

The social process of involuntary separation and the search for connection

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Abstract

Placing a loved one in care does not relieve informal caregivers' physical and emotional stresses. This study identified the unique psycho-social-spiritual processes of involuntary separation among spouses following long-term care admission. Participants were 17 spouse-caregivers (12 women and 5 men) with a mean age of 84 years who had been involuntarily separated for an average of 20 months. The basic psycho-social-spiritual process of spouse-caregiver involuntary separation was *connecting in disconnection*, which had three distinct stages: (1) Initial coping, (2) Adjusting to the new situation, and (3) Moving forward. Movement through the three stages was influenced by individuals' capacity and willingness to reach out for connection and by the abilities of others to extend accurate empathy and practical help. The implications of this study highlight spouse-caregivers' needs for connection and support not only during the crisis of separation, but in the months and years that follow.

Keywords

connection, caregiving, grounded theory, long-term care, nursing home placement, spouses

Introduction

Older adults are the most rapidly growing age group in Canada with numbers predicted to make up 23% of Canada's total population by 2030, rising to more than 10 million by 2036 (Canadian Institute for Health Information, 2017; Employment and Social Development Canada, 2014; Statistics Canada, 2020). There are more than eight million informal caregivers involved in caring for the aging populace in Canada, of which 13% are spouses or partners giving care at home (Statistics Canada, 2020). The Canadian Institute of Health Information (2020) noted that more than one-third of these informal caregivers reported being in distress and spending an average of 38 h per week providing care. Often themselves older adults and with health concerns of their own, some spouse-caregivers eventually have no choice but to become involuntarily separated through long-term care admission. All family members must make adjustments when a loved one is admitted to long-term care, but the spouse faces unique demands, including providing support for the resident and other family members, navigating familial tensions, and financial

hardships (Glasier and Arbeau, 2019; Stadnyk, 2006). Asano et al. (2021) noted that spouse caregivers reported more symptoms of depression than non-spouse caregivers. In the present study, we interviewed spouses of those admitted to long-term care to identify the psycho-social-spiritual processes that underlie this form of involuntary separation.

Connection and separation

Placing a partner in long-term care following a period of at-home caregiving is associated with stress, often appearing in

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combination with stresses that have carried over from the caregiving period, including relational challenges (Gaugler et al., 2009; Hennings et al., 2013; Majerovitz, 2007; Monin et al., 2019; Whitlatch et al., 2001). Guilt over placement, stigma of institutionalization, and feelings of failure are frequently experienced by spouses following placement, all of which can affect feelings of connection to the spouse and to others (Glasier and Arbeau, 2019; Nolan and Dellasega, 2001; Reuss et al., 2005). The placement can feel like an abandonment of their marriage vows (Glasier and Arbeau, 2019). The spouse may construct a routine, one that is responsive to their own situation and to that of their partner, to help maintain connection and cope with being separated (Førsund et al., 2016).

Emotional effects. One key challenge to continued connection to their partner is emotional burden and distress. Majerovitz (2007) and Stone and Clements (2009) observed that spousal stress and burden after care facility admission shifts from a physical burden to a largely emotional burden (see also Elmståhl, Ingvad and Maerstedt, 1998). After months or years of being in control of their loved ones' care, the spouse suddenly finds that they are a visitor in the care facility, still actively involved in a caregiving role but within a new system (Førsund et al., 2014; Glasier and Arbeau, 2019; Hennings and Froggatt, 2019; Nolan and Dellasega, 2001). This loss of control can leave the spouse feeling unrecognized and isolated (Elmståhl, Ingvad and Maerstedt, 1998; Nolan and Dellasega, 2001; Reuss et al., 2005). New caregiving roles during this time include vigilance, advocacy, visitation, and financial responsibilities (Førsund et al., 2014; Glasier and Arbeau, 2019; Hennings et al., 2013; Nolan and Dellasega, 2001; Reuss et al., 2005). Another source of emotional burden can be anticipatory grief, in which the spouse experiences distress over what they know will be an inevitable decline (Almberg et al., 2000; Casarett et al., 2001; Garand et al., 2012; Gilliland and Fleming, 1998).

Schulz et al. (2004) have argued that the institutionalization of a spouse can be more difficult than a death. Whereas the general emotional recovery of the survivor is increasingly noticeable with the passing of time, similar improvement is not typically seen with spousal institutionalization. Compared to caregivers who were not spouses, spouses "were significantly more depressed before placement and more depressed and anxious after placement" (Schulz et al., 2004: 965).

Social effect. The uniqueness of the couple's situation, now separated by physical distance and, often, also by illness such as dementia, makes it hard for family and friends to understand what the spouse is going through, leading to heavy feelings of isolation from people who were previously important sources of connection, including social

support (Førsund et al., 2014; Glasier and Arbeau, 2019). Stadnyk (2006) noted that married caregivers often experience a kind of "married widowhood" (p. 284) where they live in "limbo" (p. 290). Though still part of a marital dyad, the spouse now lives alone and, in many ways, feels like a widow or widower (Førsund et al., 2014; Glasier and Arbeau, 2019; Hennings and Froggatt, 2019). The purpose of the marriage relationship takes on a new tenor (Roelofs et al., 2019). These changes can feel awkward socially and can discourage the spouse from engaging in social activities (Stadnyk, 2006).

Spiritual effects. Among spiritual or religious persons, turning to their beliefs can play a key role in adjusting to involuntary separation. Although less well explored than the social and emotional effects of separation, spiritual and religious factors have been identified as meaningful to the placement experience, whether the placement is viewed as a gift or a trial (Bartlett, 1993). Many participants in one early study of involuntary separation (Bartlett, 1993) turned to religious coping to help them navigate what felt like the loss of their marriage in the face of strong feelings of commitment to maintaining connection with their spouse. Glasier and Arbeau (2019) noted similar findings, with some describing their faith as an "anchor" holding them steady amid chaos, even if they simultaneously struggled with understanding how God could allow this to happen to them. Sidell (2000) found that spiritual support was one predictor of continuing marital happiness following long-term care admission. In their research with largely Latino participants of predominantly Roman Catholic or other Christian religion, Herrera et al. (2009) found that caregivers were less likely to describe their caregiver role as burdensome if they had more intrinsic and organizational religiosity, speculating that this finding was due to increased access to both practical and emotional support. Active participation in church services (Glasier and Arbeau, 2019; Herrera et al., 2009), and the depth of participants' spiritual beliefs (Herrera et al., 2009) appears to have a positive impact on ability to cope, although more passive forms of religious coping may be associated with increased depressive symptoms (Asano et al., 2021).

