Nurses' Work:
Balancing Personal and Professional
Caregiving Careers

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Quarante infirmières travaillant à plein temps et donnant également des soins chez elles se sont portées volontaires pour une étude qualitative sur les professions oeuvrant dans la prestation de soins combinés. Chaque répondante nota quotidiennement ses activités de soignante pendant deux périodes représentatives de 24 heures. Les infirmières furent interrogées avant et après avoir pris leurs notes. La plupart d'entre elles subissaient de fortes tensions liées aux soins, aussi bien dans leur vie professionnelle que dans leur vie privée. Elles étaient en général relativement satisfaites de leur vie (aussi bien privée que professionnelle) et trouvaient qu'elles maîtrisaient un peu mieux leur vie au travail que leur vie à leur domicile. Pour ce qui concerne les tensions ou les conflits auxquels elles ont fait allusion, les thèmes suivants sont revenus le plus fréquemment : des attentes élevées, le sentiment d'être déchirées entre deux mondes, de travailler isolément, et de mettre les bouchées doubles. Les avantages comprenaient la rémunération, la reconnaissance et l'estime de soi, les opportunités de croissance personnelle et de croissance familiale.

Forty full-time nurses who were also responsible for providing care to individuals in their private lives volunteered for a qualitative study of combined caregiving careers. Each respondent kept a diary of caregiving activities during two representative 24-hour periods, and was interviewed prior to, and after diary-recording. Most nurses experienced high levels of stress associated with caregiving in both their professional and private lives. In general, they were relatively satisfied with their lives in both spheres, and felt a slightly greater sense of control in their work lives than in their home lives. Regarding the tensions/conflicts they alluded to, the following themes emerged: an ethic of high expectation, feeling torn between two worlds, a sense of working in isolation, and working in overdrive. The rewards/benefits included remuneration, recognition and self-esteem, opportunities for personal growth, and opportunities for family growth.

The quality of nurses' work lives within a climate of health care reform characterized by down-sizing and fiscal restraint continues to be an issue of concern because of its ultimate effect on patient care. While traditionally research has focused on work as separate and distinct from family, there is increasing recognition of spillover effects, both positive and negative, in balancing personal and professional careers. The current study derived from concerns about the quality of nurses' lives in light of severe constraints that have resulted in a work environment that increasingly embraces an ideology of productivity, efficiency, and cost effectiveness. Such an ideology is not easily married with an ethic and ideal of care that permeates not only the

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professional, but also the personal lives of nurses. The vast majority of nurses, who are married and have children and other family responsibilities, begin their days in the informal sector by providing care to husbands and children, move into the formal sector where they render care to non-family members, and then return home to resume domestic obligations. The worlds of work and family interface in ways that are yet to be fully understood. Consequently, the purpose of this research was to more fully understand the experience of nurses whose personal and professional lives both centre on the provision of care to others. More specifically, the objectives were to investigate the subjective dimensions of the care that nurses provide at home and at work, the challenges and opportunities associated with such care, and the outcomes of balancing two careers that centre on the provision of care.

Literature Review

The literature addressing the process and outcomes of balancing personal and professional careers is rudimentary and derives primarily from studies designed to investigate work and well-being, the provision of formal and informal care, and role characteristics. In large measure, these studies are situated within the context of feminist and social science scholarship. Feminist scholarship points to the centrality of care in women's lives; the invisible nature of much of women's work; the relationship of this work to poverty, vulnerability, and disadvantage; and gender inequalities associated with the provision of care. Social science scholarship takes a role theory and stress and adaptation approach to analysis that focuses on role stresses and strains, role and inter-role conflict and role accumulation. Both bodies of literature point to the difficulties that women have in juggling multiple roles (Marshall, Barnett, Baruch & Pleck, 1990). Despite Parsonian distinctions between instrumental tasks and affective relations (Abel & Nelson, 1990), the provision of care is seen to involve love and labour, caring *for* while caring *about* (Graham, 1983; Ungerson, 1987; Waerness, 1984).

