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Résumé

Les infirmières agissant comme soignantes auprès d'un proche âgé ou comment négocier la frontière entre vie personnelle et professionnelle

Catherine Ward-Griffin

L'évolution récente en matière de soins aux personnes âgées se traduit par une dépendance accrue sur la famille. Il a été démontré que donner des soins est une dimension centrale et courante de la vie personnelle et professionnelle de nombreuses femmes; le présent article aborde les difficultés que vivent les femmes chargées de dispenser des soins dans ces deux sphères à la fois (les «soignantes chargées d'une double tâche»). L'auteure avance que la distinction entre soins rémunérés et soins non rémunérés à la base de notre conception des soins aux personnes âgées pose problème, tout particulièrement pour les professionnelles de la santé. Selon les conclusions d'une étude qualitative menée auprès d'un groupe d'infirmières autorisées chargées de dispenser des soins à un proche âgé, ces dernières chevauchent les sphères publique et privée et, par conséquent, doivent sans cesse négocier la ligne de démarcation entre rôle professionnel et rôle familial. Ces résultats mettent en lumière la nécessité d'explorer l'interface entre vie de famille et vie au travail et de définir des politiques visant à protéger l'état de santé des intervenantes.

Mots clés : infirmières, soins aux personnes âgées

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Nurses as Caregivers of Elderly Relatives: Negotiating Personal and Professional Boundaries

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Recent changes in patterns of care provision for the elderly have led to an increasing reliance on family care. Although caring has been found to be a central and common feature of the personal and professional lives of many women, this paper discusses the challenges faced by women who provide care in both their work and their family lives ("double-duty caregivers"). The author argues that the separation of paid caregiving and unpaid family caregiving in the conceptualizion of elder care is problematic, particularly for health-care professionals. Findings from a qualitative study with registered nurses providing care to elderly relatives revealed that these women are located at the juncture of public and private domains of caregiving, where they must constantly negotiate the boundaries between their professional and personal caregiving roles. The findings highlight the need to explore the interface between women's family and work lives and the need for policies that promote the health of double-duty caregivers.

Keywords: family caregiving, nursing, elder care, health promotion, narratives, feminist inquiry

Introduction

Caregiving of frail elderly people is being acknowledged as one of the major challenges facing Western societies (Jutras, 1990). A number of factors account for this situation. In Canada, recent changes in patterns of care provision for the elderly, including health-care restructuring, closure of long-term-care facilities, under-funding of home care (Canada's Association for the Fifty-Plus, 1999; Chappell, 1999; Kosny, 1999), and early hospital discharge (Armstrong et al., 2003), have led to an increasing reliance on family members; health-care reforms are sending more care, and more complex care, home (Armstrong, 2002). Although there may be a group of kin that provides assistance to an older individual, the literature suggests that there is generally one person who provides most of this care, and that person is most often a woman (Armstrong & Armstrong, 2001; Chappell, 1993). Female family members provide the majority of caregiving support to elders (Aronson, 1991; Medjuck, O'Brien, & Tozer, 1992), with wives and daughters predominating (Keefe & Fancey, 2002). Daughters are three times more likely than sons to be primary caregivers to their elderly parents (Kosny). However, the availability of female family members to provide this care may be decreasing as a result of the substantial rise in the labour-force participation of women. The percentage of Canadian women in the paid labour force has increased from 46.7% in 1977 to 57% in 1997 (Statistics Canada, 1999).

Women also account for over 80% of those providing paid care (Armstrong et al., 2003). Vertical and horizontal gender segregation in employment is reflected in the caring professions (Hugman, 1991; Jackson, 2003). For example, nursing continues to be dominated by women. In Canada, approximately 95% of all nurses are women (Statistics Canada, 1996). Moreover, female nurses are more likely than male nurses to work with elderly people (Hugman). The relative absence of men from nursing practice, particularly in elder care, highlights the gendered nature of caregiving. This persistent gender differential in both paid and unpaid caregiving means that shifts in the delivery of health care from institutions to the household tend to affect women more than men (Gregor, 1997; McKeever, 1994). Consequently, in times of economic constraints, when public expenditures on formal services for the elderly are either reduced or frozen, it is usually women who shoulder the physical, social, emotional, and financial costs of family caregiving (Armstrong & Armstrong, 1994; Aronson, 1992; Hooyman, 1990; McKeever; Neysmith, 1991). Even without these constraints, women feel responsible and are held responsible for delivering quality care, often at risk to their own health (Armstrong et al.).

