Subjugation and Resistance in Older Gay Men’s Health Care Experiences

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy in Social and Behavioural Health Sciences

Dalla Lana School of Public Health
University of Toronto

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2019

Abstract

The scholarship on aging among lesbian, gay, bisexual, transgender, and queer (LGBTQ) adults has, in recent years, experienced unprecedented growth. Despite this emerging body of literature, research on older gay men’s health care experiences remains limited.

This qualitative study, which is framed theoretically by Foucauldian governmentality and intersectionality, and informed methodologically by a poststructuralist approach to grounded theory known as situational analysis, attempts to address this gap in the literature. Specifically, drawing on interviews with 27 Toronto-based gay men ages 50 and over, 16 of whom reported being HIV-positive at the time of recruitment, the study offers insight on the health care experiences of older gay men. More specifically, the study highlights processes of subjugation and resistance reflected in the accounts of the participants.

Chapter 1 provides a critical review of the literature, highlights the role of Foucauldian governmentality and intersectionality in situating the study theoretically, and outlines the study’s research design. Chapter 2 contains an overview of the study’s key findings, which specifically delineate how sociohistorically significant discursive forces rooted in homophobia and HIV stigma, older gay men’s interpretations of medical practices, as well as institutional constructions
of gay aging bodies, together reflect the role of the HIV/AIDS epidemic in shaping older gay men’s subjugation and resistance across health settings. Drawing on the study’s insights, and the centrality of Foucauldian governmentality in supporting the conceptualization of these findings, chapter 3 examines the utility of this theoretical framework in guiding and enriching qualitative studies informed by situational analysis. Chapter 4 utilizes the accounts of this study’s HIV-positive participants to identify the health care and social service needs of this population, and incorporates an intersectional lens to conceptualize variations in the service priorities of this group along dimensions of difference such as socioeconomic status, ability, and race. Finally, chapter 5 concludes with a discussion of the study’s contributions to substantive and theoretical bodies of scholarship, and an overview of the inquiry’s implications for policy and practice in the area of gay aging.
Acknowledgments

First, I would like to thank my families: my mother, Steve, my grandmother, Moe, Michelle, baby Justin, the Moussavian family, the Iliou family, the Wong family, and Sarah. All of you mean the world to me, and I would not have made it so far in my academic and professional career without your love and support. To my mother, your compassion and your vision for a better world have been my life’s greatest sources of inspiration, and your undying belief in my potential has given me courage and will more times than I can count – I love you more than you will ever know. To my brother Moe, thank you for always loving me, seeing the best in me, and for being the first person in my life to help me come to terms with being different. To my grandmother, I strive to embody the love, good faith, kindness, and unparalleled wisdom you have modeled for me since the day I was born, and will always do my best to bring these attributes to my work as a researcher. Sofia and George, you have been my beloved family in Toronto and have welcomed me into your lives with a warmth and kindness for which I can never thank you enough. To my best friend Sarah, whom I love dearly, thank you for reminding me to be present, to laugh, and to enjoy life through my time in graduate school. To my beautiful, one of a kind partner Steve, whom I adore and admire beyond words, you somehow manage to continue leaving me speechless with your daily (and sometimes extreme!) gestures of love and affection. My PhD, and this dissertation specifically, would not have been possible without your unwavering encouragement, support, love, and attention.

I will be forever grateful to my committee members, who have gone over and beyond in their mentorship and guidance. To my supervisor Lori, thank you, from the very bottom of my heart, for being the absolute best source of support and learning a graduate student could hope for. You have been an exceptional mentor to me, both personally and professionally, and someone whose commitment to ethically responsive and accountable scholarship I aspire to. Although I am already in grief at the prospect of losing you as a supervisor, I genuinely hope to continue working with you (and learning from you) for many, many years to come. Carol and Daniel, thank you so very much for your patience with me, and for always seeing my potential as committee members. Both of you have consistently offered me such relevant and thoughtful feedback on my dissertation, and have worked tirelessly to ensure I produce my best work. Carol, I am particularly thankful to you for pushing me to articulate my thoughts with greater
concision and simplicity, and for believing in me even when I had my strongest doubts. Daniel, I am incredibly grateful to you for helping me to deepen my analyses and to account for important nuances in my application of theory and methodology. On a personal note, I am also extremely appreciative of how available, open, and flexible you have been to offer me feedback and direction at any given opportunity. I have made a habit of bragging about my ‘dream team’ committee to fellow PhD students, mostly because all three of you together are really any graduate student’s dream!

To my PhD cohort, the Re:searching for LGBTQ2S Health Team, my many mentors, several faculty members and students at the Factor-Inwentash Faculty of Social Work I have had the pleasure of getting to know, my queer and trans families, and my other friends and colleagues, I cannot thank you enough for your support throughout the course of my doctoral studies. These have been a very stressful and personally challenging five years, and I have admittedly had difficulty being present as much as I would have liked, but having a few of you to talk to, spend time with, and laugh with, has made this process so much easier. I would particularly like to thank Kinnon MacKinnon here, who has been a tremendous source of friendship and support for me, and who has on countless occasions done more than I would ever expect of a friend to make my life easier and more enjoyable. I hope we continue being close for many years to come. Thank you also to Nakia Lee-Foon for making me laugh and helping me take myself less seriously throughout the course of my PhD. I would, in addition, like to thank Dr. Brian O’Neill, whose ongoing mentorship in my academic career has meant the world to me.

I would like to extend a very sincere thanks to the Toronto Senior Pride Network, the 519, REALIZE Canada, and LOFT Community Services for supporting my research, particularly while I was in the process of recruiting participants. This project would not have been possible without your support and input! I would also like to acknowledge the Canadian Institutes of Health Research (CIHR) for awarding me a Doctoral Research Award, which provided me with rich opportunities for helping me develop and execute this project, produce the work presented in this dissertation, and disseminate this study’s insights at various academic conferences. Similarly, I am sincerely grateful to the Dalla Lana School of Public Health, including its administrative staff, for helping me materialize my research interests with resources for completing my doctoral work.
To the University of British Columbia’s School of Social Work, thank you enormously for offering me the opportunity of a lifetime to start my academic career with such a brilliant and talented group of scholars. I cannot wait to begin teaching and developing my program of research at the School, and to explore opportunities for collaboration with faculty members. It is difficult for me to put into words just how exceptionally excited I am about the next few years of my academic career!

Most importantly, I would like to thank the men who generously contributed their time and their stories to this project as participants. I have learned so much from all of you, and although at times I was deeply troubled and saddened to hear what some of you have experienced, I was often equally (if not more) inspired by the tremendous strength and courage many of you have drawn upon in your lives to build incredible lives, beautiful families of choice, and thriving communities. Thank you, infinitely, for willingly bringing me into your lives and inviting me to learn from your words. I promise to remember and reflect on your stories, long after my PhD.
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Chapter 1

1 Introduction

1.1 Problem Statement and Research Questions

There exists an emerging body of work that seeks to address and generate insight on aging in lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations (Addis et al., 2009; Fredriksen-Goldsen & Muraco, 2010). Given the historical tendency for literature in the area of queer studies to neglect analyses of the life course, and similarly, the lack of theoretical and empirical attention to issues surrounding sexuality and gender identity within the field of gerontology (Brown, 2009), the study of LGBTQ aging is important for addressing cross-disciplinary gaps in knowledge. In addition, in light of the systemic stigma and discrimination that older LGBTQ adults experience (Brown, 2009; Brotman et al., 2015), the generation of empirical insight on the unique realities of LGBTQ aging may be necessary in the pursuit of rectifying health and social disparities affecting this marginalized group (Addis et al., 2009).

As discrimination among older LGBTQ adults has been identified with remarkable prominence in medical settings (Addis et al., 2009), the study of this group’s experiences navigating systems of health care may be considered a priority in this growing field. Across subcategories of older LGBTQ adults, gay men are recognized as a population with a unique history that contextualizes this group’s contemporary experiences of stigma and discrimination in accessing systems of care delivery (Wight et al., 2012). In particular, this group’s social context has been characterized by disproportionate exposure to the HIV/AIDS epidemic, both historically and in the present (Cahill & Valadez, 2013). As such, many in this population experience a unique confluence of barriers, within the context of their health care experiences, that comprises stigma surrounding old age, same-sex sexuality, and HIV, among other factors (Wight et al., 2012). Accordingly, inquiry on health care access among older gay men, including those living with HIV, as well as those whose experiences are shaped by the history of HIV/AIDS, may be considered particularly compelling as a site of analysis within the broader literature on LGBTQ aging.

Of note, nearly all of the limited body of empirical literature on LGBTQ aging, and gay aging specifically, addresses the social conditions and experiences of older sexual and gender minority adults located in industrialized societies across Europe and North America (Addis et al., 2009;
Fredriksen-Goldsen & Muraco, 2010). Furthermore, much of this scholarship is based on the accounts of aging LGBTQ adults who are located in urban centres (Addis et al., 2009; Cahill & Valadez, 2013; Fredriksen-Goldsen & Muraco, 2010; Rosenfeld et al., 2012). As such, although this body of work contains insights that may be significantly limited in their transferability to geopolitical contexts outside the urban, industrialized metropole, it is ideally suited to informing research conducted in OECD member states, including Canada, and in large, urban centres in particular.

My doctoral research examines the subjugation and resistance of Toronto-based older gay men in health care settings. Subjugation, as discussed in the context of this research, refers to the collection of social processes that underpin the production of subjects; in Foucauldian terms, subjects are both targets of control by social actors in relative positions of power, and are also capable of resistance against sources of normative power (Berard, 1999; Foucault, 2000). As the production of marginal subjects is the very foundation on which systems of domination are predicated (Berard, 1999; Foucault, 2000), the study of processes associated with subjugation and resistance may be considered particularly relevant in contributing to greater insight into specific social conditions and mechanisms that lie at the core of marginalization. Given that older gay men, particularly those living with HIV, are believed to experience discrimination grounded in multiple sources of marginalization (e.g., ageism, heterosexism, and HIV stigma, among others), especially in their experiences of navigating health systems (Addis et al., 2009; Cahill & Valadez, 2013), the examination of subjugation and resistance among older gay men seeking or receiving care is relevant in generating a more sophisticated analysis of social phenomena underlying these expressions of discrimination. Additionally, in light of the highlighted need for more empirical inquiry on aging LGBTQ adults’ problematic experiences with systems of medical care in general (Addis et al., 2009), such work is likely to address an important gap in LGBTQ aging literature.

My doctoral work addresses the following primary research questions: (1) how are processes of subjugation and resistance reflected in the accounts of older HIV-positive and HIV-negative gay men seeking and/or receiving care in health systems?; (2) what is the comparative significance of the HIV/AIDS epidemic in constructing health care as a site of subjugation and resistance among older HIV-positive and HIV-negative gay men? and (3) what are the health care and
social service implications of conceptualizing health systems as sociohistorically significant sites of subjugation and resistance, particularly for older HIV-positive gay men? In order to examine these questions, I conducted a qualitative study, informed by the tenets of situational analysis (Clarke, 2003), in which I interviewed older HIV-positive (n=16) and HIV-negative (n=11) Toronto-based gay men who discussed their experiences of seeking and receiving care across health systems, and examined their accounts as a basis for gaining insight into phenomena of subjugation and resistance that typify this population’s interactions with health care. This dissertation, which comprises three independent manuscripts, outlines key insights produced by the findings of this study.

1.2 Theoretical Approach

Given the study’s focus on subjugation among older gay men accessing care, theoretical frameworks that highlight subjugating power as a relevant focus of social scientific inquiry were most useful in grounding this empirical work. Accordingly, I drew on Foucauldian governmentality and intersectionality, both traditions that invite complex analyses of power among those located in contexts of subjugation (Foucault, 2008; Gane, 2010; Yuval-Davis, 2006), to theoretically situate and frame the study.

1.2.1 Foucauldian Governmentality

Governmentality studies, which is a subfield of Foucauldian literature, is often understood as a body of theoretical inquiry that foregrounds how normative power operates and is exercised according to social, political, and historical context (Gane, 2010; Rose, 1996; Walters, 2012; Wehling, 2011). Walters (2012), a prominent Foucauldian scholar, specifically notes that the term “governmentality” is most commonly interpreted and used by theorists to refer to omnipresent exercises of power that aim to shape and discipline social behaviour among and upon subjects, specifically for the purpose of aligning such behaviour with normative standards of conduct. Importantly, consistent with this rendition of the term, such exercises of power are believed to be multilevel in that they may be deployed intra- or intersubjectively, or alternately, more systemically across broader levels of social organization, and they may be located both within and beyond the realm of state power. This conceptual approach in the field of governmentality studies often involves close attention to the “conduct of conduct,” or the
collection of social processes associated with shaping or controlling social behaviour among “governed” subjects, and as such, is often used to study processes of subjugation at all levels of social organization (Walters, 2012).

The body of theoretical literature on governmentality has historically been useful in conceptualizing the field of LGBTQ health, primarily due to its capacity for addressing the ubiquitous and multilevel nature of sexual and gender normativity and subjugation (Brown & Knop, 2014; Sanger, 2008). Additionally, the lens of governmentality, when used in the discipline of gerontology, has contributed greatly to conceptualizing phenomena of medicalized aging, particularly given the utility of this theoretical tradition in conceptualizing the normative surveillance and control of aging subjects deemed “frail” or “dependent” across health systems (Bjornsdottir, 2002; Pickard, 2014; Purkis, 2001). In light of the use of this framework in relevant substantive areas, and the strengths of this lens in conceptualizing phenomena of subjugation and resistance within these domains, this theoretical orientation appeared well suited to informing analyses of subjugation among older gay men accessing health care services.

### 1.2.2 Intersectionality

The social conditions and experiences of older gay men and other aging sexual minorities have often been characterized as being shaped by variable and multifaceted sources of marginalization located at the intersection of sexual identity, old age, HIV status, class, race, and ability, among other dimensions of difference (Brown, 2009; Cronin & King, 2010). Accordingly, intersectionality, which as a framework focuses on the premise that every subject occupies a social location defined by unique configurations of socially and politically intelligible experiences and identities (Crenshaw, 1989; Yuval-Davis, 2006), was utilized to complement the analytical contributions of Foucauldian governmentality in this study. As intersectional scholarship is, primarily, concerned with examining dimensions of social location that reflect social disadvantage or oppression on various grounds (Yuval-Davis, 2006), this framework is particularly well suited to analyzing the realities of older gay men and other aging sexual minorities (Cronin & King, 2010).

Yuval-Davis (2006), whose work is frequently cited as an exemplar of contemporary intersectional scholarship (Davis, 2008), has explicitly outlined the core assumptions of
intersectionality. In her paper, she has highlighted the need for scholars undertaking intersectionally-informed inquiry to account for the irreducibility of specific social differences, or the unique characteristics of subjectivity associated with configurations of race, class, sexuality, ability and an array of other factors, that underpin the social realities of those living with these markers of difference. In this work, she has also discussed intersectional inquiry as a means for critically examining potentially limitless sources of marginality and difference within complex and interrelated relations of power. McCall (2005), another prominent intersectional theorist, has differentiated between three types of intersectional scholarship: works that address intercategorical, intracategorical, and anticategorical complexities. Whereas the first body of intersectional inquiry is concerned with differences that exist between multiply marginalized groups and dominant reference populations, the second is centered on exploring variations and sources of distinction within groups affected by intersecting sources of marginality, and the third involves interrogating and deconstructing the essentialism of group identities.

Within this study, I used intersectionality primarily to draw attention to the relevance of studying complexity and variability in health care access experiences among older gay men, particularly relative to subjugation and resistance at the intersection of old age, gay sexuality, and other notable dimensions of social location that typify the identities of aging gay subjects. First, utilizing intersectional theorist Yuval-Davis’ (2006) position on the irreducibility of subjective experience, I drew on this theoretical framework to frame questions and analyses that meaningfully accounted for and addressed the potential distinctiveness of interlocking subjugation based on old age and same-sex sexuality among men, and recognized HIV-seropositivity as a salient condition residing at the intersection of aging and gay sexuality (Cahill & Valadez, 2013). In addition, I employed the work of McCall (2005) to highlight sources of difference, or intracategorical complexity, that appeared to characterize conditions of subjugation among various groups of older gay men accessing health care services, including those living with HIV, despite what were finite commonalities across members of this heterogeneous group. Importantly, this second application of intersectionality was specifically useful in delineating the service-related experiences and needs of HIV-positive gay men, whose subjugation and resistance in health systems often varied based on the nature of their exposure to factors such as homophobia, ageism, HIV stigma, poverty, ableism, and racism.
1.3 Critical Review of Relevant Literature

1.3.1 Gay Aging, the Context of HIV/AIDS History, and Health Care: Examining Subjugation at the Intersection

The voices, social conditions, and experiences of older LGBTQ adults have, until recent years, been underrepresented in mainstream bodies of social science scholarship, and in policy and practice informed by these domains of literature (Brown, 2009; King, 2016). This phenomenon, which Brown (2009) refers to as rhetorical silence, has recently started being addressed by scholars cultivating an emerging field of inquiry surrounding the issues of aging sexual and gender minority adults (Addis et al., 2009; Fredriksen-Goldsen & Muraco, 2010; King, 2016). This area of study has revealed, broadly, that older sexual minority adults experience prominent expressions of stigma and discrimination across health care, social services, and other salient contexts (Addis et al., 2009). This literature has also highlighted that these populations experience disproportionately poor health outcomes, including disability and poor self-rated physical and mental health, relative to same-age heterosexual counterparts, and has linked these outcomes to these groups’ historical and ongoing exposure to stigma, discrimination, and victimization on the basis of sexual orientation (Fredriksen-Goldsen et al., 2013). Importantly, this area of scholarship has also foregrounded salient sources of resilience in these populations, including the tendency for sexual and gender minorities to actively construct robust systems of social support to mitigate the effects of stigma and discrimination (Fredriksen-Goldsen et al., 2011).

The body of literature on older gay men, including most prominently aging gay men with HIV, has undergone recent recognition and growth, similar to trends in the broader field of LGBTQ aging research (Cahill & Valadez, 2013; Fredriksen-Goldsen & Muraco, 2010; Fredriksen-Goldsen et al., 2011). Perhaps most importantly, older gay men with experiences of living through the HIV/AIDS epidemic, regardless of their own HIV serostatus, are now acknowledged in some of this literature as a population with exposure to a unique sociohistorical context that underpins many of their psychosocial conditions and needs (Cahill & Valadez, 2013; Wight et al., 2012). Specifically, given that the stigmatized association of HIV/AIDS with gay sexuality, particularly during the early stages of the epidemic, would often diminish the willingness of mainstream health institutions to support research, prevention, and treatment of this illness
during this time (King, 1995; Mignone et al., 2014; Omoto & Crain, 1995), the current subjectivity of older gay men may be understood as being grounded at an intersection marked with complex interactions of homophobia, heterosexism, ageism, and historically-established patterns of HIV/AIDS stigma, among other social factors (Wight et al., 2012). As LGBTQ aging scholars have, in recent years, discussed the need for researchers to account for the central role of relevant historical factors, including past forms of institutionalized homophobia, in shaping the contemporary realities of older sexual and gender minority adults (Brotman et al., 2015; Fredriksen-Goldsen et al., 2013; Jennings, 2007; King, 2016), acknowledging the potentially salient influence of HIV/AIDS history on the present day subjectivities of older gay men is substantiated by the broader scholarship in this area.

Empirical evidence for the significance of this subjectivity, typified by the interlocking social realities underlying gay aging in the context of HIV/AIDS history, lies in the link between exposure to stigma and high-risk sexual behaviour among older HIV-positive gay men (Emlet et al., 2015), as well as the negatively correlated relationship between experiences of multiply-grounded stigma and measures of quality of life in members of this population (Slater et al., 2015). Furthermore, indicating the relevance of HIV history among older gay men, regardless of variations in serostatus across members of this population, seronegative and seropositive older gay men with comparably significant experiences of AIDS bereavement are known to encounter more adverse mental health outcomes than those not living with this potential source of distress (Wight et al., 2012). In line with these empirically-established insights, the study of health care access among aging gay men, in particular those living with HIV (but not excluding older HIV-negative gay men with exposure to HIV/AIDS history), is necessary in generating a greater understanding of the social mechanisms that underlie the intersection of old age, gay sexuality, and HIV stigma in a context that is known to be hostile to older LGBTQ people as a whole (Brotman et al., 2003). Such empirical inquiry may not only assist in the refinement of questions that are emerging in the field of gay aging, but may also contribute to the development of knowledge on addressing conditions of stigma that typify the experiences of older gay men.

The processes involved in creating conditions of stigma, particularly those experienced by older gay men, may best be understood by examining how subjugation targeting this group is constructed and experienced by its members. As already noted, given that the production of
marginal subjects often underpins systems of domination (Berard, 1999; Foucault, 2000), in this case including homophobia, heterosexism, ageism, and HIV stigma (among other factors) (Wight et al., 2012), examining the very social situations in which these subjects come to be construed as targets of stigma and discrimination on multiple grounds may be highly relevant as sites of analysis. As health care represents one social situation that is salient in reinforcing dominant relations of power, namely since this is a realm in which the provision of an elemental social need may be withheld on any normative basis (Angus et al., 2012; Kovandzic et al., 2011; Dixon-Woods et al., 2006), processes of subjugation located in this context may be particularly relevant as foci of inquiry. In particular, since gay men have been structurally affected by a historically grounded relationship with state-endorsed medical systems, most notably those associated with HIV care, the study of subjugation among older gay men seeking and receiving health care is especially justifiable.

1.3.2 Foucauldian Governmentality and Intersectionality: Combining Theoretical Frameworks in the Study of Subjugation among Older Gay Adults Accessing Care

Although no attempts have been made to specifically apply Foucauldian governmentality in empirical explorations of gay aging in the context of health systems, this analytical approach has been used – as already been noted – to inform separate studies of medical subjugation among gay men and older adults. Collectively, these bodies of scholarly work suggest the relevance of considering health care as a prominent site of subjugation both among gay men and those in late stages of the life course, and also imply the need to study mechanisms of resistance among those affected by these exercises of power. Brown and Knop (2014), for instance, draw on Foucauldian governmentality to empirically consider the historical role of medical subjugation by public health authorities in shaping contemporary gay subjectivity, and also rely on this analytical orientation to acknowledge processes of resistance in use by these men to resist such systems of domination. Comparably, in the field of aging, Pickard (2014) utilizes Foucauldian governmentality to empirically examine the tendency for dependence and non-productivity among older adults to be discursively medicalized in the political and economic context of neoliberalism, and simultaneously addresses the importance of attending to mechanisms of resistance that may exist among those most affected by these processes of subjugation.
Both the work of Brown and Knop (2014), as well as Pickard’s (2014) paper, imply the importance of attending to phenomena of resistance as a means for conceptualizing and eventually catalyzing social change, as it is these expressions of subversion that offer insight into how problematic exercises of power may be rejected systemically among those marginalized by these systems of domination. It is based on this premise that the questions of the current study are framed to include considerations of subjugation, in conjunction with analyses of resistance, in older gay men’s health care experiences. Despite the utility of Foucauldian governmentality in framing the study’s principal research questions on subjugation and resistance in health care settings, however, a complementary framework is needed to account for the study of distinct phenomena of marginalization and subversion, particularly those likely to vary as a function of social location, that may characterize older gay men’s realities in medical systems. As already noted, it is for this reason that intersectionality has been used together with Foucauldian governmentality to inform and guide empirical and analytical decisions made throughout the research process.

Although intersectionality-informed research on aging LGBTQ adults is extremely limited, some examples of such work exist to highlight potential sources of variation that are likely to typify the conditions of older gay men as a highly heterogeneous group. One paper by Cronin & King (2010), for instance, suggests that the social experiences of sexual minorities may vary on the basis of gender, class, and age cohort (pre- or post-gay liberation), as well as other under-studied factors. In addition, as already noted, some have emphasized the importance of HIV-serostatus among gay men in uniquely shaping experiences of multiply-grounded stigma and discrimination among members of this sexual minority (Cahill, 2007). Lastly, although no known intersectionality-informed literature exists on the experiences of racialized older gay men, it is important to note that a body of gay men’s health literature documents the importance of race in constructing distinct social conditions among gay men of colour (Ayala & Diaz, 2001; Haile et al., 2014; Wohl et al., 2013; Yue, 2008). Specifically, some of the research on the experiences of racialized gay men suggests that experiences of racism often coalesce with and reinforce expressions of homophobia and heterosexism encountered among members of this group, and that the social realities of these men may therefore be broadly distinct from those of their white counterparts (Haile et al., 2014). Based on known and theoretically relevant distinctions among
older gay men, as highlighted by intersectionality-informed work, in this study I have attempted to use intersectionality to examine health care experiences and needs among older gay men that appeared to vary as a function of HIV status, as well as exposure to poverty, ableism, and racism, among other factors.

1.4 Methodology

To address my primary research questions, I conducted a qualitative study informed by the tenets of situational analysis (Clarke, 2003), which is an approach to grounded theory that is more closely associated with poststructuralist or interpretivist paradigms than traditional grounded theory (Corbin & Strauss, 2015). Specifically, with this approach as a guiding framework, I interviewed 27 Toronto-based gay men over the age of 50, 16 of whom were HIV-positive, and 11 of whom were HIV-negative. I used data generated from these semi-structured interviews to gain insight into phenomena of subjugation and resistance among older HIV-positive and -negative gay men accessing systems of care. Prior to launching into a more detailed description of the study, however, I wish to briefly outline literature on traditional grounded theory, and use this review to discuss situational analysis as an alternative methodology that was better suited to fulfilling this study’s primary objectives.

The body of qualitative methodology known as grounded theory is, in the context of contemporary social science, rich and epistemologically multifarious (Creswell, 2007). Despite the relatively high level of heterogeneity in this contemporary literature, however, this empirical orientation finds its historical origins in a specific and unified set of assumptions, strategies, and analytical techniques (Clarke, 2003; Creswell, 2007).

Traditional grounded theory primarily involves the systematic – yet iterative – study of a specific social phenomenon, and the desired objective of such research includes the generation of theory on an area of interest (Clarke, 2003; Corbin & Strauss, 2015). In conducting such inquiry, the researcher is often concerned with addressing previously unexamined or underexamined questions of theoretical relevance, and relies on an inductive and iterative research process to generate systematic insight into these questions. Specifically, using a method known as constant comparison, the researcher analyzes data simultaneously as they are collected by regularly examining emergent findings, by comparing these to any insights previously gained through
already collected data, and by tentatively theorizing the area under study. Each time data are analyzed in constant comparison, they are usually first subject to open coding, or raw, preliminary labeling, and are gradually amalgamated into more abstract or axial categories that are selectively used to construct theory, however provisional such theorizing may be. Importantly, sampling is informed and driven by this process of constant comparison in that the criteria for key informants are developed, modified, and refined based on theoretically salient concerns that emerge through this practice of inductive analysis (Corbin & Strauss, 2015; Creswell, 2007).

Although the early literature on grounded theory historically represented a challenge to more positivist methods in use across the social sciences (Clarke, 2003; Clarke, 2005), this tradition eventually came to be critiqued for its alleged alignment with tenets of postpositivism (Charmaz, 2005). Specifically, because postpositivist discourses of validity and rigour came to appear in – and frame – some of the mainstream literature on grounded theory, a number of scholars explicitly highlighted these developments as reflective of this methodology’s apparent departure from its interpretivist origins, as captured in Glaser and Strauss’ (1967) landmark work on grounded theory methodology (Charmaz, 2005; Clarke, 2003). In the context of the current study, such criticism merits serious consideration, as several of the assumptions embedded in its primary research questions are rooted in poststructuralist epistemology, and therefore risk conflicting with the methodological underpinnings of contemporary mainstream grounded theory. Namely, because this study primarily seeks to engage in Foucauldian and intersectionally-informed analyses of subjugation and resistance among older gay men in health systems, it necessarily involves the poststructuralist project of deconstructing the very discourses underpinning these social processes. Indeed, consistent with Foucault’s position on subjugation (Foucault, 2000), as well as the work of some theorists associated with studies of intersectionality (Collins, 2009; Yuval-Davis, 2006), the use of historically, socially, and politically contextualized discourses is often fundamental in producing dominated subjects who are then believed to construct their own similarly contextualized discourses to resist such power. Therefore, a genealogical or deconstructive analysis of such text is necessary as a condition of gaining insight into the dynamics of subjugating power. The arguable need for the study to account for the array of contextual factors potentially involved in the discursive production of
subjugation, many of which may not be explicitly apparent in the accounts of participants, may
conflict with a postpositivist methodology that privileges the relatively “pure” inductive analysis
of data as a measure of rigour.

