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is associated with healthy aging (Woloski-Wruble, Oliel, Leefsma, & Hochner-Celnikier, 2010). The current study aims to fill this important gap in the literature by exploring women's stories of providing care to their spouse or partner and how these experiences have affected their sexual and intimate lives. This study understands spousal caregiving as the unpaid, informal care provided by a spouse or partner to an older adult living at home. Spousal caregiving can involve both emotional and instrumental assistance with a range of daily living activities. Sexuality and intimacy are broadly defined in this study to include sexual acts as well as cognition (e.g., knowledge, thoughts, identity), emotion (e.g., emotional closeness, affection, prolonged eye contact), and touch (e.g., holding hands, dancing) in the context of these relationships (DeLamater & Hyde, 2004).

## The Unique Nature of Women's Caring for a Spouse and or Partner

While much of the caregiving literature focuses on experiences of **family** caregivers, feminist writings have recognized the gendered nature of caregiving (Brazil et al., 2008; Strang, 2001), and have identified the different roles, responsibilities, and involvement women caregivers face when compared to other family members (Lee, 1999). For example, women spousal caregivers have been found to provide between 40 and 60 hr of care per week, approximately double that of other familial caregivers (Keating, 1999). Further, women spouses are the least likely of all family ''carers'' to seek
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Given that satisfaction with sexuality and intimacy in later years has been found to contribute to the health, well-being, and quality of life of older adults (Katz & Marshall, 2003; Weeks, 2002), it seems timely and important to understand more fully how caring for a spouse with chronic health problems impacts sexuality and intimacy within the context of the relationship and how this in turn shapes the caregiving experience for women spouses (Weeks, 2002). To this end, the current study aims to explore how older women caring for a spouse at home experience and understand their identities as women, wives, partners, caregivers, and sexual beings. The study asks how the caregiver role and its associated risks to health and well-being affect the sexual and intimate relationships of women spousal caregivers.

## Method

We used an adapted phenomenological approach in order to understand the meaning older women caregivers attribute to their experience of sexuality and intimacy (Creswell, 1998; Moustakas, 1994; Tesch, 1990). Phenomenology is a qualitative methodological approach designed to render explicit the essential meanings attributed to the lived experiences of a particular phenomenon and engages with the subjective experience as a means of both data collection and analysis (Bogdan & Biklen, 1982). A phenomenological approach focuses on understanding how people experience a situated phenomenon, such as is the case of the impact of caregiving on the experience of sexuality and intimacy, through conversation between researcher and research participant. Questions are broad and give room for the participant to tell the story of their experience. An emphasis in both data collection and analysis is placed upon how meaning is made of the lived experience. While phenomenological approaches tend toward unstructured interviewing techniques, recent phenomenological accounts have also used semistructured interviewing techniques to focus participants on particular aspects (themes) of a phenomenon (Beharry & Crozier, 2008; Haj-Yahia & Cohen, 2009). Moustakas (1994, p. 116) affirms that the interview guide can ''facilitate the obtaining of rich, vital, substantive descriptions of the co-researcher's [participant] experience of the phenomenon.'' Themes identified in our study included those related to the lived experience of caregivers, the meaning they attributed

Oh my god, of all the things that are happening to us, and I know that sex is supposed to be very important . . .

which ultimately led to a feeling of ''giving up.'' One woman spoke to us about her attempts to be

example, caregivers whose spouses had become aggressive or angry as part of their illness, feared a negative reaction if they were to bring up sexuality or intimacy, so they avoided the topic. One caregiver spoke to us about the time she brought up the topic of sexuality with her husband:

> Not well . . . he was unpleasant, you know like 'you ugly cow, like uh how can I' he said 'I can't even go to the bathroom by myself why are you bugging me with this other stuff, all you think about is you.' So uh you know I thought ok that's it. (Francine, Caregiver)

Another caregiver used to discuss these topics with her partner when he first became ill, but has since chosen not to do this anymore:

> There was no point talking to my husband about it, because like I say. It wasn't his fault, he got diabetes and all the rest, and um it's just your sex life comes to an end. (Estelle, Caregiver)

Finally, some caregivers felt that because of their partner's cognitive decline, a conversation about sexuality and intimacy would not be possible.

