2000s, after gerontologist Jo Harrison visited the United States and wrote about the potential of LGBTI ageing activism in Australia (e.g., Harrison, 1999), that researchers, policy makers and, eventually, service providers began to take notice.

To encapsulate the developments in recent years I conceptualise a series of strands, incorporating significant events and significant people. In terms of strands, it is not possible to identify any discernable beginning point, but rather points at which each strand becomes more visible as significant events and people coalesce. These strands are characterised as:

1. Activism: the involvement of individuals and groups in social change strategies;
2. Professionalisation: the subjecting of the issue to professional and academic disciplinary 'gaze'; and
3. Institutionalisation: the incorporation of the issue and responses to it within the state and its various arms (such as non-government organisations (NGOs) providing services under government contracts).

I would argue that the activism strand really came to the fore in the late 1990s to early 2000s, while the professionalisation strand emerged strongly in the mid to late 2000s. The institutionalisation strand, it is contended, has only begun to emerge in the early to mid 2010s.

In framing the developments in Australia in this way, each strand – activism, professionalisation and institutionalisation – should be treated more like Weberian ideal types than as absolute depictions of reality. That is, they are generalised concepts that accentuate certain characteristics for the purpose of analysis (Weber, 1978, cited in Lindbekk, 1992). It is recognised that for many individuals and

organisations there may be substantial cross over between these strands. This is not least because some LGBTI ageing researchers also engage in activism, as noted below. So, while distinguishing activism as separate to professionalisation and as separate to institutionalisation may seem artificial, framing developments in this way illuminates possible trends that may otherwise be obscured.

Activism

As noted, the activism strand can be seen to have gained momentum in the late 1990s and early 2000s. Harrison's (2004) doctoral thesis involved interviews with activists in the US and Australia in the late 1990s, and also comprised a log of activist incidents between 1999 and 2003. She also identified the earlier contribution in promoting LGBTI ageing of groups such as Lesbian and Gay Solidarity, Intersection, the Matrix Guild, Ten Forty Matrix, Mature Age Gays, Vintage Men, the Gentlemen's Club and the Golden Club (Harrison, 2006). She argued that in 'almost every case, these groups have received minimal or no funding and have relied on in-kind assistance to undertake this groundbreaking work' (p. 46).

An example was 'Lesbian and Gay Solidarity', originally formed in 1978 as the Gay Solidarity Group Sydney, and which organised the first Lesbian and Gay Mardi Gras on 24 June of the same year. At an evening parade, 53 lesbian and gay people were arrested, with widespread reports of policy brutality. Like the Stonewall riot a decade before, and which the Mardi Gras commemorated, the event became a watershed in the promotion of LGBTI rights in Australia, and has been held in every subsequent year, with the original marchers – known as the '78ers' – frequently being honoured. 'Lesbian and Gay Solidarity' continued and became more engaged with issues relating to ageing and aged care, perhaps reflecting the changing demographic of its members. In their submission to the Productivity Commission Inquiry, on behalf of the group, Kendall Lovett and Mannie de Saxe documented the extensive correspondence they have had with various government ministers, government departments and service providers about their failure to treat LGBTI seniors as full citizens (Lovett and De Saxe, 2010). In one letter to a member of parliament, responding to a newspaper article reporting increased funding of training courses in aged care, Lovett (2010) wrote:

> I am in my mid-eighties and I do not reside in the Brunswick area so I'm unlikely to want to train to be one of those aged-care workers. Nevertheless I am very interested in what you are talking about because I may very well need the services of a properly trained care worker at home or in a nursing home in the next few years if my physical health fails me or my same-sex partner … [In another article] a journalist pointed out that research said recent health surveys show an alarmingly high number of senior gays would rather commit suicide than risk abuse from a 'prudish and conservative' aged health-care system. … It certainly bothers me when I think of what I may be faced with

> in the future. … To meet client needs, workers in the aged-care industry require a training component in their courses inclusive of understanding and sensitivity to cultural and sexuality differences. … I would feel so very much happier if I knew this was happening, should I require a home carer or enter a nursing home. (cited in Lovett and De Saxe, 2010, p. 8)

One of the events which precipitated heightened activism from a range of LGBTI community groups was the 2009 decision by the Rudd Labor Government to not exempt (or 'grandfather' in the legal terminology) the age pension for same-sex couples after the introduction of legislation recognising same-sex relationships. What was ostensibly a very positive development – the amendment of 84 pieces of legislation to ensure that same-sex partners and the children of same-sex parents were not discriminated against (e.g., in taxation, superannuation and immigration matters) – resulted in same-sex couples having their individual pensions replaced by a much lower 'married' pension. The implication was that people who had been forced, through an historical lack of recognition of their relationship, to manage their finances separately were overnight and with limited warning treated as a married couple, required to disclose their relationship to a government agency (Centrelink) and lost approximately $185.20 per couple per fortnight. Similar negative outcomes of same-sex relationship recognition have been identified in other countries, such in as Canada in relation to tax laws (Boyd and Young, 2003). The call to 'grandfather' (exempt) the pension (Barrett and Chapman, 2001) was so that those already receiving the age pension would not have these requirements applied to them. What resulted was a campaign involving LGBTI groups, aged care organisations and professional bodies lobbying the government and speaking to the media – highlighting the negative impact of these changes on LGBTI seniors. As significant as the financial loss was the concern about revealing one's sexuality and relationship status to the authorities, given the historically poor treatment of LGBTI people. Noel Tovey, encapsulated this concern, in a letter to the Prime Minister, reproduced in the publication, *ACT Gay*:

> I am an Indigenous artist and writer and am myself 75 years of age. As an older indigenous [Aboriginal] man who is also gay, I am deeply concerned at the suffering of gay elderly people, who, like me, have experienced severe trauma in the past due to the ignorance of those around us. I was taken away from my family in 1940 [as a result of government policy to remove Aboriginal children from their families]. In 1951, while living on the streets of Melbourne I was charged with 'The Abominable Crime of Buggery'. Several of my friends have committed suicide rather than live a life of fear and shame.
>
> I have grave concerns about the 'same sex equal treatment' reforms and the way in which these may compound the suffering of elder gay people, including Indigenous people. Elderly gay people are from a generation that preceded civil rights and they were subjected to shock treatment, lobotomy and other horrors.

> They hid from view and remain mostly hidden today. Nevertheless, they are elders of our gay community who deserve protection.
>
> I implore you to protect these elderly people from the harm of being forced to reveal their identities, even in confidence, to officers from Centrelink. For this generation, there is no safe confidential context in which to 'come out'. The thought of having to do so now is causing them extreme anxiety and consequent physical harm. (cited in Lovett and De Saxe, 2010, p. 3)

The 'grandfathering' campaign was one of the first occasions when mainstream welfare organisations (e.g., Suncare Community Services, Council on the Ageing) and professional bodies (e.g., the Australian Association of Social Workers) joined with LGBTI community organisations and activists in a common enterprise. The result was that the Government committed to: review all Centrelink policies in relation to the treatment of same-sex couples; instigate a more compassionate approach to dealing with debts arising from the changes; provide $350,000 for a national education campaign about the changes; and allocate $100,000 to the Welfare Rights Network to advocate on behalf of those affected. While the 'grandfathering' was not accepted, the legacy was an increased awareness of LGBTI seniors' needs among both the campaigning organisations and the Government. Particularly valuable was the production of campaign material (e.g., submissions and media releases) that could be adapted and presented at subsequent commissions and inquiries into aged care, including the 2009 Review of the Aged Care Complaints Investigation Scheme (Walton, 2009) and, of course, the Productivity Commission Inquiry.