Based on the above considerations, I relied on a contemporary tradition of grounded theory
known as situational analysis (Clarke, 2003) to inform this study’s overall research design. This
rendition of grounded theory involves explicit attention not only to the immediate social
phenomena under study, but also to the social and discursive contexts that characterize and
construct these fields of inquiry. Specifically, situational analysis encompasses the researcher’s
attention to the salient role of contextual factors surrounding the area under investigation,
including discourses, institutional practices, and human and non-human actors, among others, in
shaping or constructing the phenomenon of primary interest (Clarke, 2003). These contextual
factors, whose often implicit presence in the text is identified by the researcher and illustrated on
diagrams known as situational maps, are used to guide the analytical processes that result in a
study’s emergent theoretical picture.

Regardless of its epistemological underpinnings, however, the objective of conducting inquiry
informed by situational analysis often includes the generation of theory or explanatory insight on
a previously unexamined or underexamined social phenomenon, similar to the aims of other
grounded theory research (Clarke, 2003). Given, within the tradition of this methodology, the
importance of creating knowledge that is not only contextually rich, but also theoretically
meaningful, it is perhaps not surprising that this approach incorporates the use of iterative
empirical strategies typically associated with conventional grounded theory, including constant
comparison and theoretical sampling. As Clarke (2003) notes, these specific techniques are
used – in conjunction with this methodology’s more poststructuralist innovations – to ensure that
the process of theory construction remain sensitive to novel insights surfacing through the
research process. Accordingly, although aligned with poststructuralism in its attention to social
phenomena as highly contextual and thus shaped by factors surrounding the area under study,
situational analysis is nonetheless a contemporary approach to generating knowledge that, as
with other grounded theory research, seeks to advance theory on nascent fields of study (Clarke,
2003).
In light of this study’s objective of theoretically and empirically advancing an area of research that has historically been relatively unexamined (Addis et al., 2009; Brown, 2009; Cahill & Valadez, 2013), and yet its goal of doing so in a manner that accounted for the contextually-nuanced phenomena of subjugation it promised to examine, situational analysis aligned well with this project as an overarching grounded theory framework for informing research design. Indeed, on the one hand, situational analysis was a promising methodology for generating substantive knowledge on the health care experiences of older gay men, the contents of which have been recognized as being both theoretically salient and yet empirically underrepresented across the disciplines of gerontology, LGBTQ studies, and other areas of inquiry (Addis et al., 2009; Brown, 2009; Cahill & Valadez, 2013). On the other hand, as the study aimed to privilege a contextually sensitive analysis of subjugation and resistance in older gay men’s experiences with health systems, situational analysis enabled processes of inquiry and theory construction in this study that remained consistent with – and accountable to – the very conceptual grounds on which its primary research questions were based and justified.

1.4.1 Sampling and Recruitment

Given the recognized need to center the voices of older sexual minorities in any empirical work on the experiences of this population, particularly in light of the historical tendency for this group to be underrepresented or altogether silenced in research (Brown, 2009; Hash & Cramer, 2003), participants in this study included older gay men who were both HIV-negative and HIV-positive. Consistent with the emerging literature on HIV aging, which has come to account for complex variations in life expectancy among those living with this illness (Cahill & Valadez, 2013), I use the term “older” in this study to refer broadly to those who are ages 50 and over. Finally, in light of important differences between the social conditions of gay, bisexual, and other men who have sex with men (MSM), and yet the tendency in some social science literature to homogenize the experiences of these sexual minority populations (Parker et al., 2016), I chose to focus exclusively on health care among older gay-identified men as a distinct site of analysis.

Based on the above considerations, I recruited 27 informants who met the study’s baseline eligibility criteria by (1) self-identifying as gay men, (2) being 50 years of age or older, (3) having had experience seeking attention, or receiving care, from licensed physicians, nurses, or
nurse practitioners at least three times in the last twelve months, and (4) have been residents of Toronto for at least the last twelve months. As, in this study, I particularly sought to foreground the insights of older gay men living with HIV, 16 of my participants were HIV-positive.

Within situational analysis, as theory is often constructed and refined on an ongoing basis, and simultaneously as data are collected and analyzed (Clarke, 2003; Clarke, 2005), I acknowledged the need to modify the baseline eligibility criteria to recruit specific participants with potential to address any emergent theoretical concerns surfacing in the process of data collection and analysis. However, the need to make major modifications to the study’s eligibility criteria did not arise. Instead, as preliminary analyses of the data appeared to suggest that older gay men’s experiences with health care appeared to vary depending on the exposure of these adults to factors such as poverty and racism in particular, I prioritized the recruitment of participants who could provide insight on these sources of heterogeneity. Specifically, I incorporated screening questions in which I asked prospective participants about their primary sources of income, as well as their race/ethnicity, and deliberately selected participants with the potential to represent as much diversity as possible on these dimensions. Although the study’s final sample was socioeconomically heterogeneous, with 13 participants who were exclusively reliant on government-administered financial benefits, only a total of 5 participants did not identify as white or Caucasian. Table 1.1 provides an overview of this sample’s demographic characteristics.

I recruited participants through AIDS service organizations (ASOs), as well as community agencies serving LGBTQ communities. These organizations agreed to distribute my recruitment materials to staff and volunteers interacting directly with service users, who then approached individuals who were potentially eligible and interested in participating, or alternately disseminated these materials directly to their community listservs via e-mail. LGBTQ organizations that provided support with recruitment included the Senior Pride Network, which is an association of individuals, service providers, and organizations that provides advocacy for older LGBTQ adults in Toronto, as well as the 519, a social service agency serving LGBTQ people in Toronto. ASOs that offered such assistance included REALIZE Canada, which is a Toronto-based umbrella organization comprising service providers in the area of HIV and aging
(among other fields of practice), as well as McEwan House, which is a facility that provides residential and other support to adults living with HIV in Toronto.

1.4.2 Data Collection

After being screened and undergoing a process of informed consent, I invited each informant to partake in a single 1 to 1.5 hour semi-structured interview (please see Appendix A for the study’s complete interview protocol). I specifically asked participants about (1) the types of health care services they may have sought or received in the year preceding the study, (2) the relevance of sexuality, HIV-status, and other dimensions of social location to their health care needs, (3) their ability to discuss sexuality and HIV with their health care providers, and (4) their overall experiences of being in medical settings as older gay men. I gave participants the option of either partaking in interviews at an office at the Dalla Lana School of Public Health, University of Toronto, or alternately, in a mutually agreed upon private setting. I recorded participant interviews using an electronic audio recorder, all of which were then transcribed either by myself (n=6) or with assistance from a professional transcriptionist who signed a confidentiality agreement prior to engaging with the study’s raw data (n=21). Following the completion of each interview, participants were compensated with CAD $20, and two public transportation tokens. I took brief field notes after each interview, and used these field notes to corroborate any insights I identified from within associated interview transcripts.

Several justifications exist for the specific domains of inquiry included in the study’s interview protocol. Foremost, however, I wish to explain the overarching relationship between questions asked in the interview protocol on the one hand, most of which centred health care experience, and the study’s objectives of examining issues of subjugation on the other. First, this approach is consistent with inquiry that is framed by Foucauldian governmentality, as much scholarship in this area – particularly when it concerns issues of power, subjugation, and resistance specifically – is based on analyses of discourse and other textual data that may only implicitly be indicative of the power relations underpinning the phenomena under study (Walters, 2012). Foucault’s (2008) own work on neoliberal governmentality, which perhaps most importantly elucidates the conditions on which relations of power are constructed in neoliberal societies, is primarily grounded in genealogic analyses of prominent texts that do not directly provide an account of
neoliberalism. These analyses, instead, implicate the sociohistorical role of the state and the market in constructing a foundation for what is now understood as contemporary normative power. Indeed, Walters (2012) explains that – particularly as contemporary governmentality often includes pervasive exercises of power at all levels of social organization – discourse residing at the level of the subject may comprise a valuable, yet indirect source of genealogic insight on the dynamics of power in a given social situation, including both subjugating and emancipatory power.

Although the relationship between the study’s interview protocol and its primary research objectives may be somewhat clearer after considering how knowledge is typically generated in the tradition of Foucauldian inquiry, a review of methodologies associated with intersectional scholarship further solidifies this link. As Yuval-Davis (2006) has noted, much of the literature on intersectionality is grounded in the subjectivity of intersectional subjects, particularly given this field’s emphasis on capturing the realities and voices of multiply marginalized groups whose conditions may have historically been systemically misrepresented or altogether excluded. Indeed, McCall (2005) has similarly noted that intersectionally-informed empirical literature often centers the subjectivity of groups with unique configurations of marginalized difference, particularly when such work is concerned with exploring within-group complexities that either problematize the marginalized social category under investigation, or reveal important differences between members of the group. Accordingly, the focus of the study’s interview protocol on the subjective experiences of older gay men, specifically within the context of health care access, was designed to support the generation of insight on how subjugation and resistance are produced or reproduced in these settings.

Although the interview protocol, in light of the foregoing discussion, is in fact broadly aligned with the theoretical assumptions informing the study’s questions and objectives, it is equally important to indicate more specifically how each of the protocol’s items addressed the study’s objectives in a manner that was consistent with situational analysis as the methodological framework I use in this study (Clarke, 2003). To this end, it is worth noting that the first two questions, which emphasized the types of health care services utilized by participants, invited discussion on health care as a social situation involving key contextual factors such as institutions, service providers, and other sources of social interaction that either hindered or
facilitated care among the older gay men being interviewed. In other words, these two questions generated data that informed the construction of a situational map, which in turn highlighted key elements of health care as the key context under study.

Questions three and four, which specifically invited participants’ insights on any potential relationships between sexuality (as well as other dimensions of their social location such as HIV status) and their health care needs, served two primary functions. First, they sought to elicit older gay men’s discursive constructions of their own subject positions in health care, and second, they aimed to generate insight on their perceived subject positions relative to other actors (i.e., service providers) in health systems. In other words, these two questions served not only to ascertain the meaning that informants attached to their subject positions, but then also invite a consideration of where they believed these subject positions were located within the context of health care as the situation or context under study. Questions five through eight, in turn, built on the preceding two items, primarily by asking participants to discuss the intelligibility and salience of their subject positions as older, potentially HIV-positive gay men among health care providers, and in so doing, to consider how their positions in health care systems actually framed and informed interactions they had with key elements of the situation under investigation.

When analyzed together, data derived from items three through eight enabled the conceptualization of interactions between key elements of the situational map, and it was with the support of this map that mechanisms involved in the production of subjugation and resistance among older gay men accessing health care systems were examined. Specifically, as these questions asked the study’s informants to reflect on how their identities as older gay men may problematically be acted upon – or alternately ignored – by health care providers as targets of intervention and service provision, data arising from this discussion included rich participant-centered accounts of how subject positions among older gay men were constructed, reinforced, or challenged when members of this group engaged systems of care. In addition, as these questions accounted for agency in older gay men’s interactions with health care services by recognizing their potential to disclose, withhold, or intentionally articulate information about their sexualities and HIV-statuses, these items also helped generate data on how these informants negotiated or resisted these processes of subjugation.
Question nine, which was designed to elicit discussion on participants’ overall experiences as older gay men in medical settings, served one primary purpose. First, particularly as questions five through eight sought to generate insight on matters of subjugation and resistance by asking participants to narrowly describe interactions they have had with medical service providers, and therefore lacked attention to other social processes potentially involving the use of power in health settings, this item functioned to capture parallel social processes that existed beyond participants’ interactions with health care professionals. As situational analysis demands attention to discursive elements of the situation under study that may not be immediately apparent, including components that may not even be human (Clarke, 2003), the inclusion of this item was particularly important in addressing phenomena of subjugating power and resistance not revealed in previous questions. It was, indeed, through this question that some of the richest data were generated on medical practices that appeared to shape older gay men’s subjugation in health settings.

Prior to concluding this section, I should briefly note that the study’s interview protocol was reviewed by Toronto’s Senior Pride Network (SPN), by individual community members attending SPN events and meetings, and also by staff and administrators at McEwan House, for feedback on the appropriateness and suitability of the interview items. Minor modifications were made to the language used in the questions, although the substantive content remained the same. Although this project was not explicitly community-based, its data collection procedures were designed to reflect the most appropriate and respectful means of engaging with older gay men on their health care experiences, and the incorporated feedback achieved this end.

1.4.3 Data Analysis

I conducted data analysis in this study simultaneously as data collection, which as an approach is consistent with grounded theory more broadly, and situational analysis more specifically (Clarke, 2003; Corbin & Strauss, 2015). The process of data analysis was inductive and iterative, meaning that as the interview transcripts were each read and compared to one another, salient preliminary themes were constructed from within these readings, and gradually assembled into higher order codes that informed the study’s emerging theoretical picture of subjugation and resistance in older gay men’s health care experiences. As noted briefly in the section on data
collection, the early stages of data collection and analysis also informed the development of a working situational map, which was then used to guide the process of theorizing along with the study’s emergent themes (Clarke, 2003; Clarke, 2005).

As a minimum of three cases is often required as a foundation for preliminary coding in the context of grounded theory (Onwuegbuzie & Leech, 2007), I started the analytical process following the conduct and transcription of the third interview, and re-engaged in analysis each time an additional interview was transcribed. Consistent with more conventional grounded theory (Corbin & Strauss, 2015), the first time data were analyzed, I generated a first set of “open” or preliminary codes, based on themes that I identified from within the three interview transcripts. I also used these open codes to develop the first iteration of a situational map. Data derived from subsequent interviews were used to modify – or expand on – these preliminary codes, and to refine the situational map.

After generating open codes, constructing a rudimentary situational map, and triangulating some of my preliminary theoretical insights with field notes I had taken following each interview, I started developing axial codes. Axial codes, in the tradition of grounded theory, are higher order categories that represent common units of meaning and links across open codes, and that in turn assist researchers in constructing relevant theory about the relationships between each of the preliminary analytic categories (Corbin & Strauss, 2015). In the context of this study, I utilized open codes, along with the rudimentary situational map used in earlier stages of data analysis, to develop axial codes representing larger, more representative analytic categories I had started identifying in older HIV-positive and HIV-negative gay men’s accounts of navigating health systems.

The last stage of data analysis involved a process of selective coding, which in the context of grounded theory studies, includes carefully selecting and integrating axial codes that most closely address a study’s research questions, and using these codes to generate a more sophisticated theoretical picture of the area under investigation (Corbin & Strauss, 2015). Within this study, selective coding comprised amalgamating axial codes – and corresponding theoretical insights – that appeared most salient in delineating how subjugation and resistance was constructed in older gay men’s health care experiences. I used Foucauldian governmentality
(Foucault, 2000; Foucault, 2008) and intersectionality (Yuval-Davis, 2006) as guiding theoretical frameworks to extrapolate selective codes that seemed most relevant in addressing the study’s research questions. Whereas I drew on Foucauldian governmentality to foreground themes that highlighted the exercise of subjugating power on older gay men, and the subversion of these men against such systems of domination, I relied on intersectionality to help me delineate how these themes of subjugating and resistive power appeared to vary among older gay men marked by dimensions of difference rooted in socioeconomic status, race, and ability. I ended the analytical process by situating my final insights within the emerging literature on older gay men (Addis et al., 2009; Brown, 2009; Fredriksen-Goldsen & Muraco, 2010).

I used NVivo to highlight and maintain a record of all open codes developed throughout the study. Other than utilizing NVivo to support this particular stage, I conducted all other aspects of data analysis manually, including the design of the various renditions of this study’s situational map. Rudimentary (Figure 1.1) and final (Figure 1.2) renditions of the situational map used to inform my analytical process are appended to the end of this dissertation.

1.5 Ethical Concerns

The study underwent review and approval by the University of Toronto’s HIV Research Ethics Board. Regardless, a number of ethical issues require acknowledgment and attention. First, as this study aimed to explore the experiences of a vulnerable population to whom stigma is often directed on the basis of gay identity and HIV status, it is important to acknowledge the increased risk of exposure to stigma among participants who disclosed information on their sexual identity and HIV status in this study. To minimize this risk, I incorporated several measures aimed at protecting the privacy and confidentiality of participants, including storing their raw data on a password-protected computer, keeping their signed consent forms in a locked cabinet at the Dalla Lana School of Public Health, anonymizing any identifiable information appearing in the participants’ raw data, and using pseudonyms to refer to individual participants throughout this dissertation.

Another risk, particularly among participants living with HIV, included the likelihood of encountering legal consequences if these men disclosed their engagement in HIV risk behaviours with partners who were unaware of the risk of HIV transmission. As failure to disclose one’s
HIV status to a sex partner is considered a criminal offense in some cases in Canada (Grace, 2013) and internationally (Grace 2015), it was important to account for legal concerns that could have arisen if any participants described such behaviour in the process of data collection.

Lastly, as I asked participants to discuss their personal experiences with health care, interviews at times involved the disclosure of potentially sensitive information. As such, a small number of participants reported encountering minor emotional distress during interviews. Given that I had anticipated the likelihood of such distress among those involved in the study, I brought a list of referrals for appropriate support and other social services each time I met with a participant, and ensured that any affected individual had information on support services that they could access following their participation in the study. I also notified all participants of the risks of experiencing emotional distress prior to their engagement in interviews, in order for them to account for this risk before agreeing to partake in the study.

1.6 Reflexivity

Reflexivity, which refers to a researcher’s practice of reflecting on the epistemological position and social location they occupy relative to their area of study, and on how these points of origin may have shaped their research process and resulting insights (Creswell, 2007), is commonly incorporated into the design of qualitative research. This is particularly the case for qualitative studies informed by methodology anchored in interpretive and/or poststructuralist traditions (Charmaz, 2005; Clarke, 2005). Given my heavy reliance on theoretical frameworks (Foucault, 2000; Foucault, 2008) and methods (Clarke, 2005) firmly grounded in poststructuralist thought, I wish to briefly discuss reflexivity as it pertains to my doctoral research.

First, it is important to note that I undertook my research from an epistemological position of acknowledging the partiality of knowledge. This means that although I utilized textual data to generate theory on processes of subjugation and resistance experienced among older gay men involved in my study, the resulting insights are acknowledged as being constructed by those involved in analytical processes, and not as representing universally transcendent ‘truths’ about these phenomena. Accordingly, the insights and conclusions presented in this dissertation are hereby acknowledged as reflecting reliance on a composite of interpretive lenses: my own, those of participants who generously clarified or corrected my assumptions about their experiences in
real time, and those of my dissertation committee members, all of whom are scholars at a large, urban School of Public Health in Canada.

Aside from clarifying the partiality of the insights presented in this dissertation, I wish to more specifically claim and account for my social location in relation to the issues under investigation. I am an HIV-negative early 30s trans woman of Iranian descent, and I started medically and socially transitioning to my identified gender during the second year of my doctoral degree. I started collecting and analyzing the data used in this dissertation while I was still early in my transition. Although I have identified openly as queer since my early adolescence, and have broadly associated with LGBTQ communities for all of my adult life, I occupy social categories that differentiate me in important ways from older gay men. Indeed, as those I interviewed were gay-identified men ages 50 and over, and as most were additionally HIV-positive, White, and from working class backgrounds, my social location reflects enough distance from my participants that I cannot credibly (and comfortably) claim I conducted my research as somebody with intimate, lived knowledge of the realities experienced among my participants. As I relied, almost entirely, on participants to clarify or correct my understanding of their accounts during interviews, it is very possible that some of the insights presented in this dissertation reflect my limitations in viscerally ‘knowing’ these realities as an outsider to the lives of older gay men.

At the same time, as I conducted interviews in early stages of my transition, participants would at times readily recognize me as a trans woman, would in these situations place me as a ‘member of the LGBTQ community,’ and would in turn often quickly develop trust in me. During moments when it was apparent to me that participants assumed I was a heterosexual, cisgender woman with questionable motives for undertaking LGBTQ health research, I would often self-disclose my trans status in an attempt to establish trust and safety with these men, and would in these cases quickly manage to secure rapport. Because of these unique dynamics, particularly in the context of data collection, it is important for me to note that my status as a trans woman likely granted me access into the lives of participants as somebody whose non-normative identity may have represented some level of proximity or familiarity for the men. Similarly, as someone with lived experience as a queer and trans person, I was intimately familiar with some of the broader issues reflected in the accounts of participants, namely those pertaining to homophobia and stigma related to non-normative identities, which enabled me to use appropriate language to
interact with and clarify some of the content presented to me by participants. Accordingly, although some of the analyses presented in the dissertation may reflect my limitations in interpreting the accounts of older gay men as a trans woman in her early 30s, it is important to acknowledge that the data generated in interviews contained rich and nuanced accounts of health care experience that, in general, originated from positions of trust and authentic engagement, and provided me with meaningful opportunities for data analysis and theory generation surrounding a domain of lived experience with which I may have had, at most, peripheral familiarity.

1.7 Summary of Dissertation Manuscripts

Aside from chapter 5, the remainder of this dissertation is divided into three manuscripts, each representing distinct scholarly contributions of this study to relevant bodies of literature. Chapter 2 (published in *Sexuality Research and Social Policy* [Kia et al., 2018]), which provides an overview of the study’s key findings, delineates processes of subjugation and resistance that are reflected in older gay men’s accounts of navigating health care, and in so doing, foregrounds the role of the HIV/AIDS epidemic in shaping health care as a site of subjugation and resistance for both HIV-positive and HIV-negative gay men ages 50 and over. Specifically, this chapter considers the salient presence of homophobia and HIV stigma as sociohistorically interdependent discursive factors that construct this group as medical subjects who are marginalized based on their association with the HIV/AIDS epidemic. Additionally, this chapter outlines the tendency among older gay men to perceive contemporary medical practices targeting this group in mainstream health settings as historical artifacts of their marginalization in the early HIV/AIDS epidemic, and the intelligibility of gay aging bodies in health systems as commemorative of HIV infection risk. Older gay men’s subjugation to each of these manifestations of subjugation is recognized, importantly, by highlighting counter-discourses used among this group in health care, the use of community-based services among those in this population who disengage from mainstream health settings, and older gay men’s deliberate capitalization of their intelligibility as subjects of risk to effect resistance and change. The paper concludes with a discussion of the study’s implications for research, policy, and practice.

Chapter 3 (under review with *Qualitative Sociology*) considers the utility of Foucauldian governmentality as an analytical framework for guiding and enriching the practice of situational
analysis, and draws on the study’s analytical process and resulting insights in substantiating this claim. Specifically, the chapter considers the role of governmentality in assisting with the identification and conceptualization of key discursive factors that appeared to be salient in constructing the health care experiences of older gay men (the situation under investigation). In addition, by examining the use of governmentality to theorize complex processes of subjugation in this study, this chapter highlights the promise of this framework in generating insight on how contextual factors actually operate and wield influence on key actors within any given situation under study. Finally, by outlining the use of governmentality in theorizing the resistive activities of older gay men in this study, this chapter illustrates the strengths of this theoretical lens in conceptualizing fluid movements of power within the practice of situational analysis. Implications for the integration of governmentality, within the emerging methodological literature on situational analysis, are considered.

Chapter 4 draws on the accounts of this study’s HIV-positive participants to extrapolate and conceptualize the health care and social service needs of this population. An intersectional framework is integrated in this chapter to highlight the distinct service priorities of older gay men whose social conditions and experiences vary based on their exposure to intersecting sources of marginalization rooted in socioeconomic status, ability, and race. The chapter outlines the salient need for specialized support services addressing the unique service-related concerns of older HIV-positive gay men participating in this study, including those pertaining to employment, personal care, peer support, and mental health. In addition, based on the accounts of HIV-positive participants, the need to training service providers about the unique social conditions and experiences of this population is highlighted, as is the relevance of initiatives that engage older HIV-positive gay men in the design and delivery of health care and social services intended for this group.

Chapter 5 examines the relevance of each of the preceding chapters as scholarly contributions that each address the dissertation’s primary research questions, and situates the insights of this study in relevant substantive, methodological, and theoretical bodies of literature. Whereas chapter 2 is revisited for its explicit role in highlighting the accounts of older HIV-positive and HIV-negative gay men in this study as being reflective of this group’s sociohistorically rooted subjugation and resistance in contemporary health care systems, chapter 3 is recognized for
outlining the analytical practices best suited to generating these insights. Chapter 4 is, finally, reconsidered as a paper that foregrounds the social conditions, experiences, and service needs of older HIV-positive gay men as a group whose marginality is prominently shaped by HIV/AIDS history, and is thus examined for its strengths in outlining the implications of this group’s unique relationship with the HIV/AIDS epidemic. After articulating the limitations associated with each of these chapters, the resulting insights of this dissertation are discussed relative to scholarship on aging in LGBTQ and HIV-positive populations. These contributions are also situated within inquiry on situational analysis and other grounded theory, and contextualized within the theoretical literature on Foucauldian governmentality and intersectionality. The dissertation concludes with a consideration of potential directions in future inquiry across each of these domains.

Of note, although the pronoun “I” is used frequently in this introduction, as well as the final section of the dissertation, chapters 2, 3, and 4 frequently include use of the pronoun “we” to acknowledge the support and collaboration of committee members in refining analyses and insights contained in each of these sections.
Chapter 2

2 Across Serostatus\(^1\): A Study of Subjugation and Resistance in Older Gay Men’s Experiences Navigating Health Care

Abstract: Despite the recognition of older gay men’s unique health needs, the health care experiences of this group have seldom been explored empirically. Accordingly, in this qualitative study, we utilize a poststructuralist approach to grounded theory known as situational analysis to examine older gay men’s experiences with health care. Specifically, we draw on interviews with 27 gay men ages 50 and over, 16 of whom disclosed being HIV-positive at the time of recruitment, to consider this group’s interactions with formal health systems. We analyze how processes of subjugation and resistance are reflected in older gay men’s narrative accounts of navigating health care, and in this process, highlight the role of the HIV/AIDS epidemic in constructing health care as a site of subjugation and resistance for these men. We inductively examine discourses, interpretations of medical practices, and constructions of aging gay bodies that together reflect the historical and contemporary role of HIV/AIDS in shaping present day systems of health care for older gay men. We conclude the paper with implications for research and policy in the area of gay aging, including the need for specialized psychosocial services targeting the needs of older gay men in health systems.

2.1 Introduction

The relationships of older gay men with health care systems are complex, due in part to the service barriers this group has historically experienced. Older gay men, often defined within the literature as gay-identified adults ages 50 and over (Addis et al., 2009; Fredriksen-Goldsen & Muraco, 2010), frequently report having experienced or witnessed the institutional exclusion of gay men within health care systems during the height of the HIV/AIDS epidemic in the 1980s and 1990s (Cole, 1996; King, 2016). Consistent with this history of discrimination across systems of care, aging gay men accessing contemporary health care commonly report lacking

\(^1\) Serostatus refers specifically to HIV status.
trust in health care providers and medical services (King, 2016; McNutt & Yakushko, 2013; Rosenfeld et al., 2012).

Although the literature on older gay men and health care is limited, existing research in this area outlines distinct, yet interrelated expressions of stigma and discrimination that have come to systemically shape the health care experiences of aging HIV-positive and HIV-negative gay men. Most notably, given the tendency for health institutions of the 1980s and 1990s to have avoided investing in research and care for gay men affected by HIV/AIDS on the basis of homophobic stigma (Cole, 1996), older HIV-positive gay men today often perceive contemporary mainstream health systems as potentially hostile and neglectful sites of care (Rosenfeld et al., 2012; Owen & Catalan, 2012). Same-age HIV-negative counterparts, interestingly, also commonly report strained relationships with health institutions, given HIV-positive partners, friends, and other peers that many in this population lost within stigma-laden health systems during the height of the HIV/AIDS epidemic (Cronin & King, 2014; Fenkl, 2012; Fredriksen-Goldsen et al., 2014; McNutt & Yakushko, 2013; Wight et al., 2012).

Consistent with this context, health care systems today are settings in which older HIV-positive (Emlet, 2006; Emlet et al., 2017; Lyons et al., 2010; Masten, 2015; Owen & Catalan, 2012) and HIV-negative gay men (Addis et al., 2009; Clover, 2006; Elliot et al., 2014; Fenkl, 2012; Fredriksen-Goldsen et al., 2009; Fredriksen-Goldsen et al., 2011; Gardner et al., 2014; Institute of Medicine, 2011; Lyons et al., 2012) expect – and often continue to experience – stigma and discrimination on the basis of sexual orientation, HIV status, socioeconomic status, and age, among other dimensions of difference. Older gay men’s engagement with these marginalizing conditions, in turn, not only hinders this population’s access to health care, but additionally impacts the health outcomes of those in this group. For instance, Emlet et al. (2017) have identified a significant association between exposure to enacted sexual minority stigma by health care providers, and the presence of sexual risk behaviours among older HIV-positive gay and bisexual men.

