

Article title: **Enduring commitment: older couples living apart**

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Abstract

As people live longer, there is an increasing possibility of couples becoming separated because one partner moves into a care home. Our qualitative mixed-method pilot study in an English town involved 8 married couples aged over 65 years to explore experiences and practices of couplehood in these circumstances. This article focuses on the most striking emergent element of expressed couplehood in these now challenged long-term relationships: commitment. Drawing on in-depth (biographical) individual and joint interviews, observations, and emotion maps, this article explores how separation affected the couples' current sense and enactment of commitment to the relationship. Commitment in the partnership is now often one-sided. How committed the community living partner feels and its enactment is heavily shaped by both the shared history of happy and unhappy periods in the relationships, and current contextual constraints, family and institutional support.

Keywords: living apart, commitment, older couples, marriage, dementia

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Introduction

In UK as in other Western contexts, married older ¹ adults (aged over 65 years) are less likely than singles to enter long-term residential care ² because partners often provide mutual care and support (Thomeer et al., 2017). Rising life expectancy is enabling couple relationships to last much longer (ONS 2013). Yet for some, increasing care and housing needs of one partner can result in involuntary separation and living apart through a care home move (Glasier and Arbeau, 2017). Unlike as in Sweden where couplehood is accommodated in these circumstances (Torge 2018), in UK a care home move almost always separates couples. With increased likelihood of progressive and chronic illnesses with age (House of Lords, 2013), more couples may likely find themselves in this situation. Given this invisibility of couplehood in UK residential care policy and practice, investigating how relationships are maintained and practiced becomes important for understanding how to support both partners.

The context and conditions shaping this form of living apart are distinct from other LAT (living apart together) (Duncan and Philips, 2011) and LLAT (living apart together in later life) relationships (Connidis, Borrell and Karlsson, 2017). Here, living apart is likely to occur in long-established, often heterosexual marriages; involving previous caregiving-receiving at home; with remote possibility of living together again. Unlike LLAT, LA/CH (living apart via care home) is in response to external constraints of increasing care and housing needs rather than a particular solution to reconciling relationship intimacy with autonomy. This form of living apart is unconventional: expectations of conducting the relationship at a distance are not a normative aspect of couplehood for married older couples.

Our pilot study in an English Town explored how couplehood is practiced and maintained by married heterosexual couples living apart in response to the greater health and care needs of one partner. We found that while self-identifying as couples (a pre-requisite for participation), CL (community living) spouses varied in the ways and extent to which they sustained this relationship. In this article we utilise the analytical lens of commitment to examine this variation, adding to literatures on commitment and living apart.

Background

Commentators note that historical time and life phase (age) at which a partnership is formed are important for understanding the socio-cultural norms shaping the conduct of intimate and family life (Bildtgard and Oberg 2017). Our sample of couples born between 1920 -1950s comprises both Post World War II and oldest members of baby boomer generations (Phillipson, 2017) who have experienced broader normative socio-cultural shifts in intimate relationships. Prior to the 1970s, in United Kingdom (UK) and other Western contexts, marriage was the only socially acceptable form of co-residential sexual relationship (Beaujouan and Bhrolcháin, 2011). The landscape of intimacy has changed since then - for those (re) partnering at ages 60 and above, it is now common to choose from alternative acceptable union forms (e.g., cohabitation, LAT) including remarriage. Notwithstanding changing sociology of intimate relationships in later life (Connidis, Borrell and Karlsson, 2017) the (heterosexual) marriage continues to be dominant amongst older adults despite the growing rise in divorce since the turn of the century, though largely for 'young' old 65-74 years (ONS 2017). In 2017, 60.0% of people aged 65+ in England were married or in a civil partnership, 10.5% divorced, 24.1% widowed and 5.5% single (ONS,2017). The proportion aged 70 years and over who were married also increased from 50.3% in 2008 to 55.8% in 2018 (ONS, 2019a). Contemporary cohorts who formed partnerships prior to 1970s grew up in a culture where marriage signaled lifelong commitment (Hackstaff, 1999).

Until late 20th century, the socio-cultural context for heterosexual marriages in the West was characterised by the breadwinner-homemaker model, with a highly gendered division of labour rather than espousing equality and partnership ideals (Chambers et al 2009). Marriage also signified sexual exclusivity. Women were primarily required to be good mothers, homemakers and partners with participation in paid work (mostly part-time, non-pensionable) acceptable if it served family interests (Wilson, 2006). The interweaving of marital commitment with gender norms and wives' child rearing responsibilities rendered marriage a highly gendered institution, disadvantaging women more than men. Financial dependency on husbands often contributed to remaining married. But as young and mid-life adults these cohorts became exposed to wider shifts in family and intimate life – particularly, increasing participation of women in paid work and rising social acceptability of other union forms and divorce. How intimate relationships are experienced therefore is likely to be variously patterned by wider socio-historical changes, individual values, beliefs and meanings

ascribed to marriage, gender, age and material circumstances, reflecting different degrees of autonomy (Widmer et al, 2006).

The research suggests that older adults in long-standing partnerships³ are more likely to stay married for life, evidencing coexistence of intimacy alongside gendered inequalities (Chambers et al., 2009). Considerable continuity is noted in the gendered patterns of everyday marital life and relationship quality pre- and post-retirement, furthering closeness or else distance and conflict. Ageing and health conditions may lead to re-negotiation and re-definition of previously shared intimacies (e.g., separate beds or rooms) including sexual intimacies (Hincliff and Gott, 2004), but gender gaps in domestic work and money management persist (Bisdee et al., 2013) with men likely to do less housework, retaining strategic control over household finances. Relationship dissatisfaction apart, those in unhappy marriages also persist (Hawkins and Booth, 2005) leading commentators to infer that marital commitment supports continuity of unhappy marriages (Chambers et al., 2009).