The activist strand of LGBTI ageing promotion continues today, with the regular lobbying of government by LGBTI community organisations and individuals when issues impacting on LGBTI seniors arise. An example is the lobbying and media coverage associated with the proposal to amend the human rights and anti-discrimination legislation. The focus of the lobbying was to ensure people entering residential care run by faith-based providers are not discriminated against on the basis of their sexuality, gender identity or relationship status. This ultimately led to the Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013 making it unlawful for faith-based providers to discriminate on these grounds. Alongside this activism has grown a professionalising strand of LGBTI ageing promotion. What I mean by this is the increasing attention given to LGBTI ageing issues by academic and professional disciplines, such as public health, health promotion, nursing and social work. This strand can be identified as having gained momentum in Australia in the mid to late 2000s.

Professionalisation

One example of the professionalising trend in LGBTI ageing promotion has been the engagement of researchers with the issue. While Harrison (1999; 2001) was not the first Australian gerontologist to examine LGBTI ageing – earlier researchers included Waite (1995), and Bennett and Thompson (1991) – it seemed that her research and activism in the early 2000s contributed to a growing awareness of the issue among academic communities. More researchers – usually LGBTI people themselves – initiated projects, often in collaboration with LGBTI community groups. In the early 2000s Peter Robinson was engaged with Chris Chamberlain in research that highlighted different groups of LGBT seniors, including those who were 'travelling well' and those who were 'doing it tough' (Chamberlain and Robinson, 2002). The Australian Research Centre in Sex, Health and Society (ARCSHS), based at La Trobe University, undertook a series of projects in collaboration with groups such as the Matrix Guild, including the influential My People studies (Barrett, 2008; Barrett, Harrison and Kent, 2009). Catherine Barrett, a senior research fellow at the Centre, who has been an enthusiastic researcher/advocate, helped initiate Val's Café, coordinated by Gay and Lesbian Health Victoria, which seeks to improve the health and wellbeing of LGBTI people by promoting safe and inclusive services. In Western Australia, GRAI (GLBTI Rights in Ageing Inc) collaborated with Curtin University in a project on retirement and aged care accommodation needs of older non-heterosexual people (Comfort et al., 2010). And in New South Wales, I initiated projects on social workers talking about sexual identity with older men (Hughes, 2008), sexual identity expression in health and aged care delivery (Hughes, 2007) and, in collaboration with Evergreen Life Care and Sujay Kentlyn, the health and wellbeing of LGBTI seniors in New South Wales.

The engagement of researchers with the issue was an understandable development in the context of activists calling for heightened awareness of the needs and concerns of LGBTI seniors. And it is clear that in Australia, as in other parts of the world (e.g., Witten and Eyler, 2012), there is overlap between these organisations and people: that activists have engaged in research and researchers have participated in activist practices. Nonetheless, the increased research on the issue enabled government departments, aged care organisations and service providers to point to research 'evidence' to demonstrate a need and provide a rationale for action (e.g., Childs, 2012). Thus, it is possible that a by-product – rightly or wrongly – has been that LGBTI ageing as an issue was given more public legitimacy because of the engagement of academic and professional disciplines. Despite this it is noteworthy that this research remains on the margins of academic enterprise, with most researchers operating with minimal funding (Comfort, 2010).

Over the same time period, not-for-profit organisations began to allocate staff time and other resources to promote LGBTI ageing, and to develop strategies and plans to address the issue. In Victoria the now defunct ALSO Foundation

released a GLBT seniors strategic plan (Birch, 2004), arising from their Older Persons Project and the earlier work of Chamberlain and Robinson (2002). In New South Wales, the AIDS Council of New South Wales (ACON) formed an ageing workgroup following the development of a Healthy Ageing Strategy (ACON, 2006), which has subsequently been replaced by an interagency group. The Queensland Association for Healthy Communities (QAHC) established an Ageing Action Group, initiated a needs survey and developed a series of resources to promote LGBTI inclusivity in aged care. Similarly in Western Australia GRAI developed resources and a set of Best Practice Guidelines for providers of retirement and residential aged care. Alongside and influencing these developments were a series of forums, workshops, roundtables and seminars. In New South Wales, for example, the Anti-Discrimination Board hosted consultation events, which led to a series of discussion papers. Both LGBTI health and mainstream gerontology conferences also began featuring presentations on LGBTI ageing. In 2006, for example, there were two symposia on the issue at the Australian Association of Gerontology national conference in Sydney. More recently aged care organisations, including Uniting Care NSW and Evergreen Life Care, have appointed LGBTI project workers.

Institutionalisation

With the growth in interest in promoting LGBTI ageing among LGBTI and aged care organisations came grant applications and tenders for contracts to deliver services directly to LGBTI seniors. One of the early awardees was Care Connect, based in south-east Queensland, which in 2010 successfully gained community aged care packages specifically targeted at LGBTI seniors (Shaw, 2013). This move demonstrated to other aged care providers and LGBTI organisations that LGBTI-specific services and resources could be tendered for and won. Further, the leader of the LGBTI programs at Care Connect won the '2013 Employee Award' by Aged and Community Services Australia (Shaw, 2013), which is the peak body representing not-for-profit and faith-based providers of residential and community services. These developments mark the emerging strand of institutionalisation – where promotion of LGBTI ageing becomes incorporated within the mainstream functions of the state and its agencies.

As suggested, the watershed period for the promotion of LGBTI ageing came with the Productivity Commission Inquiry in 2010, its 2011 report and the subsequent Government response, and, in 2012, the National LGBTI Ageing and Aged Care Strategy. Never before had LGBTI ageing been given such public prominence. Of particular significance was the period between the handing down of the Productivity Commission Inquiry recommendations and the release of the National Strategy. It is probably fair to say that many feared that the recommendations of the Inquiry would not be picked up by the Labor Government, considering the struggle that occurred over the 'grandfathering' of the Centrelink changes. However, as reflected in news reports at the time (e.g.,

Ozturk, 2012), the enthusiastic and strategic lobbying of key individuals (such as Corey Irlam and Jo Harrison) and organisations (such as the National LGBTI Health Alliance), combined with an energetic and progressive Federal Minister (Mark Butler), seemed to carry the day. Notably, Minister Butler held a series of public consultations, including an LGBTI Ageing Roundtable, which directly engaged with LGBTI people in the development of the Living Longer Living Better reforms. He also tasked the Alliance with the responsibility of coordinating consultations for the government in the development of the National Strategy.

Following the launch of the National Strategy, a series of organisations have been successful in gaining funds from the Federal Department of Health. This included Evergreen Life Care (NSW) for a project called Outrageous Ageing, an LGBTI Elders' Wellbeing Project, which focuses on research and capacity building. The National LGBTI Health Alliance has also been engaged to coordinate the rollout of Federally-funded national LGBTI awareness training in aged care, using resources developed by ACON in collaboration with a major peak-body for the aged care industry, Aged and Community Services. The training will be delivered by key LGBTI community organisations in each state, including QuAC, GLHV, ACON and GRAI. More community organisations are also bidding for home care packages. A private retirement community in the rural Victorian community of Ballan, Linton Estate, also has plans to move into residential aged care.