Despite the past and contemporary significance of health care for older gay men, there remains a dearth in studies that exclusively and comprehensively examine this population’s health care experiences. Moreover, no attempts have been made to investigate the influence of HIV/AIDS
history on aging HIV-positive and HIV-negative gay men’s interactions with health systems. As such, in this qualitative study, we analyze the health care experiences of HIV positive and HIV negative men gay men 50 years of age and older, and particularly consider the sociohistorical role of HIV/AIDS in constructing the contemporary context of health care for aging gay-identified men. We use situational analysis, which is a poststructuralist approach to grounded theory (Clarke, 2003), to inform our overall research design. For the purpose of convenience, we use the terms “aging” and “older” interchangeably in this paper to refer to adults ages 50 and older.

2.2 Subjugation and Resistance in Older Gay Men’s Relationships with Health Care

Governmentality, as a theoretical tradition, broadly considers the role of normative power in governing conduct or social behaviour across intrapersonal, interpersonal, group, organizational, structural, and systemic levels of social organization (Foucault, 2008; Walters, 2012). Consistent with its central tenet, those who investigate governmentality conceptualize subjugation as comprising the collection of normative social processes that construct and identify a social subject, or a category of social subjects, amid relations of power (Berard, 1999; Foucault, 2000). In this context, the subject commonly occupies a well-differentiated and often marginal social position that is regularly reinforced by omnipresent social processes, usually by actors in relative positions of power, but also has the capacity for agency or resistance against such exercises of power (Berard, 1999; Foucault, 2000; Foucault, 2008). Importantly, this subject is also susceptible to self-governance or self-regulation, often in response to socially sanctioned norms, discourses, and established systems of hierarchy that reflect relations of power in the social environment. Discourses, or systems of communication that are widely intelligible and utilized in particular social contexts, are considered significant as empirical sources of insight on processes of subjugation and resistance, and as such are commonly focal points of inquiry in the field of governmentality studies (McIlvenny et al., 2016).

We use this framework based on its usefulness in drawing attention to the sociohistorical role of HIV/AIDS in shaping the contemporary context of health care as a site of subjugation among both older HIV-positive and HIV-negative gay men. Indeed, given the significant extent to
which older gay men’s present day expectations or experiences of health care may be framed by the stigma and discrimination targeting this population during the height of HIV/AIDS epidemic (Cole, 1996; Fredriksen-Goldsen et al., 2014; Rosenfeld et al., 2012), we use governmentality to highlight the role of this history as a source of normative power through which aging gay men are constructed as marginalized social subjects in contemporary health care. We also draw on this tradition to consider the potential ways in which those in this group self-regulate or manage their conduct in systems of care based on their perceived positions as marginalized subjects of this history.

Importantly, although we employ governmentality to analyze the role of HIV/AIDS history in constructing conditions of subjugation among older gay men, we also rely on this framework to highlight processes of resistance this population employs to challenge or resist such exercises of power. Indeed, given the centrality of the subject’s agency in Foucauldian conceptualizations of subjugation (Foucault, 2000; Foucault, 2008; Berard, 1999; Walters, 2012), investigations of subjugation are considered incomplete without complementary insights on the subject’s resistive conduct relative to such exercises of power, and as such our consideration of resistance constitutes a core component of our study.

In examining resistance among older gay men in the context of health care, it is important to recognize that this population has historically been highly active in mobilizing socially and politically against homophobia and stigma surrounding HIV/AIDS, and has been successful in catalyzing social change in this area (King, 1995; King, 2016; Rosenfeld et al., 2012). For instance, fuelled by the tendency for health institutions to neglect addressing the HIV/AIDS epidemic in the 1980s and 1990s, gay men during this era advocated extensively for research on the disease (Epstein, 1989), and often spearheaded the development of community-based organizations mandated with delivering HIV/AIDS prevention and support programs (Brier, 2009; Chambré, 2006). In light of this history of political mobilization against subjugation in health systems, the current study encompasses attention to expressions of resistance among older gay men, alongside analyses of subjugation affecting this group. Informed by the lens of governmentality, the primary research questions driving this study are: (1) how are processes of subjugation and resistance reflected in the accounts of older HIV-positive and HIV-negative gay men seeking and/or receiving care in health systems? and (2) what is the comparative
significance of the HIV/AIDS epidemic in constructing health care as a site of subjugation and resistance among older HIV-positive and HIV-negative gay men?

2.3 Methods

2.3.1 Research Design

The current qualitative study, whose primary objective was to examine and compare the sociohistorical role of HIV/AIDS in constructing health care as a site of subjugation and resistance for older HIV-positive and HIV-negative gay men, was informed methodologically by a poststructuralist approach to grounded theory known as situational analysis (Clarke, 2003; Clarke et al., 2015). This approach typically involves inductive and emergent processes of data collection and analysis that culminate in a contextually rich theoretical account of the central area under investigation, and as such is often appropriate for informing research design on empirical studies of historically underexamined phenomena that are additionally believed to be situationally complex (Clarke et al., 2015). Given the likely contextual role of the HIV/AIDS epidemic in constructing health care as a site of subjugation and resistance for older HIV-positive and HIV-negative gay men (McNutt & Yakushko, 2013; Rosenfeld et al., 2012), and the lack of literature in this area, situational analysis was ideally suited to inform this study’s research design (Clarke et al., 2015). Of note, the study underwent review and approval by the University of Toronto’s HIV Research Ethics Board (#33523) prior to the start of participant recruitment.

2.3.2 Participants

2.3.2.1 Sample

The study’s sample consisted of 27 participants. All who were selected for participation met the study’s baseline eligibility criteria, which required that (1) participants self-identify as gay men, (2) be 50 years of age or older, and (3) have at least three experiences of seeking or receiving care from physicians or nursing professionals within the twelve months preceding their participation in the interview. These individuals ranged in age from 50 to 77, with 15 in their 50s, six in their 60s, and the remaining six in their 70s. Although the majority of participants reported being HIV-positive (n=16), this group was oversampled intentionally, given the
systemic proximity of older HIV-positive gay men to the HIV/AIDS epidemic. Importantly, although not all men who have sex with men (MSM) describe themselves as “gay,” in this study we specifically sought gay-identified men, in order to focus our analysis on processes of subjugation and resistance that may be particular to those more explicitly associating with this sexual minority status (Rosenfeld et al., 2012). Indeed, as the category of “MSM” has recently been problematized as a result of its failure to account for unique conditions of marginalization across largely heterogeneous categories of gay, bisexual, and other men who have sex with men, this was a necessary consideration (Parker et al., 2016).

2.3.2.2 Recruitment

We established partnerships with AIDS service organizations (ASOs), along with community social service agencies serving older lesbian, gay, bisexual, transgender, and queer (LGBTQ) adults, which together assisted us in recruiting participants. We disseminated recruitment posters to support and outreach staff at these organizations, who in turn distributed these recruitment materials to potentially eligible service users. Importantly, although we primarily relied on the study’s baseline eligibility criteria to inform our recruitment process, we also incorporated elements of theoretical sampling (Corbin & Strauss, 2015). For instance, given the racial and ethnic heterogeneity of gay men (Addis et al., 2009), along with the role of socioeconomic status in influencing exposure to stigma and discrimination among those in this group (Fredriksen-Goldsen et al., 2011), we were attuned to the potential need for a racially and socioeconomically diverse sample. The relevance of this sampling objective was, indeed, supported by the study’s preliminary data, which corroborated the likely salient role of these factors in shaping the health care experiences of older gay men. Accordingly, in order to recruit participants representing diversity along these dimensions of difference, we included questions surrounding race, ethnicity, and socioeconomic status in our screening questionnaires and sampled to achieve as much heterogeneity in these areas as possible. Although a significant majority of participants identified as white or Caucasian, we were successful in recruiting a socioeconomically diverse sample. Table 1.1 provides an overview of the sample’s demographic characteristics.
2.3.3 Data Collection

2.3.3.1 Instrument

Drawing on our literature review and the theoretical framework informing our research questions, we constructed an interview guide designed to invite older gay men to discuss their health care experiences and to reflect on their subject positions as older gay men in these settings (Appendix A). Community organizations assisting us with recruitment provided us with feedback on the suitability of our interview questions for older gay men, which we then incorporated in the revised versions of our interview guide. We reviewed our interview guide in two open-invitation community presentations, and solicited feedback both verbally and in writing from community members and stakeholders in attendance. Interview questions explored the following domains: (1) older gay men’s experiences of seeking and receiving care in health care settings, (2) the quality of this population’s interactions with health care professionals, and (3) the group’s overall reflections on being older gay care-seekers and care-recipients in health care settings.

2.3.3.2 Interview Process

After providing informed consent, all participants partook in 1-1.5 hour semi-structured interviews conducted by the first author. As the study’s interview guide was largely open-ended, we were able to adapt this instrument to clarify or further explore unique aspects of individual participants’ health care experiences. We compensated all participants with $20 (CAD) in cash and public transportation tokens, and audio recorded their interviews. Following the completion of each interview, the interviewer took field notes on the possible contributions of each participant’s account to the study’s emerging theoretical picture. Whereas the first six interviews were transcribed verbatim by the first author, the remaining 21 were transcribed verbatim by professional transcriptionists, all of whom were made aware of – and, in writing, agreed to safeguard – the confidentiality of the participants’ interviews.

2.3.4 Data Analysis

Consistent with situational analysis and other grounded theory studies, the first author analyzed the data iteratively through a process of continuously reading and comparing interview
transcripts and field notes, and extrapolating themes from within these readings to form the study’s emergent theoretical picture (Clarke, 2003; Clarke et al., 2015; Corbin & Strauss, 2015). Specifically, as she read individual interview transcripts and associated field notes, and then compared each to preceding transcripts, she categorized the interview data into open codes, or preliminary themes, that represented the health care accounts of participants. These open codes formed empirical grounds from which the first author began theorizing how older gay men appeared to experience care-seeking and care-receiving in contemporary systems of care, the components of which were articulated with the generation of higher order themes. Finally, in a process of selective coding, and drawing on the framework of governmentality (Foucault, 2000; Walters, 2012), she identified higher order themes that were particularly reflective of processes of subjugation and resistance in aging gay men’s accounts of navigating health care settings, and utilized these themes to generate preliminary insights in this area. All four authors independently reviewed the higher order themes, and resulting analyses, that formed the basis of this paper’s final theoretical insights, and the latter three both supported and refined the first author’s interpretation of the data.

Importantly, as situational analysis (Clarke, 2003) involves identifying contextual factors shaping the phenomena under investigation, the first author examined higher order themes to identify the various systemic, historical, structural, and institutional factors at play in constructing processes of subjugation and resistance among older gay men in health care settings. Given that one of our research questions foregrounded the potential role of the HIV/AIDS epidemic in shaping contemporary systems of care for this population, she particularly noted factors associated with this historical context. All of the contextual factors underpinning processes of subjugation and resistance among older gay men in health care were visually illustrated on a situational map, which now appears as Figure 1.1. This map was used to refine, enrich, and finalize the study’s theoretical account of these social processes.

2.4 Findings

The findings of this study indicate that both older HIV-positive and HIV-negative gay men seeking and receiving care in health settings are constructed as subjects who are recognized for their stigmatized proximity to the HIV/AIDS epidemic. Whereas processes of subjugation
affecting older gay men accessing health care often involve the reinforcement of this marginal
subject position, expressions of resistance among those in this population entail both informal
and organized attempts at challenging or subverting this position. Three themes, each reflecting
this overarching context of subjugation and resistance among aging gay men seeking and
receiving health care, are presented in this section. These include: (1) the continued discursive
salience and interdependence of homophobia and HIV stigma in contemporary care, (2) older
gay men’s construction of present day medical practices as sociohistorical artifacts of
HIV/AIDS, and (3) the identification of the gay aging body as a commemoration of risk and
resistance in health systems. Of note, in the section that follows, we use pseudonyms to describe
participants and their experiences, primarily to safeguard the privacy and confidentiality of those
who took part in our study.

2.4.1 The Discursive Salience and Interdependence of Homophobia and
HIV Stigma in Contemporary Care

Several participants in the study highlighted the pervasiveness of both homophobia and HIV
stigma in health care settings. These discursive factors often appeared to be interdependent in
the context of health systems, given that participants often described the homophobic
underpinnings of HIV stigma, as well as the pejorative linking of HIV risk with gay sexuality.
Participants commonly made reference the HIV/AIDS epidemic of the 1980s and 1990s as being
significant in constructing the relationship between these two social forces.

Among participants living with HIV, this discursive interdependence was often made apparent in
their accounts of frequently being dismissed as “irresponsible” medical subjects who became
infected with HIV as a result of their engagement in “unsanctioned” sexual behaviour as gay
men, including “unprotected” and casual sex. For instance, Ross, a white 56 year-old man on
government-administered disability benefits who had been living with HIV since the 1980s,
remarked on care providers’ homophobic perceptions of HIV-positive gay men in his age cohort
as historically promiscuous subjects of the HIV/AIDS epidemic, and thus as morally “deserving”
of the medical and social adversities associated with the disease:

 For men in my generation who are in their fifties or early fifties, I think it’s
automatically assumed … that because you’re gay you live with the AIDS virus, and
Ross explained that this perception of his position as a culpable medical subject was reflected in several of his recent interactions with health care providers. In one example, he noted that when he had started developing pre-cancerous skin abnormalities in his anal region, his family physician had dismissed his concerns for several months by attributing them to primarily benign effects of the participant’s voluntary engagement in “unsafe” (i.e., condomless) sex.

Although HIV-negative gay men in the sample discussed the salience and interdependence of homophobia and HIV stigma in health care less explicitly than their HIV-positive counterparts, a number of participants nonetheless acknowledged the presence of this discursive climate in their experiences of seeking and receiving care. Several, in making reference to the interconnectedness of homophobia and HIV stigma in health systems, described often arbitrarily being deemed susceptible to HIV by health care providers based on the commonly assumed and stigma-laden proximity of older gay men to the HIV/AIDS epidemic, and thus being marginalized by homophobic constructions of this group as immutable subjects of HIV risk. For instance, William, a 62 year-old HIV-negative man who was employed full-time in the public service, recounted that despite being aware of his monogamous partnership with a same-sex partner, his family physician would regularly refer him for HIV testing. This practice, William believed, reflected the service provider’s homophobic perception of gay men as invariably promiscuous, regardless of their reported sexual behaviours, and therefore potentially “untrustworthy” carriers of HIV risk:

I often found that in dealing with [my family physician] that there was a certain degree of cynicism in his approach to gay people. And that he would frequently insist that I be tested for HIV. I mean and I kept telling him that I'm in a - and I'm HIV negative, I'm in a committed relationship, we are faithful to each other. But it always seemed to go in one ear and out the other. And I felt that there was a certain, on his part, there was a certain degree of cynicism about truth telling by gay men … Now perhaps in practice there is an assumption made that gay men are not forthcoming
about their sexual activities, and perhaps he thought I was just another one of those men.

Although William disclosed that his family physician was himself gay-identified, this participant’s account nonetheless reflected the presence of homophobia and HIV stigma as interdependent discursive forces that position older gay men systemically as subjects of medical control in health care settings. Indeed, in the preceding quote, William highlighted his perception that perhaps his physician’s behaviour was indicative of established medical practices that had, in the context of the HIV/AIDS epidemic, come to construct gay men living through this history as unreliable medical subjects requiring ongoing surveillance.

Accordingly, whereas HIV-positive participants referred to the pervasiveness and interdependence of homophobia and HIV stigma in health care by reflecting on their positions as “culpable” medical subjects, HIV-negative counterparts implied the presence of this discursive climate by acknowledging their intelligibility as often arbitrary subjects of HIV risk. In spite of these subtle differences, HIV-positive and HIV-negative participants were similar in their conceptualizations of resistance to this discursive context. Namely, older gay men in both subsamples drew attention to their engagement with an increasingly visible counter-discourse of normalizing and institutionalizing the inclusion of gay men in health care, which some believed had been primarily catalyzed and nurtured by peer-founded AIDS service organizations since the late 1980s, to challenge the discursive limitations they encountered in contemporary mainstream care. Many, in particular, utilized this discursive source of resistance to inform health care providers of older gay men’s unique experiences and needs, and as such drew on this resource to contribute to the improvement of care for this population in health systems. Reflecting this theme, Henry, a 54 year-old man who had been living with HIV since the 1990s, noted that he had become increasingly comfortable drawing on this community-supported counter-discourse to educate service providers on his sexuality, and in turn expect better care as an aging HIV-positive gay man than had historically been the case:

I've become very comfortable and if someone treating me in any way shape or form isn't comfortable then I try to enlighten them and give them some facts and some background and say no, I'm not this hideous monster because I'm gay ... I think [this
is because of the] sharing of knowledge … like [with] the healthcare involved with positive people and gay people in general, there's a lot of different organisations out there and they're really pushing out the information … everyone is putting out information saying it's okay if you're lesbian, or it's okay if you're gay.

Henry, and several others, highlighted the significant value of this counter-discourse for aging cohorts of gay men, as many had survived through periods of HIV/AIDS history in which this vehicle of resistance had not yet been mobilized and legitimated by established networks of LGBTQ- and HIV-specific advocacy organizations, and had as such been far more limited in its availability to those accessing systems of care.

### 2.4.2 Older Gay Men’s Construction of Present Day Medical Practices as Sociohistorical Artifacts of HIV/AIDS

Based on the accounts of both HIV-positive and HIV-negative participants, HIV/AIDS history appeared to wield influence on the construction of contemporary medical practices as sites of subjugation for those in both groups. In particular, participants in the two subsamples discussed often interpreting their present day encounters with highly specialized, disease-focused, and impersonal medical services as frequently mimicking what many believed were dehumanizing approaches to HIV/AIDS care during the 1980s and 1990s. Although participants largely recognized that such approaches to care may, in general, be common across mainstream health systems intended for older adults, they nonetheless discussed filtering their current experiences with these services through the lens of their past interactions with health care.

For instance, Joshua, a white 53 year-old man who had been diagnosed with HIV nearly twenty years previous to the study, recounted a recent incident in which his interaction with impersonal reception staff at a medical clinic had triggered past memories of his dehumanization in systems of HIV/AIDS care at the time of his diagnosis, and as such had prompted him to leave the clinic prematurely:

Yeah because the feelings and remembering what it was in the early days when you had to go through all that, it comes up and I was getting anxious. The person at the reception was really rude … All of that comes into play but mostly what you remember is what you’ve gone through when [you were ill], so it was a problem.
You think, “Oh God, is it going to be like that again?” and so I just left. I thought, “No, I don’t need this,” you know, so I left.

Joshua’s account, which was representative of the experiences of other HIV-positive participants, was significant in that it highlighted older HIV-positive gay men’s likely inaccessibility to present day medical care due to their construction of these health systems as sociohistorical artifacts of their subjugation in the HIV/AIDS epidemic. As subjugation can, indeed, include a subject’s self-regulation in response to normative expectations of conduct (Berard, 1999; Foucault, 2000; Walters, 2012), older HIV-positive gay men’s historically-filtered perceptions of contemporary medical services as sites of stigma and discrimination, and their resultant disengagement from these services, are significant in reflecting their marginalized subject positions. In other words, although the participant’s experience with “rudeness” may not, in itself, be considered a manifestation of his subjugation, the interpretation of this experience as reminiscent of the HIV/AIDS epidemic, and the self-regulated response to this interpretation, reflect the internalized position of this participant as a marginalized subject.

Interestingly, among those in the HIV-negative subsample, several participants shared comparable expectations of stigmatizing treatment in systems of care, based on their past experiences of witnessing the care of their HIV-positive friends and partners. For instance, Peter, who identified himself as a white, physically healthy 70-year old HIV-negative man with small stocks to supplement his public pension, made several references to this theme in his interview. Peter had been a caregiver to HIV-positive friends and recounted the financial capacity of one of his peers to have hired home-based end-of-life care to avoid the stigma-laden neglect experienced among other HIV-positive gay men in his age cohort accessing hospital care. Reflecting on this experience, this participant highlighted his own concern over lacking the financial means to similarly privately hire care in the future if necessary:

In the beginning when my first friend died and I was the caregiver … it seemed pretty good at the time because he seemed to have had pretty good care and he was a teacher so he had good health benefits and things. So he was covered for a lot of things, mainly at-home care … People that don’t have coverage, such as myself –
[maybe] I would feel I’d want to have more [home-based] care or I would need more care and I [would] not [get] it.

This account is particularly notable as it exemplifies the potential role of socioeconomic advantage in mitigating both older HIV-positive and HIV-negative gay men’s susceptibility to receiving care in health systems they may, based at least in part on their historic relationships with mainstream medical institutions of the HIV/AIDS epidemic, expect to be unresponsive to their needs. The significant role of socioeconomic status, in this regard, figured prominently in the accounts of both HIV-positive and HIV-negative participants. Although participants infrequently discussed anticipating stigma and discrimination in health care due to past experiences that were unrelated to the HIV/AIDS epidemic, a significant number drew on their memories of caring for HIV-positive partners and friends, and specifically witnessing the exposure of these peers to stigmatizing care in health systems, in justifying these expectations.

Resistance to present day mainstream medical practices, which were often implicitly discussed as historically significant sites of subjugation, was commonly reflected in both HIV-positive and HIV-negative participants’ accounts of seeking and receiving health services from peer-founded community health organizations, many of which were established at the start of the HIV/AIDS epidemic. Several participants, most prominently, articulated the important role of these organizations in providing sexual health services, including HIV testing and treatment, which many felt uncomfortable receiving in mainstream health care settings. Illustrating this pattern, Trevor, an employed 55-year old HIV-negative man who identified as Black African-Canadian, discussed testing for HIV in such community organizations, particularly in times when he feared his requests for testing services would “out” his stigmatized identity as a gay man. Importantly, Trevor disclosed that he did not consistently test for HIV at these organizations, since he had discreetly prompted his family physician to include HIV testing as part of his annual physical examination without revealing his sexual identity. However, he had in the past presented at community-based organizations for non-routine HIV tests after occasionally engaging in high-risk sexual behaviours that he had expected needing to discuss with health care providers administering these services:
I've done odd tests at [a gay men’s health organization]. In those situations around HIV, you know, where let's say, I was testing, you know, yes I have disclosed [I am gay] to the health care provider. You know. But in general - in general I don't … I mean I think it's just the whole thing of being judged …

Of note, Trevor mentioned that he was, in particular, discreet about his identity as a gay man in mainstream health settings due to his already existing susceptibility to racism in medical systems as an aging Black man with potentially increasing health care needs:

. I still feel reasonably healthy and young [but] the older you grow, the more services you get, the more racism you face because people have less filters. You know. And so [I am] careful.

Trevor’s perception of his unique susceptibility to stigma as an older gay Black man is particularly significant in that it reflects how expectations of discrimination among aging gay men may be influenced and sometimes exacerbated by forces that intersect with homophobia and HIV stigma, including racism and ageism.

Superficially, Trevor’s account suggests the use of community-based sexual health services among older gay men as a means of avoiding stigmatization in mainstream health services. More importantly, however, it reflects the continued relevance of aging gay men’s engagement with these peer-led services, beyond the HIV/AIDS epidemic, as means of exercising agency in care-seeking and care-receiving, and thus resisting exposure to sociohistorically patterned expressions of marginalization that many in this population have come to expect in mainstream care.

2.4.3 The Gay Aging Body as a Commemoration of Risk and Resistance

2.4.3.1 The body as Commemorative of Risk

Participants in both of this study’s two subsamples recognized that their gay aging bodies were often constructed in health care settings as sociohistorical commemorations of risk. Specifically, participants discussed having their bodies perceived as sources of HIV infection risk in health care settings, both to service providers and to the public at large, with many tracing the origins of this systemic perception to the start of the HIV/AIDS epidemic.
HIV-positive participants, in particular, discussed the tendency for health care professionals to interact with their bodies as highly recognizable carriers of risk, regardless of the actual risks associated with various types of exposure. These men also often explicitly acknowledged their older gay male identities as being influential in increasing their intelligibility as carriers of HIV risk in health systems, in light of the historical association of gay men with the HIV/AIDS epidemic. Illustrating this point, several participants discussed consistently revealing their sexual identities, along with details such as HIV status and age, to health care providers who would then take precautionary measures to mitigate any perceived risks of engaging with bodies marked by the combination of these identifiers. For example, Jonathan, a 54 year-old white man, noted that he often disclosed his HIV-positive status, gay identity, and age simultaneously whenever he interacted with a new health care provider, given the risks ascribed to these dimensions of identity in health systems:

Every time I have an appointment with a new doctor, like all of the doctors I’ve met this year, that I don’t deal with regularly, they all knew from the get go. I’ll tell them. I’m … fifty-three years old, I’m HIV, and I’m gay. I smoke marijuana. I lay it all out on the table for them. So this is what you’re dealing with, you know? [I tell them I am gay] […] just because I think they need to know. You’re dealing with a gay man that’s HIV. And I think that’s important information for any doctor to know when I’m dealing with them. Because you need to take your precautions that you need to take, if you’re queezy at all about it, you know what I mean? Which I don’t think most doctors are anymore, because they understand that, you know, you can’t get it just from touching me. You know what I’m saying? Or talking to me. So I just feel it’s, that’s my responsibility.

The participant acknowledged, on one hand, that the perceived risks often historically assigned to the bodies of older HIV-positive gay men in health care were arbitrary (“most [present day] doctors … understand that … you can’t get it just from touching me”). On the other hand, Jonathan recognized that these risks nonetheless continue to be perceived in health systems, and that service users are expected to disclose their identities as older HIV-positive gay men in order to assist service providers in taking appropriate “precautionary” measures (“I think that’s important information for any doctor to know … that’s my responsibility”).
Jonathan and other participants living long-term with HIV often discussed having learned to recognize and account for their increased visibility as risk carriers during the height of the HIV/AIDS epidemic, and in several instances, noted that failure to immediately acknowledge and disclose this information in health systems shaped by this history would often result in mistreatment or lack of treatment by care providers. For instance, in discussing his experience with chemotherapy following a cancer diagnosis, Jonathan recounted feeling neglected by a nurse who he believed had likely “found out” about his HIV status by reading his chart, and who had in response become distant and dismissive with the participant:

There was one nurse at the hospital that it was like, all I kept thinking was, “what the heck are you doing here, buddy? Because you’re not very friendly … is it me?” … It’s like, I know that they see things on my chart … Well, my thought was that he found [out] that I’m HIV-positive, and he doesn’t wanna be around me. So we’ll deal with you quickly, and I’m [going to stay] away from you.

HIV-negative participants similarly referred to the historical and present day intelligibility of their bodies as carriers of risk in mainstream health systems. Reflecting on their experiences with the HIV/AIDS epidemic, these men often indicated expecting to be treated as subjects of HIV risk in mainstream health systems, and expressed concern over becoming perhaps even more intelligible as risk entities in these settings if they ever became infected with HIV. Accordingly, several participants in this subsample described feeling reluctant to discuss their sexual behaviours openly in health care, and actively feared becoming HIV-positive. For instance, Lou, a 70 year-old white man with access to a private pension and associated health benefits, discussed concerns over contracting HIV in the future, and consequently becoming stigmatized as a target of medical intervention and a highly recognizable source of HIV infection risk:

Even if they have medication, [I’d rather remain] HIV negative, you know, not positive and not have to take all these medicines and stuff, you know? … if somebody becomes HIV and all that, you can’t condemn them [but] you don’t want that either, right? … in the past when [a friend] was HIV and then AIDS and all this
stuff, apparently the medical department, they weren’t too thrilled to take care of them.

Referring to his experience of witnessing the stigma his same-age gay peers had endured after becoming HIV-positive, Lou’s concern over HIV was related both to the medical implications of living with an illness requiring complex surveillance and treatment, and to the social prospect of embodying HIV risk in health care settings as an older gay man.

