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Chapter 7

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

Allan Tyler, Nuno Nodin, Elizabeth Peel and Ian Rivers

Introduction: Diversities, Inequalities and Equities

This chapter focuses on how older gay, bisexual and heterosexual men talk about their bodies and body image, and foregrounds older men's experiences outside of a heteronormative lens – gay and bisexual, rather than heterosexual men are the primary focus. The way that people in general experience their bodies is undeniably intertwined with their social and psychological experiences. This concept of embodiment has been recognised within feminist literature (Weiss, 1999) and adopted within health discourse (e.g., Williams et al., 2009). Whilst embodiment and body image are distinct but interrelated concepts, health, psychology and sexualities literature sometimes fall short of examining how the two are mutually informing. Empirical research has largely aimed to quantify body satisfaction in terms that are not unlike the means we employ to measure the population's physical body (Cash and Pruzinsky, 2004). The bodies and images that are most often studied are those located in the discourses of women and young people, most often within heteronormative terms (Tylka and Andorka, 2012; Filiault and Drummond, 2009). The literature on older bodies, men's bodies and queer bodies¹ continues to develop, but often as discrete foci, and within a model that places ageing within a deficit model of advancing infirmity (cf. Blashill, 2011; Brennan et al., 2013; Jankowski et al., 2014). This chapter builds on research and discourse on embodiment and body image, using data from 'The RaRE study: Risk and Resilience Explored', a mixed methods study conducted in England. Our aim in this chapter is to add to understandings in psychology, sociology and health about how men over 60 years old feel about their bodies by addressing the intersections of body image, gender, sexuality, and ageing. As the academic advisors and research co-ordinator of the RaRE study, we approach the data from a range of disciplines (e.g., clinical, health and social

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

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

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

Body Image

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

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

arms because they do not want them to be thinner, for instance, ignores gendered ideals of size (Grogan and Richards, 2002). Body image researchers may make specific reference to the sexual identity of participants/sample groups, for example reporting about gay men, but the majority of research on men's body image is with heterosexual men (Tylka and Andorka, 2012). The tension this creates is a reinforcement of differences between gay and heterosexual men, a homogenisation of men of different ages, and an erasure of bisexual men. Under-reporting of body image concerns (within research and within society, e.g., to doctors) has been noted as a reaction to a belief that body image issues are the preserve of women and girls (Pope et al., 2000). Furthermore, changes in social attitudes towards sexuality – from equal marriage legislation to sex education for young people, highlight how new research is required to explore shifts that can be seen in popular culture and the media (Filiault and Drummond, 2009). New research continues to address difficulties with definitions, and redress epistemological limitations that have been identified, such as instruments that rely on culturally gendered ideals (Pruzinsky and Cash, 2004). For example, there has been a call to address 'mixed findings in relation to the impact of parents, peers, and the media on body image among males' (McCabe et al., 2010, p. 676) by: developing gender specific/sensitive instruments (i.e., the types of questions posed), acknowledging diversity between age groups; and recognising distinctions between the overlapping but different symbolic meanings of size and shape (e.g., fat and muscularity). Further work including 'longitudinal studies, studies on older men, transnational studies, and studies on intra-group diversity' have specifically been identified as essential to adding nuance to our understanding of the intersectionality between gender, sexuality and body image (Filiault and Drummond, 2009, p. 320). Much research with men continues to focus on extreme conditions and diagnosed pathologies, particularly relating to muscle dysmorphia and the 'drive for muscularity' (e.g., Hale et al., 2010; Smith et al., 2011). In contrast, within this study we have adopted an approach to address developing and undiagnosed stresses, and adopted an inclusive approach whereby clinical diagnosis of 'pathology' was not a criterion for participation.