Although it has been well documented that employed family caregivers of the elderly experience a number of adverse health effects such as increased mental and physical strain and family-work conflict (George & Gwyther, 1986; Pavalko & Woodbury, 2000; Scharlarch & Boyd, 1989), we know very little about the impact of the type of employment on women's caring work within the family. There is still much to be learned about how employed health professionals negotiate their professional and family caregiving roles. For instance, what are nurses' experiences in providing care to elderly relatives? What are the health effects of "double-duty caregiving"? How do nurses manage their double-duty caregiving role? These are the questions that are central to this paper.

Literature Review

Contemporary Theoretical Models

Much of the theoretical literature addressing the interface between work and family life conceptualizes the two spheres as either distinct or integrated. However, this separation of public and private worlds in the conceptualizion of elder care is problematic. Conventional theoretical models such as segmentation, compensation, and spillover (Loscocco & Rochelle, 1991) tend to assume that what one does at work is dissimilar to what one does in the family. The segmentation model proposes that work and "non-work" lives are totally disconnected in time, space, and function; the workplace is typically separate from the family home, the former being for production and the latter for consumption, and individuals are in each location at a different time (Andrews & Bailyn, 1993). The compensation model suggests that individuals will seek positive experiences in one domain to compensate for their negative experiences in the other (Loscocco & Rochelle). In the spillover model, work and family are separate but what happens in one sphere has an impact on the other. This last model is the most common conceptualization of the interface between work and family (Loscocco & Rochelle).

The main limitation of these three models is that they tend to downplay or ignore the gendered underpinnings of "family care" and the organization of care systems as gendered (Acker, 1990). Close examination of each model reveals the pervasive ideology of familism in which caregiving is seen as women's "natural" role. While some researchers discuss the effects of gender on the permeability of the boundaries between work and family (Guberman & Matheu, 1999), others acknowledge the impact of gender, such as women having primary responsibility for the family (Greenhaus, 1989). Although women's paid and unpaid caring work have been considered separately, their similar purposes and outcomes, as well as their combined impact on women's health, have only recently been recognized (Angus, 1994; Walters, Beardwood, Eyles, & French, 1995).

Existing Empirical Knowledge

There are only a few published studies on women who care for individuals in both their professional and their personal lives (double-duty caregivers) (Denton, Zeytinoglu, Webb, & Lian, 1999; Guberman & Maheu, 1999; Phillips, Bernard, & Chittenden, 2002; Ross, Rideout, & Carson, 1996; Rutman, 1996). Part of our difficulty in understanding the interface between work and family domains is that the majority of studies have looked at women either as unpaid family caregivers *or* as paid health-care providers, not as both. However, care work in the formal system cannot be fully understood unless one recognizes that it is women who perform the bulk of the work and that this is integral to women's unpaid caregiving (Armstrong et al., 2003).

Most of the research on employment and family care has focused on the effects of caregiving on paid work. The impact of caring on workplace participation includes absenteeism, reduced productivity, missed opportunities, and early withdrawal from the labour market (Neal, Chapman, Ingersoll-Dayton, & Emlen, 1993; Scharlarch, Sobel, & Roberts, 1991; Stone & Short, 1991). Neal et al. found that personal characteristics (e.g., age and occupation) and conditions (e.g., number of caring roles and number of hours worked) consistently predicted higher rates of absenteeism and stress among employees caring for children or elders. Employees with responsibility for elder care have reported negative effects on mental health and social participation (George & Gwyther, 1986), strain on relationships within the family (Scharlarch & Boyd, 1989), and more job/family conflict than their non-caregiving coworkers (Scharlarch & Boyd). However, employment has also been found to have positive effects on stress and mental health for employed caregivers of elders (Brody, Kleban, Johnsen, Hoffman, & Schoonover, 1987) and to have no effect on caregiver stress (Miller, 1989). One of the issues limiting the interpretation of the research regarding the effects of multiple roles is that the meaning and content of these roles are rarely elaborated.

Because most previous studies have treated employment as a unitary construct, little is known regarding the health effects of double-duty caregiving. To date, few researchers have examined the effects of caring both at home and at work. Barnett and Marshall (1992) and MacDonald (1998), in their samples of nurses, found no negative spillover between employment and parenting. In contrast, Gottlieb, Kelloway, and Martin-Matthews (1996) found that hospital-based nurses who also provided child care were more likely to experience mental and emotional spillover from the family domain to the work domain. In a study with women employed as social workers or as licensed practical nurses, Marshall, Barnett, Baruch, and Pleck (1990) also found that the high costs of caring at work or at home included high levels of psychological distress.

