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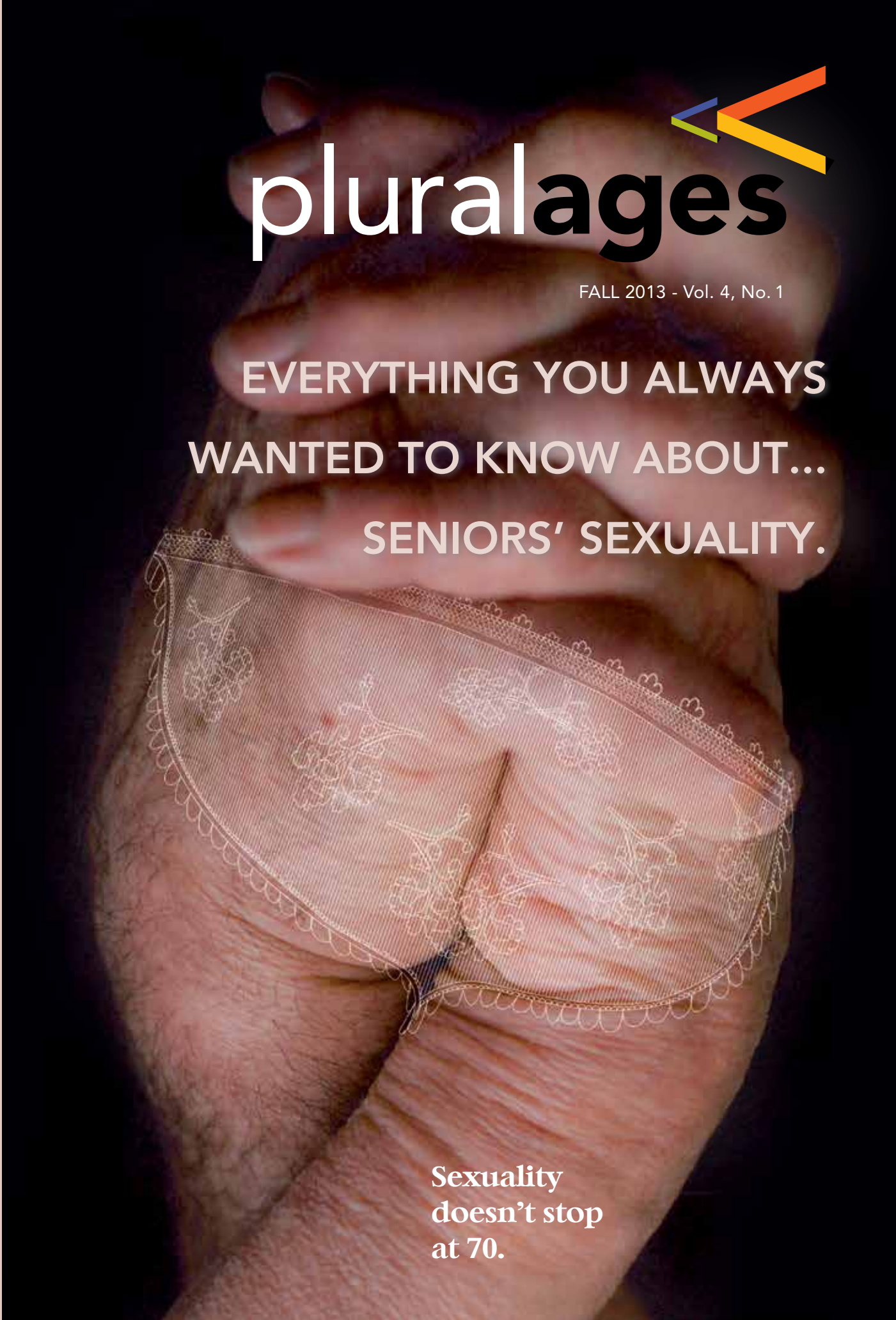
EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT... SENIORS' SEXUALITY.



Sexuality doesn't stop at 70.

COVER

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Pluralages is published by the Centre de recherche et d'expertise en gérontologie sociale (CREGÉS) of the CSSS Cavendish-Centre affilié universitaire (CAU). This magazine is designed to inform the public and raise awareness of social issues surrounding aging by, among other things, presenting the research initiatives and expertise being developed by members of the CREGÉS. Pluralages also aims to promote and foster ties between the research, education, practice and citizen action - for and by seniors - communities. Issues related to aging are presented through the lens of social gerontology, touching on such themes as diversity in aging, social and citizen recognition of the elderly, experiences with social exclusions and solidarities, political concerns, State directives and public policy targeting the aging population and its needs.

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EDITORIAL

SYMPOSIUM REVIEW

CITIZENS' FORUM

VIEWPOINTS

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The aging of the population and changes in the area of sexuality (norms, behaviours, identities and sexual orientations) are among the current demographic, economic and sociocultural issues that are capturing the attention of social science researchers. The symposium held by the Centre de recherche et d'expertise en gérontologie sociale (CREGÉS) of the CSSS Cavendish — titled "Everything You Always Wanted to Know About Seniors' Sexuality" — was an opportunity to examine this complex issue in Quebec and to identify some of the problems encountered by this segment of the population.

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Quebec demographic data show that we are experiencing a major transition as baby boomers reach the age of 65. In 2009, 14.9% of the population was aged 65 and over, with a stronger representation of women (56.5%) than men (43.5%). This imbalance, which increases with age, has an impact on household composition, with more women living alone as they get older, despite the fact that the majority of those aged 65 and over (just over 60%) are still living with a spouse. Preferred living arrangements are also changing, with an increased percentage of those aged 65 and older living in collective households (36.4% of those aged 85 and older). In this general demographic context, we are also seeing the emergence of sexual minorities: lesbian, gay, bisexual and transgender (LGBT) individuals who had long kept their identities and orientations under wraps are increasingly coming out in the wake of legal and political actions aimed at ensuring full citizenship rights in all areas, including sexuality.

This issue of *Pluralages* explores the constraints experienced by older adults in their sexual lives, whether or not they are living in a nursing home. It also looks at the challenges encountered by lesbian, gay and transgender elders. In both cases, difficulties are explored from the perspective of both elders and health care professionals or caregivers. The articles reflect, at least in part, the papers presented at the symposium and the workshops on challenges faced in the health and social services sector (e.g., professionals' and service providers' views on the sexuality of older adults, the difficulty of broaching private matters with informal caregivers, and the issue of HIV/AIDS). Representations and norms around older people's sexuality are often in contradiction with actual practices. Sexuality in this demographic cohort continues to be portrayed in a negative light, resulting in widespread tendencies to mask, deny and stigmatize. The opposed stereotypes of asexuality and hypersexuality are still very present, even though new norms and attitudes are starting to take form. Through the influence of the baby boomer generation, aging and sexuality are being constructed in a new way, with an increasing emphasis on aging well and recognition of the benefits of eroticism in later life. Empirical studies show that a significant proportion of older adults continue to be sexually active, engaging in a wide range of practices. >

Nonetheless, seniors living in nursing homes still find themselves limited in their possibilities for sexual expression by administrative rules, the attitudes of others and the surveillance of health professionals. These constraints affect the quality of their sexual life and might negatively impact their outlook on life in general. Informal caregivers often experience a disruption of their sexual life, but might feel reluctant to discuss such matters with health professionals. Similar problems are encountered by gays, lesbians and transgender people who either mask their identity and become invisible or, in revealing their identity, expose themselves to possible discrimination and rejection. The exclusion of LGBT identity at both the symbolic and institutional levels can make people reluctant to seek health and social services. LGBT individuals need to be highly adaptable and resilient in order to confront these forms of structural violence that affect their psychological and physical integrity. In all of the examples noted above, it is clear that we need to reassess the training of health professionals and service providers who are often ill-prepared to deal with these issues. Strategies must be put in place to encourage an acceptance of sexual diversity and to ensure a greater attentiveness to personal needs, desires and situations.

The presentations at the symposium suggested an ongoing ambivalence with regard to the sexuality of older people which, in Western culture, continues to be seen in a largely negative light. Our tendency to separate the mind and body, and our desire to control our passions, is particularly evident in the representation of older people, as shown by both historical and contemporary studies. Once their sexual urges have subsided with age, older people are supposed to attain a state of wisdom—the ultimate goal of existence. However, if they continue to be sexually active, they are accused (particularly women) of hypersexuality and lustfulness—behaviours that are incompatible with the sexual control required at this stage of life. A very different worldview may be found in Chinese civilization, which is much more open to sexuality as a whole. Erotic desire is considered present throughout a person's life and only ends with death. Sexuality is an expression of vitality and contributes to a person's health and well-being. It can also be considered therapeutic. According to this perspective, female and male sexuality obey the same principles. For men, aging leads to a better mastery and knowledge of erotic matters (the famous "arts of the bedroom") which can help to increase their partner's pleasure. All of these perspectives can no doubt help us reflect on how to develop more innovative approaches in the area of older people's sexuality.

Happy reading!

Sexuality is an expression of vitality and contributes to a person's health and well-being.

Colloque organisé par

Centre de santé et de services sociaux Cavendish
Health and Social Services Centre
Affilié universitaire

Centre de recherche et d'expertise en gérontologie sociale

Équipe VIES
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Tout ce que vous avez toujours voulu savoir sur la sexualité... des aînés

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Animé par Jocelyne Robert sexologue

From Myths About Sexuality and Aging to HIV/AIDS Vulnerability Among Older Adults

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Sex sells in the media, but instantly loses its glamorous quality when associated with the older population. Even today, the sexuality of older adults remains a taboo topic that elicits reactions of discomfort, disgust, denial or derision. However, there appears to be a growing interest in the subject in the media, with a proliferation of tips on how to remain sexually active in later life. Ranging from the myth of asexuality to the importance of an extended sex life, discourses on the sexuality of older adults seem contradictory and warrant further attention. Their impact on the sexual health of seniors should also be taken into account. This article aims to identify and deconstruct the myths surrounding the sexuality of seniors in order to examine their effects on an important aspect of their sexual health: namely, the risk of HIV infection.

THE MYTH OF OLDER PEOPLE'S ASEXUALITY (AND OTHER RELATED MYTHS)

Recent studies conducted in the United States[1] and Europe[2] show that between 50% and 75% of people aged 60 to 69, and approximately 25% of those aged 70 and over, are still sexually active. However, the myth of older people's asexuality persists in our society[3], supported by several preconceptions and inaccurate representations. The supposed asexuality of older people is primarily attributed to physical changes related to aging, such as erectile dysfunction, menopause (long considered to mark the end of a woman's sexual life), or a deterioration in health that presumably prevents or makes any form of sexual activity dangerous. Older people are often assumed to be asexual because of a lack of sexual interest, the supposedly inevitable loss of desire that comes with aging, the unattractiveness associated with the physical signs of aging, or an investment in the role of grandparent that is considered incompatible with a sex life. >

A second myth concerns the hypersexuality of certain older adults. Inasmuch as aging is associated with the absence of a sex life, it is not surprising that any older person who is sexual or displays an interest in sexuality is likely to be perceived as abnormal and therefore hypersexual. Walz[4] describes the figure of the older male "pervert" who acts as a sexual predator toward young women, or the older woman who wears clothing and makeup that are considered inappropriate or too provocative "for her age."

ORIGINS OF THE MYTH OF "ASEXUAL OLD AGE"

Why is the myth of asexual old age still so prevalent in our society, at least as far as people of a more advanced age are concerned? The origins of this myth may be traced to social representations of both aging and sexuality. To understand these myths, we need to bear in mind that Western societies have a very negative view of aging and tend to see older people as somehow diminished. According to the predominant agist perspective, older people are considered fragile, sickly, passive, ugly and undesirable, while sexuality is associated with images of youth, health, performance, passion, beauty and attractiveness. The value our society places on independence and economic power also helps to create a vision of old age as necessarily synonymous with dependency and incompetence. Since sexuality is one of the prerogatives of fully autonomous adults, older people, like children, are denied their right to sexuality[6].

Any older person who is sexual or displays an interest in sexuality is likely to be perceived as abnormal and therefore hypersexual.

Finally, one last myth stemming from that of the asexuality of older people concerns the normalcy of their practices. In cases where seniors' sexuality is recognized, it will necessarily be perceived as limited or standardized. According to this myth, older persons will naturally engage in heterosexual, monogamous intercourse, based on a deep emotional bond. Reinforced by a narrow and reductive perception of older people as a homogenous social group with virtually no diversity[5], this myth denies the existence, within this age cohort, of relationships between persons of the same sex, or of sexual practices outside a spousal relationship.

