The Graying of “Sexual Health”: A Critical Research Agenda

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Cet article questionne de façon critique le concept de la santé sexuelle dans son évolution par rapport aux personnes âgées. Je m’inspire d’études sociales et culturelles sur le vieillissement, d’études féministes et de sciences et technologies pour établir un programme de recherche qui traite de la santé sexuelle en tant que point articulaire pour une gamme de technologies et de processus qui façonnent la vie sexuelle de milieu et de fin de vie. Un tel programme pourrait permettre d’explorer plus en profondeur les sites et les processus par lesquels les formes de sexualité sont façonnées, les types d’agentivités sexuelles («sexual agency») disponibles aux personnes âgées et la reconstruction contemporaine du parcours de la vie sexuelle.

This paper critically interrogates the concept of sexual health as it has evolved in relation to older adults. I draw on social and cultural studies of aging, feminist studies, and science and technology studies to outline a research agenda which treats sexual health as a point of articulation for a range of technologies and processes which shape mid- and late-life sexualities. Such an agenda may be able to more fully interrogate the sites and processes by which sexualities are being shaped, the forms of sexual agency on offer to older people, and the contemporary reconstruction of sexual life courses.

EARLY IN 2010, a study published in the British Medical Journal introduced a new health expectancy indicator: “sexually active life expectancy” (Lindau and Gavrilova 2010). Defined as the “average remaining years of...
sexually active life,” the authors argue that such an indicator will be useful in “projecting public health and patient needs in the arena of sexual health” (Lindau and Gavrilova 2010, p. 818).

This study is only one of a spate of recent publications demonstrating the upsurge in interest in older adults and their “sexual health.”1 Reversing the long-held stereotypes of asexual or postsexual seniors, expectations of continued sexual functionality as an indicator of health in later life now underpin a growing medical and therapeutic industry. Clearly, new agendas have emerged which have put the relationship between aging and sexuality at center stage for both scientific research and public health promotion.

The intent of this paper is to unpack the concept of “sexual health” as it has been used in the recent literature on late-life sexuality, and to suggest that a more expansive and critical research agenda is required. As a number of scholars have noted, sociological research on both aging and sexuality has been slow to catch up with the cultural shifts in imagery and expectations about sexuality related to the aging of the baby boom and the introduction of, and widespread use of, pharmaceutical remedies for age-related sexual dysfunction (Calasanti 2004, 2009; Carpenter, Nathanson, and Kim 2006; Cronin 2006; Fraser, Maticka-Tyndale, and Smyle 2004; Gott 2006; Kirkman 2005; Marshall 2010; Vares et al. 2007). While in sociology both “aging” and “sexuality” are now understood as socially constructed and regulated across a range of institutions and contexts, there remains a fairly limited body of literature that brings these insights together, and little of this work has been incorporated into public health campaigns or reported in the mainstream media. Much of the visible ground has been ceded to clinical and therapeutic perspectives, driven by rehabilitative agendas. When sexuality and aging have been the focus of widely cited studies, they have been underpinned by a biomedical model of heterosexuality, deflecting attention from gender, sexual diversity, and the social construction of age and sexuality more generally. We thus need to ask what “sexual health” means in relation to new cultural understandings of aging. As Ken Plummer (2008) remarks: “it is time for a new critical sexual gerontology!”2 (p. 18). My main task here is the elaboration of a research agenda that might map out such a field. I aim not to come to conclusions, but to

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1. In the medical literature, these include studies from the United States (Lindau et al. 2007; Waite et al. 2009), Finland (Koskimaki et al. 2008), the Netherlands (Korfage et al. 2008), and a Pfizer-sponsored cross-national survey (Nicolosi 2004), all of which were widely reported on in the popular press (see, e.g., ABC/Reuters 2008; Agrell 2007; MSNBC 2007).

2. Plummer, editor of the journal Sexualities, makes this call in a retrospective on the first ten years of the journal, when he notices that only one article explicitly focused on aging and sexuality was published during this period. Sexuality has long been a concern for gerontology, particularly as it has figured into conceptions of “positive” or “active” aging, and periodic calls to attend to issues of aging and sexuality have appeared in the literature on aging (Butler and Lewis 1976; Levy 1994; Rubin 1968). See also Rossi’s (1986) evolutionary account, where she takes social scientists to task for assuming that most
review the literature, identify key gaps, bring together some diverse lines of analysis, and suggest a range of questions that might prompt further inquiry.