The 'Risk and Resilience Explored' (RaRE) Study

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

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

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

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

The purpose of the questionnaire was to collect data for comparison of LGBT adults' (ages 18+) experiences of particular health inequities and the experiences of a comparative sample of cisgender people who identify as heterosexual. The questionnaire included quantitative (e.g., General Health Questionnaire, GHQ-12; Goldberg and Williams, 1988; Multidimensional Scale of Perceived Social Support, Zimet et al., 1988; and Rosenberg's Self-esteem Scale, Rosenberg, 1965) and qualitative components, including open-ended questions, and was completed in online and paper formats between June and November 2013. As well as the standardised measures, new instruments were developed to assess body image issues, alcohol abuse, self-harm and suicide. These were informed by an extensive literature review and initial analysis of the first interviews. To assess body image as a health concern across multiple sites of embodiment (aesthetics, physical competence, and experiences of the functioning body, Cash and Pruzinsky, 2004), a new instrument was developed. The 16-item, RaRE Body Satisfaction Scale (RBSS) – a forced-choice Likert rating scale from strongly disagree to strongly agree – asks participants to indicate how satisfied they are with various aspects of their bodies (e.g., their body shape, their genitals, etc.) and body-related behaviours (how much they eat or exercise). The 10-item, five point Body Image Social Influence (BISI) scale⁴ was also developed to assess how participants' feelings about their bodies are influenced from different sources and groups of people (e.g., parents, childhood friends, medical professionals, people in the media).

The open-ended questions were included to capture additional detail and adapt instruments that might otherwise be exclusionary or restrictive for those with queer bodies or identities, e.g., outside normative (often binary) categories such as

‘gay’ or ‘heterosexual’. In order to gather information about possible risk and resilience

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

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

Participants

Participants were recruited through multiple channels including social media, service providers, web advertising, flyers, posters, databases available from PACE, and word-of-mouth. During the later stages of the survey, purposive sampling was done to ensure adequate numbers from different sub-groups, for example bisexual men, Black and Minority Ethnic (BME) men, and older people. This chapter focuses on the RaRE study survey data from male survey participants aged 60–83 years ($n = 62$), with a mean age of 66.4 years ($SD = 5.5$).⁵ These men make up 3 per cent of the total participants ($n = 2,078$) and 6.9 per cent of the total number of male survey respondents ($n=902$). There were 34 men who identified as gay, 18 who identified as heterosexual, and 10 who identified as bisexual. One gay man and one heterosexual man also identified as transgender.⁶ All other participants in this sub-sample identified as cisgender. While the total number of male participants over 60 in each of the listed sexual identity categories is small comparatively; the existing body image literature emphasises the importance of understanding distinctions between men and women and their feelings and experiences (Blashill, 2010). Most of the older male survey respondents identified themselves as White British (87.1 per cent). One participant identified himself as White Irish, and four men (6.5 per cent) identified as White Other (for example, American). In this age group, only three men (4.8 per cent) identified as having mixed/multiple ethnic identity, with none identifying with any other ethnic groups. Just over a quarter (25.8 per cent) of all the men over 60 were in a legally recognised relationship (i.e., married or civilly partnered). Nearly half (40.32 per cent) of the men were single. Men who had relationships that were not legally-recognised made up 19.4 per cent of participants, and an additional 14.5 per cent recorded the status of their relationship as ‘Other’, including being a widower, long-term living with a long-standing friend, and having both a legally

married partner as well as a long-term partner who is not legally-recognised (i.e., being polyamorous).

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

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

Analysis

First we analysed descriptive statistics from the quantitative sections of the large questionnaire. In order to recognise diversity within categories as well as across categories, we focused analytically on some of the variation, where very often people with diverging experiences and identities are regularly grouped together (such as ‘LGBT people’ or ‘gay *and* bisexual men’) and described in monolithic terms. We then explored the qualitative answers that were given to open-ended questions. We used thematic analysis to analyse the qualitative data (Braun and Clarke, 2006). All four of the authors familiarised themselves with the data. One (Tyler) coded the data using Microsoft Word and Excel software and pen-and-paper methods to develop groups of themes and sub-themes. From the quantitative data, we produced sets of descriptive statistics to describe demographic details as well as to indicate areas of similarity and difference between sub-groups. This data was then used to revisit the initial grouping of themes to refine the categories and map out directions for further exploration of the qualitative data where possible assumptions had been made and other relationships had not been identified. The revised themes were labelled and defined and a draft of the findings was produced. We identified three main themes: ‘The Sexed Body’; ‘The Active Body’ and ‘The Medicalised Body’. One super-ordinate theme, ‘temporal constructions of men’s bodies’, was emphasised throughout. Temporality is introduced here simply as *explicitly* relating to and existing within (and across) a period of time. Used in this context, our findings build on the claim that ‘there are significant resonances between queer subjectivity and the condition of old age. [T]he old are often, like queers, figured by the cultural imagination as being outside mainstream temporalities and standing in 30 the way of, rather than contributing to, the promise of the future’ (Port, 2012, p. 3). Notwithstanding a cross-sectional design, these men made sense of their bodies and body image through experiences, memories, and thoughts about the past, present, and future.