The Centrality of Caring

The literature is replete with evidence of the centrality of caring in women's lives. Gilligan (1982) noted that women's identity is defined in a context of relationship and judged by a standard of responsibility and caring. Through a process of socialization, girls and women assimilate the expectations and norms that surround the provision of care in our society. As a consequence, the provision of care not only shapes their private lives as daughters, wives, and mothers, but also their public lives as care providers and service users (Baines, Evans & Neysmith, 1991). Nursing has its roots in a maternal ethic of care that emphasizes service, dedication, and self-sacrifice – attributes that comprise the traditional attributes of women (Baumgart & Larsen, 1992).

Consequently, the provision of care assumes a heightened importance in the lives of nurses who are mandated to care both within the context of their families and their professions.

The Invisible Nature of Providing Care

It has been widely reported that the work of providing care is, in large measure, invisible (Baines, Evans & Neysmith, 1991; Finch & Groves, 1983). Distinctions are made between caring *for* and caring *about* (Dalley, 1988). The former refers to the instrumental and tangible tasks involved in providing care; the latter, to its expressive and affective dimensions. Despite these distinctions, there is evidence that the provision of care involves both caring *for* and caring *about* (Bowers, 1987, 1988). The lack of validation of the affective dimension of care obscures the work involved and reinforces the idea that it is natural for women to provide care. In a society that values paid work in the public sphere, women's care in the private sphere is so taken for granted that it has not been viewed as work, and has received little research attention. The provision of care in the public sphere, as in nursing, tends to remain invisible and undervalued, and the status of nurses who are responsible for such care is only marginally enhanced. Aspects of this invisible work include intuitive and holistic ways of knowing, cue sensitivity, discretionary judgment, and identification with and relatedness to patients (Fox, 1989). Daniels (1987) argued for a heightened visibility for the care that women provide as homemakers, mothers, and volunteers, not only for its economic value but for its contribution to a caring community.

Relationship of Caring to Disadvantage

Much of women's work, which is central to the maintenance of families and by extension society, remains unpaid. This undervaluing is also seen within the formal health care system. Nurses are seeing their jobs eliminated, expanded or moved from one work site to another (Glazer, 1988). Baumgart and Larsen (1992) have argued that, as with other women's work, the provision of care in nursing has been constrained by understaffing and the higher priority given to the more technical aspects of care. Despite a trend to view nurses as co-workers with physicians and team members, research demonstrates that nursing is subordinate to medical care (Edginton, 1989). This subordination is most vividly demonstrated by a salary differential that places physicians in a position of relative advantage. In addition, when compared with physicians and other health care workers nurses are in a subordinate position with respect to issues of autonomy and control over their practice (Fox, 1989).

Gender Inequalities

According to the literature, women clearly provide most of the needed care. A division of labour has evolved whereby women assume major responsibility for care and men take on the role of economic providers (Baines, Evans & Neysmith, 1991; Marshall, 1993). Although some men assume responsibility for the provision of care, their identities and opportunities are not structured and shaped by the same behavioral norms regarding care. The assumptions that men do and should have primary responsibility for providing care is not likely to be reflected in their own expectations, the expectations of those around them, or in policies and services. Within the health field, especially institutional-based health care delivery, nurses have little autonomy and decision-making power around issues related to health care, particularly at the administrative and policy level. Changing structures and the dominance of physicians and health care administrators render the position of nursing and the importance of nursing care even more invisible (Fox, 1989).