Progressive illnesses, in particular, reshape relationship and gender dynamics between couples with potentially widening intellectual and emotional gaps, often long before a partner enters a care home (Rolland, 2017). Loss of emotional, intellectual, social, and sexual intimacies, alongside disruption to well-established gendered practices of household labour, provides potential for conflict (Boyle, 2013). Practical demands of caring alongside progressive loss of reciprocity leaves the spouse in better health responsible for initiating intimacies that may have previously been shared or instigated by the other partner (Hayes et al 2009).

Unlike cohabitation and LLAT, caregiving is a normative aspect of marital commitment (Cash, Warburton and Hodgkin, 2019), becoming less gendered during later life, with husbands and wives providing similar amount and type of care when spouses are seriously ill (Langner and Furstenberg, 2020). However, caregiving approaches and strategies still tend to follow gendered expectations, norms and répertoires (Calasanti and King, 2007; Williams et al., 2017). Depending upon the quality of relationship, caregiving may be viewed positively, as an extension of intimacy; or resented and given reluctantly (Ray, 2000; BurrIDGE et al., 2007).

When informal arrangements break down, care may be handed over to a care home. Persistent negative discourse on care homes, long defined as 'institutional' and part of the

social imaginary of the fourth age (Gilleard and Higgs, 2013), means that relinquishing care may be emotionally distressing for the CL spouse and experienced as a form of abandoning (Milligan, 2005). Within UK, eligibility to move into a care home is means-tested for the cared-for individual. Couplehood is not considered or accommodated in policy and practice. Unless both partners have qualifying care needs, or (rarely) can self-fund the 'healthy' partner's place (if desired), such moves generally lead to separation and living apart. Data about partnership status at care home level is unavailable in England although most care home (CH) residents are likely to be widowed or single with a greater proportion of women (ONS 2011). Contrasting with community care policies in UK that assume availability of and increasingly rely on familial care to enable ageing -in -place, role and status of family in institutional care remains unacknowledged and unaddressed (Puurveen et al 2018).

Previous research focused solely on experiences of CL spouses (mostly married women) of CH partners with cognitive impairments (including Alzheimer's, other dementias, and Parkinson's disease) highlight the significant impact of illnesses on marital relationships and relationship maintenance when living apart. This work notes that visits were the primary way for couples to come together (Tilse, 1997; Forshund and Ytrehus, 2018), so continuing and maintaining the couple relationship fell upon the visiting spouse. Visiting frequency may indicate something about the degree of closeness but, equally, may be shaped by the CL spouse's own health and mobility, socio-economic circumstances, distance to the care home and available transport (Ross et al., 1997; Baumbusch and Phinney, 2014). LA/CH is a diverse experience. Community living (CL) spouses report: intellectual and emotional dissonance in the relationship; varied feelings of couplehood (e.g, feeling married, unmarried); adapting to new 'visiting' roles; and variously involving themselves in the lives of their (CH) partners (Kaplan, 2001; Braithwaite, 2002). Despite illness and changed qualitative experience, CL spouses express a sense of commitment to the relationship, explained variously as marital vows, love, marital duty or obligation.

Older couples' general persistence in marriages, including unsatisfactory ones, is often explained away by marital commitment. From the perspective of longevity, enduring marriages may be viewed in a unidimensional way as evidence of lifelong commitment. Consequently, commitment amongst older married couples remains under-explored

empirically. Yet, highlighting the significance of commitment, Canary & Dainton (2006) note that not only does it shape whether partners engage in relationship maintenance practices, but also that these are likely to vary by multidimensional aspects constituting commitment. How commitment in LA/CH is understood, acknowledged and enacted therefore becomes important to investigate since responsibility for continuing and maintaining the relationship lies primarily with the visiting spouse.

On Commitment

'Commitment' is broadly understood as rooted in a 'presumption', 'a hope or desire', 'belief' that one's intimate relationship will last a lifetime (Jamieson et al 2002). Theorisations of commitment often build on Johnson's (1991) multidimensional framework comprising three distinct socio-cultural elements: personal, moral, and structural. Any relationship could have all three commitment elements, a combination, or focus on one aspect.

LAT may be variously sought at different stages across the lifecourse (Duncan and Phillips, 2011; Coulter and Hu, 2017) to reconcile and/or balance couplehood with autonomous living and, especially amongst LLAT relationships, to actively resist traditional gendered arrangements (Connidis, Borrell and Karlsson, 2017). Marriage is more complex, interweaving personal, moral and structural elements of commitment with gender norms and sexual exclusivity. For married older couples, who have a longer shared relationship history with specific elements of commitments developing over time (Smart 2007) commitment may contribute to relationship durability in different ways. This includes persisting because of strong personal commitment to partners and relationships despite being based on traditional gendered norms.

Equally even when personal commitment is weak or missing such relationships are tied by structural commitments that may include practical and emotional investments in children, housing, time, finances, friends and wider family. These structural elements can hold the relationship together (Johnson 1991), as do the practical, financial and emotional costs of legally dissolving the relationship. Relationship investments in children introduce complex gendered responsibilities and commitments. As early to midlife stages of partnerships tend

to focus on children, work and the couple, bad marriages may be endured for the sake of children. Divorce may reshape relationships with adult children, especially for fathers who are likely to receive less support from adult children compared to mothers (Brown and Wright 2017) and this might also act as a structural constraint.

Moral commitments have an 'ought to' dimension that may be person, relationship specific and(or) aligned to one's (moral) self (Johnson 1991). Married older adults are often presumed to reflect relationship and/or person-specific types of moral commitment – to the marriage and the marital obligation of 'until death do us part'. Indeed, structural disadvantage over the lifecourse due to limited economic resources and access to labour/pensions may keep some older women in marriages, reflecting broader issues of class and gender.