In what follows, I draw on social and cultural studies of aging, feminist studies, and science and technology studies to outline four domains that might frame a critical sociological research agenda that treats sexual health as a point of articulation for a range of technologies and processes, and which can encourage more sustained sociological attention to the cultural reconstruction of sexual life courses. These domains include: (1) elaborating a genealogy of the concept of sexual health and its relationship to changing conceptions of life courses and discourses about "positive aging"; (2) mapping the medicalization of late-life sexuality in relation to pharmaceutical technologies; (3) analysis of the texts of sexual health and fitness; and (4) development of qualitative insights regarding how differently located individuals negotiate the sexualization of later life. Taken together, these four domains comprise a wide-ranging research agenda that may contribute to understanding the history, shape, experience, and limits of "sexual health" as a dominant idiom for thinking about sexuality in later life. Such an agenda may be able to more fully interrogate the sites and processes by which mid- and late-life sexualities are being shaped, the forms of sexual agency on offer to older people, and the potential contributions of a "critical sexual gerontology" to key areas of concern in contemporary sociology.

SEXUAL HEALTH AND THE "THIRD AGE"

Like the broader concept of "public health" (Robertson 1998), "sexual health" is a social construct whose meaning is derived from particular social, cultural, historical, and political contexts (Coleman 2007; Edwards and Coleman 2004; Giami 2002; Sandfort and Ehrhardt 2004). With respect to the "graying" of sexual health, several developments demand attention in mapping the ways in which a discourse of "sexual health" has become central to contemporary biomedical and public health interest in older peoples' sexuality, and in demonstrating the limits of that discourse for a more historically and theoretically informed understanding of aging and sexuality. I will briefly outline three of these developments: the impact of demographic change on conceptions of sexual health, the emergence of the "third age" as a particular cultural model of aging, and the centrality of body projects in later life as these become increasingly oriented toward maintaining sexual fitness.

important aspects of human development take place in childhood and adolescence, ignoring later-life changes in gender and sexuality.
First, Canada, like most Western nations, has an aging population. Declining birth rates, combined with longer life expectancies, contribute to a larger proportion of the population that is deemed “old,” and to an increase in the number of years that people will live in “old age.” Statistics Canada (2005) estimates that seniors (those 65 and over) will outnumber children (15 years of age and under) by about the year 2015, and by 2024 will constitute 20 percent of the population. This demographic shift has raised concerns about a potential strain on health care resources, and prompted interest in the health problems of senior citizens.\(^3\) As the study cited at the beginning of this paper argued:

As the older population grows . . . projecting the population structure of sexual activity is useful for anticipating need for public health resources, expertise, and services related to maintaining sexual function, regaining sexual function lost as a consequence of disease or treatments for common medical conditions that occur in later life, and preventing sexually transmitted diseases or risky sexual behaviour among older adults. (Lindau and Gavrilova 2010:810–11).

Psychologist Eli Coleman, former President of the World Association for Sexology, and instrumental in the development of the World Health Organization’s definition of sexual health, identifies increased longevity as one of the factors contributing to what he calls a “new sexual revolution”:

\[\ldots\text{people are living longer. Consequently they are sexually active longer. This has created a demand to help older people function sexually. Science has responded with more research to understand the sexuality and aging process and to develop ways of keeping people sexually active through biomedical interventions. People now have a better understanding of the menopause and andropause process . . . For men and women alike, aging will no longer signal the retirement of sexual behaviours. People will now be able to maintain virility and sexual activity much longer. (Coleman 1999/2000:5)\]

Coleman’s summary highlights the extent to which, where seniors are concerned, “sexual health” has become equated with “sexual function,” and underpinned by new, biomedically driven antidecline narratives. These narratives echo the progress story told by sexual medicine as part of the medicalization of sexuality. However, as critical historical work demonstrates, this linear recounting of demographic change leading to a problem to which medicine responds, resulting in the happy ending of biomedical interventions and better understanding, is highly problematic.

Second, as scholars in aging studies have noted, “life courses” are not what they used to be. No longer neatly divided by the conventional markers of childhood, adulthood, and old age, contemporary life courses

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\(^3\) I leave aside here the debates about whether or not population aging is the “demographic timebomb” some contend (see, e.g., Rich 2005).
are now viewed as more individualized and open to reconstruction through choices about work, leisure, and consumption. The “third age” (Laslett 1989) has become shorthand for that period of life that is postwork, but not yet “old.”4 As it has evolved as a concept in social gerontology, it is less tied to particular ages than to the experience of a healthy and active retirement. Those entering the third age are to have an expectation of a significant period of good health, activity, mobility, and appetite for new and life-enriching experiences. Sexuality is now central to this package, not only as sexual function and sexual activity are closely linked to health and vitality, but as “sexiness” becomes an important means of distinguishing oneself as “not old.” The idea of the third age is, as scholars have argued, not so much stage of life as a cultural field which has opened up the flexible demarcation of life stages to the imagination of cultural entrepreneurs and marketers (Gilleard and Higgs 2000; Katz 2005). To cite Higgs and Jones (2008), it is “a generationally saturated social terrain on which aging occurs” (p. 26). That this terrain is so centrally defined by a rejection of that which is identified as “old” links it to the expansion of antiaging industries. As the example that opened this paper demonstrates, sexual function may now be a key indicator of when one succumbs to “old age”—the end of sexually active life. And just as “retirement” is now a flexible process, no longer rigidly tied to chronological age and industrial time, the idea of a compulsory “sexual retirement” has given way to the new promises of biomedicine to make sexual fitness a lifelong project. As Kirkman (2005) suggests, sexuality is the “final frontier” for positive aging.