Role Stresses and Strains

Much of the literature centres around two theories that support different predictions about the effects of the work-family interaction for women (Valdez & Guter, 1987). On the one hand, role conflict proposes that competing demands and expectations by role senders exist for many working women as a consequence of the demanding and pervasive nature of women's home and family responsibilities. On the other hand, the conflict and overload arising from a multiplicity of roles can be overshadowed by the rewards of role accumulation. The nursing literature, in large measure, takes an approach that emphasizes the theoretical underpinnings of recruitment and retention. This body of literature focuses on situational and occupational variables such as education and training (Bartz & Maloney, 1986; Keane, Ducette, & Adler, 1985; Price & Mueller, 1981), professionalism and proletarianism (Coburn, 1988), job satisfaction (Attridge & Callahan, 1989; Dear, Wiseman, Minader, & Chase, 1982), stress, (Lobb & Reid, 1987; McCranie, Lambert, & Lambert, 1987), management styles (Taunton, Krampitz, & Woods, 1989; Duxbury & Armstrong, 1982), and age (Hansen, 1988). With few exceptions (McBride, 1988), little research has been devoted to examining how dimensions of nurses' lives at work spill over into their lives at home and vice versa.

Theoretical Perspectives

The current study was informed by the interpretive perspective in sociology and Hughes' (1971) concept of career, which distinguished between objective and subjective career. The interpretive perspective "emphasizes the human capacity to construct and share meaning and the human tendency to attempt to control, through symbolic interaction, situations in keeping with biograph-

ically meaningful intentions" (Marshall, 1979, p. 35). Hughes (1971, p. 137) defined objective career as "a series of statuses and clearly defined offices held throughout the life course, in which there are sequences of position, achievement and responsibility." Responsibilities for care in this study comprised objective dimensions of nurses' personal and professional careers. Hughes (1971, p. 137) defined subjective career as "the moving attributes in which people see their lives as whole and interpret the meaning of various attributes, actions and things that happen to them." Subjective career was conceptualized as feelings of satisfaction, stress, and control over the care they provided. The concept of career is useful because of its focus on objective and subjective reality as used in sociological analysis. In addition, the concept is congruent with the hypothesis that becoming a caregiver involves a status acquisition similar to other social statuses that are precipitated by socially recognized events, such as marriage, motherhood, and becoming a professional (Suiter & Pillemer, 1990).

Method

Study Purpose and Design

The overall objective of this study was to examine the experience of nurses whose personal and professional careers both center on the provision of care to others. Of particular interest were the feelings associated with providing care to others, and the perceived tensions and benefits that result from these combined roles. Personal interviews and diaries provided the data for analysis. Nurses were recruited to the study through notices posted in a central location at the two study sites: a 211-bed community general hospital, and a community nursing organization. Diversity of practice settings was sought to elicit a broad based understanding of professional care. Volunteers were screened to ensure they were employed in nursing on a full-time basis, and responsible for the direct provision of care to patients and to members of their own families. The response was enthusiastic: the quota of respondents was recruited to the study within five days of posting the notices.

Participants

Twenty nurses based in the community and 20 hospital-based nurses volunteered to participate in the study. The majority (*n*=32) were married and lived with their spouses. five nurses were separated or divorced and living with children for whom they were the primary caregivers. The three remaining nurses were single or widowed but living with elderly parents for whom they provided care on a daily basis. Their ages ranged from 25–64 with a median age of 40. Of the 37 respondents who had children, 26 had one or two, nine had three, and only two had four or more children. Eleven of these 37 nurses also

reported being responsible for the care of older parents or relatives. The amount of time per day reported in the provision of care at home ranged from 15 minutes to 9.2 hours, with a mean of 3.02 hours ($SD = 2.04$ hours). Such care was in addition to the hours of care provided at work. Respondents were experienced nurses who were in relatively stable professional positions: 32 had been in practice for more than 10 years; 28 had been in their current position for more than 4 years, and 10 of these nurses for more than 10 years. Nineteen respondents reported a combined family income of more than $70,000.00. Seven reported incomes ranging from $51,000.00 to $70,000.00 and 13 reported incomes from $31,000.00 to $50,000.00. Only one nurse reported an income less than $31,000.00.

