

THE UNIVERSITY OF HULL

“What are the experiences of sexual intimacy in people aged 75-85 in the UK  
in the context of partnership relationships”

being a Thesis submitted for the Degree of  
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by

Dawne Garrett

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Dedication

To FCC

In me thou see'st the twilight of such day,  
As after sunset fadeth in the west;  
Which by and by black night doth take away,  
Death's second self, that seals up all in rest.  
In me thou see'st the glowing of such fire,  
That on the ashes of his youth doth lie,  
As the death-bed whereon it must expire,  
Consum'd with that which it was nourish'd by.  
This thou perceiv'st, which makes thy love more strong,  
To love that well which thou must leave ere long.

Sonnet 73

Shakespeare 1609

## Abstract

The experiences of sexual intimacy for partnered older people are little researched. This study, situated in a life course perspective on sexuality, purposively sampled data from 11 in-depth interviews and 41 pieces of correspondence from people between the ages of 75-85 in the United Kingdom. The study used Intuitive Inquiry, a method consisting of five “Cycles”; clarification of topic, literature review and description of initial “lenses”, data collection and summaries, integration of the data with literature to produce the final “lenses” and lastly synthesises of the stages of the study to produce a final interpretation.

Data were analysed thematically and phenomenologically providing both breadth and depth. The thematic findings recorded observable acts of sexual intimacy and continuums of participant’s thoughts and feelings. The continuums were organised into five meta-themes: the effects of ageing, the nature of relationships, the family context, seeking assistance and the sexual life story. The phenomenological analysis provided “Being Together” as the essence with the constituents; Maintaining intimacy in changing circumstances, Setting current intimacy across a life course, Concern about what people think, The possibility of sexual intimacy and The spectre of death.

In addition to the findings the new contributions to the body of knowledge include; a definition of sexual intimacy in older age, the use of intuitive inquiry as a research method within the UK and a greater understanding in researching sensitive topics with older people.

The recommendations highlighted a need for increased professional understanding of older age sexual intimacy and practical interventions to preserve sexual intimacy as part of essential holistic care. Further development of the continuums is planned to develop a tool to aid identification of synchronicity or discord between couples as a potential aid to clinical and therapeutic intervention.

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## Foreword

This thesis has been compiled to illustrate my doctoral research and the contribution it makes both in the subject findings and the use of the method. The thesis comprises; the background to my subject, an overview of the method, the data analysis, findings, discussion and an integrative “Cycle” including recommendations. The structure and language are a little unorthodox, reflecting the research method and its guiding principles used throughout the thesis.

My research emerges from my work with older people over the course of my nursing career but specifically my time working with people in their own homes. In their own settings older people were more willing to discuss the issues that really affected them and I started to be asked questions about sexual intimacy. In trying to provide helpful and considered answers I looked to the evidence and found very little to inform me. This absence interested me and started my quest for a deeper understanding of the subject.

To aid reading the thesis I have set out below an initial diagram to act as a way finder through the document. For readers more used to a traditional thesis structure I have drawn parallels with thesis convention to help with navigation.

Unusually I provide a short explanation of the method immediately, in order to set out the structure of the document and to provide some context. I trust this improves both the understanding and experience of this work.

The method chosen to answer the research question is Intuitive Inquiry (Anderson, 1998) which uses a framework consisting of five “Cycles”.

## **Method Guide to reading this thesis**

The method for the study is Intuitive Inquiry which is relatively unknown in the United Kingdom and this research provides a contribution to the introduction of the method. Anderson (2011) explains that intuitive inquiry incorporates intuitive and compassionate ways of knowing in a method which involves five “Cycles”. This method is highly suited to researchers who wish to understand their topic fully and who become immersed in the subject (Braud and Anderson, 1998). Intuitive inquiry provides a systematic and rigorous approach that incorporates both objective and subjective knowledge through an interpretive process. This ensures the researcher’s point of view and the evaluations of the accounts of others are in constant dialogue. The five cycles of intuitive inquiry are set out below;

- Cycle1 involves clarifying the research topic.
- Cycle 2 looks at the literature and describes the “lenses” or major constructs the researcher has identified.
- Cycle 3 is concerned with data collection and the creation of data summaries.
- Cycle 4 integrates the data with literature to develop an understanding of the subject then produces the final “lenses”.
- Cycle 5 synthesises the stages of the study to produce a final interpretation.

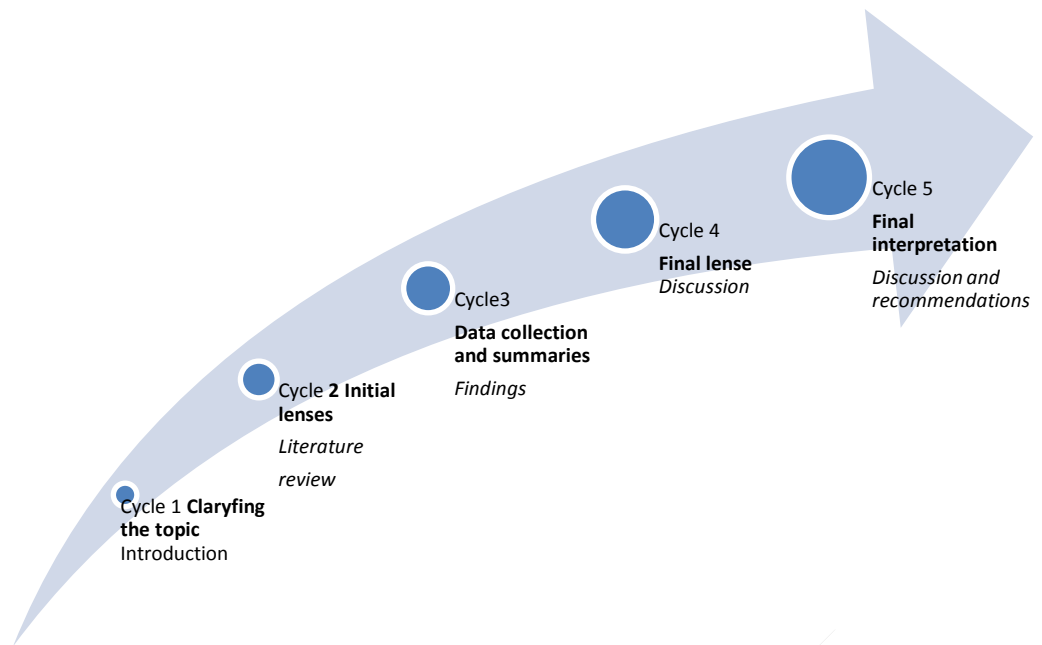


Diagram 1. Five “Cycles” of intuitive inquiry and relationship to orthodox research.

I hope this explanation will assist the reader to navigate the document.

## **Chapter 1**

### **Introduction**

My study arises from conversations with patients over the past 10 years. I have frequently been touched by the expressions of intimacy in the older couples I have worked alongside during my nursing career. The context of my clinical work is with older people, particularly those living with long - term conditions, this role allowed me work with people and their families in their own homes. I was privileged to get to know my patients over years as I worked with them until the ends of their lives, my roles as both a nurse consultant and a community matron has been to engage with people regularly and I was in the unusual professional position of seeing people when they were in their optimum health not simply when they were sick.

Over the years patients started to talk to me about their sexual activity, initially when sex had become difficult or unrewarding but later when sex changed into something that offered comfort and affirmation. Their language and words tended to be tinged with embarrassment and are often tentative.

I was fortunate to see the behaviour of older couples at close quarters, to have witnessed them looking and touching each other in ways that others may not have seen. Outside my clinical practice I spoke with people of all ages, gender, sexuality and ethnicity of what sexual intimacy might mean to older people, the responses were varied, but usually incredulous that such a thing existed, particularly conversational comments from much younger people. My discussions with older people often turned to their notion of invisibility, that they were invisible in modern society, not noticed, not listened to, just not seen. I have tried to understand this and have watched how younger people attract attention in public places.

Since planning the study I tried to stay close to older people, one of the ways I have done this was to join a bowls club, I was at least twenty years younger than the other bowls players, but they welcomed me and enjoyed laughing at my inability. It was as if I had stumbled into a private party, as if I had been given a chance to see them as they really were, the laughter and physical

closeness, of both couples and single people, men and women, had been surprising, men rubbing each other's stomachs, they would squeeze and kiss the woman, laugh and tease each other. The levels of physical contact were not something I had witnessed when I watched older people in public areas. It is almost as if they had kept it hidden and invisible from others.

### **Overview of the cultural background**

The timing of the study occurred at a unique period in United Kingdom (UK) society, the demographic was changing with larger numbers of people entering older age. The population aged 65 and over had grown by 47% since mid-1974 to make up nearly 18% of the total population in mid-2014, while the number of people aged 75 and over had increased by 89% over the same period and made up 8% of the population (Office for National Statistics, 2015).

Older people alive during the study had seen and experienced many changes in social and cultural attitudes to sexual activity through their life course, Carpenter (2016) set out a life course perspective on sexuality, explaining that the broader social and historical contexts intersect to affect sexual beliefs and behaviours over time. The life course perspective provided the underpinning theoretical framework for the study.

The focus of the study was on a group up of older adults known sociologically as "the silent generation". The silent generation is a recognised demographic cohort, however, there are no precise dates for when this generation starts or ends, typically researchers use starting dates ranging from the mid-to-late 1920s and ending dates ranging from the early-to-mid-1940. The silent generation grew up during or fought in World War II (WWII). Many of their behaviours are based on experiences during the war years and its aftermath. Men typically went out of the home to work while women stayed in the home to raise children reflecting traditional gender roles (Deaux, 1985). A frequently mentioned phrase during the childhood of these children was that they were "seen but not heard", hence the silent generation. Sociologically, they were believed to have higher levels of loyalty and a wish to be needed, in contrast to the generations that have come after them (Srinivasan 2012). The majority of the generation were retired at the time of the study, valuing financial security,

indeed financially they were often seen as one of the wealthiest generations in the UK. However, a recent study by Independent Age (2016) revealed vast inequalities among UK pensioners, with those over 75 being worse off than younger pensioners and far more likely to live in persistent poverty.

Whilst what follows is a generalisation of this generation it provides some broad sociological attributes. People in the silent generation were shaped by rationing and have a “waste not want not attitude”. They see conformity, traditional family values and comfort as important. They are a generation which understands the nobility of sacrifice for the common good, the need for productivity, and a desire not to draw attention to themselves. They have also seen huge changes in the availability, nature and effectiveness of contraception, treatment for sexually transmitted infections and sexual difficulties, as well as divorce and separation becoming increasingly common in later life (Weeks, 2002).

The participants of the study were born between 1927 and 1937. The following paragraphs describe the major social and cultural changes in the UK relating to sexual activity which have occurred during the lives of the participants. The cultural chronology will be based on the participant’s life course, setting out the major changes that occurred throughout the decades of the participant’s lives.

The participants were born in the UK between the two world wars, when the country had seen great upheaval with turmoil in social organisation and the class structure diminishing. New roles emerged for both men and women. The war had swept away many old attitudes and brought in a more egalitarian society. In addition to the decline in deference to the upper class there was a reduction of the traditional restraints on individuals, particularly younger people. People had more opportunity for leisure activities including sports, music and drinking, watching cinema and listening to the radio were popular. Venues such as cinemas and music halls afforded the chance for people to meet and relationships to develop (Brooke, 2015). The slogan “anything goes” became popular as young people became more autonomous and less restricted by the traditional chaperones and gender divided activities of the past (Jones, 2015). New careers opened up for single women, these were in

offices and schools, with salaries that helped them to be more independent. There were changes in fashion with dresses becoming bolder and revealing, it was a dress code that emphasized youth. In medicine, penicillin was discovered in 1928 (Tan and Tatsumura, 2015), which led to a cure for bacterial sexually transmitted infections. Information was more readily available with the creation of the BBC in 1927 but televisions were largely confined to wealthier households. In literature *The Well of Loneliness* by Radclyffe Hall (1928) was published in 1928 and stimulated discussion about homosexuality, later publication was discontinued due to the offense it caused.

The study's participants were born into families that experienced many of these changes and as small children they lived through the difficult years of the 1930's which included economic depression with 22% unemployment and the rise of Hitler (Hall and Ferguson , 1998). Social mores were changing with King Edward VIII abducting in order to marry a divorcee Wallis Simpson in 1936. Contraceptives became more readily available being sold in local chemists. They were made from latex and performed better than the previous rubber condoms. However, in the period 1923 – 1933, 15% of maternal deaths were due to illegal abortion (abortionrights.org. n.d.).

The 1940's began in a time of war, the participants of the study were too young to fight but may have spent a number of years with absent fathers and living in fearful, straightened times, possibly experiencing the death of their parents. The education for some of these children was broken by evacuation, with some living far away from their families (Macdonald, 2011).

As well as experiencing instability in their school education the silent generation often received little or no formal sex education, growing up at a time when sexual behaviour was not discussed and sexual feelings were suppressed. Improved access to health care occurred when, in 1948, the National Health Service (NHS) was created, providing great relief to people who had been affected by war and the difficulties of the economic depression of the 1930's.

In the same year as the creation of the NHS Kinsey's work on *Sexual Behavior in the Human Male* (Kinsey, 1948) was published providing an in-depth view

of sexual activity and progressing discussions primarily amongst medical and academic professionals. Giddens (1992:13) explains that Kinsey's findings that only about fifty percent of men were exclusively heterosexual shocked a disbelieving public at the time.

During the 1950's the UK started to experience financial growth as the country recovered from the war with developments such as commercial television and improved transport. Despite Kinsey's (1948) work the 1950's saw a time of the heteronormative family ideal, with clear gendered divisions of labour, women staying at home bringing up small families and men working to provide for them (Gallwey 2015), although as Jamieson (1998:15) points out there were many other types of family household. This ideal image of the nuclear family persists today, fashioned by the media, particularly advertising.

During the 1950's male homosexuality was illegal and over 1,000 men were imprisoned with undercover police officers used to entrap men (Dickinson et al 2012). At this time male participants of the study would be in their 20's and 30's. Many homosexual men had to hide their sexuality and a large number entered marriages and conformed to the societal norms of heterosexual relations and often had children (Dickinson et al 2012). The report the Sexual Behavior of the Human Female (Kinsey, 1953) was published exploring female sexual relations, unlike male homosexuality being a lesbian was not illegal and therefore there was little recourse if abusive actions occurred. Later, The Sexual Offences Act (1956) recognised sexual assault between women as a crime. In 1957 The Wolfenden report, properly known as The Report of the Departmental Committee on Homosexual Offences and Prostitution (1957) advised parliament that homosexuality should no longer be illegal. The population were increasingly free to express their sexuality but in the making of law and the conversations about sexual activity much greater legal control of private lives occurred.

At this time the participants of the study were engaged in relationships and finding partners, marriage remained the expected cultural relationship. Marriages were changing and the previous economic imperative was giving way to the "companionate marriage" which was more equal and supported



sexual and emotional intimacy, in contrast to the financial and power relationships within previous generations (Finch and Summerfield, 1991). However Carpenter (2016:65) explains that men and women who developed their attitudes to sexuality during this period are likely to hold more restrictive views to those who came of age in the permissive 1960's. Women were expected to be virgins when they married and this was prized by both sexes (Giddens, 1992:9)

The 1960's saw the start of formal sex education for young people, the participants of the study would not have received formal sex education and Langer (2009:755) explains "even the most liberated knew little of the facts of life and most held to strong superstition.

An intravaginal contraceptive device, also known as a cervical cap or diaphragm became available and in 1961 the oral contraceptive pill was prescribed by doctors the National Health Service. At this time it could only be prescribed to married women (FPA 2010). Women coming to the end of their reproductive lives were able to access hormone replacement therapy (HRT) which became available on the NHS in 1965.

Giddens (1992:28) suggests that the sexual revolution which occurred from the 1960's involved two elements, a revolution in female sexual autonomy and the flourishing of male and female homosexuality.

Economic prosperity was growing, with foreign travel increasing, 1963 the growth of state funded universities started with access for both men and women improving access to further education and different careers. For participants who were married their partners were often seen as best friend and confidante as well as sexual partner working at understanding each other and not following traditional behaviours (Finch and Summerfield, 1991, Langhamer, 2012).

In Masters and Johnson (1966) work they discovered much detail on the human sexual response by undertaking direct observation of men and women, this providing new understanding to both clinicians and the general public.

The Sexual Offences Act 1967 was passed, this Act decriminalised homosexual acts between two men over 21 years of age in private but only in England and Wales. The Beaumont Society, a London-based social/support group for people who cross-dress, are transvestite or who are transsexual, was founded.

The Abortion Act (1967) was passed and came into effect in 1968 the legislation allowed doctors in Great Britain to perform abortions lawfully so long as certain conditions are met the act went on to prevent a large number of deaths from illegal abortion and gave great relief to women who had unwanted pregnancies

The 1970's saw a counter attack to the permissive cultural developments with the Nationwide Festival of Light held by Christians who were concerned by the development of sexual activity outside marriage and increasing acceptance of homosexuality (Capon, 1972).

The Women's Liberation movement grew and started to critique the idealized view of the family (Jamieson 1998). The first gay pride rally was held in London during this period, demonstrating an increasing acceptance of relationships other than heterosexual. The transmission of viral STI's such as HIV and herpes arose, infections that are not curable and were sometimes fatal attracted a lot of fear and attention. The study's participants would be in their late 40's and early 50's at this time and were likely to be more settled in their lives. Those in long term relationships may have become dissatisfied with their relationship and may have been embarking on new experiences. Women in the participant group would be experiencing the menopause at this time

The Equal Pay Act 1970 was passed offering the right to equal pay for equal work. It was principally designed to support equality of opportunity and treatment for women. At this time large numbers of women were working outside the home and the Act aimed to ensure parity if men and women were undertaking the same role.

The book, *The Joy of Sex* was written by Alex Comfort (1972) he aimed to combat guilt, lack of information and misinformation by writing an accessible descriptive publication which became a bestseller.

In 1978 the first child was born as a result of in vitro fertilisation, Giddens (1992: 27) suggests that once conception can be both artificially produced and artificially inhibited sexuality became autonomous.

The first UK case of Acquired Immune Deficiency Syndrome (AIDS) was recorded when a 49-year-old man was admitted to the Brompton Hospital in London and then began a concerted public health campaign on the dangers of sexual intercourse without the use of barrier contraception. There developed a resurgence of sexual "morality", in 1988, Section 28 of the Local Government Act made an amendment to the United Kingdom's Local Government Act (1986), stating local authorities "shall not intentionally promote homosexuality or publish material with the intention of promoting homosexuality" The amendment was introduced by Margaret Thatcher the then prime minister. Following its introduction campaigns against "Clause 28" commenced (Jeffrey-Poulter 1991). Despite fears about sexually transmitted disease, discussion and individual revelations around sexual activity became more common place. Interestingly, Cline (1993) explains that for women during this period it was harder to admit to celibacy than it was to admit they were having an extramarital affair.

In the postmodern period marriage was not a pre-requisite to sex and couples were increasingly able to make their own sexual rules. The increase in free choice also meant that if relationships did not work couples were no longer compelled to stay together. Teenage women felt "entitled to engage in sexual activity at whatever age seemed appropriate to them" (Giddens, 1992:10) and newlywed partners are usually sexually experienced. By 2000 despite legislation and feminism in western societies there still remained highly differentiated gender roles with women expected to be nurturing and emotional and men to be dominant in their conduct (Prentice and Carranza, 2002). Although Cook (2004) explains there was an increase in the possibilities for people to be intimate and relax but that people's expectations of their partners had also risen. In 2010 the participants were between the ages of 73-83, it is likely they will have experienced bereavement and the death of friends if not their partner. The technological advances which have changed social activities include the development of internet dating (Houlbrook, 2006) which enabled

older people to seek different relationships to those that they have previously experienced (McWilliams and Barrett, 2014), potentially allowing them to express different elements of their sexuality or engage in different roles. In addition to the internet being used for dating, Scaunich (2014) suggests that the internet could answer potentially awkward medical questions and provide new sexual information. Older people could use the internet to purchase sexual adjuncts, including medications purporting to be Viagra, engage with online chat rooms, pornography or request sexual services. The development of medication such as Viagra can improve individual sexual activities but also resulted in an increasing medicalisation of sexual activity (Hart & Wellings 2002). Since the end of the 20<sup>th</sup> century the media, fashion and music industries have started to acknowledge the sexual sensibilities of older people and have used this to promote product consumption by older people (Hinchliff and Barrett, 2018). Additionally there was increased reporting of sexual abuse and investigations such as operation Yew Tree (Gallagher 2014).

Older people who were the participants have seen an ebb and flow in gendered activities, technological and medical innovations, increasing independence of women, changes in the function and role of marriage, increased education and understanding of sexual activities, in short, one of the greatest changes a generation could have experienced in social history within the UK. Their ability to change, respond and create social mores has never been so significant.

Having looked at the social chronology of the participants of the study I have returned to the specifics of the study and will set out some clear definitions for the particulars of the study.

## **Definitions**

The World Health Organisation (WHO) has set out some working definitions to inform the debate about sexual activity in the 21<sup>st</sup> century and this shapes much of the language within this thesis.

### **Sex**

Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually

exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females (WHO, n.d.).

## Sexual health

According to the current WHO working definition, sexual health is:

“...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled” (WHO, 2015:3).

## Sexual rights

There is a growing consensus that sexual health cannot be achieved and maintained without respect for, and protection of, certain human rights. The working definition of sexual rights given below is a WHO contribution to the continuing dialogue on human rights related to sexual health

“The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws. Rights critical to the realization of sexual health include:

- the rights to equality and non-discrimination
- the right to be free from torture or to cruel, inhumane or degrading treatment or punishment
- the right to privacy
- the rights to the highest attainable standard of health (including sexual health) and social security
- the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
- the right to decide the number and spacing of one's children

- the rights to information, as well as education
- the rights to freedom of opinion and expression, and
- the right to an effective remedy for violations of fundamental rights.

The responsible exercise of human rights requires that all persons respect the rights of others.

The application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination (WHO, 2010b:4).

These rights are beginning to be addressed in wider nursing practice and the emergence of the nursing policy to respond more fully to the public health needs of population make this a unique time in clinical practice (Public Health England, 2015). Additionally, we are starting to see new frameworks of sexuality through the life course (Carpenter and DeLamater, 2012). Carpenter (2016) suggests the life course perspective provides, a comprehensive and transferable conceptual model where sexual beliefs and conduct result from life long experience and the adoption or rejection of sexual scripts specific to their historical contents and other areas of identity, such as health.

Sexual health cannot be defined, understood or made operational without a broad consideration of sexuality, which underlies important behaviours and outcomes related to sexual health. The working definition of sexuality is:

“...a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.” (WHO, 2010 a: 4)

Sexuality is a central characteristic of being human. Maslow (1943) identified a hierarchy of human needs and at the base of the hierarchy are the "Basic needs or physiological needs" of a human being. These, he suggested, were food, water, sleep and sex. Maslow (1943) described needs at this level as being *Deficit needs* or *D-needs* and suggested that if a human being does not have enough of one of those four requirements, they will experience a sense of need to receive them, however, when the need is fulfilled a human being will feel content. Maslow (1943) has been criticised for placing sex at the level of physiological need suggesting he lists sex solely from an individualistic perspective rather than the "higher" levels of motivation Hofstede (1984). Some critics felt this placement of sex neglects the emotional, familial, and evolution implications of sex within the community, although others point out that this is true of all of the basic needs (Kendrick, 2010).

In UK society older people are often depicted as asexual beings despite a lack of empirical grounding (Gott and Hinchliff, 2003:1617), being seen as physically unattractive in a culture which values youth (Menard et al, 2015). However, these archaic stereotypes are beginning to change, with an emerging emphasis on sexuality through the life course, (Public Health England, 2015). Interestingly this has brought with it or even occurred because of, the medicalisation of sexual activity with new pharmacological advances and an increased public awareness that the physiology of sexual activity can be maintained. Usually this is seen through the prism of penile vaginal penetration as being the normative sexual activity. Menard (2015:79) explained that this approach can be problematic as it creates a "binary of functional versus dysfunctional and encourages a restriction of meaning and range in sexual expression". Carpenter's (2016) life course work expounds an intersectionality framework which acknowledges that both gender and sexual identity are entwined with other aspects of identity such as religion, disability and social class and result in the adoption of sexual beliefs and behaviours.

Syme (2014) states that older adults in western culture learn sex is for the young and beautiful, in older age sex is shameful or non-existent and this creates an internalised stigma and low self-esteem. Culturally explicit

depictions of sexualised older adults remain taboo (Menard, 2015). However, as the population ages we are beginning to see a demolition of the scripts (internalised cultural norms) that have shaped the discussions about and with older people's sexual activity and this may be an even more profound change as the baby boomer generation ages further.

As a clinician I have worked with a broad meaning of sexual health but exact definitions particularly in relation to older people are hard to find. The World Health Organisation, explains there are many and varied meanings of sexual health worldwide (WHO, n.d). There is a recognition that sexual health and wellbeing are important but that many healthcare staff feel ill prepared to meet sexual health needs. Evans (2013) identifies three main domains of sexual health and wellbeing that nurses need to be able to address. These are;

- sexual wellbeing integral to holistic care,
- sexual wellbeing associated with other health conditions
- sexual wellbeing including specific sexual problems and infections traditionally referred to as "sexual health"

As a topic which is rarely discussed amongst older people in UK society there has been a similar lack of research about the topic. In conclusion the literature review will set out whether research has caught up with the dramatic changes that are developing in the intimate relationships of older people Bildtgard and Oberg (2015).



## **Research Question**

The aim of the planned research was explore the experiences of sexual intimacy in older people. The specific objectives were to;

Uncover the personal experiences of sexual intimacy.

To identify the activities that are construed as sexual intimacy by older people.

To provide recommendations for healthcare professionals to improve the quality of care offered to older people in relation to sexual intimacy.

The exact research question being,

“What are the experiences of sexual intimacy in people aged 75-85 in the UK in the context of partnership relationships”.

## Cycle 1

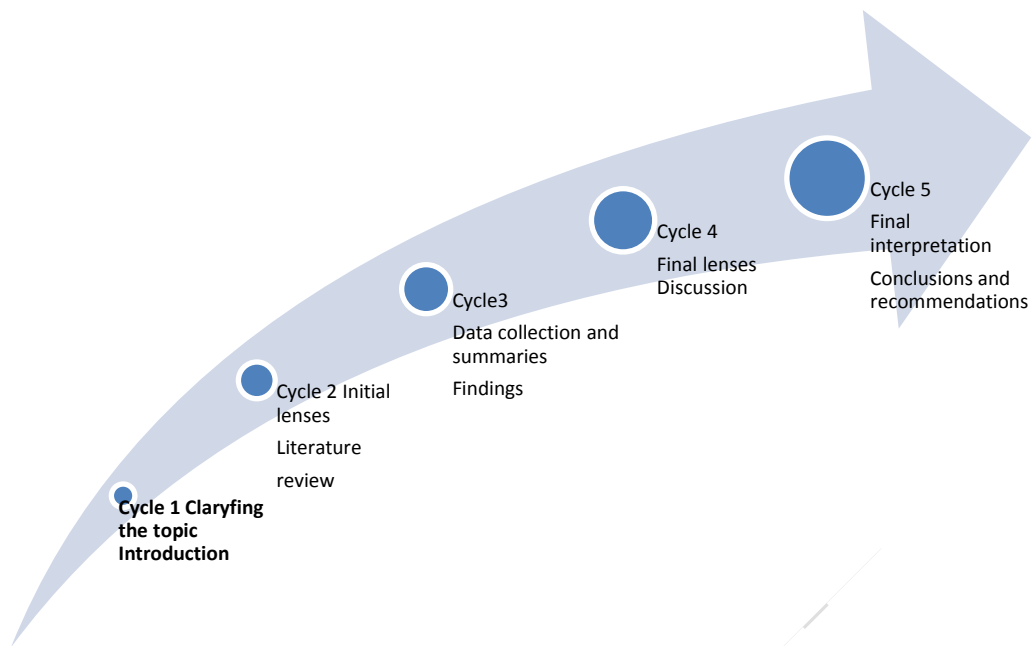


Diagram 2. Illustration of Cycle 1 in Intuitive Inquiry

I began to clarify my study, primarily in order to gain scholarship funding, which led to an urgent consideration of the research method which might achieve an answer to the question that intrigued me. It was clear the method needed to be qualitative as it appeared little was known about the topic. The qualitative paradigm is used to develop a deeper understanding of a phenomenon, situation or event and explores the totality of the topic under consideration. It addresses questions of “what” – where a subject entails a conceptualisation as a whole, its parts and how those parts are related to each other. The paradigm seeks to gain a rigorous understanding of human behaviour. It explores real world complexity. Qualitative research is particularly useful when the researcher wishes to explore subjects that are complex and subtle and if the research is trying to explain linkages and mechanisms that are hard to measure (Denzin and Lincoln, 2005, Creswell, 2006). I started to read about differing research methods, very early on I had a picture of collecting data using multiple methods, such as group discussion, email and letters, media or gallery events that would stimulate and record discussion. My nursing experience told me that some older people may prefer anonymity or may not have the language to explain their views, and therefore a wide variety of data

collection techniques would be useful. I believe the initial idea came from a book I had read many years before by Hite (1987) called *Women in Love*, she placed advertisements and received written responses, I felt that using technology, poetry and installation events might build on this. These were ideas I have tried to refine and my reading led me to scrutinise various texts about established methods. I read about qualitative research methodologies to the point of exclusion, where it became clear that it would not supply what I thought the study required.

Fortunately my supervisor suggested reading “Five Ways of Doing Qualitative Analysis (Wertz, 2011). The book provides insights into contemporary qualitative research, showcasing a number of central qualitative methodologies. The work of Rosemarie Anderson in developing the research method “Intuitive Inquiry” was a revelation. The studies of some of her PhD students appeared very similar to the way I wished to engage with the participants of my study. I found this work profoundly helpful and inspiring as a method.

Anderson (2011) describes the method which involves five Cycles, starting with developing the research area, she explained the unique features of the method include the transformation of self and culture, writing in your own voice and the theory building potential of the method. Anderson (2000) suggested a suitable topic for intuitive inquiry is:

- Compelling
- Manageable
- Clear
- Focused
- Concrete
- Researchable
- Promising

Initially Anderson (2011) suggested finding a “text” (which might be an image or poem) that draws the researcher in, that they find compelling. I had such an image for my study and had carried it in my thoughts for a number of years.

### **Cycle 1 -The Image**

The image I chose focussed on a couple who are washing up, an older couple in a dated kitchen with plywood doors, floral curtains and an enamel sink. The direction of view involved looking at them from behind and some distance away. He is tall, grey haired balding, with a grey thick knitted acrylic sweater, he wears dark slacks and his socks are grey in navy slippers. This tall slim man is supposed to be drying up, standing in front of the window gazing out on their well-tended garden. It is a warm, bright, autumn day.

She is shorter, overweight, wearing a navy skirt, she has no stockings on, her ankles are swollen and she wears pink furred lined slippers and a pale pink blouse, her bra is conical and too tight. The interaction sees her as determined, focussed on getting the job done, he is dawdling, drying things slowly, but not letting them drain properly, taking the newly washed items first, she looks at him, about to be cross, to remind him that he is not doing it right, he looks down at her and sees her pink face about reprimand him, he laughs and takes the wet tea towel out away from her in a wide swinging motion and brings it back sharply with an accurate aim and hits her bottom... she giggles.

What happened next I did not know, but this is the reoccurring image I had, the idea of a couple who are accepting of age and life, that find time to be close in unplanned, seemingly simple ways. The image is born out of my work going in and out of people’s homes in the course of community nursing. The formal knocking on their front door is replaced with entreaties to “go round the back” and “don’t stand on ceremony love” and in consequence I started to see my patients and their loved ones in more informal ways. I started to glance at their true lives.

In the first Cycle of intuitive inquiry Anderson (2011) suggested that in order to clarify the research question, the researcher should have an imaginary dialogue with the chosen text for about 20 minutes each day. As I started to

do this I began to realise my own version of the text had been taking place over a number of years, usually with me discussing my subject, with friends, family and patient groups. The photograph below is a tangible representation of the complex image which is drawn to mind when I started to clarify the subject.



**The Image**

Image 1. The image for imaginal dialogue.

The text I produced arose from needing something to have an imaginal dialogue with. In intuitive inquiry a “text” can be a photograph, historical narrative, piece of music or religious script in the more historical hermeneutic sense. My text was a poem I wrote in which I tried to encapsulate the sense of the subject I was trying to capture and provided me with a prompt for the searching of my inner thoughts about the subject.

## The Text

*Nothing planned, not a special day*

*No trips or grandchildren, coffees or fete*

*A nice day, a bright day, a sit at home and talk day*

*A light lunch, an easy lunch, lunch on a tray day*

*We talk of long held hopes, for children and friends*

*The world and wonder*

*Later on washing up, as the leaves drift down*

*An exchange, almost trouble, held back and rescued*

*Saved from the brink, reminds us we have a power*

*To laugh and feel, to love and share*

*And leave the washing up.*

These “texts”, both the image and the poem, were the tangibles with which I had daily dialogue at the start of my study in order to refine my research question. What follows is a quote from my reflective diary written at the start of the study.

*“I sit here in the cold, with my engine running, overlooking the estuary, literally in a field with a flask of soup and some homemade bread and talk to the Dictaphone like a mad woman, I hope those who pass, if they recognise me, I’m in uniform of course they will, will think I’m dictating my notes not here on making random ramblings about what this picture and this poem mean to me. It does work when I start to talk, however foolish I feel, there is something in this and saying it out loud makes me answer myself.”*

In the next Cycle I provide a literature review and develop the lenses which set out my understanding of the subject prior to data collection.

## Chapter 2

### The Literature

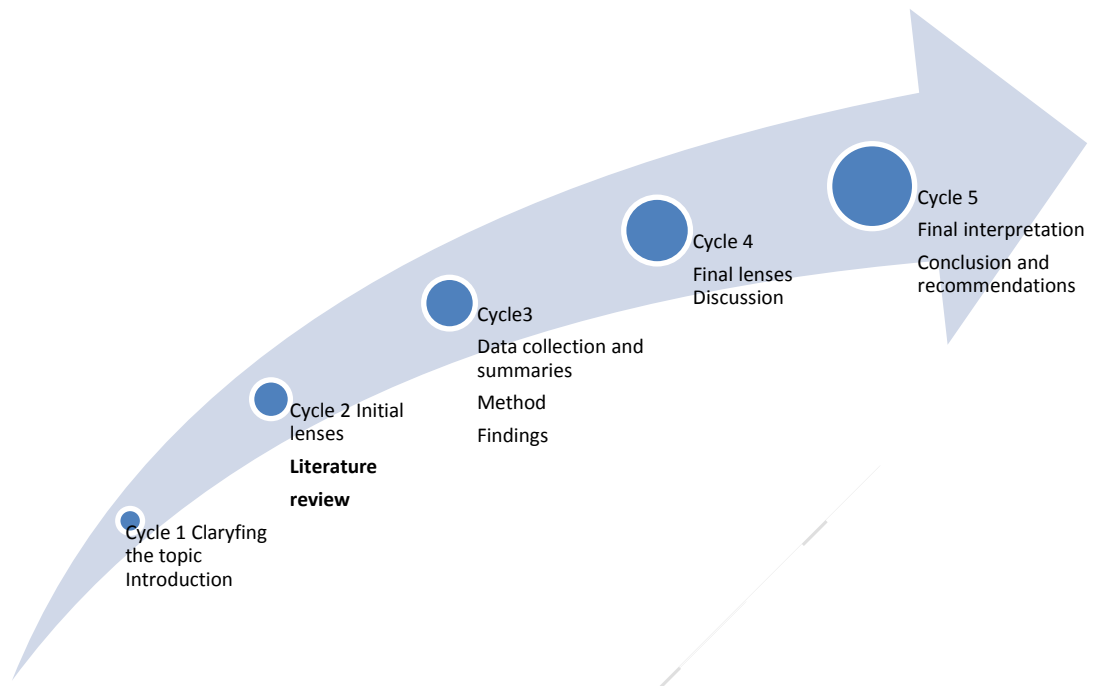


Diagram 3. Illustration of Cycle 2 in intuitive inquiry

This chapter will explore the literature and the development of the primary lenses in the second Cycle of intuitive inquiry. Commencing with an overview of this stage of intuitive inquiry, the chapter will contain details of the key theories related to sexual intimacy, the academic literature review strategy, the PRISMA details and the grey literature search strategy. What then follows is a broad overview of the literature related to sexual intimacy in people aged 75 - 85 from the United Kingdom, Europe, USA and Canada. The chapter will then provide a picture of the physiological, social and cultural background to the study, drawn from the search, followed by a synthesis of the included articles under two major headings; the barriers to sexual intimacy and the enablers to sexual intimacy in relation to older people. Finally the chapter will reveal the foreshadowed questions and explore the issue of a definition of sexual intimacy in relation to the research question.

Throughout the thesis, the spelling of aging/ageing are used as they appear in direct quotes, in the body of the text the English convention (ageing) is given preference.

## **The context of literature in Intuitive Inquiry**

Anderson (2011) describes a hermeneutic circle of interpretation, where understanding of a whole is determined by the parts of the whole and their reference to the whole. She explains that methodologically intuitive inquiry has been directly informed by the biblical hermeneutics of Schleiermacher (Bowie, 1998), philosophical hermeneutics of Gadamer (trans 2004) and the phenomenological and heuristic research developed by Moustakas (1994). Anderson (2011) suggests that intuitive inquiry incorporates intuitive and compassionate ways of knowing in a method which involves five “Cycles”. Cycle 1 is the development of the research topic as seen in Chapter 1. Anderson (2000) describes Cycle 2 as the point where the researcher reflects upon her or his own understanding of the topic in light of a set of texts found in extant literature. She suggests the researcher should prepare a list of preliminary interpretative “lenses” that express their understanding of the topic as unambiguously as possible. These Cycle 2 lenses describe the researcher’s understanding of the research topic prior to the collection of original data.

## **Key theorists related to sexual intimacy**

Prior to the formal literature review, the key theorists in the field of sexual intimacy who were writing during the life course of the participants are set out below, the aim is to provide a sense of the theoretical thinking that has occurred during the life span of potential participants. This can be used to contextualise the literature used within the study;

### **Foucault**

Foucault (1978) documented the changes to the meaning of sexuality in Western society and explained that the concept of sexuality was an invention of modernity. He suggested the human body has the ability to experience a wide range of sexual pleasures and that sexual activity has been organised by historical development not biology. Foucault’s (1978) work proposed that sexuality was important in its own right. In his opinion the rise of democracy and liberalisation in Western Europe did not result in sexual freedom but an



increase in insidious rules and control which he named “biopower” (Cocks and Houlbrook, 2006:7). Biopower is “an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations” (Foucault, 1978:140). This includes law, media, statistics, attention to deviance and sexual pathology by governments, academics, medics and statisticians producing a multi-layered concept. Foucault (1978) suggests that many cultures have fostered arts of erotic sensibility; but only Western society has developed a science of sexuality (Giddens 1992:20). Foucault (1978) argues this “discursive explosion” resulted in the spread of notions of “normal” sexual behaviour. This meant other behaviour, particularly homosexuality, was able to be pathologised. Foucault’s (1978) central idea is that the history of sexuality is the story of power (Cocks and Houlbrook 2006:9). His work does not provide a grand theory of power but offers an analytics of power (McGowan 1991). Foucault’s (1978) work has not been universally accepted particularly by Boswell (1991) and Giddens (1992) however, his work remains influential.

### **Gagnon and Simon**

Gagnon and Simon (1973) suggested that all human sexual behaviour is socially scripted. They explained that behaviour is a result of shared beliefs within a particular society or section of society, this concept is entitled social constructivism. Simon and Gagnon (1984) explained scripts are mental representations which occur on three levels, cultural scenarios, interpersonal scripts and intrapsychic scripts. Cultural scenarios provide the environment for behaviour and encompass historic and cultural ways of life including law, religion, class, media, government and education. All these factors impact on displays of sexual activity by providing social cues for behaviour.

Interpersonal scripts set out the interaction with others in encounters, scripts explain what the appropriate activities are at different stages and what meanings to attach to particular occurrences. Each individual may adapt the script to the specifics of their interaction (Simon and Gagnon, 1986).

Intrapsychic scripts reflect the ways in which people think about their individual sexuality, they are the plans that individuals make and can include fantasies, memories and mental rehearsals (Wiederman, 2015).

Simon and Gagnon (1984) suggest cultural scenarios may be all that are needed to give guidance for people to understand their roles and the meaning of their behaviour in paradigmatic societies. Paradigmatic societies have “very high degree of shared meanings and in the sense of specific or concrete meanings perceived as consistently derived from a small number of highly integrated “toaster” meanings. Therefore specific shared meanings are experienced as being consistent both within and across distinct spheres of life Simon and Gagnon (1984:102). In post-paradigmatic societies where there is a wide range of variation in the meanings associated with sexual behaviour each encounter may require “a unique adaptation of the individual to that situation” (Wiederman, 2015).

There is a life course aspect to sexual scripts with teenage and early adult years being the most unsettled, Simon and Gagnon (1984) also suggest that the ends of the life course are often thought to be pre-sexual and post-sexual and therefore often not included in cultural scenarios.

### **Giddens**

Giddens (1992) suggested that as the twentieth century progressed people had more choice in their partners and the composition of their families but he recognised that underlying traditional models still remained. Giddens (1992) reframed sexuality from lust and reproduction to an expression of love and companionship. Giddens (1992) suggests that intimacy involves self-disclosure between people, sharing their inner thoughts and feelings, this narration of self reinforces their intimacy.

The greater equality of opportunity results in both partners working and in consequence having less time to work at their relationships. Greater choice means that if relationships are not fulfilling either partner can break away and form another relationship, therefore people stayed together because they wanted to. They remained in the relationship for the sake of the relationships

importance to them as individuals, describing this as the “pure relationship”. People stayed together because of attraction, love or sexual compatibility not simply because they were parents, married or constrained by tradition. The nature of intimacy in these relationships Giddens (1992) described as “disclosing intimacy” which is seen as an intimacy between equals, however as Jamieson (1998) suggested gender inequalities can still exist alongside intimacy. Giddens (1992:27) also introduced the concept of “plastic sexuality”, plastic meaning a flexible approach, no longer fixed by biology or by social norms. Plastic sexuality means that binary associations such as married and unmarried, hetero or homosexual, normal or perverted are no longer as relevant. Giddens (1992) went on to suggest that the increased independence of women, the choice of effective contraception and a change in gender expectations enabled plastic sexuality.

### **Jamieson**

Jamieson (2011) has increased our understanding of intimacy. Explaining that intimacy has a variety of meanings and these are often understood in different ways dependent on the historical or cultural context. She suggested that intimacy always related to a close connection between people and the way in which the closeness developed. Intimacy can be emotional and cognitive, but may also be physical and bodily which may not be sexual. She explains that an intimate relationship might not be sexual and sexual contact might not be intimate (Jamieson, 2011) goes on to say current European forms of intimacy often include self-disclosure and overt emotion. The heightened appreciation of self disclosure is sociologically chronicled from the end of the twentieth century, Jamieson (2011) describes an emphasis on self –making which is the freedom to be and to make one’s self. Jamieson (2011) suggests there is an interaction between intimates and discourse which the media has shared globally she explains, intimacy continues to be multi-dimensional and in the search for equality acts of practical love and care mean more to couples than the exploration of each other's selves (Jamieson,1999).

## **Carpenter**

The gendered sexuality over the life course framework presents a comprehensive, transferrable conceptual framework for studying sexualities over the life course (Carpenter, 2016:66). The first comprehensive publication on sexualities over the life course was edited by Rossi (1994) it amalgamated the body of research and presented snapshots of the life course stages. In 2012 Carpenter and DeLamater published a book which brought together the second wave of research and theorising of sexualities over the life course. It set out a sophisticated conceptual framework and included a much wider range of life stages including people who are seen as very old and transitions such as the onset of physical disability (Carpenter, 2016). Carpenter (2016) explains that every life course can be conceptualised as a series of “trajectories” which include such things as education, family and sexuality which are punctuated by “transitions”, for example, first kiss, childbirth or divorce. Some transitions represent “turning points” which can alter a person’s life, for example, rape, gender reassignment or first homosexual relationship. Obviously transitions and turning points vary between individuals and not everyone undergoes all possible transitions (Carpenter, 2016). As each transition occurs there are advantages and disadvantages to the individuals involved, these events lead to other advantages or constraints creating a cumulative effect. For example, an individual may enter a relationship which becomes abusive, this may lead to a series of abusive relationships or the decision to become extremely careful about any further relationships and a sense of caution about giving of themselves. As people grow older in sociological terms, they accumulate positive, negative or neutral life transitions, they are also ageing biologically and psychologically, incorporating pathological changes into their life course. Carpenter (2016:70) states that “scholars taking a life course perspective on sexualities must attend carefully to physical aging, health and illness.”

It is recognised that individuals demonstrate agency, the ability to direct the courses of their lives and make choices and plans, this usually reflects their sense of self (Hitlin and Elder, 2007). Whilst social structures and institutions change overtime, so do populations, technology and social norms and there is

a mutual influence (Carpenter, 2016). In addition to the interplay between society and the individual is the intimate relationship between close individuals, partners, families and friends, these connections are called “linked lives” and can have a powerful impact on sexual trajectories (Carpenter, 2016). In addition to the linked lives, gender also plays a complex part in the life course because of the expectations on both genders, scholars agree that sexuality, gender and sexual identity are interrelated and mutually constructed. They are also influenced by race, class, religion and other aspects of social identity these effects are referred to as intersectionality (McCall, 2005). As previously discussed, Simon and Gagnon (1984) explained the role of sexual scripts and this feeds into Carpenter’s (2016) work on gendered sexuality over the life course. The appropriateness of this framework to the study became clear, as I was researching sexuality on the extremes of the life course it was highly relevant to a participant group who had witnessed some of the greatest sociological changes this century.

Having looked at the key theorists what follows is the formal literature search for the study.

## **Literature Search Strategy**

In order to obtain a broad review of the literature, in the absence of specific definitions of sexual intimacy and older people, librarian and supervisor advice was sought and the following strategy was devised.

Search terms:

Elder\*

Aged

Senior

Old\*

Geriatric

Mature Adult

And

Sex\*

Intim\*

On the following;

Web of Knowledge

Ebsco

Academic search premier

IBSS

Google scholar

Psychinfo

Social care on line

Medline

Cinahl

NHS Evidence- BNI Embase and AMED

Cochrane

The search parameters were set from 1995-onwards, looking for papers written in English, drawn from European/ North American/Canadian/Australian populations.

### **Inclusion /Exclusion Criteria for the Literature**

The results of the literature search identified 8027 articles. An additional 16 papers that had been identified during Cycle 1 of the study were also included. Once duplicates were removed there were 7304 records.

These records were initially screened by title to check their relevance to the study, if this was unclear the papers were then screened by abstract. The screening process excluded papers that focussed exclusively on people under 75, records related to single pathologies and sexual activity, such as cancer, heart disease, incontinence and major mental health diagnosis which did not identify the age of the participants were excluded as was the literature related to masturbation, as primarily the research undertaken referenced masturbation as a solitary pursuit and the focus of my study was to investigate partnership relationships. Also excluded at this stage was the literature focussed on sexual abuse, sexual activity in care homes and literature specifically related to people living with dementia. The aim of this study was to look at the broader older population who are living independently, without either cognitive impairment or safeguarding needs and with little recourse to clinical or social care.

Papers outside European /American/Canadian/Australian populations were also excluded as, pragmatically, I did not feel able to understand or explore the cultural meanings and history of sexual intimacy in non-western countries. Papers that were not written in English were removed as I am not fluent in other languages. Literature specifically related to prostitution or paid sexual services was not included in the review as the focus of the study was to be on

partnership relationships. At this stage using the above criteria 7200 papers were removed leaving 104 full text articles to be assessed for eligibility. I read these papers and removed 18 papers, 10 involved participants who were outside the age range, 6 were unpublished dissertations and 2 were not relevant. This left 86 papers that meet the inclusion criteria and were used for the literature review.



Diagram 4 The PRISMA flow diagram of the literature search.