Finally, the graying of sexual health needs to be considered against the larger theoretical terrain of the contemporary sociology of the body. Turner (1992) characterizes modern societies as “somatic,” wherein the body, “as simultaneously constraint and resistance, is the principal field of political and cultural activity” (p. 12). An explosion of scholarship on the body over the past few decades has marked out its significance as both central to sociological analysis and as a complex and contested concept. Of particular interest in the present context is the manner in which sexualized, aging bodies are exemplary in demonstrating the complex intersections of consumption, “healthism” (Crawford 1980) and biomedical expansion. Nikolas Rose (2003) has captured this complexity in his concept of “somatic individuality”: “to be a somatic individual,” he argues, “is

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4 The “third age” corresponds to what was for a long time, in North American gerontology, termed the “young old” (Neugarten 1974). However, studies of aging worldwide have increasingly adopted the language of the “third age,” and it identifies at least one research center in Canada (the Third Age Centre at St. Thomas University). The terminology originated in organizations developed to provide educational opportunities for retired persons, first in the early 1970s in France through the L’Université du Troisième Age, then popularized in English by Peter Laslett, one of the founders of the University of the Third Age movement in the United Kingdom. “U3A,” as it is now known, has since become an international phenomenon. See http://www.worldu3a.org. For an insightful analysis, see Katz and Laliberte-Rudman (2005).
to code one’s hopes and fears in terms of the biomedical body, and to try to reform, cure or improve oneself by acting on that body” (p. 54). Because our individuality is in large part rooted in our bodily existence, we have come to experience, articulate, judge, and act upon ourselves in part in the language of biomedicine. From official discourses of health promotion, through narratives of disease and suffering in the mass media, to popular discourses on dieting and exercise, we see an increasing stress on personal reconstruction through acting on the body in the name of a fitness that is simultaneously corporeal and psychological (Rose 2007b:26).

Thus, somatic individuality demands self-surveillance and risk-management in the name of health. Individuals are encouraged to be risk-averse and actively entrepreneurial with respect to their bodies through lifestyle management and consumption of expertise, and submission to therapeutic regimes. Sexuality, through the discourse of sexual health, has become central here.

To summarize, the language of “sexual health,” while dominant in biomedical, public health, and consumer-oriented marketing, may be too individualizing and too limiting to grasp the larger cultural field that is at work here. There is an important role for critical analyses of the history and contemporary configurations of sexual health in relation to age as these reflect the intersection of a range of different discourses (demographic, “positive aging,” biomedical, consumption-oriented). As I explore in the next section, the convergence of sexual medicine and antiaging industries has constructed ageing populations as “a massive and growing market for drugs and devices to treat sexual problems” (Lindau et al. 2007:763).

**THE MEDICALIZATION OF SEXUALITY**

There is now a substantial body of literature documenting the medicalization of sexuality (Tiefer 1996, 1997), a topic given new impetus after the introduction of Viagra in 1998 (Carpiano 2001; Castro-Vazquez 2006; Lexchin 2006; Loe 2004a; Mamo and Fishman 2001; Marshall 2002; Potts and Tiefer 2006; Potts et al. 2004; Vares et al. 2007). Medicalization describes that process by which, historically, more and more behaviors and experiences are brought within the purview of medicine and defined as medical events or problems.

Historical research demonstrates that medical interest in sexuality in later life has shifted dramatically over the past 150 years. Sexual

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decline in both men and women was long assumed to be an inevitable part of aging. In the nineteenth century, it was commonly held that the body held a finite set of sexual resources, and once these were depleted, they could not be recovered. While lots of advice was available to older men on how to prolong their sexual efficacy through prudent management of those resources, the unavoidable end of sexual life was something to be anticipated and accepted. Masculine and feminine life courses were viewed as diverging at puberty and converging in later life, tied to the ebb and flow of sexual hormones. Thus, for both men and women, sexual life was closely tied to reproductive life, making the climacteric its endpoint. This changed in the twentieth century as developments in endocrinology first medicalized women’s “third age” (Kaufert and Lock 1997) and as urology became the focus for research on aging and sexual function in both men and women. “Impotence” became erectile dysfunction, largely in relation to the observation of effects of various chemicals on the erectile tissues of the penis. The clinical and market success of erectile drugs such as Viagra, Cialis, and Levitra has prompted what Kramer (1993) terms “diagnostic bracket creep,” where increasingly mild degrees of erectile difficulty are seen as erectile “dysfunction,” and the drugs are being pitched to younger men.\textsuperscript{6} As Tiefer (2006:287) notes, the triumph of oral erectile medications “succeeded so thoroughly in rationalizing the idea of sexual correction and enhancement through pills that it only seems fair that such a product be made available to women,” launching the “hunt for pink Viagra” (Wyllie 2005). There has also been renewed interest in identifying a hormonal (and thus pharmaceutically correctable) basis for symptoms of sexual decline linked to the “male menopause” or “andropause” (Marshall 2009a; Watkins 2007).

