

Georgia State University

ScholarWorks @ Georgia State University

Sociology Dissertations

Department of Sociology

8-11-2020

Older Adults' Intimacy Process in the Realm of Long-term Care

Andrea F. Fitzroy

Follow this and additional works at: https://scholarworks.gsu.edu/sociology_diss

Recommended Citation

Fitzroy, Andrea F., "Older Adults' Intimacy Process in the Realm of Long-term Care." Dissertation, Georgia State University, 2020.

doi: <https://doi.org/10.57709/18629378>

This Dissertation is brought to you for free and open access by the Department of Sociology at ScholarWorks @ Georgia State University. It has been accepted for inclusion in Sociology Dissertations by an authorized administrator of ScholarWorks @ Georgia State University. For more information, please contact scholarworks@gsu.edu.

OLDER ADULTS' INTIMACY PROCESS IN THE REALM OF LONG-TERM CARE

by

ANDREA F. FITZROY

Under the Direction of Candace L. Kemp, PhD

ABSTRACT

Research confirms the importance of social relationships to mental and physical health across the lifespan. Intimacy, a component of social relationships, continues to be essential in later life, including for older adults in long-term care such as assisted living (AL). Existing research provides insight into older adults' social relationships, sexual behavior, and potential lack of intimacy. No previous study has conceptualized how individuals experience intimacy holistically and within the context of later life, health decline, and long-term care. The purpose of this dissertation was to provide an in-depth understanding of intimacy in the lives of older adults residing in AL. I address three major aims: developing a theory of intimacy in older adults' lives, examining the intimacy of care and intimate care encounters from older adults' and direct care workers' perspectives and identifying the role family members play in older adults' intimacy

process in AL. Using a life-course perspective, feminist gerontology, and a grounded theory approach, I analyzed data from the "Convoys of Care" (Kemp, PI: R01AG044368) longitudinal, qualitative research project. Data consisted of 2,224 hours of participant observation, and interviews with 28 assisted living residents (aged 58-96) and their formal and informal care partners (n=114) over two years from four diverse AL communities.

Older adults experience intimacy as an internal and external process through four dimensions: emotional, intellectual, spiritual, and physical. Intimacy may be experienced with another individual or within a group and can be platonic or familiarly, romantic, or sexual. AL residents' intimacy outlets and needs were dynamic, varied over time and were an ongoing process influenced by managing one's needs while negotiating intimacy opportunities and constraints. Residents experienced intimacy through a variety of relationships, but most often with family members, co-residents, friends, and AL staff. Through the intimacy of care, residents experienced close relationships with staff who were integral to their physical as well as emotional care needs. Family members served as cultivating intimacy in resident's lives, supporting and encouraging some relationships while discouraging others. My findings have implications for practice and provide a more comprehensive understanding of older adults' lives.

INDEX WORDS: Intimacy, Older adults, Social relationships, Bodywork, Assisted living, Long-term care

OLDER ADULTS' INTIMACY PROCESS IN THE REALM OF LONG-TERM CARE

by

ANDREA F. FITZROY

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

2020

Copyright by
Andrea F. Fitzroy
2020

OLDER ADULTS' INTIMACY PROCESS IN THE REALM OF LONG-TERM CARE

by

ANDREA F. FITZROY

Committee Chair: Candace L. Kemp

Committee: Elisabeth O. Burgess

Wendy Simonds

Electronic Version Approved:

Office of Graduate Services

College of Arts and Sciences

Georgia State University

July 2020

DEDICATION

I dedicate this work to all individuals seeking more intimacy in their lives.

ACKNOWLEDGEMENTS

I could not have completed the analysis and research contained in this dissertation without the support of many wonderful individuals. Foremost, I would like to acknowledge my dissertation committee, Ph.D. advisors, and mentors, Dr. Candace L. Kemp, Dr. Elisabeth O. Burgess, and Dr. Wendy Simonds, whose investment in my academic and professional development has been humbling. Thank you for providing me with opportunities, resources, expertise, time, and, most importantly, your support and confidence in my potential. Dr. Kemp, thank you for allowing me to use your extensive dataset from the Convoys of Care project for my dissertation, and thank you for your consistent enthusiasm in my analysis of the data. Dr. Burgess, thank you for your guidance throughout my graduate career and your mentorship in my professional pursuits. Dr. Simonds, thank you for your knowledge, suggestions for improved writing, and support throughout my graduate degree, but especially with my dissertation.

I am grateful to the researchers and participants of the Convoys of Care project. The research reported in this publication was supported by the National Institute On Aging of the National Institutes of Health under Award Number R01AG044368 to C.L. Kemp. I was very fortunate to work as a member of the Convoys research team, and the research experience and mentorship I received during this time were life-changing, encouraging me to focus my dissertation on the intimate lives of older adults. Additionally, I wish to acknowledge those who generously provided funding to assist me in the generation and presentation of this work. Receiving several GSU Gerontology Institute conference travel awards and the Fulton County Gerontology Award allowed me to further my professional pursuits, network, and present my work in professional settings. I am grateful for the GSU Provost Dissertation Fellowship that allowed me to focus solely on my dissertation during my final year of my Ph.D.

I could not have completed this dissertation without the unceasing support of my family. Thank you, Mum (Moyra Fitzroy), and Adorjan Fitzroy, for supporting my dream to pursue a doctorate. Thank you, Kiki Carr, for your constant encouragement, design and editing powers, and always thought-provoking discussions.

Finally, to my wife, Becca Fishman, thank you for your love and patience while I trudged through the many stages of preparing this dissertation. Thank you for making me feel like I can do the impossible, for cheering me on when I try, for picking me up when I stumble, and for your confidence in me when I struggle to find it.

In submitting this work for the degree of Ph.D., I am indebted to the fabulous academics and social scientists who blazed the trail before me and persevered when their ambitions were challenged. With each opportunity that arises, I will do my best to pay it forward.

Research reported in this publication was supported by the National Institute On Aging of the National Institutes of Health under Award Number R01AG062310 (to C.L. Kemp). The content is solely the responsibility of the author and does not necessarily represent the official views of the National Institutes of Health.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	V
LIST OF FIGURES	X
1 INTRODUCTION	1
1.1 Purpose of the Study	1
1.2 Research Aims	2
1.3 Contributions to the Field	3
1.4 Methods	5
1.5 Summary	5
2 THE INTIMACY PROCESS OF OLDER ADULTS: NEGOTIATING OPPORTUNITIES AND CONSTRAINTS	7
2.1 Introduction	7
2.2 Design and Methods	12
2.2.1 Settings and Sample	12
2.2.2 Data Collection	14
2.2.3 Data Analysis	14
2.3 Results	16
2.3.1 Types of Intimacy	17
2.3.2 Platonic Versus Romantic and Sexual Intimacy	29
2.3.3 Factors Influencing Intimacy: Opportunities and Constraints	33

2.3.4	<i>Reconciling Intimacy Needs with Opportunities</i>	38
2.4	Discussion and Implications	40
3	HANDLING INTIMACY: BODYWORK, CARE, AND SOCIAL RELATIONSHIPS	43
3.1	Introduction	43
3.2	Research Design and Methods	49
3.2.1	<i>Settings and Sample</i>	50
3.2.2	<i>Data Analysis</i>	51
3.3	Findings	53
3.3.1	<i>Handling Intimacy: Range of Relationships</i>	55
3.3.2	<i>Familiarity Within the Care Dyad</i>	57
3.3.3	<i>Experiences of Bodywork, Care, and Social Relationships</i>	60
3.3.4	<i>Gendered Care</i>	64
3.3.5	<i>Resident Factors</i>	66
3.3.6	<i>DCW Factors</i>	70
3.3.7	<i>AL Factors</i>	72
3.4	Discussion and Implications	74
4	CULTIVATING INTIMACY IN THE LIVES OF OLDER ADULTS: FAMILY MEMBERS' ROLES	80
4.1	Introduction	80

4.2	Design and Methods	85
4.2.1	<i>Settings and Sample</i>	86
4.2.2	<i>Analysis</i>	87
4.3	Findings	88
4.3.1	<i>Intimacy Partners</i>	88
4.3.2	<i>Cultivating Intimacy</i>	93
4.3.3	<i>Influential Factors</i>	102
4.4	Discussion	103
5	CONCLUSION	108
	REFERENCES	118

LIST OF FIGURES

Figure 2.1 Intimacy as process: Negotiating opportunities and constraints	17
Figure 3.1 Handling Intimacy: Bodywork, care, and social relationships	54

1 INTRODUCTION

1.1 Purpose of the Study

Interest in intimacy across the life course is not trivial. Researchers recognize a long-established link between intimacy, health, and well-being (Laumann et al., 2005). Intimacy enables an individual's establishment and maintenance of their identity (Erikson, 1963). And, most people pursue and cultivate close relationships, such as romantic couplings, friendships, and kinships throughout their life course. Social isolation and a lack of intimacy can adversely affect one's physical and emotional health (Cornwell & Waite, 2009; Shankar et al., 2011). However, it is not merely the presence of another person, but the development of intimacy or "closeness" that fosters good mental and physical health outcomes (Traupmann & Hatfield, 1981).

What does intimacy among individuals look like in older age and when they live in residential long-term care settings? Although residential long-term care, including assisted living (AL), promises the promotions of health and welfare of their residents, they are typically a place one wants to avoid as most individuals prefer the independence and comforts of one's private home (Eckert, Morgan, & Swamy, 2004). Today more older adults reside in AL than ever before, yet we have little understanding of older adults' intimacy in long-term care.

In the United States, the proportion and size of the older adult population grows yearly. According to the Department of Health and Human Resources' Department of Aging (2015), in 2020, over 75 million people will be over the age of 60, representing almost a quarter of the US population. With the increase of older adults includes an increase in the need for long-term care. AL communities currently comprise one of the fastest-growing industries in long-term care, with an estimated one million residents in the United States (Centers for Disease Control, 2015). AL

is a long-term residential care setting with 24-hour oversight, providing board and care in a home-like environment (Ball et al., 2005; Roth & Eckert, 2011).

Upon a superficial glance, it appears that AL offers opportunities for intimacy -- from friendly encounters with fellow residents to acts that invoke intimacy such as assistance with bathing and bodywork. Yet, home rules, an unknown direct care worker, or sterile latex gloves can potentially mar an intimate encounter. Prior research on social relationships in assisted living illustrates AL as a site for potential socioemotional intimacy between co-residents (Kemp et al. 2012), and married couples and co-residents (Kemp 2008). Burgess and colleagues provide research on sexual intimacy in long-term care (Barmon et al. 2016; Burgess et al. 2016; Bender, Burgess, and Barmon 2017). However, researchers and practitioners alike still have much to learn regarding the intricacies of intimacy in later life, especially in the context of long-term care.

1.2 Research Aims

Utilizing feminist gerontology (Ray & Fine, 1996), a life course perspective, and a sociological lens as the guiding frameworks for my dissertation, I explore the characteristics of intimacy among adults living in residential long-term care, specifically AL. Proponents of feminist gerontology stress the importance of studying older adults on their terms and giving voice to an otherwise often ignored population (Calasanti, Slevin, & King 2006; Connidis and Walker 2009). I capture the multi-faceted aspects of intimacy among older adults living in AL and receiving care. In addition to intimate relationships, encounters, and interactions with friends, family, and co-residents, individuals residing in long-term care experience assistance with intimate care acts from paid care workers with whom they may or may not be emotionally close.

My research goals for my dissertation are the following:

To provide an in-depth understanding of intimacy (and lack of intimacy) in the lives of older adults residing in long-term care. To do so, I address three specific aims:

- 1) To develop a theory of intimacy in the lives of older adults.
- 2) To examine the intimacy of care and the intimate encounters of carework from the perspectives of residents who receive care and the direct care workers who provide care in AL.
- 3) To understand the roles family members play in older adults' intimacy process and identify how family members' participation in older adults' intimate relationships varies and with what outcomes.

1.3 Contributions to the Field

Research on older adults' sexuality is expanding (e.g., Lindau et al. 2007; Hillman 2008; Frankowski & Clark 2009; Bender, Burgess & Barmon 2017), yet there has been little emphasis on a broader definition of intimacy in older adults' lives within the context of long-term care. Feminist gerontology provides a powerful lens for examining intimacy by emphasizing the importance of researching older adults on their terms (Calasanti, Slevin, & King 2006; Connidis & Walker 2009). Perhaps an emphasis on sexual behavior demonstrates the prominence of our youth-centered culture, one that prioritizes young adults' views on sex and sexuality. Instead, what might be more relevant to older adults includes a broader conceptualization of intimacy, one inclusive of a range of expressions of socio-emotional closeness. Utilizing an interdisciplinary approach, feminist gerontology, and a life course perspective as my foundation,

I contribute to the fields of gerontology and sociology, a more inclusive definition of intimacy, and explore intimacy in long-term care.

I present an analysis of data collected based on a study informed by social models of care. The convoy model of social relations conceptualizes support as dynamic and subject to change over time (Kahn & Antonucci, 1980; Antonucci & Akiyama, 1987). The term “convoy” resonates with a life course approach and emphasizes emotional intimacy (Antonucci & Akiyama, 1987). According to the convoy model, with the passing of time and over the life course, individuals’ social support network may transform in terms of structure and function; the model accounts for aid, emotional support, and affirmation (Kahn & Antonucci, 1980), which illustrates dimensions of intimacy. Before now, the convoy social relationship model had not been used to look at intimacy expression or needs among older adults receiving care.

Yet, the convoy model of social relations does not account for formal care that often accompanies later life, especially at advanced ages. Kemp, Ball, and Perkins (2013) expanded upon Kahn and Antonucci’s (1980) model to introduce the Convoys of Care model, which includes both informal and formal care providers. My research on intimacy in the lives of older adults uses the convoys of care model to consider the intimacy of care when performed by both unpaid and paid caregivers. Furthermore, I look to the role convoy members, such as family members, play in older adult’s intimacy experiences in AL. My research sheds light on the intimacy needs, desires, and preferences of older adults receiving care as well as the instances- or lack of, and experiences of intimacy in long-term care. Through the work presented here, I aim to improve the lives of older adults receiving long-term care by highlighting the implications of intimacy and intimate connections among older adults receiving care. Much of the present research on older adults receiving care focuses on the physical elements of care, symptomatic,

and disease-focused treatment. It avoids the intricate and essential aspects of emotional care that predominate the care process.

1.4 Methods

I analyzed data collected as part of the longitudinal qualitative project, “Convoys of Care: Developing Collaborative Care Partnerships in Assisted Living” (hereafter, the “Convoys of Care” study). I used data collected between 2013 and 2015 in four diverse AL communities located in and around the Atlanta, Georgia area. Data collected included 142 formal interviews, site and field note data on 2,224 hours of participant observations, and informal interviews and 809 site visits. I joined the “Convoys of Care” research team in 2014, and thus, I am very familiar with the data, including how it was collected, stored, managed, and analyzed.

The “Convoys of Care” study utilized a grounded theory approach in which data collection and analysis take place simultaneously (Corbin & Strauss, 2015). The principles of grounded theory guided my analysis. Grounded theory provides a methodical approach that derives theory from the examination of data (Glaser & Strauss, 1999). In grounded theory, during data study, the researcher identifies persistent themes or codes and then groups them into categories. The emergent categories lay the groundwork for new theory to be explored and defined. Rather than developing theory before analyzing the data, the researcher generates theory from the emerging categories and themes found in the data exploration (Corbin & Strauss, 2015).

1.5 Summary

In this chapter, I provided an overview of the goals and implications of my research. My dissertation contains three articles aimed for scholarly publication. The second chapter is titled “The Intimacy Process of Older Adults: Negotiating Opportunities and Constraints” and identifies the intimacy process older adults experience while residing in AL. The third chapter

examines the intimacy of care and older adults' social connections with direct care workers in AL and is titled "Handling Intimacy: Bodywork, Care, and Social Relationships." The fourth chapter, "Cultivating Intimacy in the Lives of Older Adults: Family Members' Roles," looks to the roles of family members in older adults' intimacy process in AL. In the final chapter, I provide a summary of the findings of my dissertation and my contribution to the literature and conclude with suggestions for future research and recommendations for practice to improve older adults' intimate lives.

2 THE INTIMACY PROCESS OF OLDER ADULTS: NEGOTIATING OPPORTUNITIES AND CONSTRAINTS

2.1 Introduction

The positive association between social relationships and well-being across the life course is well-established; numerous studies confirm the benefits of social support for physical and mental health, especially in later life (Antonucci & Akiyama, 1987; Cohen, 2004, Antonucci, Birditt, & Akiyama, 2009). Meanwhile, studies show that social isolation and a lack of social relationships contribute to higher mortality rates (Berkman & Syme, 1979; Blazer, 1982; Holt-Lunstad, Smith, & Layton, 2010; Sapphire-Bernstein & Taylor, 2013). Fingerman and colleagues (2019) find that older adults who experience a variety of social relationships, especially close social ties such as family and friends, are more likely to be active, less sedentary, and exhibit positive mood compared to those who do not. Their work also shows that variety in social relationship types also coincides with a broader range of activities throughout one's day. This pattern appears in assisted living (AL) where positive relationships with co-residents, AL staff, and others in the community indicate higher life satisfaction (Street, Burge, Quadagno, & Barrett, 2007) and subjective well-being (Street & Burge, 2012) relative to those who do not.

Additionally, research examining older adults' sexual desires and behaviors, including in long-term care (Bauer, McAuliffe, Fetherstonhaugh, 2016; Bender, Burgess, & Barmon, 2017), suggests such forms of intimacy are necessary, yet frequently unavailable, discouraged, and problematized. Despite the critical implications of social connections for well-being and health, few researchers have examined older adults' intimacy experiences in a holistic and in-depth way. Much remains unknown about intimacy in later life, especially in the context of frailty and decline.

For many individuals, later life involves frailty, loss of dependence, and the need for formal long-term care services, including residential care communities such as AL – a highly popular care option (Khatutsky et al., 2016). Relative to the medical model underlying nursing homes, ideally, AL promotes a holistic model of care, one that encourages residents' personal choice, socialization, and engagement (Kane & Kane, 2001). Yet, many AL residents move in at advanced ages with considerable care needs, including the demand for medical services (Kemp, Ball, & Perkins, 2018; Khatutsky et al., 2016). These trends represent potential challenges regarding the implementation of social care models. They may lead to an over-emphasis on meeting residents' physical care needs rather than their social and emotional needs, especially their need for intimacy. Indeed, these needs are under-investigated and not well-understood by researchers and practitioners alike. Intimacy among older adults, especially sexual expression, is frequently considered taboo, and often ignored, discouraged, or out-right prohibited in AL communities (Frankowski & Clark, 2009; Barmon, Burgess, Bender, & Moorhead, 2016).

Intimacy between individuals remains a product of social relationships and an interpersonal process (Reis, 1990). One of the main challenges with studying intimacy among older adults includes the absence of a definition that encompasses intimacy broadly defined to capture a full range of relationships and contexts. Currently, researchers suggest that intimacy in romantic relationships consists of five distinct components: commitment, interdependence, emotional intimacy (includes caring, positive regard), cognitive intimacy (includes thinking about the other; shared values), and physical intimacy (ranging from closeness to sexual expression) (Moss & Schwebel, 1993; Blieszner & de Vries, 2001). Yet, intimacy is not always romantic, can exist in a variety of relationships, and is expressed between friends, siblings, and parents, and children. Giddens defines intimacy as a process that allows individuals to possess

stability in their interpersonal relationships (1991;1992). He argues that intimacy includes a deficiency in oneself, and the search for emotional closeness describes communication between oneself and another. Giddens defines intimacy as more than just sexual behavior, but rather, as the full spectrum of relations associated with family, kinship, and friendship.

Friendships tend to be less obligatory than family relationships (Wood & Robertson, 1978), yet have a more substantial positive effect on well-being (Phillips & Fischer, 1981; Walen & Lachman, 2000) even as one ages (Larson, Mannell & Zuzanek, 1986; Fiori, Antonucci & Cortina, 2006). For older adults, especially, close friendships influence a holistic concept of one's authentic self, access to interpersonal activities, and direct care activities and support (de Vries, 2018). There remains, however, noteworthy gender differences among friendships in older age; women have more intimate friendships than older men (Felmlee & Muraco, 2009). Regardless of gender, older married persons are more likely to have same-gender friendships than cross-gender friendships (Akiyama, Elliot, & Antonucci, 1996). For older cohorts, a norm hindering friendships between older men and women includes the view that cross-gender friendships must be romantic (Adams, 1985). Older women especially may reject cross-gender associations out of fear of romantic interpretations by others (van den Hoonaard, 2006). More recent research, however, suggests that current cohorts of older men and women have favorable views of cross-gender friendships and hold similar cultural values of close ties, which include shared norms of trust, commitment, and respect of each other (Felmlee & Muraco, 2009).

Pertinent to understanding intimacy among older adults in AL is the "Convoys of Care" model (Kemp, Ball, & Perkins, 2013), which extends Kahn and Antonucci's (1980) "Convoy Model of Social Relations" to include support from formal care partners. The modified model proposes an evolutionary collaboration of care partners, including formal and informal social

network members and the care recipient. In AL, older adults usually arrive with pre-existing care convoys (i.e., networks), which then expand to include formal care workers and potentially co-residents (see Kemp et al., 2013). Convoys of care encompass the assembly of care providers, including those providing social and emotional support.

As communal settings, AL communities offer the potential for socioemotional and physical intimacy between co-residents (Kemp et al., 2012). Relationships between residents include married (Kemp, 2008, 2012) and dating couples (Kemp, 2016) as well as friends and even enemies (Kemp, Ball, Hollingsworth, & Perkins, 2012; Street & Burge, 2012). Residents may also have opportunities to develop relationships with AL staff, volunteers, and others in the setting (Ball et al., 2005; Ball et al., 2009). Good relations between direct care workers and residents positively influence care interactions (Kemp, Ball, Hollingsworth, & Lepore, 2010), residents' subjective well-being (Street & Burge, 2012), and life satisfaction (Street et al., 2007). Though most AL residents' social support comes from family members (Perkins et al., 2013), residents also depend on their friends, former neighbors, ministers, fraternity brothers and sorority sisters, volunteers, and fellow residents (Kemp et al., 2018).

Co-resident relationships represent opportunities for social support, and researchers recognize residents' social careers in AL. Kemp, Ball, Hollingsworth, and Perkins (2012) collected and analyzed data using grounded theory methods from a three-year, mixed-methods study on AL residents' social relationships. Social careers include the multilevel process of categorizing and defining relationships and how one might interact with others, especially peers, in AL. Co-resident relationships are complex and dynamic, and residents find themselves negotiating their relationships throughout their time in AL. Researchers identified *neighboring* as the most common way of interacting and relating between residents in AL. However, they also

revealed *anti-neighboring* behaviors in AL, implying that not all co-resident relationships were positive. Yet, for some residents, close social ties within AL indicated a more positive connection with the setting. Co-resident relationships were influenced by varying community and AL factors such as resources, size, and location, and by resident factors such as health conditions and personal characteristics (Kemp et al., 2012).

Despite prevailing ageist societal assumptions of older adults as non-sexual, there is ample evidence that many individuals continue to remain sexually active well into old age (Lindau et al., 2007; Frankowski & Clark, 2009). Older adults' sexual behaviors, desires, and interests are consistent with those of the general population (Hillman, 2008). Yet, current research on older adults receiving long-term care demonstrates the typical restriction to intimate relationships and intimacy (Barmon, Burgess, Bender, & Morehead, 2016). Qualitative research by Bender, Burgess, and Barmon (2017) found romantic intimacy and sexual behavior scarce in AL, and residents frequently negotiated a lack of intimate relationships in their daily lives. In their research, the term *intimacy* emerged from the language residents used to describe romantic or sexual feelings and encounters. "Flirting, teasing, and sexual joking" were part of residents' expressions of desire, used mostly, it appeared, to mainly pass the time (Bender, Burgess, & Barmon, 2017, p. 11). Researchers found that residents displayed some desire for intimacy, yet it was often ignored or passed off as "joking" behavior (Bender, Burgess, & Barmon, 2017, p. 11). Barriers to intimacy in AL included the availability or access to partners, limited privacy, and perceived or enforced social rules and norms. Yet, their findings show that AL residents negotiate the lack of intimacy by providing excuses, supplying justifications, and dismissing one's needs.

Existing research provides insight into older adults' social relationships, sexual behavior, and potential lack of intimacy. Yet, no known study has conceptualized intimacy and how individuals experience intimacy holistically and within the context of later life, frailty, and health decline, specifically in AL. Thus, our aims are to (a) provide an in-depth and holistic understanding of intimacy derived from a longitudinal study of older adults' daily lives and care experiences; and (b) identify how and why intimacy experiences vary for older adults and with what outcomes.

2.2 Design and Methods

Data for this analysis come from the qualitative, longitudinal study, "Convoys of Care: Developing Collaborative Care Partnerships in AL." The overall goal was to learn how to support informal care and care convoys in AL in ways that support residents' ability to age in place with optimal resident and caregiver quality of life. The study was guided by principles of grounded theory methods, which include a constant comparison approach during which data collection, hypothesis generation, and analysis occur at the same time (Corbin & Strauss, 2015). Georgia State University's Institutional Review Board approved the study. We used pseudonyms to protect the study sites and research participants' anonymity.

2.2.1 Settings and Sample

The first author analyzed data collected between 2013 and 2015 in four diverse AL communities in and around Atlanta, Georgia. Researchers chose these communities to maximize variation (Patton, 2015) by size, location, fee structure, ownership, resident characteristics, and other factors researchers believed might influence care arrangements (Kemp et al., 2017). Oakridge Manor, the largest community, was licensed for over 90 residents, corporately owned, and located in an urban area. Nearly all of Oakridge Manor's residents identified as African

American or Black, and many knew each other before AL. Privately-owned Garden House was licensed for about 50 residents and located in a small town. Most, though not all, residents were White. Feld House was not-for-profit with the capacity for nearly 50 residents and set in a suburban area. All residents were White, and most were Jewish. Hillside, meanwhile, was family-owned, licensed for about ten residents, and located in a rural mountain area. All residents and staff were White.

