Intra-couple Caregiving of Older Adults Living Apart Together: Commitment and Independence*

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RÉSUMÉ

Récemment, un nombre accroîssant d'adultes d'âge mûr ou plus agés se lancent dans des relations de "vivre ensemble séparément" après le divorce ou pendant le veuvage. Un "VES" est une relation intime dans laquelle les partenaires maintiennent domiciles séparées. Cette étude a examiné les types de soins pour les couples VES plus âgés et à long terme, et a dévoilé des commentaires personnels au sujet des soins pour ces couples. Nous avons interrogé 25 VES partenaires et aussi avons interrogé un groupe de comparaison de 17 personnes âgées qui se sont remariées dans les Pays-Bas, à travers une étude ancillaire à la Panel Study Pays-Bas parenté (PSP-BP). Les résultats ont révelé qu'environ la moitié de ces partenaires VES a l'intention d' échanger des soins si nécessaire (engagement du partenariat); l'autre moitié a éprouvé des sentiments ambigus, ou avait l'intention de refuser des soins (l'orientation indépendante). Toutefois, pour les partenaires VES déjà confrontés aux maladies dans leur relation actuelle, tous ont soigné partenaires dans leur besoin. La minorité de partenaires VES qui ne voulait pas échanger réciproquement les soins sont plus susceptibles de donner, plutôt que de recevoir, des soins.

ABSTRACT

Recently, rising numbers of mid-life and older adults are starting a "living apart together" (LAT) relationship following divorce or widowhood. *LAT* describes an intimate relationship wherein partners maintain separate households. This study investigated the characteristics of care arrangements in older long-term LAT couples and elicited personal comments about intra-couple care. We interviewed 25 LAT partners and a comparison group of 17 remarried older adults in the Netherlands in a side study of the Netherlands Kinship Panel Study. Results showed that about half of the LAT partners intended to exchange care if needed (partnership commitment); the other half had ambiguous feelings or intentions to refuse care (independence orientation). However, for those LAT partners already confronted with illness in their current relationship, all provided care to the partner in need. The minority of LAT partners who would not exchange care reciprocally are more likely to give as opposed to receive care.

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Most middle- and older-aged couples consist of men and women in first or subsequent marriages, who live together in a two-person household, or who share their household with one or more children. However, growing numbers of older adults have other partner and living arrangements. Especially in Northern and Western Europe, the United States, and Canada, an increasing percentage of mid-life and older adults live as cohabiting couples after divorce or bereavement (Le Bourdais & Lapierre-Adamcyk, 2004; Sassler, 2010). Some are involved in a "living apart together" (LAT) relationship, an intimate partner relationship without a shared household (de Jong Gierveld, 2004; Duncan, Carter, Phillips, Roseneil, & Stoilova, 2012; Strohm, Seltzer, Cochran, & Mays, 2009; Turcotte, 2013).

Of all adults aged 60 and older in Canada, the percentage in LAT arrangements grew from 1.8 in 2001 to 2.3 per cent in 2011 (Turcotte, 2013). According to J. Latten (personal communication, November 10, 2014) of all adults aged 50 to 64 in the Netherlands, the percentage in LAT relationships evolved from 2.6 in 2003 to 4.3 in 2013. The percentages for all adults aged 65 to 79 was 2.1 in 2013. In Sweden, always a forerunner in new forms of unions, the percentage of those in LAT relationships in the age group 60–90 years was 5.1 as of 2014 (Öberg & Bildtgard, 2014).

The LAT relationship is defined as an intimate partner relationship, where partners maintain separate households and share living quarters on an intermittent or temporary basis – that is, several days a week or on weekends (de Jong Gierveld, 2004, 2002; Duncan et al., 2012; Levin, 2004; Stevens, 2002). Long-term LAT relationships are more characteristic of older adults and endure for a longer period of time, in contrast to transitional LAT partnerships, where LAT is a temporary period prior to cohabitation and most frequently seen in younger adults (Turcotte, 2013).