Methods

Our pilot qualitative mixed-methods study carried out between 2017-2019 (pre-COVID-19) with a biographical focus (Merril and West, 2009) explored older couples' relationship experiences following separation, offering insights into changes and continuities when living apart. Combining methods including individual and joint interviews; observations; and emotion maps (Gabb and Fink, 2015) enabled sensitivity to each couple's current living arrangements and the diverse cognitive and communication capacities of CH residents (Hubbard, Downs and Tester, 2003). The Social Care Research Ethics Committee (England) granted approval under the Mental Capacity Act 2005 (REC reference:18/IEC08/0008). CH partners lacking capacity to consent were enabled to participate via individually appointed third-party Consultees who knew them well.

Self-identified couples (regardless of legal status, sex, ethnicity, or other factors) with one partner resident in a care home, were eligible to participate. Eight couples were recruited from across 4 nursing care homes in one local authority area. Prior to participation, we explained the study, inviting questions, and emphasising its voluntary nature, confidentiality, anonymity and their right to withdraw. The Consultee, usually identified by CL spouse, was contacted with an information leaflet and a form inviting their opinion on whether CH partner

would have consented to participate in the study. Individual signed consent was obtained ahead of commencing fieldwork for all CH partners through Consultees.

Data collection

We adopted a staged approach to fieldwork (see table 1). An introductory visit to meet the couple together, usually at the care home, allowed us to assess cognitive and communicative capacities of CH partners. Given limited capacities, we mainly undertook observations (mornings, early and late afternoon) with CH partners, supplemented with short interviews where feasible and following a process of ongoing informed consent (Dewing 2007). Two researchers then visited CL spouses to establish completion of emotion maps reflecting feelings of everyday life at home. We then conducted in-depth biographical interviews with CL spouses lasting 1.5-2 hours at the care home or in their homes, informed by a topic guide that explicitly explored: couple's relationship history; personal biographies of each partner; impact and implications of separation and living apart; and everyday life for both partners following separation. A visual 'relationship intimacy' instrument permitted exploring intimacies in the relationship, including : physical and sexual intimacy; caring about; doing things together; sharing; confiding; conflict resolution. Finally, joint interviews were conducted with couples in a quiet location in the care home to facilitate ethnographic and interview data about couple life (currently and previously) - how/where couples spent time together, interactive talk, gestures and displays of affection between the couple. G led the joint interviews and H/P recorded field notes about the couple's interaction.

Observations with CH partners offered insights into their daily lives in the carehome, but we could not directly elicit their perspectives on and experiences of marital relationship. We relied instead on in-depth interviews with CL spouses to gather accounts of individual and couple biographies and the relationship. Emotion maps completed by CL spouses offered insights into their everyday life and emotional experiences of living apart. Despite a joint interview and CL spouses trying to include their partners in the conversation, it was CL spouses who primarily responded on behalf of the couple. Observations were written up and interviews audio-recorded and transcribed.

Data analysis

A varied dataset for each couple was created (see table 1). Data was analysed thematically following Braun and Clarke (2006). Each author first independently familiarised herself with complete datasets for at least 2 couples, coding (Creswell, 2013) written interviews and observations and triangulating this with completed emotion maps to enable exploration of couples' experiences and relationship across the lifecourse. Since CH partners' own accounts were absent, individual in-depth interviews with CL spouses were coded for their own 'lived' and partner's 'told' life (Verd and Lopez, 2011) to produce each couples' relationship biography. The first author familiarised herself closely with entire dataset for 8 couples. Identified codes were collated and through a series of iterative writing and discussion, sorted into overarching themes. Themes were then reviewed independently by H and G against coded extracts within and across datasets before producing thick descriptions (Geertz, 1993) and a rich interpretive analytical account. We acknowledge that our interpretation of data is also informed and influenced by our positionality as married women (Walkerdine, Lucey and Melody, 2003).

Sample and fieldwork timeline

The 8 recruited couples were heterosexual, white British, and in partnerships ranging from 27-58 years prior to separation (mean marriage length 44 years) with two in remarriage partnerships. All except one had been separated for a minimum of 9 months and maximum of 3 years following CH move. The mean age of CL spouses was 76 years. The mean age of CH partners was 79 years. A couple who had lived apart for 22 out of 27 married years (long-term care) was excluded from this analysis. Findings presented here are informed by reading of whole datasets for 7 couples, with quotations drawn primarily from individual interviews with CL spouses and joint interviews. Table 1 sets out pseudonyms for the 7 couples, fieldwork timeline, and methods adopted.

< **Table 1 here: Qualitative dataset and fieldwork timeline** >

Findings: what commitments means now and how it is expressed

The fact of separation and living together apart in our sample stemmed from ill-health and the move to secure appropriate care. While these circumstances are interlinked, some couples were impacted primarily by declining health for one or both partners, while others were impacted primarily by being parted. Using the Johnson (1991) framework we look at how ill-health and separation affected commitment under three themes: 'strained relationships', 'living together apart' and 'impeded commitment'.

Strained relationships

Two couples had persisted in largely unhappy marriages, remaining committed somehow to the relationship.

Terry (79) and Tina (81) (married 56 years at interview) together experienced the death of their first infant. Terry believed that Tina's mental health became fragile after this and she gave up work. He felt she could have continued working to relieve financial hardship they experienced as a growing family, especially given his redundancies. Terry described the relationship as '*floating along*' with disagreements, little communication or trust, little real intimacy (and an opportunistic one-off infidelity by Terry). After 25 years of marriage, sexual intimacy ceased: after 50 years, Tina moved into a separate bedroom. She eventually had a stroke, leaving her doubly incontinent and unable to speak or move. In discussions with care professionals, Terry decided he was not well enough to care for Tina at home even with formal support.

Three years on, Terry visits Tina once weekly, marking her birthday and anniversaries with flowers and cards, updating her on family news. While she lives, he will keep her room and belongings at home undisturbed. '*I made a promise. I made a promise before God that I would look after her to the best of my ability until death do us part*'. The loving elements of the relationship appear to have faltered long before the separation. '*I miss her up to a point but I don't miss the hassle. I don't know how we managed to rub along together but we did.*' Terry's

commitment is now primarily moral, with a personal element in his relational identity, as Tina's husband.

