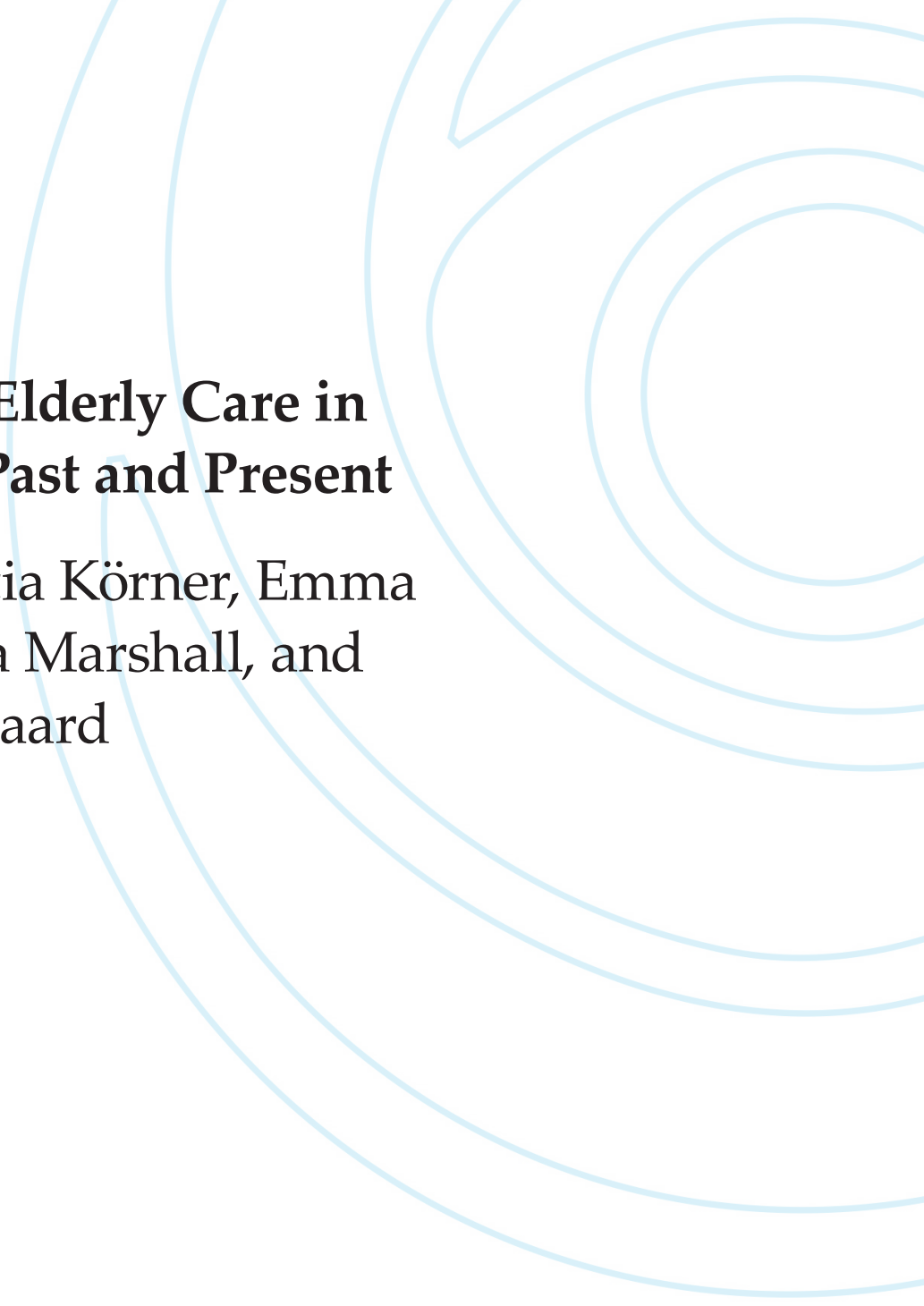




Privacy and Elderly Care in the Home – Past and Present

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Abstract

Home-based elderly care has grown markedly across Western Europe. This has happened in response to a normative emphasis on preserving the dignity, autonomy, and privacy of older individuals. While prior research has focused on care recipients, this article examines the privacy implications of homecare for cohabiting family carers who actively care for their sick relatives. Drawing on an interdisciplinary framework – combining history, sociology, and architecture – we study two contemporary Danish cases and one seventeenth-century British case. Approaching the cases through qualitative interviews, home touring, mapping, and microhistorical analysis of archival documents, we find that family carers face constraints on their privacy. A persistent sense of responsibility and vigilance towards their relatives, coupled with the routine presence of homecare professionals, requires them to continually establish boundaries in order to withdraw, create intimacy, and regulate access to the home. In contrast to early modern domestic care, which was a shared and embedded practice within larger households, today's family carers often bear the burden alone as the closest – and often sole – cohabiting relative.

Keywords

Privacy – home care – past-present – comparative case study – family carers – home – care work – boundary-drawing

Introduction

In European health policy and practice, the home – understood as a space of relaxation, autonomy, and privacy – is framed as the optimal place for elderly care and support.¹ Moreover, demographic changes, such as ageing populations and increased life expectancy, have contributed to a growing reliance on home-based care.² While familial care in the home is currently gaining renewed traction, this phenomenon builds on a long history of caregiving as a ubiquitous domestic practice in the centuries predating widespread elderly homes and hospitals for long-term, old-age care.³

Research on the experiences of cohabiting carers past and present shows that the entanglement of caregiving duties with family relationships can be emotionally burdensome.⁴ While such research explores the constraints on personal freedom and social isolation, there remains a notable gap in privacy studies relating to home care –in both contemporary and early modern cases, where the intersection between illness and privacy in the home has been neglected.⁵ Thus, by analysing the micro-strategies for constructing and negotiating experiences of privacy across three European cases, spanning early modern and contemporary contexts, we contribute new knowledge to privacy studies on the dynamics of the privacy experience. We draw on the social geographer Ted Killian's understanding that all spaces are continuously undergoing power negotiations between privacy and publicity, where privacy is the power of exclusion and publicity is the power of access.⁶ Combining methods and approaches from sociology, architecture, and social

- 1 Loa Kristine Teglgaard Christensen, "When the Institution Steps In over the Threshold", in *Forming Welfare*, ed. Jannie Rosenberg Bendsen, Mette Jerl Jensen, Katrine Lotz, Kirsten Marie Raahauge, Deane Simpson, and Kjeld Vindum (Arkitektens Forlag, 2017), 206–17; Catherine Exley and Davina Allen, "A Critical Examination of Home Care: End of Life Care as an Illustrative Case", *Social Science & Medicine* 65 (2007): 2317–27, <https://doi.org/10.1016/j.socscimed.2007.07.006>.
- 2 Ragnhild J. A. Gulestø, Gudmund Ågotnes, and Stinne Glasdam, "'Ageing in place' in Norway: A Fairclough-Inspired Discourse Analysis of a White Paper", *Health & Place* 94 (2025): 103497, <https://doi.org/10.1016/j.healthplace.2025.103497>.
- 3 Elaine Leong, *Recipes and Everyday Knowledge: Medicine, Science and the Household in Early Modern England* (University of Chicago Press, 2018), 146; Kathleen Marie Reynolds, "Sickness in Correspondence: Gentry Letter Writing and the Subject of Health in Eighteenth-Century Yorkshire, County Durham, and Northumberland" (PhD diss., Durham University, 2018), 211.
- 4 Emma Klakk et al., "Hospital in the Home: Rethinking Home, Care, and Professionalism from a Transdisciplinary Perspective", *Journal of Interdisciplinary Sciences* 10, no. 1 (2026): 1–18; Exley and Allen, "A Critical Examination of Home Care"; Elisabet Eriksson et al., "Living with a Spouse with Chronic Illness: The Challenge of Balancing Demands and Resources", *BMC Public Health* 19, no. 422 (2019), <https://doi.org/10.1186/s12889-019-6800-7>; Tessa Morgan, Aamena Bharmal, Robbie Duschinsky, and Stephen Barclay, "Experiences of Oldest-Old Caregivers Whose Partner Is Approaching End-of-Life: A Mixed-Method Systematic Review and Narrative Synthesis", *PLoS ONE* 15, no. 6 (2020): e0232401, <https://doi.org/10.1371/journal.pone.0232401>. See also Exley and Allen, "A Critical Examination of Home Care"; Stinne Glasdam, Hongxuan Xu, Ruth-Ellen Slåtsveen, Christie Stilwell, Gitte Wind, Ragnhild J. A. Gulestø, and Pier-Luc Turcotte, "Older Caregivers' Responsibilities and Strategies for Their Cohabiting Partners Living at Home: A Qualitative Systematic Literature Review", *Frontiers in Public Health* 13 (2025): 1658095, <https://doi.org/10.3389/fpubh.2025.1658095>.
- 5 Sandra Cavallo and Tessa Storey note that historians of "private life have often underestimated health concerns and the extent to which these affected internal domestic management". Sandra Cavallo and Tessa Storey, *Healthy Living in Late Renaissance Italy* (Oxford University Press, 2013), 2.
- 6 Ted Killian, "Public and Private, Power and Space", in *The Production of Public Space*, ed. Andrew Light and Jonathan M. Smith (Rowman & Littlefield, 1998), 115–34.