Across these four care communities, researchers recruited and purposively selected 28 residents to maximize variation (Patton, 2015) based on gender, race, age, religion, education, socioeconomic status, functional abilities, and cognitive function. Seventeen were women, and 11 were men. Ten identified as African American or Black and 18 as White. They ranged in age from 58 to 96 years old, with an average of 84 years. Most were widowed; three were married, three divorced, and two were never married. Among those married, two had spouses who also lived in the care community. Eleven had some form of cognitive impairment (Alzheimer's Disease or related dementia). Most residents used a mobility device such as a walker or wheelchair, while three were able to walk unassisted.

Following resident recruitment, researchers recruited their informal and formal convoy members. A total of 114 convoy participants, including 65 informal convoy members, participated. Of the informal convoy members, adult children were the most common informal care partners. However, spouses, siblings, daughters/sons-in-law, aunts/uncles, grandchildren, and friends also participated. Formal convoy members included both AL staff in addition to outside paid providers. Researchers interviewed 29 AL personnel covering a wide range of care and support activities for residents and 20 care professionals from the external community who provided care within the AL community.

2.2.2 Data Collection

A team of trained gerontology and sociology researchers collected data using multiple methods, including formal and informal in-depth interviews, participant observation, and review of residents' AL records. Data collection began with participant observation and in-depth interviews with each community's executive director(s) to understand the culture and learn about residents and staff. Next, researchers interviewed residents and convoy members. Researchers asked residents about their lives, transition to AL, informal and formal care, and experiences residing in AL. Questions about intimacy included: "Please tell me about any friends or former neighbors or other important people in your life?", "How do you feel about the contact you have with your family and friends?" and "Are you ever lonely?" Researchers conducted a total of 142 qualitative interviews with residents, executive directors, direct care workers, health care professionals, residents' family and friends, and volunteers.

Where possible, researchers visited residents weekly, and followed residents and their convoys for two years or as long as they remained in the home. We aimed for twice-monthly contact with informal convoy members. Between 2013 and 2015, researchers made 809 site visits logging 2,224 observation hours, including informal conversations with those who lived, worked, and visited the homes. Researchers recorded observations in detailed fieldnotes and created resident case profiles. Profiles documented resident and convoy characteristics and tracked continuity and change in residents' lives over time (see Kemp, Ball, & Perkins, 2019).

2.2.3 Data Analysis

NVivo 10 was used to store and help facilitate the management, coding, and analysis of the qualitative data. Researchers participated in an initial coding of the data utilizing "house-keeping" codes that organized broad concepts such as "convoy properties," "resident needs,"

“resident characteristics,” and “resident care interactions” with informal as well as formal care partners. House-keeping codes highlighted various concepts relative to care experiences, informal and formal care partners, and residents’ lives in AL. Researchers created and identified initial house-keeping codes to code all data that provided insights into how convoys organized and operated. Data collection and coding analysis co-occurred, and all researchers were involved in the data collection, coding, and analytical discussions in bi-weekly team meetings. Researchers described details of the broader study’s methods and analytic approach elsewhere (Kemp, Ball, & Perkins, 2019).

Here, we emphasize the analytic methods used to examine intimacy in residents’ lives. We followed Corbin and Strauss's (2015) three-stage coding process. The first author, Andrea Fitzroy, began by *open-coding*, which consists of line by line coding of information, in this case, data pertinent to residents’ experiences of and thoughts about intimacy. Fitzroy also open-coded the house-keeping codes: “resident characteristics”; “resident needs”; and “socioemotional care.” Open-code examples included: “engagement with others,” “lacking intimacy,” and “intimacy strategies.” Coding was guided by sensitizing concepts from the literature as well as by new themes she identified in the data.

Following open-coding, the first author engaged in axial coding (Corbin & Strauss, 2015) in collaboration with co-authors, linking initial open-coding categories and subcategories. During axial coding, she identified factors that influenced residents’ intimacy needs and experiences. During the final stage of analysis, selective coding, the authors collaborated to refine and unite the categories around the core category, which characterizes intimacy as a multi-dimensional process involving “managing needs and negotiating opportunities and constraints.” The core category connects subcategories in describing intimacy as an ongoing process that included

managing intimacy needs, while simultaneously negotiating opportunities and constraints involved in an attempt to realize them.

2.3 Results

Our core category, “managing needs and negotiating opportunities and constraints,” characterizes intimacy as a process illustrated in Figure 2.1. For study participants, intimacy was a multi-dimensional inner- and interpersonal process that involved feelings of closeness, familiarity, affection, trust, and vulnerability that could not be detached from the contexts in which relationships and interactions were embedded. As illustrated, intimacy was simultaneously a personal and interpersonal process, shaped by individuals’ needs and access to intimacy and influenced by multiple resident-, relationship partner-, and AL-factors over time.

Study participants experienced and expressed intimacy physically through action(s) or touch; intimacy was created and centered on emotional or spiritual feelings of closeness, familiarity, togetherness, acceptance and love; and intimacy was developed intellectually through conversations and shared ideas, experiences, or history, with others or internally. Participants experienced intimacy platonically (friendly or familiarly), romantically, or sexually. Residents processed intimacy inwardly, with another individual, or within a group of individuals. Such a holistic definition reflects the myriad of areas in which individuals experience (or do not experience) intimacy and also implies that the various dimensions of intimacy can be associated with different relationship partners, rather than exclusively from a spouse or romantic partner. Data also showed that residents’ intimacy outlets and needs were dynamic and varied over time.

Most residents experienced some form of intimacy in their day-to-day lives, though some did not. The majority sought, created, and sustained the intimacy process through a variety of relationships and with various individuals with fluctuations over time. Residents’ relationship

partners included co-residents, AL staff members, volunteers, family, and friends. While some residents engaged in intimate relationships with co-residents and staff, most intimate relationships in AL involved spouses, family members, and friends. Romantic and sexual relations were present among co-residents, spouses, and other romantic or dating partners.

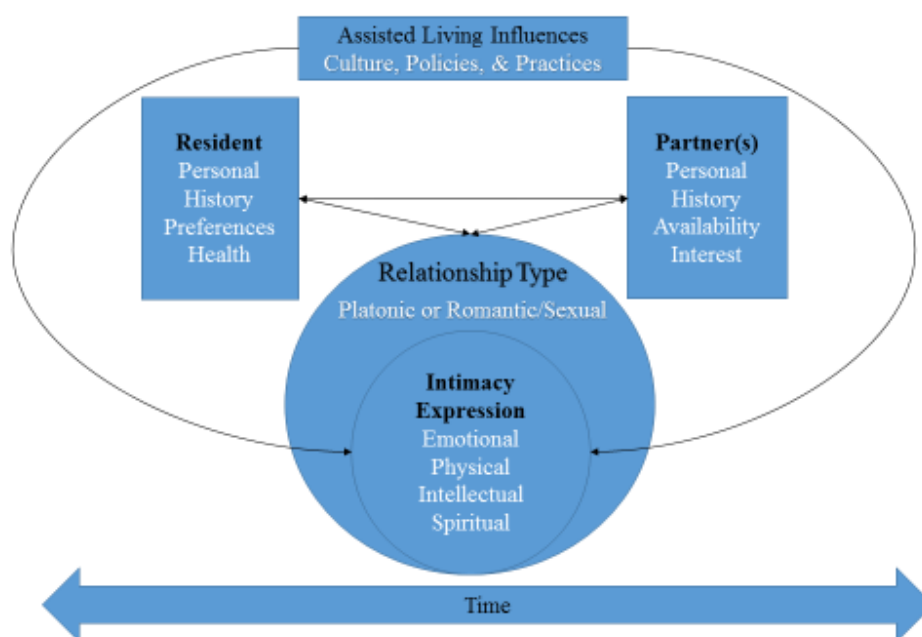


Figure 2.1 Intimacy as process: Negotiating opportunities and constraints

2.3.1 *Types of Intimacy*

Next, we define and discuss the four different dimensions of intimacy experienced by residents in AL.

2.3.1.1 *Emotional Intimacy*

The most common form of intimacy AL residents experienced and expressed was emotional intimacy. Many residents sensed and maintained an emotional closeness with a range of partners, including spouses and romantic partners, adult children, siblings, other family members, and friends living inside and outside their care community. Most arrived at AL with relationships with long-time friends and close intimate relationships with family members. For

instance, Ethel, an 87-year-old White resident, and widow, was asked about the people who provide for her emotionally, or who listen when she needs to talk. She identified her niece, her daughter, and her friends, exhibiting variations in emotional intimacy partners:

Well, I'm pretty open with my niece. We talk just about everything. I talk everything to [my daughter]. I don't have any qualms about talking to her. She might not agree with me, and that's all right. I'm sure there are other people I talk to. Some of my friends they come as the ambassadors. They've been real good friends.

Phone calls with geographically distant friends or family members provided some residents with much-needed and desired emotional intimacy. Residents also maintained and experienced emotional intimacy through in-person visits in and outside of AL, video chats, and text messages, letter writing, email, and involvement in online social media.

Other examples of emotional intimacy included closeness or familiarity between co-residents. Some residents established a connection with a collection of individuals such as their meal tablemates, those with whom they sat with three times a day.

Tablemates provided, at times, a source of emotional support for residents, especially for those who had lived in the home longer and been able to grow emotionally close over time. Intimate relationships with co-residents brought joy and engagement, especially for residents who might experience limited or no family involvement or friends outside of AL. Moira, an 80-year-old, white widow, characterized co-resident connections saying:

That is very important. I didn't have it at that last place. I am now having some social support. That is why I go play bingo and I am learning mahjong. There are some people that I find very... what is the word, the same as I am?

Like Moira, many residents recognized the importance of social support in their lives and across the lifespan. Moira's words suggest perceived commonality as a potentially critical factor influencing intimacy in her life.

Some residents formed close social relationships with AL staff, especially those with whom they interacted almost daily. Captured in fieldnote data, Peter, an 87-year-old white widower, spoke about his close relationship with Garden House staff member, Patricia, who was Black and in her mid-40s.

Peter said that the two of them were very close. He said that she was a [care] manager, but she did everything. He told me that helping him shower "was not her job, but she did it anyway." Peter said that she often would come into his room during her shift and lie down on his bed and chat. He said they talked in French quite a bit. She told him about her life in Haiti and all the places she's lived.

While speaking about how to be a "good resident" in AL, Peter shared one of his approaches, "building relationships with the people who care for" him. Though Peter and Patricia had an ongoing friendship at Garden House, there came a time when she left to pursue other opportunities. Peter expressed difficulty associated with creating, maintaining, and achieving a

close relationship only to have it suddenly change or end. The following field note data reveals his frustration:

Although Peter seemed understanding about the change brought about Patricia's departure, he said it is hard when you really get to know someone and are comfortable with them, and they leave. You have to start all over. He said, "Sometimes it's like Sisyphus – you know, the guy that pushed the stone up the hill only to have it come back down only to watch it roll back down and start all over again?"

Peter shared his concerns about sustaining friendship and intimate connections in later life and with limited control over life changes. This common scenario illustrates how much residents valued familiarity and consistency and how both are required for intimate relationships, but also the challenges residents face with sustaining intimate friendships in the context of care and later life.

Other residents formed close emotional relationships with volunteers or community members. Two of the homes provided a volunteer-run nail salon where residents were able to have their nails trimmed and painted. This weekly event was a source of fun and conversations for residents and provided an opportunity to make connections with co-residents and volunteers. The following field note excerpt provides evidence of how vital these connections might be for residents.

The volunteer Betsy came in during the activity. She had a big smile on her face and spoke to all the residents. Several called out to her. She went in the back and

gave [resident] Jane a big hug and then sat next to her. Jane had been looking a little pensive, and the attention from Betsy really perked her up.

Most residents were like Jane and had some opportunity for intimacy, yet some had unmet emotional intimacy needs related to an imbalance between needs and desires. The following field note excerpt describes Sadie's, who was 95-years old, white, and widowed, perceived social support.

As for social support, Sadie felt well supported except for someone to have a good time with... Her children and grandchildren provide most of her emotional support except for her friend Eva who is her confidant. Sadie says they tell each other everything. Eva has not been to see her, but she talks to her about twice a week. Despite saying she had good emotional support, Sadie said she often is lonely and wishes she had more time with her family.

Family members typically provided instrumental and social support to residents. Regardless of close relationships and contact with her family and a long-time best friend, Sadie had unmet intimacy needs, expressing loneliness over time throughout the study.

2.3.1.2 *Physical Intimacy*

Expressions of physical intimacy varied among individuals, yet residents viewed physical touch as an essential way of displaying closeness, familiarity, and comfort. Physical intimacy was experienced somatically through action(s) or touch. Most residents expressed physical intimacy through handholding/touching, a gentle touch on the shoulder or arm, hugs, and kisses

with spouses, dating partners, family members, and friends, and in a lesser sense with co-residents, AL staff and volunteers, and external workers.

Physical touch in AL communities routinely concerned the provision and receipt of care. A direct care worker from Hillside, a critical member in meeting residents' daily care needs, indicated the importance of touch when asked what is involved in providing quality care, "Just that you care. Touch, the slightest touch, just put your hand on their back, just to show them you care..." Direct care workers were integral to residents' care, including intimate care tasks such as bathing, dressing, hair brushing, assistance with toileting, and feeding. Assistance with care ranged from some help to total support, depending on the resident's health, mobility, and care needs. During these intimate care experiences, especially, staff-resident consistency and familiarity helped residents feel comfortable with and accept care from someone who recently might have been a stranger. Ronald, an 85-year-old African American widower, described the importance of trust when he received assistance with bathing, "Yeah, full baths. Here, it's a manner that says to me, do you trust this person? I trust them by the way they touch me, the way they touch my arm or the way it feels." Yet, the occurrence of touch alone was not indicative of feelings of intimacy. Residents specified differences between task-orientated touch, such as in care encounters, and intimate physical contact and gestures. Physical touch residents interpreted as intimacy did not occur alone, but rather, existed with other expressions of intimacy such as emotional intimacy.

In two of the homes, home culture included abundant kisses and hugs from staff and volunteers, whereas, in the other two homes, there was limited physical touch outside of care tasks. At Hillside, the smallest community, frequently and more prominently, provided physical affection than at Oakridge Manor or Feld House. In these communities, relations between staff

and residents were more formal and less likely to include physical familiarity outside of assisting with intimate care tasks.

Residents often identified physical intimacy as lacking in their lives. Yet, some residents felt fortunate to find intimacy and close companionship in AL that included or centered around physical intimacy, including Greg, a 90-year-old white widower who began a relationship with Sarah, also an older adult and a paid art instructor in the home. The following field note excerpt explains how Angela, an administrator in the home, characterized their relationship and its positive impact on Greg:

Angela smiled at me and said, “There’s Greg” and told me about his “date with Sarah.” She said that Greg told her he wouldn’t be back until the morning. Angela proceeded to tell me about their increasingly affectionate ways. Angela said that she’d gone into Greg’s room, and they were holding hands, and another time Sarah was “laying across his bed with her pants pulled up to her knees and he was massaging her feet and legs.” Angela then said, “I don’t know the nature of the relationship, and it doesn’t matter. It’s good companionship and I think it’s great.”

During his time in AL, Greg had been a caregiver to his wife, became widowed, and developed a close relationship with Sarah, which possibly had a romantic element, demonstrating the dynamic nature of his social and intimate career, which was affected by his preferences, but also the availability of intimate partners.

2.3.1.3 *Intellectual Intimacy*

Some residents sought opportunities to engage intellectually with others, which provided yet another form of intimacy. At times these interactions involved lively political debates, while at other times, they involved speculating about the meaning of life. Individuals achieved intellectual intimacy with others through conversations and sharing ideas, experiences, or life history. A few residents experienced and prioritized intellectual intimacy. However, for these residents, maintaining a level of intellectual intimacy in their lives was necessary and correlated to their life history and identity. Intellectual intimacy did not only involve philosophical topics, but also shared interests in general such one's career before retirement, subjects such as sports, and topics such as book or movie discussions. In all but the smallest home, activities personnel organized book clubs or discussion groups, which helped to engage intellectual intimacy between residents and with staff. Garden House's activity director, Gloria noted:

I have a novel club. That is not a typical thing, but because it is something I do well, it is something I initiated. It's strongly the people who are wanting to be intellectually engaged. Because there is a discussion that often follows... There is a lot of reminiscences that happens at the end.

Gloria's quote demonstrates the importance of building intimacy for some residents through the discussion of books, but also in ruminating of time passed. Gloria's book club provided not only physical space but emotional opportunities for residents to co-participate in intellectual intimacy. As the next field note excerpt shows, Gloria also reached out to residents individually,

demonstrating the influence of potential care partners' willingness and ability to engage and help address residents' needs:

Peter told me that he keeps very busy and he feels that Gloria is conspiring to keep his mind active and "not let me get stale." He said that he can't keep up with all the books, movies, podcasts, records, etc. that surround him. Peter reflected, "Every day is something different, and there are things you don't expect, and that surprise you."

Peter and Gloria's intellectual intimacy grew from periods spent discussing everything from books, movies, world and national events, to their personal histories, demonstrating the evolution of intimacy connections over time. It was with time that their intellectual exchanges grew more intimate, as they learned more about each other and shared about themselves, engaging intimately. As Gloria noted:

With Peter, he shared a lot. Our relationship is—he shared a lot of really deep things with me... in fact, when I came in Monday, he said, 'I have something I want to show you that I've never shown anyone... but this is what I wrote when I was in my 30s. This is the plan I had for my life, my goals.' I read through it and we just really have these deep conversations that really seem to be important to him too... I don't want to say Peter's wrapping things up, but he's...thinking. He's working some things out with himself.

For many residents, time spent in AL consisted of reminiscing about the lives they had lived and the choices they had made throughout their lives. Having someone with whom to process and share these feelings was vital for many residents. Some residents were apt to share their opinions with whoever would listen. In contrast, others were more reserved and shared deep conversations with those with whom they shared intellectual intimacy. Conversations regarding death and dying can be difficult for many. However, for some residents, discussions regarding end of life were vital to their sense of self and “wrapping up” their lives. As we can see through Peter and Gloria’s relationship, having and maintaining intellectual intimacy was essential to some residents.

2.3.1.4 *Spiritual Intimacy*

Spiritual intimacy encompassed spiritual or religious feelings that were shared and experienced with another person, such as with spiritual or religious leaders, and for many, their relationship with their deity. Residents spoke regarding their belief in God and their religion, experiences, and beliefs of a connection to their spiritual practice. The vast majority of residents were Protestant (46%) or Jewish (36%). For some residents, spiritual intimacy consisted of daily prayer, reading of one’s bible or prayer book, attending AL activities of devotion, bible study, or Friday Shabbat, and attending church, synagogue, or another place of worship when transportation was possible. When asked about his father’s relationship to spirituality, a son said, “The pastor at his church is—they’re actually pretty close. She’s an amazing woman in her own right, and the two of them are pretty close.” And, when asked about her mother, a daughter believed, “she’s more interested in going to the services now than ever before.” Over time, her mother increased her attendance of activities within the home that centered around her faith, such as Friday night Shabbat services.

For some residents, religion interfaced with emotional support. One example was Bobbie, an 86-year-old white widow living with dementia. When asked about his mother's emotional support, Bobbie's son explained:

I think her primary source for emotional support is her religion. She is a woman of devout faith, and I—the whole time I was growing up, anytime she was stressed, what she would do was read the Bible. She would always think that she would open the Bible to whatever the right answer for her was. I think that can—always has been and continues to be her primary source of support. I think [her daughter] certainly provides companionship and physical support. . . I don't see that Mother has any real relationships in [Garden House], but I don't think she's ever had significantly deep relationships.

As this passage implies, frequently, residents' intimacy outlets and preferences were influenced by experiences of their past. It was not uncommon for residents to maintain the intimacy habits they had learned and leaned on throughout their lifetime, and apply these experiences to their current situation in AL. Many residents maintained their spiritual practice as a method of preserving their sense of self and identity.

In all homes, religion and spirituality were central to creating feelings of home and community. They provided the basis for daily activities and routines and closeness between residents and, frequently, staff and persons from outside their AL community. At Oakridge Manor, residents were mostly Protestant and African American, including, Delores, a 78-year-old widow who ran the morning devotional study four days a week. Delores played the piano,

sang hymns, and led the attendees in bible study. Her popular event was attended by many residents, especially those with limited mobility or options for transport. Such programming provided opportunities for residents to seek and receive spiritual intimacy from the connection of spiritual exchange within a group. Delores also visited with residents who were unable to attend devotional activities due to illness or frailty. Delores described her visits with a co-resident:

She's been ill for about three months—two months now, and I make it my business to see her every single day. I go, and sit, and talk with her. She cannot get out of bed, and I consider myself very fortunate, in as much as I can get out of bed...She loves to have me come and visit with her, and her children, seemingly, like to have me visit with their mother. They work, and I make it my business to see her every single day because they can't get out every day. She, in particular, is the one that I visit all of the time. I go, and I pray with her. She loves to hear me talk, loves to hear me sing.

Spiritual exchanges of intimacy were present among co-residents and seemingly benefited both Delores and her co-resident.

At Feld House, where the residents were predominately Jewish and White, staff coordinated events around Jewish holy days and activities such as weekly Friday Shabbat service with a rabbi from the community. Many residents found a connection with others, both independently and collectively, who shared their similar views of spirituality. Here a family member described how important spiritual intimacy was to Esther, a 90-year-old, white, widow:

Well, when she was in [previous AL], they had a shuttle and they would take people to church services on Sunday, and Esther, even though she is Jewish, Esther would go to the services. Esther is filled with spirituality and sometimes it doesn't have to be in a synagogue to still be spirituality. Sometimes she went to the Methodist church and sometimes she went to the Catholic church that they drove her to with other people. She got a little bit of; we will call it spirituality that way. I think she really likes being in [Feld House] because it has the Judaism that she grew up on. And Esther, she may not see as well, I'd say that the things in her vision don't register but her hearing is fine. She has told me many times that she enjoys when the rabbi comes and the speakers come, she really enjoys those kinds of activities at [Feld House].

Through spiritual intimacy, residents forged intimacy individually, within a dyad, or a collective of individuals, such as a prayer group, providing a further illustration of the opportunities for intimacy in AL.

2.3.2 Platonic Versus Romantic and Sexual Intimacy

Much of the intimacy residents experienced was platonic, characterized by familiarity or closeness between residents, family, friends, and others. Yet, some residents experienced intimacy with others that was romantic or sexual. Romantic and sexual intimacy was also experienced physically, emotionally, intellectually, and spiritually and maintained with those living in and outside AL.

Of the three married residents, two lived with their spouse in AL, and one resident's spouse lived outside of AL. Married residents tended to have one partner with higher care needs

than the other or more care needs than their spouse could manage. This challenge landed them either together in AL with one as a care partner, such as Greg's initial situation, or one of them in AL and the other in the community. Diana, an 83-year-old white resident living with dementia, was married to Tom, who lived alone nearby and visited every other day for lunch. At times, Diana did not recognize Tom as her husband. Regardless, she enjoyed the attention she received from him on his lunch visits. Researchers observed Tom and Diana regularly holding hands, blowing kisses, being caring, and saying loving things to each other. The following field note excerpt is representative of their relationship, "Throughout lunch, Tom kept cutting chicken off of his plate and putting it on to Diana's. Each time he did so, she would say, 'You are so sweet to me. Look at you all covered in honey.'" Yet, there was change in their relationship over time, and their daughter noted:

Our mom and her dementia... He's having a hard time coming around to accept things, how they are. My dad is my mom's white swan, and I think right now, at her stage, I'm not sure she really knows that he's her husband, but he still thinks she does. I think she believes—I think she knows he's someone that cares for her, and she cares for him, and that she loves. I'm not sure that, in her present state of mind that she really realizes that he is her husband.

Diana and Tom's relationship provides an example of how intimacy can alter over time, especially within the context of dementia. Despite these changes, over the two years of the study, Diana and Tom maintained a positive and intimate relationship that brought them joy and emotional support.

Un-partnered residents with interest in romantic intimacy sought a variety of potential partners inside and outside the care community. Some found romance, intimacy, and even love in AL with co-residents. Residents experienced much meaning in these relationships, which often helped improve a resident's mood and emotional outlook. In this field note excerpt, Mavis, a white 80-year-old white widow, discussed her relationship with co-resident, Anthony:

Mavis said Anthony wants the relationship more than she does but that he makes her feel attractive as a woman and they have lots of good times together... Mavis said some of Anthony's family have met her, and that just makes it more meaningful. She said they can have fun because they can't have sex and don't depend on each other financially. Mavis said this is the first time she has felt free. She said, "I have everything I need taken care of...I am relearning to be content at this point in my life." She mentioned the fact that Anthony has some cognitive impairment, but she does not let that bother her.

Mavis adjusted some of her needs and desires for a romantic relationship due to her current situation and availability. Intimacy in later life and AL caused residents to adapt their former relationship expectations and desires. Also, Mavis appreciated the potential intimate connection with Anthony's family as an additional source of social support. Mavis and Anthony's relationship also presents the availability and possibility of intimacy for those experiencing dementia and cognitive impairment.

One resident spoke about sexual connections with those outside the community. Hannah, an 86-year-old African American widow, had a long-time “phone buddy” with whom she experienced periodic “dirty talk.” She met her “phone buddy” several years before moving to AL and maintained their relationship strictly by telephone. Hannah kept the relationship secret and hidden from most of her family and friends. Other residents yearned for more romance or sexuality in their lives and missed what they had in the past and what they felt they would never have again. Peter, for example, described missing physical, romantic intimacy with his wife:

Physically, when a man goes through all this kind of stuff, especially when you're married to a beautiful woman, a very sensual woman... and then you lose her and you lose the ability to do this kind of stuff... You just have to accept that junk.