Data Collection

Respondents kept a diary of the care they provided in their personal and professional lives. The researchers did not attempt to impose a standardized method of recording (for a fuller description of the use of diaries in the current study see Ross, Rideout & Carson, 1994). In recognition of the commitment associated with diary keeping and the potential for respondent fatigue, data collection was restricted to two 24-hour periods. Respondents selected their own method of diary keeping. They also decided on which days to record their diaries, with the proviso that these be as close to typical days as could be predicted in which both family and patient care occurred.

The diary was modelled on that used by Dressel (1990), employed a semi-structured format, contained six questions, and included one page for each hour of the day for a total of 48 pages. The first question asked respondents to describe the care they had provided in the previous hour. Such an approach allowed respondents to use their own definitions of the specific activities that were involved in caregiving rather than searching through a list of potentially irrelevant predetermined activities. This approach was congruent with the exploratory and descriptive nature of the study (Carr & Kemmis, 1986) and allowed for an understanding of care as perceived by the respondents and revealed through their responses. The second question asked about the purpose of providing the care, eliciting the cognitive processes surrounding caregiving or the thoughts respondents used to define and explain the situations they described. The third question asked respondents to describe the feelings they had about providing care, exploring the affective dimensions of caregiving. Questions 4 and 5 probed for other activities that respondents were doing along with the care they were providing, and any other activities they felt should be receiving their attention. These questions were designed to illustrate the context within which caregiving took place and the level of attention accorded to the act of caregiving. The final question provided respondents with the opportunity to evaluate the time period as stressful or

tension-producing, rewarding or pleasureable, neither or both. This question sought further elaboration of the context and an understanding of the consequences of caregiving that may not have been evident from the desciption of the situation itself.

Respondents also participated in face-to-face interviews immediately prior to and after diary keeping. During the initial interview, demographic data were gathered and the purpose and process of diary completion were explained. During the terminal interview, respondents reviewed any problems they had experienced with diary keeping and described how they decided what to include in their diaries. They also responded to single-item fixed-choice questions on a scale of 1 *(very little)* to 5 *(a great deal)*. The questions asked were: "what is your level of satisfaction with your home life," "what is your level of satisfaction with your work life," "how much control do you have over your caregiving responsibilities at home," "how much control do you have over your caregiving responsibilities at work," "how much stress is associated with your caregiving responsibilities at home," and "how much stress is associated with your caregiving responsibilities at work." Single-item indicators asking for global ratings of a particular concept are congruent with the emphasis in nursing on wholism and individualism, and are known to provide acceptable psychometric properties (Youngblut & Casper, 1993). Respondents were also provided with the opportunity to comment more fully on their responses to these questions. finally, they responded to two open-ended questions: "What are the tensions and conflicts created for you as a result of balancing two caregiving careers" and "what are the rewards and benefits of combining two caregiving careers." Interview data were transcribed and entered into microcomputer files for analysis. Upon completion of the terminal interview, respondents received an honorarium in recognition of their substantial contribution to the study. This approach is typical of that used in other studies employing diaries.

Analysis

The diaries provided a detailed record of personal and professional care provided by 40 nurses over a period of two diary days, and generated a total of 1920 hours of information about the process of providing care (forthcoming in another paper) and the outcomes of balancing personal and professional careers that both center on an ideology of care.

The work of Berg (1989) provided direction for content analysis of verbatim data. The goal of analysis was that emergent categories and themes should reflect the meaning of messages provided by respondents and retain, as much as possible, the exact wording used in their comments. Data reduction involved coding and clustering of data. Data reconstruction and synthesis

