Us and Them: Otherism in Work with Older and Very Old People

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The term 'otherism', often referred to as 'othering', derives from the English terms 'other' or 'otherness', which translate as 'different' or 'other'. Otherism describes a process in which individual persons or groups ('us') are distinguished from other persons or groups ('the others'). In this social process, people or groups are thus constructed as "different". In doing so, the non-self group is always categorised as "different" and "foreign", as it deviates from the "norm", which serves as the justification for exclusion (see https://diversity-arts-culture.berlin/woerterbuch/othering).

Older people often experience discrimination explicitly because of their age or are labelled as deficient or no longer capable (Butler, 1969; WHO, 2021). Otherisms do not refer solely to age-specific forms of discrimination; indeed, older people in particular may be affected by multiple forms of stigmatisation – due to their age, health limitations, dementia, their background or social situation, or a non-heteronormative identity or life story.

Sexuality and identity in later life are particularly affected by such processes of othering. Older adults who express sexual needs or wish to enter into intimate relationships deviate from the social norm of 'youthful sexuality' and are therefore often perceived as inappropriate or problematic. This perception frequently leads to the pathologisation or moralisation of their behaviour, particularly in institutional care settings. In later life, discrimination can also intensify because dependencies increase: people are more reliant on professional support, institutional structures (care, support, housing) and formalised regulations. Here, it is not merely 'support' that is organised, but normality is also established: those perceived as 'inappropriate' are afforded less space (both literally and symbolically), less credibility and less scope for action. This is particularly relevant where sexuality and intimacy are already socially taboo: norms then function not as an explicit prohibition, but as 'not being intended' (Gagnon & Simon, 1973; Goffman, 1963).

An example from everyday life

In a residential care home, staff in the staff room talk about "the residents being difficult again today". What does that actually mean? Essentially, they are referring to several different people with individual needs. The collective term 'the residents' creates distance. Specific causes of restlessness or dissatisfaction are initially ignored. This small example illustrates what is meant by 'othering': a first, presumably unconscious, step has been taken towards 'us carers' versus 'these difficult residents', who are viewed as a homogeneous group.

Suggestions for your own work

Professional carers can observe and reflect on their own behaviour in everyday life:

- In which situations do I use this contrast between 'we' and 'them' (e.g. 'the clients', those in care', those we look after')?
- What effect does this language have on our attitude and our actions?
- How could we describe the same situation in a more individualised and appreciative way?

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It becomes clear that at the heart of 'otherism' lies the division into 'we' and 'them'. This distinction is often made unconsciously, for example when professionals distance themselves from those in need of care or those under their care, or when decisions are made exclusively within the team without involving the people concerned. Psychologically, this often serves as a means of self-orientation and protection against emotional overload. And it often simplifies the work when everyone is treated according to the same standards. After all, the reverse is also true: the more individual needs are assessed, the higher the expectations of those in care that these needs will be met. However, this is often simply not possible within the given working hours and budget. Nevertheless, it is worthwhile for both individuals and institutions to reflect on where we can support and avoid otherisms.

"Other-isms" become more pronounced in old age

Although discrimination does not begin in old age, its effects can accumulate and become institutionally entrenched as people grow older. Two mechanisms are particularly central to this:

1. Life-course accumulation:

Inequalities persist over years and decades (such as lower incomes, poorer access to healthcare, gaps in employment histories, and lower pensions) and become more visible in old age (Dannefer, 2003; Levitas et al., 2007).

2. Institutional dependency:

As support systems expand, the rules, routines and interpretative frameworks of institutions become the central yardstick for recognition and exclusion (Goffman, 1961; Foucault, 1976).

Institutional framework and sexuality in later life

In the context of sexuality and intimacy, **a third factor comes into play: sexuality in old age is often culturally taboo** – as a result, norms exert a particularly strong influence through silence, avoidance of the subject, and implicit boundaries of appropriateness (Goffman, 1963; Gagnon & Simon, 1973). Even though sexuality and identity remain central components of human life throughout the entire lifespan, these topics are frequently taboo in later life. This establishes an institutional 'order of normality' in which autonomy and adulthood are devalued. Two mechanisms converge here: ageism, i.e. the devaluation or discrimination based on age, and ableism, i.e. the normalisation of performance and autonomy as the standard, which can lead to desexualisation, infantilisation, over-protection or blanket doubt regarding the capacity to give consent (Campbell, 2009; Goodley, 2014).