Sexed Bodies: Performative Masculinity as Worth

We identified ‘The Sexed Body’ as a theme about how older men understand their

bodies through a gendered, cultural lens. Within this theme, these participants described their self-worth in relation to embodied performances of masculinity. They describe a hegemonic masculinity (Connell, 1995) that has been personally and culturally reinforced through the media and, in the case of gay men, through social interaction within ‘the gay scene’.⁷ Participants’ responses indicate that these men view their bodies as symbolic markers of their performative selves, where hegemonic masculinity is a marker of esteem for a ‘good’ body and for being a ‘good’ boy or man. All participants were asked whether or not they had been considered a ‘sissy’, a ‘tomboy’, or just ‘different’ from others. Overall, 28 of the 62 men over 60 (45.2 per cent) responded ‘yes’ to this question, with gay men reporting the most ‘yes’ answers (18/34; 52.9 per cent). Over a quarter (5/18; 27.8 per cent) of heterosexual men also answered ‘yes’ to this question. Bisexual men answered ‘yes’ and ‘no’ in equal numbers. Participants were given two additional free-text fields to give details and expand on their answers. All who responded ‘yes’ provided additional responses, a few of which explained that their difference was not gender-related. For instance, one heterosexual man said he was unique because of the business his father ran; another gay man reported being singled out for having dark skin. These comments reinforce two points: first, identification with difference was not always remembered negatively by participants; second, we are reminded of intersectional identifications – where a person identifies or is identified as ‘different’ or ‘other’ to a group in early parts of their life and in more than one way, such as skin colour *and* sexuality (Riggs and das Nair, 2012). More often, however, the ‘differences’ in this study were explained as being related to a non-hegemonic performance of masculinity. For some of the men, they described themselves as being ‘effeminate’ (Gay man, 72) or displaying ‘latent gay presentation’ (Gay man, 67). In 1967, the year that sex between men (aged 21 years and older) was decriminalised in England,⁸ participants in this group were already between the ages of 14 and 37. Referring to their growing up, some used more euphemistic terms, echoing the derogatory nature with which their diversity was viewed. For instance, one gay man (aged 74) recounted ‘At school, [I was] considered as a “Nance” but that was at school, not now’. Behaviours that were deemed to be feminine or not-masculine-enough were derided. These respondents reported being judged and (de)valued based on the success or failure of performances of masculinity. This type of hegemonic regulation was not limited to gay men. Men who identified as heterosexual, but described themselves in terms like ‘non macho’ (Heterosexual man, 71) or ‘bookish’ (Heterosexual man, 63) also shared memories that accentuated disapproval from other men while they were growing up. One heterosexual respondent (aged 62) described himself as being considered different because he was artistic.

7 We use ‘the gay scene’ as this was the language used by participants. However, we acknowledge the problematic erasure of the broader LGBTQ population in queer community and

commercial spaces when ‘the gay scene’ is the preferred language. In 1967, sex between men was decriminalised in England, but the age of consent was set at 21 until it was lowered to 18 in 1993 and to 16 – equal with heterosexual – in 2001. Sex between men was not decriminalised in other parts of the UK until the 1980s (Scotland and Northern Ireland) and the 1990s (Channel Islands and Isle of Man).

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

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

Attractive Bodies

Within the responses, there was an emphasis on attraction and attractiveness from gay and bisexual men; however, this was largely absent from the responses of the heterosexual men. Perhaps because of the wording of some of the questions about LGBT people and body image, only two of the heterosexual men made comments about the role of the body in sexual, romantic, or social attraction between people. Most heterosexually identified men replied that they did not know (n=5) or left the question blank (n=11). Normative and idealised bodies were reported as being directed and produced throughout participants’ adult years by two sources: the media and, in the case of gay men, ‘the gay scene’. The survey data revealed a tension wherein only 16.1 per cent of all of the men in the 60 years and over group indicated that the people in the media had an influence on their own body image. However, in the qualitative responses, more than one third (n=16, 36.4 per cent) of gay and bisexual men explicitly identified images in the media as being either problematic and/or the way to improve issues of body image for individuals and as a mark of social health. Gay men talked about ‘media representation’ (Gay man, 68) and ‘unrealistic images in the media – perfect teeth, airbrushed photos’ (Gay man, 62) with a focus on ‘perfect people’ (Gay man, 65). This was identified as one of the key issues that added to problems with body image: ‘I don’t think the media helps – most people on TV and in the public eye are cool, sexy and look great –and most of the general population don’t’ (Gay man, 64). Men said that they did not see the same diversity in the media as they did in their lived

