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RESEARCH

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Relationship intimacy in older couples when one partner has mild cognitive impairment: A qualitative study

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Abstract

Objective: In this research, we examine perceptions of couple relationships and intimacy among older couples when one partner is diagnosed with mild cognitive impairment (MCI), based on ambiguous loss theory.

Background: Many studies have examined couples with one partner affected by dementia, yet few have explored intimacy when the affected partner is diagnosed with MCI.

Method: A qualitative-phenomenological approach in which data were collected through in-depth, semistructured, face-to-face interviews with 16 men and women aged 67–90.

Results: The nondiagnosed partners live in the present while acknowledging the changes caused by aging and the diagnosis. In contrast, the diagnosed partners tend to live in the past. In line with ambiguous loss theory, the nondiagnosed partners reported that their diagnosed spouses are physically present yet many aspects of their personalities are partially absent.

Conclusion: The findings reveal two patterns of coping with the consequences of loss. Understanding these relationships offers insights into how to care for individuals with MCI.

Implications: The results highlight that individuals with MCI and their partners do not invariably constitute a homogenous group, necessitating a critical appraisal of partners' roles and expectations before initiating therapeutic interventions.

KEYWORDS
aging, ambiguous loss, cognitive impairment, couple relations, health aging, intimacy, late life

INTRODUCTION

Intimate relationships are a fundamental aspect of human existence. These relationships confer a sense of security, support, and interconnectedness that persists throughout life (Mahieu et al., 2017). The significance of intimate couple relations throughout the life cycle raises questions regarding how couples deal with challenges in general, and with challenges characteristic of old age in particular (Ayalon et al., 2019; Levkovich et al., 2018). One of the challenges couples must face in later life is the need to adapt to physical and psychological changes in their partners (Gewirtz-Meydan et al., 2019).

Much like problems with physical health, cognitive impairment affects both partners in a marriage (Ayalon et al., 2021). The literature examining dyadic relationships reveals significant associations between physical health and relationship quality among married adults (Yorgason & Choi, 2016). These associations are also influenced by the physical and intrapsychic condition of each partner, the way the partners perceive their relationship, and the relational pattern they have developed over the years (J. S. Fisher et al., 2020). This is especially true in cases when the couple is forced to deal with drastic changes in their relationship because one partner has been diagnosed with an illness (Wadham et al., 2016), including mild cognitive impairment (MCI), which is the focus of this research. The current study examines couple relationships and intimacy among older people when one of the partners has been diagnosed with MCI. It explores how the partners perceive their relationship in view of the changes caused by such a diagnosis, as well as the ways they cope with the emerging reality as influenced by the partner's cognitive impairment.

Couple relationships in which one partner has MCI

In clinical terms, MCI is situated along a continuum ranging from normal aging and the development of Alzheimer's disease (Golomb et al., 2004). The common symptoms of MCI include memory problems, communication difficulties, and changes in mood and behavior (Richardson et al., 2019). Individuals with MCI usually require little physical help and as a rule continue to be able to do what they did in the past. Nevertheless, the literature emphasizes that as the disease progresses, the damage it causes to diagnosed individuals and to their close environment may increase (Connors et al., 2019; Gomersall et al., 2015).

A diagnosis of MCI introduces profound changes into the dynamics of a couple's relationship, particularly in terms of intimacy and sexuality (Conway et al., 2018; Yorgason et al., 2020). As MCI progresses, the diagnosed spouse becomes increasingly dependent on the partner, causing expectations and potential burdens to escalate. This dependency, coupled with the physical and other limitations associated with MCI, can chip away at an individual's self-esteem and sense of worth, with potential repercussions on the well-being of both partners (Holdsworth & McCabe, 2018; Yorgason & Choi, 2016).

The ripple effects of MCI on relationships are far-reaching. A review study underscored these effects, revealing a decrease in reciprocity, communication, shared activities, and overall happiness within the relationship (Evans & Lee, 2014). These effects are not confined to the emotional realm; they also impinge on physical independence, freedom of movement, and other aspects that contribute to psychological well-being (Gomersall et al., 2015; Wadham et al., 2016). A qualitative study involving 11 spousal dyads revealed a silver lining amid the challenges. Caregivers acknowledged that despite the associated anxiety, depression, and burden, caregiving also had positive elements in that it highlighted the resilience and adaptability inherent in such relationships (Daley et al., 2017).