history, we provide social and spatial perspectives to examine how social access and exclusion are negotiated in home care situations.

Context: home care past and present

In Denmark, municipal home care is a publicly funded service provided to citizens who qualify for assistance with daily living due to age, illness, or disability.⁷ The country's 98 municipalities are responsible for organizing and delivering the care, which typically includes practical help (e.g. cleaning, laundry), personal care (e.g. bathing, dressing), and rehabilitative support (e.g. physiotherapy). Today, elderly care is predominantly home-based, with approximately 160,000 older adults receiving municipal home care services, compared to around 40,000 residing in institutional settings such as nursing homes or assisted living facilities.⁸ This home-based elderly care depends heavily on the involvement of usually cohabiting family carers, such as spouses.

Family-supported home care is not a new phenomenon. In the early modern era (ca. 1500–1800 CE), familial care at home was the norm for sick people, including the elderly and those receiving end-of-life care.⁹ The historians Helen Berry and Elizabeth Foyster argue that the early modern elderly were well integrated and respected in society, and so supported during illness.¹⁰ “Communities of care” blended the private and public, as neighbours, friends, and professional medical practitioners regularly visited the home to perform emotional and physical labour for the sick alongside inhabitants.¹¹ Through a nuanced examination of privacy during illness and home care, this article's historical discussion demonstrates that, even when elderly people had significant domestic resources (both social and material), terminal illness in old age, confinement, and the need for continuous care complicated relations both within and beyond the home. This provides a fruitful point of comparison with present-day familial care and the micro-strategies of privacy of those who provide it.

7 Individuals receiving municipal elderly care in Denmark are typically referred to as “citizens” (*borgere*) to underscore that they are not hospitalized.

8 Danmarks Statistik, “Sociale ydelser til ældre”, <https://www.dst.dk/da/Statistik/emner/sociale-forhold/social-stoette/sociale-ydelser-til-aeldre>, accessed 8 October 2025; Ældre Sagen, “Beboere på plejehjem”, <https://www.aeldresagen.dk/maerkesager-og-resultater/maerkesager/plejehjem/fakta/beboere-paa-plejehjem>, accessed 8 October 2025.

9 Alun Withey, *Physick and the Family: Health, Medicine and Care in Wales, 1600–1750* (Manchester University Press, 2011), 162. See also Emma Marshall, “The Sickbed”, in *Building Early Modern Privacy: A Combined Spatial and Social Perspective*, ed. Natalie Patricia Körner, Johannes Ljunberg, Peter Thule Kristensen, and Mette Birkedal Bruun (UCL Press, forthcoming).

10 Helen Berry and Elizabeth Foyster, “Ageing and Loneliness in England, 1500–1800”, in *The Routledge History of Loneliness*, ed. Katie Barclay, Elaine Chalus, and Deborah Simonton (Routledge, 2023), 219–20.

11 Charmian Mansell, “Reconstructing the Labour of Care in Early Modern England”, *Historical Journal* 67 (2024): 24–6, <https://doi.org/10.1017/S0018246X23000444>.

Methods

We are employing a comparative case-study approach, comparing negotiations of privacy in home care contexts horizontally (across locations) and transversally (across time) through two contemporary Danish cases and one seventeenth-century British case.¹² Inspired by Lesley Bartlett and Frances Vavrus's comparative case-study approach, we seek not only to identify similarities and differences across time and place, but also to trace the social processes underpinning privacy.¹³ By combining different disciplinary methods and approaches from architecture, sociology, and social history – namely, qualitative, semi-structured interviews, home touring, mapping, and microhistorical analysis of archival documents – we aim to provide a nuanced understanding of the different processes that shape family carers' experience of privacy when caring for their relatives at home.

Choosing the cases

The main selection criterion for the three cases was that the care recipient was cared for at home by a cohabiting family carer as well as by non-familial carers, in order to understand the privacy strategies of the family carer in response to the care-related interactions. We aimed to investigate differing housing types and locations, which can affect spatial privacy strategies and home care access. To comprehensively trace the dynamic social process of privacy, we defined as few selection criteria as possible to avoid separating cases from their contexts or reducing them to their selection parameters.¹⁴ Table 1 provides an overview of the three cases.

	Case 1: Allan and Bente, 2025¹⁵	Case 2: Sten and Kirsten, 2025	Case 3: Peg and Ralph, 1696
Care recipient	Bente (aged 88). ¹⁶ At the time of the interview, she is bedridden, not able to speak, and has received professional home care for two years.	Kirsten (aged 79). At the time of the interview, she alternates between lying in bed and sitting in a wheelchair, has limited ability to speak, and has received professional home care for a year.	Ralph (aged 82). He experienced a terminal decline across three months, becoming increasingly bedridden as his physical and cognitive condition deteriorated.

12 Lesley Bartlett and Frances Vavrus, "Comparative Case Studies: An Innovative Approach", *Nordic Journal of Comparative and International Education* 1, no. 1 (2017): 9.

13 Bartlett and Vavrus, "Comparative Case Studies".

14 Bartlett and Vavrus, "Comparative Case Studies".

15 Pseudonyms have been applied for care recipient, family carer, and home care professional in the two contemporary cases.

16 The age of the participants was not important for our study. However, with the Elderly Act (Ældreloven) from 2025, "holistic care" (*helhedspleje*) was introduced in Denmark, which is aimed at people above the retirement age of 67, who qualify for assistance due to age, illness, or disability. Holistic care aims for cohesion in care and support, and emphasizes the home as a central setting for integrated

	Case 1: Allan and Bente, 2025¹⁵	Case 2: Sten and Kirsten, 2025	Case 3: Peg and Ralph, 1696
Family carer	Allan (aged 88), retired, is Bente's cohabiting spouse and carer. He is employed by the municipality for approx. 14 hours per month and assists in two of the daily home care visits. ¹⁷	Sten (aged 82), retired, is Kirsten's cohabiting spouse and carer.	Margaret (known as 'Peg', aged 30 or 31), Ralph's niece, moved into his home to care for him during his final illness.
Additional carers	Home care staff visit four times a day, in addition to a nurse, who administers morphine three times a day. Occasional assistance from the couple's children and grandchildren.	Home care staff visit four times a day. Sten occasionally receives visits from a physiotherapist. Occasional assistance from the couple's children.	Live-in domestic servants, including a housekeeper and several maids and manservants.
Housing type	Four-room apartment on the second floor	Two-storey house	Claydon House, a large country mansion
Location	Copenhagen, capital city of Denmark	Smaller town in Western Zealand, Denmark	Buckinghamshire, ca. 95 km from London, United Kingdom
Methods and sources	Semi-structured interviews with family carer, Allan, and home care professional, Michael; home touring (spring 2025)	Semi-structured interviews with family carer, Sten, and home care professional, Marianne; home touring; mapping (spring 2025)	Microhistorical analysis of letters from the Verney family archive, written between July and September 1696 ¹⁸

Table 1: Presentation of the cases

and person-centred support. Thus, people above the retirement age are the most frequent receivers of home care, but not the only target group. See "Hjemmehjælp/helhedspleje; Bliv boende hjemme med hjælp og støtte", Viden og Rådgivning, Ældre Sagen, last modified on May 30, 2026, <https://www.aeldresagen.dk/viden-og-raadgivning/hjaelp-og-stoette/hjemmehjaelp> and "Ældrelov", Retsinformation, accessed June 4, 2026, <https://www.retsinformation.dk/eli/lta/2024/1651#P47>.