Another important point related to the perception of the elderly as asexual concerns the association between sexuality and attractiveness. According to Gott[7], there is a tendency to consider sexuality an intrinsic quality that is perceived through a person's appearance. Being sexually attractive, according to the predominant criteria of beauty and desirability in our society, is more of a sexuality marker than sexual behaviours themselves. In fact, those whose bodies do not conform to ideal beauty standards are not considered sexual beings. Magnified by the agism in our society and tendency to denigrate the aging body, this implicit assumption feeds the myth of asexual old age. It is also important to note that older women risk being more affected by this presupposition than men, because of the double standard in place requiring women to have a perfect body and to maintain a youthful, seductive appearance[8].

Finally, the myth of asexual old age originates in two assumptions related to sexuality[9]. The first concerns the natural aspect of sexuality, which is primarily aimed at procreation. This conception of sexuality, reinforced by Christian morality and the works of early sexologists, has helped to create a view of non-reproductive sexuality as morally reprehensible, abnormal and even pathological. Although our contemporary society increasingly dissociates sexuality from reproduction, sexual activities with a reproductive goal still seem more legitimate than those purely motivated by pleasure.

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The second assumption underlying the myth of asexual old age lies in the identification of sexuality with intercourse. The focus on this sexual practice, considered the basic standard, implies that all sexual activities without penetration are substitutes. Since the sexual activity of older people is often based on non-penetrative practices (on account of health problems, erectile dysfunction or vaginal dryness), it is not considered to be truly sexual.

THE MYTH OF THE "SEXY OLDIE"

It is important to note that, parallel to the myth of asexual old age, a second myth is emerging that is likely to become more prominent: that of the sexy oldie. Breaking with agist preconceptions about the sexless life of older people, this new myth promotes the benefits of remaining sexually active until an advanced age. As Gott[10] underscores, the importance attached to the sexuality of older people, now considered necessary for successful aging, is helping to construct a new set of stereotypes that could be just as reductive and problematic as the preceding ones. The first of these myths is based on the idea that remaining sexually active is necessary for healthy aging. In line with the recent trend to promote successful, active aging, this perspective makes the maintenance of physical health a primary objective, transforming sexuality into a necessity, or even a responsibility—with an accusing finger pointed at those who fail to conform.

Moreover, the myth of sexual activity as key to remaining in good health can be accompanied by a second myth: that of the importance of sexual performance[11]. This myth is influenced by the medicalization and pharmacologization of erectile dysfunction associated with aging—now pathologized and seen as a sexual dysfunction requiring treatment—as well as the excessive focus on intercourse. The myth supports the idea that people cannot enjoy satisfying sex in their later years without using sexual pharmaceuticals to maintain a level of performance in line with societal norms.

A MAJOR IMPACT OF THESE MYTHS: HIV AMONG SENIORS

The final question to be asked is whether these myths have an impact on the sexual health of seniors and, more specifically, whether they can be linked to the continuous rise in new HIV infections among older people in Western societies. In 2009, 28.4% of new HIV diagnoses in Quebec were among people aged 50 and over, compared to only 16% in 2002[12]. Another notable point with regard to HIV among people aged 50 and over concerns the high percentage of newly infected heterosexual men and women, which is equivalent to that of men who have sex with men in this age group. Among the factors contributing to the high number of new infections among older adults is the use of medications for erectile dysfunction[13]. The desire to prolong intercourse by using sexual pharmaceuticals is not problematic in itself, but we should question whether it is not in part influenced by new myths promoting an active sex life and sexual performance among older adults.

Beyond this issue, which is a topic in itself, the major problem is not so much the use of sexual pharmaceuticals by older people as the absence of accompanying HIV prevention measures. This problem is not limited to seniors who take these medications, but concerns the entire older population. The absence of HIV prevention campaigns targeting seniors, the lack of information and prevention advice offered by health professionals, and the older population's ignorance about HIV are some of the factors driving the increase in new HIV infections in this age group[14]. One of the main reasons older people do not use condoms, resulting in an increased risk of HIV infection, lies in the belief shared by health professionals and seniors themselves that they are not at risk. This false belief is closely tied to myths related to the asexuality of older people. Internalized by older individuals, these myths make them reluctant, among other things, to discuss sexuality with their caregivers out of shame or fear of being negatively judged[15]. Health professionals who see the older population as asexual or as only engaging in sexual activities within spousal or heterosexual relationships, feel uncomfortable asking older patients about their sex lives, or simply imagine that they do not engage in high-risk practices[16]. It is clear that the myths surrounding the sexuality of older people have very concrete implications and are a major obstacle to the HIV prevention work that health professionals should be carrying out with this population. We need to take urgent action to change mindsets and to make health practitioners aware of the prevalence of these myths in order to deconstruct them and enhance the quality of older people's sexual lives.

These myths make them reluctant, among other things, to discuss sexuality with their caregivers out of shame or fear of being negatively judged.

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Creating a Welcoming Environment for Transsexual and Transgender Elders in Health and Social Services:

Research Data on Barriers and Strategies

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There continues to be widespread ignorance and even misunderstanding around the aging transsexual and transgender population (trans elders) in the health and social services sector. This article aims to remedy this situation by presenting general information[1] as well as the summary results of an intervention research project on aging among trans people, conducted through a partnership between the community organization Aide aux transsexuels et transexuelles du Québec and the Quebec Research Chair on Homophobia (UQAM). Examples are drawn from interviews with 12 trans persons aged 54 to 81, and five community organization workers and professionals from the health and social services sector.

WHO ARE TRANS PEOPLE?

Gender identity refers to a person's subjective sense of his or her own gender—in other words, whether the person self-identifies as a man or woman. Trans people's gender identity is not the same as the sex assigned to them at birth based on apparent biological data. The term "trans" refers to a wide range of identities that people may adopt, or that may be assigned to them, as a result of this lack of correspondence between their gender identity and assigned sex. Trans identity can therefore refer to individuals who self-identify as transsexual or transgender, or those who have transitioned and now self-identify as either men or women, and not as trans persons. In certain cases, the term also refers to people who perceive themselves as not conforming to gender norms.

It is important to respect the terms preferred by trans people and to use the appropriate pronouns for their lived gender. That is why the term "trans man" is used to refer to a person categorized as a girl at birth, but who self-identifies as male. Similarly, "trans woman" refers to a person categorized as a boy at birth, but who self-identifies as female. Sexual orientation refers to an individual's emotional and sexual attraction toward a person of the same or opposite sex, or people of both sexes. It should not be confused with gender identity. A trans person can just as easily be heterosexual, homosexual or bisexual.

DIFFERENT PATHWAYS TO TRANSITION

The term "transition" refers to the emotional and physical process during which a person perceives him or herself (or is perceived by others) as changing gender identity. The process can include a social, medical and legal transition. Social transition refers to the interpersonal and social aspects of the transition, which may include a "coming out" (the moment when the person reveals his or her desire to make the transition to significant others, family and friends); a request to be called by a new name with the corresponding pronoun ("he" or "she"); and a change of wardrobe to match the new identity. Medical transition refers to the medical procedures involved in sex reassignment, for example hormone therapy possibly combined with surgeries. Legal transition involves taking steps to legally change a name and sex designation on identity documents (in Quebec, this is administered by the Registrar of Civil Status)[2].

Transition stages should not be seen as following a set course. In fact, transition pathways are very varied. Our research shows that trans elders are faced with two major types of barriers. The first concerns the extremely rigid standards of care governing access to the various stages of medical transition in Quebec. These standards, and their associated requirements, are numerous. They include costly psychological assessments, long waiting times and the obligation to complete certain stages (such as surgery) before being entitled to legally change one's sex designation[3]. It is important to note that not all trans people seeking

health care and social services have gone through all of these social, medical and legal transition stages. Not all want to do so either. Thus, either by choice or because of various obstacles, some trans individuals will have an appearance, an anatomy or identity documents that are not in accordance with gender norms.

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The second type of barrier involves aging-related problems that could complicate access to medical transition or even rule it out in certain cases. Numerous health care providers are insufficiently aware of the interactions of hormone therapy with other medical treatments and certain health problems. They tend to be overly cautious and will interrupt hormone therapy at the slightest problem—or even to prevent potential problems—when such action is not necessary. While the reluctance of health care professionals to provide hormone therapy or to perform sex reassignment procedures on older adults is often unjustified or exaggerated, there are very real medical contraindications (aging-related or not) that prevent certain older people from seeking such treatments. Consider the example of Linda, who has two types of cancer and is suffering from other health problems (anaemia and diabetes), which not only prevent her from being treated for her cancers but also make it impossible for her to complete her transition.

A cancer is a cancer. I have to have certain operations for my health problems. But I can't have the results [of a sex reassignment surgery] before. It's distressing. I'm really sad, because I should be "complete" by now.
(Linda, 57 years)

In addition to dealing with her deep disappointment, Linda has to navigate the health system with identity documents indicating a male first name and sex, which has resulted in many difficult experiences for her.

Trans elders have followed a variety of paths. Some made their transition early and have spent many years adjusting to the various aspects of life in their chosen gender. They might have accumulated negative experiences and health-related problems, either because their social environment was more repressive during their youth or because the hormone doses prescribed at the time were much higher than those recommended today. In other cases, a variety of factors could lead people to start their transition late—for example, the desire to wait for children to move out of the family home, or to wait for retirement or the death of parents or a long-term spouse. Since such a change is rarely easily accepted by family and friends, trans elders can feel very isolated, in addition to having to cope with health problems that might threaten their eligibility for certain transition stages.

BARRIERS ENCOUNTERED IN HEALTH AND SOCIAL SERVICES

Trans elders can encounter three types of barriers when seeking appropriate health care and social services.

1

Certain vulnerabilities can complicate access to care and services or increase the likelihood of having a negative experience. A first factor is the impossibility for trans elders to be recognized according to their self-identified gender, because they have been unable to get their identity documents changed, for example. Certain people blend into the general population more easily—notably those who began their transition early—while others are more identifiable as trans people, or are perceived as failing to comply with gender norms. Because they have no choice but to reveal their trans identity, these people run a greater risk of receiving inferior quality services, and also of suffering discrimination and violence in other spheres of their life, which could in turn affect their health and well-being. The second vulnerability factor is the accumulation of negative experiences, particularly in the health and social services system. A number of trans elders have said they experience a lot of shame and fear when they are required to seek these services. Some fear reliving negative experiences, which could lead them to neglect their needs, even if they know they have health problems.

2

Difficulties can also arise when professionals in the health and social services sector are uncomfortable about trans identity, have prejudices or feel an aversion toward trans people and their physical appearance. These attitudes can be manifested in a variety of ways, ranging from simple embarrassment on seeing the anatomy of a trans individual to failure to propose certain types of care related to the genital organs. Moreover, some of the more common exams performed on aging patients (prostate exam, mammogram, etc.) can become sources of fear, humiliation and even shame for many trans elders who do not feel comfortable revealing their anatomy. Certain professionals might, out of curiosity or based on their prejudices, undermine the dignity of trans people by asking them questions about their sexuality or anatomy when this information is not necessary to deliver the care or services in question. They might also reveal the identity of a trans individual to their colleagues without the former's consent. That is what happened to Monique. Her doctor invited colleagues to attend a procedure without consulting her beforehand.

> *At one point, I went to hospital to have my urinary tract dilated [a treatment she has to have regularly since her sex reassignment surgery]. Immediately, the fact that I was a trans person... I found myself surrounded by staff members and that made me feel uncomfortable. Even those who work in the field are curious.*
> **(Monique, 67 years)**

Finally, it is important to note the homophobic or transphobic words and gestures of certain professionals, which can range from a refusal to provide services to mistreatment or violence.

3

A last category of barriers is tied to the institutional structure of the health and social services sector. First, institutional erasure[4] makes trans people invisible or reduces them to anomalies, thus contributing to the lack of information around their realities and needs. Second, trans people of all ages are confronted by an institutional invisibility tied to the rigid way in which the sexes are differentiated and segregated in the health and social services sector, leaving no room for people whose gender identity does not neatly fit into either category. Finally, the psychiatrization of trans identity >

reinforces the view that it is a mental illness, which might lead professionals to erroneously perceive the problems of trans people as psychiatric in nature, particularly in an emergency or crisis situation.

STRATEGIES TO CREATE A MORE WELCOMING ENVIRONMENT FOR TRANS PEOPLE

It is crucial that individuals receive adequate care and that their dignity be respected. Following are some strategies mostly aimed at professionals in the health and social services sector who are likely to directly interact with trans elders.