2.4.3.2 The body as Commemorative of Resistance

Across both subsamples, participants indicated resisting the construction of aging gay bodies as commemorative constructions of risk, often by discussing their historical and ongoing contributions in helping to create community-based networks of care and advocacy that together recognize and materialize the emancipatory potential of aging gay bodies. Among HIV-positive participants, several men discussed the significant role that they have played in supporting the development and enhancement of AIDS service organizations, many of which have as a result evolved into systems of support and advocacy that value older HIV-positive gay men’s bodies as legitimate sources of agency. For instance, Stephen, a 56 year-old gay-identified white man who had been living with HIV for over ten years, described having volunteered long-term at an ASO, and in this capacity, having advocated for changes to humanize the agency’s approach to interacting with HIV-positive bodies. Not only did this participant encourage the organization to revise its potentially stigmatizing policies and procedures surrounding the intake of new service users, but in initiating this movement, he also challenged this ASO to recognize the capacity for older HIV-positive gay men’s bodies to act as agents of change, and not simply recipients of care, within service settings:

I took over [the ASO] … I became head of the front desk and all that to reorganize stuff because they liked my approach and all that. They would take people that [would] come out from the elevator [and] all these people [would be] gawking at you, stripping you off naked [with invasive questions] and all that kind of stuff, and I said to them, I said do you know what that feels like? … So we changed all the procedures and everything there … If you can’t walk in there and get some kind of comfort or some kind of help, what do you do?
Although HIV-negative participants less explicitly discussed resisting the construction of aging gay bodies as carriers of HIV risk, several of these men described engaging with care and advocacy organizations to challenge stigma-laden constructions of older gay men in health care. In sharing these experiences, some of the participants indicated publicly and widely voicing their concerns with the support of LGBTQ groups, and thus forcing health care systems to interact with their bodies not just as marginalized subjects of medical intervention, but also as potential catalysts of change. One such participant was Sam, a 77 year-old gay-identified HIV-negative white man. In the year preceding the study, he had been presented with an opportunity to voice his experiences and needs when representatives of a local LGBTQ advocacy organization had requested to meet with health care administrators from a nearby hospital to discuss the institution’s treatment of older LGBTQ adults, and had invited the participant, a long-time volunteer and member of the community organization, to join the discussion. During the meeting, Sam had spoken publicly about his recent experience with a hospital-based care provider who had made stereotypical assumptions about older gay men’s promiscuity, and in so doing, had drawn attention to the presence of homophobia in this setting. In recounting this event, the participant discussed being met with surprise by a health care administrator who had not anticipated the presence of an aging gay man with direct service experience at this meeting:

    We have to infiltrate the educational programming and medical schools so that the stereotypes of what’s expected and what’s real [regarding older gay men] are clearly defined … We did have one meeting at [a large local hospital] … we had the director of senior services in the meeting, and he told us how wonderful his services were … And [I said] don’t tell me, from my own personal experience that I should like what you’re offering … And I think he was a bit shocked because he didn’t expect anybody who actually had the experience to share experience with the audience that was there.

Sam’s experience is significant in that it highlights how aging gay men often use their presence, with support from advocacy organizations many of these adults may have historically helped to develop and maintain, as compelling forces for change. Such mobilization, in turn, reflects aging gay men’s capacity for claiming agency in health care settings, and thus resisting constructions of their bodies as static and stigma-laden carriers of risk within these systems.
2.5 Discussion

The study’s findings globally indicate that older gay men are regularly constructed as subjects with stigmatized proximity to the HIV/AIDS epidemic across health systems. Accordingly, processes of subjugation and resistance shaping this population’s health care experiences appear to be rooted in this social and historical context. Three themes, in particular, illustrate the role of older gay men’s perceived association with the HIV/AIDS epidemic in influencing conditions of subjugation and resistance for this group. These include, first, the interdependence of HIV stigma and homophobia as salient systems of power that construct older gay men as marginal subjects in mainstream health care settings, and the use of a counter-discourse among this group to resist this discursive climate. The next theme comprises older gay men’s constructions of present day medical practices as being reminiscent of the stigma-laden and discriminatory health care many experienced in early stages of the HIV/AIDS epidemic, and in response, this group’s resistive behaviours of seeking and receiving particular types of care (i.e., sexual health services) outside of mainstream health systems. Finally, the last theme encompasses the intelligibility of older gay men’s bodies as representing HIV infection risk in health systems, which this population appears to resist by rendering their bodies visible in health systems as catalysts of institutional change.

Interestingly, the accounts of both HIV-positive and HIV-negative participants contained references to each of the three themes as representations of the effects of HIV/AIDS history on contemporary systems of care. However, whereas older gay men living with HIV often explicitly drew on their direct experiences with health care in identifying these phenomena, HIV-negative participants often reflected on their experiences of caring for friends or partners who had lived with HIV. Importantly, for some participants, factors such as poverty and racism intersected with homophobia, HIV stigma, and ageism, and as such heightened their susceptibility to sociohistorically rooted expressions of subjugation in systems of care.

The framework of governmentality assisted us with conceptualizing processes of subjugation that were reflected in the accounts of participants. Most notably, we applied this framework in constructing insight on the role of the HIV/AIDS epidemic as a source of normative power that shapes the health care experiences of older gay men. Specifically, we first used this theoretical
lens to highlight the role of prominent discursive forces, including HIV stigma and homophobia, that reflected the influence of this sociohistorical context on the construction and reinforcement of older gay men’s marginalized subject positions in health care. Next, we drew on governmentality to attend to the self-regulatory tendencies of aging gay men as manifestations of this group’s subjugation in health care. These included older gay men’s disengagement from present day medical services, particularly when such services were constructed among this group as artifacts of the HIV/AIDS epidemic, along with aging gay men’s recognition and resultant conduct of their bodies as historically intelligible carriers of HIV infection risk in mainstream health care. Our analysis of subjugation, in turn, facilitated explorations of resistive conduct among older gay men. Indeed, as subjugation is often defined in governmentality studies as being generative of resistance (Berard, 1999; Foucault, 2000), we developed insights on older gay men’s resistive activities by identifying this group’s attempts at challenging the discursive and self-regulatory processes we had conceptualized earlier as underpinning their marginalization in systems of care. Accordingly, we drew on governmentality’s conceptualization of resistance to attend closely to older gay men’s development and use of counter-discursive activities, their establishment and engagement of alternate systems of care, as well as the autonomous and constructive mobilization of their otherwise stigmatized bodies.

In recognition of the foregoing, it is worth noting the primary theoretical implication of our work for the field of governmentality studies. Most importantly, this study highlights the need for scholars drawing on traditions of governmentality to recognize the salience and intersectional nature of targeted oppressive discourses as factors that may be key in shaping institutional conditions of subjugation and resistance for multiply marginalized groups. Indeed, in our study, homophobia and HIV stigma, which featured not only as interdependent discursive forces, but also as intersecting and historically rooted systems of power, were elemental in constructing processes of subject formation and resistance among older gay men in mainstream health systems. Although theorists working within traditions of intersectionality have long theorized the prominence of dominant discourses that target socially intelligible categories of difference (King, 2016; Yuval-Davis, 2006), scholars in the field of governmentality studies have often overlooked the analysis of more systemic discursive forces that marginalize dimensions such as sexual identity, gender, race, and class. Indeed, those engaged in studies of governmentality
have often discussed the use of this framework to conceptualize manifestations of normative power that are highly context-specific and exercised primarily at the intra- or inter-subjective level (Gane, 2010; Walters, 2012). Some have also noted the arguably excessive use of this theoretical lens to conceptualize and problematize exercises of power that are sanctioned by state and market entities of the neoliberal regime (Walters, 2012). As exemplified in our work, the theoretical framework of governmentality can, in addition to its more common applications, account for normative systems of power that target particular dimensions of difference, and as such be utilized to examine processes of subjugation and resistance unique to the institutional experiences of a multiply marginalized group.

The findings of this study both support and expand on the literature on older gay men’s health care experiences. On one hand, as research on older HIV-positive gay men’s health care experiences has in the past drawn attention to the salience of historical homophobia and HIV stigma in this context (Emlet, 2006; Owen & Catalan, 2012; Rosenfeld et al., 2012), the prominence of these factors in shaping the experiences of this study’s HIV-positive participants corroborates what has been already indicated in this literature. On another hand, however, as the literature on older HIV-negative gay men has only theoretically acknowledged this group’s experiences with the HIV/AIDS epidemic as potentially being influential on their experiences with health care (King, 2016; McNutt & Yakushko) without empirically exploring this possibility, the accounts of this study’s HIV-negative participants provide focused evidence for a phenomenon that has primarily been discussed conceptually until now. Indeed, this study provides insight on the role of older HIV-negative gay men’s relationships with the HIV/AIDS epidemic in constructing this group’s perceptions of present day mainstream health systems as neglectful or stigmatizing of these men’s identities and sexual practices. Finally, the study’s novel findings on the present day importance of HIV/AIDS service organizations for older gay men merit attention. Indeed, the existing literature has often considered the historically significant role of community-based HIV/AIDS care networks among gay men living through the epidemic of the 1980s and 1990s (Cole, 1996; Fredriksen-Goldsen et al., 2014) without necessarily investigating the continued salience of these resources as systems of care, support, and advocacy for the same cohort of gay men today. As such, this study expands on the literature by substantiating the more contemporary relevance of these networks for gay men ages
50 and over, many of whom still draw on these resources to build capacity and mobilize resistance against mainstream health care systems that often continue to be perceived as exclusionary.

Importantly, this study draws attention to the prominent role of HIV/AIDS history in shaping contemporary medical services for older HIV-positive and HIV-negative gay men, and in constructing today’s aging gay bodies as risk carriers. These particular findings, which reflect some of the more implicit effects of HIV/AIDS history on the marginalizing social context of health care for both groups of older gay men, are entirely unique to this study. This is perhaps not surprising, as no known studies have in the past empirically considered the sociohistorical influence of the HIV/AIDS epidemic on the lives of older gay men accessing health care and other institutional settings, and as insight on this area of inquiry is therefore limited. Although a recent review paper has emphasized the importance of comprehensively accounting for the social history of HIV/AIDS in empirical studies of older HIV-positive gay men’s relationships with health care, social services, and other social systems (Rosenfeld et al., 2012), the findings of the current study distinctly highlight the need to more fully account for this sociohistorical context in research with both aging HIV-positive and HIV-negative gay men. Given, in particular, both groups’ constructions of present day health systems as historically significant sites of subjugation, and their resultant disengagement from these settings, more contextually attuned inquiry is needed to explore how the effects of this history can be addressed with older gay men, and in turn how mainstream systems of care can successfully reengage this population. Such research would not only generate more comprehensive insight on the health care needs of aging gay men, but it would also help inform the development of health services that may be perceived as more accessible to this population.

Aside from informing ongoing research, the findings of the study are significant in their implications for health care policy. Most importantly, given that several HIV-positive and HIV-negative participants discussed interpreting their present day experiences with highly disease-focused medical practices as at times mimicking the dehumanizing conditions of the HIV/AIDS epidemic, the study’s findings can be used to develop a range of psychosocial support services, including trauma counselling, peer support, and medical advocacy that better address the effects of this history. For instance, in order to account for older gay men’s historically-influenced
disengagement from contemporary health systems, mainstream health services can partner with ASOs and LGBTQ community agencies to offer peer-delivered assistance with health care navigation for older HIV-positive and LGBTQ adults, including aging gay men. Such programming would not only function to broker access to mainstream health institutions for older gay men and other groups potentially affected by the history of the HIV/AIDS epidemic (Fredriksen-Goldsen et al., 2014), but it would more importantly build on and enhance the existing capacities of ASOs and LGBTQ organizations as systems of care and advocacy.

In addition to offering more comprehensive psychosocial support, including peer-delivered services, contemporary health care systems can be designed to universally provide information on local LGBTQ and HIV/AIDS community-based agencies to all service users. This implication is particularly relevant, given that some older gay men in this study described feeling uncomfortable seeking certain types of care (i.e., sexual health services) that would “out” their sexual identities in mainstream health care settings (Grace et al. 2018), and at the same time indicated their willingness to access community-based organizations to address such needs. Importantly, in light of the few participants who explicitly indicated withholding information on their sexual identity in mainstream health care services, the universal dissemination of information on community-based agencies may be particularly useful in reaching adults who may not necessarily be identifiable to service providers as older gay men. Finally, given the extent to which participants’ expectations and experiences with stigma and discrimination in health care settings had either been formed or reinforced as a result of their experiences with service providers in these settings, the findings of this study can be used to develop policies mandating the exposure of health care professionals to anti-oppressive training on the health care experiences and needs of older gay men. This training would, in particular, ideally enhance the sensitivity of care providers to older gay men’s historically-influenced expectations of experiencing stigma and discrimination in health systems, and as such encourage these providers to practice reflexively using behaviour and language that affirm gay sexuality and HIV status among older adults.

Based on these findings, not only does this study represent a notable contribution in the literature on older gay men, but it serves to provide preliminary insights on the health care experiences of this group more specifically. Regardless, several limitations are important to note. First, as the
study’s sample contained an underrepresentation of racialized participants, its findings cannot be said to fully account for the intersecting influence of racism on the health care experiences of older gay men who may not be white/Caucasian. Although exposure to racism was identified in the study’s findings as potentially exacerbating older gay men’s vulnerability to expressions of stigma and discrimination, further investigation in this area is needed to more comprehensively unpack and conceptualize this phenomenon. In addition, as the study was conducted in a large Canadian city, the findings may be primarily transferable to urban centres located in advanced industrialized societies, and accordingly may not be transferable to older gay men situated in other geographic contexts. Future inquiry addressing these gaps will serve to enrich this study’s insights, and by extension, assist with the generation of comprehensive knowledge on the historically influenced health care context of older gay men.
Chapter 3

3 Innovating the Study of Context: Exploring the Utility of Foucauldian Governmentality as a Framework for Enriching Situational Analyses

Abstract: Situational analysis has, as an emerging poststructuralist approach to grounded theory, recently grown in use across a diverse range of disciplines and substantive areas. In this paper, we consider the complementarity of Foucauldian governmentality as a theoretical framework for supporting and enriching situational analyses. Our work is based on the findings of a recent study, informed by situational analysis, in which we interviewed 27 HIV-positive (n=16) and HIV-negative (n=11) gay men ages 50 and over about their health care experiences, and used these data to examine processes of subjugation and resistance reflected in their accounts. Reflecting on our analytical process, we consider the utility of governmentality in identifying salient discursive forces within a situation of interest, in theorizing how contextual factors operate on and influence the experiences of key actors in a field of inquiry, and in generating insight on fluid uses of power within an area under examination.

3.1 Introduction

In recent years, grounded theory approaches with roots in poststructuralist thought (Charmaz, 2006; Clarke, 2003; Clarke, 2005) have emerged to challenge the allegedly postpositivist origins (Charmaz, 2006) of this qualitative methodology. One such approach is situational analysis (Clarke, 2003; Clarke, 2005), the conceptual origins of which lie in symbolic interactionist studies, as well as postmodern and poststructuralist scholarship. Although situational analysis, over the last decade, has grown in its utilization across numerous social science disciplines and diverse substantive areas (e.g., Atallah, 2017; King & Leask, 2017; Salazar et al., 2016), no attempts have yet been made to explore the usefulness of specific theoretical frameworks in guiding the analytical processes of studies informed by this method. Such theoretical reflexivity could generate an enriched understanding of what may be yielded from drawing on various theoretical frameworks.
In this paper, we explore the utility of Foucauldian governmentality in conceptualizing the findings of a situational analysis of subjugation and resistance in older gay men’s health care experiences. We start with a brief overview of Foucauldian governmentality, and discuss various applications of this framework that have thus far been recognized by scholars writing in this theoretical tradition. Next, after discussing our study’s substantive area and explaining our use of situational analysis to inform research design within this field of inquiry, we analyze the relevance of governmentality as a framework for supporting and guiding our analytical activities in the context of this study. Specifically, we consider our use of this lens to identify and conceptualize discursive forces that appeared to prominently shape the health care experiences of older gay men, to generate insight on how salient contextual factors appeared to wield influence on the subjugation and resistance of older gay men in health care, and to examine fluid movements and uses of power within our area of inquiry. We conclude our paper with implications of our analysis for research informed by the tenets of situational analysis.

### 3.2 Foucauldian Governmentality: An Overview

The works of Michel Foucault have frequently been used among poststructuralists to problematize the construction of social conditions that drive the exercise and exchange of power (Larsen, 2011; Lemke, 2011; Walters, 2012). Consistent with this tradition, Foucault's work in the area of governmentality (Foucault, 2008; Foucault, 2010; Foucault, 2011) broadly considers the role of normative sources of power in shaping conduct or social behaviour (Gane, 2010; Walters, 2012). Discourses, or intelligible systems of communication that are sanctioned within particular social and historical contexts, are often believed to prominently reflect normative relations of power, and are thus considered particularly salient sites of analysis within this area of Foucauldian scholarship (Foucault, 2000; Walters, 2012).

Governmentality studies, as a field of theoretical inquiry, has grown over time to consider the regulatory function of discursive and other interactional forces across various levels of social organization (Walters, 2012). Although governmentality has most frequently been used to deconstruct sources of power sanctioned by state and market entities of the neoliberal regime (Gane, 2010; Walters, 2012), scholars have also emphasized the potential for this framework to conceptualize derivatives of power that are situated in and drawn upon the full range of
intrapersonal, interpersonal, organizational, and broader systemic contexts (Walters, 2012). Consistent with the original conception of this theoretical orientation, this work postulates that subjects (those who are constructed as targets of control when power is exercised in any given context), not only experience conditions of subjugation, but are also believed to possess the capacity for resistance to their marginality (Berard, 1999; Foucault, 2000). Of note, scholars in the field of governmentality studies often examine discourse to empirically substantiate expressions of subjugation and resistance reflected in normative texts, and also to consider the sources of normative power that construct conditions of subjugation and resistance in the first place (McIlvenny et al., 2016). Consistent with the theoretical literature on governmentality, our use of this framework implies our attention to multi-level sources of normative power, our concern with processes of subjugation and resistance as focal areas of inquiry, and our recognition of discourse as a particularly salient vehicle for effecting and reinforcing relations of power.

3.3 The Study: Investigating Subjugation and Resistance in Older Gay men’s Experiences Navigating Health Care Systems

Contemporary empirical literature on older gay men’s interactions with health systems and health care providers in North America, Europe, and other regions of the industrialized world is limited. However, the small body of research on the health care experiences of those in this group, often defined among scholars in this area as gay men ages 50 and over, indicates this population encounters prominent expressions of stigma and discrimination in care settings (Addis et al., 2009; Clover, 2006; Elliot et al., 2014; Rosenfeld et al., 2012). Older gay men living with HIV are, in particular, affected by these social processes in health systems, given the interlocking forces of homophobia and HIV stigma that have historically positioned this group as a marginalized category of care recipients (Cole, 1996; Emlet, 2006; Owen & Catalan, 2012; Rosenfeld, et al., 2012). Although HIV-negative gay men may not have directly experienced the historical conditions of marginalization that have shaped the interactions of their HIV-positive counterparts with health systems, the health care experiences of many in this group have nonetheless been shaped by their indirect exposure to combined expressions of homophobia and HIV stigma. Given that older HIV-negative gay men often report having cared for gay HIV-
positive partners and friends through the HIV/AIDS epidemic, many have witnessed the stigmatization and mistreatment of these peers in health care, and based on these experiences, have come to expect hostility or neglect in health systems (Cronin & King, 2014; Fenkl, 2012; Fredriksen-Goldsen et al., 2014; McNutt & Yakushko, 2013; Wight et al., 2012). As a result, the salience of stigma and discrimination across present day health settings, both among older HIV-positive (Emlet, 2006; Emlet et al., 2017a; Lyons et al., 2012; Masten, 2015; Owen & Catalan, 2012) and HIV-negative gay men (Addis et al., 2009; Clover, 2006; Elliot et al., 2014; Fenkl, 2012; Fredriksen-Goldsen et al., 2011; Gardner et al., 2014; Grace et al., 2018; Institute of Medicine, 2011; Lyons et al., 2012), is perhaps not surprising. Yet, there is a scarcity in focused studies of older gay men’s health care experiences, particularly those that consider the combined realities of both HIV-positive and HIV-negative men.

We aimed to examine aging gay men’s accounts of engaging with health systems, and particularly focused on systems of marginalization, including homophobia, HIV stigma and ageism, at play in constructing the health care context of older gay men (Addis et al., 2009; Rosenfeld et al., 2012). We drew on Foucauldian governmentality to inform nuanced analyses of power. Using this lens allowed for a conceptualization of the mechanisms involved in establishing and reinforcing the marginalization of older gay men in health care as processes of subjugation, and the HIV/AIDS epidemic as a potential source of normative power underpinning the subjugation of older gay men in this context. Given, within the tradition of governmentality, the co-existence of resistance within conditions of subjugation (Berard, 1999; Foucault, 2000), we were also able to use this lens to attend to the resistive activities of older gay men in systems of care. Present day cohorts of older gay men (King, 2016; Rosenfeld et al., 2012), along with their deceased peers (Smith, 1990), have historically enacted remarkable expressions of resistance to their marginalization in systems of care by leading movements to advocate for scientific research on HIV/AIDS during the 1980s and 1990s (Epstein, 1989), and by establishing extensive systems of community-based support and advocacy for gay men living with HIV in the same time period (Brier, 2009; Chambré, 2006). In light of the legacy of resistance in this population, we deemed it necessary to recognize and highlight ongoing resistive activities undertaken by older gay men to challenge their continuing subjugation within contemporary health systems.
We chose to investigate the following primary research questions: (1) how are processes of subjugation and resistance reflected in the accounts of older HIV-positive and HIV-negative gay men seeking and/or receiving care in health systems?; and (2) what is the comparative significance of the HIV/AIDS epidemic in constructing health care as a site of subjugation and resistance among older HIV-positive and HIV-negative gay men? In the sections that follow, we describe our utilization of situational analysis to guide our empirical study of these questions, and our use of Foucauldian governmentality to enrich the study’s analytical activities. This paper’s content is based on insights we gleaned, during this research process, on the theoretical complementarity of Foucauldian governmentality as a conceptual framework in studies informed methodologically by situational analysis. Importantly, although we recognize that the study’s questions were originally informed by governmentality, and thus led to findings that were most easily expressed using constructs associated with this body of scholarship (e.g., “subjugation” and “resistance”), in this paper we explore the usefulness of governmentality as a vehicle for analyzing raw data in situational analyses that may or may not be conceptually grounded in Foucauldian scholarship. In other words, we highlight the complementary of this framework in guiding the practice of situational analysis from the preliminary stages of data analysis, regardless of the constructs used to frame a study’s original research questions, rather than highlighting how governmentality can be used posthoc to reconceptualize the findings of a study originally framed in Foucauldian language.

### 3.4 Methods

#### 3.4.1 Research Design

We used situational analysis (Clarke, 2003; Clarke, 2005), which involves the inductive and emergent generation and analysis of textual data, to examine and develop theory on the phenomenon under investigation. In light of this methodological framework’s conceptual underpinnings in symbolic interactionism and poststructuralist thought, the use of situational analysis entails attention to contextual factors that appear salient in constructing or shaping the area of interest (Clarke, 2005). Unlike other traditions of grounded theory, researchers drawing on this critical research strategy often map the presence and influence of contextual factors across the field of study, and use this situational map to guide the analytical process. Given, within more traditional approaches to grounded theory (Corbin & Strauss, 2015), the tendency
for text to be conceptualized as being directly reflective of the area under investigation, and less as being a constructed product of contextual factors, situational analysis may be seen as distinctively more compatible with poststructuralist thought than earlier traditions of grounded theory.

3.4.2 Participants

This study underwent review and approval by the University of Toronto’s HIV Research Ethics Board (#33523). All participants involved in the study provided informed consent prior to their engagement in the research process.

3.4.2.1 Recruitment

We recruited participants with assistance from AIDS services organizations (ASOs) and community agencies serving older lesbian, gay, bisexual, transgender, and queer (LGBTQ) adults in Toronto, Canada. After establishing partnerships with these organizations, we distributed our recruitment materials to outreach and support workers employed in these settings, who then shared information on our study with potentially eligible older gay men.

3.4.2.2 Sample

Our sample consisted of 27 participants who (1) self-identified as gay men, (2) were ages 50 and over, and (3) had at least three experiences of seeking or receiving care from physicians or nursing professionals in the 12 months preceding their involvement in the study. The participants ranged in age from 50 to 77. While a majority were in their 50s (n=15), six were in their 60s, and another six in their 70s. We deliberately oversampled HIV-positive adults (n=16) in order to ensure adequate representation of those whose lived experiences we believed could yield particularly relevant insights on the influence of the HIV/AIDS epidemic on the health care experiences of older gay men. Importantly, although we acknowledge that not all men who have sex with men (MSM) identify as “gay,” we intentionally only included presently self-identified gay men in our sample to focus our analysis on experiences of subjugation and resistance that we believed would be unique to this group. Given significant differences between the social contexts of gay, bisexual, and other men who have sex with men (Parker et al., 2016), we chose
to exclusively examine the health care experiences of older gay men as a distinct domain of study.

Although we primarily utilized our study’s baseline eligibility criteria to guide our recruitment process, we also drew on elements of theoretical sampling (Corbin & Strauss, 2015). For instance, based on our review of the limited literature, we were aware of significant variations in experiences of stigma and discrimination, most often based on factors such as race (Addis et al., 2009) and socioeconomic status (Fredriksen-Goldsen et al., 2011), across diverse categories of older gay men. When these insights were corroborated by early analyses of our own data, we implemented recruitment measures to achieve as much racial, ethnic, and socioeconomic heterogeneity in our sample as possible. Specifically, we included questions surrounding race, ethnicity, and socioeconomic status in our screening questionnaire, and recruited participants representing diversity along these intersectional dimensions of difference. Although a large majority of our final sample identified racially as White or Caucasian, we were able to achieve a socioeconomically heterogeneous sample. Table 1.1 provides a descriptive overview of the sample’s demographic characteristics.

3.4.3 Data Collection

After providing informed consent, participants were each invited to take part in 1-1.5 hour in-depth, semi-structured interviews that was guided by an interview protocol. Based on a review of the relevant literature, as well as feedback from our community partners, we developed an interview protocol in which we invited participants to discuss their experiences with health care systems. Questions we included in this guide fell into three broad categories that were each designed to elicit: (1) participants’ experiences of seeking and receiving care in health care settings in the 12 months preceding the study, (2) the perceived quality of these adults’ interactions with health care professionals during the same time period, and (3) the participants’ overall reflections on their health care needs as aging gay men, based on any of their recent and/or past experiences with health systems. We designed these interview items to be sufficiently open-ended to accommodate for follow-up and clarification questions based on the insights arising in individual participant interviews. As a result, although we did not identify the need for further refinement of our instrument following the start of our data collection process, as
is often the case in grounded theory studies, we did incorporate minor probes into our existing interview guide to account for and further explore insights shared by participants in the early stages of data collection (Clarke, 2003; Corbin & Strauss, 2015).

We audio-recorded each interview and transcribed these accounts verbatim. Following the completion of each interview, we compensated all participants with $20 CAD and two public transportation tokens.

### 3.4.4 Data Analysis

In line with the tenets of situational analysis, as well as other qualitative approaches associated with grounded theory (Charmaz, 2006; Corbin & Strauss, 2015), we analyzed our data iteratively by reading and continually comparing our interview transcripts and field notes, and extrapolating themes that we believed best represented commonalities across the accounts of participants. As our study was informed by situational analysis (Clarke, 2003; Clarke, 2005), we drew on these themes to identify the contextual factors that appeared most salient in shaping conditions of subjugation and resistance among older gay men in health care, and illustrated these factors and their interrelationships in a situational map. This diagram was elemental in supporting our development of theory on the health care experiences of our participants. A condensed version of the final diagram, as well as an earlier, more rudimentary rendition of the study’s situational map, appear respectively as Figure 1.1 and Figure 1.2.

Our utilization of governmentality (Foucault, 2000; Walters, 2012) assisted us in guiding and enriching our conceptualization of the contextual factors underpinning processes of subjugation and resistance, often recognized in Foucauldian literature as normative sources of power (Foucault, 2000; Foucault, 2008; Foucault, 2010; Foucault, 2011; Walters, 2012), that were reflected in emergent themes. In other words, our development of the situational map, along with the theoretical picture of older gay men’s health care experiences it supported, was largely based on our application of Foucauldian governmentality to conceptualize processes of subjugation and resistance, as well as the contextual factors shaping these phenomena, from within our data. In the section that follows, we more comprehensively explore how our use of this analytical lens enabled us to refine and enrich our situational analysis of the area under investigation.
3.5 Summary of Findings

We found that older gay men in health care settings were, regardless of HIV status, intelligible as a population with a history of systemic exposure to HIV infection, and thus often constructed as a category of subjects immutably associated with the HIV/AIDS epidemic. Accordingly, processes of subjugation unique to the health care experiences of this group primarily involved the establishment or reinforcement of this stigmatizing subject position within the institutional context of health systems. Expressions of resistance, on the other hand, typically comprised acts of subversion to challenge these marginalizing mechanisms of subject formation.