In a survey of 892 office and visiting employees of three home-care agencies, Denton et al. (1999) found that work-related stress was experienced most acutely by nurses, therapists, and those in managerial positions. Similarly, Ross et al. (1996) found that most nurses experienced high levels of stress in both their professional lives and their personal lives caring for relatives of all ages. In a study with male and female nurses caring for an elderly relative, Walters et al. (1996) report a positive association with health problems for the women only, indicating that women may be particularly affected by the increasing reliance on family care of elders. These findings point to the potential negative effects for women of the "double day" or "second shift" of caregiving (Hochschild, 1989).

In a qualitative study with five women who were both paid healthcare workers (home-support workers, long-term-care managers, nurses) and unpaid caregivers of elderly relatives, Rutman (1996) found a sense of powerlessness and distress that cut across the paid/unpaid caregiver distinction. In a qualitative study with 25 employed women, eight of whom were professionals (nurses, lawyers, researchers), Guberman and Maheu (1999) examined the complex process of juggling work and elder-care responsibilities. They found the impact of caregiving on employment to be an end product of making adjustments and accommodations in order to achieve equilibrium among the various demands placed on them.

Despite many contributions to our understanding of combined employment and family caregiving, we have not examined the content and meaning of women's caregiving activities in both their work and their family lives. Research that draws links between paid and unpaid caregiving is sorely needed (Morris, 2001). Only when the results of such research are known can we fully understand the health effects of simultaneous participation in the private and public domains of caregiving.

Theoretical Perspective

The current study was informed by a socialist-feminist perspective, most notably the writings of Ungerson (1990). One of Ungerson's major contributions to the debate concerning the public and private spheres of caring is the development of a typology that encompasses caring in both domains. She argues, along with others (Waerness, 1984), that the conceptual splitting of formal and informal care poses a false dichotomy by assuming that the nature of the relationship in each of these spheres is unique. Accordingly, Ungerson suggests that it would be more fruitful to determine

> the exact circumstances — formal or informal — under which caring labour is exploited labour, the exact circumstances — formal or informal — where it is labour willingly and/or lovingly given, and the exact circumstances — formal or informal — under which the best possible standard of care, combining continuity, consistency, and respect between carer and cared-for, can be provided. (p. 13)

Application of a socialist-feminist perspective has a number of advantages. First, research grounded in socialist-feminist thought provides a set of sensitive and complex analytical tools for understanding double-duty caregiving. It explicitly recognizes caring as both "labour and love" that crosses the boundaries between public and private. In other words, *caring for* and *caring about* occur in both the public and private spheres and these spheres are interwoven. Second, this perspective is based on the premise that work and family are interdependent through reproduction and production (Pascall, 1986). The construct of reproduction-production with its emphasis on unpaid and paid work highlights the artificial boundaries between work and family. Finally, socialist-feminist inquiry focuses on the gendered interface of the market, the family, and the state — that is, the capitalist state has a direct interest and role in reinforcing the separation of the public and private spheres and supporting gendered patterns of caring (Walby, 1994). According to Baines, Evans, and Neysmith (1991), a socialist-feminist approach to caregiving "helps to bring women's labour out of the household closet, explores its connections to other forms of work, and begins to integrate domestic labour into a feminist analysis of the family, the economy, and the state" (p. 20). Thus, a socialist-feminist approach promises to address some of the aforementioned limitations, in conventional theoretical frameworks, to studying the interface of professional and personal caregiving.

The underlying principles and assumptions of feminist methodologies situate them within a critical approach to research (Neysmith, 1995). The critical tradition posits that knowledge transformation entails going beyond understanding why things are the way they are, to studying how they are maintained that way, and thus suggests alternative images as to what could be (Fine, 1994; Neysmith, 1995). This reflexivity is grounded in the belief that there is something better, and that knowledge helps us to achieve it (Denzin & Lincoln, 1994). Consequently feminist research offers us an opportunity to engage in the development and implementation of progressive social policies that promote the health of women and men.

Method

Purpose and Design

Caring has been identified as the essence of nursing (Leininger, 1981; Watson, 1988), which is essential to professional practice (Benner & Wrubel, 1989; Clayton, Murray, Horner, & Greene, 1991; Green-Hernandez, 1991). Yet little is known about the relationship between *caring for* and *caring about*, nor do we fully understand the multidimensional aspects of caring in the personal lives of nurses. Thus, an exploratory qualitative approach was chosen. This is an appropriate method for examining the dimensions, strategies, and consequences of a particular phenomenon (Lofland & Lofland, 1995; Morse, 1994). The primary aim of this feminist narrative study was to critically examine nurses' experiences in providing care to elderly relatives.