While early critiques of medicalization saw it as something imposed by professionals on ordinary people, and as something to be resisted (see, e.g., Illich 1976), more recent approaches argue for more complex accounts (Ballard and Elston 2005). Medicalization today is often driven by commercial and market interests (and creation of consumer demand) rather than professional expansion (Conrad 2005). Others have noted a shift from medicalization, which involves the exertion of “clinical and social control over particular conditions” to biomedicalization, which emphasizes the “transformation of bodies and lives” (Clarke et al. 2003). The (bio)medicalization of late-life sexuality is demonstrative of both of these points. However, as Nikolas Rose (2007a) suggests, medicalization as a concept might best be viewed as “the starting point of an analysis, a sign of the need for analysis,

\textsuperscript{6} A study of prescription claims data in the United States in the first five years of Viagra’s availability showed that, while men over 56 continued to fill the most prescriptions, rates of use slowed in older men, while those 18 to 45 were the fastest growing group of users (Delate, Simmons, and Motheral 2004).
but it should not be the conclusion of an analysis” (p. 702). As he has argued, “it is too simple to see actual or potential patients as passive beings, acted upon by the marketing devices of Big Pharma who invent medical conditions and manipulate individuals into identifying with them” (Rose 2006:480). A particularly productive field for researching the medicalization of sexuality in later life might be to bring together work on sexuality with that on the biomedicalization of aging (Estes and Binney 1989; Kaufman, Shim, and Russ 2004), to more adequately map out intersections with the discourses and technologies of “positive aging” and “antiaging” (Kampf and Botelho 2009).

For example, we might see sexual medicine as operating within what I have termed the “pharmaceutical imagination,” a linear model of scientific progress which is demonstrated by the move from psychological to physiological explanations for sexual problems, with aim of developing pharmaceutical solutions for the latter (Marshall 2009b). It provides a world view, shared by patients, practitioners, researchers, and industry, which not only explains disorders, but embodies assumptions about their nature, shaping our experience (or anticipation?) of them. The pharmaceutical imagination, with its optimism that better chemical solutions are on the way, fits well with the culture of “positive” aging/antiaging. As Kaufman et al. (2004) note, “the coupling of hope with the normalization of life-extending interventions affects our understandings of a ‘normal’ and therefore desired old age” (p. 736). Perhaps one does not actually need to use pharmaceutical remedies to experience this shift: revised standards of sexual functionality, premised on biotechnical possibilities, reconstruct sexual life courses in such a way as to set new expectations of aging and sexuality as these are forged in sexual medicine.

The extent to which sexual function has become promoted as a key indicator of successful aging, and the ways in which biomedical technologies of sexual rehabilitation are promoted as antiaging technologies are both areas that deserve further analysis. Some research has already noted that the close association of sexual health with overall health in older people manifests in a contemporary emphasis on “virility surveillance” (Marshall 2010). Individuals are encouraged to continually monitor their sexual function, and physicians are encouraged to ask their older patients about their sex lives as a part of routine health checks. Sexual function is seen as either a sign of good health or a warning sign of disease and disorder (especially for men) (Lindau et al. 2007; Shabsigh 2006), and regular sex is promoted as delivering a range of health (and in particular for women) beauty benefits (Ehrenfeld 2007; Jannini et al. 2009; Koskimaki et al. 2008). We are exhorted to manage our risk factors, and the threat of a decreased “sex life expectancy” is increasingly used to promote particular lifestyle modifications and/or health regimens: “...patients may be motivated to stop smoking or to adhere to drug regimens if the behaviour changes are expected to prolong or preserve a sexually active or
sexually satisfying life” (Lindau and Gavrilova 2010:811). Revised expectations about sexual functionality in later life, and the absorption of these into health promotion discourses, are reshaping sexual life courses, and creating new sites of anxiety about our ability to meet these expectations.

Finally, the medicalization of later-life sexuality might also be taken as a starting point for more fully exploring the ways in which sexual and gender difference are constructed and negotiated. As a number of analysts have argued, the pressure to remain sexually active is not only related to demonstrating youth and vitality, but also masculinity and femininity (Calasanti and King 2005; Marshall and Katz 2006). Marshall and Katz (2006) discuss the “re-sexing” of aging bodies, referring to the process whereby hormonal, medical, and pharmaceutical technologies, supported by lifestyle industries and sexual health campaigns, are designed to eliminate ageing as a barrier to youthful levels of sexual function and performance, but in distinctly gendered and heterosexist ways. Gendered and sexualized aging bodies have become lucrative resources for biotechnology markets, and it appears that technologies to re-sex aging bodies have displaced traditional models of convergence and androgyny for aging men and women.