Accepting that junk required reconciling opportunities and constraints as Peter continued:

Well, I'm happy, and I have a lot to be grateful for. I have a great family and great support. I have a place to live. My health is reasonably good, minus some problems. But, I miss my wife. I miss kissing her. I miss her perfume, touching her, and being intimate.

Despite receiving adequate physical and social support from his family and AL staff, Peter still yearned for the emotional, physical, romantic intimacy he had shared with his wife. Though he was unable to engage in a romantic relationship again, he compensated by centering emotional and intellectual intimacy with specific others, ranging from family members, friends, and AL staff.

2.3.3 Factors Influencing Intimacy: Opportunities and Constraints

Our analysis showed intersecting resident-, potential partner-, and AL-level factors that combined over time to influence the intimacy process in AL. Factors that influenced AL residents' experiences in intimacy included access to an intimacy partner, one's marital status, gender, health, and physical mobility, and personal life history. Potential intimacy partner factors included their relationship to the resident, availability, proximity, and interest in pursuing a close intimate relationship, platonic or romantic. AL factors that influenced the intimacy process were home culture, policies, and practices. The most prominent factor that influenced a resident's access to intimacy, in general, was the accessibility to another individual who was willing and able to engage.

2.3.3.1 Resident Factors

A resident's life history, intimacy experiences, and preferences for intimacy influenced the intimacy process and opportunities for intimacy in AL. Residents arrived at AL with a life history of intimacy experiences, preferences, and practices. Some individuals needed or desired more intimacy in their lives, while others had few intimacy needs. The need for close connections with others, intimacy, is highly variable, even in older age. One's intimacy history appears to shape their intimacy present, and perhaps future intimacy engagements. Other personal factors related to intimacy experienced in AL included a resident's gender, health and frailty, and previous intimacy experiences.

Gender imbalance in AL meant limited opportunities for women to have cross-gender relationships and for men to have same-gender relationships, including friendships. One's physical and cognitive function might also hinder intimate encounters, especially romantic. For instance, when asked about any on-site dating potential, Hannah said that the men in AL were

“like children” and needed more care and support than she was willing to offer. Other women residents also complained about a “lack of men” in the home. Men also sought or expressed desired opportunities to have closer friendships with other men or ruminated friendships or other relationships past.

Marital status limited or provided intimacy. Most residents were widowed and, like Peter, reminisced about their lost partners. Dorothy, an 86-year-old African American widow, described her experience, saying:

Oh, I do get lonely, but not terribly lonely. There’s always somebody I could communicate with or something I can do. I’ve got so much stuff that I haven’t read that I’ve got piled up to read, and things to play. No, I don’t really get lonely, but I miss [George], my husband. I miss him. I just miss him - just an empty place in my life.

Dorothy’s sorrow was similar to Peter’s, as they both felt they had the instrumental and social support required to be content with life. Still, they continued to feel a missing piece in their lives, a specific type of intimacy that was not easily found, especially in AL.

Other residents spoke about maintaining connection and intimacy with a spouse, family member, or friend who had died, a shared experience among widows and widowers, especially those who had experienced a long or happy marriage. Some widows shared that they still had a relationship with their spouse who had passed and continued to feel connected to them. Many widowed residents continued to wear their wedding rings.

A resident's health and level of frailty were factors that affected their intimacy experiences. Most residents arrived in AL with multiple health issues, including incontinence, cognitive impairment, mental health, sight, hearing, and mobility issues. These conditions frequently affected residents' relationships with each other. One resident who used an oxygen tank lamented, "I'm so afraid to be around people because the oxygen makes so much noise. I have to take a deeper breath than ordinary," causing her to self-isolate and limit connections with others. Residents who enjoyed better physical, cognitive, and mental functions were more likely to congregate together and form social bonds. Hearing loss was a factor that residents, staff, and family members felt limited residents' engagement and potential intimacy. Here a son speaks of the difficulties his mother had before wearing hearing aids, "Between not having the hearing aids and her shaking she feels like she cannot participate, she cannot be involved." After she began wearing hearing aids, his mother was more likely to participate in conversations and engagement with others. The following field note excerpt includes two residents who, with a little bit of extra energy, were able to overcome their difficulties in hearing and engage in an intimate exchange.

Emily went on to say how difficult it is in social situations when one cannot hear. She said it is very "isolating," and often, she does not go to activities because she cannot hear. Emily told me that Rabena also is hard of hearing, which Rabena confirmed. Rabena does not wear hearing aids. Emily said that she and Rabena usually can understand one another, and the other day they had a 30-minute conversation outside and never once had to ask the other to repeat what she had said.

A resident's health conditions sometimes limited them not only in terms of leaving the AL home but also their individual rooms, making them less likely to engage with others. When asked about her history of engaging with others, Deanna, a 64-year-old African American divorcee, responded, "No. Not really. As a matter of fact, I used to do all the things, but now, with my brain aneurysm, I don't see anybody," indicating her isolation from others not only outside of AL but within as well.

Residents who made close intimate friendships in AL and then experienced the death of their friend acted more cautious about making another friend in the home to avoid such a loss again. In the following field note excerpt, Peter from Garden House spoke of his hesitation to make new friends due to what he considered the finality of moving into AL.

Peter reminded me that he could "drop dead at any time." He also said that it is hard when you see people you care about because you never know if it is going to be the last time... Peter told me, "I am very aware that this is the type of place people come to die." He told me that he'd come to this realization about three months after he moved in... He then talked about not wanting to get too close to anyone.

Peter shared that to protect himself from possible future emotional pain he had limited his attempts at intimate relationships with co-residents. Researchers observed that his closest connections with others included staff, such as Gloria, and younger family members, indicating the importance of intimacy partner factors as well.

2.3.3.2 *Partner Factors*

The main partner factors that influenced intimacy in AL included the partner's relationship to the resident, their availability and proximity, and their interest in pursuing a close relationship. As identified previously, most intimate relationships were with family members, spouses and dating partners, or long-term friends. AL residents, staff, and family members considered some relationships in AL inappropriate, such as a romantic, and for some homes, emotionally intimate, relationships with a staff member or volunteer, or even with another resident. Thus, one's relationship with a resident deemed the appropriateness of intimacy. An intimacy partner's availability and location proximity also influenced intimacy as few residents had the technological skills or transportation available to engage in and maintain long-distance relationships. Finally, a potential intimacy partner must display an interest in pursuing a close intimate relationship. To participate in intimacy with another, one needed an available and interested partner.

2.3.3.3 *AL Home Culture, Policies, & Practices*

AL home culture influenced availability and access to intimacy for residents. Policies and practices influenced AL culture. As shown previously, AL communities such as Feld House and Hillside had a more family-like or homey feel, and others, typically larger homes, such as Oakridge Manor, were more formal socially and in interactions with staff and co-residents. Yet, most AL communities provided a variety of opportunities for socialization for residents among their peers in the form of collective spaces, communal meals, formal activities, and staff's encouragement of residents to engage. In the following interview excerpt, a 90-year-old, white, widower's daughter explains how Garden House addresses more than just her father's health care needs but also his desires for closeness and engagement with others.

Certainly, his wants and needs are few in terms of what he asks for. I think Garden House is a big part of that because he has people checking on him daily. [Garden House Resident Director] is always in there engaging with him. I think if he was in a place that didn't necessarily have that kind of structure to it, I think my role would—I mean, I would feel like I needed to daily provide him a lot more of those things. While I do talk to him daily, I don't feel like I have to be out there every couple of days.

2.3.4 Reconciling Intimacy Needs with Opportunities

Residents experienced a variety of relationships, and their daily lives in AL provided both opportunities and constraints in experiencing intimacy. Residents successful in creating and achieving intimacy with others exhibited feeling more fulfilled lives in AL. When asked, the majority of our interviewed residents responded they did not feel lonely. Yet, for residents who desired but lacked intimate outlets, the effects were often feelings of loneliness and isolation, including for Jacob, an 89 -year-old widower:

Yeah, I get lonely. I'd have to define loneliness as a more of a desire than anything else. That sometimes is physical desire, an emotional desire, even a spiritual desire. Even though I do a lot of reading... but it doesn't click the way I want it to click.

Some residents who lacked sufficient intimacy actively sought opportunities for intimacy in AL. Residents looked to co-residents, staff members, health care professionals, home volunteers, and their family and friends for increased intimacy in their daily lives. Some residents attempted to increase their intimacy opportunities. For example, Greg started providing the devotional at Garden House to be closer to Sarah, the home's art instructor. He was also involved with the local veteran's group to increase his opportunities for male friendship and maintained his strategy of circulating the AL dining room to improve connections with other residents. Residents' strategies for increasing intimacy with co-residents ranged from circulating the dining room during meals, leaving one's door open to the hallway, attending activities and events, and distributing the mail for the home. Residents maintained these approaches to increase the potential for interaction and social exchange with others. Field note data captured a researcher's discussion with Michael, an 87-year-old white Garden House resident who wished for more opportunity for co-resident relationships:

Michael paused and then said, "Well, you know what my favorite thing to do is?" I paused and considered my response. "Talk?" I asked. He laughed and said, "Well, that was a good guess." He said, "I am trying to get them to have a coffee area at Garden House. So, we can sit and talk, you know. Not in the dining room. But maybe we can sit down and have lunch or a coffee and talk."

Michael desired more intimacy and connections with others in his life in AL, consistent with many of his peers. For those residents who preserved for more intimacy in their lives, seeking

opportunities for intimacy, many were able to fulfill much of their intimacy needs despite the limitations.

2.4 Discussion and Implications

We aimed to provide an in-depth and holistic understanding of older adults' intimacy experience(s) and identify how and why such intimacy experiences vary for older adults receiving long-term care. Study findings demonstrate that intimacy is an ongoing process influenced by managing one's needs while negotiating intimacy opportunities and constraints. Most residents in AL experienced intimacy in their daily lives. Our findings are congruent with Reis and Shaver's work (1988) and their "interpersonal process model of intimacy," where intimacy is a reciprocal process between two individuals developing and sharing intimacy. Yet, in our findings, the intimacy process also involved managing one's needs for intimacy (type, frequency, and with whom) while negotiating one's needs with intimacy opportunities and constraints. Intimacy may be physical, emotional, intellectual, or spiritual and either platonic, familiarly, or sexual/romantic. Our conceptual model presents the factors influencing intimacy experiences in AL, including residents' life history and preferences, health and frailty, and access to a potential intimacy partner. Modifiable factors affecting residents' intimacy experience in AL include home culture, availability of activities and shared spaces, and openness to residents' romantic or intimate partnerships. AL residents experienced intimacy internally, within a dyad, and within groups. While some residents felt their intimacy needs remained unmet, others were strategic in increasing intimacy opportunities in their lives. Our conceptual model is a framework with which to base future research on intimacy in older adult's lives.

One explanation for the variability of intimacy in AL includes the diverse lived experiences of intimacy. Older adults arrived at AL with a history of intimacy experiences,

including one's preferences and needs for intimacy. For some older adults, AL may have expanded their intimacy involvement by providing connections to potential intimacy partners such as co-residents, staff members, home volunteers, and family and friends. Our findings regarding older widows' experiences regarding the intimacy of past relationships as central rather than seeking a current relationship or when intimacy opportunities are limited are consistent with Bender, Burgess, and Barmon's (2017) research on the lack of intimacy in AL. It might seem unusual that intimacy is lacking in a communal living environment, such as AL, yet, many residents found themselves missing intimacy in their lives. Some residents who found it challenging to make intimate connections within the home sought opportunities elsewhere, downplayed the significance of intimacy in their lives, or even acted inappropriately. Other residents managed their needs with limited prospects by implementing strategies to increase intimacy opportunities. We also found that residents in better cognitive and physical health were more likely to socialize with others in similar health. This finding is consistent with previous research regarding social relationships in AL (Sandhu, Kemp, Ball, Burgess, & Perkins, 2013). Implications of our study incite the importance of identifying and attempting to meet the intimacy needs of AL residents to provide a more holistic care model. A comprehensive care model meets not only individuals' physical needs but attends to their emotional and intimacy needs as well.

It is essential to understand the modifiable factors that can promote intimacy in AL, such as AL home culture, policies, and staff training. Home-provided activities and areas to socialize increased intimacy opportunities for residents. Additionally, practitioners can improve the well-being of older adults by intervening with their care convoys to strengthen and enhance intimacy opportunities for residents. Our research has implications for how professionals in the field of

AL can create and foster opportunities for intimacy for residents and how researchers should continue to study the role of intimacy in older peoples' lives. Furthermore, our research has implications for how we study intimacy and older adults, including the need to study the process of intimacy over time and embedded within care conditions.

There were some limitations to this study. First, the intention of the original convoy study was not to look at intimacy but rather the care needs and collaborations of care convoys in AL. However, the research data attained through the convoy study was vast and reflected the diversity of AL residents and their experiences over time. Second, the researchers selected the data sites and residents and their convoys based on the variety of AL residents across the United States, yet used only four AL sites. Future analysis and research are needed to continue to obtain more knowledge regarding older adults' intimacy experiences.

More research is needed to further analyze intimacy partnerships in AL, such as with care workers, family, and friends. Further research would provide a more in-depth understanding of how these care partners impact older adults' intimacy processes. Additional study looking at the intimacy process of younger individuals receiving long-term care would give us an enhanced understanding of the complexities of care and intimacy. Despite these limitations, our analysis provides a better understanding of intimacy in AL. Our definition of intimacy and the different dimensions of intimacy deliver an essential contribution to the area of gerontology and provide a more comprehensive understanding of the lives of older adults.

3 HANDLING INTIMACY: BODYWORK, CARE, AND SOCIAL RELATIONSHIPS

3.1 Introduction

Individuals live longer, increasingly frailer lives with chronic illnesses, and are more likely to need long-term care (Khatutsky et al., 2016). Assisted living (AL) is the fastest-growing type of long-term care in the United States; more older adults are moving into AL than ever before (Stevenson & Grabowski, 2010; Khatutsky et al., 2016). Ideally, AL promotes a home-like atmosphere and offers a holistic approach to residents' care needs (Kane & Kane, 2001). AL endorses a social model of care, where care needs include social and emotional care and emphasizes connections with others and resident agency and choice. Yet, we understand little about the close intimate relationships residents may form while residing in AL. The typical AL resident is 85 years old, physically and cognitively frail, diagnosed with multiple chronic conditions, and most often, a woman (Khatutsky et al., 2016). Although estimates vary widely, almost half of AL residents experience dementia (Caffrey et al., 2012). Most residents require help with multiple activities of daily living (ADL), instrumental activities of daily living (IADL), and medication management (Khatutsky et al., 2016). Direct care workers (DCWs) provide much of AL residents' care. For residents with high care needs, direct care staff is integral to their intimate care needs such as bathing, dressing, hair brushing, assistance with toileting, and feeding (Khatutsky et al., 2016).

DCWs may be certified nursing assistants or have some college education, while others may have little formal training in elder care or bodywork (Ball, Hollingsworth, & Lepore, 2010; Kelly, Morgan, Kemp, & Deichert, 2018). Most DCWs are women with a mean age of 38.3 years old (Kelly et al., 2018, p.9). Direct care work can be physically and emotionally exhausting work, low-paying, and low-status in society (Twigg, 2000; Ball et al., 2005). Many AL workers

derive meaning from their work with residents, and the relationships they form are essential to their job satisfaction and job performance (Ball et al., 2009; Kemp, Ball, Hollingsworth, & Lepore, 2010; Morgan et al., 2013).

Resident-DCW relationships are critical to the latter's experience and performance (Morgan et al., 2013), and ultimately, the care process. Crucial components of "compassionate care" in AL include human touch and interpersonal warmth, having someone to talk to, and sensitivity in performing intimate care and bodywork (Morgan et al., 2011). Research reveals the challenges and, at times, the discomfort that individuals experience in receiving, and providing, intimate care (Twigg, 2000, 2002; Meyer, Donnelly, & Weerakoon, 2007).

Care encompasses both physical and emotional work. Care is interactive: one individual provides care, and another receives it. Individuals receiving care are often active in the care process (Russell, Bunting, & Gregory, 1997; Kemp et al., 2018). Reciprocity in care dyads adds value to the relationship for both care partners (Roe, Whattam, Young, & Diamond, 2001). A person's need for care can conflict with their values of independence and autonomy, especially as care needs become more frequent over time (Ball et al., 2004). The trajectory of care for older adults tends to be far more complicated and unpredictable than it is for younger individuals needing care, with more and greater crisis episodes (Martin-Matthews, 2000). Most older adults have full agency in decision-making for themselves, but as they age and their care needs increase, they often have less control in deciding their care (Perkins et al., 2010).

Care provided in AL includes bodywork, work that "involves direct, hands-on activities, handling, assessing and manipulating bodies" (Twigg, Wolkowitz, Cohen, & Nettleton, 2011, p.172). Bodywork is a fundamental element of the intimate care AL residents receive. Bodywork often violates the social norms of handling another's body, especially in terms of touch, odor,

and appearance (Twigg et al., 2011). When paid staff provide bodywork in an institutionalized setting, such as a nursing home or hospital, some of the intimacies of the experience are lost. In these settings, staff performs bodywork at a specific time and place, arranged and scheduled according to the institution. In these institutions, the needs of other residents and the monitoring of supervisors and staff also impact the bodywork experience for both individuals involved (Diamond, 1995; Twigg, 2000). Twigg and colleagues state that bringing “intimate bodycare, [in] this ordered [work] space disrupts its meanings, challenges its privacies, and redistributes its spaces” (2002, p.177). The private/public dichotomy of long-term care environments further complicates the space that is home for some and the workplace for others.

Bodywork is considered highly feminized work as women traditionally perform most of the labor (Cohen & Wolkowitz, 2018). Most of older adults’ care consists of women providing for other women (Aronson, 1992). Twigg and colleagues also argue that bodywork “borders on the ambiguous territory of sexuality” (2011, p. 178), as it involves the handling of another’s body, including the potential of undressing and bathing. This distinction, along with the notion of hegemonic masculinity that positions men as potentially sexually predatory (Connell, 1995), limits men’s access to bodies of all genders. Consequently, both men and women who need assistance with ADLs, and specifically bodywork, show a preference for a female care partner (Twigg et al., 2011).

Individuals who receive care, especially those who are older and frail, are physically and emotionally vulnerable due to the power dynamics of care (Gibson, 1998). In a healthcare setting, there is a power imbalance between those receiving care, who are typically older, frailer, often naked or exposed, and lying prone. The worker providing care is usually younger, stronger, clothed, and standing above (Twigg, Wolkowitz, Cohen, & Nettleton, 2011). However, both care

providers and AL residents can be either vulnerable or empowered, depending on status and circumstances (Kemp, Ball, & Perkins, 2013).

Older men and women receiving informal care, non-paid care typically from family members and friends, may respond to care differently. Older women may interpret receiving care as a loss of independence and an invasion of privacy (Roe et al., 2001). Older men receiving care might also resist assistance with tasks that threaten their masculinity, such as problem-solving or financial support (Calasanti & Slevin, 2001). Both men and women report not wanting to burden their children with their care (Twigg, 2002), demonstrating the need for formal long-term care.

While much of the research examines bodywork in the context of nursing homes (Diamond, 2009), in-home (Ray & Street, 2006), or community care (Twigg, 2000, 2002), some researchers have investigated the significance of care for individuals working or living in AL. Ball and co-researchers (2009) explored the meanings of relationships between DCWs and AL residents using a grounded theory approach (Strauss & Corbin, 1998). They analyzed data from two AL communities—a non-profit with 35 residents, and a for-profit with 75 beds (Ball et al., 2009). Their results highlight the importance of the relationships between DCWs and residents to staff job satisfaction and retention. They found that staff and resident relationships impact and influence the care process, both positively and negatively. Furthermore, the meaning created in these care arrangements brought both AL staff and residents positive support.

Building on work by Ball et al. (2009), Kemp and colleagues examined resident and staff relationships using a larger, more diverse sample of data from 45 AL homes (Kemp, Ball, Hollingsworth, & Lepore, 2010). Reviewing qualitative interviews with administrators and DCWs, and using grounded theory methods (Strauss & Corbin, 1998), they found that most DCWs identify their relationships with residents as the most satisfying part of their job (Kemp et

al., 2010). However, not all relationships were positive; they ranged from “close,” “friend-like,” or “family-like,” to “difficult,” and even “abusive.” Yet, DCWs’ rewarding relationships with residents appear to counteract the problematic and dissatisfying aspects of their work. Researchers found three levels of factors influenced DCWs’ relationships with residents: community factors, such as the location of the AL home; facility factors, such as size, ownership, and fees; and individual characteristics, for example, race, class, health status, attitudes, behaviors, and family involvement (Kemp et al., 2010). Their findings suggest that DCWs having more quality time available to spend with residents improves the likelihood of a close personal relationship between DCWs and residents, which in turn influences and improves care. One DCW sums this up by saying, “the more I like the residents, the better of a job I do” (Kemp et al., 2010 p.161). The emotional closeness in ongoing relationships between staff and residents promotes personalized care. However, few studies explore the intricacies and personal responses to DCWs and AL residents’ intimate care experiences. Twigg, a leading researcher in bodywork, emphasizes the struggle in studying bodywork, specifically touch, in the care process, noting that “touch is hard to study, both clients and care workers find it difficult to talk about” (Twigg, 2000a, p.61). Intimate care may be challenging to research, but has a significant potential impact on the care process. Little, if any, research exists that focuses on intimate care and the social relationships between AL residents and DCWs.

The Convoys of Care model informs the present research and is an extension of Kahn and Antonucci’s (1980) “Convoy Model of Social Relations” (Kemp, Ball, & Perkins, 2013). The revised model includes both formal and informal care partners, including those who may not have close relationships with care recipients. Care convoys are the dynamic combination of informal and formal care partners who provide all types of care, from social and emotional care

to ADLs, and consequently, have implications for aging in place and quality of life and care (Kemp, Ball, & Perkins, 2013).

Using data from the study “Convoys of Care: Developing Collaborative Care Partnerships in AL” (hereafter, the “Convoys Study”), I build on previous research examining residents’ care arrangements and relationships. Previous analysis from the study highlights the impact of care providers’ abilities, AL residents’ diverse needs, and a holistic understanding of care over time (Kemp, Ball, & Perkins, 2019). Kemp et al. (2019) studied formal healthcare provided in AL and found numerous multi-level factors influencing the variety of ways care is delivered. In AL, the “individualizing” of healthcare for residents results from a delicate balance of DCW’s responses to resident care needs. Researchers identified the importance of “communicative competence” by DCWs in communicating residents’ health changes (Kemp et al., 2019a). In both studies, researchers established that because of their exposure and time spent with residents, DCWs are essential to ongoing monitoring and communication of residents’ health. In the context of daily life and care routines, typically, they are the first to note changes or complications and can provide timely and appropriate care to residents, assuming they know the resident (Kemp, Ball, & Perkins, 2019; Kemp et al., 2019a).

Additional analysis provides an in-depth holistic understanding of intimacy as expressed in AL (See Chapter 2; Fitzroy, Kemp, & Burgess, forthcoming). Using Convoys data, we conceptualized intimacy as a multi-dimensional inner- and interpersonal process that involved feelings of closeness, familiarity, affection, trust, and vulnerability that cannot be detached from the embedded contexts of relationships and interactions. Intimacy is expressed in four different ways: physical intimacy by touch, emotional intimacy through emotional exchange with another, intellectual intimacy through the exchange of knowledge and conversations, and spiritual

intimacy with a religious or spiritual partner or one's deity (Fitzroy, Kemp, & Burgess, forthcoming). Intimacy can be platonic, romantic, or sexual. Older adults arrive at AL with a history of intimacy experiences, relationships, and preferences that impact their current connections with others and their needs for intimacy. Conflicting factors influence access to intimacy in AL: gender, health, and presence of a partner willing and able to engage intimately. Some residents implemented strategies to encourage and improve their possibilities of intimacy in AL. The intimacy process is present in AL as residents create and maintain intimacy through a variety of relationships, including those providing their care. In AL, DCWs have the potential for close relationships with residents, especially in light of the daily care process. Nevertheless, what remains unknown are the intricacies of how both residents and their consistent care partners, DCWs, experience daily care interactions over time and how the process of intimacy is involved. The following analysis builds on this work.

Here I aim to examine the intimate care relationships of residents and DCWs in AL. Analyzing data from the Convoys study, I ask: (1) How do residents and DCWs experience the care process over time; and (2) What accounts for variation in these experiences?

3.2 Research Design and Methods

This paper presents an analysis of data collected as part of the grounded theory methods (Corbin & Strauss, 2015), longitudinal, qualitative project, "Convoys of Care: Developing Collaborative Care Partnerships in AL." The overall goal of the Convoys study was to learn how to support care convoys in AL in ways that promote residents' ability to age in place with optimal resident and caregiver quality of life. Researchers apply the convoys of care model to AL, where residents' care convoys can include co-residents, family and friends, AL staff, external care workers, volunteers, and others from the community (Kemp et al., 2018). Eighteen

researchers, including myself, faculty, staff, and graduate students from the Gerontology Institute at Georgia State University, spent two years in eight AL communities. Researchers collected data in several ways. The team made weekly visits to the communities, which included informal conversations with those who lived, worked, and visited the homes. We conducted in-depth interviews with AL residents, executive directors, DCWs, health professionals, residents' family and friends, and volunteers. We assigned pseudonyms for the AL communities and participants to preserve their privacy. Georgia State University's Institutional review board approved this study. Pseudonyms are used to protect homes' and participants' anonymity.

3.2.1 Settings and Sample

Here, I use data collected between 2013 and 2015 in four AL communities and involving 28 residents and 114 members of their care networks. Convoy's researchers selected four assisted living communities based on variability in location, size, ownership, residents' demographics, and functional status. All homes were in or around the Atlanta, Georgia area. Oakridge Manor was the largest community, licensed for nearly 100 residents, corporately owned, and located in an urban area. The majority of the residents were African American. Privately-owned Garden House, licensed for over 50, was located in a small town. Most residents were White. Feld House was foundation-run and licensed for over 40, mostly Jewish residents, and located in an Atlanta suburb. Licensed for ten residents, privately-owned Hillside was the smallest home. Hillside was situated in a rural mountain area, and all their residents were white.