Factors that help and that hinder. The combination of a continuing caregiving burden and new separation burden contributes to a unique and sometimes overwhelming set of challenges for spouse-caregivers during the long process of separation (Elmståhl, Ingvad and Maerstedt, 1998; Hennings et al., 2013). The spouse may feel less tired and less overwhelmed following admission, but new stressors arise in their stead (Gaugler et al., 2009; Whitlatch et al., 2001). Consequently, emotional distress can continue or even increase following admission (Elmståhl, Ingvad and Maerstedt, 1998; Førsund et al., 2016; Førsund et al., 2014;

Gaugler et al., 2004; Hennings et al., 2013). Indeed, the literature supports that, with stressors continuing post-admission, spouses, particularly those who had taken on a caregiving role, generally do *not* experience improvements in their psychological wellbeing over the long term (Lieberman and Fisher, 2001; Zarit and Whitlatch, 1993).

Personal factors. Older spouses, those reporting poorer physical health and lower income, and those providing care for individuals with significant cognitive decline are at highest risk for problems, most notably for depression (Brown and Bond, 2016); Canadian Institute of Health Information (2018); Gaugler et al. (2009); Hango (2020); Majerovitz (2007); Schulz et al. (2004); Turcotte, 2015). Moreover, the nature of the spousal relationship can have a considerable impact on how involuntary separation is experienced (Forsund et al., 2014; Glasier and Arbeau, 2019; Monin et al., 2017). The stronger the emotional bond of the dyad, the greater the experienced emotional distress and sense of loss (Lieberman and Fisher, 2001).

The role of the care facility. The qualities of the long-term care facility and its staff are key to how the caregiver experiences the long-term care admission of their partner. In Canada, bed availability can be the deciding factor in when an individual moves into long-term care and where they go. Reuss et al. (2005) noted the importance of a welcoming environment upon arrival at the care facility, while Mullin, Simpson, and Froggatt (2013) specifically highlighted good communication between care workers and families, warm and friendly staff, and cleanliness. Conversely, an introduction to the care facility that the spouse perceives as cold or apathetic exacerbates the difficulty of the transition. Perceptions of poor quality of care make for a more negative transition for families as it becomes harder to reconcile the decision to place their loved one into care, though the opposite is also true—when they feel their loved one is well cared for, family members reported feelings of relief and reduced fear and anxiety (Reuss et al., 2005; Stone and Clements, 2009).

Nolan and Dellasega (2001) emphasized the importance of the early formulation of trust between the care facility staff and the spouse. Lack of confidence in the quality of care in the facility to which their partner has been admitted may make spouses extra vigilant, feeling like they need to be around to ensure sufficient care for their loved one while adding extra burden onto themselves (Majerovitz, 2007; Tornatore and Grant, 2002). The commute to the facility may become a particular source of stress, particularly when the spouse has difficulty with driving or cannot drive at all; this strain is further intensified when there are no children living nearby to assist in making the trip—but also when the individual lives in a region with harsh weather conditions, such as the Canadian prairies (Gaugler et al., 2004; Majerovitz, 2007; Stone and Clements, 2009).

The present study

Evidence of continuing distress following spousal admission into care calls for continuing exploration of the processes that may have an impact on this distress. Although there has been a good amount of research examining the longer-term effects of involuntary spousal separation, most do not go beyond three or 4 years (Gaugler et al., 2009). Sidell (2000) is an exception whose study extended 15 years after admission and still found evidence of burden and distress. Gaugler et al. (2009) emphasize the need to investigate the specific needs of caregivers during and after the admission process. Moreover, although there exist counselling interventions that have shown some promise including tele-counselling, peer support, emotion-focused therapy, and educational seminars, these interventions would be improved with better clarity regarding the particular processes that are connected to the experience of involuntary separation. Accordingly, the goal of the present study was to better understand and more precisely delineate the psycho-social-spiritual processes underlying involuntary separation.

Method

Design

This study used both original data and secondary analysis of existing data. The design was approved by the Research Ethics Board of [BLINDED FOR REVIEW], File Number 15G02. We approached the research question inductively using grounded theory as described by Charmaz (2006). Grounded theory is particularly suited to this study because the approach seeks to build theory by uncovering and understanding the social processes involved in participants' daily interactions with the world. This method emphasizes immersion into the data—using its own rigorous procedures and extensive credibility checks—to develop a theory that is 'grounded' entirely in what the participants have shared (Charmaz, 2006; Fassinger, 2005; Glaser and Holton, 2005).

Sample and data collection

To identify and describe the psycho-social-spiritual processes involved in the shift in connection during involuntary separation in the context of the Canadian healthcare system, 12 individual interviews and a focus group were conducted with a total of 17 participants (12 female, 5 male) aged 70 to 95. Participants had been married an average of 55 years (range 22-69) and separated for an average of 20 months (range 1-48). All participants were of Western or Central European descent and identified as either nonreligious or Christian. Most had spent their lives in rural, agricultural settings on the Canadian prairies,

moving into a small city at retirement. They were recruited from two care facilities.

Secondary analysis of existing data was used for initial analysis with additional participants recruited until saturation was reached. The original data took the form of responses to semi-scripted questions focused on participants' experiences of involuntary separation. Questions were open-ended and sought to identify any aspects of their experience that the participants found noteworthy. The same questions were used in the interviews with the two new participants for this study. Each interview and focus group gave space for participants to talk about what mattered to them, as well as for follow-up questions, clarification, and further probing of participant responses. All interviews took place with individuals living in the same geographical area and followed the same recruitment criteria: (a) they had provided care for their spouse (married or common-law), (b) their spouse had since been admitted (or was awaiting admittance) into a long-term care facility, (c) fluency in English. All interviews were conducted by the lead author. The data sets were comparable with little difference in themes or sub-categories.

Existing data. Grounded theory was used to conduct a secondary analysis of the existing data from interviews with 10 participants (7 female, 3 male; *M* age 88.9 years; range 70–95 years) conducted approximately 3 years prior to the present study. They had been married an average of 51.8 years (range 20–66 years). The average length of time since spousal admission into long-term care was 14 months (range 2–48 months), with the exception of one partner who was in hospital awaiting long-term care admission. One partner was no longer living.

New data. The additional individual interviews and the focus group followed the same recruitment procedure. The unscripted focus group served as both an additional opportunity for data collection and as an in-depth credibility check and took place approximately 8 months following completion of all individual interviews. Average age of the 7 new study participants (5 female, 2 male) was 79.6 years (range 73–87). Participants had been married for an average of 59.1 years (range 53–69 years) and had been separated by long-term care admission for an average of 26 months (range 9–48 months); all spouses but one were still living.

Ethical considerations

The experience of long-term care admission and involuntary separation is a heavy topic to ask participants to explore. The informed consent procedure described the voluntary nature of each participant's involvement, emphasizing that they could withdraw at any time without consequence. Interviews were held where participants felt most

comfortable. Many invited the lead author into their homes to talk over tea or coffee and cookies, while others chose a comfortable, private space made available at one of the care facilities. The latter was also where the focus group was held. Focus group participants were asked not to share anything about other group members without that person's explicit permission. The lead researcher was trained in holding appropriate, compassionate space in potentially distressing interview settings. Two chaplains associated with long-term care facilities offered their services free of charge to any participants who wished to have support after the interview, either immediately or in the days or weeks following.