¹⁷ In Denmark, it is possible for relatives of individuals who are seriously ill or terminally ill to be employed by the municipality as caregivers. This care allowance is granted following an assessment visit by the home care service, during which it is ensured, on the one hand, that both the patient and the relative consent to the care arrangement, and, on the other, that the relative is deemed capable of performing the required duties. See, for example, "Plejeorlov til pasning af nærtstående i hjemmet", Sundhed.dk, accessed September 26, 2025, <https://www.sundhed.dk/borger/patienthaandbogen/sociale-ydelser/tilskuds-og-stoettemuligheder-efter-serviceloven-mv/plejeorlov-til-pasning-af-naertstaaende-i-hjemmet>

¹⁸ M636/49 (microfilms of the Verney Papers), British Library (hereafter BL).

In Case 1, the family carer, Allan, was recruited through one of the authors of this article as a gatekeeper, and the home care professional, Michael, was contacted via snowball sampling through Allan.¹⁹ In Case 2, the family carer, Sten, and the home care professional, Marianne, were recruited via a managing employee of the municipality. The selection criterion for the interviewed home care professionals was that they worked in the case homes, and could thus add further case-specific details about the familial carers' strategies for privacy and their own practices in the homes.

The sources of Case 3 come from the Verney family archive, whose vast collection of detailed personal letters offers an unparalleled level of insight into domestic life at Claydon House. The letters studied for this article were primarily written by Peg, Sir Ralph Verney's unmarried niece and his primary caregiver.²⁰ Peg's perspective is supplemented by correspondence written by or about others who were allowed or denied access to Ralph, including his son, sister, and servants. These sources document the micro-strategies which shaped and were shaped by spatial use, social dynamics, and privacy within the caregiving structure of the household and wider family during Ralph's final illness.

Approaching the cases

The sources of the historical and the contemporary cases differ significantly. For the contemporary cases data has to be generated, whereas in the historical case sources have to be chosen from an archive. Thus, approaching the historical case entails choosing how to read the sources. In contrast, for the contemporary cases we choose how to generate data.²¹ This section describes these different approaches.

For the early modern archival sources, we have employed a microhistorical approach, which is particularly apt for investigations of personal experiences and their relationship to broader historical processes and mentalities.²² This means that we analyse information about interactions gleaned from close reading of the personal letters detailing health and care of a single person at the end of his life, within the context of broader early modern socio-cultural attitudes, expectations, and structures.

Reading between the lines and against the grain of letters encourages thinking about what is *not* said as much as what *is* said, and the associated power dynamics at play. For example, while Peg writes primarily about Ralph's condition, we can infer her own atti-

19 Guro Korsnes Kristensen and Malin Noem Ravn, "The Voices Heard and the Voices Silenced: Recruitment Processes in Qualitative Interview Studies", *Qualitative Research* 15, no. 6 (2015): 722–37, <https://doi.org/10.1177/1468794114567496>.

20 Ralph had been a widower for forty-six years at the time of his death. However, his niece Peg moved into his home and essentially fulfilled the spousal role during his illness, and thus her experiences can reasonably be compared with those of the carers in the contemporary cases.

21 "Data generation" refers to what is often named "data collection", but acknowledges that we as researchers cannot collect preexisting data; instead, our interaction with data – shaped by our assumptions, questions, and choices – generates data: see Maria J. Mayan, "Data Collection", in *Essentials of Qualitative Inquiry* (Routledge, 2023), 153–83.

22 István M. Szijártó, "Introduction: Against Simple Truths", in *What Is Microhistory? Theory and Practice*, ed. Sigurður Gylfi Magnússon and István M. Szijártó (Routledge, 2013), 7.

vities and experiences, and those of servants, friends, and family members connected to him through cohabitation and care during illness. We will analyse the letters as figurative spaces of privacy in and of themselves. Writing about particular illness experiences to a select audience does not simply describe or represent privacy, but also actively creates it through the intimacy of sharing sensitive information. However, such letters simultaneously represent a breach of privacy for Ralph, whose condition is laid bare in detail.²³

There is no surviving floor plan of Claydon House as it was at the time of Ralph's death, and it was significantly remodelled about fifty years later. Nevertheless, we can make some informed assumptions about layout and privacy based on Peg's letters and on contextual knowledge of similar country houses of the period. For instance, Ralph's bedchamber is likely to have been a large upstairs room, with an adjoining corner room used for dressing.²⁴ The bedchamber was probably reached, either directly or via a small servant's room, by backstairs which connected the downstairs service quarters to the upper floors.²⁵

While visiting the homes of the contemporary Danish cases formed an important part of this study, what mattered the most about the spatial layout was how it affected the privacy experience of the family carer. To comprehensively understand personal experiences with attention to material and spatial aspects of privacy in the home, data about the contemporary cases were generated through semi-structured qualitative interviews, in conjunction with home touring and mapping activities with family carers.

As part of the interviews, we conducted audio-recorded home touring, where the interviewees showed us the spaces in their homes used for caregiving.²⁶ Healthcare equipment encountered during the home tour prompted conversation about where and how care was taking place.²⁷ In addition to the home touring, mapping provided spatial and behavioural information. In Case 1, a printed floor plan of Allan and Bente's home was introduced to explore where the care work took place (Figure 2). During the interview with Sten (Case 2), we asked him to draw a floor plan of his home to indicate which rooms the care professionals work in and move through, and to reflect on the spatial changes resulting from home care (Figure 3).

23 Johannes Ljungberg and Natacha Klein Käfer, "Introduction: Languages, Settings, and Networks for Early Modern Private Conversations", in *Tracing Private Conversations in Everyday Life: Talking in Everyday Life* (Palgrave Macmillan, 2024), 4, 11–12.

24 BL, M636/49, Margaret Adams to John Verney, 6 September 1696; Mark Girouard, *Life in the English Country House: A Social and Architectural History* (New Haven: Yale University Press, 1978), 206.

25 Geoffrey Beard, *The National Trust Book of the English House Interior* (Viking/Penguin, 1990), 137; Susie West, "Social Space and the English Country House", in *The Familiar Past? Archaeologies of Later Historical Britain*, ed. Sarah Tarlow and Susie West (Routledge, 1999), 119. For more on alterations made to the Claydon's structure in the 1650s, see Nicola Jane Miles, "Sir Ralph Verney in Exile: Material Consumption and the Seventeenth-Century Gentry" (PhD diss., University of Southampton, 2021), 52.

26 All interviews were audio-recorded, conducted in Danish by EK and KM, and subsequently transcribed. Quotes have been translated by the authors with attention to spoken language, including pauses and everyday phrasing.

27 Sarah Pink, Kerstin Leder Mackley, Roxana Morosanu, Val Mitchell, and Tracy Bhamra, *Making Homes: Ethnography and Design* (Bloomsbury Academic, 2017).