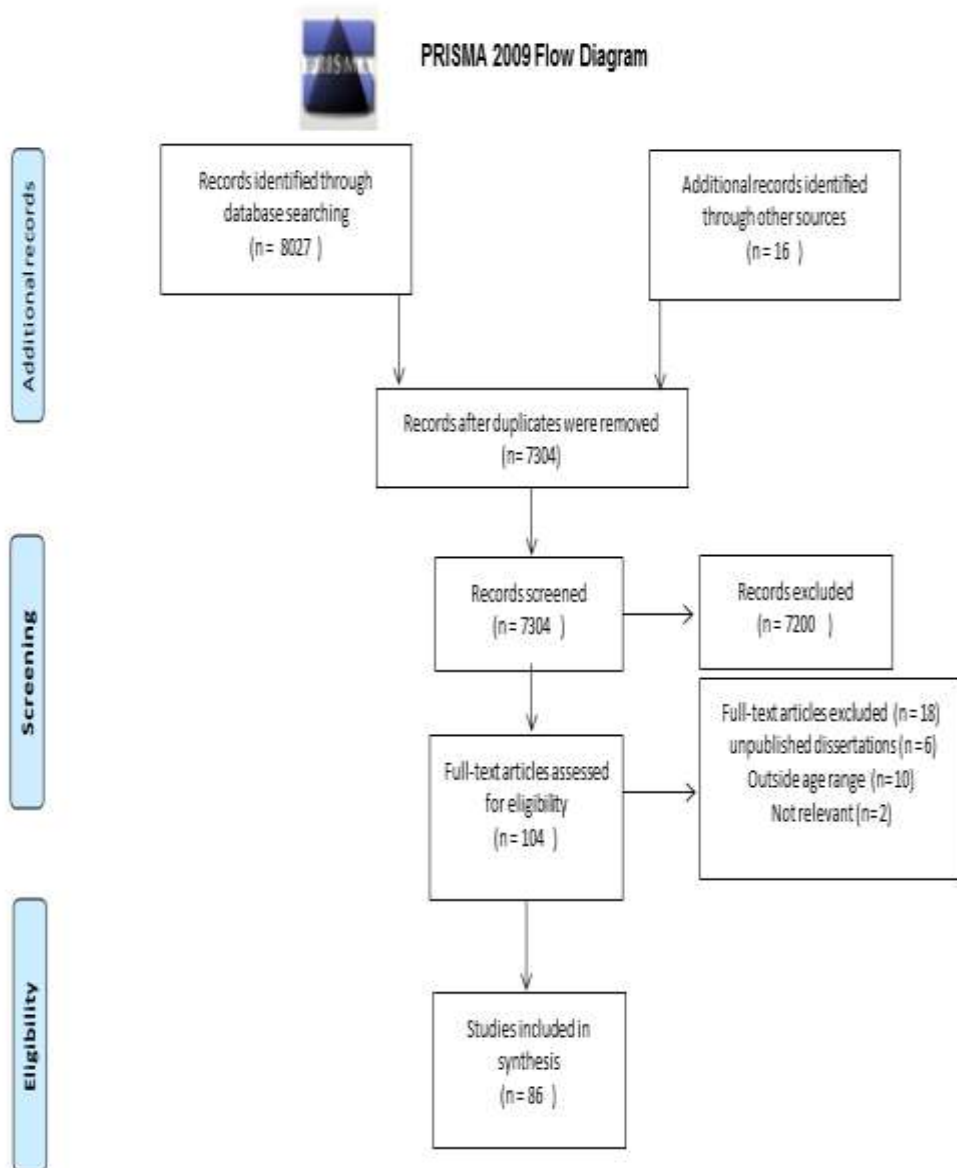


Diagram 4. PRISMA Flow Diagram

## **Grey literature**

The grey literature was searched using the following terms using Google search engine,

Sexual Intimacy and

Elder\*

Aged

Senior

Old\*

Geriatric

Mature Adult

Grey literature is usually seen as publications outside traditional academic publishing, it can include reports, government and policy documents. The publications often come from the third sector and charitable organisations as well as private companies (New York Medical Academy, n.d.). Grey literature is usually accessed through internet search engines such as Google and Bing.

The standard of quality, review and production of grey literature can vary and it can be difficult to access (New York Medical Academy, n.d.). Grey literature was important in this study as I wanted to understand the types of information related to sexual intimacy available to the general public, notably the web sites and information that could be accessed easily by older people if they were using the internet. The evidence suggests that when looking at web based information accessed through traditional search engines only the first two pages of any search term results are scrutinised and there is evidence that demonstrates people rarely look from the third web page onwards (Brin and Page, 2017). I was concerned about my professional standing and professional registration during the literature search in case I inadvertently viewed illegal and offensive content. Conversations with my supervisors and the university librarian indicated that, in terms of university policy, this was

unchartered territory. We devised some governance strategies to manage the situation. The computer internet security settings were set to “high” to avoid any highly pornographic material and the literature search was conducted using the following safeguards.

- The grey literature was only searched from the university premises
- A record was kept of the search strategy
- My supervisors and the University Librarian were informed at the beginning and end of my search periods (via email)
- The “strict filter” was used whilst searching.
- I undertook to report any worrying or upsetting material.

I am aware that in putting in place these safeguards I would not be faithfully replicating the sites older people might find for themselves but my professional concerns were such that following supervisory advice the need for safeguards was apparent. In producing the literature review the grey literature has been woven into each section alongside its academic counterpart.

### **The Literature- An Introduction**

Having read the full texts of all the included literature I decided that, in order to start to fully understand the research question in light of the literature, I needed to make sense of the themes around the subject. I thought in detail about those books and articles I had read and three themes emerged in my mind. Firstly there was information that set the scene, providing facts, population data, biological findings and cultural changes in relation to older people, these I have included as an overview. Secondly there were a large number of articles that focussed on the negative trends concerning older people and sexual intimacy which I have included as barriers. Finally I was able to find some hopeful and positive literature which I have entitled enablers to sexual intimacy.

The aim of Cycle 2 was to look at the literature related to sexual intimacy in people over 75 and to establish my “lenses”. The term sexual intimacy is often a coy reference to sexual intercourse and the terms, sexuality, intercourse, sexual intimacy and sexual activity are used in an interrelated way within the literature. As previously stated there is no clear and consistent definition of

sexual intimacy in relation to older people, indeed the WHO acknowledges its own working definition of sexual intimacy is currently only a contribution to the debate (WHO, 2010). It is difficult to conceive how researchers can, therefore, capture what sexual intimacy means to older people. Consequently when reviewing papers the term's varied meaning was problematic in consistent analysis of the findings. The initial literature search resulted in studies that projected an extremely negative picture of sexual intimacy in older age, with research on sexual abuse, care homes and dementia forming the majority of the literature. Once papers that referenced these areas had been excluded the bulk of the literature was predominately engaged with the physical changes resultant in ageing and diseases more prevalent in older people. These studies usually related to a particular symptom or disease process, such as ischaemic heart disease or urinary incontinence, with suggestions how this may be medically overcome.

In addition to there being a lack of clarity over the meaning of sexual intimacy there is no agreed definition of "older people". Some studies included people from age 45, as Gott (2003) states, in a review essay, the collective term older people can embrace anyone from 40-100. With those caveats acknowledged I tried to make sense of the extant literature and carefully considered my own understanding in relation to this.

### **Overview of the Research Literature – Where we are now**

The following overview is drawn from the papers included in the literature review. Langer (2012) tells us we are sexual beings from birth to death, that sexuality continues through the life span and expressions of sexuality change over time. In the United Kingdom (UK) older people have never lived so long and many enjoy an excellent quality of life, although it must be acknowledged that many older people are living with two or more long - term conditions (Age UK, 2015). Retirement extends for a longer period than it has ever done before and many older people have greater solitude and privacy now that families are smaller and adult children are less likely to co-habit. This development allows them time and privacy to express their feelings for each other (DeLamater, 2012). Older people are now seen as consumers of new and exciting goods

and services such as holidays, aesthetic innovations and functional adaptations (Kohlbacher and Herstatt, 2011). In a society that staunchly remains preoccupied by youth and vitality (DeLamater, 2012) older people are key responders to a shift in culture from a frail but wise older age to the golden years of extended life and youth. This change potentially affords them new opportunities to make use of goods and services which are specifically targeted at older age groups. Older people are developing new models of living together, new ways of financing and managing their lives against a background of politics and media which sadly focuses on the burden of ageing, particularly in terms of the cost of health and social care. Additionally divorce and separation are increasingly common in later life (Weeks, 2002) resulting in new ways of living and loving. However, Gott (2002) reminds us that older people are not a homogenous group and they do not necessarily hold similar views and experiences. Within UK culture, where youth and sexual activity are synonymous with a good quality of life, the sexual activity of older people is under researched, under discussed and poorly understood. Internationally the World Health Organisation (WHO) produced two reports in 2010 Measuring Sexual Health (WHO 2010a) and A Framework for Action (WHO 2010b); which aim to promote good sexual health. Both documents sadly failed to include sexual activity in older people. Whilst successive UK governments profess their respect for older people as a voting cohort, attempting to address their needs and reflect their wishes in policy documents about health services, social care, pensions and housing, what is lacking is any cohesive national policy about older age sexual health needs. Policy documents under address the issues of sexuality and older people, there is no mention of sexual health in the National Service Framework for Older people (DH, 2001) and no focus on older people in the sexual health policy documents despite the significant cultural changes that have been seen in the past fifty five years particularly those associated with sexual behaviour. Which have ranged from the “swinging sixties” to the advent of drugs such as Sildenafil (Viagra) in 1998 and access to relationship sites for older people via the internet in the last two decades.

Whilst it is clear that men and women engage in sexual activity in their 70's and 80's (DeLamater, 2012) the majority of research into older people's sexuality has occurred post 2005. The focus of research has been on the biomedical issues, finding treatments for "newly" discovered problems notably erectile dysfunction and vaginal dryness (Pariser and Niedermier, 1998). The continuation of relationships into increasing older age and the development of inter-generational marriages and remarriage is becoming common (Weeks, 2002). Second or third long-term partners and the increase in sexual discourse, arts, media and services for older people would argue for the production of a positive, inclusive and vibrant range of resources and evidence for those researching the area, however, comprehensive theoretical models remain lacking. DeLamater (2012) asks us to remember that sex is culture and time specific and Skultety (2007) suggests one of the primary reasons why research into sexuality and ageing is slow is the belief of healthcare providers that the topic should be left to specialists.

### **The Literature – Nature and Composition**

There are very few primary research studies relating to sexual intimacy, but these include the work of Ahmetoglu (2010), Brown (2006), Byers (2005), Dickson (2005), Gott and Hinchliff (2003), Heiman (2011), Hurd Clarke (2006), Johnson (1998), Kirby (2005) and Robinson and Molzahn (2007). Many of these studies are on the periphery of sexual intimacy but have been included due to the wide range within the search term "sexual intimacy".

The majority of papers included in this chapter are reviews or summaries, the data often being secondary, drawn from national surveys. This has resulted in a wide variety of findings. Where authors have been specific about results relating to clear age cohorts, I have focussed on those between the ages of 75-85, however, where findings are broad, I have included the results from age 65 upward. The academic literature concerning sexual intimacy in older age is largely drawn from Northern America; there are a relatively small number of primary research studies with many articles being reviews or summation. In addition to the issue of an agreed definition of sexual intimacy and the wide age bands used in some articles, questions often ask respondents to report

their sexual activity retrospectively and this can range from one week to one year. The focus of the research literature for people aged 75-85 is on the female experience due to the numbers of surviving women within this cohort. Zeiss and Kasl-Godley (2001) state most of what is known about sexual activity is from cross sectional studies and it is often impossible to ascertain whether the changes are due to age rather than cohort or time effects.

Inclusion in studies is acknowledged as poor with many authors stating the work is limited by a lack of diversity in ethnicity, sexual orientation and gender. Zeiss and Kasl-Godley (2001) explain there is a lack of research on representative samples of healthy older people and suggest the research has low response rates typically (30-50%) and selection bias is common as primarily the participants are Caucasian , heterosexual , well-educated adults.

Review of the grey literature largely provided suggestions of physical sexual positions that might be adopted by older people who were having difficulties with penile vaginal penetration. Within this literature there were also examples of how these sexual problems may be overcome through medication, physical positions and counselling but do suggest there is some hope that sexual intimacy may be achieved or reawakened in older age. The grey literature extols the recent developments in medicine that have brought the opportunity for older people to continue and re-establish sexual intercourse using phosphodiesterase- 5 enzyme inhibitors (drugs which include Viagra), high quality lubricant and hormonal augmentation. The cosmetic industry and aesthetic practitioners offer the opportunity to reshape, re model and resurface the outward appearance of older age and commercial websites, dating agencies and services increase the availability of sexual activity both in frequency and potential enjoyment. Sigusch (1998) describes these developments as part of a neo sexual revolution and suggests it has little to do with our understanding of intimacy.

## **Physiology of sexual ageing**

This section will provide a brief overview of the normal ageing process in relation to sexuality and will be divided into three broad areas: the process of sexual ageing in relation to both genders, followed by changes specifically relating to women, and finally changes specifically related to men. It is widely recognised that there is great individuality about the extent and timing of these changes. In addition the more sexually active the person is the fewer the physical changes the person is likely to experience in his or her pattern of response (Skultety, 2007). Zeiss and Kasl-Godley (2001) acknowledged that where a decline in sexual activity occurs this is usually due to age associated change and reduction in mobility, although it must be stated that long-term conditions, such as diabetes, cardiovascular disease and cancer have a negative impact on sexual activity and that the prevalence of such conditions increases with age. Gott and Hinchliff (2003) found that, understandably, health problems were a barrier to sexual activity for some of their participants. Long - term conditions which directly impact on primary and secondary sexual organs have been highlighted in this section, some of the issues relating to wider ill health have been briefly set out in the following sections but the focus of this study is on sexual intimacy in normality not ill health.

### **Physiological changes relating to sexual function in both men and women**

During the life course the normal reduction of testosterone, which occurs in both genders, has profound effects. Weeks (2002) states testosterone supports the libido and is produced by the testes and ovaries, however, for several years after the menopause the ovaries also supply small amounts of testosterone as well as oestrogen and androstenedione (Mueller, 1997). Meston (1997) in a review of the physiological evidence concerning sexual ageing states a reduction in libido is noted in men, supported by age based findings from cross sectional studies which demonstrate a decline in desire and sexual activity (Skultety, 2007). These changes are attributed to a decrease in testosterone and differences in androgen sensitivity which start from the fifth decade; by age 80 men may only have a sixth of the testosterone



they had when they were young. Decrease in serum testosterone parallels a decline in libido and there appears to be little evidence that supplementing the hormone results in improvement in desire in men with normal baseline testosterone. Zeiss and Kasl-Godley (2001) in an early review of the literature, state older people are likely to show slowed sexual response time in both genders.

### **Issues related to urinary incontinence**

Urinary incontinence can have considerable impact on older people's sexual activity due to its effects on self-esteem if living with incontinence and desire if ones partner experiences incontinence. Urinary incontinence occurs when the normal process of storing and passing urine is disrupted; it is usually divided into three categories: stress, urge and overflow. Stress incontinence occurs when the pelvic floor muscles are weak or damaged or the urethral sphincter is damaged in women. Frequent causes are nerve damage during childbirth, obesity, oestrogen depletion and some medication. Urge incontinence is the urgent and frequent need to pass urine which can be caused by a problem with detrusor muscle over activity (Garrett and Tomlin, 2015). Causes of which include neurological conditions such as Parkinson's disease or multiple sclerosis, urinary tract infections, alcohol and caffeine, constipation and medication. Overflow incontinence, also called chronic urinary retention, is often caused by bladder obstruction. In men this may be due to enlarged prostate and in both genders by constipation or bladder stones.

### **Physiological changes related to sexual intimacy specific to women**

Women within the age range 75-85 will have experienced the menopause. Ambler et al (2012) in an American review of the literature relating to sexual function in elderly women state the prevalence of sexual dysfunction (difficulties associated with sexual activity) in post-menopausal women is self-reported between 68-86%. The physical changes most frequently commented upon in relation to the female body is the decline in oestrogen production and its implications for urogenital ageing (Pariser and Niedermier, 1998). Urogenital ageing is particularly associated with vaginal dryness and atrophy, with the consequences for individuals ranging from none to severe. Symptoms

can include, vulval pain, dyspareunia (painful sexual intercourse) and itching (Zeiss and Kasl-Godley, 2001). In addition there may be reduced lubrication (Skultety, 2007) associated with sexual arousal and a reduction in vaginal blood flow and engorgement. Pariser and Niedermier (1998) states that in the US 50% of postmenopausal women will develop urogenital atrophy. Meston's (1997) review of aging and sexuality drew on dated papers but revealed that older age brought with it a reduction in pubic hair, loss of fat from the mons pubis, atrophy of the labia majora and increased risk of breast and endometrial cancer. Mueller (1997) explains the clitoris diminishes in size and Pariser and Niedermier (1998) add that vaginal penetration may be more difficult as the labia may not fully elevate, the vaginal barrel shortens and narrows and the cervix may drop increasing the chance of cervical bumping. Vaginal contractions are fewer and weaker but the orgasmic or multi-orgasmic response remains (Skultety, 2007). The impact of the menopause on sexual functioning may mean a reduction in the quality of sexual intercourse but should not impact on other sexual activity (Ambler et al, 2012). Pariser and Niedermier (1998) identify urinary incontinence as another sequelae of oestrogen reduction and it may result in irritability, incontinence, urethritis and recurrent urinary tract infections. Mueller (1997) suggests that regular pelvic floor exercises increase tone and reduce urinary incontinence and that hormone replacement therapy (HRT) may still be appropriate for some women which may ameliorate some discomfort. Pariser and Niedermier (1998) write that there are many myths associated with the menopause but conclude that with good health, a good relationship and appropriate medical care sexual vigour may continue in the mature years of a woman's life, however, there is little clarity about what mature years are or what represents sexual vigour. They go on to point out that as women have no refractory period, (the refractory period is the recovery phase after orgasm during which it is physiologically impossible for a man to have additional orgasms) given the right circumstances the potential for women to experience multiple orgasms remains. The literature does expose an increasing medicalisation of female sexual function (Pariser and Niedermier, 1998) with many treatments such as lubrication being available over the counter in pharmacies and increasingly supermarkets.

As previously suggested there is an increased prevalence of both breast and endometrial cancer in older women. Treatment for breast cancer has obvious implications for sexual intimacy: mastectomy can be sexually devastating and whilst women who have conservative treatment are less psychologically distressed, pharmacological treatment such as Tamoxifen may have negative sexual side effects (Pariser and Niedermier, 1998). Zeiss and Kasl-Godley (2001) explain that when the female partner experiences health related changes sexual activity often continues in a way that may not be possible for a male partner experiencing erection difficulties.

### **Physiological changes relating to sexual intimacy specific to men**

Having discussed the fact that a reduction in testosterone can have profound effects on libido, in men the reduction may also result in less hard erections, weaker ejaculations, longer time to ejaculation, additionally there is a decreased likelihood of orgasms and longer refractory periods (the time taken from ejaculation to subsequent erection), Pariser and Niedermier (1998); Zeiss and Kasl-Godley (2001) further explain that the refractory period may lengthen from minutes in young men to hours or days for older men.

It is clear that men experience changes in the sexual response cycle in addition to a reduction in testosterone, Meston (1997) states there is a decline in scrotal vasocongestion, reduced tensing of the scrotal sac and delayed erection. Penile sensitivity also decreases with age and rates of impotence in men of 65 are reported to be over 25% (Montorsi et al., 2003). Impotence can devastate men, leading to sexual avoidance and aversion, the nature of partner's responses to sexual problems is significant as lack of support leads to further difficulties (Li et al., 2016). Pariser and Niedermier (1998) suggest there are an estimated 10-20 million men who are impotent in the United States of America (US) but this does not reflect on the fact that if coitus is not possible it should not preclude sexual intimacy. Issues such as Widower's Syndrome Dunn (1988) may also occur; this usually commences over the age of 50, when, following the death of a partner, there is a reduction in sexual desire during the grieving period. Subsequently, when the widower becomes involved in his first relationship following the death of his partner, he may experience

impotence due to a variety of issues, which may set up a negative cycle of fear and panic. The research in this area has focussed on heterosexual couples.

Some health benefits associated with sexual activity have been identified. Davey-Smith et al. (1997) found the mortality risk was 50% lower in men who had orgasms twice a week or more than in men who had sex less than once a month. The gradient was most marked in coronary heart disease, although the ages of the participants were in the younger range of older people. However, Gott (2003) argues that the idea of sex as physical activity and being good for you is countered by an absence of evidence that lack of sexual activity makes you sick.

### **Prostatism**

Prostatism occurs when there is overgrowth of the prostate gland, which may be benign or malignant. The prevalence increases with age. The symptom of nocturia (passing urine at night and frequently associated with prostatism) is common, around one third of men will develop urinary tract (outflow) symptoms, of which the principal underlying cause is benign prostatic hyperplasia (over growth of the prostate) (NICE 2014b). Once symptoms arise, the progress is variable and unpredictable with about one third of patients improving, one third remaining stable and one third deteriorating. It is estimated that the lifetime risk of developing microscopic prostate cancer is about 30%, of developing clinical disease 10%, and dying from prostate cancer 3%. Both the symptoms and surgical intervention can have a profound effect on a couple's sexual intimacy (NICE, 2014a).

In summary, physiological sexual changes occur for both men and women in older age and these may impact on their previous choice of sexual function; however such changes do not necessarily result in an inability to maintain sexual activity or even coitus. Meston (1997) having reviewed the many physiological sexually related changes that accompany normal ageing, suggested that men and women should not fall into the psycho-social trap of expecting or trying to force the same sexual response as their youth but it is equally important that they do not follow negative myths which make decreased physical intimacy an inevitable consequence of older age. In a

review of sexual expression in later life (DeLamater, 2012) explained that whilst it is clear that normal ageing does cause physical changes, they do not necessarily result in a decline in sexual functioning. Good physical health and access to a healthy partner are shown to allow older people to remain sexually active. Weeks (2002) in his paper looking at ageist attitudes and stereotyping identifies that ageing and sexual dysfunction are not inextricably linked. DeLamater's (2012) review of the literature related to sexuality in later life suggested there is little evidence that normal physiological changes have an impact on sexual functioning and that those which do need not be permanent. Zeiss and Kasl-Godley (2001) support this in saying changes in the sexual response cycle need not interfere with sexual activity because compensatory strategies are easily implemented.

### **Barriers to Sexual Intimacy in Older Age**

As previously mentioned the physical effects of ageing are not necessarily a barrier to sexual activity but other barriers do exist. This section explores additional psycho social implications for sexual intimacy in older age, looking at the evidence in the following domains: availability of partners, media, attitudes, relationship influences, religion and finally interaction with healthcare professionals.

#### **Partner Availability**

A very sad fact played out in the literature is a simple lack of availability for heterosexual women over 75 of potential partners for those who are single/divorced or widowed and an increased availability for older men due the differences in life expectancy for the sexes. Skultety (2007) reports the greatest barrier to sexual activity was absence of a partner. The loss of partner or lack of partner has a great effect on an individual's desire to engage in sexual intimacy. In a UK based study of 44 participants aged between 50-92, almost equally split between genders Gott and Hinchliff (2003:1626) discovered a " sub-set of participants (typically widowed) who did not consider sex to be of any importance to their lives neither had a current sexual partner, nor thought that they would form a new sexual relationship in their lifetime". Weeks (2002) in a UK review of age related attitudes discovered that sexual

interest is significantly higher in people with sexual partners. In terms of relevant studies about sexual relations, most research involves couples and for many older women access to a partner is difficult. Unfortunately less is known about the sexual activity of older people without permanent partners (DeLamater, 2012). The issue of availability of partners does have significant impact on quality of life. Weeks (2002), explains that sexual deprivation reduces quality of life but choosing to become celibate is likely to cause less unhappiness than enforced celibacy.

### **Media portrayals**

In general older people are underrepresented in most types of media coverage, Armstrong (2006) talks about the invisibility of older people. Blando (2001) in a paper entitled "Twice Hidden", looking at American culture, additionally suggested that gay older people are the invisible of the invisible minority. The pervasive view is of older people as frail, sometimes wise, dependants. Day time UK television is full of adverts for stair lifts, wills and home delivered meals reinforcing stereotypes of older age dependency. While those few advertisements that attempt to display older people in a more positive light focus on the unusual or are intended to surprise with daring feats of physical activity. Armstrong (2006) suggests that the majority of media portrayals use both sexual and gender stereotypes. She goes on to explain that when displaying sexual intimacy in a media context, the benchmark is usually performance-orientated sexual standards. The gold standard of sexual relationships is heterosexual intercourse involving young, usually white, middle class people. Weeks (2002) explained that older women, unlike their younger counterparts who are given a strongly sexualised value, are frequently portrayed as asexual and not sexually attractive.

Additionally Armstrong (2006) suggested that the media engage in the glamorisation of non-relational sexuality and clandestine affairs. Rarely are older people seen in this context, although there has been recent interest in older age sexual relations in films such as *Best Exotic Marigold Hotel* and *Hope Springs* and television programmes such as *Last Tango in Halifax*. Skultety (2007) points out there have been a proliferation of self-help books relating to

older age sexual activity and there are some media portrayals of older people as healthy and attractive. There is a difficulty that these highly positive portrayals may be seen as not relevant to the majority of older people and a little “other-worldly”. An additional concern is the notion that such portrayals may reinforce low sexual self-esteem if there are images portrayed of other older people getting close to the sexual gold standard when the intended consumers of the images are unable to do so. Weeks (2002) supports this stating older people’s views about their sexuality are mediated by the responses they receive from their partners, health care professionals and the media. Comfort (1977), three decades ago, described the media’s ability to maintain long standing belief systems as “bewitchment by expectation” and believes this is a disservice to both young and older people alike.

### **Psychological factors**

This subsection deals with literature relating to psychological barriers to sexual intimacy. It is the intention to focus on studies that involve the general population not those identified by virtue of pathology, dysfunction or distress such as depression, phobia, abuse and other mental health diagnoses.

The importance of sexuality to older people is clear. A US survey of American Association of Retired Persons (1999) revealed that in answering the question, “Does sex becomes less important to people as they age?” 39 % of men and 37 % of woman agreed but when posed the question” Is sex only for younger people?” Only 2% of men and 5% of women agreed. In the UK Gott (2003) found there is an expectation that sex will become less frequent in normal ageing. Interestingly men are more likely to report sex as being important in older age than women (DeLamater, 2012).

It is suggested that many of the physiological changes associated with sexual activity in older age can be overcome if the couple have positive attitudes (Zeiss and Kasl-Godley, 2001). Their American review of the literature relating to sexuality found that where there were liberal positive attitudes, a sense of self-worth and psychological wellbeing there is a greater interest in sexual activity and satisfaction. It should be noted that this review drew primarily on pre 1995 literature. The notion of overcoming physiological change may not

be an issue for those couples who are content with the situation they are experiencing and they may have developed new ways of expressing their sexuality. For others it may be that the relentless focus on the gold standard of sex stops couples embracing their changes and prevents them from growing into a new phase in their relationships.

Desire is frequently mentioned in the studies reviewed from the literature. Unfortunately there is little clarity in definition but it would appear that older women are less likely to report sexual desire and there is a positive relationship between desire and engaging in sexual behaviour (DeLamater, 2012). This is further supported by Pariser and Niedermier (1998) who found that a reduction in sexual interest and desire is associated with ageing but is reported in women more commonly than men, the reasons for this are unclear. Skultety (2007) states that stress, life changes and previous negative experience may influence sexual desire and satisfaction with sex. She suggests and the most common barrier to sexual intercourse was lack of interest with over 20% of woman over 50 reporting this. Skultety (2007) goes on to say age was not a significant predictor of lack of sexual interest but the belief that ageing reduces sexual desire was.

The previous section related to media influences explained that in western culture sex is only for the young (Langer, 2012). In addition the image of the stereotypical dirty old man and frigid older woman remain and that ageism is a psychological reaction as it is not based on the biological facts of ageing. Ageist beliefs endure despite improved understanding of sexuality and effective treatment for dysfunctions (Weeks, 2002). Over a decade ago Gott (2003) reported that the stereotype of an asexual old age remained despite any empirical grounding. Kaas (1981) explored the concept of geriatric sexuality breakdown syndrome through which elderly people internalise the negative attitude to which they are exposed and perceive themselves as non-sexual. DeLamater (2012) echoed the idea that physical changes should not impact on the person's ability for sexual functioning and that the changes people experience are the result of social values. Clearly a couple's attitudes to sexuality are an important influence on sexual behaviour. He also states some older people have enduring attitudes about the purpose of sexual activity



including Pronatalism, the view that sexual activity is for procreation. This can have negative psychological effects as the absence of the ability to reproduce influences sexual activity if men and woman see womanhood in terms of motherhood or for religious or cultural reasons view sexual intimacy as a means of reproduction alone. Weeks (2002) suggests that society's normative evaluation of the retained capacity for sex, despite older age, relationship status or health, as perceived by that individual is an important determinant in sexual activity. Despite societal discussion about sexuality, entrenched views of "normal behaviours" remain. Weeks (2002) goes on to explain that cultural ageism has an impact on what is taboo and its restrictions also focus on what people should not imagine; this results in negative feelings, making sexual activity less enjoyable. He states that this can lead to thinking distortions often seen in people suffering depression. Whilst this appears plausible, he offers very little supporting evidence. Zeiss and Kasl-Godley (2001) suggest where there are positive sexual attitudes, greater sexual knowledge and relationship satisfaction there is a greater interest in sexual activity and satisfaction.

### **Relationship factors**

In addition to painting a picture of the current state of older relationships this section includes financial considerations, independence and family influences. Gott (2006) explains that later life divorces and remarriage rates are steadily increasing, resulting in a more positive experience of older age for a number of people as previously older people may have felt compelled to remain in unsatisfactory relationships due to social mores. Conversely Blando (2001) suggests gay older people are more likely to live alone and have the additional stressors of limited family support.

Many older people who engage in new relationships have concerns about the effects on their wider families in practical and financial terms. The bringing together of houses or apartments has resulted in different forms of co-habitation sometimes referred to as Living Apart Together (Karlsson and Borell 2002) where people perceive themselves as a couple but for family or financial reasons choose to own or rent their own homes. Bildtgard and Oberg (2015)

reflect on how little research has been undertaken on the forms these relationships take and the lack of focus on re-partnering later in life.

Previous studies have demonstrated that heterosexual older women, particularly, are concerned with the financial risk of entering into a relationship with a new man and in addition are fearful of a loss of autonomy. One of the major aspects to this disquiet is the fear of having to take on the role of nurse as a partner's health begins to deteriorate (Bildtgard and Oberg 2015). Byers (2005) in an American study of 87 older individuals in long standing relationships measured their sexual and relationship satisfaction at 2 months and 18 months post commencement of the study and found the quality of intimate communication accounted for part of the concurrent changes in relationship satisfaction and sexual satisfaction. DeLamater (2012) states that men report a greater incidence and frequency of sexual activity, including sexual intercourse, than women, it must be acknowledged however that sexual intercourse usually occurs in couples and men are more likely to have a partner than women within the 75-85 age group.

There appears to be a particular need for intimacy to ensure affirmation in a relationship. Kirby (2005) studied unmet intimacy needs in 84 married couples and found that an increase in intimacy meant an increase in relationship satisfaction but again a clear definition of intimacy was lacking. Byers (2005) in a longitudinal survey found that sexual satisfaction and relationship satisfaction changed concurrently. There is evidence that age is seen a coping factor when sex is less frequent or has stopped and that couples have the ability to adjust to circumstances but cooperation is required (Weeks, 2002).

### **Access to advice from health care professionals**

It is recognised that sexuality and sexual health needs are an under assessed component of health care practice. Watters and Boyd (2009) believe sexuality is rarely addressed by healthcare professionals and Gott and Hinchliff (2003) found that a number of their participants said they had never had an opportunity to speak about sex before and welcomed the opportunity. It is important to note that only six people in their study sample were over 70. Peate (2004) suggests that nurses' are often the first healthcare professionals that

patients talk to and the attitude of the nurse may affect the consultation. There is some debate in the value of knowing your healthcare professional Peate (2004) writes that difficulties may occur if the patient has known the healthcare professional for a number of years, as there may be embarrassment, however, there may be advantages if there is a current therapeutic relationship and mutual rapport. Mueller (1997) explained that a nurse's discomfort with the subject may cause them to unconsciously limit their interaction that would otherwise promote a discussion of the person's sexual needs. Skultety (2007) suggested that healthcare professionals must acknowledge their difficulties about discussing sex and realise we are all influenced by societal and cultural messages about sexuality. Gott and Hinchliff (2003) argued that we are not raising the issue of sexual needs with patients and suggests that within gerontology issues of sexuality have been "annexed" as specialist clinical interventions or obscure research topics. Even when onward specialist referral occurs, Armstrong (2006), reported that much of the sex therapy literature tends to focus on depersonalised and goal orientated models of sexuality which may not be appropriate for older people. Pariser and Niedermier (1998) suggest that talking to older people about sex is a challenge for many health professionals and expands this in practical terms to say that these discussions should be done when the person is fully clothed using softly phrased open ended questions.

We know that older people are less likely to use condoms and that within the UK the prevalence of sexually transmitted infections (STI's) is increasing in later life. Although there are less reported STI's in older age groups in comparison to younger people the numbers are increasing (Public Health England, 2016), demonstrating a clear need for clinicians to address matters of sexuality with older people. Equally, sexual wellbeing should include a respectful attitude between individuals and the WHO (2010b) suggests that for sexual relations to healthy they should be free from disease, discrimination, violence and coercion.

Healthcare professionals need to be aware that patients often use diagnostic terminology in imprecise ways. Gott (2003) suggests that the inclusion of sex as being something which is desirable for health instantly puts the activity in

the domain of healthcare professionals. In consequence this means that professionals are required to have an understanding about the evidence base to support sexual activity. Skultety (2007) explains that health care professionals, even those with vast experience in the care of older people continue to report discomfort and a lack of knowledge regarding older people's sexuality. Zeiss and Kasl-Godley (2001) believe health professionals should use information sensitively to guide discussions about sexuality; similarly Peate (2004) explains attitudes to sexual health can play an influential and significant role in older people's sexual identity. Whilst good history taking is important, Skultety (2007) explains sexual discussion is less about the details and more about the beliefs and ideas relating to sexual activity. She states it is crucial to allow and encourage a broad definition of and consider a range of sexual behaviours and not purely concentrate on sexual intercourse. Pariser and Niedermier (1998) state that organic causes of sexual difficulty should be looked at first – but this may medicalise sexual activity still further. Ambler et al (2012) believe that further research may spark better management allowing patients to live more enjoyable lives and an understanding of normal ageing may help physicians give patients realistic and encouraging advice on sexuality. Skultety (2007) suggested sexual dysfunction is not part of ageing but a complex set of diagnoses determined by culture, expectations, definition of problems and recognition by healthcare providers. The challenge for practice is to determine if healthcare professionals have the skill, knowledge, time or ability to understand the psychological and social components of sexual activity.

## **Religion**

The role of religion in older people's lives is very individual but there is some consensus from the major religions about sexual activity and older people. All agree that sexual activity within marriage is acceptable. There is a difference in doctrine and guidance about sexual guidance outside marriage and differences in how individuals interpret that guidance. Within the UK The House of Bishops in "Some Issues in Human Sexuality" (House of Bishops Group, 2003:99) set out some common ground stating that although in a "fallen world" all sexual activity is to a certain degree affected by sin, there is nothing

intrinsically evil about sexual activity as such and that both marriage and celibacy are equally valid forms of Christian discipleship, going on to state that sexual relationships must be marked by the virtues of love, fidelity and respect for the integrity of one's sexual partner". There would appear to be a tension for those older people who are religious but living in unmarried relationships or engaging in sexual activity outside marriage.

### **Medication**

It is acknowledged that older people have a higher prevalence of long-term conditions (Age UK, 2015) and that treatments for such conditions usually involve medication; additionally older people are more likely to be taking prophylactic medication as their risk of co morbidity increases with age. There is a large amount of literature on the effects of medication; however, most of the studies are small scale in relation to people between the ages of 75-85. Pharmacologically, although older people take the most medication, drug related studies in this age group are underrepresented and relatively little is known of the effects of medication on sexuality in this age group. DeLamater (2012) analysed the data from the American Association of Retired Persons (AARP, 1999) and concluded that desire was negatively related to the use of anticoagulants, cardiovascular and anti-hypertensive medications for men and women; additionally taking lipid lowering medication negatively impacted on sexual desire in women (DeLamater and Sill, 2005); the data used for this analysis represented an age cohort of 70+. Pariser and Niedermier (1998) set out a useful table establishing to some of the barriers associated with sexual intimacy in later years as related to women, many of which also apply to men.

Sexual Symptom	Possible Cause
Loss of libido	Depressive disorders Relationship conflict (can include verbal or physical abuse) Medical illness (e.g., diabetes, cancer, arthritis) Endocrine factors (hypothyroidism, hyperprolactinemia) Changes in partner's appearance Drugs (e.g., psychotropic, alcohol, marijuana)
Lack of arousal manifested by vasocongestion or lubrication response	Relationship problems Previous sexual trauma Inadequate lower genital tract vasocongestion due to inadequate oestrogen support Chemotherapy Anticholinergic medication Drugs (e.g. SSRI's)

Table 1. Sexual difficulties and potential causes

The literature reveals that poor communication, ill health and a lack of sexual desire result in a decline in sexual intimacy and that a healthy committed relationship with mutual attraction and respect is an important dimension in maintaining sexual activity (Pariser and Niedermier, 1998).

This section has demonstrated how little empirical evidence there is on the barriers to sexual intimacy but establishes a wide range of psycho-social issues that might be at play. These barriers include relationship influences, including those with extended family, religion, medication, the media, and the quality of interaction with healthcare professionals.

## **Enablers for Sexual Intimacy in Older Age**

Some of the broad categories of the enablers for sexual intimacy are consistent with the barriers set out in the previous section. These show a different or opposite angle on the issues related to older people trying to re-establish or maintain sexual intimacy. This section looks at the positive effects of relationships and access to services, medication and information which can support sexual intimacy in older couples.

### **Relationships**

It is widely acknowledged that physical and mental wellbeing are important to sexual expression (DeLamater, 2012) and that within relationships sexual intimacy can be a great joy and contribute to a sense of comfort and wellbeing (Pariser and Niedermier, 1998). The current generation of older people in Europe, North America, Canada and Australia, have access to some of the best healthcare in the world and come from countries where the standard of living is high. Unlike their predecessors they have long periods of retirement and frequently have the health, time and money to invest in their relationships.

The research on quality of life (QoL) reveals that sexual and relationship satisfaction is interlinked. International measures of QoL such as WHOQOL – OLD include questions such as, “Are you satisfied with your opportunities for physical contact?” and “Are you satisfied with the level of intimacy in your relationship?” Robinson and Molzahn (2007) in a study involving people from 60-99 years of age found a statistically significant relationship between intimacy scores and quality of life ( $r = .42$ ). The questions used in WHOQOL – OLD are particularly useful as they do not focus on sexual intercourse and can capture sexual intimacy without intercourse; the nature of the questioning means the survey is more accessible to responders who are not heterosexual.

It is believed that people who have consensual sexually intimate relationships live longer, are happier with the quality of their lives, have higher self-esteem and less depressive symptoms (DeLamater, 2012). Kiecolt-Glaser and Newton (2001) suggest that regular consensual sexual expression contributes to physical and psychological wellbeing and may reduce physical and mental

health problems. Physiologically orgasm and ejaculation lead to release of oxytocin in men and sexual stimulation, arousal and orgasm lead to feelings of warmth and relaxation. Weeks (2002) believes that sex is vital to the actual and ideal self-concepts of older people, Loehr et al (1997) suggest that sexual intercourse is important in the maintenance of healthy interpersonal relationships. As well as penetrative sex intimate touching is clearly important in older age, Zeiss and Kasl-Godley's (2001) study explains of those living with a partner, 60% reported engaging in touching/holding hands, embracing/hugging and kissing on a daily basis. In addition Gott and Hinchliff (2003) found that physical intimacy through cuddling and touching appears central to well-being when penetrative sex is no longer possible. Hurd Clarke (2006) in qualitative data from 24 women in a study in British Columbia with participants aged 52-90 found that women in later life demonstrated a shift from the emphasis of sexual intercourse and passion to a greater valuing of companionship, cuddling, affection and intimacy. However, in the most recent review DeLamater (2012) states there is very little actual data on the potential benefits of sexual activity for quality of life.

Relationships are changing in later life with divorce, remarriage and intergenerational marriage becoming more common (Harries and De las Casas, 2013). In addition the notion of falling in love with one's partner again following child rearing and busy work lives emerges. The grey literature search, particularly important as it is likely to be accessed by older people themselves, found the bulk of the web pages focussed on hints and tips for improving the physical act of sexual intercourse; usually this was heterosexual and the images were most commonly of white, affluent individuals. Zeiss and Kasl-Godley (2001) suggests planning more time for sexual activities, being sensitive to the changes in one's own and one's partner's bodies; the use of external aids and different positions may help to maintain sexual intimacy in older age. The grey literature revealed wide access to sex aids and medication which aimed to promote sexual activity, Pariser and Niedermier (1998) state that vibrators may be particularly useful.

In terms of maintaining relationships DeLamater et al. (2008) review of recent research demonstrated that satisfaction with sexual relationship was predicted



by relationship satisfaction and frequency of sexual activity. Skultety (2007) explains past interest in sexual activity is correlated with continued enjoyment of sexual intimacy. Sex may also be seen as a refuge from the trials and difficulties of older life. Kirby (2005) in a study of 84 married couples in USA found that negative communication reduces intimacy but that increased intimacy increases relationship satisfaction.

When developing new relationships Dickson et al (2005), in a study of 15 women over the age of 60, found the need for independence and the need for companionship resulted in gender conflict between dating partners. Gott's (2002) study found that sex outside relationships was rarely expressed and the idea of one night stands was not mentioned. The dating sites which have developed may have changed this, as Gott's (2002) study was more than a decade ago.

## **Culture**

The expression of sexual needs is important at any age and contributes to the definition of an individual as a valuable and respected human being (Watters and Boyd, 2009). The public display of older people's sexuality is very important in avoiding the development of negative societal impressions. There has been a recent increase in film portrayals of intimacy in older people. These positive images of sexual intimacy with high profile beautiful older people can help to challenge stereotypes and may ask us to question our assumptions about the nature of sexual intimacy in older age. Cotton (2005) reports on "Still Doing It" a film following the lives of nine women aged 67-87 years of age which confronts stereotypes and celebrates the positive effects of being older when engaging in sexual behaviour. The women believe that in the future there will be new ways of satisfying sexual urges. Cotton (2005) describes it as "portrayal of sexuality as life giving energy that holds back the curtain of death" and reminds us all to enjoy the moments of joy our body gives us.

## **Information about Sexuality for Older People**

There are specific websites for older people and many self-help books available, the web sites often suggest changing the type of sexual activity to

non-penetrative sex, mutual masturbation and giving and receiving oral sex. Some effort has been made in curriculum development for older people attending educational programmes related to sexuality Brick et al's (2009) curriculum work in the US has been an attempt to address this issue, although there is almost no empirical research to show if information on sexuality influences sexual activity in later life (DeLamater, 2012). Education in the US such as "Older, Wiser, Sexually Smarter" does provide new opportunities for older people to discuss their sexual needs. Burgess (2004) states older people are often misinformed about normal ageing and often rely on stereotypes in order to understand sexuality and older adults. However, the description by Hafford-Letchfield et al (2010) of a drama project about older people's intimacy and sexuality that generated socio-educational tools to devise personalised outcomes for older people's care services demonstrated something unexpected. In terms of the development of this project, which was aimed at social work students, it was the older people themselves that wanted to push the boundaries of intimacy included in the educational resource.

The second largest theme within the grey literature involved biomedical issues and sexual dysfunction. This information was surrounded by adverts for services such as counselling and lifestyle change. Even before the second page was reached on the search engine most of the terms no longer produced websites that related to older people. There were a few positive websites, usually American that provided information to dispel myths about sexual activity and older people, promoting physical exercise and some educational institutions offering courses on older age and suggesting new models of care. DeLamater (2012) acknowledges it is particularly important to explore the relationship between sexual activities other than penile –vaginal intercourse and relationship quality in later life.

### **Medication**

It would be inaccurate not to relate some of the pharmacological enhancements to sexual activity. One of the most commonly mentioned adjuncts was the use of phosphodiesterase- 5 enzyme inhibitors (drugs which include Viagra) for men experiencing erectile dysfunction which, whilst it does

not cause erections, affects the response to sexual stimulation by increasing blood flow to the corpora cavernosa and corpora spongiosum by smooth muscle relaxation, enhancing erections. The widespread use of this drug and others in the group clearly demonstrates a need for such medication and there has been some interesting cascade prescribing within couples. As Sildenafil (Viagra) is commenced the need for post-menopausal androgens increases for female partners (Pariser and Niedermeir, 1998), additionally and not necessarily in conjunction to, hormone replacement therapy (HRT). Lubrication, both water soluble and oestrogen enhanced, is now more readily available and frequently prescribed. As well as these newer medications and preparations a more sophisticated use of analgesia may also promote sexual activity by allaying pain.

This section has demonstrated that there is a wide range of interventions taking place that support sexual intimacy and the picture is likely to further develop over the coming years but the evidence base is scant and the potential for enhancing sexual intimacy not fully understood.

### **Summation of Chapter – Cycle 2**

Cycle 2 is a three stage process, first the researcher is asked to familiarise herself with the broad empirical findings and choose a series of texts directly related to the subject. Second, the researcher identifies a unique set of texts for imaginal dialogue and finally based on the dialogue she prepares a set of preliminary interpretive lenses prior to data collection. Anderson and Braud (2011) describe the process of developing the preliminary interpretive lenses. The aim is for the researcher to articulate their personal values, assumptions and understandings prior to data collection. As previously explained they suggest the researcher returns to imaginal dialogue using texts chosen from the extant literature directly related to the study. The imaginal dialogue is similar to the process undertaken in Cycle 1 but this time Anderson and Braud (2011) suggest that the researcher becomes more conceptual and intellectual when working with the subject over time. In their book “Transforming the Self and Others through Research” (Anderson and Braud, 2011) the authors provide a series of experimental exercises to guide the researcher in the

process of intuitive inquiry, encouraging the identification, often visually, of the texts which “standout” or enthuse. The lenses revealed in my examination of the literature revealed a focus on a negative, disadvantaged view of older age sexual intimacy but provided little empirical evidence to support this. This resonated with the impression I had gained from my patients and my observations of the lives around me. The primary studies often explore sexual dysfunctions and the reviews frequently expound negative aspects of sexual ageing without exploration of the possibilities for improvement.

### **Cycle 2 Lenses**

Anderson (2011) explained the actual process of the development of Cycle 2 lenses is usually quick and easy after the long work in the ongoing imaginal dialogue which will have prepared the way for emergence of the lenses both consciously and unconsciously. She described the process as one more akin to creative imagination or brainstorming. The lenses that initially emerged were a mire of coy terms and supposition about what sexual intimacy is for older people, a landscape of sexual dysfunction, lack of availability of partners, the need for support and encouragement in committed relationships where communication is highly valued and of a more vibrant and accessible media milieu. My reflective diary at the time explains

“I went to watch Best Exotic Marigold Hotel and thought about older infidelity, about what the Karma Sutra says about older people’s intimacy. Notable concepts of the film that resonated were the notion of older people being invisible which led me to think about invisible sex. Sex that is not talked about and therefore not exciting. The second thought was of sex that never dies and never goes away, thinking about how the film might be a way of starting discussions off when talking to the participants.”

Reflective Diary September 2012

Anderson (2011) explained the generation of the lenses is often free flowing and involves conscious and unconscious processes and that, ordinarily, ten to twelve lenses are adequate to capture the nuanced range of most research

topics. She explained at a certain point the researcher knows they have integrated the Cycle 2 texts sufficiently and they are often generated in an hour or two. I had one to two clear lenses from the reading of the extant literature and the rest emerged over the courses of a dull wet afternoon when I was galvanised by a sense of “getting on with it”. The styles of individual researchers are reflected in the generation of lenses, my own style appears succinct and has poetic overtones.

My initial lenses are set out below

- Lack of availability of partners,
- Entrenched images of vulnerability
- Keeping joyful, magical secrets
- Dirty old man, frigid old women
- Muddling through the inevitable changes
- Negotiating new lifestyles
- Reclaiming sex from the young
- Leaving it to the specialists
- Using it or losing it.
- A twilight in knowledge and understanding

The stating of the Cycle 2 lenses completes the forward arc of the hermeneutical process, which tends to be inward looking and then makes ready for Cycle 3 which shifts to looking at others experience of the topic.

### **Definition of sexual intimacy**

In reading the literature I was keen to find a workable definition of sexual intimacy in relation to older people that would endure through the data collection. The word Intimacy comes from the Latin *intimus*, meaning innermost and deepest (Latin Dictionary, n.d.). The verb intimate means to “to state or make known”. Intimacy requires dialogue, transparency, vulnerability and reciprocity. Moss and Schwebel (1993) suggested that intimacy has five distinct components; commitment, mutuality, emotional intimacy (caring, positive regard), cognitive intimacy (thinking about the other person) and physical intimacy. The concept of intimacy is clearly bound within definitions of

love, interpersonal relationships and sexual activity. Moss and Schwebel (1993) found over 61 definitions of intimacy in romantic relationships and distilled this into seven themes that were found in at least 50% of the definitions. These were;

- An exchange or mutual interaction
- In-depth affective awareness-expressiveness
- In-depth cognitive awareness-expressiveness
- In-depth physical awareness-expressiveness
- A shared commitment and feeling of cohesion
- Communication or self-disclosure
- A generalised sense of being close to another.

Whilst there has been some attempt to define intimacy in the context of romantic relationships, Gross (2005) explained that striking changes have occurred in intimacy and family life over the last half century. He suggested that in the late modern period there is a tendency to individualisation that manifests itself in a decline in the standardised models of intimate relationships. Within sexual intimacy the definition is even more elusive. Langer (2012) states there is no real definition of intimacy and the definition of sexual intimacy is harder. Gott and Hinchliff (2003) found that people place different meanings and different descriptions on what sex is and Johnson (1998) suggests a definition of intimacy is necessary. Using the literature around the definitions of intimacy and my deeper understanding of the literature pertaining to sexual intimacy and older people I developed the following definition to guide the study.