This convergence is central to 'other-isms' because it demonstrates that exclusion arises not only from individual prejudices, but also through institutional routines and status attributions (Goffman, 1961; Campbell, 2009).

Other-ism: Mechanisms for structuring sexuality and intimacy

- **Invisibility**

Invisibility means that needs are not asked about, not documented, and not taken into account. As a result, 'not addressed' quickly becomes 'non-existent' (Link & Phelan, 2001; Goffman, 1963). This affects marginalised groups particularly severely, as they already face stigma more frequently and coming out (e.g. as queer or trans) can be fraught with risk.

The invisibility of queer life stories

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Many older gay people lived through a time when homosexuality was a criminal offence and gay people were despised by many of their contemporaries. Similarly, trans* people met with little understanding in the past. These experiences shape trust, feelings of shame and how one deals with openness regarding one's own life story.

Key point: Silence or concealment is not neutrality. It reinforces the norm that 'old age = non-sexual' and shifts the burden of responsibility onto those affected, requiring them first to 'prove' or 'courageously' express their needs (Goffman, 1963; Link & Phelan, 2001).

Reflection questions for one's own practice

- How diverse in terms of gender and relationships are our forms and conversations designed?
- Do we actively signal that different life choices are respected?

- **Desexualisation & infantilisation**

Desexualisation is more than just 'no sex' – it is a judgement of status: the person is no longer regarded as a legitimate subject of desire, intimacy and self-determination. Ableism reinforces this judgement when the need for care or assistance is confused with a lack of legal capacity (Campbell, 2009; Goodley, 2014).

Key point: This illustrates how care can tip over into incapacitation. This is less a matter of 'individual misconduct' than a structural risk when protection is universally prioritised over autonomy (Beauchamp & Childress, 2019).

- **Moral regulation through trivialisation or defensiveness**

Moral regulation often manifests in the smallest of reactions (glances, jokes, looking away, trivialisation) and produces shame (Goffman, 1963). Sexuality in old age thus clashes with cultural notions in which sexuality is linked to youth, attractiveness and performance (Gagnon & Simon, 1973).

Key point: Trivialisation ("cute") denies intimacy any seriousness and shifts it into a childish register. Defence ("is that really necessary at your age?") marks it as unacceptable. In both cases, exclusion occurs without an explicit prohibition.

- **Pathologisation**

When sexuality becomes visible in old age, it is often perceived as a 'problem': as a dysfunction, symptom or risk.

Key point: A dual logic emerges: 1. Sexuality is regarded as 'non-existent'; 2. when it does become visible, it is primarily framed as a risk or deviation. This often prevents a perspective focused on quality of life.

- **Over-regulation stemming from uncertainty ("to be on the safe side")**

Where guidelines are lacking, institutions often respond with blanket rules. These affect marginalised individuals particularly hard, as they frequently have fewer support networks, face greater risks of stigma and exposure, and have less power to voice complaints (Spade, 2015; Link & Phelan, 2001).

Key point: If an issue is officially 'not on the agenda', there are no professional avenues available in the event of a conflict. Informal norms (morality, shame, etc.) then come into play – and this is precisely where 'other-isms' are reproduced.

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An intersectional perspective: When identities intersect

Othering has a particularly strong effect when multiple characteristics come together. Older people are not just old – they may also have a history of migration, belong to a religious minority, be queer, live with a disability, or be socially disadvantaged. These overlaps (intersections) increase the risk of being overlooked, misunderstood or treated stereotypically.