Many of these organisations have, for a number of years, walked a fine line between advocacy and political lobbying for its constituency, on the one hand, and adhering to government priorities through the awarding of public money for the delivery of resources and services, on the other. This tension is well documented in the literature on the not-for-profit sector, leading to the critique that these organisations run the risk of losing their distinctive value base (Neville, 2009), and of becoming simply another arm of government (Housego and O'Brien, 2012). The power exercised by government – a clear example of coercive isomorphism (homogenisation due to political mandate or societal pressures) – is most evident in the accountability obligations that accompany the receipt of public funding, as well as in the direct restriction of advocacy activities where substantial funding has been received. For example, with regard to the latter, the conservative Queensland Government included a clause in contracts that organisations receiving 50 per cent or more of their funding from the Government were not allowed to engage in advocacy activities. Further, they were not even allowed to link on their website to organisations that were engaging in advocacy. Not long after the Government was elected it withdrew $2.5 million of funding from the Queensland Association for Healthy Communities (QAHC), and engaged in a substantial critique of this organisation claiming that it had lost its focus on HIV/AIDS (Longhurst, 2012). This led to changes to the organisation's leadership and provided the context in which it returned its name to the Queensland AIDS Council (Longhurst, 2013). A key concern for community organisations is that this kind of coercive isomorphism may lead to 'mission drift' (Housego and O'Brien, 2012) – whereby the purpose of the organisation shifts, and sometimes is lost, because organisations are designing

themselves around funders' priorities, and their accountability and auditing requirements, rather than the needs of their constituent communities.

What does this mean, then, for LGBTI organisations moving into the field of community and residential aged care, and what does it mean for aged care organisations seeking to provide services to LGBTI consumers? How challenging will it be for not-for-profit organisations to stay connected to their communities and to social justice values while participating in a system that is increasingly dominated by the neoliberal practices of consumerism and competition? In the next section I address the challenges for these organisations in resisting isomorphism, maintaining their capacity to speak out, and responding to the diversity of the needs of their constituent communities.

Challenges in Managing Institutionalisation and Resisting Isomorphism

Thus far, it is too early to indicate the extent to which organisations providing LGBTI aged care services, including those delivering training to aged care providers, are becoming 'institutionalised' as another arm of government. While it is likely that any organisation that engages with and accepts funding from government will become institutionalised to some extent, the more significant question is the extent to which they will become isomorphic. That is, as discussed earlier, the extent to which organisations will become similar to each other, sometimes even to the detriment of their own mission and effective functioning, because they rely so much on other organisations and the power and legitimacy of being part of this organisational field or sector. As noted earlier in this chapter, DiMaggio and Powell (1983) posed a series of hypotheses that can be used as a basis for assessing these risks of becoming isomorphic. The following discussion considers these hypotheses in relation to the development of organisational responses to LGBTI ageing and aged care. Given development of these responses is at such an early stage in Australia, the analysis is necessarily speculative, and future research will be required to provide evidence for or against the arguments. Nonetheless, it does provide some direction for this analysis and enables service providers to consider the risks associated with development of organisational responses.

The first hypothesis is: 'the greater the dependence of an organization on another organization, the more similar it will become to that organization in structure, climate, and behavioural focus' (DiMaggio and Powell, 1983, p. 154). The implication of this is that the more organisations providing LGBTI aged care services rely on other organisations, including particular government departments and other funders, the greater the likelihood of isomorphism. As noted, the potential for coercive isomorphism is considerable given the contractual obligations that will be tied to the funds awarded. One speculative interpretation is that organisations providing LGBTI aged care services, including those providing aged care training, might come to rely on other aged care organisations for the referral of clients or for maintaining a relationship whereby training is provided

not just on one occasion but over the longer term. Thus, the question for these organisations is how they will respond to this exchange relationship. There is a danger that they will, consciously or not, manage (or manipulate) their message about LGBTI ageing in a way that is palatable to these organisations on which they rely for funding.

The risk here is that coercive isomorphism will become present in the moral and normative expectations of agencies engaged with organisations providing LGBTI aged care services. In the desire to identify and respond to an LGBTI constituency, there may be insufficient regard given to historical tensions between lesbians, gay men, bisexual people, transgender people and intersex people, which can have historical undertones. Monro and Richardson (2011) highlighted ongoing concerns of misogyny among gay men, the questioning of the existence of bisexuality, and gay men and lesbians distancing themselves from transgender people. Added to this, in the Australian context, is intersex people, whose needs and experiences may differ substantially from LGBT people (Alzheimer's Australia, 2014). Further, there is a danger that LGBTI identities will become presented in essentialised ways or in ways that reflect normative heterosexual identities, relationships and practices. As Cooper (2006) identified in her analysis of local government practices in the UK, this raises the question of how those on the margins of those identities and relationships – such as sexually and gender queer people, those who frequent sex clubs and beats (cottages), those engaging in polyamorous relationships, those who identify as asexual, or those identifying with S&M practices – will be reflected in the messages that are conveyed. How this kind of exploration of the queer terrain can even be spoken of in encounters with managers and employees of some aged care providers, such as faith-based providers, is unclear.

The second hypothesis posed by DiMaggio and Powell (1983, p. 154) is: 'the greater the centralization of organization A's resource supply, the greater the extent to which organization A will change isomorphically to resemble the organizations on which it depends for resources'. So organisations whose income (both in terms of funding and referrals) comes from a small number of sources will become increasingly at risk of conforming to the norms and values of those other organisations. Thus the pressures noted above may be amplified for organisations in these kinds of situations. The challenge here is for organisations to develop multiple revenue streams, some of which are independent of government. In this way, they may become able to resist 'mission drift' and continue to divert resources to prioritised endeavours within their constituent communities, while also meeting governments' and funders' expectations. While worsening macro-economic conditions may limit the extent to which such options are available, alternative sources of revenue may need to be sourced anyway if, like in the UK (King, 2015), government funding and support reduces or becomes more inconsistent. There are numerous examples in the Australian context of organisations choosing to refuse government funding. For example some not-for profit agencies refused contracts that would require them to administer the Federal

Government's financial case management policy, whereby vulnerable clients would have their social security payments suspended for failing to meet welfare-to-work participation requirements (Neville, 2009). Crowdfunding through social media is one strategy than is gaining increasing attention among not-for-profit organisations. While civic crowdfunding, that has the dual purpose of generating revenue for local communities and building social capital, is less common that enterprise-based crowdfunding, it is on an upward trajectory with increasing numbers of community projects being funded (Stiver et al., 2014).

The third of DiMaggio and Powell's hypotheses is more reflective of the pressures of mimetic isomorphism, whereby organisations mimic each other because they lack the technology to achieve their goals: 'The more uncertain the relationship between the means and ends the greater the extent to which an organization will model itself after organizations it perceives to be successful' (DiMaggio and Powell, 1983, p. 154). Organisations, particularly new ones, that have a sense of what they want to do, but lack the knowledge or technology to achieve it, are likely to model themselves on the practices of other organisations within their field or sector. For example, it is possible that models for LGBTI aged care training in Australia developed by organisations such as the AIDS Council of New South Wales (ACON) may become adopted uncritically by other organisations, regardless of the applicability to their own unique communities. Or new providers of home care packages may look to the strategies employed by other organisations that have successfully recruited clients to take-up these packages. A challenge in the future may be the withdrawal of funding, for example to organisations providing the LGBTI aged care training, thus creating uncertainty with these organisations' environments. In this context, based on DiMaggio and Powell's (1983) hypothesis, it is possible that some organisations will look to others, which they perceive to be more successful, to see how they have managed such a crisis.