Theoretical framework: Ambiguous loss

Ambiguous loss (Boss, 1999) describes a situation in which someone is still alive but is absent from the lives of loved ones. Such a situation can take two forms: One is physical absence with emotional presence, as in the case of a soldier who is taken prisoner and is absent from his family for a very long time. The other is physical presence accompanied by psychological absence, as in cases of dementia (Boss, 2016). Psychological absence is confusing because the emotional bond appears to be missing or gradually slipping away. In the case of dementia and MCI diagnoses as well, individuals may no longer resemble the people they used to be. Family members may even question whether the person who is psychologically absent is still part of the family, thus raising further questions regarding shifting roles in the family (Beatie et al., 2021; Gomersall et al., 2015).

Ambiguous loss among older couples with MCI

In the current study, we chose the theory of ambiguous loss as the theoretical basis for the research. Given that dementia, including neurodegenerative forms such as Alzheimer's disease, is classified as a terminal illness, it precipitates multifaceted and enduring losses for both the diagnosed individual and the caregiver (Nathanson & Rogers, 2020). These losses span various domains, including roles, connections, functions, and relationships, often leading to concealed distress and emotional pain. Such losses are termed "ambiguous" because of their often unacknowledged or unidentified nature, which can impede progression through a typical grief cycle toward integration (Boss, 2016; Hovland, 2018). The lack of recognition can further exacerbate the emotional distress associated with these losses, underscoring the complex nature of coping with dementia (Nathanson & Rogers, 2020). Indeed, the caregiver cannot grieve over the loss of the diagnosed spouse, for the spouse is still present and there are no social rites appropriate for mourning such a loss (Boss, 2016).

Marital relationships in which one spouse has MCI are characterized by strong ambivalence on the part of the caregiver between sympathy for the diagnosed spouse's suffering and anger over the sacrifices necessitated by caring for the spouse (Balintona, 2018; G. G. Fisher et al., 2011). Indeed, the multiple losses characterizing the progression of dementia lead caregivers to develop anticipatory grief—a specific feeling of grief prior to the death of a family member (Pérez-González et al., 2021).

Relationships with a spouse who has been diagnosed with MCI are characterized by sharp fluctuations between two poles. One end of the pole represents all the familiar aspects of their life as a couple, together with attachment patterns that have been constructed over the years (Albert et al., 2022). The other end of the pole represents the psychological perspective. Although husband and wife physically occupy the same home, the diagnosed spouse seems to be absent to the point of being a stranger, leaving the caregiver spouse in an ambiguous situation, often for many years (Nathanson & Rogers, 2020).

Current Study

Substantial evidence indicates that cognitive impairment progressively modifies the dynamics between affected individuals and their family members and has a pronounced impact on relationships between older married couples due to a decrease in companionship and mutual support (Gallagher & Rickenbach, 2020; Holdsworth & McCabe, 2018; Wadham et al., 2016). Correspondingly, the grief associated with the loss of this relationship experienced by the spouse of the cognitively impaired individual is substantial (Nathanson & Rogers, 2020).

Most previous studies have adopted the viewpoint of the partner who is not cognitively impaired (Arbel et al., 2019; Kraijo, 2016). This study, in contrast, underscores the importance of considering the individual perspectives of both partners. Recent research has begun to focus on the characteristics of a high-quality dyadic relationship from the viewpoints of both partners as the cognitive impairment progresses (Cheung et al., 2022; Rippon et al., 2020).

Despite growing recognition of the importance of couple relationships in later life, research on dementia among married couples has often focused on the later stages of the illness (Sandberg, 2023; Youell, 2015). The current study examines these topics among older couples in which one partner has been diagnosed with MCI. This stage may be prolonged and entail numerous changes to intimacy and the marital relationship. In many cases, the diagnosed partner remains able to function well on the physical level but begins to exhibit some degree of memory loss or disruption of thought patterns (Richardson et al., 2019). These unanticipated changes in the couple relationship force the caregiving partner to reorganize and redefine the relationship, particularly in terms of intimacy and sexuality (Conway et al., 2018; Yorgason et al., 2020). These extremely complex changes underscore the need to examine how partners in such a relationship, both individually and together, deal with issues connected to couple relationships and intimacy.