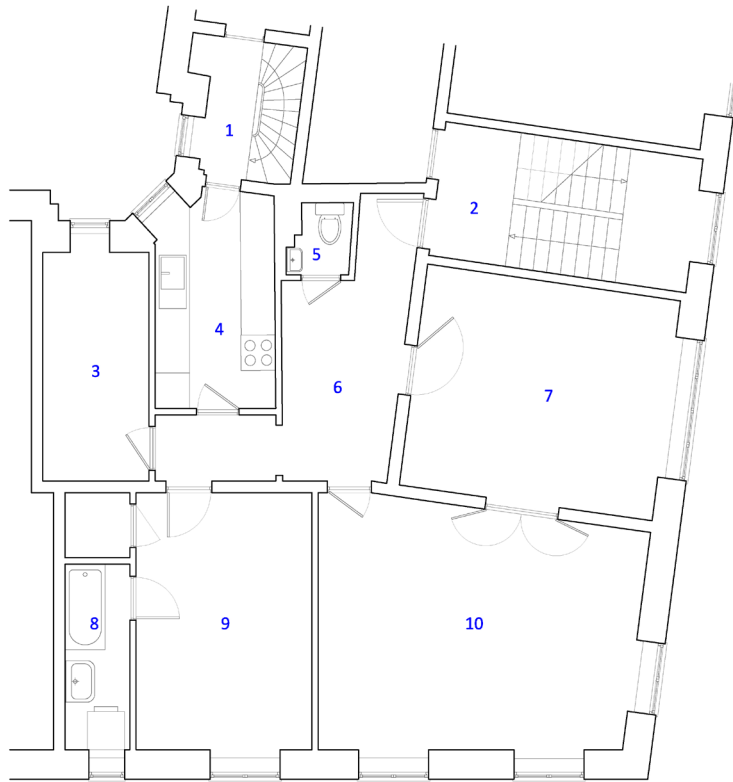


Figure 2: Floor plan of Allan and Bente's apartment used in the Case 1 interviews. Rooms numbered for ease of reference in the interviews.

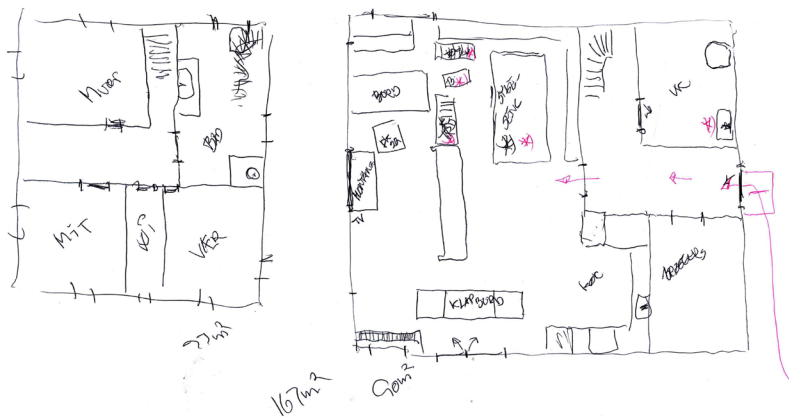


Figure 3: Floor plans (first floor on the left, ground floor on the right) drawn by Sten during the interview (Case 2). The pink arrows show the routes of the home care professionals through the house. This sketch shows an example of how spatial reflections were integrated in the interview through mapping exercises.

The home touring and the mapping activity allowed us to explore and document the spatial aspects of the home care activities in a participatory manner, and to situate the verbal accounts spatially.²⁸ Based on official floor plans, the interviews and mapping activities, home tours, and photographs, the architect on the research team drew floor plans of the two contemporary homes, indicating the different zones and routes involved in the care work.²⁹ In addition, she made drawings that document spatial interventions resulting from home-based elderly care. The drawings and floor plans function both as visual representations of the data and as a shared analytical tool integrating insights derived from the different data sources.³⁰

The interviews with home care professionals followed the same structure as the interviews with family carers, but with questions prompting the point of view of the home care professionals. Again, floor plans served as a visual aid to prompt conversation about how they moved around and used the home

²⁸ Pink et al., *Making Homes*, 117–18.

²⁹ The two interviewers had visited both homes, while the architect had only been in the home of Case 1.

³⁰ The floor plans and the drawings are shown in the analysis section.

during their visits. The interviews were conducted via video call to accommodate their work schedules.

As an initial step of the analysis, the interviewers familiarized themselves with the material through listening and transcribing, creating codes stemming from the empirical data to allow for diverse empirical findings.³¹ The coding was simultaneously inductive, ongoing, and iterative, involving close reading of the data, presentation of preliminary findings, and interdisciplinary discussions within the author group.³²

Ethical considerations about interviewing and visiting homes

The interviewees' homes present an intimate and private setting, allowing us to establish confidentiality and trust during the interviews, in which we touched upon sensitive topics such as intimacy, illness, death, and loneliness.³³ Before beginning the interviews, we introduced ourselves and our project to the care-receiving spouses, who, for health reasons, were not able to participate in the interview.

The interviews focused on the experiences of the family carers, and their responses represent only their own views. All interviewees gave informed consent to their participation and our use of the material for research and outreach purposes. In addition, they were given the opportunity to review and withdraw any part of the interview, but none chose to do so. All traceable details have been anonymized.

Analytical and theoretical framework

For this study we are particularly interested in privacy as a reciprocal, social process, one which is based both on claiming privacy and on being granted privacy. Here we build on historical and anthropological privacy studies that have explored the communal and interactional aspects of privacy.³⁴ In the words of the church historian Mette Birkedal Bruun, privacy is "an act of drawing boundaries". It is a social process that manages co-presence by controlling access and drawing on the "power to exclude", to quote Ted Kilian.³⁵ Thus,

31 Stefan Timmermans and Iddo Tavory, "Theory Construction in Qualitative Research: From Grounded Theory to Abductive Analysis", *Sociological Theory* 30, no. 3 (2012): 167–86, <https://doi.org/10.1177/0735275112457914>.

32 Anne Galletta, *Mastering the Semi-Structured Interview and Beyond* (New York University Press, 2013).

33 Pink et al., *Making Homes*, 104; Kati Hämäläinen and Susanna Rautio, "Participants' Home as an Interview Context When Studying Sensitive Family Issues", *Journal of Comparative Social Work* 8, no. 1 (2013): 41–70, <https://doi.org/10.31265/jcsw.v8i1.93>.

34 On the reciprocal aspects of privacy, see Catherine Beck, "Breaching the Cabin Walls: Madness, Privacy, and Care at Sea in the Eighteenth-Century British Navy", in *Privacy at Sea: Practices, Spaces, and Communication in Maritime History*, ed. Natacha Klein Käfer (Palgrave Macmillan, 2023), https://doi.org/10.1007/978-3-031-35847-0_14. See also Natalie Patricia Körner, "The Kitchen", in Körner et al., *Building Early Modern Privacy*; and Asta Mønsted and Natalie Patricia Körner, "Privacy in the Greenlandic Inuit House of the 19th Century", in *Oxford Handbook of Historical Privacy Studies*, ed. Mette Birkedal Bruun, Natacha Klein Käfer, and Sari Nauman (Oxford University Press, forthcoming).

35 This approach to privacy builds on Mette Birkedal Bruun's work on early modern privacy: Mette Birkedal Bruun, "Towards an Approach to Early Modern Privacy: The Retirement of the Great

we analyse the boundary-drawing strategies of family carers. This approach is rooted in literature on cohabiting family caregivers, which shows that family carers continually relate to and interact with the care recipient and additional carers when navigating the needs of the care recipient and themselves.³⁶ Contributing to this literature by adding boundary-drawing for privacy to these strategies, we will structure our analysis in a threefold framework of the family carers' boundary-drawing: first, around themselves; second, for or with the care recipient; and third, with or towards additional carers. It should be noted that there can be significant overlap between these three types of (inclusive) boundary-drawing, as each affects the others.

Negotiation of privacy through the drawing of boundaries is based on gestural, social, relational, and spatial practices and conditions. These negotiations become intensified or disrupted when they take place in a home accommodating care activities, which has become a space of both domesticity and healthcare, occupied by both inhabiting and visiting caregivers. Drawing on first-hand verbal accounts and spatial arrangements across the three cases, we examine how family carers carve out pockets of privacy under the changing conditions of their homes, family relationships, and everyday lives.³⁷ We will show that, in both past and present times, the process of creating privacy under such conditions is continual and relational and, importantly, cannot be achieved by an individual alone but often depends on social cooperation.