With increasing age and as a result of deteriorating health conditions, the likelihood arises that an older person may require support and care. Research has indicated that care provided by cohabiting older partners might not match the mutual care provided by older married couples (Moustgaard & Martikainen, 2009; Noël-Miller, 2011; Sherman, 2012). Additionally, research by Duncan et al. (2012) and Duncan, Phillips, Carter, Roseneil, and Stoilova (2014) on intra-couple support and care provided by LAT partners showed that a substantial portion of partners in LAT arrangements support one another in everyday activities, but when it comes to care during illness, LAT partners lag behind cohabiting partners. However, most research into care exchanges within LAT relationships does not specifically address the situation of older adults involved in long-term LAT relationships. This is disappointing because this is the age group most likely to be confronted with health problems in the couple dyad.

Faced with the dilemma of growing demands for services among aging populations, and the need to contain the costs of care provision, many governments have reformed their long-term care services in the past 15 years. Publicly supported long-term care services (both for residential and home care) are restricted, and policy makers increasingly seek to activate and maintain network members as caregivers for older adults confronted with deteriorating health conditions (Pavolini & Ranci, 2008; see also van den Broek, Dykstra, & van der Veen). The Dutch government, for example, legislated new rules that increase the caring responsibilities of partners and children (Grootegoed, Van Barneveld, & Duyvendak, 2015). Additionally, the government of Alberta has positioned government support as a last resort:

> "Individuals have primary responsibility for preparing for their senior years. This includes meeting their own basic needs, and securing the resources they will require for the lifestyle they choose as they age. Individuals, their families and support networks also play important roles in supporting wellness and well-being, such as encouraging healthy lifestyles and accessing medical care when necessary." (Government of Alberta, 2010, p. iii)

Given this policy climate, it is important to examine intra-couple care, particularly the functioning of care exchanges in couples that do not share households and to assess whether these new requirements are manageable for them. Investigating the attitudes and behavior of older LAT partners with respect to taking an active role in caring for their partners is a timely endeavor. The objective of this study was to enhance understandings of LAT care exchanges by comparing long-term elderly LAT partners with elderly remarried adults. This comparison informed our research question: What can be said about the attitudes and behaviors of older long-term LAT partners regarding their role as primary caregivers of their partners, in cases of illness and hospitalization? We used qualitative data from a mini-panel side-study of the Netherlands Kinship Panel Study to investigate long-term LAT bonds by exploring nuances and differentiations in care arrangements and by eliciting personal comments and ideas regarding intra-couple care exchanges.

Conceptual Background

LAT after Divorce or Widowhood

Starting an LAT relationship in later life, after divorce or widowhood, can be an attractive alternative for co-residential couple relationships. LAT arrangements can shield children and families from perceived

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interlopers (Cross-Barnet, Cherlin, & Burton, 2011; de Jong Gierveld & Merz, 2013; Levin, 2004; Or, 2013; Strohm et al., 2009; Turcotte, 2013; Upton-Davis, 2015) or they can support personal preferences, such as a wish for independence (Duncan & Phillips, 2010; Funk & Kobayashi, 2014; Haskey, 2005; Milan & Peters, 2003; Moustgaard & Martikainen, 2009; Stevens, 2002).

Research by Régnier-Loilier, Beaujouan, and Villeneuve-Gokalp (2009) on LAT partners in France enumerated four types of LAT partners, one of which was LAT seniors aged 55 and over. Among these senior LAT partners, more than 80 per cent were divorced or widowed, had non-cohabiting children, had partners living within a mean of 30 minutes' travel time, and were involved in LAT primarily for reasons other than practical constraints such as working in different regions of the country. This set of characteristics aligns with research outcomes among LAT partners in the United Kingdom (Duncan et al., 2012), which found that younger adults are more frequently in LAT relationships because of practical constraints. Turcotte (2013) showed that only a minority of Canadian LAT partners aged 60 and older wanted to share a household with their current partner eventually. In fact, de Jong Gierveld (2004) showed that a long-term LAT relationship in later life is an attractive option especially for older widows and divorced women, who, by partnering in this way, combine commitment and intimacy with their wish for independence and self-reliance. However, the extent to which commitment in long-term LAT relationships of older re-partnered adults encompasses personal care in cases of a partner's illness or hospitalization remains unknown.