The fourth hypothesis follows on from the third: 'the more ambiguous the goals of an organization, the greater the extent to which the organization will model itself after organizations that it perceives to be successful' (DiMaggio and Powell, 1983, p. 155). Here the focus is not so much on a lack of technology, but lack of clarity about the purpose to which technology should be used. DiMaggio and Powell argued that those organisations with unclear goals are more likely than others to rely on outward appearances for legitimacy. Further, where there is conflict over goals, simply copying other organisations and their priorities can avoid the difficult negotiation necessary to resolve the conflict. For LGBTI community organisations and others seeking to respond to the needs of LGBTI seniors, the key challenge may be keeping their goals aligned with the priorities of LGBTI community members. Where new public money for services targeting LGBTI older people becomes available or where a new market is perceived, there is a danger that organisations that may have little history of working with LGBTI communities may want to move into this field. Thus, the challenge in terms of resisting these kinds of mimetic isomorphism for organisations providing LGBTI

aged care services is to remain (or become) deeply connected to and understanding of the needs of their constituent communities. And for these needs to be directly translated into the mission and goals of the organisation, not only symbolically but also in terms of how funding is allocated within the organisation. This is clearly a challenge for new organisations emerging within this field, but it is also a challenge for well-established organisations, particularly if they have experienced some 'mission drift'.

The fifth and sixth hypotheses relate to the normative processes associated with professionalisation. The fifth hypothesis states that 'The greater the reliance on academic credentials in choosing managerial and staff personnel, the greater the extent to which an organization will become like other organizations in its field' (DiMaggio and Powell, 1983, p. 155). Similarly the sixth hypothesis posits that the more these staff belong to trade and professional associations, then the greater is the likelihood of isomoprhism (DiMaggio and Powell, 1983, p. 155). The argument here is that the degree to which the organisation is occupied by professional staff, the more it is influenced by the dominant ideas and models perpetuated by professional education and that are shared within professional networks. Thus dominant knowledge is shared across organisations through this professional 'class', members of which may move jobs easily across organisations (including funders) within the field, rather than being drawn from the organisation's constituent community. Many working in the not-for-profit sector in Australia would be familiar with the regular traffic of staff between NGOs, and from NGOs to government, particularly when government salaries are higher (Victorian Council of Social Service [VCOSS], 2007). For organisations providing LGBTI aged care services, following general trends for not-for-profit agencies (Suarez, 2011), growth in the size of the organisation (e.g., operating budget, number of employees) is likely to lead to an increasingly professionalised workforce. This is especially so in terms of the recruitment of managerial staff and consultants, given the need to develop high-level grant seeking and grant management techniques as the organisation expands (Suarez, 2011). Again, the challenge is for organisations to stay engaged with their constituent communities in order to ensure that professional knowledge is not privileged above other sources of knowledge, including the knowledge that community members have about their own lives and concerns.

The institutionalising trend for organisations providing LGBTI aged care services is difficult to avoid if they seek and receive government funding to deliver these services. As argued, what is of greater significance is the risk of isomorphism that comes with this institutionalising process. Key strategies organisations can employ to ward this off include: ensuring that the organisation is not overly dependent on a small number of others; maximising a diversity of funding sources; being clear about organisational mission and goals; and staying connected to constituent communities and their needs.

As discussed, a real challenge is for the diversity, complexity and ambiguity of LGBTI identities and communities to be reflected in the way organisations

provide LGBTI aged care services. The aged care sector is comprised of many different organisations, some with what might be perceived as conservative or traditional values. Fear of being placed in a residential care facility run by a conservative faith-based provider has been frequently reported in Australian research (e.g., Hughes, 2009). The consultations contributing to the development of the National Strategy involved considerable discussion about the importance of acknowledging this diversity. Indeed the Strategy states that 'The diversity within LGBTI communities is acknowledged and celebrated, and the individual and specific needs of people within those communities are recognised and addressed in the provision of aged care services' (Department of Health and Ageing, 2012b, p. 9). Questions arise though about how, practically, people who may be identified as queer or as having a non-normative LGBTI identity are engaged with and acknowledged. For example, it is unclear how this diversity will be reflected in the consultation strategies that are developed (as required by the Strategy).

The purpose of this chapter was to chart the promotion of LGBTI ageing as an issue in Australia and pose questions, based on DiMaggio and Powell's (1983) hypotheses, about the institutionalising trends that may emerge in organisational responses to this issue. Because these responses are at such an early stage of development, the analysis is necessarily speculative. What is required is a more detailed analysis of the institutionalising process and its impact. Key lines of inquiry could be its effect on the activist and professionalising strands of LGBTI ageing promotion and the opportunity for critiquing organisational and policy strategies. An important concern may be that organisations' advocacy and activist priorities become restricted by contract requirements or political pressure. How organisations facilitate or restrict the expression of diversity and 'non-socially appropriate' views across the LGBTI terrain may be another line of investigation. As argued by Suddaby (2010), the focus of research should not only be on the outcomes of institutionalising processes (e.g., measuring the extent to which organisations have become isomorphic or their impact on the field), but also on the processes of institutionalisation. One strategy for this is by developing detailed case studies of organisations to explore the 'institutional story' (Suddaby, 2010, p. 18).

Conclusion

The Productivity Commission's Inquiry into Caring for Older Australians, the introduction of the Living Longer Living Better reform program, and the development of the National LGBTI Ageing and Aged Care Strategy 2012, mark the beginning of a new era in LGBTI ageing in Australia. The potential for more aged care organisations to become LGBTI-friendly is considerable, just as is there considerable scope for more LGBTI community organisations to enter the field of aged care, as both educators and direct service providers. I have suggested in this chapter that this reflects an emerging strand of institutionalisation, whereby LGBTI

ageing promotion becomes more incorporated within the functions of the state and its agencies. Given the aged care reform program is underpinned by neoliberal values of competition and consumerism, there remain questions regarding the capacity of organisations to maintain their advocacy and social justice missions.

I have highlighted some of the challenges for organisations in resisting coercive, mimetic and normative isomorphism. Key strategies for countering these challenges include staying connected to constituent communities, making sure their needs are reflected in organisational missions and decision making, not becoming overly reliant on a small number of funding or referral organisations, and diversifying funding sources, including sourcing non-government funds through strategies such as crowdfunding. There are also questions about what will happen to the professionalising and activist strands within LGBTI ageing promotion in Australia. These strands are essential for ensuring that issues of equity and social justice are not lost, and that the diversity of LGBTI communities and identities continue to be represented and advocated for in the aged care system.