involved identification and verification of patterns and themes. The unit of analysis included words, phrases, and sentences that respondents used to describe their experience. Initial coding involved a careful and minute reading of verbatim responses, which had been entered into the Ethnograph software package (Seidel, Kjolseth & Seymour, 1988), to determine tentative abstractions reflecting the data. Categories were formulated both deductively (for the six single-item questions) and inductively (for the two open-ended questions) by sorting abstractions into clusters that were judged as grouping together. Tally sheets were created to ensure the relevancy of the categories to particular questions and to a significant proportion of respondents. Two coders reviewed the data to ensure consistency of analysis and when disagreement occurred, a third coder was consulted. Although this process is considered by some reseachers to violate the process of induction (Morse, 1994), in the current study, discussion continued until consensus was achieved regarding the analysis. As coding became repetitious, level of specificity changed and patterns and themes were identified from the coding categories. Respondents' own words were used to generate patterns and themes. After patterns and themes were identified, the data were once again read to confirm or verify that each pattern and theme reflected the experience of respondents. Illustrative comments reflecting each theme were then extracted from the data for reporting purposes. It was important to ensure that comments selected were illustrative of respondents' experience. Consequently, once again, two coders reviewed the comments to determine that they reflected the pattern or theme, and when disagreement occurred a third was consulted to achieve concensus.

Findings

Subjective Dimensions of Nurses' Lives

The subjective dimensions of nurses' lives were reflected in the six single-item interview questions inquiring about the level of satisfaction, stress, and control they experienced providing care at home and at work. The results were pooled according to the subjective ratings of these variables as *low* (1 or 2) or *high* (4 or 5) and respondents were assigned to either a high or low group. Additional data were derived from respondents' verbatim comments explaining more fully their responses to these six questions.

Level of satisfaction at work. Twenty-five respondents reported a high level of satisfaction with their work lives. They felt confident and competent with respect to the provision of care, and derived pleasure from patients and the challenges and rewards of their work, as reflected in the following comments: I feel comfortable and know what I need to know to carry out the job well." "Each of my days is different and a challenge." " When people are very appreciative of the care I provide, I feel as if I have made an important contribution." Respondents reporting a low level of satisfaction (*n*=5) re-

ported interpersonal conflicts with supervisors, uncertainty with respect to their jobs in the current economic climate, and dissatisfaction with the organizational dimensions of their work lives. Comments reflecting these views included: "Changes in administration at work are creating difficulties for me." "Things are much more demanding now than before...my patients are much heavier... supervisors are not helpful." "I'm working more weekends and shifts."

Level of stress at work. Respondents reporting a high level of stress at work (*n*=21) spoke of the conditions of their work as stressful, including dealing with crises, death and dying, and constant change. They also spoke of bureaucratic constraints, inflexible organizational policies, impending budget cutbacks, resultant layoffs, and changing organizational configurations, as stressful. Also reported as contributing to a higher level of stress were relationships of conflict with supervisors, pressure to increase productivity, and the need to negotiate care with others, including home care personnel and physicians. Respondents who reported a low level of stress (*n*=8) described feeling confident in their knowledge of patients and related clinical situations, and trusting in their ability to make correct decisions vis-à-vis the provision of care.

Level of control at work. Eighteen respondents evaluated their level of control at work as high. These nurses spoke of the importance of being flexible and able to adapt to the unexpected. Additionally, they referred to the importance of pacing themselves, developing more confidence in their decision-making abilities with increasing experience, and having others (peers and colleagues) as backups and resources. One community-based nurse spoke of having to learn to trust other nurses so that she could feel confident in turning over patients to their care. She stated: "This trust helps me feel in control." Others spoke of trying to help patients assume responsibility for their own care as a method of being in control. Only two nurses reported that they experienced a low level of control at work. They spoke of the pressures associated with increasing expectations around productivity, for example, increasing caseloads on the part of a hospital-based nurse, and decreasing amount of time for direct patient care on the part of a community-based nurse.

