# EXPERIENCES AND PERCEPTIONS OF CONNECTION AMONG CONTINUING CARE RESIDENTS IN ALBERTA

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## DEDICATION

For my mom.

## ABSTRACT

This study explores how connection is perceived and experienced among continuing care residents in Alberta. Data for this secondary analysis included transcripts from semi-structued interviews with 12 resident participants conducted between 2018-2019. For this analysis, connection is broadly conceptualized to include: connection to self, connection to others, and connection to body.

Three themes were developed using reflexive thematic analysis, including: 1) connection to self: continuing care settings may offer unique opportunities for connection to self through continued self-expression and self-discovery; 2) connection to others: despite challenges associated with living in residential care, participants maintained and strengthened their connections with others; and 3) seeking connection to body through sexual expression.

Findings from this study discuss the barriers and facilitators to connection in this population, while recognizing the unique context of publicly funded continuing care homes by situating findings within the existing critical care scholarship. Although residents experienced rich forms of connection, structural barriers such as heavily regimented care delivery and decades of funding cuts can impede a felt sense of connection among residents.

## ETHICS STATEMENT

Data for this study were collected as part of a larger study on sexual expression in publicly funded continuing care homes in Alberta. The dataset was collected via telephone and in-person interviews at multiple care homes across Alberta by a research team led by my thesis supervisor, Dr. Julia Brassolotto. All resident participants were their own legal decision-makers and gave informed consent to participate. The primary study was approved by the University of Alberta Research Office Board (Pro00067720).

## USE OF GENERATIVE AI

Grammarly, a form of generative AI, was sparsely used to check for spelling and grammar similarly to the Editor tab in Microsoft Word. I produced all the written content in this thesis.

## ACKNOWLEDGEMENTS

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# CHAPTER 1: INTRODUCTION

## Introduction

In this thesis, I explore how connection is experienced by residents of continuing care homes in Alberta. I situate this inquiry in the context of loneliness and social isolation as a growing public health issue generally, and in continuing care homes specifically. Social isolation and loneliness are prevalent worldwide, with one in six people in experiencing loneliness (WHO, 2026). Research increasingly demonstrates that social isolation and loneliness have serious impacts on physical and mental health, quality of life, and longevity (WHO, 2026). The World Health Organization (2025) has identified seven key drivers of loneliness and social isolation. These include poor health, marginalization, low income, living alone, weak community infrastructure, life transitions, and unhealthy use of digital technologies. Older adults moving into continuing care homes to receive 24-hour nursing care likely experience a number of these drivers. For instance, a scoping review established that individual, system, and structural factors all contribute to social isolation among continuing care residents (Boamah et al., 2021). These factors include communication challenges (individual), potential changes in geographical community when entering care homes (system), and the structure and delivery of care (Boamah et al., 2021). As the prevalence and risk of loneliness among continuing care residents has been well established (Boamah et al., 2021; Victor, 2012; Simard & Volicer, 2020). I was interested in focusing on health promoting, positive experiences of connection that may be beneficial in addressing loneliness or social isolation in this population.

In this thesis, I detail a reflexive thematic analysis of connection in Albertan continuing care homes. The data for this project were collected as part of a broader study on sexual expression in continuing care from 2018-2019 (Brassolotto et al., 2020a; Brassolotto et al., 2020b; Howard et al., 2020). The original study was led by my thesis supervisor, Dr. Julia Brassolotto and her

colleague Dr. Lisa Howard. The primary project was a two-phased approach focusing on care staff (phase one) and residents and family members (phase two). This dataset was chosen for my project given my interest in connection in care homes, the availability of these data, and the feasibility of this analysis for a beginner researcher. Although sexual expression includes multiple forms of connection, this dataset has not been previously explored in relation to loneliness or connection. To emphasize the relatively under-represented experiences of residents, my secondary analysis included only the transcripts from interviews with resident participants. In my analysis, I examined barriers and facilitators of connection, as well as how connection is described and experienced among residents. This process, along with details about the original dataset and methods are discussed further in Chapter 2.

This thesis contains three chapters. In this first chapter, I discuss loneliness as a public health issue, present connection as a means of health promotion as it is implicated in addressing the loneliness epidemic, provide an overview of connection in continuing care, and describe the continuing care home context in Alberta. Finally, I position myself as a researcher including my personal and disciplinary reflexivity. Chapter 2 is a manuscript detailing the findings of my reflexive thematic analysis and a brief discussion of their implications. Chapter 3 expands upon this discussion with consideration of implications for research, policy, and practice, as well as reflections on my learning.

**Key concepts**

The interrelated concepts of loneliness, social isolation, intimacy, and connection are central to this thesis. Throughout this thesis, I use these terms in accordance with these definitions, with acknowledgement that they are not exhaustive definitions, that there is not consensus about

their definitions (Prohaska et al., 2020) and that some of the terms are not entirely distinct from one another – or may be used interchangeably in the cited scholarship.

***Social isolation*** describes limited or lack of interpersonal interactions or separation from contact with others (Nicholson, 2009; Perissinotto et al., 2019). It is an objective measure of a person's social network, social participation, and/or the number of their close relationships. For older adults, social isolation can result from declines in physical or mental health and mobility, environmental or transportational barriers, or major life transitions (e.g., retirement, deaths of family members or friends, or moving into residential care) (Employment and Social Development Canada [ESDC], 2024; Boahmah et al., 2021).

Whereas social isolation refers to limited social contact that is objectively measurable, ***loneliness*** is a subjective negative feeling characterized by inadequate meaningful connections (Prohaska et al., 2020). It refers to the "subjective experience resulting from a discrepancy between desired and actual close personal relationships" (Perissinotto et al., 2019; Holt-Lunstad et al., 2017). It is not simply being alone but feeling disconnected from others, which can occur even in the presence of others if those relationships are not fulfilling (Victor, 2012). Loneliness can present both alongside and independently of social isolation. Loneliness has been put forth as an at-risk outcome of low levels of social connection (Perissinotto et al., 2019).

***Connection*** broadly refers to positive feelings of relationality. It refers to the sense of being linked or related to others, which can be emotional, social, or intellectual. It can also encompass a felt sense of alignment, attunement, or authenticity. Throughout this thesis, I use the term "connection" quite expansively. I refer to a personal felt sense of connection but extend the relationality beyond solely the interpersonal. Specifically, I consider 1) connection to oneself (e.g., one's past and present identities, experiences, or fantasies), 2) connection to one's body, and 3)

connection to others. This global conceptualization of connection aligns with other scholarship on this topic.

Chapman et al. (2024) focus largely on social connection in long-term care (LTC) homes. Their work emphasizes the importance of becoming familiar with life in the LTC home to support social connection, physical and virtual access beyond the LTC home as strategies to maintain connections, getting to know residents to deepen relationships; and using person-centred approaches to build social connection (Chapman et al., 2024). Similarly, when exploring opportunities to facilitate social connection in continuing care homes, a UK study identified the importance of: personalisation regarding residents' interests, preferences, and cognitive abilities; facilitating activities that foster a sense of community and involvement with others; and finding things residents share in common (Misiak et al., 2025). This scholarship provides valuable insight into addressing loneliness through social programs and person-centred care strategies that promote connection.

Given the dataset used in my study, I was attentive to sexual expression as a form of connection. "Sexual expression" describes a range of relationships, identities, and behaviours. This can include fantasizing; physical acts such as kissing, touching, hugging, masturbation, sex acts, and personal expression such as grooming and self-presentation; and sexual identity and orientation (Brassolotto et al., 2020a). These examples highlight that connection can be an expression of sexuality (e.g., an intimate partnership with another person) and/or an outcome of sexual activities (e.g., a felt sense of belonging). In other words, sexual expression, in its diverse forms, can facilitate many types of connection. Schubert and Pope (2020) described how the transition to living in a residential care home can bring forth discomfort in engaging in sexually expressive activities of daily living for residents, such as bathing or physical intimacy. This

discomfort felt among residents impacted how they experienced connection both to themselves and others in the care home (Schubert & Pope, 2020).

In my analysis, I was attentive to the topics described above, as well as other meaningful forms of connection that may not have been included or foregrounded in related scholarship. My broad conceptualization of "connection" accounts for both social and internal processes. Such internal processes could include the felt sense of connection to one's authentic self or to one's body, which are not currently captured in studies of perceptions and experiences of connection that have focused on interpersonal intimacy or social connection.

***Intimacy*** involves close, personal relationships characterized by emotional openness, trust, and deep understanding between individuals (Reis & Shaver, 2018). It can manifest in romantic, familial, or platonic relationships where individuals share their vulnerabilities and experiences with one another. In contrast with connection, intimacy does not cover the interpersonal relationship with oneself, such as changes in self-perception and self-concepts over one's lifetime. "Intimacy" refers to the quality of the connection with someone, whereas "connection" describes the overarching experience. For example, intimacy among adults in continuing care homes was found to include emotional and physical aspects such as "emotional intimacy", "physical intimacy", "intellectual intimacy", and "spiritual intimacy" (Fitzroy et al., 2022). This typology reinforces the diverse sources that can provide a felt sense of intimacy or connection. As these concepts are interrelated, the boundaries between intimacy and connection can be fluid. For instance, personal grooming practices such as wearing makeup or shaving one's beard are relevant to discussions of both sexual expression and connection. This will be explored in further detail later in my thesis. Similarly, one's relationship to one's body has implications for loneliness in older adults, as findings suggest that poor body image is associated with increased loneliness

through a felt sense of stigma (Barnett et al., 2020). Those with diminished body image, or who are experiencing disconnection or dissociation from their bodies, are less likely to engage with others, which could lead to increased feelings of loneliness (Cacioppo et al., 2009).

**Loneliness as a public health issue**

Humans are social creatures with basic needs for connection, community, and belonging. These needs are so significant that 'social connection' is a well-established determinant of health (Public Health Agency of Canada [PHAC], 2024). Loneliness has been identified as a growing public health issue. It has been associated with inherit health risks akin to smoking or obesity (Holt-Lunstad et al., 2017; U.S. Surgeon General, 2023). These adverse health risks are concerning, given reported rates of loneliness are rising globally, leading to the U.S. Surgeon General issuing a report on the "epidemic of loneliness" (U.S. Surgeon General, 2023). Meanwhile, the United Kingdom established a Ministry of Loneliness in 2019 (CBC News, 2018) and Canada established an Intersectoral Collaboration (ISC) for loneliness (Savage et al., 2023). The ISC came in response to reports that Canada ranks as the loneliest country with over a third of adults over the age of 65 reporting often feeling lonely (Statistics Canada, 2021). Two of the core tenets of the ISC are to establish a national policy to foster connections and to increase public awareness of the importance of social connection (Women's Age Lab, 2024).

