Intersections of Ageing, Gender and Sexualities

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Intersecting identities of age, gender and sexual orientation in gay and bisexual men’s narratives of prostate cancer

Julie Fish

Intersectionality and health

Intersectionality is emerging as a key theoretical approach in health research, bringing a distinctive lens to understanding nuanced differences in health status, health experiences and health outcomes (Fish, 2008). This chapter draws on McCall’s (2005) approach of intra-categorical complexity to examine the cross-cutting identities of age, gender and sexual orientation in the narratives of gay and bisexual (GB) men who took part in a study of their experiences of prostate cancer. Although McCall’s (2005) typology of intersectionality has been widely cited (for example, Fish, 2008; Cronin and King, 2010; Monro and Richardson, 2010), I will first offer a brief overview. She identifies three approaches to intersectionality, which she conceptualises as anti-categorical, inter-categorical and intra-categorical intersectionality. In brief, anti-categorical approaches, such as queer theory, seek to dismantle identity categories. The second approach, inter-categorical complexity has constituted the most common analysis of power and subordination across social groups characterised by privilege and penalty. While this approach has usefully identified the differential experiences between the principal categories of race or gender, it is often the case that other marginalised social groups are homogenised. The contingent, temporal and risky nature of GB men’s experiences are reflected in the titles of papers: men face the challenge of prostate cancer as they age (Asencio et al., 2009), the threat of sexual disqualification (Ussher et al., 2017), sexual dysfunction (Hartman et al., 2014) and are reported to experience worse health-related quality of life (Hart et al., 2011).
This chapter contributes to the developing field of intersectional approaches to men’s health (Griffith, 2012) by drawing on an intra-categorical approach which offers a fine-grained analysis of differences within social categories by exploring their complexity and nuance. Such an approach seeks to complicate and critically engage with identity categories to reveal multiple and often conflicting experiences of power and subordination, and derives meaning ‘from the partial crystallization of social relations in the identities of particular groups’ (McCall, 2005: 1781).

In the next section of the chapter, I consider the wider social context to enable exploration of how the intersections of age, gender and sexual orientation may affect the lives of GB men and influence their lived reality of prostate cancer.

**Age and ageing in the lives of gay and bisexual men**

Prostate cancer is a disease which primarily affects men in their sixties or early seventies (Blank et al., 2009). Previous research has revealed that GB men are diagnosed at a younger age than other men (Wasserug et al., 2013), suggesting they may have to cope with the disease through mid-life with potentially longer-term and distinctive impacts on their quality of life. Biomedical approaches define ‘successful ageing’ in terms of limiting the impact of chronic disease on physical and mental capabilities (Bowling and Dieppe, 2005); a diagnosis of prostate cancer, then, might hinder successful ageing. Men with prostate cancer may undergo a range of treatments including surgery, radiotherapy and hormone therapy; while they are becoming more effective in extending life expectancy, they do have complex sequelae for men’s physical, psychological and sexual well-being.

In public perceptions, GB men are sometimes depicted as sad and isolated individuals who are more likely to live alone (Robinson, 2016); moreover, in some GB male spaces they may feel excluded from the youth-oriented scene (Simpson, 2015; King, 2016). Psychosocial theories of successful ageing emphasise the development of psychological resources such as effective strategies in the face of changing circumstances and positive relationships with others. Although GB men did not have the benefit of feminist activism which developed social networks and solidarity among lesbian and bisexual women (Wilkens, 2016), they did mobilise highly effective campaigns in the fight against AIDS (Shilts, 1987). GB men over 50 comprise the cohort most likely to have been affected by the HIV/AIDS pandemic and whose social networks have been damaged by
multiple bereavements (Owen and Catalan, 2012). Moreover, they are the group affected by the penalties of privatised relationships enforced by the 1967 Sexual Offences Act which may have affected their sense of a publicly validated self. A framework informed by intersectionality emphasises both the threats and resilience for GB men in facing a life-threatening disease. Prostate cancer, because of the possibility of sexual ‘dysfunction’, may pose a singular threat to sexual identities, but GB men may be able to draw on psychological resources developed through their (previous) outsider status and the social relationships forged through activism around HIV/AIDS.