*“In the context of partnership relationships, particularly those of long standing, sexual intimacy for older people may be seen as a reciprocal or mutual action or sense of presence which results in a shared experience or frisson. This moment or moments in time invoke a sexual excitement, contentment or pleasure which have both physical and emotional elements that are life affirming.”*

## **Foreshadowed Questions**

The literature revealed many interesting and new angles for research. The range of questions I considered were wide, a notable and enduring thought was whether I should make changes in the age range of the participants I would work with. I wanted my study to have something to offer professionals as the population ages and I was torn whether to look at the current cohort of older old people, who have unique experiences in terms of wholesale societal and technological change or looking at younger older people (55-65) who may have more in common with future generations of older people. By recruiting from the baby boomer generation whose experience might be very different from those people who are currently 75-85 I was anxious I might lose the wisdom and understanding of the generation that had lived through and adapted to so much change.

The literature had also exposed me to the lack of diversity in many of the studies previously undertaken. My thoughts around this resulted in a raft of questions that might have addressed the need for research in areas of ethnic, sexuality and gender diversity. The questions included;

- Should I consider a study primarily based with men due to the gender difference and under researched nature of expressions of sexual intimacy in men?
- Should I work with older people who are not currently in relationships as little is known about their sexual activity?
- Should I actively focus on gay and lesbian participants or people from ethnic minorities as this is under researched?
- Was my original idea too broad, I had planned to look at three aspects of sexual intimacy, that of the definition as described by older people, the expectations older people had prior to becoming 75, and the experience they had post age 75?

My conclusions were pragmatic, intuitive and informed by the lenses from Cycles 1 and 2 of the study. I have always been interested in and have worked with older, old people, my scholarship funding has been to look at both genders

and I had always wished to work with the general population not smaller groups, to increase relevance. I was particularly interested in the interplay within partnerships, but not exclusively heterosexual. I decided to stay with my intuition, to be guided by the question I that originally called me, as my chosen method schools me.

The literature revealed a lack of definition of sexual intimacy; in light of this it seems inappropriate to try to look at expectations and experiences of such a nebulous concept. My initial response to the lack of a clear definition was to ask the question “What does sexual intimacy mean to you and your partner?” Again I was challenged by the idea that responses would be “sugar coated” and in consequence I thought again of my image from Cycle 1, I am seeking the behaviours as well as thoughts that equate to older peoples meanings of sexual intimacy in their personal contexts.

Therefore the research question is look at the experiences of sexual intimacy for people between the ages of 75-85 in the context of partnership relationships within in the UK. From that base I planned to uncover the participant’s thoughts, feelings and behaviours and in so doing, develop a definition of sexual intimacy in their context.

The question asked of the participants will be broad and unstructured to allow the participants to direct my understandings. After much thought the opening suggestion is,

“What are your experiences of sexual intimacy with your partner?”



## Chapter 3

### The method and rationale, data collection and findings

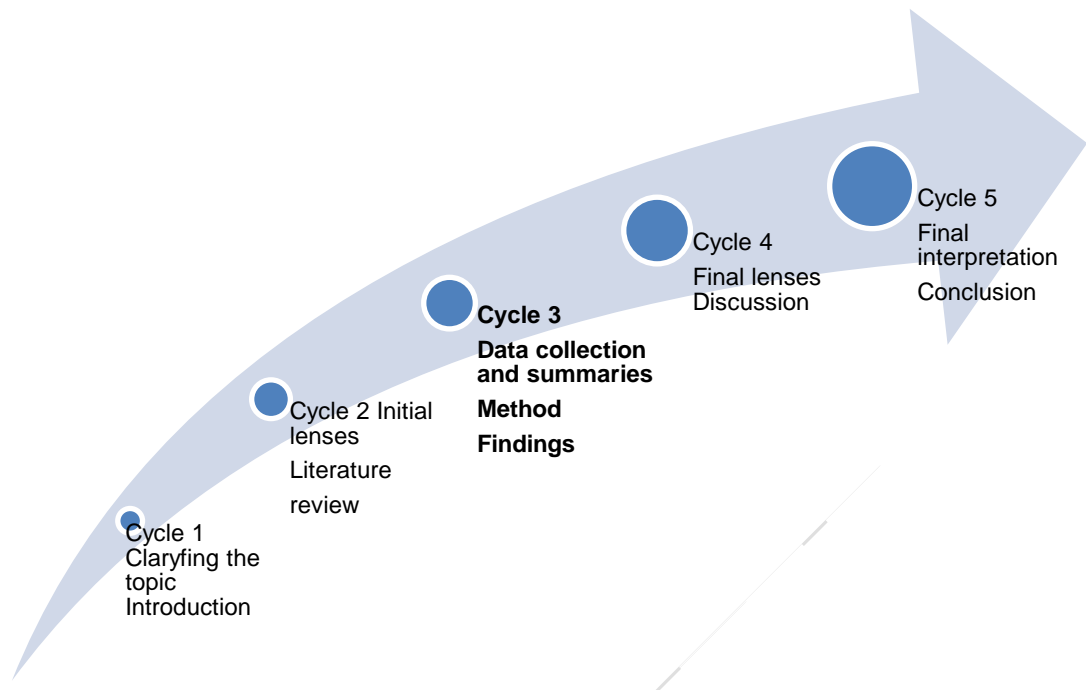


Diagram 5 Illustration of Cycle 3 in Intuitive Inquiry

This chapter incorporates great detail about the method as well as the data from the participants, thereby completing the forward hermeneutical arc (Anderson, 2011). This chapter has the greatest deviation from a traditional thesis and I have used both images and diagrams to aid the reader's navigation of the chapter. It combines the rationale for using intuitive inquiry, a methodological overview, an explanation of the method and data collection process and reflections on recruiting participants to the study.

It leads on to the data analysis which looked at the data in different ways and comprised;

- A thematic analysis of the entirety of the data identifying the breath of the findings
- A phemenologically inspired analysis of the in-depth interviews, thereby providing depth within the analysis.

Finally the chapter reveals the findings of the study which are set out using four components

- The observable acts of sexual intimacy
- The continuums of the participant's thoughts and feelings about sexual intimacy
- The phenomenological essence of sexual intimacy and its constituents
- A rhythm and meter to the delivery of details about sexual intimacy

Diagram 6 sets out the data analysis in a diagrammatic form.

It is important to note that discussion of the findings does not occur until Cycle 4 of intuitive inquiry which forms the next chapter of this thesis. There is, therefore, some duplication of the data to reinforce the findings from Cycle 3 in the discussion in Cycle 4.

### **Rationale for choosing intuitive inquiry**

The subject of sexual intimacy is highly personal and sometimes secret, therefore undertaking the research required a high level of sensitivity and a method that would uncover the data respectfully and with compassion. I was cognisant that quantitative research methods would not honour the subject in such a personal or nurturing way and as so little was known about the subject there would be little basis for testing an hypothesis. Equally, the huge number of potential variables in sexual behaviour between partners would mean attempts at generalisability of findings within the confines of a doctoral study would not be possible. For the above reasons the use of a quantitative methodology was disregarded at an early stage. My clinical work with patients over the years has allowed me to develop an intuitive and experiential approach to discussing their issues relating to sexuality which has resulted in developing previously unconscious skills of language, timing and humour. This further strengthened my desire for locating a qualitative method that could answer the research question and enhance professional practice.

I was drawn to intuitive inquiry through my clinical path and because I was aware that potential participants may not have the language or desire to reveal their most intimate feelings verbally, therefore the study would require interpretation based on tacit understanding. I explored a range of qualitative methods including; narrative analysis, discourse analysis, ethnography and

grounded theory considering them to a point of exclusion. I then investigated intuitive inquiry and found no reason to exclude it as a research method for the question as it met the needs of the research beautifully.

My reasons for the exclusion of the other differing methods were carefully considered. I knew the method had to be chosen to answer the research question, drawing out the essential messages from the participants. I also had experience of working with older people, both clinically and in previous research studies. I understood a little of the fatigue they might experience both physically and psychologically if engaged in protracted interviews. I was also aware of the length of history they have to offer by virtue of their years and the balance needed to capture meaningful data whilst respecting the participant. I was particularly concerned whether any method chosen would work for people who might not be able to articulate their experience or who felt constrained by social, cultural or religious stigma or shame. Earlier reading of the literature indicated that discussions with older people about sexual issues required careful sensitivity on the part of the researcher. I have set out below the essentials of the methods I have considered providing a brief summary and the reasons for exclusion;

### **Grounded Theory**

Emerging from the disciplinary debates of the 1960's grounded theory, as described by Glaser and Strauss (1967), was primarily aimed at sociologists but has been adopted by many disciplines including nursing. Described as an inductive methodology it involves the generation of theory. Grounded theory takes the interpretation of meaning in social interaction and sets out the interrelationship between perceptual meaning of the participants and their actions. Grounded theory supplies a set of research procedures to provide a theoretical explanation grounded in the study data. The procedures lead to the emergence of conceptual categories, which occur following coding of the collected data. The codes are then grouped as concepts and finally into categories. The theory comprises a collection of categories that detail the subject of the research. The work of Glaser and Strauss (1967) was developed from its positivist version by Strauss and

Corbin (1998) who provided guidance on procedures and techniques which were later criticised for encouraging the forcing of data and differences in the use of the coding paradigm.

More recently constructivist grounded theory has emerged rooted in pragmatism and asserts that theories are constructed by the researcher as a result of interactions or co constructions with the participants. Charmaz (2011) explains constructivist grounded theory as a systematic but flexible method with simultaneous data collection and analysis using comparative methods and providing tools for constructing theories. She suggests that it provides flexible guidelines that demystify the process of analysis and encourages the researcher to stay involved.

My undergraduate primary research and research I had undertaken as part of my consultant nurse role used grounded theory, it was the qualitative research method I was most familiar with and I was sure that within the confines of a doctoral program I would not have the capacity to reach data saturation in the time frame and the development of theory was hugely ambitious in the context of this research question and might not reflected in the individual nuances of sexual intimacy.

### **Narrative Analysis**

Riley and Hawe (2005) explain that narrative inquiry captures how people make sense of the world, they describe a 'thinking through' of events that is captured in stories.

Narrative analysis provides an opportunity to analyse stories which may be oral or written. It focusses on the multiple "turns" those stories take. The narratives can be created as a result of an interview or occurring as part of everyday story telling. There is no prescribed length or format and they can be a means of sharing a biography or life story. In focussing on events and their meanings narratives can reveal common structural features when participants recount an experience or event (Riessman, 1993). Narrative analysis takes the "story" as the investigative focus and there are a wide range of ways to view and analyse such stories. The narrative approach

looks closely at the sentences constructed by the storyteller and the information and meaning they portray. Riley and Hawe (2005) suggest the sentences can be categorised in the following ways;

*Descriptive sentences*, which is a sentence or paragraph that sets the scene, but has no temporal role in the scene.

*Consecutive sentences*, where there is a logical scheme to where the sentence fits into the narrative.

*Consequential sentences*, where the words have causal implications in the story.

*Evaluative sentences*, showing something of the attitude of the story teller.

Riley and Hawe (2005) explain these types of sentences give meaning to the story. If they are *transformative*, they express a change in how the storyteller evaluates something, such as an epiphany.

My concerns with the method included problems related to data collection. The time that it would take for the participants to recount their stories would be a potential issue, eighty five years of life provides a considerable history, and to relive this in the context of an interview about sexual intimacy would take a long time. The subject is something that has the potential to widely deviate from the focus of the study thereby generating large amounts of data that would be potentially unwieldy, particularly for the relatively novice researcher. As well as the implications for the study, the levels of fatigue caused by recounting life stories are considerable. As a clinician managing consultations with people who are seen as older old there is a delicate balance between being respectful and obtaining the detail required to make meaningful interventions and being oversaturated with information and exhausting the individual thereby missing further key points. I was also concerned that the method, in my hands, could reduce the feelings and emotions expressed into something more formulaic which would not describe the diversity and energy of the experience. I was also anxious to capture what was not said by the participants as this might reveal areas in which the person was not able to explore with a researcher. For all these

reasons I finally chose to discount narrative analysis as the research method for this study.

### **Discourse analysis**

Discourse analysis examines how language is used to accomplish personal, social, and political projects. Discourse analytic approaches are influenced by a wide range of disciplines including anthropology, linguistics, cultural studies, gender studies, social psychology and philosophy. Philosophically contributions have been made by Wittgenstein, Foucault and Austin (Potter and Wetherell, 1987). Often described as the analysis of language 'beyond the sentence, in discourse analysis the researcher is studying larger sections of dialogue and the way in which they work together. The context of the dialogue within the piece is also important, as looking at sentences individually can produce different meanings than when taking them together as a single discourse. The change in perspective can revise the interpretation of the first sentence following a reading of the second. The act of going back and re-interpreting meaning of previous sentences is called reframing. A key aspect of discourse analysis is in turn-taking, as the name implies this occurs when another person starts to speak or takes over a conversation. This can be heralded by the current speaker demonstrating changes in phrasing, intonation or pauses in the conversation. A new "turn" or "floor" will occur when another person takes over the conversation or waits until there is a pause, different speakers will react in different ways and this can change their responses within a conversation. Potter and Wetherell (1987) explain that texts are approached in their own right and not as a route to the attitudes, events or cognitive processes beyond. In discourse analysis the different ways in which participants listen is relevant, differences in eye contact and giving verbal "listener feedback" to the person speaking changes the quality of the interaction. Researchers using this method use terms such as "discourse markers" which break speech into sections such as a "but" and "oh" and "speech act" which denotes the action words make such as "open the door".

I disregarded this method for similar reasons to narrative analysis. I was uncertain about the amount of data I would be able to acquire, with concerns

about both the depth and volume. I found it difficult to engage with methods that focused on the absolute or thoughts and thinking behind the stories when sexual intimacy is so much about feelings and emotions. I was aware from my work with older people that when speaking about sexual intimacy so much was revealed in the non-verbal language the people displayed and I was uncertain that such a focus on use of verbal language would yield rich results or that I would have the time to develop the skills during my research into such a sensitive topic.

## **Ethnography**

Ethnography is the study of culture, social interactions, behaviours, and perceptions that occur within groups and communities (Hammersley and Atkinson, 2001). Originating from anthropological studies of remote societies, in the early twentieth century researchers such as Malinowski and Radcliffe-Brown participated in these societies over long periods and documented their social arrangements and belief systems.

Ethnography aims to afford holistic insights into the actions and views of participants, as well as the context they inhabit, providing detailed observations and interviews. The task of ethnographers is to document the culture, the perspectives and practices, of the people in these settings. The aim is to 'get inside' the way each group of people sees the world. (Hammersley and Atkinson, 2001).

Prominence is given to exploring the characteristics of a specific social phenomenon, the data are collected often using field notes and are unstructured. Ethnographers typically gather observations, drawn from direct engagement and involvement with the world they are studying recording a variety of elements in their field notes. During their observations, ethnographers routinely use informal or conversational interviews, which allow them to discuss or ask questions about events. This type of interview technique can be useful in gaining candid accounts from individuals. Ethnographers also gather formal in-depth interviews and documentary data such as minutes of meetings, diaries, and photographs. Ethnographers can focus upon specific

features, for example, nurse and patient relationships that occur within a research setting (Cowdell, 2013).

Analysis of data is undertaken in an inductive manner, that is to say the data are examined to identify and to categorise themes and key issues that “emerge” from the accounts. Through a careful analysis of their data, using this inductive process, ethnographers generate tentative theoretical explanations from their empirical work (Reeves et al, 2008).

Reflexivity is an essential tenet in ethnography and is particularly relevant because of the relationship between the researcher and the participants. The researcher needs to be sensitive to the potential ethical issues that arise from the closeness of the relationships.

I discounted this method for ethical, professional and practical reasons. Obtaining formal approval from research ethics committees can be a complicated process. To present an ethical application that would be involve studying sexual intimacy ethnographically would be fraught with issues, the nature of the study and the prevailing literature would give rise to many concerns largely relating to adult safeguarding. Professionally any plans of observing intimate relations between older people and being immersed in their culture for a doctoral study might, understandably, have resulted in referral to my professional body by friends or family of the participant or by my colleagues. Ethnographic interviews may have ameliorated some of the issues but my search then led to Intuitive Inquiry.

### **Intuitive Inquiry**

Whilst this method is relatively unknown in the UK, it immediately promised great possibility in answering the research question. Intuitive inquiry is a qualitative research method established by Rosemarie Anderson at The Institute of Transpersonal Psychology Palo Alto California. It was devised as a general approach to study transformative experience. Braud and Anderson (1998) suggest that many of the techniques and strategies can be blended with other methods.



Anderson (2011) explains that intuitive inquiry incorporates intuitive and compassionate ways of knowing in a method which involves five “Cycles”. This method is highly suited to researchers who wish to understand their topic fully, who become immersed in the subject (Braud and Anderson, 1998). Intuitive inquiry provides a systematic approach that incorporates both objective and subjective knowledge through an interpretive process. This ensures the researcher’s point of view and the evaluations of the accounts of others are in constant dialogue. The more I read about Anderson’s (2011) method, with the experience brought with me from ten years of considering the topic, the intuitive nature of the approach resonated more closely to the research question than any other option I explored. I had already developed some ideas related to the question and needed to be sure this could be incorporated in the work without providing undue or undisclosed influence. The need for transparency was paramount. I researched the method in more detail I experienced concerns relating to data collection as previous intuitive inquiry studies had often used embodied writings and I was unsure whether the participants I was hoping to recruit would be able or willing to produce this type of data. However, intuitive inquiry studies have also used other diverse forms of data collection with great success (Anderson, 2000). The flexibility this method would offer was very appealing both in terms of data collection and data analysis. Intuitive inquiry was first inspired by the challenges of conducting research in the field of transpersonal psychology, to explore the farther reaches of human nature (Anderson, 2000). She suggests that research into the rich dimensions of being human had often been stymied by a reliance on experimental methods.

Anderson (2011) describes intuitive inquiry as a hermeneutical circle of interpretation and explains that methodologically intuitive inquiry has been directly informed by the biblical hermeneutics of Schleiermacher, philosophical hermeneutics of Gadamer and the phenomenological and heuristic research developed by Moustakas. A brief discussion of the each follows below to outline the underpinning philosophy of Anderson’s method (Anderson, 2011).

## **Underpinning philosophies**

### **Heuristic Inquiry**

Heuristic inquiry is, in essence, a research process designed for the exploration and interpretation of human experience (Moustakas, 1990). The word heuristic comes from the Greek “heurskein” which means to discover or find. Its reference is to a process of internal searching which allows discovery of the nature and meaning of experience. Heuristics includes the development of methods and procedures for further investigation and analysis (Moustakas, 1994:17). Moustakas goes on to say that the self of the researcher is present throughout the process of heuristic inquiry and as the phenomenon is understood in increasing depth the researcher also experiences a growing self-knowledge and self-awareness. Heuristic processes incorporate creative self-processes and self-discoveries (Moustakas, 1994). It acknowledges the involvement of the researcher, indeed in many heuristic studies the researcher’s experience becomes the main focus of the research. Alternatively, as in this study, the method may be used when the researcher is passionate about the research question. Moustakas (1994:18) describes six phases of heuristic research.

- Initial engagement
- Immersion in the topic and the question
- Incubation
- Illumination
- Explication
- Culmination of the research in creative synthesis

Heuristic research is intended to have a transformative effect on the researcher. I have been honest from the moment I commenced my study about my desire for the research to make me a more enlightened clinician, such that I am able to respond to my patients needs in a sensitive and knowledgeable way. An additional goal has been to embrace the subject as a preparation for my own older age. Hiles (2001) in a conference paper about heuristic inquiry describes this well saying that in undertaking research we wish to make an

addition to knowledge but that we also undertake research because we care and wish to make a difference.

Moustakas's provides a summary of the core processes of heuristic inquiry (Moustakas, 1990: 15-27),

- Identify with the focus of the inquiry, the heuristic process involves getting inside the research question, becoming one with it, living it.
- Self-dialogue  
Self-dialogue is the critical beginning, allowing the phenomenon to speak directly to one's own experience. Knowledge grows out of direct human experience and discovery involves self-inquiry, openness to one's own experience.
- Tacit knowing
- In addition to knowledge that we can make explicit, there is knowledge that is implicit to our actions and experiences. This tacit dimension is ineffable and unspecifiable, it underlies and precedes intuition and can guide the researcher into untapped directions and sources of meaning.
- Intuition  
Intuition provides the bridge between explicit and tacit knowledge. Intuition makes possible the seeing of things as wholes. Every act of achieving integration, unity or wholeness requires intuition.
- Indwelling  
This refers to the conscious and deliberate process of turning inward to seek a deeper, more extended comprehension of a quality or theme of human experience.
- Focussing  
Focussing is inner attention, a staying with, a sustained process of systematically contacting the central meanings of an experience. It enables one to see something as it is and to make whatever shifts are necessary to make contact with necessary awareness and insight.
- Internal frame of reference

The outcome of the heuristic process in terms of knowledge and experience must be placed in the context of the experiencer's own internal frame of reference.

Adapted from Hiles (2001)

This process starts by engaging with the research question, as seen in Cycle 1, the initial engagement is to discover an intense interest, a passionate concern that calls out to the researcher, one that holds important social meanings and personal, compelling implications. The research question that emerges lingers with the researcher, awaiting the disciplined commitment that will reveal its underlying meanings. There is an immersion in the question which requires alertness, concentration and self-searching, virtually anything connected with the question becomes raw material for immersion (Anderson, 2011). These activities are followed by a retreat from the intense focus, allowing the expansion of knowledge to take place at a more subtle level, enabling the inner tacit dimension and intuition to clarify and extend understanding. Anderson (2011) describes breakthroughs as moments of illumination when the researcher is open and receptive to tacit knowledge and intuition. It involves modifying old understanding or new discovery and can be followed by an examination or “explication” of what has been awakened in the researcher’s consciousness that culminates in creative synthesis. Moustakas’s work has been critiqued by Sela-Smith (2002) who suggested that his focus has shifted from the self’s experience of the experience to focusing on the experience. This shift has resulted in a model of ambivalence, reflected in the differences between what he introduced as his theory and what he presented in his application. She believed this has occurred due to Moustakas resistance to experiencing personal distress. However, it is important to note that, in intuitive inquiry Anderson (2011) describes many of the facets of Moustakas’ works in their original form and encourages the focus on self’s experience when engaging with research.

### **Hermeneutic Inquiry**

Originating in a biblical tradition hermeneutics is frequently defined as ‘methods of interpretation’, with biblical hermeneutics described as methodology of Biblical interpretation, particularly setting out ‘rules’ for biblical

interpretation (Mead, 2007). Since Schleiermacher (1768-1834) the use of the term, “hermeneutics” (from Hermes, the messenger god) is understood as the fundamental philosophical and theological assumptions behind different methods of interpretation. The interpretivist view advocates that human actions are meaningful, and the outcomes of these actions constitute meaningful material which calls for interpretation. Verla et al (1991) stated that whilst originally hermeneutics was the discipline of interpreting ancient texts it has been extended to denote the other types of interpretation, understood as enactment or bringing forth of meaning from a background of understanding. Modern hermeneutics can be defined as the discipline of interpretive theory, and that interpretation includes written, verbal and nonverbal communication. Kinsella (2006) sets out five characteristics of a hermeneutic approach which include, seeking understanding rather than explanation, acknowledging the situated location of interpretation, recognising the role of language and historicity in interpretation, viewing inquiry as conversation; and being comfortable with ambiguity.

Philosophical hermeneutics refers to a theory of knowledge first discussed by Heidegger (1889 -1976). Risser (1997) tells us that philosophical hermeneutics is, first of all, hermeneutics of the humanities, specifically, the humanities as they emerge out of German Romanticism. Risser (1997) explains that for philosophical hermeneutics understanding takes place in all aspects of experiencing. Philosophical hermeneutics was developed further by Gadamer (2004) and essentially explores how understanding at a fundamental level occurs. Situated in twentieth century philosophy Gadamer (2004) attempts to mediate between philosophy and the sciences by moving beyond scientific theory and methodology. He considers the conditions and limits of science within the whole of human life, suggesting science can fulfil its function when it acknowledges its limits and the role of philosophy should be to make this clear to us. Philosophical hermeneutics is part of a philosophical movement that attempted to overcome the one sided view of positivism. Gadamer (2004:556) explains that that hermeneutic reflection “discloses conditions of truth in the sciences that do not derive from the logic of scientific discovery but are prior to it”. He suggests that the ideal of “science” leads

people to be orientated toward the methodological correctness of procedure and in consequence away from reflection.

In summary, Gadamer (2004) tells us that hermeneutics does not simply provide a method for finding truth, it is also a means of finding out what conditions make truth possible. These underpinnings in addition to the work of Moustakas provides for a method which looks beyond and seeks to unlock the whole and the parts of the whole.

### **Cycle 3 Intuitive Inquiry - Method**

Anderson (2011) explains that intuitive inquiry incorporates intuitive and compassionate ways of knowing in a method which involves five “Cycles”. Braud and Anderson (1998) suggests that this method is highly suited to researcher’s who wish to understand their topics fully, who become immersed in the subject, she likens it to “a lover exploring a beloved’s hand”, that the ordinary is extraordinary.

Intuitive inquiry provides a systematic approach that incorporates both objective and subjective knowledge through an interpretive process. This ensures the researcher’s point of view and the evaluations of the accounts of others are in constant dialogue. Anderson (2000) explains that the heuristic contribution to this research method honours the notion that the personal is universal and additionally that the personal is political. Clearly these statements are drawn from the contribution of feminist research methods. She explains that the inter connectedness of the personal and the political provides a scientific insight if used compassionately. In refining her method Anderson (2000) states that intuitive inquiry seeks to provide an approach to research that systematically incorporates both objective and subjective knowledge through a step by step interpretive process.

Anderson (2000) describes the essential features of intuitive inquiry;

- The heart of compassion as value and principle of validation and consensus
- Sympathetic resonance as a validation procedure

- Constructing the social context of knowledge: Building validity through circles of sympathetic resonance
- The personal is universal
- The personal is political
- The interconnectedness of scientific insight
- Trust the ritual; The discipline of procedures and protocols
- The element of delight and surprise in scientific inquiry
- The function of compassionate knowing (soft wisdoms of the heart) in scientific inquiry
- The human voice unique and particular

Set out below is a brief explanation of each of these essential features.

### **The heart of compassion as value and principle of validation and consensus;**

Anderson (2000) speaks of compassion in the research process both to the participants and their data and the intended audience. Braud and Anderson (1998) suggest compassion allows us to ask the most important questions and guides us towards rich and expansive theories regarding human experience. My own study dealing with intimate, personal and private activities of older people requires a high degree of compassion and care. Interestingly, Anderson (2011) tells us that in addition to compassionate listening, analysis and synthesis studies using intuitive inquiry should be written using a heartfelt style which considers the audience. This had particular importance as I wish to share the findings with a wide group of older people, as well as academics and practitioners.

### **Sympathetic resonance as a validation procedure**

Anderson (1998) describes the notion of “sympathetic resonance” with an analogy stating “If someone plucks a string on a cello on one side of the room, a string of a cello on the opposite side will begin to vibrate too. Striking a tuning fork will vibrate another some distance away” (Anderson 1998:73). “The resonance communicates and connects directly and immediately without

intermediaries except air and space” (Anderson, 2000:23). She suggests the principle is that research can function more like poetry having an immediate recognition of an experience explained by another. Sympathetic resonance is a validation procedure for the researcher’s particular insight and synthesis and that a measure of validity can occur because there is a bond of sympathy between a researcher and the work (Romanyshyn, 2007). He goes on to suggest that for Anderson the validity of one’s research is tested by whether it harmonises with the experience of another (Romanyshyn, 2007). Braud and Anderson (1998) also establish that describing the richness of human experience may require metaphors, similes and symbols. My ambition on completion of the study is in publically sharing some of the findings. To display some direct quotes alongside, photographs and images such that the audience experiences a sensation of entering an art gallery or display. In this way making the research instantly accessible to the public and participants.

### **Building validity through circles of sympathetic resonance**

The importance of the social and political context is emphasised by Anderson (2000) and she suggests through the validation procedures of consonant, dissonant and neutral sympathetic resonance, subgroup by subgroup it is possible to create a type of mapping which might allow the findings to be immediately apprehended or recognised. Anderson (2011) also states that the researcher’s insight analyses can also be verified using conventional experimental, quantitative procedures. The principle of letting the data define the necessary analysis is both exciting and daunting. Exciting in its possibilities and daunting because it will require a wide understanding of data analysis processes.

### **The personal is universal**

Intuitive inquiry places the experience and interpretation of the researcher centrally whether the data is qualitative or quantitative, clearly drawing on the work of Moustakas (1990). This heuristic contribution suggests we are at a threshold of appreciating, knowing and acknowledging an aspect of life we all may share and that some of the synthesised, particular experiences will seem familiar and understandable yet remote and unknown as well. My research subject is remote in personal chronology for many and therefore unknown, but



the experiences of sexual intimacy across the life span may make certain aspects familiar and understandable.

### **The personal is political**

Drawing on feminist critique of research, Anderson (2000) suggests that there are valuable insights in the interconnectedness of the personal and political aspects of daily life, she expands on this in saying “for the feminist researcher, all actions are political and at their best have the power to emancipate, liberate, enliven and energise human life and possibilities for all people” (Anderson, 2000 p78). I was particularly drawn to this as I would hope that the study encouraged older people and healthcare professionals to talk more openly about their sexual needs and the types of support that they would find helpful. The method had sincere resonance with the research I planned as I believe older people are political in the widest sense, the invisibility of older people is seen in the literature and in clinical practice, they often carry a sense of being a burden, of being infirm and no longer useful in a society that values youth and vitality. Paradoxically, they are increasingly needed by younger generations to provide child care and practical advice, they are the babysitters, seamstresses, plumbers, mechanics to their time pressured off spring, who are unable to cook, mend or repair. They are spoken of as a financial drain on society if they become physically unwell or develop dementia and yet they are courted and soothed by politicians as they remain the group most likely to vote in national elections. So their lives are individual and political.

### **The interconnectedness of scientific insight**

Anderson (2000) explains that in bringing together the principles of the personal being universal and the personal being political we come full circle. She says “what is particularly sacred in human life is also manifested in the individual and community aspects of our lives and in the unity that brings us together” (Anderson, 2000:79). She writes that research that delves into human experience demands compassion and understanding of human expression and the inter connectedness of the personal political universal circle. My research also adds the dimension of a physical inter connectedness by virtue of the changes that older people are dealing with in their intimate lives.

### **Rigour - Trust the ritual; the discipline of procedures and protocols**

Research procedures and protocols can be seen as ritual (Anderson, 2000) and once procedures are in place they should be followed with care and precision, she goes on to state that over time good methods like good maps generate trust. The ritual helps to maintain the rigour required in qualitative research generally and in intuitive inquiry specifically. In the development of qualitative research, there has been differing criteria to assess rigour, frequently used are credibility, dependability, confirmability and transferability (Lincoln and Guba, 1985). Credibility refers to the value and believability of the findings and involves conducting the research in a transparent manner with integrity. Anderson (2000) tells us that in intuitive inquiry an introspective and intuitive perspective is demanding and rigorous and believes that following procedures allows the researcher to relax into the sustaining process of the investigation. 'Dependability' is concerned with the stability of data and scrutinises the consistency of the processes of the study, ensuring errors in methodology or interpretation are not made (Lincoln and Guba, 1985). Confirmability refers to the degree to which the results could be confirmed or corroborated by others. Wertz et al (2011) explain that part of the rigour in qualitative investigation is self-disclosure and reflexivity, it is important we are privy to the standpoint of the researcher, as an essential tenet of contemporary qualitative research is that is "radically relational", that although the aim is knowledge the research will reveal the values and personal qualities of the researcher and in order confirm the rigour we must understand the researchers standpoint. Transferability refers to whether or not particular findings can be transferred to another similar context or situation. In intuitive inquiry this can also be likened to notion of the personal being universal.

I was very keen to understand the method as fully as possible and in addition to the published literature I have read presentations by Anderson (2008) to round my knowledge of the underpinning rigour within the method. I felt this was particularly important as the use of intuitive inquiry is rare in the UK and sits in a contemporary and highly developed understanding of qualitative research. In my final reflection in Cycle 5 I use Finlay's (2011) 4 R's to scrutinise the thesis in terms of rigour, resonance, reflexivity and relevance.

### **The element of delight and surprise in scientific inquiry**

Anderson (2011) states that most research entails delight and surprise, that intuition leads to new ways of looking at old problems and that intuitive methods set a “methodological stage for new ideas to happen” (Anderson, 2000:80).

### **The function of compassionate knowing (soft wisdoms of the heart) in scientific inquiry**

Compassionate knowing is a softness (Anderson, 2000), by living thoroughly with the experience studied, the researcher looks around from inside the experience and notes what is there. There is a search until the essential qualities of the experience come to life as the researcher’s own experience. Eventually an entire panorama of the experience can be seen. The effects of this are often transformational for the individual researcher.

### **The human voice unique and particular**

Anderson (2000) tells us that the human voice is unique and particularly that the researcher must stay close to the spoken word and the behaviours demonstrated by participants. She provides hope in saying we can be accurate and always remember that the capabilities of the self are enormous.

This concludes the philosophical underpinnings of the method and what follows is the practical application of the method as described by Anderson (2011), with details of the types of intuition that can be engaged within the research method.

### **Intuitive Inquiry: Method**

Having explained that intuitive inquiry uses five iterative cycles which form a complete hermeneutical circle of interpretation, establishing the perspective is the forward arc of the process and evaluation forms the reverse arc (Anderson, 2001). The method encourages an inclusive and connected manner of conceptualising research topics and collecting and analysing data. Within the method, analysis and interpretation pivot around the researcher’s intuition. Anderson (2011) presents a typology of five modes of intuition which has been

drawn from the work of Assagioli (1990), Diekman (1982) Goldberg (1983), Koestler (1990) and Vaughan (1979). These are set out below;

- Unconscious, symbolic and imaginal process,  
This describes researchers who live active symbolic lives in which dreams, imaginal processes, somatic experiences are commonplace.
- Psychic or parapsychological experiences whilst generally unacknowledged as sources of scientific insight they are aspects of what are called exceptional scientific insights
- Sensory modes of intuition which include a feeling of heightened sense, not only of the five major senses but also visceral, kinaesthetic and proprioceptive.
- Empathetic identification
- Through our wounds, intuitive styles that settle along a researchers personality in response to their own wounds

In summarising the method in Cycle 3 Anderson (2011) explains that the researcher;

- selects the source of data on the subject
- develops criteria for the selection of data
- collects data
- prepares descriptive analyses of data that represents the voices of the participants or other narrators of the data.

The researcher collects data on the topic, by identifying the target population/texts and creates procedures for recruiting a sample of participants or texts, the researcher then defines selection criteria that will retain participants who will inform the research topic. The following section describes both the strategies for data collection and some of the difficulties that were encountered.

## **Data Collection Strategy**

I aimed to recruit independent older people using a variety of techniques including purposive sampling, where the participants are chosen because of their specific knowledge, convenience sampling, for example in shopping centres or seaside resorts and snowball sampling where older people themselves were encouraged to suggest to their friends or families that they may wish to contact me. The participants were approached via many and varied routes including clubs, post offices, advertisements and word of mouth. They were provided with flyers or post cards telling them about the study and offering them the chance to contact me via letter, telephone, face to face or email. Radio, group presentations or gallery events that stimulate interest were planned. Exclusion criteria comprised people who were not between the ages of 75-85, not in partnership relationships and, unfortunately, those who cannot speak or write in English as I had no funding for interpretation.

My clinical experience told me that some older people may prefer anonymity or may not have the language to explain their feelings, and therefore a variety of data collection techniques were employed. The participants were able to choose their preferred method of sharing their experiences. Anderson (2011) suggests the researcher follows their intuition and enthusiasm and selects inviting and challenging data sources. She expands this saying that the researcher deliberately chooses data sources that challenge their Cycle 2 lenses.

I felt the subject may benefit some of the potential participants if they were able to express their experiences anonymously. I investigated the advantages of face to face interviews, using the telephone and written communication. Opdenakker (2006) discusses the advantages and disadvantages of the following interview techniques in qualitative research; face-to-face interviews, telephone interviews and email interviews.

### **Face to face interviews**

Face to face interviews are the embodiment of communication occurring in the same time and place and these conversations take advantage of social cues. The strength of the participants voice, their intonation and body language

allows the interviewer greater insight than simply the verbal answer to any question. However, the presence of the researcher can encourage unintended effects, for example when the researcher's behaviour unconsciously guides the interviewee in a particular direction. This disadvantage can be reduced by researcher awareness of the effect. In face to face interviews there is no significant time delay between question and answer; the interviewer and interviewee can directly react on what the other says or does and this can both improve and confuse the quality of the interaction. The discussion allows spontaneity of the participant's answers as there is not a period of extended reflection but the interviewer requires a consistently high level of concentration both listening to answers and posing questions. Wengraf (2001:194) speaks of "double attention", and explains,

"You must be both listening to the informant's responses to understand what he or she is trying to get at and, at the same time, you must be bearing in mind your needs to ensure that all your questions are liable to get answered within the fixed time at the level of depth and detail that you need".

Opdenakker (2006) describes the final advantage of face to face interviews as the ease in which they be terminated as compared to other interview methods. In the interaction both the participant and the researcher can provide clues that the interview is nearing completion. As previously discussed I was particularly keen to ensure that any participant distress or fatigue could be acknowledged and managed in a sensitive way and face to face interviews would accommodate this. The logistics of the venues were troublesome. I needed to ensure they were accessible, both for the individual on arrival but also for transport to and from the venue. Interviewing in someone's own home ameliorated these issues and influenced the power differential in the relationship, however, there would be no anonymity for the participant and potential lone working issues for me in such an arrangement.

### **Telephone interviews**

One of the advantages of telephone interviewing is the extended access to participants when compared to face to face interviews. Mann and Stewart (2000) make a distinction in the following categories:

Geographical access - participants can be drawn from a wide geographical range at very little cost. This was important in my study as I was anxious to be as inclusive as possible. The added benefit is that I would not have to travel great distances, this was particularly appealing as my time to undertake the study, as a part time researcher, was very limited.

Hard to reach populations - Mann and Stewart (2000) identify that telephone interviews enable researchers to contact populations that might be difficult to work with on a face to face basis. They cite mothers at home with small children, but this equally applies to older people with mobility issues.

Sensitive accounts - Some personal issues are so sensitive that participants might be reluctant to discuss them face to face with an interviewer, clearly this had great resonance with my subject area.

Obviously the greatest disadvantage of telephone interviewing is the reduction of non - verbal information and the inability to create a conducive environment but social cues as voice and intonation are still available. Technically it can be harder to record telephone interviews prior to transcription.

### **E-mail interviews**

One of the advantages of e-mail interviewing is the potential extended access to participants, although this is less relevant for the age group in this study. The major disadvantage of using e-mail is the complete lack of ability to observe non-verbal communication. However, an additional and important advantage of email is both the participant and the researcher can carefully consider and craft their responses.

Anderson (2000) provides guidance for the researcher in conducting interviews and explains the process of reflective listening is an essential skill. She describes this as; exploring and recording the features of the researcher's experience or motivation for the study, using the results of inner reflection as a template to listen to experience of others and to facilitate similar processes in participants which can initiate a field of sympathetic resonance. Anderson (1998) also suggests that that the researcher's ability in reflective listening can facilitate a similar process in the research participants. This is an interesting suggestion requiring, I believe, great skill as a researcher.

I gave considerable thought to the approaches to data collection I felt all had benefits and challenges, following further discussion with older people and colleagues I decided to offer all three opportunities to the participants which ensured they were able to make choices that suited their individual needs.

Having chosen a wide range of ways in which the participants might share their experiences I detailed the data collection strategy. Data collection was planned to take place over a 16 month period; the aim was to ensure the different methods of participant recruitment and be controlled so as not to overwhelm me with data. Conversely, if it was difficult to recruit participants this time frame would allow opportunity for more vigorous recruitment. Recruitment issues and data collection have been expanded on in the section “invitation to participate”.

**Invitation to participate** – Recruitment, data collection and ethical implications.

This section explores the issues related to inviting participants to take part in the study, it provides an explanation of the strategies used and the reasons behind those choices. The section also provides a reflective chronology and demonstrates the challenges and rewards in seeking research participants to be involved with a study exploring a sensitive subject, as well as the ethical implications. It also includes the process of data collection. Prior to commencing data collection I gave considerable thought to the recruitment strategy, whilst I was excited to progress the study, I was equally nervous to ensure recruitment provided meaningful opportunities to elicit the richest information from the participants. This came from a desire to get the study right and a concern underpinned by my background as a nurse “to do no harm”. Embedded in my practice is Beauchamp and Childress (2009) ethical framework. I had been the deputy chair of a clinical ethics committee and the principles of beneficence, non-maleficence, justice and autonomy are very important guides for my conduct. I was determined that the research I engaged in would adhere to these principles.

Braud and Anderson (1998) describe a number of techniques which can be employed to provide the best possible circumstances for participants in order to achieve rich data, these include, reflective listening, considering the audience, ritualising intention and trickstering. Anderson and Braud (2011)



explain that intention is the skill of efficient attention deployment and the skill of visualisation, this can be ritualised should the researcher wish by developing a concrete and structured physical procedure or ceremony.

I found simply entering the university, heading to the hot desk I used, in what was frequently an empty room, started the ritual, outside was a path with a long herb border, as a gardener, I was able to name and consider the medicinal purposes of the plants, whenever I reached an impasse in my concentration or understanding I would walk the border and this would allow me to focus more deeply.

Trickstering is a technique used in intuitive inquiry that is designed to confound, to create the paradox that challenges our assumptions, it is designed to exaggerate, dramatise or extend and is often achieved by using creative processes. In my interim viva tried trickstering, I had rehearsed creation of a suitable physical environment, the preparation of potential examiners by constructing appealing invitations.

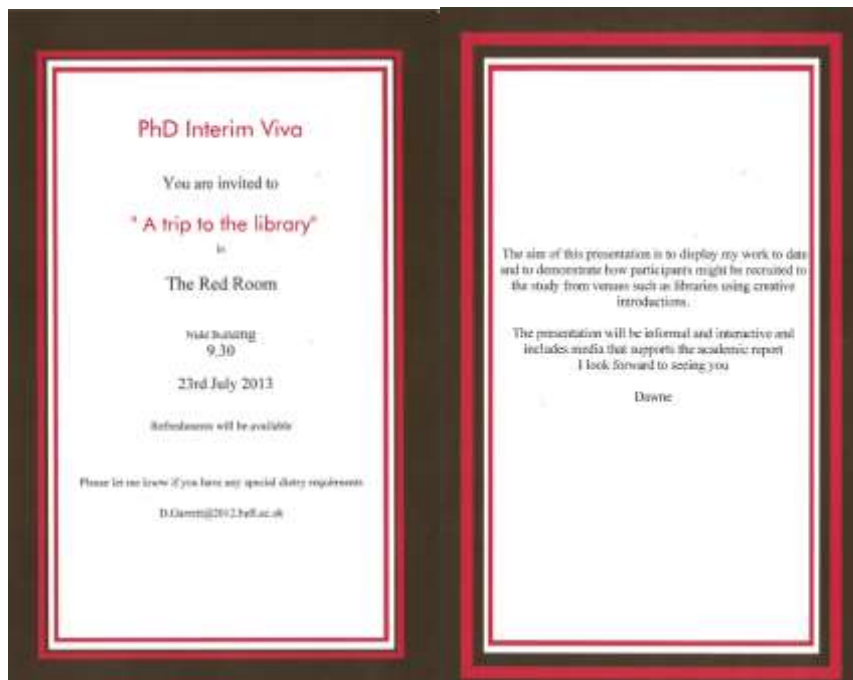


Image 2 Viva Invitation

This invitation was well received by the examiners and heightened my recruitment optimism. I then developed some flyers and post cards, which

were informed by discussions with colleagues and older people, which I was then able to use in the recruitment process.

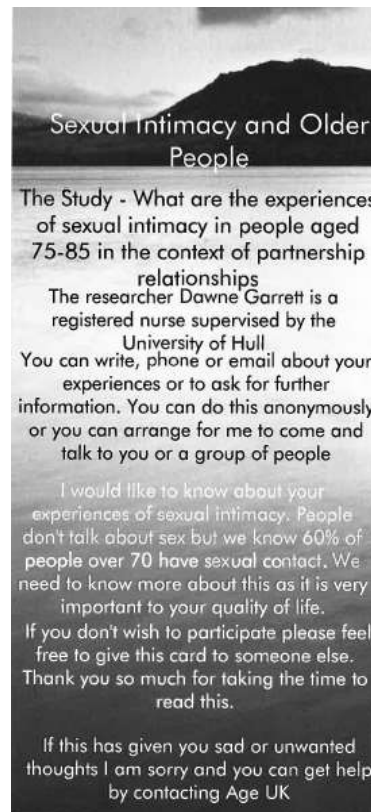
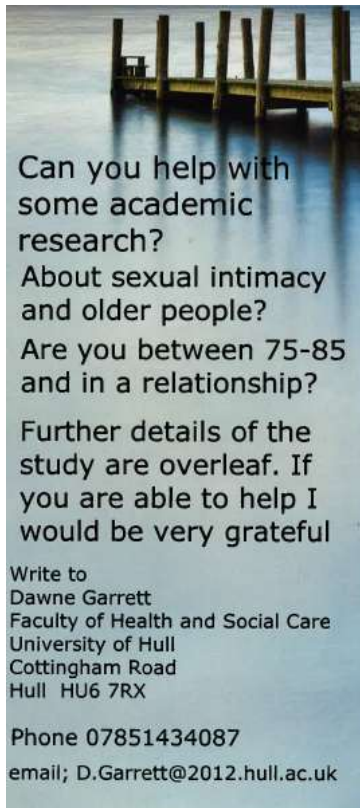


Image 3 Flyer Front and Back

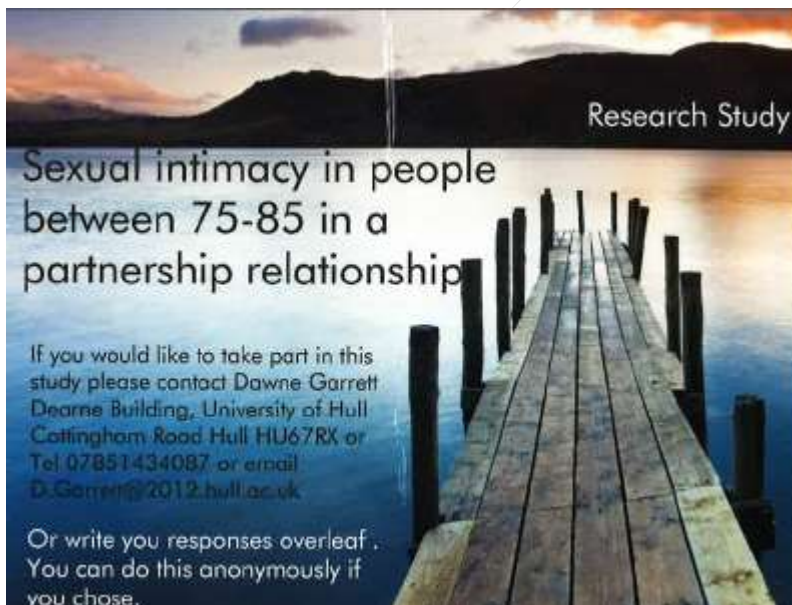


Image 4. Postcard Front

The cards had enough detail to allow people to understand that the research was an academic study and the cards provided contact details of myself and my supervisor in case they wished to check the veracity of the study. I always explained that there was ethical approval for the study. I also included details of a helpline in case the

distribution of the flyers caused distress or people wished to follow up prior life events. I purchased a “pay as you go” mobile phone to allow people to leave messages and for me to respond. This allowed a designated line for both confidentiality and safety purposes.

I believed that recruitment to the study, whilst potentially sensitive, would be highly possible but certainly not easy. I considered a wide variety of approaches and settled on a multi-faceted design which included the use of personal communication, distributing leaflets and flyers and asking assistance from third parties. As I previously discussed, intuitively I felt a mixed approach would allow anonymity for those people who wanted to participate but wished to maintain privacy. The strategy gave participants the opportunity to write, telephone or email. I hoped that other older people would want to tell their stories but they needed to understand my motivations prior to talking to me.

The recruitment strategy also gave participants opportunities to meet to me and then if they wished to continue they could engage in an in-depth interview.

The recruitment strategy involved;

- Giving out flyers in areas that had a high proportion of older visitors
- Advertising in older peoples magazines
- Advertising on web sites related to older people’s issues.
- Approaching older people’s charities and clubs
- Advertising on community notice boards

Appendix 4 demonstrates examples of the groups that were approached to participate.

Gledhill et al. (2008) used a similar approach in a study which involved recruiting older people to research sexuality, using word of mouth, advertising, community based seminars and direct solicitation. Whilst this was an Australian study there are clear parallels in the strategies we both used. She found that word of mouth was the most successful technique. I discovered her work after completing my data collection and was surprised and delighted to

compare both the similarities and differences. Gledhill et al. (2008) had a high proportion of participants from the gay community and a large proportion of men and she was able to involve healthcare professionals in assisting with recruitment. Whereas I achieved an equal gender split and had one participant from the gay community. I was not able to use healthcare establishments or personnel to assist in recruitment as I did not have the appropriate ethics approval. This had been a deliberate decision as I was particularly intent in accessing older people at their most well.