Analysis

The caregiver's micro-strategies for privacy

In all three cases, the family carers attempt to carve out privacy for themselves, even as their ability to draw boundaries is impaired by being constantly responsible for monitoring and supporting the care recipient. This often comes in response to a somewhat involuntary new role as caregiver. While it is, for example, unclear whether Ralph selected Peg as his caregiver, or she volunteered to move into his home for this purpose, she likely had limited say in taking on her new responsibility. Unmarried women often performed this role within the premodern family, travelling between homes to provide care for the

Condé", in "Early Modern Privacy: Sources and Approaches", ed. Michaël Green, Lars Cyril Nørgaard, and Mette Birkedal Bruun, special issue, *Intersections: Interdisciplinary Studies in Early Modern Culture* 78 (2022): 12–60. In term of privacy as a social process, see also Irwin Altman, "Privacy Regulation: Culturally Universal or Culturally Specific?", *Journal of Social Issues* 33, no. 3 (1977): 82, 16370030, <https://doi.org/10.1111/j.1540-4560.1977.tb01883.x>. See also Kilian's approach to privacy as the power to exclude: Kilian, "Public and Private, Power and Space". For more on managing co-presence, see Joachim Eibach, "From Open House to Privacy? Domestic Life from the Perspective of Diaries", in *The Routledge History of the Domestic Sphere in Europe*, ed. Joachim Eibach and Margareth Lanzinger (Routledge, 2020), 347–63.

36 Glasdam et al., "Older Caregivers' Responsibilities and Strategies".

37 Mette Birkedal Bruun and Natacha Klein Käfer, "Pockets of Privacy in the Maritime World: An Epilogue", in Käfer, *Privacy at Sea*, https://doi.org/10.1007/978-3-031-35847-0_14.

sick, elderly, or young children as needed.³⁸ Such women, although vital members of the family, often had less agency or authority than their married counterparts. Peg thus remained a subordinate and temporary inhabitant at Claydon throughout her uncle's illness. Ralph discouraged the rest of his large family from visiting him. To his son John, he wrote: "I would not have you come down knowing you are full of businesse"; this was later reiterated by Peg, who stated that [Ralph] "would by no means have you come because he knows you had business".³⁹ Ralph's sister wrote: "I dare not give my selfe that satisffaction of coming without y[ou]r line for feare of displeasing you [...] if you wo[ul]d have mee come you wo[ul]d have let me know your mind."⁴⁰ Clearly, in the early stages of his illness, Ralph retained the power of boundary-drawing and control of access.

However, Peg wrote regularly to her cousin John with detailed accounts of Ralph's drastically deteriorating health and the care he was receiving, granting John a degree of access to Ralph. We could interpret this as a betrayal of Ralph's privacy and, indeed, Peg seemingly acknowledged this, telling John "he knows not of my writing", and "I did not [*illegible*] to him, or to any body else, that I had sent you word of his illness".⁴¹ Several historians have noted that early modern letters were often read aloud or passed on, and so were not strictly "private".⁴² However, Peg's statement that she was writing unbeknownst to her uncle signalled intended confidentiality. Crucially, the letters to John helped Peg cope with the emotional and social isolation of caregiving; they were figurative spaces in which the sharing of intimate information about Ralph's condition nurtured bonds of trust and confidence between the cousins. According to the historians Johannes Ljungberg and Natacha Klein Käfer's notion of privacy as "social-interactional engagement" in hidden conversations, Peg's letters represent her carving out of privacy and her personal navigation of the boundaries defined by Ralph in his exclusion of John.⁴³ If her cousin could not experience his father's sickness first-hand, Peg could create the shared illusion of his physical presence for both their benefits.⁴⁴

A second micro-strategy for carving out pockets of privacy was delegating some caregiving tasks to Ralph's servants. For example, on 11 August, Peg noted "I was thinking to stay all night: but leaving of him so well: I went to see him yesterday morning."⁴⁵ She explains that "Richard", probably a manservant, "sett up with [Ralph] Last Night"; later in his illness, Ralph's servants "watched every night all this week".⁴⁶ This shared the burden of vigilance and must have provided some relief for Peg, who could take a break from

38 Amy M. Froide, *Never Married: Singlewomen in Early Modern England* (Oxford University Press, 2005), 76.

39 Sir Ralph Verney to John Verney, 9 August 1696, BL, M636/49; Margaret Adams to John Verney, 11 August 1696, BL, M636/49.

40 Lady Cardy Gardiner to Sir Ralph Verney, 11 August 1696, BL, M636/49.

41 Margaret Adams to John Verney, 11 August 1696, BL, M636/49.

42 For example, Rosemary O'Day, "Tudor and Stuart Women: Their Lives Through Their Letters", in *Early Modern Women's Letter Writing, 1450–1700*, ed. James Daybell (Palgrave, 2001), 419.

43 Ljungberg and Käfer, "Introduction", 4, 11–12.

44 Bruce Redford, *The Converse of the Pen: Acts of Intimacy in the Eighteenth-Century Familiar Letter* (University of Chicago Press, 1986), 7.

45 Margaret Adams to John Verney, 11 August 1696, BL, M636/49.

46 Margaret Adams to John Verney, 11 August 1696, BL, M636/49; Margaret Adams to John Verney, 24 September 1696, BL, M636/49.

her monitoring duties, particularly overnight, by transferring them to a trusted person with whom Ralph was familiar.

Shortly before Ralph's death, Peg wrote that, "if one gives him a spoonful of any thing to moisten his mouth which is hot & dry [...] it returns back with frothy phlegm", and in the same letter said that "he has suffered us to shift a clean sheet under him every day & indeed all his servants are as diligent & careful of him as possible".⁴⁷ The use of "one" and "us" mean we cannot be certain who is doing the work here, but the subsequent mentions of servants suggests that they were at least partly involved. It is possible that Peg delegated these "messy" tasks to preserve her sense of privacy in relation to Ralph, or his in relation to her. It was likely judged inappropriate for a gentlewoman to deal with bedding stained with sweat, urine, or faeces (and we know that Ralph was incontinent at this time), whereas servants dealt with bodily waste materials daily in the course of their work.⁴⁸ The hierarchy of domestic labour, closely linked to social status, therefore had implications of experiences of privacy.

Just as Peg would have had the opportunity to withdraw to her bedchamber or downstairs rooms to write, while servants were watching Ralph in his sickroom, Sten uses the upstairs of his home as a place to physically withdraw from healthcare duties (Figure



Figure 4: Floor plan of Sten and Kirsten's house, drawn from their actual floor plan and Sten's accounts during the interview. The dashed line shows the typical care personnel route. The entire first floor of the house, marked in grey, is used only by Sten.

47 Mary E. Fissell, "Introduction: Women, Health and Healing in Early Modern Europe", in "Women, Health, and Healing in Early Modern Europe", special issue, *Bulletin of the History of Medicine* 82, no. 1 (2008), 10–11; Margaret Adams to John Verney, 24 September 1696, BL, M636/49.

48 Amanda Vickery notes that gentlewomen could textually appropriate servants' labour, questioning whether the eighteenth-century diarist Elizabeth Shackleton "actually got her hands dirty" in the household described in her writings: Amanda Vickery, *The Gentleman's Daughter: Women's Lives in Georgian England* (Yale University Press, 1998), 149. See also Katie Barclay, "Gossip, Intimacy, and the Early Modern Scottish Household", in *Fama and Her Sisters: Gossip and Rumour in Early Modern Europe*, ed. Heather Kerr and Claire Walker (Brepols, 2015), 190.

4). To bridge the spatial distance to the sick bed, he has installed a baby monitor and a camera which he can access through a phone app. This allows him to feel reassured while continuing his routines, such as sleeping in the upstairs bedroom, while his wife, Kirsten, sleeps downstairs in a hospital bed in the living room. He says:

I'm here 24 hours a day, and I have a camera so I can check on her at night. I have to get up to pee – I'm an old man, you know. And then I take a quick look to see if she's sleeping peacefully, and so on. There's also a baby monitor, so she can call me if needed.