experiences, and this related to seeing older bodies, and bodies that were 'ordinary'. Some men said that the influence of unrealistic images and unrepresentative bodies was a problem across society generally, rather than being an issue for just LGBT people. As one gay man (aged 65) commented: 'I am not convinced that it is a problem restricted to the LGBT community. I think that media advertisements and an over emphasis on "celebrities" and their lifestyles contributes to dissatisfaction'. Two of the heterosexual men rated the media as having a great influence on their own body image; however, again, none of the heterosexual men made any additional comment about attractiveness or the media. Whilst our initial impression was that this may be due to the wording of the study rather than a lack of reflexivity about how heterosexual men do or do not feel pressure about their bodies from the media, many of the women – across all sexual identities – expressed very clear and more emphatic views about how they felt the media impacts all people and perpetuates unrealistic ideals.

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

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

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

Attraction and Competition

One of the surprising tensions that repeatedly stood out in the responses from gay men was the notion of competition *between* men for the attraction and attention of other men (or *another man*). Discourses about ‘gay men’, ‘the gay community’, ‘the gay scene’ and so forth reinforce the idea of a collective group: ‘the challenge for modern advocates of community, therefore, is to imagine community without either neo-tribalism or self-immolation’ (Weeks, 2011, p. 30). What the older participants in our study identified was the interaction *between* individuals and the individualistic feeling of the gay sub-culture that they had experienced: they attributed problems with body image to ‘competition for sexual/romantic attraction’ (Gay man, 60) and ‘the competitive aspect of being in a gay community’ (Gay man, 70). For some, feelings were not about competition *with* younger men, but had been experienced more so *as* younger men than in their current stage of life.

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

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

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

of changes. This, in turn, contextualises their comments about sex as symbolic (of) belonging and as a way of interacting socially. For many, ageing may reinforce the experience of being ‘queer’ or ‘other’; whilst for some – particularly heteronormative – men, the cultural devaluation of the ageing body might mark their initiation to an ‘outsider’ identity (Clarke et al., 2012).

At the crux of this can be the rejection and stigma from heteronormative culture and the emphasis placed on that alternative social network, having often taken the form of a commercial scene and/or a sexualised environment (explicitly or implicitly). A paradox to this conundrum: men who are single may be more isolated *and* men who feel isolated maybe looking for romantic or sexual connection, *as well as* non-sexual, social connection. There may be a need for more compartmentalisation of different social and sexual aims by individuals, or a need for more attention to how single, older men can recreate and strengthen networks for companionship and intimacy later in life.

Active Bodies

The second major theme we identified in the qualitative data related to sport and active bodies. Within the group, the men emphasised and elaborated on two opposing sub-themes that were also divided diachronically. The first was that lack of ability and/or enjoyment of sports and athletic activities in youth were common amongst the men who reported feeling different as young people. The second was that men who talked about being active now – in their older years – indicated that this was interrelated with a positive outlook on physical, as well as social and mental health. The stereotypical view that gay men lack the same ability or interest in sport as heterosexual men is one that has been challenged in recent years (Ziegler and Buzinski, 2007), but a gender hierarchy is maintained within a dominant repertoire that femininity in sport is incompatible or inferior. All these older men, regardless of sexual identity, who reported memories of being made to feel different or a ‘sissy’ made specific mention of the types of hobbies and activities that were associated with masculinity. When we asked men why they felt different, or to elaborate on why they were called a sissy in their youth, answers from one bisexual man and eight of the gay men included specific mention of sport. Examples include ‘manly sport never interested me’ (Gay man, 74) or just ‘bad at sport’ (Bisexual man, 77). Throughout, sport was explicitly denoted as a ‘manly’ pursuit: ‘Heavier than others, less masculine, not at all interested in sports or politics’ (Trans* identified gay man, 62). The body that did not participate in sports was an unsporting body, and equated with a sense of queerness: ‘I was a clumsy, chubby boy with a pronounced lisp. No interest in sports’ (Gay man, 60). Reading these accounts within a framework of queer theory, body fat, co-ordination and even speech are accounted as antithetical to a sporting interest. In other words, we can observe a pattern of *collocations* or associations between