As indicated above, loneliness is a highly individualized experience and is not necessarily correlated with the number of close relationships (Holt-Lunstad, 2021). For instance, there is a popular adage that "you can feel lonely in a crowd" (Perissinotto et al., 2019). Therefore, simply being in the presence of other people may not reduce the felt sense of loneliness. As a result, standardized interventions to address loneliness via increased social contact can be challenging (Akhter-Khan & Au, 2020). The risk for loneliness is not equally distributed among the population,

with older adults and those living in continuing care homes identified as vulnerable populations for loneliness. Available studies report that residents in continuing care reported feeling lonely at double the rates of their peers living in the community (Victor, 2012; Simard & Volicer, 2020). Most Canadians aged 65 and older reported they would opt against moving into residential care should they require that level of support (Flanagan et al., 2023). Additionally, older adults may face stigma regarding sexuality and sexual expression, particularly in continuing care homes (Villar et al., 2015). This stigma can prevent people from exploring valuable forms of embodied and interpersonal connection that improves their health and enriches their quality of life (Brassolotto et al., 2020b). For my project, I sought to examine how continuing care residents experience connection. There have been many studies concerned with intervening on social connection in this population, in hopes of improving measurable health outcomes (Lem et al., 2021). However, increasing social connection also has intrinsic benefits related to pleasure and well-being – it feels good to be connected with others (Martino et al., 2015). To date, efforts to address loneliness in Canada have focused on increasing opportunities for social connection and reducing isolation and disconnection by increasing awareness of the risks, and funding programs for at-risk populations such as older adults (Public Health Agency of Canada [PHAC], 2024; National Seniors Council, 2025). From a public health perspective, there are certain interventions at the community level or through program delivery that can help to facilitate connection with the goal of subsequently addressing loneliness, such as community-based group exercise programs (Hwang et al., 2019). Additionally, the decreasing availability of ‘third places’ (that is, public locations outside of home and work that facilitate social interactions) has had negative effects on the health and well-being of North Americans. Third places can provide an important upstream

health intervention that allows for significant improvements in the structure, function, and community of neighbourhoods in which they exist (Finlay et al., 2019).

While loneliness can be experienced by anyone, seniors have been identified as experiencing an increased risk of isolation and subsequent loneliness, in part due to changes in health status, mobility, and daily environment (ESDC, 2024). Loneliness among older adults has been linked to earlier cognitive decline, increased acute care utilization, and premature death (Perissinotto et al., 2012). This suggests that not only is loneliness contraindicated for healthy aging, loneliness among seniors also becomes a health services issue.

Further, older adults living in continuing care homes are at an especially pronounced risk of isolation and loneliness (Public Health Agency of Canada [PHAC], 2024). This may seem counterintuitive as continuing care facilities appear to have the right ingredients to foster connection and social belonging. For instance, they are communal living arrangements necessitated by the need for medical care, residents have all exited the workforce and have reduced domestic responsibilities, and they have regular recreation programming such as games and exercise classes that could foster new connections. However, many practices commonly found in continuing care homes increase risk of loneliness among seniors. These factors include recreation activities that are not aligned with residents' abilities or interests, poor roommate pairings, potential language barriers between staff and residents, relocating away from one's community of origin, and exclusionary organizational practices such as discrimination against one's identity or cognitive ability (Boamah et al., 2021). Furthermore, as discussed in greater detail in the following section, continuing care homes have a history of prioritizing medical care over residents' social and emotional needs and have experienced decades of funding cuts that have limited their capacity to address these needs (Armstrong & Daly, 2004; Graff-McRae, 2021).

**Continuing care in Alberta**

Continuing care homes offer around-the-clock care for those who require personal support and ongoing medical care due to chronic conditions and/or age-related decline. Other jurisdictions may refer to these as nursing homes, long-term care, or assisted living facilities. In Alberta, "continuing care" includes both assisted living and long-term care homes, which reflect different levels of care (Alberta Health Services, 2024). As there are a range of circumstances that could lead to someone accessing continuing care, there are different levels of support available. In Alberta, there are three types of continuing care homes. Continuing Care Home Type A, formerly referred to as long-term care, provides twenty-four hour personal and healthcare support for those with heightened care needs (Alberta Health Services, 2024a). People who retain cognitive capacity but may have experienced physical decline due to illness may reside in a Type B home – previously known as supportive living (Alberta Health Services, 2024a). Type C refers to hospice care, which includes palliative and end-of-life care (Alberta Health Services, 2024a) but was not included in this study. This is important to keep in mind as continuing care homes have a very diverse population of residents with equally diverse care needs. The participants included in my study resided in what is now referred to as Continuing Care Type A (Howard et al., 2020).

Continuing care homes are a unique healthcare delivery model as they exist at the intersection between acute care and residential living (Armstrong, 2010). This intersection leads to care homes becoming a combination of staff workplaces and residents' homes. Initially, these care homes were modelled after acute care delivery, leading to an overreliance on outcome-based checklists (Thompson et al., 2021; Braedley et al., 2023). This led to overemphasizing medical care needs at the expense of holistic care. In response, a shift towards more wraparound support for continuing care residents, termed "person-centred care" has been prioritized for the last twenty years (Caspar et al., 2020; Nolan et al., 2004; Simmons & Rahman, 2014).

Briefly, person-centred care refers to considering the holistic needs of each resident (Armstrong & Daly, 2004; Caspar, et al., 2020). This includes their individual preferences, histories, and distinct needs. Although medical care needs are important, personal care support needs, including dressing, mobility, and social needs also play a key role in residents' overall well-being and creating a homelike environment (Caspar et al., 2020). However, this can be complex to implement considering the vast differences in abilities and required supports across residents. To address these discrepancies and support this shift, the culture change movement was introduced to support the necessary organizational changes in continuing care homes (Caspar et al., 2020; Nolan et al., 2004; Simmons & Rahman, 2014). The culture change movement, in theory, works to address the staffing and organizational structures at the level of the care home. However, there are vast differences between care homes in terms of their ability to implement and maintain such organizational culture change (Caspar et al., 2020). Due to staffing and resource constraints, person-centred care and the culture change movement rarely unfold seamlessly in practice. There is a widening discrepancy between an increase in demand for care and available staff (Armstrong & Daly, 2004; Graff-McRae, 2021). For instance, concerns about staff not having the capacity and resources to appropriately care for residents' social needs were raised at least twenty years ago and continue to pose challenges today (Armstrong & Daly, 2004, Graff-McRae, 2021). Findings from this project will contribute to the ongoing discussion of person-centred care and connection in Albertan continuing care homes. I focus on how connection is experienced among continuing care residents and identify barriers and facilitators to such connections.

**Reflexivity**

I am an early career researcher with an academic background in sociology and public health, and a keen interest in social determinants of health and health equity. Because of this

combination of interests and academic training, my perspective is often attuned to tensions between structure and agency (that is, the recognition that micro level actions take place in and are shaped by meso level systems and macro level structures). I am often attentive to areas of critique in hopes of affecting change (Little, 2023; Raphael et al., 2020). Sociology, like public health, is concerned with groups of people as the unit of analysis and how power is distributed in society (Little, 2023). This focus on intersectionality, how one's societal positioning and identities combine and overlap (Crenshaw, 1989), and how one's identities and proximity to privilege intersect and combine to inform our experiences informs much of my critical perspective, which allows me to critically assess the impact of privilege and power imbalances through a public health lens. This is relevant as both my public health and sociology training focus on access issues and social determinants of health. These disciplines both highlight relevant tensions and power structures (Raphael et al., 2020). As a result, I am inclined to situate participants' accounts within broader social, political, and economic contexts.

Public health approaches to sexual health often focus on risk prevention or harm reduction. For instance, the prevention of unwanted pregnancies or reducing the risk and impact of sexually transmitted and blood-borne infections (PHAC, 2018). However, public health is also involved in sexual health promotion and education that addresses consent, healthy relationships, pleasure, bodily autonomy, and the reduction of stigma (Condran, 2014). For this project, I aimed to highlight that in addition to the health risks of sexual practices, pleasure and connection also have benefits that can and should be promoted in continuing care settings. This is not to discount the potential risks involved, but rather to emphasize the health-promoting aspects of sexual expression that can be better supported. Therefore, proactive support for sexual expression in continuing care can very much be considered both a public health and a sociological endeavor.

My positionality, including my academic background, has influenced how I approached this study in both conscious and unconscious ways. I come to this research project as a white, cisgendered woman, early in my research career. My identity and social positioning certainly informed how I approached this analysis. It is important to acknowledge my social positioning as another researcher may identify themes in this dataset that differ from my own. This is an accepted and appreciated aspect of qualitative research (Braun & Clarke, 2021). Though I do not have firsthand experience of residential care homes as a resident, I do have firsthand experience of continuing care homes as a family member of a resident. My grandfather lived in a (Type A) continuing care home in Edmonton, Alberta, from 2019 until he passed in July 2024. Throughout my analysis, I have often drawn on my experiences visiting him and the broad frame of reference regarding continuing care homes this provided me, while also leaving space to notice and appreciate when participants' experiences diverge from mine and my grandfather's.

At a time of increasing disconnection and loneliness, there is a fruitful opportunity to explore means of connection that are not often offered to continuing care residents. In the following chapter, I outline findings from my analysis and discuss their implications.

# CHAPTER 2: EXPERIENCES AND PERCEPTIONS OF CONNECTION AMONG CONTINUING CARE RESIDENTS IN ALBERTA

## INTRODUCTION

Connection and loneliness are related yet distinct concepts that have come into heightened focus in recent years. Loneliness is particularly pertinent as it has been found to be associated with adverse health outcomes (Park et al., 2020). Loneliness, defined as the subjective lack of close and fulfilling social relationships (Holt-Lunstad, 2021), is highly prevalent with more than a third of older adults living in Canada reporting often feeling lonely (Statistics Canada, 2025). Certain populations are at higher risk of loneliness, including older adults (ESDC, 2024). Connection has gained public interest as a response to the loneliness epidemic (U.S. Surgeon General, 2023). Because loneliness is caused by a lack of fulfilling relationships, it cannot be solved solely through increasing social interactions or being in a densely populated setting. While increasing opportunities for relationships to naturally develop can be beneficial, more effort is required to intervene on loneliness. Guidelines for fostering social connection at both the individual and community level have been recently established. These include prioritizing social connection and fostering environments that support connection at both the individual and community level (Canadian Alliance for Social Connection and Health [CASCH], 2024).

In this chapter, I present findings from a reflexive thematic analysis on resident experiences of connection in continuing care. The three key themes I generated through this analysis are (1) connection to self: continuing care settings may offer a unique opportunity for connection to self through continued self-expression and self-discovery, (2) connection to others: despite challenges associated with living in residential care, participants maintained and strengthened their connections with others, and (3) seeking connection to body through sexual expression. I include analytic takeaways and a subsequent discussion of their implications in later sections of my thesis.