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Chapter 10
Internet Dating, Sexual Intimacy and Older People

Chris Beasley and Mary Holmes

Introduction

Why does sexuality matter in discussions of older people? Focusing here on heterosexuality, we argue that it matters because social interconnection involves sexuality in the form of embodied intimacies. It matters because a failure to include sexuality in discussions of social interconnection has some highly problematic consequences. The link between sexual health and well-being is now well established. *The Global Study of Sexual Attitudes and Behaviours*, which involved a large sample of men and women[1] aged 40–80 from 29 countries, found that over three quarters of participants agreed that 'satisfactory sex' was essential to maintenance of relationships and was associated with an overall sense of health and well-being (see for example, Laumann et al. 2005). A wide range of studies reiterate that sexual expression is by no means an optional extra but appears to be 'an essential aspect of our lives' (Barrett, 2011, p. 32; see also Planned Parenthood Federation of America, 2003) that is predictive of a heightened quality of life (Weeks, 2002). Thus attention is needed to desire for sexual intimacy amongst older people, as well as disabled people, and many others (Seymour and Lupton, 2004). As Barrett (2011) notes:

> [t]here is a significant body of evidence linking sexual health to emotional well-being of older people. Despite this, few health or human service organisations have programs to promote the sexual health of older clients. (p. 31)

If given the opportunity, older people themselves express the importance of sexuality in living well. As a woman participant in a study by Sue Malta said: 'I can hardly walk, but there is nothing like a romp in bed to make me feel alive' (cited in Cooper, 2008). Yet older dependent people in institutional care are typically offered no privacy, no shared beds, no opportunities for pleasure, flirting, dating, romance, sex. The lack of attention to older people's sexuality is also evident in that information they receive typically ignores it. For example the

1 It appears that the respondents were not asked about whether their sexual partners were same or different sex.

National Stroke Foundation (Australia's) audit (2010, p. 32) on whether patients were given information about the impact on sexuality after a stroke found that only 12 per cent were given any information on this issue.

Despite the importance of sexuality to well-being, the sexually embodied intimacies of older people are frequently ignored. For example, care theorists do put social connection *and* embodiment on the socio-political agenda, whether they focus upon micro one-to-one caring relationships or care as a macro social practice with institutional and governance implications. Yet, even these thinkers tend to deal only with quite specific aspects of embodiment – typically those to do with bodily maintenance and nurturance, such as elder and child care (Beasley and Bacchi, 2012). As Davina Cooper (2009) has also noted, care is conceived in a distinctly desexualised way. Understandings of social interconnection, in our view, demand a more expansive understanding of embodied intersubjectivity. We wish to look for a more substantive way of gripping together the corporeal, emotional and the socio-political – of grasping simultaneously the sociality of flesh and physicality of social life. This includes integrating sexuality into our conceptions of social connection.

The desexualised framing of social connection and intimacy amongst older people suggests that new approaches and terminologies are necessary. In previous work (for example, Beasley and Bacchi, 2012) our inclination has been to consider new vocabularies (the language of 'social flesh') that are more robustly attentive to sexuality, and also enable consideration of emotional reflexivity. The language of social flesh foregrounds that close relationships rest upon intimacy and interconnection, constituted by a set of often highly emotional practices (Holmes, 2010). However, whatever the frameworks we employ to consider social connection, the central point remains that sexuality must be included in our deliberations.

If social interconnection includes embodied intimacies such as sexuality, then this recognition has two important ramifications. Firstly it means a requirement to develop new directions in our research, and secondly it means asking, what might the most useful means be for exploring such possibilities and developments? In this chapter we consider the question of such new research directions. We examine how older people's sexuality is usually discussed, suggest how instead we might link elder sexual practice to social change, and finally explore how internet dating amongst older people might provide some illustrations of ways in which they might escape sexual convention.

Internet Dating as a Central Focus

In this chapter we consider the issue of sexuality as it relates to intimacy within the specific context of internet dating among older people. Sexuality in this analysis includes not merely sexual acts, practices and experiences but also a conglomerate of institutions, identities, social assumptions and customs, as well as resources

and labour (Beasley et al., 2012; Jackson, 1999). Intimacy, on the other hand, is employed to refer to a more diffuse arena than sexuality, concerned with a sense of close, embodied and particularised personal connection (Budgeon, 2008; Jamieson, 1999; Roseneil and Budgeon, 2004). This is typically not only about the individuals that experience it but also embedded in relationalities beyond it (Smart, 2007). Sexuality and intimacy overlap though they are not reducible to each other. In this chapter we are interested in this overlap.

Looking at internet dating assists us in considerations of how we might adequately attend to sexuality in thinking about older people's connections to others and their contribution to social change. Internet dating may be described as a 'purposeful form of meeting new people through specifically designed internet sites' (Barraket and Henry-Waring, 2008, p. 149). It is a relatively new phenomenon, with 'the net' becoming established in the 1990s and commercial dating sites soon following. These sites make use of new technology and vary in how they operate but broadly speaking follow similar principles to previous newspaper 'personal ads' and other existing forms of matchmaking (Barraket and Henry-Waring, 2009; Hardey, 2002; Whitty et al., 2008). On the other hand, this new and expanding form may also offer some new possibilities.

Internet dating is an increasingly popular means of undertaking a form of social interconnection involving the aim of sexuality/intimacy for all age groups and sexual preferences (Barraket and Henry-Waring, 2008, p. 150; Couch and Liamputtong, 2008; Hillier and Harrison, 2007; Whitty, 2008). Users over 55 may still be less likely to visit internet dating sites than younger users, at least in America (Smith and Duggan, 2013, p. 13), but the proportion is likely to rise as the numbers of older people that are making use of the internet is increasing in many countries, including Australia and the UK (Australian Bureau of Statistics, 2011; Office of National Statistics UK, 2013; Scottish Government, 2013). There appears to be worldwide increased use of internet dating as the means for older people to undertake intimate/sexual relationships (Malta cited in Cooper, 2008; see also Malta, 2013). While definitions of 'older' vary (Tarrant, 2010), the use of internet dating amongst older people is of increasing social significance, given that by 2051 it is predicted that 25 per cent of the Australian population will be aged over 65 (Malta, 2007, p. 85) and similarly for the UK (MacInnes and Pérez Díaz, 2009). Moreover, according to the World Health Organisation (WHO) the 'greying' of the world's population is global (WHO, 2002, pp. 6–7) and the growing number of older people – including the rising number of single older adults – will be accompanied by a parallel increase in life expectancy (Malta, 2013). These older people will not necessarily be dependent and may well continue to live active lives (Spijker and MacInnes, 2013). In this context, despite the growing significance of internet dating, specifically in relation to older people (Hogan et al., 2011), literature on this topic is limited. The literature that exists also tends to be dominated by psychological/therapeutic, demographic or health risk orientations. By contrast, our aim is to provide some insight into the practice and meanings of internet dating amongst older people while linking this back to

considerations of social connection and to better understand ageing sexualities in the internet age.

In the first instance research on sexuality and older people has largely reflected widespread ageism and heterosexism, (DeLamater and Sill, 2005; Gott et al., 2004; Osbourne et al., 2002) by assuming that older people are not sexual, that queer older people do not exist, or even that any sexual expression amongst older people is problematic, strange or unseemly (Barrett et al., 2008; Brown, 2009). Denmark (2002, p. 17) notes that 'one of the most pervasive myths in our society is the belief that a decrease in sexual interest and a diminished capacity for sexual behaviour are an intrinsic part of the aging process' (see also Adams et al., 2003, p. 405; Malta, 2007, p. 84). Rather than older age being inevitably constituted as sexless, as noted earlier sexuality remains important to older people (see for example, DeLamater and Sill, 2005). Australian singles over 51, however they meet, 'are the most likely age group to have sex on the first date' (Noone, 2012). Internet dating similarly facilitates sexual intimacies, and Malta's study (2007) suggests that older participants (between the ages of 60–92) in internet dating were actually relatively quick to become sexually intimate with those they met.