LAT and Care: "Doing Good Partnership"

Older adults who remarry, cohabit, or enter into an LAT relationship after divorce or widowhood often have complex partner and family histories, resulting in large and diffuse kinship networks. These networks can encompass biological children, stepchildren, grandchildren from biological or stepchildren, siblings from both partners, and other family members. Given the advanced age of the new partners, many of their children have left the parental home, but this does not preclude a child's evaluation of their parent's new partnership. Depending on the specific situation of the new older couple, some new partners will be recognized as a member of the family and invited to participate in familial activities while some are not. Non-cohabiting partners are less likely to be accepted as a family member than cohabiting partners (Koren, 2014; Koren & Lipman-Schiby, 2014). In many cases, children of the new partner are recognized as stepchildren and are treated and supported equally to biological children; in other cases, children interpret the re-partnering of parents as a replacement for couplehood but not for parenthood, and, consequently, emotional difficulties and ambivalence are reported (de Jong Gierveld & Merz, 2013; Koren & Lipman-Schiby, 2014).

Given the diversity and fluidity of re-partnered older adults' relationships, individuals must affirm to others that these new relationships are actually family relationships. By "doing family things", new partners can display the fundamental social nature of their family practices (Finch, 2007), be it in the context of remarriage, cohabitation, or LAT arrangements. A crucial question for new partners is their preparedness to "do right by their family and partner" and care for the partner in cases of serious illness or hospitalization; the commitment of older LAT partners is frequently doubted.

Boundaries between kin and friendship relationships often are blurred (Spencer & Pahl, 2006); however, the normative framing of family and friendship ties remains distinct in several important regards. According to Allan (2008), friendship ties are characterized more frequently by negotiations and flexibility (for friendship roles, see also Keating, Otfinowski, Wenger, Fast, & Derksen, 2003; Lapierre & Keating, 2013), as compared to the normative and material constraints that guide family network responsibilities.

There are indications that the more care needed from an LAT partner, the greater the risk that a partner will try to avoid or even refuse to provide care. As Karlsson, Johansson, Gerdner, and Borell (2007) have shown, very few LAT partners would end their relationship because of their partner's ill-health, but most of them envisage taking on a relatively limited degree of care for their partner. In taking the aforementioned perspectives into account, we can further refine our research question. Are there variations (more or less oriented towards "good partnership") in intra-couple care attitudes of older LAT partners in cases where their partner needs help? Do LAT partners' care behaviours differ according to whether they prioritize commitment to demonstrate that they are "good partners" versus prioritizing negotiation, flexibility, and independence as characteristic of friendship roles (Keating et al., 2003; Lapierre & Keating, 2013; Pahl & Spencer, 2004)? In answering these questions, context has to be taken into account. Caregiving may be contingent on the presence of other kin, non-kin, work responsibilities, and upon personal constraints such as age and health conditions. For example, LAT partners living with dependent children face several constraints in taking care of a non-cohabiting partner.

Methods

Participants

In this study, I used qualitative methods to explore ideas about care giving and receiving, and about the

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motives to provide or not provide care. Moreover, qualitative methods are convenient in exploring perceived obstacles to care exchanges. The open character of qualitative methods allows eliciting social norms that influence commitment to exchange care in either a married co-resident couple's situation or in a situation of LAT. I analysed qualitative data collected via semi-structured interviews with a selection of Wave 2 Netherlands Kinship Panel Study (NKPS) respondents. At Wave 1 (2003–2004), computer-assisted personal interviews were conducted with 8,161 men and women aged 18 to 79 (Dykstra et al., 2005). At Wave 2 (2006–2007), 6,085 of the respondents were re-interviewed (Dykstra et al., 2007). Adults older than age 50 at Wave 2 with new partners after their divorce or widowhood ($n = 350$) were at the core of this study; these included 251 men and women who lived with a new partner and were remarried (69%) or cohabiting (31%) and 99 men and women who had an LAT relationship with a new partner.

At the end of the interviews at Wave 2, I solicited respondents for participation in a follow-up interview. I invited only a subsample of follow-up respondents to be involved in this in-depth study; two refused because of health reasons. In total, we interviewed 25 LAT adults and 17 remarried adults for this study. A professional interviewer and the author of this manuscript conducted the interviews in 2008–2009. All the interviews were conducted in respondents' homes throughout the Netherlands. The mean duration of the interviews was 60 to 90 minutes. The 25 interviews with LAT adults encompassed 14 males and 11 females, and the 17 interviews with remarried older adults encompassed 8 male and 9 female interviewees. All were in heterosexual relationships. Note that interviewees each represented a separate couple. All of the LAT partners lived in one-person households. Mean age during the fieldwork phase of Wave 2 was 62 years for the LAT interviewees and 64 years for the remarried interviewees.