For instance, an unmarried, lesbian resident with a Turkish family background will have experienced exclusion differently from a woman born in Germany of German origin who has married her partner. The latter is also likely to fit in better with the facility's routines, as the fact of being married is asked of everyone anyway. However, care cannot simply settle for adapting to what suits the majority. This is all the more true in an increasingly diverse society, where a single solution that fits everyone will become ever rarer. Now that society has evolved to the point where, with the opening up of marriage, people of the same sex are also 'seen', care must respond accordingly. A gay man who has experienced discrimination must no longer find himself in a situation where he feels he has to hide his identity in a care home for fear of renewed rejection. A resident with a refugee background may react sensitively to loud noises or situations of control – without this being immediately recognised as a biographically conditioned reaction.

Intersectional thinking means not reducing people to a single category, but perceiving the complexities of their lived realities and recognising that where these intersect, the pressures can reinforce one another.

Suggestions for professionals

Educational and care professionals bear a special responsibility. Through further training and professional development, professionals can gain confidence in their actions and strengthen their professional approach.

Key aspects of working in the context of othering are:

- Reflection on one's own values, norms and uncertainties regarding sexuality in old age.
- Knowledge and communication of knowledge regarding legal and ethical principles.
- Promoting an open team culture in which difficult situations can be discussed.
- Actively protecting privacy, intimacy and self-determination.
- Incorporating biographical work to better assess individual needs.

Key principles for avoiding othering

- **Creating safe and respectful spaces**

A key element is the creation of spaces where sexuality and identity can be discussed openly. This requires a respectful attitude, language that is sensitive to discrimination, and actively addressing one's own prejudices. Such space is particularly crucial for LGBTQIA+ older people, as they often bring with them a lifetime of experiences of discrimination (Fredriksen-Goldsen et al., 2017).

Reflection questions

- Which ways of life are tacitly considered 'normal' in our setting?
- Who has to adapt to our procedures – and where could we be more flexible?

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- o How do we distinguish between organisational boundaries and mere habit?

- **Inclusive communication practices**

Inclusive communication means shaping language and behaviour in such a way that everyone feels addressed and respected. This includes avoiding heteronormative assumptions (“Is your wife coming to visit you too?”), using gender-neutral language, and practising active listening in conversations. Professionals should not avoid conversations about sexuality, but rather guide them sensitively and professionally.

- o Describe rather than judge: “I’ve noticed…” instead of “that’s inappropriate”.
- o Open, non-judgemental questions: “What is important to you in terms of intimacy/privacy/relationships?”
- o Do not make assumptions: do not make assumptions about sexual orientation, gender, relationship status or “family model” (Warner, 1991).

Language and cultural attributions:

- o When do we hastily interpret behaviour in cultural or religious terms?
- o What questions could we ask instead of making assumptions?
- o How openly do we talk about diverse ways of life, so that same-sex residents can also feel safe?

- **Migration, language and power:** Language is a key factor in othering. If older people do not speak German, or speak it only to a limited extent, they are more quickly labelled as ‘disoriented’ or ‘uncooperative’.

- o Where do we confuse language barriers with cognitive impairments?
- o What options for professional language mediation are we aware of and do we utilise?
- o How can we strengthen non-verbal communication and culturally sensitive care without reducing people to their ‘culture’?

And also:

- **Intake interviews/forms:** How are they designed in our setting? Heteronormative assumptions (“husband/wife”) are also evident in admission interviews and forms in care settings, rendering other relationships invisible.

Othering also arises when institutional processes tacitly assume a “standard biography”: heterosexual, German-speaking, raised in the Christian faith.

- **Privacy and confidentiality**

Privacy is a fundamental human right and takes on particular significance in care contexts. In long-term care facilities, it is often restricted by shared rooms, organisational procedures or staff shortages. Intimacy and opportunities for privacy must be actively protected here in particular, for example through lockable rooms, clear visiting regulations and confidential settings for conversation. Without privacy, intimacy is hardly possible – especially in shared rooms.

- **Informed consent in cases of fluctuating mental capacity**

A particularly sensitive issue is the question of capacity to consent in people with dementia or other cognitive impairments. Current ethical approaches advocate viewing consent not exclusively as a static state, but as a dynamic process. Wishes, non-verbal signals and previous biographical statements should be included in the assessment (Dewing, 2007).