### **Ethical Approval**

The completion of University Research Ethics Committee submission post interim viva created a practical focus for the possibilities and potential challenges of the study. Sydor (2013) explains that research into sensitive topics often involves groups that are hard to reach, the paradox in this study is that older people are a large and potentially very accessible part of the population. The difficulty that emerged was finding older people who were happy to talk about sexual intimacy. Sydor (2013) suggests that hard to reach groups are, by definition, difficult for the researcher to access. I knew I would be able to reach potential participants but my concern was that I would not be able to engage them in a way so that they felt comfortable to fully participate. I was also aware of the allied issue that is the lack of research readiness in older age groups. Patel et al (2003) identify the main factor adversely affecting research response rates is greater age.

Questions from the University Research Ethics Committee helped me to clarify my thoughts about the process of accessing post interview support, should it be needed by potential participants. I had email communication with Age UK to ensure I could provide their help line as a point of contact for anyone who suffered distress. I was mindful when giving out cards to strangers there ought to be some means of support if they were surprised or concerned by the invitation. This might have occurred due to recent bereavement or if the request brought up unwanted thoughts about prior situations that were distressing or abusive. In considering these safeguards I reflected on my previous discovery that issues relating to older people's sexuality in the

literature framed sexual intimacy in later life as abusive or distressing. I was aware that I was couching my research invitations in the same way. It is extremely easy to slip into an ageist erotophobic view, even as a researcher passionate about the construction of societal influences that positively perceive older age sexuality. However, if my requests for participation had caused offence or distress there needed to be some way of supporting the individual and I believed access to helplines was necessary. I remained concerned that this might be seen as patronising and recognised that all adults are capable of making their own choices and seeking help for their own needs but I believed in handing somebody an invitation I may have exposed them to something they have tried to avoid or may have been protecting themselves from confronting.

The preparation of the cards took some time in order to shape them appropriately. I had joined a bowls club of which every other member was over 75 in order to immerse myself in older life, to have a sense of activity which brought people together, the anticipation of meeting people with similar interests and something of the nature of getting together as a long standing group of men and woman. I mentioned this in the first cycle of the work and described how this gave me the opportunity to see what others do not necessarily see, the fun, laughter, physical contact and teasing that occurred verbally. Additionally I witnessed the large amount of caressing, kissing rubbing and poking that happened between couples, single people, men and men and men and woman. This led to my second cycle 2 lens being entitled "keeping joyful magical secrets". The bowls group provided a frame of reference for my thoughts about recruitment I imagined their responses to the invitation or requests and thought very carefully about the role of a middle aged woman approaching older men and whether this would have been alienating. Simpson (2016) in his research focussing on older people in care homes matched interviewer gender and where possible age to the participant. I was not able to offer this but felt the offer of responding in writing or by telephone might be helpful if potential participants were concerned by face to face meetings with me.

## **Details of recruitment process**

Initially I had a number of participants who came forward for the study through word of mouth from academic colleagues. The potential interview participants telephoned or emailed me to express their interest in taking part in the study, I then sent a participant information sheet (Appendix 1) to the potential participant explaining the study, the process and contact details. I asked the people who had approached me over the telephone if they would like to meet me to tell me about their experiences or whether they preferred to be interviewed over the telephone. For those participants who wished to meet face to face, I explained I was happy to go to their homes or meet in a venue of their choice. The participants that I met face to face signed consent forms, Appendix 2 provides a copy of the consent form, those participants who were interviewed over the telephone gave verbal consent which was recorded. The practical issues related to informing the participants were underpinned by Beauchamp and Childress (2009) four ethical principles. Firstly, autonomy, which is the right for an individual to make his or her own choice. Clearly the proposed participants for this study are older adults and have the right to decide whether they should engage in the study, the methods of recruitment are without coercion and there is no power relationship. Secondly, beneficence, the principle of acting with the best interest of the other in mind. The literature reveals that older people can feel invisible and not of benefit to society, participation in research may be life affirming and positive within older people's lives. Thirdly, non-maleficence which espouses the principle that "above all, do no harm," it must be acknowledged the subject of the research might evoke sadness, perhaps if someone is recently bereaved, or fear, if an older person has been or is in an abusive relationship. I talked through these potential issues with a group of safeguarding experts. In consequence the participant information sheet contained contact details for support should potential participants be distressed. The final principle is justice, a concept that emphasizes fairness and equality for individuals. This study involves a subject about which little is known and in broad terms older age is under researched. Older people have the right to a full life and the chance to pass on their knowledge, this research gave them an opportunity to share their experiences.

The participants who completed postcards or flyers did not receive an information sheet as they sent their contributions in anonymously and consent was presumed on the grounds that they chose to return the cards.

The first participant was keen to meet face to face and we chose a large local tea room and a quiet time of the day in order to avoid being overheard or to pick up large amounts of background noise on the recorder. Others who lived further away or perhaps wished for a higher level of anonymity chose to participate in telephone interviews.

Following this initial flurry the approaches then diminished. I genuinely believed that older people would be interested and I was so immersed in the research, as I had previously been so engaged in practice, that I found it frustrating and incomprehensible that people would not engage with the study.

One salutatory weekend I had approached a national online group related to older people where I had asked the moderator to post online a request for participants. I followed the events online as the weekend unfolded. The responses from the on line members were distressing, I felt I had got my approach so wrong, some of the transcript taken from the members follows below.

“Hmmm. I just musing about why and how this research project obtained approval. There is an assertion that 'this is very important to the quality of life'. Really? Who said so? And based on what evidence? I would have thought good health and positive relationships were much more important. And anyway, what is the hypothesis? What is this researcher hoping to prove? And what, in the name of all that's wonderful, does she think the outcomes would be? Sorry to go off on one, but I really do wonder sometimes about the usefulness and purpose of this 'research'. And as Mary so pointedly remarked above, in more elegant terms than this, IT'S NONE OF YOUR BUSINESS.”

I struggled to know whether to respond and explain myself but decided I wasn't a member of the online group and therefore had no right to intrude. Clarke

(2006) suggested that researchers should allow themselves to be exposed to the observations and sensitivities of participants in order to help increase understanding of the possibilities and problems of conducting qualitative interviews. Greenwood (2009) also explains that she found that older people, do not expect to be asked about their experiences or for their opinions about their health care. However, by seeking out groups of older people I was providing a clear demonstration that their views were being sought. While useful this online experience heightened my concern and diminished my confidence about the study. I also reconsidered the level of detail in explaining the purpose of the study when trying to recruit participants.

I continued to try and place flyers in areas that had a high prevalence of older visitors but many organisations refused, saying that the older people they were involved with would not wish to have the opportunity to participate. I began to see why older people would not wish to talk about sexual intimacy as the extremely vigorous level of gatekeeping by younger adults became manifest and re-affirmed ideas that there were negative connotations attached to older people having sexual relations. This is in direct opposition to Gledhill's (2008) work in Australia where she was able to display her flyers without apparent difficulty. An extract from my reflective diary reveals a little of my feelings at the time;

*“So surprised at the refusals to let me deliver my leaflets in county council buildings. Concerned I will never get any participants for the study. I think all students must feel this. I almost don't want to get a response for fear of what to do with it.”*

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Shortly after this particularly ill-fated weekend I was approached by an independent filmmaker who was commissioned by a major national television channel to make three films looking at sexuality and older people, I was pleased to be invited to meet with her and we talked about the research and how the television channel might be able to assist with recruitment if I ran some focus groups, they would also fund these events. The potential was wonderful for the research, from the beginning I was mindful and worried about the way



in which the participants would be involved and the exposure this would entail. I reasoned that if people chose to attend it would have been made clear they were going to be filmed and broadcasted and they were unlikely to be from vulnerable groups therefore my concerns were simply patronising. I spoke with my supervisors and we agreed this was an opportunity worth pursuing.

I had to resubmit my ethics application for amendment and spent some time preparing myself for running the focus groups. Over two months were spent in discussions with television channel and my employers who were also prepared to support me in collecting the data. Constantly I had a nagging doubt that this was not the right approach but the opportunity was too good to waste. Toward the end of the two months, following discussions and correspondence, the University Research Ethics Committee asked me to make some third party guarantees which concerned the activities of the television channel. These were not in my gift and simultaneously the producer asked me to increase the number of participants to over 100, in an attempt to “improve the statistics”. With great sadness I decided not to continue with the project for the following reasons;

- To recruit such a large number of people even if it were achievable would not give them any meaningful time to “tell their stories” and their comments would likely to be used as just sound bites.
- The university ethics committee request could not be honestly met
- The ethos of the producer was not congruent with the essential tenets of qualitative research

I believed for a time that I would never get enough participants and that my judgement in trying to undertake this study was completely flawed. Harris and Dyson (2001) explain that recruitment of older people to research studies can be a complex process, that it is important not to underestimate this difficulty and to ensure that the data collection period is sufficient. They state there is a need to continue to develop and refine recruitment skills and strategies to maximize the involvement of older people to research and whilst this work is old and was written about acute care, these issues clearly remain.

With this in mind I went back to the method and re read Anderson's (2011) ideas of trickstering, of turning the study upside down. I found that when I really considered engagement from a participant perspective the idea of speaking to a complete stranger about intimate activities was frightening and burdensome. I began to believe that the opinions of my colleagues and friends were right and the participants had to know and see me before they would engage in the study. It was as if they needed to check my motivation was genuine and to assure themselves that my interest was not prurient or disingenuous. I began to try and recruit people from groups I had involvement with and made a real effort to approach community groups which needed a speaker, so that I could talk about research in nursing and then suggest at the end that they may also like to be part of the study. This felt more comfortable for the participants but I worried that I was being dishonest in my approach.

I engaged in this different strategy and began to contact some the national groups that support older people such as Age UK and specialist buddying agencies. I was invited to speak at one session where older people act as support buddies to people with long-term conditions, notably respiratory disease and falls. This offered me an opportunity to share some of the information about older people's sexual activity in order to help the group respond to any questions from the people for whom they were acting as "buddies".

Appendix 3 provides an example of the handouts for the groups.

I was invited to speak to one group which consisted of fifteen older men and woman all of which had had health care "buddie" training and were aware of the content of the session. The link to the group had been made via one of my supervisors. I was really pleased to talk to the group as it allowed me to share my knowledge about sexual activity to enhance the support they offered to older people and it was in my area of clinical expertise which provided me a confidence in meeting and speaking with the group. The group all knew each other, having worked together for a number of years in a volunteer capacity. I set out some confidentiality guidance and explained I would be available for a

while after the session if anyone wanted to discuss the session. As with the leaflets and flyers I was mindful that people may have found there were issues that the conversation provokes that may need further discussion or explanation or even support. I was aware that is not appropriate to enter into an extended or counselling relationships with participants or people interested in the study. However, professionally and ethically from a deontological perspective I had a duty to signpost participants to appropriate support or interventions. I always thought about this prior to beginning a talk or indeed a presentation and let people know I am comfortable if, for whatever reason, they need to leave during my presentations, but if I am honest, I imagined that if people were attending the talk or presentation they would be broadly comfortable with discussions around sexuality.

With one group of older people I was invited to speak to I introduced the session and as part of setting out the ground rules, I said that conversations about sexual activity can create discomfort or sadness and I was completely accepting if people felt they needed to leave the room. Whilst speaking I felt able to hide behind a façade of knowledge and drew on my nursing skill in managing embarrassment. I asked the group to think about intimacy in the context of the lives of the people they were “buddies” with. I felt that this distancing from the topic and trying to view it through the eyes of other people might make the conversation easier for the group and perhaps myself, suggested that as they developed relationships with their “buddies” that the people they work with might ask them questions that they couldn’t pose to professionals. I explained a little of the research findings so far and briefly went through the main themes of the literature review. I went on to talk about normal ageing and common pathology associated with sexual intimacy. I used medical terms and then followed that up with colloquial names for the issues I was discussing. The interaction became lively and clearly provoked an energetic and comfortable discussion with the group members. At one point a man who had been talking with the group suddenly said “I have to go now” and quietly left, the group continued with the debate but did not say goodbye to the gentleman and I had a horrible sense of unease. However, I needed to

continue the presentation and really wished I had a research assistant or colleague to check on the wellbeing of the gentleman.

One member of the group felt it would be useful for “Drop In” sessions at local venues to allow people to have an opportunity to talk about their sexual health problems, the group spoke about how they might facilitate this with one female member saying she would be happy to go on some training to learn how to do this. The session ended on a very positive note and I offered to work with the group to develop some sort of ongoing support.

Afterward I was keen to engage with the gentleman who had walked out, to check on his wellbeing but as the other group members left he returned and spoke to me about his distress. He wished for an active sex life and his wife was, in his view, rebuffing his attention, we spoke about his relationship and he felt that attendance at Relate would be useful. Two other gentleman saw me at the end of the meeting, one to say he thought his wife had dementia and we discussed the possibility of a joint visit to their GP, with his wife’s consent, as they were regular attenders and had a good relationship with the GP. The final gentleman told me he had been sexually abused and had only recently disclosed this. He was having therapy and had some emergency contact details which I suggested he might use. He agreed to this. I thought about how brave it must have been for him to attend the discussion and how this might have been at odds with any therapeutic plan his therapist and he might have agreed upon.

These interactions increased my concern and I talked about the events with my supervisors. I found comfort in the words of Patel (2003) who explains that researchers bring with them personal qualities alongside their training and these can be extremely useful. Patel (2003) suggests a caring and compassionate attitude, professional ethics and attention to detail alongside the demonstration of respect, tolerance and tact are important. Experience in health services and familiarity with the specialist field and the population are highlighted as desirable. I knew from prior feedback that I could demonstrate these and I went on to reflect further about my role when using groups as a means of potential recruitment to the study.

These events caused me to change the magnification of my lens (Anderson, 2011) when looking at the subject. Instead of continuing to focus intently on the subject I was drawn to receiving more impersonal engagement from other age groups, thereby moving away from the intensity of emotion in the study. I became increasingly aware of the issues of gatekeeping, notably by children, or younger family members but also by the wider community, shopkeepers, moderators of websites and cultural establishments. I started to look at the literature around researching sensitive topics and gatekeeping. Perhaps this was about a personal fear about the difficulties of the research and a need for validation from professional colleagues and peers.

At this time two years into my doctoral course I was appointed to a national post which required a considerable amount of travel. I frequently found myself talking to older people on trains and at the conclusion of our conversations, usually because one of us was about to disembark, I was able to hand out a card which offered my details and a chance of speaking to me about the research topic. I was able to be more targeted in my approach as during the course of conversation I became aware if people were in relationships.

As a consequence of my new role I was invited to deliver a session at an event held by the Royal College of Nursing called the "BIG Question". The "BIG Question" is a forum to discuss research methodologies and methods with professionals from all disciplines and I had opportunity to recount my work and to receive both feedback and validation. As the event unfolded I began to think about how much discussion and energy my topic evoked. I began to believe this might be a way of engaging further participants, perhaps by offering to speak on my study. In discussions with a librarian at the event she told me about a technique used to teach students about artefacts called, "deep looking", which is linked to the use of senses in understanding objects (Chatterjee, 2010) she felt it had parallels with my work. I read about this deep way of experiencing objects which described a way of finding meaning in an everyday items, explaining that it is not enough to look at the external and material, it is about revealing its place in deep structure and requires a certain way of seeing. I was interested in the links and tried to practice this approach

on my original image chosen in Cycle 1 (Anderson, 2011). This return to my primary inspiration gave me some confidence and enthusiasm to continue.

My next approach was to engage with community groups which primarily served older people, this included organisations such as the Women's Institute, gardening clubs and support groups for older people. The responses were varied. Some group leaders were happy to invite me but frequently there was a tone of embarrassment and rebuttal were often couched in terms "I would love you to come but our members find it too difficult".

I was able to have an introduction to an older gay men's group and returned to thoughts of Simpson (2016) in matching interviewers to participants and I considered inviting a gay male friend to act as conduit in terms of language and familiarity, perhaps this was an attempt to protect myself from unease in light of the previous group meeting where so many difficulties were unearthed. I struggled to decide if this was ethically appropriate and finally decided to explore issues of language and activity with gay male friends as well as looking at both the academic and popular literature about gay male sexual intimacy.

An extract from my reflective diary reveals a little of my thinking at the time

"Meeting with a gay male friend tonight, hoping to understand a little more about terms, language and activities. I am anxious that older gay men may speak using language that is not transparent to me in letters or conversation. I will be happy to ask for clarification but I'm anxious that if I don't have a basic grasp of commonly used terms I will end up altering the flow of the conversation or interaction and this might be stifling or embarrassing. I recognised that each participant experience and language is different but I want to have a broad understanding to help them and me feel comfortable and relaxed"

Reflective Diary 27<sup>th</sup> September 2012

Interestingly, it was the easiest and most comfortable group I met with, perhaps because my own levels of sensitivity had been heightened or perhaps because of the extremely thorough preparation I had done or they were simply a very

easy group to speak with. Anderson (2011) explains that if the researchers approach is sufficiently well prepared the data collection will be informed by not only the intellectual process but by feelings and intuitive considerations and in so doing we and others will benefit from what is learnt.

At this point I needed more time to complete my data collection and with great reluctance I decided to request an extension in the data collection period from the ethics committee, who generously agreed. In planning my PhD journey I had added a few months for “slippage” and this provided some lessening of my concerns. At this point I had six in-depth interview transcripts as well as data from 40 participants who had provided written material in the form of postcards and emails. Subsequently, I recruited another two people who provided in-depth interviews and I had long discussions whether this was “enough” data. I looked at previous studies using intuitive inquiry which seemed to have the same number of participant interviews. All the time I felt angry about the issue of numbers, the study was never intended to be representative, the meaning of sexual intimacy is probably infinite, different people with different partners at different times, the options were massive. This study aimed to look in-depth at the experiences of the fabulous participants who came forward. My final conclusion was this is a PhD study, it is the start of an academic career, there is a pragmatism that has to be considered and eight participants were enough, but having tried to convince both myself and supervisors of this, intuitively, I felt this was not right, particularly the lack of input I had had from men. I had interviewed two male participants and six women so I was resolved to keep recruiting.

At the same time as collecting data I had been writing for publication. I had a number of articles published from the literature review I had undertaken and also had a couple of articles I had written with a colleague about skin and appearance in later life published. These articles provided an unexpected and wonderful outcome, I was approached by an older lady whose husband wanted to participate. This then resulted in two other male friends of his coming forward, finally I felt satisfied and relieved that I had 11 participants and nearly 50,000 words of data to look at I really felt this was all that was manageable for the study. The recruitment process provided me with some insights into

engaging older participants and I have provided some ideas for other researcher's within Cycle 5.

Pseudonym	Age	Marital Status	Venue
Catherine	82	Widowed Not living together	Home
Gloria	Mid 70's	Single Living Apart	Coffee Shop
Joan	74	Married Living together	Telephone
Phillip	75	Married Living together	Telephone
Jolene	77	Married living together	Telephone
Felicity	84	Widowed Not living together	Telephone
Helen	Mid 70's	Married Living together	Telephone
David	75	Widower Not living together	Home
Richard	Late 70's	Married Living together	Telephone
Fred 80	80	Married Living together	Telephone
Ray 79	Late 70's	Single Living apart	Telephone

**Table 2. Summary of the interviewed participants**

Below are details of the participants who provided written data, not all participants provided the range of biographical detail this may reflect their wishes to remain truly anonymous. However, I have detailed the information provided to give some insight into the participants.

Gender	Age Range	Marital status where known
Male n = 7	75-79	Married n = 2 Partnered n = 1 Unknown n = 4
Female n = 13	76 - 84	Married n = 3 Partnered n = 4 Unknown n = 6
Unknown n = 21		Married n = 0 Partnered n = 1 Unknown n = 20

**Table 3. Summary of Participants who provided written data**



## Data Analysis and Findings

Having collected and transcribed the interview data verbatim, I set about trying to organise it in a way that best allowed expression of the participant's voices prior to data analysis. Anderson and Braud (2011) explain that descriptive analysis and presentation of the data in Cycle 3 should be creative and that there are many possibilities in types of data analysis in intuitive inquiry. As there is no prescribed method of data analysis in intuitive inquiry, the research analysis should be led by the data. This means the researcher needs an understanding of a broad range of methods of data analysis. I was fortunate to undertake a postgraduate certificate in research training alongside my doctoral programme and this exposed me to an array of options in data analysis. Additionally, I had previously reviewed methods of data analysis whilst researching the methodology for the study including; discourse analysis (Potter and Wetherell, 1987); narrative analysis (Riessman, 1993), phenomenological data analysis (Wertz, 2011) and thematic analysis (Braun and Clarke, 2006). I had also read some of the work of Anderson's doctoral students who had used a variety of data analysis techniques including; thematic analysis (Dufrechou, 2004), thematic analysis with personal resonance (Hoffman, 2004) and edited transcripts (Esbjorn-Hargens, 2004),

In intuitive inquiry data analysis should accommodate the data that is presented, in this study it was anticipated that there would be a range of data mediums, for example, emails and letters and it was likely to contain key concepts and themes such that qualitative content or thematic analysis could be applied. Thematic analysis (Braun and Clarke, 2006) involves identifying implicit and explicit ideas within the data, recognising important moments in the data and encoding it prior to interpretation. The interpretation can include comparing theme frequencies, identifying theme co-occurrence, and graphically displaying relationships between different themes. Caelli et al (2003) caution that general qualitative research must address four key areas;

- The theoretical positioning of the researcher
- The congruence between methodology and methods

- The strategies to establish rigour
- The analytic lens through which the data are examined.

These principles were adhered to when analysing the data. The data were initially managed in two broad groups; the in-depth participant data and the data that came from the postcards, emails and flyers. As analysis progressed the resonance between the two types of data became apparent and intertwined.

### **Participant Interview Data**

The data from the participant interviews were prepared using descriptive summaries. Anderson (2011) describes one of her studies and explains that following transcription the participant interviews are read through a number of times for overall sense and meaning. The texts are then analysed and meaning units identified. Finlay (2011) explains that breaking data into meaning units makes it more manageable. A meaning unit occurs where there is a transition of meaning within the text. Anderson (2011) suggests the meaning units might then be sorted into thematic categories. She expands on this, stating that meaning units may need to be sorted and reconfigured a number of times. This may be done using computer edit and paste functions or, as in my own case, by physically engaging with the text, cutting up the text and rearranging it on larger paper or surfaces. Again Anderson (2011) encourages an imaginal dialogue with the text and explains intuitive breakthrough insights might emerge.

Anderson (2000) describes a set of specific research skills needed for the intuitive researcher;

- Trickstering
- Indwelling
- Varying magnification
- Incubating the data
- The importance of the audience

Anderson (1998) explains that “Trickstering” can lead to a sense of auspicious bewilderment which Romanyshyn (2007:297) describes as “a moment of being stopped by the text, puzzling over a passage are a way in which the text is wounding the researcher.” Anderson (1998) goes on to describe a period of “Indwelling” as an intuitive research skill, drawing on the work of Moustakas (1990) and describes a process of turning inward, to seek deeply. Moustakas (1990) suggests it is to gaze with unwavering attention and concentration. Indwelling is a process that is conscious and deliberate but not lineal or logical. It encourages the researcher to find clues in everyday activities, to look for chance and serendipity. To date my own study has found clues in films, radio programs, fiction, friendships and music. Once clues are found, one dwells inside them and considers their meaning and associations. Anderson (2000:14) believes that “some of the most productive encounters are the most confusing and bewildering, compelling and arresting images may become gateways for greater understanding”. An additional skill explained by Anderson (2000), whose original work as a scientist made her familiar with microscopes, describes looking at a slide using “varying magnifications” which made objects change. It is the difference between seeing in detail and seeing globally, this is a theme running through the analysis of data. The researcher needs to decide how much detail is required, at any given time, to understand the findings. This alternation between micro and macro analysis, can form and confirm new understandings about the data. Anderson (2011) explains that through immersion in the mundane researchers may be driven into dead ends, but paradoxically this can unlock the bigger picture. The skill of “Incubation” is a time when the researcher rests from the study to allow the intuitive process to unfold, Anderson (2000) suggests that it is easy to minimise the importance of relaxation when considering the data within a research study but this incubation can be key to discovering new understanding.

The data were then organised and summarised in this study using thematic analysis and individual descriptive summaries. The summary reports are the preparation for the Cycle 4 lenses and allow the reader to review the data in a descriptive form, free from deep analysis (Anderson, 2015).

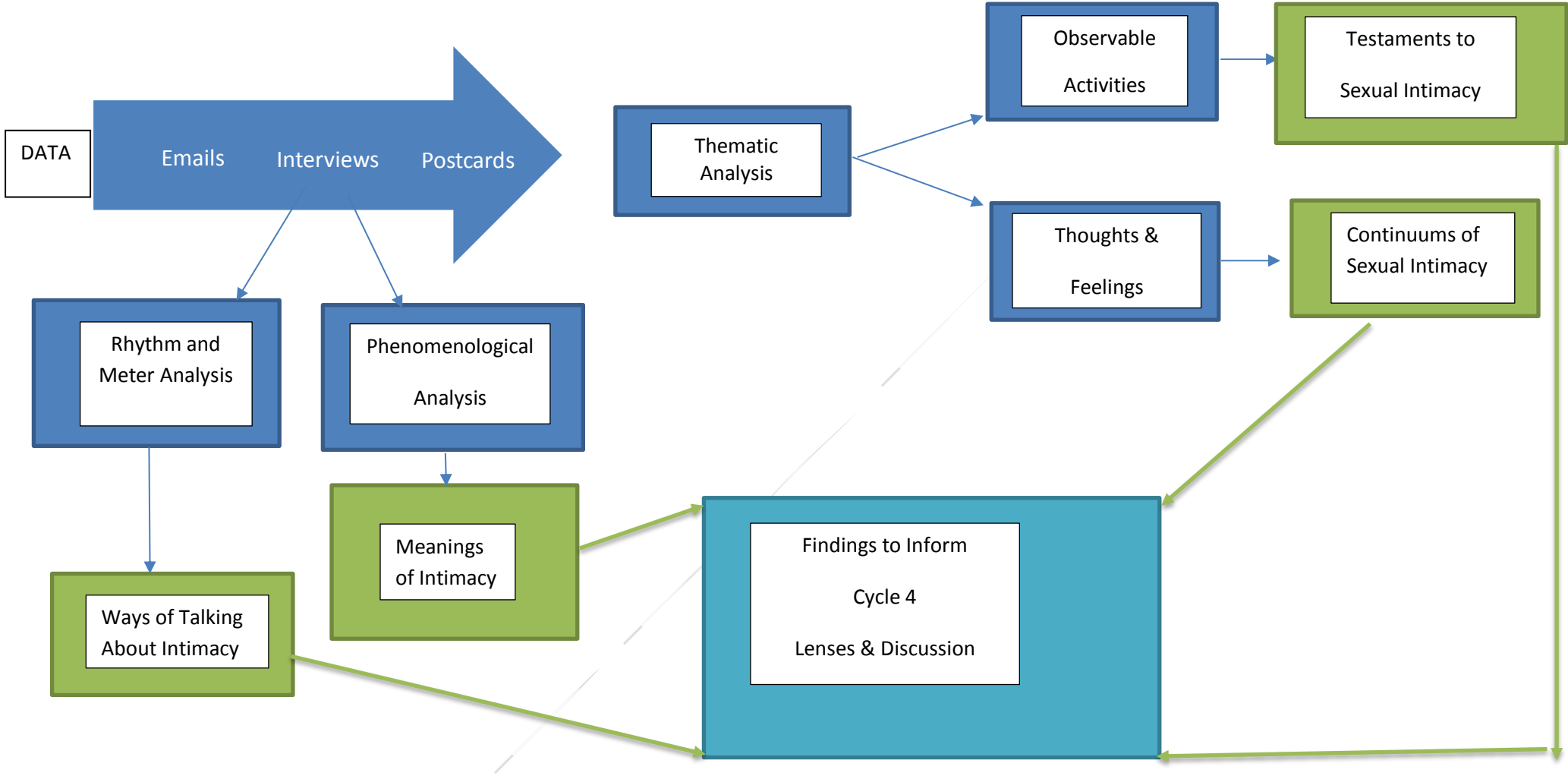
Intuitively I knew there were a number of ways I could summarise the data but as I had spoken with the participants and read the cards and emails I became aware of different qualities, from the superficial almost flippant and humorous, to painful in-depth spoken revelations.

I had read about the breadth and depth of qualitative analysis (Todres and Galvin, 2005) and this met the needs of the data well. I chose a broad thematic analysis to provide an understanding of the wide ranging content, initially the data revealed two broad components, observable expressions of sexual intimacy and the thoughts and feelings of the participants. The thoughts and feelings fell into continuums.

I chose a phenomenologically inspired analysis of the in-depth data which comprised eleven in-depth interview transcripts. In addition to the phenomenological understanding of the subject the interview data revealed a “rhythm and meter” that was discernible from the way the participants spoke about their experiences of sexual intimacy and this will be also be reflected in the findings.

Diagram 6 provides a visual representation of these four aspects of the data analysis and the resultant findings.

Diagram 6 Diagrammatic representation of data analysis and resultant findings



## **Thematic summaries**

I analysed the data looking for themes that emerged from the transcriptions of interviews, emails, and post cards. Any data from people that fell outside of the age range of the study was excluded, the exception being one person who was 74 as they would have met the age criteria within the period of data collection.

Written data from postcards and flyers was often easy to interpret as the information was pithy and short.

The transcriptions of the participant interviews required a higher level of discernment and I frequently returned to the transcript to ensure I understood both the meaning and the context.

## **Observable Acts - Testaments to Sexual Intimacy**

The first aspect of the data that emerged was the participant's testaments to sexual intimacy. These were the physical manifestations of sexual intimacy, the tokens and actions that others would see or perhaps might see if they looked closely. Some actions, kissing, holding hands, cuddling were displayed publically, others, such as cross dressing, frottage, penetrative intercourse were physical manifestations not intended to be seen by others. This section shows the ways in which the participants demonstrated the physical aspects of their sexual intimacy. Where the participants have told me their age or gender I have acknowledged them, where they have given me a name I have used a consistent pseudonym for that participant. In displaying the data I tried to move from the "gold standard" mind-set, to accept the testaments to intimacy from the view point of the participant. I present these revelations as if walking down the street, passing the couple or a chance glance into a window, the words created visual images and I have included my understanding in the form of photographs and paintings. These are images freely available from websites and personal photographs.

The activity most mentioned was being close, closeness was physical, emotional and spiritual. Here I have displayed those aspects of closeness that would be tangible to the observer, the personal experience and dialogue

around closeness is demonstrated in the sections of the data that follow in testaments to intimacy.

### Being close



Being close has many aspects, here the participants have explained in the context of a testament to sexual intimacy;

*“you know sharing the days that’s really what is a big part of intimacy, you know I had something close like I had that with Alan, to say I love you”*

David 75

- |      |   |           |
|------|---|-----------|
| Card | <i>To always greet me with a smile and a friendly word</i>  |           |
| Card | <i>Closeness and cuddles. Enjoy spending time in each other’s company</i>                             | Female    |
| Card | <i>Very important feeling close in all ways , cuddles and hugs, able to talk about anything</i>       | Female    |
| Card | <i>Always being able and available, totally with my husband even though he is physically disabled</i> | 78 Female |

Card *Physical closeness- someone to hold at night and to hold me*

Card *Being close in all areas not sex* 77 Female

The participants use the word “close” to portray many meanings; physical connectedness, emotional resonance, comfort, availability and intellectual nearness.

### **Cuddling**



A number of participants talked about cuddling as proxy for penetrative intercourse;

- *Intimacy to me is physical affection, hugs, cuddles and kisses. We can no longer have sex as my husband had a very radical prostate operation 3 years ago.*

Anonymous Card

Others described being close as way of maintaining sexual intimacy and reinforcing affection;



*“Having a regular cuddle / hug the power of touch even a casual tap in passing reinforces affection.”*

Anonymous Card

*We cuddle all the time I would miss the touch and tender feeling*

Anonymous Card

*“ And yes something about a curve body that you snuggle around isn’t there... intensely comforting and relaxing if people want to this then I think we should be aided and abetted as much as it can be...”*

Helen 75

Cuddles also seem to be a precursor for further sexual activity, perhaps classically labelled foreplay.

Card *Intimacy between two people, touching, kissing cuddling massage, masturbation, bodily contact undressed*

Card *Sexual intimacy is not very frequent but still enjoyable. Cuddling in the morning is very important* Female

Card *Feeling able to communicate with partner about cuddling and enjoying each other’s body. Not being embarrassed about touching and kissing. Continuing to do the things which we did when we were young*



## Kisses

Like cuddling kissing takes on many dimensions and has many intentions but kissing is the most socially acceptable demonstration of intimacy, sexual or otherwise,

Kissing can recall past pleasures;

*“ yes I think so, there’s a number to me if I hold Pam’s hand to me that’s sexual, if I put my face against hers to me that’s sexual we have a dum diddly um dum dum... and then I kiss her, which we have always done since, since we were young and if I do that know she starts laughing”*

Richard late 70’s

And perhaps obligations;

*“but he’s not em a demonstrative person. . . . em he would never leave without giving me a kiss”*

Catherine 82

The descriptions of the kisses both public and private reflect the stages of the relationship and the couple’s interconnectedness.

## Music and Dancing



There were a number of social activities that the participants discussed that they viewed as sexually intimate occasions. Dancing and listening to music were seen as a source of sexual intimacy. Sometimes causing tension between partners;

*“and he knows she goes dancing with this chap, she like dancing, and he took her to a dance somewhere in the town, he sits there and she doesn’t get asked for a dance because he is sat there”*

Gloria Mid 70’s

And sometimes opportunities for flirting;

*“yes we like listening to the you know 60’s 70’s music you know the old . . . you know petticoat music..... we like to listen a lot to that and to love songs on a Sunday morning on the radio we like to listen to them “*

Joan 75

*“the weekend it’s a class or something, next Tuesday I go there, there is a dishy man who makes you a cup of tea.”*

Gloria Mid 70’s

The ability for music and dancing to connect directly with the participant’s reminiscence of intimacy may reflect the activities of courtship.

## Laughing



Laughter was often mentioned as a way of engaging with each other;

*“Oh you know poking, tickling, joining in with the dog making him jump on him, perhaps get hold of him in the kitchen and have a silly dance that type of thing . . . . when the mood takes me”*

Joan 75

*“Laughter is one of the biggest things in a life and in a relationship . . . whether it is a good one or a bad one you can still make it liveable,*

Jolene 78

Email *It’s not always about sex. Sometimes the best intimacy is where you lay back and laugh at silly things, hold each other and enjoy each other’s company* 77 Female

*“to me laughter and love are the key things you are left with.”*

Richard late 70’s

Laughter runs through the participant’s lives with their partners, sometimes uplifting them and at other moments as a way of managing difficult situations.

## Sexual Intercourse



Revelations around intercourse ranged from passionate new relationships to enduring longstanding partnerships;

*“So I think that’s the big thing about intimacy it’s the emotional side as well as sex, sex is nice but it is the icing on the cake!”*

David 75

*“Yes um it’s not half as much as it was all those years ago when I first met her”*

Ray 79

Card *Full sex would be great but I am less energetic than I was so once or twice at a go is enough talking, hugging , cuddling, stroking, sweet nothing are all JUST AS IMPORTANT as full or part sex though. I have always needed a lot of foreplay and now that can take the place of full sex. Alone time together is also important, bondage and D/S are acts of intimacy too. Just telling or being told things in a D/S voice is sexy even making the bed or the washing*

*“oh yes absolutely, arhhh in fact full anal sex er that has to be with somebody that I have known for a while and trust them or em I know their status as I want to be safe, I do have quite a stock of safe sex*

*packs, laughs but to be honest other than anal sex, the other can be just as satisfying. “*

David 75

Sexual intercourse is perhaps the most obvious expression of sexual intimacy discussed by the participants in many variations.

### **Being Naked /Skin to Skin**



*“We have always gone to bed with no clothes on we always slept naturally and what I’m finding now is that to just be able to cuddle Polly in bed um usually her backs towards me and usually I just lie there and cup her breasts in my hand and just lie there and we fall asleep and she just finds that very comforting too,”*

Fred 80

*“well ok, er well I suppose sexual intimacy is very important, we cuddle we hold hands we kiss , we always sleep with nothing on, so we cuddle up, we appreciate each other, that’s very important”*

Phillip 75

Card *Intimacy in my life is essential but not necessarily penetration, anal sex. Touching, cuddling, feeling, kissing etc., all important. And closeness and nudity.*

Male



## Sexual Paraphernalia

### Cross dressing



*“er yeh ,and then again another big area that, there has been more and more prevalent is the cross dressing yeh that’s it yeh yeh which I’m fine with I have no problem with it, in fact to be honest that’s something I enjoy myself... laughs”*

David 75

Card *Holding hands , cuddling on the couch/bed, massage doing things together e.g., going for walk eating*

Male

*Kissing, snogging, access to erotic magazines , internet access to erotic sites and helps to visit a gay bar/group*

Card *Healthy emotional relationship with opportunities for sex within physical and leisure pastimes. Also groups with gay interests to promote reminiscence and memory recall*

Male

Card *Outside Sex*

Anonymous

This section has drawn out the data which has described sexual intimacy in ways that could be seen by an observer, the data has been taken from both



the in-depth interviews and the cards that were sent in by participants. These findings will be discussed in Cycle 4 in conjunction with the literature and my own reflections on the findings.

### **Continuums of thoughts and feeling about sexual intimacy**

The second presentation of the data was the emergence of continuums. The transcriptions and cards were read and re-read. The data were then grouped into broad concepts, for example, “not seeking professional help” or “the description of a positive sexual life story”. Having looked at the data for a period of about ten days I suddenly had a moment of clarity as for each piece of narrative there seemed to be an opposite and contrary view. Anderson (2000) explains that throughout qualitative data analysis and particularly in intuitive inquiry the most important feature is intuitive breakthroughs when patterns seem to shape themselves and the data reveals new information. The emergence of the continuums happened after the data had been grouped, I was anxious to ensure I was not forcing the data and revisited the transcripts and cards for confirmation of context as well as the words. Over the next few weeks this analysis developed in continuums upon which most of the data sat.

The next part of the chapter maps the continuums diagrammatically and is then followed by relevant data being presented on each continuum, again as with the “testaments to sexual intimacy” these findings will be discussed in Cycle 4 in conjunction with the literature and my own reflections.

## **FIRST LEVEL CONTINUUMS – BROAD THEMES**

**Negative sexual life story**

**Not seeking help when difficulties arise**

**Clandestine expressions of sexual intimacy**

**Sexual meanings attached to events**

**Relationships remaining stable**

**Not able to discuss sexual activity**

**Embarrassed about own sexual intimacy**

**Keeping lovers separate**

**Disturbed by ageing**

**Muddling through**

**Inequality of couples sexual expression**

**Dating**

**Positive sexual life story**

**Feeling comfortable to seek help**

**Demonstrative public expressions**

**No sexual connotations to everyday events**

**Relationships rapidly evolving**

**Able to discuss sexual intimacy**

**Content about own sexual intimacy**

**Fusing as a couple**

**Relaxed about ageing**

**Striving for the gold standard**

**Equality of sexual expression**

**Maintaining a relationship**

**Disapproval from friends and family**

**Confines of poor health**

**Changing residence**

**Financial tensions**

**Not using sexual paraphernalia**

**Approval from friends and family**

**integrating health changes**

**Holding on to home**

**Financial unification**

**Using sexual paraphernalia**

What follows are examples of the data that sit along the span of each continuum. The data is simply presented and carries neither comment nor interpretation.

**Not seeking professional help**

**Seeking professional help**

*“no I wouldn’t it, wouldn’t be a family doctor like they used to be, it would just be a different person each time you go to a doctor it’s very rare I go”.*

*“ No, no its fine cos, because it is an LGBT friendly practice, in fact we have got poster up from (local gay group) in most of them around here they do sometimes have a Pride in Practice, if fact yes, in fact where ever possible it is the same GP that my partner had.”*

David 75

Card *Medical assistance needs particularly for promotion of orgasm*

Male

*“Yes I would read it in a book or magazine, I would I would read about that type of thing but it isn’t something I talk about.”*

Joan 75

*“Oh yes I certainly would talk talk to my GP .... I suspect I would, I would make sure the doctor was a male doctor.”*

Phillip 75

*“No I don’t think so, so long as the person involved was competent and professional.”*

Helen 75

**Embarrassed about own sexual intimacy**

**Content about own sexual intimacy**

*“was my education it’s unfortunate that because for most people of my age, sex was dirty, and whenever you did it although you always enjoyed it, it was a bit you know yuk....”*

Richard late 70’s

*“um sigh, just be yourselves, play it by ear, do what you feel is natural, if it don’t feel right don’t do it! It’s silly getting involved in something that is not going to work even if there is a load of sex, that’s only going to last for a while.”*

Ray 79

*“Buying stuff? (lubricants) perhaps embarrassment, yes, particularly when you are older, people look at you.”*

Joan 75

**Not able to discuss  
sexual intimacy**

**Able to discuss sexual  
sexual intimacy**

*“Er no not really, it’s rare the subject comes up .....um I don’t think everybody is, I think there are couples that stop early, you, you know there are other who carry on as long as they can but if it came to it, I would talk to people in the pub or whatever it um, I don’t bring the subject up, I don’t go down there and say cor we done this last night and all that... well it’s been known some men do.....that’s right yea, yea, we had an old couple down the pub Saturday night 85 they were ....and she says oh he wants his sex when we get home !”*

Ray 79

*“you know it’s really a lack of a moral level now that is making it difficult for people like yourself and organisations to know exactly what everybody wants, you know if you go back to my young day I was born in 1940 and I can remember one boy in our school who tried it on and he couldn’t get up and you know everybody.. Gasp .....everybody oh wasn’t it awful you know and that was it, and you know my situation, I*

*didn't know A from a bulls foot. You know all this information at very young ages I think it's overload, you know the with the internet, the personal thing, we have got all the information near to hand television and basically."*

Richard late 70's

*"I have a friend down in town where Alan came from, after he moved and he's completely open about the sexual side of it. The one from village he's not, er I mean he accepts his sexuality, but I mean he keeps very ..... nobody on the outside of his circle."*

David 75

*"No No . . . I wouldn't discuss that (sex) with anybody."*

Joan 75

*"Oh let me think. . I don't know it, it's very hard to know what other people get up to, whether other old men of my age are sexually active laughs, if they are I sometimes wonder whether others stop earlier, and whether they regret it and so I sometimes. .and it seems to be a slight lack of information and whether they would know what to do about erectile dysfunction etc. I guess it depends on whether the woman climaxes"*

Phillip 75

*"My feeling was that the study was very interesting in its own right and was probably something that was largely, um ignored in the medical field and so I just thought I was very happy to go ahead with it if I can be of any help."*

*"um yes I do think older people are reluctant to talk about it. I think sometimes they feel that is maybe not appropriate and who would want to listen to it.....I think they do, they may hedge around it in very general terms um..... I'm not sure this is entirely confined to older people."*

Helen 75

**Negative sexual life story**

**Positive sexual life story**

*“So therefore I had very heavy female influence, but not much of the male. I was very much brought up a catholic where you know you can’t do anything, you can only have sex when you are married and it gave a feeling of sex being dirty.”*

Richard late 70’s

*“No, No I hadn’t a clue”*

Joan 75

*“I must add that Polly has had as a child a very traumatic life um with a family member she was abused. And this has affected her sexual response , there are positions she doesn’t like .....it really is quite traumatic but having said that she has grown through that,”*

Fred 80

*“and you know that idea that when we get married we will have to sex every night, you know when young people ask me or talk to me about it, I say look you go on as though...you know you will wear the bloody thing out....you know I really am straight forward and I say to them.....you couldn’t keep it up, it becomes part of life you know if you haven’t got a friendship you haven’t got anything, you know you might as well go on and sort of hire prostitutes”*

Richard late 70’s

**Clandestine expressions of sexual intimacy**

**Demonstrative public expressions sexual intimacy**

*“No no, my view is that Pam is there and whenever carers come in, and we have continuity, our carers have been with us for four years and I will give her a kiss and I will say, sorry carers but I love my wife.”*

Richard late 70’s

*“not, no it would depend on the other guys attitude but for the most part ah no because well Alan and me we first did we, ere, all like lovey dovey*

*inside the village, but then it grew down we didn't do it very much we would have a good snog just the two of us, but fine no but um, I think nowadays even though, erm, it's supposed to fine with society although there is a question mark over that its whether it remarked on or not."*

David 75

*"Oh yes . . . banter, a lot of banter oh yes, when I play cards with a group, we have a cribbage night I walk in there and they go, oh god she's here again what the hell are you doing here get out on the corner and make some money! Or they'll come up and give you a hug and kiss oh my honey I haven't seen you for so long, nobody gets shook up about that."*

Jolene 78

**No sexual connotations to everyday events**

**sexual meanings attached to everyday events**

*"Its little things you do through the day, you have a quick kiss or something put your arms round each other um just general being with each other, you don't impose on anyone it's just casual whatever happens."*

Ray 79

*"They just pretend they want a dance partner, that's just what they are, they would love to meet someone."*

Gloria mid 70's

*"Oh I said if he wants to stay he can stay and he did but he got and I think to certain extent he got pleasure out of seeing me . . . . ."*

Catherine 82



*“Yes I think I do, I don’t think . . . yeh we have, er more time together than we did when we had all the children about, em er and he’s not worked for a long time so we have been together constantly for quite some time, sighs er sometimes life just gets boring”*

Joan 75

*“Yes I get, I suppose so, I mean obviously we look at things and think oh yes we had a dirty weekend there or such like but that doesn’t happen that often and er . . . because we have the real thing we, we have memories of the past but we don’t kind of dwell on them a vast amount, em and other activities like playing badminton together or looking round old towns em are not particularly sexually charged . . . we might be holding hands together etc. I suppose you might think there is some physical thing about that but that’s not not . . . .”*

Phillip 75

**Relationships rapidly evolving**

**Relationships remaining stable**

Card – Given verbally and verbally consented and written down whilst travelling  
Male 75

*“We just go with the flow, we have a symbiotic relationship, every year we have a summer break it gets rid of the sadness and the gloom. Everyday whenever I get in I say hello darling and I give her a kiss. We don’t have sex anymore but sometimes when we are in the kitchen I will creep up behind her and give her a cuddle, it’s important, it keeps our marriage alive when we watch tele I always sit down and hold her hand.”*

Richard late 70’s

*“I rang Ian who runs the club, to see if any rooms were coming up and he said oh that Tom he’s coming and I thought . . . . I said to Mavis, she’s 85, if anything’s funny I’m coming back to a mattress in your room and she said what a holiday you are going to have! . . .”*

Gloria Mid 70’s

*"We had together to very slow dances and here's the stupid thing there no way, but I could manage and I look at him and I said do remember when we could really do this? And he said pah I'm all cracked now it was though a connection . . .we hadn't danced for many years but we weren't dancing like we normally would you know we were really together . . . .it more tolerant , than were we grow up we try to look after each other "*

Jolene 78

*"Well the idea really is....similar interests and a big I think ... a big thing is is ....er trips out together ...walks or you know, know , just going for a coffee something like that, er that was one of the issues with er the guy I that was seeing he was from town, um a 39 year old I reckon he was not going to get round to it, it no was, was all too many issues but that was one of them and I .....er yes he was just coming over here, arr ok we had nice chats and that but there was really nothing more developing than that..."*

David 75

### **Disturbed by ageing**

### **Relaxed about ageing**

*"Yes, yes and I thought he would be thinking I was younger than I am and think oh, and I thought he would be upset and think I'll get rid of her, that's my main thing you see."*

Gloria mid 70's

*"I do like, to be honest a young guy preferably, but it's not the be all, when I say this and end all, it's nice if they are younger er and I guess what you might call a toy boy. There are guys that always prefer an older man there is a niche, where they do like the older men"*

David 75

## Keeping lovers separate

## Fusing as a couple

*“It’s something you’ll never in you will never in your born days you think you will do but it’s something. . .I’ll never regret doing it. No two people look through the same lens but you can get the same idea what the picture is, it was pretty good.”*

Jolene 78

*“They like to have someone to come over or to go shopping with . . . but they don’t want to get married, they just want a “booty” call!”*

Jolene 78

*“Yes I never ever told people I had a a . . . I kept a little bit back I think it pays . . .to be a bit discreet.”*

Gloria Mid 70’s

## Muddling through

## Striving for the gold standard

*“No I think it overcomes the pain..... you get it in your mind and that’s all that matters at the time...obviously if you have a broken leg or sumink you have to slow down”*

Ray 79

*“Yeh I think we have a good relationship....its ..sigh I suppose the sexual side is as toned down from what it used to be”*

Fred 80

*“She saw that I had had a shave and she gave me a great big cuddle, waggling her hips at me and pushing me and all her sort of excitement ... but of course it was the wrong time if you like, but there that’s sort of mood in her dies down and I think that over years I’ve learnt to temper my desire .. sigh .. I presume it the ageing process where my sexual desire is actually weakening...”*

Fred 80

*“But you see he has he has only got a tiny little bell . . . But to me it was quite . . .but he was crying and screaming and its . . . all soft but it was a really good night..... laughs”*

Gloria Mid 70's

*“When we were first friends um well sex was like disease you know we were at it all the time”*

Catherine 82

**Disapproval from friends  
and family**

**Approval from friends  
and family**

*“Um and there was a problem with my youngest daughter and she thought she didn't like her.....“she knew it wasn't someone I'd just found, I known the family for a long time,”*

Ray 79

*“Mark said was “I'm pleased that its Uncle John if it had been a stranger I would have been very hesitant, because its Uncle John I can accept it em.”*

Catherine 82

*“Well I think your children want to carry on safely in the notion that the only time you had sex was when they were conceived and they carry this ....”*