A FRIENDLY APPROACH AND OPEN SETTING

It is important that trans people feel comfortable about revealing their trans identity. Simple gestures, such as putting up posters or leaving out brochures portraying trans individuals in positive terms can make a huge difference and encourage the latter to let down their guard and speak openly about their experiences. It is also important to respect their identity. In cases of doubt, it is better to respectfully ask the question than to make assumptions. Professionals can simply ask the person whether s/he prefers to be referred to as male or female and should then make an effort to respect this preference. Through your words and actions, show >

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trans individuals that you recognize their chosen identity and that you see them the way they want to be seen. You can also write the person's desired first name and pronoun in their file and ask your colleagues and reception staff to use them (particularly in waiting rooms). For medical files, where the person's legal name is required, you can simply add a sticker with the person's preferred name. Finally, you can set an example for your colleagues by respecting the identity of trans people.

ADAPT CARE AND SERVICES

A respectful discussion is a first step toward better adapted care and services. If you have questions about the anatomy of trans individuals for medical reasons, ask them whether they are comfortable talking about their body and their transition process. Before asking delicate questions, explain what you need to know and why. It is also important to be tactful when proposing an exam related to the genital organs and to be understanding if a trans elder is initially unwilling to have the exam. For people requiring certain types of care, such as personal care, be aware that their anatomy might not correspond to their identity and that these situations may be even more embarrassing for them. It is also important to treat trans identity as confidential information to avoid embarrassing or outing individuals without their consent, or exposing them to discrimination or mistreatment. If you are required to reveal a person's trans identity for professional reasons, advise him or her and explain the reasons. Finally, it is important to note that a positive relationship established with a service provider in the health and social services sector can often counterbalance the difficulties and discrimination individuals might experience with other professionals or in other areas of their life.

Finally, we invite you to visit the website of the organization Aide aux transsexuels et transexuelles du Québec **(atq1980.org),** as well as the sites of other organizations working in the field of trans health. You will find information and tools that will help you respond appropriately to trans individuals of all ages and provide them with adequate care[5].

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1. This information is taken from (among other sources) the intervention guide *Intervenir auprès des aîné.e.s trans: s'outiller pour rendre les milieux de la santé et des services sociaux plus inclusifs.*

   Hébert, B., Enriquez, M. C. and L. Chamberland (2013). *Intervenir auprès des aîné.e.s trans: s'outiller pour rendre les milieux de la santé et des services sociaux plus inclusifs.* Montreal, Aide aux transsexuels et transsexuelles du Québec.

2. To find out more, visit the site www.atq1980.org/aine-es-trans/definitions (in French).

3. To find out more, visit the site www.atq1980.org/aine-es-trans/faire-sa-transition (in French).

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Taking the Realities and Needs of Gay and Lesbian Seniors into Account: Possible Courses of Action

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In this article, I will present some of the main social issues affecting gay and lesbian seniors in their interactions with the health and social services system. I will then examine these issues using various components of the conceptual framework for social exclusion developed by the VIES research team.

It is important to note two important points regarding the elderly population. The first is that this population has grown considerably in recent years—an increase that will become more marked over the next few decades[1]. Secondly, the elderly population, including gay and lesbian seniors, is not a homogenous group: older people have a diverse range of social characteristics and life journeys[2].

BRIEF LOOK AT THE PAST EXPERIENCES OF GAY AND LESBIAN SENIORS

Historically, the elderly gay and lesbian population has experienced discrimination and stigmatization tied to prevailing legal, medical and social discourses.

It is important to note that only in 1969 was homosexuality decriminalized in Canada, with the passing of Bill C-150 (the Criminal Law Amendment Act, 1968-69). In 1973, homosexuality was removed from the DSM-II (Diagnostic and Statistical Manual of Mental Disorders) by the American Psychiatric Association (APA), thus ceasing to be considered a mental disorder[3]. On the other hand, heterosexism—which may be defined as "a belief in the normativity or superiority of heterosexuality, an assumption of heterosexuality that is applied to all individuals" [Translation][4]—was the dominant discourse in society. This discourse had repercussions on all areas of people's lives, leading many gays and lesbians to be shunned, even by their biological family.

Despite the major institutional and social changes that have occurred in recent years, the cohort of gay and lesbian elders remains largely silent and invisible[5]. Members of this generation continue to feel socially invisible, are reluctant to disclose their sexual orientation to service providers, and still feel the effects of discrimination and stigmatization.

SOME SOCIAL ISSUES

Experiences of discrimination and stigmatization have strongly contributed to the invisibility of this population. To cope with difficulties encountered over the course of their lives, such as intolerance or rejection by loved ones, gay and lesbian elders have developed a variety of survival techniques such as masking their sexual orientation or the identity of their partner, or avoiding gay and lesbian communities[6]. For a number of these individuals, real or anticipated fears related to homophobia[a], heterosexism or discrimination are still present and may constitute a barrier to health and social services, as well as community organization activities[6,7]. Gay and lesbian seniors may fear that they will be treated differently or inadequately by service professionals and volunteers, or that they will not be accepted and respected by other seniors in retirement homes, nursing homes or organizations for seniors[8].

Gay and lesbian seniors use a number of identity-based strategies to negotiate disclosure of their sexual orientation, depending on the context in which they find themselves (e.g., private or public) and according to anticipated costs and benefits[9]. Some gay and lesbian couples will refer to each other as friends to protect their privacy and avoid negative reactions[6,10]. Other gay and lesbian elders do not see their sexual identity as overly important and prefer to keep it private[11]. Nonetheless, disclosure is often necessary in order for professionals to better respond to the needs and realities of these seniors, and to include their partners in the organization of care and services[6]. The invisibility of gay and lesbian elders is therefore a very important issue, because it may compromise the delivery of adequate services to this population.

This generation of elders has also developed adaptive strategies in response to experiences of homophobia. For example, some who were rejected by their biological family have created a family of choice, consisting of close friends who are "like family." Such strategies can increase seniors' resilience and independence, helping them to better adjust to the aging process[6,12]. Certain studies also reveal that gay and lesbian elders find age-related stigma less painful than the stigma[b] around homosexuality they experienced throughout their youth[13]. In addition, those who have accepted their sexual orientation and have built a positive gay or lesbian identity have an easier time coping with the many challenges of aging[14].

Some gay and lesbian couples will refer to each other as friends to protect their privacy and avoid negative reactions.

The partners, family of choice and friends of gay and lesbian seniors are a source of well-being, support and assistance[15]. The family of choice is a community of belonging in which individuals offer each other mutual support[16]. This support helps to build self-esteem and happiness[7]. It is therefore important for health and social service providers to take this entire social network into account. However, many gay and lesbian elders suffer from isolation and loneliness[17], as a result of previous negative experiences leading to social withdrawal and fears of rejection.

The various issues noted above could lead to inequalities. The social exclusion conceptual framework provides an interesting model to understand the process whereby gay and lesbian seniors may experience social exclusion, and to suggest courses of action to improve services to this population.

SOCIAL EXCLUSION OF GAY AND LESBIAN SENIORS

The conceptual framework developed by the VIES team[18] is based on a multidimensional concept of social exclusion defined as: "A process of non-recognition and the withholding of rights and resources from certain segments of the population, resulting from a power struggle among groups with divergent visions and interests. This process leads to inequalities and, eventually, to exclusion in seven areas of social life:

1. **symbolic exclusion**
2. **identity-based exclusion**
3. **socio-political exclusion**
4. **institutional exclusion**
5. **economic exclusion**
6. **exclusion involving socially significant others**
7. **geographical exclusion". [Translation]**

I will now look at four closely interrelated aspects of social exclusion that help to highlight the difficulties experienced by gay and lesbian seniors[18].

Symbolic exclusion

"is characterized by negative images and representations associated with a group, or by the negation of the group's place and roles within society" [Translation]. The silence and invisibility surrounding the elderly homosexual population result in a failure to recognize their needs, which in turn makes it more difficult for them to disclose their sexual orientation when necessary.

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Identity-based exclusion

"refers to an identity that is reduced to a single community of belonging... thus denying the multiple other facets of identity..." [Translation]. Failure to recognize the multiple facets of gay and lesbian seniors' identity and their different journeys and lifestyles can have an impact on their decision to disclose their sexual orientation and on their ability to express themselves according to their chosen life course.

Institutional exclusion

"involves non-existent or reduced access for seniors to policies and social and health protection measures provided by social and political institutions" [Translation]. Institutional exclusion, which translates into inadequate services among other things, occurs when the needs of the elderly gay and lesbian population are not voiced, understood and taken into account.

Exclusion involving socially significant others

"is characterized by non-existent or fewer social networks, or rejection by these networks" [Translation]. Stigmatization, discrimination and the loss of a life partner can intensify this type of exclusion.

COURSES OF ACTION

Following are courses of action aimed at countering the above-mentioned forms of social exclusion of gay and lesbian seniors. This non-exhaustive list of actions and interventions is drawn from the literature on the health and social service needs of this population[6,7,8,10,11,16,19].

Community organizations can help to break the isolation and social exclusion experienced by gay and lesbian seniors by putting in place adapted and inclusive services. We need to embrace the challenge of reaching out to gay and lesbian seniors (who are often invisible) and encouraging them to take advantage of available services and activities. It is also important to continue research on gay and lesbian seniors in order to better recognize and understand their realities and needs.

- **Do not assume that individuals are heterosexual**
- Recognize the multiple aspects of individuals' identity, their life experiences, their lifestyle and their contributions
- **Develop education and awareness programs based on the diverse range of experiences of gay and lesbian elders in order to offer a range of adapted, accessible services and to develop policies ensuring equity among seniors**
- Help to create safe, open and inclusive environments
- **Promote sexual diversity and the positive expression of this diversity in service organizations and workplaces by displaying posters with positive images and symbols related to the gay and lesbian community, thus inviting seniors to open up with confidence**
- Help to forge formal and informal social networks by creating meeting places that are likely to attract gay and lesbian elders
- **Set up support groups adapted to the needs and realities of gay and lesbian seniors (caregiver groups, bereavement groups, etc.)**
- Include partners, families of choice and community organizations in decision-making strategies and processes concerning gay and lesbian seniors

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a. "The fear, hatred, or mistrust of gays and lesbians often expressed in overt displays of discrimination" (Brotman et al., 2006: 2).

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b. Goffman (1963) defined stigma as "the phenomenon whereby an individual with an attribute which is deeply discredited by his/her society is rejected as a result of the attribute" (p. 12).

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The Sexuality of Elderly Nursing Home Residents: A Need for Recognition

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"Due recognition is not just a courtesy we owe people. It is a vital human need."
Charles Taylor[1]

Like anyone else, older people living in nursing homes are sexed and sexualized human beings who, in varying degrees, have erotic desires and emotional needs. They express their sexual needs in different ways, for instance through language and touch. To a large extent, these needs can only be satisfied if caregivers recognize and understand them, and offer the necessary assistance to improve the quality of residents' sexual lives. Caregivers can use shared observations of sexual manifestations as a tool to identify and acknowledge the sexuality of older adults. This approach can help us to recognize the importance of individuals' sexual lives and the relevance of a positive approach to sexuality.

RESEARCH PROJECT

Some caregivers are astonished when they are invited to participate in a training program on the sexual life of elderly nursing home residents. When asked to report on expressions of sexuality they might have observed among residents, they exclaim, "There's nothing going on!" They fail to see such expressions, because sexuality is not supposed to exist in this group. However, they might report catching a resident in the act of masturbating. This event is often considered exceptional within a sick, elderly population that apparently has no interest in sexuality. In this context, caregivers question the pertinence of a training session on the topic, since they refuse residents the right to "exist as sexually marked beings" [translation][2]. It is important, however, to note that other caregivers have a different >

response to the sexuality of residents and are keen to receive training in order to provide better support and care.

As a training activity[3], we ask participants to gather data by observing manifestations of sexuality and consulting with their colleagues[a]. This initial activity allows them to discover different expressions of sexuality among residents. They become aware that residents have a more or less active sexual life and that it is important to provide the necessary support. The commitment of caregivers to assist residents in this way presupposes their recognition of the latter's sexual identity and sexuality.

Caregivers are increasingly encouraged to recognize the sexual needs and rights of older people: "The recognition of sexuality as a real part of the older person's life is important"[4]. However, a demand for recognition can remain wishful thinking if it is not explicit. This article aims to present various ways of recognizing the sexual life of elderly nursing home residents. These modes of recognition are based on data drawn from the scientific literature and from our observations during training activities.