different words (Baker, 2003). The meaning of the body is (re)constructed when it is positioned within structures and hierarchies of gendered performance, body shape and sport, all of which are themselves reinforced as mutually informing and co-constructive as they are repeatedly remembered together. The body is ‘othered’ as an indexical signification of the social self. In another example, the syntagmatic association of intellect, personality, sexuality and gender are all set against sport as defining – and stigmatising – a man’s identity: ‘Because I was more intelligent, more sensitive, attracted [...] to other boys/men, a little effeminate, and not remotely interested in sports (compulsory at school, which I hated anyway)’ (Gay man, 72). The emphasis placed on sport as a part of defining the masculine body fits within the construct of hegemonic masculinity (Jarvis, 2006), but the emphasis that men placed upon it both within and across their responses marked it out as something that warranted further attention on its own. What made it even more interesting were the accounts of how sport was seen as an extremely positive part of other men’s lives, particularly as they attributed it as central to continued good health.

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

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

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

In his response to our invitation to share details about his health and well-being, this participant details a very holistic approach to activity. Fewer than 15 per cent of adults over 75 years report exercise that lasts longer than 10 minutes (Fox et al., 2011), but he is physically very active, as well as socially, intellectually and culturally engaged and stimulated. His response indicates his interest in self-care, and the pleasure he derives from being active and involved in a friendship and a community that he actively maintains. This association with the social aspect of physical activity was echoed by participants who were less mobile or more affected by pain. For these men, challenges to physical health or mobility had a knock-on effect by limiting the amount they could socialise, as well as undertake regular exercise. Physical health also affects their social and mental well-being. Physical problems perpetuate, compound and accentuate isolation, and provide barriers to regular social and physical activities. In this example, arthritis and a hip replacement had become obstacles.

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

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

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

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

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

In this example, the man spoke collectively, implicitly including his wife when he wrote about walking the dog for exercise (Peel, Douglas, Parry and Lawton, 2010). He went on to describe keeping in touch with their children and their active participation in each other’s lives. Again reinforcing the intersections of physical and social health, but also emphasising that a physical disability does not preclude an active, engaged life. Some of the responses about being active in older age challenged a number of stereotypes. For example, one man described having lived with HIV since he was 37 in the 1980s: ‘Having been HIV+ for 31 years I do try and do plenty of exercise and swim a lot. I have always believed a moving target is harder to hit’ (Gay man, 68). As well as challenging stereotypes that would associate older men with inactivity generally, what he reported emphasises the narrative that men who have HIV (and not AIDS) have a higher awareness of health issues and medical concerns, yet they evaluate their fitness and health

similarly to men who do not have HIV (Blashill and Vander Wal, 2011). His answer did not describe having HIV as unproblematic – indeed he described ongoing struggles with stigma and self-esteem – but his story illustrates the dramatic social, medical and technological changes that he has witnessed in his life. As an active, older man living with HIV in England he can provide an affirmative example of how older men, people living with HIV, and older people living with intersectional challenges from illness or injury can sometimes be proactive in adapting to their circumstances, and emphasise action for healthier living.

Medicalised Bodies: ‘My GP Told Me that I was “Disgustingly Healthy”’

The third theme we found in these data from older men highlighted understanding about their bodies in medicalised terms. Because of the nature of the study, we specifically invited people to offer additional information about their health and wellness. As well as examples of health and wellness, some people described injury and illness. Older men indicated that their doctors and/or health professionals had some influence on how they felt about their bodies. Medical conditions and histories were detailed by a number of participants and included comparisons with peers as well as temporal comparisons, including comparisons with their past self *and* anticipation of their future self. In response to a question about the people in their lives they felt had influenced their body image, these respondents indicated that doctors and health professionals had roughly an equal amount of influence as romantic partners, and more influence than for any of the other categories listed, such as parents, friends, or people they see in their leisure time. This finding was roughly the same for gay and heterosexual men, whereas bisexual men rated the influence of their doctor lower in comparison to romantic partners, friends and childhood friends; an issue unexplored in previous research with men across a general population (Tylka and Andorka, 2012). The language that the men used to talk about their bodies revealed experience and rehearsal with a technical, medical vocabulary, including a number of shorthand abbreviations that would be unfamiliar to a cohort who have neither experience nor exposure with their particular diagnosis and treatment. For instance, terms such as ‘recent angioplasty’ (Heterosexual man, 68) and ‘only had physical problems: OA [osteoarthritis], Hip replacement, RA [rheumatoid arthritis], subacromial impingement [trapped tendons or tendonitis] and torn rotator cuff tendon, disc herniation’ (Gay man, 60) were used. We read a number of detailed descriptions where men talked about physical as well as mental health. In talking about their bodies in medical terms, we noted the complex intersectionality between age, sexuality, and a framework of temporality, ‘in the sense of how time is experienced or perceived and in the sense of how available time might be filled’ (Port, 2012, p. 5), or in cases like the participant below, nullified. Men referred to their health and bodies by talking about a past standard of health they had experienced as younger men. Some noted recent changes to their health. Others gave accounts of past or long-