Data analysis

Sessions were conducted in English, audiotaped, and transcribed verbatim. Participant names have been changed. ATLAS.ti was used to track coding which was completed using phrase-by-phrase analysis. The lead author visited and revisited the data, being open each time to new interpretations and new codes. Memos were used extensively along with initial, focused, and theoretical coding to explore the extent to which an experience is rooted in broader situations and relationships (Charmaz, 2006). Once coding began, 2126 initial codes were identified and were later narrowed manually to 28 focused codes or categories. Concept maps were created using CmapTools to visually represent these categories and their interconnections. It was through this mapping process that the core category, main categories, and subcategories took shape. All analysis was completed manually with the software used as organizational tools to track and visualize emerging themes. The core category represents the basic psycho-social-spiritual process involved in involuntary separation that ties together all other categories and subcategories; it is through the lens of the core category that all other elements are understood (Mills et al., 2006). According to Glaser and Holton (2005), a core category is the central outcome of grounded theory research and is what connects the data together as a "core variable" (p. 1). Glaser and Holton (2005) outlined 11 criteria for a core category, the first of which includes centrality to the data, that it occurs often, that it takes time to identify it, and that it relates in a meaningful way to other categories. To be considered a basic process rather than simply a core category requires "two or more clear emergent stages" (Glaser and Holton, 2005: p. 2). In other words, a basic social process is the central variable in a studied phenomenon and it is dynamic with at least two distinct shifts over time.

Rigour and validation

Rigour and validation of grounded theory are ensured by careful implementation of the method's procedures

Content	Name	Age	Married (years)	Separated (months)
Original data	Lily	78	59	18
	Mae	70	47	36
	Sarah	95	20	24
	Rita	88	66	18
	Gladys		60	36
	Jean	75	39	1
	Bernie		59	6
	Jacob	84	62	1
	Richard	80	56	13
	Hilda	77	56	5
New data with original questions	Faye		64	46
	Leonard		59	14
Credibility check	Jean, Richard, Hilda	Follow-up calls to 3 original participants		
New data from focus group (& credibility check)	Wallace	80	55	24
	Tracy	87	69	15
	Marie	78	56	48
	Ida	80	59	9
	Gertrude	73	54	26
Credibility check	LTC facility chaplain			
Credibility check	RN - LTC unit manager			
Credibility check	3rd author			
Credibility check	4th author			

Figure 1. Participant characteristics and timeline of data gathering and credibility checks.

(Charmaz, 2006; Fassinger, 2005; Glaser and Holton, 2005; Morse, 2007). This includes theoretical sampling, extensive memo writing, coding, and repeating all as needed until data saturation has been achieved and a core category emerges. Figure 1 To ensure rigour in the present study, we followed the above protocols and used three additional credibility checks: a focus group, three follow-up conversations with past participants, and feedback from two long-term care professionals. Consistent with the theoretical sampling requirement of grounded theory, the focus group was conducted partway through data analysis with new participants who met the same study criteria and who were from the same geographical area as the initial interviews (Charmaz, 2006; Fassinger, 2005; Morse, 2007). Participants were given a brief presentation outlining the findings from the preliminary data analysis of the individual interviews and were invited to reflect and respond with feedback from their own experiences. Audio recordings were transcribed verbatim and analyzed in the same manner as the individual interviews. Individuals in the follow-up conversations 3 years later were similarly invited to comment on the

preliminary study themes. The third credibility check entailed soliciting feedback on the study findings from a nursing unit manager and a chaplain at one of the local long-term care facilities.

Results

The heart of grounded theory is the core category, the lens through which the main categories and subcategories are understood. The core category that emerged was *connecting in disconnection*.

We will devote significant space to describing the many forms that connecting—and disconnecting—can take, but the message to take away is this: The outworking of connecting in disconnection is unique for each individual, but the need for connection is common to all. This need to connect is evident both when it is met and when it is left unmet (disconnecting). The main categories and subcategories are held together by this core lens (Figure 2). The psycho-social-spiritual process of connecting evolves through three distinct stages: initial news and coping,

adjusting to the new situation, and moving forward (Figure 3). And within each of the three unique stages of involuntary separation there emerged four forms of the basic psycho-social-spiritual process of connecting: identity, family, social world, and faith. Each of these forms of connecting will be addressed following the description of the three stages.

The three stages

Stage one - initial coping. In the first stage, individuals received the news of imminent separation and were left scrambling to get ready for their spouses’ physical move and all the associated details, prompting a need for *initial coping*. They were often in a crisis or near-crisis state of shock, grief, guilt, and feelings of failure, coupled with relief that they no longer bore sole spousal caregiving responsibility. The crucial drive for connecting at this stage

was seen in the determination that the relationship would be unaffected by the separation, despite recognition that their disconnection meant that the relationship would never be the same.

Gladys, married to her husband for 60 years and involuntarily separated for three, shared about caring for her husband as his functioning declined due to Lewy body dementia. When she got the call that there was a room for her husband, she went into a state of near panic until help came in the form of her housekeeper:

Well, I don't have any kids here. I have a young lady who does cleaning for me ... and she helped me get [my husband] moved because all of a sudden, [that] morning, "We're moving [my husband] now", I've got to clean out his [hospital] room, I've got to get a wheelchair, I've got to get a cab or a bus or something, and it's going to be here at 10:30 in the morning in the wintertime and I said, "I can't do this, I'm only one person." (Gladys)

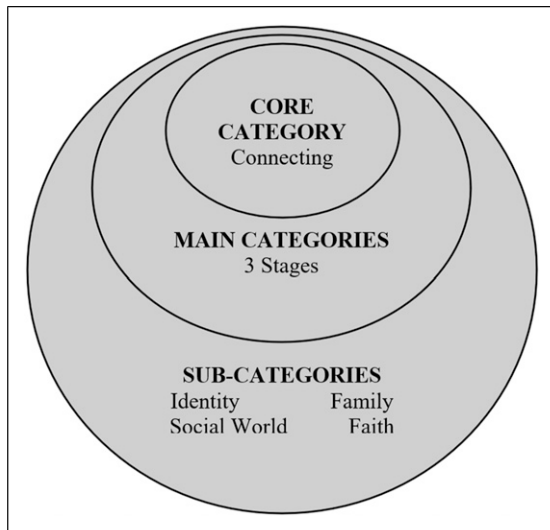


Figure 2. The core category and its outworking categories.