As the mention of “24 hours a day” implies, family carers are always on duty and required to mostly remain at home with the care recipient.

Sten's ability to draw boundaries, in the sense of regulating access to himself, is suspended, as the boundaries – staying at home – have been drawn for him by his partner's illness. Leaving Kirsten, who is still partially mobile and thus vulnerable to falls, even briefly alone presents a logistical problem, which causes a strong sense of constraint. In Sten's words, “what's exhausting is that I feel shut in. Incredibly restricted. Every time I need to go somewhere, I really have to think it through, keep an eye on things, and be ready to head back home.” Allan feels equally bound to his home. He regrets especially that he can no longer travel: “I couldn't even dream of taking a trip down to Gran Canaria [...] knowing that she's lying here at home, waiting to die.” Both husbands describe their situation using phrases such as “I can't do anything outside the home”, “I feel so trapped”, and “tied down”. Additional visits from professional carers, would, according to Sten and Allan, only increase their sense of constantly needing to be at home. However, their spouses' limited mobility also enables them to retain care-labour free space within the home (Figure 5).

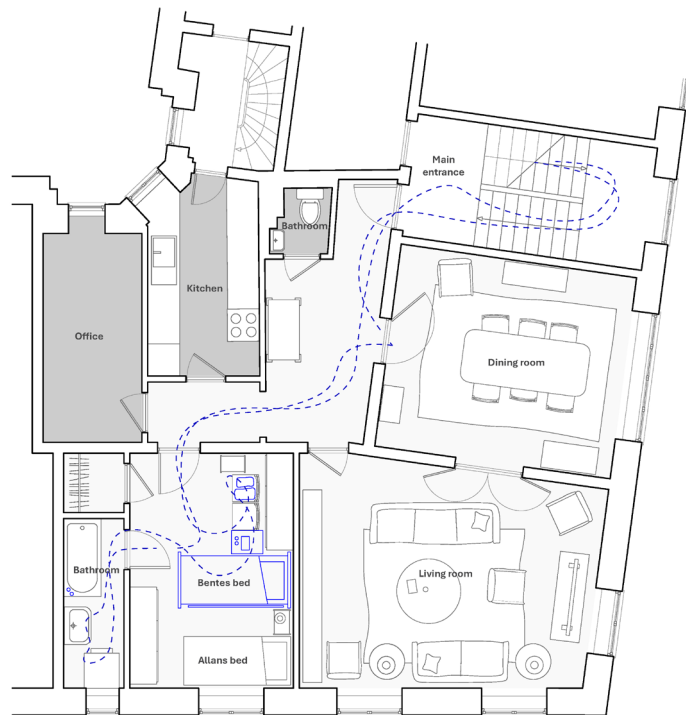


Figure 5: Floor plan of Allan and Bente's apartment. The dashed line shows the typical route taken by care personnel during visits. The rooms marked in grey – Allan's office, the kitchen, and the bathroom – are used exclusively by Allan.

Support from children and grandchildren, in collaboration with the municipal healthcare providers, gives Sten and Allan the occasional opportunity to physically leave the

home care situation. Allan sometimes visits friends and travels in Denmark; Sten likes to go swimming. However, even as they separate themselves spatially from the home care context, they can never mentally withdraw. In Allan's words, "I can manage to go away for a few days, as long as I know that my grandchild or [...] my daughter is here. That's okay. And then I can call home all the time." Allan and Sten thus draw temporary spatial boundaries within their homes by keeping certain rooms free from healthcare equipment, personnel, and even the care recipient, or by leaving the home. Despite these spatial measures, in light of understanding privacy as a reciprocal and social process, achieving it becomes complicated when their spouses cannot grant them privacy, even when Sten and Allan would like to claim it.

Privacy shared with the care recipient

It is, however, possible for the family carer to create moments of privacy and normalcy with or for the care recipient by temporarily drawing boundaries to exclude the omnipresence of sickness. Privacy for the patient is nearly impossible, considering that their well-being depends on being surveilled. In the early modern period, this monitoring practice was referred to as "watching", "keeping", or "sitting up" when it took place overnight.⁴⁹ It required constant attention to be paid to Ralph's body, including his appearance, appetite and diet, rate of breathing and excreta, and quality and patterns of sleep. Peg's letters are filled with details monitored about the patient's condition, as in this example:

we perceived his hands especially the right one to swell a little, & his face but chiefly the right side [...] hee was took wth a violent fitt of coughing but it did raise little or nothing [...] hee has gon to stoole I believe at least 10 times to day & they say only clear water.⁵⁰

Peg not only watched but also listened for expressions of pain and illness, noting Ralph's "all most perpetual" coughing, his "crying out" when moved, the "rattling in his throat", and even the sound of his bowel movements.⁵¹

This multi-sensory surveillance, alongside the pervasion of the sounds (and probably also smells) of illness throughout the domestic space, must have compromised both Peg's and Ralph's ability to experience personal privacy. However, her proximity as his chosen, trusted carer can be interpreted as a kind of intimacy. While "normalcy" was impeded by Ralph's sickness, Peg's attention and activity on and around her uncle's body constructed a zone of privacy around the pair. Its boundaries were somewhat permeable – Peg's use of plural pronouns such as "we" and "they" suggests that servants were also privy to their master's bodily functions and dysfunctions – but Ralph continued to prohibit his son and sister from witnessing his physical condition. Peg thus occupied a prominent and even privileged position as one of the very few permitted to share in Ralph's illness experience.

⁴⁹ Hannah Newton, *The Sick Child in Early Modern England, 1580–1720* (Oxford University Press, 2012), 95.

⁵⁰ Margaret Adams to John Verney, 9 August 1696, BL, M636/49.

⁵¹ Margaret Adams to John Verney, 9 August & 24 September 1696, BL, M636/49.

Occasionally, Peg and Ralph cooperated to include houseguests into their zone of privacy. Ralph was confined to the vicinity of his bedchamber from the beginning of his health decline, and not able to entertain in the customary downstairs spaces of the drawing or dining rooms. When a small group of cousins and friends visited Claydon on 10 August, he wanted to enjoy their company, but Peg “perswaded him to [...] not goe down”. Instead, the group attempted to replicate a typical dinner in a different setting; “we sett in his dressing room & he dined at table with us”.⁵² This strategy not only helped to create a semblance of normalcy for Ralph and his household but was also a token of trust towards his close friends, whom he invited into an intimate and usually private space adjacent to his bedchamber-turned-sick chamber.

Sten and Allan similarly try to create moments of normalcy and agency for their wives. As when guests visit Allan, when we visited him for the interview we were introduced to Bente, in an attempt to include her. Sten creates moments of agency for his wife through personalized spatial interventions. For example, he has “put up a net because Kirsten throws down her duvet and pillows. That way, she can get them back without me having to come down at night.” Kirsten can thus independently pull up her blanket from the football net that bridges the gap between her bed and the bookshelf (Figure 6).

Caring for a partner and caring for oneself, caring about their condition as a person and as a care recipient become entangled, as Sten’s related concern with Kirsten falling out of bed shows:

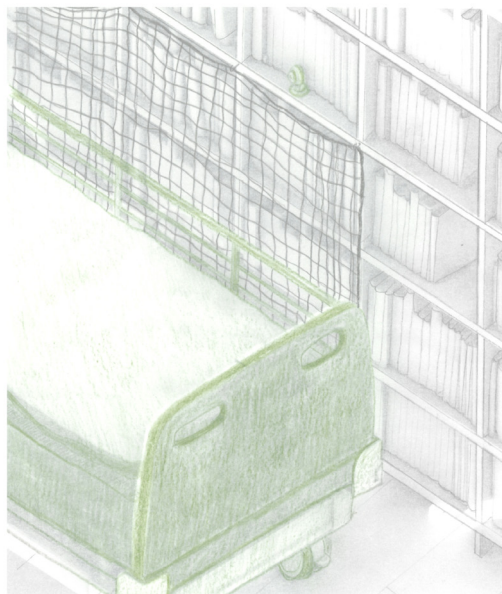


Figure 6: Illustration of the hospital bed in the living room where Kirsten sleeps. On the shelf beside the bed is the net that Sten installed to prevent Kirsten from losing her duvet during the night, along with the video camera he set up to monitor her via an app on his phone.