**Gender and hegemonic masculinity**

Prostate cancer is often assumed to be a couple’s disease which those in heterosexual, married or long-term, monogamous relationships go through together (Asencio et al., 2009). The significance of spousal support is implied in titles such as ‘getting through’ rather than ‘going under’ (Emslie et al., 2009). The extensive literature on prostate cancer is permeated by discourses of hegemonic masculinity where men work to control their emotions and distance themselves from feelings of vulnerability. Within such hegemonic gender regimes, women perform the role of nurturers and carers, encouraging men to seek a diagnosis, making notes at medical consultations, supporting them to change their lifestyles (such as alcohol consumption), and taking responsibility for their husband’s health. In a strategy described as emotional buffering, women colluded in their husband’s silence, because interjecting with a question during a medical consultation stirred up men’s emotions (Boehmer and Clark, 2001). In these accounts, women played a key role in doing emotional labour with, and on behalf of, men to promote their recovery. Moreover, the treatments for prostate cancer may bring life-altering physical and sexual consequences including urinary incontinence and erectile dysfunction which can affect a man’s sense of masculinity. Within discourses of hegemonic masculinity, men deny the effects of these embodied changes on their relationships and are reluctant to discuss their symptoms with other men or seek help from healthcare professionals (Boehmer and Clark, 2001). These experiential and affective responses, shaped by social and cultural expectations of masculinity, can render invisible other experiences of prostate cancer. Speer (2001) argues that hegemonic masculinity constitutes a cultural category which men draw on in contingent, temporal and context-specific ways. In this way, notions of hegemonic masculinity may operate in a distinctive register for GB men. Wall and Kristjanson
(2005) have argued that collateral or subordinated masculinities allow for the expression of other, more nuanced, experiences. They pose the question: would a reframing of the construct of masculinity elicit other knowledge and experiences?

**Sexual orientation**

The heteronormativity underpinning the social organisation of care provides a structure which at times constrains or limits GB men’s access to, or degree of comfort, in healthcare. The agential act of disclosure can enable GB men to reframe health communications, allowing them to bring their whole selves to the health encounter. But their interactions are often underpinned by an awkward choreography wherein GB men talk of fragmented patterns of disclosure (Fish and Williamson, 2016), highlighting the uneasiness during, in addition to the planning which preceded, the consultations with oncologists or other professionals. Structural or multi-systemic factors may influence access to cancer treatment and care including an individual’s knowledge of symptoms and health-seeking behaviours, their sources of support from partners and friends, cultural norms including health beliefs and previous health-related experiences, and community factors such as support groups, availability of information and resources (Hutchinson et al., 2006). Previous studies have suggested that GB men experience significantly worse health-related quality of life than heterosexual men. Moreover, the standard tools used to assess quality of life may reflect the concerns of heterosexual prostate cancer patients (Lee et al., 2013).

In the substantial literature on prostate cancer, GB men’s experiences have been largely overlooked. According to Wall and Kristjanson (2005), they have been included as participants in mainstream studies but excluded from the presentation and discussion of findings. As a consequence, GB men with prostate cancer have been described by researchers as a ‘forgotten’ (Latini, 2013); ‘invisible’ (Blank, 2005) or a ‘hidden’ population (Filiault et al., 2008).

The study discussed in this chapter has a small sample, as do a number of other studies of prostate cancer and GB men, for example Filiault et al., (2008) three men, Thomas et al., (2013) 10 men, Hartman et al., (2014) six men. However, the intention of this chapter is to contribute to theory development rather than to make claims to represent the experiences of GB men with prostate cancer.
Methodology

Recruitment

The study was funded as a 12-month project by a local cancer charity; interviews were conducted between July and December 2014 (see Fish and Williamson, 2016). Purposive sampling strategies were adopted that included a range of community-based organisations, diverse media outlets and social media which are well established in qualitative research (Carter and Little, 2007). A project-designed flyer was utilised which summarised the aims of the study; potential participants contacted the researcher by mobile phone, email or social media and an initial discussion took place about the aims and purpose of the study. Participants were sent a participant information sheet, provided informed consent and gave brief demographic information before taking part in the study.