Sally (72) and Shaun's (82) experience demonstrates how profoundly health issues can impact already difficult relationships. Despite 50 years marriage, Sally maintains no direct contact with Shaun, a CH resident for 3 years, now with advanced Alzheimer's, bedbound, and unable to speak. She does not want to visit, feeling no remorse, regret or guilt. With support from her wider family (and Sally working intermittently) the relationship survived difficult times through redundancies, financial hardship, postnatal depression, and raising children. Sally believes her developing Multiple Sclerosis in her early 40s broke the relationship: *'He always said it ruined his life. And I said what about mine?'* Subsequently, she felt unsupported and badly treated by Shaun. *'I did think about it [leaving him] but it would have disrupted [childrens' education].'*

Formally diagnosed with Alzheimer's' at around 70, Shaun remained home for 10 years with Sally caring for him despite his non-conversation, following her around obsessively, accusing her of having affairs and stealing money. Feeling vulnerable and unsafe, she could no longer cope with his desire for physical and sexual intimacy. Her growing resentment turned into *'wanting to get rid of him'*. Eventually Shaun's sectioning opened formal discussions with practitioners about a move. With family support, Sally decided she could no longer live with him.

Describing herself as a *'dementia widow'*, Sally notes *'I'm legally married. Until he dies, I shan't be free. And he could outlive me'*, clearly feeling structural commitment. Yet some element of moral commitment remains *'[Leaving him now] it wouldn't be right thing to do and it isn't as if someone is waiting for me'*. Although identifying as being part of a couple Sally no longer feels the need to enact commitment within it. Her sister who lives locally oversees Shaun's welfare visiting the care home as required, and their children also visit him infrequently when they can make it. LA offers Sally a space and a defense against the complications of proactively separating, and her own poor health helps her avoid familial or social pressures for not visiting.

Terry and Sally explicitly and implicitly negotiated the extent of their felt and enacted commitment. Within their already emotionally distant relationships, LA became a *de facto* separation in terms of the relationship and living arrangements, with which both seem content.

Living together apart

Married for 46 years, Ben (70) describes how Becky's (78) stroke 13 years ago changed their relationship. *'My life ended when she had the stroke really[...], and so did hers [...] she's not Becky anymore, she's not the woman that I married, and I'm not the man she married either[...]she's totally different, totally dependent. When we got married she was totally independent.'* For Ben, the loss of highly valued personal intimacies is profound: lack of joint decision making and sexual intimacy; constraints on doing things together, including conversations (given Becky's memory problems): lack of speech and mobility.

Across the 2 years of her CH residency, spending the day with Becky became central to Ben's daily routine. *'[I feel part of a couple] that's why I come in every day to see her [...] Yeah that hasn't changed.'* Intimacies the couple share now include kisses from Ben, a peck on cheek from Becky as directed by him, holding hands when she is in bed, spending time together in the care home lounge and occasional trips out for coffee or a meal.

Relying on intimate knowledge of Becky's tastes he does 'small things' (painting nails, doing hair, helping choose jewelry, coaxing to eat). However, identifying sexual intimacy as an important relationship need, sexual loyalty (previously integral) is no longer part of his commitment to Becky. A year or so following the stroke Ben began a sexual relationship alongside his continued commitment to Becky. Although Becky's recognition of Ben remains intact (as observed she gestured enthusiastically making excited sounds when she spotted Ben with researchers as she was being wheeled out for a bath) Ben thinks disclosing this affair to Becky is pointless given her cognitive incapacities.

Ben initially cared for Becky at home for 10 years, dismissing formal domiciliary support as unreliable, but eventually felt they both needed a social life and stimulation: *'I think it's better for her to be here and there's some stimulation. And I get away [...], otherwise I'd go bloody stir crazy.'* For them, cultural and social influences, proximate or distal, had been less important: commitment was personal between them, including the joint decision not to have children. From cohabiting, they married primarily to secure residency for Becky, then a foreign national. Despite Ben's sense that Becky is not the same woman he married, and no evident external pressure to remain married, he demonstrates persisting personal and moral commitment. Arguably, living apart allows Ben to simultaneously maintain commitment to Becky and to live his own life as he wishes, although he admits to an ongoing moral dilemma of whether he has done the right thing by Becky.

Through LA/CH, Ben negotiated his emergent relationship context to balance his commitment to his partner and to himself. For the CL spouses introduced next, the breakdown of care arrangements at home due to their partners' progressive cognitive illnesses, drove the separation by LA/CH.

For Ken (79) and Kelly (86), married 55 years, Kelly's move to a CH 9 months pre-interview came after nearly 5 years of home care with formal support. Kelly had mental health problems, including paranoia. Ken initially resisted the idea of a CH but gradually accepted when Kelly lost physical mobility he could no longer cope with caring responsibilities. He describes mixed emotions about the separation: relief, loneliness, and guilt since Kelly resisted the move.

When Kelly did come in here I personally felt a great relief after she was here [...] I don't mean elated [...], but I did feel like a burden had been lifted off of my shoulders, but then that burden lifted became a big void of not having Kelly at home. And I still have it [...] You get used to it, but that's not changing it, you get used to it because you have to not because you want to.

After having five children, and long before she became ill, Kelly decided she didn't want to sleep together anymore. Ken reflects on *'ups and downs'* in the relationship, which he strongly believes all marriages have, yet he feels they supported each other through difficult

times, and despite each thinking at times of leaving, they never separated. Indeed, Ken feels their relationship became stronger - *'she's my life, she always has been, she hasn't always known it though, that's the thing.'* Ken now has very practical ways of enacting commitment, overseeing Kelly's care, caring about and for her including undertaking her personal grooming needs. He holds hands, shows affection and talks to her even though conversation is becoming increasingly difficult due to her memory loss. Much time together is spent in Kelly's room as she cannot be seated comfortably in the lounge. Accepting physical separation, Ken bridges the gap by visiting daily, seeing it as a new routine within their long marriage. His commitment is primarily personal, to the love of his life.