## Background

As detailed further in Chapter 1, loneliness is a multifaceted health and healthcare services issue. The Public Health Agency of Canada recognizes older adults as an at-risk population for experiencing loneliness (PHAC, 2024). As a result, they have put forth guidelines to combat loneliness in this population. These include systemic changes such as empowering healthcare providers with tools to assess for and identify those at risk of loneliness, and for intervening on loneliness with an individualized approach such as social prescribing. For instance, providing a written prescription to participate in group activities that provide opportunities to form social bonds (Conn et al., 2024). This echoes sentiments of the culture change movement which focuses on person-centred care delivery in residential care homes to embrace the medical, personal care, and social needs of residents (Armstrong & Daly, 2004; Caspar et al., 2020; Nolan et al., 2004; Simmons & Rahman, 2014). Due to the significant impact loneliness can have on quality of life and related health outcomes, social connection is designated as a social determinant of health (PHAC, 2024). In the literature, loneliness and related concepts have been discussed in various ways. For instance, a systematic review of the association between physical health outcomes and social connection among those living in residential care homes found that social connectedness could be a modifiable risk factor worthy of further analysis and intervention (Lim et al., 2023).

## Continuing care homes and person-centred care

In recent years, there has been a discernable shift towards responding to the unique demands of residents in long-term residential care homes. For instance, when residents enter long-term care homes, it is generally accepted that that is where they will remain for the remainder of their life (Alberta Health Services, 2024a). As a result, residents could spend decades living in continuing care. This type of care delivery structure then becomes a distinct intersection of

homelife for the residents and workplaces for care staff. A major implication of this is that care staff comprise a considerable portion of the residents' social networks and opportunities for socialization and connection. This dynamic is recognized by and embraced by many care staff (Ball et al., 2009). However, inadequate funding and low staffing ratios have resulted in suboptimal working conditions (Armstrong & Daly, 2004; Graff-McRae, 2021; Armstrong & Braedley, 2023). The intricacies of this intersection of working and living are discussed in further detail in later sections. The gap between how care delivery is structured and the needs of the residents is what led to calls for person-centred care and the subsequent culture-change movement (Caspar et al., 2020).

The culture change movement describes a model of organizational change required to support changes in healthcare services delivery, such as lower staff-to-resident ratios, increased time for charting, and an increased focus on building rapport with residents (Caspar et al., 2020). Successful implementation of person-centred care requires both financial support and organizational support. For the organization, management and administration would need to introduce a change management procedure that moves away from a focus on task-based care and towards a more collaborative approach between care staff that allows them to share a more holistic perspective of the resident. Within the current protocols, there is often not enough time for staff to spend the extra care and time it takes to build a rapport with their residents, nor is there funded hours for care staff to share such insight with their colleagues (Caspar et al., 2020). As is often the case with organizational changes, certain care homes, such as those with empowering and transparent leadership, are better equipped to change processes and foster interdependent teamwork from care staff (Caspar et al., 2020).

## Connection in continuing care homes

Among extant scholarship on connection in continuing care homes, social connection has been the most widely studied. Research by both Misiak et al., (2025) and Chapman et al., (2024) established the importance of familiarity and commonalities were important foundational components to facilitating a felt sense of social connection. However, social connection is not all encapsulating for how connection can be perceived and experienced. Established literature has explored various concepts related to connection in continuing care. For example, Fitzroy et al. (2022), explored the experiences of residents in assisted living communities and identified four types of intimacy among continuing care residents: emotional, physical, intellectual, and spiritual intimacy, while Schubert & Pope (2020) explored a desire for intimate expression through the lens of sexual expression. Similarly, Morgan et al. (2019) have suggested there is a "look of loneliness" that contributes to a cycle of feeling and outwardly expressing loneliness, both preventing one from reaching out and can keep others from trying to form a connection. To my knowledge, there has not been published inquiries into the barriers and facilitators of these other forms of connection. For my project, I was interested in a perceived or felt sense of connection in its various forms.

## Methods

In this section, I outline the research questions developed for this inquiry, describe the research design for the original project, and detail the analytic steps of my secondary reflexive thematic approach.

## Research questions

1. How is connection described and experienced by residents in Alberta's continuing care settings?
2. What are the perceived barriers to feelings of connection in this setting?
3. What are the perceived facilitators to feelings of connection in this setting?

**Data collection**

My thesis project is a descriptive secondary analysis of data collected as part of a qualitative exploratory study. These data were collected via telephone and in-person interviews at multiple continuing care homes across Alberta by a research team led by Dr. Julia Brassolotto and Dr. Lisa Howard from 2018 to 2019. Participants were recruited through purposive sampling. To participate, resident participants needed to have resided in a continuing care home for at least six months, have the cognitive capacity to consent to participate, and be interested in speaking about sexual expression in continuing care (this could include their own experiences and/or their broader views on the topic) (Howard et al., 2020). The lead researchers verbally described the study and interview process and received verbal consent to participate from all participants. This qualitative exploratory study aimed to gain insight into sexual expression in Alberta from different perspectives. Data collection for this project included a phased approach, where phase one included care staff and administrators, while phase two included residents and family members (Howard et al., 2020). Residents and family members were interviewed between May 2018 - March 2019. Interviews with twelve residents took place in-person or over the phone, using a semi-structured interview guide with open ended questions. Interviews ranged from 45-75 minutes in length and were transcribed verbatim by a professional transcriptionist.

For my thesis, I used a subset of the phase two dataset, including interview transcripts from the twelve resident participants. While participants' demographic information was not explicitly collected, participants ranged in age from 42 to 91 years old (with most participants in the 60–80-year range) and lived in publicly funded continuing care homes. Seven of the resident participants were women, and five were men. Since this is a secondary analysis of an existing dataset, the sample size of the resident participants was pre-determined. However, the focus of this inquiry is to develop a deeper understanding of residents' lived experience rather than to draw generalizable

conclusions. All resident participants were their own legal decision-makers and gave informed consent to participate. The primary study was approved by the University of Alberta Research Office Board (Pro00067720).

## Reflexive Thematic Analysis

Reflexive thematic analysis is a rigourous and credible qualitative research method that enables researchers to develop, analyze, and interpret patterns across a dataset (Braun & Clarke, 2021). A defining part of reflexive thematic analysis versus thematic analysis is that reflexive thematic analysis acknowledges and honours the active participation and positionality of the researcher while generating themes as opposed to passively uncovering them in the data (Braun & Clarke, 2021).

Reflexive thematic analysis includes six phases: data familiarization, coding, initial theme generation, theme development, and writing up. These phases are discussed in detail below. While these phases represent different aspects of the coding process, Braun and Clarke (2021) are adamant that this is an iterative process rather than linear. It is expected and encouraged that an inquiry will involve working through the steps and oscillating between previous and subsequent stages as part of the analytic process. I ensured rigour and credibility by following these phases closely and soliciting the support of three skilled academic researchers on my thesis committee throughout my project.

## Data Analysis

### *Phase One: Data Familiarization*

In phase one, data familiarization, I read through the twelve interview transcripts twice. For the first read-through, I read in order of the transcripts and took rudimentary notes and reflections, while focusing on reading for a general overview and meaning. On the second read-

through, I changed the order in which I read the transcripts. This was recommended to view the dataset in a new light and allow for other insights to develop while lessening the risk of waning attention and skipping over parts inadvertently (Braun & Clarke, 2021). This also set the scene for the dataset, rather than the individual transcripts, to become the unit of analysis. This is important as reflexive thematic analysis is concerned with finding patterns of meaning *across* a dataset. As I often work in different locations and different times of day, I used this to my advantage in the data familiarization phase. On the second read-through, I was more intentional about taking written and audio notes of emerging reflections and early thoughts. This proved beneficial when I began coding in the next phase.

***Phase Two: Coding***

In reflexive thematic analysis, codes are the smallest unit of measurement*,* though they are an interim step toward themes – the final and accepted unit of analysis (Braun & Clarke, 2021). Coding involves applying 'tags' to participant quotes within the dataset that signify a particular thought or insight. Codes are the building blocks of themes, with many codes combining to form a theme. Following the advice of my thesis supervisor, I initially coded each transcript descriptively to simply reflect what participants were describing. For example, some of these initial inductive codes included "change in perspective over time," "acceptance regarding end of life," "asking for privacy," and "finding a sense of normalcy." My next round of coding was more deductive (Braun & Clarke, 2021), with a focus on implicit and explicit descriptions of connection. This approach allowed me to identify diverse experiences of connection and helped to ensure that I was generating insights that could explicitly answer my research questions.

As much of my work processes are digital, I used that to my advantage when working through coding my dataset, I made use of the comment function in Microsoft Word to apply codes

to the transcripts and developed a macro—a custom computer function—to export more than 500 into an Excel spreadsheet to form my codebook. Once I had all 525 codes in one Excel spreadsheet, I began the process of grouping and reorganizing them into potential themes. To do this, I colour coordinated the rows in Excel with a descriptive label. Some of these initial labels included "tension in continuing care," "desire for dating/romantic interests," "personal grooming," "change in ability/dependence," and both "barriers" and "facilitators." During the next phase, which is discussed in further detail below, I began the process of naming my themes.

***Phase Three: Initial Theme Generation***

Themes are the unit of analysis that I used to answer my research questions. Generating initial themes involved grouping the codes developed in phase two to find commonalities across the dataset. This phase is aptly referred to as generating themes to signify that themes are not discovered, rather, they are built and determined by the researcher drawing on the established scholarly literature and relying on the knowledge of the dataset as a whole (Braun & Clarke, 2021).

Allowing both codes and themes to evolve is an expected and encouraged part of the process and demonstrates the iterative nature of reflexive thematic analysis. These earlier phases of analysis help inform the researcher's thought process and are highly individualized in terms of findings and processes.

At this stage, it is not uncommon for some codes to move up to the level of initial themes or be discarded entirely. I experienced both during my analysis. For example, I discarded the code "near death," while I collapsed aspects of "personal grooming" and "evolution of self-concept" into the category "connection to self." An important distinction I kept in mind during this stage was that I needed to look for concepts or patterns across the dataset rather than grouped topics or sentiments in individual or only limited transcripts. This is also an important stage to remember

where I am relative to the dataset. Each phase of breaking down and building the data back together leads to being a step removed from the dataset. This context flows nicely into the next phase of theme development and was a key factor in developing the themes I discuss later in this chapter. Through discussions with my thesis committee, I iteratively identified three broad conceptualizations of connection that formed the basis for my themes. These were connection to self, connection to body, and connection to others.