In sum, when medicine associates successful aging with “sexual health,” defined according to certain kinds of sexual capacities, based on youthful, heterosexist standards, there is an implicit message of risk and decline in the absence of intervention. As Emily Wentzell (2007) summarizes, “to encourage older individuals’ sexuality while demanding that their sexual performance meet universal phallocentric norms is to create a situation in which older people cannot be properly sexual without medical intervention” (p. 375).

THE TEXTS OF SEXUAL HEALTH AND FITNESS

To a large extent, the domains outlined above—sexual health and the sexualization of the “third age,” and the medicalization of later life sexuality—draw on historical and theoretical analyses. However, elaboration of their contemporary and emergent dimensions requires a more sustained analysis of the texts of the technologies of sexual health and fitness as these...
enroll aging individuals, and are both descriptive and prescriptive in constructing sexualized, aging bodies. I draw here on Brian Pronger’s (2002) analysis of “texts of the technology of physical fitness.” Pronger describes an “intertextual ensemble” which includes five key fields or elements: official policy and health promotion initiatives of government agencies; the texts of academic science; popular books, magazines, and videos; physical fitness products; and popular representations of the “fit” body. Through “description, inscription, and prescription,” this ensemble “shapes the technological culture of physical fitness,” “establishing a logos . . . that attempts to circumscribe how we understand the body and ultimately how it should live” (Pronger 2002:123). Applying this ensemble to the texts of the technologies of sexual health and fitness, we might see the following as exemplary fields of analysis:

1. **Official policy and health promotion initiatives of government agencies:** Sexual “health,” generally synonymous with sexual “function,” is now included in government health promotion mandate. These include a range of initiatives, from Health Canada’s “droopy cigarette” warnings on cigarette packages to publications by the Public Health Agency of Canada on healthy sexual activity for senior citizens. As they describe their role: “Health Canada and the Public Health Agency of Canada work together to promote, improve, maintain, and protect the health of Canadians. Together, they gather and disseminate information on healthy, balanced lifestyles—including the sexual health of Canada’s seniors” (Public Health Agency of Canada 2006:3).

Some provincial governments also provide information on “healthy sexuality” to their senior citizens, either with their own documents (e.g., Alberta) or with links to Health Canada’s information (e.g., British Columbia). The Canadian government has actively promoted the consumption of health information online (Hirji 2004) and sexual health information in particular is seen as appropriate to online dissemination to seniors as it allows them to search for information anonymously and without having to leave home (Adams, Oye, and Parker 2003). This makes Web-based sexual health promotion texts a particularly important site for research, asking questions about how sexual health in later life has become a political concern, what images and expectations are being conveyed, how both individual and public resources are to be deployed in its pursuit, and to what extent commercial motives infiltrate even the “official” texts of health promotion.\(^9\)

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9. For example, in the Public Health Agency of Canada document cited above, the key survey data cited are from a study conducted by a private marketing firm for Pfizer, the makers of Viagra (Leger
2. *The texts of academic science:* Since the late 1990s, a constellation of professional associations and journals has emerged to provide a new focus on aging and sexuality from a biomedical perspective. The contemporary scientific landscape includes an expanded range of academic associations, institutions, CME\(^{10}\) credits, and journals that promote an interdisciplinary focus on aging and sexual health, but which unites around a model of late-life sexuality which is defined by the maintenance of youthful standards of (hetero)sexual desire and performance. Taken together, these provide an important field of analysis for understanding constructions of aging and sexuality, the significance of the age/sex problematic to scientific conceptions of human development, and the manner in which scientific work provides the framework for commercial and popularized conceptions of biological possibilities.

As work in science and technology studies has demonstrated, it is important for social scientists to understand how scientific “truths” are produced in laboratories and clinics, and how scientific communities circulate, validate, and contest these. We might ask then, how new knowledge claims about the sexuality of aging bodies are made, how they are naturalized, and how consensus (if any) about these claims is achieved. Inspiration for this task might be found in feminist science studies, which has recognized the need to engage with science to understand how “matter comes to matter” (Barad 1999:108). There is a long history of feminist critique of the ways in which medical and scientific texts have constructed women’s bodies and sexualities, and how cultural (mis)beliefs about women have masqueraded as scientific “fact,” circulated through laboratory and clinical practices, journals, and textbooks. Applying this critical perspective to the science on aging and sex, there are important questions to be asked about, for example, how samples are selected, how “sexual activity” is operationalized, how endpoints for evaluative clinical research are constructed, and how etiologies and disease entities shift in relation to available technologies. How do the texts of sexual medicine, particularly where these are concerned with older people, reflect a self-understanding of the knowledge produced as linear, progressive, and cumulative? More generally, analysis of the texts of professional networks, journals, and

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\(^{10}\) CME refers to “continuing medical education,” and physicians are required to complete a certain number of these credits to maintain their certification.

