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Chapter 10
Ageism and Sexuality



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10.1 Introduction

In contemporary society, sexuality, intimacy, and sexual identities are considered central to a meaningful personal life, and on a fundamental level, constitute one of our basic human needs and rights. Until relatively recently however, much of the literature and discussion on these issues tended not to acknowledge older people and the topic remained taboo. These silences are further enshrined in many areas of social policy and practice in relation to ageing support and mirror older people's invisibility in other areas of society. This chapter explores some of the dominant

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discourses about sexuality, intimacy, and sexual identities in later life. By drawing on a range of secondary literature, it examines the different positions and contexts that situate the 'practice' (Foucault 1981) of sexuality in later life.

In relation to older people, preoccupation with sexuality and beliefs about 'normal' or 'appropriate' sexual behavior remains firmly entrenched in society, despite popular exposure. Sexuality in later life is mainly addressed from the biomedical perspective (DeLamater and Koepsel 2015), assuming there is a natural decline in the individual's sexual functioning in later life (Gewirtz-Meydan and Ayalon 2017), which needs to be treated with medication (Gledhill and Schweitzer 2014). Some other main issues and key myths that have been conceptualized in relation to older people's sexuality include: a lack of sexual desire that accompanies ageing; the physical unattractiveness and undesirability of older people, which is particularly evident in relation to gender; the idea that it is shameful and perverse for older people to engage in sexual activity; the invisibility of the older Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQ&I) community, and individuals who may need to return to the 'closet' in later life (Hafford-Letchfield 2008).

In the current chapter, we explore how ageism is constructed through the influences of attitudes promoted by the media, attitudes by younger people towards sexuality in later life, older people's attitudes towards their own sexuality and attitudes of those who provide care services.

Sexuality is defined by the World Health Organization as the integration of "somatic, emotional, intellectual and social aspects of sexual being, in ways that are positive, enriching and that enhance personality, community and love" (WHO, 2006). This holistic definition articulates sexuality as a state of being beyond sexual activity or sexual relationships. It includes notions of intimacy where there is close association, familiarity and shared personal knowledge between people, suggesting a degree of caring, sympathy or emotional understanding. The notion of sexual identity or sexual orientation adds complex dimensions, which may include political and community elements of how people relate to one another. Researchers are also beginning to note greater fluidity in sexuality over the life span, further complicating our definitions of sexual identities, including gender identities, which may not coincide with sexual orientation (Willis et al. 2016).

10.2 Attitudes and Perceptions of the Media

The media has an important role in shaping the public image of later life and sexuality.

(DeLamater and Koepsel 2015). In the media "ageing" and "sexuality" are portrayed and understood as unrelated concepts. The voices presented in the media frequently contradict. There is a repeated assertion that sexuality continues to play an important role as people age (Scherrer 2009). Notions such as 'sexy senior' or 'sexy oldie' are partly replacing stereotypical notions such as 'dried up old woman', 'nasty/dirty old man' or 'asexual oldies' (Marshall 2011; Steinke 1994; Vares 2009). Yet, older people who remain sexually active are stereotyped by the popular media, as well. Heterosexist concepts such as *cougar* or *MILF* (Acronym for 'Mother, I'd

like to fuck') are introduced by the popular media and represent stereotypical, ageist approaches towards older people's sexuality and toward older women in particular (Alarie and Carmichael 2015). Thus, while these labels acknowledge sexual desire in older persons, they portray negative aspects and reinforce the concept of most older persons as asexual (Montemurro and Siefken 2014).

Due to the emphasis on youthfulness by mass media, older men and women are underrepresented in advertisements. Moreover, when they do appear, they are typically peripheral, grouped with others or in a specific context such as insurance plans (Hurd Clarke et al. 2014; Low and Dupuis-Blanchard 2013). Images of older people relating to specific advertisements, such as pensions or health care products are associated with notions of burden frailty, loneliness or vulnerability (Media and diversity in an ageing society, 2002–2004), which reflect stereotypical expectations about later life (Prieler 2012; Williams et al. 2010) and convey them to society. A discourse analysis of how Canadian newspapers and magazines portray and construct older people's sexuality is a good example (Wada et al. 2015). The dominant, idealized notion of remaining young-looking, physically attractive and sexually active was highlighted, which marginalized older people who chose not to conform to that ideal or were unable to do so. This dominant ideal alongside with the successful ageing paradigm that encourages older people to stay sexually active, have led to a reconstruction of sexuality in later life.