Researchers selected 28 residents and their care convoys to study in-depth based on variation in residents' gender, race, age, religion, education, availability of kin, socioeconomic status, functional abilities, and cognitive status. Researchers made weekly visits with residents,

performed in-depth interviews with those who were cognitively able, and reviewed their AL records.

Of the 28 residents, 17 were women, and 11 were men. Ten identified as Black or African American, and 18 were White. The majority were widowed (64%); three were currently married, three divorced, and two never married. Eleven experienced some form of cognitive impairment (Alzheimer's Disease or dementia). The majority needed assistance with mobility and used a walker or wheelchair. Over half of the sample required assistance with three or more ADLs, 82% needed assistance with three or more IADLs. Seventy-five percent needed help in managing medication. Fifty-seven percent required assistance with three or more activities of daily living. Twenty-four of the 28 residents (86%) received at least some intimate care assistance during the study. DCWs provided most of the residents' care, though personal care also was provided by formal private care aides, health care workers, and family members and friends. This analysis focuses on the care delivered by DCWs to residents in AL.

Researchers conducted in-depth interviews with 18 DCWs, all women. Most identified as Black or African American. They ranged in age from 28 to 66 years. Their employment tenure within the community ranged from less than one to nine years. Most had at least some college education, and about half had additional long-term care training.

3.2.2 Data Analysis

Following Corbin and Strauss' (2015) Grounded Theory Methods, researchers began with line-by-line coding of all data. The Convoys study's researchers utilized the qualitative software NVivo 11 to store, manage, and facilitate coding and analysis of the data. As part of the extensive Convoys study, the research team coded the researcher-collected fieldnotes creating codes used to identify broad themes in the data (Kemp, Ball, & Perkins, 2019). Using NVivo 11,

I applied these codes to narrow the fieldnote data to instances regarding residents' care by DCWs. These codes included "activities of daily living," "socioemotional care," and "medication management." Following Grounded Theory Methods (Corbin & Strauss, 2015), I began "open coding," the resulting sample of the dataset. Examples of the open codes included: "maintaining dignity," "DCW knowledge of resident," and "connecting emotionally." I then organized the initial "open codes" to "parent codes," considering the relationships between the codes, including possible scenarios that caused variation and with what outcomes.

I also reviewed and coded DCWs' and residents' formal interviews to further my analysis - looking to the words of participants to describe their intimate care experiences in AL. I was interested in capturing the complexities of how residents and DCWs interpret and participate in intimate care that I may not have caught only using the house-keeping codes. Researchers had created in-depth profiles for all AL sites and residents utilizing data from interviews, in-person observations, and homes' and residents' records. I studied the home profiles to support my analysis of how the AL homes' culture influenced the care experience between residents and DCWs. The homes' profiles included descriptions of the homes' setting, ownership, staffing, residents, care culture, policies, and practices, among other factors that influenced residents' care.

Grounded theory methods include three types of coding (Corbin & Strauss, 2015). I moved on to axial coding to link initial categories and subcategories I had identified in open coding. I created analysis charts and documented factors that influenced and shaped intimate care over time for residents and DCWs. Through axial coding, I identified connections between intimate care and conditions and strategies that varied by resident, DCW, and situation. For example, specific residents needed more intimate care than others, thus requiring more time

spent with DCWs. Factors such as residents' needs, staff availability, and home policies influenced residents' preferences. Residents' preferences included specific care workers or a particular time to bathe. Finally, I developed and joined concepts structured around my core category, "handling intimacy: bodywork, care, and social relationships" to explain the intimate care processes residents and DCWs experience in AL.

3.3 Findings

Handling Intimacy: Bodywork, Care, and Social Relationships

The core category describes intimate care between residents and DCWs in AL, specifically within the context of bodywork, care, and social relationships. "Handling intimacy: bodywork, care, and social relationships" refers to the various types of interactions and ways of relating between participants during the care process, and how these interactions and relationships vary and may change dynamically over time. As Figure 3.1 illustrates, residents and DCWs are joint partners in the intimacy of care through bodywork, care, and social relationships. The intimacy of care was embedded within societal norms, and in location, AL in this case, and their collaboration. Many factors, including familiarity in the care dyad, relationship history, and the availability of reciprocity, in addition to individual resident and DCW factors, also influenced these close, potentially intimate relationships.

Bodywork and intimate care in AL included assistance with: toileting, dressing, bathing and showering, grooming, shaving, hair-brushing, transferring, ambulating, medication management, and eating. Individuals' care interactions and care need varied, dependent on various factors such as physical and emotional health, cognitive and physical abilities, level of frailty, and presence of decline. For many residents, at times, intimate care from a DCW was emotionally or physically uncomfortable. Often these intimate care experiences improved for

both participants over time, with increased familiarity and by maintaining a routine. However, some instances lacked the intimacy of care. Many residents exhibited a preference for a familiar or specific DCW to provide their intimate care and bodywork. Residents and DCWs implemented strategies to improve their intimate care experiences.

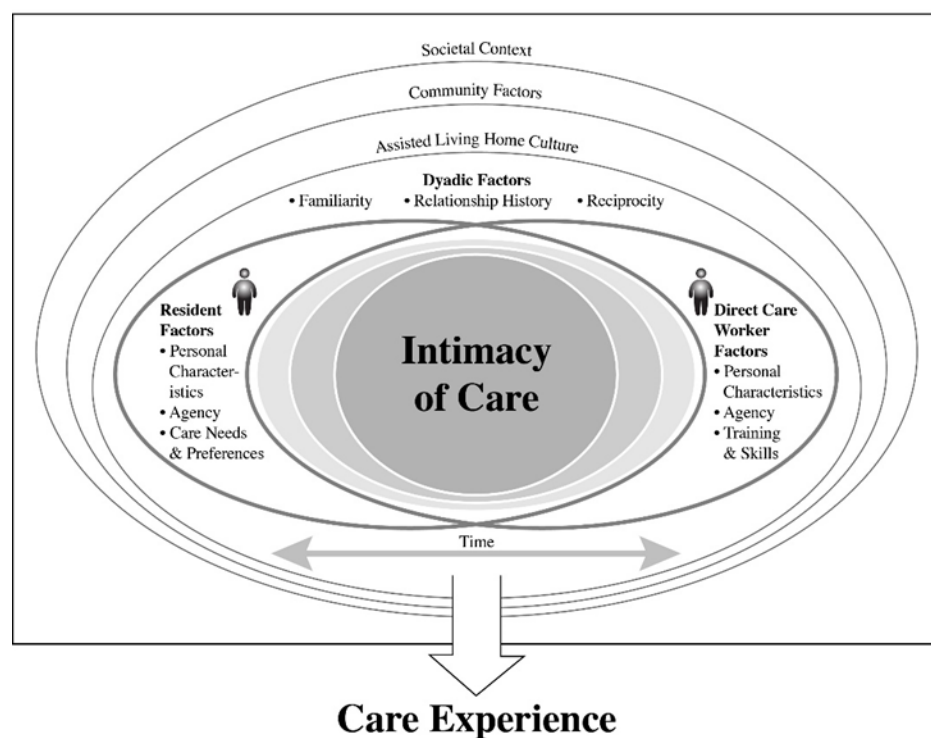


Figure 3.1 Handling Intimacy: Bodywork, care, and social relationships

As Figure 3.1 demonstrates, over time, the intimacy of care improved (grows as a resident and DCW moves towards each other) or diminished (gets reduced as resident and DCW moves away from each other). Individual-, dyadic-, and location-factors influenced the resident's and DCW's relationship. The intimacy of care was simultaneously an inner- and interpersonal process, shaped by residents' care needs, agency, and personal characteristics in addition to DCWs' skills and experiences in providing intimate care and bodywork, agency, and personal characteristics. Another crucial aspect of the dyadic process was the history of the dyadic relationship overtime. The process of handling intimacy was situated within the location of

intimate care events, and thus highly influenced by AL homes' culture, policies, and practices. Experiences of intimacy, from bodywork to relationships, varied dynamically over time for both AL residents and DCWs. Additionally, my analysis affirms the reproduction of societal gender stereotypes in the interaction of providing intimate care.

3.3.1 Handling Intimacy: Range of Relationships

Bodywork consisted of touch and physically manipulating or moving another's body. It was physical work that could look and feel clinical to both participants, DCWs and residents. At a base level, bodywork was intimate due to the private nature of handling another's body. Bodywork, when performed well, was handled with confidence and skill. Shelia, a white resident in her 80s, described the challenges of receiving care, saying, "This gets harder and harder each day." When bodywork was done poorly, with hesitation, error, or mishandling, it might mar the process for both individuals. Even some residents viewed the work of handling their older bodies as unpleasant. Residents joked about someone else washing or handling their "old" bodies. Nonetheless, bodywork was needed to meet their care needs.

Bodywork by itself is interaction without progression as care is required to move from bodywork to social relationships. "Care" encompassed more than task-oriented bodywork and care-tasks and included intimate gestures, words, and touch. DCW's inclusion of care during bodywork included attempts to minimize the uncomfortable feelings that might ensue during bodywork and maximize the potential for a positive encounter and future interactions and care relationships. DCW's expressions of compassion helped to conceal the potentially clinical nature of bodywork. DCWs applied care during bodywork by incorporating residents' personalities, preferences, and being aware of residents' emotional states or moods. Care was dynamic, as a DCW made adjustments to the care process dependent on circumstances and events.

It was the relational aspects of care that moved the DCW and resident dyad from a care-based entity to a mutually-involved social relationship. In regards to the DCW who assisted her with bathing, Dolly, White, and aged 83 said, “I know I shouldn’t have favorites, but some are just better than others,” indicating there was more to bodywork than just skill. DCWs also indicated they had favorites as well. Lashawn, a DCW in her 30s and Black, said, “you like some, not others,” and “you have your favorites.” What began as care dyads, with time, getting to know one another, trust, respect, and reciprocity, might evolve into an intimate social relationship. Emotional reciprocity within the dyad was vital to becoming a close relationship. Reciprocity included conversations that consisted of mutual sharing and listening, asking questions about each other, sharing of feelings, concerns, and interests, and the ability to provide and receive emotional support when needed. Noteworthy, these are also components of emotional intimacy. While the emotional give and take in the dyad might not always be equal, some reciprocity was needed to progress to an intimate relationship.

Residents and DCWs experienced diverse intimate care relationship dyads. Some dyads experienced more positive relationships than others, others improved over time, and some dyads remained contentious throughout the study. However, dyads who were able to enhance the intimacy of care were more likely to experience the positive impacts of the social relationship. Both individuals, resident and DCW, had the power to grow, disrupt, and even damage the intimacy of care, the care process, and the relationship. Some care dyads were antagonistic, which made the care process more difficult for the resident and DCW. Other care dyads were affirmative, and the relationship evolved to include emotional intimacy and support.

3.3.2 *Familiarity Within the Care Dyad*

Typically, the resident-DCW dyad met as strangers and navigated the care process together. Familiarity within the dyad and a sense of a routine influenced the intimacy of care. In the following field note excerpt, Jackson, who was 90 years old and African American, spoke about the care he received from DCW Carol, and implied that he grew more comfortable with time than when he first arrived in AL with receiving assistance with his showering:

Jackson mused that he had changed his attitude since first moving into Oakridge Manor.... He told me he's come to trust Carol, who helps him with a shower Monday through Friday.

Tenure in the home allowed Jackson to learn to trust the person providing his intimate care. Trust was an essential factor in the process of intimate care that typically took time and maintenance. In her interview, when asked about the care she received in the home, Maggie, who was 97 years old and white, responded with the following:

I personally am very pleased with my care, and I don't think I would get that attention everywhere. The individual girls, I call them girls.... are very pleasant and—For instance, there's one girl who showers me every day, and she's great. Now, the other days that she's not here, I really miss her, but what can you do? You can't—She's very considerate and very careful.... She's really great, and I'm very much at ease when she's around. Now, there are a couple of others, one in particular, that I don't want around me at all.

Maggie noted that she was comfortable with the DCW who assisted her with showering and appreciated the extra consideration she provided. Feeling at ease made the bathing experience much more pleasant for the care dyad. However, there were instances of dyad-incompatibility, where residents felt more comfortable with some DCWs over others. As Maggie identified, residents typically found themselves becoming more comfortable with specific DCWs, trusting them with their care. James, a 90-year-old white resident who needed assistance with bathing, spoke about the importance of familiarity, comfort, and routine in intimate care.

We talked about the help James receives in the shower, and he explained that “No one does it like [DCW] Maureen. We have a routine.” He told me that Maureen had been out on Tuesday because she’d been called to jury duty and that whenever she is out, she writes out detailed instructions for whoever is helping James. He said, “They must be so scared to come in here and help me shower....” He then said, “You know, it takes about four or five times before we all get comfortable and it becomes routine for them. It just doesn’t work all that well when they send people in ad hoc.”

The intimacy of care took time for the care dyad to become familiar with each other and learn how to provide and receive care in a way that promoted dignity for both. DCWs were more likely to provide quality care when they utilized their knowledge about a resident’s preferences and personality. Here, Frank, who was 80-years old and white, spoke about the importance of reliability and the ability of DCW, Carol, to anticipate his needs, making the care process more comfortable.

Frank told me about Carol [DCW] and how wonderful she is. He said that she is so good to him, is so very reliable, and is very good at “anticipating” his “needs.” Frank seemed to really understand how unique Carol is in terms of going “above and beyond.”

Frank discussed the impact of Carol going “above and beyond” to best meet his care needs. There were many instances where DCWs went beyond the scope of expectations to provide the best care experience for the resident. In the following field note excerpt, Maxwell, an 85 -year-old, African American resident, spoke of an uncomfortable topic regarding toileting:

He said, early on, when he was here, he had a conversation with the DCW. He was embarrassed that he could not reach around to properly wipe himself after a [bowel movement]. He commented to the DCW that he was sorry that she had to do it and look at the backside of an 85-year-old man. She had replied that he didn't need to feel sorry about it. She said that everybody would be in the situation at some point in their lives and that it was her job and that she didn't mind doing it.

Maxwell not only expressed his frustration in needing care but also acceptance. Accepting one needed care was not an easy task for many of the residents, men and women. Janet, a 92-year-old white resident, spoke about the difficulties of asking for help, she said, “You know Savannah [DCW] helped me today and I asked her, ‘Savannah, am I too independent?’” Savannah responded that Janet should accept help when someone offers it. Receiving assistance with

intimate care was difficult for some residents, as it was for Maxwell and Janet, but time and increased familiarity improved the intimacy of the care process.

3.3.3 Experiences of Bodywork, Care, and Social Relationships

3.3.3.1 Residents

Residents and DCWs demonstrated diverse experiences as participants in intimate care and bodywork in AL. The type and amount of intimate care a resident needed varied over time. Intimate care needs lessened when residents experienced improvements in health, including physical and cognitive function, and increased with health decline or an acute health event, such as a fall or sudden illness. Some residents only needed intimate care after a health crisis, such as Samuel, a 90-year-old white resident, who broke his leg. However, there were other residents, such as Edith, a 95-year-old African American resident who needed increasingly more intimate care daily as she declined and neared the end of her life.

Some residents accepted help with intimate care tasks readily, while others were more resistant to assistance with bodywork. Others still expressed frustration over not having their care needs met, or met quickly enough. Vera, a 76-year-old African American resident who had Parkinson's Disease and used a wheelchair, expressed her frustration with the staff assistance she received at night: "When you need help, you have to wait, and it is just very disturbing that you can't get what you need in the way of help." Often residents interpreted care, or lack of care, as a reflection of the DCW's values and characteristics, or even their feelings towards the resident. Not receiving help in a timely or appropriate matter, as considered by the resident, might impact the dyadic relationship and the intimacy of care not only in the moment but in the long term. One negative interaction or impression held the possibility to influence future care contact.

Most residents exhibited a preference for specific DCWs to assist with their intimate care. Birdie, an 88-year-old white resident with severe cognitive impairment, like many of the residents, was adamant about whom she favored in the care process. In the following quote, Birdie's daughter signified the importance of listening to residents' requests and preferences for certain DCWs, and to avoid others:

I know that she's not going to love every single caregiver who is there. There is one [DCW] that she has stated she doesn't want to have anything to do with at all. I questioned her very carefully about you know, why she didn't want this caregiver at all. Was it a matter of her being mean to her, or was this person just not being warm and fuzzy. You know, I talked to her for a long time about it, and what it boiled down to was this person was not warm and fuzzy. She's not rough. She's not demeaning. She's not unkind. She's just not warm and fuzzy.

Birdie expressed a preference for DCWs who exhibited a "warm and fuzzy" approach, behavior, and attitude. Birdie expected a specific demeanor from the individuals providing her care, a common sentiment among residents, especially women. Often, DCWs were expected to provide emotional labor and emotional support to residents in addition to providing the physical labor of care.

3.3.3.2 *DCWs*

DCWs experiences with intimate care and bodywork varied by the situation, resident, throughout the homes, and over time. However, most DCWs found the connection and relationships with residents as the most fulfilling part of their job. When asked about her

relationship with residents, DCW Celeste responded, laughing, “I have 35 grandparents,” indicating the close connections she had formed in the home. Celeste went on to say, “And that's probably 90% of why I love the job, to be able to interact with them and have those relationships with them day to day.” For many DCWs, close relationships with residents were the highlight of their job. Handling intimate care work was simply part of their daily routine, and provided DCWs opportunities to make emotional connections with residents. For example, when asked about her experience in the home, Lori, a DCW, was very familiar with all the residents in the home she worked and knew their abilities and preferences. Lori said she considered a few of them friends and noted that she provided emotional support when she could. However, DCWs found some residents easier to work with than others. On occasion, DCWs exhibited frustration during or after intimate care or bodywork, typically when residents were resistant to care. DCW Maxine, who worked in long-term care for over 30 years, shared that her approach to a resident when they first moved in and throughout their time in AL was critical to the intimate care process in the following quote from her interview:

I think the approach is very important, especially when they've first move in because they have left their home and they're in a new atmosphere. You have to be aware of how you approach them. Even though they may have lived here for a long time, you still have to be aware of your approach because you don't know what they're feelin' like that day. They might say, “Oh, I don't feel well,” and you say, “Well, what's wrong?” “Oh, my arm hurts,” or “My leg hurts,” or “I just hurt all over,” or “I just don't know,” or “I'm lookin' for my mother.” It depends on the relationship that you have with that resident, and like I said, it depends on your approach.

Maxine's insight included her understanding of some of the challenges residents face residing in AL, including the potential loss of agency, the presence of chronic pain, and feelings of confusion.

Despite these difficulties, DCWs were able to provide quality individual intimate care to residents in ways that promoted the intimacy of care. For instance, DCW Giselle shared: "they shouldn't just see your face four times a day when you're bringing 'em their plate, and when you're givin' 'em a bath. Really, sittin' down with them and maybe sittin' on the porch with 'em. Or just sittin' in the room holdin' their hand. Talkin' about the TV show." Social relationships helped DCWs know and learn how to anticipate and best meet residents' care needs. Giselle described this process: "You just really have to be careful...about what you say. Don't hurt 'em [emotionally]. Don't make 'em feel less than. Then from there, you start buildin' a friendship." Building a friendship included getting to know residents better, sharing life stories, and learning residents' preferences, all components of intimacy.

From building a friendship, DCWs were able to increase residents' trust and, ultimately, improve the care process and intimacy of care for both parties involved. For example, DCW Jane shared an experience she had with resident Thomas, a white resident in his 50s who was in chronic pain and often resisted care. Jane began bringing his daily newspaper to him and learned he was a local football fan. She encouraged and engaged in conversations with him about football when she was assisting him with bathing or shaving. Jane's attempts at connecting emotionally with Thomas proved successful, as it made the intimate care process easier for both, and enhanced an emotional connection between the two.

3.3.4 *Gendered Care*

Normative gender assumptions and stereotypes were abundant and persistent in AL and influenced how one interpreted, strategized, and participated in the intimate care process. Residents' gender influenced care interactions and DCWs' strategies to provide the best care. In the following examples from DCWs' interviews, who were both women, the resident's gender was prominent in how one could provide the best and most dignified care.

I think high-quality care is grooming. I think that is one of the main things that they get their showers, that the men are shaved, that they get a haircut, that the women look good, their nails look good. I think that's number one when it comes to high quality.

Men, you treat them a little different than women. Women, some of them are more modest. Men sometimes are more modest. They might want a man, but they might want you to do certain things for them than they would a male [DCW].

As these examples illustrate, DCWs determined residents' care needs and preferences based on the residents' gender. Moreover, the second passage demonstrates the significance of both the residents' and DCWs' gender in care interactions. Sorting by gender was common in the homes, and some activities were gender-focused, such as hair salons for women and a shaving club for men.

Participants' gender influenced the intimacy of care. DCWs treated men and women in ways to support their dignity, often determined by social norms around gender and gender relationships. DCWs, all who were women in this study, treated men in ways designed to

reinforce their masculinity and male ego. In the following interview excerpt, DCW Maureen shared what happened when she encountered a resident who had had an incontinence incident the night prior:

When I tell you easily embarrassed, you don't know. He's easily embarrassed. Accidents. He's a man. Got his ego. He don't want you to know that he had an accident this morning. I go in, I see it. I say nothing.

DCWs took it upon themselves to preserve residents' dignity by subtly ignoring behaviors or situations that might challenge men's masculine identity, which they felt attributed to their sense of pride. For example, rituals of facial shaving reinforced masculinity. DCWs preserved women's femininity through an emphasis on beauty, connecting emotionally, and encouraging compliance.

Residents and DCWs employed the use of flirting and joking behaviors to ease the discomfort that might arise during intimate care or embarrassment. While male residents were more likely to exhibit flirting with female DCWs, we observed engagement in joking and humor from both residents and DCWs. For example, when DCW Joanie was helping move and settle Irene, an 80-year-old white resident, into a seat in the living room, she asked Irene where she would like to sit. Irene responded, "Any old place, just don't throw me out," causing both to chuckle. Additionally, there was often joking about "illegal drugs" when residents received their medications. This type of friendly banter was common among residents, and DCWs often used it to disrupt the monotony typical in AL. In the following field note excerpt, resident James shared a story regarding DCW Maureen. With familiarity in the relationship, James and Maureen both

appeared to feel comfortable with joking behavior and what some might consider flirting behavior. Flirting and sexual banter was more common among different-gender relationships than same-gender connections.

James told me that when he returned from the hospital, he hadn't seen Maureen (DCW) in a while. She came to help him in the morning and he was sitting on the edge of the bed with a towel on. When he heard her voice, he stood up and said, "Do you mind if an old naked white guy gives you a hug?" She said, "Of course not," and they both laughed. James got his hug.

Familiarity and comfort made it possible for James and Maureen to engage in joking and flirting behavior that was accepted by both parties. In another incident, James complained about cold water during his showers, saying to a female DCW, "I know I'm over-sexed, but the cold showers are a little much." Once the water heater was repaired, and the water was warm again, James continued his sexual humor and joked to Maureen about not "burning" his "baby maker off." Sexual joking or flirting behavior was received more positively from residents who were in good cognitive health, with limited or no signs of dementia. Even DCWs shared that they utilized a joking tone as a strategy when working with residents. DCW Elaine shared, "I think when they're havin' a bad day...Laughter is good medicine for them."

3.3.5 Resident Factors

Resident factors that influenced the intimacy of care process included the level of care one needed, as indicated by their physical and cognitive health, availability of agency in decision-making around care, and personal characteristics. Life-course experiences with care,

physical and cognitive frailty, and interpersonal relationship history and skills influenced the care process. For example, resident Vera, who was 78 and white, had generalized anxiety, which impacted her care process as well. She was wary of unfamiliar DCWs, and on days when she was experiencing significant anxiety was more likely to resist care.

Eleven of the residents had Alzheimer's Disease or other forms of dementia. Cognitive impairment might include feelings of uncertainty, confusion, and memory loss, which could impact the intimacy of care experience. The relationship built by residents and DCWs throughout the care experience provided the foundation of the intimate care process. Times when a resident exhibited fear, anxiety, or anger during the intimate care process, a factor more likely for those experiencing dementia, threatened the intimacy of care. In the following field note excerpt, DCW Alexandra spoke about the challenges of intimate care with a resident, Ruth, who was 83, white, and had Alzheimer's Disease.

Alexandra told me about Ruth that she is one of the ones in the dementia-care-unit who does the most for herself. She doesn't like help being bathed or if she has an [incontinence] accident and needs changing. If they are providing more assistance than she wants or is comfortable with from a privacy standpoint, a fair amount of negotiation is required.

For Ruth, negotiation included letting Ruth sleep in later in the mornings to "let her have her beauty sleep." Some days when Ruth was particularly challenging, DCWs would use her husband, who lived in the community nearby, as a negotiating tool by saying, "John's coming. Don't you want us to help you get ready for him?" This tactic usually worked. Residents' agency

and choice, even, but perhaps especially in the light of dementia, was imperative in the intimacy of care. Alexandra also shared a situation when she was attempting to shower Ruth. As the fieldnote described, “Ruth reached under the front of Alexandra’s shirt, digging her fingernails into Alexandra’s stomach, and asking how she would like it if a stranger was trying to give her a shower.” Ruth’s behavior was evidence of her fear and confusion. Alexandra said that while it hurt physically, she also recognized it “probably was extremely unsettling for someone you don’t know to try to give you a shower,” emphasizing the importance of residents’ familiarity with the DCW providing intimate care, seeking permission to touch a resident, and explaining the care process.