***Phase Four: Developing and Reviewing Themes***

In this phase, I continued to review and develop my themes. The key difference between this phase and phase three is that I was more focused and concerned with going back to my dataset rather than working with individual codes and initial themes. Once I generated a theme that I could justify as having defined contextual boundaries (i.e. ensuring the themes are clear and distinct from one another) and that I could tell an engaging story related to my research question, I evaluated it across all twelve transcripts that form my dataset. To assist with this process, I used the following five evaluation questions for developing themes developed by Dr. Virginia Braun (2024):

1. Does it tell us something interesting about the research question?
2. Does it seem to capture something "important" to understand?
3. Is there a clear central organizing concept?
4. Are there multiple facets of meaning the theme covers?
5. Could I tell a rich, interpretative, interesting story about this?

For my project, I felt I could tell a rich, engaging story about "connection to self" given the experiences described by the residents, but that another preliminary theme, "queerness in continuing care", was not prominent enough across the dataset. Given this, I moved forward with

the initial theme “connection to self” and folded in the data about queerness as a component of the broader theme.

It was also during this time that I considered the contextual boundaries of each theme from each other. I aimed to generate rich, deep, and engaging themes I could describe from my dataset. I often found myself feeling that some themes blended and I was unable to draw clear boundaries between them. This was particularly important when considering the evaluative questions above as I wanted to ensure I could describe three distinct themes in depth. As I worked through this phase, I used my research questions to guide my analysis, with the intention of refining each of the theme names in the next phase.

***Phase Five: Refining, Defining, and Naming Themes***

At this phase, I continued to refine my themes with a particular focus on developing engaging, descriptive, and meaningful theme names. Braun (2024) noted that single-word themes are not feasible in reflexive thematic analysis as they do not provide enough context. Accordingly, I further developed my theme names to provide additional context with more narrative theme names rather than descriptive terms. For instance, the concept of “connection to self” became the theme “Continuing care settings may offer a unique opportunity for connection to self through continued self-expression and self-discovery.”

***Phase Six: Writing Up***

The final phase of reflexive thematic analysis includes drafting the report of the analytic process, describing the themes, and reporting the findings (Braun & Clarke, 2021). This is a distinct phase, as the writing process contributes to a deeper analysis and exists within the analytic process. While many of the previous phases involved generating and organizing insights to inform the analytic process, reporting the findings considers the audience or reader. This is a part of the

methodology of reflexive thematic analysis as the researcher must be able to communicate their themes and implications while summarizing and outlining their analytic journey to get there. Braun and Clarke (2021) purport that writing the final deliverable – in this case, my thesis project – is part of the analytic process as the analysis continues to take shape as it is discussed in writing.

I can attest to this, as much of my analysis solidified through the writing process. As to be expected, many of the themes melded and flowed into each other (Braun & Clarke, 2021). I found myself refining theme names, re-drawing contextual boundaries, and further crystallizing my insights through writing this thesis project.

## Findings

### Theme 1. Connection to self: Continuing care settings may offer unique opportunities for connection to self through continued self-expression and self-discovery.

Residents in continuing care settings may experience more time and space for self-reflection and new pursuits since their basic needs are taken care of by staff. This is distinct from retirement in that their needs related to food procurement and preparation and home maintenance are taken care of for them. Continuing care provides a unique context in which residents move into a new space with people in somewhat similar life circumstances (i.e., requiring assistance with daily living, no longer in the workforce). With this shift, there is opportunity to enter a new chapter where one can perhaps reinvent themselves or show up without the same constraints to which they had previously been held.

The first theme I generated throughout this analysis is centred around the idea that continuing care homes can offer unique opportunities for personal growth and exploration of self. Connection to self describes the intrinsic sense of relating to one's cognitions, beliefs, and how their self-perception has evolved over time. Participants described their evolving connection to

self with reference to two key subthemes: 1) appreciation of individuality, and 2) a sense of openness and curiosity to new experiences.

***Appreciation of individuality***

Maintaining a sense of personal identity through physical appearance was a facilitator to a richer connection to oneself while living in a continuing care home. For example, many participants in this study expressed turning to their personal grooming practices to foster and maintain their individuality and sense of personal identity. This aligns closely with the person-centred care movement and honours residents' humanity, personal preferences, and personal histories. For instance, when speaking about his life before and after his traumatic brain injury, Resident 7 indicated that physical appearance was still important to him:

> Well, I always relied on my good looks… because I used to be a quarterback for [university]… The [staff] do my hair. I brush my teeth; I put on my cologne. I always like to smell nice… I pick my own clothes (Resident 7).

Similarly, when Resident 8 spoke about her love of handbags and the importance of maintaining the highlights in her hair, she claimed, "whether I'm top of the line or bottom of the heap, I want to feel good about me," explaining that maintaining her personal appearance is important to her, even if widespread ageism in society makes it harder for older women to feel attractive. Continuing preferred personal care practices and style choices allowed this resident to connect with her past self and maintain her sense of individuality. Several participants highlighted the importance of maintaining their appearance and its significance for their sense of self, and their sense of the care home being a home. As described by Resident 6, dedicated grooming time offers a much-welcomed sense of normalcy in continuing care, as well as an opportunity to maintain continuity in individualized self-presentation:

> A lot of the focus here is just on maintaining and care for the body…I think care facilities could have more staff so that, with a little more time…making us feel pretty and normal.

> They can make sure that [our] hair is done nicely, and our clothing is straightened properly, just as a person would do before they leave the house in the morning (Resident 6).

Another participant (Resident 8) claimed that residents are often split into "care parts" and that tending to one's appearance is an accessible way to maintain individuality and personhood. The concept of being split into fragmented "care parts" suggests that residents can feel that they are seen only for their medical care requirements rather than as a full human being with preferences, desires, and goals. For this participant, tending to one's needs in a more universal sense rather than solely focusing on her medical and daily care needs aided in maintaining her autonomy and sense of self as her bodily function declines. This is an important aspect in maintaining a connection to self while navigating through requiring and accepting care with activities of daily living. This was described nicely by another resident, who emphasized that attending to these individual preferences also supported self-confidence and readiness to interact with others:

> I wear makeup… I make my hair nice when I go out, because I want to present the world to meet who I am, and I am me, and I'm very happy being me. I'm going to be the best me I can be to the world, the way they see me. …If I need help with choosing my earrings, or makeup – put my makeup on, I'll get help with that (Resident 12).

Supporting individual expression through activities such as personal grooming helped participants feel like themselves in this new living arrangement. As Resident 6 mentioned, facilitating grooming "just as a person would do before they leave the house in the morning" (Resident 6) allows for more individuality and continuity of self-expression when living in a residential care setting. This is an important insight that reinforces the importance of personal grooming as a part of holistic care for residents.

***Continued self-discovery and exploration***

Engaging in ongoing self-discovery was important for many participants. This challenges dominant notions of older adults being stuck in their ways (Heid et al., 2015), and of continuing care residents being in a persistent state of decline. As noted by one participant (Resident 2) voicing the importance of self-expression, residents in continuing care are not simply waiting to die. Instead, several residents expressed ways in which they continue to expand and explore their perceptions of themselves while living in continuing care. For example, while dining out with his companion aide, Resident 2 was pursued by the waiter – a possibility he had not considered since requiring a wheelchair:

> …I said, "You realize I'm in a wheelchair?" And he looked [me] up and down and he said, "Yes, but you're still looking okay." And I never thought of myself as looking okay because all my life, I've been a large fellow, or the teddy bear that people come to (Resident 2).

Resident 2 had not previously considered himself as attractive to others. Notably, as he describes in the quote above, he never saw himself as "looking okay", which is associated with self-esteem and self-confidence (Bale, 2013). This evolution of self-perception, alongside with living authentically as an out gay man, came to fruition during his time in continuing care. This participant's experience challenges the popular thinking that moving into a care home primarily involves a series of losses (of previous social roles, of physical abilities, of independence, etc.). Resident 2's story reveals that care homes residents do not *necessarily* become lonelier and more isolated, and that rich personal and interpersonal connections are still possible.

Other residents experienced ongoing self-discovery through changes in their views on important issues while living in continuing care. For instance, one resident described his previously held ableist views and how those sentiments have changed throughout his time living in residential care:

> …I'm just trying to think of my own self when I wasn't crippled [sic] and didn't even know I would be. Like I probably wouldn't…say no to going out with somebody who was in a wheelchair, but…I would probably go with the walking people and kind of now I'm like 'Jesus, am I so shallow that I would think that way?' And it happened to me (Resident 3).

This quote reveals an example of ongoing self-discovery and exploration as Resident 3 expressed seeing others for who they are rather than by their use of a mobility aid. He described a humbling change in values, shifting from focusing on ability and independent mobility, towards prioritizing personality and compatibility. This shift in thinking, and the corresponding openness to potential partners who also have a disability, also created the possibility for less "shallow" dating experiences and new connections.

Other residents expressed changes in how they see themselves in relation to others. For instance, one resident described himself as having previously been "a player" and not especially thoughtful in relationships. Following his traumatic brain injury and newfound life in continuing care, he explained how his sense of self had evolved:

> Respondent: I want to feel like I belong, belong to someone.
> Interviewer: Belong to someone. That's a little different than [Resident 7] as 'the player'. That's a different man.
> Respondent: Now I'm switched over. Like before I had no conscience. Now I care (Resident 7).

There are many ways that one's self-concept can grow and change over the life course and remaining open to integrating new experiences into how oneself is perceived is important for self-connection (Klussman et al., 2022). These residents demonstrated that there is room for expansion and self-discovery within the continuing care context. Recognizing that one's self concept and perception of self can change over time, even amidst a shift into residential care homes, is an important perspective when considering both connection and holistic person-centred care.

**Theme 2. Connection to others: Despite challenges associated with living in residential care, participants maintained and strengthened their connections with others.**

Residential care environments can create barriers to connection via rigid care schedules, limited visiting hours, built environments that are not designed to support intimate connections, and the prioritization of medical care delivery. Despite this context, participants in this study were still able to develop new relationships and support and maintain existing relationships with others both within and outside of the care home. The development of these relationships was not without barriers or challenges, which included staff intervention, impersonal care, and the structure of task-based care. These challenges are supported by the extant literature (Armstrong & Daly, 2004). However, there were also notable facilitators of connection, including proximity, communal living, and the formation of deep, fulfilling bonds with others that may not have developed outside of a residential care home setting. In this section, I outline both the barriers and facilitators of continuing care residents connecting with others.