Key characteristics of the first stage were relinquishing control, finding comfort in the care given to their partner, advocacy and concern for the partner, and financial changes. Having confidence in their partner’s new caregivers was crucial for peace of mind. Hilda, for example, spoke of a nurse who was *“very considerate, very good. ... Compassionate, caring. He would make it easier for me to leave to go home in the evenings. ... My [husband] was in good hands.”*

The central drive for connecting during the initial coping stage was seen in either a stalwart resolution that the couple’s love for one another would withstand the separation, feelings of brokenness over a perception of having failed their partner and their marriage, or a sense of comfort with the new arrangements. Comfort was present *only* when the separation did not include geographical distance or a significant change in routine, such as when the couple resided in the same multi-level care facility. Bernie, a retired farmer and rancher, had been married for 59 years and

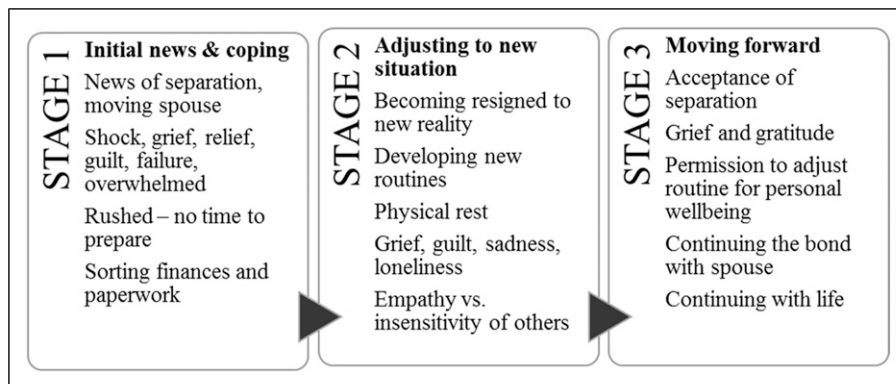


Figure 3. The three stages of core category: connecting.

separated for 6 months. In his case, he fetched his wife from upstairs each morning to spend the day together, taking her back to the unit at night. Bernie seemed untroubled by what was technically a separation. Faye did not experience such comfort; “*When I walked in, he just said, “She put me here,” and he started to cry. ... So I walked away ... you know, I had to walk away.*”

Jean’s situation was unique: 75 years old and married to her husband for 39 years, she had no children and her extended family lived in another country. Her husband was placed into care 1 month before her interview by her friends after Jean had been temporarily hospitalized.

I cried and cried all the time there in the hospital. I just cried. I just couldn’t see it, you know, that I wasn’t there and he was gone. You know, he was just gone ... and that was so hard to do. I would have a hard time putting him in when I am still home because I kept postponing it too, but when all of a sudden he is gone and next time you come out of the hospital, you have to visit (at the facility) and he is not here anymore, that was devastating. (Jean)

No matter who made the final decision, many participants struggled with handing over their loved one’s care. Faye and her husband had been married for 64 years and separated for nearly four due to his deteriorating dementia: “*And you know, I think that’s the hardest thing I had to, that decision to say, ‘Okay, I can’t keep him at home anymore.’ That was the hardest thing I did.*” (Faye)

Richard was an 80-year-old man who still maintained the family home and large yard independently. A school principal prior to retiring, he and his wife had been married 56 years until his wife’s dementia became too much to manage in community. “*It was the hardest thing I ever did in my whole life. ... So I signed the papers and [date] was the worst day of my life.*” (Richard)

Similarly, Wallace, age 80, married for 55 years and separated for two, made the decision to admit his wife into the hospital for assessment and said, “*The day I had to put her in the hospital, I cried for weeks. (tearful) It was so hard.*”

Participants struggled with the abruptness of the shift from caregiving to involuntary separation. Some participants continued to give care however they could, such as doing their laundry or staying well-informed about their partner’s care. Hilda was 77 years old and had been married for 56 years and separated for 5 months before her husband passed away in care.

Trying to keep on top of his health issues with the nurses. Because I was so used to doing that, that’s something I just couldn’t relinquish. I just ... ‘cause I had looked after him all those years, and I just ... I was probably a pest. I don’t know, but they were always kind. They didn’t tell me to scram or get lost or anything. (Hilda)

Rita felt disconcerted by new, unwanted responsibilities following her husband’s placement.

My husband said it, 1 day he was upset and he said, ‘Well, you’re the boss, you decide.’ And I thought, yeah, I am but I don’t want to be. I don’t want to be but I have to be. (tearful) ... Yeah, all of a sudden everything from gassing up the car to paying insurance and doing the banking, all of it’s my responsibility. All of the major decisions are, are mine. (Rita)

Rita, age 88, and her husband had been married for 66 years following an engagement that spanned most of the duration of World War II, and had been separated for 18 months.

The adjustment to separation was uniquely impacted by each participant’s situation. When asked about the time shortly after her husband was moved to long-term care, Sarah said, “*Some people they’re so sad they can’t see, and, and to me it doesn’t bother.*” Sarah, age 95, and her husband had been married 20 years. She had stated plainly that she and her husband were not close and that this marriage—her second—had not been what she expected after her good relationship with her first husband of 49 years. Sarah was visually impaired and visited her husband when she was able, but she spent more of her energy on her adult children and their families. Sarah represented a negative case in our study in that she did not follow the three stages very clearly, yet it was evident that she nonetheless fit the core category of *connecting in disconnection* in that she shared about already feeling disconnected from her husband prior to his placement and more connected to her family, all of which lessened the impact of her separation.

A second negative case was Lily, age 78, who at the time of the interview had been married for 59 years and separated for 18 months. She shared of the decades of difficulty in having a partner with mental illness on the rural prairies when there were no mental health supports beyond the police and hospital. For her, the separation was hard but she commented that, after years of dealing with her husband’s mental illness, “*When you’ve gone through all that, then something like this is probably not even the worst.*” She said that she had often felt like a single parent, so when it came to adjusting to being separated, “*It wasn’t... that hard to adjust when you ... you were just about like you were alone then anyway, eh.*”

Those participants with deep roots in the community spoke warmly of a sense of comfort and connection in the generational presence at their partner’s long-term care facility. Rita found comfort not only in the memories of other family members who had spent their final years at the same facility, but also in familial connections to current residents and care workers: “*Dad, his mom, brothers, sisters have passed away at [care facility]. So... and when we took [my husband] to [care facility] my sister was on one side of the*

wall of him, his sister-in-law was around the corner, and my other sister-in-law, she was his night nurse. So he was surrounded by his family when we moved him in." Similarly, Lily expressed deep gratitude that her husband and another close family member were placed in the same facility and that she lived in the same community in independent living.

Stage two - adjusting to the new situation. In stage two, adjusting to the new situation, participants began the work of developing new routines to stay connected to their partner—yet, because the work of connecting happened during a process that is primarily one of disconnection, loneliness and guilt over the separation were also hallmarks of this stage. The impact of loneliness was attenuated when other family or friends made concerted, empathetic efforts to connect with the partner in care, but it intensified in the absence of such meaningful efforts by others, or when others approached them with insensitivity, even if it was well-intended.