Level of satisfaction at home. Respondents reporting a high level of satisfaction with their home lives (*n*=13) referred to their husbands as very supportive, understanding, and helpful. Additionally, they spoke of the contribution made by other members of their families including parents, parents-in-law, and children. Descriptions of their family situations created the impression of people who worked together, almost spontaneously, without requiring a great deal of direction or organizing on the part of respondents. For example, one nurse stated: "I come from a closely knit family that

provides lots of support... everybody does something...is responsible for their share at home." Those who reported only a low level of satisfaction with their home lives (*n*=8) described a state of disorganization within their families. This disorganization stemmed, in some instances, from difficult events such as a death in the family, financial reverses, or unemployment on the part of husbands; in other instances, from problematic relationships with husbands and difficulties with children. The following comments provide a sense of the complexity of one nurse's life: "I am working on my bachelor's degree, we are renovating the house, both of my parents-in-law have recently died, my husband lost his job six months ago and only recently was hired by a company that requires that he travel a great deal. I am currently on my own and finding it difficult." Although this account can in no way be viewed as typical, it sheds light on the level of complexity involved, for some, in combining work and family lives.

Level of stress at home. Respondents reporting a high level of stress in their home lives (*n*=26) spoke of problematic relationships with husbands and children, situational crises such as illness and/or death in the family, financial constraints, and the heavy care required by young children and older and disabled parents. Those reporting only a low level of stress at home (*n*=8) spoke of the benefits of support from, and clear and frequent communication with, husbands and children, and good health within families. Additionally, these respondents were able to lower their standards with respect to the up-keep of their homes. One nurse's comment exemplified this finding: "The house doesn't bother me any more...I don't feel guilty that it isn't sparkling clean all the time...it has become everybody's responsibility." Another nurse commented: "I've learned that I can't do everything and I don't try any more."

Level of control at home. Respondents reporting a high level of control at home (*n*=14) described "letting go" of high expectations related to house-work, and were able to set priorities, make choices, and be flexible with respect to household routines. A large component of control apparently related to housekeeping activities and household routines. One respondent who reported a high level of control at home stated: "I can say no...the world doesn't revolve around me...everyone can manage." Another suggested: "Do things as they come up...and hope they get done...if not, they'll get done tomorrow." Still another said: "...the dirt gets left behind...but it doesn't bother me...I can walk out and leave it and it doesn't worry me." In contrast, those reporting only a low level of control at home (*n*=9) spoke of high expectations and a perceived feeling of lack of support with respect to house-hold management. One such nurse commented: "I'm a very meticulous person and like things done a certain way...my expectations are too high." Another remarked "...if I don't do the chores, they don't get done...my hus-band takes no initiative whatsoever...we also have different standards of

housekeeping." The presence of young children and babies in the home also contributed to the sense of a low level control.

Balancing Careers: Tensions and Conflicts

To further explore nurses' experiences of caregiving, data from the two open-ended questions inquiring about the balancing of personal and professional caregiving careers were combined and analyzed. Regarding tensions and conflicts, the emergent themes included an ethic of high expectation, feeling torn between two worlds, a sense of working in isolation, and working in overdrive.

Ethic of high expectation. Respondents described trying to do both jobs well, perceived that their expectations were at times unrealistic, and felt guilty about aspects of care they were unable to carry out. Increasing acuity of patients' situations and budget cutbacks and layoffs in their own and their families' work lives caused intensification of nurses' work. Conflict arose with respect to the expectations of husbands and supervisors, and respondents needed husbands and children to be more sensitive to their responsibilities both in and out of the home. Respondents also felt burdened by having so many people depend on them, and recognized that they needed to decide priorities, yet spoke of finding it difficult to do so. As one respondent stated, "I can't do it all perfectly."

Feeling torn between two worlds. The great number and variety of responsibilities associated with conducting of two careers caused respondents to feel torn between two worlds. Respondents felt obligated to provide care to both their families and patients. They felt particularly conflicted when they had to make alternative care arrangements for their sick children. Furthermore, they assumed responsibility for the care of extended family members, friends, neighbours, and colleagues. Additionally, many also had responsibilities related to the pursuit of a university degree and participation in community, church, and cultural activities. Respondents were very busy individuals. The provision of care, while a central feature of their lives, was only one of the many dimensions of their lives. The following comments exemplify the notion of feeling torn between two worlds: "There are many times when I want to be in two places at once." "I feel pulled in so many directions." There is not enough of me to go around."