Most residents identified their health as good or fair, yet most needed assistance with intimate care. The amount of intimate care a resident required influenced the intimacy of the care process. Some residents exhibited frustration in needing care. Clara, who was 90 years old, African American, and increasingly needing more care, expressed her disappointment in her physical decline by saying, “This gets harder and harder each day.” Frailty and pain were factors that affected residents’ and DCWs’ interactions and the intimacy of care. Feelings of pain influenced residents’ perspectives, outlooks, and interactions with others. Residents talked about pain as a factor in the intimacy of care. In the following field note excerpt, Lucille, who was 92, white, and suffered from varicose veins, applied strategies to avoid discomfort during assistance with her support hose:

Lucille saves the pair that is easier to put on for the times when [DCW] Joanne is dressing her because Joanne is “ornery” and not as gentle as she could be. Lucille says she lets Rebecca put on the stockings that are more difficult because she is so gentle and

good at it. Lucille tells Rebecca all the time that she needs to teach the others how to do it.

Lucille's example included not only her preference for one DCW over another but also her attempts to make the experience more endurable. Some relationships with DCWs were more difficult than others.

Over time and with experience, some residents implemented strategies, such as Lucille, to maximize the positive aspects of receiving care, while minimizing the negative. Residents sometimes used humor as a way to shield their embarrassment in needing and receiving care. One son spoke about his father's response to his assistance with showering; the following captured in an interview excerpt:

You've got people who are washing you down every morning. I think he's making fun with it. He says, "I'm the luckiest man. I come in there, and I get naked, and a bunch of women run around me and scrub me down. He's making fun of it, but the reality is, yeah, you do give up a lot of your control.

Here we see that the resident used humor to avoid embarrassment and emotional discomfort in receiving intimate care and bodywork. Residents and DCWs worked to maintain residents' dignity, employing tactics such as humor and joking behavior.

Personal agency regarding decision-making around their care also influenced the residents' care process. Residents who felt they were able to make some decisions around care, such as time of showering, or who helped with intimate care tasks, were more likely to have

positive care experiences. Even for Lucille, being able to choose specific stockings to wear on certain days was a mode of agency that influenced her care process. Many residents valued their independence, which often made the receipt of intimate care more difficult. The availability of residents' agency in decision-making around care improved the intimate care process. For example, resident James and DCW Maureen established a routine for his bathing. Maureen communicated to James times when she knew she would be away from the home so that he was prepared for another DCW to assist him with bathing. The following field note excerpt describes such an instance:

James was glad that Maureen came back the following day. He said that Maureen would have called to tell him if she was going to be out longer than a day explaining, "Because that's Maureen and she likes me to know what's going on. She is a hard worker, and so great to me." When Maureen returned the next day, he asked what would have happened if she'd been called away longer, she confirmed that she would have called to let him know.

DCWs found that keeping residents informed of changes and throughout the care process improved the intimacy of care. Residents also wanted to be regarded with dignity and respect, and some spoke about not wanting to be "treated like a child" or a "baby" when receiving care.

3.3.6 DCW Factors

DCWs' factors that influenced the intimacy of care included DCWs' characteristics, agency in decision making around care, and their training and skills. DCWs' philosophy and approach to care influenced the intimate care they provided and the handling of care. In their

interviews, DCWs shared their understanding and belief of what constituted high-quality care. Their answers ranged from getting to know the resident better, to maintaining a schedule, to “caring for them as they would for themselves.” Most DCWs identified getting to know the resident and gaining their trust as most important in providing quality care, essential elements for fostering the intimacy of care.

DCWs also spoke about their approach to care, which influenced the intimacy of care. Here, Yolanda shared her philosophy in assisting residents with intimate care:

You have to have a passion in [your] heart.... Anybody in the whole, wide world can go in, give somebody a bath, but to give somebody a bath and make them feel comfortable, and to do it, [with] love in your heart, that's completely different.

As Yolanda expressed, the intimacy of care was a goal she attempted to reach by serving the residents from her heart. Many DCWs held strong beliefs and pride regarding their role in residents' lives and believed that their position was more than just a job.

DCWs who had been in the home longer had prior experience providing intimate care and bodywork, and felt more comfortable providing intimate care were more likely to have more positive relationships with residents. Marsha expressed her commitment to her role as a DCW, saying: “This is our specialty, and it's what we've been trained to do. We take classes all the time. We know what we're doing,” indicating the importance of ongoing training and experience. More experienced DCWs spoke about those who were newer to the profession and how much they had to learn. These relationships influenced the intimacy of care and the quality of care for

both involved. Finally, the AL home culture, policies, and practices influenced DCWs' ability to exhibit agency in making decisions or taking time with intimate care.

3.3.7 AL Factors

An AL's culture also influenced intimate care. AL community factors such as size, ownership, location, and staffing levels and training influenced home culture, which in turn contributed to how DCWs managed residents' intimate care. For example, in the largest and corporate-owned home, Oakridge Manor, all DCWs were either certified nursing assistants or were encouraged to pursue this training. The administrator at Oakridge Manor highlighted the importance of DCWs' customer service and corporate training. Yet, she added the significance of "They care. They're compassionate. They love what they do," emphasizing the need for emotional labor as well. Conversely, Hillside was a much smaller community, rural, and privately owned by family members. In regards to hiring DCWs, one of the administrators said:

There would be people that [had] no training whatsoever will be the best employees because they love our residents. If you love 'em, everything else falls in place. You're gonna want to do for 'em. You're gonna want to take care of 'em. If they're wet, you're gonna wanna change 'em because you love 'em.

The staff must reflect the cultural values of Hillside's owners. Hillside encouraged a more family-like atmosphere, which influenced how DCWs interacted with residents: using pet-names, saying "I love you," and providing physical affection with hugs and kisses.

Adequate staff present to meet the care needs of residents also influenced the intimacy of care process, described by DCW Lori in the following quote, "When you're understaffed, you

just kinda wash the face and wash under the arms and put 'em in a chair and send them on their way.” Additionally, DCWs needed to be able to trust their co-workers to assist them when needed and to maintain the level of quality care in the home.

A common theme across the homes was scheduling and the importance of “keeping to the schedule.” Residents specified the lack of choice in scheduling bathing and showers and highlighted the importance of the consistency in staff, especially in intimate care. A DCW’s knowledge of residents’ preference and personality helped in times when needing to encourage a resident to do something such as adhering to a toileting schedule or managing anxiety and emotions. Yet there was some flexibility in subscribing to a schedule for some residents, such as Ruth who was able to wake up later in the morning as arranged by her family members and the home. In her formal interview, DCW Susanne, who had worked in AL for seven years, said, “I think over time with the residents where I’m at, it’s all about them knowing that they can trust you and more, so being reliable.” The intimate care process was easier for the care dyad when staff performed it at consistent times and locations. DCWs utilized their knowledge of residents as a strategy to help residents to adhere to schedules and to make the experience more pleasant. However, when trying to maintain the home’s schedule, DCWs felt frustration at times while conflicted with concern for the residents as the following quote from DCW Daria’s interview includes:

I said, “I’m going to Mr. Walter. I’ll be right back.” Went over to Mr. Walter. Set up his bathroom. It’s shower time; today’s Monday. Need to shower. He said, “Why you harassing me. Haven’t you ever been 93?” He said, “I’m an old man. I retire. I stop working. You come in here to harass me.” I was gone. I was gone. I felt bad for the

whole day because he's right. I don't feel like showering today. He's not gonna die. He's not gonna smell worse than anybody else. I'm so serious. He's not gonna die. To me, I have a job to do. They come in to give him a shower, today's Monday. Today is his shower day, and the only way they can put the ointment on him is if he gets a shower. Guess what, put the ointment on him if you want, don't put it. It doesn't matter. The fact is that he said to me, "I don't feel like getting up today. Can I just rest?"

This quote confirms the importance of agency for both the resident and the DCW striving to meet the care needs of the resident while meeting the demands of a home's schedule.

Furthermore, this quote is evident of the importance of listening to and adhering to residents' rights. DCWs could only successfully use their knowledge of residents' personalities, needs, and preferences if the DCW was empowered to make care decisions and adjust for the situation, thus indicating a need for flexibility and independence among DCWs' expectations and role.

3.4 Discussion and Implications

This research aimed to examine the intimate care relationships of residents and DCWs in AL. Findings demonstrate that in AL, residents and DCWs are co-participants in the intimacy of care when engaged in intimate care and bodywork. The core category, handling intimacy: bodywork, care, and social relationships, captures the complexity and potential of residents' and DCWs' intimate relationships. The intimacy of care in these care dyads improves or deteriorates over time dependent on several factors, including: familiarity in the care dyad; the agency of the partners; and individual factors such as residents' care needs and DCWs' skills and experiences. My findings confirm that older adults are participants in the care process (Kemp et al., 2018). Residents exhibited preferences for specific individuals to manage their intimate care;

specifically, those with whom they felt more comfortable. Over time, most resident-DCW dyads became more familiar with each other, which improved the intimate care process for both.

This work builds on previous findings of the intimacy process as experienced by AL residents (See Chapter 2). AL residents experience intimacy and intimate relationships with a variety of partners, including those who provide their daily care, DCWs. My findings show that both DCWs and residents are participants in the intimacy of care and attempt to improve their care experiences, and ultimately the care relationship, through emotional reciprocity, a vital element of the intimacy process (Fitzroy, Kemp, & Burgess, forthcoming; see Chapter 2). Here the focus was on the intimate relationships forged between residents and DCWs through the care process. Additional analysis exploring other intimate partners, such as family members and friends, is still needed to understand the array of potential intimate relationships available to AL residents.

A significant strength of this work is the adaptability of the handling intimacy process model (Figure 3.1). Here, I applied the model to the care experience of day-to-day intimate care and bodywork in AL. Yet, this model's adaptability is vast, and participants and researchers can apply it to other care experiences such as in-home care, care in nursing homes, or hospice care. Additional research using this approach would broaden our understanding of the intimacy of care as experienced by the individuals involved in the care process.

My findings support previous Convoys' analysis of AL, including the critical role DCWs play in residents' quality of life and care (Kemp et al., 2019). DCWs are essential in residents' ongoing health monitoring, including both pain and chronic medical conditions, health, functional status, and medication management (Kemp et al., 2019). DCWs are vital in monitoring residents' acute care and are often the first to recognize when there is an illness or

injury. They play an indispensable role in communicating residents' health changes as they occur and providing intervention before what might become a health crisis (Kemp et al., 2019b). My findings and previous Convoys' findings support the need for consistency in residents' care partners to provide quality care. Our analyses show evidence of how health changes, including pain and chronic conditions, can affect residents' quality of life (Kemp et al., 2019b).

Twigg's (2000a, 2000b) critical exploration of bodywork within the context of community care provided a foundation for this analysis. My findings parallel Twigg's in that bodywork is difficult for both care partners involved and is challenging to discuss. However, as this data shows, when bodywork is ongoing and with a familiar care partner, such as often the case in AL, it presents the opportunity for the formation of a close social relationship between care partners. The resulting partnership can improve the quality of life and quality of care for both parties involved. Furthermore, it is these close relationships that make the challenging aspects of DCWs' position more manageable and give meaning to DCWs' jobs.

Even though the majority of DCWs and residents are women; conventional gender ideals shape AL staff and residents' interactions. Traditional gender ideals and stereotypes influenced how care partners negotiated, approached or received care. DCWs and residents relied on gender stereotypes when implementing strategies for care. Further study is needed to probe the links between gender and social inequality in the care experiences of older women and men; and how these links are further complicated by classifying factors such as race, class, national status, sexual orientation and age (young-old vs. oldest-old) (Calasanti & Slevin, 2001; Estes, 2001). These inequalities and intersections of power influence individuals' experiences in AL.

AL is a home for some individuals and a workplace for others, and previous research articulates this imbalance (Ball et al., 2005; Burgess, Barmon, Moorhead, Perkins, & Bender,

2018; Kemp, Ball, Hollingsworth & Lepore, 2010). The majority of our residents were white, while the majority of the DCWs were Black, inconsistent with national trends (Kelly, et al., 2018; Khatutsky et al., 2016). Nevertheless, the intersections of race, socioeconomic position, and gender are present in AL and influence a power imbalance between residents and DCWs. Researchers have found that sexual harassment in AL is frequent (Burgess et al., 2018). Staff must continually negotiate and respond to harassment based on their interpretation of the event (Burgess et al., 2018). Staff's response to unwanted attention from residents included redirecting, refusing to engage, or reframing the situation to stay on task. There is a power imbalance present in this environment, where both residents and DCWs find themselves often vulnerable and yet at other times, with power, depending on the situation and circumstances (Kemp, Ball, & Perkins, 2013).

DCWs often are required to exhibit the skills and capabilities of managing their personal feelings while attending to the intimate care needs of residents. Residents, family members, and AL staff and supervisors expect DCWs to be empathetic, compassionate, and patient while providing the hard labor of intimate care and bodywork. Also, DCWs are expected to meet residents' socioemotional needs. AL administrative staff, as well as residents and their informal convoys, expect DCWs to act with timely care and consideration to residents' individual needs. The results of this analysis match others' who have identified the emotional expectations of care work in nursing (Lopez, 2006; Theodosius, 2008) and the commodification of emotion work in care work in general (England, 2005; Hochschild, 1979, 2003). Despite the potential costs, including low pay, the death of a close resident, and high turnover among workers, DCWs exhibited joy in their work and found working with older adults very rewarding. However, this does not compensate financially for the emotional labor that is expected of them.

This research has limitations. First, all of the DCWs interviewed were women. The percentage of male workers in AL is steadily increasing (Kelly, Craft Morgan, Kemp, & Deichert, 2018), and further studies including male DCWs would provide a broader understanding of intimate care work in AL. Additionally, DCWs are not the only providers of care in AL. Additional research regarding the intimacy of care in other areas of care and support, such as hospice or end of life care, would continue to build on our knowledge of the care process. The Convoys of Care model (Kemp et al., 2013) provides a theorizing standpoint from which to study the diverse experiences of older adults in long-term care as it encompasses the constellation of care partners involved in older adults' lives. By looking at the experiences of those who provide care to older adults, as well as those receiving care, we can better analyze their lived experiences of care.

My findings have implications for policy and practice aimed at improving the care process for AL residents and DCWs. On a structural level, AL homes might encourage resident and DCW relationships by providing opportunities for engagement outside of the care dynamic. AL practices must allow time and encourage residents and DCWs to take time to socialize and get to know one another. Residents and their convoys should provide detailed information regarding residents' characteristics, preferences, and life history. This aspect is especially poignant for residents with dementia or who are unable to verbally or otherwise communicate this information to DCWs. Before engagement in intimate care, new DCWs should introduce themselves to residents, and more familiar DCWs might remind residents of their name and state what they are doing throughout the care process. Residents should have agency regarding their intimate care, such as choosing when to shower or bathe, what to wear, and the ability to work with a familiar or specific DCW. DCWs should be able to make adjustments as they deem

needed that best meet residents' needs. DCWs should have access to training and education opportunities regarding care implementation and other factors that influence the care process, such as residents' cognitive health. DCWs play a central role in monitoring changes to residents' care needs and preferences. Supporting and identifying the significant role of AL staff can promote both resident and staff satisfaction and care quality. Optimizing intimacy in care relationships improves the likelihood of balancing the needs, attributes, and preferences of both residents and DCWs.

4 CULTIVATING INTIMACY IN THE LIVES OF OLDER ADULTS: FAMILY MEMBERS' ROLES

4.1 Introduction

This article uses data from a longitudinal, qualitative study on older adults and their care networks to explore family members' roles and involvement in older adults' intimate relationships. Findings reveal that family members are integral to older adults' intimate lives. Family members were regularly intimacy partners, yet they also cultivated older adults' intimacy processes. Family members supported and encouraged some relationships while at other times negotiated older adults' distance from others. Recent research has not adequately addressed the complexity of family members' roles in older adults' intimate lives, especially in the context of residential long-term care. Here, I address the knowledge gap by providing an in-depth consideration of how older adults and their family members negotiate intimacy and intimate relationships in assisted living. The research presented here is relevant to the current literature on older adulthood, family life, social relationships, intimacy, and is applicable across care settings.

Assisted living (AL), a popular long-term care option for older adults needing at least some care, typically offers oversight 24-hours a day where one also eats, sleeps, and socializes (Kane & Kane, 2001; Khatutsky et al., 2016). Part of the appeal of AL, especially for family members, includes the belief that their loved one may live as independently as possible but with the security of attentive staff (Barmon, Burgess, Bender, & Moorhead, 2016). A resident may never need to leave their AL home, as mobile doctors and nurses become more common, medication is delivered through the mail, residents eat communally, and social and religious activities are provided in-house (Ball et al., 2005; Khatutsky et al., 2016; Kemp et al., 2019).

In the United States, the typical AL resident is 85 years old, physically and cognitively frail, and diagnosed with multiple chronic conditions (Khatutsky et al., 2016; Kistler et al., 2017). Although estimates vary widely, almost half of AL residents have a dementia diagnosis, and most require help with multiple activities of daily living (ADLs), instrumental activities of daily living (IADLs), and medication management (Khatutsky et al., 2016). Women outnumber men, and most residents in AL are widowed (63%) (Khatutsky et al., 2016). The average length of stay in AL is a little over two and a half years; 15% of residents living in AL for five or more years (Khatutsky et al., 2016).

AL residents have contact with individuals inside and outside their care communities. A recent national survey found that over a month, 42% of AL residents had visitors several times a week, 26% had visitors weekly, 33% had visitors less than weekly; 9% had no visitors (Khatutsky et al., 2016). Researchers classify three main types of social relationships in AL: friends and family outside of AL, co-residents, and paid caregivers (including both AL staff and outside paid caregivers such as doctors or hospice workers) (Ball et al., 2000; Tompkins et al., 2012; Perkins et al., 2013). Older adults residing in AL communities identify social relationships, contact with family and friends, and the availability and participation in social activities as positive influences on their overall quality of life (Ball et al., 2000). Forming social relationships (with co-residents, families, friends, and staff members), and finding ways to spend time meaningfully impact a resident's quality of life (Ball et al., 2000; Street & Burge, 2012). Social involvement and interaction is a primary appeal for AL and what ideally differentiates them from nursing homes (Yamasaki & Sharf, 2011).

Perkins, Ball, Kemp, and Hollingsworth (2013) completed a three-year mixed methods study of older adult's social relationships in AL. Using structured interviews, as well as social

network mapping, they found that AL residents spent most of their time and emotional energy in established familial ties, connections with family members that they have had over their lifetime. These family ties were more important to AL residents' overall well-being, including both physical and emotional health, than co-resident or other relationships in AL. However, while family ties were a positive indicator of health, more "close" relationships were not necessarily beneficial to resident's overall health and well-being, indicating that not all family ties are equal or even positive (Perkins et al., 2013).

Kemp's (2011) research on married couples in AL sheds light on their and their care partners' experiences. Adult children's support included assistance with their parents' transition to AL, while also meeting the collective needs of the couple and wanting to keep them together while receiving long term care. Relocation to AL did not mark the end of assistance from adult children, and instead, support continued throughout and over time in AL. Adult children visited and "checked-in" frequently while providing social and emotional support. They even found themselves mediating between their parents and encouraging their parents to be more active and take advantage of AL social activities (Kemp, 2011). While AL provides a majority of the formal care AL residents need, their family members and friends still support much of their social and emotional needs.

Seeking to advance research on the intersection of formal and informal care, Kemp, Ball, & Perkins (2013) drew on and extended Kahn and Antonucci's (1980) "Convoy Model of Social Support" in their "Convoys of Care" model. Expanded, modified, and applied to the care process, the "Convoys of Care" metaphor suggests an evolutionary community of care partners involving both formal and informal caregivers and their care recipients. It also implies the need to study entire networks and over time. In AL, residents are embedded in "convoys" of close,

and not so close, personal relationships with the formal, such as direct care workers, AL staff, and medical professionals, and informal, such as family and friends, caregivers in their lives (Kemp et al., 2013).

Kemp et al. (2018) applied the “Convoys” model to the longitudinal study of AL resident’s care arrangements. Based on the analysis of data collected from 28 residents and 114 of their care partners, they found residents’ care convoys included both informal and formal care partners. Informal and formal care partners worked independently or shared responsibility for providing care and support. For most, residents’ family members formed the majority of their informal convoy members. Based on consensus, communication, and collaboration among convoy members, researchers identified three main convoy types: “cohesive, fragmented, and discordant,” indicating the diversity of convoys and how informal caregivers organize themselves (Kemp et al., 2018, p.e15). While most convoys existed cohesively, there was variation over time as residents and their informal convoy members experienced change, and adjustment in convoy collaboration was necessary. Their work demonstrates the significance of the roles of family members in providing residents social and emotional needs while allowing residents some autonomy in their lives.

AL’s staff and structure impact residents’ autonomy and availability of sexual freedom in AL (Barmon, Burgess, Bender, & Moorhead, 2016). Family was responsive in this role, as staff were found to prevent or manage residents’ sexuality and intimacy to reduce the potential for conflict with family members. More recent work indicates a lack of intimacy opportunities and barriers to intimacy in AL, including the availability of and access to desirable partners, lack of privacy, and ageist social norms and internalized ageism that decrees intimate behavior as unfitting of older adults (Bender, Burgess, & Barmon, 2017). Though AL residents expressed a

range in desire for an intimate relationship, from no interest to actively seeking an intimacy partner, residents often ignored their needs and desires to better align with the present opportunities, or rather, lack of opportunities for intimacy in AL.

Building on the aforementioned work, my recent AL research examined residents' daily lives and interactions and conceptualized intimacy as a multidimensional internal and external process for AL residents (Fitzroy, Kemp, & Burgess, Forthcoming; see Chapter 2). Older adults relocate to AL with a history of intimacy experiences, relationships, and preferences that influence their present intimate connections and their needs for intimacy. Our research shows that intimacy is a process involving four key dimensions, including physical intimacy by touch, emotional intimacy through emotional exchange with another, intellectual intimacy through the exchange of knowledge and conversation with another, and spiritual intimacy regarding spiritual or religious connection with another or one's deity (Fitzroy, Kemp, & Burgess, forthcoming; see Chapter 2). Intimacy with another could be platonic, romantic, or sexual. Intersecting factors such as one's gender, health, and access to a partner who is willing and able to engage intimately influence intimacy in AL and impact residents' opportunities for close relationships (Kemp, 2008; Bender, Burgess, & Barmon, 2017). Experiences in AL, such as the loss of a co-resident or friend, as well as slim prospects for intimacy, may limit one's opportunities for intimacy. Some residents implemented strategies to encourage and improve their possibilities of intimacy in AL. We found intimate relationships were valuable to residents, impacting their daily lives, and overall well-being. My recent research finds that intimacy and close relationships with AL staff influence residents' care reception and quality of care (see Chapter 3). Currently, the roles family members play in older adults' intimacy experiences, and opportunities in long-term care remain under-examined.

Existing research provides valuable insights into older adult's intimate lives, including their intimate partners, and the intersection with receiving care. Previously, I identified older adults' intimacy opportunities and constraints in AL and the possibility of formal care partners as potential intimacy partners. Yet, while older adults seek and attempt to improve their intimacy opportunities in AL, we do not fully know the role of family members in residents' intimacy process. This article aims to: 1) understand the roles family members play in older adults' intimacy process; and 2) identify how family members' participation in older adults' intimate relationships varies and with what outcomes.

4.2 Design and Methods

This analysis employs data drawn from a National Institute on Aging-funded qualitative study (R01AG044368-01A1 to Candace L. Kemp) guided by the "Convoys of Care" model (Kemp, Ball, & Perkins, 2013) and involving data collection in diverse AL residences in and around the Atlanta, Georgia area. The overall aim of the "Convoys" study was to learn how to support caregivers in ways that build collaborative care partnerships and improve resident and caregiver quality of life and also facilitate residents' ability to age in place. The research was guided by grounded theory methods (GTM), which includes a constant comparison approach during which data collection, hypothesis building, and analysis occur at the same time (Corbin & Strauss, 2015). Adding to previous grounded theory research, the Convoys of Care model provides a "sensitizing concept" for my current analysis (Charmaz, 2007). Georgia State University's Institutional Review Board approved this study. For privacy and anonymity, I use pseudonyms for research sites and participants.

4.2.1 Settings and Sample

Here, I analyze data collected between 2013 and 2015 in four AL communities chosen to maximize variation (Patton, 2015) by size, location, fee structure, ownership, resident characteristics, and other factors the convoys researchers understood might influence care arrangements. Oakridge Manor, the largest community, was licensed for over 90 residents, corporately owned, and located in an urban area. Nearly all Oakridge Manor's residents were African American, and many had been friends in the surrounding community before arriving at AL. The second home was the privately-owned Garden House, which was licensed for over 50 residents and located in a small town. Most, though not all of Garden House's residents were white. Feld House was not-for-profit with the capacity for less than 50 residents and located in a suburban area. All residents were white, and most were Jewish. Hillside, meanwhile, was family-owned, licensed for 11 residents, and located in a rural mountain area. At Hillside, all residents and staff were white.

Gerontology and sociology researchers recruited 28 residents from the four sites to participate in the Convoys' study over two years unless the resident moved out or passed away. Residents were purposively selected to maximize variation (Patton, 2015) based on gender, race, age, religion, education, socioeconomic status, functional abilities, and cognitive status. Of the 28 residents, 17 were women, and 11 were men. Ten identified as African American or Black and 18 white. Residents ranged in age from 58 to 96 years old, with an average of 84 years. Most were widowed; three were married, three divorced, and two were never married. Among those who were currently married, two had spouses living in the same AL community. Eleven of the sample had Alzheimer's Disease or related dementia. Four residents relocated and three died during the two-year study period.

Researchers also recruited residents' informal and formal convoy members. A total of 114 convoy participants, including 65 informal convoy members, participated. Residents' family members and friends comprised the latter group. Adult children were the most common informal care partners, yet, spouses, siblings, daughters/sons-in-law, aunts, uncles, grandchildren, and friends also participated in interviews and monthly follow-ups (Kemp et al., 2018). Most informal caregivers interviewed were women (70%) and identified as white (83%). The majority were married, had at least some college education, and slightly less than half were retired or unemployed.