Measures and Procedures of the Qualitative Study

Researchers had ample information on the respondents' socio-demographics, partner status and partner history, children, social network, and health status, based on the data gathered at Waves 1 and 2 of the NKPS surveys. Thus, the semi-structured interview guide for this study included various aspects of the participants' relationships with their partners, children, and other family members. Separate modules were used to investigate the mechanisms behind emotional, instrumental, and financial support, and personal care, respectively.

This study investigated the most demanding aspect of relationships: personal care provided to a sick person. To open the personal care module, respondents answered the following question: "Have you been ill during the past few years, or have you been in the hospital and needed time at home to recover? Who cared for you during that period of time? Who did most of the job? How did you tackle this situation?" The same question, though centered on the partner's health rather than the respondent's, was then posed. If the interviewee answered "not applicable", a follow-up question was posed: "Have you considered how you would cope if you or your partner became ill and needed support to recover from illness or hospitalization?" The respondents had ample time to answer these questions. During the interview, the interviewer asked additional questions for clarification and further insight. The data showed that 13 of the 25 LAT individuals had experienced giving and/or receiving care from their partner; 7 of 17 remarried respondents had experienced giving and/or receiving care from the partner.

Interviews were recorded and transcribed to prepare the data for entry into the qualitative data system. The analysis procedure started with inductive open coding of the interview texts, resulting in a set of coding categories (Glaser & Strauss, 1967; LaRossa, 2005). Next, we examined and compared the coding categories to note similarities and differences. The coding categories were combined into clusters of related categories. Coding schemes were revised and expanded as our interpretations and explanations progressed.

Results

Attitudes of Older Re-partnered Adults

In this section, I first address the answers of interviewees who had not provided care to their current partner or received care from their partner. Attitudes differed to a large extent. We elicited responses about "doing good partnership", as well as ambivalent attitudes and explicit refusals to care. I ended the analyses with four categories: (1) unconditional intent to "do good partnership"; (2) intent to do good partnership while maintaining an awareness of age and health obstacles; (3) ambivalence and mixed feelings regarding care exchanges; and (4) explicitly refusing care, while emphasizing independence. Each of the four categories will be illustrated with examples. Choices for illustration were made according to data richness.

Intent to Do Good Partnership

The data showed that several older adults expect reciprocal care within their current partner relationship. A man, aged 58 years, remarried for 18 years, formulated his expectations regarding future care briefly and to the point as follows:

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> "It is obvious that you would do that …"

A 60-year-old woman, remarried for 10 years, was more detailed in formulating her ideas. She explicitly mentioned that the couple bond served as a care paradigm for the future:

> "We are confining ourselves to our couple situation. We don't intend to bother the children. Yes. We prefer to do it ourselves. Eventually, quite a lot less, but we'll do it ourselves."

This woman also referred to the possible role of children in caring for their parents, but that option was not portrayed as preferable. She released the children from obligations and expectations, which were, in her view, associated primarily with the couple bond. A 73-year-old woman, LAT partner for five years, formulated her expectations regarding reciprocal care as follows:

> "… we will care for each other. Yes, I am convinced we will."

These three examples showed intent to provide care from both an LAT partner perspective and a remarried perspective.

Intent to Do Good Partnership, while Being Aware of Age and Health Obstacles

Older adults that we interviewed were aware of potential limitations to their care provision. A common source of concern was the onset of their own health problems, particularly in interviewees in the older and oldest age brackets. One of the remarried men, aged 72 years, whole-heartedly answered "yes" when asked whether he would care for his partner were she to fall ill or need care to recover, but also mentioned his concerns regarding intensive care:

> "Yes, … but when it comes to intensive care, then it is another story. I don't know if I can manage to carry it off … I think I would have problems".

Unconditional care expectations were also expressed by an 83-year-old man, LAT partner for 15 years:

> "I would care for her, of course, I would care for her. If necessary, I will never let her down. But of course, I am 13 years older than she is.… and age matters a lot".

These statements referred to the possibility that age and health problems might be an obstacle to care provision. However, the intent to support was present in these answers. A 78-year-old woman, LAT partner for 23 years, gave her feelings as follows:

> "No, you can't expect that an older person would come over to care for me. That's utter nonsense. I should not want that, shouldn't I?"