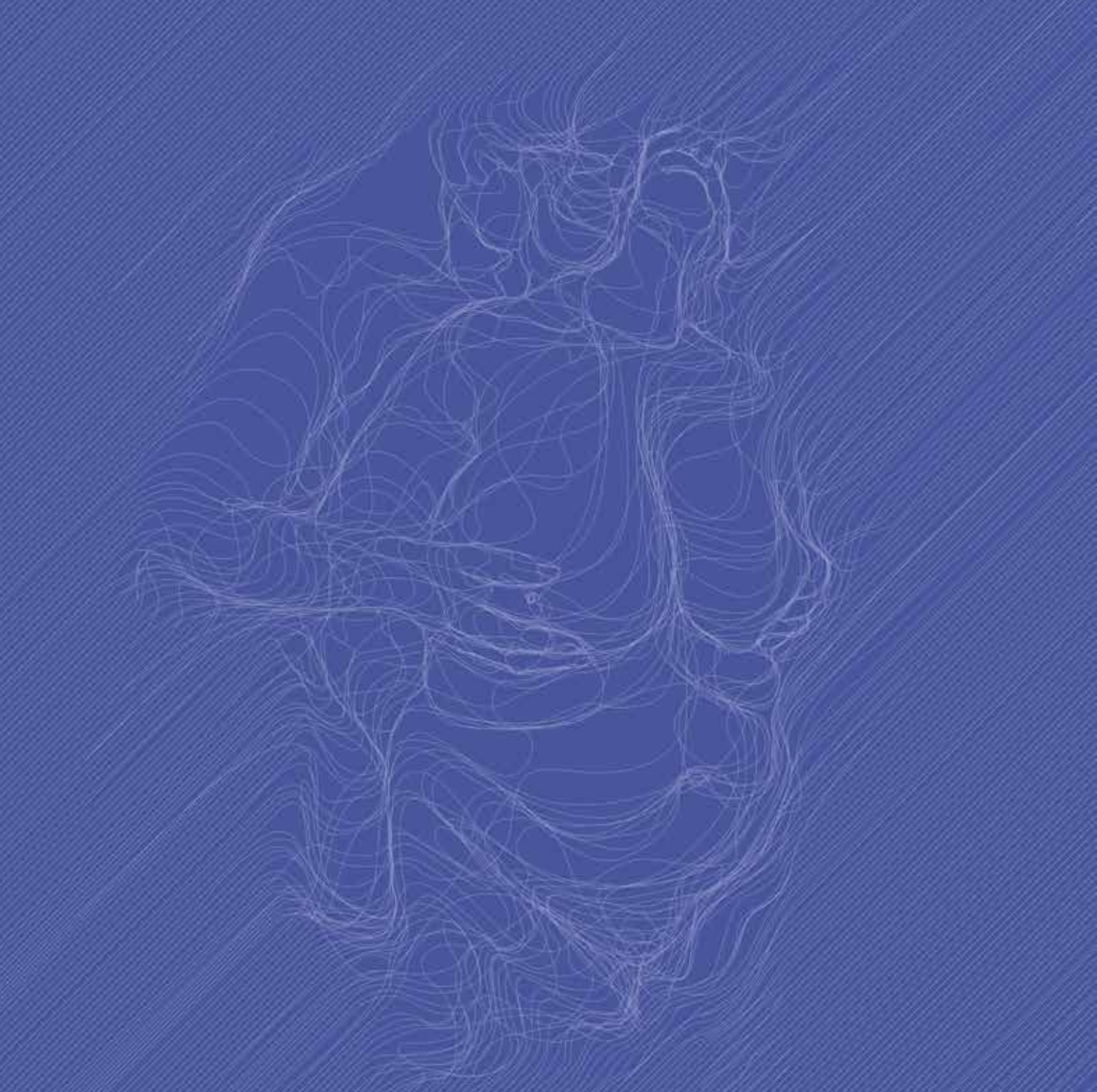
DEFINING RECOGNITION

To recognize is to "acknowledge as true after having expressed denial or doubt" [translation][5]. Caregivers are able to recognize the sexual needs of residents after carrying out observation exercises. At first, they are sceptical, but their research leads them to acknowledge the existence of sexuality among residents. Recognition involves a cognitive process of identification of signs of sexuality among older people. Ricœur[6] notes that recognition also involves a practical gesture of confirmation that attests to the capacities and responsibilities of the persons concerned. In telling off a resident who voluntarily touches her breasts or buttocks, a female caregiver is recognizing his sexual needs. Her reaction not only conveys her displeasure; it also confirms the sexual nature of the gestures. Recognizing the sexuality of residents does not involve accepting all of their demands. Caregivers should react to inappropriate and disrespectful gestures in a spirit of understanding and respect, seeking to establish dialogue and find appropriate responses to the resident's sexual needs: "I understand that you have sexual desires, but my role is to provide care, not to be a sexual partner".

RECOGNIZING SEXUAL MANIFESTATIONS

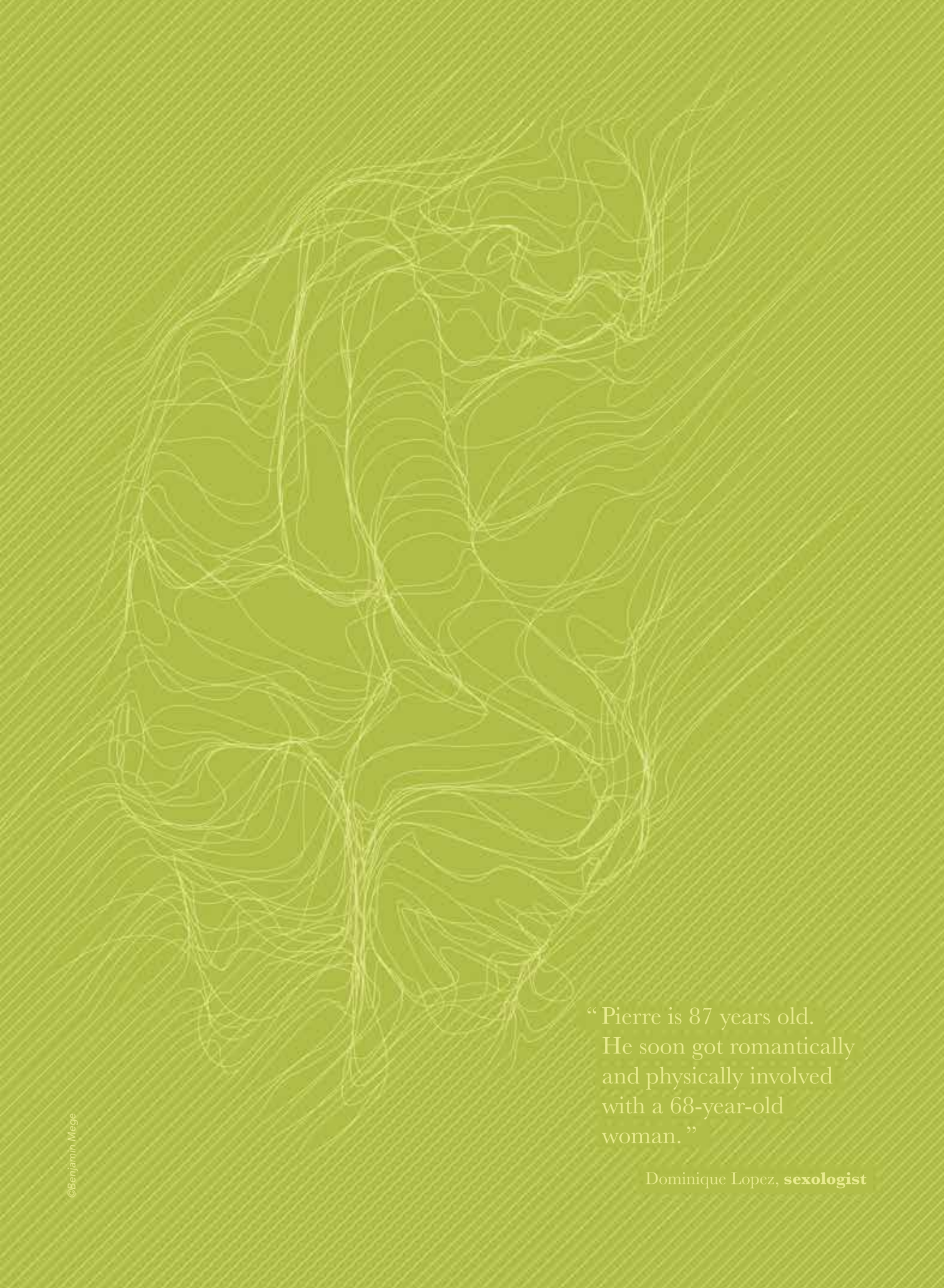
During their observations, caregivers realize that expressions of sexuality are not standard or identical for all residents, but vary according to individual and social characteristics. People will express their sexuality in multiple ways as they try to satisfy their sexual needs. Some residents might be content to look at a person surreptitiously or insistently. Others might enjoy looking at naked bodies in the media, which give them sensations of pleasure and feed their erotic fantasies. In two studies, the majority of older people interviewed said they had sexual thoughts and fantasies[7,8]. Rather than simply looking in silence, some residents use language to express their sexual desires and urges. They enjoy talking about sexual things, either in a subtle or crude manner. They like to give compliments and to make comments that reflect their interest in sexuality. They frequently use erotic humour[9]. After expressing their sexuality through language, some residents show it by exposing their body or sexual practices. Others might request favours, ranging from a simple kiss to genital caresses. In some cases, these

In two studies, the majority of older people interviewed said they had sexual thoughts and fantasies.



“ This isn’t a brothel;
it’s a long-term care facility.
If we put the beds closer together,
who knows what they’ll get up to? ”

Jeanne, **health care aide**



“Pierre is 87 years old. He soon got romantically and physically involved with a 68-year-old woman.”

Dominique Lopez, **sexologist**

requests are insistent and can take the form of sexual harassment[10].

Sexual needs may also be met through touch, primarily self-touching. Residents might engage in autoerotic practices. For some, masturbation is the only realistically accessible form of sexual activity, since they cannot or do not want to have a sexual partner. Some residents touch other individuals with their permission. However, non-consensual sexual practices raise ethical and legal issues. Some might venture to touch a caregiver's breasts or buttocks while others might exchange caresses with a person who agrees to enter into an intimate relationship with them—with our without financial remuneration. This person could be a spouse, a friend, another resident or an escort. In certain cases, sexual needs are satisfied only by kisses on the mouth or cheek. In the absence of a sexual partner, needs may be met through substitute behaviours, such as taking pleasure in eating and drinking. Ehrenfeld et al.[11] have defined three types of sexual behaviours: loving and caring, romantic and erotic.

While residents have sexual desires, few engage in sexual relations[12,13]. In most cases, the expression of sexuality does not occur frequently. The advanced age and physical condition of residents are not conducive to an active sex life. However, some residents have a constitution and life experience that make them more interested in sexuality than others. They are more sexually sensitive and excitable, and have a stronger sex drive than other residents. It is also possible to observe manifestations of hypersexuality caused by neurological disorders[14].

POSITIVE RECOGNITION

Through their observation exercises, caregivers are able to recognize the existence of a sexual life among elderly residents. They acknowledge that sexuality is an integral part of life at all stages and they understand that it is a central component of residents' identity. These caregivers also recognize the ability of lucid residents to manage their sexual life. The latter are able to find and seduce a partner, and to give and receive pleasure. They are able to control their sexual urges and ensure that sexual relations with a partner are consensual.

One of the first impacts of positive recognition is the development of an understanding that there are important physical, psychological and social benefits associated with the satisfaction of sexual needs. Some seek sexual activity to obtain erotic pleasure. By expressing their sexuality, people can experience the enjoyable sensations and emotions related to satisfying a sexual need. Although many residents' lives are burdened with pain and suffering, there is still room for various forms of pleasure. The search for sexual pleasure is accompanied by a desire to satisfy psychological needs such as feeling pleasant emotions, expressing love and attachment, and consolidating one's sexual identity. It is also accompanied by a desire to fulfil social needs such as meeting someone special, giving and receiving pleasure, and building a relationship. In short, the satisfaction of sexual needs helps to improve residents' quality of life[15].

A second result of positive recognition involves planning and coordinating professional actions to ensure residents' sexual well-being. An institutional project could be developed and applied, providing general guidelines for appropriate attitudes and behaviours, thus making it possible for residents to enjoy a healthy and fulfilling sex life[16]. This frame of reference allows caregivers to discuss their observations and decide, together with residents, on a set of rules to ensure that adequate services are provided.