Sample

Participants were recruited from two community health-care agencies in southwestern Ontario, Canada, over a 6-month period (January–June 1999). All registered nurses received a letter in their workplace mailboxes inviting them to participate in the study (*n* = 72). To be eligible, they had to speak and understand English, provide at least 1 hour of care per week to an elderly relative or friend, and be employed full-time or part-time at one of the two agencies. Fifty-nine responses were received (65% response rate). Most of the respondents indicated that they were ineligible to participate (40 responses), while four indicated a lack of interest. Ultimately, 15 nurses were enrolled in the study.

The participants ranged in age from 23 to 64 years, with a mean age of 44 years. The majority were married (66%), held a diploma in nursing (83%), and were employed part-time as community nurses (66%). Participants provided care to their parents (66%), parents-in-law (13%), grandparents (7%), sister (7%), or spouse (7%). One third of the sample provided care to two or more elderly relatives. The majority of the elders had been receiving weekly care within their own homes from 3 months to 11 years, with a mean of 5 years. At the time of the interview, 13 of the 15 participants were providing care to an elderly family member. Two participants had recently experienced the death of their fathers.

Data Collection and Analysis

Narrative inquiry was used for this study, specifically as a framework for conceptualizing the interview and interpreting the interview data. According to Sandelowski (1991), narratives are "stories that include a temporal ordering of events and an effort to make something of those events: to render, or to signify the experiences of persons-in-flux in a personally and culturally coherent, plausible manner" (p. 162). Moreover, narratives constitute a type of causal thinking in that each story explores questions of human agency and explains lives. They offer insight into the way in which individuals view their lives and into the connections between past and present and self and society (Riessman, 1993). Thus, narrative inquiry in this study served to explore new understandings of the interface of women's paid and unpaid caring work and identify possibilities for positive action and change among participants and society.

The main sources of data were 15 in-depth audiotaped interviews and their corresponding field notes. Demographic data were collected from the participants at the end of each interview and analyzed using descriptive statistics. Interviews were scheduled at a mutually convenient time and place and an in-depth focused interviewing approach was used (Merton, Fiske, & Kendall, 1990). Twelve of the interviews were conducted in the participant's home or office. In three cases, at the request of the participant, the interview was carried out in the researcher's home or office.

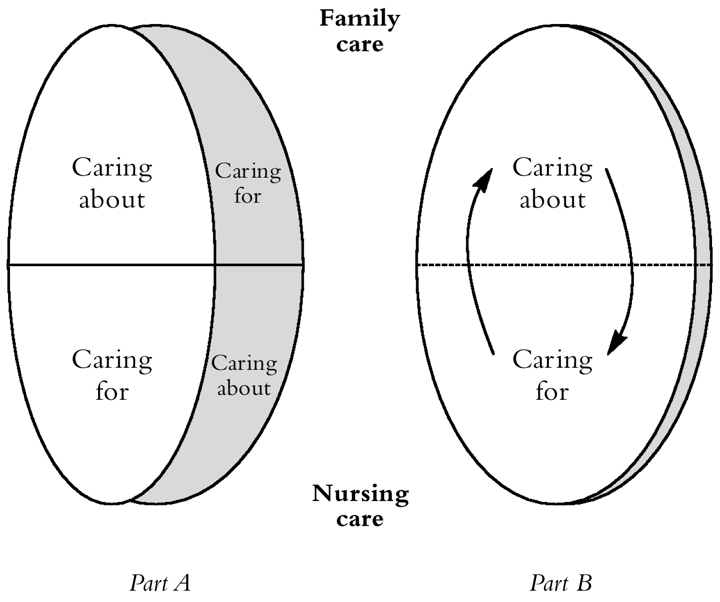
In keeping with the narrative approach, participants were asked nondirective questions designed to trigger dialogue about their caregiving as a nurse and as a family member. This approach served to encourage the participant to discuss what she thought was important. It also provided an opportunity for the participant to "story" her experience (Riessman, 1993). In response to open-ended questions (e.g., What is it like to care for a family member? What are the advantages/disadvantages of engaging in both personal and professional caregiving?), most participants discussed their double-duty caregiving experiences without further prompting. At times, probes and questions were used to clarify or ensure accurate interpretation of the story. The interviews lasted from 60 to 120 minutes, with an average of 90 minutes. Participants were also given the opportunity to attend one of two follow-up focus group meetings in order to respond to emerging interpretations of their experience, as well as to clarify or elaborate on their ideas; 13 of the 15 participants attended one of these meetings, which served as a means for the researcher to check the key findings from the individual interviews.