In developing the foregoing theoretical picture, we extrapolated three themes (Kia et al., 2018) from our data to substantiate this context of subjugation and resistance in the health care accounts of older gay men. The first of these themes highlighted the role of homophobia and HIV stigma, across mainstream health systems, as salient discursive factors that appeared to operate interdependently to construct older gay men’s marginalizing association with the HIV/AIDS epidemic in these settings, both historically and in the present day. Our next theme encompassed older gay men’s perceptions of contemporary medical practices as sociohistorical artifacts of the early HIV/AIDS epidemic’s marginalizing conditions, and thus domains from which they, as disadvantaged subjects of this history, continued to disengage. Finally, our last theme elucidated the role of gay aging bodies, based on participants’ accounts, as commemorating risk within mainstream health settings, and as simultaneously representing resistance among older gay men who have used their visibility and physical presence as gay men to establish community-based networks of health advocacy and support for their peers. In the section that follows, we analyze the utility of Foucauldian governmentality in assisting us with conceptualizing the above phenomena as contextually situated expressions of subjugation and resistance, and in this process, substantiate the complementarity of Foucauldian governmentality as a framework for guiding the practice of situational analysis.
3.6 Foucauldian Governmentality: A Framework for Enriching a Situational Analysis of Health Care among Older Gay Men

3.6.1 Identifying the Deployment of Homophobia and HIV Stigma as Key Discursive Forces

Our use of Foucauldian governmentality enabled us to identify the systemic and historical underpinnings of certain discursive forces, namely those rooted in homophobia and HIV stigma, in constructing conditions of subjugation among older gay men in health care. While the methodology of situational analysis provided us with a framework for more broadly identifying discourses operating within the context of health care among older gay men (Clarke, 2003; Clarke, 2005), it was through our application of governmentality that we developed an appreciation of the significance of particular discursive forces in shaping health systems as sites of subjugation for aging gay men.

Consistent with the tenets of situational analysis (Clarke, 2003), we began our analytical process by searching for discursive factors, alongside other contextual elements, that appeared to shape the health care experiences of older gay men. As, in the practice of situational analysis, discourses include any socially intelligible systems of communication operating within a context under study (Clarke, 2003; Clarke, 2005), we initially relied on this broad definition to attend to any shared bodies of text or meaning that appeared foregrounded across the accounts of participants. In taking on this exercise, we became particularly cognizant of the assumptions that several of the participants believed were made about older gay men by care providers in health settings, and attempted to identify the discourses on which some of these stereotypes appeared to be based. Perhaps the most prominent of the assumptions discussed among participants involved the perception of aging HIV-positive and HIV-negative men as promiscuous and sexually reckless, and thus as “irresponsible” and morally subservient subjects of medical care. In turn, the discursive process underlying this stereotype appeared to comprise the categorization of older gay men as sexually deviant “others” whose historically voluntary engagement in unsanctioned sexual practices rendered them not only less entitled to medical autonomy, but also culpable for their medical conditions. Indeed, our interview with Ross, a white 56 year-old man who had been living with HIV since the late 1980s, contained an excerpt that highlighted this discursive othering of older gay men living with HIV in particular. This account, which we have referenced
elsewhere (Kia et al., 2018) reflected not only the potential for such an othering process to diminish the power of older gay men to partake in the discursive construction of assumptions made about them in health care settings, but also to vilify those in this population as “culpable” and thus morally “undeserving” subjects of medical care:

For men in my generation who are in their fifties or early fifties, I think it’s automatically assumed … that because you’re gay you live with the AIDS virus, and because you’re gay you’re a slut and you deserve to live the way you’ve – that you deserve whatever comes your way.

Given the recognized relevance of discursive factors as core components of meaning-making within the framework of situational analysis (Clarke, 2003), we became particularly attentive to the role of these contextual elements in constructing perceptions of older gay men in health care settings. Applying our conceptual framework of Foucauldian governmentality in this area, however, enabled us to additionally consider the power relations reflected in this categorization of older gay men by health institutions, and also to theorize the sources of normative power from which these discursive forces were likely to have originated. As salient discourses are, in fact, often considered significant in the literature on governmentality for reflecting relations of power in any given social context (McIlvenny et al., 2016), we were compelled through our use of this analytical lens to examine these discursive forces as empirical markers of the normative context surrounding older gay men’s subjugation in health care.

Drawing on the framework of governmentality (Berard 1999; Foucault, 2000; Foucault, 2008), we cross-referenced our emerging discursive picture with the small body of literature outlining the normative conditions that have historically underpinned this group’s interactions with health institutions. In this process, we came across scholarship that documented unique barriers to health care access among gay men in the early stages of the HIV/AIDS epidemic, the discursive undercurrents of which appeared to bear similarity to those reflected in our data. Specifically, we found theoretical and empirical literature that highlighted the tendency for medical systems of this era to systemically withhold research funding and care for gay men affected by HIV/AIDS, based on the stigmatizing and often homophobic attribution of the epidemic’s growth to gay men’s non-normative sexual practices (Brier, 2009; Chambré, 2006; Cole, 1996; Epstein, 1989;
King, 2016; Rosenfeld et al., 2012). Indeed, this historical account reflected an “othering” of gay men, based on the homophobic linking of gay sexuality with promiscuity and HIV risk, that paralleled the discursive construction of older gay men’s marginalized positions as “undeserving” care recipients in present day health systems. Importantly, as our participants were all ages 50 and over, and had thus presumably experienced or witnessed the systemic exclusion of gay men (particularly those living with HIV) from health systems in the 1980s and 1990s, the discursive continuity we identified across the early HIV/AIDS epidemic and into the present day seemed particularly relevant in our analysis.

Recognizing this historical context, we began conceptualizing the discursive forces we had identified in our data as interdependent systems of homophobia and HIV stigma that had persisted through the history of the HIV/AIDS epidemic to “other” older HIV-positive and HIV-negative gay men in health settings. Indeed, given that a number of participants, regardless of HIV status, explicitly traced the origins of these discursive factors to the HIV/AIDS epidemic, and specifically discussed the distinct effects of this history on older cohorts of gay men in present day health systems, our theorizing in this area appeared well substantiated. For instance, Joshua, a 53 year-old White man who had been diagnosed HIV-positive in the late 1990s, highlighted his historically consistent, yet increasingly implicit experiences with homophobically motivated expressions of HIV stigma in health care. He explained that he and his same-age gay peers often distinctly recognized the more subtle manifestations of contemporary homophobia and HIV stigma in health systems, given the continuous exposure of older gay men to this discursive context of HIV/AIDS from earlier stages of the epidemic to the present day:

[Nowadays], when you say “HIV” [in a health care setting], it’s [still] almost like you can see they’re pulling down a shade and it says “shame” across it. It’s not only what I feel but it’s also their actions, their tone, what they say back in that moment. It’s unfortunate but I will say it’s getting better … It’s the generations behind me that are in their teens, 20’s, 30’s, they’re not feeling it the way I did and a lot of my friends who never made it, who have died. They don’t understand [why I’ve come to perceive stigma the way I do]. It’s almost like you’re talking about World War 1 to them. It’s so long ago, the 80s and 90s. [It’s like] you’re talking about something that happened far away and long ago.
Indeed, Joshua’s account reflected the discursive categorization of older gay men, in particular those living with HIV, as shameful “others” whose entitlements to care were regularly delegitimized. More importantly, as Joshua recounted his experience with this context during the 1980s and 1990s, at a time when he himself was HIV-negative but had friends who were living with the illness, the quote illustrated the unique and historically continuous exposure of both older HIV-positive and HIV-negative gay men to this discursive climate through the HIV/AIDS epidemic. Finally, the participant explained that as a consequence of older gay men’s long-term positioning within this discursive environment as marginalized “others,” many in this group had come to readily recognize the ubiquity of homophobia and HIV stigma in health systems in a way that their younger counterparts often did not.

Had we not utilized Foucauldian governmentality to identify and conceptualize the potential sources of normative power from which the discursive “othering” of older gay men in our sample appeared to originate, we would have perhaps failed to account for the historical forces of homophobia and HIV stigma underpinning this phenomenon. In other words, whereas the framework of situational analysis alone enabled us to recognize salient discursive factors (i.e., homophobia and HIV stigma) involved in constructing the health care experiences of older gay men in our study, our application of governmentality provided us with the means to more comprehensively situate this finding in its sociohistorical context of the early HIV/AIDS epidemic. In turn, our situational analysis of older gay men’s health care experiences, and the discursive elements constructing this domain, more fully accounted for the social and historical conditions underpinning both. Given the importance of developing a contextually rich account of the area under investigation in studies informed by situational analysis (Clarke, 2003; Clarke, 2005), our use of Foucauldian governmentality in this example greatly enhanced not only the quality of our theorizing, but also our practice of this methodological approach.

3.6.2 Subject Formation: Conceptualizing How Contextual Factors Operate on Key Actors within a Situation under Study

Within situational analysis, investigators often consider how contextual factors wield influence on phenomena of interest, and in particular, on key actors within the situation under study (Clarke, 2003; Clarke, 2005). As such, in order to answer our research questions, we were compelled to examine how the contextual elements we had identified, including the discursive
forces described above, were deployed to shape the subjugation of older gay men across health systems. We utilized Foucauldian governmentality’s rich account of subject formation to guide and enrich our analytical work in this area (Berard, 1999; Foucault, 2000; Foucault, 2008; Walters, 2012). The usefulness of governmentality in this domain is perhaps not surprising, given that this tradition conceptualizes subject formation as involving the use of normative power to establish and reinforce subject position (Berard, 1999; Foucault, 2000; Foucault, 2008). Thus, this lens informed our analyses surrounding the movement, deployment, and effects of contextually situated power within a given social context.

Consistent with situational analysis (Clarke, 2003; Clarke, 2005), after highlighting discursive factors that appeared salient in the health care accounts of older gay men, we started directing our attention to the ways in which these contextual factors shaped the experiences of key actors (i.e., older gay men) within our situation of interest. The central theme that arose at this stage in the analytical process highlighted the tendency for direct care activities in contemporary mainstream health systems to frequently reflect historical expressions of homophobia and HIV stigma associated with the HIV/AIDS epidemic. Several of the participants discussed being identifiable as subjects of risk, primarily when their identities as older gay men became visible in health systems, and in these instances described being treated with measures of surveillance and control based on aging gay men’s historically perceived and stigmatizing proximity to HIV/AIDS. For instance, Vic, a 60 year-old White man who was diagnosed with HIV less than five years prior to his involvement in the study, recalled a relatively recent event in which he was placed in isolation after being perceived as being a gay man. Interestingly, as the event took place eight years prior to the study, and thus before the participant was diagnosed with HIV, his treatment as a subject of risk in this situation was medically unnecessary, and therefore potentially reflective of the effects of systemic homophobia and HIV stigma on health institutions’ practices with older gay men:

It was assumed then I was gay just because, you know, their reaction to my voice … hand movements, whatever. So, it was assumed that you were doing bad things … One time I had to go [to the hospital], and they assumed I was [gay] … I had a very high fever so they put me in isolation, and everybody came in gloves and masks …
And I actually asked them why they did, they said well, you know, you’re HIV … I said no, I’m not, I’m just a gay man who’s sick right now.

As is apparent in Vic’s account, the participant experienced medical practices that were seemingly shaped by the stigmatizing association of aging gay men with HIV infection risk. This example, like several others in our data, highlighted the tendency for discursive forces of homophobia and HIV stigma to shape the delivery of direct medical care in mainstream health institutions, and in so doing, to actively construct and act on older gay men as subjects of surveillance and control. Indeed, given that Vic was subject to intrusive precautionary measures based on his perceived identity as a gay man, and thus his near-immediate, yet unsubstantiated association with HIV, this example illustrates the homophobic and stigmatizing construction of older gay men as disease vectors whose lack of medical autonomy may systemically be seen as justifiable.

Although we identified several other examples of explicit “risk containment” practices that illustrated how key discursive forces actually wielded influence over older gay men in health care, this theoretical picture did not account for certain nuances in our data. Specifically, as participants often discussed the covert nature and effects of homophobia and HIV stigma in health care, we recognized that highly visible manifestations of these factors (such as Vic’s experience described above) were unlikely to represent the most ubiquitous processes of subject formation among older gay men in contemporary health systems. Indeed, given that participants such as Miguel, a 62 year-old Latino man who had been diagnosed with HIV in the mid 1990s, described implicit expressions of homophobia and HIV stigma as perhaps being most common in contemporary health systems, we were compelled to develop insights that accounted for more subtle processes of subject formation:

Now [health care providers] are more careful than before because [there are laws] against homophobia. And they don't want to lose their jobs, right? And they have to be polite, they have to be. But … you can feel it. I can feel it.

Conceptualizing how it was that participants such as Miguel would indirectly “feel” the presence of homophobia and HIV stigma, and conduct themselves accordingly in health systems, became critical to us in developing a more comprehensive analysis of our area of study.
It was at this stage that Foucauldian governmentality (Berard, 1999; Foucault, 2000; Foucault, 2008) became particularly useful in directing and enriching our analytical process. Given that the theoretical literature on governmentality often conceptualizes subject formation as processes that can take place at any level of social organization, ranging from the intrasubjective to the broadly systemic (Berard, 1999; Walters, 2012), we began to search across our data for sites of subject formation we may have initially overlooked. In particular, we considered accounts that appeared to reflect intrasubjective processes of self-governance, as the literature on governmentality foregrounds the tendency for subjects to self-regulate in response to the largely implicit normative conditions of health and other service institutions across contemporary neoliberal regimes (Brown & Knop, 2014; Larsen, 2011; Lemke, 2011). Drawing on this theoretical framework to primarily centre our attention on processes of subject formation located within the subject, we began to develop more nuanced insights on these phenomena. Most importantly, we started examining the potential internalization of key discursive forces among older gay men in health care settings, namely homophobia and HIV stigma associated with the HIV/AIDS epidemic, and explored how such intrasubjective processes had come to shape the conduct of these men across health systems.

Utilizing the lens of governmentality, we began recognizing that participants would often acknowledge the ubiquitous construction of older gay men as historically intelligible subjects of HIV risk, based on their past experiences with more overt expressions of stigma and discrimination. We also noted that participants with such awareness perceived the need to strategically manage information on their sexual identities and HIV status in order to avoid experiencing stigma, discrimination, and other barriers to care. In other words, we ascertained that subject formation among older gay men in health settings was often the product of self-regulatory conduct, which many in our sample had developed historically in response to the discursive conditions of medical institutions. Our interview with Gerard, a 50 year-old HIV-negative Filipino man who also had professional experience as a health care provider, contained excerpts that specifically drew attention to self-regulation as a primary vehicle of subject formation among our participants. Specifically, after acknowledging that gay sexuality had historically become almost exclusively relevant as a determinant of HIV infection risk in the context of health care, at a later point in the interview he discussed the likely tendency among
older gay men to withhold information on their sexual identity in health care settings, unless medically necessary, for fear of encountering homophobia and HIV stigma. He also emphasized what he believed was a particular threat, among older HIV-positive gay men, of encountering disease-related stigma, and thus acknowledged the relevance of managing information on HIV regardless of his own status:

Unfortunately, sexual orientation is always equated to … health care needs that are associated with sex, right? Like apart from say … the possibility of contracting, I don't know, HIV, there is nothing too specific [that is recognized] about, you know, being [gay]. … It’s tough enough that as an older gay man, you … make sure that you don’t necessarily speak about your sexual orientation to health care providers when it’s not pertinent to your health care issues. But to have to be HIV positive, I can just imagine that it’s probably going to be like a double stigma.

Similar to Gerard, many other participants described managing information on sexual identity and HIV status diligently, either by withholding these details in order to avert discrimination, or by disclosing HIV-positive status proactively to avoid being accused of jeopardizing the “safety” of health care providers. Many, in describing this selective exposure of their identities, acknowledged the historically stigmatizing association of gay sexuality with HIV infection risk as a factor that often influenced such conduct, and thus highlighted this practice as a product of the discursive factors surrounding this group’s subjugation in health systems.

As this pattern of self-regulation represented perhaps the most common and prominent mechanism of subject formation across our interviews, we foregrounded intrasubjective processes in explaining how discursive forces identified in our findings appeared to effect subjugation on older gay men in health care. Foucauldian governmentality, by enabling us to direct our attention to a site of subject formation that may have not immediately been apparent in our data, helped us generate insight on the most salient processes involved in constructing conditions of subjugation among older gay men in health care. Relying exclusively on situational analysis, we would have been able to identify less occluded social processes underpinning older gay men’s marginalization in health care, including the overt discrimination of this population by health care providers. However, governmentality provided us with the
means to highlight and conceptualize the less explicit, but more ubiquitous mechanisms at play. Given, within situational analysis, the importance of comprehensively delineating how contextual factors identified in a field of study actually appear to construct or shape the phenomenon of interest (Clarke, 2003; Clarke, 2005), our use of Foucauldian governmentality to conceptualize subject formation supported the development of a nuanced and robust analysis of aging gay men’s subjugation within health systems. In other words, our utilization of this framework enabled us to generate a more complete and sophisticated account of how contextual elements within our situation of interest could wield influence on the social conditions and experiences of the key actors in our study.

3.6.3 Theorizing Fluidity in the Use of Power

Our use of Foucauldian governmentality provided us with a strong conceptual framework from which to account for and theorize the fluid use of power in the context of older gay men’s health care experiences. Given, with situational analyses, the recognized need to acknowledge and examine the multidirectionality of influence across elements of a context under study (Clarke, 2005), we were particularly compelled to examine not only exercises of power that established and reinforced older gay men’s marginality in health systems, but also the range of resistive activities used by this group to reclaim power in these settings. Indeed, not only did the pursuit of this objective align well with the tenets of situational analysis, but it additionally accounted for the historic role of gay men in challenging expressions of homophobia and HIV stigma in mainstream health institutions (Brier, 2009; Chambré, 2006, Epstein, 1989). Given, within governmentality studies, the explicitly recognized capacity for the subject to express and mobilize resistance within any context of subjugation (Berard, 1999; Foucault, 2010; Foucault, 2011; Sanger, 2008; Walters, 2012), the use of this framework appeared particularly well-suited to helping us locate and theorize resistive uses of power among older gay men in health care.

Within the theoretical tradition of governmentality (Foucault, 2008; Foucault, 2010; Foucault, 2011; Walters, 2012), the potential for resistive activity is believed to exist in any event where power is deployed to construct conditions of subjugation. Accordingly, we reviewed examples of subject formation in our participants’ accounts to identify co-existing expressions of resistance located within these experiences. Using the lens of governmentality, we came across a number
of specific examples in which participants would disengage with health care systems, intentionally, when they perceived the presence of homophobia and HIV stigma in these settings. Although these avoidant behaviours among older gay men could be interpreted to reflect their subjugation in mainstream health institutions, in several of these instances participants described either locating alternate systems of care, or reshaping their subsequent experiences with stigmatizing care settings in order to better meet their health needs. In other words, these acts of disengagement, when coupled with the participants’ attempts at finding other means of addressing their health concerns, reflected the reclamation of autonomous power among older gay men within contexts of subjugation.

Our interview with Derek, a 54 year-old white man who had been diagnosed with HIV approximately 20 years prior to the study, contained examples that highlighted this participant’s disengagement, and negotiated reengagement, with a health care setting where he had perceived homophobically motivated HIV stigma. The participant first indicated that after he had encountered a nurse at his family physician’s clinic whose demeanour appeared to reflect the homophobic and stigma-laden “othering” of older HIV-positive gay men in health care, he had initially chosen to remove himself from this setting:

Once [when] I thought I had pink eye … I went to a triage nurse [at my clinic], and she was going through my file and first says, “you’re here quite a lot.” … After she examined me, she says, “we’re short two doctors today; no one can see you.” And I left, and I should’ve just sat there … I felt as if, well, you’re gay and you’re HIV, you don’t really deserve health care, and I was boiling.

In spite of Derek’s initial retreat from this clinic, he complained about this incident to another nurse at the same setting, who encouraged him to explicitly refuse care from the care provider described above. After accepting this advice, Derek chose to stay with his family physician, primarily as the clinic was well connected with other medical providers and as such granted him streamlined and timely access to specialist care:

I jokingly told another nurse, and … my nurse said to me, “Derek, you have control of your health care – ask not to see her.” So she’s still there [but] I don’t see her … I’m not gonna leave cause [it’s] my clinic … when I have to see the gastro guy, they
bring him to me. They bring him to the clinic. Certain people they bring to the clinic so I don’t have to go to the hospital.

Derek’s account was significant in that it highlighted his identification and use of resources within his family physician’s clinic to potentiate his agency as a health care user, despite the presence of discursive forces in this context that positioned him as an “undeserving” subject of medical care. Indeed, the participant’s decision to articulate his need for stigma-free health services, and to continue receiving care from his resource-rich clinic on his own terms, reflected the participant’s ability to wield resistive power against a process of subject formation that would have otherwise led to his disengagement from this health system. Perhaps most notably, the manifestation of homophobically motivated HIV stigma, as a key discursive force underpinning the prospect of Derek’s subjugation in this setting, arguably functioned as a catalyst for this participant’s deployment of resistive power. Foucauldian governmentality, by drawing our attention to processes of subjugation as themselves being generative of resistance (Foucault, 2008; Foucault, 2010; Foucault, 2011), enabled us to recognize resistive practices that appeared to emerge fluidly from within oppressive conditions of subject formation. Without our application of this analytical orientation, we would have likely overlooked numerous examples of resistance, including the one recounted by Derek, given their entanglement with processes of subjugation.

Although Derek’s account represented resistance at the level of direct care, it is important to note that several participants similarly described the reclamation and use of power, in contexts of subjugation, to effect resistance at the institutional level. Some, in particular, indicated that in light of the systemic challenges they had experienced historically across health systems, they had taken part in initiatives to challenge institutionalized conditions of homophobia and HIV stigma in health care settings.

Colin, a 54 year-old white man who had been living with HIV for over twenty years, was one such participant. After describing having experienced significant neglect and hostility in health systems, particularly during the early stages of his diagnosis in the early 1990s, he explained that he had, as a result of these experiences, become involved in activities spearheaded by AIDS service organizations (ASOs) to educate junior physicians in providing more inclusive care.
Colin had, in other words, capitalized on his visibility as an older gay HIV-positive health care recipient to speak directly about his experiences with new physicians, and in so doing, drawn on his subjugation to attempt fostering emancipatory change for himself and his peers at the level of medical practice:

I've done with [a local ASO] … a number of training scenarios with second year medical students and they have [an] open house and people go in and speak with them and it doesn't necessarily have to be about positive - being positive, but it's all about the healthcare system and what people come to expect. And I think that's sort of a very good exposure to get students in that second year to get them starting to interact with different communities, so to speak, and say yes, there are these people, like I said before, you're going to encounter them, so the sooner you become comfortable or aware of these other communities, the easier it'll be in the long run for everyone.

Several HIV-negative participants, particularly those with past experiences of caring for HIV-positive partners and friends, also discussed partaking in institutionally-targeted resistive activities after being exposed to the subjugation of their same-age peers in health care settings. Patrick, an HIV-negative 77 year-old white man, for instance, indicated that he had, while taking care of his late HIV-positive partner, challenged a local AIDS service organization during the early epidemic to resist fatalistic narratives of death and dying often used to describe HIV-positive gay men during this time (Sontag, 1989). He had particularly done so as he believed acquiescence with these narratives reflected complacency with the dearth of research on HIV prevention and treatment at the beginning of the epidemic:

Actually, I was [angry] here, in Canada, at that time because we found out my partner had HIV, and the only course that [a local ASO] had that they could give [was], “How to deal with a dying partner?” … I got very angry at [the organizer] for teaching that course because it gave no hope and it was based upon very little education or research.

As the participant described having taken on various leadership roles within ASOs and LGBTQ community organizations since this period, his account was significant in illustrating the
importance of his exposure and resistance to this context of subjugation as a catalyst for his career in activism and community development.

The foregoing examples, which we highlighted after considering the potential ensnarement of multi-level resistive activities within conditions of subjugation, were made apparent to us once we used the lens of Foucauldian governmentality to conceptualize the fluid deployment of power in older gay men’s experiences with health care. Indeed, the literature on governmentality not only recognizes the possibility for normative power to be wielded on subjects within a given social context, but also for resistive power to subvert and reshape dominant systems of control at any level of social organization (Foucault, 2008; Foucault, 2010; Foucault, 2011). Accordingly, we were able to locate systemically influential expressions of resistance across the participants’ accounts of their marginalization in systems of care. In other words, the lens of governmentality assisted us in identifying and conceptualizing expressions of resistive power that were constructed and deployed by older gay men, from within their positions of subjugation, to effect micro- and macro-level change in health institutions.

As situational analyses are considered more robust when they account for the fluid directionality of influence across elements of the context under investigation (Clarke, 2005), the use of Foucauldian governmentality at this stage of our analytical process enhanced the quality and rigour of our findings. Indeed, as use of this lens enabled us to comprehensively map not only the conditions of subjugation underpinning older gay men’s health care experiences, but also the salient expressions of resistance used by this group to challenge its marginalization in health settings, governmentality enabled us to develop a sophisticated analysis of the movement of power within our area of study. Had we not utilized our Foucauldian framework to identify and conceptualize the subversive activities of older gay men in our sample, we may have failed to capture the full extent of this population’s expressions of resistance. Indeed, given the theoretical co-existence of subjugation and resistance within the tradition of governmentality (Berard, 1999; Foucault, 2000), our application of this lens directed our attention to all sites of subjugation as potential sources of resistance, and thus forced us to consider the otherwise less apparent subversive activities of older gay men that were ensnared within this group’s marginalization in health systems. Accordingly, by drawing on governmentality to enrich our
conceptualization of the study’s findings, we were able to render a more comprehensive and nuanced account of the movement of power within the context of health care for older gay men.

3.7 Discussion

In this paper, we analyzed the utility of using Foucauldian governmentality (Berard, 1999; Foucault, 2000; Foucault, 2008; Walters, 2012) to guide the conceptual activities associated with our situational analysis of older gay men’s experiences with health care systems. After providing a summative overview of our study’s primary findings, we outlined three ways in which we were able to draw on this theoretical framework to deepen our analysis of a context that appeared, based on our review of the literature (Elliott et al., 2014; Emlet, 2006; Rosenfeld et al., 2012), to be influenced and constructed by complex systems of power. Specifically, we discussed the role of this lens in enhancing our insights into the function of discursive forces, namely those rooted in homophobia and HIV stigma, as contextual factors that appeared to be salient in constructing conditions of subjugation among older gay men in health care. We also analyzed the usefulness of governmentality in helping us generate insight into how salient contextual factors, including interdependent discursive expressions of homophobia and HIV stigma, influenced and operated on the experiences of the key actors in our situation of interest. Finally, given our use of governmentality to highlight and theorize salient expressions of resistance among older gay men within a context otherwise shaped by conditions of subjugation, we examined the capacity for this lens to assist us in identifying and conceptualizing fluidity in the deployment of power. Accordingly, this paper illustrates the capacity for Foucauldian governmentality to support rich conceptualizations of power, particularly when it is used to guide situational analyses of contexts marked by complex systems of normative domination.

Considering the complementarity of various theoretical frameworks with situational analysis is relevant and necessary. Indeed, as this methodological approach, unlike more postpositivist traditions of grounded theory (Corbin & Strauss, 2015), recognizes the researcher’s role in co-constructing empirical accounts of any phenomenon under study (Clarke, 2003; Clarke, 2005), the investigator’s theoretical position requires consideration. Most importantly, evaluating the usefulness of various theoretical frameworks, across examples of situational analysis, is likely to lead to greater appreciation of the role of theory in conceptualizing and enriching the findings of
studies informed by this methodology. Such theoretical reflexivity would also, notably, yield understanding on the appropriateness of using certain frameworks to examine specific questions of interest. Despite the need for such literature, there remains a considerable dearth in works that explore the potential synergies between various theoretical lenses and the practice of situational analysis. Given the postmodern underpinnings of this methodological approach (Clarke, 2003), it is perhaps even more surprising that to our knowledge, no attempts have yet been made to consider the utility of postmodern and poststructuralist theoretical literature in enriching situational analyses. Accordingly, we believe our study offers important implications for the future of this contemporary approach to grounded theory.

As situational analysis often requires researchers to recognize and highlight how power originates, moves, wields influence, and is exchanged across the elements of any given context under study (Clarke, 2003; Clarke, 2005; Clarke & Keller, 2014), the utility of governmentality in delineating these social processes makes it a particularly compelling framework for enriching the insights of studies informed by this approach. Given that the literature on governmentality conceptualizes power as fluid, and thus dynamic and deployable at any level of social organization (Foucault, 2000; Walters), this analytical orientation is particularly conducive to supporting the cross-context and multi-level mapping of power often required in situational analyses (Clarke, 2003; Clarke, 2005).