Caregivers stated that they rarely brought up intimacy or sexuality with friends or family. For example, when speaking about her friendship circle, this participant stated:

> None of my friends have ever spoken about . . . We've said things about not having sex . . . another friend doesn't talk about it. No one talks about it. One friend talked about it at some point and I sort of mentioned something. But it isn't something that any of us talked about, our actual sex lives. (Sidney, Caregiver)

Conversations about sexuality in general were rare. When they did occur, caregivers felt that ''it didn't do any good talking about it really'' (Estelle, Caregiver), because ''even if it would have helped, I couldn't do anything. It was a 'fait accomplit', let me put it that way'' (Estelle, Caregiver).

Caregivers told us that they would not talk about sexuality and intimacy with their service providers for a number of reasons. As stated above, some abo-270.4(p)3.7-292.5()timen-Caregivers

> I mean the area of sexuality has always been a part of the evaluation, the global evaluation that is done in the home care setting but it's usually one of the areas that is consistently left blank, because people just don't approach that issue. (Shannon, Service Provider)

Service providers described some of the assumptions that are made about older women caregivers, such as "I think it's this assumption that with everything else going on in their lives that sexuality just kind of gets thrown on the back burner . . . I know that's not always true, but that's often the assumption" (Tony, Service Provider).

In summary, considering participant's narratives of sexuality as "irrelevant" and service provider's assumptions and discomforts, it is not surprising that sexuality is a topic absent in the caregiver and health care service provider encounter.

## Discussion and Conclusion

Our findings reveal several emergent themes related to the ways in which caregiving impacts the expression of sexuality and intimacy among women spousal caregivers. First, our study confirms the work of previous research which has emphasized how the caregiving role becomes all encompassing for older women, taking over other aspects of selfhood for women engaged in this type of care to their spouses (Brazil et al., 2008; Cheung & Hocking, 2004; Keating, 1999; Lee, 1999; Montgomery et al., 2000; Strang, 2001). Previous research on caregiver identity has explored caregivers' work and social lives (Arksey & Glendinning, 2008; Bainbridge, Cregan, & Kulik, 2006; Druxbury, Higgins, & Schroeder, 2009). Our findings contribute to this scholarship by adding findings related to women caregivers' sexual identity. The data confirm that sexual identity, like other aspects of caregiver identity previously researched, becomes subsumed with the weight of the tasks of caregiving. This leaves women little room to express their sexual selves within their relationships. For most women, their sexual identity is "put away," overshadowed by the demands of providing care. For some, women have tried to maintain a sexual life with their partners to no avail, either as a result of the shift in their perception of their partner as "care receiver" or because their partner has rejected their efforts to do so. Unfortunately, social expectations regarding older women as "asexual" or "undesirable" feed into women's perceptions of themselves, rendering the requirement to "give up" on their sexual lives once becoming caregivers. Women cope with their changed identities and realities by conceptualizing sexuality as "irrelevant" to their current lived experience. We are left to wonder about whether or not sexuality and intimacy are actually irrelevant to older women caring for their partners or if this is what women must tell themselves so that they can continue providing care under circumstances in which selfhood is denied. In some situations, the intersection of ageism in the form of "older women as asexual" (DeLamater & Sill, 2005) and denial of selfhood related to caregiving work together to limit older women caregivers' sense of possibility as sexual beings.

Still, women find ways to counter this experience in their daily lives. Women told us about how acts of intimacy experienced alone, with their partners, or with others with whom they share affection, provide opportunities to experience some forms of sexuality and intimacy within or despite their caregiving roles and responsibilities. It is important for these acts to be noted and visible, as they challenge our assumptions about older women as asexual beings. These findings add to the caregiving and sexuality literature by making us more aware of what older women caregivers need, and what they are already doing for themselves. Acknowledging the ways in which older women caregivers continue to experience sexuality and intimacy shows us that sexual expression is a continuum to be honored and supported, particularly within health and social care services designed to address the needs of caregivers. Recognizing the expression of sexuality and intimacy as part of an older women's health agenda is a necessary strategy to respond to older women caregivers' needs and realities.

Most women maintained that sexuality and intimacy are irrelevant to the point that they would not discuss these subjects with friends, family, or service providers. This is exacerbated by situations of silence and invisibility regarding sexuality and intimacy in the heath care encounter originating with service providers themselves, who by omission, either reinforce that sexuality is indeed irrele-

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