Marketing 2001). The Government of Ontario contracts out the production of health information for its HealthyOntario Web site to MediResource Inc., a firm which, according to its Web site, also provides “targeted marketing” which includes “content syndication” to assist industry in getting “targeted reach to consumers, patients, and physicians” (http://www.mediresource.com).
conferences can pose questions about how the sexuality of older people has been constructed as a scientific “object” or bounded field of inquiry. To borrow a turn of phrase from Foucault (1978), we might ask how the new sexual science constitutes sexualized seniors as yet another “strategic unity” which consolidates “specific mechanisms of knowledge and power centering on sex” (p. 103).

3. **Popular texts: books, magazines, newspapers, television:** A comprehensive content analysis of the dissemination of information on aging and sexuality through popular media remains to be done. This is a particularly significant task given the importance of popular media in the overall project of health promotion in contemporary societies, with its focus on lifestyle, consumption, and management of risk (Bunton, Nettleton, and Burrows 1995). Magazines, newspapers, trade books, and television programs are key means by which expert knowledge is disseminated and circulated to target populations. Mass media has long responded to the demand that older adults be “health literate”; how has this expanded to the demand to develop sexual health literacy in popular texts? Questions here might follow an analysis of the production of scientific knowledge as outlined above, inquiring into the ways in which those “facts” are constructed, framed, and communicated to lay readers, and how they are incorporated into blueprints for healthy living which includes the maintenance of sexual function. While a number of studies have illustrated the potential of popular media such as magazines for illuminating the construction of gendered health claims, a more sustained focus on the construction of sexuality and aging is warranted.

4. **The technologies of sexual health and fitness:** A more novel field of analysis may be found in discursive analysis of a range of texts related to the technologies of sexual health and fitness as these are prescribed, marketed, and explained to older people. An obvious starting point would include marketing materials and treatment regimens for prescription and nonprescription drugs and devices. For example, research on the marketing of erectile dysfunction drugs has demonstrated key shifts in constructions of masculine sexuality (Lexchin 2006; Loe 2001; Mamo and Fishman 2001). Calasanti (2007) has explored similar themes in advertisements for antiaging products. The anticipation of pharmaceutical treatments for desire deficits in aging women will open a whole new field of inquiry here.

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12. As I write this, there are currently no approved medications for female sexual dysfunction, although drugs such as Viagra and testosterone may be prescribed to women off-label, and a number of drugs
Less obvious, but equally important in mapping this field might be promotional and membership materials for recreational spaces (such as gyms and fitness clubs), activities (such as online dating services), vacation packages (such as cruises), and residential spaces (such as “active retirement” communities) directed at older people which implicitly or explicitly reference sexuality and sexual potential as part of their structure. We might also analyze the layouts and protocols for care facilities, which are increasingly recognizing the need to set out guidelines for managing the sexuality of their residents (Apex Information 2008; Everett 2007).

In researching this domain, we might look for inspiration to work in science and technology studies, where the idea that technologies and users are “co-constructed” has generated a fascinating body of research (see, e.g., Oudshoorn and Pinch 2003). Technologies of sexuality configure older users in particular ways, and may provide key means of understanding how the imperatives of sexual health are constructed.

5. **Popular representations of the fit body:** The sexually fit aging body is a relative newcomer to popular representations of the fit body. Thus, updating the already considerable body of research on “images of aging” (Blaikie 1999; Featherstone and Wernick 1991) is required to reflect new portrayals of seniors as sexual agents. While earlier reviews criticized media portrayals of older people as asexual or as held up to ridicule for expressing sexuality, more recent images include that of the “sexy senior” (Walz 2002). However, we need to critically examine if these newer images are as progressive as they might at first appear to be. In doing so, recent work in feminist cultural studies that has explored the sexualization of culture might be instructive. Feona Attwood (2009) refers to “mainstreaming sex” whereby media-saturated culture has constructed contemporary sexuality as liberated, stylish, and central to the construction of self-identity. For example, Rosalind Gill (2008) has analyzed a range of new “figures” in advertising that construct contemporary female agency, including the young, heterosexually desiring “midriff,” the vengeful woman, and the “hot lesbian.” While in some ways these new representations suggest a positive trend, offering more agentic and powerful forms of female sexual agency, Gill (2008) cautions against too celebratory a reading, asking whether
or not they in fact underpin a new “disciplinary technology of sex-
iness” that operates within a “profoundly heteronormative frame-
work” (p. 54). We might ask the same questions of new represen-
tations of “sexy seniors” in the bodyscape of consumer culture, as
“sexiness” and “hotness” become lifelong body projects, and as that
heteronormative framework is further secured.