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- **Professional relationships and ethical responsibility**

Staff often find themselves caught between the need to provide support and maintaining professional distance. It is crucial to recognise that it is both legitimate and necessary to acknowledge needs for closeness and intimacy, without exploiting relationships of dependency or overstepping boundaries. Regular supervision and ethical case discussions can be helpful in this regard.

- **Uncertainty without guidelines:** When sexuality is 'not addressed', ad hoc restrictions often arise in the event of a conflict (Spade, 2015).

Risk factors & prevention strategies

- **Moral judgement**

Reactions from care staff that are not neutral, but instead judge sexuality in older people or among queer individuals – e.g. as 'unpleasant', 'disgusting' or, conversely, trivialising it in a childish manner.

Examples:

  - A care worker says: "At that age, that shouldn't be happening anymore…".
  - Giggling or disparaging looks at same-sex intimacy.
  - Trivialisation: "Oh, those two are as sweet as teenagers".

Strategy: here it is advisable to formulate a team standard: "describe rather than judge", or to make use of supervision or establish peer case consultation.

- **Ableist protective logic**

The sexuality of older people is restricted or even prevented under the guise of "protection"; particularly in cases of cognitive impairment and often without any genuine assessment of self-determination taking place. The problem here is that self-determination is restricted in favour of an excessive notion of protection.

Examples:

  - A relationship is prevented because a person has dementia ("She cannot decide that").
  - Relatives or staff forbid visits from a partner "for their protection".
  - Intimacy is categorically deemed "dangerous".

Strategy: Here, it is recommended to implement transparent consent management, structured procedures and guidelines to ensure the protection of vulnerable adults (children, young people) from any form of violence, abuse, exploitation or neglect (safeguarding pathways), good documentation and always a case-by-case assessment (Beauchamp & Childress, 2019).

- **Tokenism**

Symbolic "inclusion" without genuine structural change. The problem arises when this occurs without further inclusive measures and a corresponding attitude. In such cases, tokenism becomes a sham inclusion and real problems persist.

Examples:

  - Well-intentioned: the rainbow flag in the entrance area – but the staff are not trained.
  - The mission statement mentions 'diversity' – but complaints from LGBTQI+ people are ignored.

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- Although there is a ‘queer liaison officer’, they have no decision-making authority.

Strategy: Self-critical review within the organisation

- Language (do we use inclusive language?)
- Spaces (do we have, for example, safe spaces?)
- Rules (are they sensitive to discrimination?)
- Complaints procedures (who can access them, and how accessible and effective are they?)

- **Culturalisation**

Behaviour or needs are hastily attributed to “culture” rather than considering the individual’s perspective. This reduces people to stereotypes, which reinforces othering.

Examples:

- “That’s taboo in your culture, isn’t it?”
- Assuming that a person suppresses their sexuality because of their background.
- Making sweeping generalisations about “religious families”.

Strategy:

- Ask individuals directly rather than making unreflective assumptions.
- Focus on intersectional approaches (e.g. Patricia Hill Collins & Sirma Bilge).

Specific examples of inclusive practice

- Forms/medical history: Use of neutral terms in forms (“partner”, “significant other”), optional: pronouns/titles.
- Privacy as standard: Respecting rooms/private spaces, “Do not disturb” options, agreeing on clear knock-before-entering rules.
- Team culture: Establish a routine of reflection (“What triggers us? Which norm is at play here?”) rather than resorting to jokes or defensiveness (Goffman, 1963).

Summary

Inclusive practice means creating the conditions to make diversity in old age a real possibility. This includes a safe and respectful environment, inclusive communication, the protection of privacy, and a sensitive approach to informed consent. These aspects form the basis of ethical practice. Particularly in care contexts, it is necessary to critically question institutional structures and strengthen individual autonomy. Otherism becomes more complex when old age interacts with experiences of migration, racism, queer lifestyles or language barriers. A professional approach to working with older people therefore also means thinking intersectionally: not jumping to conclusions, but remaining curious, asking biographical questions and neither dramatising nor ignoring differences. A diversity-sensitive, power-critical care practice strengthens dignity, security and a sense of belonging – particularly for people who have already experienced exclusion in their lives.

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