***"They operate your body for you and I'm constantly at odds": practices impeding connection***

Throughout my analysis, I identified several practices across care homes that impeded opportunities for residents to connect with others. This included: 1) a dominant focus on task-based care or an "assembly line style of living" (Resident 3), 2) limited interactions with the care staff when receiving care, and 3) strict visiting hours. The roots of these issues have been acknowledged through the person-centred care movement and are discussed in greater detail in the subsequent discussion section. As Resident 8 alludes to below, rapport building between the care staff and residents can have a considerable positive effect on residents' sense of connection; however, several participants in this study described impersonal staff interactions:

> Respondent: I think that there's something missing – something's missing… even "good morning. Good morning, how are you?" Don't just come in there, shut the door and start…

> Interviewer: Do you mean you'd like, when the staff come in, for them to have a bit of a relationship with you?
> Respondent: Yes, yes! They're just doing robots, doing robots. And we're good – you know, like, that's okay, but when they come into here, to our heart.
> Interviewer: Yeah, you're pointing at your chest. When they come inside the room, you're showing me that they also come in here, and you're pointing into your heart.
> Respondent: Yes.
> Interviewer: Okay, and you want some more of a connection like that?
> Respondent: Yes, yes (Resident 8).

While pleasantries and greetings may sound trivial to some, communication with care staff forms a significant portion of residents' social world and daily social interactions. The person-centred care movement recognizes this and works to support staff to deliver care humanely and compassionately (Calisi et al., 2016). As Resident 8 describes above, 'robotic' care delivery fails to embrace these interactions as opportunities for meaningful connection. While overworked staff are prioritizing healthcare outcomes, residents can be left feeling disregarded. This is both a unique and important intersection of care delivery and residential living with important implications that will be further explored in later sections. Encouraging staff to take time for rapport building, as is stressed in person-centred care (Armstrong & Daly, 2004; Caspar et al., 2020), could highlight the home component of residential living. Similarly, Resident 3 said that he often felt as though he "just live[s] there" and that "they operate your body for you" when receiving task-based care.

> It's like wow, you know, living here … I mean… you just live here. You're just here and they – if the little cog on the wheel gets mixed up and someone else is going to have to wait and so we kind of can't have that. We got to keep on time… And you know, that's the part that's so hard – I mean [to] have a relationship because you got to keep with what [staff] are doing because they run your life in a sense. Like not telling you what to do or whatever but, you know, they operate your body for you and I'm constantly at odds…You got to always follow the rules. Like some army or something, prison (Resident 3).

Resident 3 provides a rich analogy regarding the tensions that come with living in residential care, notably, requiring support from staff while balancing his romantic relationship. The quote above echoes other residents' stark language comparing residential care with machinery – robotic staff,

cogs in wheels, assembly line living – alluding to a lack of bodily agency. This care delivery structure, and subsequent felt disempowerment create substantial barriers to connection and are revisited in the discussion section following my findings.

The same resident described the difficulties of having a rigid care schedule and strict visiting hours and how those impacted his ability to engage in meaningful connections with romantic partners:

> I mean it worked for the most part, but she felt kind of nervous, shy kind of. Like if we decided to be – get a little romantic, you know, because the door doesn't lock. So of course, you just come up with ways, and we did but she still would feel kind of like she's on the clock. They want [her] out of here by 11:00. Your times to be romantic are kind of cut into quarters and if they maybe had more – I don't know, [flexibility] around like times of, you know, bedtimes and stuff like that… Like it's so crazy this assembly line style living that I often feel like I'm kind of – I can't keep up with…a regular life. I just can't do it and it's hard to get somebody who is involved in regular life to be able to, you know, accept all the things that I put up with (Resident 3).

Resident 3 highlights the challenges with maintaining romantic relationships in a care home environment that is not designed to support these forms of connection.

When considering asking for privacy with a potential romantic partner, Resident 8 shared that they could envision asking some staff members for privacy, but not others. This discrepancy is highlighted further when considering "you don't get to choose" your care workers.

> Interviewer 2: So what if you did find someone who you were interested in having some private and intimate time with, do you think you could let the staff know about that now, now that there has been that time?
> Respondent: You know something, if one staff here, one staff there and one staff there, they weren't buying, but you don't always get your staff. You don't get to choose (Resident 8).

The inconsistency of care worker support for this form of connection reflects and extends the previous passages as it implies that some staff are more flexible or approachable than others. While it is expected in a continuing care home to have different staff working with different

residents on a rotating basis, having different expectations or anticipating different levels of support from staff highlights the need for both collaboration among staff and organizational policies to ensure consistency across care delivery and opportunities for residents to engage in meaningful connections. Structural factors such as insufficient rapport, and inflexible practices for care delivery and visiting hours, were most implicated in challenges to a felt sense of connection among continuing care residents.

***Finding chosen family: forming deep bonds in continuing care homes***

Despite the aforementioned barriers to connection identified in this dataset, residents also described rich connections they formed with others within the continuing care context. For instance, two neighbouring residents forged a sibling-like relationship after meeting in their residential care home:

> I said, "But we get on. We're very close." I said, "She's my big sister. I've never had an older sibling at all. She's never had a younger one." Then she [nurse] said, "But you're in long-term care." I said, "Honey, we are a long-term care, yes. But we became a family in long-term care." I said, "We're not blood related, no. But that doesn't mean you can't be extremely close and be related." I said, "I have a family here. We do have a family here" (Resident 2).

This quote – and the familial language therein – demonstrates the depth of connection that is possible in a continuing care home. While Resident 2 alluded to certain staff being dismissive and unsupportive of the connection, it is possible that the continuing care home structure offered the frequency of contact and opportunity necessary to foster such an intimate bond. The two residents met in their residential care home, suggesting that deep connection is indeed possible in such an environment. Similarly, two other study participants (Residents 9 & 10) met and married while living in their care home. Despite requiring a fair amount of physical assistance with the activities of daily living (and to facilitate their intimate life), they indicated that their relationship provided them with important emotional support and physical intimacy. In their case, care staff were

particularly supportive of the relationship and made concerted efforts to facilitate their intimate connections.

Another resident described a close bond she was able to form with one of the staff members through her time in continuing care and also described it as a sibling-like bond:

> I'm pretty close with [staff member] too, like she – I've known her since she was at the [care home], so she's kind of like a sister to me… and we try to see each other like a couple times a week just for a visit and stuff (Resident 11).

While residents expressed different manifestations of connection (e.g., sibling-like relationships or marriages) the forging of familial-like bonds in continuing care was mentioned several times in the dataset. Such patterns demonstrate that close connections with others are desired and sought out in continuing care settings. Recognizing and embracing this desire for diverse forms of connection (platonic, intimate, physical, etc.), provide rich insight into the experiences of residents living in continuing care homes. Facilitating and supporting connections between residents in this way could lead to creative ways of addressing feelings of isolation or loneliness. For example, physical touch, such as holding hands, can elicit warm feelings and deep bonds for both parties:

> Respondent: I hold hands quite a bit with [her] because she really needs it.
> Interviewer: What do you think she needs it for? What does it give her?
> Respondent: Well, she's got so much against her, and her health is not good and her husband comes in, [but] she needs somebody to be like that. And her daughter knows that I do it. And her daughter is quite happy about it. Yeah.
> Interviewer: How do you think that nourishes [her]? Like you say that she's got so much going on for her, how do you think it nourishes her? How do you know it helps?
> Respondent: Well, she brightens up. She just like, she turns a different colour (Resident 4).

These positive expressions of care and connecting with others demonstrate the benefits of frequent contact and association that can come with living in a residential care setting. Participants described forging deep, family-like bonds with fellow residents, and in some cases, staff members. Barriers to connection can largely be attributed to how care delivery is structured in continuing

care. An overreliance on care outcomes and prioritizing efficiency at the expense of rapport building led to residents expressing friction when it comes to connecting with others. This was evidenced by frustration from residents about how they received care, both in terms of how they are expected to participate in that care and how they are approached by staff. Despite the barriers to intimacy and connection that are identified in the previous section, meaningful connections can and do emerge for care home residents and it is worthwhile to ensure that those connections are supported. Connection was most readily facilitated when residents were keenly attuned to their need for connection to others and to the needs of others, and when they expressed active involvement and engagement in seeking out and fostering those relationships, and when such relationships were supported (or at the very least not discouraged) by staff.

**Theme 3. Seeking connection to body through sexual expression.**

Several participants described how life in continuing care caused disruption in their felt sense of connection to their bodies. At the same time, other residents described how they were able to reclaim a sense of bodily pleasure while living in continuing care and detailed creative ways to connect with their bodies through sexual expression. There was a noticeable difference between residents with more independent mobility compared to those who required additional support from care staff. Residents who required more physical support from care staff expressed greater disconnection from their bodies and less bodily autonomy.

***Bodily experiences of connection are impeded by routinized care delivery***

When a resident moves into a continuing care home, they receive intimate bodily care from a variety of staff members, and their bodies are often treated primarily as sites of medical care. This can have implications for their comfort with(in) their body, with being touched, or with the notion that their bodies might still be sites for joy and pleasure. This had strong implications for a

felt sense of bodily connection. As Resident 2 explains further, there is a noticeable difference between felt sense of touch for connection and for medical purposes:

> It's very important. We thrive on touch. We crave the human touch. But especially if you have dementia, people need – most people believe you don't need to touch. That is when you need touch so much. … [A nurse's aide] came into the room one evening and I was crying. And he said, "What's wrong?" And I said, "I miss being touched." "You get touched all the time." I said, "Yes, to be washed, to be bathed. Never just to be touched" (Resident 2).

Medicalized touch, that is touch for the purposes of medical or intimate bodily care tasks, is further implicated in a felt sense of connection, and residents' bodies can become compartmentalized (e.g., into "care parts") and de-sexualized.

Another instance of routinized care that affected participants' experiences of bodily connection was the limited privacy that they were afforded. Resident 6 mentioned how the routine nature of intimate or bodily care tasks for staff came at the detriment of her previously held standards for modesty:

> Things like even talking about bowel movements, to me that's a personal thing. They'll be talking, "Oh, here you need a laxative, you're constipated." Things like that in the middle of the dining room. It's just there isn't the modesty and privacy that you're used to. If you have company over, you wouldn't be talking about that type thing…like, when they're giving you a shower, you'll be sitting there and lying there naked, and they'll be opening your room door to the hallway. It's not just people that work here that walk by – all the other people like family members, other people, people bringing supplies and things, that type of thing (Resident 6).

Private hygiene tasks, such as bathing or toileting, become hyper-normalized care tasks for staff in continuing care, resulting in disregarding modesty and privacy for the residents on the receiving end of care. These disruptions can affect the perceived dignitity of the residents. In order to adapt to these conditions, Resident 6 had to grapple with the vulnerability and discomfort involved with having others provide her intimate bodily care in a hurried, congregate long-term care setting:

> You have to accept that intimacy right away with whoever walks in your room door, and it's a stranger and they're going to be undressing you and changing you, and feeding you

> and everything, it's a little different than just sitting there, "Okay, I'm going to meet you and we'll have coffee and talk a bit and then we'll decided where we're going to go" (Resident 6).