Secondly, ageism is also reflected in the ongoing assumption that older people are technophobic 'digital immigrants' and have little knowledge, skill or interest in new technologies (M. N. Cooper, 2000; Fong et al., 2001; Prensky, 2001; Philbeck, 1997; Adler, 1996). Yet it would seem, according to the Australian Bureau of Statistics (ABS), and other sources, that the number of older people accessing the internet is steadily rising and once the shift to online technology is made these users are as engaged as younger people (ABS, 2011; Fox, 2004; Malta, 2007).

Thirdly, ageist perspectives regarding sexuality and use of technology combine to produce a focus in internet dating studies on the young (see for example, Hillier et al., 2012; Hillier and Harrison, 2007; Clark, 1998). Research on older people, sexuality and internet usage is in its infancy. An emphasis on older people is rare in the literature on internet dating, and there is little in the way of research outside of the USA. There is a very occasional paper considering how older people use the internet in ways that enhance their sexuality (Adams et al., 2010; Malta, 2007; Malta and Farquharson, 2014), but often little is said about sexuality or the focus is upon health risks such as increasing vulnerability to sexually transmitted diseases (for example, Noone, 2012; Bateson et al., 2011; McWilliams and Barrett, 2012, see also National Institute on Aging, US Department of Health and Human Services). In other words, there is restricted focus on interactive social meanings and positive social directions.

Relatedly, scholarship attending to internet dating and older people is limited in terms of qualitative work or analysis of values and practices. This restricted attention to qualitative interpretive investigation is in many ways reflective of rather narrow concerns in the internet literature generally. The underdeveloped character of qualitative interpretive investigation in the field means that it is difficult to assess whether internet dating for older people

involves any innovations in attitudes and practices concerning, for example, equity around gender and sexuality (although see McWilliams and Barrett, 2012). Consequently, there is limited thinking about whether internet dating might herald new directions in intimacy for a group that has grown up with the expectation that undertaking sexual relationships begins with face-to-face encounters often arising through existing social networks. The issue of the extent to which internet dating represents the possibility of sexual and social innovations or the continuation of existing modes of meeting/matchmaking has been raised in the literature (Finkel et al., 2012; Heino et al., 2010, p. 428; Barraket and Henry-Waring, 2008, p. 149; McWilliams and Barrett, 2012) but this is often considered in the narrow sense of new technical options such as expanding choices in partners or enhanced ability to seek matching partner characteristics available as a result of the technology. There is also some limited debate about the advantages and disadvantages of internet meetings compared with traditional off-line meetings. Such considerations include the possibility of encountering people beyond existing social circles, increased safety, less emphasis upon bodies and appearance, and enhanced personal control. These are usually weighed against issues such as the problematic marketisation of the self and opportunities for deception (Barraket and Henry-Waring, 2008).

However, this debate is typically pitched at the level of descriptions of individual interactions with only some consideration about how, for example, increased safety or alternatively greater risk might generate or repress opportunities for new forms of social interconnection and associated power relations including new forms of gendered sexual relations between heterosexual men and women. Yet this is surely a highly significant issue in terms of understanding potential directions for social change, as well for the future development of facilities and services for older people.

Heterodox Directions in Ageing (Hetero)sexualities

We have said so far that putting together social interconnection and sexuality requires new research directions and that our focus on sexuality, internet dating and heterosexual older people reveals two gaps in the existing literature: a gap around attention to older people and around directions for social change.

In this setting we aim to consider heterosexuality by looking at internet dating and older people through the particular lens of attending to heterodox (non-normative) hetero-sexualities. Rather than simply looking at the question of whether older people undertaking internet dating are engaged in ‘new’ or supposedly more individually advantageous activities (in technological or social terms), we are interested in whether innovations in social interconnection and power relations arise, whether the emergence of internet dating has produced directions for progressive social change around hetero gendered sexualities.

In this approach we draw on our previous work concerning innovations in heterosexuality and hetero-masculinity with attention to emerging innovative modes of sexual intimacy (Beasley et al., 2012). In this case we intend to concentrate upon older heterosexual people seeking sexual intimacy through internet dating. As noted in that earlier work, we suggest that it is necessary to challenge the orthodoxy that heterosexuality is homogeneous and synonymous with heteronormativity (the institutionalised dominance of the idea that heterosexuality is *the* natural, normal and best form of sexuality, see Warner, 1999). If heterosexuality is *simply* equated with heteronormativity, the hegemonic coherence of heteronormativity is ironically upheld. Furthermore, social change is then conceived as arising only at the margins. In contrast, our concern is to 'undo' heterosexuality, to undo the illusory homogeneity and authority of the heteronorm, in similar fashion to Butler's 'undoing' or 'troubling' of gender (Butler, 2004, 1990), as well as opening up space for considerations of social change.

Instead of heterosexuality looking like a homogenous monolith, in Figure 10.1 it is possible to visualise a framework for considering the diverse range of the non-normative. At its normative core, 'cissexuality'[2] describes a space where heterosexuality is indeed to be equated with heteronormativity and where sexed body, gender, sexual orientation, desire, sexual practice and inter-relationality align neatly with what is deemed to be the hegemonic (Harrison, 2013, pp. 12–13). Beyond this, there are comfortable and unthinking normative options which are perhaps less strictly aligned with the hegemonic but are nevertheless hegemonically satisfactory. However, from this point onwards, the figure describes a potentially non-normative terrain. With regard to hetero-masculinity, the non-normative stretches from 'divergence' through to the entirely 'heretical'. Moving out from the norm, we first encounter divergence. To diverge involves staying connected to the norm but to behave in ways that challenge its boundaries. For example, a wife may constantly demand sex from her husband, to the extent that this upsets normative notions of wifely sexual passivity, but it is contained within the limits of heterosexual marriage. To transgress means wandering from the straight and narrow path, but not usually deliberately. A man, for example, may occasionally enjoy being fucked by his wife wearing a dildo, without either of them permanently altering their normatively gendered relationship in other ways. Subversion more consciously undermines the norm reflexively, if not necessarily radically. For example, committed couples who do not cohabit, question in an ongoing way whether heterosexual relationships

2 This terminology is still emerging and there are several meanings attached to it. Nevertheless, it is typically located as the antonym of 'transsexual' and in our usage combines 'cisgender' (alignment of sex designated at birth with gender identification) and 'straight' – that is, we use it as a shorthand for clear-cut alignment with heteronormative heterosexuality. See also *Urban Dictionary*, Definition of cissexual and *Oxford English Dictionary Online*, Definition of cisgender.

have to be the centre of life and whether fulfilling heterosexual experiences are limited to penises penetrating vaginas. Dissidence is both intentional and more radical in its departure from the norm. A dissident heterosexual is likely to question boundaries between homosexual and heterosexual and/or might include practices such as group sex and polyamory (for more detail see Beasley et al., 2015). Questions about how or why people might travel out or back between these different levels await further research, but it is clear that this model might help us consider sexuality in more fluid ways, both within heterosexual practices and across boundaries with same-sex experience.

We note that our attention to older people and the non-normative in this chapter provides precisely a new research direction that we suggested was necessarily associated with exploring sexuality as a site of social interconnection. Attending to the non-normative in heterosexuality offers a new research frame for analysis of sexuality (and internet dating more specifically) as a form of social connection and intimacy amongst older people.