Helen 75

**Inequality of couples  
sexual expression**

**Equality of  
sexual expression**

*“What she, she did, she said oh, she was complaining about this chap, well quite a nice chap, she said he'll come but he doesn't get there before seven, he's the other side of town than he'll go oh its nine o clock*

*now. Good Night and its got like that . . . .and she says I'm not getting anything from it at all."*

Gloria mid 70's

*"I think so, yeh and um and in the last, I suppose the last eight or nine years apart from the kiss, em he would occasionally if we were out . . . .or I would get hold of his hand but he never did it to me unless he sought of . . ."*

Catherine 82

*"Oh we do have sexual contacts ....oh a couple of times a month, maybe it's enough for me I think my husband would like it more."*

Joan 75

### **Dating**

### **Maintaining a relationship**

*"I specifically asked him about what the attraction was, whereas with the older age group and he said he found that the older ones weren't as promiscuous as younger ones and I think the er the maturity they have a more mature outlook on life"*

David 75

*Card Male -"In seeking future partners would be looking for middle age group who are slim."*

*"Well my wife was still alive and when she passed away, I didn't see her and then her sister said come round for Christmas, well I never mix business and pleasure and I had worked for her sister but well I gave in, she said my sister will be there and a couple of others on their own, er but then it took a long .. quite a while I saw her New Year's Eve after that and the er Valentine's day er .....I think you have a lot more experience of the world, of people and things like that um yeh I don't know, yeh"*

Ray 79

Card      Essentially I seek in the first instance a platonic companionship with a potential partner. As long as we remain friends then anything more is bonus.      Male 85

Card      After 54 years married we have experienced almost all aspects of intimacy, both sexual and platonic. As we have aged the sexual side has only slightly diminished and platonic love has increased.      Male

*“So he came with us for this erm birthday meal and he just didn’t want me to . . . come home, (said quietly) he wanted me to stay . . .”*

Catherine 82

**Confines of poor health**

**integrating health changes**

Card      No sexual intimacy as such because of 70’s operation on partner which stopped that. it would be nice just to have closeness      Female

*“I think you can say that from being seventy I think because he couldn’t manage sex erm ,because he did have prostate trouble, I think this was his way of he just never talked about it he never said anything . . .”*

Catherine 82

*“So for example probably about 4-5 years ago my husband had to have um a prostate operation ... a TURP ... and the consultant was great he said beforehand you know there maybe erectile problems I can help with that.....and so that was nice and then subsequently talking to other men and other couples and I have been quite up front about this um and they were very interested to know, it seemed to help because they*

*defin... I think women tend to talk about things like that more readily than men do ... does that make sense"*

Helen 75

*"but he has he has problems with . . . he's a diabetic and he has problems with . . .*

*Researcher – erections?*

*Yes . . . and I find it painful as well so . . ."*

Joan 75

*"Terry had prostate cancer and after he had that cancer operation he had no desire."*

Jolene 78

*"Yes when he first had surgery I think they got it all, I think they caught it early enough er his doctor was one of the best, he did prostates and his wife did breast cancer! They were quite a team. But he told Terry when we went back for our check-up he said this will affect your sex life and Terry look and said at my age why should I care" and the Doc looked at me and said you could slip him a certain kind of pill! And I said if the spirt isn't willing why bother. The doc said just find yourself a nice discreet boyfriend."*

Jolene 78

*" Of course it is my view is , over the 42 years we have been married and over those 42 years if you love one another and stand by one another you grow closer and closer and closer and I find that I, you know, I really am closer to Pam, I mean she was diagnosed in 2008 er but she she's had it from 2005 and it is only now , of course you know as well as anybody that Alzheimer's in young people is very rapid and you know she has done I think a good ten years and therefore the consultant says she is at the end of life."*

Richard late 70's

*“..... a couple of years ago I got ..oh god It can never remember ...is it lichen ... sclerosis...so I lived with the itching and went to see her she was brilliant and when I went for my check-up she said everything looks fine, everything looks nice and moist and she said then do you have any problems with intercourse, so I mean she raised it and I would have been very happy to tell her if I had but I didn't have...”*

Helen 75

“What is sexual intimacy – low libido

Too tired not feeling sexy – not wanting to show my body card

### **Changing residence**

### **Holding on to home**

*“Well, um we thought of living together but when she was working she had she needed so much space and I wanted a lot of space and we couldn't find anywhere suitable”*

Ray 79

*“When I was in hospital the last time, mine said to me have I ever thought of moving from here and going into a sort of group dwelling like thing, em where there's a em a lounge em and I have thought about it since, no this is mine er they are all private, eh I own this place and I am quite happy here I do miss company em I have been quite busy this morning with company and one thing and another which has been nice”*

Catherine 82

*“And I say there is no way we would have moved in together or if we had moved in together I would be moving into his er and he would have been in charge of it, his family would have been able to walk in at any time open the fridge and say “oh you have got nothing much in there for me to eat” oh yes I fancy that and just eat it, my children have had to knock on the door, this is how I felt, em it was a em it is clear open*



*friendship at all and I don't think he realises that, I am pleased we haven't moved in together I am pleased we kept our own places"*

Catherine 82

### **Financial tensions**

### **Financial Unification**

*"I felt that it he is not a generous man at all em and it was only occasionally if we happened to be shopping together t . .it would be "I will pay for that, but that would only be once in six months but I was paying everything and this was something else I got to sort of two years ago I have been taken for a mug here, it's costing its awful to say it I know, but I have got more money in my purse now then I have had for a long time because he had accepted that just pay for everything"*

Catherine 82

### **Not using sexual adjuncts**

### **Using sexual adjuncts**

*"I think so yes I'm not keen on taking tablets or medicines but you know if you had to, I would do , I don't them willy nilly you know some people do just for the sake of it more or less..."*

*Researcher- if you needed something like viagra would you get it from your GP or the internet?*

*"No, no, definitely not, that is something I wouldn't do you just don't know what you are getting..."*

Ray 79

*"But if I need anything else I go into Clone Zone and that ....*

*Researcher – do they do deliveries?*

*David – yes they do actually and clothing as well I get that on line,*

*Researcher –Do you get that from a special site?*

*David – No, usually places like Marks and Spenser, Primark, occasionally on line there are some specialist er sites as well, for shoes*

*it would always be a shop so you can try them on for stuff like underwear sometimes there are sites you can bargain*

*Researcher – specialised clothing like rubber or leather ...*

*David – Oh yes, yes anything like that..... in shops.”*

David 75

*“Well of course if they don't tell and you don't tell the other one what's wrong um make excuses...then it doesn't do any good does it ... well if Rachel's got a problem she'll say keep away until we have sorted it out....yeh there is various things you can do...referring to the KY jelly you go and buy that cos that's over the counter its not on the internet. I wouldn't buy anything like that off the internet.”*

Ray 79

*“ I used to work in a private pharmacy and I don't know how or why but his son got some Viagra, he was working in London all the time em, I know he did have problems in that area what it was I don't know and he gave his Dad some and John was using one and he*

*Researcher – did it work?*

*Catherine - No bloody thing no and I know I don't know if I have still got in my draw but I found some and I thought oh my goodness I said to him now and he said now what are talking about but if I said to him a few years ago about it would say no it didn't do any bloody good.”*

Catherine 82

*“There is a limit, there is a limit of of medication to four tablets per month, at first it was Viagra which actually didn't work and I did have to pay for them on private prescription but linked to the prostate as such they switched me over to the NHS*

*Researcher- Now how many can you have a month?*

*David –Four, there is there is technically a limit four which is fine, though having said that there are times when I can get an extra, at first I did have to pay for them*

*Researcher- Do you get through the internet or through your GP.*

*David- GP I would never get it off the internet no no any medication full stop is strictly via GP but medication a different matter if it like vitamins.”*

David 75

*“Interjects the answer is yes that I would but I wouldn’t just go along. I wouldn’t go on the internet and buy some Viagra.”*

Phillip 75

*“.....um Martin accepted Viagra fortunately he turned out not to need it given time...but it is there as an extra.....and I was very glad about that because we do have sex... I have a doctor who’s female and she’s brilliant ... I’m still on HRT and I’ve told her that I intend to die taking it! I looked her firmly in the eye and said ... you wait till you get to me age...then you might and she laughed, so I still take HRT and I don’t have any problems with sexual intercourse”*

Helen 75

Card Tamoxifen has caused reduced libido for me. Female  
Vaginal dryness is sometimes a problem, if I was in a care home I would like to have time alone with my partner. Sexual intimacy means close cuddling and touching and talking as well as having sexual fulfilment.

Card We can no longer have sex as my husband had a very radical prostate operation 3 years ago.

*“Oh yes she is still my Pam, we have a picture of our wedding on the mantle shelf right next to Pam and I see the girl in the picture, I don’t look on her as a poor person, the thing I found isn’t your patience is*

*automatically increased .... I am happy in doing what I can that I can protect her and comfort and go on the journey”*

Richard late 70's

*“er hip replacement, it was a hip revision, it was a very very, long operation, in fact, I was scheduled to be in theatre for two hours I was in theatre for four and half...and um its only know I am learning from the surgeon what he actually did to me, you know he literally took my femur apart to get the old prosthesis out ,in order to get the new one in Laughs ...therefore in terms of sexual relationship with Polly it's been non-existent “*

Fred 80

*“But um ar we actually we are I feel better it's been 4 months since the operation um I'm walking ok now, so I have had a big hill to climb I feel a lot better and my sexual desires are coming back gradually to the point that the other week she got me aroused but rather than having full sex we actually masturbated each other. And that relieved a lot of tension and I could feel it relieved a lot of tension in Polly as well.”*

Fred 80

This concludes the presentation of the data which fell on the continuums displaying the thoughts and feelings of the participants. Along with the “testaments to sexual intimacy” they provide a breadth of data which will be fully discussed in Cycle 4. In order to do full justice the participants I decided to look in-depth at the data as well. What follows is a phenomenologically inspired consideration of the data which is drawn from the in-depth interviews with ten participants.

### **Phenomenological Insights from the in- depth interviews**

The in-depth interview data allowed further, deeper, analysis in order to understand the whole story of each of the participants as they saw their sexual intimacy. I read and re read the transcripts, occasionally intentionally distractedly, sometimes out loud, to uncover new meanings and ideas. On

occasions the data were deep and resonant but sometimes it was stilted and difficult. I read more about the ways in which others had analysed their data in intuitive inquiry and the many differing methods that had been chosen. Wertz (2011) explains that phenomenological analysis is an appropriate method of data analysis in intuitive inquiry but equally other diverse methods can be chosen.

I was drawn to descriptive phenomenology and read a number of books and articles for example Finlay (2009), Finlay (2011), Van Manen (1990), Dahlberg (2006). I really desired to “get it right”, perhaps searching for something formulaic, confined, straight forward but I kept being pulled back to the texts themselves and the complex simplicity of Anderson’s model. In searching for a transparent set of activities to analyse the in-depth data, my knowledge grew still further about the diverse philosophical underpinnings and variants of phenomenology.

Finlay (2011) writes of phenomenology in action, and describes four facets

- The focus on the lived experience
- Phenomenological attitude
- Rich description
- Transformative relational process

The further I read, the nature of the interviews and the participants made me question whether this approach was right for the data. The interviews were singular and relatively short. The depth of the data variable across the interviews and within the interviews. The nature of the participants, their fatigue and sensory impairments, particularly using the telephone, detracted from the quality.

I wondered how a descriptive phenomenological approach would work with the data, which weaved its way through a long life course, where individuals remembered their sexual intimacy in different times, with different people. Wade and DeLamater (2002) found that people adopted more sexually permissive activities at different points in their lives, notably when becoming single having been in a relationship but they returned to their more typical

behaviour about a year after a new relationship started. It was some of these nuances of sexual experience I was keen to capture. After much consideration and discussion I felt that the process of in-depth participant interview data analysis was phenomenologically inspired and I endeavoured to develop a phenomenological attitude.

I also became aware how, as a nurse, my training and experience seemed to compel me to “do” something with information I receive. A lifetime of co-producing plans of care, writing up treatment plans, requesting diagnostics and prescribing medication has always meant interpretation of information. To produce phenomenological data summaries that were truly descriptive was hard, almost counter intuitive. In preparing both the testaments to intimacy and the continuums of thoughts and feelings I was able to screen the data, to divide it up and merge the themes. I had been physically doing something with the voices of the participants now I had to stand back and let the words of the participants wash over me, I distilled their transcriptions into data summaries. I have added a data summary (Appendix 7) from my interview with Jolene. The introduction, consent arrangements and my discussion of details of the research have been removed as have the final thanks and safety netting. Jolene’s words have also been used within the testaments to sexual intimacy and the continuums of thoughts and feelings but here they are seen in their entirety. In this interview Jolene spoke a lot about her family in an informative but superficial way, detailing the names, occupations, location and characters of her children, grandchildren and great grandchildren. I have removed this narrative from the data and focussed on the parts of the conversation related to sexual intimacy. Jolene was 78 married to her second husband, she had had seven children two of which had died in childhood. Jolene made a personally significant revelation in the interview, that of having a long term extra marital relationship which took my breath away.

## **Phenomenological analysis**

Phenomenology is the study of “phenomena” or things, drawing meaning from the way they appear in our experience. This is particularly relevant in my study as sexual intimacy has a plethora of individual meaning to participants as they experience it, to find an “essence” was crucial.

In learning about development of phenomenology and the philosophical tradition I became confused and lost, feeling I had grasped an understanding that then simply swam away. I read about Husserl and Heidegger and whilst reading it made clear and apparent sense but I was never fully able to explain the nuances. Intuitively I was drawn to the phrase “to the things themselves” which is clear. I further considered what Anderson (2000) intended from her method. I returned to her influences and the work of Merleau-Ponty (1962). Merleau-Ponty's explanations of the role perception plays in understanding the world, as well as engaging with the world, and clarifying the full set of possibilities made sense. Merleau-Ponty (1962) emphasised the body, rather than the conscious, as the primary site of knowing the world and this resonated in terms of my study, the body being the primary component in experiencing sexual intimacy, he maintained that the body and the things it perceived could not be disentangled from each other.

However, it is argued that our experience is normally much richer than simply sensation, therefore phenomenology has a greater realm of meaning, including the significance of objects, events, tools, the flow of time, the self, and others, which happen in our “life-world”.

Phenomenology studies the structure of various types of experience ranging from perception, thought, memory, imagination, emotion, desire, and volition to bodily awareness, embodied action, and social activity. The structure of these forms of experience involves what Husserl (1900, 1901) called “intentionality”, the property of consciousness that it is a consciousness of or about something. Our experience is directed toward things, particular concepts that might be thoughts, ideas or images. These make up the meaning or content of a given experience, and are distinct from the things they present or

mean. Phenomenology attempts to uncover the inner essential nature of the “thing” called the “essence”, the true being of the phenomena, it is what makes the thing what it is (Van Manen, 1990).

The basic intentional structure of consciousness, we find in reflection or analysis, involves further forms of experience. Phenomenology develops a complex account of temporal and spatial awareness, attention, awareness of experience, self-awareness and the different roles of the self and others, as well as embodied action, linguistic activity, social interaction and everyday activity in our surrounding life-world. It is what is experienced and how it is experienced (Wertz, 2011).

As I began to understand these concepts the method of phenomenological data analysis became clearer and after a number of faltering starts I was ready to start data analysis.

The use of descriptive phenomenology within in an interpretive method such as intuitive inquiry may not sit comfortably all researchers and requires further explanation. Intuitive inquiry stands within the hermeneutical tradition, however, Anderson (2011) explains that there is great flexibility in her method and the data should lead the researcher to the type of data analysis required. Within intuitive inquiry the data may be qualitative or indeed quantitative or even a mixture of both (Anderson and Braud 2011). She says her soft structure lends both intellectual precision and freedom of expression to the method (Anderson 2000). Whilst intuitive inquiry is a unique method, Anderson (2011) says its procedures and processes can be adapted and integrated with other analytical approaches to research and scholarship (Anderson 2011:245). In the third cycle of intuitive inquiry descriptive summaries are produced, Anderson and Braud 2011:49 request that the accounts of the data are in a descriptive a manner as possible. Wertz et al (2011:91) explains that some qualitative researchers believe that all description is interpretation and question the claim that description can provide fidelity. Certainly as a novice researcher and with the awareness of my personal tendency to interpret all interactions quickly, rushing to draw conclusions as my clinical practice demands, pure description would challenge and may elude me. Intuitively for



these reasons I wanted to attempt the unprejudiced description, the call to the things themselves, evoked by Husserlian phenomenology which allows the matters to speak clearly, avoiding any interpretation (Husserl 1900, 1901). This “Pure” phenomenology, Wertz et al. (2011:91), provides the description of the phenomena by eidetic analysis delivers knowledge that faithfully reflects the lived experience. The idea of pure description in Cycle 3 is supported by Anderson (2011:253) who explains that in this cycle the researcher prepares descriptive presentation of data and that data interpretation does not begin until Cycle 4.

This part of the study was an opportunity to develop my research skills and to do the data full justice. Without the use of descriptive phenomenology within the interpretive paradigm certainly one of the constituents “the spectre of death” would never have been revealed.

The first distillation of the texts described succinctly the essential features of sexual intimacy as explained by the participants. The results seemed stark, factual and cold, without the warm voice that the participants relayed the original messages. Wertz (2011) describes his phenomenology as a traditional, relatively disinterested, scientific process. It was the sense of being disinterested that troubled me and was so alien to my usual clinical attempts to engage and “do” something with the information I receive.

Once all the texts had been completed and looked at anew they were analysed for meaning. Having previously examined the data using broad thematic analysis this in-depth phenomenological account required turning my new knowledge and emerging skill to the data. I deliberately chose a Husserlian descriptive perspective because it would help me analyse the data in a different way from the highly interpretive work I had already undertaken in the data analysis, particularly relating to testaments of sexual intimacy and the continuums of thoughts and feelings. Dahlberg (2006) recounts Husserl’s original warning was that there is a risk that essences can be “interpreted away” mindful of this I hoped to uncover different meaning from the data.

I have tried to bracket my understanding of the phenomenon. Bracketing, Wertz (2011) describes, as laying aside past knowledge/presuppositions. In

attempting to do this I realised it was just that, an attempt and would require much skill and frequent practice to be something I could faithfully undertake.

The participant's description is broken into meaning units, then meanings are systemically extracted and examined in differing ways to obtain a clear account of the general structure of the phenomenon (Finlay, 2011).

This involved an intensive period of working with the texts both close up and then in an abstracted, disinterested way to allow the meaning of the phenomenon, the essence, to emerge. I then studied the text for meaning units, marking each point where there was a transition in meaning in the data, an example of this is provided in the transcript of my interview with Ray;

*"I think you have a lot more experience of the world of people and things like that um yeh I don't know, yeh I suppose so getting to know someone else getting together, we have never lived together as such..."*

In one short phrase he explains where he sits in his sexual chronology, in his life course;

*"I think you have a lot more experience of the world of people and things like that um yeh"*

Identifying experience, a worldliness, of sexual things over time (temporality)

Ray then changes meaning,

*"I don't know, yeh I suppose so getting to know someone else getting together"*, speaking of a newness and a togetherness (relationality)

Then turning to the way they cohabit and what that means for him

*"we have never lived together as such..."* (relationality and spatiality)

I then went back and forth between all the texts identifying the meaning units, repeatedly and over time.

The lived experience in the texts revealed the essential meaning which holds all the aspects together and within which the other parts are situated.

The essence emerged as “Being Together” held within it the parts of the whole that include;

- Maintaining intimacy in changing circumstances
- Setting current intimacy across a life course
- Concern about what people think
- The possibility of sexual intimacy
- The spectre of death

### **Being Together**

“Being together” means to continue to develop as an existing or new couple, to change, adapt but remain close and maintain wellbeing. Part of being together is maintaining sexual intimacy in the face of changing circumstances both corporally and in habitation. There is an acceptance of changes in physical responses which varies in individuals and between couples. They set their current situation in the context of a life course acknowledging the earlier events “turning points” and expressing their wishes for the future. They also express a concern about how they will be viewed if they discuss or display sexual intimacy. The participants describe adaptations and seek affirmation and explanation of the way in which they are managing them. What binds all these parts is a sense of togetherness, of being together and being in it together. As Dahlberg (2006:14) explains the constituents are individualisations or particulars of the structure and thus the essence must be seen in every constituent. This is summed up by David,

*“you know sharing the days thing, that’s really what a big part of intimacy is, you know I had something close”*

Being together has many expressions but is always present in participant’s explanation of sexual intimacy, Jolene describes this,

*“We had together to very slow dances and here’s the stupid thing there no way, but I could manage and I look at him and I said do remember when we could really do this? And he said pah I’m all cracked now it was though a*

*connection . . .we hadn't danced for many years but we weren't dancing like we normally would you know we were really together . . . . “*

Jolene 78

*“we enjoy being away together er we enjoy our company together when we are away, I think more than being at home”.*

Joan 75

*“we appreciate each other, that's very important”*

Phillip 75

“Being Together” emerged as the essence and was present in all the conversations with the participants, it was the characteristic without which sexual intimacy for older people would not be what it is it is, the landscape in which five other characters played their parts.

### **Maintaining intimacy in declining health**

Analysis revealed that the effects of ill health on sexual intimacy are very apparent to the participants, usually as a slow gradual loss of previous function, often brought on by the effects of long-term conditions or surgery;

*“If I couldn't get an erection yes...but touch wood I can still, um I've had a couple of little problems I had a cyst in the wrong place and I had a little operation and then I had a biopsy on my prostate, that was a full anaesthetic so it's put us back a couple of months but not now I am on the way back yeh.*

Ray 79

Participants spoke of the way they managed the changes, David describes regular weekly sexual intercourse with a partner known as (MG) and the possibility of another partner who is arriving shortly but qualifies this by saying if sex does not happen he will still be satisfied;

*“no ... no um um er particularly with the MG I am satisfied.....That's with anyone else well there is one coming this afternoon if he does turn up again*

*that's optional it's not something I would push um if it happens I would be quite satisfied."*

He speaks of his needs for medication to attain penetrative sexual intercourse, how his responses have changed and how he is managing this change;

*"Well it has changed and there are factors whereby I did have an enlarged prostate last year and that has effected things down below whereby em if I ....if I need to have sex I will take Cilalis and I did have to go and see the GP last week really to see if there is anything more he can give me"*

David 75

For others maintaining sexual intimacy is doing something different, Joan explains;

*"Er no I think it is important we still have a bit of cuddling, I mean we don't cuddle that much but it is important we have that little bit for us."*

Going on to say;

*"It's enough for me I think my husband would like it more but he has he has problems with . . . he's a diabetic and he has problems with . . . (erections)"*

Joan 75

The participants set out the issues in a factual way, decline just is, and they do not rail or despair, just accept, adapt and move on in different ways.

### **Setting current intimacy in the life course**

The participants are consciously aware of their togetherness as life circumstances change, they project forward and delve back into prior meanings they have of togetherness, through their lives in a sexual chronology. Often the participants explain their outlook in terms of their formative family experiences, harking back to the way in which they were brought up. They reflect on seminal moments in their sexual development and review them in the context of the current knowledge and perspective.

*"I mean sort of looking back erm ..... with my first wife Hope.....em sigh. Because in many respects I was very innocent about sex erm, it it it was a very .....once she had allowed me to have intercourse with er before we were married ... it became the only thing I wanted and then she became pregnant and she lost that baby."*

Fred 80

For others there is a sense of the cessation of sexual intercourse, of a time for things to change, Joan describes this,

*"Well we are getting too old for that well I . . .am anyway, well I think I had enough when I was younger."*

Joan 75

### **Concern about what other people think**

Residing in a culture that frequently thinks of older people as asexual and often not able to discuss sexual matters with healthcare professionals, friends or family, the participants own views of their sexual needs and behaviour is coloured by this clandestine life.

They revealed an anxiety about what other people would think, including the general public they live amongst, Joan explains;

*"Yes, particularly when you are older people look at you."*

Joan 75

This concern is supported by Gloria who had entered a new relationship in later life, she was concerned about people she knew seeing expressions of sexual intimacy;

*"Actually as soon as I met him in the town. When he comes to meet me, he first thing he did when he met me was give me a kiss, I was worried because the ambulance was going past and they all know me"*

Gloria Mid 70's

Phillip clearly states;

*“We wouldn’t want to overtly kiss in front of anybody really”*

Phillip 75

He then goes on to discuss the uncertainty about displays of affection in public places were not simply confined to areas where younger people might observe them, Phillip explains they experience discomfort in revealing intimacy regardless of “audience”.

*“Em can’t say I have, I mean as I said I’ll, general point of view would be that we don’t mind holding hands in public or me putting my arm round Jane in public from time to time, walking down the street, erm arm in arm, that sort of thing and perhaps an occasional peck, we wouldn’t distinguish much between older than younger people, or if I did it would be the older people I would be less keen on of overtly displaying affection on the grounds it would be more like showing off then, sort of we still still have a sex life and you don’t.*

Phillip 75

The quotes showed a concern about what “other” people think about the maintenance of sexual intimacy and a surprise when it is discussed.

### **Possibility of sexual intimacy**

Throughout all the difficulties the participants saw a potential for sexual intimacy, it remained, even in difficult circumstances, as something desirable that could be achieved.

Helen speaks generally;

*“I think that in later life you want physical relationships to continue every opportunity should be explored so it can carry on... if it means something to people it’s part of their wellbeing, you know why not, why not.”*

Helen 75

The possibility of sexual intimacy is present in all the summaries, for some it is actual penetrative sex on a regular basis, for others it is a chance or opportunity that does not happen frequently but does come. For all participants the possibility of sexual intimacy remains;

Gloria says

*“Someone said, oh that Andy he’s coming and I thought . . . . I said to Gladys, she’s 85, if anything’s funny I’m coming back to a mattress in your room and she said, what a holiday you are going to have!”*

Gloria mid 70’s

Ray explains the possibilities further, in the context of new relationships in later life,

*“It was different, you’re more mature, you know what you are doing....hopefully.”*

Ray 79

### **The spectre of death**

The spectre of death was an uncomfortable finding and one that emerged at the end of the analysis, it had a nagging presence in my mind. It was logical that older people would talk about the death of partners but this was much, much more. It was present in the discussions with all the participants, sometimes mentioned in passing and sometimes as the focus of their conversations. The most memorable is Richard, whose wife was dying from Alzheimer’s disease;

*“When you die and we talk about like that and she’s not really frightened of dying it’s the process and I just feel it’s my love for Pam.... that makes me fall in for what her needs are and all, I mean just before you phoned, she was saying I love you so much and bits and pieces, and I just went across and put my cheek against her cheek and told her I love her, I always find kissing her around the face around the cheek I kiss her on the side of the mouth so she knows its special.”*

Richard late 70’s

Death is also mentioned in passing, as part of later life , very different than discussion you might have with younger people if talking about sexual intimacy, Gloria speaks about this on a couple of occasions;



*“Yes, yes you get couples, there’s one . . . this lady and gentleman they are always arguing, laughs they are real good dancers and somebody told me that she’s got a terminal illness.”*

*“She looks lost now because she has always had a good husband and she went on a cruise with her friend and her husband but her husband had some cancerous thing diagnosed at the same time as hers but he’s still alright at the moment, they have gone as a threesome and if anything happened to him she would always have her but you can tell they are missing their partner.”*

Gloria mid 70’s

Some of the participants mentioned their partners death as potentially being the end of sexual intimacy for them, although others such as Ray went on to explain about engaging in a new relationship,

*“I must say I lost my wife 5 years ago...”*

*Researcher- Did you find it difficult to go back into a relationship?*

*.... No ..not really it was a good year before...I knew Rachel 20 years ago but only as a customer I was a plumber and I redid her house when she got divorced and there was twenty years between that...”*

Ray 79

Jolene describes an inevitability of death,

*“Life can take make twists and turns for older couples, 95% of my dear friends are widows or widowers know. We are in that age group”*

Jolene 78

The effect of death is recounted: Catherine speaks of the death of her estranged brother and writing to his wife and this leads her on to speaking about her husband his difficulties with sexual intercourse.

*“He had a horrible death he had been poorly with cancer for six years erm he had two carers going in four times a day.”*

*“No there again my husband was only 43 when he died and for a number of years sex was very difficult for him anyway he had cancer of the colon and in that area.”*

Catherine 82

They also talk about the effects of death on children

*“her father was killed at Dunkirk he was in the navy and his ship was hit, he was sunk he got the ....died, which left her mother with this two year old little girl, she has an older daughter erm .....my glasses have all gone funny on me...”*

Fred 80

And the effects of parental death on offspring when the person left choses to engage in a new relationship

*“Um I did meet a lady she is probably little younger than me but her husband has died and she has a new partner who she had known for many years and his partner died too and there was quite some time between them and she and he eventually, you know, started going out to together and it developed into something more meaningful and eventually they got married but she, she had two children, and her daughter took a very long time to um to come to terms with um that she actually had a serious relationship”.*

Helen 75

And sometimes recounted the death of their lover with humour.

*“When I asked him about cremation or burial .... He was absolutely adamant about that, he said if you cremate me I will come back and haunt you!”*

David 75

The phenomenological analysis revealed a dimension that was not discovered in the thematic data analysis that produced the observable indications of sexual intimacy or in the continuums of contemplations and sentiments. Whilst this facet of data analysis has been time consuming it has yield considerable

personal new knowledge and the essence of sexual intimacy as experienced by the participants.

The constituents uncovered in this part of the data analysis go on to inform Cycle 4 where the findings are discussed and the final lenses are revealed.

A final section of the data analysis follows. Whilst listening to the audiotapes and reading the transcriptions and case summaries a rhythm in the way in which the participants told their stories went through my head, it was inescapable and tantalising.

**Rhythm and Meter** – The elusive nuance of delivery

One of the interesting findings in the interview data was the way in which the participants spoke about sexual intimacy, they opened the conversation and seemed to test me out with their language and the nature of the revelation  
Image 5. Pattern of Conversation I

it was as if they moved close to the subject and then pulled away and this process went on until it rose to a crescendo they gave one large revelation which I have a called the “big reveal”.



I became aware of these revelations when typing the transcripts and it was further discerned whilst analysing the data. I have struggled to capture this discovery in a meaningful way and have tried to explore ways in which to represent it or find a framework to describe it. I first used a visual approach mapping the conversation using rolls of brown paper and colours representing the speech.



Image 6. Pattern of Conversation II

I spoke with curators of theatrical bookshops and found some clues in the works about drama and the voice. Rodenburg (1998:4) describes, the need for words tapping into “all parts of our body mind and spirit, is signalled in our breath bubbles up through our voice until finally, with a sense of relief and release the words escape us by means of articulation”. This process helped clarify my hunch and I intuitively felt that there would be a way of explaining this revelation. I wondered if there was something in English literature or poetry analysis that would provide a tool to help me unlock this notion. I looked back on my investigations of methods from the earlier Cycles to see if another method would have been more helpful in uncovering this tentative finding. Narrative analysis focusing on the telling of a story which has multiple turns during the conversation that may share common structural features may have yielded findings but there was something more dynamic the words, something in the pacing and crescendo that I was not convinced it would capture.

I spoke with my supervisors and they agreed that a discussion with one of the English professors would be helpful. I read about autobiographical critique, researched theatrical and poetic analysis and considered narrative analysis. Sadly this worked proved to be futile. I had erased the tape recordings following transcription as required by my ethics approval and without the tapes

I was unable to remember the intonation, flow and silences which were clearly an essential part of the rhythm and meter of this alluring discovery. It was with deep regret I abandoned this finding but hope it may develop into some post-doctoral work.

I was now at the point of the study which represents the return arc of hermeneutical discovery, I had arrived at my findings and had further clarified my own thinking about the subject. What follows is a summary of those findings.

### **Summary of the findings**

The study's findings are presented here in three ways that provide both the breadth and depth of what sexual intimacy means to the participants. Firstly the visible actions which the participants describe, those things they reveal to people who might observe them, they comprise;

Being close –physically

Cuddling

Kissing

Music and dancing

Sexual intercourse

Being naked

Sharing a bed

Sexual adjuncts

Secondly, the thematic findings revealed continuums, where individual participants revealed a range of expressions of intimacy along similar planes but with divergent scope. This formed the following continuums;

Not seeking help when difficulties arise	Feeling comfortable to seek help
Embarrassed about own sexual intimacy	Content about own sexual intimacy
Not able to discuss sexual activity	Able to discuss sexual intimacy
Negative sexual life story	Positive sexual life story
Clandestine expressions of intimacy	Demonstrative public expressions
No sexual connotations to events	Sexual meanings attached to events
Relationships rapidly evolving	Relationships remaining stable
Disturbed by ageing	Relaxed about ageing
Keeping lovers separate	Fusing as a couple
Muddling through	Striving for the gold standard
Disapproval from friends and family	Approval from friends and family
Inequality of couples sexual expression	Equality of sexual expression
Dating	Maintaining a relationship
Confines of poor health	Integrating health changes
Changing residence	Holding on to home
Financial tensions	Financial Unification

The overlap in some of the continuums acknowledges the interrelationship and complexity of sexual intimacy as discussed by the participants. These findings which demonstrate the breadth and range of the participant's experiences lend themselves to further grouping as meta-themes but are displayed here in their complete configuration.

The lived experience in the texts revealed the essential meaning which holds all the aspects together and within which the other parts are situated.

The essence emerged as “Being Together” held within it the parts of the whole that include;

- Maintaining intimacy in changing circumstances
- Setting current intimacy across a life course
- Concern about what people think
- The possibility of sexual intimacy
- The spectre of death

This summary of the findings makes evident the range and relational attributes of sexual intimacy providing the basis for discussion in the next cycle.

In Chapter 4 I discuss the new knowledge in the light of an update of the literature and the personal and scientific insights that the findings bring.

## Chapter 4

### Cycle 4

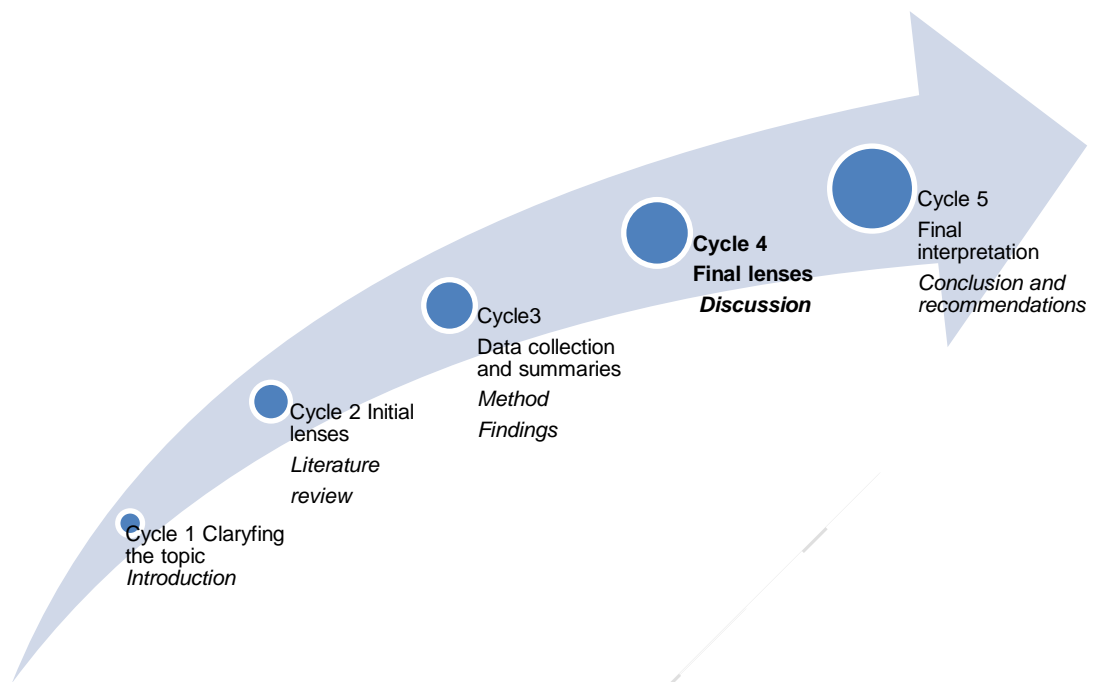


Diagram 7. Illustration of Cycle 4 in Intuitive Inquiry

In this chapter there is a cycling of the literature with the data collected in the study and personal insights leading to the articulation of the new lenses which emerge from the findings. These second lenses are then compared to those divined in Cycle 2.

#### **Second Literature Search**

The nature of part time study meant time had passed as I reached this point. I was keen to re-examine the extant literature. I returned to my earlier literature review and used the same search strategy, but changed the date search parameters from 2012- January 2017 (the date of the search). I was struck by the sheer number of articles, over 7,500 roughly equivalent to the entire number of the previous search which had spanned 1995-2012. Clearly the subject was gaining greater research interest which was pleasing. Following high level screening I was left with 44 full text articles to read. The results of



this additional literature, along with the papers from the initial literature review will be weaved in with the findings from the study data.

The method requests that I interpret the data in order to modify, move and expand my understanding of the topic (Anderson, 2004). This Cycle allows me to incorporate the experiences of the participants and represent the findings based on an interpretation of Cycle 3 from this my final Cycle 4 lenses are revealed.

In comparing my Cycles 2 and 4 lenses the reader can evaluate the changes and refinements of my understanding of sexual intimacy. Anderson (2004) explains the most important features of interpreting the data come through illuminating moments, when patterns reveal themselves. She suggests that in understanding lenses that were entirely new and unexpected, “change lenses” they reveal a significant progression from the lenses presented in Cycle 2, and the “seed lenses” signify lenses that were nascent in the lenses of Cycle 2 but are further developed and nuanced in the course of the intuitive inquiry. Anderson (2004) recommends this tri-part formulation in the presentation of Cycle 4 lenses to allow readers to see the comparisons.

My original Cycle 2 lenses are set out below;

- Lack of availability of partners,
- Entrenched images of vulnerability
- Keeping joyful, magical secrets
- Dirty old man, frigid old women
- Muddling through the inevitable changes
- Negotiating new lifestyles
- Reclaiming sex from the young
- Leaving it to the specialists
- Using it or losing it.
- A twilight in knowledge and understanding

In Chapter 3 the findings from the participants revealed three different facets;

- Observable acts of sexual intimacy which I have named “testaments to sexual intimacy” as if the reader might peek through the window and observe an older couple displaying them.
- Continuums of the explanations of sexual intimacy as described by individual participants. These continuums have considerable interrelation and have been combined to form meta-themes.
- The phenomenological analysis of the findings provided “Being Together” as the essence of sexual intimacy with the constituents;
  - Maintaining intimacy in changing circumstances
  - Setting current intimacy across a life course
  - Concern about what people think
  - The possibility of sexual intimacy
  - The spectre of death

Each of these facets of the findings will be reflected on in turn and will include the literature. At the end of the chapter a new set of lenses will be revealed and comparison will be made to the original set discovered in Cycle 2.

## Discussion of Findings

### Testaments to sexual intimacy – the observable acts of sexual intimacy

These are portrayed as if the reader might peek through the window and observe an older couple displaying them. The testaments include;

Being close – both physically and mentally

Cuddling

Kissing

Music and dancing

Sexual intercourse

Being naked

Sharing a bed

Sexual adjuncts

**Being close** was one of the clear testaments to sexual intimacy revealed in all forms of the data. The participants talk about sharing the days, smiles and friendly words and being totally available for each other. It is argued that older age affords greater opportunities for people for to be close both physically and emotionally as the demands of employment often reduce or individuals have more control and choice over the engagement in these as Richard explains

*“Well we have not had intercourse for some time now, but you know, cuddling um that sort of being close and touch”* going on to say, *“over the 42 years we have been married and over those 42 years if you love one another and stand by one another you grow closer and closer and closer and I find that I you know I really am closer to Pam,”*

Bildtgard and Oberg (2014) propose that time is a structuring condition behind new intimate relationships in later life. They explain that the available free time can be channelled into personal interests and desires. They go on to suggest that for some of their study informants older age was an opportunity for a new

and fundamentally different foundations for intimate relationships in later life. In Sandberg's (2013) study with older males the participants explained sexuality was more elongated and can stretch over an entire evening or an entire day. Bildtgard and Oberg (2014) also describe the paradox of greater post reproductive free time and the awareness of diminished remaining time across the life span. This chimes with later analysis in this research on the way in which participants structured their responses within the interviews and the emphasis, sometimes oblique, that the end of time is close. Further detail of this phenomenon is picked up in the detailed analysis of the participant interviews.

The notion of "being together", of spending intimate pleasant time can contribute to improved mental health, decreased levels of stress and loneliness (Blieszner, 2007). Freixcas et al (2015) in a study which involved older Spanish women discovered that a personal interest in emotional relationships and sexual practices is one element that determines the possibility of enjoying post-menopausal sexuality. It would appear that in order to make most of the opportunities older age presents, being close and giving attention to the relationship are important.

Card	<i>Being close in all areas not sex</i>	77	Female
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**Cuddling** is described by many participants as either a precursor to or a proxy for sexual intimacy saying such things as "*Having a regular cuddle/hug, the power of touch*" – card. Physiologically cuddling releases oxytocin the hormone frequently called the "love hormone" which increases our connection to others. Oxytocin is normally produced by the paraventricular nucleus of the hypothalamus and released by the posterior pituitary gland. There is consensus that oxytocin modulates fear and anxiety and has been cited in pain reduction (Huffmeijer et al, 2013). However, as Huffmeijer (2013) explains, we remain unclear about any possible age related changes to the oxytocin system due to the paucity of research in this area. For the participants cuddling clearly remained an important component to sexual intimacy saying;

*“We cuddle all the time” – card*

*“Intimacy to me is physical affection hugs, cuddles and kisses” – card*

Freixcas et al. (2015) found that over 23% of women in her study wanted more caressing. Whilst cuddling was important to many of the participants in this study Fisher (2010) found that within a study of retired Americans 27% had neither kissed nor cuddled in the last six months.

**Kissing** is perhaps the most obvious and expected act of sexual intimacy that was raised by the participants. As humans we recognise the lips as being the most exposed erogenous zone but kissing takes on many forms and has many meanings, the participants spoke of some of the different meanings they attached to kissing.

From the start of a relationship in older age,

*“The first thing he did when he met me was give me a kiss”, - Gloria*

Mutz (2016) explains the peck is considered to be reminiscent of many people's first kisses and it is typically a quick, playful exchange as both people keep their lips closed. For people who are kissing for the first time or just started dating, Mutz (2016) states a peck is 'all about testing the waters'. It is a sign that a person would like to continue a physical relationship but wants to make sure that the other person feels the same. This expression of intent can also remain in relationships enduring over many years. Kirshenbaum (2011) describes kissing as a behaviour that has evolved to facilitate three essential human needs that of sex drive (lust), romantic love (attraction) and a sense of calmness and security (attachment), these different attributes of kissing are seen in the descriptions from the participants;

*“Every day whenever I get in I say hello darling and give her a kiss” (dictated card)*

*“but he’s not em a demonstrative person. . . . em he would never leave without giving me a kiss”*

However, there does seem to be social mores for older people about kissing in the eyes of the public,

*“It might be a kiss on lips it wouldn’t be a lot of laughs tongue kissing etc. but we might peck each other I suppose”*

Phillip 75

*“Well, um, he parks up the driveway but any of the kissing is done in the house, erm, I did once kiss him in the car but he was uncomfortable with that ..... any of the kissing is done in the house.”*

David 75

As a relationship deepens a kiss becomes a sign of comfort as it can be an intimate way to say 'hello' or 'goodbye' to your partner (Mutz, 2016). Richard describes it as a way of preparing for a final goodbye as his wife moves closer to the end of her life,

*“I always find kissing her around the face around the cheek I kiss her on the side of the mouth so she knows it’s special”.*

Richard late 70’s

### **Music and Dancing**

It is recognised that older people often need a longer period of stimulation prior to sexual intimacy and many self-help websites suggest listening to music or dancing together as foreplay. It is widely believed that music can provide pleasure in the following domains;

- reward, motivation and pleasure
- stress and arousal;
- immunity; and
- social affiliation.

These domains parallel many of the known neurochemical systems including dopamine and opioids, cortisol, serotonin and oxytocin (Chanda and Levitin, 2013). Joan describes this,

*“Yes we like listening to the you know 60’s 70’s music you know the old . . you know petticoat music”*

Jolene goes on to describe the intensity of feeling that can be evoked when dancing together,

*“We had together to very slow dances and here’s the stupid thing there no way . .but I could manage and I look at him and I said do remember when we could really do this? And he said pah I’m all cracked now it was though a connection . . .we hadn’t danced for many years but we weren’t dancing like we normally would you know we were really together . . . .*

Synchronized activities, such as music and dance have long been known to foster feelings of social connection, specifically interpersonal trust and bonding (Chanda and Levitin, 2013). Sandberg (2013) explains touch and intimacy are of key significance in sexual relations and cites touch within dance as important for a number of participants in her study with heterosexual men aged between the ages of 67-87 in Sweden. It is clear that music can be a very a personal pleasure and is clearly not for everyone;

*“It seems very odd to think of listening to music to be a physical expression of love sounds perplexed it might be an expression of intimacy but it’s not a usual one”*

Phillip 75

Music can also provide a history and backdrop to a couple’s sexual intimacy,

*“I met Polly through the music club because I’ve always been involved in music and I met Polly through music”*

Fred 80

Kirshingbaum (2011) explains the nature of physical closeness in terms of primal behaviours and relays the need for human beings to understand the smell, touch and pheromones that help us establish a physical connection. For many older people dancing was a socially acceptable way of experiencing closeness with potential partners in their younger years. As growing up in the

1930 and 1940's was relatively restrictive in opportunities for physical and sexual engagement between genders and same sex relationships were illegal for males and socially taboo for females. Dancing was a rare opportunity for physical closeness and it appears that for many this pleasure endures.

### **Sexual Intercourse**

Bradway and Beard (2014) tell us that in the last decade there has been a paradigm shift in the US, referred to as the "new aging movement" by social gerontologists. In this "new aging" movement sexual decline is no longer seen as an inevitable part of growing older and they cite the use of prescribed drugs to maintain sexual intercourse as an activity through the life course examples of "new aging" from the participants included;

*As we have aged the sexual side has only slightly diminished- card*

*I still have regular sexual intercourse at present –card*

Bradway and Beard (2014) state the development of "new aging" as movement can also be damaging to some older people as it further increases the pressure to have ageless functional bodies and libidos. For some participants sexual intercourse remained the gold standard of sexual intimacy,

*" I guess the analogy would be, if you can't walk or run as far as you used to be able to you can still enjoy a short walk . . .you have to accept it the analogous with oh we can't have sex anymore we will have to make do with cuddling "*

Phillip 75

The gold standard of sexual relationships has been explained as heterosexual intercourse involving young, usually white, middle class people (Armstrong, 2006). It is important to note there still remains a significant lack of research about older people's sexual behaviour (Syme, 2014) and that which is conducted is usually with the "young" old typically under 75 years of age (Bradway and Beard, 2014). Fisher's (2010) study reveal 59.8 percent of the participants surveyed who were over the age of 70 had had sexual intercourse



in the last six months. In this study many participants did acknowledge a change in their sexual behaviour,

*Sexual intimacy is not very frequent but still enjoyable – card female*

*Intimacy in my life is essential but not necessarily penetration (anal) sex - card*

*“Well it has done, yes um, it’s not half as much as it was all those years ago when I first met her”*

Ray 79

The participants described changes in their sexual lives but as Galinsky and White (2014), discovered in a longitudinal survey as relationships progressed the couples expressed less unhappiness and they suggest this might be because unhappy couples are more likely divorce or split up. For some of the participants, although they cease to have sexual intercourse, their relationship remains intact;

*“He (the consultant) said this (operation) will affect your sex life and Terry looked and said at my age why should I care” and the Doc looked at me and said you could slip him a certain kind of pill! ”*

Jolene 78

Conversely another participant talked about an increase in frequency of sex within a new relationship,

*“When we were first friends um well, sex was like disease you know we were at it all the time”*

Catherine 82

*“Full sex would be great but I am less energetic than I was so once or twice at a go is enough” - Card*

## **Being Naked**

A number of the participants expressed their feelings about the importance being naked with their partners; these included sleeping together without clothes,

*Sleeping together naked – card*

*“We always sleep with nothing on, so we cuddle up, we appreciate each other, that’s very important”,*

Phillip 75

Others responses describe being naked within the home,

*“I had never been one to walk around with no clothes or just pants on or something like that but even now he will walk around with no clothes on er and you know he has been like,*

*Researcher – did that encourage you?*

*“Yes I was a bit freer with things than how I was”*

Catherine 82

*Bodily contact undressed- card*

*Naked cuddles –card*

*Bathing and showering together – card*

*Closeness and nudity - card*

However, for an anonymous participant they explained that they found revealing their body difficult,

*Not wanting to show my body – card*

## **Sharing a Bed**

Sharing a bed is seen to be an act of intimacy by many of the participants and indeed by society; it is extremely rare in current western society for adults to share a bed without being in an intimate relationship. One of the participants spoke of the development in the context of a new relationship.