term illness, and some described a compounding of health concerns where new conditions emerged in addition to on-going issues.

I have been HIV positive since 2000 and was diagnosed when infected. Peer support groups at [Name] and elsewhere helped a great deal in my coming out at age 57. I had a soft tissue sarcoma removed from my [leg] with no side effects. I never stopped work until I retired in 2012 age 66. [...] I have 7 been [on] a 20mg a day dose of citalopram for depression for over 11 years, and the staying alive is not a priority (Gay man, 67).

Like the examples in earlier sections, this man goes on to write about his experiences with social and medical challenges together with accounts of resilience. In this abbreviated example, he gives an account that includes physical and mental health, interventions and continuation with ordinary routine, past and current illness and construction of his feelings about the future. In his longer, written answer, this same man also gave us details about his relationship with his children and grandchildren. These accounts, along with his medical history are framed within a narrative that reveals the acceptance, as well as the rejection and stigma, that he has experienced in relation to coming out as gay. The qualitative data is invaluable here, not just in revealing the detail and the contradictions, but also the shifting subject positions for a population who are commonly described – even within this chapter – in very categorical terms. From his answer, we also learn about the interrelationship of his medical history with his family and sexual history: that he came out as gay to his wife when he was diagnosed with HIV after which he experienced depression and considered ending his life. In this case, temporality explicitly frames the intersectionality and an imagined future is both challenged and challenging. A quarter of people living with an HIV diagnosis in the UK are now aged 50 and over (Yin et al., 2014). Whilst the overall number of new infections of HIV in the UK has decreased slightly, both the proportion and number of diagnoses amongst older adults has increased (Yin et al., 2014). For example, in 2012, 31 per cent of heterosexual men who were diagnosed with HIV were aged 50 years or older; however, whilst most gay, bisexual and other men who have sex with men (MSM) do not have HIV, they continue to be disproportionately affected by HIV. In our sample, five of the men who identified as gay (15 per cent) talked about having HIV, but none of the men who identified as heterosexual or bisexual. This is significantly higher than the proportion of all gay, bisexual and other MSM living with HIV within the national population (5.88 per cent or 1/17,⁹ Yin et al., 2014). This may be related to sampling for the RaRE study; however, the process of HIV diagnosis and ‘coming out’ to partners may also affect how MSM identify their own sexuality to themselves and others.

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

Older adults (over 50 years) have also been found less likely to disclose their HIV status than younger people (Emlet, 2006). The time at which the men responding to our study were diagnosed with HIV ranged from three decades before to within the previous few years. What may disrupt dominant ideas about sex and sexual health amongst older men is exemplified by the man who was diagnosed with HIV in his retirement.

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

The idea that people in their sixties are at risk of HIV and other sexually transmitted infections runs contrary to the mythologised ideology of the heterosexual matrix (Rubin, 1993). Older people in England are discursively constructed as married and monogamous, and retirement infers a slowing down, not the kind of body that is at risk of HIV and STIs (see also Chepngeno-Langat and Hosegood, this volume). Yet, this adds to a relatively recent understanding that intimate life continues into and through our older years and changes to patterns of marriage, partnership, and divorce have played a role in exposing a generation who may be less aware of or feel able to manage their own risk. This man suggests he may have depression and expresses his feelings in a way that is typical of depression and common amongst people who have been diagnosed with many medical conditions, including HIV as described here (Blashill and Vander Wal, 2011). Stigma has been significantly associated with negative self-image, depression, poor mental health and increased disability (Fredriksen-Goldsen et al., 2012). This pattern of depression related to diagnosis with HIV intersects with depression related to other life changes that may or may not be directly or indirectly interrelated, such as a partner's reaction.