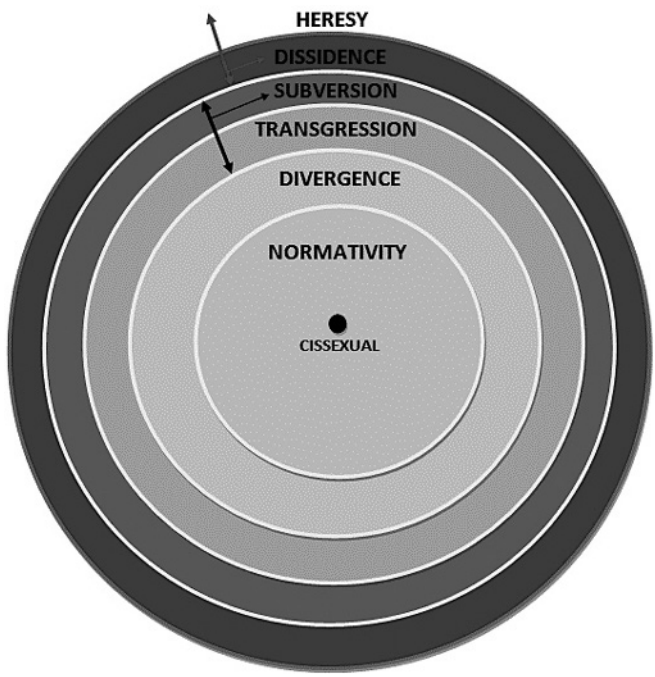

Figure 10.1 Locating heterodox heterosexualities – from normative to heretical

Possible Directions for Exploring Older People, Internet Dating and Sexuality

We want to flesh out some of the possibilities for non-normative directions by making use of publically available online material discussing internet dating, particularly internet dating involving those who self-designate as heterosexual. The value and challenges of using online sources as social science data has been strongly set out by David Beer and Roger Burrows (2007), but care must be taken to use them ethically (Holmes and Burrows, 2012, pp. 109–10; Baker and Whitty, 2008, pp. 43–5). None of the material cited in this chapter involves entering member-only areas or registering for internet dating sites, all could be accessed by any member of the public with internet access, and individuals are only identified if writing blogs and thus clearly aiming for a public audience. The material employed in our discussion was searched via search engines using search terms such as 'seniors internet dating' or 'internet dating discussion forums'. While it does not constitute a systematic exploration of online sources, it does provide illustrative suggestions and highlights the need for further qualitative research focusing upon non-normative opportunities.

It may be of course that internet dating is not necessarily a site for such possibilities. Technological innovation may not necessarily be associated with social innovation. Indeed there are signs that what Sara Ahmed (2004, p. 11, 60, 89–95) describes as 'sticky' affects – that is, intransigent attachments to 'traditional' social interactions, in this case traditional conceptions of romantic 'meeting up' – may still be in play (see for example, Whitty, 2008). In this context, one blog by a participant in online dating notes:

> [y]ou might think online dating would create some much-needed "fairness" between the sexes. In the realm of hetero courtship, tradition still reigns supreme. The Internet could be the great democratizer, the great playing field-leveler. …
>
> Maybe in this environment where we are safely sequestered behind screens, we can get past some of the lingering gender-based "rules" … Wouldn't that be nice?
>
> But it seems quite clear to me that we're not there yet. I'm partly to blame, and you probably are too. I'm a feminist, sex-positive 21st century lady whose photos include me posing in a Rosie the Riveter Halloween costume. I write about gender on the Internet for crying out loud! But every day, when I log into the dating site of my choice, I play the passive role, the receiver of attention, the awaiter of messages …
>
> It's not behavior I'm particularly proud of either. Why don't I write messages first? … Why do I not respond politely to every message, even the ones I'm not interested in? … .Because it's just so easy (Moss, 2013)

Moss notes the continued reign of traditional gender expectations within her internet dating practices, even though she is a 'sex-positive feminist' who believes that heterosexual women can enjoy sex (Beasley et al., 2012, pp. 20–21). Online dating has not yet brought freedom from gender rules and norms and she finds herself passively awaiting messages, as do many women internet daters (Frohlick and Migliardi, 2011, pp. 79–81; Smaill, 2004, pp. 94–6). It is not at all clear that internet dating undermines, let alone challenges established gender norms (McWilliams and Barrett, 2012).

Indeed, the advice older users of internet sites are given may actively reinforce normative ideas about gender difference. For example, a blog attached to a UK 'older dating' site reflects some of those norms, as can be seen in an entry by Sarah Hussey (2014):

> [m]eet intelligent senior singles on Older Dating Online who are interesting and appreciate the difference between the sexes. Ever since Cinderella women have enjoyed the allure of shoes.

Similarly the blog intones that for 'fifty plus senior single men gadgets are a form of bonding'. This is hardly a radical interruption of gender stereotypes and relations. On the other hand, when we add concern with sexuality and internet dating to the new research agenda of attending to older people, there are some possible signs in favour of heterodox innovation.

Some of these innovations may be divergent in offering a gentle challenge to notions that older people are asexual. As Tarrant (2010), Calasanti (2009), Sandberg (2009) and Hearn and Sandberg (2009), among others, have noted in relation to older men, older people should not be ignored in social research as they may provide unexpected examples of social innovation. While older people are frequently viewed in de-sexualised ways, they appear in some of the scholarship on internet dating to challenge this. For example, Frohlick and Migliardi (2011, pp. 79–80) tell of 63 year old heterosexual Jen who may not want to 'show her boobs' in her picture but whose profile says 'seeking sexy senior' and who explains that she would be happy to date younger men. She may be looking for a long term relationship, rather than casual sex, but is keen to avoid 'boring widowers' (see also McWilliams and Barrett, 2012, p. 426). Other over-50 heterosexual women in Frohlick and Migliardi's study (2011, p. 83) report that they have enjoyed the opportunities internet dating has provided to have casual sex. Moreover, though older heterosexuals are differently socially situated, they may find more common ground than when they were younger as they negotiate intimate/sexual social bonds.

The social status and experiences of heterosexual men and women may converge somewhat as they age. Older heterosexual men are less clearly in a comparatively privileged position over time as they are increasingly located in paradoxical relations of power with regard to sexism and ageism. They lose the power attached to occupational status once they retire and struggle to present

themselves as sexually powerful as age brings with it a loss in erectile enthusiasm (Calasanti, 2009, 2004; Hughes, 2011; Pain and Hopkins, 2010, p. 79; Tarrant, 2010, p. 1581). Older women over time become even more disadvantaged with regard to a confluent marginalisation around gender and age. They lose the youthful attractiveness that gives women sexual and social prestige. However, they may gain independence and a sense of enhanced agency after being divorced or widowed (McWilliams and Barrett, 2012). As these older men and women both find themselves shifting social status (including loss of status related to hetero-gendered notions of embodied capacity and attractiveness), and hence to a degree sharing rather more ground than they might have in their youth (Hughes, 2011; Bennett, 2007; Hearn, 2007; Rhohlinger, 2002), does this produce innovative heterodox forms of heterosexual intimacy? The novel terrain of internet dating may provide a place in which such potential non-normative innovations are required and may even flourish.