It is important to note that this woman's answer was not an outright refusal: it was an expression of uncertainty and a process of weighing the options of accepting or refusing care. The questioning conclusion of "I should not want that, shouldn't I?" was a moment where she seemingly sought the interviewers' approval.

Ambivalence and Mixed Feelings Regarding Care Exchanges

Whether the quality of the partner bond was a factor encouraging or discouraging the provision of care was not explicitly interrogated in the study. However, one interviewee's comment that the poor quality of her marriage bond played a part in her mixed feelings regarding receiving care from her current partner was relevant. A remarried woman, aged 59, answered:

> "I would care for him, but I wouldn't accept his help, no … our love is over …".

Note that in this case of doubt and refusal, the receipt of care was the first action that was refused and not the provision of care.

The next example, from a 65-year-old woman in an LAT partnership for 11 years, also reflected uncertainty, although her initial words seemed to express a strong attitude:

> "No, I intend NOT to care for him. No … It does not feel good, of course … but, … eh, if we were married, then you would care and now, I don't do it. … I talked about this with others. One says, you can do somewhat more. And another one says, no, I entirely agree with you, because you have another type of relation, you are not married, you do your own thing. But I feel somewhat guilty. It is difficult".

In her uncertainty about providing and receiving care, she made an important distinction between LAT partnership and marriage; because she was not married, she did not have reciprocal care obligations. It seems that the commitment between this interviewee and her partner was not strong enough to function as an alternative basis for guaranteeing a certain amount of care to the partner in need or a desire to do good partnership.

Explicitly Refusing Care while Emphasizing Independence

Another aspect of the LAT partner relationship was elicited in the following statement by a 67-year-old woman, who had had an LAT partner for one year:

> "I would care for him. I know that I would do so, because I cared for my [deceased, JG] husband for … I don't know … many, many years. But if I fell ill, I would prefer another solution. I am a member of "Dennenheuvel" [a type of "in kind" health care insurance]. So, if something happened,

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> I will be cared for in Dennenheuvel. There you have a private room, nurses, and so on. It costs me a pretty penny … but everything is taken care of".

This interviewee was fully anticipating caring for her LAT partner, based on her experience of caring for her deceased spouse; however, she did not expect to receive care from her current LAT partner. The second part of her answer reflected a common perception of LAT individuals as primarily oriented towards long-term independence and as prioritizing a less-committed bond with the partner: sharing the household for a fixed number of days, not sharing finances, and only partly sharing social circles. However, the inclination to secure care via Dennenheuvel could alternately be seen as a prudent action taken while living alone after widowhood.

These findings demonstrate that remarried older adults are aware of their commitment towards their spouses; they take an affirmative approach in articulating their attitudes regarding hypothetical care situations. Remarried adults expect reciprocal care by virtue of doing good partnership. One of the remarried older adults, who said that she would refuse to accept care, was clear about her motives: "our love is over". In this case, the impetus to do good partnership was absent.

In contrast to remarried older adults, care attitudes of LAT partners were mixed. Of the 12 LAT interviewees who had not yet given or received care from one another, half expected reciprocal care; these LAT partners apparently intended to do good partnership. Conversely, about half of LAT partners did not utilize the doing-good-partnership paradigm; some of them stated that they would refuse to provide care, and several of them desired independence should they fall ill.

Behavior of Older Re-partnered Adults

Here I examine the care behavior of older remarried and LAT men and women who experienced serious health problems during their current partner relationship. How did they behave in these circumstances? My analyses revealed three different categories: (1) demonstrating good partnership; (2) a combination of doing good partnership and ambivalent feelings; and (3) the refusal of care.

Demonstrating Good Partnership

All of the remarried interviewees, confronted with their own or their partner's health problems, supported one another and provided care as did all but one of the LAT interviewees. All remarried interviewees referred to their obligations towards their partner, and mentioned their willingness to exhibit good partnership. No hesitation, age, or health problems prevented the remarried older adults from caring for their partners and both care giving and care receiving were mentioned as indicators of their dedication to one another.

The majority of the LAT partners who experienced situations of ill-health in their current relationship exchanged care. However, details of their behavior and the personal feelings related to this behavior were diverse. The following interviewee illustrates the unconditional dedication of LAT partners to one another; both subscribed to the idea of good partnership. A 65-year-old man, LAT partner for three years observed:

> "We had a traffic accident, she was in hospital, critically wounded. She more or less recovered, but needed a lot of care. And I was there … helped her, bathing, keeping house … everything, yes, everything. Because she couldn't do anything herself … do one's duty to your partner, although it is a LAT relationship, … be ready to help".