Participants

Seven GB men who had received a diagnosis for prostate cancer within the previous six months to five years were recruited to a larger qualitative study about cancer care (see Table 1). Inclusion criteria were that participants should self-define as gay or bisexual.

Data collection

Semi-structured interviews lasting between one–two hours took place in a location of the participants’ choice, mainly their own homes or in university or other private offices; these were digitally recorded and transcribed verbatim. An interview topic schedule, designed in collaboration with a stakeholder group that included a gay man

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<th>Pseudonym</th>
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<tr>
<td>1. Quentin</td>
<td>56</td>
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<td>2. Karl</td>
<td>59</td>
<td>Gay man</td>
<td>Partnered</td>
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<td>3. Noel</td>
<td>69</td>
<td>Gay man</td>
<td>Newly partnered</td>
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<td>4. Tim</td>
<td>65</td>
<td>Bisexual man</td>
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<td>5. Nathan</td>
<td>43</td>
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<td>6. Craig</td>
<td>65</td>
<td>Gay man</td>
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<td>7. Norman</td>
<td>52</td>
<td>Gay man</td>
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with prostate cancer, included broad, open-ended questions with the intention of facilitating diverse experiences of cancer treatment, care and psycho-social support.

**Ethical considerations**

Ethical approval was obtained from one of De Montfort University’s Faculty Research Ethics Committee in December 2013. The study was conducted in accordance with the British Psychological Society, Code of Research Ethics (BPS, 2010). Participants were provided with full information to enable them to take part, confidentiality and privacy were assured and we obtained informed consent; a distress protocol was implemented and participants had the right to pause, reconvene or terminate the interview. All data was anonymised, participants were allocated a pseudonym and data was securely stored.

**Thematic analysis**

Initial meanings were generated from the data following immersive readings. A coding frame was devised using concepts relevant to an intersectional framework. The themes were then refined to make sure the ‘overall story the analysis tells’ reflects the data collected (Braun and Clark, 2006: 87).

**Gay and bisexual men’s embodied sense of self**

Men do not simply have bodies; their bodies mediate their experiences of everyday lives. Embodiment refers to altered corporeality, but also the social and cultural contexts in which men inhabit their bodies in the world. Cancer is often conceived of as a disease affecting somatic health through the identification of risk factors, biomarkers and predisposing genes. Embodiment encapsulates how cancer affects the ways that men think and feel about their bodies. Rather than proposing a mind/body dichotomy, embodiment conceptualises their symbiotic relationship. In this theme, I reflect on men’s embodied sense of self following treatment. Tim resists being positioned as an older bisexual man with prostate cancer by ‘keeping quiet’ about his illness until he has to tell people: “I am now a pensioner and I am probably looked at in a different light. I am an older man with cancer, oh dear, poor old thing. And I don’t want to give myself that label” (Tim, bisexual man, aged 65).
Tim says he is looked at in a different light because of his age and possibly his employment status (pensioner), but the additional experience of prostate cancer means that he would be looked at with pity: “oh dear”. Moreover, his embodied experience of the illness subtly alters his identity from a man to an object or a “thing”. His personhood becomes at stake. He feels that the ‘label’ of cancer subsumes his other identities. Currently, his illness is being managed and he shows no visible signs of it; because of this, he can choose whether or when to adopt the cancer label.

In the men’s narratives, prostate cancer has led them to develop a new sense of their bodies. Their talk is characterised by feelings of an altered body, of being highly sensitised to signs of further changes, they express a sense that they could not trust their bodies and feelings of vulnerability. Karl articulates his sense of physical vulnerability implied by his use of ‘major’ illness, but he also expresses disbelief in his sense of the surreal:

‘I feel very vulnerable in comparison to how I used to feel. I’ve never been ill ill, I’ve had all the usual ailments but nothing really major, and I think this sort of, it took me by surprise and I think there’s a feeling that you can no longer trust your body to do what you expected it to do. … It still doesn’t seem real when I say I’ve got cancer.’