Adjusting to living alone after many decades of marriage followed by months or years of caregiving was understandably very difficult for most participants. Days that used to revolve around care activities were completely changed. Jacob, age 84, married for 62 years and separated for 1 month, shared; *"Even if she's here ... I'd get up, go look, oh, watch her for a while, see how she is breathing, and I can't do that now. She's not there."* Rita and her husband spent many hours talking on the phone every day. She treasured these calls, but they were sometimes bittersweet; *"We'll have a nice conversation and I hang up [tearful] and I sit and I look around, and I'm looking at empty walls. I'm alone. ... So ... it's 1 day at a time. ... It's getting easier. But yet the loneliness is there."* Some participants admitted that they no longer enjoyed cooking, saying *"I love cooking and he loved to eat. Well now, anything's good enough. You know, you don't fuss for one person"* (Rita). For Leonard, it was dancing. A retired truck driver and oddjobber, he and his wife were married 59 years and had been separated for 14 months. He used to love dancing with his wife, but *"I couldn't dance now; I consider it disloyal to her."*

Whereas some participants shared about sleeping well again following their partner's admission into care, others found bedtime unsettling. When asked what the toughest parts of her days were, Faye said, *"Going home and sleeping alone."* Similarly, Leonard said, *"I find sleep eludes me, uh. I read more than I read in the rest of my life. Sometimes at 12:30 I'm still reading."* For Rita and Richard, the house itself became disquieting; *"You know, like I say, I sit and I look at four empty walls"* (Rita), *"And you sit here and ... the house is quiet"* (Richard). Marie, 78, married for 56 years, and separated for more than 4 years was asked to reflect on her overall experience; she responded with, *"Well, it doesn't get any easier. You just push on."*

Nearly all participants visited their partners daily or near-daily, usually for hours at a time. Feelings of failure decreased while *adjusting to the new situation*, although many still felt the guilt of the placement decision. They grieved the loss of their shared lives. Loneliness was particularly acute during this stage, helped only when participants could meaningfully connect with other family or friends. Loneliness and feelings of isolation intensified when participants experienced disconnection from others, which further reinforced the disconnection inbuilt in involuntary separation.

Many participants emphasized that a key change while *adjusting to the new situation* was becoming an advocate for their partner. Ida, age 80, married for 59 years, and separated for 9 months, said that she made her position clear to care facility staff:

I said to them, "This is my husband. Now you've got to remember this is my husband and I want him treated with respect and I want him treated kindly even if he doesn't know what he's doing because he can't help that." (Ida)

Gladys and Hilda became advocates out of what they perceived as painful necessity. Gladys's documentation of neglectful behaviour resulted in one worker being fired. Hilda's tracking of her husband's medications led her to stand against what she believed was an example of over-medicating; *"Like that one time when he was in the hospital and then they put him on the ... that I just can't agree with. They put him on this psycho pill ... [big sigh]. Lord, forbid that they do that to people so that they can handle them."*

Gladys and Hilda brokered peace with the staff at their respective care facilities, but for Gladys, it took months. *"It took a while to kind of... um... to get them to accept me, I guess. And for me to, perhaps, probably be a little more patient with them"* (Gladys). Ida alluded to her own process of balancing advocacy with relinquishing control and added, *"That was definitely really a journey for me and it still is to this day. I can come in and I feel that he's not cleaned up like he should be. I always think, 'Oh, if I had him at home, he wouldn't be looking like that'"* (Ida).

Gladys emphasized the importance of advocating for loved ones in care but noted that she had to learn how to find *"the line where you're not invading um, the territory of staff, but still accomplishing what you see that needs to be done for your loved one."* Hilda acknowledged that, through her interactions with care workers, *"It opened my eyes to the fact that there are a lot of hurting people and that there are a lot of good healthcare people working in those facilities."*

Stage three – moving forward. In the third stage, participants shifted their focus more onto embracing life amid their circumstances, *moving forward* in acceptance. The stage of *moving forward* was characterized by grief tempered by gratitude for what they had and for the people around them.

Those who were *moving forward* began to allow themselves personal time away from their partners, continuing to emphasize the spousal bond while also giving themselves permission to embrace a wider social circle, forming new friendships (and letting go of unsupportive ones), and sometimes travelling to visit friends and family.

For participants in this stage, the impact of connection in the face of disconnection, and their abilities to accept and reciprocate connection, had evolved in identifiable ways over time. These various shifts became the distinct basic social process of connecting. They developed resilience earned through continued vulnerability and genuine connections with family and their social worlds, and through wrestling through their own evolving personal identities and spiritual beliefs. They still struggled with mixed emotions, but they also experienced internal change that allowed them to accept their circumstances and to find moments of joy within it. Ida's husband did not always recognize her anymore, so she visited him for herself and for her own peace of mind; *"I go to see him for me because right now it's not me that he knows a lot of times. I'm many people sometimes, and that's okay. As long as he's content. If I go and he's content, then I feel good about it"* (Ida).

Ida also expressed frustration with a perceived lack of compassion and sensitivity from others in the early days of her involuntary separation. However, having watched her sister go through it several years before her, Ida reflected that it was not fair of her to expect people to understand what she was going through and no longer harboured anger or frustration.

A lot of people don't understand when you talk about what's going on and I was the same way. I don't fault anybody for that because I didn't have a clue what somebody would go through on a journey. So I didn't, I didn't understand. I couldn't understand. Nobody can understand this unless they're walking it.
(Ida)

Four forms of connecting

Within each of the three unique stages of involuntary separation there emerged four forms of the basic psychosocial-spiritual process of connecting in disconnection: identity, family, social world, and faith (Figure 4). How participants experienced each of the four forms of connecting shaped their adjustment to being involuntarily separated. Each of these four forms of connecting was relevant to each of the three stages of involuntary separation, but differed with respect to the associated challenges, needs, and actions. As the four forms of connecting threaded and evolved through the three stages, the unique challenges associated with each form at each stage tended to resolve with more distinct endpoints, such as relinquishing control of the physical care of their spouse and finding other ways to

connect (*initial coping*), and finding a new financial equilibrium, which often made space for participants to focus on growing new connections or strengthening existing ones (*adjusting to the new situation* and *moving forward*).

Identity. Participants grappled with aspects of their identity in a different way at each stage, often beginning with feelings of having failed as a spouse (*initial coping*). Jacob shared that he felt like a failure *"most of the time."* For some, spousal admission to long-term care involved an unwelcome and unwanted role reversal which many experienced as disconnecting. Such was the case for Gladys: *"My husband said it, 1 day he was upset and he said, 'Well, you're the boss, you decide.' And I thought, yeah, I am but I don't want to be. I don't want to be but I have to be."* Jean commented that she felt she had been *"going into widowhood"* for some time already and that their marriage was *"not a partnership in that sense anymore. It's just that somebody you can take care of."* The challenge to identity in the second stage was typically that of a sense of being in a social "limbo." Rita explained, *"when this happens, you don't fit in with married people, and you don't fit in with widows."*

Richard described himself as still feeling like his old self as a person and as a husband, but that he had grown more self-reflective. *"You try very, very hard not to be selfish. I mean, every time I say, 'Hey, you know, tonight I, I just, I'm just too tired. I, I just can't go.' And you say to yourself, 'Well, are you starting to make excuses?'"* He added that he re-evaluates his life more often and, a year later, he still second-guessed his decision to place his wife in care. In our interview and subsequent phone calls, Richard came across as confident overall, but there were echoes peppered throughout that hinted at feelings of failure when it came to his wife's care. He also seemed to have an internal tug-of-war between his own needs and wishes for rest and social activity and his powerful feelings of love and obligation toward his wife. It came across as a perception that if he pursued meaningful connections for himself, it meant he was disconnecting from—or dishonouring—his relationship with his wife.