There are two crucial elements of his statement: "do one's duty to your partner" and "although it is a LAT relationship". Doing one's duty to your partner suggests that one's actions are reflective of responsibilities within the partnership. This commitment was made despite the fact that the respondent indicated that LAT relationships are perceived as less committed: "although it is a LAT relationship". This language suggests that this LAT couple applied the doing-good-partnership paradigm onto their LAT bond. This interviewee expressed his awareness of others' views of differences between marriage and the LAT bond, yet voluntarily adopted good partnership practices and acted accordingly.

Combination of Good Partnership and Ambivalent Feelings

Two of the LAT interviewees did receive all necessary care from their partners, but voiced conflicting feelings about having accepted care while attempting to maintain independence. One such statement involved a 68-year-old woman, in an LAT for 15 years:

> "I was very ill … foot amputation, blood poisoning, and so on … 13 operations … In returning home, I could manage myself. I could bandage my wounds myself – there was nothing wrong with my hands, you see…. climbing the stairs to my bedroom on my knees …". *Interviewer: And your partner, did he care for you?* "Yes, he came more frequently, yes, yes … and also helped with heavy tasks and such things. But I cooked the meals myself, with my knee on a stool in the kitchen …".

This respondent's answer was indicative of her quest to stay independent and practice self-help. However, her partner was present, and he visited more frequently to help her out with several aspects of daily life, which spoke to the strength of this partner bond and suggested that the LAT relationship's quality was associated with caregiving. This example demonstrated hesitance to receive care on the recipient's part, not a hesitance to

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give care by the partner. A reluctance to be a burden on one's LAT partner and a desire to be independent for as long as possible appeared to be associated in this answer.

An Offer of Care Not Accepted

The third category of LAT partners' behaviors in cases of one partner's ill-health concerns the refusal to accept care. One 55-year-old woman, in an LAT relationship for 7 years, detailed a scenario:

> "He had a serious accident … lost his right hand in a circular saw … in returning home from the hospital, he managed to do everything himself. No, he never accepts help. He wants to do it himself, writing with his left hand, he does not give up …". *Interviewer: And what about you, did you offer to help him out?* "Yes, we discussed that, but really, he is so stubborn … I had to bite back my comments …".

This LAT interviewee offered to care for her partner, but was refused; as such, the willingness of the partner to receive care was a key factor in whether care giving arrangements materialized.

In sum, the data showed that any differences between remarried couples and LAT partners were not related to a lack of partners' willingness to supply care, but with a partner's refusal to accept care. The prioritization of independence and a reluctance to be a burden were important reasons behind care refusals.

Discussion

Care attitudes and behavior are fruitful starting points for the investigation of care exchanges in older long-term LAT partners. In terms of care attitudes, those of older LAT partners who have not confronted a current partner's illness or hospitalization differ from the care attitudes of older remarried partners, and within the group of LAT partners, there is diversity in care attitudes. While the majority of remarried older adults express their care attitudes with a guarantee of unconditional commitment related to the idea of displaying good partnership, only half of the older LAT partners expressed parallel attitudes, and these were similarly linked to the idea of doing good partnership. The other half of the LAT partners have ambivalent or negative attitudes towards giving or receiving care. These remaining LAT partners explicitly related their attitudes to the opportunity for greater autonomy associated with not being married. Self-sufficiency and maintaining independence are core concepts mentioned in this context. This picture is more or less aligned with research outcomes of Duncan et al. (2012, 2014), where no more than 20 percent of the LAT partners' attitudes were oriented towards caring for ill partners.

However, care behavior among LAT partners who have confronted the illness of a partner is much different. Dedicated care behavior is noted in all LAT (and remarried) partners who have been confronted with illness of a partner. All interviewees displayed good partnership – the LAT partners as well as the remarried spouses. The beliefs associated with this care exchange behavior require further investigation. Many LAT partners who accepted care felt uneasy about having done so, and several of them attempted to avoid receiving care. These interviewees spoke of striving to maintain total self-reliance even while receiving care. One could say that with this avoidance, interviewees diminished the importance of displaying good partnership. It is vital to note that it is not the offer, but the acceptance, of care that forms the barrier to care exchange behavior in LAT relationships. The need to not be a burden is evident in the words of these interviewees, who proudly detailed their independence: "I cooked the meals myself, with my knee on a stool in the kitchen …" (a female LAT partner, after amputation of her foot), and "he managed to do everything himself, writing with his left hand …" (a female LAT interviewee about her partner after he lost his right hand in a circular saw).