Foucauldian governmentality is, most notably, an appropriate theoretical framework for complementing situational analyses that centre questions surrounding the use and effects of normative power in any context of interest. Although this implication is perhaps self-evident, it is important to note that despite a growing interest in the use of situational analysis to inform studies that prioritize questions of normative power (Atallah, 2017; King & Leask, 2017; Pérez & Cannella, 2013; Salazar & Öhman, 2015; Salazar et al., 2016), Foucauldian governmentality is yet to be used as an analytical framework in this body of literature. Indeed, although this literature has in the past integrated a range of theoretical lenses, including critical eco-systemic (Atallah, 2017), intersectional (Perez & Cannella, 2013), and relational gender theories (Salazar & Öhman, 2015; Salazar et al., 2016), this area of work has yet to explicitly draw on Foucauldian governmentality as a complementary theoretical orientation. Given that a number of scholars within this field of study have, in their situational analyses, recognized complexities in
competing systems of discursive power (King & Leask, 2017; Salazar & Öhman, 2017), as well as fluid exercises of power across multiple levels of social organization (Pérez & Cannella, 2013; Salazar et al., 2016), governmentality’s capacity for supporting dynamic and multi-level conceptualizations of power may be of particular interest to those in this growing area. The incorporation of this lens may not only enrich insights derived from existing situational analyses, but may also inspire new questions surrounding the deployment and influence of normative power across a variety of social contexts.

Despite the promise of Foucauldian governmentality as a complementary theoretical framework for studies informed by situational analysis, it is important to note some limitations of utilizing this lens in the context of such empirical work. Most importantly, as governmentality has, in the past, been problematized for sometimes failing to adequately recognize the agency of subjects whose marginality frequently becomes the central issue under investigation (Savransky, 2014), it is important to deliberately incorporate analyses of resistance in conjunction with conceptualizations of subjugation that are generated through applications of governmentality. In addition, as marginalized groups may experience subjugation based on their unique exposure to intersecting, yet substantively distinct systems of oppression (Yuval-Davis, 2006), governmentality-informed analyses of normative power may fall short if they do not account for specific systemic forces shaping the social context of a group whose experiences are of primary interest to the researcher. Accordingly, the use of governmentality, within the practice of situational analysis, may be particularly compelling if it is utilized together with critical theories that comprehensively account for diverse systems of marginalization potentially at play in any given area of study.

Situational analysis, as an approach that was initially designed to challenge the allegedly postpositivist conventions of traditional grounded theory (Clarke, 2003; Clarke, 2005), continues to evolve and adapt in its applications across diverse disciplines and substantive areas (Clarke & Keller, 2014). Given the growth in studies that are informed by this methodological orientation, it is particularly pertinent at this point in time to consider how conceptual processes conducted in studies informed by this methodology can be enriched with complementary theoretical frameworks. As already noted, such reflexive theorizing will likely assist researchers using this approach to select theoretical frameworks with the greatest potential to comprehensively address
conceptual issues reflected in their areas of interest. In light of a recent call against oversimplifying the application of situational analysis, and thus exploring new ways of complicating and innovating the practice of this method (Clarke & Keller, 2014), this prospect is not only relevant, but also timely.
Chapter 4

4 "They Haven't Made a Slot for us Yet": Conceptualizing the Health Care and Social Service Needs of Older Gay men Living with HIV

Abstract: In this paper, we use the findings of a qualitative study on older gay men’s health care experiences to identify the service needs of gay men aging with HIV. Our analysis is based on the accounts of 16 HIV-positive gay-identified men, ages 50 and over, who were each interviewed about their experiences with systems of care in 1-1.5 hour semi-structured interviews. We draw on an intersectional framework, which theoretically accounts for and highlights interlocking expressions of marginalization in groups affected by multiple systems of oppression, to outline the service needs of older HIV-positive gay men based on the apparent social conditions underpinning the health care accounts of participants in our study. To this end, we highlight the practical, social, and mental health needs of this population, as well as services that could be designed to address these concerns. We also emphasize the relevance of training caring professionals serving older HIV-positive gay men to better recognize and account for the unique social conditions and experiences of this population, and articulate the need for initiatives that more fully engage those in this group in the development and delivery of services intended for their use.

4.1 Introduction

The social conditions and experiences of older HIV-positive gay men are increasingly acknowledged as unique, yet often under-examined (Cahill & Valadez, 2013; Rosenfeld et al., 2012). Given this group’s exposure to stigma and discrimination, often on the basis of sexual identity, HIV status, and age, among other factors (Addis et al., 2009; Emlet, 2006; Fredriksen-Goldsen et al., 2011; King, 2016; Rosenfeld et al., 2012), this emerging recognition is perhaps unsurprising. The dearth of research on older HIV-positive gay men’s experiences and needs in the context of health care and social services represents perhaps the most salient gap in the scholarship in this area. Indeed, despite the growth in literature on health care and social services targeting older lesbian, gay, bisexual, transgender, and queer (LGBTQ) adults more
In this paper, we analyze data from a qualitative study of the health care experiences of older gay men to understand the service needs of aging gay men living with HIV across systems of formal care. We use intersectionality as a primary theoretical framework and consider the needs of this population across both health care and social services, as participants commonly referenced both systems of care in describing their service-related experiences and concerns. Importantly, in this paper, the terms “older” and “aging” will be used interchangeably to refer to adults ages 50 and older, consistent with literature in the area of LGBTQ aging (Addis et al., 2009).

4.2 Older HIV-Positive Gay Men in Health Care and Social Services

There exists a small, but rich body of literature that captures the unique social context surrounding the experiences of older HIV-positive gay men (Addis et al., 2009; Emlet, 2006; Emlet et al., 2017; Lyons et al., 2010; Masten, 2015). Empirical studies in this area have, among other issues, highlighted the tendency for this group to experience systemic expressions of homophobia, HIV stigma, and ageism in health care and social services (Emlet, 2006; Lyons et al., 2010; Masten, 2015; Owen & Catalan, 2012). Owen and Catalan’s (2012) work, for instance, has foregrounded the tendency for some older HIV-positive gay men to fear the prospect of requiring residential care in late life, given their past experiences with hostility in mainstream health settings. The expected and experienced stigma and discrimination that aging HIV-positive gay men encounter has been found to impede this population’s access to services across formal systems of care (Emlet, 2006; Lyons et al., 2010; Masten, 2015; Owen & Catalan, 2012; Rosenfeld et al., 2012). Interestingly, despite the significance of health care and social services as sites in which older HIV-gay men have been found to experience salient expressions of marginalization (Owen & Catalan, 2012), no attempts have yet been made to more exclusively and comprehensively examine the health care and social service experiences and needs of this population. Instead, the scholarship in this area has indirectly contributed to insights surrounding this group’s interactions with services through broader investigations of this population’s aging experiences (Lyons et al., 2010; Masten, 2015; Owen & Catalan, 2012), or
through more general studies of this population’s exposure to stigma and discrimination (Emlet, 2006).

Existing literature has, aside from highlighting contemporary systems of care as volatile contexts for older HIV-positive gay men, outlined the historical conditions that appear to have uniquely shaped this group’s relationships with these service settings. Throughout the 1980s and 1990s, gay men affected by HIV/AIDS experienced systemic homophobia within health care institutions (Cole, 1996). These experiences are recognized to have constructed aging HIV-positive gay men’s mistrust of health care and social services today (Fredriksen-Goldsen et al., 2011; Rosenfeld et al., 2012). Indeed, some have articulated the likely role of this social and historical context in shaping this population’s expectations that future encounters will likely include stigma and neglect (Rosenfeld et al., 2012; King, 2016). Informal communities of support arose to address the needs of HIV-positive gay men during the height of the epidemic (King, 1995; Omoto & Crain, 1995), and catalyzed the development of community-based organizations that have come to represent viable alternatives to mainstream health and social service systems among aging HIV-positive gay men (Brier, 2009; Chambré, 2006; Rosenfeld et al., 2012).

In light of the complexities underpinning the social conditions and overall experiences of older gay men living with HIV, it is perhaps surprising that focused analyses of this population’s contemporary health care and social service needs remain limited (Rosenfeld et al., 2012). Greater insight on this population’s service needs is not only necessary insofar as it would inform the development of care systems that more appropriately address the concerns of a highly marginalized group, but it is also timely and relevant in light of the growing and increasingly visible communities of HIV-positive gay men ages 50 and over (Cahill & Valadez, 2013).

4.3 Intersectionality as a Theoretical Framework for Research on the Experiences and Needs of Older HIV-Positive Gay Men

Given the significant heterogeneity in populations of older LGBTQ adults, including gay-identified men living with HIV, LGBTQ aging scholars have frequently emphasized the importance of accounting for diversity in research involving older sexual and gender minorities (Addis et al., 2009; Fredriksen-Goldsen et al., 2011). More specifically, those in this area have highlighted the need to comprehensively acknowledge and examine variations in the social
realities of older LGBTQ adults based on factors such as sexual identity, age, HIV status, socioeconomic status, race, and gender, among others (Addis et al., 2009; Cronin & King, 2010; King, 2016; Rosenfeld et al., 2012). As focused inquiry on older HIV-positive gay men’s social issues continues to be limited, there exist no known attempts at delineating the potentially multifaceted service experiences and needs of this heterogeneous population (Rosenfeld et al., 2012). Based not only on the potential variability of older HIV-positive gay men’s social conditions, but also the dearth in works that account for such diversity, we use intersectionality (McCall, 2005; Yuval-Davis, 2006) as a framework to extrapolate and conceptualize this population’s service needs without obscuring important particularities and sources of distinction within the group.

Intersectionality, as a theoretical framework, originates in traditions of antiracist feminist scholarship (Crenshaw, 1989; Collins, 2009; hooks, 1981; Watkins-Hayes, 2014; Yuval-Davis, 2006). Scholars writing in this theoretical tradition have historically problematized models of oppression that highlight single axes of difference (e.g., “race” or “gender”) as bases for theorizing the experiences of those who may be marginalized on multiple grounds (Crenshaw, 1989). Some, drawing on this critique, have proposed intersectional frameworks that instead account for cohabiting systems of oppressions, based on dimensions such as race, gender, class, sexual orientation, and others, which together construct the social contexts of Black women and others who are subjugated at various intersections of marginality (Cho et al., 2013; Collins, 2009). These markers of difference are believed to reinforce one another, or produce altogether unique realities, when consolidated in the context of subjective experience (Collins, 2009). The framework of intersectionality has grown significantly, since its inception, as an analytical vehicle for conceptualizing the policy and practice implications of research surrounding the social conditions and experiences of multiply marginalized groups (Bowleg, 2012; Dhamoon, 2011; Grace, 2013; Hankivsky et al., 2010; Hankivsky et al., 2014). For instance, Hankivsky et al. (2010) have explored the utility of intersectionality as a framework for informing research and policy in the area of women’s health in Canada, given its potential to foreground, account for, and help conceptualize responses to social issues underlying the health disparities of women across intersecting dimensions of marginality. Given the aforementioned strengths of intersectionality as a framework for not only identifying and theorizing the complex confluence
of systemic forces that affect multiply marginalized groups, but also for developing policy and practice implications of such inquiry, this framework is useful in helping to elucidate the service needs of older gay men living with HIV.

Importantly, we use the work of McCall (2005) to guide our application of intersectionality in this paper. This writer differentiates between intersectional projects that investigate intercategorical, intracategorical, and anticategorical complexities. Whereas the first area of scholarship includes projects that are concerned with examining distinctions between multiply marginalized groups and dominant reference groups, the second field prioritizes the study of within-group differences among populations marginalized on multiple grounds, and the third comprises scholarship in which the apparent essentialism of group identities is altogether interrogated and deconstructed. Given our primary objective of identifying service needs that both account for the marginalization of older HIV-positive gay men at the intersection of old age, sexual identity, and HIV status (Rosenfeld et al., 2012), and also reflect the potential heterogeneity within this group based on factors such as socioeconomic status, ability, and race (Addis et al., 2009; Fredriksen-Goldsen et al., 2011; King, 2016), we primarily draw on intersectionality to investigate intracategorical complexity. As we outline the service needs of older HIV-positive gay men below, we not only consider each in light of the common sources of intersectional marginalization that affect this group (i.e., gay identity, HIV status, and age), but also explore unique expressions of each need based on configurations of difference among those in this heterogeneous population.

4.4 The Study: Investigating Subjugation and Resistance in Older Gay Men’s Experiences Navigating Health Care Systems

In our original study (Kia et al., 2018), we examined the health care experiences of older gay men, and included both the accounts of HIV-positive (n=16) and HIV-negative (n=11) adults. Given our particular interest in studying health care as a context in which older gay men are systemically exposed to stigma and discrimination (Addis et al., 2009; Rosenfeld et al., 2012), we were initially interested in analyzing the health care accounts of our participants as empirical sources of insight on the subjugation of older gay men in health care. In light of the marginalization of both older HIV-positive and HIV-negative gay men in health care (Rosenfeld
et al., 2012; McNutt & Yakushko, 2013), we were inclined to examine the accounts of these two groups together.

Recognizing the influential movements that gay men spearheaded during the HIV/AIDS epidemic of the 1980s and 1990s to advocate for research on the disease (Epstein, 1989; Smith, 1990), and to create community-based networks of HIV prevention and care (Brier, 2009; Chambré, 2006), we complemented our analyses of subjugation with considerations of how older gay men appeared to challenge or resist conditions of marginalization in health care. Accordingly, we designed our study explicitly to explore the health care experiences of older gay men not only as sources of insight on subjugation, but also as grounds for substantiating this group’s resistive activities in health systems.

Our findings broadly indicated that across health systems, both older HIV-positive and HIV-negative gay men were systemically constructed as subjects immutably associated with the HIV/AIDS epidemic, and were often accordingly identified as carriers of HIV infection risk, regardless of medical history or engagement in risk behaviours. In line with this central theme, processes of subjugation reflected in our participants’ accounts often encompassed the establishment and reinforcement of this stigmatizing subject position among older gay men in health care. In contrast, mechanisms of resistance comprised older gay men’s attempts at challenging or subverting such positioning in health systems.

Of note, although a Foucauldian framework (Foucault, 2000; Foucault, 2008) was used to frame our research questions, and to initially address these questions based on our examination of participant interviews, the analysis presented in the current paper is not directly informed by Foucauldian scholarship. Instead, an intersectional framework (McCall, 2005; Yuval-Davis, 2006) is used to identify the service-related priorities of this population, from within insights we developed through our study of subjugation and resistance in older gay men’s health care experiences, to account for multiple systems of marginalization that may be at play in shaping conditions of service use among this population. The central questions we explore in this paper, which we address drawing exclusively on the accounts of HIV-positive participants, are as follows: (1) what are the service needs of older HIV-positive gay men in health care and social services, based on the health care accounts of those in this population?; and (2) how do these
needs vary or develop at intersections of marginalization represented in our sample of gay men aging with HIV?

4.5 Methods

Our qualitative study was informed methodologically by a poststructuralist approach to grounded theory, known as situational analysis, which involves the inductive and iterative collection and analysis of qualitative data (Clarke, 2003; Clarke, 2005). Unlike most other variants of grounded theory, however, this framework requires particular attention to contextual factors that appear salient in shaping or constructing the phenomenon under investigation (Clarke, 2005). These contextual factors are often illustrated visually on a diagram known as a situational map, and are actively used to inform and guide the development of theory (Clarke, 2003). Although the use of situational analysis characterized our research with both HIV-positive and HIV-negative participants, in this paper we rely entirely on the data we collected from HIV-positive men in our sample, as already noted.

4.5.1 Statement on Ethics

This study underwent review and approval by the University of Toronto’s HIV Research Ethics Board (#33523). All of the study’s participants provided informed consent prior to their engagement in the research process.

4.5.2 Participants

4.5.2.1 Recruitment

We recruited participants with the support of community-based social service agencies serving older lesbian, gay, bisexual, transgender, and queer (LGBTQ) adults, along with AIDS service organizations (ASOs) in Toronto, Canada. After developing partnerships within this network of service providers, we disseminated our recruitment materials to workers employed in these settings, and requested that they identify and contact individuals who would potentially be eligible and interested in participating.

Despite primarily relying on the study’s initial eligibility criteria to inform the recruitment process, we also incorporated elements of theoretical sampling in this process. Specifically, as
our initial review of the literature revealed to us that factors such as poverty and race often intersected with experiences of encountering homophobia and HIV-stigma among older gay men (Addis et al., 2009; Fredriksen-Goldsen et al., 2011), and as our preliminary analyses of the emergent data appeared aligned with the insights of this literature, we incorporated measures to capture as much socioeconomic and racial heterogeneity in our sample as possible. To this end, we included questions surrounding income and race in our screening process, and attempted to invite participants representing the greatest potential diversity along these dimensions of difference.

4.5.2.2 Sample

Our sample comprised 27 participants who met the study’s eligibility criteria by (1) self-identifying as gay men, (2) being 50 years of age or older, (3) and having had three or more experiences of having sought or received health care from physicians and/or nursing professionals in the preceding 12 months. We deliberately recruited a large proportion of HIV-positive men (n=16), given the particular proximity of this group to the HIV/AIDS epidemic, and thus the relevant insights of these adults on the role of this history in shaping contemporary health care for older gay men. Of the 16 HIV-positive participants, 11 were in their 50s, four were in their 60s, and one was in his 70s. Although we recognize that a significant proportion of men who have sex with men (MSM) may not necessarily use the identifier “gay” to describe themselves, we intentionally limited the study to those who labeled their sexual orientation accordingly. Given our interest in examining experiences of subjugation and resistance that were specific to adults currently self-identifying as “gay men,” this measure was necessary. Indeed, as scholars have recently drawn attention to the significant heterogeneity of MSM, and thus the need to account for distinctions in the experiences and needs of gay, bisexual, and other men in this broader category, our decision to exclusively investigate older gay men’s experiences aligned well with scholarship in this area (Parker et al., 2016). Although, within our sample of HIV-positive participants, the majority of the men identified as White or Caucasian, our sample reflected socioeconomic heterogeneity, given its inclusion of 11 adults who were exclusively reliant on government-administered financial benefits, and 5 who had access to private sources of income. Table 1.1 provides an overview of the demographic characteristics of both HIV-positive and HIV-negative gay men recruited for participation in our study.
4.5.3 Data Collection

After providing informed consent, each of our participants took part in a 1-1.5 hour semi-structured interview conducted by this paper’s first author. Questions included in our interview guide were designed to elicit discussion on: (1) participants’ experiences with seeking and receiving care in health settings, (2) the perceived quality of care the participants received across health care, and (3) participants’ reflections on navigating formal systems of care as older gay men. Of note, HIV-positive participants were also invited to comment on their engagement with services specific to those living with HIV, and were additionally asked to reflect on their experiences of utilizing health services as HIV-positive care recipients. We developed and refined our interview items by identifying potentially relevant areas of investigation highlighted in the literature on older gay men, and by soliciting and incorporating feedback from our community partners.

As our interview protocol was intentionally designed to be sufficiently open-ended to enable clarification and any relevant follow-up questions based on the insights of individual participants, we did not alter or refine our protocol throughout the data collection process, as is often the case in grounded theory studies (Clarke, 2003; Corbin & Strauss, 2015). All of our interviews were audio-recorded and transcribed verbatim. Following the completion of each interview, we compensated all of our participants with $20 CAD in cash, and two public transportation tokens.

4.5.4 Data Analysis

Consistent with situational analysis (Clarke, 2003; Clarke, 2005), we analyzed our data iteratively by reading and continuously comparing field notes and interview transcripts, and using these emergent data to develop analytic categories that appeared to capture salient themes reflected in the accounts of participants. We then used these themes to develop a theoretical picture of subjugation and resistance in older gay men’s health care experiences. Among HIV-positive participants, some of these themes included being cast by service providers as “undeserving” of care on the basis of homophobia and HIV stigma, and being often exclusively identified and acted upon as carriers of HIV risk. Although we initially analyzed the accounts of HIV-positive and HIV-negative participants separately, we then reanalyzed these data together to
construct theoretical insight on the marginalization and resistive activities of older gay men in health care across both subsamples.

As situational analysis often requires focused attention to contextual factors that appear to shape the phenomenon under investigation, we highlighted and illustrated contextual elements of health care that appeared particularly significant in influencing processes of subjugation and resistance among older HIV-positive and HIV-negative gay men across health settings in a working situational map (Clarke, 2003), and used this diagram to inform our process of theorizing. Some of the contextual elements we highlighted specifically included discursive forces and institutional practices that appeared salient in constructing and reinforcing processes of subjugation and resistance reflected in our preliminary themes. The final rendition of our study’s situational map appears in this paper as Figure 1.1.

The analysis presented in our paper reflects an intersectional reconceptualization of the data provided by HIV-positive participants to identify the diverse health care and social service needs of this population. We began this process by reviewing our analysis of older HIV-positive gay men’s subjugation and resistance across systems of care, specifically to delineate implications of this analytical picture for services accessed by this group. Following this stage, and drawing upon McCall’s (2005) notion of intracategorical complexity, we searched for and highlighted salient intra-group distinctions, across dimensions of marginalization represented in our data (i.e., socioeconomic status, ability, and race), and drew on this process to refine our interpretation of older HIV-positive men’s health care and social service needs.

4.6 Findings: Conceptualizing Older HIV-Positive Gay Men’s Needs Across Health Care and Social Services

4.6.1 Specialized Support Services for Older HIV-Positive Gay Men in Systems of Care

Most importantly, HIV-positive participants in our study regularly indicated that older gay men living with the disease were often not recognized as a population with distinct experiences across contemporary health and social service systems, and that therefore services frequently failed to address their unique needs in areas such as employment, personal care, and mental health. This finding is perhaps unsurprising, as present day networks of HIV care across industrialized
societies were primarily founded during the 1980s and 1990s, at a time when HIV was still conceptualized as an acutely life-limiting condition often affecting younger gay men, and thus were not developed to support older adults living chronically with HIV (Cahill & Valadez, 2013; Owen & Catalan, 2012; Rosenfeld et al., 2012). Len, a 54 year-old white man who had been living with HIV for over 15 years, not only explicitly named the lack of attention to the priorities and concerns of older HIV-positive gay men in health care and social services, but also highlighted the psychosocial needs of this population that were often left unmet as a result of this group’s historical and ongoing invisibility across systems of care:

It’s almost like they haven’t made a slot for us yet. It’s like, okay, we had the panic, I didn’t die, you kept me alive … Help me have a life. I’m not an HIV person, I’m a person living with HIV. I don’t want to just live. I want to have a life. I need to do something. And you don’t have that the older you get.

Indeed, Len juxtaposed the presence of medical systems that had supported his physical survival – along with that of other gay men – during the HIV/AIDS epidemic (“we had the panic, I didn’t die”), together with the lack of resources currently in place to enrich his quality of life as an older adult with a limited access to meaningful support and activities (“I need to do something”) intended specifically for gay men aging with HIV. Accordingly, his account reflected the invisibility of his social position, across systems of care, as an older HIV-positive gay man whose priorities had evolved beyond having access to medical treatments for HIV. As this theme of invisibility, particularly relative to older HIV-positive gay men’s psychosocial needs, surfaced commonly, our analysis begins with a consideration of specialized support services that could be developed to recognize and exclusively address the direct, yet extra-medical concerns of this population.

4.6.1.1 Practical Support: Employment Services

Several HIV-positive participants discussed the importance of employment in helping them achieve optimal quality of life. Many described having had to forego their participation in the labour market in order to become eligible for disability benefits that would cover treatment and care for HIV, and in this process, expressed having lost their socioeconomic stability and their overall sense of purpose. Accordingly, participants commonly highlighted the need for policies
and services that would enable them to find and accept employment opportunities, not only to address the conditions of poverty frequently characterizing the lives of older HIV-positive gay men, but also to enrich the overall quality of life of these adults. Indeed, Joshua, a white 53 year-old man who had been diagnosed with HIV nearly twenty years prior to the study, emphasized the critical need for such brokerage:

Our age group, they don’t know what to do and I think that’s an area that they need to work on. It’s like, “Okay, so these people need jobs.” We’re not talking about Tim Horton’s [Canadian chain coffee shop], we’re talking a job, a meaningful job, because volunteering, I do so much [at a local ASO] that’s meaningful and it’s huge. It’s a job and I do as much as someone who’s getting paid in their actual career so there should be no difference in that to me. I don’t understand that. You have all these new recruits coming out of school, which is terrific, but there’s this age group that really needs to get out there. They’re not dying, they’re living, so you have to help them find a reason to do that.

Not only did Joshua articulate the meaningfulness of policies and services that would help connect older HIV-positive gay men with employment, but by drawing on his experiences as a volunteer with a local ASO, he also highlighted the knowledge and skills he would be able to contribute in contexts he was perhaps more familiar with than those without his lived experience. As the men frequently reported having accumulated a diverse range of credentials and employment experiences (ranging from retail and manual labour to postgraduate training and professional experience) prior to being diagnosed with HIV, Joshua’s account of his potential for labour market participation is representative of the experiences of other men in our sample. Notably, this participant also highlighted the importance of employment as a means for affirming this population’s survival in the context of a disease that, particularly at the intersection of old age, is often incorrectly equated with premature death (“They’re not dying, they’re living”).

Several participants indicated unique barriers to employment that would need to be addressed in the design and delivery of work-enabling policies and services for specific groups of older HIV-positive gay men. For instance, Arturo, a 62 year-old Latino man who had been diagnosed with HIV in the mid 1990s, indicated that he frequently encountered attitudes that reflected an
“acceptance” of his status as unemployed, primarily since he was over the age of 60, and also because he spoke with an accent that he believed exposed his status as a Latino newcomer. To substantiate the presence of these attitudes, he described a recent conversation he had had about his labour market potential with an acquaintance who was also a health care provider:

Then we were talking about the jobs or whatever and she came to me, oh, no offence, but you know what? You don't get a job, you know why? It's because [of] your accent!

Accounts such as Arturo’s reflect the need for policies and services that challenge perceptions of certain categories of HIV-positive men, including newcomers, as being particularly “unemployable.” They also emphasize the need for services that support these adults in navigating job markets that may stigmatize them not only on the basis of HIV status, sexual orientation, and age, but also on factors that are located at intersections of race and immigration status.

4.6.1.2 Practical Support: Access to Safe Personal Care

Several participants discussed the importance of receiving assistance with personal care and other daily activities, particularly when experiencing physical limitations or declines associated with HIV and co-occurring conditions, and highlighted the need for this care to be free of stigma and discrimination. Many specifically identified this need after recounting experiences with care providers who were hostile to the men on the basis of their identities as older gay adults living with HIV. For instance, Vic, a 60 year-old participant who had been diagnosed with a HIV in the five years preceding the study, indicated that while requiring home-based wound care during a period of illness, he had encountered a home care worker who was uncomfortable with his sexual orientation and HIV status:

He walked in with his scarf, his gloves, and his winter jacket on and was about to take the padding out of my open wound and re-pad it [and] I went, “no! You’re not even going to take your scarf off?” … And you can feel that with anybody, like you can feel that with a physiotherapist, you can feel that with an OT, any sort of feeling that they’re not comfortable with you that will come through.
In light of such encounters, Vic noted that he had started specifically requesting home care providers who would not “have problems” with who he was as an older HIV-positive gay man:

I always do tell the supervisor, because they come and talk to you first, that I’m HIV-positive, I’m a gay male, if there’s going to be any … nursing staff hav[ing]
problems with it just please don’t send them. I mean, I got to the point of, like, just
don’t send them…

Importantly, this participant highlighted the significance of gay- and HIV-friendly personal care, particularly as this kind of care is commonly delivered in home environments that often represent rare bastions of safety for a highly stigmatized population:

That’s my safe space, it’s my home, it’s the only place I feel really safe and you’ve just made it unsafe for me.

Vic’s account is notable in that it reflects the distinct concerns of those in this population who also live with episodic, chronic, and lifelong disabilities. Indeed, given that narratives such as Vic’s were particularly frequent among those in our sample living with disabilities, many of whom required such care, and additionally echoed this participant’s fears and experiences associated with hostile home-based support, these expressions of need may be situated at the intersection of age, gay identity, HIV status, and disability. As the co-occurrence of disability is often highlighted as a common experience among those aging with HIV (Cahill & Valadez, 2013), the concerns of those at this intersection specifically merit consideration.

4.6.1.3 Peer-Based Systems of Social Support

The theme of isolation featured frequently in the accounts of HIV-positive participants. Many explained this experience as being the product of having lost multiple HIV-positive partners, friends, and others in their social networks over the course of the epidemic. Devon, a 59 year-old White man who had been diagnosed with HIV almost 25 years prior to the study, commented on this experience explicitly:
There was a time when I used to have a lot of friends, but in the last few years, I’ve lost a lot of friends. And it’s just sort of like, you know, you’re basically, you’re surviving on your own now.