Take, for example, journalist Mireille Silcoff’s description of “Zoomer,”
a glossy Canadian lifestyle magazine that bills itself as for “40s, 50s, 60s,
70s, 80s plus”:

The magazine promotes a new kind of archetypal ideal. It is a person, say, 73,
who goes footloose in five-inch Jimmy Choo stilettos. A person who can toss
back a large late dinner of steak and bold Shiraz after a full, extremely hip day
of dieting, ab crunching, “chilling”, Pilates, hardcore jogging, subtle cosmetic
surgery, not looking one’s age, shopping without dropping, and engaging in
various non-old person modes of “getting your game on,” including the super
hot sex of one’s twenties. (Silcoff 2010)

While Silcoff exaggerates for effect here, the “archetypal ideal” she
sketches here taps into a range of recent shifts in the representation and
cultural expectations of aging bodies and identities. There is no question
that sexuality is now central to images of aging, but just as feminists have
asked with respect to the sexualization of other groups (such as young
girls), we should ask what the potential effects of “compulsory sexual
agency” might be. Is a new, disciplinary form of the “beauty myth” un-
der construction for both men and women? To what extent is sexualization
of later life proceeding under the guise of sexual health promotion? Is this
a uniquely heterosexual set of representations, or is the negation of “old”
and “sexy” being reversed in gay culture as well? Clearly, these are all
open questions.

NEGOTIATING THE SEXUALIZATION OF LATER LIFE:
QUALITATIVE INSIGHTS

While the theoretical, historical, and textual fields of analysis outlined
above have the potential to yield a range of insights, they have their limits,
in that they cannot tell us about the lived experience of aging. While it is
important to understand the history and current cultural configurations
of aging and sexuality, it is equally important to know how older people
negotiate this landscape and reflexively incorporate its expectations and
resources. Thus, the fourth key terrain for research is to explore how the
images and technologies of sexual health and fitness are made available
to, taken up, refused, or anticipated by older people. In particular, there is
a critical need for more qualitative research on aging and sexuality which
recognizes diversity in late-life sexualities and which can provide ballast to the one-size-fits-all model promoted by biomedicine.

There is now a body of literature to build on which has used qualitative research to explore late-life sexualities in lesbian and gay populations (Cronin 2006; Heaphy 2007; Heaphy, Yip, and Thompson 2004; Herdt and de Vries 2004; Rosenfeld 2009; Slevin 2006); older heterosexual men and women (Gott 2004; Gott and Hinchcliff 2003; Hurd Clarke 2006); Viagra users, potential users and their partners (Loe 2004b; Potts et al. 2003, 2004, 2006); and older couples in long-term relationships (Kleinplatz et al. 2009). A richer, more complex picture of aging and sexuality is starting to take form, and we are beginning to appreciate the manner in which older men and women are “forging their own pathways to intimacy” (Connidis 2006:149). However, there is much we still do not know, and as the cultural terrain on which aging occurs continues to shift, new questions continue to be generated.

Following work in the “cultures of aging” tradition, we might ask how sexuality is central to the “generational habitus” of the “third age.” As the “baby boom” enters adulthood, what generationally linked expectations about sexuality do they bring to a redefinition of this cultural field? In particular, as a number of authors have suggested, the distinction between the “third” and “fourth” ages is complex and in need of research on the boundary work necessary to sustain their distinction (Gilleard and Higgs 2007; Higgs and Jones 2008; Twigg 2004).

We might begin to think through these questions with a return to the important relationship of sexuality to life cycle stages as identified by Gagnon and Simon (1973) in establishing a social basis for “sexual conduct.” A life-course perspective on sexuality was central to their classic social constructionist work on “sexual scripts.” As they note, “There are few roles or dimensions of identity that are more burdened with life cycle stage specifications or more troubled by the transformations accompanying life cycle stage changes than the sexual” (Simon and Gagnon 1986:112). Importantly, it is not only that one’s location in the life cycle suggests (or limits) the possibility of particular forms of sexuality, but that “sexual activity affirms our claim to a specific stage of the life cycle” (Simon and Gagnon 1986:115). This latter insight is crucial to the current emphasis on sexual activity as a marker of continuing vitality and youth, where the end of one’s “sexual life expectancy” may now be a marker of entry into

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13 Lillian Rubin’s recent 60 On Up: The Truth about Aging in America (2007) while not focused on sexuality, also uses qualitative research and autobiographical analysis to critique what she sees as the “hype” over life-long sexual function.