NEGATIVE RECOGNITION

Caregivers' actions often involve forms of negative recognition. In such cases, the sexual needs of residents are ignored or disparaged. For example, a caregiver might react with indifference to an expression of sexuality or might refuse to answer a resident's question. The caregiver sends the message that the resident's

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sexuality is not important. The resident's sexual life may have been important before s/he was admitted to the nursing home, but now that life has no value. Most often, caregivers ignore and do not concern themselves with such matters. Residents are seen as beings who have no interest in sexuality or who can forego sexual expression without any inconvenience[17]. Even if some caregivers believe that residents have sexual needs, they do not think it is necessary for them to express their sexuality.

Residents learn to suppress their desires and mask their sexual needs. Negative recognition produces narcissistic injury caused by a devaluation of the self and sexual identity. For example, a resident caught masturbating in his room will feel humiliated at being told off. This process becomes even more insidious when residents are encouraged to take part in the devaluation process by conforming to the asexual identity ascribed to them.

It goes without saying that residents refuse and oppose this devaluation of their personal and sexual identity. They experience a feeling of injustice at being treated like second-class citizens whose freedom and autonomy have been taken away from them. They claim their right to a sexual life by demanding that their sexual privacy be respected. Conflicts may arise between residents and caregivers, each defending their respective interests. Such conflicts have been recorded in life narratives[18]. In this context, Habermas[19] invites both parties to defend their interests through discussion and deliberation, each side seeking to convince the other. This dialogue requires a recognition of equality among all parties concerned.

CONCLUSION

During their initial training, caregivers rarely have an opportunity to discuss the sexuality of elderly nursing home residents. This helps to reinforce the view that residents simply do not have a sexual life. It is important that training programs encourage caregivers to take residents' sexuality into account—a topic that is often

not discussed at nursing homes. By learning about the sexuality of residents and observing the various ways in which it is expressed, caregivers may discover a rich and complex reality that is not limited to intercourse. Shared observations are an effective way to restore a climate of positive recognition regarding the sexual needs and rights of residents. Caregivers come to realize that the expression of sexuality improves residents' health, gives them pleasure and joy, and enhances their self-esteem and appreciation of others.

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a. Observation is the first step toward reaching a common diagnosis and deciding on a plan of action. Shared observation involves "group reporting using a shared vocabulary and offering complementary, multiple perspectives. It provides a more comprehensive view based on shared knowledge, mutual recognition and a culture of partnership, and allows stakeholders to decide on a project tailored to their specific needs" [translation].

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The Impact of Spousal Caregiving on Older Women's Experiences of Sexuality and Intimacy

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Over the past two decades, there has been increasing recognition of the emotional, social and financial consequences experienced by women providing care to an ailing spouse or partner. However, sexuality and intimacy within the context of caregiving have remained relatively unexplored in the literature. Some research has shown that intimacy appears to play a role in women spouses' positive caregiving experiences. Women who are able to maintain companionship, friendship, physical and emotional closeness within their relationships appear to experience more caregiving rewards than those who do not[1]. Yet, despite preliminary evidence that intimacy between women spouses and their partners may positively impact their caregiving experiences, intimacy is rarely defined or examined[2].

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RESEARCH PROJECT

Other research has focused on sexuality and intimacy in the context of caring for a spouse or partner with a cognitive illness, such as Alzheimer's[3,4,5]. Findings from this research indicate that indeed caregiving has an impact on the couple relationship[6,7], and that caregivers rarely discuss these concerns with health and social care providers[8]. The absence of empirical literature and practice approaches examining intimacy and caregiving may, in part, be due to stereotypes associated with aging, where older adults, especially women, are seen as asexual[9,10].

Considering that it has been shown that a satisfying sexual and intimate life in older adulthood contributes to the quality of life and healthy aging[11,12], it is important to examine the impact of spousal caregiving on women's experience of their sexual and intimate lives. It is our hope that this research will help fill the knowledge gap in this area and lead to improved outcomes for older women caregivers and an increased capacity of health and social care providers to address sexuality and intimacy in their practice with these clients.

METHODOLOGY

In order to explore how older women understand their experience of caregiving, we used an adapted phenomenological approach[13,14,15]. This approach was particularly relevant as the emphasis of data collection and analysis is on how meaning is created from a participant's lived experience. We sought to identify older women caregivers who were caring for a spouse or partner in the home, resided in the community and who were aged 60 years or older. Through outreach in health and social service agencies, we recruited a final sample of six women caregivers; this small sample size is consistent with a phenomenological approach. Key informant interviews with health and social care professionals were also conducted in order to enhance our analysis and provide an additional perspective on the emergent themes. Interviews took place with 10 service providers who work with older adult caregivers at a community service centre.

FINDINGS

Women we spoke with identified a number of shifts in their identity as a result of their caregiving role. These included a shift from spouse to that of caregiver, as well as from sexual to asexual or unattractive. The role of caregiver became all-encompassing for women, leaving little room in the caregiver-care receiver dynamic for sexuality and intimacy. Some women stated that for them sexuality had become irrelevant, whether in the context of their life course or because of the impact of their caregiving role. These findings were echoed by key informant interviews with service providers, who felt that sexuality and intimacy are not priorities for women who are overwhelmed by their caregiving tasks.

Despite women stating that there was no longer sexual activity between them and their partners, they continued to find ways to express their intimacy and sexuality. Some women spoke of cuddling, doing nice things for one another, remembering the intimacy they had once shared with their partners, or masturbation. The women interviewed do not talk to their partners, friends or family about sexuality or intimacy, some having had negative experiences when trying to do so. Most striking however, was that all of the women interviewed stated that they would not discuss sexuality and intimacy with a health or social care provider, due to perceived service provider discomfort. It appears from our research that older women caregivers rarely, if ever, talk to anyone about their sexual and intimate lives. This finding leads us to wonder about the resulting consequences for the health and well-being of older women caregivers.

Key informant interviews with health and social service professionals added depth to our understanding of what older women caregivers expressed. Service providers all felt that sexuality and intimacy are important subjects to address in their work with caregivers for a variety of reasons. Some service providers stated that sexuality and intimacy are simply an important part of a couple's relationship, while others explained that by addressing sexuality and intimacy other issues can surface, such as underlying medical problems or abuse.

Older women caregivers rarely, if ever, talk to anyone about their sexual and intimate lives. This finding leads us to wonder about the resulting consequences for the health and well-being of older women caregivers.

Service providers elaborated on the almost complete silence around the topic of sexuality and intimacy in the health care encounter, and identified numerous barriers to addressing this issue in their practice. They attribute some of the silence around this subject to myths and taboos related to older adults and sexuality, which likely play a role in the discomfort with this topic. They told us that they find bringing up sexuality and intimacy with their clients to be "tricky" and "awkward", and many hesitate to address this subject because they imagine that it is not important for caregivers. Discomfort on the part of clinicians, as well as the perceived discomfort of clients, stem from the private nature of the topic, while others cited client age and/or gender as having an influence on their ability to address this subject. Service providers thought that when meeting with a client of the same gender, or of a similar age, it would be an easier subject to address.

Institutional-related barriers also contribute to silence around sexuality and intimacy in the health care encounter. Service providers told us that sexuality and intimacy is a topic that has not been pushed forward as important within their organization. For example, most service providers with whom we spoke, told us that clients are rarely asked the sexuality-related question on the Multiclientele Assessment Tool (OEMC); this section is consistently left blank or marked not applicable/not

addressed. Supervisors do not enforce the asking of this question and service providers feel that this contributes to a perception of sexuality and intimacy as being irrelevant for older clients. Service providers stated that they are not encouraged to discuss these issues with clients, or trained on how to bring up and address sexuality and intimacy in their practice.

Despite these barriers, some service providers do attempt to address sexuality and intimacy with their caregiving clients. Service providers told us that in order to bring up this topic it is important to first develop a rapport and trust with clients, as well as to introduce the subject slowly by using the word 'intimacy' before talking about sexuality. Service providers with more clinical experience and who were older, felt that these factors made talking about sexuality and intimacy easier, as much for them as for their clients.

RECOMMENDATIONS

In order to better meet the needs of older women caregivers, service providers have an important role to play in bringing up and addressing sexuality and intimacy with their clients. Our interviews with service providers resulted in some recommendations for improved practice with this clientele.

Service providers are interested in learning from older adults in order to get a better sense of how aging and sexuality are experienced, and which needs result. Service providers spoke about their need for training to address discomfort and to learn strategies for initiating discussions with clients about sexuality and intimacy. Trainings can also be an opportunity to provide information and to address ageist assumptions regarding older adults' sexuality.

Service providers also suggested information sessions and workshops for older adults on sexuality. Workshops could be gender specific, for couples, individuals, or illness specific; all could help in addressing issues such as internalized stigma, self-esteem, and the role changes associated with caregiving.

Expanding existing services for older adult caregivers can help facilitate discussions about sexuality and intimacy with clients. As service providers noted, these conversations are easier when there has been sufficient time to build a rapport and trust with clients, highlighting the importance of long-term counseling initiatives. Caregiver support programs, as well as post-diagnosis counseling and follow-up, are other areas where service providers have an opportunity to bring up sexuality and intimacy.

Finally, ongoing research and the dissemination of information is critical in continuing to understand the impact of caregiving on sexuality and intimacy, and to better address the needs of older adult caregivers.

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HIV/AIDS and Seniors: Let's Break the Silence!

Diane Goulet

Member of the board of directors of Maison Plein Cœur

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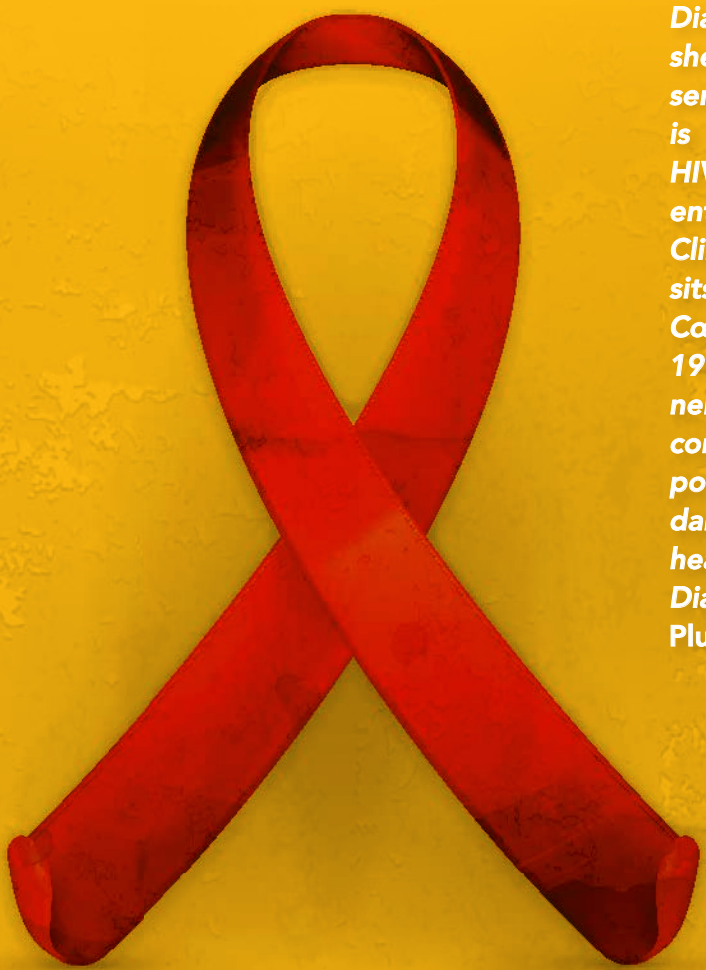


Diane Goulet is 68 years old. For many years, she has volunteered at organizations providing services to people living with HIV/AIDS. She is particularly focused on women living with HIV/AIDS. She has also worked as a data entry technician on research projects at the Clinique médicale Quartier latin. She currently sits on the board of directors of Maison Plein Cœur, a community organization founded in 1991 and located in Montreal's Centre-Sud neighbourhood[1]. The organization aims to combat the solitude, isolation and increasing poverty of people living with HIV/AIDS. Its fundamental objectives are illness prevention and health promotion. This article summarizes what Diane Goulet had to say during an interview for Pluralages.

COULD YOU TELL ME ABOUT YOUR VOLUNTEER WORK?