Rita (79) and Roy (88) (married 58 years) often lived apart early in their marriage communicating through letters. Roy's work took him all over the world: Rita ran the household, raising two daughters, working part-time. Rita describes a happy and trusting marriage, despite financial uncertainties. She moved into a separate bedroom 12 years ago following heart surgery that made her *'restless in bed'*, which Roy amicably accepted. They had got to a comfortable place where physical intimacy mattered more than sexual intimacy.

Rita cared for Roy at home for many years eventually with formal support, feeling guilty at first about Roy's move to CH as his dementia progressed. She has been visiting at least 3-4 times weekly for the past 3 years: *'he can't remember my name. Not always anyway [...] he's safe and secure [...] I say to him do you like it here? Oh yes.'*

'We're still a couple. As far as I'm concerned and I think as far as he's concerned. He just knows'. Personally committed to the relationship, she believes Roy is too, despite his condition. She emphasises that LA is not new for them. Like Ben and Ken, Rita adapted by remaining closely involved in Roy's daily CH life. Spending much of their time together in the lounge, Roy does not initiate conversations, responding with 'yes' or 'no' when Rita speaks to him, actively leaning over, straining to listen and respond. Rita plans and thinks ahead about how to keep him engaged during the visit, bringing in food, photo albums and calendars (of his favorite dogs), touching and patting him frequently. Regularly decorating and updating his room with family photos, wildlife posters and souvenirs is an important relationship practice for Rita.

A positive perception and memory of shared history partly explains Ben, Ken, and Rita's personal commitment. Expressed through daily acts of caring for and about their partners, they continue to reaffirm commitment, actively renegotiating shifts in connectedness with their partners and their own needs, despite challenges of illness, reciprocity and of LA/CH. Their willingness to visit and organize their daily life around their partners is arguably aided by health and financial resources.

Impeded commitment

Danny's (82) expression of commitment to Dina (80) his wife of 40 years, in a care home for 3 years, is bound up with love, and a continued desire to live with her. *'I still love her as much as ever [...] and much more really [...] feel like I've lost something.* He describes being lonely, living apart experienced as physically and emotionally a hard loss – *'I've been with her all that while, and all of a sudden bang, gone. And it's the first time really in all that time that we've been apart.'* Dina had been living at home with Alzheimer's but as this progressed it became very difficult for Danny, a long-term wheelchair user, especially when she started wandering outside. Initially Danny hoped they might move together into accommodation with care, but this was never discussed as a possibility.

A re-marriage for both, each already had children: *'we'd no children at all between us, but we got on well. We travelled the world [...] my physical disability didn't help in that respect, I was curtailed as to what I could do and what I couldn't do. But she put up with me.'* Danny can no longer drive, or afford many taxis, so he depends on lifts when his own children (mostly daughter) from his first marriage can help. But short irregular visits are unsatisfactory for him, particularly as he finds Dina's progressively growing distance and un-responsiveness highly demoralizing. Dina likes to walk, rarely sitting down or making a conversation, leaving Danny to follow her around in his wheelchair when at the care home. Danny is beginning to wonder whether he should visit or spend precious resources on taxis only to feel rejected. For him doing and displaying his couple relationship amounts to taking Dina's pictures when he is there and sharing these with family and friends on Facebook. Unlike Rita, he is unable to accept the growing lack of recognition and responsiveness. He feels the only way to be fully

part of someone's life is *'to live with them really, you're actually in the room and things happen while you're there. That's the only way you can do it'* but there is no current prospect of an arrangement that would enable them to live together in a CH.

Especially in positive relationships, the inability to bridge the separation physically and emotionally hurts the CL spouse. *'I think we had a good life together[..] I don't see anything wrong with it at all, which makes it even worse for me.'* Danny's commitment is personal but can't be enacted in ways that matter to him. LA/CH is creating a distance in their relationship with Danny working hard to avoid loneliness.

Percy's (85) first marriage eventually floundered on his wife's mistrust regarding imagined infidelity while he worked away for extended periods. He subsequently met and married Penny (now 75) about 30 years ago. Penny was an entertainer and Percy describes them as a team- *'we worked together. I don't believe in the one way.'* In this remarriage, Percy appears to have prioritised commitment to the relationship over work, in contrast with his first marriage keeping very close to his wife.

A decade ago, Penny's only son from a previous marriage sustained serious injuries resulting in a long-term coma, affecting Penny deeply. A non-smoker/drinker himself, during this period Percy accommodated Penny's heavy smoking and drinking. Over time she started showing signs of dementia. Percy tried to keep her engaged in her hobbies as his own health started deteriorating. Two years ago, his GP suggested a care home for Penny as Percy's worsening heart condition now required avoiding the stress of coping and safeguarding her. Percy's daughter and daughter-in-law undertook responsibility for managing the couple's ongoing health issues and arranged a permanent care home place for Penny. Accepting this was hard for Percy, but he sees the move as essential for both. *'I've got to look after myself to look after her. Because we were very happy, I know it's cost me a lot of money to keep her in [CH] but I felt that she was being well looked after'.*

At the time of interview, Percy was in fragile health awaiting a heart operation and visiting Penny only when he felt well enough to drive. Percy demonstrated strong personal commitment over many years and still regards them as a couple – *'she's never out of my mind,*

always in the conversations like with my children.' Penny observably enjoys Percy's company, exhibiting a degree of familiarity and making small comments toward him. Now unable to enact much commitment to Penny until after his operation, Percy thinks he may seem selfish putting his own health first, but he emphasises that illness is forcing him to prioritise and divide his commitment.

Contextual constraints of health, material circumstances and the institutional system are in different ways shaping Danny and Percy's enactment of commitment. Adult children have stepped in to bridge the gaps but, as in Danny's case, their efforts may not be enough to maintain the relationship in ways that matter to the CL spouse.