Engaging in sexual activities has become an indicator of success or failure of the ageing process (Gott 2005; Katz 2002; Katz and Marshall 2003), which vacillates between 'normal' or 'pathological' and successful or unsuccessful ageing. Whereas a more positive image of older people's sexuality is certainly welcome, these kinds of advertisements and implicit messages to remain sexually active in older age create a division in which those who chose a different way may be defined as nonfunctional or as failing to age successfully. The representations of older people in print media established and reinforced the paradox that while sexuality is crucial to remaining youthful and aging successfully, youth and beauty are essential requisites for active sexual engagement. (Wada et al. 2015). Older people are expected to use pharmaceutical and medical interventions to sustain and enhance sexual functioning (Wada et al. 2015; Wentzell 2013) and intercourse is still presented as the "gold standard of sexuality" in later life (Gott 2005, p.14).

Emphasizing heterosexual ideals (e.g., penetration, orgasm, younger-looking) enhances ageism and the anti-ageing consumer culture (Hurd Clarke 2010; Katz and Marshall 2003). In-depth interviews with 44 women, ages 50–70 years, revealed that women respond to ageism and social obsession with youthfulness and discrimination against older people by engaging in beauty work such as hair dye, make-up, cosmetic surgery, and non-surgical cosmetic procedures, in order to fight social invisibility (Clarke and Griffin 2008). Advertisements for creams that 'will make you look 10 years younger' and the growth of cosmetic surgery are usually aimed towards the third-age, which is characterized by active sexual engagement. This creates an artificial distinction between the third age and the fourth age, when older people are seen as becoming non-sexual (Wada et al. 2015). The consequence of the divergence between the third and the fourth ages is growing stigmatization and ageism towards people as they grow older. The subtext underlying this type of advertis-

ing portrays older people as unattractive. While anti-ageing and pharmaceutical interventions are portrayed as enabling older people to restore their sexual functioning and youthfulness, they shape public perceptions of ageing as a pathological, rather than a normal, natural process (González 2007; Gott 2005; Katz and Marshall 2003).

It seems that despite the increasing recognition by mass media of older people as sexual human beings, ageing is still presented in a very narrow and one-dimensional mode. The gaps between the idealized images of ageing and the subjective experience can harm older people's self-image. As a result, sexual desire and enjoyment, achieving orgasm and frequency of sexual activity might diminish (Koch et al. 2005).

10.3 Attitudes and Perceptions of the Young Towards Older People's Sexuality

Studies have indicated that younger adults have accepting, tolerant, open-minded and positive attitudes towards sexuality in later life (Allen and Roberto 2009; Freeman et al. 2014). A survey of college students regarding their sexual attitudes and behaviors, both currently and projecting into later life, found that although younger adults were optimistic about continued sexual enjoyment in later life, they also believed many of the current myths about ageing. They expected considerably diminished sexual activity, along with increased sexual problems. Their expectations regarding sexual activity in later life were more conservative than their current attitudes were (Floyd and Weiss 2001).

Nonetheless, explicitly ageist attitudes toward sexuality might be difficult to detect (Thompson et al. 2014) and the implicit and explicit attitudes reported might diverge (Mahieu et al. 2011; Thompson et al. 2014). Acceptance of sexuality in older people by younger individuals seems to be a more 'politically correct' approach, whereas negative perceptions are portrayed as 'old-fashioned' and primitive. Evidence for this was found in a study that used an implicit attitudes test, which operates beyond conscious awareness (Lai and Hynie 2011). The study was conducted among 305 young adult university students who rated men and women's likely interest in a range of sexual activities. Their responses regarding younger (their own age) and older (65 years or older) individuals were compared. Participants perceived older people to be significantly less interested in sexual activities than were younger generations. However, both older men and older women were rated as varying between 'somewhat' to 'very interested' in both traditional and experimental forms of sexual activity. Another study (Thompson et al. 2014) examined young adults' explicit and implicit attitudes regarding the sexuality of older people. The authors reported that, consistent with other contemporary research (Lai and Hynie 2011), when asked, young adults explicitly reported positive views about the sexu-

ality of older people; however, implicit attitudes towards sexuality and ageing were negative.