4.2.2 Analysis

To identify family members' roles in older adult's intimate lives, I analyzed residents' and family members' interviews and researcher-created fieldnotes utilizing GTM (Strauss & Corbin, 2015). GTM includes a three-stage coding process: open, axial, and selective coding (Corbin & Strauss, 2015). First, I examined the data based on my questions about family involvement in residents' intimate relationships through open coding. Examples of initial codes included "support," "conflict," and "independence." During axial coding, I created analysis charts that identified residents' preference and presence of intimacy, relationships with family members, and family members' responses to and involvement in residents' intimate relationships. I also employed the analysis charts to identify individual and convoy factors that influenced families' interactions and reactions to residents' intimate relationships. Last, I refined and unified concepts through selective coding, structured around my core category, "cultivating intimacy." The core category links subcategories to illustrate the variable ways family members are involved in AL residents' intimacy process and intimate relationships. I used the qualitative software NVivo 12 to store, manage, and facilitate coding and analysis of the data.

4.3 Findings

Cultivating Intimacy

My core category, “cultivating intimacy,” reveals the various ways family members were involved in older adults’ intimacy processes in AL. AL residents pursued, created, and maintained intimacy through an assortment of relationships with various individuals, including family members in and outside of AL (Fitzroy, Kemp, & Burgess, Forthcoming; See Chapter 2). With family members as potential intimacy partners, residents experienced intimacy through four key dimensions: emotional, physical, intellectual, and spiritual (Fitzroy, Kemp, & Burgess, Forthcoming). For most AL residents, family members played an essential role as intimacy partners, and they often cultivated residents’ intimacy experiences. In cultivating intimacy, family members who were intimacy partners acted directly or indirectly as facilitators or hinderers of intimacy. The level of family members’ involvement ranged in intensity, with some being highly involved in their loved one’s intimacy process while others were minimally involved or not at all. Over time, family members’ participation in residents’ intimacy experiences were dynamic and variable.

4.3.1 Intimacy Partners

For most AL residents, at least one family member provided emotional connection, and residents experienced intimacy within these relationships. Family members played an important role in residents’ intimacy process, engaging with them in emotional, physical, and in a lesser context, spiritual and intellectual intimacy. Joanie, for example, was 88 years old, white, and a widow, was asked by a researcher during her interview, “who provides love and affection?” Her response was, “Well, it is really family. It is not a matter of who is here being affectionate, helpful, yes. Most people are helpful here. Affection, I think, is reserved for family.” Although

other social relationships in and outside of AL were supportive, Joanie reserved love and affection, including emotional and physical intimacy, for her family. Another widowed white resident, 95-year-old Sadie, responded similarly to Joanie when asked the same question. Sadie said, “I don’t have it with outsiders, acquaintances I call them. I get it from my family,” expressing a theme among residents that family members were a common source of close emotional and physical intimacy.

Most residents had adult children with whom they maintained relationships and were integral in advocating and organizing their care in AL and provided intimacy and emotional support. When asked about her visits with her son, Olivia, 85-years-old, African American, and widowed, said they “chat” easily and frequently and followed with, “He’s just a wonderful son. That’s all I could say wonderful.” Nadine, aged 91, white and widowed, described her relationships with her son and his wife and children, “They don’t ever come into the apartment.... Without [saying], before they leave, ‘I love you, mom,’ and with a hug,” illustrating the presence and importance of both emotional and physical intimacy with family members.

Some adult children recognized the critical role they played in their parents’ intimacy experiences. Speaking of her support and relationship with her 90 -year-old mother, one daughter said, “In terms of the psychological and emotional stuff, the friendship, the companionship, that kind of thing, you know [that is] probably more of what I do.” Frequently family members assisted with instrumental activities, such as shopping and financial advisement and support, yet most also were central in the direct provision of emotional support and intimacy.

Residents typically recognized their adult children as essential outlets for intimacy and assistance in maintaining a connection to the world outside of and their lives before AL. Many of

the residents identified their adult children as critical sources of emotional intimacy. When asked about what she did when her daughter visited at the AL, Joanie said,

Sometimes she will just help me do something I am trying to do. Sometimes we just sit and talk. Yesterday she took me to lunch and then we went to the doctor. Sometimes she will just take me out to the grocery, just for the fun of being out.

Family members attempted to keep residents connected to the larger world outside of AL through social engagement and trips outside. Frequently family members provided socioemotional support and connection under the guise of instrumental activities such as driving to a doctor's visit or taking them shopping.

Several residents spoke of close intimate connections with their sibling(s). Some siblings had been emotionally close throughout their lifetime, and others found intimacy with their sibling later in life. For most, their relationship with their sibling was one of the most extended relationships of their lifetime. Julie's sister described their relationship:

Julie and I are like kindred souls in a lot of ways. I enjoy being with my sister. She will make me laugh, and I make her laugh, and sometimes we say things and have the capacity to be quite silly together... I think Julie enjoys being with me the same way I enjoy being with her.

Julie's sister indicated the importance and benefits of emotional intimacy for both of them.

Another sister spoke about the significance of keeping her brother, Cory, a white resident in his

50s, connected to the news and events outside of AL. Frequently she brought a recent newspaper when she visited Cory as she found it vital for them to “just talk about current events” to have “something to stimulate his brain,” representing the process of intellectual intimacy between them.

Though most AL residents were widowed, three were married, and their spouses served as significant intimacy partners. Typically, one spouse needed more care than the other, leading at least one but sometimes both of them to AL. A daughter spoke of her parents’ relationship where her mother, Maxine, who was 83 years old, white, and diagnosed with dementia, lived in AL, and her father visited almost daily. Though there were times when Maxine did not recognize her husband, they maintained a secure emotional and physical connection. Maxine’s husband described his strategy, saying, “I like to get her out at least once a week or every other week. We sit and hold hands, and I throw kisses at her. I think she needs that extra reassurance.” Maxine appeared to be delighted with the positive physical and emotional intimacy with her husband. Their daughter said of her parents and her mother’s move to AL, “They’ve gone back to the happiness that they had, prior to the diagnosis and everything... They hold hands, and they whisper sweet nothings, and they still have that relationship,” demonstrating the positive effects of the relationship for both of her parents. Another resident, Larry, regarded his wife as his “best friend” and added she was “more than that,” indicating the importance of his intimate partner. A third couple, the Richardsons, shared a room and were very emotionally close and dependent on each other. A staff member shared the following about the couple, “They’re literally the left and right hand. They each lie on their twin beds facing each other in their room and continuously talk to each other about how they can get out of here [AL].” Thus, though few residents were

currently married, for those who were married, their spouse served as a critical intimate emotional and physical connection.

Most relationships with family members had been ongoing throughout a residents' life. Yet, there were several instances where intimacy in familial relationships amplified over time. Some residents found themselves growing emotionally closer with a specific family member as time passed in AL. Researchers' asked Joanie's daughter if she had always been close to her mother or if they had gotten closer with time. The daughter responded, saying, "I would say yes, we have gotten closer as she has needed me more, and I can. She is alone, without my dad, so I would say yes, we have gotten closer." Joanie's daughter felt an increased responsibility for her mother's emotional intimacy due to her assumed limited intimacy opportunities.

Prior to the study, Luna, who was 90 years old, white, and widowed, transitioned from living in another state to moving cross-country to live with her daughter and son-in-law. She then moved to an AL community her daughter selected due to its proximity to their home. Luna talked about their relationship, saying, "I always knew she was a good daughter, always. I am lucky I had two [daughters], but she is closer to me because of her distance from where I lived and, of course, the last few years." Luna called her closest daughter, "my village," indicating the importance of having someone who provided not only care and instrumental assistance but also emotional support and intimacy.

Residents frequently experienced increases in family members' involvement during health crises. Edie, 87-years-old, white, and widowed, described having a very close connection with her granddaughter, including when she was hospitalized. She explained:

She stayed with me all night. They took a picture of her holding my hand all night. She slept with me all night. She would not leave. That is the relationship that we have. She calls me so often. Yesterday she called me, and she said, 'I am bringing you dinner tomorrow night. I am going to bring the children from school, and I am going to sit and eat with you tomorrow night.'

Here we see an intensification in intimacy and close connectedness during a health crisis, a shared response across residents' close relationships with family members. When residents experienced an emergency, their family members often increased emotional, spiritual, and physical intimacy. Concern for the resident's well-being and quality of life were mediating factors that influenced family members' emotional intimacy and support. One resident spoke of his appreciation of the emotional intimacy he had with his family members, sharing that he received "a call from Shari (daughter), Linda (daughter), and his sister-in-law" one Sunday. He went on to say, "They are determined that I will not die lonely." Both family members and residents recognized the inevitability of death, especially in the context of long-term care and the importance of an intimate connection with those with whom they felt they had limited time.

4.3.2 Cultivating Intimacy

For most residents, family members who were intimacy partners also influenced their intimate relationships with others, in and outside of AL. Family members sometimes encouraged their older family member to engage with others, especially in AL with peers, and increase their intimacy opportunities. When asked about his hopes for his mother in AL, one son articulated a common sentiment, "And maybe in the future, she might make some friends." In some cases, family members served as intimacy gatekeepers, facilitating residents' access to and experiences

of intimate relationships with others. Family members encouraged and aided residents' connection with others, and, in other cases, they attempted to discourage intimate relationships.

4.3.2.1 *Encouraging and Facilitating Intimacy*

Residents' family members frequently helped them connect or maintain close relationships, including with other family members, but also co-residents, AL staff, friends, and romantic partners. Family members involved residents in family outings, trips, holidays, and in decision-making concerning the AL community and location. While outliers, some family trips included, for one resident, a choir conference, and another resident, a veteran, a visit to the U.S. war memorial in Washington, D.C. One son spoke about bringing his father to visit his granddaughter in Philadelphia, saying, "We thought it would be good to take him with us because they were always pretty close, and he gets to see her even less than we do... It was pretty neat. She arranged to have a bunch of her friends have dinner with him," indicating the importance of this intergenerational relationship. Yet, most family trips occurred within an hour of the AL. Some families facilitated more travel and visits for residents to renew or maintain intimate ties. These visits were integral in helping residents maintain long-term social relationships. For most residents, family members were vital in coordinating visits or calls with other family members and friends. Some family members encouraged and positively influenced multi-generational connections with AL visits, trips outside the home, and phone or video calls with younger family members, such as grandchildren and great-grandchildren.

Family members who wanted to encourage a resident's relationships with others might provide them with a cellphone, teach them how to use the phone, enter family members' and friends' numbers in the phone and help with troubleshooting and support when the resident

found the phone use difficult. In the following quote, a resident's daughter discussed her attempts to connect her mother with her grandchildren and great-grandchildren:

When I am there [AL], I call them [grandchildren & great-grandchildren] on FaceTime, and they talk. I'm not sure they tried to get her since she's been in memory care. It was very frustrating before because they would call and call and call, and I don't know if she didn't hear the phone. I think she did hear it. I think she just didn't answer it.

Here, the daughter expressed her frustration but also the importance of keeping her mother connected to younger family members. Despite the frequent failures, she persisted in creating intimate connections for her mother. Fewer than half the residents used email and social media to communicate with family and friends, and again, their family members, typically adult children or grandchildren, assisted them as needed with technology.

Family members also helped residents maintain old friendships. In one case, a resident's son arranged for his mother's long-time best friend who lived in a different state to visit her in AL. Regarding the surprise visit, he said,

I got it on video, she was just practically floored. She was shaking with excitement; it was really cool. It's tough to make people happy like that; they don't really have much, you know, friends. She probably thought she would never see her friends again.

Perceptive family members recognized the importance of friendships and emotional intimacy in their loved one's life and fostered opportunities for their family member's intimacy maintenance and support.

Family members cultivated residents' intimacy outlets and opportunities by assisting with their choice of AL community. Some families moved residents into an AL with similar religious or cultural values such as Feld House or Oakridge Manor. At these homes, residents were able to maintain ties to existing emotional or spiritual intimate relationships. Family members also encouraged new friendships with residents with similar backgrounds, thus increasing emotional, intellectual, and spiritual intimacy. One son spoke of the importance of finding Feld House for his mother, saying, "you have at least a lot in common with other people... There are a lot of connections I see among residents, 'well I worked for [a regional Jewish organization],' 'well I did too,'" where residents were able to connect through their Jewish heritage and faith.

There were also instances where family members resisted moving an older family member from a current AL due to co-resident friendships and friends who lived nearby. A daughter spoke of her mothers' attachment to a co-resident when considering moving her from her present AL:

Our goal is to keep her in Feld House as long as we possibly can because she is happy there. She has her friend Bernice, and they have a very nice relationship, and I think it would be really detrimental to her to have to move somewhere else unless it was physically impossible for her to stay there.

Family members considered the importance of social relationships, specifically, the availability of emotional intimacy, to residents' well-being. Cory's sister said the following when discussing his friendships in and out of AL, "I have thought of moving Cory, but I don't want to disrupt his friends that he's made friends with because a lot of his friends are from this area that he has somehow or another hoodwinked into visiting him all the time." Thus, we see that family members' cultivation of residents' intimate relationships allowed residents to remain in AL and age in place.

In cultivating intimacy, family members sometimes included co-residents in their visits and when taking the resident outside of AL for a meal or family event. Family members sat with residents and their tablemates at mealtimes to coordinate and facilitate positive social relationships, and some included co-residents and staff members in birthday celebrations by bringing and sharing dessert. One daughter talked about her strategy to help her mother make positive connections in AL and said, "I came in on mom's birthday I brought bagels for the staff and a birthday cake for her table at lunch." She went on to say that she appreciated the physical care but also the emotional support staff provided to her mother. She concluded, saying, "I think that the people that work there for the most part really try so hard to make this [experience] not be terrible." In another example, a residents' son advocated for his mother when the AL staff moved her tablemate and friend to another table during mealtimes. Family members were often aware of and considered residents' intimacy needs by encouraging intimacy with others, especially those easily accessible such as co-residents and AL staff members.

Sometimes family members supported and helped residents maintain their romantic relationships. Family members, for example, might ensure a married couple could share their living space in AL, such as the case of one of our married couples, the Richardsons, or that a

resident could receive visits from a romantic partner. Family members were more likely to encourage involvement when they perceived a romantic relationship with their family member in AL as appropriate or added value to the resident's life. Julie, 63-years-old, white, and diagnosed with Alzheimer's disease, had a boyfriend she had met two years before AL and after a challenging divorce. When researchers asked Julie's daughter, "what is most important to her quality of life" and "what makes her happy," her response was Julie's boyfriend, George. Julie's relationship with George was strongly encouraged by her family members. Before Julie's move into AL, and when looking for a long-term care option for Julie, her family considered the role George played in her life and ensured that she was able to continue their relationship once she was living in AL. Due to Julie's dementia, her family members were more likely to be involved in coordinating her romantic relationships. Julie's family recognized the importance of her relationship with George and not only encouraged their relationship but advocated for them, as evidenced in the following quote from a friend of the family:

One of the funny things [Julie's daughter] may have told you, when she was finding Feld House for Julie, is that Julie has a boyfriend. Can he spend the night? Of course, you worry, and they worry. We were very appreciative that [staff and administration at Feld House] were open-minded. We knew, once they met him, they would see how wonderful she is with him, and calm when he's around.

In addition to the family's support, the AL supported Julie's romantic relationship. Yet, over time in AL, Julie's family was inconsistent in coordinating her visits with George, as he lived about two hours away and had limited transportation. Inconsistency in providing material

support of intimate relationships was common among family members over time. There was often more material support at move-in and during and after a health crisis and decreases over time when family members had other concerns or were less involved in residents' lives.

Nevertheless, for most residents, their close family members were vital in cultivating their intimacy opportunities, encouraging and facilitating outlets for intimate relationships with others. To best meet residents' intimacy needs, family members might consider residents' preferences and personal history. Perceptive family members recognized that residents' intimacy preferences were integral to their perception of the quality of their life and care. Here a daughter speaks of her mother's quality of life: "I think she would define quality of life very differently than I would. For her, probably the quality of her life depends on her ability to get her religious needs met and maybe secondarily her connection with her family," indicating the importance of spiritual intimacy and emotional connection for her mother.

Another daughter considered her mother's emotional intimacy needs, saying that, "having her cell phone is very important, being able to reach out to people when she needs to is very important." Others considered their family members' preference for emotional intimacy, spirituality, physical touch, or intellectual connection when making decisions affecting residents' daily lives. For example, Marie's children considered her quality of life when they encouraged her to wear her hearing aids so she could better engage with other residents. Other attempts to improve the quality of life for residents included hiring a private aide not only for ADL support but also, and perhaps more importantly, for companionship.

In family members' concern for their AL resident's well-being and quality of life, they considered the presence of intimacy and emotional, social connections in their lives. Here, a resident's son shares his view on the importance of close emotional relationships in his mother's

life. His mother, Eloisa, was 80 years old, white, and widowed. After losing her husband and before moving to AL, her son said she was:

Very depressed, cried all the time. It was like it wasn't even my mother there. And then when she moved here, I just think that all the socialization, being around people, making some friends, you know, having the comfort that if you need help, somebody is here for you. And I think that was the best medicine I could have ever given her.

Most residents' family members understood the importance of autonomy, social relationships, and intimacy in their lives to improve and maintain the best quality of life for them in AL. Family members regularly acted as intimacy partners and cultivating intimacy, influencing, typically in a positive regard, residents' access to intimacy in AL.

4.3.2.2 *Discouraging Intimacy*

While family members regularly served as intimacy partners and cultivated positive intimacy connections, I also identified family members who impeded residents' intimate relationships, both romantic and platonic. Though few residents were involved in romantic relationships, there were cases where some family members supported the connection, and others disapproved. Joe, who was 90 years old and white, moved into AL with his wife, who passed away shortly after. He experienced a period of mourning and then became emotionally, and possibly physically, intimately involved with Sarah, an older adult herself, who was an art instructor in the home. Joe was excited about his relationship with Sarah, sharing with researchers how much he enjoyed "another chance at life." Joe continued, saying that Sarah was "wonderful company" and "a companion" for "however long that lasts." Joe's son was

supportive of their relationship and encouraged his father to pursue it, saying, “I’m happy for you, Dad.” In contrast, Joe’s daughter disapproved of the relationship. Regarding his daughter, Joe said, “My daughter is staying away,” and went on to share that she “is always telling [me] what not to do or what to do.” Of his son, Joe said, “At least I have one supportive child.” Joe’s daughter attempted to discourage her father from the relationship, stating her distrust of Sarah, but was unable to convince Joe. Joe then set communication and visitation boundaries with his daughter, causing her to distance herself from the relationship with her father and his relationship with Sarah.

In some cases, family members had limited or no involvement in residents’ lives. Joe’s son talked about their family members, including his brother, who was not involved in Joe’s life, saying, “Dad gets along with the extended family just fine. My brother’s the only one that’s a wild card, and it’s not really combative or anything. It’s just he’s just not interested.” This quote indicates the variation in the roles family members played in residents’ lives, where some were “just not interested,” indifferent, and uninvolved.

In other cases, family members actively discouraged intimate relationships with potentially dangerous individuals or those with whom they had an adverse history. Megan, a 60-year-old African American resident, had a brother who had previously stolen money from her. Megan’s aunt and uncle limited contact within this relationship out of concern for Megan and her safety. AL staff knew that he was not allowed to visit Megan without them present. One staff member explained, “We’ve been alerted to note if her brother ever calls... that he’s not supposed to be in the room with her alone.” Because of Megan’s dementia and history of exploitation, her family members’ monitored and controlled potentially harmful relationships.

4.3.3 Influential Factors

I identified multiple interrelated factors influencing residents' family members' involvement in intimacy partnership or cultivating intimacy. Several AL community factors fostered family members' cultivation of residents' intimate relationships. First, some homes persisted in sponsoring and supporting family support and encouraging family members' relationships with residents. For example, at Oakridge Manor, Garden House, and Feld House, family members were invited and encouraged to attend occasional events and activities, such as holiday parties or community-led events. AL communities encouraged family engagement with residents with physical space for family members to socialize when visiting residents outside of their room. Regular communication from AL staff and administration to family members was a crucial factor when it occurred and a barrier when it was lacking. Additional factors that supported families' influence on residents' social relationships included the opportunity for a married couple to share a room, such as the case of Joe and his wife. Furthermore, some homes allowed residents to have over-night visitors, such as Julie's experience at Feld House.

Relationship history between residents and their family members was vital in their cultivating residents' intimate relationships. Family members who had a close relationship with the resident before moving into AL regularly maintained contact, especially residents' adult children. Yet, location and proximity to residents also influenced family members' involvement in older adults' intimate lives. Family members who lived closer to the site of the resident's AL were more likely to be involved in their intimate relationship.

Resident factors that influenced their family's involvement in their intimate relationships included the type of relationship they were involved in and their cognitive and physical health. The relationship type greatly influenced families' participation in older adults' intimate

relationships. Family members more often supported residents' relationships that were platonic or not romantic, yet family members were less likely to be involved in these relationships overall. Perceived romantic relationships were more likely to provoke a response, either positive or negative, from family members than platonic or friendly relationships—for example, the case with Joe's family members regarding his relationship with Sarah. Yet, family members worked at cultivating intimacy for residents with a variety of intimacy dimensions and partners.

4.4 Discussion

My analysis contributes to the research on intimacy and older adults' intimate relationships. Using GTM, this study aimed to understand the role(s) family members play in older adults' intimacy process and identify how family members' participation in older adults' intimate relationships varies and with what outcomes. My findings and analysis of the influence of older adults' family members on their intimacy process in AL identified family members' roles as both partners in intimacy and "cultivating intimacy." Most residents had at least one family member with whom they shared a close, intimate connection. Residents' close relationships with family members included emotional and physical intimacy, and in a lesser but still significant sense, spiritual and intellectual intimacy. Residents' family members who were intimacy partners also regularly acted as intimacy cultivators, influencing AL residents' relationships. Cultivating intimacy outlets included both supporting some relationships while discouraging or preventing others deemed unfit or potentially harmful to their older family member. Over time, family members' involvement in residents' intimate relationships varied, increasing at times of change, such as a resident's health crisis. An earlier analysis of residents' health care and convoys communication speaks to the role of families in AL (Kemp, Ball, &

Perkins, 2019; Kemp et al., 2019). Yet, this analysis addresses the intimacy element of familial relationships and residents' intimacy processes in AL.

Similar to previous research, most AL residents identified at least one family member as a vital close relationship (Kemp et al., 2013). Yet, there was variability across and within these intimate relationships. Family members regularly acted as mediators of intimacy and intimacy gatekeepers, encouraging most connections, but discouraging links they perceived to be dangerous for their older family member in AL. Residents in better physical and cognitive health who disagreed with their family members' involvement in their relationships were likely to ignore their warnings, continuing with the relationship as they wished. For residents in poorer health and more dependent on their family member, they were more likely to abide by their wishes and avoid engagement with potentially harmful partners. The presence of cognitive impairment, which is common among older adults residing in long-term care (Khatutsky et al., 2016), also influenced family members' involvement in older adult's intimate relationships. Family members concerned for the safety of their loved one may act as "gatekeepers" of intimacy, shielding their family member away from potential danger but also from possible intimacy ties. In their article regarding residents' rights, autonomy, and sexual freedom in AL, Barmon, Burgess, Bender, and Moorhead (2016) also found that AL staff followed family members' wishes in regards to residents' access to intimacy and sexual freedom to reduce potential conflict with and between family members. "Watchful oversight" and "reporting" of possible intimacy or sexual connections were aimed to be protective but were also found to be restrictive, limiting residents' access to potential relationships (Barmon, Burgess, Bender, & Moorhead, 2016).

There were other instances where family members disagreed with each other over the resident's intimate relationship, causing tension within the family dynamics. Previous analysis of the convoys of care data identified stability and change in family dynamics over time spent in AL (Kemp et al., 2018). In the most supportive convoy type, cohesive, convoy members regularly engaged in collaboration and communication and identified specific goals for their older family member in AL. I found that family members who served as intimacy partners were consistent in recognizing their older adults' preferences and prioritized intimacy as a goal.

My findings confirm existing research that shows most AL residents maintain emotional connections with family members outside of AL, but that not all relationships were positive or supportive (Kemp et al., 2018; Perkins et al., 2013). Yet, family members typically recognized the positive effects of social relationships for residents. These family members were more likely to cultivate intimacy opportunities for their older family member as they understood the importance of social relations to AL residents' overall well-being and quality of life. This finding is consistent with Ball and colleagues' (2000) conclusion that forming social relationships positively impact AL residents' lives.

Previous research on AL co-resident relationships identified the existence of residents' "social careers" in AL (Kemp, Ball, Hollingsworth, & Perkins, 2012). My analysis contributes to research on AL residents' social careers, experiencing continuity, and change over time. AL residents maintained the ability to choose to engage in co-resident relationships, and family members provided support to these relationships. I echo Kemp, Ball, Hollingsworth, and Perkins's (2012) suggestions of supporting residents' social connections with others through the availability of physical space in AL, such as community rooms. Additionally, providing emotional support such as grief counseling on-site upon the death of a co-resident would also aid

in residents' emotional health. My findings designate the opportunities both AL staff, and family members have in supporting residents' intimate connections and friendships.

My research also found that siblings served as potential intimacy partners to residents in AL. Sibling relationships are unique as they are typically one of the most extended relationships in one's lifetime. Connidis (1989) also found sibling relationships to be meaningful in later life, siblings often serving as close friends and providing emotional support. Consistent with Connidis' findings, I similarly found that siblings who had a history of a positive relationship were more likely to have an intimate connection in later life.

The strengths of this study and my previous analysis of intimacy in AL (See Chapters 2 & 3) include the importance of studying not only AL residents but also their care convoys, which included family members, friends, and formal care partners. This longitudinal study allowed me to identify changes over time in residents' intimate relationships and relationships with family members. Life and relationship histories are significant in older adults' intimacy stories. This research would have been incomplete without being able to analyze the continuity and changes over time in residents' intimate relationships.