In this man's account, he was previously married to a woman and his diagnosis prompted him to tell his wife. He talks about her reaction and their subsequent divorce. These experiences and changes in identity are invisible – or make false assumptions about causality – when research is designed to focus on sexual identities as being fixed through people's lives. The medicalised body is also the social body. The interplay of the physical, mental and social tripartite advocated in some models of understanding body image (Tylka and Andorka, 2012; Tylka, 2011) is brought forward in the participant's own words. In one of his answers, our oldest participant, aged 83 years, touched on all of the major themes: the sexed body, the active body, and the medicalised body, combined to construct the temporal body.

Although I am over 80 years old I certainly don't feel it and I am regularly taken for

being much younger probably because I am of quite slim build with no excess bodyweight (comes of being an athlete when I was younger and keeping up with a reasonable amount of exercise even in my later years). My GP told me when I had my annual “MOT” last month that I was “disgustingly healthy” for my age (whatever that may mean). I live alone (and have done since the break-up of a long-term relationship 8 years ago (after being together 24 years). The relationship did not end on a sour note and we have still remained friends it was just the age gap that was there interfered in things (I was much older). Both of our families were supportive of us and our relationship and both families have remained in touch in a caring way since the breakup. This has certainly been a great help to me in overcoming some of the difficulties that arise if one is living alone when you are older (Gay man, 84).

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

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

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

Conclusions: Contexts and Temporal Bodies

In our analysis of the data for this study, we found three themes about how our older male participants understand men’s bodies and body image. We have described these as ‘The Sexed Body’; ‘The Active Body’ and ‘The Medicalised Body’. As we continue analysis across different subsets, we emphasise the development of one super-ordinate theme, ‘The Temporal Body’. Using a model that acknowledges physical, social and temporal factors to understand men’s body image is helpful to address the provision and access of health services for older men (Tylka and Andorka, 2012). Including factors (or mediators) of body appearance, functional performance, *and* social influences offers a holistic perspective. It creates a space for dialogue and a recognition of the interconnectedness of physical, mental and social health and well-being. Expectations of (hegemonic) masculinity and heteronormative gender roles can continue to influence how men are viewed as they age and how they see themselves. Gender, gender roles, and sexuality ‘scripts’ inform the lives and experiences of men as well as women, however they identify with heterosexual, bisexual, gay, trans* or cisgender. Rather than being ignored in the name of

‘equality’, men’s gender and sexuality might better be acknowledged within practice and mainstream service provision, and used to redress structural and social inequities related to the social expectations of these scripts.

Many of the examples we have used as illustrations are from gay men by virtue of number and descriptiveness, but men of all sexual identities were proud advocates of rude health even in their late 70s and early 80s, which they attributed to maintaining or adopting an active lifestyle: sporting, cultural and social. They emphasised the interrelatedness of feeling physically and mentally well. In cases where men faced physical obstacles to mobility and activity, men expressed greater concern related to increasing or compounding existing feelings of isolation. Compounding age and health issues were a concern for these older men, sometimes related to health inequities. Changes in family and social structures were interrelated with changes in health. A sense of connection was related to how secure and supported men reported feeling. As well as their ‘romantic partners’, older men attributed the most influence on the feelings they had about their bodies to their doctors or health professionals. The men used a medicalised language to talk about their bodies, describing detailed medical histories and using medical terminology and jargon. As well as describing their past bodies, again they contextualised their current health experiences in social terms.

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

One man’s view was that problems with body image for LGBT people were related to ‘dress code and attitude’ and that the solution was to ‘dress and act as normal people do’ (Heterosexual man, 67). Without further elaboration from him, we might read this as an example of continuing hegemonic regulation of how ‘normal’ bodies should look, dress and behave. In our aim to explore risk and resilience, we can identify continued tensions between social expectations of

‘heteronormative’ performativity and how all older people embody ‘queer’ to a greater or lesser degree (Port, 2012). Liberal ideologies are paradoxically restrictive within repertoires of ‘age-appropriateness’, heteronormativity, homonormativity and biological determinism (Weber, 2012). Even as inequities based on sexuality are addressed and reduced, new hierarchies emerge. We must continue to explore the lived experiences of people with evermore individuated identities within the broad categories we address as heterosexual, gay and bisexual.

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