A sense of working in isolation. Respondents described situations that suggested they had a sense of working in isolation. This feeling was intensified by the fact that nurses had few opportunities to interact and develop collegial relationships with each other (discussing issues related to patient care as well as issues of a more personal nature) and by the fact that the hierarchy impeded communication with those responsible for policy development and imple-

mentation. Husbands and children were seldom mentioned as active partici-
pants in the care provided at home. Rather, the major impression was that
family members were receivers of, rather than participants in, care. Even
when families played a more active role, such involvement had to be orches-
trated by delegating, organizing, and supervising – activities that felt very
much like "more work" for respondents.

Working in overdrive. This theme was exemplified by comments such as
"there is not enough time...I am always on the run," "I need more time...there
is always more to do," and "I often wonder how things will all get done."
Nurses spoke of bringing their work home and always trying to catch up.
Working evenings, and nights, and weekends interfered with regular activities
at home. Nurses reported feeling preoccupied, in the centre of things with
everyone expecting them to solve problems, and not having any time for
themselves. Nurses who worked in overdrive also experienced conflict
between their desires to carry out the more affective dimensions of care and
the requirements to work more efficiently and cost effectively. Although they
valued being with, listening to, and supporting patients and families (invisible
aspects of care), such dimensions of care were often neglected because time
available for carrying them out was limited. Working in overdrive resulted in
spillover between personal and professional lives.

Balancing Careers: Rewards and Benefits

The rewards and benefits of combining two caregiving careers were both
monetary and non-monetary, including recognition and self-esteem, oppor-
tunities for personal growth, and opportunities for family growth. Financial
rewards were reported by the majority of respondents. For these nurses,
combining two careers was not optional; they needed to work outside the
home. One nurse stated: "I am a single mother who looks after her mother as
well...I have no option...I need the money." Nevertheless, some respondents
received satisfaction from being in control of their own financial resources, or
being able to provide extras for their families. This sense of control contrib-
uted to feelings of esteem and self-worth. For example, one respondent stated:
"I like being a breadwinner...having my own money and making decisions
about how I spend it adds to my sense of competence." Another said that
having her own money gave her a sense of freedom and self-sufficiency.

Feelings of recognition and self-esteem also came from respondents' real-
ization that they were making a valuable contribution to society. One stated
that combining two careers made her feel like "a functioning and valuable
member of society." Respondents also described how combining careers
provided their lives with a focus, increased their level of independence, and
contributed to their self-confidence. One commented that the care she

provided as a nurse made her feel effective and increased her self-respect. Another stated: "I know that I can function by myself if something were to happen to my husband." Respondents also spoke of the positive responses of patients and, to a lesser extent their own families to their work. One said: "It makes me feel good to know that patients value the care I have to offer." Another reported that her family was proud of the fact that she was a nurse.

Opportunities for personal growth were also viewed as benefits of balancing personal and professional careers. Respondents spoke of learning from the experiences of their patients, finding self-fulfilment, developing a broader perspective, and the contribution that their careers made to their relationships with spouses and others. For example, one nurse stated "I have more to bring to my relationship with my husband...it [combining careers] makes me a more interesting person." There were also comments that demonstrated the effects of one career on the other, such as: "Community nursing makes your life broader and helps you in your own personal life." Another respondent said: "I now have a better understanding of older people, which helps me with the emotional issues within my own family."

Opportunities for family growth were also viewed as outcomes of combining personal and professional careers. Many comments in the data indicated that the combining of two careers encouraged the development of independence in children. For example: "It's healthier for the children...they become more adaptable," and "Children become more socially independent and able to fend for themselves." Respondents felt that they were helping their children to assume some responsibility at home, and setting a good example for their children by allowing them to see that mothers were working and contributing to society.