*“Any way he wanted to join the walks I had been on one and he wanted to come on the holiday but there were no spaces but at that time then it was June, just a single rooms and so he couldn’t go and then I rang (male friends name) who runs the club to see if any rooms were coming up and he said oh that (partners name) he’s coming and I thought . . . . I said to a friend, she’s 85, if anything’s funny I’m coming back to a mattress in your room and she said what a holiday you are going to have! ”*

Gloria mid 70’s

For couples who have had enduring relationships sharing a bed is part of the maintenance of the relationship and a cause of distress if that is not possible,

*“Oh yes! emphatic yes yes, we get upset if we get two single beds when we go away...um just touching feet or something you know but you even do it in your sleep you know that the other person is there ”.*

Ray 79

*“ We still share the same bed and we make a double bed up in the motor home we don’t use the single bed, we like to be together asleep together even if it’s only just to be aside of each other,”*

Joan 75

Difficulties can arise when one person in the couple requires healthcare at home, in this case when the participant’s wife is at the end of her life,

*“When the hospital came out and said we can’t get you a double bed we have got to get a single one”*

Richard late 70’s

Richards’s sadness was evident in our interview, the chance encounters and intimacy if sharing a bed had been taken away from him.

For another participant the end of the sexual life together had been marked by moving into single beds,

*“With Terry it would kind of be lost cause, yes, so you know we get twin beds”*

Jolene 78

## **Sexual Adjuncts**

This section looks at the adjuncts to sexual intimacy used by the participants. As well as a strong desire to maintain sexual intimacy they also spoke of the wish to maintain their usual sexual practices.

One card explained the intimacy experienced in sado masochistic activity.

*Bondage and D/S are acts of intimacy – card*

Brick et al (2009) suggested how older people might enjoy a mutually satisfying sexual life, providing practical advice, they recommended new ideas, positions and the incorporation of sex toys. The use of these adjuncts was described by the participants taking sexual intimacy into new and different forms.

David explained *“again another big area that there been more and more prevalent is the cross dressing”*

He went on to say he did not usually purchase his feminine clothes on line – *“No usually places like Marks and Spencer, Primark, occasionally on line, there are some specialist er sites as well for shoes, it would always be a shop so you can try them on for stuff like under wear sometimes there are sites you can get bargains”*.

Researcher – specialised clothing like rubber or leather ...

David – *“Oh yes yes anything like that..... in shops.”*

David 75

One of the most commonly mentioned adjuncts was the use of phosphodiesterase- 5 enzyme inhibitors (drugs in the Viagra group) for men experiencing erectile dysfunction. This group of medications are now commonly prescribed to men over 65 years of age. They have a good safety record but there are important side effects which include changes in the times within heart rhythm (prolonged QT interval) and this can be exacerbated in combination with cardiac medication. Other side effects can include facial flushing, headaches, nasal congestion and gastric disturbance. It is particularly

important that phosphodiesterase- 5 enzyme inhibitors are not taken with nitrate drugs (often given for angina) as they can reduce blood pressure, similar reactions can occur if given with alpha blockers,(drugs given for prostate problems) (Mahan Buttaro et al, 2014). The obvious difficulty is that the men who are most likely to need assistance with erectile dysfunction are those who are likely to have cardiovascular and prostate pathology and this presents the need for a delicate prescribing balance for clinicians. Additionally there are limits to the amount of medication that can be prescribed on the NHS and prescribing patterns are monitored at a clinical commissioning level.

David found the restriction on the number of tablets meant he had to purchase additional supplies in the form of private prescription.

Researcher- *“Now how many can you have a month?”*

*“Four, there is there is technically a limit four which is fine though having said that there are times when I can get an extra at first I did have to pay for them”*

David 75

The rationing of the phosphodiesterase- 5 enzyme inhibitors has not really been challenged within the UK and it is not clear how it was decided that four tablets a month was to be the standard option. Some clinical commissioning groups allow eight tablets per eight week period which does allow a little more flexibility. The difficulty with this standard approach is that for many men over the age of 75 four tablets per month may be too many. Northrup et al's (2013) repeat of the 1999 American Association of Retired Persons Study found that in people over 50 in the US 31% percent of couples had sex once a week, 28% a couple of times a month and 33% rarely or never. Clearly four tablets would be more than many older couples needed but for others, like David, supplies would be inadequate. Benchmarking penetrative sex intercourse at once a week creates further societal pressures on older people not only to have penetrative sex but to undertake it once a week.

Other participants spoke of their encounters with healthcare professionals and the provision phosphodiesterase- 5 enzyme inhibitors

Helen described the consultation leading up to her husband's prostatectomy

*“the consultant was younger than us but not like a 22 year old, we certainly had some written information about the operation including the possible side effects”*

*..... “Martin accepted Viagra fortunately he turned out not to need it given time...but it is there as an extra.....and I was very glad about that because we do have sex...”*

*Helen 75*

All the participants who spoke of taking phosphodiesterase- 5 enzyme inhibitors explained they would only get them from their GP not via advertisements,

*“I would never get it off the internet, no no any medication full stop is strictly via GP but medication a different matter if it was like vitamins.”*

*David 75*

*“The answer is is yes (to taking phosphodiesterase- 5 enzyme inhibitors if needed) that I would but I wouldn’t just go along. . I wouldn’t go on the internet and buy some Viagra”*

*Phillip 75*

Guidelines from the European Association of Urology advises the choice of phosphodiesterase- 5 enzyme inhibitors depends on the frequency of intercourse and the man’s personal experience of these drugs. However, the Department of Health has amended regulations to allow unrestricted prescribing of generic sildenafil for men with erectile dysfunction, Avanafil, tadalafil, vardenafil, branded sildenafil and alprostadil may only be prescribed on the NHS in certain circumstances (NICE, 2014b).

An additional adjunct to sexual intimacy that both male and female participants spoke of was sexual lubricants. Mahan Buttaro et al (2014) explain that more frequent intercourse and the use of lubricants can be helpful in promoting vaginal lubrication. The availability of sexual lubricants in many commercial outlets had not helped Joan purchase them,

*“I wouldn’t no, he would but I wouldn’t “*

Researcher –*“what would stop you?”*

*“buying stuff? perhaps embarrassment.....particularly when you are older, people look at you”*

Joan 75

David accessed free supplies through sexual health clinics

*“in fact it is in the safe sex packs ...But if I need anything else I go into clone zone(retail outlet) and that “*

David 75

Ray 79- explained *“you go and buy that cos that’s over the counter it’s not on the internet. I wouldn’t buy anything like that off the internet.”*

It is clear that the participants wished to manage any sexual difficulties with the support of healthcare practitioners, which creates a pressing need for clinicians to engage in this subject. Healthcare staff need to be informed about physical, psychological and social interventions which would benefit older people and most importantly to be prepared, both professionally and personally, to raise issues related with sexual intimacy. We have heard from a number of older people within the study how grateful they were that sexual issues were raised within consultations and once raised how there could then be an open dialogue.

In summary this section has revealed the testaments to intimacy that could be observed by others when looking at the behaviours of older people expressing sexual intimacy, these included; being close – both physically and mentally, cuddling, kissing, music and dancing, sexual intercourse, being naked, sharing a bed and using sexual adjuncts. The participants have revealed different personal preferences but there is a commonality of physical expression that reflects lust, attraction and attachment. The findings were regardless of gender but were influenced by the length of relationship. Many of the participants spoke of their current actions in the context of a sexual chronology which often

included other past partners many of whom were no longer living. Carpenter (2016) describes these linked lives can have a profound impact on sexual trajectories particularly in a socio historical context.

In the next section I discuss the findings that relate to how participants experience sexual intimacy and reflect where they are positioned as individuals on continuums that emerged from the data in Cycle 3.

### **The Continuums Meta-Themes**

The continuums represented the participant data that detailed experiences which had commonality but were across a spectrum.

In Cycle 3 they were presented in following way;

Not seeking help when difficulties arise	Feeling comfortable to seek help
Embarrassed about own sexual intimacy	Content about own sexual intimacy
Not able to discuss sexual activity	Able to discuss sexual intimacy
Negative sexual life story	Positive sexual life story
Clandestine expressions of intimacy	Demonstrative public expressions
No sexual connotations to everyday events	Sexual meanings attached to events
Relationships rapidly evolving	Relationships remaining stable
Disturbed by ageing	Relaxed about ageing
Keeping lovers separate	Fusing as a couple
Muddling through	Striving for the gold standard
Disapproval from friends and family	Approval from friends and family
Inequality of couples sexual expression	Equality of sexual expression
Dating	Maintaining a relationship
Confines of poor health	Integrating health changes



Changing residence

Holding on to home

Financial tensions

Financial Unification

In this discussion the sixteen broad themes have been combined into five slightly wider, interwoven, meta-themes. The overlap in some of the continuums requires discussion that draws on data and the evidence within adjacent themes. The aim is to provide a discussion of the findings that is not reductionist and acknowledges the interrelationship and complexity of sexual intimacy as discussed by the participants. The meta-themes have an intuitive grouping emerging from physiology, relational aspects, life course and help seeking attributes.

The themes have been linked into the following meta-themes

**Effects of ageing meta-theme which includes;**

Disturbed by ageing

Relaxed about ageing

Confines of poor health

integrating health changes

Muddling through

Striving for the gold standard

**The nature of relationships meta theme which includes;**

Dating

Maintaining a relationship

Relationships rapidly evolving

Relationships remaining stable

Clandestine expressions of intimacy

Demonstrative public expressions

**The family context meta-theme which includes;**

Keeping lovers separate

Fusing as a couple

Changing residence

Holding on to home

Financial tensions

Financial Unification

Disapproval from friends and family

Approval from friends and family

### **Seeking assistance meta-theme which includes;**

Not seeking help when difficulties arise seek help	Feeling comfortable to
Embarrassed about own sexual intimacy intimacy	Content about own sexual
Not able to discuss sexual activity	Able to discuss sexual intimacy

### **The sexual life story meta-theme which includes;**

Negative sexual life story	Positive sexual life story
Inequality of couples sexual expression	Equality of sexual expression
No sexual connotations to everyday events events	Sexual meanings attached to

### **The effects of ageing**

The participants experiences are situated in their ageing, Bradway and Beard (2014) explain that the historical epoch in which respondents come of age is important as it influences their chronology and thinking. Sandberg (2013:19) suggests a framework that aligns sexual changes that accompany ageing as the continuous production of differences. Many of the participants spoke about the ageing process, some still focussing on the desirability of youth,

*“Yes, yes and I thought he would be thinking I was younger than I am and think oh and I thought he would be upset and think I’ll get rid of her. that’s my main thing you see”*

Gloria mid 70’s

*“ I do like, to be honest a young guy preferably, but its not the be all when I say this and end all it’s nice if they are younger er and I guess what you might call a toy boy. There are guys that always prefer an older man there is a niche were they do like the older men”*

Fileborn et al (2015) describes a societal binary view of older people as asexual or “sexy oldie” focussed penile vaginal penetrative intercourse and youthful models of sex rather than intimate touch and affection. Freixas et al (2016) states, for the women in her study, sex is fundamentally genital, heterosexual and that autoerotism is associated with guilt. Freixas et al (2016) whose study was with older Spanish women found 76% said their sexual desire had diminished. This situation was not unique to women in the study. One of the male participants in this study, Fred, says;

*“yeh I think we have a good relationship....its ..sigh I suppose the sexual side is as toned down from what it used to be”*

Fred 80

Despite a wide range of perceptions about ageing the influence of changes in health were often discussed, notably fatigue, surgery and in women the effects of the menopause. Freixas et al (2016) found 10% over women over 70’s said their own self-image affected their current sexuality.

Bradway and Beard (2014) argue there is over diagnosis of sexual dysfunction with problems based on a medicalised and deficit based model which enables men to seek a quick fix for their perceived problems. Mano and Fishburn (2001) explain that biomedical models often reinforce a fixation of restoring penetrative sex by providing ways of overcoming erectile dysfunction and vaginal dryness. Some of these issues were discussed in the section in this study on sexual paraphernalia. Bradway and Beard (2014) suggest this ready response might mean we ignore the psychological and social causes of changes related to sexual intimacy for older people and that there may be unintentional consequences. This was not born out by most of the participants in this study, as Helen demonstrates when speaking about her husband’s prostate surgery.

*“So for example probably about 4-5 years ago my husband had to have um a prostate operation ... a TURP .. and the consultant was great he said beforehand you know there maybe erectile problems I can help*

*with that.....and so that was nice and then subsequently talking to other men and other couples and I have been quite up front about this um and they were very interested to know , it seemed to help because they defin... I think women tend to talk about things like that more readily than men do ... does that make sense” - Helen 75*

Helen highlighted the discussion they had as a couple but also the conversations they engage in with friends. However, others like Catherine and her partner did not speak about the issues even between themselves,

*“I think you can say that from being seventy I think because he couldn't manage sex erm ,because he did have prostate trouble, I think this was his way of... he just never talked about it he never said anything . .”*

Catherine 82

Card No sexual intimacy as such because of 70's Female operation on partner which stopped that. it would be nice just to have closeness

Fileborn et al (2015) explains that male erectile dysfunction increases with age, diabetes or prostate pathology and in consequence this frequently influences the women's sexual practices if they are in a heterosexual relationship. Many participants remained intimate in the absence of penetrative sex but did not always identify this intimacy as a form of sexual activity.

Fileborn et al (2015) speaks of the issues related to prescribed medication and the wide range of drugs which cause general reduction in libido. In this study

An anonymous card says

*“What is sexual intimacy – low libido, Too tired not feeling sexy – not wanting to show my body.*

Fred explains about his libido;

*“She saw that I had had a shave and she gave me a great big cuddle wagging her hips at me and pushing me and all her sort of excitement ... but of course it was the wrong time if you like, but there that's sort of*

*mood in her deep down and I think that over years I've learnt to temper my desire .. . I presume it the ageing process where my sexual desire is actually weakening..."*

Fred 80

Freixas et al (2016) argue that sexual difficulties are not an intrinsic aspect of ageing but are a complex set of factors determined by the values and cultural expectations that surround sexuality.

Multiple issues of ageing were present both for men and women in the study;

*"A couple of years ago I got ..oh god It can never remember ...is it lichen ... sclerosis....so I lived with the itching and went to see her she was brilliant and when I went for my check-up she said everything looks fine, everything looks nice and moist and she said then do you have any problems with intercourse, so I mean she raised it and I would have been very happy to tell her if I had but I didn't have..." -Helen 75*

On the continuum between muddling through and striving for the gold standard Ray explains some of the beneficial effects of sex on the issues of ageing;

*"No I think it overcomes the pain..... you get it in your mind and that's all that matters at the time ...obviously if you have a broken leg or sumink you have to slow down"*

Ray 79

Fileborn et al (2015) reflects there is a representation of successful female ageing as remaining engaged in youthful sex which Hinchliff and Gott (2008) refer to as the "sexy oldie" where sex is heteronormative with penetration occurring frequently. The grey literature searches revealed a number of self-help websites for both men and women provide advice to achieve or maintain this goal providing suggestions such as,

1. Communicate
2. Use a lubricant
3. Try a new position
4. Explore and discover

5. Make love in the morning
  6. Get some extra assistance
  7. Defy convention
  8. Set the mood
  9. Build up to it
  10. Increase stimulation
- (Senior Sex 2014)

This kind of information which is accessible on the internet provides helpful advice to older people but relies on the person having the necessary computer literacy and the ability and motivation to wade through a vast number of web sites that are plying medication or remedies for sexual difficulties. It is easy to see how unreliable and problematic access to high quality information can be.

Fileborn et al (2015) goes on to explain how the gap between sexual desire and activity, paradoxically, can be limiting if older people still desire sexual intercourse but it can also be liberating because the expectation of sex might be removed in later years. For Richard whose partner was at the end of her life he felt he was unlikely to have sex again,

*“I you know, you know its respect for your partner at the end of the day to me and I can honestly say to that my wife and I have no intention of finding anyone else for sex and or anything else,*

Freixas et al (2016) describe a qualitative difference in the experience and reality of sex after 70 , not simply that the desire for sex disappears but that there might be limited opportunities for women often due to partner loss (Das et al, 2011). There is, however, a small rise in those older women who experience new desire in sexual activity as they age. As has been previously stated sexual difficulties are not an intrinsic aspect of ageing but are a complex set of factors determined by the values and cultural expectations that surround sexuality.

We have seen in this meta-theme the effects of ageing are keenly felt by older people and alongside is the societal expectation that sex in older age is at least diminished if not absent. Whilst this theme is born out in the literature it is not as simplistic as older people age and in consequence desire less sexuality

intimacy or take on the mantle of asexuality. The individual nature of the circumstances, prior experience and expectations also shapes the experience and generalisations are not particularly helpful.

**The nature of relationships meta-theme which includes;**

Dating	Maintaining a relationship
Relationships rapidly evolving	Relationships remaining stable
Disapproval from friends and family	Approval from friends and family
Clandestine expressions of sexual intimacy	Demonstrative public expressions

The notion of dating in older age is becoming more common in the second decade of the twentieth century, particularly with the emergence of dating sites on the internet, singles groups for holidays and the more informal social events that occur in communities up and down the country. Participants spoke of friends who had used dating sites, their own new relationships and dancing groups being a means of introduction. They did express difficulties in these new relationships from a family and societal viewpoint. Loe (2011) discusses the concept of linked lives, where, as people become older they become more dependent on friends and family, who become stakeholders in the lives of older people and feel involved in the individual's choices and behaviours. This was seen in the recruitment phase of the study where both family and wider society acted as gate keepers when trying to approach participants. In linked lives having people invested in actions of the older person can mean opportunities for starting new relationships or continuing sexual expression may be reduced or uncomfortable to initiate.

A number of participants spoke of how they had developed new relationships, often in the context of their previous partner having died. They spoke of how courtships have changed over time reflecting back on initial courtships of their youth and on how they are now more experienced in relationships;

*“Well my wife was still alive and when she passed away, I didn’t see her and then her sister said come round for Christmas well I never mix*

*business and pleasure and I had worked for her sister but I well gave in, she said my sister will be there and a couple of others on their own, er but then it took a long .. quite awhile I saw her new year's eve after that and the er Valentine's Day er*

*Researcher- did it feel strange starting again ....*

*"I think you have a lot more experience of the world of people and things like that um yeh I don't know, yeh I suppose so getting to know someone else getting together, we have never lived together as such..."*

*Ray 79*

David is more focussed on the sexual side of a new relationship but still explains how important it is to know and trust a new partner;

*"oh yes (emphatic) absolutely, arhhh in fact full anal sex er that has to be with somebody that I have known for a while and trust them or em, I know their status as I want to be safe I do have quite a stock of safe sex packs, laughs laughs but to be honest other than anal sex the other can be just as satisfying".*

*David 75*

David was the only one of the participants to talk about participating in safe sexual practices in new relationships, perhaps he had benefitted from the sexual health advice that had been targeted at homosexual men in the 1980's. Helen raised the issue of sexually transmitted infections in the context of an acquaintance;

*"there must be an awareness that older people do have sex.... I remember .... This is not about me but a very close friend of mine told me that her mother in law had been widowed for quite a while came to see her and said she was going to go on holiday to Spain with a group of female friends and her intention was if she met somebody she would have sex with them and what did her daughter in law think of them.....and was she horrified and my friend said no that's absolutely fine...and just make sure you take some condoms and the mother in*



*law said don't be ridiculous...I can't get pregnant you know that ..and Jane said to her I know that but you can get sexually transmitted disease ... and the mother was ....it was about 15 years ago when age AIDS publicity had a much higher profile than it is now and yet it hadn't clicked with her....that she could be a risk of getting a disease....”*

*Helen 75*

Stuart and Graham (2015) state the number of people over 50 living with human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) will account for half the people in the US with the disease, mostly because people with it are living longer but also because they are engaging in risky sexual behaviour. Since post-menopausal women do not worry about pregnancy, they may be unthinkingly putting themselves at risk of STI's. Fileborn et al (2015) explains there is a lack of information about safe sex practices for older people and Omole et al (2014) suggests this may be because older people might not have received advice about condom use. It is important to remember that the silent generation saw great changes in the use and quality of condoms. In their life time condoms have become high quality carefully manufactured commodities and their use promoted widely, whereas previously, contraceptive use was only legal within marriage and condoms were bulky and difficult to use. An additional health related concern is that some of the symptoms of sexually transmitted infection may also mimic some of the uncomfortable symptoms of urogenital ageing such as itching or dyspareunia. Older people experiencing these symptoms may feel that the symptoms are as a result of older age and not seek help for an STI.

In this meta-theme the participants describe their enduring relationships and ones that were still developing, the pace of the relationships was very individual.

Card      Verbally given and written down whilst travelling.      76      Male

*“We just go with the flow we have a symbiotic relationship every year we have a summer break it gets rid of the sadness and the gloom.*

*Everyday whenever I get in I say hello darling and I give her a kiss. We don't have sex anymore but sometimes when we are in the kitchen I will creep up behind her and give her a cuddle, its important, it keeps our marriage alive when we watch tele I always sit down and hold her hand"*

*"I think that is a very individual in between the death of the partner and the arrival of a new person um would be um .. my friend...about a year ago she met some man um who he like very much and who....had been married to the same woman for many years very happily and she had died an.. and I think after six months after his wife had died and I know him too and he said .... Sighed ... he knew his wife wouldn't have wanted him to spend his life alone ...um ... and that he liked woman he enjoyed their company which actually a lot of men don't do they .. when you think about it or they are men's men, I don't mean gay they like to do boy things, so they went out a few time and they ... she really like him she .. he obviously liked her too but in the end he broke it off telling her he wasn't as over his wife as he thought, he wasn't ready enough to sort out a new replacement or relationship ... I'm sure he was very sad about it."*

*Helen 75*

*...it's more tolerant , than were we grow up we try to look after each other "*

*Jolene 78*

One area which was raised by many of the participants was the need to keep their relationships separate from friends and children or to manage the process closely.

The participants spoke of concern about new relationships in the context of their current families, usually adult children. They reflected on the ideas of replacement of spouse if they were widowed and how their children would feel if they felt if their late mother or father had been replaced.

Catherine describes

*“No no all that Mark said was “I’m pleased that it’s Uncle John if it had been a stranger I would have been very hesitant because it’s Uncle John I can accept it em”*

Catherine 82

Bradway and Beard (2014) explain despite sex being a significant desire and need that all humans share and experience throughout the life course. Older people’s sexual expression is often ignored or ridiculed by younger members of society. Gloria has a view on why children particularly find it hard to accept new partners of their parents

*It’s inheritance isn’t it, they will say it isn’t but it is,*

Gloria Mid 70’s

but Helen feels it is a more emotional issue,

*“She and he eventually, you know, started going out to together and it developed into something more meaningful and eventually they got married but she, she had two children, and her daughter took a very long time to um to come to terms with um that she actually had a serious relationship and it wasn’t quick after her husband had died and you know that was quite a definite gap but the daughter obviously didn’t like having her father replaced.”*

Helen 75

Despite the grief or loss experienced by adult children Omole et al (2014) explains such a loss of physical and emotional intimacy is a profound and ignored source of suffering for older people. Whether older people feel comfortable about expressing their intimacy in both enduring and new relationships is individual but in for the participants most were reticent about public displays of intimacy (except within their own homes).

Richard explains,

*“ No no, my view is that Pam is there and whenever carers come in, and we have continuity, our carers have been with us for four years and*

*I will give her a kiss and I will say sorry carers but I love my wife,”*

Richard late 70's

But for David the picture is very different,

*“No it would depend on the other guys attitude but for the most part ah no because well Alan and me we first did we, ere, all like lovey dovey inside the village (openly gay area) but then it grew down we didn't do it very much we would have a good snog just the two of us but fine no but um I think nowadays even though erm it's supposed to fine with society although there is a question mark over that its whether it remarked on or not”*

David 75

Bradway and Beard (2014) describe a cultural entwinement of sexuality with youth and beauty encourages people of all ages to perceive the sexual expression of older people as abnormal or disgusting and those who are sexual as deviant. As a gay man who first had sexual experiences when it was illegal to be homosexual David may be doubly disadvantaged.

However, when going out with a group of older people Jolene states the situation is different;

*“Oh yes . . . banter, a lot of banter, oh yes when I play cards with a group, we have a cribbage night I walk in there and they go oh god she's here again what the hell are you doing here get out on the corner and make some money! or they'll come up and give you a hug and kiss oh my honey I haven't seen you for so long , nobody gets shook up about that.”*

This was my experience of joining the bowls club, that public displays of affection were not an issue providing the majority of the members of the group were older people and knew each other.

The continuums in this section are closely entwined with the issues relating to the households of older couples who are in new relationships; this is also picked up in the meta-theme overleaf, that of the family context.

**The family context meta-theme which includes;**

Keeping lovers separate

Fusing as a couple

Changing residence

Holding on to home

Financial tensions

Financial Unification

For some participants within the study said they were “fused” in their relationship. Although his wife was dying Richard still continued to see themselves as a couple, he can imagine no other relationship;

*“er but the whole thing is I have no intention, I would not take my wedding ring off or if anybody starts showing any “well now you are free “and I would say sorry I still love my wife and hopefully that would start to put them off, and if it came to it I would say sorry I am not longer into to that game and I stop that years ago I’m no longer interested”*

Richard late 70’s

Whereas Jolene, who had a relationship outside her marriage for a long period of time, always kept the relationship separate, just as there is very little data about sexual intimacy in older age, there is even less written about extra marital relationships in older age;

*“It’s something you’ll never in you will never in your born day’s think you will do but it’s something. . .I’ll never regret doing it. No two people look through the same lens but you can get the same idea what the picture is, it was pretty good.”*

Jolene 78

Jolene also describes the relationship an older neighbour has with a male friend where it is entirely about sex, there is no pretence of romantic involvement and that relationship is separate from their friends and family;

*“they like to have someone to come over or to go shopping with . . . but they don’t want to get married, they just want a “booty” call ! laughs”*

Jolene 78

Gloria who has a younger partner also keeps that relationship separate from her friends despite romantic involvement;

*“Yes I never ever told people I had a a . . . I kept a little bit back I think it pays . . .to be a bit discreet “*

In Fileborn et al's (2015) study some participants said older women experiencing sexual pleasure was taboo even among their peers. Societal influences that render older people as asexual means that sexuality can be internalised and they may feel sexual activity is dirty or shameful. Such feelings are steeped in their personal sexual chronology and then reinforced by societal views. As Bradway and Beard (2014) explain, some older adults are embarrassed by their active sexuality and others do not act on, or admit to having, sexual urges because they internalise societal stereotypes. Some of the participants discussed the issues related to moving in together. Karlsson and Borell (2002) explain many older people who engage in new relationships have concerns about the effects on their wider families in practical and financial terms. Ray tells us,

*“well, um we thought of living together but when she was working she had she needed so much space and I wanted a lot of space and we couldn't find anywhere suitable”*

Ray 79

The bringing together of houses or apartments has resulted in different forms of co-habitation sometimes referred to as Living Apart Together (Karlsson and Borell, 2002) where people perceive themselves as a couple but for family or financial reasons choose to own or rent their own homes.

*“and I say there is no way we would have moved in together or if we had moved in together I would be moving into his er and he would have been in charge of it his family would have been able to walk in at any time open the fridge and say “oh you have got nothing much in there for me to eat” oh yes I fancy that and just eat it, my children have had to knock on the door, this is how I felt em it was a em it is clear open*

*friendship at all and I don't think he realises that, I am pleased we haven't moved in together I am pleased we kept our own places"*

Catherine 82

Previous studies have demonstrated that older women, particularly, are concerned with the financial risk of entering into a relationship with a man and in addition are fearful of a loss of autonomy. Catherine goes on to explain;

*"when I was in hospital the last time mine said to me have I ever thought of moving from here and going into a sort of group dwelling like thing em where there's a em a lounge em pause and I have thought about it since no this is mine er they are all private eh I own this place and I am quite happy here "*

Omole et al (2014) states that a change of accommodation such as joining a care home can signal the end of sexual life for individuals due to the open nature of communities and the practical implications of shared living.

### **Seeking assistance meta-theme which includes;**

Not seeking help when difficulties arise	Feeling comfortable to seek help
Embarrassed about own sexual intimacy	Content about own sexual intimacy
Not able to discuss sexual activity	Able to discuss sexual intimacy

This meta-theme looks at three interweaving continuums that emerged from the findings, it looks at how the participants felt about their sexual activity, whether they were able to discuss it with partners and friends and their inclination to raise issues with health care professionals.

Some of the participants were very strong in their refusal to discuss their sexual intimacy. Freixas et al (2016) found that her female participants had a great reluctance for older people to talk about sex. Joan mentioned;

Researcher – *"Is it something you would talk to your friends about?"*

*"No No . . . I wouldn't discuss that with anybody".*

But there are older people who feel able to discuss their relationships between themselves and with their friends and family even with the wider community. This difference can be partially explained by events along the life course. Freixas et al. (2016) describe sex in older age comprising a wide range of experiences which are heavily influenced by personal history as Joan 75 explains, she was brought up by her mother's mother;

*Joan 75- "Yes we weren't allowed to touch anything (parts of her body) or that was such a No No with grandma"*

One of the areas where studies have explored older people's sexual health is in discussions with health care professionals. Gott and Hinchliff (2003) explain that older people are rarely asked about their sexual health needs but when they are provided with the opportunity they are often pleased to discuss issues. There are very few models or assessment tools for assisting healthcare practitioners in the recognition or treatment of older peoples sexual health needs. One of the most common models which is the PLISSIT model of sex therapy sets out a therapeutic framework in which such issues can be discussed. Created by Annon (1976), the PLISSIT model; a proposed conceptual scheme for the behavioural treatment of sexual problems. PLISSIT has four levels of increasing intervention and interaction related to what kind of and how much help is given to a client. The varying levels largely revolve around what the client is looking for and how comfortable they are in discussing sexuality and sexual health.

The first level is **permission**, which involves the clinician giving the person permission to feel comfortable about a topic or permission to change their lifestyle or to get medical assistance. This level was created because many clients only require the permission to speak and voice their concerns about sexual issues in order to understand and move past them, often without needing the other levels of the model. The clinician in acting as a receptive, nonjudgmental listening partner, allows the client to discuss matters that would otherwise be too embarrassing for the individual to discuss.



The second level is **limited information**, wherein the client is supplied with limited and specific information on the topics of discussion. Because there is a significant amount of information available, healthcare professionals must learn what sexual topics the client wishes to discuss, so that information, organisations, and support groups for those specific subjects can be provided.

The third level is **specific suggestions**, where the specialist gives the client suggestions related to the specific situations and assignments to do in order to help the client fix the mental or health problem. This can include suggestions on how to deal with sex related diseases or information on how to better achieve sexual satisfaction by the client changing their sexual behaviour. The suggestions may be as simple as recommending exercise or can involve specific regimens of activity or medications.

The fourth and final level is **intensive therapy**, which has the clinician refer the client to other mental and medical health professionals that can help the client deal with the deeper, underlying issues and concerns being expressed. This level, with the onset of the internet age, may also refer to a specialist suggesting professional online resources for the client to browse about their specific issue in a more private setting.

Annon 1976

We have long acknowledged that there is need for healthcare practitioners to undertake an holistic assessment but it has been identifies that there are a number of barriers to this (Evans, 2013), in a continuing professional development article, he explains the difficulties in categorising sexual health, particularly in the presence of many and varied meanings and interpretations. Evans (2013) explains that some nurses feel ill equipped and may be too embarrassed to talk about sexual implications of medical conditions or treatment regimes. It is clear that the sexual needs of older people are rarely discussed in the pre-registration curriculum of any health care professionals (Omole et al., 2014) and the American Psychological Association believes sex is not discussed enough and there is inadequate training of physicians. Balami

(2011) in a study which surveyed 120 geriatricians found that only 57% took a sexual history but 97% believed patients with sexual problems should have help.

The lack of mutual discussion within the healthcare setting can result in increased embarrassment for older people and in consequence reluctance to raise the issue. This is not a specifically a US or UK issue. Freixas et al. (2016) explain that older women's sex lives are one of the most important areas of silence in Spanish culture.

For many older people both the normal processes of ageing and the pathological changes go unresolved because they are unable to seek help. In consequence older people who desire sexual intimacy keep this to themselves if they are experiencing difficulties and they may not feel able to approach healthcare practitioners. Those who do feel able to seek support may be asking for assistance from staff who are inadequately prepared and understand little about the person's values and mores. Some older people have gender and age requirements in order to feel comfortable discussing intimacy issues;

Phillip explains *"No emphatic I suspect I would, I would make sure the doctor was a male doctor"*

Phillip 75

Omole et al (2014) state older people can be particularly embarrassed if the health professional is young, of the opposite gender or is in a role they do not fully understand.

*"I would have no idea what the practice nurse knew and I would be hardly likely to go a pharmacist if I was having erection problems"*

Phillip 75

From the literature we have a picture of ill prepared health care professionals and embarrassed patients not discussing an important issue that has cultural taboo. Foucault (1984) suggested using the phrase "the triple edict", comprising taboo, nonexistence and silence and this triad was particularly

relevant to the descriptions of some of those who responded to the study. However, a number of the participants did feel comfortable discussing their needs,

*“Um I think I would probably go for the GP for my, for the GP I usually go to if I could but if he wasn’t available I wouldn’t have any desperate objection to go to anybody else it’s slightly, in some senses it might be easier with a stranger”.*

Phillip 75

Fileborn et al (2015) identified a common theme of a lack of information or advice. The sense of sexual self varies and embarrassment can block discussions with partners old and new some participants felt comfortable speaking to medical staff about their needs. Sandberg (2013) describes the medicalisation of sexual function as increasingly common partly due to greater awareness and partly because there is a range of medication now available. Fileborn et al (2015) explain that in their study participants expressed a need for education and resources in order to gain greater control and make choices about over their sexual experience. Practitioners should be able to discuss other forms of sexual pleasure and avoid imposing normative views on what older women’s sex lives should look like.

**The sexual life story meta-theme which includes;**

Negative sexual life story

Positive sexual life story

Inequality of couples  
sexual expression

Equality of sexual  
sexual expression

No sexual meaning  
to everyday events

Sexual meanings attached  
to everyday events

Older people have long and highly individual sexual life stories, participants gave their information in the context of sexual histories often referring to significant past events. Freixas et al (2016) explain that ideas and practices related to sexuality in youth become a system that determines the satisfactory experience of sex in older life.

Many described sad or distressing events that were not unexpected in lives which have spanned many decades and seen great changes in culture, medicine and understanding. Participants revealed difficulties in their sexual life story, of being ill informed in childhood, marrying early due pregnancy, affairs, bereavement and abuse.

Richard explained;

*“I was very much brought up a catholic where you know you can’t do anything, you can only have sex when you are married and it gave a feeling of sex being dirty”*

Richard late 70’s

Fred revealed he had affairs in his first marriage and said;

*“when I left I lived with another women and I met Polly through the music club because I’ve always been involved in music and I met Polly through music and um I’ve been once, I moved in with her which would be thirty years ago we meet in June thirty years ago and I have been faithful to her ever since. ....- because it was sort of ..I don’t know, a different relationship”*

Fred 80

The participants tried to explain the “reasons” for their current experience, they were not keen to delve into the detail and were simply accepting. It is important to say that none of the participants described current relationships that were abusive and this might well reflect the notion that people who are living within abuse relationships were not likely to enter the research. A previous study Freixas et al (2016) with 42 Spanish women over the age of 60 found 12.1% of the participants experienced unpleasant flashbacks and

4.26% said sexual insecurity affected their sexual activity.

One participant, Fred, did describe the sexual abuse his wife experienced

*“ I must say that Polly has had as a child a very traumatic life, um with a family member she was abused and this has affected her sexual*

*response , there are positions she doesn't like .....it really is quite traumatic but having said that she has grown through that,"*

Fred 80

Joan said of her first sexual experiences

*" No No I hadn't a clue"*

Joan 75

Fileborn et al (2015) state the context of the relationship and individual trajectories are fundamental to women's lives in understanding how they negotiate their sexual subjectivity. Richard provides a male perspective,

*"It becomes part of life you know, if you haven't got a friendship you haven't got anything, you know you might as well go on as sort of hire prostitutes"*

Richard late 70's

There is some evidence that positive changes do occur in later life and that new opportunities can emerge. Fileborn et al's (2015) research with partnered women in Australia reveals that older women's experiences of sex and sexuality are fluid.

A number of the participants spoke of very positive sexual histories and felt able to articulate their needs. Freixas et al (2016) found that 2.13% of older Spanish women wished to take the initiative. Fileborn et al (2015) suggest some women had a strong sense of what worked for them sexually and were more confident in asking for it. Jolene explained how she embarked on an affair after decades of marriage as sex with her husband had stopped.

*"It's something you'll never in you will never in your born day's think you will do but it's something. . .I'll never regret doing it. No two people look through the same lens but you can get the same idea what the picture is, it was pretty good."*

Jolene 78

And Helen explains her plans for the future

*...I have a doctor who's female and she's brilliant ... I'm still on HRT  
and I've told her that I intend to die taking it!* Helen 75

Inequality of sexual expression spans two major areas; firstly, the wider cultural perception in which men are fêted for sexual activity in older age and women are seen as asexual or the polar opposite of "sexy oldie". Fileborn et al (2015) state traditional gender roles, social and cultural views in later life shape sexual activity and desire in old age. Secondly the differences in sexual desire within relationships. Participants spoke of difference in desire in relationships of long standing and those which were relatively new. Freixas et al (2016) found that 12.77% of participants wanted to feel less obligation to engage in sexual activity.

The continuums illustrate the themes that were common throughout the data but individuals themselves were situated at varying points. One potential use for these continuums would be the development of a tool which might allow individuals or indeed couples to situate themselves on the continuums in order to commence a discussion with clinicians or with each other.

### **Phenomenological Findings**

In this part of the chapter I focus on the phenomenological findings which emerged from the data. Phenomenological analysis aims to provide a clear, accurate and complete description of the experience as it appears to those who have experienced it (Moustakas, 1991, Polkinghorn, 1989). In the data analysis section of Chapter 3 the participant's descriptions were broken down into meaning units, from these units the meanings were systemically extracted and examined in differing ways to obtain a clear account of the general structure of the phenomenon (Finlay, 2011). This process required my upmost attention and produced the greatest moments of discomfort and frustration I drew upon all the skills that Anderson (2011) describes as being required of a researcher using intuitive inquiry.

The lived experience in the texts revealed the essential meaning (essence) which held all the aspects together and within which the other parts were situated.

The essence was revealed as “Being Together” held within it were the parts of the whole that include;

- Maintaining intimacy in changing circumstances
- Setting current intimacy across a life course
- Concern about what people think
- The possibility of sexual intimacy
- The spectre of death

The essence and its constituents are described below and considered in relation to the literature and my own reflections.

### **Being Together**

To the participants to “be together” means to continue to develop as an existing or new couple, to change, adapt but remain close and maintain wellbeing. Syme (2014) identifies that intimate partners can be the most influential source of social support and that intimacy affects well-being through the construction of joint beliefs, behaviours and pooled resources. It would appear that part of “being together” is maintaining sexual intimacy in the face of changing circumstances both corporally and in habitation. There is an acceptance of changes in physical responses which varies in individuals and between couples. The changing nature of sexual relations is not always negative. Menard et al (2014), in a Canadian phenomenological study looking at older people having optimal sex, engaged with participants who reported having experienced “great sex”. Menard et al (2014) explain that the individual and relational factors that occur during the lifespan that led to optimal sexual experiences were overcoming early learning, openness to experience, mutual empathy and structure and depth of the relationship. In the phenomenological data the participants set their current situation in the context of a life course, acknowledging the earlier sexual events and expressing their wishes for

sexual intimacy in the future. Carpenter (2012) explains that both physical and mental health shape sexual feelings and conduct not only in the present but over time. The participants also expressed a concern about how they are viewed by wider society if they discuss or display sexual intimacy. The participants describe their adaptations and seek affirmation when providing explanations of the way in which they are currently managing. What binds all these parts is a sense of togetherness, of being together and being in it together. As Dahlberg (2006; 14) explains, the constituents are individualisations or particulars of the structure and thus the essence must be seen in every constituent.

Being together has many expressions but is always present in participant's explanation of sexual intimacy, Jolene describes this,

*"We had together to very slow dances and here's the stupid thing there no way, but I could manage and I look at him and I said do remember when we could really do this? And he said pah I'm all cracked now, it was though a connection . . . we hadn't danced for many years but we weren't dancing like we normally would you know we were really together . . . ."*

Jolene 78

Other participants explain,

*"but it's nice if you've got somebody who says you look nice em, you know if you have got a partner to go on with, there's a lot to be said".*

Gloria mid 70's

*"so he came with us for this erm birthday meal and he just didn't want me to . . . come home, ( said quietly) he wanted me to stay . . .pause pause"*

Catherine 82

*"we enjoy being away together er we enjoy our company together when we are away, I think more than being at home".*

Joan 75



Bildtgard and Oberg (2015) explain that post retirement provides time, free time to engage in personal pursuits or to spend additional time being together.

*“we appreciate each other, that’s very important”*

Phillip 75

Being together emerged as the essence and was present in all conversations with the participants. It was the characteristic without which sexual intimacy for older people would not be what it is, the landscape in which five other characters of maintaining intimacy in changing circumstances, setting current intimacy across a life course, concern about what people think, the possibility of sexual intimacy and the spectre of death play their parts.

### **Maintaining intimacy in changing circumstances**

Phenomenological analysis revealed that the effects of ill health on sexual intimacy are very apparent to the participants, usually this was as a slow gradual loss of previous activity often associated with long-term health conditions but sometimes acutely in the face of surgery or terminal illness.

*“if I couldn’t get an erection yes...but touch wood I can still, um I’ve had a couple of little problems I had a cyst in the wrong place and I had a little operation and then I had a biopsy on my prostate, that was a full anaesthetic so it’s put us back a couple of months but not now I am on the way back yeh.”*

Ray 79

67% of older men and 50% of older women described sex as being critical for a good relationship (Fisher, 2010) and the drive to maintain a sexual relationship appears strong. Galinsky and Waite (2014) in a quantitative study looking at secondary data in the US found that poor physical health was linked to lower positive and higher negative marital quality.

The participants spoke of the way in which they managed the changes that the vagaries of health had brought them,

*“I carried on after my first heart attack and I was ok but then things went a bit wrong and after four or five years I was not very well at all I went for a cardiac check-up and em I was . . . I said to the consultant I saw will I be alright to go away on a holiday in about a month’s time er it’s a big holiday we are all going to go to South Africa because he because John had lived there for a long time and his wife, they had sort of emigrated em and he had never wanted to take me before but he decided he would but a fortnight before we were due to go out I had another heart attack and so he still went because we were going to stay with friends of his. Em and em he still went because we would have lost everything were as I got all mine back on the insurance and everything and then after that we decided, were not right with me em and I would see a cardiologist and one thing and another and I had heart bypass um a year just about a year I had the bypass, I had to have a hysterectomy . . . ”*

*Catherine 82*

Despite all these life threatening difficulties Catherine and her partner continued to have a sexually intimate relationship but penetrative sex stopped. Delamater (2012) suggests that sexual intercourse is not the only way older men achieve sexual satisfaction and that the engagement in other activities of a sexual nature can be rewarding. Menard et al (2014) explain older individual are more likely to move away from culturally defined internalised norms for acceptable sexual activity. Lindau and Gavrilova (2010) found retaining an interest in sex was positively associated with good health and Syme (2014) asserts that a positive sex life can decrease pain sensitivity, lower levels of depression and increase self-esteem. For others maintaining sexual intimacy is doing something different, changing and adapting, Joan explains,

*“er no I think it is important we still have a bit of cuddling, I mean we don’t cuddle that much but it is important we have that little bit for us.”*

*Joan 75*

Syme's (2014) work supports this change of activity in saying many older adults shift the concept of sexuality to include other pleasurable and intimate behaviours such as hugging and kissing. The earlier "testaments to intimacy" describes this within this study.

The participants set out the issues in a factual way, they explain changes just as is, they don't rail or despair just accept, adapt and move on in different ways.

### **Setting current intimacy in the life course**

The participants are consciously aware of their togetherness as life circumstances change, they project forward and delve back into prior meanings they have of togetherness through their lives in a sexual chronology. Often the participants explained their outlook in terms of their formative family experiences harking back to the way in which they were brought up. They reflect on seminal/germinal moments in their sexual development and review them in the context of their current knowledge and perspective.

*"I mean sort of looking back erm ..... with my first wife Hope.....em sigh because in many respects I was very innocent about sex erm, it it was a very .....once she had allowed me to have intercourse with er before we were married ... it became the only thing I wanted and then she became pregnant and she lost that baby."*

Fred 80

For others there is a sense of the cessation of sexual intercourse, of a time for things to change, Joan describes this,

*"well we are getting too old for that well I . . .am anyway, well I think I had enough when I was younger".*

Joan 75

Refining sexual relationships is a common theme in older adulthood and that penetrative sexual behaviours may shift alongside changes in body image and sexual self-esteem. Western values of beauty, which often draw on notions of youth and beauty, are particularly influential for women (Syme, 2014).

However, Menard et al (2014), in a study about optimal sex suggest many of the older participants experienced their best sex within the context of a long-term relationship. The authors explain that knowledge of one's partner was an important contributor to optimal sexual experiences and was especially relevant in long-term relationships. This may provide an added pressure for those older people who start a new relationship in later life.

Carpenter (2016) sets out some of the essential elements researchers must adhere to when studying gendered sexualities and proposes it is the trajectories, turning points and transitions that must be adhered to and this is borne out in the comments from the participants.

### **Concern about what other people think**

Residing in a culture that frequently thinks of older people as asexual and where older people often feel unable to discuss sexual matters with healthcare professionals, friends or family, the participants own view of their sexual needs and behaviour is coloured by this clandestine life. They revealed an anxiety about what other people would think, including the general public they live amongst, Joan explains,

*“yes, particularly when you are older people look at you”*

Joan 75

This concern is supported by Gloria who had entered a new relationship in later life, she was concerned about people she knew seeing expressions of sexual intimacy that she and her new partner enjoyed.

*I was worried because the ambulance was going past and they all know me”*

*Gloria mid 70's*

Syme (2014) explains older adults learn sex is for the young and beautiful, in older age sex is shameful or non-existent and this creates an internalised stigma and low self-esteem. Lesbian, gay, bisexual and transgendered older adults are even less likely to express their needs.

Phillip clearly states

*“We wouldn’t want to overtly kiss in front of anybody really”*

*Phillip 75*

He then goes on to discuss the uncertainty about displays of affection in public places were not simply confined to areas where younger people might observe them, Phillip explains they experience discomfort in revealing intimacy regardless of “audience”.

*“em can’t say I have, I mean as I said I’ll ...general point of view would be that we don’t mind holding hands in public or me putting my arm round Jane in public from time to time, walking down the street erm arm in arm that sort of thing and perhaps an occasional peck ,we wouldn’t distinguish much between older than younger people, or if I did it would be the older people I would be less keen on of overtly displaying affection on the grounds it would be more like showing off then , sort of we still still have a sex life and you don’t.”*

*Phillip 75*

The quotes showed a concern about what “other” people think about the maintenance of sexual intimacy and a surprise when it is discussed. However, Fisher (2010), in an American study suggests older adults are becoming more open in their beliefs about sexuality and cites a majority now endorsing sex outside marriage perhaps endorsing a change from previous social mores. Syme (2014) believes that older people have a lack of knowledge about sex and remain embarrassed or uncomfortable experiencing a stigma related to beliefs about sexual behaviour in older adults being inappropriate. Conversely, Menard et al (2014) found some older people spontaneously and separately remark how their sexual experiences have improved in quality over their life course. Carpenter (2016) explains that the adherence to or discarding of sexual scripts is a key feature in life course theory and it would seem that the participants of the study displayed both characteristics. Sexual scripts are an explanation of how men and women are expected to interact with the opposite gender particularly in intimate or sexual relations (Gagnon and Simon, 1973).

Although the authors go on to explain that working through shame and doubt is part of rising above negative messages and was crucial for participants on a journey towards optimal sexual experiences.

### **Possibility of sexual intimacy**

Throughout all the difficulties the participants saw a potential for sexual intimacy, it remained, even in difficult circumstances, as something desirable that could be achieved.

Helen speaks generally,

*“I think that in later life you want physical relationships to continue, every opportunity should be explored so it can carry on... if it means something to people its part of their wellbeing, you know why not, why not.”*

Helen 75

The possibility of sexual intimacy is present in all the summaries, for some it is actual penetrative sex on a regular basis, for others it is a chance or opportunity that doesn't happen frequently but does come for all participants the possibility of sexual intimacy remains.

Gloria says,

*“oh that Andy he's coming and I thought . . . . I said to Gladys, she's 85, if anything's funny I'm coming back to a mattress in your room and she said, what a holiday you are going to have!”*

Gloria mid 70's

Ray explains the possibilities further, in the context of new relationships in later life

*“it was different, you're more mature, you know what you are doing....hopefully.”*

Ray 79

David describes regular weekly sexual intercourse with a partner known as MG and the possibility of sex with another partner who is arriving shortly but qualifies this by saying if sex doesn't happen he will still be satisfied.

*“no ... no um um er particularly with the MG I am satisfied.....That's with anyone else, well there is one coming this afternoon if he does turn up, again that's optional it's not something I would push, um if it happens I would be quite satisfied.”*

*David 75*

He speaks of his needs for medication to attain penetrative (anal) sexual intercourse, how his responses have changed and how he is managing this change.

*“Well it has changed and there are factors whereby I did have an enlarged prostate last year and that has affected things down below whereby em if I ....if I need to have sex I will take Cilalis and I did have to go and see the GP last week really to see if there is anything more he can give me”*

*David 75*

Hillman (2011) explains within the notion of the possibility of sexual intimacy sits a deficient in sexual health education. For many older people the fear of unwanted pregnancy has driven their contraceptive use including condoms. Sex in later life negates the risk of pregnancy for women and for most men, although it should be remembered that some older men may be engaged in relationships with women of child bearing age. Once the risk of pregnancy is removed some of the sexual health messages about sexually transmitted infection (STI) are missed by older people. This generation of older people did not have messages targeted at them during campaigns to prevent the rise in HIV or chlamydia and current health promotion has not been aimed at this age group. There has been a notable rise in STI's in people over 65 with poor health promotion, increased travel and rise in casual relations being blamed. Hillman (2011) suggests there remain misconceptions about sexual risk and

preventative practices and that there is a fear of negotiating condom use for older people.