Most of the discussion about sex assumes heterogeneity and lacks awareness of LGBTQ&I issues. These assumptions sustain a language for discussing relationships and life in a heteronormative way (Hafford-Letchfield 2008). Within the LGBTQ&I community, ageing issues may not be prioritized, resulting in the lack of a valued role for older lesbians and gay men. Such experiences, combined with a history of stigmatization, can subject older LGBTQ&I people to increased risk of depression, substance misuse, unnecessary institutionalization and premature death. Similar to misperceptions about older heterosexual people and their sexual lives, the majority of older LGBTQ&I people continue to have sexual desires and needs. A Gay and Gray Project study (2006) found that just over three-quarters of respondents said that they had active sexual lives and over half felt that their sexuality had an important positive impact on their lives. Therefore, adjustment to ageing is significantly related to satisfaction with one's sexual identity and the role society plays in shaping an individual's acceptance and sense of fulfillment from life experiences.

> Being lesbian, gay or bisexual is about more than defining your sex life. It shapes the way you experience life, your interests, likes, dislikes, humor, friendship, and attitudes. A care plan that neglects to include this huge part of a person's individuality is clearly incomplete and is likely to fall short of meeting that person's needs (Gay and Gray Project 2006).

The LGBTQ&I community, like any other, has some tension between generations related to sexuality. For example, within the LGBTQ&I community accusations of ageism are common – older men in particular often report feeling alienated from younger groups whom they perceive focus too much on appearance (body fascism). Meanwhile, younger LGBTQ&I people have reported that they are wary that older LGBTQ&I people only see them through a sexual lens (ILC 2011). Little intergenerational work has been done to explore the potential for increasing understanding in the context of the LGBTQ&I community, even though the old and young LGBTQ&I live side by side (ILC 2011).

In summary, attitudes held by the younger generations towards older people are important, as they potentially impact their behavior toward older people, as well as the beliefs and attitudes of older people towards sexuality.

10.4 Attitudes of Older People Towards Their Own Sexuality

Studies examining sexual behavior and attitudes of older people towards their own sexuality, reported that most engage in partner or other intimate relationships and view sexuality as an important part of life (Lindau et al. 2007). Findings from a study conducted in Nigeria, revealed that older people portray sexuality as an important aspect of later life, with heterosexual intercourse construed as having physical and spiritual consequences (Agunbiade and Ayotunde 2015). Yet,

research has consistently found that older people often internalize stereotypes and myths regarding late-life sex/sexuality and often are hesitant to express their sexuality.

A particularly significant indication of internalizing ageism is the reluctance of older people to discuss sexual issues with their primary care physician, due to fear that sex in later life does not meet with societal expectations and therefore, might be disapproved of by healthcare providers (Gott and Hinchliff 2003). Implicit in many stories was the perception that older people are not or should not be sexual beings. According to Vares (2009), older women internalize societal norms of beauty and ageism, view themselves as unattractive and perceive their bodies in negative ways such as 'wilting', getting 'rolls', 'sags' and 'flabby'.

In an attempt to combat ageism, older people undergo many beauty and anti-ageing treatments (Vares 2009) and consume pharmaceuticals aimed to enhance sexual performance (Gledhill and Schweitzer 2014; Katz and Marshall 2003; Wentzell 2013). Unfortunately, beauty and anti-ageing treatments and pharmaceuticals to enhance sexual performance do not always lead to satisfaction. Older people reported pharmaceuticals were often prescribed without assessment of the factors involved and without warning of side effects. They found pharmaceuticals aimed to enhance sexual performance ineffective and costly (Gledhill and Schweitzer 2014). Similarly, older women, who knew about vaginal lubricants, said that they felt that sex was still physically uncomfortable even when using lubrication (Shea 2011). In addition, while men were concerned about erectile function, women agreed that in older age, a companion is more important than sex and that they engage in sex as part of an obligation to sexually satisfy their partner (Baldissera et al. 2012). Shea (2011) opined that expanding the notion of sexuality beyond sexual intercourse is necessary. Absence of sexual activity may reflect a desire for liberation from sexual obligations, an acceptance of changing circumstances or the informed choice of other social priorities. There are also grey areas in relation to these issues, for example, the misunderstood orientation of asexuality, where one's identity is not aligned with sexual attraction or activity.