Unlike with other conditions such as full-blown dementia, the features of MCI are more subtle, such that the members of the couple may have difficulty identifying and responding to the condition. Indeed, the presence and impact of this condition can fluctuate. In this study we adopted a qualitative-phenomenological approach and posed the following research questions in the context of the theory of ambiguous loss in old age (Boss, 2016; Nathanson & Rogers, 2020): How do couples in which one partner has been diagnosed with MCI perceive the couple relationship and intimacy? How does each partner perceive the couple relationship in view of the changes occurring in their relationship? How do the partners deal with the new couple reality emerging from the cognitive decline?

METHOD

The study adopted the qualitative-phenomenological approach by focusing on the lived experiences of older couples when one partner has been diagnosed with MCI (Patton, 2015). Qualitative research was chosen to enable participants to tell their stories and assign meaning to their experiences. Qualitative research is based on the understanding that reality is constructed through the unique perceptions of individuals who share a common experience or phenomenon. In the context of dyadic research, the inclusion of perspectives from both members of the couple enhances the depth and breadth of the overall picture (Eisikovits & Koren, 2010). This integration of multiple realities allows for a more nuanced examination of the specific couple under investigation, providing an additional layer of insight (Collaço et al., 2021).

Procedure

The study was approved by the Helsinki Committee of Clalit Health Services (the largest HMO in Israel). Participation in the study was based on the following inclusion criteria: one partner diagnosed with MCI, over age 60 years, and Hebrew speakers. Participants were recruited with the help of five primary care physicians working at five primary care clinics affiliated with the

HMO's Department for Family Medicine in the Haifa and Western Galilee district. The physicians identified older couples in which one partner had been diagnosed with MCI and who met the above inclusion criteria. The physicians referred all couples who expressed their willingness to participate in the study to the researchers. All respondents signed a consent form prior to participation. Respondents were informed they could stop the interview at any time or refrain from responding to certain questions that made them uncomfortable. No incentives were offered. Participants were identified and recruited during 2019.

Participants

The sample included eight couples in which one of the partners was diagnosed with MCI: eight men (age range 78–90 years, mean age 83.5 years) and eight women (age range 67–90 years, mean age of 78.5 years). Five women and three men were diagnosed with MCI. The mean duration of their marriage was 58 years. We concluded data collection once we reached saturation and no additional themes emerged from the data (Creswell & Poth, 2016).

Research tools

The data were collected by semistructured interviews. Each partner was interviewed separately, without the presence of the other partner. These interviews were designed to understand what the interviewees perceive and what significance they attribute to the phenomenon under study. Both interviewers were female. One is a psychotherapist (PhD) and the other a social worker (MA), and both are experienced in conducting qualitative research. The interviews were conducted according to an interview guide that included significant key areas yet was flexible enough to facilitate dialogue between interviewer and interviewee as well as meaningful self-expression (Creswell & Poth, 2016). The interview also included questions about different emotions, the type of care provided to the spouse, and the interviewee's coping mechanisms (Appendix). The interviews took place in the participants' homes and lasted approximately 1 hour. Participants were assured that their confidentiality would be maintained, and pseudonyms would be used. Each interview was recorded and later transcribed verbatim.

Data analysis

A dyadic qualitative examination was employed to scrutinize the relationship dynamics and intimacy in a group of older couples in which one partner was diagnosed with MCI. This dyadic modality facilitates exploration and identification of intersecting perspectives as well as disparities between dyadic participants, particularly in instances where data collection is conducted independently for each individual (Collaço et al., 2021). The topics discussed arose not only from the questions posed to the interviewees but also from experiences that the participants brought up. The adapted dyadic exploration was predicated upon the framework model (Collaço et al., 2021; Eisikovits & Koren, 2010) and encapsulates several sequential phases of data analysis, as detailed in Table 1.

Trustworthiness

We used the concepts of trustworthiness and authenticity as outlined by Lincoln and Guba (2013). Three researchers, two of them senior researchers (IL, LA), employed investigator

TABLE 1 Stages of dyadic analysis.