Discussion

Caregiving has been identified as a central and common feature of the personal and professional lives of many women. While much is known about the instrumental and affective dimensions of such care, less is known about the experience of balancing personal and professional careers that both centre on an ideology of care. The current paper explored this phenomenon among full-time nurses who were also caregivers in their homes.

Although respondents were relatively satisfied with both their private and professional lives, more women reported higher levels of satisfaction with their work lives than with their home lives. Their verbatim comments suggest that feelings of control are important to feelings of satisfaction at home and at work. Confidence and competence, involvement in decision-making, and a

sense of flexibility in workplace all contributed to a positive work experience. Bureaucratic constraints, inflexible policies, feelings of uncertainty regarding the future, and interpersonal conflict were all reported by nurses experiencing higher stress, and lower satisfaction and control in the workplace. Husbands and children who were supportive and helpful made home life more positive for respondents. Open and frequent communication among family members, setting realistic expectations, and having good health were all identified as specific components of a satisfactory home life. Difficulties such as unemployment of the spouse, death in the family, and financial constraints all contributed to low satisfaction with life both at home and at work. Unattainable expectations for self, spouse, and other family members contributed to more negative feelings. Professional caregiving is also associated with remuneration and periodic performance appraisals, which may in themselves be sources of satisfaction.

Limitations

In the current study the small sample size and non-random nature of attaining respondents precludes generalization of findings to a larger population of nurses. Nevertheless, findings should be regarded as transferable, in the sense that it is likely that other nurses who combine personal and professional caregiving careers will also identify similar experiences and response to these experiences. Furthermore, the richness of this type of data yields fruitful insights into the complexity of having two careers that centre on the provision of care.

Implications

The general impressions derived from the current study are that women who provide care in both their personal and professional lives do cope, and in many cases, manage well. However, ways to enhance the quality of nurses' lives, both at home and at work, were identified.

Nurses need to find ways of having both private and professional lives without exploiting themselves and others. In large measure, they have internalized an ethic of high expectation which, at times, serves to their disadvantage. By letting go of unrealistic expectations for care at home and at work, nurses may come to accept the notion that they can't do it all perfectly. It seems crucial that they find time for themselves in the form of recreation, leisure, and cultural activities at home , and lunch and leisure breaks at work. Accepting the assistance offered by husbands and families, and asking for help if it is not offered might reduce the demands of household and family maintenance. Furthermore, where economically feasible, nurses might consider increasing the use of paid help within their homes rather than feeling that they must do all the work themselves.

Husbands and children need to play a bigger role in family and household management. Help from husbands in particular, and children, where appropriate, to take the initiative to do what requires doing around the home would be viewed positively. In this way, nurses might feel less responsible for orchestrating their participation, an endeavour, that to them feels very much like more work. Husbands and children, particularly older children, need to be more knowledgeable about and more sensitive to the work requirements of nurses. There are times when nurses need to talk and have the nature of their work outside the home more fully understood and appreciated by their families.

An improvement in the quality of nurses' work lives will have a spillover effect on their home lives. Employers need to facilitate the combining of personal and professional careers that both centre on the provision of care to others. For example, health care organizations might benefit from developing employee assistance programs that meet the needs of employees with heavy and/or unexpected caregiving responsibilities at home. Employers of nurses also need to recognize and value interpersonal expertise as going hand in hand with technical expertise. Nurses value spending time with patients, listening to them, and talking with them. However, they are often unable to carry out these more cognitive and affective (invisible) dimensions of nursing, resulting in frustration about the quality of care they provide. Collaboration should help to reduce nurses' sense of working in isolation, and physical space and time for nurses to meet with each other are crucial. finally, nurses need to feel confident about their level of nursing knowledge and skill. Continuing education and in-service programs offered at the organizational level were suggested as ways to maintain their competence in a health care system where change is the only constant.

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