Recognizing this context of isolation, a number of participants highlighted the difficulties they believed were brought on by a lack of informal social support. Devon, for instance, remarked on the emotional burdens of living with a limited social network by discussing the link between his poor mental health and his loneliness:

Well, I mean, I do get depressed, you know? And that comes and goes … And I think that’s just out of boredom more than anything else, you know? Like I live alone, I have two cats, I live alone, but I get lonely. So it gets depressing.

In addition to emphasizing the significant emotional challenges associated with isolation, participants most commonly described fearing the prospect of requiring assistance with personal, financial, and medical decision-making in the absence of family or friends they felt they could trust. For instance, Ian, a White 58 year-old man who had been living with HIV for over twenty years, explained that he was aware of only one estranged nephew who could assume responsibility for his affairs, but that he was reluctant to entrust the distant relative with this role if he were to decline in his capacity to make his own decisions:

You certainly want the person to be good at it, to be good at returning phone calls and answering letters and be proactive – [someone who’s] going to make sure those forms are filled out and sent back to the government, especially when there’s almost zero assets, there’s zero money … [this role] would all go to my eldest nephew and, like, we don’t speak. He has nothing to do with me. Do I want him making decisions about my end of life care? No. So that’s something to take home and put in your pocket is this group of men are going to be out there and they’re going to be dealing with loneliness, isolation and without the assistances they need for their end of life care.

Participants who were more advanced in their illness, as well as those exclusively reliant on government-administered benefits, most commonly discussed the material risks associated with
lacking a robust social network. In this way, Ian’s account is highly indicative of the conditions that likely render social support particularly critical among poor gay men aging with HIV, and especially among those who live with – or at risk for – developing physical and cognitive impairment, and in turn illustrates the salience of poverty and disability as intersections marked by unique expressions of service need.

Some participants, drawing on their concerns and fears surrounding their experiences of isolation, specifically articulated the need for formal and well-resourced systems of peer support to assist older HIV-positive gay men with their unique needs. Joshua, who was quoted earlier in this paper, noted that such institutionalized peer support could, in addition to addressing the profound isolation experienced among gay men aging with HIV, assist those in this population with navigating and accessing complex systems of health care. He also emphasized the appropriateness of such programming, given the salience of peer-based services targeting HIV-positive people in the earlier stages of the epidemic:

If healthcare agencies or hospitals would open up to sort of what the Buddy Program [a peer support service to assist HIV-positive gay men with navigating health care systems] was like when AIDS first came out … the peerage can be for aging or for whatever. If that was sort of opened up, that’d be great because it’s helping on both sides but the people that are at the healthcare setting, having a need and looking for a service, if they had someone that they would share it with, lean on, whatever. You know, “That’s your new buddy.” I think that might be beneficial.

In developing peer-based systems of support, it may be necessary to ensure the inclusion and engagement of peers whose lived experiences adequately reflect the heterogeneity of older HIV-positive gay men. Given, indeed, that the social conditions and experiences of aging gay men living with HIV are not only shaped by stigma and discrimination based on age, gay identity, and HIV status, but are also often affected by factors such as poverty and disability (e.g., as reflected in Ian’s story), along with racism (e.g., as illustrated in Arturo’s account), it is important to ensure diversity in the composition of those providing peer support service along salient dimensions of difference.
4.6.1.4 Mental Health Support for Past Traumas

HIV-positive participants often discussed having experienced multiple traumatic events throughout their lives, with many specifically emphasizing the high frequency and severity of these events following their HIV diagnoses. The men, for instance, commonly indicated having lost family support after “coming out” as gay men living with HIV, having grieved the HIV-related deaths of multiple partners and friends, and having encountered numerous barriers to accessing medical and social services as a result of the stigma and discrimination targeting HIV-positive gay men during the early HIV/AIDS epidemic. Our interview with Ross, a white 56 year-old man who had been living with HIV since the 1980s, included several accounts of traumatic loss, including his estrangement from his family after he had been diagnosed with HIV: “it was when I told my mother that I had the AIDS virus, from that point on I lost all family.”

Reflecting on his numerous losses, Ross explained the importance of formal mental health support, often in the form of psychotherapy, in helping him survive these experiences. Indeed, although he recognized the stigma attached to seeking and receiving services from mental health professionals, he also acknowledged the critical nature of such health care in mitigating his depressive symptoms and lowering his risk of suicide:

I wish I could get over the thoughts that sometimes life is not worth living, but that’s just something the medical profession can help me get over … [but] depression is something that people can’t deal with on their own [and] If you don’t reach out you don’t get help.

Interestingly, Ross noted that he only began accessing psychotherapy after being diagnosed with cancer in the year preceding the study, and had not been offered such support prior to this life event. He had also been able to secure such mental health support only after explicitly requesting it:

I was only [offered support] because I asked myself. I had to ask the doctor who does the non-invasive cancer treatments if he could book me an appointment with a social worker.
Given the frequency and magnitude of traumatic experiences to which HIV-positive participants in this study had been exposed through the epidemic of the 1980s and 1990s, it is surprising that most articulated a lack of mental health services offered specifically to address the needs of older HIV-positive gay men. Although Ross was eventually able to secure such care for his mental health, he had only been able to do so after experiencing a health concern that was largely unrelated to HIV, and until this time had been forced to manage his trauma in isolation for over twenty years. The need for specialized mental health support targeting the needs of older HIV-positive gay men, while often lacking, is arguably relevant and necessary based on this population’s systemic exposure to traumatic life events.

4.6.2 Training for Service Providers Caring for Older HIV-Positive Gay Men

HIV-positive participants in our study overwhelmingly described feeling distressed after stigmatizing and discriminatory encounters with health care and social service providers. For instance, Harold, a 58 year-old white man who had been diagnosed with HIV within the 10 years prior to our study, indicated that he had regularly encountered care professionals who appeared hostile to aging gay men living with HIV, and substantiated this claim by recounting a recent (<12 months preceding the study) event in which a physician had openly expressed his discomfort with the participant’s HIV status:

I was uncomfortable when [the doctor] was doing something, and he yelled at me: “don’t move around, I don’t want your contaminated blood contaminating me!” And I’m like … I froze [after that] … I just hear those words over and over … hearing that contaminated thing, like towards me, like I wasn’t a person, I was nothing.

Based on experiences such as Harold’s, several participants highlighted the relevance of educating health care and social service professionals on recognizing, accounting for, and addressing the systemic conditions of stigma and discrimination to which older HIV-positive gay men are regularly exposed. For instance, Ian, who was quoted earlier in this paper, described the tendency for older HIV-positive gay men to often expect hostility across systems of care, particularly given the prolonged exposure of this group to homophobia and HIV stigma through the HIV/AIDS epidemic. Drawing on this observation, he remarked on the relevance of educating service providers on older HIV-positive gay men’s historical and ongoing
marginalization as subjects of the HIV/AIDS epidemic, and through this training, encouraging them to use communication styles with these adults that minimize their perceived fears of experiencing stigma and discrimination whenever they enter formal systems of care:

[I] think that [service providers] should … go the extra mile with those people [older HIV-positive gay men] knowing that, you know, these people have been marginalized. They may still be marginalized in a setting like [a local Catholic hospital]. Are we going to make sure we - make sure there’s no space there where the person would insert that thought [that they are being discriminated against]?

As Ian remarked on the need for service providers to be acquainted with the historical marginalization of aging HIV-positive gay men across systems of care, his account highlighted the need for health and social service professionals to be cognizant and account for expressions and effects of stigma that may be unique to the intersection of late adulthood, gay identity, and HIV stigma.

Based on the foregoing, it may be necessary to train providers serving older HIV-positive gay men on recognizing that those in this group, as members of a population with historically disproportionate exposure to the stigma and discrimination targeting HIV-positive people, may be particularly susceptible to expecting and experiencing hostility within systems of care. Service providers may also benefit from learning communication skills that convey safety and openness with marginalized groups, including gay men aging with HIV, many of whom are likely to fear mistreatment by those in positions in power.

4.6.3 Mobilizing Older HIV-Positive Gay Men’s Capacities to Develop and Improve Services

At the level of policy and programming, participants living with HIV frequently discussed the need for engaging older HIV-positive gay men in helping to develop and improve health care and social services for this population. Many, in particular, discussed the uniqueness of this population’s service needs at the intersection of age, gay identity, HIV-status, race, and socioeconomic status, among other dimensions of difference. Highlighting the distinctiveness of these needs, these men frequently emphasized the need for capitalizing on the direct insights of older HIV-positive gay men in designing and delivering services intended for their use. Some,
describing the marginalization they additionally experienced on the basis of race, socioeconomic status, ability, and other factors, also specifically discussed the relevance of ensuring that such processes of community-based program development account comprehensively for the diversity of older HIV-positive gay men’s lived experiences.

Terrell, a 57 year-old HIV-positive man who identified as Afro-Caribbean-Canadian, and was a long-term volunteer for an AIDS service organization serving HIV-positive people of colour, noted the importance of drawing on the lived experiences of those in diverse communities of older HIV-positive gay men to develop services that would comprehensively reflect their specific experiences and needs. He also directed attention to the function of such work in cultivating meaning and purpose among older HIV-positive gay men, many of whom ordinarily lack exposure to activities that affirm their knowledge, skills, and experiences:

Maybe start with where people are at right now, you know, in community, in society … service users [need] to inform, to advise, to create, to be more hands-on, to actually have a function and a purpose in the community, to carry forward programs … You service [programs] yourself for your community, for you, by you, through you.

Several participants provided examples of how their lived experiences could be mobilized to inform services addressing the needs of older HIV-positive gay men. For instance, Colin, a 54 year-old man who had been diagnosed with HIV more than twenty years prior to the study, indicated that he had recently started collaborating with a local ASO and a nearby university to assist with training medical students. Through in-classroom talks and interactive activities in which he had shared his lived experiences, he had attempted to humanize the stories of older HIV-positive gay men for prospective physicians, and had in turn helped cultivate greater sensitivity among service providers his peers would potentially encounter in the future:

I've done with [a local ASO] … a number of training scenarios with second year medical students and they have open house and people go in and speak with them … And I think that's sort of a very good exposure to get students in that second year to get them starting to interact with different communities, so to speak, and say yes, there are these people, like I said before, you're going to encounter them, so the
sooner you become comfortable or aware of these other communities, the easier it'll be in the long run for everyone.

As HIV-positive men in our study commonly discussed the importance of training programs for caring professionals serving older HIV-positive gay men, this participant’s account illustrates how community-based knowledge and experience may be mobilized to address an identified need. Although Colin described collaborating with institutions that had willingly come to support his work with medical students, participants often remarked on the absence of initiatives that regularly fostered and supported such community engagement.

4.7 Discussion

Older HIV-positive gay men merit recognition as a population with distinct service-related experiences and needs. The accounts of participants living with HIV in our study substantiate the relevance of such recognition, given not only the unique concerns highlighted by these men, but also the group-tailored responses many believed would be necessary to improve the accessibility and overall quality of health care and social service for those in this population. The insights outlined in this paper, specifically, highlight an array of specialized services, including practical support for issues such as employment and personal care, institutionalized sources of peer-based social support, as well as mental health services, that could address the particular service issues of older HIV-positive gay men across these domains. They also draw attention to the need for education targeting service providers on the unique social conditions, experiences, and needs of gay men aging with HIV, and indicate the relevance of mobilizing the existing capacities of older HIV-positive gay men to develop and enhance services designed to address the needs of this population.

As no focused attempts have yet been made at identifying and conceptualizing the health care and social service needs of older HIV-positive gay men, this paper’s analysis in this area represents a unique contribution to the limited literature on the experiences of this population. Given that exposure to stigma and discrimination, particularly in the context of health care and social services (Rosenfeld et al., 2012), has often been identified as being key in shaping the social conditions of gay men living with HIV (Emlet, 2006; Owen & Catalan, 2012), this paper most importantly offers insights on cultivating service environments that better account for and
address these systemic forces. For instance, the recommendation to develop stigma-free personal care services for older HIV-positive gay men, and to train service providers to more readily understand the context of stigma and discrimination that often typifies the lives of those in this population, both potentiate targeted changes to health care and social services that could render them more accessible to gay men aging with HIV. Although, in the context of our original study (Kia et al., 2018), both older HIV-positive and HIV-negative gay men expressed the need for stigma-free home-based health services, and discussed the relevance of service provider training, the former group discussed these needs much more prominently, and situated these priorities in the context of their elevated exposure to intersecting expressions of homophobia, HIV stigma, and ageism. It is also important to mention that HIV-positive men, by virtue of having to access health systems more frequently to receive chronic care services for HIV and co-occurring conditions, appeared more explicitly affected by the lack of appropriate services and the presence of undertrained service providers.

Aside from outlining services that could help to address the marginalization of older HIV-positive gay men across systems of care, this paper also provides examples of resources that could function to mitigate the experiences of grief and isolation that are often said to characterize the social conditions of this group (Emlet et al., 2017; Masten, 2015; Owen & Catalan, 2012). Indeed, the mental health services and institutionalized systems of peer-based support that we describe in our paper could, respectively, address these issues. Finally, contributions of this paper are evident in its identification of service needs – and accompanying policy and practice responses – that have yet to be consistently recognized in the growing body of literature on the experiences of older HIV-positive gay men. For instance, participants’ wishes for employment, for greater engagement in the development and delivery of services intended for their use, and for services that may be designed to formally account for and address these needs, reflect novel insights surrounding the service-related priorities and concerns of older HIV-positive gay men.

Interestingly, although participants whose accounts formed the basis of our analysis regularly described service needs typically associated with managing HIV-related decline (e.g., personal care services), they also emphasized their wishes for resources not typically thought to align with the priorities of those living long-term with chronic illness, namely those related to securing employment (Owen & Catalan, 2012). The co-existence of these apparently conflicting service
needs reflects the varied health status of older HIV-positive gay men. As HIV is increasingly considered both a chronic condition with the potential to lower life expectancy, and simultaneously an illness with symptoms and long-term effects that can be medically delayed over the span of years through consistent exposure to treatment (Cahill & Valadez, 2013), this finding is not surprising. Given that HIV trajectory, among gay men aging with HIV, appears to vary systemically as a function of experience with factors such as racism and poverty (Cahill & Valadez, 2013; Samji et al., 2013), it is particularly important to recognize that differences in the service needs and priorities of those in this group may reflect lifetime exposure to diverse and intersecting sources of marginalization. Recognizing that older HIV-positive gay men may have vastly different service-related priorities, depending on both their overall health at specific points in time, and the systemic factors that are likely to shape their experiences of living with HIV, may be critical in establishing services that comprehensively address the multifaceted needs of this population and account for intersectional differences underpinning the health of those in this group.

Beyond accounting for the diversity of older HIV-positive gay men relative to the health status of these adults, we were able to conceptualize variations in the service needs of this population along social dimensions of difference through our use of intersectionality (McCall, 2005; Yuval-Davis, 2006). More specifically, drawing on the work of McCall (2005), we developed insight into the intracategorical heterogeneity of aging HIV-positive gay men’s service needs, particularly when sources of marginalization based on race, socioeconomic status, and (dis)ability appeared to intersect with old age, gay identity, and HIV status in the context of health care and social services. For instance, whereas both immigrant older HIV-positive gay men of colour interviewed in our study seemed to articulate similar employment needs as their White, Canadian-born counterparts, we highlighted the likelihood for the employment concerns of those in this group to be met with greater indifference by service providers, given the diminished value assigned to the skills and experiences of these men, and thus their perceived ‘unemployability,’ based on their social locations as racial minority newcomers. Similarly, we conceptualized the provision of stigma-free personal care services as being perhaps most critical in supporting the service needs of aging HIV-positive gay men living with episodic, chronic, and
lifelong disabilities, and we emphasized the likely salience of peer-based social support for those in this population experiencing physical and cognitive decline in conditions of poverty.

Importantly, given the low number of participants in our sample identifying as non-White (n=3), it is important to note that our analysis is likely incomplete in its conceptualization of service needs that may be unique to older racialized HIV-positive gay men. Accordingly, focused inquiry is needed in this area to generate more comprehensive insight into the service-related experiences and concerns of this multiply marginalized group. Given the theoretical utility of intersectionality (McCall, 2005; Yuval-Davis, 2006) in helping us investigate the heterogeneity of service needs along certain dimensions of difference within our sample of older HIV-positive gay men, scholars engaged in this field of study may wish to draw on literature associated with this theoretical tradition to frame and guide future work in this area. Indeed, as scholars in the area of HIV and aging have cautioned that lacking attention to intersectional differences in this field could result in a body of literature that fails to account for the experiences and needs of multiply marginalized HIV-positive older adults with distinct social conditions and service priorities (Cahill & Valadez, 2013), this recommendation is particularly relevant.

It is important to note that our analysis of service needs among aging HIV-positive gay men, although supported empirically, represents a preliminary attempt at gauging the concerns and priorities of this diverse population across systems of health care and social services. Given, in particular, that our work is based on the accounts of HIV-positive participants living in a large urban centre in Canada, it is likely that similar analyses of this population’s service needs in other contexts may yield novel and unique insights, and contribute to a more nuanced rendition of this group’s issues in formal systems of care. A growth in empirically grounded studies of older HIV-positive gay men’s service-related experiences and concerns, in turn, may contribute to an evidence base that could be used to catalyze improvements in the overall quality and accessibility of health care and social services for this historically marginalized population.
Chapter 5

5 Discussion

5.1 Introduction

Drawing on a qualitative study of older gay men’s health care experiences, my doctoral research examined the subjugation and resistance of this group across contemporary health systems. I chose this area of study based not only on the limited body of literature that indicates older gay men’s historical and ongoing exposure to stigma and discrimination in health care settings (Emlet, 2006; King, 2016; McNutt & Yakushko, 2013; Rosenfeld et al., 2012), but also on the continued dearth of research focused exclusively on health care as the site of analysis. The qualitative study, which involved interviews with both HIV-positive (n=16) and HIV-negative (n=11) gay men ages 50 and over in Toronto, was informed by situational analysis, which is an approach to grounded theory rooted in symbolic interactionism and poststructuralist thought (Clarke, 2003; Clarke, 2005). The study’s research questions and analytical processes were framed and guided theoretically by Foucauldian governmentality (Foucault, 2000; Foucault, 2008; Walters, 2012) and intersectionality (McCall, 2005; Yuval-Davis, 2006).

The dissertation was divided into three main chapters that each outlined key insights gleaned from my doctoral research. Chapter 2 provided an overview of my research findings, specifically by outlining the three primary themes generated in the process of reviewing the participants’ interviews and constructing theory from within this analytical process. These three themes, collectively, drew attention to the sociohistorical role of the HIV/AIDS epidemic in constructing older gay men as subjects who were marginalized in health systems based on their perceived association with the disease. Whereas processes of subjugation primarily involved the construction or reinforcement of this subject position among older gay men across systems of care, resistance often encompassed the subversion of aging gay men to such positioning.

The first of the primary themes highlighted the role of homophobia and HIV stigma, within health institutions, as interdependent discursive forces that constructed older gay men’s stigmatizing association with HIV risk through the early history of the illness and into the present day. The second theme elucidated older gay men’s perception of contemporary medical
practices as artifacts of their subjugation by health systems in the context of HIV/AIDS history, and thus their ongoing disengagement from mainstream health services. Finally, the third theme highlighted the visibility of the aging gay body in health systems as both a carrier of HIV infection risk among health care providers, and as a vehicle of resistance among older gay men who capitalize on this visibility to address stigma and discrimination against aging gay men in health institutions.

Drawing on the study’s analytical process and the resulting insights, chapter 3 examined the utility of Foucauldian governmentality (Foucault, 2000; Foucault, 2008) as a theoretical framework for informing and guiding the practice of situational analysis. Specifically, this section considered the usefulness of governmentality as a conceptual tool for enriching situational analyses surrounding the uses and effects of power. First, governmentality was highlighted as a framework that enabled the conceptualization of discursive forces found to be salient in the accounts of older gay men involved in the study. The relevance of this lens was additionally justified based on its role, within the study’s analytical process, in directing attention to complex intrasubjective processes of subject formation underpinning the subjugation of older gay men in health systems. Finally, drawing on the study’s insights surrounding older gay men’s resistance in health care, governmentality was discussed as a lens with potential to foreground the fluid movement of power in studies informed by situational analysis.

In chapter 4, the analyzed accounts of the study’s HIV-positive participants were used to identify the health care and social service needs of this population. Of note, intersectionality (McCall, 2005; Yuval-Davis, 2006) was used as a guiding theoretical framework to attend to and conceptualize the service priorities of older HIV-positive gay men whose social conditions were marked by diverse systems of oppression, including poverty, ableism, and racism. The relevance of specialized support services targeting the needs of older HIV-positive gay men, particularly in the areas of employment, personal care, peer-based support, and mental health, were foregrounded, given the men’s accounts of interacting with services that often overlooked the unique concerns of older HIV-positive gay men. Aside from outlining these service priorities, the chapter also highlighted the need for targeted training on the social conditions and experiences of aging HIV-positive gay men for service providers supporting this population. Finally, the importance of engaging older HIV-positive gay men across health care and social
services was emphasized, given that the participants often expressed a need for directly supporting the design and development of services intended for their use.

The chapters comprehensively address the study’s primary research questions. Chapter 2 not only illustrates processes of subjugation and resistance that are reflected in the accounts of older gay men interviewed for this study, but it also draws attention to the comparative sociohistorical significance of the HIV/AIDS epidemic in constructing these processes for both HIV-positive and HIV-negative adults in the sample. Chapter 3, by drawing on the study’s analytical process to substantiate the utility of Foucauldian governmentality as a complementary framework for enriching situational analyses, offers insight into theoretical and methodological traditions that may best be suited to investigating the sociohistorically contextualized subjugation and resistance of older gay men in health care. Finally, chapter 4 highlights the unique relationship of older HIV-positive gay men with the HIV/AIDS epidemic by identifying distinctive health care and social service needs that this population has developed largely in response to the social and historical forces surrounding gay men aging with HIV. Together, the chapters contribute significantly to the literature on LGBTQ aging by foregrounding the importance of considering the role of social history in shaping the present day issues of older sexual minority adults. In addition, the three works highlight the relevance of theoretical and methodological frameworks grounded in poststructuralist thought, including situational analysis (Clarke, 2003), Foucauldian governmentality (Foucault, 2000; Foucault, 2008), and intracategorical intersectionality (McCall, 2005; Yuval-Davis, 2006) in informing empirical inquiry in the field of LGBTQ aging. In the sections that follow, I discuss these and other contributions of my work with greater specificity, and discuss limitations of this study.

5.2 Research Contributions

Scholarship in the area of lesbian, gay, bisexual, transgender, and queer aging continues to be limited, but has experienced growth in recent years (Addis et al., 2009; Brotman et al., 2003; Brown, 2009; Cahill, 2007; Finkenauer et al., 2012; Fredriksen-Goldsen & Muraco, 2010; King, 2014; Rose & Hospital, 2015). Scholars in this area have emphasized not only the higher proportion of adults over age 50 in industrialized societies (Addis et al., 2009; Cahill & Valadez, 2013), but also the increasingly visible communities of aging LGBTQ populations (Brown,
2009; Cahill, 2007), in justifying the expansion of literature in this field of study. They have also, in arguing for the growth of an evidence base that could serve to inform responses to the adverse social conditions of aging LGBTQ adults, emphasized the marginalization of older sexual and gender minorities at the intersection of old age and LGBTQ status (Brown, 2009). As already noted, no known studies have focused exclusively on the health care experiences of older gay men as a primary site of analysis, despite the existence of research that has indicated the significance of health systems as contexts in which stigma and discrimination are most prominent for gay men over the age of 50 (King, 2016; Lyons et al., 2010; Rosenfeld et al., 2012). Accordingly, this study addresses an important gap in the empirical literature on LGBTQ aging more broadly, and in the research on older gay men more specifically.

In relation to the more general literature on the experiences of older LGBTQ adults, this study draws attention to the potential importance of social history in uniquely shaping the contemporary realities of older adults within particular categories of LGBTQ identity. Given the prominent role of the HIV/AIDS epidemic in constructing older gay men’s health care experiences in this study, this inquiry foregrounds some of the historically rooted forces that underpin the subjugation of aging gay men in the present day, and in so doing, indicates the relevance of examining historical influences that potentially shape the marginalization of other older LGBTQ adults. Indeed, scholars in the field of LGBTQ aging have already articulated the relevance of examining historical factors uniquely shaping the realities of distinct categories of aging sexual and gender minorities (Brotman et al., 2015; Jennings, 2007; King, 2016). As such, the contributions of this study in substantiating sociohistorically-informed inquiry in this area merit particular attention. Some have, for instance, highlighted the prominent exposure of older lesbians to involuntary psychiatric hospitalization in the decades following the Second World War, and have theorized the potentially significant role of this history in influencing this group’s contemporary expectations and experiences with health and social service institutions (Jennings, 2007; Putney et al., 2016). Others have discussed how different cohorts of older LGBTQ adults may have had varying levels of exposure to “gay liberation” movements, with those ages 70+ potentially having had limited opportunities to engage with these movements; thus, these experiences may construct the present day experiences of aging sexual and gender minorities distinctively across age cohorts (Brotman et al., 2015; Cronin & King, 2010). This study, by
empirically elucidating the salience of HIV/AIDS history in influencing processes of subjugation and resistance in older gay men’s contemporary health care experiences, affirms LGBTQ aging scholars’ theoretically-informed calls for centering relevant historical factors in the framing and investigation of research questions in this area.

Aside from highlighting the study’s contributions in the broader area of LGBTQ aging, it is also important to situate the findings of this research in the literature on older gay men’s experiences more specifically. As already noted, general investigations of older gay men’s aging experiences have revealed the tendency for this population to encounter prominent expressions of marginalization in health systems (Clover, 2006; Emlet, 2006; Fenkl, 2012; Fredriksen-Goldsen et al., 2011; Masten, 2015; Owen & Catalan, 2012; Rosenfeld et al., 2012), yet no attempts have been made to exclusively attend to the health care experiences of this population as a central site of analysis. As such, the findings of this study offer uniquely focused insights on an area of study that had, until this point, arguably remained under-examined. Consistent with its contributions to the broader field of LGBTQ aging, the study substantiates the need for researchers to recognize common historical factors that may hold significance across seemingly disparate domains of research in the area of gay aging.

Most notably, this study emphasizes the central role of the HIV/AIDS epidemic in constructing health care for both older HIV-negative and HIV-positive gay men, and thus illustrates the shared sociohistorical context underpinning the realities of the two groups. Scholars investigating aging gay men’s experiences often examine the social conditions of HIV-negative and HIV-positive adults separately (Emlet, 2006; Emlet et al., 2017a; Clover, 2006; Elliot et al., 2014; Fenkl, 2012; Gardner et al., 2014; Lyons et al., 2012; Masten, 2015), primarily based on the assumption that the two groups’ experiences are disparate enough to warrant independent analyses (Elliot et al., 2014; Lyons et al., 2012). The findings presented in this dissertation, contrary to what is frequently assumed by researchers in this area, highlight the common role of HIV/AIDS history in constructing the marginalization of older gay men, regardless of HIV status. As such, this study substantiates the need for further inquiry on the shared realities and concerns of aging HIV-positive and HIV-negative gay men. Such research would, on the one hand, account for the role of HIV/AIDS history in marking the marginalization of older HIV-negative gay men today, and on the other, it would help foreground the significance of
homophobia in influencing expressions of HIV stigma to which gay men aging with HIV are often subjected. As scholars in the area of gay aging have theorized the importance of acknowledging the influence of the HIV/AIDS epidemic in shaping older gay men’s experiences (Fredriksen-Goldsen et al., 2011; King, 2016), and have also called for inquiry that more explicitly accounts for the homophobic foundation on which HIV stigma targeting aging gay men has been based (Rosenfeld et al., 2012), such work would address key priorities identified in the literature.