A blog attached to an Australian dating website for older people might provide some indication of internet dating as having innovative possibilities in the form of divergence for its apparently heterosexual users. As Bruce MacDonald asks, 'Can older dating help you face change?':

> [o]lder dating with other senior singles in Brisbane can provide you with a support network of friends and a special senior single partner to help you through these changes, support can be really essential when your life is in a state of flux and within the senior single community of Older Dating Online Australia you are bound to find others like you who have "been there and done that". The very nature of older dating means that the majority of senior single members have faced major change!

Of course, this contribution to the blog is not an account of older heterosexuals' experiences with internet dating but a way of promoting the site and encouraging people to join. Yet it claims that older people do not necessarily face 'fewer major life changes' as they get older and that internet dating may be a positive factor in adapting to those changes. The posting does not mention sex specifically, but elsewhere in the blog there are indications that sex may be involved in older people facing and embracing change.

While few might venture toward the more heretical, or 'queer' end of heterodox innovations, age may interact with new technologies to enable more possibilities for less sensational, perhaps more common, but nonetheless significant innovations that transgress or subvert norms around ageing and sexuality. These innovations might be more easily found amongst the young-old (60–74) than the old-old (75 and older). One analysis of heterosexuals' online personal advertisements found the young-old more likely to mention adventure, romance, sexual interests, and seeking a soul mate and less likely to mention health (Alterovitza and Mendelsohn, 2013). Moreover, internet dating may for example enable what might be described as 'mundane polyamory'. Dating several people at once is a comparatively easy

possibility, available to both older heterosexual women and men. While it is not a simple matter to have the energy, time or opportunity to develop connections with more than one person off-line, this is relatively simply done online. Indeed the online dating sites are set up on the basis that site members will browse a range of profiles and very likely interact with several on and off site. This will occur as a necessary part of the 'sorting' through of different dating possibilities, but enables such connections to continue, resulting in more than one relationship. In addition, at least some internet daters may have multiple profiles over more than one site, which may also facilitate conducting more than one relationship simultaneously (Frohlick and Migliardi, 2011, p. 78; Smaill, 2004, p. 102).

At a less dramatic, transgressive level, episodic multiple dating as a mode of mundane polyamory is common within internet dating, which is more difficult in off-line contexts. There are regular comments by internet dating users indicating that they can and do talk and meet with several potential partners for varying periods of time as they 'sort' through their options. Indeed internet dating sites are precisely set up for such episodic multiple connections to arise. It is not yet clear whether older people are also using internet dating to facilitate ongoing and intentional polyamory.

Other subversive options such as inter-generational sex and beat-style casual stranger-sex are possible for older heterosexual women (see Malta, 2007; Frohlick and Migliardi, 2011, p. 83). Establishing the extent of such activity and the kinds of experiences involved requires further research but there are some tantalising indications of it occurring. For example, an entry in a UK based 'Casual Encounters Blog' (2011), which is accompanied by a photo of a topless 'older' woman says:

> [d]ating in a modern world can be scary for those that are older or over the hill. If you are over 40 or 50, then phrases like "internet dating" and "casual nsa [no strings attached] encounters" might seem a little foreign to you. There are ways for people to date at every age. It doesn't matter what you are looking for, your age, your race, or your gender. We each have a group of our peers who are looking for the very same thing.

The claim here is that there are older people who might be looking for casual sexual encounters, and this direct appeal to them via an online site suggests there is some expectation that they may look for those encounters online. In contrast to some of the myths about asexual older people, this and other online sources contain some expectation that older people might want to engage in sexual activity and not just within traditional relationships. Similar claims are made, although not verified, by a poster (using a pseudonym identifying him as male) on the 'Very Naughty' discussion forum. He suggests that 'older' women want to engage in casual, non-monogomous heterosex and use the internet to achieve this:

> [o]lder women are still up for a bit of 'Hanky Panky' and [if] they are smart they hook up with partners on internet dating sites. This is a fantastic route to getting

> laid for millions of older women who want to keep their dating low key – out of the eyes of snooping friends and family.

This description then drifts towards fantasy and contains a far from radical or egalitarian vision of older heterosexual women's experiences of online dating. All the same, it does challenge the notion that older women are asexual. Yet there is little academic research available about older women's experiences and to what extent they might use internet dating sites in the ways this poster suggests. As already noted (see Frohlick and Migliardi, 2011, p. 83) older women could use internet dating to 'get laid' in casual sexual encounters, and may do so to keep their sexual activity separate from friends and families (see Stephens, 1976). If significant numbers of older women are pairing with younger men, this also upsets the usual gender hierarchies in which older men select younger sexual partners who are traditionally deemed more attractive than older counterparts. This has some potential to challenge sexual hierarchies which assume that men will be the older, more experienced and more dominant partner in sex. However, the term 'older' is relative and may not mean very old. One of the two comments responding to this posting on the Very Naughty discussion forum thinks it '[s]ounds like interesting, but some good looking older women that visits gym' would have to be offering herself. As noted earlier, sexual activity amongst older adults is thought to require a youthful appearance (Featherstone and Hepworth, 1991; McWilliams and Barrett, 2012), and the constructions of gender and sexuality on this internet forum appear to support this argument.

Thus, while these non-normative possibilities are usually temporary and contingent, they may promote or invoke modes of sexual intimacy in sexual practices and relationships that have political meaning and are of interest in terms of social change. And, if so, very likely there are policy, institutional and service implications.

Conclusion

Sexuality is frequently unrecognised and under-theorised as a mode of ageing social interconnection. Yet this failure to fully integrate sexuality into considering older people's lives cannot be sustained in the face of its well evidenced links with health and wellbeing. This has implications for the adequacy of policy, and health and service provision. However, to include sexuality, and in particular sexuality and older people, in our understanding of intimate arrangements requires new research directions. We focus upon the instance of older people and internet dating as a means to consider sexuality and social connection, and find that there is a significant research gap not merely in relation to older people but also in terms of considerations of social change.

In order to flesh out research directions that attend to sexuality, older people and change we consider hetero-sexuality not as a synonym for heteronormativity

but rather as a site for heterodox (non-normative) possibilities in the realm of the dominant. This contribution draws on a theoretical model of heterosexualities as diverse and as ranging from cissexual normative forms to divergent, transgressive and subversive forms which may challenge sexual norms even if they are not entirely heretical. While it is possible that such a framework will demonstrate much that remains normative, the focus upon older people and new technologies in relation to sexual intimacy may reveal heterodox innovations which are politically significant. Some possibilities have been sketched out, including how internet dating may offer divergence in challenging conceptions of older people as asexual and how it might facilitate transgressions such as mundane forms of polyamory, or subversions such as casual sexual encounters. This new research terrain offers a means to seeking out developments in sexuality and associated possibilities for social change, which are relevant to the future development of facilities/services for older people. Such a terrain demands further empirical research, which we aim to undertake shortly.

By examining heterodox forms of heterosexuality amongst older people as seen via internet dating, we are able to consider the advantages and limits of the growth of cyber social interconnectedness and sexual intimacy amongst an ever growing older population. This might help legitimise a concern with sexuality and with the almost taboo subject of older people's sexual practices and relationships. We argue that terms like 'social flesh' (Beasley and Bacchi, 2012) will assist us in such tasks by conceptually foregrounding the sexual in social connection. This in turn promises an account of older people's lives as ones in which they can be seen not simply as passive recipients of care but as often sharing their bodies with each other in socially connecting sexual practices that can challenge and contribute to changing social norms.

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