Menard et al (2014) explain for the participants in her study, the good sex came about as the result of a very deliberate choice. The interviewees mentioned they intentionally practiced skills and sought out experiences they believed might help. It is reminiscent of the Cycle 2 lens "Use it or lose it".

### **The Spectre of Death,**

I have been inspired to look at this particular aspect which only emerged from the in-depth interviews that of the Spectre of Death, this was a unique finding that only emerged after moving away from the data analysis for a period of time. Anderson (2001) discusses "varying magnification" within the study and explains, using a microscope as a metaphor, looking at a slide using different magnifications which made objects change, the difference between seeing in detail and seeing globally is a theme running through the analysis of data. It was only when I retreated from the data a little I discovered this finding which brings into acute focus the difference a study with older people as participants has with any similar study with young or middle aged interviewees. Anderson (2001) explains the researcher needs to decide how much detail is required, at any given time, to understand the findings. This alternation between micro and macro analysis, can form and confirm new understandings about the data. She goes on to suggest that through immersion in the mundane a researcher may be driven into dead ends, but paradoxically this can unlock the bigger picture. In this study a thread was revealed that ran through the data which I have named the spectre of death. The spectre of death describes the frequent references in the data made by the participants of the closeness of death. It chimes with work of Bildtgard and Oberg (2015) who discuss time as a structuring condition behind new intimate relationships in later life. They theorise that post reproductive free time and remaining time have an important formative influence on new relationships later in life and describe a paradox of having lots of free time but little time left in life. For participants in this study the sense of a little time left was present in the frequent references to death, the notion that death was part of their lives and discussed in a matter of fact



way. It moves from an interweaving of passing references of acquaintances or friends who have died to the acute sadness of the realisation that one's partner is dying.

*“ Well is there a partner because she has been once before and this woman, she was a bit dotty, she's not doing it anymore, there was this man and he had only lost his wife last week, it sounds awful don't it . . . .laughs and she said he might be coming back”.*

Gloria mid 70's

*“Yes, unfortunately Pam is in the later stages of Alzheimer's and she has just transferred over to the NHS end of life care”*

Richard late 70's

*“but I must say I lost my wife 5 years ago...”*

Ray 79

Throughout the interviews the participants spoke of other relationships which had ended in death including those of their parents and friends. This presence of death in their conversations may be a reminder of how little time is left and the importance of enjoying a good quality of life before the inevitable end. Bildtgard and Oberg (2015) in their Swedish study found that although death was a constant companion for their participants most informants claimed not to worry about it.

Similarly in this study participants said,

*“ yes yes you get couples, there's one . . . This lady and gentleman they are always arguing, laughs they are real good dancers and somebody told me that she's got a terminal illness”*

Gloria mid 70's

*“And therefore, um I don't understand everything she says, but what I'm trying very hard to do is to make her know she is not on her own on her journey”.*

Richard late 70's

In speaking of his wife's forthcoming death Richard also describes the way in which death had previously affected the lives and procreation of their children.

*“ And the whole thing this Pam and I have got one child and we did that because at the time we had our Cathy we had both our mothers with cancer and in between that Pam's father died ..... of like a lung complaint, he fell down stairs and within week was dead, it's almost like you are looking in one direction and wondering which mother was going to go and you look over your shoulder and your father is gone, it's one of those things”.*

He goes on to explain how even in the closeness of death he and his wife maintain an intimate relationship;

*“When you die, and we talk about like that ,and she's not really frightened of dying it's the process and I just feel it's my love for Pam.... that makes me fall in for what her needs are and all, I mean just before you phoned, she was saying I love you so much and bits and pieces, and I just went across and put my cheek against her cheek and told her I love her, I always find kissing her around the face around the cheek I kiss her on the side of the mouth so she knows its special”*

Richard late 70's

Bildtgard and Oberg (2015) have described a sense of urgency in the realisation of finitude, that relationships are fragile and life together must be lived deliberately. They explain the acknowledgement that the remaining life together can be short and this increases the focus on seizing the day.

Felicity was a participant who helped with the trickstering component of the study and has not been mentioned previously as she no longer had a partner and therefore fell outside the study .Trickstering is a technique used in intuitive inquiry that is designed to confound, to create the paradox that challenges our assumptions, it is designed to exaggerate, dramatise or extend and is often achieved by using creative processes (Anderson, 2004). I asked Felicity to look at my work when I found it hard to gain participants, to critique my

approach and to deliberately explain why people would not participate. In looking at the study she also spoke about her experiences.

Felicity provides a history

*“Oh I’ve got one close friend he is now 90 and he lost his male partner three years after my husband died and we became great friends but now he is 90 he has lost all interest in doing anything”*

Felicity 84

She also speaks of the death of one partner being the opportunity to engage in another relationship and have more children.

*“That is very interesting because these men, widowers, who get married for the second time because their wife has died, in their 70’s and 80’s and they have another child .....sounds shocked. It’s very interesting, acquaintances, there were two that had died and they were in their 70’s and within six months they had married again !”*

Felicity 84

The desire to seize the day is one suggestion for such actions that couples make quick decisions to fulfil relationship plans before it is too late arguing there is nothing to be gained by being cautious (Bildtgard and Oberg, 2015). This can often be to the chagrin of children and family who may believe it is too quick or disrespectful to the previous spouse’s memory.

Jolene speaks of the additional changes death brings, the way in which life goes on but the practical implications change.

*“ you know that’s about it most of my friends are widows or widowers and in the later part of their lives when they, you know when, a friends husband came down with Alzheimer’s you know she didn’t have an idea where bills were paid , how to get plumbing done and she had to learn hard and fast.”*

Jolene 78

Phillip explains how he tempers his intimate responses in consideration of influence death has had over his peers.

*"I would be less keen on..... of overtly displaying affection .....Especially if its lots of women or any number of women many of whom whose husbands have died,"*

Phillip 75

David – *"I would prefer a male carer, having said that and I know that one the nursing side of it, they are all female and I just have to accept that Alan did have, in his last months, he did have treatment with a catheter and er he ere injections oh I used to know it off by heart".*

David 75

The effects of death is recounted by the participants, Catherine speaks of the death of her estranged brother and writing to his wife and this leads her on to speaking about John (her partner) and his lack of support to her and finally his difficulties with sexual intercourse;

*"he had a horrible death he had been poorly with cancer for six years erm he had two carers going in four times a day"*

Catherine 82

Whilst most of the participants had lost their partners later in the life course Catherine had lost her husband whilst young,

*"No there again my husband was only 43 when he died and for a number of years sex was very difficult for him anyway he had cancer of the colon and in that area,"*

Catherine 82

Carpenter (2016) explains the transitions in life when people move from one role to another are key in life course theory. For Catherine her young widowhood was an untimely transition and this would add to potential cumulative disadvantages that shape her sexual ideas and behaviour but

equally the positive experiences she had in developing a new relationship add to the cumulative advantages through her life course.

Helen spoke of the effect of death in changing the structure of relationships, with the notion of new relationships resulting in different forms of co-habitation such as Living Apart Together (Karlsson and Borell, 2002) where people perceive themselves as a couple but for family or financial reasons choose to own or rent their own homes or an even more remote state such as friends with benefits. Friends with benefits is defined as a friend with whom one has an occasional and casual sexual relationship, or a no strings encounter what Jolene termed a booty call. These are all examples of “seizing the day” Bildtgard and Oberg (2015),

*“I have two friends in that position their husbands died and another friend who was left by her partner probably about 14 years um... and they said I would never live with another man ...but both of them would like a partner for sex, for companionship, for someone to do something together”.*

Helen 75

Kotter-Gruhn et al’s (2010) research found that the perception of limited remaining time was related to attitudes, behaviour and goal setting. They also found that very old adults had accurate perceptions of their nearness to death.

The discussion of death formed part of the chronology given by many of the participants, they spoke of how death had shaped the formative years, the

*“Her father was killed at Dunkirk he was in the navy and his ship was hit, he was sunk he got the ....died, which left her mother with this two year old little girl, she has an older daughter erm .....my glasses have all gone funny on me...”*

Fred 80

Some of the participants considered what they would do following the death of their partner with Helen explaining...

*"I know now I am an intensely territorial like if Martin died ..this is MY... house and if I had somebody else living it..... it would raise the hackles on the back of my neck.....if the did anything wrong .. I don't mean wrong and I think when you are older you have more complex lives you have .....friends already and thing is that you do that you are unwilling to give up, should it be necessary, but when you are younger you don't think about that so much."*

She goes on to say;

*"I think that is a very individual in between the death of the partner and the arrival of a new person um would be um .. my friend...about a year ago she met some man um who he like very much and who....had been married to the same woman for many years very happily and she had died an.. and I think after six months after his wife had died and I know him too and he said .... Sighed ... he knew his wife wouldn't have wanted him to spend his life alone"*

Helen 75

Taylor (2014) in a phenomenological study that looked at the experiences of sexuality and intimacy in terminal illness, discussed the experience of connecting and disconnecting within the coupled relationship, she describes this as a state of being "towards death as a couple", going on to say the coupled relationship is also dying.

In the study participants thoughts turned to relationships after the death of a couple with Helen saying;

*"Um I did meet a lady she is probably little younger than me but her husband has died and she has a new partner who she had known for many years and his partner died too and there was quite some time between them and she and he eventually, you know, started going out to together and it developed into something more meaningful and eventually they got married but she, she had two children, and her daughter took a very long time to um to come to terms with um that she actually had a serious relationship"*

*“ I know he’s clear and not with my late partner never did because we knew....in fact right at the beginning we were both tested...and it came back fine...”*

The phenomenological analysis revealed this constituent that was not discovered in the thematic data analysis that produced the observable indications of sexual intimacy or in the continuums related to thoughts and feelings. Whilst this facet of data analysis has been time consuming and complex it has yielded considerable new knowledge and a constituent of sexual intimacy as experienced by the participants.

#### **Cycle 4 Lenses**

Cycle 4 integrates the data with literature to develop an understanding of the subject then produce the final “lenses”. Anderson and Braud (2011) explain that the research process transforms the preliminary interpretative lenses from Cycle 2 in light of engagement with the collected data into the new understanding which are seen as the Cycle 4 lenses. Again Anderson and Braud (2011) provide some experimental exercises to help the researcher prepare for the development of Cycle 4 lenses, these involve focusing on your own intuitive style. Anderson and Braud (2011) believe there are many initiative styles. I completed the exercises but was not able to identify the perfect antecedents to encourage my own intuitive style. Anderson and Braud (2011) explain that knowing how one’s intuitive processes work makes it easier to have breakthrough insights. I had learnt from the work in Cycle 2 that I had to be doing something with my body, moving or creating something in an automatic way in order to think. I produced some lenses but knew they were simplistic and forced. I became aware my most intuitive work in my clinical practice occurred when I was under pressure, usually when someone was very unwell or distressed or when I am teaching someone who is working alongside me. I also have moments of insights when presenting at events or conferences, clearly being in pressurised circumstances suits my intuitive style. By chance

I came across the perfect circumstances for the development of lenses. I was asked to give a presentation on my work at a national ethics conference, I was anxious about this and had created a workshop that had audience involvement. The audience were senior ethicists based in the UK and this increased my anxiety. Once the workshop was over I took questions and someone asked what the key new learning from my research was. I was immediately able to list the discoveries I made, to judge what was important, what was new and what had changed. As I was explaining this to the audience I saw the lenses I had been searching and it seemed to be a woman on the stage rather than me who was articulating them. This “third person” approach worked well for me but I had to contrive situations where I was “giving a presentation” in order to achieve the clarity I was seeking.

What follows is the description of the Cycle 4 lenses that emerged after delivering a presentation but followed up by a period of indwelling.

- Making hay while the sun shines
- I'm a dirty old man I'm a dirty old woman
- Hope and promise of sexual activity
- The potential loss of creativity and change
- The power of media and medicine
- The little die and the big death
- What comes next, a dawn in understanding
- The whispering professional voice
- Increased chances of relationships

The next section looks at the comparison between the Cycle 2 and Cycle 4 lenses to illustrate where the research has taken me. It exposes the differences in understanding from the initial Cycles drawing on the contributions from the participants and the additional review of the literature.

For ease I have set out the Cycle 2 lenses are set out below;



- Lack of availability of partners,
- Entrenched images of vulnerability
- Keeping joyful, magical secrets
- Dirty old man, frigid old women
- Muddling through the inevitable changes
- Negotiating new lifestyles
- Reclaiming sex from the young
- Leaving it to the specialists
- Using it or losing it.
- A twilight in knowledge and understanding

The completion of Cycle 4 presents the final interpretive lenses, it is the culmination of personal engagement, the literature and the generously offered participant data (Anderson, 2011).

There is now a detailed comparison between the final lenses and the Cycle 2 lenses which were described at the start of the study. The degree of difference between the lenses is varied, some have been changed from their origins and have been challenged by the process, others are entirely new and unexpected, some had their beginnings in the Cycle 2 lenses and have grown. Esbjorn (2003) titles the range of lenses as “change”, “new” and “seed” lenses. Change lenses are those which emerge through earlier assumptions that have been challenged, changed or transformed through the research. New lenses are unexpected findings that delight and enthrall and the “seed lenses” signify lenses that were nascent in the lenses of Cycle 2 but greatly nuanced and developed in the course of the intuitive inquiry (Anderson, 2004). I have added an addition to describe the lenses which merged and took on a greater complexity, a richness that captured the 360 degree nature of the data analysis and simply would not fit into the three types of lens, previously described. I have entitled these lenses “compound lenses”, built of more than one previous lens, they occur where the diverse aspects of vision become fused together. In science a compound lens is one that consists of several simple lenses usually arranged along a common axis. The analogy from this study is where

the lenses that were clear and transparent in Cycle 2 (simple lenses) over time become fused to form one entity, the compound lens with a common axis. An example of a compound lens are concepts of “Lack of availability of partners” and “Negotiating new lifestyles” were simple lenses in Cycle 2 that became the broader, more nuanced lens of “Increased chances of relationships”. This compound lens occurred as the participants and further literature informed the understanding of the topic, exposing richer opportunities through such things as intergenerational marriage, divorce and extra martial affairs rather than the simplistic understanding that because men die earlier than women in the UK, there are many heterosexual women who do not experience sexual intimacy because there are no men available for them.

In order to provide an overview from the discussion I have provided a table below which identifies both the Cycle 2 and 4 lenses and describes the type of lenses they emerged as.

Cycle 2	Cycle 4	Lens Type
<ul style="list-style-type: none"> <li>Lack of availability of partners,</li> </ul>	Increased chances of relationships	Compound
<ul style="list-style-type: none"> <li>Negotiating new lifestyles</li> </ul>	Increased chances of relationships	Compound
<ul style="list-style-type: none"> <li>Using it or losing it.</li> </ul>	Making hay while the sun shines	Seed
<ul style="list-style-type: none"> <li>Entrenched images of vulnerability</li> </ul>	Entrenched images of vulnerability	Seed
<ul style="list-style-type: none"> <li>Keeping joyful, magical secrets</li> </ul>	Hope and promise of sexual activity	Compound
<ul style="list-style-type: none"> <li>Reclaiming sex from the young</li> </ul>	Hope and promise of sexual activity	Compound
<ul style="list-style-type: none"> <li>Dirty old man, frigid old women</li> </ul>	I'm a dirty old man I'm a dirty old woman	Seed
<ul style="list-style-type: none"> <li>Muddling through the inevitable changes</li> </ul>	The potential loss of creativity and change	Change
<ul style="list-style-type: none"> <li>Leaving it to the specialists</li> </ul>	The power of media and medicine	Change
<ul style="list-style-type: none"> <li>A twilight in knowledge and understanding</li> </ul>	The whispering professional voice	Seed
	What comes next, a dawn in understanding	New
	The little die and the big death	New

Table 4. Comparison of Cycle 2 and Cycle 4 Lenses

If we first focus on the Cycle 2 lenses of the “lack of availability of partners” and “negotiating new relationships”, they became intertwined in Cycle 4 and

grew into the compound lens “increased chances of relationships”. The lenses which in Cycle 2 I generated from my exposure to the literature and my own experience in working with older people changed dramatically as the research evolved. Older people are beginning to explore new relationship models, such as “living apart together” (Karlsson and Borell, 2002), where older people perceive themselves as a couple but for family or financial reasons choose to maintain separate homes. Additionally, older people are increasingly experiencing intergenerational sex and may have multiple partners. As Giddens (1992) explained, in the later part of the last century individuals were now able to pursue relationships for the quality of the relationship alone, breaking the confines of tradition and increasingly without the moral sanction of either society or state. These potential ways of living are maintaining the promise of sexual intimacy in later life and can be supported by new medicines and new technology as well as refined products and an increasing social freedom which has changed through the life course of the silent generation (Carpenter 2016). This then became a compound lens encapsulating the idea of “negotiating new lifestyles”.

“Using it or losing it” was a lens that reflected the literature that people who had good sex lives continued to have good sex lives, that the act begot the act and that some older people wished to continue their sexual intimacy and were prepared to work at it. Older age is a time which is frequently synonymous with loss, including loss of mobility, loss of money, loss of homes and loss of partners. The Cycle 2 lens had a sense of hard work, many of the participants spoke about the need to keep going, to hang on to what they had to maintain the close connections that comprises intimacy (Jamieson 2011). The study data initially chimed with this first lens but as the participants spoke further about their relationships, particularly new relationships, there was a much more joyous tone, a sense of fun and of grasping opportunities. As Simon and Gagnon (1984) explain post-paradigmatic societies such as the UK have a wide variety of sexual behaviour and individuals can develop their own paths. The sense of fun and of opportunity resonated with the phenomenological constituent of “the promise of sexual intimacy” but was more urgent and more driven. Having reflected on the findings along with some of the literature a

change lens emerged of something more light hearted and positive, this change lens has been entitled “making hay while the sun shines” and harks back to the more agricultural beginnings that many of the silent generation experienced.

The lens “entrenched images of vulnerability” which originally established that older people were as seen as vulnerable by society at large continued throughout the course of the research as Simon and Gagnon (1984) suggests there is little sense of sexual scripting as people at the ends of the life course are frequently seen to be post sexual. Additionally, in UK culture, in which the research was situated, older people are indeed seen as vulnerable, in need of protection, rarely seen as sexual beings, never depraved or predatory and often barely capable of making their own choices. My work in researching this topic occurred at a time of a sexual exorcism in the UK when there were many high profile court cases into historical sexual abuse of children following investigations such as Operation Yew Tree which commenced in 2012. There were a large number of inquiries into historical sexual misconduct in established organisations such as the British Broadcasting Corporation and a number of high profile schools. Many of the convicted perpetrators of these historical sexual crimes were now older men and had been high profile media celebrities’, people who were still considered role models, young for their years, trendy aspirational figures with knighthoods or accolades. This provided an urgent need to think about what would happen if one of the participants of the research intimated or explained that they were a perpetrator of sexual abuse. All the ethical questions from sponsors and the university ethics committee focused on the actions I would need to take if I discovered one of the participants was being abused in some way. I had put in place access to a help line and I have considerable experience managing such circumstances as I have previously been a safeguarding lead. Nobody had raised the issue of older people being perpetrators of sexual crimes or illegal activity. Clearly this demonstrated how we, particularly healthcare professionals, maintained a perception or image of older people being sexually vulnerable due partly to the focus of our mandatory training and clinically we are more likely to see people who have experienced abuse. In the initial literature review I explained in some

detail that the original search relating to sexual intimacy resulted in studies that projected an extremely negative and vulnerable picture of sexual activity in older age, with research on sexual abuse, care homes and sexual activity whilst living with dementia forming the majority of the literature. As professionals we are shaped by these images and our training and practice is such that the most frequent discussions many of us have about sexual intimacy relating to older people are concerned with safeguarding issues and those of mental capacity. This lens remains despite the growing body of research and discussion in mainstream literature, I am constantly faced with disbelief that sexual activity occurs between consenting older people when talking to people, regardless of their occupation or age. Far from Foucault's (1978) "discursive explosion" conversations between professionals, in medicine, nursing and the judiciary have been scant in respect to older peoples' sexual activity. Therefore this lens remains unchanged and continues into Cycle 4.

The two Cycle 2 lenses "keeping joyful, magical secrets" and "reclaiming sex from the young" fused over the course of the study, becoming a compound lens of the "hope and promise of sexual activity". This reflected the magic of possibility that things can be rearranged, augmented and changed. However, these feelings or intentions are often kept secret from others, this maybe to heighten the sense of sexual frisson but may also relate to the notion of embarrassment or shame (Syme 2014). It links to participant's interviews and contains the idea that sex is for people of all ages. Reclaiming sex from the young was a powerful message from the literature that large numbers of older people do not feel older age puts you past sex and that this myth should be countered thereby developing new cultural scenarios (Simon and Gagnon 1984) if not for themselves but for others in their generation, this was supported by some but not all of the participants. These two lenses joined in promise and hope to make the compound lens seen in Cycle 4.

In Cycle 2 as I meditated on the literature, particularly the grey literature, the lens "dirty old man, frigid old women" emerged. As the interviews took place I began to sense a clear and definable change which was articulated in Cycle 3 findings as "I'm a dirty old man, I'm a dirty old woman"



Image 7 Seaside Postcards

When it commenced as a seed lens drawn from the literature support by cultural codes and displays such as postcards and comedic programs such as Benny Hill and the Carry On Film series. These are views which are now seem as anachronistic but were very much part of the consciousness of the silent generation, when portrayals and visual images of anything sexual rare and those that were seen were talked about as being “naughty or saucy” supporting Foucault’s (1978) earlier suggestions about an insidious increase in rules and control. Langer (2012) explains that in western culture sex is seen as being only for the young. The initial lens focused on the fact that stereotypical images of dirty old man and frigid older woman remain and ageist beliefs endure despite improved understanding of sexuality and effective treatment for sexual difficulties (Weeks 2002). The stereotype is gendered and enduring. The reality for the participants was more complex, the sense that being older and engaged in sex was considered inappropriate by some of the participants and should be hidden (Menard, 2015). It is a kind of internalised shame. There seem to be links with patterns in eroto-phobia and homophobia, of internalising desires not talking about them and therefore perpetuating a shame. It is the dichotomy between keeping joyful magical secrets to keeping shameful secrets. The life course work provides some explanation of why for some older people sexual intimacy should be celebrated and for others it should be hidden. It is entwined in the uptake of sexual scripts and social and historical context of their sexualities as well as the other key identity features such as health, social class and ethnicity. In Cycle 4 the developed lens encapsulates the shame both genders allude to in being named “dirty old man, dirty old woman”.

“Muddling through the inevitable changes” was a lens that changed dramatically during the course of the study and became the change lens “The potential loss of creativity and change”. The original understanding of this lens was the sense that older couples managed the changes that occurred in later life with a sense of togetherness, of making the best of things and without complaint, they muddled through. Jamieson (2011) explains that intimacy is multi-dimensional and that equality can mean practical acts of love and care. It reflected something of their generation, the silent generation, who had endured much and learnt to be grateful. Through the course of the study in reflecting on the data and the most recent literature, I had moments of clarity and realised the expected changes of ill health and normal ageing that were, until recently, being managed by couples are now in danger of being medicalised, as Foucault (1978) suggested confining sexuality and “cures” from sexual ills into medicine retains both control and censorship. These perceived difficulties are now subsumed into the development of magic bullets, Viagra, pumps, injections, that deal with physical functioning rather than the negotiation and creativity that happens between couples. This reinforces the gold standard of sex, maintaining or re-establishing penetrative heterosexual sex. Such innovations or treatments do not address the emotional and psychological changes that happen as part of ageing in a sexual intimate relationship or the continuation of sexual intimacy that does not involve penetration. Potentially it reinforces two tiers of sexual relations and diminishes creativity and new phase accomplishment by trying to continue a standard that for some older people has never been achieved. Hence the Cycle 4 lens “The potential loss of creativity and change”.

“Leaving it to the specialists” changed into the lens “The power of media and medicine”. In Cycle 2 this lens emerged from the sentiments of healthcare staff that discussing sex was something best left to specialists, those in genito - urinary clinics, sex therapists or psychologists, that the subject was dangerous to discuss and should be left alone similar to Foucault’s (1978) earlier suggestions that originally knowledge was held by an elite. Interestingly, it seems that many professionals defer to an elite within their own ranks, those who have the skill and time to engage in sexual conversations with older people Mueller (1997). The staff believed the correct decision, should a sexual



issue be brought up by patients was to refer on to the specialists rather than an acceptance that discussion about sexual health is an essential part of a holistic clinical assessment, something they should all undertake. Over the five years of the study, this notion is changing but still far from being part of a holistic assessment for older people, what is described, rather troublingly, as Comprehensive Geriatric Assessment (CGA). CGA is seen as the evidence based approach in clinical assessment of older people's needs (Welsh et al., 2013) whilst mentioning both social and mental health considerations it does not explicitly reference assessment of sexual health needs. Clinical conversations were more embedded in urogenital settings both in discussions about surgical interventions such as prostatectomy, as part of continence assessments and to a lesser extent medication, both drugs specifically requested to resolve erectile function difficulties and those medications such as beta blockers that have erectile difficulties as a side-effect. I was fortunate in having an article published in a nursing journal with a large clinical readership written with a continence nurse specialist which addresses some of the issues of assessment demonstrating an increased willingness of mainstream nursing journals to publish articles on sexual assessment by "general nurses" (Garrett and Tomlin, 2015). The more I considered this lens in the later stages of this study I started to experience a sensation of stealth, or attitudes trying to creep up on and take control of the sexual intimacy of others, of the media and medicine usurping couples who were trying to manage their own issues. During the course of the study there was a sudden proliferation in British films, television series and articles about sexual activities and older people. Often the characters were portrayed by "national treasures" such as Judi Dench, Maggi Smith and Tom Conti, this awareness and open discussion about sex, new relationships and love in later life was to be applauded, however, the use of such beautiful and relatively youthful stars means a resonance of such lives may be difficult for "normal" older people. It also supports the idea seen in the "gold standard" of sex that it is for the beautiful and the young (Armstrong 2006). My change lens reflected this move to control and shape the lives of older people in a way that has increased societal pressure on the young.

The seed lens “A twilight in knowledge and understanding” developed into “the whispering professional voice”. This started with the clarity that we, as professionals, do not know enough about sexual intimacy, rarely talk about it and often do not wish to understand or engage in discussions about it that somehow sexual intimacy is outside our sphere of practice. As the study progressed and I started to talk to many groups at conferences or in study sessions, when they were able to step back from every day practice, many staff are interested in the notion of sexual intimacy and how their patients experienced it. They agreed that there should be an assessment of sexual health needs and acknowledged it was part of an holistic assessment at any age but felt stifled by their own lack of knowledge and skill (Peate 2004). Additionally, the processes inherent in current healthcare systems are not conducive to supporting unplanned sensitive communication. Examples of the process difficulties can easily be seen, for nurse practitioners to raise these issues in GP surgeries it is difficult during the limited time slots they had, similarly for staff working in acute trusts the emphasis was on managing the acute illness. Clinical areas which offered opportunity for sexual health assessment or discussions were rehabilitation settings and those which involved pre clerking or outpatients.

However, we have seen the increase in research literature in the subject, the emerging arts and media exposure of sexual intimacy, the body of knowledge is growing, there are whispers that perhaps we are not good at talking to patients and other professionals about sexual intimacy.

A new lens is “a dawn in understanding” and the sense of what is to come for this research area both for patients and professionals. This is a new lens developed out of the study, the next generation of older people and new possibilities in clinical practice supported by cultural and lifestyle changes. It is an optimistic lens of a baby boomers shaping services and having more freedom to discuss their needs. The technical potential in sexual robots, better medication, more open communication wider internet opportunities for products and services are all possible. We see changes in Jamieson’s (2011) ideas of privileged knowledge of individuals within relationships. That “disclosing intimacy” between partners in a time when divorce or death may be

more common for the participants means the idea of having privileged knowledge of another is only transitory and as relationships change the participant's privileged knowledge has previously been shared with deceased partners.

It should be acknowledged these are potentials in developed wealthy countries and there will be huge global variations Jamieson (2011).

The final and most powerful lens is a new lens entitled "the little die and the big death", it describes one of the unique contributions of this study that death is ever close to the participants. It is an artistic lens that echo's something of sexual intimacy in literature and poetry. The language of Shakespeare's time uses the euphemism that to die is to experience an orgasm and the French describe orgasm as "le petit mort" ("the little death"). Aristotle believed sex had a direct life shortening effect and the work of the metaphysical poets, John Donne writing "each such act, they say, diminish the length of life a day". So death has often been present in our ideas of sex of draining and of taking the life from us or in the very real sense of sexual transmitted infections, notably AIDS which (Giddens 1992) reconnected sexuality with death. For the participants death was an ever present neighbour, entwined in their lives now, harked back to in passing or discussed in troubling reality as Carpenter (2016) explains death features clearly as a turning point as it approaches and for those left behind. Death was often a galvaniser since they had of seizing the day or truly understanding what life was about, a wisdom and discussion unique to sexual conversations. Death was something that was unlikely in any conversation with other age groups about sexual intimacy.

## Chapter 5 Completing the hermeneutic circle

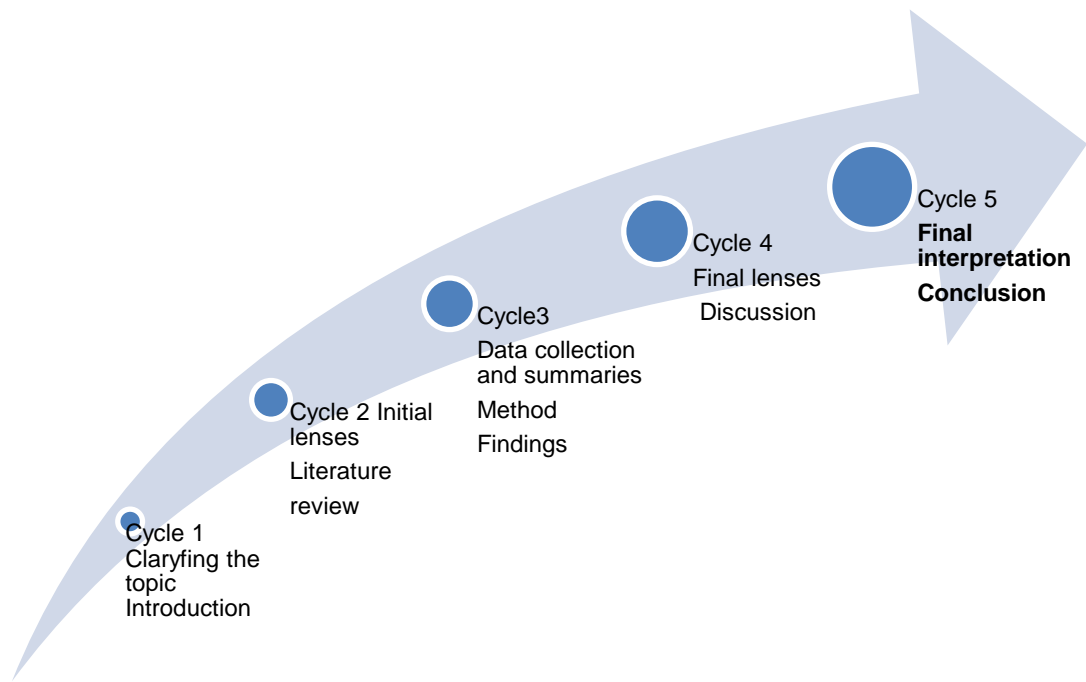


Diagram 8. Illustration of Cycle 5 in Intuitive Inquiry

In Cycle 5, the intuitive researcher stands back from the entire research process to date and takes into consideration all aspects of the study anew, as though drawing a larger hermeneutical circle around the hermeneutical circle prescribed by the forward and return arcs of the study (Anderson, 2011). Moustakas (1994) explained that the hermeneutical circle is where scientific understanding occurs, it is where we correct our prejudices or set them aside to hear what is said to us. Our understanding of the subject is as a whole which is established by reference to the individual parts and our understanding of each individual part is in turn referenced to the whole.

In a conventional empirical study, the researcher returns to the literature review conducted prior to data collection and reevaluates that theoretical and empirical literature in light of the results. The final integrative arc of intuitive inquiry is more demanding still. Not only must the researcher re-evaluate the literature in light of the results of the study, but review the elements of the forward and return arc in order to evaluate both the efficacy of the hermeneutical process (Anderson, 2011).

In other words, the researcher must determine what is valuable about the study and what is not, sorting through the assets and liability of the forward and return arcs and their own view of the research topic. In Cycle 5 intuitive researchers must honestly evaluate and tell what they have learned and what they feel is still undisclosed about the topic.

In considering the research I reflected on what has been learnt about sexual intimacy not just within the study or from the literature, but also from those I have presented to or spoken with, and I have focussed on the hermeneutical circle as urged by Anderson (2011). All the different discussions of sexual intimacy I have engaged in have shaped my understanding, these have been with family and friends, colleagues and participants, on line and on twitter. The conversations have been thought provoking and challenging I have frequently been questioned at conferences and when delivering presentations and this has been hugely helpful in clarifying my thinking. Appendix 4 gives details of the speaking events and conferences at which I have presented.

This section looks at the strengths of the study and the areas that might have been illuminated further. Additionally, setting out my learning about researching sensitive issues with older people and some interesting omissions in the ethical thinking about the study. The Cycle also explains the desire for post-doctoral work, notably in the way in which participants in the study delivered their stories, reflecting the findings involving the rhythm and meter of the dialogue. As previously mentioned in the discussion about data analysis, the interview data revealed an unusual delivery in the way in which the participants spoke about sexual intimacy. They opened the conversation and seemed to test me out with their language and the nature of their revelations. The possibility of documenting this finding thoroughly within the study has been lost but remains alluring. Included in this reflection is the study's unique contribution to the body of knowledge about sexual intimacy and older people in the UK.

From the outset it was clear sexual intimacy for older people was a private, little known phenomenon, an essentially human behaviour shrouded in

mystery. The findings were set in the context of UK culture and western morality enveloped the understandings of bodily pursuits. The cultural and moral elements were particularly relevant to the silence of the generation who participated. This generation, those who are now in their late seventies and eighties, are seen as traditionalists who had lived and learnt through great social upheaval and the deprivations of the WWII and its resultant rationing. The literature review revealed a dearth of primary research and a lack of clear definitions in order to progress the study. I had to establish a well-developed understanding of the aspects of the sexual behaviour I planned to look at, this understanding was synthesised from the literature and my own imaginal dialogue with the image I had chosen and the poem I had written. In order to define the scope for the work, which pragmatically had to be undertaken in the confines of the doctoral programme, I needed a definition to explain the topic. Through the course of this research a unique definition of sexual intimacy in relation to older people has been created;

*“In the context of partnership relationships, particularly those of long standing, sexual intimacy for older people may be seen a reciprocal or mutual action or sense of presence which results in a shared experience or frisson. This moment or moments in time evoke a sexual excitement, contentment or pleasure which have both physical and emotional elements that are life affirming.”*

This forms my first contribution to the body of knowledge about sexual intimacy. This definition has been shared widely through my presentations and the reports to the Florence Nightingale Foundation.

Having established a definition informed by the literature I considered the main themes generated by scrutinising the extant literature. Many themes chimed with my personal knowledge and thinking from the years before commencing my formal research but a number of the themes were new. In Cycle 2 I described the literature review and creation of the primary lenses for the study. Three overarching themes emerged in my mind. Firstly, there was information that set the scene, providing facts, population data, biological findings and cultural changes related to older people that I included as an overview, most

of this information I was familiar with particularly the physiological factors related to ageing. Secondly, there were a large number of articles that focussed on the negative views concerning older people and sexual intimacy which I documented as barriers. The sheer quantity of this negative information focussing on disabilities and difficulties shocked me and demonstrated these intense, ingrained negative attitudes to older people's sex lives. Finally, I was able to find some hopeful and positive literature which I entitled enablers to sexual intimacy, this demonstrated successful sexual ageing and the enhancements people made to their demonstration of sexual intimacy. This section was initially refreshing but as the study progressed I became aware of the dangers of over medicalising enhancements to sexual intimacy and how these developments, particularly in pharmacology can reduce the creativity and flexibility of older relationships.

### **Contributions to the body of knowledge**

The findings in Chapter 4 and the final Cycle 4 lenses revealed new constructs in the knowledge around older age sexual intimacy. The close proximity of death in the lives of older people and their desire to seize the moment while it was still available, regardless of social mores, came across as a new consideration within sexual intimacy research. The range of observable acts of sexual intimacy including cross dressing and sado machoism that do not change simply because the person ages have been rarely mentioned in the extant literature. The notion of internalised stigma, not being able to speak about ones sexual needs because it seems wrong to still be engaged in sexual activity and this thought supported by the fact that we, as healthcare professionals, generally fail to discuss the subject except prior to invasive surgery. All these were new findings and add to the body of knowledge.

The study provides a deeper understanding of the phenomenological perspective from a group of people who are rarely approached to participate in research, the essence of being together, whether in new or enduring relationships was important, particularly in the context of healthcare where the majority of our work focuses on the individual rather than the couple. The constituents of the phenomenological findings.

- Maintaining intimacy in changing circumstances
- Setting current intimacy across a life course
- Concern about what people think
- The possibility of sexual intimacy
- The spectre of death

All the above provide a greater understanding of the lived experience of older age sexuality and teach us much about how to address issues of sexual intimacy cross the later life course.

The strengths of the study include new learning about researching sensitive topics with an older old population have relevance and have been written up for publication. I was particularly motivated to ensure that any findings were published alongside the research and that an increase in awareness can be made current and not wait for the five years until the study was completed. In addition to the publications (Appendix 4) the use of radio and twitter was extremely important to me. Finlay (2011) describes good qualitative research as demonstrating relevance that it adds to the body of knowledge, enriches our understanding of the issue and can improve practice, I hope that I have achieved a little of this in the study.

## **Cycle 5**

My reflections on the hermeneutical circle are set out in four broad sections; The subject, the method, professional and the personal transformation. In each section I have endeavoured to articulate the contribution of the research to the wider body knowledge and my own transformation and I have also described the limitations of the study.

## **Reflections on sexual intimacy**

The study has added further evidence to the body of knowledge particularly in the ways older people manage their sexuality in the eyes of the wider world, keeping the activities distant and rarely initiating any discussions about them,



despite a readiness to talk when approached by healthcare professionals. The closeness of death appears in older people's conversations about their lives even when they are discussing a joyful event. This adds to our understanding of sexual intimacy in older age and is the second unique and perhaps surprising contribution.

The limitations of the study were in the time available for data collection, the study could have run for a number of years and yielded further results. Sexual intimacy is a uniquely individual subject, influenced by the desires and behaviour of one current partner, the sexual life course and the computations are huge. The difficulties in recruitment hindered the study and lost time, as did the work with the television company that did not come to fruition, it was a source of frustration but fundamentally it was important ethically to withdraw from a piece of work that might have been superficial and sensationalist. Conversely a documentary might have showcased the potential of sexual intimacy to a wider audience including older people and had further reach than an academic study. I do not believe it would have served to improve the quality of my research but may be worth revisiting now that there is data on which to build messages.

As previously discussed in Cycle 4 of particular personal sadness was the inability to usefully capture the rhythm and meter which seemed to emanate from the discussions. I had thought this might have provided an aid to communication with patients when discussing sexual issues in the practice setting. There was a tantalising moment when I envisaged a learning aid for professionals that would alert them to the moments in conversation when an older person was most able to reveal their difficulties and the healthcare professional might be able to identify this point and provide optimum circumstances for disclosure. As I reflect on this part of study, I have had a moment of clarity in considering the tempo, crescendo and pause of the delivery style of the participants, I wonder now if musical interpretation might be the key and this tantalising thought galvanises me to consider another piece of research.

An additional area for future consideration is the possibility that when generating the continuums from the data they might be used for identification of synchronicity or discord between couples. An example might be asking couples to identify where they sit along the continuums prior to a consultation or therapy session and areas of convergence might be positively highlighted and areas of divergence might be addressed and worked on by couples with therapists or healthcare practitioners. These two aspects of the study lend themselves to further research work.

### **Reflections on the method**

In reflecting on the method section of my learning I explore what I have learnt about qualitative methodologies, methods and data analysis, notably the experience of using intuitive inquiry and the practice of phenomenology in explaining the credibility and rigour of the method and the unique contribution this study makes within UK research methods. Finlay (2011) describes the best qualitative research as having evidence of rigour, resonance, reflexivity and relevance, ultimately only the reader can assess the quality of the work in this way but within the thesis I have tried to assess the work using this criteria. The decision to use intuitive inquiry was not a difficult one, it came from a joyous leap of “fit” as soon as I read Anderson’s (2011) work I knew I had found what I was looking for. I had spent some time investigating the appropriateness of other methods. I explored a range of qualitative methods including, narrative analysis, discourse analysis, ethnography and grounded theory considering them to a point of exclusion and then found no reason to exclude intuitive inquiry.

I have revisited my reflective diary that was written at the time of searching for an appropriate methodology to answer the question and see that following a supervision session I have written;

“Carefully consider good practice in issues of recruitment, DON’T MIX METHODOLOGY – read Five ways of analysing data – Wertz”

August 2012

In re reading this I can say that I have been true to the method and the issues of recruitment did indeed require considerable thought and tenacity.

The use of intuitive inquiry may be the first in a UK study, I contacted Rosemarie Anderson at the beginning of the study and she was not aware of it being used. Intuitive inquiry has provided a flexible, rigorous, creative and rewarding method to uncover the experiences of sexual intimacy for older people. I have been faithful to the directions set out by Anderson (2011) and trusted that the ritual would guide me. I have managed the thesis using the structure laid down by Anderson (2011) aware that there was built in flexibility to be guided by intuition and the nature of the data as it emerged. As a novice researcher, there were times I felt lost in the philosophical underpinnings of the method but in seeking to understand the essentials of intuitive inquiry I learnt so much about qualitative research methods. My learning was also supported by undertaking a post graduate research certificate in research training alongside this programme of study. I hope my journey through the research demonstrates how I have systematically thought through my actions, guided by the method and that the interpretation of the findings is plausible. Finlay (2011) states that audit or testing should be possible in good qualitative research, I had the opportunity throughout the study to present my work at conferences and to give presentations to peers, in addition to my supervisors which enabled me to receive feedback and to get some sense of whether the work was plausible. Finlay (2011) believes that dialogue with others is a way of establishing rigour and there has been various waypoints along the journey when I have been able to speak with older people to hear their views on the research.

Research procedures and protocols can be seen as ritual (Anderson, 2000), of embedding rigour and once procedures are in place they should be followed with care and precision; over time good methodologies like good maps generate trust. This idea I liken to rigour, to doing something well, thoroughly articulating the choices made and the reasons for those choices. Anderson (2000) tells us that an introspective and intuitive perspective is demanding and rigorous and believes that following procedures allows the researcher to relax

into the sustaining process of the investigation. I suspect I have brought a very British sensibility to the process, that I have been a little constrained, anxious not to alienate the reader but the method provided me with perfect clarity, every time I became lost I returned to Andersons work and like opening a map it guided me to my destination.

I chose intuitive inquiry, when I was seeking funding it was the chosen method and has endured, it was dynamic and exciting finding out about the method was an invigorating as finding out about the subject. As a part time student the nature of studying is disjointed, it is hard to immerse yourself in complex ideas for relatively short periods of time but intuitive inquiry afforded me that privilege by providing a map that I diligently followed.

In Cycle 2 Anderson and Braud (2011) provide experimental exercises to guide the researcher in the process of intuitive inquiry, encouraging the identification, often visually, of the texts which “standout” or enthuse. The process involves using aids to record ones thoughts, such as pencils, scissors, crafting pieces etc., I am very easily distracted and find thinking difficult unless the right side of my brain is engaged in activity, recording my ideas on paper was too distracting as I started to doodle or make things. Finally I found a process which worked for me, I would go to a local retreat with my articles, have tea and read them and then I would walk around the lake. The first time round I would be observing the changes in the trees, the plants that were coming up, usually with a scarf around me to shelter from the wind. Then I would repeat the walk which would allow me to think about and talk to the texts, I would repeat the process until I had nothing more to say. I would use my Dictaphone or simply retain the thoughts in my memory (I am fortunate to have a good memory). Then, usually wet and cold, I would sit by the wood burner and write the most important impressions I had. I hope my openness about the research process throughout the thesis goes in some part to demonstrate my self-awareness. Finlay (2011) in writing about reflexivity asks the researcher to consider their own subjectivity and positioning and to demonstrate ethical integrity within the study. I have given many examples of my internal questioning throughout the study and trust the deliberations and actions have

demonstrated this. Below is an extract from my reflective diary in December 2016 providing an example but throughout the thesis I have explained my reasoning in order that my decision making is transparent and reflexivity apparent.

“Wish I had some training in psychology before I started this, some of the terms and arrangements within intuitive inquiry would have been easier to grasp; the notions of archetypes and scripts were not something I have encountered. If, when I first decided on this method, I had had a broad understanding of phenomenology I may have undertaken the interviews in a different way,”

### **Professional Reflections**

Anderson would see this as the transformational process that the study brings to the individual researcher, for other students who have used her method, they are highly revelatory sometimes painful documents. As indicated earlier the work has had a more tentative and restrained personal transformation for me. The narrative deals with my personal growth and understanding whilst undertaking the study, revealing some of my motivations for the study which were hidden at the start of the work, my understanding of the power of professional training and how interpretation is the devil on your shoulder as a clinical nurse.

In helping to understand the ever presence of interpretation in nursing and what it means to be nurse, to care for people emotionally and practically, to offer one's self as an instrument of support. I had a chance conversation with a PhD student from another university whose study was looking at the assessment process in nursing, our thoughts coincided about the shaping of behaviour at work and the way in which we thought of our work

Set out below are the details from that conversation written in my reflective diary;

“we both raised the same issue, of our difficulties in simply understanding our data, rather than trying to use it, to formulate or devise a treatment or intervention. She felt she had just started to enjoy her data, to play with it were

the words she used. She was much newer to her nursing career and perhaps more fluid in the way she thought the information participants gave her.”

For a lot of the time I had to keep myself in check, to truly listen to my participants, to be still and absorb their words not run ahead and assume an ending. There is a truism in clinical practice that the last thing the patient says, the one said as he leaving through the door is the most important. I had to stay in the conversation to capture that rather than interpret what had gone before. My professional understanding has increased, particularly in sharing my insights with others and attempts to make sexual intimacy “mainstream”. There is so much to be done, not simply in the sharing of knowledge but in helping staff manage their own discomforts about the topic and in acceptance of the wide diversity of beliefs and values. It is in this richness we are more able to support the people we work with and each other.

### **Personal Reflection**

So finally what does this all mean to me, a 54 year old grandmother, a lesbian who has had a painful, vibrant and enduring relationship with sexual intimacy, had I experienced any of the personal transformation Anderson describes as part of intuitive inquiry? Clearly being drawn to this study is not just chance and cannot simply be explained in the conversations I have had with patients. I have had long conversations with patients about gardening and their pets, about finance and the nature of being unwell, none of those subjects stimulated a desire to research and think about for five years and to write thousands of words.

Throughout my life the sequale of sex has brought me serious illness, a premature child, a dead child, many operations, time away from work and associated medical complications that nearly took my life by way of a respiratory arrest and the love of someone who, literally, saved my life. It has brought me enduring emotional pain, social ridicule, long periods of hiding and intrigue and finally a relationship that I had never dreamed of. My lack of knowledge about psychology would, at the beginning of this research, never have allowed me to see the links in choice of subject, my hidden fears for later

life, but this work has enabled me to understand something of this. I have great hopes for a future where intimacy is always possible and where those who have gone before quietly share their special knowledge of what makes things work and how sexual intimacy can be as diverse and special as it has always been.

My research has not caused me to up sticks, change my career, experience a road to Damascus moment, rather it has led me to a more comfortable place of small enjoyment and thankfulness. The process of study was carried out in university in a new geographical area a couple of hundred miles from my home, I was over 50 years old and home sick for the first time. I was deeply frustrated by this dislocating experience and the research provided something consuming and purposeful that I could do. In consequence I never resented the time spent on it or the struggles I had with new learning and understanding, except perhaps the philosophical underpinnings of phenomenology which both perplexed and excited me. So in the uncovering more about sexual intimacy I have moved from a hugely driven and unkind place to an acceptance of differing possibilities more real and more valuable than I imagined.

## **Conclusion**

The conclusion concisely sets out the contributions to knowledge that the thesis makes, both empirical and theoretical and including the implications for practice and education.

- The first empirical contribution is the discovery of the in which older people acknowledge and appear content with the closeness of death in their lives, death appears in older people's conversations about their lives even when they are discussing a joyful event. There is a sense that the awareness of death encourages older people to seize the day and grasp opportunities for sexual intimacy. This adds to our understanding of sexual intimacy in older age.
- The second empirical contribution was revealed in the observable actions of sexual intimacy and uncovered two findings which were not

previously explored in the literature. Firstly, the importance that older people place on being naked together and secondly the significance of sharing a bed.

- The study's first theoretical contribution is a new definition of sexual intimacy for older people.