Discussion

Despite CH partners progressively losing ability to reciprocate, CL spouses maintained relationships. However how relationships were maintained and practiced varied widely. The concept of commitment offers a useful lens to help interrogate these variations. In LA/CH circumstances, the shape of commitment is now very often one-sided. We find that enacting and navigating commitments does not automatically stem from being married, but likely evolves and changes in the context of the relationship. A relationship history approach to exploring experiences of LA /CH couples offers insights into how very different and individual experience and consequences are in these circumstances. Their histories affect current relationships but are not the whole story of how and why CL spouses remain committed.

Kapinus and Johnson (2002) argued a need to attend to the multifaceted nature of commitment alongside the balance of commitments in different types of relationships and over time. Although partnerships were rooted in structural and legal commitments of marriage, most CL spouses tended to emphasise personal aspects of commitment holding the relationship together. Two CL spouses no longer treasured the relationship, stressing a minimal or a binding commitment, largely moral and/or structural, but enough for self-identification as 'a couple'. For these spouses, care homes acquiring primary responsibility for CH partners' care enabled them to renegotiate their obligations, challenging the discourse and expectation of (gendered) care as an aspect of marital commitment.

Specific partnership histories, perceptions and future considerations (as partners may never again cohabit) can not only relationally shape CL spouses' ongoing acknowledgement and display (or not) of commitments, but also influence whether and to what extent CL spouses participate in relationship maintenance. Some CL spouses continued to organise daily life around the life of their CH partner, putting in more emotional and embodied relationship work to sustain intimacy and connectedness. Others fitted their partners around their own daily life and in comparison, were less (or not) involved. CL spouses also varied in the extent to which they felt guilty and/or ambivalent about agreeing their partner should move into a care home, even as they were in their 2nd or 3rd year of living apart.

Viewed as a process, 'commitments' are fluid, developing and changing over time (Smart 2007). Although heard through the voice of the CL spouses this was evident in the personal and relational biographies of couples where entering the relationship set the context for commitments to develop. Personal commitments were facilitated or hindered, surfacing moral and structural aspects. We note that personal commitment may persist despite other aspects of commitment (for example to sexual fidelity, or joint decision-making) consciously or unconsciously disappearing, without ending the relationship.

While somewhat disturbed, commitment endures in one form or another (personal, moral or structural) with continuity (of history, memories and biographies) within relationships, informing understandings that contribute to present interactions. If positive, and where financial and health resources enable, shared histories can fill in gaps created by loss of crucial intimacies such as communication, or partners' growing lack of recognition and responsiveness. Instead of being lost (Forsund et al., 2015) couplehood takes on different forms coming through different perceptions and practices of commitment.

Our findings challenge previous ideas that LA/CH separation may not always be voluntary since it can sometimes be actively sought. Further work is required to explore differences in behaviours here between men and women. Living apart can become a mechanism, by default or design, to balance commitments to partner/relationship and self - or it can become a hindrance to enacting commitment. Where relationships have already deteriorated and do not improve, LA/CH may offer CL spouses an amicable alternative to dissolving a relationship,

avoiding the stress and complications of legal dissolution. Where, actively sought, LA/CH enables flexibly reconciling own interests with commitment to the CH partner and relationship. Living apart therefore offers opportunities to renegotiate the balance of commitment and its enactment, in turn offering a more individualized way of living for some CL spouses, although not carefree. For others distance becomes a problem when serious health conditions and/or resource constraints impede visiting: and place becomes significant because of the mediating role of both the domestic home and care home.

Unlike LAT and LLAT involving an intention for future marriage/cohabitation or an alternative to it, LA/CH occurs within the context of well-developed long relationships and to continue the spousal relationship in late life. Findings suggest that when we consider relationship commitment in these circumstances, we need to understand how relationships can change over time, with potential shifts in emotional intensity, meaning, and expression. Whereas at other lifecourse stages (Carter 2012), commitment is about building up the relationship, here commitment is more about tenacity and choices in the face of extremely challenging circumstances. Contrasted with other lifecourse stages, the balance of commitments likely involves negotiations around commitment to a partner/relationship and emerging commitment to self (rather than to family and work).

We recognise our sample is uneven, with more male CL spouses than female. This may have influenced our findings as gendered repertoires can affect what commitments are accepted and enacted – though not definitively. Despite actively recruiting couples to the study (departing from previous work), CH partners were unable to articulate their perceptions of the relationship, although we observed at length how they interacted (or not) with their spouses. Methodologically, however, inclusion of the ‘couple’ uncovered new knowledge. Unlike previously, we could capture spouses who were ‘more and less’ involved in daily life of their CH partners. We noted that adult daughters stepped in to support commitments where CL spouses’ experienced health or financial constraints. But exploring why or how these commitments were negotiated within the wider family was beyond the scope of this study.

While no readily available UK data exists on numbers of LA /CH couples, it is likely that as couples live longer with progressive conditions, more may find themselves in this situation. We were unable to reach partners who have stopped visiting whether or not they still regard themselves as part of a couple. However, given the varied nature of commitment seen in this study, we cannot safely conclude that if partners do not visit there is no commitment. Prevailing external circumstances, lack of emotional or practical support, and CL spouse's own deteriorating health can make expressing and enacting commitment difficult.

As evidenced from this study, longstanding marriages of older adults may signify the lifelong but multifaceted nature of commitment, suggesting need for nuanced understandings rather than seeing commitment as a straightforward generational expression of marital obligations and duty. Nature of felt commitment tended to reflect in the extent to which and type of relationship practices CL spouses engaged in (for example, demonstrating affection, holding hands or taking care of bills) (Canary and Dainton, 2006). We note that personal and relational biographies, material, and contextual constraints relationally shape (Burkitt 2016) the felt nature and enactment of commitment. Further exploration is required of how meanings ascribed to commitment between partners in these final years of the relationship are influenced by: age with reference to health; finitude of life; adult children (if any); and differential financial and legal impacts of separation. More consideration is needed on what this varied nature of commitment means in practice for care homes, social workers, and the wellbeing of LA/CH couples.