Stage		Analysis
Stage 1	Transcription	Verbatim transcription of the interviews.
Stage 2	Familiarization with the interview	Intimate acquaintance with the data was established by means of repeated readings of the interviews and periodic revisits to the reflective notes of three researchers.
Stage 3	Coding	The researchers thoroughly read the transcript and allocated relevant codes to distinct lines of text based on the couple's experiences and needs. The codes reflected the emotional reactions and intimate relationship needs over time. Transcription coding was conducted independently for the male and female partners.
Stage 4	Charting codes into table of themes	The codes were organized into a Word table. This involved formulating a table with overarching themes, guided by the questions posed and the codes extracted from the participants' transcripts. Appropriate quotes from the interviews were placed under each central theme, for example, ways of coping, state of intimacy today, and more.
Stage 5	Dyadic analysis	Dyadic codes were formulated based on the overarching themes and subthemes unique to each couple. This procedure also included dyads mentioned by one partner and not the other.
Stage 6	Interpreting the data	Using this procedure, we identified patterns that included several subthemes along a continuum, thus presenting a more complex version of reality than the first version. The researchers reviewed and verified the revised results and data analysis.

Note: Based on Eisikovits and Koren (2010) and Collaço et al. (2021).

triangulation to achieve credibility and confirmability. The interviews were transcribed verbatim, allowing the researchers to revisit the original narratives. Each researcher reviewed the transcriptions independently while engaging in continuous reflection and actively acknowledging their personal experiences and biases throughout all stages of the study and analysis. The chosen quotes, which encompassed a significant portion of the interview content, were meticulously translated from Hebrew to English (Yunus et al., 2022). Two native speakers, one with professional translation expertise, thoroughly verified the accuracy of the translations. To ensure credibility, the researchers used continuous observation and note-taking. A qualified expert in qualitative research closely monitored the data collection and processing procedures to validate the accuracy and authenticity of their experiences and inner sentiments. Their approval of the results further established data reliability. By interviewing dyads to obtain data from multiple sources, we were able to triangulate the data and develop a more comprehensive understanding of the themes.

FINDINGS

Qualitative analysis of the interviews yielded three main themes:

1. "Absent presence": Loss of self as individuals and as a couple. In this theme the two partners did not share a coherent and sequential memory of the relationship. Additionally, the undiagnosed partners described how personality changes in their spouse contributed to ambiguity.
2. "Yearning for touch": Loss experienced in couple intimacy. This theme was marked by enduring desire for previous intimate connections and obstacles encountered in

reestablishing past levels of ardor and intimacy, coupled with recognition of altered sexual intimacy.

3. Asymmetry in the relationship between caregiver and care recipient. These dyads employed a coping strategy that sought to dismantle the entrenched and unequivocal societal dichotomy of the caregiver–care recipient dynamic. The dyads articulated their attempts to nullify the possible imbalance when one partner needs assistance.

Theme 1: "Absent presence": Loss of self as individuals and as a couple

The participants described the many losses they experienced that were related to old age, including the loss of abilities, friends, and intimate contact. One of the main losses they described was related to their self-perceptions, their identity, and the changes occurring in the identity of their partner's identity—either the partner diagnosed with MCI or the nondiagnosed partner. Both partners described themselves as being tangibly present. Yet on a deeper level, they were aware they no longer possess the same physical and psychological resources as in the past and during their life together as a couple: "No. I accept things. I think I am the same Michal but I no longer am [she laughs]. It's … a feeling … It doesn't matter if it's a man or a woman. Something also happens to the individual's personality!" (Michal, 82 years old and diagnosed with MCI). Personality changes also cause ambiguity. The undiagnosed spouses described how someone outside the relationship might perceive these personality changes as marginal. For them, however, these changes produced a sudden sense of strangeness after years of knowing one another:

> And I notice things that worry me a lot … because I see that in any event … she's not what she once was … she forgets…. Usually when we went to the city she would wash the dishes. Since we've been here, I've washed them…. She used to prepare breakfast, but this doesn't happen now…. You see, she's lost interest. (Donn, 78 years old, nondiagnosed)

These descriptions indicate that when the two partners do not share the same coherent and sequential memory of the relationship, the relationship is subject to stress, especially in the face of the diagnosed partner's cognitive loss and physical presence. As Rama indicated, her good memories are tied to the past and not necessarily to memories of the couple relationship:

> I have a very good memory when it comes to my childhood, something he doesn't have. He's in denial…. I have already given up, because I tell him a lot of things and he doesn't remember at all, so I talk about them less and less … I don't talk about things so much, I don't remember so much. I don't know any more. (Rama, 70 years old, nondiagnosed)

The concept of absent presence is exemplified by the following vignette reflecting how the two partners view their relationship. Whereas the nondiagnosed partner is fully aware of the changes and losses that have occurred over time, the diagnosed partner talks as if nothing has changed. Hence, even though they both talk about the exact same topic, subjectively they view it very differently. According to the nondiagnosed partner, "She doesn't want to visit friends, she doesn't want friends to come over, we used to belong to a sports club. She used to go all the time. But this is long gone" (Jack, 90 years old, nondiagnosed). The diagnosed partner, in contrast, portrays her social and physical engagement in a completely different light:

> We belong to a club. So, we exercise and I am really good at volleyball. I used to be really good at sports. Everything is fine. No complaints. No complaints about

> marriage and not about the children. Everything is fine. (Yael, 85 years old, diagnosed with MCI)

Theme 2: "Yearning for touch": Loss experienced in couple intimacy

Another joint loss experienced by both members of a couple can be seen in the ongoing yearning for their former intimate contact and the challenges they face in achieving their former passion and intimacy. The nondiagnosed spouses reported that the absent presence of the spouse with MCI creates a situation in which they yearn to be touched and enclosed and safeguarded by their partner's embrace. The nondiagnosed spouse is often lonely in the relationship, even though the other partner is physically present:

> We lie together in the same bed. If something happens in the middle of the night, and something happens every day, I need to be alert. To watch over her. I watch over her and she watches over me. Lately, in terms of cognition, the situation has quickly gotten worse. It's not only her memory. She doesn't always understand things. She isn't always aware of things in time. Priorities, what needs to be done first. It's strange for her. And it hurts me. (Shlomo, 85 years old, nondiagnosed)

Jack (90 years old, nondiagnosed) described the loss of intimacy by recounting a conversation with his wife Michal (85 years old) 2 years previously:

> She doesn't remember this, but I reminded her that two years ago, all of a sudden, she said to me, "Jack, I'm 80 years old and it doesn't suit me anymore all of this caressing and necking." I said, "But remember, one day you will want it and it will be very difficult for you…" Two years ago, it completely stopped and exactly a year ago the cognitive decline seemed to worsen.

For Jack, this conversation appears to be a self-fulfilling prophecy. Two years ago, before the diagnosis, their sexual desire was combined with fear of aging. Jack tried to explain that at the time everything depended on them and their desires. But a year ago it became clear to him that because of his wife's cognitive decline, sexual intimacy between them was no longer possible.

The yearning for physical contact is not limited to the nondiagnosed spouse, as can be seen in the following statement by Lilly, a 78-year-old woman diagnosed with MCI: "We do touch each other and get closer, but there is a difference. We cannot have sexual intercourse. Perhaps he can, but I can't."

Theme 3: Asymmetry in the relationship between caregiver and care recipient

The coping style used by most couples attempts to abolish the familiar and absolute social division in the caregiver–care recipient relationship. The couples described their attempts to eliminate this potential asymmetry in which one of the partners requires help. This asymmetry has the potential to endanger the entire couple relationship and turn it into a burden for the couple and those around them. By relying on the mutual relations of trust they have built over the years, the partners challenge the usual power relations in the caregiver–care recipient relationship.

> I can't do a lot, but I've begun doing a few things now that he likes. I love making him the chicken soup that he loves. She [care worker] doesn't know how to do this. These are things that she doesn't know. I make it for him. Because I love him and I want him to enjoy himself, like before. (Lilly, 78 years old, diagnosed with MCI)

In the following vignette, Debra (80 years old, undiagnosed spouse) demonstrates the need to avoid the caregiver–care recipient relationship: "I do not take care of him. He is independent. Over the years, we divided the work between us. I take care of the kitchen, food, clothes, etc. He takes care of banks and financial bills." Shmuel, her partner, described his confidence and trust in his wife:

> First of all, I always listen to her. She makes many decisions for my sake. She has good common sense, which in my view is good and healthy. I trust her 100%. But there are things she trusts me with. She trusts my decisions. (Shmuel, 82 years old, diagnosed with MCI)

Another coping strategy that was used by a minority of participants focuses on the resource provided by a strong basic connection that makes it possible to maintain a very valuable friendship rooted in deep love. Couples who use this strategy accumulated this love over many years and look for what they share rather than for what is unfamiliar and separates them. By discovering what they still share, such as a hobby or a joint activity from the past, they can strengthen their communication and emphasize what still exists rather than what is missing.