14 For example, despite the popularity and success of erectile dysfunction medications, it is estimated that approximately half of prescriptions are not refilled (Nehra et al. 2003) but little is known about why those prescriptions are not renewed.
the final stage of life. Certainly this is the sense given by the researchers who devised that concept in dividing late life into “sexually active” and after. The distinction between the “third age” and the final stage of life (the “fourth age”) is not based on chronological age, but is, as cultural studies of aging demonstrates, a qualitative and embodied distinction, based on an expanding array of functions, capabilities, and appearances (Higgs and Jones 2008; Katz 2010; Katz and Marshall 2004; Twigg 2004). As sexuality is added to that list, an ability to meet youthful standards of sexual function and appearance becomes part of the boundary work, and more potential risks to its achievement (and hence the threat of decline into the “fourth age”) are identified. But how do individuals reflexively take on such concepts in understanding their own life course? How do expectations of sexual function and its age-related changes foster anxiety or anticipation in third-agers?

Higgs and Jones (2008) offer the concept of an “arc of acquiescence” to explore trajectories of aging in a social context where it is expected that individuals will manage—and optimize—their bodily capital; where the “capacity to resist both the appearance of ageing and bodily decline in later life becomes a form of distinction in itself” (p. 86). The “arc of acquiescence” maps the “withdrawal from body maintenance and the greater acceptance of bodily limits,” and will reflect differences among those with varying levels of social, cultural, and economic capital. As they summarize it:

The utility of this concept . . . is that rather than seeing ageing as a purely personal misfortune or a socially constructed artifice the arc of acquiescence allows for the individual experience of ageing to be situated within a social context all the time being aware that even under the new circumstances of later life issues of capacity and performance are still important. (Higgs and Jones 2008:87)

Applying this concept to the study of aging and sexuality may provide fruitful ways of understanding the different strategies through which older people engage with body projects related to sexuality (including decision making about when to “get out of the market”). It will also open key questions about how social location—at the intersection of sexual, racial, and class hierarchies—may impact individual motivation and ability to “extend” the arc of acquiescence through various acts of consumption (of both products and expertise).

In taking up these questions, we need to avoid juxtaposing conceptions of “natural” or “authentically aged” bodies to those deemed technologically enhanced. Instead, we might ask how people incorporate expectations about sexual function into their sense of embodiment, and how gendered identities become tied to embodied standards of sexual functionality. In other words, how is the performance of gender and sexuality becoming
a life-long project for both men and women, bolstered by the facticity of science?

**CONCLUSIONS: RETHINKING THE AGING, SEXUAL BODY**

In this paper, I have suggested that a critical and multidimensional focus on aging and sexuality in sociology is both overdue and imperative. Given a recent focus on “sexual health” in older people evident in biomedicine, consumer culture, and health promotion, unpacking this notion is a productive starting point. I have argued that the language of “sexual health” is restrictive in the resources it provides for thinking through issues related to aging and sexuality. While certainly some valuable insights have emerged from those working within this perspective, overly naturalist, and essentialist conceptions of sexual drives and sexual bodies linger. Aging is treated primarily as a process of adaptation, with successful aging as an individualistic accomplishment centered on the maintenance of youthful standards of sexual function and attractiveness.

It seems clear that expectations about sexual function across the life course are reworking assumptions about biology to meet cultural standards. While certainly the more positive images of eldersex that have accompanied the pharmaceutical reconstruction of sexual life courses are an improvement over past views that saw older people as both undesiring and undesirable, I have suggested that caution should be exercised regarding an overly celebratory reading of the new discourse of “sexy seniors.” The biomedical re-sexing of aging bodies is profoundly heteronormative and phallocentric, and the hegemonic framing of sexuality as an innate, biological drive, or imperative weighs heavily. There is an important role for critical social studies to expose and expand the constructions of mid- and late-life sexuality currently promoted by biomedical and consumerist discourses. As others have suggested, the contradictory alternatives of an asexual old age and the “sexy oldie” discourse do not provide much of a range of positions for people to take up, nor do they resonate with what qualitative research has found about older peoples’ experience (Gott 2004; Hinchcliff and Gott 2008; Vares 2009).

The critical research agenda sketched out here suggests four key domains for future inquiry that may prompt us to more thoroughly interrogate both historical and emergent trends in the texts and technologies of aging and sexuality, as well as the experience of older people as they negotiate this new terrain. My intent has been to raise more questions than are answered. In conclusion, I want to suggest that, as a point of departure, we might put aging, sexualized bodies at the center of our analysis. The intersections of age, sexuality, gender, and “health” all point to the body and embodiment as the terrain where key questions are played out. In addition, as Jeff Hearn (2008:39) has suggested, “[a]geing sexualities
may challenge bodily (hetero)sexual normativity” and in doing so, sexuality might provide a productive point of interface for scholars working from the perspectives of aging studies, disability studies, queer studies, and feminist studies (see also Wentzell 2006). We need to attend to aging, sexualized, gendered bodies as constantly being reconfigured, through biomedical possibilities as well as cultural politics that foster ageless aging while at the same time creating anxieties about health risks and decline. In doing so, sociology and allied critical perspectives have the opportunity to contribute to thinking through the age/sex problematic as one of the most interesting on the contemporary landscape of sexuality studies—and one which we all likely hope to experience.

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