Although the type of touch Resident 6 is describing above is not sexual in nature, she is expressing desire for an introduction or 'warm up' that would prepare the body and mind to transition into intimate contact. Most often, the vulnerability and exposure of being naked around others is restricted to romantic or sexual encounters, where some type of foreplay is normalized and expected prior to intimate touch. While the touch of a paid care provider is certainly not sexual, Resident 6 has highlighted that the absence of such an introduction can be incongruent with one's expectations and experiences of physical intimacy and vulnerability. This can lead to residents feeling the need to acquiesce to intimate bodily care without proper transition or privacy merely due to their need for assistance with activities of daily living, such as bathing.

Privacy was available to residents; however, many residents expressed that it often needed to be requested, "if I want some privacy, I tell them to shut the door and leave the door shut" (Resident 4). Other residents discussed requesting privacy and changes to care routines so they could have uninterrupted time with their partners:

> 'You just got to tell us, so we'll stay the heck out of there. There'll be no interruptions' and stuff. So, I guess it's kind of up to me to be telling them that I would be having a friend over… And you know, they try their best to not screw up your evening for you. But as long as we're following their rules … So, [partner] is coming over tonight and then they – you know. But I get put into bed around 8:30-9pm (Resident 3).

As Resident 3 detailed above, the onus is on him to ask staff for privacy. While he expressed that staff are willing to be flexible when it comes to care delivery while his partner is visiting, there is an expectation of abiding by strict parameters such as the visit ending before he is assisted into bed, which occurs before 9pm nightly. The quote above demonstrates an acquired flexibility – for example, if he made a request for privacy, there is an expectation of strict adherence to visiting hours, which end at 11pm nightly. Similarly, there was little to no ability for the care home to

facilitate him hosting his partner overnight. This rigidity and contrast to a living in a "normal environment" impacted his bodily experience of connection in the way he is accustomed. Rather than being able to relax and enjoy himself, he often felt rushed, leading to restrictions on when and how long he can experience physical closeness, indicating "you can be close for a very limited amount of time" in continuing care (Resident 3). Structural barriers such as highly routinized care delivery affected how participants experienced a felt sense of connection to their body. Routinized care, in these examples, led to intermittent recognition of residents' right to privacy and bodily autonomy, ultimately contributing to medicalization and desexualization of residents' bodies. Consequently, residents were left to navigate any tension resulting from feeling dissociated from their bodies. Simultaneously, residents were left to consider the extent they were able to advocate for their own need for privacy.

***Residents seeking out opportunities for bodily pleasure***

Despite the challenges posed by the continuing care environment, some participants found innovative ways to (re)connect with their bodies and engage in bodily pleasure. Three participants in this study separately expressed the importance of reading erotic novels or using a "personal toy" to experience pleasure. Resident 11 found a way to reclaim an embodied or felt sense of pleasure in her body through regular masturbation:

> …I also have a personal toy that I like to use at night and sometimes the staff kind of embarrass me because they say they don't understand why I have to use it and stuff. …I don't have a boyfriend or a husband anymore (Resident 11).

Resident 11 regularly engaged in bodily pleasure despite the judgements imposed by some staff members – which could have become a barrier. Notably, this resident relied upon the care staff to help access her toy. Specifically, she required their assistance with retrieving the toy from her nightstand and when one vibrator broke, a recreation therapist assisted her with ordering a new

one. Resident 11's story is thus one that highlights a commitment to feeling good in one's body despite more limited autonomy and a somewhat unsupportive environment. For another resident, erotic novels became an accessible way for her to experience bodily connection and intimacy.

> I'll read a good book for a good tingle, you know, like, a good romance novel... If you want love, get it from a book. It's a lot safer and you get a new guy every time, and you're not breaking your heart or anyone else's... I get the glow, the warm, fuzzy glow of love and intimacy through my books that I read (Resident 12).

The glow and tingle from her books allowed Resident 12 to access a warm sense of connection accessible to her from within her care home. Resident 1 was similarly creative, as he used products available to him in the care home to create an artificial vagina for the purpose of self-pleasure:

> What I did realize is with the two bandages that I've been using in lieu of the compression stockings that I had… I was looking at them and thinking, 'oh well, what might be interesting and easier to keep clean is using a tube bandage because of the elasticity and taking a condom and using it as the inside so that sperm can be kept confined and then just discarded instead of using say a fleshlight that has to be cleaned afterwards. But using a condom as kind of the inner skin and with suitable lubricant and all that sort of stuff, making an artificial vagina for myself. So, I've got all the bits now and I just have to do the experiment (Resident 1).

Notably, Resident 1 could seek out bodily pleasure in this way without the involvement of care staff. This contrasts with the experience of Resident 12 above, who required assistance from staff to access this form of sexual expression. The variation in residents' ability to engage in activities of bodily pleasure had ramifications for the experience of pleasure itself. For Resident 11, who needed staff to retrieve and clean her personal toy for each use, the involvement of staff added friction to her pursuit of bodily pleasure. In contrast, Resident 1 had the ability to create and maintain these tools independent from care staff. The distinction between experiences of bodily pleasure highlights that opportunities for bodily pleasure are not equally distributed.

While person-centred care can address some nuance in access, as evidenced by Resident 11 enlisting the help of staff retrieving her toy, meso level interventions could more effectively

target unequal opportunities for bodily pleasure among residents. For example, greater support and encouragement in continuing care homes could further normalize residents accessing and experiencing bodily pleasure in meaningful ways. Residents are disproportionately left to create their own opportunities for embodied connection. Incorporating facilitating opportunities for residents to experience bodily pleasure, into the purview of continuing care homes would make such endeavors more widely available to residents.

As will be discussed further in the following section, these findings offer important insights on what is and what is not working well for fostering connections in continuing care. By centring the direct experiences of residents, these findings add to our collective understanding of the barriers to and opportunities for connection among continuing care residents across Alberta.

## Discussion

### *Synthesis of findings*

Continuing care homes are often perceived as lonely or isolating places (Flanagan et al., 2023). Through the culture change movement and recreation therapy activities, care staff have worked towards making these homes more home-like and improving resident quality of life. These efforts are particularly important given the growing international loneliness epidemic (U.S. Surgeon General, 2023; World Health Organization, 2025) and the heightened risks posed for older adults (ESDC, 2024). My findings suggest that although there are barriers to connection in Alberta's care homes due to the structure and delivery of care, residents sought out and found opportunities to engage in ongoing and evolving connection to their truer selves, to their bodies, and to others in the care home. These connections have yielded meaningful outcomes such as living more authentically and openly, discarding prejudices of their youth, showing up confidently in the world, feeling good in their bodies, and forging familial-like connections in their new home.

While these residents have unique individual experiences, together they demonstrate diversity and expansiveness in how we can conceptualize connection. To my knowledge, no study has aimed to broadly conceptualize how connection is felt and experienced among residents of continuing care homes in Alberta. Through this thesis, I outline how connection is described and experienced through connection with one's past self or identity, one's body, and other people. My findings provide a unique lens for exploring connection. As previously described, sexual expression is an underexplored means for promoting or facilitating connection in this population. However, there has been a growing body of knowledge on feelings of embodiment among older adults in continuing care (Kontos & Martin, 2013; Grigorovich & Kontos, 2018). Notably, how one expresses themselves through the clothes they wear is an established framework for embodiment among those with dementia (Kontos & Martin, 2013; Twigg, 2010). This aligns with of my findings, particularly ***appreciation of individuality*****,** where I noted the importance of personal expression through clothing, makeup, and accessories in one's felt sense of connection to self. Similarly, my findings outlined in **Theme 3: Seeking connection to body through sexual expression,** by emphasizing the residents' perspective of navigating "oppressive organizational practices" (Grigorovich & Kontos, 2018), while offering creative, relational, and embodied ways of accessing bodily pleasure through sexual expression.

Although these studies were conducted in continuing care residents living with dementia, my findings add to the extant literature that there are additional implications for care home residents that retain cognitive capacity. In the following subsections, I present the context of these findings and discuss the barriers and facilitators of connection in this setting.

*Systemic and structural context*

My findings regarding the barriers to connection largely reflect meso level health system constraints and macro level structural issues. That is, how care is delivered by staff (meso), and the broader organizational structure of continuing care in Alberta (macro). As such, it is important to contextualize the settings in which continuing care is provided and in which connection can flourish or is stifled. When considering continuing care homes, it is understood that care work is a relationship between the recipient and care provider and the "conditions of work are the conditions of care" (Armstrong & Braedley, 2023). These conditions will be examined in further detail below. For my study, the sampled continuing care homes were all publicly funded by Alberta Health Services, the provincial healthcare services delivery organization (Brassolotto et al., 2020b; Alberta Health Services, 2024a). This is notable, as continuing care, and public health more broadly in Alberta, has been at the receiving end of significant staffing shortages and budget cuts for decades (Graff-McRae, 2021). Additionally, Alberta Health Services faced significant organizational restructuring after this data was collected (Alberta Health Services, 2024b). These changes and the implications will be discussed further in Chapter 3.

Much of the Canadian critical care work scholarship speaks to the increasing commodification of care via the New Public Management approach introduced in the 1980s-1990s (Glor, 2001). This approach was designed to restructure public services and apply private sector practices to increase efficiency and minimize costs (Glor, 2001). While originally developed to improve efficiency in auto manufacturing, the approach was increasingly applied to the health sector. The New Public Management approach is modelled on Fordism (Lanoix, 2011). Fordism, with its assembly lines, mass production, and extreme task specialization, significantly increased output but deepened worker alienation by making jobs monotonous, repetitive, and disconnected

from the final product, treating workers like machine parts, removing control, and leading to dissatisfaction, though higher wages temporarily offset discontent by enabling mass consumption, creating a complex relationship where efficiency clashed with human fulfilment (Watson, 2019).

The echoes of this approach are evident in my findings when we hear about care workers moving through their schedules as line items to complete, rather than relational care that prioritizes connection. This was apparent when participants used language related to "assembly line style living," "care parts," and "robotic in their delivery." This is significant, as in continuing care settings, the conditions of work are also the living conditions for the residents (Armstrong & Braedley, 2023). The New Public Management approach is in direct conflict with the relational ethos of person-centred care. Personal care delivery, that is, providing support for activities of daily living, requires physical skills for repositioning patients, dressing, and bathing work, as well as emotional skills and labour. While providing safe and sufficient care is a priority, personal care is when staff would be most attuned to residents and could in theory use such moments as opportunities for richer social connection, such as during bathing or meal support (Lanoix, 2011).