> Since we have been married for over 50 years, it's not what it once was…. There was and there remains a very deep friendship in this relationship, absolutely, absolutely! And, it's not so easy when I notice occurrences that worry me a lot. Today he remembers things, perhaps from 50 years ago and stories from the army … I always laugh. (Yisraela, 78 years old, nondiagnosed spouse)

Tim, a 79-year-old man diagnosed with MCI, described the couple's present-day closeness, which is rooted in their sense of togetherness from the past and in some ways still exists:

> We used to have fun, we would walk to the sea every day; then there weren't a lot of people who walked there, go to a movie and a restaurant, or out dancing, it was another life…. Okay, we still have our togetherness now, but it's a different kind of togetherness … it's togetherness in that I love her and I feel she cares about me.

DISCUSSION

In the current study, we examined perceptions of couple relationships and intimacy among couples in which one partner was diagnosed with MCI. The concept of absent presence emerging from the current study reflects two main psychological losses along the couple relationship continuum. The first is psychological loss, which includes gaps in the ability to tell the couple's narrative, changes in what the couple once did together, and the inability to maintain and retain the couple's history. The second is the loss of intimacy and the yearning for touch. According to the literature, couples in which one partner has cognitive decline feel ambiguous about their surroundings and their families because of their psychological loss (Boss, 2016). This psychological ambiguity emerges because the diagnosed partner is physically present, but familiar parts of her or his personality are absent (Pérez-González et al., 2021). These couples experience different types of losses every day but are unable to predict the changes yet to come.

Stress in these relationships was no longer conceptualized in terms of the individual but rather in terms of the dyad (Bodenmann et al., 2011). Dyadic coping requires that both partners cope mutually with stress by providing and receiving support from each other and engaging in joint problem-solving and shared emotion regulation (J. S. Fisher et al., 2020; Yorgason & Choi, 2016). Therefore, couples may respond as a unit rather than as individuals. Over the years, married couples accumulate many experiences and emotional and behavioral patterns connected to each other and to their couple relationship. The results of this study demonstrated the loss of certain elements tied to these joint memories and of certain former habits as a dyad. These losses affect both spouses, who attempt to hold on to longstanding narratives they no longer share. The formerly uniform, sequential, and agreed-upon narrative of the couple relationship becomes a narrative full of "holes," one that is missing significant parts. The difficulties emerge when one spouse no longer shares memories of the couple relationship (Albert, 2022; Sandberg et al., 2023), especially memories that are usually recalled at ambiguous and temporary moments (Eskola et al., 2022; Swall et al., 2020). Therefore, when the couple self is in danger, the spouse may not be able to experience herself or himself in an integrative manner because the joint mirror reflecting their experiences is no longer there (Stedje et al., 2023).

The partners who were not diagnosed with MCI described how they perceive their loved one as physically present but at the same time absent in their daily life. These results are consistent with those of earlier studies showing losses of dyadic interaction, intimacy, and partner relationships as well as the challenges of providing care and the spouses' acceptance, adaptation, and coping (Holdsworth & McCabe, 2018; Yorgason & Choi, 2016). The partners diagnosed with MCI stated that at times they even feel absent from themselves, as if "something in my personality changed." MCI often affects an individual's ability to generate new ideas or patterns of thinking. It often leaves its victims with a sense of self-alienation and loneliness as they move between states of "self" presence to states of absence (Gomersall et al., 2015; Wadham et al., 2016).

Another feature of absent presence is related to the loss of the couple's "sense of self." The partners not diagnosed with MCI were overwhelmed by the loss of their sense of being part of a couple, distressed about the present, and worried about what may happen in the future. Similar findings have been reported in the research literature (Arbel et al., 2019; Kraijo, 2016). In contrast, the diagnosed spouses stated that they sensed no differences between their past and present activities as a couple. Moreover, some of them even reported an improvement in their couple relationship. This loss of a couple's sense of self can be explained in terms of a mirror, in which the spouses see one another as a reflection of how their partner perceives them (J. S. Fisher et al., 2020).