*"In the context of partnership relationships, particularly those of long standing, sexual intimacy for older people may be seen a reciprocal or mutual action or sense of presence which results in a shared experience or frisson. This moment or moments in time evoke a sexual excitement, contentment or pleasure which have both physical and emotional elements that are life affirming."*

- The second theoretical contribution are the continuums which were organised into five meta-themes: the effects of ageing, the nature of relationships, the family context, seeking assistance and the sexual life story. These continuums which can be seen in their entirety on p 164 provide a spectrum on which individuals might identify their current personal positions. There is potential to devise an assessment tool that might be used for identification of synchronicity or discord in sexual intimacy between couples.
- The final contribution is the use of intuitive inquiry as a method for researching older people's sexual intimacy. The method is highly suited to developing a deep understanding of the topic under consideration and allows the researcher to immerse in the subject (Braud and Anderson, 1998). Additionally, intuitive inquiry provides a systematic and rigorous approach that incorporates both objective and subjective knowledge through an interpretive process. The flexibility of the method, both in data collection and data analysis allows the researcher to be guided by both the participants and the data. This method allowed a sensitivity to the participants and countenanced creative approaches to data analysis without which some of the unique findings would not have been revealed.



## **Implications for health practice and education**

Ultimately this research was about being able to improve the care healthcare professionals offer our patients in relation to their sexual intimacy.

It is clear that sexual intimacy remains an under discussed and under considered part of healthcare practice. Sometimes added to the “too difficult or too specialist” area of assessment and intervention. It is also clear that many older people are keen to discuss their issues and may value particular interventions. Understanding sexual healthcare models and implementation of strategies such as the PLISSIT model (Annon, 1976) may give practitioners the underpinning framework to manage these situations. Advanced communication skills training, which are frequently used, for example in end of life care, might be extended to include discussions around sexuality, as should opportunity to practice these skills. Healthcare practitioners should be encouraged to discuss sexual intimacy in clinical supervision in order to understand their own concerns and to feel more confident in raising the topic with their patients. Comprehensive Geriatric Assessment (Welsh et al, 2013) should be broadened in it is remit to include sexuality and work has been undertaken with the British Geriatric Society in order to develop this.

In prescribing practice the side effects of medication should always be considered in relation to the effect on sexual intimacy and conversations with patients around prescribing may also provide an opportunity to discuss sexual health needs.

Healthcare practitioners should recognise that some older people wish to remain naked particularly with partners to allow skin to skin contact and they should be afforded the privacy and time and to do this. This may need to result in changes in practice in organisational settings such as hospital and care homes. Additionally those practitioners supplying equipment to older people, particularly related to pressure relief and to assist transferring from bed to chair should lobby and encourage manufacturers and commissioning bodies to source mattresses and hoisting / transferring equipment that are compatible with double beds.

In healthcare education sexual intimacy should be routinely included as part of education to undertake holistic assessment and the necessary communication skills practiced in a safe environment in both pre and post registration education. The reflective nature of clinical practice should encourage practitioners to explore their own views about sexuality across the life course and to be aware of the individual nature of sexual health needs.

An understanding of what constitutes good sexual health and sexual health advice is very important and healthcare practitioners should be taught this with particular reference to the knowledge, skills and attributes their own professional group can bring to the patients sexual journey. All staff should be able to articulate public health messages around sexual intimacy and should be aware of which agencies and specialist services can be accessed if required.

Finally,

In sharing my work as it developed and to provide some momentum in the subject I do stand-up evenings as part of events hosted by a professional comedian who was also a scientist. These events allowed me to talk to a public audience and I chose to do this through poetry. I now conclude my thesis as I started, with a poem;

### **Poem - Intuitively Researching the Vital**

This is too rude

This is unheard of

In tea rooms and halls the search it began

Doors shut, phones unanswered, flyers discarded

But I know you're interested

And I know it's real

I know I can uncover it

Just tell me how you feel.

Victoria Wood she sang about it, Halifax is famed

Beaten on the bottom with a woman's weekly

Indian marigolds the same.

I know you're interested

And I know it's real

I know I can uncover it

Just tell me how you feel.

The radio and notice board

I tried to pull you in

The say you are invisible

But I can see your game.

You haunt the country side

You sidle round the town

You're having out there

You just don't give a dam

AND I know you're interested

I know I can uncover it

Just tell me how you feel.

Ok so you're embarrassed  
You can't talk about it yet  
But I'm a nurse you see  
I know your blood, your pee and sweat  
Your tears and gapping sadness  
The little time that's left.

SO I know you're interested  
And I know it's real  
I know I can uncover it  
Just tell me how you feel.  
You grab it both hands  
And feel its life and spread  
Deaths dark spectres there  
But it doesn't have you yet  
I know you are still interested  
And I know that it's still real  
I know I can uncover it  
Just tell me how you feel.

You're small and old and precious,  
Your children think they care  
To keep you safe and trouble free

We really can't go there.

I know you are still interested

And I know that it's still real

I know I can uncover it

Just tell me how you feel.

And you still want a life

To breathe and laugh and dare

And yes the ones you loved have left

But still there's more to spare

Some tenderness and sex

You're kissing and fucking

Rubbing and sucking

Injecting the energy

Warming the bones

Still

So I know why you are still interested

And I know that it's still real

I know I can uncover it

Just tell me how you feel.

In saunas and on cruises  
In hotels and at home  
Over 30% over once a week  
You're doing it more than the young

AND I know you're interested

And I know it's real

I know I can uncover it

Just tell me how you feel.

And now you let me with tantalising glances

Of love and primal lust

Bondage and cross dressing

Music and dancing

Ashes to ashes

Dust to dust.

Always nearby your spectre of death

Ok so you're embarrassed

You can't talk about it yet

But I'm a nurse you see

I know your blood, your pee and sweat

Your tears and gapping sadness

The little time that's left.

SO I know you're interested

And I know it's real

I know I can uncover it

Just tell me how you feel.

You keep it all in hidden from the young

Underground under covers

Under tone

But worse still you keep it from yourselves

Hidden smitten dazed and disgusted,

You can't do it

Won't do it, shouldn't do it, but you do

Come out in light the ultimate cupboard

Do it love it share your thoughts

And I stand privileged, embarrassed at your generosity

In awe of your kindness.

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## **Appendices**

### **Appendix 1. Participant Information sheet**

#### **PARTICIPANT INFORMATION SHEET**

##### **Study Title**

**“What are the experiences of sexual intimacy in people between 75-85 years of age in the United Kingdom in the context of partnership relationships?”**

Thank you for considering taking part in this research study. Before you decide if you would like to participate you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish.

Part 1 tells you the purpose of the study and what will happen if you take part.

Part 2 gives you more information about the conduct of the study. You are welcome to ask me if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

##### **PART 1**

###### **What is the purpose of the study?**

The purpose of this study is to find out more about older peoples experiences of sexual intimacy. We are not exclusively interested in sexual intercourse but the intimate activities that are part of your relationship. The information we gather from this study will be used to help to influence services for older people. It is being undertaken as part of a PhD in Healthcare Studies.

### **Why have I been invited?**

You have been invited to participate as you are between 75-85 years old during the study and have a partner. We hope you will be able to share your thoughts and experiences about sexual intimacy so we can learn from it.

### **Do I have to take part?**

No you don't have to take part. It is up to you to decide. I will describe the study and go through this information sheet, which is yours to keep. I will ask you to sign a consent form to show that you have agreed to take part. You are free to withdraw at any time without giving a reason.

### **What will happen to me if I take part?**

If you agree to take part in the study you will be asked to complete a consent form and then talk to the researcher. The interview will be audio taped.

### **Expenses and payments**

Unfortunately I am not able to provide expenses or payments but I will offer you refreshments.

### **What are the possible advantages and disadvantages of taking part?**

Taking part in this study may be helpful in influencing services for older people

A potential issue is that participants may choose to reveal sensitive information, which results in sadness or discomfort. I am an experienced nurse who can support you if this happens or tell you who is available to help you.

### **Will my taking part in the study be kept confidential?**

Yes. I will follow ethical and legal practice and ensure all information about you will be handled in confidence. Your name and personal details will not be recorded in the research study. The information you give may be quoted by in a publication but your name will not be used.

This completes Part 1. If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

## **PART 2**

### **What will happen if I don't want to carry on with the study?**

You are free to withdraw from the study at any time. Any information you provide can be withdrawn up to the time of transcription. (The point where your information will be anonymised).

### **What if there is a problem?**

It is very unlikely that this study would cause any harm. If you find the experience of participating uncomfortable or upsetting you are free to withdraw at any time without giving a reason. If the study brings up any sad or unwanted thoughts the interview can be stopped and you will be given information of services that can support you.

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do her best to answer your questions, Researchers Name Dawne Garrett. You can also talk to my lead supervisor Prof Mark Hayter. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure.

### **Will my taking part in this study be kept confidential?**

- Your confidentiality will be safeguarded during and after the study in the following ways. Your contact details will be stored in a locked filing cabinet at The University of Hull which is accessible only to the Researcher
- Your name will not be recorded on the audio tape of the interview, if you use names when being interviewed these will given a pseudonym during transcription. The tapes will be stored as above.
- All recorded data will be stored securely for until the end of the study and then destroyed.

### **What will happen to the results of the research study?**

The researcher will use the information from the interview to help teach healthcare professionals, and influence services for older people.

The results of the study may be published and presented at conferences.

You will not identifiable in these publications or presentations.

The researcher will send you a summary of the research for your information if you would like.

### **Who is organising and funding the research?**

This research is being organised by Dawne Garrett a PhD Student in the Faculty of Health and Social Care at The University of Hull. I am a registered nurse with many years working with older people. I am very experienced in discussing sexual matters.

My work is supervised by Professor Mark Hayter and Professor Kate Galvin  
My course is supported by the University of Hull.



### **Who has reviewed the study?**

The research has been approved by The Faculty of Health and Social Care Research Ethics Committee, University of Hull. The role of the committee is to ensure that your safety, rights, wellbeing and dignity are protected. If you choose to participate in this study you will be given a copy of this participant information sheet and a signed copy of your consent form.

### **Further information and contact details**

If you would like any further information you are welcome to contact Researcher Name on 07851434087  
Thank you for reading this information.

### **Support is available from**

Age UK.

You can contact the Information & Advice Team by calling 0800 169 65 65. (They are open seven days a week, 8 am - 7 pm).

Alternatively a full list of the downloadable information guides and leaflets published by Age UK can be found by following the link below:

<http://www.ageuk.org.uk/publications/>



## **Appendix 3. Example of Handouts given to participants during presentations**

### **Talking with older people about sexual intimacy**

With ageing comes change, and sexual function is one part of that change. Though the human body may not work exactly the way it used to, older people can and should enjoy the intimacies and pleasures of closeness with another person. The physical changes people experience don't have to mean that intercourse and intimacy are out of the question. Intimate physical and emotional connections are natural and healthy. Intimacy in later years stimulates the body much like exercise does.

"Individuals with sexual and intimate relationships will have better health and well-being than those whose relationships function less well or who lack such relationships," as Linda J. Waite of the University of Chicago says.

There are very few UK studies but The University of Chicago surveyed 3,000 older people about their sexual habits. In the youngest age group, 57 to 64 years old, 84 percent of men and 62 percent of women reported having intercourse with a partner in the last year. The oldest age group, ages 75 to 85, reported 38 percent of men and 17 percent of women having intercourse. Even though the findings show that fewer people are engaging in sexual activity as they age, ultimately the survey participants presented an optimistic view of sex and ageing.

### **Learn About the Ageing Body**

It is easier to understand what an older person is going through if you know about the specific changes the senior body experiences as it ages, including sexual functions. While body is different, each one is probably more limited in sexual function than it used to be. This includes physical abilities and the level of emotional desires for intercourse or intimacy. The physical changes of normal ageing affect both men and women, which in turn change sexual

experience in later years even healthy bodies are subject to change. If a person has concerns, he or she should consult their doctor as there is a lot that can be done.

Here are the most common ways that the ageing body changes in relation to sexual function:

Men – Erectile dysfunction (ED) is the loss of ability to have and keep an erection, and a delay in getting an erection. ED may also mean the need for more manual stimulation to achieve an erection; a longer time between erection and ejaculation; shorter and less forceful orgasms; rapid loss of penis firmness after ejaculation; and a long time interval before erection is able to be achieved again, this can be up to a week.

Women – The vagina can shorten and narrow, vaginal walls can become thinner and a little stiffer, and there is less secretion of vaginal lubrication.

Disease and illness can also affect a person's ability to have and enjoy sex. These include breathless, chronic pain, diabetes, heart disease, incontinence, and stroke. Certain medications for health issues such as hypertension and heart disease, and some operations such as prostate surgery, can interfere with normal sexual function as well.

### **Talking to people**

The older person's thoughts and feelings about his or her own body may reduce sexual expression and discovery. If you are perceptive when it comes to these types of concerns, people will appreciate your thorough understanding and may feel more comfortable opening up to you.

Times have changed since many people first became sexually active, and many older people may have only been with one sexual partner. Divorce and remarriage are more common and many people now have relationships with much younger partners. It is not uncommon for older people to be in a relationship but not live together.

Talking about how sex is different and about sexually transmitted diseases (STDs) are important topics.

Older people can definitely find a way to have happy and fulfilling sexual lives if they wish. The keys are creativity and open communication between partners. Realise that arousal takes longer and that you need to make adjustments for bodies that have changes. One suggestion is to use all of the senses in the experience. Sex doesn't have to mean intercourse; it just needs to provide comfort and satisfaction for the people involved. Regular communication about what is important to both partners helps to keep the intimacy and sex life alive.

## Top Tips

**Communication is key to intimacy** - Create open lines of good communication with your partner about your desires, thoughts, and feelings. Good communication helps you feel closer to each other and can make sex more pleasurable.

**Creativity Counts** - Your body may not be as flexible or capable as it used to be. This requires an adjustment to how you and your partner define and approach sex. This may include other activities beyond traditional intercourse, such as sensual massage. Experts agree that seniors should experiment and find what works best for you and your partner.

**Healthy mind and body** - Exercise and a healthy diet help you feel better about yourself, and a healthy body is better able to enjoy sex. Partners can enjoy exercising or cooking nutritious meals together. Find physically and mentally stimulating activities that you can do alone or with your partner.

**Know yourself well** - Figure out what sexual activity means to you. Is emotional intimacy or physical contact more important to you? Are there certain times of day when you have more energy for intercourse? What do you need to do to increase your ability to participate in sexual activity? Asking yourself questions brings out an honest approach to sex with your partner.

**Seeking help** - If you are having trouble with your sex life, talk to your doctor or nurse. Medications you are taking may affect your ability to have sex, and your doctor can help to create a healthy lifestyle that will promote a good sexual life.

Source: Adapted from Mayo Clinic Seniorsite.com 800.653.1785 and Society of Certified Senior Advisors [www.csa.us](http://www.csa.us)

## Appendix 4 Publications and Presentations related to the study

### Publications

Garrett, D. (2015) Experiences of sexual intimacy among older people. *British Journal of Nursing*, 24(12), 639-639.

Garrett, D. (2014) Practice question. *Nursing Older People*, 26(1), 14.

Garrett, D. (2014) Psychosocial barriers to sexual intimacy for older people. *British Journal of Nursing*, 23(6), 327-331.

Garrett, D. and Tomlin, K., (2015) Incontinence and sexuality in later life  
*Nursing Older People* 27(6) 26-9.

Garrett, D. (2011) Practice question: Sexual behaviour. *Nursing Older People*, 23(2)10.

Cowdell, F. & Garrett, D. (2014) Older people and skin: challenging perceptions of the ageing process. *Journal of Aesthetic Nursing*, 3(10), 490-494.

Garrett, D. (2015) The taboo of sex in care homes for older people – Interview with Adam Weymouth available online:

<http://www.bbc.co.uk/news/magazine-33278117>

Garrett, D. (2016) Practice question Sexuality and health promotion: How might we broach sexual health issues with older people? *Nursing Older People*. 28 (1), 14-14.

## Presentations

Garrett, D. (2013) *Breaking Barriers to Sexual Intimacy for Older People - Best Practice Interventions for Health Care Professionals*. Best Practice Conference Northern Lincolnshire and Goole Hospitals NHS Foundation Trust 13<sup>th</sup> May Scunthorpe

Garrett, D. (2014) *Just when the mood takes – older people and sexual intimacy* RCN Older People's Conference 25<sup>th</sup> March Birmingham

Garrett, D. (2014) *The Big Question* Royal College of Nursing Cavendish Square 3<sup>rd</sup> October London

Garrett, D. (2014) *The Research Question* Women's Institute Evening Event 12<sup>th</sup> October Lincolnshire

Garrett, D. (2015) *Sexual intimacy research with older people* British Geriatric Society Autumn Meeting 16<sup>th</sup> October Brighton

Garrett, D. (2015) *Sexual Intimacy and Older People* BBC Local Radio Interviews [BBC Radio Devon](#), [BBC Radio Somerset](#), [BBC Radio Tees](#), [BBC Radio York](#), [BBC Radio Manchester](#), [BBC Radio Shropshire](#), [BBC Radio Berkshire](#) and [BBC Radio Sheffield](#) 21<sup>st</sup> October

Garrett, D. (2016) *Sexual Intimacy Research Age Speaks* East London Radio 11<sup>th</sup> February

Garrett, D., Butler-Cole, V., Phair, L. & Heath, H. 2016 *Sexual Intimacy and Capacity* United Kingdom Dementia Congress 4<sup>th</sup> November Brighton

Garrett, D. (2016) *Rights, Duties and Therapeutic Relationships* United Kingdom Clinical Ethics Conference 17<sup>th</sup> June Poole

Garrett, D. (2016) *Sexual Intimacy & older people: strategies for recruiting participants in sensitive research* - Poster European Nurses Conference 5<sup>th</sup> October Rotterdam



Garrett, D. (2016) *Research Stand up the Science Show off* 9<sup>th</sup> November  
Cambridge

Garrett, D. (2017) Twitter chat *Sexual Intimacy and issues of capacity* RCN  
15<sup>th</sup> February London

Garrett, D. (2017) “*Have you heard the one about the old couple having sex?*”  
RCN Congress Comedy Evening 15<sup>th</sup> May Liverpool

Garrett, D. 2017 *Sexual Intimacy* St Andrews Healthcare 7<sup>th</sup> July Northampton

### **Additional Academic Activities**

In addition I have completed a post graduate certificate in research training

## Appendix 5 Example of a Case Summary

Case Summary 8 David – face to face interview Own home 75 year old retired civil servant. David was a gentleman I meet whilst speaking to a group of gay men at a support charity in a northern city.

I had been very concerned about speaking to this group, particularly about the words and language used when describing male homosexual activity. I spent time talking to gay friends to understand not only the range and scope of activities but the context and slang used. David asked me to meet in his home which involved a long drive which gave me opportunity to focus on the interview.

David was welcoming and seemed very relaxed, it transpired he had been involved in previous research studies. He moved into discussing the subject very quickly. David explained he found partners through placing adverts

Researcher – Thank you that's looks lovely (cup of tea) .So you are obviously well loved in the community I noticed a really warm response from everybody...

David – I'm just my natural self I suppose, just being natural and I mean I don't, I don't differentiate between people or er between ages er from I mean in the I adverts, the adverts I put in the paper I have friends between 40 to 75 from adverts

Researcher - Fantastic, when you are doing the adverts do you ask for anything in particular?

David – Well the idea really is....similar interests and a big I think ... a big thing is is ....er trips out together ...walks or you know know just going for a coffee something like that er that was one of the issues with er the guy I that was seeing he was from Anytown um a 39 year old I reckon he was not going to get round to it it no was was all too many issues but that was one of them and I .....

Researcher- Yes?

David, er yes he was just coming over here arr ok we had nice chats and that but there was really nothing more developing than that...

It became clear that as well as companionship David was keen to engage in sexual relationships with the men he meet through adverts. He was also cognisant to potential health risks.

David yer yer oh yes I always put friend ship and possible relationship, but that often happens way down the line, I have a guy who comes over one day a week that's really just a friendship which will never lead to anything more than that in a sense, obviously he has an estrange wife and he see his children so I say that's just fine I'm glad he has got a family life as well but we get on very very well and well em I genuinely care for him as well and when he comes over um

David... yes I mean the guy from Anytown, we'll call him the Monday Guy (MG) em we do have the physical side as well, the sex side as well, ummm its fine we both um know our status um we are all absolutely negative across the board.

Researcher – Is that something that worries you

David- well I do if if there is likely to be any sex involved I usually ask them at the first stages...

Researcher -well we know sexually transmitted diseases are going up in older people, do you always insist on condoms and things like that?

David- well er with the guy ...from er the MG no

Researcher- because you ...

David - know he's clear and not with my late partner never did because we knew....in fact right at the beginning we were both tested...and it came back fine...and again you know I do, ask every so often when they were last tested, yes yes and particularly again if there is still **the** wife around, all be it in the back ground, if they have had any sex with the wife, ah yes that's with the MG the answer is no

Researcher -and that's because you aren't certain who the wife has also slept with or because it put you off?

David - yeh well it's really thinking of..... not that it would be necessarily because there is any sexual problem with the wife but mainly because it's another person in the equation

We went on to talk about opportunities and activities for meeting people.

Researcher- I understand..... and other stuff like just meeting men.... like cruising?

David – Well that's, well I have done, but I don't nowadays but you go through stages...I suppose like anyone cruising, cottaging, saunas stuff like that but well as .... Not now

Researcher- is that about stages of your life?

David – Yes I think its really individual, its down to the individual and you get at the sauna a range of age groups there I go to I go to them and em ok ...probably more not necessarily that many are on the younger side by young say I mean 20's and 30's for sake of argument probably more 30/40 upwards um I think the oldest has been around 79

Researcher- and do you think that about a physical awareness of their bodies?

David – er yes, yes I think it is, yeh with the young ones, there is other ways of meeting guys for sex, on line I suppose

Researcher -Do you think some of the stuff..... like.....eh...eh eh... is going to go?

David No I don't think it ever will. cottaging I think will erm be less and less and particularly with, because of the law, cruising no I don't think so , there is a well-known area near the village and I think that will always come about and you know because even if they are married, for a bit of

Researcher- and that's no strings just sex?

David - that's it yes, yes exactly

Researcher- is that something you are interested in?

David then began to talk how the impact of health issues on his sexual activity.

David - no ... no um um er particularly with the MG I am satisfied.....That's with anyone else, well there is one coming this afternoon, if he does turn up again that's optional, it's not something I would push um if it happens I would be quite satisfied.

Researcher – has that changed for you

David – Well it has changed and there are factors whereby I did have an enlarged prostate last year and that has effected things down below whereby em if I ....if I need to have sex I will take Cilalis and I did have to go and see the GP last week really to see if there is anything more he can give me ....and I will follow that through as well. So I am conscious of the fact of the erectile problems as well...

Researcher- When you had your prostate operation did they talk to you about erectile problems?

David ...Yes yes more particularly beforehand and they told me the effect of the semen, that basically the semen would be kept inside it, fair enough though I have had to accept it and its better than having all the prostate problems yeh and the biggest thing is that it is benign.

Researcher- has it changed your enjoyment?

David - err no no I still enjoy it, as I say it it is the just the fact of even with the Cialis its just I have got limited time, even though the MG is very, very attractive but again there has to be an attractiveness. I have a guy I keep in contact with by phone he came down from Scotland for a week last September and he's a great guy, blind, which is not an issue at all, em and but he was very overweight 19 stone. So to be honest on the physical side of it no, no I'm not being siziest!

Researcher – have your tastes changed?

David – I do like, to be honest a young guy preferably, but its not the be all when I say this and end all it's nice if they are younger er and I guess what you

might call a toy boy. There are guys that always prefer an older man, there is a niche where they do like the older men, I mean the guy from Anytown I specifically asked him about what the attraction was with the older age group and he said he found that the older ones weren't as promiscuous as younger ones and I think the er the maturity they have a more mature outlook on life

Researcher –stuff like phone sex and porn is that something?

David - ..er no, at first the guy from Anytown first he went for that but er that just stopped died for the two of us but again I think the attitude really is we have got each other.....

David went on to talk about some of the emotional issues when meeting men sexual relationships and we then explored issues about medication used to enhance sexual activity.

Researcher – does he stay over?

David- he comes we have sex and he goes, that is another one of the issues with the guy from Anytown he was supposed to be coming over to stay for new year but at the time he got delayed because of the weather at the time but it has come out subsequently that he had no intention of staying. We discussed it I mean but I was still seeing the MG and but um he did and difference to the xx I did short while finish with this guy but I thought why should I? He is a thoroughly decent guy ye and well even thought I didn't say it out right I thought well, you know he has got to accept that I have got some friends and at the same time other than you that I will have physical relations with. Yes so er so I don't go here there and everywhere

Researcher - ..and say someones come over is it always full sex or is cuddling, touching enough?

David - oh yes (emphatic) absolutely arhhh in fact full anal sex er that has to be with somebody that I have known for a while and trust them or em I know their status as I want to be safe I do have quite a stock of safe sex packs,

laughs laughs but to be honest other than anal sex the other can be just as satisfying .

Researcher – in getting your medication,

David - there is a limit there is a limit of of medication to four tablets per month at first it was viagra which actually didn't work and I did have to pay for them on private prescription but linked to the prostate as such they switched me over to the NHS

Researcher- Now how many can you have a month?

David –Four, there is there is technically a limit four which is fine though having said that there are times when I can get an extra at first I did have to pay for them

Researcher- Do you get through the internet or through your GP.

David- GP I would never get it off the internet no no any medication full stop is strictly via GP but medication a different matter if it like vitamins.

Researcher- Having that conversation with the GP was that hard?

David- No no its fine cos, because it is an LGBT friendly practice, in fact we have got poster up from (local gay group) in most of them around here they do sometimes have a pride in practice if fact yes in fact where ever possible it is the same GP that xxx (partner) had ?

Researcher – they knew both of you?

David- Yeh oh yes yes no its fine same time I would always have a LGBT practice and I would always always want a male GP I would never feel happy with a female GP yes yes.

Researcher –when you were in hospital ...when you had your operation did you have to stay in hospital ?

David- yes that right yes just under 48 hours and I had it done on the Friday and I was in all day on the Saturday and came out tea timeish on the Sunday

Researcher – did you notice, was there any difficulties in the healthcare staff talking to you about the side effects of the operation?

David- No, No its alright yes fine, because at that time xxx had passed away I originally put down surviving civil partner, it was the fact of the civil partnership was fine it was stable partnership it was fine, all of them completely accepted it and it was fine. Also I am on the PPG as well, yes we meet roughly every couple of months.

Researcher – your friends of the same age are they as comfortable about discussing things as you?

David- it varies really, um I mean I have a friend although we only keep in contact by phone these days, he's 10 years younger than me, he has actually got a partner but he's not in a civil partnership, he's fine he doesn't push it, I don't think anybody does, in that kind of sense, but he is comfortable with it I have a friend down in xxx where xxx came from after he moved and he's completely open about the sexual side of it. The one from xxx hes not, er I mean he accepts his sexuality, but I mean he keeps very nobody on the outside of his circle

Researcher – um things in later life if you needed physical care ...

David – I would prefer a male carer, having said that and I know that one the nursing side of it, they are all female and I just have to accept that xx did have, in his last months ,he did have treatment with a catheter and er he ere injections oh I used to know it off by heart.....

Researcher – morphine?

David -like for his thrombosis

Researcher – Clexane

David- one of those anyway, I think he was progressed onto the warfarin, so again I first can over to but then he got used to injecting himself but again they were all female but I think with the carers side yeh um I would it were a choice have a man...



Researcher – we do have many more male nurses, so things like your friends come here, do you go out with them ?

David- yes I think we are more going out a meal or a drink .....

Researcher – do display affection when you go out ?

David – not, no it would depend on the other guys attitude but for the most part ah no because well xx and me we first did we, ere, all like lovey dovey inside the village but then it grew down we didn't do it very much we would have a good snog just the two of us but fine no but um I think nowadays even though erm its supposed to fine with society although there is a question mark over that its whether it remarked on or not .... Perhaps ....

Researcher – what things would you like ?

David – probably ,I well, probably I, hold hands but if it was if it was a relatively secure areas like in (name of a gay bar) we would have a snog.

Researcher – Do you think that maybe not showing your physical affection in public makes it more exciting in private?

David- yes yes it does, ye ye I mean there again like the guy from, the guy from xx MG well um he parks up the driveway but any of the kissing is done in the house erm I did once kiss him in the car but he was uncomfortable with that and I respect him for that, um it depends on really whether there is a gelling between between two, I think that is really you know what ever age really and whatever stage of being out as well, er you know I mean basically I mean there is an attraction.

Researcher – there needs to be physical attraction and a mental attraction ....and the deal breaker between receiving and giving sex, passive and active?

David – YES surely, are well you see, you ask them that's really, you find it exists, you ask them and sometimes they will give you signals in the bedroom, occasionally people will say in the adverts what they want ,yes um I have noticed some of them do, some of them do in the newspaper adverts, but more on line , but like the newspaper adverts they are moderated ,there's a quite

right there are limits, er yeh ,and then again another big area that there been more and more prevalent is the cross dressing

Researcher –Yes

David – laugh and laugh well er that scene

do you think that might play into the stereo.... idea that one's a man and ones a woman?

David – yes yes yes I think it is yes yeh, I mean er its ..I mean the guy from xxx he cross dresses that's fine,

Researcher –did you know that when you started the relationship

David- er no I didn't actually no not with him, very often you do know ...

Researcher – how do you know?

David - well they tell you !

Researcher – laughs I thought there might be some code!

David – laughs no again it's in the kind of replies that you pick up from the ads erm

Researcher –do they say enjoys cross dressing?

David – yeh that's it yeh yeh which I'm fine with I have no problem with it in fact to be honest that's something I enjoy myself... laughs laugh

Researcher – Do you both do it at the same time?

David – no no usually its just one er the only exception the ex guy from xxx he did for a little while but not to any extend ,I think you find the the butch / femme so to speak er you know it wouldn't really work if you were both femmes.

Researcher – In terms of crossing dressing what's that about?

David – I think it is really the fact of, I mean again the MG he does make an effort, he's got some nice stuff and that , he likes that, he likes the stuff he puts

on, you know it gives us pleasure and again I have no problems with it, in fact last, in fact last September whenever it was, albeit only briefly, I meet up with a guy a few times over at xxx and um his was, em he was cross dressing he has an alter ego with a name as well and everything but I'll tell you one thing and my god he puts some effort into it laughs, laughs yeh I mean I complimented him I think, I think as well that the thing too, it is to make an effort and always think I should complement them,

Researcher – and if, and if, this is real ignorance on my part,

David – No No

Researcher – if one of you plays a more feminine role does that usually mean the more likely to be the passive partner?

David-yes yep yes yep yes..... its fine

Researcher – Clearly your sex drive remains really strong.....

David- I hope as long as possible as long as possible, probably would deteriorate but I think what is helping as well I am on testosterone replacement therapy as well again in fact before I started on it my reading 2-3 and last time it was 50 wand I am awaiting my results it works out at abdomen one day and thighs the other day, I think that is helping well....

Researcher – are you ever tempted to use more

David oh no no it put it on in the morning once I have had my shower before I get dressed I put it on then the only times I would not is when I am going on holiday because I don't like taking it through customs.

Researcher – In terms of the internet....

David – I don't use it for dating, simple reason, is cost you are talking in terms of ten pounds plus probably about £15 per month, you can put put a free profile on but if you go beyond that .....

Researcher – is it more useful for buying stuff like lubrication on line?

David- I don't know perhaps with that in fact it is in the safe sex packs ...

But if I need anything else I go into clone zone and that

Researcher – do they do deliveries?

David – yes they do actually and clothing as well I get that on line,

Researcher –Do you get that from a special site?

David – No usually places like Marks and Spenser, Primark, occasionally on line there are some specialist er sites as well for shoes it would always be a shop so you can try them on for stuff like underwear sometimes there are sites you can bargains

Researcher – specialised clothing like rubber or leather ...

David – Oh yes yes anything like that..... in shops.

Researcher – thank you so much David this has been so so useful

David-it has been such a pleasure to help.

Researcher – Is there anything else you would like to tell me?

David – I think the thing I would like to say the thing about intimacy its not just about the physical side, its about the emotional side, um phone calls and you know I still miss xx you know talking . I can say anything and everything we my mate xxxxxx down in xxxx er about over an hour and half last night on the phone

Researcher –What were you talking about?

David- you know sharing the day's thing that's really what is a big part of intimacy, you know I had something close like I had that with xxx to say I love you I mean there is his picture up there you

Researcher – how old is he in that one

David – he was er he was 57 in that one but I always say good morning love

Researcher – doesn't sound daft

David- when I asked him about crenation or burial .... He was absolutely adamant about that, he said if you crenate me I will come back and haunt you! So I think that's the big thing about intimacy it's the emotional side as well as sex, sex is nice but it is the icing on the cake!

Researcher- Thank you so much

David- it's been a pleasure.

## Appendix 6 Example of a full transcript

Transcript - Helen

Researcher – Good Morning is that Helen? It's Dawne Garrett

Helen – Hello Dawne

Researcher- Is it convenient to speak?

Helen –Yes it is I have just finished my coffee, I'll be able to concentrate fully

Researcher- that's perfect thank you so much. Did you have a lovely Christmas?

Helen –We did and then we went to the Caribbean for ten day with a couple friends,

Researcher- How lovely

Helen – With sunshine and swimming, yes very chilled out

Researcher- Perfect . . . . as I expect you know, I just have a little bit of consent to go through so that you understand the study. .if it's alright for you .would like to take a verbal consent I'll just go through the questions and then I'll put the tape recorder on, is that alright?

Researcher – oh yes, the purpose of the study is to find out more about sexual intimacy and older people and that is not exclusively about sexual intercourse it's about any sexual or intimate contact between people who see themselves as couples in whatever form that takes.

Helen, - ok

Researcher – the information is part of my PhD and it has ethics approval from the University of Hull um you have been invited because you have kindly come forward to participate the.... er study will be taped, the aim of the work is to

influence particularly health care services for older people. Very occasionally discussing this can make people feel uncomfortable and I have an arrangement with Age UK that their helpline can be contacted if you have any concerns after today.

Helen- ok

Researcher- In terms of keeping it all confidential what happens is I will transcribe the interviews, I will take out and any names that are used, I may use direct quotes but they will never be attributed to you

Helen – that’s absolutely fine

Researcher I will use a pseudonym so if you have a particular name that you would like to be just let me know

Helen – why don’t you call me Helen?

Researcher- oh lovely I’ll call you Helen. Are all those things alright?

Helen – yes that’s fine

Researcher – and if at any point you want to stop, take a break or discontinue at any point just let me know.

Helen yes ok.

Researcher- um I just wondered your initial impressions about hearing about the study.

Helen –um My feeling was that the study was very interesting in its own right and was probably something that was largely um ignored in the medical field and so I just thought I was very happy to go ahead with it if I can be of any help.

Researcher That’s so useful, as we sometimes find older people find it difficult to talk about intimacy

Helen- perhaps unpleasant to talk about?

Researcher- is that something you have heard?

Helen- um yes I do think older people are reluctant to talk about it. I think sometimes they feel that is maybe not appropriate and who would want to listen to it.....I think they do, they may hedge around it in very general terms um..... I'm not sure this is entirely confined to older people as I would have said there is a section of middle aged people who also tend to not to talk about it. I have a good range of friends of all ages but I don't tend to talk about sexual intimacy with them except in a very general way. ....So for example probably about 4-5 years ago my husband had to have um a prostate operation... a turp... and the consultant was great he said beforehand you know there maybe erectile problems I can help with that.....and so that was nice and then subsequently talking to other men and other couples and I have been quite up front about this um and they were very interested to know, it seemed to help because they defin... I think women tend to talk about things like that more readily than men do ... does that make sense

Researcher absolutely makes sense.... did it help that in this situation that the consultant spoke about it first...would you and your partner have talked about it if he hadn't broached it first?

Helen- I don't ... I think it ... because I was with Martin at the time and I think it was unlikely I would have said anything in case it worried Martin and planted the idea in his mind but he might well have done I mean I went on the internet and looked up all the background information and martin spectacularly did not do this, he's a biologist he knows but he could have done but he chose particularly not have that information given to him,

Researcher- One of the things we have found is that age difference can change the interaction would that have ...

Helen- no I don't think so, so long as the person involved was competent and professional, I don't feel either Martin or I would have had difficulty discussing it with somebody much younger and the consultant was younger than us but not like a 22 year old, we certainly had some written information about the operation including the possible side effects

Researcher – and medication?



Helen -no they haven't I can't think of anything.... I could talk about me own experience more?

Researcher- if you feel able to

Helen .....Um Martin accepted Viagra fortunately he turned out not to need it given time...but it is there as an extra.....and I was very glad about that because we do have sex... I have a doctor who's female and she's brilliant ... I'm still on HRT and I've told her that I intend to die taking it! I looked her firmly in the eye and said ... you wait till you get to me age...then you might and she laughed, so I still take HRT and I don't have any problems with sexual intercourse but she asked me about it..... a couple of years ago I got ..Oh god It can never remember ...is it lichen ... sclerosis....

Researcher Yep

Helen – so I lived with the itching and went to see her she was brilliant and when I went for my check-up she said everything looks fine, everything looks nice and moist and she said then do you have any problems with intercourse, so I mean she raised it and I would have been very happy to tell her if I had but I didn't have...

Researcher -do you think there is a place for us as healthcare professionals raising it more?

Helen..... Long pause..... I think it is almost impossible to answer that .....some people might be offend but other people might be very glad they might be please not to have to raise it themselves, My feeling is if you give somebody the opportunity in a gentle way not saying HOWS YOUR SEX LIFE ... how's your lubrication going on..... um some people might be embarrassed but here must be more gentle lead in so that people either shut it down who wanted to or open it up if they could do ... if they wanted,

Researcher- what I reflect on, is that we ask so many sensitive questions and I hope we do that sensitively.....some people prefer to have a family member or friend with them when seeing health care professionals....

Helen- I can imagine that its really helpful to take family members to get you to the appointment but I can't imagine there are many people who would like to have a family member in a gynaecological appointment you, I wouldn't and I'm not easily embarrassed by things....but many years ago.....this is just an example of how people can help....I had a polp in my uterus.....it was found in a routine scan and they decided they would have to remove it and it had to be done under general anaesthetic and it was done in XXXX and when I went.....a dedicated nurse sat there and said ... I will hold your hand.....whilst they carried out the operation... I didn't specifically need the support because I wasn't stressed or scared but for somebody who was anxious about it or embarrassed about it I thought that was brilliant...

Researcher- we know that older people do have sexually intimate lives but this is not always reflected in our culture....

Helen - well I think your children want to carry on safely in the notion that the only time you had sex was when they were conceived and they carry this ....

Researcher laughs

Helen- and they carry this with them..... laughs and laughs... there must be an awareness that older people do have sex.... I remember .... This is not about me but a very close friend of mine told me that her mother in law had been widowed for quite a while came to see her and said she was going to go on holiday to Spain with a group of female friends and her intention was if she met somebody she would have sex with them and what did her daughter in law think of them.....and was she horrified and my friend said no that's absolutely fine...and just make sure you take some condoms and the mother in law said don't be ridiculous...I can't get pregnant you know that ..and Jane said to her I know that but you can get sexually transmitted disease ... and the mother was ....it was about 15 years ago when age AIDS publicity had a much higher profile than it is now and yet it hadn't clicked with her....that she could be a risk of getting a disease....

Researcher -one of the other things we are beginning to see is older people who have much younger partners.....or in relationships where they don't live together but see themselves as partners...

Helen - I have two friends in that position their husbands died and another friend who was left by her partner probably about 14 years um... and they said I would never live with another man ...but both of them would like a partner for sex, for companionship, for someone to do something together because if you want to go out for a meal, see a film, to go with someone is much more fun. So that you can see through it and talk about it afterwards, also I think as you get older you .... Clearly become more set in your ways... I certainly am ... if I meet my husband now he wouldn't last two weeks..... laughs..... he would drive me bananas but we meet when we were nineteen.. Laughs .....so you grow together and you accept patterns of behaviour and I know now I am an intensely territorial like if Martin died .. this is MY... house and if I had somebody else living it..... it would raise the hackles on the back of my neck.....if they did anything wrong .. I don't mean wrong and I think when you are older you have more complex lives you have .....friends already and things that you do that you are unwilling to give up, should it be necessary, but when you are younger you don't think about that so much .... It the hormones that are raging. So I think there is a lot more ... particularly for professional woman .....who have you know careers.. they are doing to certain extent what you want when they want and how so to have somebody interrupt that ... on like a full time basis could be quite disruptive ... does that make sense?

Researcher-It completely makes sense... Do you think there is any unease or disrespect about the partner who has died if someone comes into a house... ?

Helen I think that is a very individual in between the death of the partner and the arrival of a new person um would be um... my friend...about a year ago she met some man um who he like very much and who....had been married to the same woman for many years very happily and she had died an.. And I think after six months after his wife had died and I know him too and he said .... Sighed ... he knew his wife wouldn't have wanted him to spend his life alone ...um ... and that. He liked woman he enjoyed their company which actually a

lot of men don't do they .. when you think about it or they are men's men, I don't mean gay they like to do boy things, so they went out a few time and they ... she really like him she .. he obviously liked her too but in the end he broke it off telling her he wasn't as over his wife as he thought, he wasn't ready enough to sort out a new replacement or relationship ... I'm sure he was very sad about it. Um I did meet a lady she is probably little younger than me but her husband has died and she has a new partner who she had known for many years and his partner died too and there was quite some time between them and she and he eventually, you know, started going out to together and it developed into something more meaningful and eventually they got married but she , she had two children, and her daughter took a very long time to um to come to terms with um that she actually had a serious relationship and it wasn't quick after her husband had died and you know that was quite a definite gap but the daughter obviously didn't like having her father replaced.

Researcher - the relationship between parents and children when they are reengaging in relationships , sometimes we also hear about the implications of peoples faiths or religions in new relationships...

Helen Its not something I have ever thought about as I am a complete atheist you don't want my views on the church... laughs and laughs

Researcher – no that's fine... laughs

Helen -I think that in later life you want physical relationships to continue every opportunity should be explored so it can carry on... if it means something to people it's part of their wellbeing, you know why not, why not, I know some people with some forms of dementia engage in inappropriate behaviour and that's probably something that needs to be dealt with differently but if people are compos mentos and want whatever it is then that's absolutely fine as an old lady myself, I see myself horribly probably sleeping with a Labrador.... I thought which I find disgusting and I don't believe dogs should be even upstairs let alone in your bed .....Laugh and laughs

Researcher –laughs, but it would be warm

Helen -and yes something about a curve body that you snuggle around isn't there... intensely comforting and relaxing if people want to this then I think we should be aided and abetted as much as it can be...

Researcher fantastic I will reflect that in the study... Is there anything else you would like to tell me?

Helen- I can't think of anything,

Researcher- It's been hugely helpful

Helen – I've enjoyed talking to you it been so interesting, and all the very best with your study

Researcher thank you so much

Helen , thank you Dawne

Researcher -Take Care, Goodbye

Helen - Goodbye

## Appendix 7

### *Example of a data summary*

*Jolene. . .laughter is one of the biggest things in a life and in a relationship . . . whether it is a good one or a bad one you can still make it liveable, we, . . .in this household it goes, we go on maybe a little different from others, em so since our kids flew the nest we each have our own room yeh it is separate room here . . .Terry had prostate cancer and after he had that cancer operation he had no desire . . . he is a stubborn old Scandinavian to show affection . . . they don't do, if you get a hug it's a million pound one! They care but they can't express their feelings, so you either you chose to live around that so since I have had shingles he brings me a tea or fixes me up yeh . . .he does know how the hell to sweep a floor though! You learn to live in your own comfort zone, in this household he has his garden and walks the dogs and groans when he can't find things. Cos somebody must of moved it! Life can take make twists and turns for older couples, 95% of my dear friends are widows or widowers now. We are in that age group, but most of them . . .one seems to take that authoritative role now mostly it's the woman who becomes the authoritative when the male was the dominate but as the years go by oh they would say that woman's is driving the car . . .where I grew up woman drive tractors and cars . . .did the farm work, milk the cows.*

*Researcher- Do you think there is something in that kind of change of power in the relationship . . .you call it authority?*

*Jolene - Oh definitely the ideas and feelings you had when you were 20 or 30 are totally different from 40-50 and by 90 if you haven't got right ,why bother, just keep chugging along, you know that's about it, most of my friends are widows or widowers and in the later part of their lives when they you know when a friends husband came down with Alzheimer's you know she didn't have an idea where bills were paid , how to get plumbing done and she had to learn hard and fast. The authority shifted in the house, it is different, no relationship stays the same, we are older you have different interests, different quiet times.*

Oh . . . for thirty years, I can tell this because it will go no further, I had a very close friend . . . . .silence . . . . .he was always there to pick me up, he got my morning call and my evening call, em but we both knew we would never walk out of the marriages we were in and we can accept that and we were as discreet as you could possibly be. It didn't harm people and we were discreet and. . . . . we didn't harm people, so it's not a relationship everybody can handle but for me it was a life saver. I was going . . . I can't say I was depressive but I was getting in a rut, didn't want go out . . . Terry and I love to dance, we went to a wedding and he can cut a very smooth dance on the dance floor. We had together to very slow dances and here's the stupid thing there's no way . . .but I could manage and I look at him and I said do remember when we could really do this? And he said pah! I'm all cracked now, . . . . . it was though a connection . . .we hadn't danced for many years but we weren't dancing like we normally would, you know we were really together . . . .It's more tolerant , than we were, we grow up we try to look after each other . .if you can do it you do, if you need help you shout at a neighbour . . .here come give me a hand, we share a lot here although we are a little tiny town in the middle of nowhere . . .and I think that makes a big difference for lonely couples . . . we do not have to lock our door, it's kind of a cushion . . .if you were in a city, there's a fear, it would be different ,can you comprehend that? If we want to take an afternoon and go somewhere you just get in the car and go you don't have to plan three days ahead. . .

Researcher - That kind of spontaneity, you know, do you think it helps your partnership?

Jolene - oh yes, we have that here you know, my neighbours across the road they have been married 48 years they were going to be gone for a couple of days ok fine we just watch the house, being the place we live in we don't see fights I don't say we we don't argue, there is no underlying hostility in relationships here, people can just go off for a few days

Researcher- One of the things other people have talked about is the intimacy they have when they are on holiday . . .

*Jolene- yeh yeah. .hard to say really , with Terry it would kind of be lost cause, yes so you know we get twin beds it's different, I think some that have been married for about 50 years do although they go to dance club, they go to cards, yeah differently .*

*Researcher- I just wonder about activities, dancing, playing cards. . . .*

*Jolene Oh yes . . banter a lot of banter oh yes when I play cards with a group, we have a cribbage night I walk in there and they go oh god she's here, again what the hell are you doing here! get out on the corner and make some money! or they'll come up and give you a hug and kiss oh my, I haven't seen you for so long , nobody gets shook up about that. You got it ok, I go to visit a friend in the hospital and I'll say you booked in a poor hotel! It's a more open line of communication kidding back and forth, teasing. We have one here who used to play every Saturday night and he would make sure the lead singer would make sure to say hello to every single lady on the floor. I he didn't know the name he would ask the waitress so no one was excluded and that way it makes the couples feel good that there wife was noticed*

*Researcher -do you think jealousy does diminish in older age? Is that your experience?*

*Jolene- I think so you don't see jealous around here very often, people are curious when my elder brother came, the neighbour said hello you're a pretty boy, are you married, why not and then are those your own teeth I was dying, she was a sweet old lady . .*

*Researcher – if he had responded, do think that widowed ladies would be happy to meet somebody new?*

*Jolene - o-h definitely definitely, there are a few who say I'll never get married again but . . Mrs X she is her 90's but when she was in her 80's her two great grandchildren were knocking on my door early in the morning and I said what are you doing you should be a school now "We missed the bus" and I said why and they said mother (who was a school teacher) got called in and all they had to do was walk to the bus and they missed it but they walked over to grandmas to get a lift but she had a car there, she had her boyfriend there and*



*we didn't want to interrupt. . . to me that was so funny . . with her boyfriend  
.....but she have her friend, she would have him come over but she said she  
wasn't going to get married and be a nurse to another old crock*

*Researcher- people do say that are happy to have a new relationship and  
sometimes they are worried about the financial situation*

*Jolene – yes very much so especially Jane who was older than me they like to  
have a friend, they like to have someone to go to dinner with, they like to have  
someone to come over or to go shopping with . . . but they don't want to get  
married, they just want a “booty” call ! laughs, I think that is beautiful.*

*When asked if older people were looking for sexual intimacy*

*I thinks both men and women, definitely both . . .not all the gentleman, most  
of them here have had prostate problems and cancer is prevalent , when he  
first had surgery I think they got it all I think they caught it early enough er his  
doctor was one of the best, he did prostates and his wife did breast cancer !  
They were quite a team. But he told Terry, when we went back for our check-  
up, he said this will affect your sex life and Terry looked and said at my age  
why should I care” and the Doc looked at me and said you could slip him a  
certain kind of pill! And I said if the spirt isn't willing why bother. The doc said  
just find yourself a nice discreet boyfriend. Is not something you go looking for,  
but if it walks into your world it's like a ton of bricks. It's something you'll never  
in, you will never in your born days think you will do, but it's something. . .I'll  
never regret doing it. No two people look through the same lens but you can  
get the same idea what the picture is, it was pretty good.*

Come, let us take a muster speedily:  
Doomsday is near; die all, die merrily.

Shakespeare

Henry IV, Part 1(c. 1597), Act IV, scene 1, line 133.