The gap between how care is delivered and the standards for care have been referred to as a '90-second minute', in which care workers have far more to accomplish than the allotted time allows (Armstrong & Armstrong, 2002, as cited in Bourgeault, 2010). This discrepancy of task-based care leads to an assembly line approach in which only the most basic needs are met. As noted in my findings, residents are not always afforded the privacy to which they were previously acustomed. My findings extend the existing scholarship by providing new insight into how task-based care impedes connection between residents and staff, and between residents. As detailed in my subtheme, *"they operate your body for you and I'm constantly at odds": practices impeding*

*connection*, it is task-based care that is the most poignant barrier for connection. An overreliance on task-based care led to constraints on considering holistic needs of the residents.

Previous scholarship from the perspectives of care staff have echoed such sentiments with much dissatisfaction (Banerjee et al., 2015.) That is, care staff would also like more time to provide meaningful relational care and are constrained by the conditions in which they work. The findings from my study further extend this conversation by adding the resident perspective and experience. For instance, rather than a bath becoming a rapport-building and interactive relational experience between resident and staff, it becomes a hurried and standardized utilitarian checkmark (Armstrong, Choiniere et al., 2023). This is also seen with such regimented schedules and systems around visiting hours, recreational activities, and more. Something such as personal grooming, or hair styling, might seem frivolous to a care staff member who has limited time to get a resident dressed in the morning. In contrast my findings suggest that for residents, maintaining one's physical appearance can meaningfully improve feelings of authenticity and self-confidence. Further, my findings provide examples of care staff who delivered exemplary work as evidenced by the development of familial-like relationships between care staff and residents and other examples of meaningful connections, suggesting that positive change is possible. While the perspective of staff and administrators were not included in this analysis, there is evidence that staff too are negatively impacted by regimented care delivery.

Similarly, fixed schedules for care tasks are helpful for scheduling and consistency across care teams but can pose challenges for residents who have significant others visiting and face interruptions or cut their visits short. My analysis confirmed this as one resident noted that if one "cog on the wheel" is off in the schedule, the rest of the day can easily fall apart (Resident 3). My findings, notably *seeking connection to body through sexual expression*, expands on the current

understanding of Fordist care delivery practices by presenting firsthand experiences – for example, prioritizing efficiency over privacy for hygiene tasks. For care homes, modelling care delivery on Fordism results in residents becoming the product. The realized costs of such practices are faced by both workers and residents in continuing care. Since connection requires time and rapport-building, it is seen as a nuisance that threatens efficiency – a hallmark symbol of a successful assembly-line.

The existing literature makes clear that care homes are regularly under-staffed, and the staff are over-worked (Armstrong & Daly, 2004; Braedley et al., 2018). The focus of their work has shifted to task-based checklists and robust documentation. Care staff often do not have the time or capacity to support the kind of relational, person-centred care that would vastly improve resident quality of life, which commonly results in moral distress and burnout (Braedley et al., 2018). Their working conditions establish the context for residents' opportunities for connection.

*Resisting New Public Management: The Culture Change Movement's potential to better facilitate connection*

There have been calls for continuing care reform to address much of these concerns, specifically through the culture change movement. However, as with any organizational change, some continuing care homes are more adept at implementing new practices than others and have varying degrees of access to resources, including staffing. For example, care homes that more prominently adopted a person-centred care approach had supportive, empowering leadership (Caspar et al., 2020). These changes require creating and fostering a collaborative team environment between the care staff. This would also require additional time and funding for a more comprehensive focus on rapport-building and charting. As much of the skills are learned on the job, and there is rarely one right way to perform care tasks, teamwork and collaboration between

workers is a necessity (Armstrong, 2001; Caspar et al., 2020). However, when efficiency, speed, and measurable productivity are most highly regarded, tenuous interpersonal dynamics between care workers can create friction for implementing individualized care (Caspar et al., 2020). In turn, this impacts the residents' experience of connection as the built and social environments of continuing care homes can inadvertently create barriers to connection through a Fordist care delivery model.

My findings suggest that the lack of rapport and holistic care alongside the emotional labour required to provide care in such settings interferes with the residents' self-perception and bodily agency, and it impedes their opportunities for deeper connection with others. As described in my findings above, there are opportunities and examples of residents deepening or furthering their sense of connection to themselves despite the predominant care delivery approach and individual caregiver's values, beliefs, and biases associated with ageism and sexuality. As Fordism aims to separate the worker from the final product, reports of robotic care delivery are perhaps unsurprising. Due to the organizational and financial constraints, care workers would need to perform unpaid labour to meet their own standards of care (Aronson & Neysmith, 1996, as cited in Lanoix, 2011). In this way, care staff are unable to meet their own standards, and residents are left with unmet care needs.

Within the culture change movement, there have been calls to create a more homelike environment for residents in continuing care, particularly by leveraging the unique skills and expertise of therapeutic recreation professionals (Chapman et al., 2024; Caspar et al., 2024). Recreation therapists, who are allied health professionals that promote functional health and wellbeing outcomes through leisure (Daly & Kunstler, 2019 as cited in Caspar et al., 2024). However, therapeutic recreation professionals face a similar burden of austerity and criticism due

to their lack of quantifiable health outcomes (Caspar et al., 2024). However, one study found that care homes that valued therapeutic recreation professionals, saw leisure as valuable for health outcomes among residents, and had supportive management demonstrated stronger evidence towards positively changing the culture in their continuing care home (Caspar et al., 2024). Although therapeutic recreation was only discussed tangentially in my dataset, therapeutic recreation professionals could be an underutilized resource for enabling and fostering connection, given the diversity in experiences and the requisite adaptability needed to implement findings from my study. This recommendation is explored further in Chapter 3.

*Implications for scholarship on resident intimacy and connection*

Despite challenges with the continuing care sector, the loneliness epidemic, and the political and economic structures involved, participants in my study described meaningful experiences and perceptions of connection to one's past self or identity, one's body, and other people. Interestingly, these expressions and perceptions of connection all surfaced in their discussions about sexual expression. This expanded view of sexual expression refined and extended previous scholarship on connection by broadening previous models of related concepts in continuing care homes. For example, my findings further support personal grooming, a form of sexual expression (Schubert & Pope, 2020), as a facilitator for experiencing connection in continuing care residents. A recent meta-analysis on sexual expression in older adults has noted that long-term care staff infrequently recognize personal grooming as a form of sexual expression (Ho & Goh, 2022). Embracing sexual expression, through personal grooming, as a facilitator to experiencing connection adds relevance and depth to support ongoing implementation of person-centred care in continuing care homes (Armstrong & Daly, 2004; Caspar, et al., 2020).

Further, my findings add the direct perspective of continuing care residents, such as in **Theme 2: Despite challenges associated with living in residential care, participants maintained and strengthened their connections with others,** to the extant literature regarding the culture change movement. While the experiences themselves represent micro level implications, this finding adds richness and depth to the significance and need for culture change in continuing care. As shown in my study, residents' experience of connection was heavily impeded by the structural barriers the culture change movement seeks to address, namely increased time for rapport and connecting building between staff and residents (Caspar et al., 2020).

Intimacy, a related concept to connection, has been conceptualized as an interpersonal process including emotional, physical, intellectual, and spiritual forms of intimacy (Fitzroy et al, 2022). Although Fitzroy et al., (2022) focused on the typology and conceptualization of intimacy in continuing care residents, there was congruence and expansion when our findings are considered in parallel. In both studies, residents noted a difference between touch to demonstrate emotional care and purposive touch to address medical or personal care needs (Fitzroy et al., 2022). Similarly, residents in both studies sought physical non-sexual touch from fellow residents as a form of intimacy (Fitzroy et al., 2022), or as in reflected in my findings above, a felt experience of connection.

My findings offer unique insight into the experience and perception of connection among residents of continuing care homes in Alberta. I found that sexual expression, an emerging area of interest in this population, additionally led to diverse experiences and perceptions of connection among continuing care residents. Continuing care residents experienced rich connection to themselves, their bodies, and to others. Further, my findings add nuance to the barriers to and faciliators of connection in a continuing care home setting.

## Limitations

This was a secondary analysis of a dataset that was focused explicitly on experiences and perceptions of sexual expression among continuing care residents. This original focus (and the questions included in the semi-structured interview guide) shaped and informed the types of stories and information shared by participants. While there was enough discussion of broader concepts of connection and intimacy to develop rich, meaningful themes, as evidenced by my findings, there are other potential forms of and avenues for connection that were not captured in this study. As such, there is room for further scholarship to investigate these experiences more directly. Additionally, since I did not conduct the interviews myself, I did not have the ability to ask probing or follow-up questions. This is a natural limitation of secondary data analysis. Another limitation is that since data were collected for this study in 2018-2019, continuing care homes have since faced significant shifts due to both the COVID-19 pandemic and organizational restructuring for Alberta Health Services (Alberta Health Services, 2024b). As a result, my findings reflect a snapshot in time that may be somewhat different than the present moment. The impacts of the restructuring of Alberta Health Services will be discussed further in Chapter 3. While the COVID-19 pandemic led to many changes in care delivery (and increased isolation of continuing care residents), these findings may provide a baseline comparison for future studies.

## Conclusion

These findings contribute to the ongoing scholarship regarding continuing care in Alberta by joining together critical care work scholarship, sexual expression, and resident connection. My project adds depth and richness from the often underrepresented resident perspective. Much of my findings align with and expand upon findings in the existing literature, suggesting that connection may be experienced in more expansive ways than has been previously established. Further, my

findings emphasize the impact of machinic care provision on the well-being of continuing care workers described by Banerjee et al. (2015) and add the residents' experience of such care. Continuing care homes exist at a unique intersection of scholarship and expertise that brings together many insights and experiences. Future research in this area should continue to amplify the voices of the residents, while considering overarching structures that influence how care is provisioned.

In the following chapter, I will discuss broader implications of my findings, recommendations that could foster opportunities for connection among continuing care residents, and close with a reflection on my journey as a researcher during my thesis project.

# CHAPTER 3: IMPLICATIONS, RECOMMENDATIONS, AND REFLECTIONS

## Introduction

While care delivery, staffing, and organizational structures all influence how connection is experienced and perceived, so does the larger health care delivery system in publicly funded care homes. In May 2024, the Alberta provincial government announced significant changes to both the Ministry of Health and Alberta Health Services, the centralized organization tasked with healthcare delivery in Alberta (Alberta Health Services, 2024b). This led to programs and services previously under the purview of the health ministry to be divided into the Ministry of Primary and Preventative Health Services and the Ministry of Hospital and Surgical Services. Meanwhile, Alberta Health Services reorganized into Acute Care Alberta, Recovery Alberta, Primary Care Alberta, and Assisted Living and Social Services (Alberta Health Services, 2024b). This is not the first time the primary healthcare services delivery organization has faced significant organizational overhaul.