(Karl, gay man, aged 59)

Embodiment encapsulates the integration of the body and the mind in illness experiences. The changes wrought on the body are a constant reminder of illness so that prostate cancer is always an immediate and present experience even after treatment:

‘It does make me think now … because I was told if it’s going to go anywhere … it’s going to go into my bones … every time I get … a twinge in my leg it feels like it’s in my bones … I am conscious of things on my body’s inside. Does it [metastases] feel like that? I don’t know. So you are permanently conscious about that kind of thing.’

(Nathan, gay man, aged 43)

Previous (inter-categorical) research suggests that gay men have a greater fear of cancer recurrence (Hart et al., 2011); in the above data extract, this fear is expressed in intrusive thoughts which may be triggered by ‘normal’ bodily functions such as muscle spasms. Nathan
has become more conscious of the internal workings of the body: “the body’s inside” and his thoughts turn to self-care activities which may prevent recurrence of the disease.

Some of the men articulated a sense of bodily acceptance, but managing the side-effects of treatment, such as urinary incontinence, was a concern in daily living:

‘I don’t want to wear pads – I just don’t want to do that … the bladder and bowel will always be weaker, so I have to work around that. So if I’m coming to a meeting … I don’t eat and I don’t drink … it impacts upon you psychologically.’ (Quentin, gay man, aged 56)

Only one man articulated a sense that being open about identity had contributed to improved outcomes for cancer. His comfort about his identity in healthcare enabled him to cope better with the bodily impact of cancer:

‘I’ve only been out probably about 10 years or something like that, I’m nearly 70 now, but if I wasn’t [out] … if I had gone back to the old me, all that added stress I’m sure in my own mind it’s, […] the outcomes of these treatments wouldn’t have been so good.’ (Noel, gay man, aged 69)

Tim, as the only bisexual man in the study, suggests that being comfortable about one’s identity is reflected in a coherent sense of self:

‘I know a number of bisexual men who are absolutely scared stiff of anybody finding out … I don’t think they are right in their attitude, but because prostate cancer tends to be a middle-aged and elderly men’s problem, it is a generation that is perhaps not comfortable in its own skin.’ (Tim, bisexual man, aged 65)

In these narratives, men express a sense of vulnerability and heightened awareness of their bodies following prostate cancer treatment. In a previous study (Asencio et al., 2009) of gay men’s perceptions of prostate cancer, younger men said they would choose treatments more likely to retain sexual functioning; while older men, being more focused on survival, would choose surgery to remove all trace of cancer. In the experiences reported here older men were also concerned by the impacts of treatment on their sexual relationships.
The concept of embodiment draws on notions of the ‘sociological body’ (Thomas-MacLean, 2005) wherein the body forms the means by which we live our identities in the world. Prostate cancer brings men’s bodies into sharper focus: for some the body is consciously present in the mind. For others, strategies of accommodation form part and parcel of everyday life; for example, Quentin sought to prevent urinary incontinence by not eating or drinking before a meeting and taking a change of clothes.

**Managing the emotional roller-coaster of prostate cancer diagnosis and treatment**

In discursive representations of hegemonic masculinity, heterosexual men are not able to express their emotions, or allow themselves to feel fear, or acknowledge they need help (for example, Cecil et al., 2010). Instead, presumed heterosexual men put emotional distance between themselves and the implications of the diagnosis. In previous studies of spousal support, heterosexual women perform the necessary emotional labour by acting as a buffer between heterosexual men and their illness (Wall and Kristjanson, 2005). Asking for help is a challenge to masculinity as it undermines men’s sense of ‘mastery’; Norman suggests the lack of ability to ask for help limits his leverage of social support for cancer: “Being a man gets in the way of being a man with prostate cancer. I am not going to stop and ask for directions, I will die before I do that” (Norman, gay man, aged 52).

Norman recognises that, for himself and other men, being a man means that he cannot ask for directions as that would deny a crucial element of power and control invested in hegemonic masculinity, which not only prevents men from seeking support but also curtails the ability to share their emotions. For GB men who are already subordinated by hegemonic ideals, this would pose a further intersectional de-masculinisation of their sense of self. By contrast, Noel made the decision to tell people early in his diagnosis, unlike his sister who had a stiff upper lip (she died of breast cancer); he found reassurance in speaking to an ex-partner of a friend.