This study has some limitations. First, the convoy's researchers interviewed multiple family members and gathered data for most family members but were unable to interview all family members. Next, while residents and AL sites were selected to maximize variation, this analysis utilizes only four locations in and around one geographical area. Incontestably there is an atmosphere of compulsory heterosexism among older adults receiving long term care. There were no same-gender romantic involvements in the study homes, to our knowledge. Yet, gay and lesbian older adults do reside in AL and are more likely to conceal their sexuality or romantic interests due to the prevailing harmful and discriminatory responses of AL staff and co-residents

(Frankowski & Clark, 2009). Future directions for research include exploring the intimacy needs and experiences of sexual minority populations in AL and opportunities to improve their AL experience.

My analysis indicates the importance of the availability of intimacy for residents in AL and understanding the modifiable factors that can promote intimacy in AL. Researchers and practitioners alike have a responsibility to enhance the well-being of older adults. They can do so by intervening with care convoys to improve and strengthen intimacy opportunities for residents. Intimacy opportunities for residents include encouragement of connecting with similar co-residents, providing physical space for friends and family gatherings, providing grief support upon the loss of an intimate partner, and encouraging family members to be more involved in residents' lives.

My findings on family members' roles in older adults' lives have implications for their quality of life in long-term care. Too often, practitioners overlook residents' social and emotional needs when seeking to meet the high-demands of AL residents' health or physical concerns. Attending to health crises often outweighs the preventative efforts of supporting residents' emotional health and intimacy needs. Previous research, my own (Fitzroy, Kemp, & Burgess, Forthcoming) and others (Street, Burge, Quadagno & Barrett, 2007; Street & Burge, 2012; Perkins, Ball, Kemp, & Hollingsworth, 2013), shows the significance of positive well-being and intimate relationships in AL and my findings here add to this body of work. Additionally, family members' involvement in AL residents' lives has shown a definite link to aging in place, a desire among many residents and their families (Ball et al., 2004). Attending to AL residents' intimacy needs and identifying ways of improving familial support is essential when applying a social care model of support and enhancing residents' quality of life in AL.

5 CONCLUSION

For my dissertation, I analyzed data from the Convoys of Care study, which consisted of fieldnote data, interviews, memos, profiles, and other materials from two years of observation and ethnographic research at four assisted living (AL) communities. The purpose of my research was to identify and analyze older adults' intimacy experiences while residing in long-term care, specifically, AL. I aimed to 1) develop a theory about the intimate lives of older adults in long-term care; 2) examine the intimacy of care and the intimate encounters of carework from the perspectives of residents who receive care and the direct care workers (DCW) who provide it in AL; and, 3) understand the roles family members play in older adults' intimacy process and identify how family members' participation in those relationships varies. Feminist gerontology and a life course approach were the foundations of my research.

In the second chapter (first article) I aimed to (1) provide an in-depth and holistic understanding of intimacy derived from a longitudinal study of older adults' daily lives and care experiences, and (2) identify how and why intimacy experiences vary for older adults and with what outcomes. My findings include the core category, "managing needs and negotiating opportunities and constraints," which characterizes intimacy as an ongoing process (demonstrated in Figure 2.1). AL residents experienced intimacy through a multi-dimensional inner and interpersonal process that involved feelings of closeness, familiarity, affection, trust, and vulnerability. AL residents' intimacy process connected the contexts in which relationships and interactions were embedded, in this case, AL. As illustrated by the conceptual model, AL residents experienced intimacy as simultaneously a personal and interpersonal process. The intimacy process was shaped by individuals' needs and access and influenced by multiple resident-, relationship partner-, and AL-factors and over time. AL residents experienced and

expressed intimacy physically through action(s) or touch; created through and centered on emotional or spiritual feelings of closeness, familiarity, togetherness, acceptance, and love; and developed intellectually through conversations and shared ideas, experiences, or history, with others or internally. Intimacy was platonic (friendly or familiarly) or romantic. Individuals experienced intimacy inwardly, with another, or within a group. One explanation for variability in older adults' intimacy experiences is the diversity of lived experiences and personal intimacy histories. Older adults arrive at AL with a life history of intimacy experiences, including preferences and needs for intimacy. For some older adults, the move to AL might have increased their intimacy opportunities because of the availability of potential intimacy partners such as co-residents, staff members, home volunteers, family, and friends. Modifiable factors that influenced older adults' intimacy process in AL included: availability of an intimacy partner, AL culture, and staff's knowledge of residents.

In the third chapter (the second article), I examined the intimate care relationships of residents and DCWs in AL. Specifically, I asked, (1) how do residents and DCWs experience the care process over time, and (2) what accounts for variation in these experiences? My core category, "Handling intimacy: bodywork, care, and social relationships," referred to the various forms of collaboration and methods of relating between AL residents and DCWs during the intimate care process. These care interactions and relationships varied, and many transformed dynamically over time. As illustrated by Figure 3.1, residents and DCWs were joint partners in the intimacy of care through bodywork, care, and social relationships. Intimate care in AL included more than just bodywork, and improved care processes included the creation, collaboration, and maintenance of social relationships throughout the care process and with time. The intimacy of care, typically obtained through open communication between care partners,

availability of decision-making abilities for both, consistency in care partners, and upholding dignity, over time improved the quality of care and quality of life for residents and DCWs. Modifiable factors that influenced the intimacy of care included DCWs' knowledge and understanding of individual residents' care needs and preferences and the ability to make adjustments due to circumstances. However, DCWs could only successfully use their knowledge of residents' personalities, needs, and preferences if they were empowered to make care decisions and adjustments indicating the necessity for flexibility and independence regarding DCWs' expectations and role.

In the fourth chapter (the third article), I aimed to: (1) understand the roles family members play in older adults' intimacy process, and (2) identify how family members' participation in older adults' intimate relationships varies and with what outcomes. My findings, including the core category, "cultivating intimacy," revealed the various ways family members were involved in older adults' intimacy process in AL. AL residents pursued, created, and maintained intimacy through an assortment of relationships with various individuals, including family members. With family members as potential intimacy partners, residents experienced intimacy through four key dimensions: emotional, physical, intellectual, and spiritual. For most AL residents, family members played an essential role as intimacy partners. Yet, they often cultivated residents' intimacy experiences and acted directly or indirectly as facilitators or hinderers of intimacy. Intimacy opportunities for residents included encouragement of connecting with similar co-residents, providing physical space for friends and family gatherings, providing grief support upon the loss of an intimate partner or co-resident, and encouraging family members to be more involved in residents' lives.

I used feminist gerontology, a life-course perspective, and grounded theory approach to analyze data from the “Convoys of Care” longitudinal, qualitative research project. My research on intimacy in older adults’ lives applied the convoys of care model to assess AL residents’ intimacy experiences, including with informal and formal convoy members (Kemp, Ball, & Perkins, 2013). I addressed the role of convoy members, specifically family and DCWs, in older adults’ intimacy experiences in AL.

Both feminist gerontology and a life course approach emphasize the importance of recognizing diverse lived experiences and the diversity of older adults. Feminist gerontology (Ray & Fine, 1999) accentuates power relations and intersecting oppressions across the life course, which influenced my analysis. Power dynamics were present in AL. A critical finding was the importance of supporting residents’ and DCWs’ agency in decision making around addressing older adults’ intimacy needs. Furthermore, a life course approach emphasizes a social perspective and reflection of an individuals’ entire life, including others’ influences, for a better understanding of their current situation. My findings show older adults arrived at long-term care with a life history of intimacy experiences, preferences, needs, and desires, while also recognizing the influences of societal and internalized ageism.

My use of grounded theory methods (Corbin & Strauss, 2015) led me to develop new ideas regarding older adults’ intimacy experiences from inductive reasoning and methodical analysis of the data. My research illuminates the varied experiences of diverse older adults’ intimacy in long-term care, including their intimacy process, intimate relationships, and their experiences and expectations of intimate care and bodywork. Older adults receiving long-term residential care are involved in the internal and external process of intimacy. AL offers new opportunities and constraints to older adults’ intimacy access and process. Informal and formal

caregivers act as intimacy partners, but also as cultivating older adults' intimacy options. The convoys of care model emphasized the importance of studying individuals' whole convoys to better understand the lived experiences of older adults receiving care (Kemp, Ball, & Perkins, 2013). I conducted a thorough analysis and better understood the lived experiences of AL residents through the insight and feedback of their formal and informal care partners. I amplified the words and experiences of older adults in this research. Yet, this work would have been incomplete without the valuable contributions from their family, friends, and care partners.

I found the intimacy process complex, and individuals experienced and desired different dimensions of intimacy. While most AL residents experienced emotional intimacy in their daily lives, others prioritized or specifically sought out other dimensions of intimacy -- physical, intellectual, or spiritual. Often, prioritized intimacy dimensions were consistent with residents' life history and past preferences, such as those seeking intellectual or spiritual intimacy. Older adults experienced intimacy personally and inwardly, but also with another individual, or within a group.

Consistent across the three articles, I found that AL residents regularly sought out and strategized ways to increase intimacy in their lives. Across co-resident relationships, residents were more likely to engage in intimacy with others in similar or better cognitive and physical health. Among relationships with care partners, particularly DCWs, feelings of reciprocity, similarity, respect, and consistency, were vital. Residents were active participants in the care process and co-partners with DCWs in the intimacy of care. Also, care partner familiarity and consistency regarding times and schedules were essential to residents' participation in care. Dementia, other forms of cognitive distress, and feelings of pain impacted residents' role in the care process. Yet, bodywork and close intimate care presented opportunities for emotional

connections between residents and DCWs. DCWs held a critical position in AL residents' lives, not only as care partners but also as confidants and friends. DCWs derived significant meaning and importance from their jobs, often noting that emotional connections with residents inspired them to continue to do the work. Conversely, residents, family members, and other staff and upper management expected DCWs to perform emotional labor for them to do their job well.

AL residents' family members were intimacy partners, and many acted in cultivating their intimacy experiences. Family members regularly were involved in residents' intimate relationships, both platonic and romantic. Residents who were in better cognitive and physical health were more likely to advocate for their own intimacy experiences. In contrast, more vulnerable residents were more likely to comply with their family members' warnings or wishes. My findings also indicated the importance of sibling relationships in later life and long-term care.

Additionally, intimate relationships with others – siblings, other family members, co-residents, and staff – may lead to more substantive support from even more informal care partners. For example, residents' co-residents' family members might invite them to family outings or check-in on them when visiting AL. Intimate relationships provided social and emotional support that could lead to other forms of support.

My research emphasizes the need for a holistic care model that includes the intimacy process and different dimensions of intimacy across care types and locations. Studying intimacy in older adulthood and within the context of long-term care provides researchers, practitioners, older adults, and their family and friends, a more thorough understanding of social support in later life. My conceptual models (Figure 2.1 and Figure 3.1) provide frameworks for future studies on the intimacy process and intimacy of care. I encourage research on older adults'

intimacy process in other care arenas, such as community, home, nursing, and hospice care. Additionally, heteronormativity is prevalent in AL, and research regarding the intimacy process and experiences of lesbian, gay, bisexual, queer, and transgender individuals is critical to serving these populations better.

Long-term care needs a revolution, one that emphasizes intimacy, independence, agency, dignity, and privacy. Individuals' sexual and intimacy histories and personal identities are often overlooked or avoided in long-term care settings. However, to treat older adults as homogenous disregards much of what impacts their lives, social relationships, and experiences. Among individuals, depression, anxiety, grief, and shame can mark later life, especially in the context of long-term care. Care with an emphasis on intimacy and intimate relationships would change the landscape of AL and long-term care. AL professionals might encourage intimacy among residents through the implementation of a more holistic care model. Though AL professionals should not assume the desire for sexuality in later life, conversations around intimacy and sexuality may open communication for older adult's intimacy needs. Professionals can provide guidance, education, and an open ear of acceptance for older adults seeking more intimacy in their lives. Yet, long-term care professionals must be aware of societal, cultural, and religious factors that may influence older adults' intimacy values, expectations, and experiences. For many older adults who encounter changes in later life, intimacy with another might come as a welcome experience. Individuals experience life-long needs for intimacy, even amidst other losses, such as a partner, or physical and cognitive changes.

Currently, as I complete this dissertation, we are amidst a global pandemic, unlike any most of us in the Western world have seen in our lifetimes. The first individuals to become infected with COVID-19 in the United States included residents at a long-term care community

in Washington state in February 2020 (Kaiser Family Foundation, 2020). Now, almost six months later, the country remains in a state of quarantined shut-down with an emphasis on “social distancing” to limit the spread of the disease. Those most at risk of hospitalization and death from COVID-19 are individuals over the age of 65, those with preexisting health conditions, and Black, Latino, and Indigenous people (Dowd et al., 2020). With little government support, much less consensus on how to best control the spread of the disease in long-term care communities, the situation continues to leave much of our most vulnerable populations at risk. At this time, over 40% of COVID-19 related deaths have occurred in long-term care communities (Kaiser Family Foundation, 2020). COVID-19 spreads differently in long-term care communities than in the general population. In long-term care communities, physical distancing is almost impossible due to the physical care needs of residents and the close quarters in which they live, and currently, staff does not have adequate access to personal protective equipment (Pillemer, Subramanian, & Hupert, 2020). There have been significant decreases in in-person visits from family and friends; exercise, social, and religious services; and social gatherings in long-term care communities to curb the spread of the disease. These measures increase social isolation, loneliness, and negatively impact the emotional and physical health of residents of long-term care communities (Lewis et al., 2020).

Social isolation, a collective experience among older adults amidst the COVID-19 crisis, increases the likelihood of depression, anxiety, poor physical and emotional health, and even earlier death (Laumann et al., 2004; Cornwell & Waite, 2009; Shankar et al., 2011). My research emphasizes the importance of intimacy in older adults’ lives and the need to combat social isolation among long-term care residents. Previous studies on intimacy in older adults’ lives focused on romantic or sexual intimacy and discussed the lack of romantic and sexual intimacy

in long-term care (Frankowski & Clark, 2009; Wiskerke & Manthorpe, 2016; Bender, Burgess, and Barmon, 2017). However, I found that most older adults in AL experience some form of intimacy in their lives, though more often, it was emotional and platonic.

My research supports life course theory's distinction of studying individuals across the life span. Furthermore, my research confirms the life course theory of linked-lives -- that throughout our lives, we remain connected to specific individuals (most often family members), and these relationships influence each other (Elder, Johnson, & Crosnoe, 2003). My findings ratify the solidity of social relations over the life course for most individuals, yet also highlight the availability and importance of new connections in later life. My findings also support socioemotional selectivity theory (Carstensen, Isaacowitz, & Charles, 1999). I confirm that older adults are deliberative in their social connections and strategize ways to improve intimacy opportunities with others. Additionally, my findings support many others' work on the importance of spirituality in later life, as I found many AL residents emphasized the importance of spiritual and intellectual intimacy in their lives.

My findings highlight the implications of intimacy and intimate connections in later life and the realm of long-term care. I emphasize the importance of addressing the diverse lived experiences of older adults upon intake to AL and throughout their stay that includes acknowledging and honoring intimacy histories and preferences. In light of the current COVID-19 pandemic, I also want to include recommendations for improving intimacy opportunities and experiences for older adults currently in long-term care communities. I recommend the hiring and training of a specific communications coordinator to manage, plan, and assist AL residents with maintaining communication and relationships through technology and devices with family and friends outside of AL. While my findings emphasize that most AL residents experience

some intimacy in their daily lives, with the increase in social distancing procedures and limited in-person visits from family and friends, this may likely change. My work is timely amidst the current pandemic as my findings emphasize the need for more and deliberative support of social relationships and intimacy in long-term care.

In this ever-changing world, all have been greatly affected by the COVID-19 pandemic; its effects will impact our world for years to come. All aspects of life have changed, with an emphasis on “social distancing” and the isolation of older adults to avoid infection. Yet, research shows that the effects of isolation and lack of intimacy in older adults’ lives can be disastrous to one’s physical and emotional health. No one knows how long the pandemic will last nor its ultimate impact on the mental and physical health of the population at large. Additionally, unknown is the impact on the current cohort of older adults living in long-term care communities and their social connections and emotional health. My research centers the diverse and complex intimate lives of older adults receiving long-term care in AL and their informal and formal care partners. Experiences of intimacy and the existence of intimacy can be a measure of quality of life and quality of care that we should emphasize in long-term care. In sum, my findings stress a holistic approach to care that incorporates and supports individuals’ emotional, physical, intellectual, and spiritual intimacy process and preferences.

REFERENCES

CHAPTER 1: Introduction

- Antonucci, T. C., & Akiyama, H. (1987). Social Networks in Adult Life and a Preliminary Examination of the Convoy Model. *Journal of Gerontology*, 42(5), 519–527.
<https://doi.org/10.1093/geronj/42.5.519>
- Ball, M. M., Perkins, M. M., Whittington, F. J., Combs, B. L., Hollingsworth, C., & King, S. V. (2005). *Communities of care: Assisted living for African American elders*. Johns Hopkins University Press.
- Bender, A. A., Burgess, E. O., & Barmon, C. (2017). Negotiating the Lack of Intimacy in Assisted Living: Resident Desires, Barriers, and Strategies. *Journal of Applied Gerontology*, 39(1), 28–39. <https://doi.org/10.1177/0733464817746756>
- Burgess, E. O., Barmon, C., Moorhead, J. R., Perkins, M. M., & Bender, A. A. (2016). “That Is So Common Everyday . . . Everywhere You Go”: Sexual Harassment of Workers in Assisted Living. *Journal of Applied Gerontology*, 37(4), 397–418.
<https://doi.org/10.1177/0733464816630635>
- Calasanti, T., Slevin, K., & King, N. (2006). Ageism and Feminism: From "Et Cetera" to Center. *NWSA Journal*, 18(1), 13-30.
- Centers for Disease Control, & Khatutsky. (2016). *Residential care communities and their residents in 2010: a national portrait* (DHHS publication; no. (PHS) 2016–1041). Retrieved from <https://stacks.cdc.gov/view/cdc/39062>
- Connidis, I. A., & Walker, A. J. (2009). (Re)visioning gender, age, and aging in families. In S. A. Lloyd, A.L.Few, & K.R.Allen(Eds.), *Handbook of feminist family studies* (pp. 147 – 159). Los Angeles: Sage.

- Corbin, J., & Strauss, A. L. (2015). *Basics of Qualitative Research* (4th ed.). Thousand Oaks, Canada: SAGE Publications.
- Cornwell, E. Y., & Waite, L. J. (2009). Social Disconnectedness, Perceived Isolation, and Health among Older Adults. *Journal of Health and Social Behavior*, 50(1), 31–48.
<https://doi.org/10.1177/002214650905000103>
- Eckert, J. K., Morgan, L. A., & Swamy, N. (2004). Preferences for Receipt of Care Among Community-Dwelling Adults. *Journal of Aging & Social Policy*, 16(2), 49–65.
https://doi.org/10.1300/j031v16n02_04
- Erikson, E. H. (1963). *Eight ages of man, Childhood and Society*. New York, Norton and Company, 247-274.
- Frankowski, A. C., & Clark, L. J. (2009). Sexuality and intimacy in assisted living: Residents' perspectives and experiences. *Sexuality Research and Social Policy Journal of NSRC*, 6(4), 25-37.
- Glaser, B. G., & Strauss, A. L. (2017). *Discovery of grounded theory: Strategies for qualitative research*. Routledge.
- Hillman, J. (2008). Sexual issues and aging within the context of work with older adult patients. *Professional Psychology: Research and Practice*, 39(3), 290–297. <https://doi.org/10.1037/0735-7028.39.3.290>
- Kahn, R. L., & Antonucci, T. C. (1980). Convoys over the life course: A life course approach. *Life span development and behavior*, 253-286.
- Kemp, C. L. (2008). Negotiating Transitions in Later Life: Married Couples in Assisted Living. *Journal of Applied Gerontology*, 27(3), 231–251.
<https://doi.org/10.1177/0733464807311656>

- Kemp, C. L., Ball, M. M., Hollingsworth, C., & Perkins, M. M. (2012). Strangers and friends: Residents' social careers in AL. *J Gerontol B Psychol Sci Soc Sci*, 67(4), 491-502. <https://doi.org/10.1093/geronb/gbs043>
- Kemp, C. L., Ball, M. M., & Perkins, M. M. (2013). Convoys of care: Theorizing intersections of formal and informal care. *Journal of Aging Studies*. Vol. 27: 15-29.
- Khatutsky, G. (2016). *Residential Care Communities and Their Residents in 2010: A National Portrait*. Retrieved from https://www.cdc.gov/nchs/data/nsrcf/nsrcf_chartbook.pdf
- Laumann, E. O., N., A., Glasser, D. B., Paik, A., Gingell, C., Moreira, E., & Wang, T. (2004). Sexual problems among women and men aged 40–80 y: prevalence and correlates identified in the Global Study of Sexual Attitudes and Behaviors. *International Journal of Impotence Research*, 17(1), 39–57. <https://doi.org/10.1038/sj.ijir.3901250>
- Lindau, S. T., Schumm, L. P., Laumann, E. O., Levinson, W., O'Muircheartaigh, C. A., & Waite, L. J. (2007). A Study of Sexuality and Health among Older Adults in the United States. *New England Journal of Medicine*, 357(8), 762–774. <https://doi.org/10.1056/nejmoa067423>
- Ray, R. E., & Fine, M. (1999). Researching to Transgress: The Need for Critical Feminism in Gerontology. *Journal of Women & Aging*, 11(2–3), 171–184. https://doi.org/10.1300/j074v11n02_12
- Roth, E. G., & Eckert, J. K. (2011). The vernacular landscape of assisted living. *Journal of Aging Studies*, 25(3), 215–224. <https://doi.org/10.1016/j.jaging.2011.03.005>
- Shankar, A., McMunn, A., Banks, J., & Steptoe, A. (2011). Loneliness, social isolation, and behavioral and biological health indicators in older adults. *Health Psychology*, 30(4), 377–385. <https://doi.org/10.1037/a0022826>

Traupmann, J., & Hatfield, E. (1981). Love and its effect on mental and physical health. *Aging: Stability and change in the family*, 253-274.

CHAPTER 2: The Intimacy Process of Older Adults: Negotiating Opportunities and Constraints

Adams, R. G. (1985). People Would Talk: Normative Barriers to Cross-Sex Friendships for Elderly Women. *The Gerontologist*, 25(6), 605–611.

<https://doi.org/10.1093/geront/25.6.605>

Akiyama, H., Elliott, K., & Antonucci, T. C. (1996). Same-Sex and Cross-Sex Relationships. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 51B(6), P374–P382. <https://doi.org/10.1093/geronb/51b.6.p374>

Antonucci, T. C., & Akiyama, H. (1987). Social Networks in Adult Life and a Preliminary Examination of the Convoy Model. *Journal of Gerontology*, 42(5), 519–527.

<https://doi.org/10.1093/geronj/42.5.519>

Antonucci, T. C., Birditt, K. S., & Akiyama, H. (2009). *Convoys of social relations: An interdisciplinary approach*. In V. L. Bengtson, D. Gans, N. M. Pulney, & M. Silverstein (Eds.), *Handbook of theories of aging* (p. 247–260). Springer Publishing Co.

Ball, M. M., Perkins, M. M., Whittington, F. J., Combs, B. L., Hollingsworth, C., & King, S. V. (2005). *Communities of care: Assisted living for African American elders*. John Wiley & Sons.

Ball, M. M., Perkins, M. M., Hollingsworth, C., Whittington, F. J., & King, S. V. (2008).

Pathways to Assisted Living. *Journal of Applied Gerontology*, 28(1), 81–108.

<https://doi.org/10.1177/0733464808323451>

Barmon, C., Burgess, E. O., Bender, A. A., & Morehead, J. R. (2016). Understanding Sexual Freedom and Autonomy in AL: Discourse of Residents' Rights Among

- Staff and Administrators. *Journals of Gerontology: Social Sciences*, Vol. 00 (No. 00), 1-11. <https://doi.org/geronb/gbw068>
- Bauer, M., McAuliffe, L., & Featherstonehaugh, D. (2016). Older People and Sexuality in Residential Aged Care: Reconstructing Normality. In Peel, E. & Harding, R., (Eds.) *Ageing and Sexualities: Interdisciplinary Perspectives* (pp. 119-138). New York, NY: Routledge.
- Bender, A. A., Burgess, E. O., & Barmon, C. (2017). Negotiating the Lack of Intimacy in AL: Resident Desires, Barriers, and Strategies. *Journal of Applied Gerontology*, 1-25. <https://doi.org/10.1177/0733464817746756>
- Berkman, L. F., & Syme, S. L. (1979). Social Networks, Host Resistance, and Mortality. *American Journal of Epidemiology*, 109(2), 186–204. <https://doi.org/10.1093/oxfordjournals.aje.a112674>
- Blazer, D. G. (1982). Social support and mortality in an elderly community population. *American Journal of Epidemiology*, Volume 115(5), 684–694. <https://doi.org/10.1093/oxfordjournals.aje.a113351>
- Blieszner, R. (2001). ‘She’ll Be on My Heart’: Intimacy Among Friends. *Generations*, Vol. 25(No. 2), 48-54.
- Blieszner, R., & de Vries, B. (2001). Introduction: Perspectives on Intimacy. *Generations*, Vol. 25(No. 2), 1-2.
- Centers for Disease Control, & Khatutsky. (2016). *Residential care communities and their residents in 2010: a national portrait* (DHHS publication ; no. (PHS) 2016–1041). Retrieved from <https://stacks.cdc.gov/view/cdc/39062>
- Cohen, S. (2004). Social Relationships and Health. *American Psychologist*, 59(8), 676–684.

<https://doi.org/10.1037/0003-066x.59.8.676>

Corbin, J., & Strauss, A. L. (2015). *Basics of Qualitative Research* (4th ed.). Thousand Oaks, Canada: SAGE Publications.

de Vries, B. (2018). The Unsung Bonds of Friendship – and Caring – Among Older Adults. *Generations*, Vol. 42(No. 3), 77-81.