Although this study highlights elements of shared experience across the health care accounts of older HIV-positive and HIV-negative gay men, it is also important to note the unique insights that this inquiry yields on the social conditions, experiences, and service needs of gay men aging with HIV. As, to date, there have been no focused attempts at empirically examining the health care and social service needs of older HIV-positive gay men, chapter 4 of this dissertation is particularly significant in its potential to address a significant gap in the literature. Emphasizing HIV-positive participants’ perceived invisibility across formal systems of care as a frame of reference, this chapter outlines the need for older HIV-positive gay men’s unique voices and priorities to be recognized in the development and delivery of health care and social services. Although the broader literature on LGBTQ aging has recognized that the marginalization of older sexual and gender minorities is often rooted in this group’s rhetorical silence (Brown, 2009), or its systemic invisibility across mainstream domains of research, policy, and practice, this study is the first to substantiate the relevance of this phenomenon for gay men aging with HIV specifically. This inquiry is also the first to identify implications of older HIV-positive gay men’s invisibility in health care and social services by outlining the needs of this group across systems of care. Indeed, chapter 4 of this dissertation highlights the relevance of services addressing the concerns of aging HIV-positive gay men, including those pertaining to employment, the provision of personal care, mental health, and peer support, as well as the need for service provider education on the issues of this population, and the engagement of this group in the development and delivery of services intended for its use.

Given recent calls for research exploring the service priorities of gay men aging with HIV (Cahill & Valadez, 2013; Rosenfeld et al., 2012), and the continued dearth of focused inquiry in this area, the insights above are important insofar as they represent an evidence base that
researchers, service providers, and community members could draw on to develop and evaluate interventions aimed at addressing the health and well-being of this population. Such a body of intervention research could serve to increase the visibility of older HIV-positive gay men as a group whose distinctive experiences and concerns have yet to be acknowledged across mainstream systems of care, and more importantly, it could inform the development of policies and programs that more comprehensively account for the needs of this marginalized population. In light of the intersectional lens (McCall, 2005; Yuval-Davis, 2006) employed in this study to conceptualize the service priorities of gay men aging with HIV, this body of scholarship would ideally highlight salient distinctions in the service experiences and needs of older HIV-positive gay men marginalized on the basis of diverse and interrelated dimensions of difference such as socioeconomic status, ability, and race.

5.3 Theoretical Contributions

Foucauldian governmentality (Foucault, 2000; Foucault, 2008; Walters, 2012) was used as a primary theoretical framework in this study to centre questions surrounding the subjugation and resistance of older gay men in the context of health care. This lens was also used to direct data analysis, and to help identify and theorize processes of subjugation and resistance reflected in the health care accounts of the study’s participants. Intersectionality (McCall, 2005; Yuval-Davis, 2006), as a secondary framework, was utilized to conceptualize variations in the social conditions and experiences of older gay men, particularly those living with HIV, based on exposure of the men to interrelated factors such as poverty, ableism, and racism. Importantly, intersectionality was also less explicitly used at the outset of the study to foreground old age, gay identity, and HIV status, within the context of health care, as a salient and underexamined intersection requiring further investigation (Cahill & Valadez, 2013; King, 2016), and to highlight HIV status in particular as a relevant marker of difference among aging gay men (Rosenfeld et al., 2012). Given the extensive use of Foucauldian governmentality and intersectionality in this study, there exist several implications of this inquiry for both bodies of theoretical literature.

The use of governmentality, in the context of data analysis, enabled the examination of the sociohistorical role of homophobia and HIV stigma as salient discursive forces underpinning the
subjected and resistance of older gay men in health settings. Accordingly, the study illustrated the potential for this theoretical tradition to foreground key systems of oppression as being influential in shaping processes of subject formation and subjugation, and as catalysts for resistive activity. As the framework of governmentality has seldom been credited for its potential to conceptualize processes of marginalization as forces of normative government, the study’s insights in this area are significant. Indeed, although this lens has often been recognized for its utility in theorizing expressions and practices of normative power found at the intra- or inter-subjective level (Walters, 2012), or at the level of the neoliberal state and the market (Gane, 2010), it has not been widely acknowledged for its potential applicability in analyses that centre questions of intersectional marginalization. This study, by highlighting the usefulness of governmentality in guiding sophisticated examinations on the origins, exercises, effects, and movements of normative power associated with systems of oppression, foregrounds primarily novel applications of this analytical orientation.

Foremost, this study illustrates the promise of Foucauldian governmentality in analyzing the sociohistorical conditions underpinning a group’s marginalization within a particular institutional context. In this inquiry, governmentality was used to highlight the HIV/AIDS epidemic as the historical foundation on which discursive manifestations of homophobia and HIV stigma targeting older gay men in health care are often based. As such, the study indicated the potential utility of this framework in directing attention to the social and historical factors that underpin and explain the pervasiveness and effects of systemic forces on marginalized groups within particular institutional and structural contexts.

Foucauldian governmentality may, as a result of the study’s fruitful application of this analytical lens, be considered a useful theoretical framework for conceptualizing the historical origins and influence of other manifestations of normative marginalization. As systems of marginality are, indeed, often rooted in historically salient institutions and structures that may have constructed and reinforced relations of power across social dimensions of difference (Collins, 2009), governmentality’s strengths in this area imply its potential utility in contextualizing contemporary manifestations of marginalization as products of social history. This type of analysis would enable researchers and theorists to enhance their insights into the conditions that continue enabling systems of oppression. For instance, as noted earlier, given the prominent role
of psychiatry in historically shaping the realities of subjugation among older lesbians in a variety of institutional settings (Jennings, 2007; Putney et al., 2016), the use of governmentality in this area may yield important insights on how this history continues to construct the marginalization of this group in contemporary mental health settings (Putney et al., 2016). Such theoretical work would, in turn, result in knowledge on what may be required to disrupt historical patterns of marginality that limit the resistance of older lesbians against institutions associated with psychiatry.

Aside from its implications for theoretical literature in the area of governmentality, the study is also notable for its contributions to intersectional scholarship. Intersectionality (Yuval-Davis, 2006; McCall, 2005), as a theoretical framework, was used at the outset of this study to foreground the interlocking of older age, gay identity, and HIV status as a salient social location requiring further inquiry and analysis. This lens was also utilized, perhaps more explicitly, in chapter four to help conceptualize and draw out variations in the service needs of older HIV-positive gay men, based on their health care accounts, along dimensions of difference such as socioeconomic status, ability, and race. Given that the analysis presented in chapter 4 drew primarily on the study’s original findings on subjugation and resistance, which were conceptualized using Foucauldian governmentality, this chapter highlighted the complementary potential of intersectional frameworks in studies informed by governmentality. As no known attempts have yet been made to explicitly complement studies informed principally by Foucauldian governmentality with intersectional analyses, the study’s contributions in this area merit attention.

Intersectionality, historically, has been concerned with accounting for and examining interlocking systems of power and oppression that shape the social conditions and experiences of multiply marginalized groups (Yuval-Davis, Collins, 2009). In other words, this lens is often used to examine systemic, cross-context expressions of marginalization, and is rarely utilized to theorize the normative, institution-specific processes of subject formation and subversion that often feature as sites of analysis in studies informed by Foucauldian governmentality. However, as the institutional subjugation and resistance of older HIV-positive gay men in this study appeared to be rooted in interdependent and sociohistorically salient systemic forces, namely homophobia and HIV stigma, intersectionality seemed promising as a framework for identifying
the service needs of this group from within this study’s governmentality-informed insights. The use of an intersectional lens, in this capacity, did in fact yield an important and nuanced analysis of older HIV-positive gay men’s needs in health care and social services. The incorporation of an intersectional framework not only helped account for the sociohistorical role of homophobia and HIV stigma in shaping and influencing the present day service priorities of aging HIV-positive gay men, but it also enabled a consideration of differences in this heterogeneous group’s service needs based on variable exposure of its members to factors such as poverty, ableism, and racism.

This study findings highlight the potential utility of an intersectional perspective in helping to tease out the insights of governmentality-informed inquiry, particularly when pervasive, interlocking systems of oppression appear to figure prominently as normative sources of government. Such practice would, indeed, help to situate studies of governmentality within their relevant systemic and structural contexts, and in turn enable scholars in this area to better conceptualize the broader social implications of such inquiry. Given the diverse applications of intersectional perspectives across substantive, methodological, and theoretical bodies of scholarship (Bowleg, 2008; Cho et al., 2013; Dhamoon & Hankivsky, 2011; Grace, 2013; Grace, 2014; Nash, 2008; Smooth, 2013; Watkins-Hayes, 2014; Winker & Degele, 2011), and the recognition of intersectionality’s malleability as a strength of this tradition (Davis, 2008), this prospect is in line with how uses of intersectional scholarship have materialized and been envisioned.

5.4 Methodological Contributions

The research contributes significantly to the literature on situational analysis (Clarke, 2003; Clarke, 2005). Most importantly, as discussed in chapter 3, the study involved the use of Foucauldian governmentality (Foucault, 2000; Foucault, 2008) to enrich insights generated in the context of data collection and analysis, and as such illustrated the potential for enhancing the practice of situational analysis through explicit incorporation of theory at various stages of the research process. For example, given the utilization of governmentality to foreground central, yet not immediately apparent sociohistorical factors involved in constructing the phenomena under investigation, this study highlighted the potential for relying on compatible theoretical
frameworks to refine attention to the range and complexity of contextual factors presenting in studies informed by situational analysis.

The above contribution is notable, given that situational analysis is anchored in the tradition of grounded theory, a methodological orientation historically characterized by relatively “unobstructed” analyses of raw qualitative data to generate theory (Corbin & Strauss, 2015; Creswell, 2007). Indeed, although constructivist and poststructuralist grounded theory scholars have, in recent years, recognized the potential value of pre-existing theory in enriching qualitative studies informed by grounded theory methodology (Charmaz, 2005; Clarke, 2003; Clarke, 2005), the empirical literature in this area predominantly (though not exclusively) continues to reflect reliance on primary textual data to generate theory, and as such frequently fails to incorporate extraneous theory for the purpose of augmenting analyses (Clarke & Keller, 2014). This study, by demonstrating the potential for relevant pre-existing theory to guide and enhance insight into salient areas under investigation in the context of studies informed by situational analysis, represents an exemplar on the use of theoretical literature to deepen interpretations of data developed in grounded theory research. Given a recent call for theoretically complicating the practice of situational analysis, specifically in light of the promise of this methodological approach for informing sophisticated interpretations of social, political, and other contextual factors shaping social phenomena of interest to grounded theory researchers (Clarke & Keller, 2014), this strength merits particular attention.

Chapter 3 included a review of the limited body of theoretically informed situational analyses relevant to this study (Atallah, 2017; Perez & Cannella, 2013; Salazar & Öhman, 2015; Salazar et al., 2016). As noted in this chapter, although all of these works reflect interest in questions surrounding the deployment and effects of normative power, none of them incorporate use of Foucauldian governmentality to enrich presented theoretical insights. Given the demonstrated utility of governmentality as a particularly relevant framework for enhancing situational analyses concerned with investigating phenomena related to the operation of normative power, this study substantiates the usefulness of a specific theoretical tradition for strengthening attention to nuance and complexity in theory generated through the practice of situational analysis. In highlighting the relevance of Foucauldian governmentality for augmenting certain types of situational analysis, the current research potentiates the growth of theoretically informed studies
informed by this approach, and is likely to contribute to the limited, yet growing body of methodological literature exploring the incorporation of relevant social science theory in the conduct of situational analysis (Clarke, 2005; Clarke & Keller, 2014).

5.5 Implications for Policy and Practice

Although chapter 4 contained an analysis of older HIV-positive gay men’s health care and social service needs, based on accounts of this study’s HIV-positive participants, it is importantly to briefly examine policy and practice implications of the study more generally. As has already been noted throughout this dissertation, the health care experiences of both HIV-positive and HIV-negative men participating in this study reflected the continued influence of HIV/AIDS history on this broader population’s expectations and experiences in the context of accessing health care. Specifically, given how men in both groups discussed frequently being stigmatized as carriers of HIV risk across mainstream health settings, and having been consistently marginalized based on their association with the illness throughout the history of the HIV/AIDS epidemic, many expected and/or experienced stigma and discrimination in health care on these grounds. Based on the salience of this overarching theme in typifying the context of health care utilization for aging gay men, implications of the research for policy and practice primarily address this finding.

First, at the level of health care policy, it is important for older gay men to be recognized for its marginalization in medical systems on the basis of its stigmatized intelligibility as a population disproportionately affected by exposure to the HIV/AIDS epidemic. Indeed, given that this study represents the first to empirically substantiate the significant role of the epidemic in shaping the contemporary health care experiences of older gay men, regardless of HIV status, its findings may be used to inform the development of health care programs and policies that better account for how this historical context has affected older gay men’s relationships with mainstream health systems. For instance, the insights of this study justify the creation of health clinics, home care agencies, and inpatient medical facilities (e.g., those offering residential care) that are exclusively developed by gay men and intended for use by older adults identifying as gay. Indeed, as participants in this study often discussed more readily engaging with community-based systems of care as a result of developing feelings of mistrust toward
mainstream health systems through the HIV/AIDS epidemic, such resources may make necessary health services more accessible and responsive to gay men ages 50 and over. In addition, as older gay men involved in this study often discussed the importance of partaking in forms of community engagement and development to mobilize resistance against their subjugation in systems of care, such community-based and -driven initiatives would also address other notable priorities in this area.

Although the creation of such community-based health institutions may not be considered feasible at present, the increasingly visible population of older LGBTQ adults in industrialized societies (Cahill, 2007) may provide an impetus for the creation of small networks of community-based care for groups of sexual and gender minority adults, particularly in large urban centres. Indeed, given that resources such as LGBTQ-only residential care facilities have been envisioned in the literature on LGBTQ aging and among aging sexual and gender minority adults (Hughes, 2008), the need for the establishment of such care systems may eventually gain recognition in the context of health care policy. Importantly, given the intersectional heterogeneity of older gay men’s health care experiences (Cronin & King, 2010), resources tailoring to the unique needs of this population may need to account for variations in health care need based on unique configurations of sexual identity, socioeconomic status, race, and ability reflected in the social locations of those in this group.

At the level of practice, service providers in mainstream health services may need to become more cognizant of the unique experiences and needs of older gay men accessing health care. As discussed in chapter 4, to achieve this outcome, health care providers may need to be trained more consistently on recognizing and accounting for the social and historical factors that shape the unique experiences and needs of older gay men in medical systems. Although chapter 4 outlines the relevance of such training as a vehicle for addressing the service priorities of gay men aging with HIV, such training would also render formal systems of care more responsive to the needs of HIV-negative gay men. As HIV-negative men interviewed in this study frequently discussed the need for training programs aimed at sensitizing service providers to the effects of this group’s historically stigmatizing (though medically arbitrary) association with HIV, such training would address the circumstances of those in this population comparably to those of their HIV-positive counterparts.
Such professional education would, at the very least, foreground the role of HIV history in shaping older gay men’s relationships with health systems, and help practitioners to recognize and address historically rooted sources of mistrust that may surface interpersonally among aging gay men seeking and receiving health services. In so doing, it would begin addressing manifestations of HIV stigma that currently target both older HIV-positive and HIV-negative gay men in health care. Indeed, HIV stigma was commonly discussed among participants as covertly surfacing in their interactions with health care providers, often by way of communication styles and practices that would reignite memories of their dehumanization as stigmatized subjects of HIV/AIDS early in the epidemic. Accordingly, greater sensitivity to this sociohistorical context underlying older gay men’s health care experiences, among service providers, may potentiate the cultivation of professional practices that are less likely to signal the presence of HIV stigma for older gay men.

Although such training programs would, alone, fail to address the structural and systemic issues that hinder the capacity for mainstream health systems to meet the needs of older gay men, they may gradually catalyze improvements across health systems if implemented consistently across settings, and in conjunction with the population-specific health care programs and services mentioned above. Indeed, as LGBTQ aging scholars have discussed the need to render the voices of older sexual and gender minorities visible within the context of service provider education, primarily given the role of such education in shaping disciplinary and institutional norms (Brown, 2009), the value of such work should not be underestimated as a complementary means of effecting structural change.

5.6 Reflexivity

Prior to considering the limitations of this study, I wish to briefly revisit reflexivity in relation to my doctoral work. As noted in the introductory chapter, I approached my work from an epistemological position of acknowledging the partiality and socially constructed nature of knowledge, which is consistent with the poststructuralist underpinnings of theoretical and methodological frameworks I used to inform my research (Clarke, 2003; Clarke, 2005; Clarke & Keller, 2014; Creswell, 2007; Foucault, 2000; Foucault, 2008; Yuval-Davis, 2006). I also acknowledged the complexity of my social location, as an early 30s trans woman of Iranian
descent, in presenting both opportunities and challenges associated with collecting and interpreting the accounts of older gay men participating in this study.

Here, it is important for me to acknowledge, specifically, that given my social location as a junior scholar with lived experience as a queer and trans person, I may have been particularly sensitized to certain themes reflected in the data. In particular, as I conducted most of my data collection and analysis early in my transition, I may have been uniquely attuned to expressions of anti-LGBTQ stigma and discrimination directed at participants involved in the study, and my prominent foregrounding of these themes in my dissertation may, in part, reflect this aspect of my positionality as a researcher. Indeed, had I not had some lived experience with processes of anti-LGBTQ stigma and discrimination, I may have failed to consider, as deeply as I did, the role of these forces (as situated in their sociohistorical context) in shaping contemporary health care among older gay men.

Having emphasized the above qualifier, it is similarly important for me to note that I would regularly acknowledge, throughout my research process, distinctions in social location between myself and the participants, and would regularly reflect on these differences to account for limitations in my interpretation of the data. Indeed, as the participants were all gay men over the age of 50, and as most were additionally white and from working class backgrounds, my social location, in fact, represented more of a distance than a point of proximity. Accordingly, I would frequently clarify with participants, during interviews, whether my preliminary impressions reflected the essence of their accounts, and would attend closely to any corrections and modifications that participants would make to my interpretations when I would read and analyze interview transcripts. Indeed, my foregrounding of homophobia and HIV stigma, though perhaps initially motivated by my sensitivity to these issues, did in fact reflect the prominence of these themes across the accounts of the men involved in the study. In addition, as noted in my introductory chapter, my visibility and openness as a trans woman, by virtue of representing membership with LGBTQ communities more generally, granted me access to and engagement with areas of lived experience, among the participants, that may have otherwise not been made available to me as a researcher.
5.7 Study Limitations

Despite the strengths of the study, relative to its implications for research, theory, policy, and practice, several of its shortcomings are important to acknowledge. Foremost, and perhaps most importantly, the study was conducted in a large urban centre in Canada that has experienced significant growth in health care and social services for gay men and HIV-affected communities, and as such the findings may be limited in transferability. Indeed, as the voices and needs of older LGBTQ adults continue to be completely invisible in the design and delivery of services in certain regions, even within industrialized societies (Brotman et al., 2015; Brown, 2009), and older sexual and gender minorities experience profound marginalization in these contexts as a result (Brown, 2009), this limitation is significant. Although interviews with the study’s participants did highlight the continued subjugation of older gay men in systems of care, such expressions of marginalization would have likely been qualitatively different, and perhaps more pronounced, had the study featured interviews with aging gay men in another social and/or geopolitical context. As older LGBTQ adults have, for instance, been found to experience stigma and discrimination much more prominently in rural environments (Addis et al., 2009; Hughes, 2008), the accounts of this study’s participants may not adequately reflect conditions of marginality among older gay men outside of large cities.

Similarly, as this study’s sample contained a significant underrepresentation of racialized older gay men, the findings may not comprehensively represent the realities of aging gay men who experience racism alongside systemic forces such as ageism, homophobia, and HIV stigma. Although the literature on racialized older gay men is extremely limited, preliminary insights in this area reveal that those in this population experience unique conditions of oppression that are constructed based on the group’s exposure to intersecting systems of marginalization (Kim et al., 2017; Otis & Harley, 2016). For instance, research on aging African American gay men has indicated that those in this population may experience significant isolation within both African American and gay communities, and as a result may have access to particularly limited systems of social support (Woody, 2014). Although some of the men included in the current study did briefly address issues surrounding their distinctive social locations as older racialized gay men, a greater number of participants in this category would have likely yielded further insights in this
area. Accordingly, future research on older gay men’s interactions with health systems may need to ensure better representation of adults with exposure to systems of oppression based on race.

5.8 Final Remarks

This dissertation examined subjugation and resistance in older gay men’s experiences navigating health care systems. This area of research was justifiable based on the dearth in focused studies of older gay men’s health care experiences, combined with the limited knowledge on health care as a potentially salient site of stigma and discrimination among those in this population. The findings of the study indicated, substantively, that older gay men continue to be marginalized in health systems based on their stigmatized association with the HIV/AIDS epidemic, and that many in this group resist this subjugation by drawing on their on their visibility as subjects of the epidemic to engage with and attempt to effect change across health care systems.

Given that the study was framed theoretically by Foucauldian governmentality and intersectionality, and informed in research design by situational analysis, the research highlighted notable theoretical and methodological insights. Specifically, governmentality was found to enrich the practice of situational analysis, particularly by supporting the conceptualization of context-specific phenomena that often require attention in studies informed by situational analysis. Intersectionality, on the other hand, was found to be useful in helping to foreground the intersection of older age, gay identity, and HIV status as a salient site of analysis, and to help elucidate important distinctions in the service issues of this study’s HIV-positive participants along dimensions such as socioeconomic status, ability, and race.

Although the study is marked by apparent limitations, including the underrepresentation of racialized participants, it is significant for contributing insights on older gay men’s experiences with health care systems, an area that has consistently been recognized in the LGBTQ aging literature as one requiring further exploration and analysis (Addis et al., 2009; Fredriksen-Goldsen & Muraco, 2010). Indeed, despite its limitations, this study promises to inform future inquiry in the area of LGBTQ aging that more comprehensively accounts for sociohistorical factors shaping the realities of older sexual and gender minority adults, and additionally holds potential for catalyzing studies that more consistently foreground the salient influence of the HIV/AIDS epidemic on older gay men’s contemporary social conditions and experiences more
specifically. This work also offers innovative insights on configuring relevant theoretical frameworks and methodological orientations to inform future research in the emerging field of LGBTQ aging. By addressing important gaps in the literature, this study promises not only to contribute to the continued expansion of research on the social conditions and experiences of older LGBTQ adults, but also to inform the development of policies, programs, and practices that better tailor to the concerns of older gay men accessing health care services.


Bjornsdottir, K. (2002). From the state to the family: Reconfiguring the responsibility for long-term care nursing at home.” *Nursing Inquiry, 9*, 3-11.


References


Table 1.1: Demographic Characteristics of Participants

<table>
<thead>
<tr>
<th></th>
<th>HIV-Positive Subsample (n=16)</th>
<th>HIV-Negative Subsample (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages 50-59</td>
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<td>4</td>
</tr>
<tr>
<td>Ages 60-69</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Ages 70+</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>Racial/Ethnic Identity</strong></td>
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<td></td>
</tr>
<tr>
<td>White/Caucasian</td>
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<td>9</td>
</tr>
<tr>
<td>Black/Afro-Caribbean/African</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other (Latin, Asian/Pacific Islander, Mixed Race)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Socioeconomic Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusively reliant on government-administered financial benefits for income</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Access to private sources of income</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>
Figures 1.1 and 1.2

The relationship of older gay men with HIV/AIDS

Present day systems of care as experienced among older gay men

- The continued discursive influence of homophobia with HIV stigma in contemporary care
- The construction of present day medical practices as sociohistorical artifacts of HIV/AIDS
- The identification of the gay aging body as a commemoration of risk and resistance

Figure 1.1 - The role of HIV/AIDS history in constructing contemporary systems of care as sites of subjugation and resistance for older HIV-positive and HIV-negative gay men

Discursive Forces
- Homophobia
- HIV stigma and HIV risk
- Ageism
- Gay men as ‘responsible’ agents of the HIV epidemic
- Aging as a site of heightened risk
- Medical curricula
- Reductive discourses of gay positivity

Temporal Elements
- HIV/AIDS as an acute, life-limiting condition vs. HIV as a chronic illness
- Proliferation of community-based LGBTQ health and social services
- Persistence of homophobia and HIV stigma in health care

Institutions
- Mainstream health services
- LGBTQ community organizations
- AIDS service organizations
- Community-based sexual health services
- Home support services
- Long-term care
- Employment and income services

Spatial Elements
- Receiving care in institutional contexts vs. community/home settings
- Variations in Processes of Subjugation and Resistance
- Poverty, ableism, and racism as factors that heighten exposure to homophobia, HIV stigma, and ageism

Key Actors
- Present day older gay men
- Older gay men’s bodies
- Community activists
- Deceased partners/friends/peers of older gay men
- Health care providers
- Health care administrators
- Researchers

Non-Human Elements
- Medical practices associated with chronic care for older adults
- HIV prevention strategies and treatments

Figure 1.2 - Rudimentary situational map of older gay men’s health care experiences
Appendix A: Interview Protocol

1. Can you tell me what it means for you to identify as a gay man?

   a. How relevant do you think your sexual identity is when it comes to your health care needs?

2. Other than your sexual identity, are there aspects of your identity or experiences, for example your age, HIV status, ethnicity, race, mental health status, addiction history, gender, class background, or other aspects that you feel are relevant or important to mention when you think about your experiences of accessing services?

   a. How relevant do you think these other aspects of your identity are when it comes to your health care needs?

   b. When you think about the health settings you’re in most frequently, to what extent do you feel like you’re able to bring your whole self to these settings? Are there ever pieces of yourself or your identity that don’t seem to fit in these settings?

3. What kinds of health care services have you sought and/or received in the last year?
   When I say “health services,” I mean any services delivered by an Ontario-licensed physician, or an Ontario-licensed nurse or nurse practitioner – these can include sexual health, mental health, or addiction services, in addition to any services you’d receive in a family doctor’s clinic, a specialist clinic, or a hospital.

   a. In general, what were these experiences like for you?

   b. Can you tell me about the process of seeking or receiving any services you’ve received in the last year?

   c. What, if any, barriers did you experience in getting the care you were hoping to receive?

      i. What, if anything, helped you overcome these barriers?
d. What, if anything, did you find useful in helping you get the care you were hoping to receive?

*If Participant identifies as HIV*:

4. Can you tell me how long you’ve been living with HIV? How, if at all, does being HIV+ impact you in your everyday life?
   
a. Can you tell me about any HIV treatment or care you sought and/or received in the last year?
   
b. In general, what were these experiences like for you?
   
c. What, if any, barriers did you experience in getting the care you were hoping to receive?
      
i. What, if anything, helped you overcome these barriers?
   
d. What, if anything, did you find useful in helping you get the care you were hoping to receive?

5. To what extent do you feel comfortable discussing your sexual identity with health care providers?
   
a. What, if anything, makes you feel more comfortable discussing your sexual identity with health care providers?
   
b. What, if anything, makes you feel less comfortable discussing your sexual identity with health care providers?
   
c. How do you decide when to disclose your identity, and when not to disclose?

6. If any of your health care providers know about your sexual identity as a gay man, how have they come to know this information?
a. How, if at all, have any of these care providers used information about your sexuality to make decisions about your care?

b. If any don’t know about your sexuality, what has prevented them from knowing this information?

   i. If you have withheld information about your sexuality from any health care providers, what do you think has prevented you from divulging this information?

   ii. How useful do you think it would be for care providers to know about your sexuality?

*If participant identifies as HIV+:*

7. To what extent do you feel comfortable discussing your HIV status with health care providers?

   a. What, if anything, makes you feel more comfortable discussing your HIV status with health care providers?

   b. What, if anything, makes you feel less comfortable discussing your HIV status with health care providers?

8. If any, some, or all of your health care providers know about your HIV status, how have they come to know this information?

   a. How, if at all, have any of these care providers used information about your HIV status to make decisions about your care?

   b. If any don’t know about your HIV status, what has prevented them from knowing this information?

      i. If you have withheld information about your HIV status from any health care providers, what do you think has prevented you from divulging this information?
ii. **How useful do you think it would be for care providers to know about your HIV status?**

9. Earlier, I asked you about specific interactions you’ve had with physicians and nurses. Recognizing that you might interact not only with these professionals, but also with other patients, and with many other types of health care providers such social workers, rehab professionals, and others, can you tell me about your overall experiences being in medical settings over the last year? These settings can include doctors’ offices, hospitals, laboratories, and other medical facilities in which you sought or received health care.

   a. Overall, how comfortable were you in these settings?

      i. What were your reasons for feeling comfortable or uncomfortable?

   b. To what extent, if at all, do you feel you are perceived or recognized as a gay man in these settings?

      i. What are your reasons for feeling you are – or are not – perceived or recognized as a gay man in medical settings?

      ii. To what extent, if at all, do you want to be perceived or recognized as a gay man in medical settings?

      iii. If you feel you are perceived as a gay man in medical settings, how does this affect your overall care and treatment in these settings, if at all?

   c. Can you tell me about any difficulties or challenges you’ve experienced in medical settings over the last year, if there are any you haven’t yet discussed?

10. Do you have any thoughts on what could be done to improve health care services for gay men ages 50 and over?