I've been on the board of Maison Plein Cœur for the past four years. Before that, I was very involved in the organization, and I also volunteered at a group for women called CASM, the Centre for AIDS Services of Montreal. We created documents to empower HIV-positive women. I also participated in the development of a guide called *Sharing Together for Life*, which is available online[2]. It's designed to inform service providers about issues related to disclosure or non-disclosure of HIV status: what to say, when and is it necessary? We also created a brochure to raise awareness around HIV-positive women. As a member of the board of directors of Maison Plein Cœur, I attend the Canadian AIDS Society's Annual General Meeting every year where I talk about aging with HIV/AIDS.

WHY ARE YOU CONCERNED ABOUT THIS ISSUE?

Before, people who contracted HIV/AIDS died young—it was as simple as that. But today, there are many people who are aging with HIV/AIDS. I meet a number of individuals who found out they were HIV-positive in the 1980s. They're not the vast majority, because many at the time died, but they're still alive and they're getting older. Others who found out later and had access to better medication are also aging. In addition, more and more of those contracting the virus are older adults[3].

Through my volunteer work, I've been in situations or heard stories that have made me realize just how little we know about the various experiences of older adults with regard to HIV/AIDS. For example, there was the case of an 80-year-old woman who, after her husband's death, went to see a doctor because she wasn't feeling well. She had a series of tests that all came back negative. Finally one doctor tested her for HIV and the test came back positive. The other doctors hadn't thought to order the test, because she wasn't in a high-risk category. How long had she been HIV-positive? Because you don't necessarily get sick—it really depends on the person. Had her husband been sick? Is that why he died? We don't know. But this woman found out she was HIV-positive at the age of 80. Not an easy situation.

Other older women decide to travel south after a grieving period or separation, and they meet men who might become lovers. When they return home, they discover they've contracted HIV. Often, they're grandmothers. When we invited them to join a support group, they didn't want to. They didn't want to talk about it—not with their family or anyone else. I recently helped a woman my age who discovered she is HIV-positive. We talked about different resources. It's hard to accept, but she's doing better.

WHAT ARE THE MAIN DIFFICULTIES ENCOUNTERED BY OLDER PEOPLE LIVING WITH HIV/AIDS?

As we all know, this disease involves a lot of taboos and rejection. People are afraid. When I told someone I was doing volunteer work with HIV-positive people, she asked me whether I was afraid. Afraid of what? There are a lot of misconceptions and prejudices out there. And yet nobody is completely safe.

If the person is a man, people assume he's gay. If it's a woman, they assume she sleeps around. When you find out someone is HIV-positive, you shouldn't always blame the person. It's normal to have sexual relations, even later in life. If a person finds out he or she is HIV-positive, and on top of that has to deal with rejection, it's terrible!

If you tell your loved ones you have cancer, you receive care and sympathy. If you say you're HIV-positive, that changes everything. "You must have asked for it!" Not only do people think and say it's your fault; some might even distance themselves from you out of fear or prejudice. Individuals living with HIV become isolated as a result. They experience as great

a shock as if they had cancer, but they don't get sympathy from their family, friends and even some health professionals.

Before, we used to see cases where doctors and other health professionals refused to treat HIV-positive patients. Things have changed, but there's still a lot more to be done. Nurses don't receive adequate training in this area. In their courses, they spend almost no time on HIV-related topics. And yet the number of HIV-infected people is on the rise.

YOU'RE PARTICULARLY CONCERNED ABOUT THE SITUATION IN RETIREMENT HOMES. COULD YOU ELABORATE?

When I moved to a retirement home, I realized people were completely ignorant about this issue. Older people don't talk about it; they figure it doesn't concern them and they have no idea how to protect themselves. All because HIV/AIDS is associated with sex, and older people aren't supposed to be thinking about that. But in retirement homes, behind closed doors, people get up to all kinds of things! It's perfectly normal!

They experience as great a shock as if they had cancer, but they don't get sympathy from their family, friends and even some health professionals.

People who are aging with HIV/AIDS, or who contracted the virus in their fifties or later are moving to retirement homes. There are spots reserved for HIV-positive people (in retirement homes, low-cost housing and so on), but that doesn't mean they all go there! When I moved to a retirement home, I realized we have to talk about this, because people aren't aware.

HIV rates are increasing among older people. It's not necessarily a dramatic increase, but it's an increase all the same. It's connected with Viagra and similar medications. Men are having sexual relations later in life, and women often haven't had many partners. They had one husband and are now widows or separated, and they meet another man. They've never used a condom before and they figure it's not necessary. Later they find out they're HIV-positive.

Because of all the stigma, most people living with HIV don't want anyone to know. They're cautious, because they've often been rejected in the past and they're afraid of being rejected again. In retirement homes, news travels fast and people might become isolated. Sometimes older people don't disclose their status to anyone—not their children, family or friends. When they arrive at a retirement home, the issue of disclosure versus non-disclosure becomes important. They don't want others to know, but at the same time they might have to reveal their status if they become ill. Or the nurses might find out, because they recognize the medications the person is taking. It's not easy.

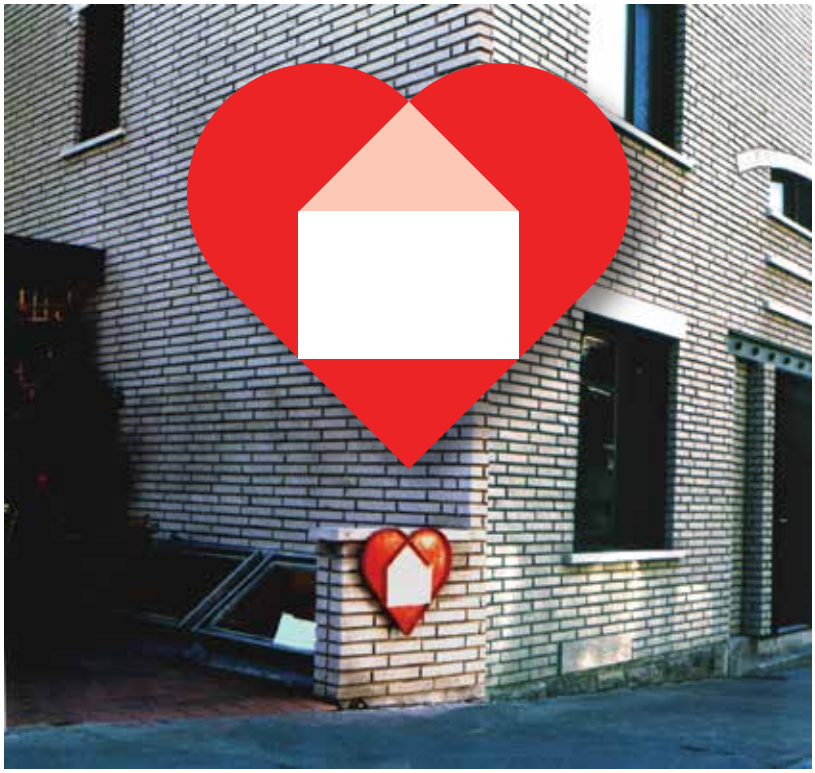
THE IMPORTANCE OF TALKING ABOUT IT...

When I arrived at the retirement home, I felt things had to change. We had to do something, to start bringing this issue out into the open. At the time, the directors at my retirement home (and at other homes) weren't very keen on the idea. The government has to get involved as well. We have to give talks and get people to change their views.

We have to face the facts. That's the message I want to get across: even if you're a senior; even if you think you're not HIV-positive; even if you've never used a condom; even if you meet someone at the retirement home who seems

very nice, you don't know that person's HIV status. There are people who don't know that they're HIV-positive and who transmit the virus that way. On the other hand, it's important to understand that being HIV-positive today is not the same as before. With the medications we have today, the viral load is undetectable and transmission rates are very low.

We need to hold meetings. The problem is, when we organize meetings in retirement homes, half the people don't show up. It's important for people to come and talk, and to find out how to protect themselves. It's also important for them to understand that it's not dangerous to live in the same retirement home as someone who is HIV-positive. We need to reach a point where people living with HIV/AIDS are not afraid and are no longer shunned.



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1. www.maisonpleincoeur.org.
2. This project was led by Dr. Johanne Otis, a professor at UQÀM's sexology department and holder of the Canada Research Chair in Health Education. For more information, visit: www.catie.ca/en/pc/program/sharing-together-life.
3. Close to a third of new diagnoses in 2009 were among people aged 50 and over. See Isabelle Wallach's article, on page 8 of this issue.

Conference Review:
A Feminist Perspective

Gisèle Bourret

On behalf of the senior women's committee of the Fédération des femmes du Québec
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Pictures from the Exposition **VisÂges et TémoignÂges.**
Un regard sur la beauté de la vieillesse, des réflexions remplies de sagesse!
Organized by Les Petits Frères, Fall 2012.

As head of the senior women's committee of the Fédération des femmes du Québec, I would like first of all to express my appreciation to the organizing committee for holding a symposium on this important theme. It is certainly time we deconstructed the myths and taboos surrounding older people's sexuality, and the symposium program went a long way toward doing just that. I would like to underscore, among other things, your boldness in addressing topics that are generally not spoken about, such as sexual diversity (lesbian, gay, bisexual and transgender elders). In my view, the symposium met its main objectives.

I was struck, however, by two elements during discussions following the presentations and workshops: the views of certain participants regarding sexual aggression, and the suggestion of escort services as a possible way to meet men's sexual needs.

Experts almost unanimously agree today that sexual aggression does not stem from a suppressed or restrained sexual urge, but rather from a desire to dominate and subjugate another person without their consent. Sexual aggression is an unjustifiable abuse, regardless of the age of the aggressor and victim. Abusers must come to recognize this fact so as not to repeat their behaviour. This, in my view, should be the goal of intervention initiatives.

Certain conversations during the symposium seemed to suggest that one possible solution (a form of damage control) would be to direct the aggressor toward an escort. Such a solution would not, to put it mildly, be beneficial in the least to the aggressor and would not be at all reassuring for the women (residents and staff members) around him. It would also reinforce the belief that, in the case of an escort, the issue of sexual aggression is irrelevant!

This leads me to the second point—the use of escorts as a possible solution. I was disconcerted to learn that certain institutions are seriously looking into offering this service to older men. This raises a number of social issues, of which I will discuss only a few.

The first involves reproducing a double standard around male and female sexuality—with male sexuality seen in terms of satisfying urgent needs. In this view, it is imperative that we offer "services" to satisfy these needs, and one of the fastest and easiest ways to do this would be to call on an escort. It also spares us the trouble of coming up with more imaginative ways to allow men ***and women*** *in retirement and nursing homes to express their sexuality in a spirit of mutual respect and dignity. Such an exploratory and innovative exercise would allow the needs (expressed or not) of both parties to be taken into account.*

Secondly, it is important to note that, in our view, sexual "services" such as those provided by escorts cannot be considered on the same terms as other forms of "care." Within the women's movement in particular, an important part of the goal to establish equality between men and women involves countering the commodification of women's bodies—even though there is not unanimous agreement regarding prostitution and sex work.

To support recourse to sex workers for residents in government-approved nursing homes is equivalent to arguing in favour of sex work—which is a highly debatable position. We therefore need to think more carefully about the impacts of such a decision.

To conclude, I feel that female sexuality was not sufficiently discussed at the symposium, and that the sexuality of seniors was implicitly seen through the lens of male sexuality. In this vein, we would have liked the title of the symposium to be gender-neutral.

These are some of the questions and thoughts I would like to share with you following my participation in the symposium. I thank you for your attention and wish you good luck in your work.

Female Sexuality Through the Eyes of a "Vintage" Woman

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By demystifying the unknown and revealing identities, taboos and much more, the symposium on the sexuality of older people helped to shake commonly held beliefs on the topic. I had the pleasure of interviewing Quebec sexologist and author Jocelyne Robert, who expertly hosted the day-long event. Here are some questions and answers inspired by the symposium and tied to Jocelyne's latest book, Les femmes vintage ("vintage women").

ACB: Could you briefly describe a "vintage" woman?

JR: *She's a baby boomer. She's over 50 and is authentic—unaltered and delectable, like a good vintage port. Just because she's past the taboo 50- or 60-year mark, she's not about to be put in quarantine! Vintage women have no frame of reference, because their predecessors were already considered old at that age or had passed away. So they have to invent their lives as they go along. They want to enjoy the many years that lie ahead. They're a whole new breed, without historic precedent.*

ACB: What is the difference between a vintage woman and other generations of women?