Specific, narrow societal norms and expectations were found to be main barriers to expressing sexual needs and sexuality, and to raising or discussing sexually-related issues with professionals. Internalizing societal norms and ageism caused sexual problems that were attributed to ageing, to be viewed as normal and irreversible or untreatable (Gott and Hinchliff 2003). Other barriers to discussing sexually-related issues with physicians were personal embarrassment, lack of knowledge and awareness, fear of wasting the doctor's time, or indirect presentation of sexual dysfunction hidden by other symptoms (Gott and Hinchliff 2003; Humphery and Nazareth 2001). Contextual/structural barriers, such as lack of time, lack of availability of secondary psychosexual services, lack of doctors' freedom to prescribe (Humphery and Nazareth 2001), setting and privacy (Sarkadi and Rosenqvist 2001) were noted, as well.

10.5 Attitudes and Perceptions of Primary Care Providers and Long-Term Care Staff

Sexual activity in later life is closely linked to physical health, diseases and functional decline (Dennerstein et al. 2002; Kontula and Haavio-Mannila 2009; Lindau et al. 2007; Mulligan et al. 2006). Therefore it is expected to be addressed by primary care providers who tend to serve as the primary 'gatekeepers' (Hughes and Wittmann 2015).

However, it is unclear, how well primary care providers' formal education has prepared them to address sexual health concerns among older people. Primary care physicians' knowledge of sexuality in later life was found to vary across studies. Whereas some studies reported adequate (Hughes and Wittmann 2015) or average/moderate (Mahieu et al. 2016) knowledge regarding sexual health issues in older people, others indicated limited and insufficient knowledge (Dogan et al. 2008; Mahieu et al. 2011; Snyder and Zweig 2010) among physicians. A recent review found that healthcare professionals often consider older people's sexuality as outside their scope of practice and lack knowledge and confidence in this area (Haesler et al. 2016). Obtaining relevant knowledge regarding sexuality in later life is especially important for adequately addressing older patients' sexual health concerns, for diagnosing problems, for recommending adequate treatment (Gewirtz-Meydan and Ayalon 2017) and for assisting older people to overcome barriers to sexual expression (Rheaume and Mitty 2008). Yet, physicians report they receive inadequate and insufficient education about sexuality in later life (Dogan et al. 2008; Gott et al. 2004). As a result, sexual issues are not raised during routine healthcare visits or interactions with older people and physicians' awareness of sexual issues in later life is very low (Gott et al. 2004).

Maes and Louis (2011) found that only 2% of a random sample of 500 American Academy of Nurse Practitioners members indicated they always conduct a sexual history with their patients aged 50 and older, whereas 23.4% never or seldom do such an assessment. Similarly, a study conducted among 144 psychiatrists in the US (Bouman and Arcelus 2001) found that sexual history is often omitted in the psychiatric assessment of older men. This often results in inappropriate referral and treatment procedures.

Knowledge and attitudes towards sexuality in later life were positively linked in many studies (Mahieu et al. 2016), making it difficult to determine causality. Ageist attitudes are not uncommon among health care providers (Dogan et al. 2008; Langer-Most and Langer 2010) and they have a great effect on the legitimacy of expressing sexuality in later life. A qualitative study conducted among general practitioners (Gott et al. 2004) revealed clear ageist attitudes toward sexuality of older people, as discussing sexual health issues seemed more relevant to younger patients, then older patients. In addition, sex was not recognized as an appropriate topic for discussion with older people. Nonetheless, no matter what the reasons for differential attitudes towards older people, it is clear that physicians exhibit strong biases in their approach to them. A recent study (Gewirtz-Meydan and Ayalon 2017) used