The second loss is related to the desire for touch. The findings indicate that for the participating couples, intimate and sexual touch was replaced by protective touch, expressed mainly by sleeping in the same bed and touching the diagnosed spouse out of a sense of worry and concern. The couples' descriptions of their yearning for touch and the absence of certain elements of intimate touch suggest a loss of what was and a fear that the relationship will dissolve in the future due to the lack of physical touch in the present. Human beings need intimacy to provide them with a sense of security, support, connection, and belonging in life (Holdsworth & McCabe, 2018). Research has shown the importance of touch for mental health, especially during crises (Albert, 2022; Ayalon et al., 2019; Yorgason & Choi, 2016).

Physical touching is of major importance to wellbeing (Ayalon et al., 2021; Levkovich et al., 2021). Indeed, to reject any sort of touching may have a detrimental effect on both partners (Yorgason et al., 2020). The findings of the present study suggest that the participants still use touch to communicate affection for their partners. Despite changes in the relationship, participants still maintained some form of intimacy in their marriages. Intimacy promotes a more positive outlook in caring relationships (Conway et al., 2018; Yorgason et al., 2020). All participants suggested that dementia had an impact on their experience of sexual intimacy. Indeed, the participants understood the lived experience of sex and physical intimacy in relation to the dementia itself. Maintaining physical intimacy and sexual contact with someone who has dementia is not straightforward or simple (Gomersall et al., 2015; Stedje et al., 2023). The participants highlighted the complexity of this aspect of their relationship. They underscored how these experiences may be couched in other social experiences, such as notions of gender roles, the caregiver role, and social perceptions of sex among older adults.

The approach of *challenging the caregiver–care recipient relationship* reflects the unification of two psychological resources amassed by the couple over the years: mutuality and trust in one another. In essence, the couple "challenges" the expectation that they will enter into a caregiver–care recipient relationship. The research literature shows that cases in which one partner is ill lead to asymmetry, as the nondiagnosed partner is required to take care of the diagnosed partner (Gomersall et al., 2015; Johnston & Terp, 2015). The findings of our study show that couples pool their strengths, each according to her or his ability, to help the couple relationship both physically and emotionally. The two halves become a whole marked by both physical and psychological capabilities. Thus, the partners experience their joint capabilities together, enabling them to function better both mentally and physically while increasing their sense of self-esteem and psychological well-being as a couple. The dyadic research in this study offered joint observation of both parties, yielding a broad picture, in contrast to studies in this field that focused solely on the nondiagnosed spouses (Arbel et al., 2019; Kraijo, 2016).

The coping style of *friendship combined with life* focuses on the existing friendship between husband and wife rather than on the challenges. This style relies on two essential elements: love and a robust foundation for the connection. The couples chose to use the relationship they created over many years as the basis for their positive coping strategy. This friendship enabled them to work together to face their many losses in the present. Our participants suggested that it is better to focus on what they have now than on what they lost so as to generate satisfaction and psychological well-being. Indeed, another study on this topic found that joint couple activities in old age make a significant contribution to sense of self-worth, sense of control, physical and psychological health, and quality of life (Heintzman & Patriqiun, 2012).

The cultural variances observed in acceptance of relationship changes among older people may be attributable to the complex interplay among individual, familial, and cultural influences, all of which shape perceptions of partnership and familial constructs (Koren & Ayalon, 2023). Israel serves as a unique case study in that its cultural dynamics are positioned at the crossroads of tradition and modernity and attempt to balance between familial obligations and self-determinism (Koren, 2022). These dynamics are especially discernible in the nation's policy structure, which, while advocating the rights and welfare of individuals and couples, simultaneously entrusts families with caring for older family members (Koren & Ayalon, 2023). The pervading societal norm that emphasizes commitment to one's partner further adds to this complexity (Koren, 2022; Koren & Ayalon, 2023).