The shift to *moving forward*, the third stage, came about when the participant could find confidence in having a bond with their partner *and* investing in their own individual, social, and spiritual wellbeing. Rita said she did not think differently about herself as a person, but the rest of her reply spoke of creating an identity for herself apart from her husband, of fostering connections outside of her relationship with him. It was clear in our discussion that Rita was entirely committed to her husband and was continually orienting herself toward him, yet she was simultaneously developing the awareness that she also needed to turn positively toward herself. *"I know that I have to make a life for myself. And whatever I put into it is what, how would I*

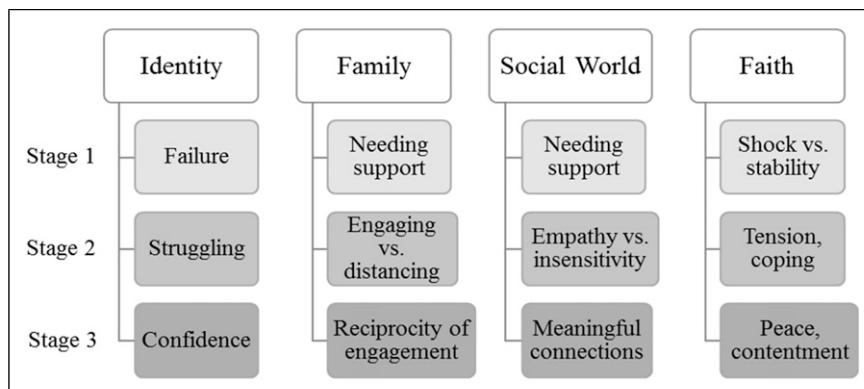


Figure 4. The four categories and subcategories that are uniquely present in each stage of core category: connecting.

say, it's going to either tear me down or it's going to lift me up" (Rita). Rita felt confident that she had done her best. "I feel within myself, I gave [husband] 100% of myself as a wife. And he has done the same. ... We still love each other, and I don't think that'll ever change."

Family. Family was a powerful source of connection, support, and meaning when family members were present and engaged. It was often family who recognized the increasing care needs and initiated the long-term care admission process, beginning the stage called *initial coping*. Participants' choices were greatly impacted by the people around them who either reached out and offered connection or created distance and a sense of disconnection (stage two, *adjusting to the new situation*). Mae, age 70, married for 47 years and separated for three, had dairy farmed with her husband prior to retirement. Her husband's physical deterioration led to his care admission. Mae specifically mentioned the value of her friends and family helping in small, practical ways:

[Son] made sure the gas was put in the car. That might be just a small thing, but... I had no idea how to put gas in the car, getting that cap off, so at first, when the car was getting near empty, I would call one of the boys over and ask them if they could put gas in the car for me. (Mae)

When family relationships involved *disconnection*, participants felt it keenly. Richard shared that "My son avoids that place [care facility] like the plague" because he found it too discouraging and difficult to see his mom in that environment. It was clearly painful for Richard to watch his son disconnect from his mother—Richard's wife—and to indirectly disconnect from Richard as well. Two participants had moved to this city to be closer to family when their partner began to need extensive care. Faye was content with her decision to move, but Leonard had regrets: his plan to strengthen connections to family backfired when his

relationship with his daughter deteriorated. At the time of our interview, his daughter was not speaking to him and refused to visit her mother in care. "It's just like kicking your legs out from under you, you know, for me, because...that's why I came here" (Leonard).

Whether their children and other family members were geographically near or far, visits or going out for coffee, phone calls, and emails were appreciated by participants. Hilda spoke gratefully of her son and grandson who kept her computer in good running condition so she could stay in daily contact with her siblings via email; she waited eagerly for each reply (stage three). Sarah commented that: "My kids always say, 'We'll look after you,' you know. And they do...I'm so lucky I got good kids. Oh, am I lucky! Today I get phone call from them, all three." Participants were also encouraged, even proud, when their family members connected with the spouse in care.

"And [granddaughter] was so good with him, you know. ...And even the other day she phoned me, and she said, 'Wow, I hope I can get down to [town] to see Grandpa before I go back to school,' you know (laughs)." (Lily)

Social world. In stage one, initial news and coping, participants had little space for social connections. Opportunities and desires for connecting with others began to grow in stage two, adjusting to the new situation, and these connections were typically well-developed by stage three, moving forward. The contrast of connection and disconnection was clear as participants described their social worlds. Some spoke of their own efforts to reach out and be involved with others, while others shared about barriers. Some spoke of friends who stood by them and did the work of staying connected when they could not—while others told stories of friendships that stagnated, became awkward, and eventually disappeared.

Leonard, having moved to be near family, connected with his friends primarily through email. He laughed as he spoke

about the jokes and funny stories they sent each other. He appreciated having laughter in his life and added that his friends sometimes also sent him useful information, as well, such as a short video that had helped him better understand his wife's condition. Leonard also visited with his new condo neighbours: *"I find sometimes I go do exercise and I come back and there's a half a dozen women sitting there, so I'll sit there and listen and it helps."* A key connection that Leonard made was with other members of a caregiver support group. He found that, *if you can talk to somebody with a little authority or even if they're kinda guessing, but if they've been there, done that, or they've seen this, then it kinda stabilizes you."*

Richard volunteered in the local community partly because it was *"when I get to talk to people. That's why almost, well, I volunteer because I said, 'It's a chance to talk to somebody.'"* Mae would go to stay with friends for a few days whenever she felt overwhelmed. Gertrude and Tracy from the focus group were friends who met at their husbands' care facility. Theirs was a mutual turning toward connection that involved visiting together *"every night and that helps an awful lot"* (Gertrude).

Some participants had little capacity to invest in their social lives even in stage two. Emotional exhaustion, feeling overwhelmed, personal health, and financial limitations contributed to disconnection. Hilda had downplayed her husband's condition to friends and to her church, reflecting that, *"Maybe I should have told more people what was going on so people would have been more understanding, but I never thought of that at the time."* Richard held back because he worried that others might think he was seeking a new partner—but he desperately wanted others to reach out.

You get to the point where you say, 'Well, you know, nobody calls, nobody comes, and you start to believe nobody cares.'...I don't think that's quite true. I think that people do care, but they...I don't think they mean to distance themselves, but they just don't know, maybe they just don't know what to do, what to say. Well, just treat me normally. (Richard)

Moreover, budget limitations precluded many social activities; for example, Rita's community had a weekly fellowship supper but the \$13 cost was far too expensive. Others noted that they themselves experienced poor health and limited mobility.