JR: *Older generations of women felt less pressure to stay young at all costs and to avoid becoming old, fat or unattractive. Vintage women lived through the sexual and feminist revolution. They experienced free love and communes. They're the first batch of boomer grannies who want to maintain their status as women. Younger generations of women were born into a culture of sex, bodies, cash, "pathetic" surgery, and the reification of women's bodies and genitals. They're under enormous pressure to conform to a stereotypical model. Women with balloon breasts, bee-stung lips, stretched eyes and Botoxed foreheads all end up looking the same. For the vast majority of women, even young women, it's very difficult to look like that without having work done. For a woman in her late prime (i.e., a vintage woman), it's impossible. Those who get caught up in the quest for eternal youth end up looking like avatars or mass-produced human beings.*

ACB: How is the sexuality of vintage women different?

JR: *They're the first generation of sexed and sexual grandmothers (as a group, because prior to now, there were obviously individual postmenopausal women who remained sexual). They don't feel they have to stop being attractive or seducing and being seduced.* >

ACB: What do you mean by the female aging process?

JR: *The aging process is more challenging for women than it is for men. Challenging, because they are subject to a separate set of constraints and discourses. Aging is not a choice, but society doesn't give us the right to age either. I try to introduce the idea that beauty is not the exclusive privilege of the young, because it comes in many forms. If we were even just a tiny bit open to this idea, women would accept their aging selves much more and would more happily embrace age-related changes that give a patina to the body without making it unattractive.*

ACB: In your book, you refer to a fictitious character named Gwendoline Dubois—an erotic, uninhibited woman who goes further than the baby boomer generation of women. Do you think this emerging woman will be able to lessen the taboos associated with the sexuality of aging women?

JR: *Yes and no. If we recognize that she exists, or that she could exist, that would already be a victory.*

ACB: Sexuality is often focused on sexual performance, without taking the game of seduction into account. This woman you describe has, from a young age, been a vehicle for stereotypes related to beauty and to the role (shaped by religious thinking) that she is supposed to fulfil in a relationship and in society. In the 1970s, we had the sexual liberation movement. Do you think the early feminists feel there is more openness today as far as women's roles and sexual identity are concerned?

JR: *A person's sexual identity never dies, but their sexual expression (be it homosexual, heterosexual or autosexual) can become muted. A woman (like a man) needs to be seen as a woman right up to the end. Sexual identity is an internal, intrapsychic feeling of belonging to a group—of women, if you're a woman and of men, if you're a man. It's expressed through the need to be recognized as a woman or man until death, and through the pride that comes with that recognition.*

ACB: What do you think of feminism in relation to sexuality and the aging of women?

JR: *One of the failures of feminism is precisely women's dread of growing old—their desire to stay young at any cost. Women's phobia about revealing their age is one of the most obvious failures of feminism.*

ACB: Do you think that vintage feminists will be able to get rid of these age taboos for future generations of women?

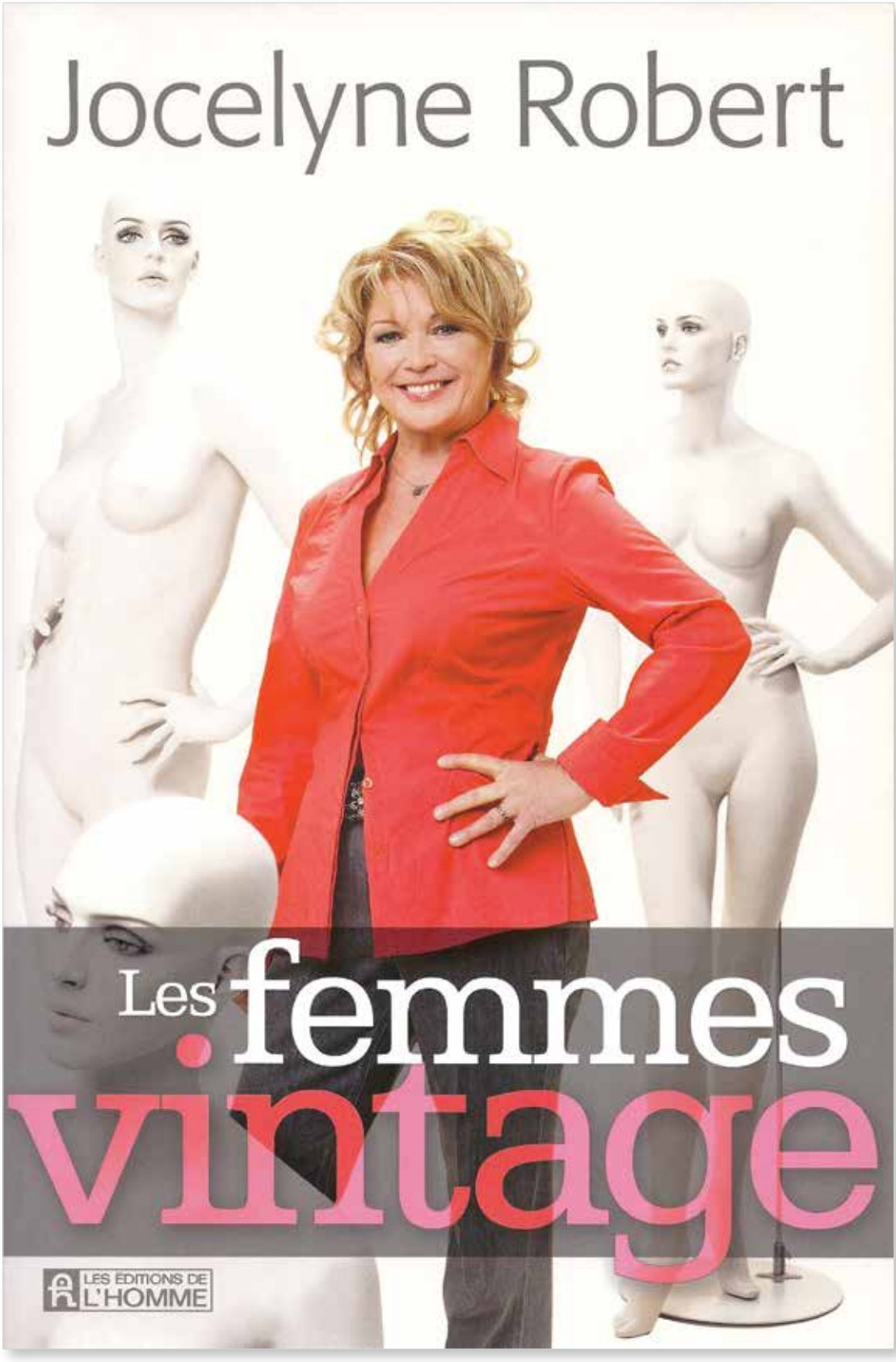
JR: *Certainly not entirely, but I think they can make a difference. They have to dare to speak out instead of remaining silent and in the shadows.*

ACB: Do you think the value placed on beautiful bodies and youth influences the role of seduction among women past the age of sixty? And among women living in nursing homes?

JR: *Definitely; it's inevitable.*

ACB: You talk about the "Viagraman" phenomenon. Do you think this increases the already substantial pressure on women to avoid becoming fat, unattractive or old?

JR: *It's an additional constraint. I've heard women half-jokingly say, "Oh, I'd better get ready—Granddad's taken his pill!" There are also women in their seventies who genuinely enjoy penetration. The danger with Viagra is that it's seen as an easy alternative to taking a closer look at the relationship. Couples might also miss out on a wide range of possible erotic exchanges that don't involve penetration. I think a lot of Viagramen turn to younger women, because they think women their age aren't "turned on"—not always because they don't find them desirable.*


Jocelyne Robert
Les femmes vintage
LES ÉDITIONS DE L'HOMME

Vintage women don't always feel free to openly express their desire. They feel they're not allowed to, precisely because they no longer correspond to the established model (young, fresh, and in line with dominant beauty stereotypes).

ACB: How can vintage women help to change preconceived ideas regarding the sexuality of older people?

JR: *By expressing themselves and being visible.*

At the end of the interview, I insisted Jocelyne Robert have the last word.

I'd like us to stop believing that wrinkles are obscene. Much more obscene, to my mind, is a 40-year-old who tries to look like a young nymphet or a 60-year-old who has herself remodelled to look half her age. I find plastic surgery pathetic, because it fixes and petrifies the skin, creating a look I associate far more with death (immobility and smoothness) than with beauty (movement and life). In my experience, women past the age of 50 are beautiful and desirable inasmuch as they are alive and feel desire. Women who opt for cosmetic procedures to stay seductive and desirable are presumably unaware of the fact that eroticism lies in movement, not stasis.

For me, agism is an imprisonment, a putting to death long before actual death occurs. The cult of youth is an ideology, a religion, an idolatry, an illusion. We should rather draw a distinction between a person's chronological and subjective age. At the time of this writing, it's 33 degrees outside in Montreal—40 with the humidity factor. The same is true for a person's age. How old you feel seems to be a much more accurate and authentic measure to me. In other words, you're old when you feel old. It could be at 40 or 90 or never, depending on external "temperature" readings such as your environment, how others see and judge you, etc., and internal readings, such as personal satisfaction and self-esteem. Unfortunately, the outside temperature often influences what we feel inside.

In all Western societies, there is now a critical mass of women (the baby boomers) who, although they are the most numerous and active, belong to an unnamed age group. At 60, you're no longer in your prime, but you're not an old woman either. That which is not named doesn't exist. In Les femmes vintage, I wanted to name something that's as plain as the nose on your face.

>> Check out Jocelyne Robert's blog at: ***jocelynerobert.com***

70 Years Old... and in the Closet?

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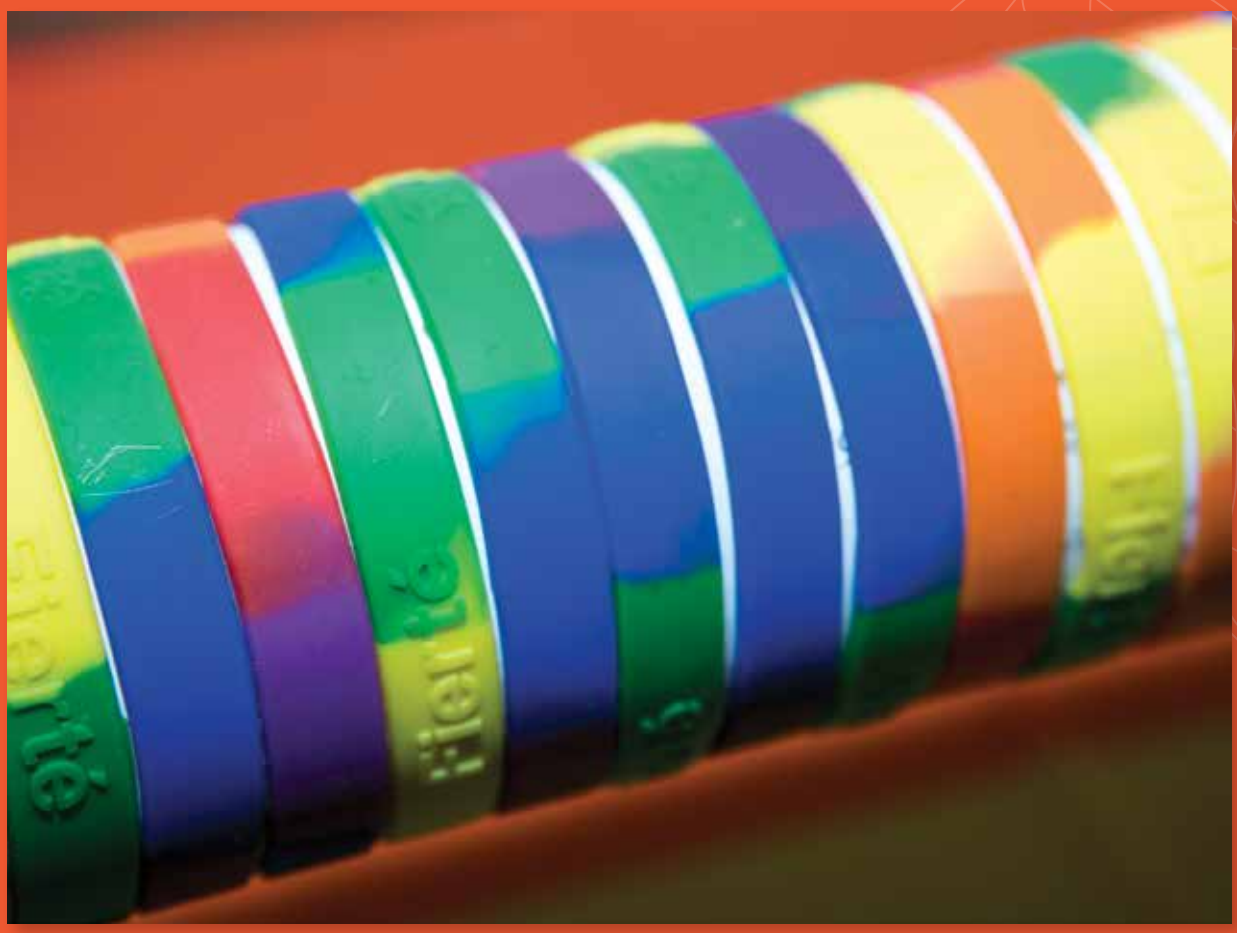
***70 ans... et au placard?* is a must-see television documentary by Robin McKenna on the little-known realities and issues faced by lesbian, gay, bisexual and transgender (LGBT) elders in Ontario's French-speaking community.**

The film opens with one man's compelling account: "It was really tough. I knew I was attracted to men, but it wasn't something you spoke about." The film's participants describe their long-standing fears—of being found out, excluded and rejected—in life narratives that are both poignant and deeply troubling.