Alberta Health Services was established as the central organizing healthcare services delivery organization in 2009. At the time, it brought together nine regional health authorities and three government agencies (Veitch, 2018). A decade after its launch as a central health care delivery system, Alberta Health Services was flourishing in both patient outcomes and health economics. Notably, though, increasing capacity for continuing care in the province was of concern (Veitch, 2018). Much of the successes for acute outcomes were a product of reducing overhead and executive leadership burden, while creating an organizational culture that focused on continuing improvements in patient care and supported staff of all levels and backgrounds (Veitch, 2018). Alberta Health Services was, in fact, a global leader in healthcare system delivery (Veitch, 2018). For this expanded discussion, I will focus on the implications of the reorganization of Alberta Health Services as it relates to my thesis findings. It is important to consider the current context

and structure of healthcare delivery in Alberta, as data for this study was collected under a previous model. Addressing the current healthcare services organizational model allows for more integration for application and within related scholarship. I then shift my focus to situating my findings more broadly within public health. I close this chapter with recommendations, reflections on my thesis process, and closing insights.

**Broader implications of findings**

As noted earlier, social connection is a determinant of health and a basic need (PHAC, 2018). Social connection has been shown to be preventative against feelings of loneliness (Holt-Lunstad, 2021). Although continuing care homes are often stereotyped as isolating, my findings demonstrate many rich forms of connection in these settings. Interestingly, connection was also felt and experienced through sexual expression, which is an under-supported aspect of resident life even though it is rife with potential for supporting diverse forms of connection. Many jurisdictions, including Canada, United States, United Kingdom, Australia, and New Zealand, have funded public health campaigns to increase awareness of the risks of social isolation, and to subsequently encourage connectedness among their citizens (National Seniors Council, 2025). This an important first step as awareness is required for social change and intervention. While loneliness is a public health issue with many implications, such as increased healthcare utilization and depression (Holt-Lunstad et al., 2017; Perissinotto et al., 2012), public health awareness campaigns need to do more to encourage and embrace social change to address the loneliness epidemic.

My findings add conceptual insights to our current understanding of what connection can look like in the continuing care context by identifying key barriers and facilitators to connection across three levels: to oneself, one's body, and to others. By being attentive to a broader conceptualization of connection than simply social interaction, there is increased room for intervention. Additionally,

adopting a broader view of connection allows for more diverse avenues for meeting establishing and fostering connection. Similarly, a shift among wider societal perspectives of aging, decline, and residential care homes would be impactful. Along a conceptual understanding of connection, actionable insights foreground in the experiences and perceptions of connection can lead to change.

Below, I outline my recommendations for how to foster connection in continuing care homes based on my findings. For publicly funded care homes such as those in this study, there are practices that can be implemented by the care homes as well as through provincial government funding and overarching healthcare delivery organizations.

**Recommendations**

Building from the residents' experiences and perceptions of connection in my thesis, I have three recommendations.

1. Leverage public health approaches to promote sexual expression as a fundamental aspect of life for continuing care residents

While public health often approaches sexual health through risk reduction, such as preventing STBBIs, there is an opportunity for public health as a practice to be more involved in supporting culture change in continuing care homes. This could be taken up by programs and policymakers to increase awareness regarding the importance of broad experiences of connection within continuing care homes. Public health as a discipline represents diverse skill sets that combine skills in health promotion, program planning, evaluation, and advocacy (National Collaborating Centres for Public Health [NCCPH], 2025). These can be applied to affect positive changes in continuing care homes, particularly when it comes to sexual expression. The extant literature has called for developing and promoting sexual health guidelines for continuing care homes in Alberta for the

benefit of staff, residents, and family members (Brassolotto, 2025). My findings demonstrate that supporting sexual expression in this population can have additional health promoting benefits, such as fostering opportunities for connection. Extant scholarship has supported recognizing sexual expression as part of residents' holistic needs (Brassolotto et al., 2020a; Brassolotto et al., 2020b; Schubert & Pope, 2020) and incorporating facilitating meeting such needs into the purview of continuing care (Brassolotto, 2025). For example, increased enrolment in a freely available online course that outlines sexual expression in continuing care (Sexual Expression in Care, n.d.). Increased staff support for sexual expression among continuing care residents inadvertently supports person-centred care. One accessible and meaningful way of doing this is acknowledging and embracing the importance of personal grooming, an aspect of sexual expression. Allowing care staff time and resources to support personal grooming for residents would provide meaningful opportunities for residents to experience authenticity, confidence, and connection in under-accessed, yet important, aspects of life such as sexual expression.

Along with supporting residents' need for self-presentation, changes to practices that impede residents' connection to others would result in meaningful change. For instance, greater flexibility for visiting hours, including opportunities for both planned and spontaneous overnight guests. This would allow for residents to enjoy time with partners who reside outside the care home, while allowing for greater fulfilment of sexual expression.

As continuing care homes continue to navigate decreased funding combined with organizational reform, creativity and innovation will be essential to foster connection (Graff-McRae, 2011). As mobility and independence are often limited for continuing care residents, providing diverse media and resources within the care home is of utmost importance. As discussed earlier, continuing care can become a vibrant phase of life. Allowing for this type of engagement

through embracing diversity of both residents and staff can facilitate connection in innovative ways.

2. Further embrace therapeutic recreation professionals in continuing care homes

Recreation therapists are uniquely positioned to have the skill and expertise to provide flexible and adaptable programming for continuing care residents (Caspar et al., 2024). Both the provincial government and continuing care homes themselves would be implicated in this recommendation. Further embracing therapeutic recreation professionals includes designing and implementing recreational programming that can be individualized to the care home context and for individual residents as needed. To facilitate this recommendation, the provincial government would be responsible for ensuring there is adequate funding and resources for therapeutic recreation among continuing care homes. Meanwhile, continuing care home organizations and administrators are well positioned to ensuring they employ and embrace therapeutic recreation professionals to their full potential.

For example, therapeutic recreation professionals can deliver meaningful programs that allow for residents to organically connect with others over shared interests in an interactive and engaging way. These could include board game events, book clubs, or other discussion groups. The engagement of the participants in this study highlight that there may be a willingness to engage in intellectually stimulating discussions if such activities were offered.

Additionally, their training in and attention to the therapeutic benefits of recreation and leisure make them well-positioned to be advocates for the value of sexual expression and activities that promote connection and quality of life. Increased agency and recognition as key care team members would allow therapeutic recreation professionals to apply their skillsets to implement and adapt flexible programming that best suits the unique needs of the residents at the individual

care home level. For example, establishing a library lending program that allows for a diverse media and books to be made available that allows residents to consider and/or continue to embrace their sexual expression. In such a scenario, therapeutic recreation therapists could support sexual expression, social connection, and person-centred care, further demonstrating their salient role in continuing care homes.

3. Increase provincial governmental funding for continuing care homes

While the previous two recommendations offer conceptual insights, increased funding for the continuing care sector is required to effect meaningful change. I echo the many calls for increased funding for residential and aged care (Graff-McRae, 2021; Armstrong & Daly, 2004). Increasing funding for continuing care homes would provide many benefits for fostering and facilitating connection and improving quality of life. My findings add an additional perspective on how increasing funding, particularly to support person-centred care, would be effective. Lower staff to resident ratios and increasing paid time for care work and documentation would allow for more rapport building and identification of and support for individual resident needs (Armstrong, Jacobsen et al, 2023). Additionally, prioritizing employing other allied health professionals such as recreation therapists as detailed in the previous recommendation would alleviate some stress on front-line care workers, while improving the experience and quality of life of residents. Without adequate funding, the continuing care landscape and the exceptionally skilled workforce who largely have the expertise to implement the required changes will continue to deteriorate leading to a worsening experience of continuing care in Alberta for both staff and residents.

**Reflections**

Throughout this thesis process, I aimed to draw on the experiences and knowledge I gained throughout my graduate program in Health Sciences, as well as my undergraduate training in

Sociology. My formal education in these areas heavily influence my perspectives for both my worldview and my approach to health research, notably that my perspective leans more critical and population-level focused.

I have gained many skills, experiences, and knowledge from my graduate training. As I near the end of this process, I look back at my thesis project with new perspectives. I entered my graduate program with the intention of completing a quantitative thesis project and ultimately shifted to pursue a qualitative project, which left me with a renewed appreciation for qualitative research. I found that I still often bring a quantitative orientation to my research. This was most demonstrated by my tendency to initially frame my findings as correlational or generalizable rather than exploratory. If I were to undertake a project like this quantitatively, I would be curious about how connection can be amplified. To study this, I would aim to determine characteristics of residents that reported higher levels of connection or connectedness on a validated scale. In a quantitative master's thesis, I would likely be using previously established scales and metrics in the literature at the expense of the richness and depth of qualitative findings, such as in this project. For future qualitative research aims, I would be curious about how one knows they are connected, what it feels like to be connected to self and others, and how to remedy gaps between desired and felt connection. While I was prepared for the iterative nature of qualitative research, I was surprised at how much deep work and metacognition qualitative analysis required. I am immensely grateful to have had the opportunity to hone my skills in both quantitative and qualitative research and have a renewed passion and appreciation for both research methodologies.

When I reflect on this process and thesis project, a few key takeaways stand out to me. While I entered this program with passion and excitement, I was apprehensive about my ability to complete a thesis project due to the required self-discipline, motivation, and independence. There

were many times throughout this journey that I wished I elected for a course-based master's program. However, now that I am nearing submission of my completed thesis, I am grateful for the experience and the many lessons I learned that are unique to a thesis-based program.

The most important part of any thesis project is having a good relationship with your supervisor. I am grateful for the support and direction I had from my thesis supervisor. Secondly, the importance of having clear, conceptual bounds for your thesis, or at the very least a clear direction. My thesis project and process took many turns, and I often relied on the support of my supervisor to keep me on course. Relatedly, patience, flexibility, and resiliency are important skills to develop and hone while in any graduate program or research project. I often underestimated how much time and energy each part of my thesis would take. As outlined in earlier sections, reflexive thematic analysis is iterative. I certainly found that to be true when designing and conducting a qualitative research project. If I were to start this, or a similar project from the beginning, I would focus on embracing the journey while being aware of the destination. I was often intimidated by the thesis process and moving forward, I will give myself more permission to lean into the discomfort that comes with learning, combining, and applying new skills.

**Closing insights**

Connection comes in many forms and occurs in many places. Given the significant health benefits associated with higher levels of connectedness, and the positive feelings associated with connection and embodiment, more efforts and resources should serve to highlight and affirm connection whenever possible. This thesis was an exploratory analysis of a secondary dataset among continuing care residents in Alberta. My findings provide insight into how connection is perceived and experienced, as well as barriers and facilitators of the experience of connection.

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