Sometimes others were responsible for the disconnections. Tracy, age 87, married for 69 years and separated for 15 months, observed that though some friends had stuck with her through her husband's admission to care, some had not—*"Once you can't join into everything, well, they just forget about you."* Gladys explained that these disconnections happened in part because, *"you're not a couple, I'm not a widow. And it's like a death because our friends were couples and you're not a couple anymore and you're not part of that social scene."*

Faith. In stage one, participants who were religious gave one of two responses: they reported being rocked with uncertainty about how God could allow such deep suffering, or they emphasized that their faith gave them stability amid chaos. Whether they experienced the shock or the stability, there always seemed to be some tension in stage two as they did the difficult work of adjusting. Participants wrestled with how to resolve the tension between their faith and their suffering even as connecting with that faith came to be a primary form of coping for many. Rita said a despairing prayer: *"The thought came, 'God...why can't you answer my prayer that my husband doesn't have to leave me?' At the time, there was an anger to think that now why does he have to be that sick, that I can't look after him?"*

Many participants at this stage felt helpless. **Table 1** Amid that helplessness was, among the religious participants, an anchor of prayer and of faith that God was directing their path even if it was not a path they wished to take. Jean continued to wrestle with an internal conflict between faith and worry; *"I shouldn't worry about it because the Lord will provide that way too...but you can't help it sometime and...yeah, I still find it hard to deal with."* Only 4 weeks separated, her feelings were rawer than most, yet for those who moved through the next stages, signs of that tension being resolved were evident by the time that they were *moving forward*.

Discussion

The basic psycho-social-spiritual process of involuntary separation, fundamentally an experience of disconnection, is *connecting*. The need for connection is present from the onset of involuntary separation and continues years later. Initially, the predominant focus is typically on desire for closeness with the partner in care, and it is doubtful that this ever goes away. However, there are opportunities for connection with others, with identity, and with faith threaded throughout these three steps, and these opportunities—where they succeed and where they fail—are what we have endeavoured to outline in the present study.

Participants felt that, against their wishes, they went from being a single unit of "us," to a "me" and a "them." Accordingly, many initially grieved what they perceived as having failed as a spouse: had they done a better job of caregiving, the couple could have stayed at home, together. As they began to accept their limitations and the natural consequences thereof, many wrestled with formulating a new identity that integrated the significant impact of involuntary separation (stage two). If they reached stage three, participants had either resolved or made peace with their new sense of personal identity. Precisely what this looked like varied for each participant, from a *strengthened* identity as wife or husband to a *shifted* identity that included a

Table 1. The three stages of connecting overlapped with categories and subcategories of results.

Stage 1 Initial news and coping	Stage 2 Adjusting to new situation	Stage 3 Moving forward
Unique challenges	Unique challenges	Resolution of major challenges of involuntary separation
-Relinquishing control	-The work of separating	-Identity: Confident
-Moving spouse to facility	-Life at home (aftershocks)	-Faith: Peaceful, content
-Involuntarily separating	-Involved in spouse's life	-Family: Reciprocity of engagement
-Preparing and learning	-Comfort in good care	-Social world: Meaningful
-Filing paperwork	-Advocacy & concern for care	
-Identity: Failure	-Financial shift	
-Family: Needing support	-Identity: Struggling	
-Social world: Needing support	-Faith: Tension, coping	
- Faith: Shock vs stability	-Family: Engaging vs. distancing	
	-Social world: Empathy vs. insensitivity	

growing sense of autonomy while still nurturing their bonds with their partners.

Although all participants appeared to experience the three stages in the same order, each participant's individual experiences of connection or disconnection to their identity, family, social world, and faith influenced their movement through the stages. However, the authors do not believe this theory should be used as a rulebook to tell others how they *must* go through the process of involuntary separation, but rather as a guide, showing how others have experienced it, and perhaps even bringing a sense of hope that others have walked a similar path and found a sense of peace. Moreover, whereas each stage had marked elements that were common across participants (Figures 2 and 3), the unique aspects of each participant's experience are also noteworthy. For example, some went through the first stage or stages quickly, whereas others moved much more slowly, or experienced the death of their spouse prior to reaching stage three.

Along each participant's process through the three stages, there were innumerable points where they made a choice to either reach toward care and support via one or more of the four forms of connecting, or to pull away, furthering the disconnection that is already starkly present in involuntary separation. These choices were greatly influenced by the people around them and their own choices to reach out in supportive ways or to create distance. Those who pulled away from others—or those without significant others in their lives—felt more isolated in their experiences and seemed to struggle more intensely with feelings of doubt and sadness. This further disconnection may result in greater difficulty and resistance toward shifting their personal identities to allow for their increasing independence. If they have spiritual beliefs, they may also struggle more to reconcile those beliefs with their ongoing painful experiences.

Those who resist connecting may have supportive people who are limited by factors such as geographical distance or ignorance of how to appropriately show support, or who are

unwilling to put aside their own perceptions of the situation and instead respond in judgmental or otherwise unhelpful ways. The unsupportive actions—whether willful or well-intended—are especially painful to the spouse and can lead to the spouse giving up on receiving helpful support from family members or social circles. By the time participants were *adjusting to the new situation*, after the initial crisis had passed, there was a noticeable dichotomy among participants of connection versus disconnection with their children and others. When old friends and acquaintances fell away, some participants felt powerless to form new ones. Others pressed into their existing relationships and reached out to others with whom they felt a kinship. Richard was a curious case in that he did both: he was constantly reaching for—and in many ways, receiving—connection, but he also felt the painful stings of every pinprick of rejection and insensitive comments. Of note, those participants whose connection needs were met typically regained the ability to respond in kind. This reciprocity was a hallmark of those who were *moving forward*. Here, participants spoke of mutual give-and-take in their relationships, especially with family. Those participants who were in stage three felt loved and supported and they enjoyed being able to actively show their love and support in return.

Individuals who frequently sought—and received—connection with others did not necessarily experience less pain than those who were more disconnected, but they were able to walk in their suffering with the sense that others were walking alongside them. They tended to have support in the long-term rather than only in the initial stage of crisis (*initial coping*); they were more effectively able to combat their feelings of guilt for having to move their partners (*adjusting to the new situation*); and they were more likely to reflect on positives (*moving forward*). They were also more likely to express their feelings and have more self-awareness and acceptance of their conflicting emotions.