two similar case vignettes, describing young (N = 110) vs. older (N = 126) adults who presented the same indication for sexual performance anxiety. The treating physicians revealed an obvious age bias, as adults in the "older" vignette were more likely to be diagnosed with erectile dysfunction, whereas those in the "younger" vignette were more likely to be correctly diagnosed with sexual performance anxiety. Moreover, older people's dysfunction was more likely to be attributed to hormonal changes, health problems and decreased sexual desire rather than to psychological factors. Lastly, physicians were more likely to recommend testosterone replacement therapy and products which contain PDE5 inhibitors (such as Viagra™, Levitra™ or Cialis™), as well as referral to urology for the "older" vignette, whereas the 'younger" vignette was more often referred to a sexologist and received a more positive prognosis. These results clearly demonstrate that older people's sexual issues are more likely to be addressed through medical technology, whereas younger adults are more likely to be offered interventions in line with the biopsychosocial model, which is currently advocated for sexual issues.

Attitudes towards sexuality in later life, among staff in long-term care (LTC) facilities, are very relevant to the level of sexual expression among residents (Elias and Ryan 2011; McAuliffe et al. 2007). Staff attitudes define the institutional stance on this issue, which can range from restricting sexual expression to being responsive to or even promoting residents' sexual needs (Roach 2004). Although most studies indicate that LTC staff have positive attitudes of (Bouman et al. 2007; Mahieu et al. 2011), they are far from perfect. Staff knowledge regarding sexuality in later life is limited (Mahieu et al. 2011, 2016), personal comfort discussing sexually-related issues is low (Gilmer et al. 2010), trivial circumstances required for sexual expression (as privacy) are not facilitated (Gilmer et al. 2010) and a clear policy regarding the issue is generally lacking, leaving each institution to formalize policy regarding this issue independently, if at all (Bauer et al. 2009).

Prior to entering care facilities, prospective residents are not provided with information about how their sexual and intimacy needs will be respected (Bauer et al. 2009), nor do nurses routinely enquire about sexual practices and conduct sexual health assessments among older residents (McAuliffe et al. 2007). In addition, even though the majority of LTC staff believe residents have sexual needs that should be acknowledged and supported, the need was not regularly assessed due to discomfort about the topic among the staff, negative attitudes among the staff towards older people, as well as a lack of privacy and unclear institutional policy regarding the issue (Gilmer et al. 2010). Lastly, it should be noted, not all explicit, positive attitudes truly represent inner-thoughts or feelings (Thompson et al. 2014). In a study conducted among LTC staff, respondents acknowledged the existence of negative reactions towards masturbation only among other colleagues. When asked for their own opinion, they stated they viewed masturbation as normal and acceptable behavior (Villar and Serrat 2016). Sexual expression among LGBTQ&I people can be even more difficult in LTC facilities where any kind of sexual expression is censored or where judgments are made about those who are not in long-term relationships or have multiple sexual partners. This can be particularly stressful when the person finds him- or herself in a care environment where they will inevitably have

less personal freedom. When the person also has dementia, sexual disinhibition might lead to more openly sexual behavior, which might be more quickly labeled as deviant (Knocker 2012).

Staff perceptions and responses to residents' sexual behavior were found to be associated with personal level of comfort related to sexuality issues, the ethos within the employing organization (Roach 2004) and experience and age of the LTC staff. Older care staff reflected more positive attitudes towards later life sexuality, as they have more years of work experience in their field (Bouman et al. 2007). Knowledge and attitudes proved to be positively related, indicating that greater knowledge of sexuality among older people is associated with more positive attitudes toward sexuality in later life (Mahieu et al. 2016). Attitudes and beliefs towards older people expressing their sexuality in LTC facilities, including same sex couples and people with dementia, became more permissive after staff education (Bauer et al. 2013). Education is an important factor in dispelling commonly held, negative views of residential care staff about older people expressing their sexuality. Thus, it is very important to provide this information to LTC and nursing home staff (Bauer et al. 2013; Mahieu et al. 2016).