Felmlee, D., & Muraco, A. (2009). Gender and Friendship Norms Among Older Adults. *Research on Aging*, Vol. 31(No. 3), 318-344. <https://doi.org/10.1177/0164027508330719>

Fingerman, K. L., Huo, M., Charles, S. T., & Umberson, D. J. (2019). Variety Is the Spice of Late Life: Social Integration and Daily Activity. *The Journals of Gerontology: Series B*, 1–12. <https://doi.org/10.1093/geronb/gbz007>

Fiori, K. L., Antonucci, T.C., & Cortina, K. S., (2006). Social Network Typologies and Mental Health Among Older Adults, *The Journals of Gerontology: Series B*, 61(1), 25–32. <https://doi.org/10.1093/geronb/61.1.P25>

Frankowski, A. C., & Clark, L. J. (2009). Sexuality and intimacy in assisted living: Residents' perspectives and experiences. *Sexuality Research and Social Policy Journal of NSRC*, 6(4), 25-37.

Giddens, A. (1991). *Modernity and Self-Identity: Self and Society in the Late Modern Age*. Stanford, CA: Stanford University Press.

Giddens, A. (1992). *The Transformation of Intimacy: Sexuality, Love and Eroticism in Modern Societies*. Cambridge, UK: Polity Press.

Hillman, J. (2008). Sexual issues and aging within the context of work with older adult patients. *Professional Psychology: Research and Practice*, 39(3), 290–297. <https://doi.org/10.1037/0735-7028.39.3.290>

- Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine*, 7(7), e1000316.
- Kahn, R. L., & Antonucci, T. C. (1980). Convoys over the life course: A life course approach. *Life span development and behavior*, 253-286.
- Kane, R. L., & Kane, R. A. (2001). What Older People Want From Long-Term Care, And How They Can Get It. *Health Affairs*, 20(6), 114–127. <https://doi.org/10.1377/hlthaff.20.6.114>
- Kemp, C. L. (2008). Negotiating Transitions in Later Life: Married Couples in Assisted Living. *Journal of Applied Gerontology*, 27(3), 231–251.
<https://doi.org/10.1177/0733464807311656>
- Kemp, C. L. (2012). Married couples in assisted living: Adult children’s experiences providing support. *Journal of Family Issues*, 33(5), 639-661.
- Kemp, C. L., Ball, M. M., Hollingsworth, C., & Lepore, M. J. (2010). Connections with residents: “It’s all about the residents for me.”. *Frontline workers in assisted living*, 147-170.
- Kemp, C. L., Ball, M. M., Hollingsworth, C., & Perkins, M. M. (2012). Strangers and friends: Residents’ social careers in AL. *J Gerontol B Psychol Sci Soc Sci*,67(4), 491-502. <https://doi.org/10.1093/geronb/gbs043>
- Kemp, C. L., Ball, M. M., & Perkins, M. M. (2013). Convoys of care: Theorizing intersections of formal and informal care. *Journal of Aging Studies*. Vol. 27: 15-29.
[doi:10.1016/j.jaging.2012.10.002](https://doi.org/10.1016/j.jaging.2012.10.002) NIHMS:415156NIHMS:415156
- Kemp, C. L., Ball, M. M., Morgan, J. C., Doyle, P. J., Burgess, E. O., Dillard, J. A., Barmon, C. E., Fitzroy, A. F., Helmly, V. E., Avent, E. S., & Perkins, M. M. (2017). Exposing the Backstage: Critical Reflections on a Longitudinal Qualitative Study of Residents’ Care

- Networks in AL. *Qualitative Health Research*, Vol. 27 (No. 8), 1190 – 1202.
- Kemp, C.L., Ball, M. M., Morgan, J. C., Doyle, P. J., Burgess, E. O. & Perkins, M. M. (2018). Maneuvering together, apart, and at odds: residents' care convoys in AL. *J Gerontol B Psychol Sci Soc Sci*, 73(4), e13–e23. <https://doi.org/10.1093/geronb/gbx184>
- Kemp, C. L., Ball, M. M., & Perkins, M. M. (2016). Couples' social careers in assisted living: Reconciling individual and shared situations. *The Gerontologist*, 56(5), 841-854.
- Kemp, C. L., Ball, M. M., & Perkins, M. M. (2019). Individualization and the health care mosaic in assisted living. *The Gerontologist*, 59(4), 644-654.
- Khatutsky, G., C. Ormond, JM Wiener, and AM Greene. 2016. "Residential Care Communities and Their Residents in 2010: A National Portrait." *Stacks CDC.Gov*.
- Larson, R., Mannell, R., & Zuzanek, J. (1986). Daily well-being of older adults with friends and family. *Psychology and Aging*, 1(2), 117-126.
<http://dx.doi.org/10.1037/0882-7974.1.2.117>
- Lindau, S. T., Schumm, L. P., Laumann, E. O., Levinson, W., O'Muirheartaigh, C. A., & Waite, L. J. (2007). A Study of Sexuality and Health among Older Adults in the United States. *New England Journal of Medicine*, 357(8), 762–774.
<https://doi.org/10.1056/nejmoa067423>
- Moss, B. F., & Schwebel, A. I. (1993). Defining Intimacy in Romantic Relationships. *Family Relations*, Vol. 42 (No. 1), 31-37. <https://www.jstor.org/stable/584918>
- Patton, M. Q. (2015). Sampling, Qualitative (Purposeful). *The Blackwell Encyclopedia of Sociology*, 1. <https://doi.org/10.1002/9781405165518.wbeoss012.pub2>

- Perkins, M. M., Ball, M. M., Kemp, C. L., & Hollingsworth, C. (2012). Social Relations and Resident Health in Assisted Living: An Application of the Convoy Model. *The Gerontologist*, 53(3), 495–507. <https://doi.org/10.1093/geront/gns124>
- Phillips, S. L., & Fischer, C. S. (1981). Measuring social support networks in general populations. *Stressful life events and their contexts*, 223-233.
- Reis, H.T. (1990). The Role of Intimacy in Interpersonal Relations. *Journal of Social and Clinical Psychology* 9(1):15–30.
- Reis, H. T., & Shaver, P. (1988). Intimacy as an interpersonal process. *Handbook of personal relationships*.
- Sandhu, N. K., Kemp, C. L., Ball, M.M., Burgess, E.O., & Perkins, M.M., (2013). Coming Together and Pulling Apart: Exploring the Influence of Functional Status on Co-Resident Relationships in AL. *Journal of Aging Studies* 27(4):317–329.
- Saphire-Bernstein, S., & Taylor, S. E. (2013). Close relationships and subjective well-being. In I. Boniwell & S. David (Eds.), *Oxford handbook of happiness* (pp. 821–833). London, England: Oxford University Press.
- Street, D., & Burge, S. W. (2012). Residential Context, Social Relationships, and Subjective Well-Being in AL. *Research on Aging*, 34(3), 365-394.
<https://doi.org/10.1177/0164027511423928>
- Street, D., Burge, S., Quadagno, J., & Barrett, A. (2007). The Salience of Social Relationships for Resident Well-Being in AL, *The Journals of Gerontology: Series B*, 62(2), S129–S134. <https://doi.org/10.1093/geronb/62.2.S129>
- Van den Hoonaard, D. K. (2006). *The widowed self: The older woman's journey through widowhood*. Wilfrid Laurier Univ. Press.

- Walen, H. R., & Lachman, M. E. (2000). Social Support and Strain from Partner, Family, and Friends: Costs and Benefits for Men and Women in Adulthood. *Journal of Social and Personal Relationships*, 17(1), 5–30. <https://doi.org/10.1177/0265407500171001>
- Wood, V., & Robertson, J. (1978). Friendship and Kinship Interaction: Differential Effect on the Morale of the Elderly. *Journal of Marriage and Family*, 40(2), 367-375.
[doi:10.2307/350767](https://doi.org/10.2307/350767)

CHAPTER 3: Handling Intimacy: Bodywork, Care, and Social Relationships

Aronson, J. (1992). Women's Sense of Responsibility for the Care of Old People: "But who else is going to do it?" *Gender & Society*, 6(1), 8–29.

<https://doi.org/10.1177/089124392006001002>

Ball, M. M., Perkins, M. M., Whittington, F. J., Hollingsworth, C., King, S. V., & Combs, B. L. (2004). Independence in AL. *Journal of Aging Studies*, 18(4), 467–483.

<https://doi.org/10.1016/j.jaging.2004.06.002>

Ball, M.M., Lepore, M. L., Perkins, M. M., Hollingsworth, C., & Sweatman, M. (2009). "They are the reason I come to work": The meaning of resident–staff relationships in AL.

Journal of Aging Studies, 23(1), 37–47. <https://doi.org/10.1016/j.jaging.2007.09.006>

Ball, M.M., Perkins, M. M., Whittington, F. J., Hollingsworth, C., King, S. V., & Combs, B. L. (2005). *Communities of Care: AL for African American Elders*. Atlanta: Johns Hopkins University Press.

Burgess, E. O., Barmon, C., Moorhead, J. R., Perkins, M. M., & Bender, A. A. (2018). "That Is So Common Everyday . . . Everywhere You Go": Sexual Harassment of Workers in AL. *Journal of Applied Gerontology*, 37(4), 397–418.

<https://doi.org/10.1177/0733464816630635>

Caffrey, C. (2012). *Residents living in residential care facilities: United States, 2010* (No. 91). National Center for Health Statistics.

Calasanti, T. M., & Slevin, K. F. (2001). *Gender, Social Inequalities, and Aging*. Walnut Creek, CA: AltaMira Press.

Cohen, R. L., & Wolkowitz, C. (2017). The Feminization of Body Work. *Gender, Work & Organization*, 25(1), 42–62. <https://doi.org/10.1111/gwao.12186>

- Connell, R. W. (2005). *Masculinities*. Cambridge: Polity Press.
- Corbin, J., & Strauss, A. L. (2015). *Basics of Qualitative Research*. Los Angeles: SAGE Publications.
- Diamond, T. (1995). *Making Gray Gold: Narratives of Nursing Home Care*. Chicago: University of Chicago Press.
- Eckert, J. K., Carder, P. C., Morgan, L. A., Frankowski, A. C., Roth, E. G., Zimmerman, S., Dobbs, D. (2009). *Inside AL: The Search for Home*. Baltimore, Maryland: Johns Hopkins University Press.
- England, P. (2005). Emerging Theories of Care Work. *Annual Review of Sociology*, 31(1), 381–399. <https://doi.org/10.1146/annurev.soc.31.041304.122317>
- Estes, C. L., & Carroll L. Estes and Associates. (2001). *Social Policy and Aging: A Critical Perspective*. SAGE Publications.
- Glaser, B. G., & Strauss, A. L. (1999). *Theoretical sampling The discovery of grounded theory: strategies for qualitative research*. Sage Publications
- Gibson, D. (1995). *Aged Care: Old Policies, New Problems*. Cambridge, United Kingdom: Cambridge University Press.
- Hochschild, A. R. (1979). Emotion Work, Feeling Rules, and Social Structure. *American Journal of Sociology*, 85(3), 551–575. <https://doi.org/10.1086/227049>
- Hochschild, A. R. (2003). *The Commercialization of Intimate Life: Notes from Home and Work*. Los Angeles: University of California Press.
- Kahn, R. L., & Antonucci, T. C. (1980). Convoys over the life course: A life course approach. *Life span development and behavior*, 253-286.

- Kane, R. L., & Kane, R. A. (2001). What Older People Want From Long-Term Care, And How They Can Get It. *Health Affairs*, 20(6), 114–127. <https://doi.org/10.1377/hlthaff.20.6.114>
- Kelly, C., Craft Morgan, J., Kemp, C. L., & Deichert, J. (2018). A Profile of the Assisted Living Direct Care Workforce in the United States. *Journal of Applied Gerontology*, 073346481875700. <https://doi.org/10.1177/0733464818757000>
- Kemp, C. L., Ball, M. M., Hollingsworth, C., & Lepore, M. J. (2010). Connections with residents: “It’s all about the residents for me.” In Mary M. Ball, Molly M. Perkins, Carole Hollingsworth, and Candace L. Kemp (Eds.), *Frontline Workers in Assisted Living* (pp. 147-170). Baltimore, MD: Johns Hopkins University Press.
- Kemp, C. L., Ball, M. M., Morgan, J. C., Doyle, P. J., Burgess, E. O., & Perkins, M. M. (2018). Maneuvering Together, Apart, and at Odds: Residents’ Care Convoys in Assisted Living. *The Journals of Gerontology: Series B*, 73(4), e13–e23. <https://doi.org/10.1093/geronb/gbx184>
- Kemp, C. L., Ball, M. M., & Perkins, M. M. (2013). Convoys of care: Theorizing intersections of formal and informal care. *Journal of Aging Studies*, 27, 15–29. <https://doi.org/10.1016/j.jaging.2012.10.002>
- Kemp, C.L., Ball, M. M., Hollingsworth, C., & Lepore, M. J. (2010). Connection with residents: “It’s all about the residents for me.” *Frontline Workers in AL*.
- Kemp, C.L., Ball, M. M., Jason, K., Appel, J. D., & Fitzroy, A. F. (2019). Communicative Competence: Responding to Residents’ Health Changes in AL. *The Gerontologist*. <https://doi.org/10.1093/geront/gnz119>
- Kemp, C.L., Ball, M. M., & Perkins, M. M. (2019). Individualization and the Health Care Mosaic in AL. *The Gerontologist*, 59(4), 644–654. <https://doi.org/10.1093/geront/gny065>

- Kemp, C.L., Ball, M. M., & Perkins, M. M. (2019). Charting the course: Analytic processes used in a study of residents' care networks in assisted living. In A. Humble & E. Radinane (Eds.), *Going beyond 'themes emerged': Real stories of how qualitative analysis happens*. Oxon, UK: Taylor & Francis.
- Khatutsky, G., Ormond, C., Wiener, J. M., Greene, A. M., Johnson, R., Jessup, E. A., & Harris-Kojetin, L. (2016). Residential care communities and their residents in 2010: A national portrait. (DHHS Publication No. 2016-1041). Hyattsville, MD: National Center for Health Statistics.
- Lopez, S. H. (2006). Emotional Labor and Organized Emotional Care. *Work and Occupations*, 33(2), 133–160. <https://doi.org/10.1177/0730888405284567>
- Meyer, M., Donnelly, M., & Weerakoon, P. (2007). 'They're taking the place of my hands': perspectives of people using personal care. *Disability & Society*, 22(6), 595–608. <https://doi.org/10.1080/09687590701560204>
- Morgan, J. C., Dill, J., & Kalleberg, A. L. (2013). The quality of healthcare jobs: can intrinsic rewards compensate for low extrinsic rewards? *Work, Employment and Society*, 27(5), 802–822. <https://doi.org/10.1177/0950017012474707>
- Ray, R. A., & Street, A. F. (2006). Caregiver bodywork: family members' experiences of caring for a person with motor neurone disease. *Journal of advanced nursing*, 56(1), 35-43.
- Roe, B., Whattam, M., Young, H., & Diamond, M. (2001). Elders' perceptions of formal and informal care: aspects of getting and receiving help for their activities of daily living. *Journal of Clinical Nursing*, 10(3), 398–405. <https://doi.org/10.1046/j.1365-2702.2001.00484.x>

- Russell, C. K., Bunting, S. M., & Gregory, D. M. (1997). Protective care-receiving: the active role of care-recipients. *Journal of Advanced Nursing*, 25(3), 532–540.
<https://doi.org/10.1046/j.1365-2648.1997.1997025532.x>
- Stevenson, D. G., & Grabowski, D. C. (2010). Sizing Up The Market For AL. *Health Affairs*, 29(1), 35–43. <https://doi.org/10.1377/hlthaff.2009.0527>
- Corbin, J., & Strauss, A. L. (1998). *Basics of Qualitative Research*. Los Angeles: SAGE Publications.
- Theodosius, C. (2008). *Emotional labour in health care: The unmanaged heart of nursing*. Routledge.
- Twigg, J. (2000a). *Bathing--the Body and Community Care*. London: Routledge.
- Twigg, J. (2000b). Carework as a form of bodywork. *Ageing and Society*, 20(4), 389–411.
<https://doi.org/10.1017/S0144686X99007801>
- Twigg, J. (2002). Carework and bodywork. *Understanding Care, Welfare, and Community: A Reader*, 285.
- Twigg, J., Wolkowitz, C., Cohen, R. L., & Nettleton, S. (2011). *Body Work in Health and Social Care: Critical Themes, New Agendas*. West Sussex: Wiley.
- Twigg, Julia, Wolkowitz, C., Cohen, R. L., & Nettleton, S. (2011). Conceptualising body work in health and social care. *Sociology of Health & Illness*, 33(2), 171–188.
<https://doi.org/10.1111/j.1467-9566.2010.01323.x>

CHAPTER 4: Cultivating Intimacy in the Lives of Older Adults: Family Members' Roles

Ball, M. M., Perkins, M. M., Whittington, F. J., Combs, B. L., Hollingsworth, C., & King, S. V.

(2005). *Communities of care: Assisted living for African American elders*. John Wiley & Sons.

Ball, M. M., Whittington, F. J., Perkins, M. M., Patterson, V. L., Hollingsworth, C., King, S. V.,

& Combs, B. L. (2000). Quality of Life in Assisted Living Facilities: Viewpoints of Residents. *Journal of Applied Gerontology*, *19*(3), 304–325.

<https://doi.org/10.1177/073346480001900304>

Barmon, C., Burgess, E. O., Bender, A. A., & Moorhead, J. R., Jr. (2016). Understanding Sexual Freedom and Autonomy in Assisted Living: Discourse of Residents' Rights Among Staff and Administrators. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, gbw068. <https://doi.org/10.1093/geronb/gbw068>

Bender, A. A., Burgess, E. O., & Barmon, C. (2017). Negotiating the Lack of Intimacy in Assisted Living: Resident Desires, Barriers, and Strategies. *Journal of Applied Gerontology*, *39*(1), 28–39. <https://doi.org/10.1177/0733464817746756>

Charmaz, K., & Belgrave, L. L. (2007). Grounded theory. *The Blackwell encyclopedia of sociology*.

Connidis, I. A. (1989). Siblings as Friends in Later Life. *American Behavioral Scientist*, *33*(1), 81–93. <https://doi.org/10.1177/0002764289033001008>

Corbin, J., & Strauss, A. L. (2015). *Basics of Qualitative Research*. Los Angeles: SAGE Publications.

Frankowski, A. C., & Clark, L. J. (2009). Sexuality and intimacy in assisted living: Residents'

- perspectives and experiences. *Sexuality Research and Social Policy*, 6(4), 25–37.
<https://doi.org/10.1525/srsp.2009.6.4.25>
- Kahn, R. L., & Antonucci, T. C. (1980). Convoys over the life course: A life course approach. *Life span development and behavior*, 253-286.
- Kane, R. L., & Kane, R. A. (2001). What Older People Want From Long-Term Care, And How They Can Get It. *Health Affairs*, 20(6), 114–127. <https://doi.org/10.1377/hlthaff.20.6.114>
- Kemp, C. L. (2008). Negotiating Transitions in Later Life: Married Couples in Assisted Living. *Journal of Applied Gerontology*, 27(3), 231–251.
<https://doi.org/10.1177/0733464807311656>
- Kemp, C.L., Ball, M. M., Jason, K., Appel, J. D., & Fitzroy, A. F. (2019). Communicative Competence: Responding to Residents’ Health Changes in AL. *The Gerontologist*.
<https://doi.org/10.1093/geront/gnz119>
- Kemp, C. L., Ball, M. M., Morgan, J. C., Doyle, P. J., Burgess, E. O., & Perkins, M. M. (2018). Maneuvering Together, Apart, and at Odds: Residents’ Care Convoys in Assisted Living. *The Journals of Gerontology: Series B*, 73(4), e13–e23.
- Kemp, C. L., Ball, M. M., & Perkins, M. M. (2013). Convoys of care: Theorizing intersections of formal and informal care. *Journal of Aging Studies*, 27(1), 15–29.
<https://doi.org/10.1016/j.jaging.2012.10.002>
- Kemp, C. L., Ball, M. M., & Perkins, M. M. (2018). Individualization and the Health Care Mosaic in Assisted Living. *The Gerontologist*, 59(4), 644–654.
<https://doi.org/10.1093/geront/gny065>
- Khatutsky, G., Ormond, C., Wiener, J. M., Greene, A. M., Johnson, R., Jessup, E. A., & Harris-Kojetin, L. (2016). Residential care communities and their residents in 2010: A national

- portrait. (DHHS Publication No. 2016-1041). Hyattsville, MD: National Center for Health Statistics.
- Kistler, C. E., Zimmerman, S., Ward, K. T., Reed, D., Golin, C., & Lewis, C. L. (2016). Health of Older Adults in Assisted Living and Implications for Preventive Care. *The Gerontologist*, gnw053. <https://doi.org/10.1093/geront/gnw053>
- Patton, M. Q. (2015). Sampling, Qualitative (Purposeful). *The Blackwell Encyclopedia of Sociology*, 1. <https://doi.org/10.1002/9781405165518.wbeoss012.pub2>
- Perkins, M. M., Ball, M. M., Kemp, C. L., & Hollingsworth, C. (2013). Social Relations and Resident Health in Assisted Living: An Application of the Convoy Model. *The Gerontologist*, 53(3), 495–507. <https://doi.org/10.1093/geront/gns124>
- Street, D., Burge, S., Quadagno, J., & Barrett, A. (2007). The Salience of Social Relationships for Resident Well-Being in AL, *The Journals of Gerontology: Series B*, 62(2), S129–S134. <https://doi.org/10.1093/geronb/62.2.S129>
- Street, D., & Burge, S. W. (2012). Residential Context, Social Relationships, and Subjective Well-Being in Assisted Living. *Research on Aging*, 34(3), 365–394. <https://doi.org/10.1177/0164027511423928>
- Tompkins, C. J., Ihara, E. S., Cusick, A., & Park, N. S. (2012). “Maintaining Connections but Wanting More”: The Continuity of Familial Relationships Among Assisted-Living Residents. *Journal of Gerontological Social Work*, 55(3), 249–261. <https://doi.org/10.1080/01634372.2011.639439>
- Yamasaki, J., & Sharf, B. F. (2011). Opting out while fitting in: How residents make sense of assisted living and cope with community life. *Journal of Aging Studies*, 25(1), 13–21. <https://doi.org/10.1016/j.jaging.2010.08.005>

CHAPTER 5: Conclusion

- Bender, A. A., Burgess, E. O., & Barmon, C. (2017). Negotiating the Lack of Intimacy in Assisted Living: Resident Desires, Barriers, and Strategies. *Journal of Applied Gerontology, 39*(1), 28–39. <https://doi.org/10.1177/0733464817746756>
- Carstensen, L. L., Isaacowitz, D. M., & Charles, S. T. (1999). Taking time seriously: A theory of socioemotional selectivity. *American Psychologist, 54*(3), 165–181. <https://doi.org/10.1037/0003-066x.54.3.165>
- Corbin, J., & Strauss, A. L. (2015). *Basics of Qualitative Research* (4th ed.). Thousand Oaks, Canada: SAGE Publications.
- Cornwell, E. Y., & Waite, L. J. (2009). Social Disconnectedness, Perceived Isolation, and Health among Older Adults. *Journal of Health and Social Behavior, 50*(1), 31–48. <https://doi.org/10.1177/002214650905000103>
- Dowd, J. B., Andriano, L., Brazel, D. M., Rotondi, V., Block, P., Ding, X., ... Mills, M. C. (2020). Demographic science aids in understanding the spread and fatality rates of COVID-19. *Proceedings of the National Academy of Sciences, 117*(18), 9696–9698. <https://doi.org/10.1073/pnas.2004911117>
- Elder G.H., Johnson M.K., Crosnoe R. (2003) The Emergence and Development of Life Course Theory. In: Mortimer J.T., Shanahan M.J. (eds) Handbook of the Life Course. Handbooks of Sociology and Social Research. Springer, Boston, MA
- Frankowski, A. C., & Clark, L. J. (2009). Sexuality and intimacy in assisted living: Residents' perspectives and experiences. *Sexuality Research and Social Policy, 6*(4), 25–37. <https://doi.org/10.1525/srsp.2009.6.4.25>
- Kaiser Family Foundation. State reports of long-term care facility cases and deaths related to

COVID-19 (as of May 28, 2020). Accessed June 27, 2020.

<https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/>

Kemp, Candace L., Ball, M. M., & Perkins, M. M. (2013). Convoys of care: Theorizing intersections of formal and informal care. *Journal of Aging Studies*, 27(1), 15–29.

<https://doi.org/10.1016/j.jaging.2012.10.002>

Laumann, E. O., N., A., Glasser, D. B., Paik, A., Gingell, C., Moreira, E., & Wang, T. (2004).

Sexual problems among women and men aged 40–80 y: prevalence and correlates identified in the Global Study of Sexual Attitudes and Behaviors. *International Journal of Impotence Research*, 17(1), 39–57. <https://doi.org/10.1038/sj.ijir.3901250>

Lewis, C., Shay, T., Jacobson, G., MacIntosh, A., & Abrams, M. K. (2020, April). *How the*

COVID-19 Pandemic Could Increase Social Isolation, and How Providers and Policymakers Can Keep Us Connected. The Commonwealth Fund. Retrieved from

<https://www.commonwealthfund.org/blog/2020/how-covid-19-pandemic-could-increase-social-isolation-and-how-providers-and-policymakers>

Pillemer, K., Subramanian, L., & Hupert, N. (2020). The Importance of Long-term Care

Populations in Models of COVID-19. *JAMA*, x. <https://doi.org/10.1001/jama.2020.9540>

Ray, R. E., & Fine, M. (1999). Researching to Transgress: The Need for Critical Feminism in Gerontology. *Journal of Women & Aging*, 11(2–3), 171–184.

https://doi.org/10.1300/j074v11n02_12

Wiskerke, E., & Manthorpe, J. (2016). New relationships and intimacy in long-term care: The

views of relatives of residents with dementia and care home staff. *Dementia*, 17(4), 405–422. <https://doi.org/10.1177/1471301216647814>