Meanwhile, Nathan, as a single gay man, perhaps with a smaller social network, struggles to find social support and a place to express his emotions:

‘I think there’s probably, the biggest thing is to me is that where do you go, who do you talk to? ... I looked round ... and there’s nothing, you don’t feel confident enough to go
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into places to ask … But there’s nothing that’s specifically said anything about cancer … if I hadn’t seen on Facebook that there was a support group in [northern city] I probably would have been sat here thinking well who do I talk to? Is there somebody?’ (Nathan, gay man, aged 43)

Nathan articulates a strong sense of being alone with the illness. Others have suggested that there are no sources of information for GB men with prostate cancer (Duncan et al., 2011). GB men without cancer, who were asked about sources of support for cancer, said that they would attend a mainstream support group believing that men undergoing treatment for prostate cancer would be welcoming of any man in the same situation (Blank et al., 2009). In many of the accounts here, the men said that the heteronormative environment of such groups militated against their engagement in them. They said they would not be able to express their feelings or seek support in such a group. This is partly because some heterosexual men struggle to express their emotions and do not talk to other men without their wives being present. But also discussing the implications of prostate cancer treatment in relation to anal sex was difficult in heteronormative environments.

In the early stages of the disease, not talking seemed to be a strategy where men in a coupled relationship were able to circumvent the biographical disruption posed by cancer to resume life as usual following the diagnosis (Bury, 1982). Quentin and his partner carried on as if nothing had happened, but he describes the period as a “very dark” and “scary” place. A number of men talked about the use of meditation or mindfulness as strategies in coping with their cancer, while others had drawn on learning through personal growth to be expressive of emotions rather than try to problem-solve:

‘And heart circle is all about how do I feel, what do I want, no story, and nobody tries to fix me, even I don’t try and fix myself I just say it the way that it is. And I found that so powerful and we were really good at it. And sometimes I would cry for three or four minutes and cry like a hundred yards in my heart not just in my head and in my eyeballs, like an elephant [roars].’ (Norman, gay man, aged 52)

In this extract, Norman is able to articulate his profound emotional response to the disease and challenge his previous conceptions of his own sense of masculinity. The men in this study re-evaluated their
lives and relationships, which brought a new focus on the things that matter. For Nathan, cancer meant that he no longer defers things and has found a “bigger drive in my life”. Wall and Kristjanson (2005: 95) provide a critique of the tendency of previous studies to present hegemonic masculinity as unproblematised in prostate cancer narratives arguing that it has enabled the researchers to present their findings in a ‘less complex form (men, after all, are just men)’.

Intimate and sexual relationships following prostate cancer

In the literature, prostate cancer is said to pose particular problems for GB men’s sexuality and sexual behaviours due to the diversity of their ‘sexual practices and sexual roles’ (Asencio et al., 2009: 45). While this does foreground GB men’s sexual needs as equally important to those of heterosexual men, it also perhaps tends to reinscribe historic assumptions of GB men as having an over-sexualised identity. The impact of treatment on men’s sexuality and sexual behaviours featured in most of the narratives.

Erectile functioning can have different meanings for GB men due to the need for an erect penis in some forms of sex between men. Karl expresses his frustration at the lack of understanding by oncology professionals about the impact of treatment on his sexual relationships. He felt that professionals presented a picture of the treatment effects as “over sanitised”, “over simplified” and “far too optimistic”. He was told that he would feel poorly for two months, but that any erectile problems could be treated with Viagra. For GB men, the advice that you can resume sexual activity takes no account of men’s sexual preferences and practices. While this may be an effective treatment in heterosexual relationships, where men can have insertive sex with a softer penis, anal sex requires a firmer erection. He turned to a public blog to counter the assumption that a ‘soft orgasm’ gives equal pleasure:

‘I remember it was the Macmillan nurse who said to me about these soft orgasms, you know, they can be as good as everything you’ve experienced up until now. Well I’ve told her since they’re crap. I actually wrote it in a blog and she read the blog before I’d told her and she said I remember that was me that said that to you. She said “I never realised.” I think she and probably the doctor were being as honest as they could but I don’t think they really understood.’ (Karl, gay man, aged 59)
The absence of ejaculation, which the nurse had euphemistically described as “dry orgasms”, may have a different impact on men’s intimate relationships because of the intimacy associated with the exchange of semen during sex between men:

‘… amongst gay men there’s this big thing about the actual show of cum. You can’t do that anymore so that’s gone as well.’ (Karl, gay man, aged 59)

The notion of sexual disqualification did feature in some men’s accounts of their feelings about sex and sexual performance. For Karl, previously, his sex life was 10 out of 10; now it’s probably 2 out of 10. Another man discussed how he and his partner had renegotiated sexual intimacy within their relationship:

‘To start with the erectile thing wasn’t too much of a problem, you modify things as you go along … we have been together now for 22 years and to live with and love someone and share your life for that length of time and still be best friends you know life moves on, life has all sorts of twists and changes and turn arounds, and in both our lives quite a lot has changed. I think it would be a bit naïve to assume that things would stand still. And you take the ups and downs and make your modifications as you go along.’ (Craig, gay man, aged 65)

For some GB men, open relationships present a way of addressing differing sex needs. By setting mutually agreed boundaries a partner can have sex with another man outside of the couple relationship; other men may choose to have multiple sexual relationships. Noel and his partner have come to a negotiated agreement about meeting sexual needs:

‘There’s been some testing times because with the treatments, although my libido is still there it’s much, much reduced. In all honesty, I don’t know if part of that is just because of my age anyway. And he’s a younger guy but I recognise that he’s got needs and we come more or less to an agreement. Well I am not going to be following his every move or anything like that, if he gets his needs met elsewhere, as long as he respects my point of view as well and up to yet that’s working. Again I’m not saying that’s
Norman is able to achieve sexual satisfaction through a change in his sexual behaviour and in how he thinks about sex:

‘When my libido got switched off I thought that was the end of the world … I thought I was in charge, my dick was in charge … I don’t think men realise how we are designed until it got switched off and I discovered sensuality, it’s like shit I can have better sex without my cock getting in the way, I have never experienced that before.’ (Norman, gay man, aged 52)

The changes following treatment may have different impacts on men’s sexuality because of the importance of the prostate as an erogenous zone in sex for GB men; moreover the presence of an erect phallus and the exchange of semen are both intimate and erotic for many GB men. Alongside the sense of loss that Karl expresses, some men find resourceful ways of achieving sexual satisfaction by other forms of sensuality, as Norman has been able to do through his commitment to personal growth. For other men, accommodating these changes through open relationships or intimacy may take different forms in longer-term relationships.

Discussion

Intersectional approaches pay attention to ‘privilege and penalty’ (Bowleg, 2013) in the lives of GB men with prostate cancer. This data allows us also to understand men’s strategies of resistance in coping with adversity. They are not privileged by heterosexual gender relations, but their narratives here suggest they draw on discourses of hegemonic masculinity in contingent and temporal ways. Norman had set up a support group for prostate cancer, but (‘being a man’) found that he was unable to ask for support for his own needs. Subsequently, by drawing on strategies for personal growth he was able to build resilience in coping with cancer in distinct ways. GB men in this small sample, did look to each other for emotional support.

The data presented in this chapter suggests that GB men’s gender is problematised by other cross-cutting identities such as age and sexual orientation. The interaction of their multiple identities suggests that they ‘do’ gender (Butler, 1990) in subtly different ways and in the
absence of gender relations wherein women perform the role of maintaining heterosexual men’s health. GB men do not merely occupy the spaces left by hegemonic masculinity, but when they deploy hegemonic masculinity they do it differently from heterosexual men. There were perhaps greater penalties expressed in the accounts of men who were single; Nathan articulated a sense of isolation in finding someone to talk to. There are wider implications for this data; there are only three cancer support groups in the UK which provide a vital function in GB men’s recovery, but these are sustained by men who face a life-threatening illness in a voluntary capacity.

References
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