And I’ve set up one of those fold-out beds [...] which I put up after she [once] climbed out of her bed. I set it up in the evening. If she were to climb out again [...] she would fall onto something soft. If she were to injure her hip, that would be a disaster.

Unlike with such practical and preventive interventions, when it comes to micro-strategies of shared moments of privacy with the care recipient, the distinction between a niece and a marital partner becomes significant. While Peg strengthened the familial bond through the act of providing attentive and meticulous healthcare, Sten and Allan find ways of maintaining intimate moments to evoke a time predating the carer–patient relationship. The level of attention to detail they provide would be difficult to replicate by professional carers,

⁵² Margaret Adams to John Verney, 11 August 1696, BL, M636/49.

whose workdays consist of tightly timed tasks and dense daily sequence of patient visits. Regarding Kirsten's diet, for example, Sten is attentive to her preferences: "I've figured out what Kirsten likes [...] salmon sandwiches and shrimp sandwiches." Besides just as considerately keeping track of Bente's fluid intake, Allan takes time to brighten her day in ways that are reminiscent of the time predating her illness: "I sing songs to my wife from our old hymn book." Even though she can no longer join him – "We have sung our last song together", Allan says – he continues, "the reason is love". Allan also still sleeps next to Bente in their shared bedroom, although their shared double bed has been split to accommodate Bente's hospital bed (Figure 7).

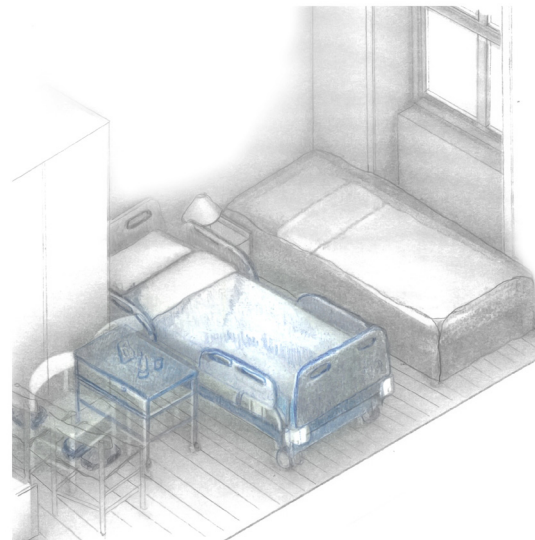


Figure 7: Illustration of Allan and Bente's bedroom. The blue furniture indicates healthcare equipment (hospital bed, sliding sheets, underpads, and diapers). The illustration was made after Bente passed away and is based on Allan's descriptions and our memories from the interview visit.

However, when a friend of Allan's suggested moving Bente's hospital bed into the living room so she could watch TV, Allan chose not to. He keeps the living room as a zone that is free of healthcare – only on rare occasions does he invite select professional carers in.



Figure 8: Illustration of the shower head connected to the sink, and a plastic sheet to cover the cupboard, in Sten and Kirsten's ground-floor bathroom, installed by the municipality.

By contrast, Kirsten's hospital bed is placed in the combined living-dining area because her movements are restricted to the ground floor. A makeshift shower has been installed in their downstairs bathroom to facilitate assisted bathing (Figure 8), along with a raised toilet seat. Here, the main living areas are clearly marked by the presence of care equipment, like a patient lift, a wheelchair, and training equipment.

While Sten has kept the first floor free of care-related equipment, and Allan limits the care activities to the shared bedroom, spatial privacy is volatile – independently of the size and layout of homes. In Sten's and Allan's cases, there is always the latent possibility that municipal staff might come upstairs or into the living room. In the context of home care, spaces are rarely completely private. Intimate experiences such as sleeping next to each other or serving favourite dishes take place in the same areas where healthcare professionals perform care work. This is seen also in Peg and Ralph's case, where guests are invited into his dressing room.

The nuances of care in the home, ranging from pragmatic to intimate, constantly shift the power balance between relational privacy and the public nature of medical monitoring. A sense of shared, private space and moments marking a close relationship are marred by diapers and the smell of faeces, gloves, assistive devices, and sickbeds. The rearrangement of personal belongings and furniture further contributes to disrupting previous privacy zones that are now subjected to publicly supervised care. Just as the care recipient's ability to establish privacy boundaries is significantly reduced due to dependency and illness, so too is the caregiving spouse's.

Privacy from additional carers

Beyond the carer–patient relationship, the presence of additional carers such as professional carers or servants requires constant negotiations of access to spaces in the home, access to knowledge about the care recipients' situation, and access to healthcare equipment in the home.

Peg shared responsibility for caregiving with Ralph's domestic servants, who functioned as supplementary carers. They differ from modern municipal carers in that they were not medical specialists or care professionals, although several of their quotidian tasks helped to promote and maintain health. The servants also differ from professional carers in that they were household residents, contemporarily defined as "family" and bound to their master by complex, reciprocal socio-economic obligations.⁵³ While these individuals were familiar to and probably trusted by Ralph, Peg knew them less well, and so it is possible that her sense of privacy was compromised by providing care alongside them. On the other hand, she was accustomed to the presence of servants in her own home; Claydon was a large house with some possibility for demarcated spaces enabling avoidance, and it seems that Peg split the caregiving tasks between herself and the servants rather than working together at the same time. For example, only one watcher at a time was needed, and her letters imply that she was not present when servants moved Ralph from bed to chair and changed his bedsheets. The morning after Ralph's manservant had sat up with him overnight on Peg's orders, she "desiard him to come to tell me how he was". This brief comment illustrates her role as an overseer of Ralph's condition and care, and her control of both physical access to, and knowledge of, the patient.

However, her boundary-drawing practices sometimes compromised Ralph's privacy as she prioritized her own practical, and perhaps emotional, needs above his stated wishes. On 9 August, Peg wrote of her "unspeakable satisfaction" should her cousin John arrive "speedily" at Claydon, "for your company is much long'd for by all", despite previously conveying Ralph's desire for John to stay in London.⁵⁴ John, as a middle-aged gentleman, would be unlikely to do any serious physical caregiving for his father. Nonetheless, his presence would undoubtedly have offered Peg some comfort and social support. As far as we know, John did not visit his dying father. However, as Ralph slipped from conscious-

53 Naomi Tadmor, "The Concept of Household-Family in Eighteenth Century England", *Past & Present* 151 (1996): 112.

54 Margaret Adams to John Verney, 9 August 1696, BL, M636/49.

ness in the final few days of his life, Peg admitted his other niece – and her cousin – Cary Stewkeley to Ralph’s bedside. This was a clear breach of Ralph’s wishes, as Peg explained in a letter that “while he was sensible he would not permitt [Cary]”. Ralph had lost any remaining power to draw boundaries or implement strategies for privacy. It seems, moreover, that Peg had too. She stated that Cary arrived ready to “direct us: watching us all w[i]th great diligence & having pen & inke ready to commit all to paper”, referring to Peg’s and the servants’ caregiving activities.⁵⁵ The observer thus became the observed; Peg’s decision to allow Cary into this space altered the dynamics of Ralph’s sickroom and diminished the personal privacy she had previously established as his primary caregiver.

As described in the previous section, Peg created shared privacy with Ralph through dedicated monitoring. In the contemporary cases, comparing notes on observed symptoms with the professional carers plays an important role. Allan describes the dilemma of how, during their visits, he simultaneously wants “to be there and not be there”, elaborating that he feels he needs to know such details as “whether she has had a bowel movement or not”. From the perspective of the professional carers – in Case 2 that of Marianne, who provides care for Kirsten – collaborating with the family carers improves their work:

And along the way, we also have a conversation with Sten, because he is often curious... if there is something different about Kirsten that he might not have noticed. It could be something on her skin, it could be her mood, or he might tell us that it has been a difficult night, or an easy night – something that helps us do the best we can while we’re there.