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Through these narratives, we discover some of the challenging realities faced by LGBT seniors and the place they have, and will have, in the current health system (home care, retirement homes, specific programs). The documentary also looks at the issue of access to services in French and suggests that LGBT seniors should not have to choose between two identities: their identity as native French speakers and their sexual identity.

Jean-Rock Boutin, the founder of FrancoQueer, an association serving Ontario's francophone LGBT population, explains: "Treating everyone the same means treating everyone as if they were straight," which immediately excludes the realities of the LGBT population. The account of another participant who lost his partner reveals his suffering during the grieving process. There are many poignant accounts of people's hidden lives: "We could never share our happiest moments." This immense sense of solitude is a recurring theme throughout.

Participants also describe their apprehension about having to "go back into the closet" as they age, showing that nothing can be taken for granted. The social recognition of LGBT elders is a battle that must be waged in all spheres of society, which is why this documentary is so important.

A certain number of gay and lesbian elders have experienced various forms of discrimination during their life, ranging from insults to institutionalization, with the result that many have become invisible. The baby boomer generation wants to change this reality. During the documentary, we meet Line Chamberland, a researcher and professor in UQAM's department of sexology and holder of the Research Chair on Homophobia, who has participated in studies conducted at McGill University on gay and lesbian seniors. She stresses the need to raise awareness at the institutional level in order to create inclusive, safe environments for LGBT seniors. We also discover a gay-friendly private retirement home—an option for LGBT seniors who want to live in an environment that takes into account their realities.

Education is key to forging new discourses and mindsets, dispelling prejudices and ensuring that LGBT seniors can feel safe and accepted. It is also important to ensure that people living in Ontario are able to receive adequate services in French, especially in their later years.

What needs to be done to bring about change? This is the crucial question the documentary invites us to ponder. The first step is to become aware of the needs, fears and realities of LGBT seniors. The documentary makes it abundantly clear that people cannot remain invisible out of fear of discrimination. Gay and lesbian elders no longer want to remain silent. They want to be themselves, in all areas of their lives. They hope that society will accept their different realities. Their voices must be heard beyond our institutions and pave the way for the creation of more inclusive and equitable environments.

70 ans et... au placard? is a moving documentary that gives a voice and face to a population that has been living in the shadows for too long.

A documentary produced by Médiatique inc. and directed by Robin McKenna for Radio-Canada in 2012. Length: 49:12.

>> To watch the trailer: ***www.youtube.com/watch?v=kV0w_-7km4M***

Communicating Around a Taboo: The Sexuality of People Aged 70 and Over

Statements gathered by Véronique Billette, *Ph.D.*

Coordinator of the FQRSC research program Vieillissements, Exclusions sociales et solidarités (VIES)

In this issue of* Pluralages*, we are delighted to present various images from a graphic design dissertation completed in 2009 by Benjamin Mege, a graduate student in applied arts (FORM, Lycée des Arènes, Toulouse, France).

The project, titled "Communicating around a taboo: the sexuality of people aged 70 and over," sought to analyze the nature of taboos in our society and to find different ways to communicate them to a broad audience. Benjamin Mege is interested in the taboos that influence how we relate to the world around us. He has created a "roadmap" of persistent taboos in France around topics such as aging, death, money, incest, sex, sexually transmitted infections and sexual deviance. The sexuality of older people occupies an important place among these taboos.

©Benjamin Mege

The project was based on a series of interviews conducted at retirement homes in Toulouse and Clermont-Ferrand (France), and on a review of the literature on taboos, aging and the sexuality of older adults. The interviews confirmed the existence of a taboo around the sexuality of older people—one that is even more deeply entrenched than that around the sexuality of children and teenagers. This taboo came to the surface in a number of ways: the interviewer's realization of his own taboos and prejudices; his reluctance to reveal the interview topic to the administrators of certain retirement homes in order to avoid negative responses; and the need to "beat around the bush" before addressing the topic directly with interviewees in order to set them at ease. The interviews conducted with older adults and staff members at >

the retirement homes revealed that people living in these environments have active sexual lives. Sexual relations, new relationships, breakups, the desire to have a sex life despite health issues or medication, and the desire to be attractive and to have relationships are all part of daily life at a retirement home. Beyond prejudices, and despite physical and psychological barriers, older adults find different ways to express their sexuality and desires past the age of seventy. However, this reality is only rarely discussed and taken into account in the delivery of care and services.

Mege's personal observations and analysis of the interview transcripts allowed him to identify three communication objectives aimed at breaking this taboo:

Raise the issue of sexuality at retirement homes or find artistic media to spark discussion around this topic in a hospital environment

Educate professional caregivers

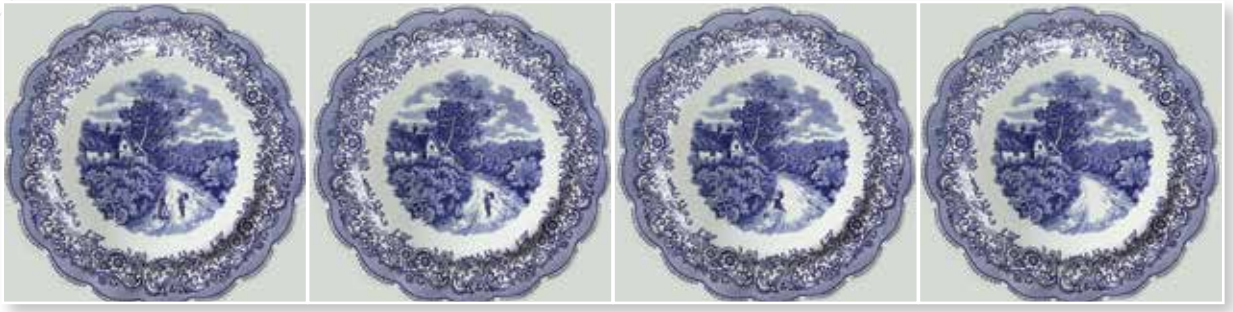
Raise public awareness around the topic of sexuality past the age of seventy

He proposed a wide variety of ideas in his dissertation, ranging from the creation of an artistic exhibition that would travel to a number of retirement homes in France, to the production of bus shelter posters to raise public awareness or posters targeting retirement home personnel and residents (see pages 26-27 of this issue). One of the original ideas presented in connection with the travelling exhibition was to produce an animated ceramic piece: during the exhibition, the image on a porcelain dish would gradually be replaced by a sexually suggestive image. Technically, this involved printing plates with heat-sensitive ink that would display a different image according to the temperature of the plate (see images below). In this specific case, after a hot meal had been served on the plate, the sexually suggestive animation would be activated as the plate cooled. An interesting way to spark discussion around the dinner table!

All aspects of the project emphasized the need to raise awareness around the diverse realities of older people's sexual lives in order to start a conversation involving seniors, professionals and the general public—a conversation that will help to dispel myths, broaden horizons and improve the quality of life at retirement homes for current and future residents.

For more information, please contact Benjamin Mege at the following email address: **mege.benjamin@gmail.com**.

Mege, Benjamin (2009). *Communiquer sur un tabou : la sexualité des personnes de plus de 70 ans.* Graphic design dissertation, Graduate Diploma in Applied Arts, FORM, Lycée des Arènes, Toulouse, France.



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SEX OVER FIFTY

By The Society of Obstetricians and Gynaecologists of Canada (SOGC)

Sexuality, sensuality and the urge to love and be loved don't fade with age. Our sex-life changes as we age, but it doesn't disappear! In fact, most Canadians over 65 are sexually active and say that sex is important to them.

Our sexuality is not just what we do, or how often we do it. Our sexuality includes how we think, how we feel and how we act. It is a natural and important part of living and enjoying life. Our pattern of sexual activity does not change much with age. If you were sexually active in your younger years, you will probably continue to be sexually active as you grow older – though health situations may change the way that you express your sexuality.

>> *sexualityandu.ca/sexual-health/sex-over-fifty*

NO RETIREMENT WHEN IT COMES TO SEX

by Sophie Marcotte, February 11, 2013 – This article is part of the "Let's talk about sexuality" issue?

"'Sex among the elderly is one of the last major taboos,' states Claire Dubé, a nurse in her sixties who gives talks on this topic, among others. 'People seem to think that once women are past menopause, they no longer experience sexual desire and stop engaging in any kind of sexual behaviour.'"

>> *gazettedesfemmes.ca/6552/pas-de-retraite-pour-le-sexe*

THE AGE OF DESIRE, OR BEING "FULLY SEXUAL" AT 78

by Jocelyne Robert, sexologist

We always imagine our parents and grandparents as only sleeping in the same bed. Of course they sleep. They need to get some rest in between lovemaking sessions! Sometimes they sleep, sometimes they fight, sometimes they have sex. That's life. That's love.

>> *jocelynerobert.com/2010/11/01/lage-du-desir-ou-full-sexuelle-a-78-ans*

SAFER SEX FOR SENIORS

If you're looking for answers about the unique challenges, opportunities and joy of sex and intimacy in our later years, *you've come to the right place* — SaferSex4Seniors.org provides accurate, up-to-date information from experts in the field. Congratulations on your ageless curiosity.

You're here because you know how important it is that the sexual intimacy you enjoy be as safe as possible. "Safer sex" means sex in which you can address concerns about sexually transmitted infections (STIs) with smart actions, wise communication and the use of the condoms that reduce risk.

>> *safersex4seniors.org*

Communication in palliative care Training offered in English Formation offerte en anglais	jeudi 14 novembre 2013	Patrick Durivage et Luiza Zacchia Soins palliatifs à domicile CSSS Cavendish	CSSS Cavendish Site CLSC René-Cassin 5800, boul. Cavendish 6e étage, salle 31	40 $ Dîner non inclus
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Les soins palliatifs et l'aide au proche : une formation pour professionnels multidisciplinaires - Formation offerte en français	vendredi 17 janvier 2014	Patrick Durivage Soins palliatifs à domicile CSSS Cavendish	CSSS Cavendish Site CLSC René-Cassin 5800, boul. Cavendish 6e étage, salle 31	40 $ Dîner non inclus
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Jog your mind! Promoting the intellectual vitality of seniors Training offered in English Formation offerte en anglais	vendredi 14 mars 2014	Norma Gilbert Prévention et promotion Santé et vieillissement CSSS Cavendish	CSSS Cavendish Site CLSC René-Cassin 5800, boul. Cavendish 6e étage, salle 31	40 $ Dîner non inclus
Introduction aux soins palliatifs à domicile	jeudi 10 avril 2014	Patrick Durivage Soins palliatifs à domicile CSSS Cavendish	CSSS Cavendish Site CLSC René-Cassin 5800, boul. Cavendish 6e étage, salle 19-20-21	40 $ Dîner non inclus
Intervention auprès des personnes âgées en soins palliatifs	jeudi 8 mai 2013 vendredi 9 mai 2014	Patrick Durivage Soins palliatifs à domicile CSSS Cavendish Isabelle Van Pevenage Chercheure en CREGÉS	CSSS Cavendish Site CLSC René-Cassin 5800, boul. Cavendish 6e étage, salle 31	160 $ Dîner inclus
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Short-term counseling to caregivers Training offered in English Formation offerte en anglais	jeudi 29 mai 2014	Pam Orzeck Centre de soutien aux proches aidants CSSS Cavendish	CSSS Cavendish Site CLSC René-Cassin 5800, boul. Cavendish 6e étage, salle 31	80 $ Dîner inclus

Online registration:
www.creges.ca/site/partage-des-savoirs/formations/inscription-aux-formations
by phone: 514-484-7878 ext.: 1603
or by e-mail: creges.cvd@ssss.gouv.qc.ca

*NB: Training is free for CSSS Cavendish staff, volunteers and interns.

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