Notes

1. We acknowledge the concept of 'older' is not definitive and for purposes of our study is defined as age 65 and over.
2. The term care home is used for both residential care homes and nursing homes with registered nursing staff present in the latter. Although both types of care home are financed through means testing, nursing homes gain some financial support through the NHS.

3. What might constitute a 'longstanding' marriage is lacking definition. However, some, for example (see Lauer and Lauer 1986; Alfred-Cooper 1998) define marriages lasting at least 15 years and over as long-term.

References

- Bambusch, J. and Phinney, A. (2014) Invisible hands: the role of highly involved families in long-term residential care, *Journal of Family Nursing*, 20(1), 73-97
- Beaujouan, É. And Ní Bhrolcháin, M. (2011) Cohabitation and marriage in Britain since the 1970s. *Population Trends*, 145, 35–59
- Bisdee, D., Daly, T., & Price, D. (2012). Behind Closed Doors: Older Couples and the Gendered Management of Household Money. *Social Policy and Society*, 12, 163 - 174.
- Braithwaite, D. (2002) 'Married widowhood': maintaining couplehood when one spouse is living in a nursing home, *Southern Communication Journal*, 67(2), 160-179
- Brown, S. and Wright, M. (2017). Marriage, Cohabitation, and Divorce in Later Life, *Innovation in Aging*, 1(2) igx015, <https://doi.org/10.1093/geroni/igx015>
- Boyle, G. (2013) Still a woman's job: the division of housework in couples living with dementia, *Families, Relationships and Societies*, 2(1), 5-12
- Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology, *Qualitative Research in Psychology*, 3(2), 77-101
- Burkitt, I. (2016) Relational agency: Relational sociology, agency and interaction. *European Journal of Social Theory*, 19(3), 322-339.
- Burridge, L, Winch, S., and Clavarino, A. (2007) Reluctance to care: a systematic review and development of a conceptual framework, *Cancer Nursing*, 30(2), E9-19

- Calasanti, T., and King, N. 2007. Taking 'women's work' 'like a man': husbands' experiences of care work. *The Gerontologist*, 47(4), 516-527.
- Cash, B., Warburton, J., and Hodgkin, S. (2019), Expectations of care within marriage of older couples, *Australasian Journal on Ageing*, 38(1), E19-E24
- Carter, J. (2012). What is commitment? Women's accounts of intimate attachment. *Families, Relationships and Societies* 1(2), 137–153
- Canary, D. J., and Dainton, M. (2006). Maintaining Relationships. In A. L. Vangelisti & D. Perlman (Eds.), *The Cambridge handbook of personal relationships* (pp. 727–743). Cambridge University Press. <https://doi.org/10.1017/CBO9780511606632.040>
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (Third Edit). Los Agneles: Sage Publications.
- Chambers, P., Allan, G., Phillipson, C., and Ray , M. (2009), *Family practices in later life*, Policy Press: Bristol, 39-51
- Connidis, I. A., Borell, K., Karlsson, S. G. (2017). Ambivalence and living apart together in later life: A critical research proposal. *Journal of Marriage and Family*, 79(5), 1404–1418. <https://doi.org/10.1111/jomf.12417>
- Coulter, R. and Hu, Y. (2017) 'Living Apart Together and Cohabitation Intentions in Great Britain', *Journal of Family Issues*, 38(12), pp. 1701–1729. doi: [10.1177/0192513X15619461](https://doi.org/10.1177/0192513X15619461).
- Duncan, S., Phillips, M. (2011). People who live apart together (LATs): New family form or just a stage? *International Review of Sociology*, 21, 513-532.
- Dewing, J. (2008) Process Consent and Research with Older Persons Living with

Dementia. *Research Ethics*, 4(2), 59-64.

Forsund, L.H., and Ytrehus, S. (2018), Finding a place to connect: a qualitative study exploring the influences of the physical and social environments on spouses' opportunities to maintain relationships when visiting a partner with dementia living in long-term care, *Dementia*, 17(7), 858-879

Forsund, L.H., Skovdahl, K., Kiik, R., and Ytrehus, S. (2015) The loss of a shared lifetime: a qualitative study exploring spouses' experiences of losing couplehood with their partner with dementia in institutional care, *Journal of Clinical Nursing*, 24(1-2), 121-130

Gabb, J. and Fink, J. (2015). *Couple relationships in the 21st century*. Basingstoke: Palgrave Macmillan.

Gilleard, C., and Higgs, P. (2013). The fourth age and the concept of a 'social imaginary': A theoretical excursus. *Journal of aging studies*, 27(4), 368–376.
<https://doi.org/10.1016/j.jaging.2013.08.004>

Hawkins, N. and Booth, A. (2005) Unhappily Ever After: Effects of Long-Term, Low-Quality Marriages on Well-Being, *Social Forces*, Volume 84(1), 451–471

Hayes, J., Boylstein, C., and Zimmerman, M. (2009) Living and loving with dementia: negotiating spousal and caregiving identity through narrative, *Journal of Aging Studies*, 23(1), 48-59

Hackstaff K. (1999). *Marriage in a culture of divorce*. Philadelphia, PA: Temple University Press

Hinchcliff, S. and Gott, M.(2004) Intimacy, commitment and adaptation: sexual relationships within long-term marriages, *Journal of Personal and Social Relationships*, 21(5), 595-609