Mikulincer and Shaver (2008) described the three-part response to grief or separation from an attachment figure as

protest, despair, and reorganization. These three states have clear overlap with the stages of connecting described in the present study. Elements of the protest state were often alluded to by our study participants in reference to the first stage (initial coping). Protest was evident when they spoke about delaying admitting their partners and it continued after the decision was made and the partner was moved into care. Despair was evident in the second stage (adjusting to the new situation). Most participants spoke about the conflicting feelings of guilt and failure but also relief that they experienced over the decision to pursue spousal placement. In reorganization, the third state, individuals seek new attachment figures and seek to crystallize their new identities. In this study, former partnerships of co-attachment (i.e., their husband or wife) became unequal relationships, particularly when the unwell partner was experiencing cognitive deterioration. For these participants, the disconnection had already begun and there was a complex breach of attachment in the relationship: their co-attachment figure was increasingly no longer mentally present, leaving the participant to try to reorganize their identity as husband or wife, as an individual, and as an individual within their worlds of family and friends. Those who had strong family, church, or social connections were able to transfer their attachments more readily onto new safe havens in order to feel secure. Participants without these support structures were more likely to feel untethered and it took them longer to reorganize and find their new stability. Indeed, some of our participants did not yet present as having successfully navigated reorganization. They remained disconnected.

Recommendations

The findings of the present study support a number of recommendations for support providers and others who interact with spouses experiencing involuntary separation, namely, education and preparation for the spouse and for others. We suggest that long-term care facilities might prepare information packets with an overview of admission procedures, a checklist of tasks to be completed, and contact information for resources. They might also offer information sessions for family and friends, designate one contact person at the care facility to help participants feel less lost, and facilitate peer support opportunities (e.g., care facilities might recruit volunteers who have gone through the experience themselves and who feel ready to now walk alongside someone else). These suggestions are echoed in Hango (2020) who listed the needs expressed in the Statistics Canada 2020 General Social Survey as a mix of financial, practical, and emotional support as well as respite options.

Considerations

This study provides both a generational context and a Canadian context to the research on involuntary separation. It

gives voice to the lived experience of a significant portion of society—older adults, including the oldest-old who, for example, remembered the Great Depression of the 1930s, World War II, and the advent of television. One participant described how the war delayed her wedding for 4 years because her husband had refused to risk her becoming a widow. Another spoke of what it was like to watch her husband experience mental illness since the 1950s, long before their town had a psychiatrist or any kind of mental health resources.

Whether participants moved more toward connecting or disconnecting, they all showed a strong sense of *resilience*. Perhaps even more so in the rural and small-town setting of southeast Alberta, there is a strong sense of independence and self-reliance that, for many, was necessary for their survival. Those who were more *disconnecting* came across as being held up internally by sheer force of will, while those who were more *connecting* were bolstered by the people in their worlds. We posit that those participants who leaned toward disconnecting (such as emotional avoidance and extreme independence) were no less resilient than those who more readily inclined toward connecting; however, those who sought—and received—connection were able to experience moments of harmony within their pain.

Weather conditions also had a notably negative impact for some participants. Like most of Canada, southern Alberta has its share of extreme weather during much of the year. Some participants noted that even though they were healthy and physically independent, they chose not to drive in bad weather or poor road conditions. One participant mentioned taking the bus, but this was not a viable option for everyone. Few could afford a taxi. This meant they were unable to visit their partner as frequently as they wanted unless someone was available to drive them. Participants who lived on-site in multi-level facilities noted that ease of access smoothed the transition into separation (see also Glasier and Arbeau, 2019; Torgé, 2020).

Strengths and limitations

The study is strengthened by its homogenous participant sample, which offers a window of greater depth and meaning into this particular population. Much of the existing research in this area has been completed in larger urban centres; the present study, in contrast, was conducted with participants from rural and semi-rural settings. Although qualitative research is valuable for its potential for depth of description but limited (by design) in its ability to generalize beyond the sample under study, grounded theory is a bold methodology that aims to identify the processes of a phenomenon to the extent that it *does* become generalizable beyond the sample population (Hood, 2007). According to Mills et al. (2006), grounded theory “illuminates common issues for people in a way that allows them to identify with theory and use it in their own lives” (p. 32).

We posit that the basic human experiences contained within the four forms of the basic process of connecting—as experienced through interactions (whether connecting or disconnecting) with significant helpers, family, and social contacts—will apply to many others experiencing involuntary separation. Likewise, we posit that the three stages of connecting delineated in the present paper—initial news and coping, adjusting to life apart, and moving forward—may provide a general framework within which the unique experiences of other individuals facing involuntary separation can be understood. Additionally, many of these findings are supported by existing literature from elsewhere in Canada, the United States, and internationally (see Førsund et al., 2016; Glasier and Arbeau, 2019; Hennings et al., 2013; Majerovitz, 2007; Nolan and Dellasega, 2001; Reuss et al., 2005; Roelofs et al., 2019; Schulz et al., 2004; Stone and Clements, 2009). Thus, the present study merits a high level of confidence for its value as a general starting point in conceptualizing the process of involuntary separation and is likely to be helpful in a variety of contexts.

For example, spousal separation through long-term care admission shares commonalities with other forms of involuntary separation from a partner or spouse. Separation due to a military deployment, for example, was investigated by Wood et al. (2019) as an example of an attachment-related threat, with effects on feelings of cohesion and satisfaction. Merolla (2010) explained that couples in which one or more members of the dyad are in the military engage in behaviours to maintain connection that are specific to the nature of their relationship. They emphasized that a balance of creativity and intentionality is needed in response to the separation, particularly when communication is limited. Findings from research into involuntary separation when one spouse is incarcerated align closely with the research on military deployments, emphasizing that the spouse remaining at home engages in deliberate behaviours intended to maintain connection throughout the separation (Nickels, 2020). Similarly, couples experiencing involuntary separation due to long-term care admission can experience communication challenges, especially when the spouse is unable to visit because of financial or mobility constraints, and they likewise engage in behaviours intended to maintain and affirm their bonds. We contend that the framework provided in our study can also be applied to these experiences.

Future directions

It seems many separating spouses are willing and eager to talk about their experiences. Studies should be broadened across Canada, including rural areas. Focus could also be placed on further exploration of gender, spirituality, and other factors on the experience of involuntary separation. The present study has put forward a new framework for understanding and conceptualizing this topic, but there is much

room to explore how this framework may be adapted or transformed within other settings or to other populations, such as incarceration or military deployment.

Conclusion

Involuntary separation is experienced uniquely by each individual, but an element common to everyone is connecting. For most, being involuntarily separated is a crisis with traumatic consequences that can echo for years after the initial move. Movement through the three identified stages of this basic social process is influenced twofold: (1) by the individual's willingness to reach out for connection and to accept the support that is offered, and (2) by the ability and readiness of others (family, social circles, and professionals) to extend accurate empathy, help with problem-solving, and educate spouses and the broader community. When each component is aligned, spouses experience a smoother progression through the three stages. Here they nurture their bonds with their spouses, they continue to grieve their losses, and they simultaneously embrace life, family, friendship, and faith with gratitude.

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Ethical statement

Ethical approval

This study used both original data and secondary analysis of existing data. The design was approved by the Research Ethics Board of Trinity Western University, File Number 15G02.

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