In examining these outcomes, the following three caveats are important. First, the mean age of the LAT partners in this study is 62 years. Older partners are aware of the fact that in cases of illness they firstly must rely on their partner; children might be available, but are presumably involved with obligations to their own dependent children and to their work. The circumstances of these mid-life and older LAT partnered adults are not comparable to the LAT partner respondents in the Duncan et al. (2012, 2014) study, where a majority were in the young adult age group. The fact that only a low percentage of young adult LAT partners intend to care for their partners is understandable because the lives of young adults are still interwoven with parents who might be relied upon to take care of them in cases of illness.

A second caveat is that older LAT partnerships are characterized by longer durations: the mean duration for the interviewed LAT partners in this study is above nine years. For that reason, we identified them as long-term LAT couples. The longer duration of their LAT bonds may facilitate the development and deepening of couples' commitment and consequently a stronger wish to display their dedication and commitment to doing good partnership.

Third, at older ages, and often after a period of living alone after widowhood or divorce, mid-life

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and older LAT adults are satisfied with intermittently sharing a household with a new partner; at the same time, they cherish having personal time to be in contact with children, siblings, and old friends, consequently safeguarding their social networks (deJong Gierveld, 2002). This is the more important because research shows that children of varied ages are openly ambivalent regarding a parent's new partner, and may try to impede co-residence of their parent with a new partner (de Jong Gierveld & Merz, 2013; Levin, 2004). Thus, older LAT partners have the positive aspects of commitment and intimacy with the new partner alongside time for independence and to spend according to personal wishes. These balances might increase their quality of life such that when illness occurs, older LAT partners are available to care for one another and display good partnership.

Strikingly, in the text of the LAT interviewees, no reference is made to negotiating amount or type of care to be provided. Therefore, older LAT partners are not using the roles of friends and friendship as paradigms of care; it is the idea of doing good partnership that is a more fruitful concept in interpreting older long-term LAT partners' intra-couple care behavior. By orienting themselves with this idea, LAT partners illustrated that the couples' commitment is more important in guiding their behavior than the formal type and structure of their living arrangement. As Roseneil and Budgeon (2004) have shown, many individuals who are connected to one another but not sharing households are still prepared to provide care, and in discovering these bonds they broaden the scope of care providers beyond marriage and family roles. Future survey research must discern whether the current research outcomes represent care behavior of a broad sample of older LAT couples.

While this study highlights some interesting findings regarding care exchanges of older long-term LAT couples, several limitations must be considered. This study is small in scope: analysed data came from 25 LAT partners and 17 remarried older adults. The names and addresses came from the representative NKPS survey, but the numbers investigated are small. Although the attitudes and behaviors presented in this study are individual ones, they served to elicit more-general patterns relevant for understanding care in older couples, such as demonstrating good partnership and the role of independence. Survey data are needed to investigate more precisely the division of LAT individuals oriented towards care-giving and those with attitudes of refraining from exchanging care, and to investigate in detail the actual instances of care.

This study analysed cross-sectional data, which prevents inferences about causal associations: LAT interviewees whose attitudes were associated with not exchanging care could not be followed until the need for care was realized. Consequently, the process of linking attitudes against actual behavior in a later stage of life was impossible. Up until now, in discussing partner relationships we have not differentiated between heterosexual and same-sex couples. The number of same-sex partner bonds is increasing and realized in either a marriage type of couple relationship, in cohabitation, or in LAT relationships. However, all interviewees in this study were in heterosexual couples.

Policy makers, intending to allocate more of the care tasks to informal care givers and to decrease the coverage of publicly financed home care in order to lower costs, might be interested in the outcomes of the current study. Older long-term LAT partners are indeed involved in reciprocal care exchanges with their partners. Consequently, the reliance of this group of older adults living alone is not predominantly situated in the formal care arena. Remarried co-residing couples, as well as older adults in LAT relationships, and both men and women, provided care in cases of need. To what extent the care behavior of LAT partners can be expected to endure for a very long period of time must be investigated, taking into consideration the time needed to travel to one's partner.

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