House of Lords. 2013. 'Ready for ageing?' Select Committee on Public Service

- and Demographic Change. Report of Session 2012–13. HL Paper 140. London: The Stationery Office Limited.
- Hubbard, G., Downs, M. and Tester, S. (2003). Including older people with dementia in research: challenges and strategies. *Aging & Mental health*, 7, 351–362.
- Jamieson, L., Anderson, M., McCrone, D., Bechhofer, F., Stewart, R., and Li, Y. (2002). Cohabitation and commitment: Partnership plans of young men and women. *The Sociological Review* 50(3): 356–377
- Johnson, M. (1991) Commitment to personal relationships. In: W. Jones and Periman, D. (eds.). *Advances in Personal Relationships* (3.) London: Jessica Kingsley, 117–143
- Kaplan, L.(2001) A couplehood typology for spouses of institutionalised persons with Alzheimer’s disease: perceptions of ‘we-I’, *Family Relations*, 50(1), 87-96
- Kapinus, C., and Johnson, M. (2002) Personal , moral and structural commitment to marriage: gender and the effects of family life cycle stage, *Sociological Focus*, 35(2), 189-205
- Langner, L. , & Furstenberg, F. (2020). Gender Differences in Spousal Caregivers' Care and Housework: Fact or Fiction?. *The journals of gerontology. Series B, Psychological sciences and social sciences*, 75(1), 173–183. <https://doi.org/10.1093/geronb/gby087>
- Merrill, B. & West, L. (2009). *Using Biographical Methods in Social Research*. Sage.
- Milligan, C. (2005) From home to ‘home’: situating emotions within the caregiving experience, *Environment and Planning A*, 37(12) 2105-2120.
- ONS (2011) *2011 Census analysis: What Does the 2011 Census Tell Us About People Living in Communal Establishments*[online]Available at <https://www.ons.gov.uk/peoplepopulationandcommunity/housing/articles/2011censusanalysiswhatdoesthe2011censustellusaboutpeoplelivingincommunalestablishments/2015-02-11> [Accessed 21 October 2021]

ONS (2013) What does the 2011 census tell us about older people? Published by

Office for National Statistics [online] Accessed from

http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171776_325486.pdf [Accessed 20 September 2021]

ONS (2017) *Marriage and divorce on the rise at 65 and over* [online] Available at

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/marriagecohabitationandcivilpartnerships/articles/marriageanddivorceontheriseat65andover/2017-07-18>

ONS (2019) *Population estimates by marital status and living arrangements, England and*

Wales:2018 [online] Available at

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/populationestimatesbymaritalstatusandlivingarrangements/2018#how-have-patterns-of-marital-status-changed-over-the-last-decade>

[Accessed 20 November 2020]

SCIE .(2020). *Dementia at a glance* [online] available at

<https://www.scie.org.uk/dementia/about/> [accessed 20 October 2021]

Smart, C. (2007). *Personal life*. Cambridge: Polity Press

Puurveen G, Baumbusch J, and Gandhi P. (2018) From family involvement to family

inclusion in nursing home settings: a critical interpretive synthesis. *Journal of Family Nursing* 24(1), 60–85.

Ray, M. (2000) Older women, long-term marriage and care, in M.Bernard, J.Phillips,

L.Machin, and V.Harding-Davides (eds) , *Women ageing: changing identities , challenging myths*, London: Routledge, 148-67

Ross, M., Rosenthal, C., and Dawson, P. (1997), Spousal caregiving in the institutional

- setting: visiting, *Journal of Clinical Nursing*, 6, 473-483
- Rolland, J.S. (2017) Neurocognitive impairment: addressing couple and family challenges, *Family Process*, 56(4), 799-818
- Tilse, C. 1997. She wouldn't dump me: the purpose and meaning of visiting a spouse in residential care. *Journal of Family Studies*, 3 (2), 196-208.
- Thomeer, M.K., Mudrazija, S. and Ange, J.L. (2017) Relationship status and long-term care facility use in later life, *Journal of Gerontology B: Psychological and Social Sciences*, 71(4) 711-723
- Verd, J. M., & López, M. (2011). The rewards of a qualitative approach to life-course research. The example of the effects of social protection policies on career paths. *Qualitative Social Research*, 12(3).
- Walkerdine, V., Lucey, H., & Melody, J. (2003). Subjectivity and qualitative method. In T. May (Ed.), *Qualitative research in action* (pp. 179-196). London: Sage
- Widmer, É., Kellerhals, J. & Lévy, R. (2006). What Pluralization of Family Relations : Conflicts, Conjugal Interaction Styles, and Social Milieu. *Revue française de sociologie*, 5(5), 131-156. <https://doi.org/10.3917/rfs.475.0131>
- Wilson, D. (2006) A new look at the affluent worker: the good working mother in post-war Britain, *Twentieth Century British History*, 17(2), 206-229
- Williams, L.A., Giddings, L.S., Bellamy, G., and Gott, M. (2017) 'Because it's the wife who has to look after the man': a descriptive qualitative study of older women and the intersection of gender and the provision of family caregiving at the end of life, *Palliative Medicine*, 31(3) , 223-230.

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Table 1: Qualitative dataset and fieldwork timeline

	*Pseudonym (with age)	Emotion mapping (CL spouse)	Individual in-depth interview (CL spouse)	Individual short Interview and observation s (CH partners) where consultee consent received	**Observatio ns with CH partners in presence of CL spouse as per consultee	Joint couple Interview
1	Percy (85) and Penny (75)	October- November 2018	November 2018	March 2019 – September 2019 (6 observation s including short interviews)	n/a	April 2019
2	Sally (72) and Shaun (82)	December 2018 – January 2018	December 2018	March 2019 – September 2019 (6 observation s)	n/a	None as Sally does not visit
3	Rita (80) and Roy(89)	December 2018- January 2018	February 2019		April – September 2019 (6 observations)	May 2019
4	Ben (70) and Becky (78)	May- June 2019	March 2019	March – July 2019 (5	n/a	May 2019

				observations)		
5	Terry (79) and Tina (81)	October – November 2018	October 2018	October 2018 – April 2019 (3 observations only)	n/a	None as passed away
6	Danny (82) and Dina (80)	October- November 2018	November 2018	March – September 2019 (6 observations including short interviews)	n/a	April 2019
7	Ken (79) and Kellie (86)	Refused	April 2019	N/A	None	None as consultee permission not received

*Pseudonym: names in bold refer to the community living partner

**Permission granted for observation of CH partners but only in presence of their CL spouses