Couples work toward a joint goal to attain a feeling of satisfaction and self-worth. Indeed, the spouses in this study appear to be "in sync" even in the face of absences. This sense of being in sync with one's significant other via aspects of psychological growth can be understood in terms of Kohut's (1971) self-psychology. Kohut posited that the experience of developing the "selfobject" leads to "merger." This ability to merge encourages satisfaction and a feeling of calm and nourishes the continuation of ideals and aspirations. It reflects an understanding of the human need to be part of the world and part of something bigger than oneself (Brown, 2017).

Despite the importance of this qualitative study, it has a few limitations. The sample was small, comprising 16 participants in total. In addition, the sample was drawn from a population in Israel. This limited sample size and unique population constrain the generalizability of the findings. People who met the inclusion criteria were referred by their family physicians for participation in the study. The level of MCI may vary among the participants, potentially influencing the research findings. Moreover, the participants in this study were exclusively Israeli, heterosexual, married individuals. As such, the experiential outcomes derived from these participants may not fully incorporate the range of experiences encountered by individuals from different ethnic, cultural, or relationship contexts (e.g., individuals in same-sex or nonmarital relationships). Subsequent studies should incorporate these dimensions to achieve a more comprehensive understanding. Additionally, further exploration is needed with reference to the diagnosis and progression of the disease to achieve more nuanced insights.

IMPLICATIONS

These couples have lost aspects of their sense of self as a couple; they need to employ flexible thinking. The literature discusses the use of flexibility when coping with such situations (Boss, 2016; Merrick et al., 2016). By focusing on emotional nurturance rather than on the pain of what once was and is no longer there, the partners can create a space for their couple relationship to continue. In this space, they can act flexibly by focusing on what is taking place in the present and by interacting to promote their mutual psychological welfare. Hence, our findings add to the literature on dyadic coping (Landis et al., 2013) by demonstrating the varied ways in which couples cope with stressful events in their lives.

Given that ambiguous loss may persist indefinitely without resolution, interventions are needed that focus on bolstering resilience (Boss, 2016). These interventions underscore the capacity to live amid uncertainty, thereby normalizing existence within the realm of the unknown. The following six steps are recommended for enhancing resilience in the face of ambiguous loss: (a) deriving meaning, (b) mastering adaptation, (c) reconstructing self-identity, (d) acknowledging and normalizing ambivalence, (e) reassessing attachment, and (f) fostering new hope (Boss, 2012).

CONCLUSIONS

When one member of a couple has MCI, both partners experience significant and ongoing losses, including the ability to define "who" the couple is. After so many years as a couple, each partner has difficulty defining the self without input from the other partner, who serves as a mirror of sorts. In spite of the many difficulties posed by such a situation, these couples were able to choose different coping styles that enabled them to continue moving forward while fostering psychological welfare, closeness, and intimacy. The use of these coping styles teaches us that individuals are able to extract meaning from a complex reality. When people are in such a reality, finding meaning in the "little details" of life appears to be natural. Therefore, by choosing a coping style rather than deciding to give up on a long-term attachment relationship, the spouses are able to give of themselves fully, deeply, and with empathy. Their coping styles help them continue to maintain a loving relationship, even when facing changes posed by nature and life.

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APPENDIX A: Interview questions posed to members of older couples in which one partner has mild cognitive impairment

1. Tell me about yourself.
2. How did you meet your spouse?
3. Please tell me about your relationship with your spouse.
4. How did you first find out that your family member was ill? (What feelings did you have? How have your feelings changed between first discovering the illness and now?)
5. Sometimes people in this situation describe an emotion that feels like they have lost their partner. What are your thoughts about this? Did you experience any feelings resembling loss? If so, what was that like? What did you feel you were losing? How have these feelings of loss changed between the time you found out and now?
6. Please tell me about your relationship before the illness.
7. How do you need to cope in the relationship today?
    a. How would you characterize your intimacy today?
    b. How has your couple intimacy changed?
8. What changes do you attribute to the illness and what changes do you think are connected to aging?
9. What do you miss?
10. Can you tell me about the care/treatment of your spouse?
    a. How does the care/treatment affect your relationship?
11. What are the tools that help you cope with the relationship?
12. What is your social life like today, in terms of your couple relationship?
13. In your opinion, what is the most important thing you would like others to know about the effect of the illness on the couple relationship, if indeed there is such an effect?