Sten echoes Marianne in describing how important it is to him to be present during her visits – yet he adds a slightly more supervisory nuance. He likes to follow the process and ensure that his wife receives the appropriate care: “So in that way, here at home, I can make sure that everything is as it should be. And I can also keep an eye on hygiene.” Just like Sten, Allan also values access to the professional carers’ insights of his wife’s condition, and they exchange observations.

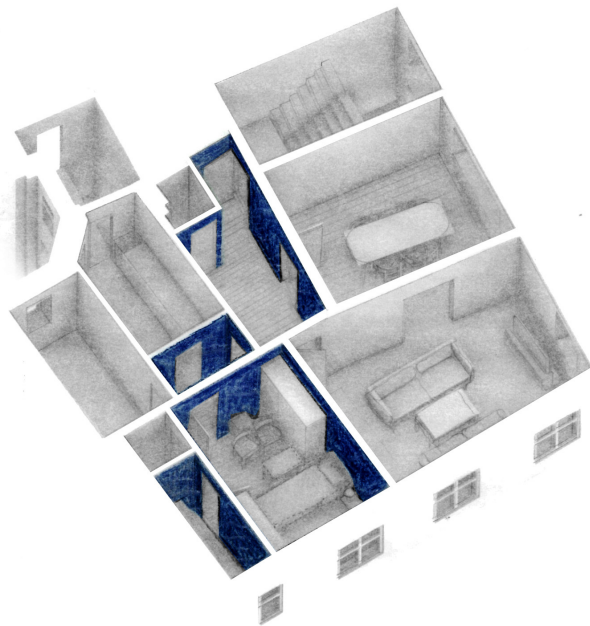
The continuous monitoring described by Peg, Sten, and Allan reveals why simply increasing home care assistance would not necessarily provide the relatives with respite. Feeling responsible and curious about their relatives’ well-being, they cannot fully disengage during the home care visits or servants’ shifts, as they remain involved in overseeing and coordinating care. Sten and Allan could use the time of professional carer’s visits as an opportunity for withdrawal. Instead, and despite overall satisfaction with the work of the professional carers, they prefer to be present.

In trying to understand Sten’s and Allan’s micro-strategies towards privacy *from* the additional carers, their ways of managing their access are revealing. Beginning with managing access via the front door – the threshold between what is often perceived as public and private – the two cases differ significantly. While Sten has agreed to install an electronic key system, allowing the home care providers to enter independently of his

⁵⁵ Margaret Adams to John Verney, 24 September 1696, BL, M636/49.

presence, Allan has not shared his keys.⁵⁶ In an effort to maintain the power of exclusion – privacy in Kilian’s terms – Allan explains that, when home care workers enter his home, they “step into something private”. As a result, he must be present to open the door for each visit. Sten, on the other hand, might be seen as giving up a degree of privacy by agreeing to the electronic key system; however, at the same time he gives himself increased freedom to be absent.

Even with independent access, as in Case 2, acknowledgement of threshold crossings is upheld: employees ring the bell and wait a certain amount of time before entering. Upon entry, they immediately identify themselves, ensuring their presence is clearly announced. This practice may be interpreted as a way of acknowledging that the home is the domain of the residents, not the care workers. Michael, the interviewed care worker who visits Bente, notes: “And if I have a key, I always ring the doorbell before I go in. I don’t ring it over and over, just a little, you know. I think that’s just common courtesy, to do that. So they know someone is coming, right?” Marianne is also aware of the delicacy of the front door as a home’s privacy boundary: “Of course, when it comes to being respectful upon entering someone else’s home, you announce your arrival. And before stepping too far inside, I always call out, ‘It’s home care’, and then my name.”



As we move further into the home to examine the spatial aspects of home care from within, additional boundaries, zones, and demarcations become apparent. Certain rooms – or, in Sten’s case, the entire first floor – remain a relatively private domain: partly because the care workers simply do not need to enter these areas, or partly because some rooms are consciously preserved as private by Sten and Allan. Although the care workers have no reason to come upstairs, Sten explicitly asserts that that part of the house is private through his ways of inhabiting it: “That’s also a kind of free space for me. I don’t walk around upstairs in a bathrobe after I’ve taken a shower. I walk around naked.” Sten thus actively claims the space as private despite the constant possibility of a boundary transgression. For example, he once experienced

Figure 9: Axonometric illustration of Allan and Kirsten’s apartment. The coloured interior walls indicate the areas where the care personnel typically work.

⁵⁶ In many Danish municipalities, electronic key systems have been installed in the homes of consenting residents receiving elderly care, thereby enabling the home care personnel to access the homes themselves. See, for example, Aarhus Kommune, “Elektroniske låse”, accessed September 26, 2025, <https://velfaerdsteknologi.aarhus.dk/projekter-og-indsatser/taet-paa-borgerne/velfaerdsteknologier-i-hjemmeplejen/elektroniske-laase>.

a care worker walking up the stairs to deliver a message while he was on the first floor. The potential of care professionals entering zones of the home that are unrelated to the care work adds an additional strain to the husbands' ability to draw and uphold privacy boundaries. While this strain may largely be imagined – given that the home care staff generally show considerable respect for the residents' privacy – the risk of losing control over these boundaries remains present.

In Allan's case, when it comes to the rooms that home care workers rarely or never enter, one can observe how he and the staff establish and perform boundaries, maintaining certain zones as private. For instance, the home care professional Michael explains that he almost never enters spaces beyond his work areas (mostly Bente's bedside; Figure 9) unless Allan explicitly requests it: "No, I never go in unless he asks or calls for me. [...] Well, if the TV is on and there's some kind of sports thing happening, then I might pop in to take a look. [...] But otherwise, I don't just go into rooms without a reason." Similarly, Allan explains that, if he wants the home care workers to access non-work-related rooms, he has to invite them: "If they come in here, it's because you want to invite them in – if they have time for a soda or whatever they'd like. I've offered them that sometimes." A micro-strategy of creating a sense of privacy is thus created by the professional carers and the family carer by respecting spatial boundaries where possible. It is notable that spaces can be both private and public spaces – that is, shared with professional carers – depending on the circumstance. If Sten or Allen gesture withdrawal, such as going upstairs or watching TV without engaging, the external carers can allow for the experience of privacy by not engaging or entering specific areas.

Conclusion

Family caregivers like Peg, Allan, and Sten develop micro-strategies for privacy. These strategies must constantly adjust to the restricting circumstances created by elderly home care: a need for constant vigilance, a continued sense of responsibility in light of the care recipient's vulnerability, and an ongoing interaction with numerous additional carers at all times of the day. Kilian's concept of ongoing negotiations around spatial privacy and publicity – understood as a dynamic interplay between the power to exclude and the power to access – helps clarify how the burden of familial home care results in the experience of limited privacy. Both dimensions are restricted for the family caregivers: being bound to the home limits access to other spaces and relationships, while the presence of care workers and ongoing caregiving demands constrain their ability to draw boundaries. Strategies such as leaving some care responsibilities to family members or servants, temporarily withdrawing, or creating moments of intimacy with the care recipient can facilitate privacy for the family carer. However, it can be difficult for a family carer to mentally withdraw from their responsibilities towards the care recipient, both out of love and out of duty. When understanding privacy as a reciprocal and social process, the social dynamics necessary for experiencing privacy collapse when the care recipient is so ill that they cannot grant the family carer privacy and time to withdraw. Thus, the family carers can only assume that their constant presence is necessary and desired.

The past–present comparison in this paper reveals that cohabitation constellations affect the possibility and nature of shared care work: Ralph was more familiar with the live-in servants than Kirsten and Bente were with the continual turnover of municipal workers. Representing the common living situation in the Global North, the contemporary cases show that couplehood and the nuclear family can generate a fragile and burdensome situation when extra care and support is required, whereas larger and more complex households, common in the early modern period, might offer more immediate relief from care tasks. Yet, for the familial carer, privacy is compromised independent of the familiarity with the additional carers. The care responsibilities of cohabiting family carers restrict the possibilities for them to create private and intimate moments for themselves and together with their relatives in their homes.

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