10.6 Conclusions and Recommendations

Sexuality in later life remains a largely unexplored and taboo topic. It is characterized by a dual nature and dominated by social constructivism. Despite recognition that sexuality is important to the quality of life of older people, this chapter identifies ageist perceptions regarding sexuality in later life among the media, young people, healthcare service providers and among older people. Any discussion needs to deconstruct the myths and stereotypes that deny older people their own unique sense of sexual being and the right to express it (McAuliffe et al. 2007). Rooted in and compounding ageism, are irrational fears, stereotypical thinking and lack of knowledge, resulting in attitudes and behaviors that constitute significant barriers to sexual expression, the enjoyment of sexuality and achieving a sense of self in later life (Snyder and Zweig 2010). Surveys conducted in several countries consistently found that older people indicated the importance of remaining sexually active as a major component of their quality of life and well-being (Kontula and Haavio-Mannila 2009). Research has shown that older people continue to engage in various sexual activities, such as penetrative sex, oral sex, and masturbation even in the eighth and ninth decades of life (Lindau et al. 2007). Hence, the expressed desire to remain sexually active is often accompanied by corresponding behaviors. Similarly, researchers have failed to challenge age-related stereotyping by placing older people outside the remit of national, population-based surveys on sexuality and sexual health issues, reinforcing the notion that these are not relevant to this sector of the community. When studies were conducted, they tended to focus on the more problematic aspects of sex, such as dysfunction in sexual performance or challenging behavior associated with cognitive, psychological or biological changes (for

example, disinhibition associated with conditions such as dementia). All of these serve to promote a medical model of older people's sexuality (Hafford-Letchfield 2008).

Not least, most research has neglected the voices of older people themselves, which are essential to capturing the diversity of experiences of sexuality and to challenging dominant discourses. This requires examination of how older people's experiences are incorporated into the discourse of people working with and relating to them. Sexuality is fundamental to social organization and is an important focus of power and resilience. Placing it at the center of an analysis of ageing and later life can provide insights into the possibilities of reworking the stereotypes and social practices that shape attitudes and subsequent actions when providing services and support.

Finally, until relatively recently, the research literature has tended not to acknowledge ethnic or cultural diversity. Many studies were framed from a white, middle-class, male, heterosexual perspective, suggesting a need for more cross-cultural studies. Fewer studies utilized representative samples exploring the sexual histories of older LGBTQ&I people and none collected information on gender identity. Due to a lack of representative, population-based samples, older LGBTQ&I people, and others with a history of same-sex sexual desire, behavior or identity, remain invisible (Brown and Grossman 2014).

Concurrently, paradigms for active and successful ageing reinforce high expectations concerning sexual behaviors, activities and desire, which are often inconsistent with the reality of many older people (Woloski-Wruble et al. 2010). Encouraging older people to stay sexually active in a way that is inconsistent with their reality, is another form of ageism (DeLamater and Koepsel 2015; Marshall 2012). Although it is agreed that some sexual changes and dysfunctions can be due to hormonal and other physical changes or long-term conditions related to ageing (Dennerstein et al. 2002; Mulligan et al. 2006), focusing on biological aspects alone might facilitate a narrow, counter-productive perspective (Hillman 2008). A biopsychosocial model is a multidisciplinary approach to the diagnosis and treatment of sexual problems, as it considers psychological and social factors such as stereotypes, gender socialization, partner availability, socioeconomic status, ethnicity, religious beliefs, and sexual orientation, in addition to biological influences (DeLamater and Sill 2005; Hillman 2008). Professional care providers including medical practitioners, nurses, social workers, psychologists and physical therapists are required to understand physiological and psychological factors that may impede the expression of sexuality in order to help older people manage sexual issues (Hillman 2008). Older adults can incorporate negative perceptions towards older people, which might hinder sexual expression in later life. Promoting realistic attitudes, alongside overthrowing ageist perceptions are required in order to enable older people to express their sexuality and sexual identity freely and fully. Open and legitimate discussions regarding sexuality in later life are needed to enable the expression of older adults' sexuality and to promote their sexual health. More robust explorations of ageist myths regarding sexuality in later life including qualitative, implicit and explicit research

perspectives are required to reach a comprehensive understanding of ageism torowards older adult's sexuality.

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