As soon as possible after each interview, data were transcribed and analyzed. Following the guidelines of Lofland and Lofland (1995), early analysis focused on key phrases and themes that emerged from the data. As themes emerged (e.g., "feelings of affection"; "feeling torn"), an initial coding system also emerged, which produced numerous and various codes. These codes were inserted into the text by hand and then entered into NUD*IST, a computer program used to facilitate qualitative analysis (Richards & Richards, 1994). While this analytic strategy was helpful in identifying specific coding categories across many cases, the participants' stories were not completely revealed. As a means of capturing the complexity of their double-duty experiences, the 15 transcripts were examined as a whole. As suggested by Riessman (1993), attention was paid to the sequence of events, the type of language used, the meaning of the action, and any resolution of conflict. During the final stage of analysis a conceptual model was developed (see Figure 1). This was refined through re-examination of the themes from the initial stage of analysis.

Results

The goal of this study was to examine the interface between personal and professional caregiving amongst nurses. Participants made visible the different and sometimes competing discourses that are available for analyzing their experiences of double-duty caregiving. A discourse is a set of beliefs, values, and assumptions that is socially shared and often unconsciously reflected in language (Ristock & Pennel, 1996). Significantly, not all available discourses will have the same weight and value in a particular situation (O'Connor, 1999). For instance, discourses that represent dominant assumptions and ideologies are particularly powerful. This means

Figure 1 ***Caring About and Caring For***



that people have multiple discourses exerting varying degrees of influence on how they view their experiences.

Dimensions of Double-Duty Caregiving

In this study, the two dimensions of caring, *caring about* and *caring for,* were inextricably linked for the double-duty caregivers. While *caring about* involves feelings of affection and love, *caring for* has to do with tending to physical, mental, and emotional needs (Ungerson, 1990). In the dominant discourse, family care and nursing care are conceptualized as two distinct types of caregiving, delineated along the lines of *caring about* and *caring for,* respectively. However, in the current study there was evidence of *caring about* and *caring for* in both family care and nursing care, though in varying degrees (see Figure 1, Part A). Thus, four story lines associated with the two dimensions of caregiving emerged: (1) *caring about in family care,* (2) *caring about in nursing care,* (3) *caring for in family care,* and (4) *caring for in nursing care.* These story lines competed to provide the framework for the participants' double-duty caregiving experiences.

Caring about. The first set of story lines that emerged related to *caring about* elderly family members and elderly patients, respectively. Not surprisingly, most participants revealed strong feelings of affection for their elderly relatives, particularly daughters caring for their mothers. It is interesting to note, however, that the women did not speak about their emotional involvement with their relatives unless it prevented them from fulfilling their caregiving duties. According to many of the participants, emotional attachment to a family member during care caused a number of problems. Natalie said:

> *All of sudden my mother was disabled, and when her health status changed I panicked. I think it's because of the emotional factor. You're subjective. You're not objective. And we had such a close relationship as a mother and daughter that all of a sudden I saw her changing. She became an elderly lady and I didn't like it… It is very difficult to look after her when you're so emotionally attached.*

On reflection, the participants frequently compared the care of their relatives to the care of their clients. Heather described how her feelings for her relatives differed from those for her clients and how this influenced the caregiving experience:

> *When I saw my parents suffering, I suffered. I think that's the difference. I find with my clients that I'm able to step back and be more of a tour guide with whatever their problem is.… I'd be more desperate for them [parents] to be safe and alive. When you're at work, you're able to separate the respective boundary of any individual and you become more of a professional, helping or guiding. When it's your parent and someone you love so intensely, you just want more for them to be safe and healthy.*

With respect to their nursing care, all of the participants reported that they experienced some degree of attachment to their clients. Although they were careful not to get "too attached," they formed family-like emotional ties with certain clients. Monique said:

> *If I go in and only see them a couple of times, it's hard for me to care…I do care…but it takes time. I mean, there are families…I've been visiting for 5 months almost every night, doing something for them, and…as much as you try not to get involved emotionally and personally, you do. I do, anyway. And you really do care about them.*

Echoing their beliefs about family caregiving and emotional attachment, the participants claimed that they could not care for clients adequately if these feelings were too strong. One nurse, Millie, had severed her nursing relationship with an 82-year-old woman who lived alone:

> *I visited her as her nurse for about a year or so…it kind of grew into a friendship and I knew then that I couldn't do both…I either had to be her nurse and cut it off at that, or not be her nurse and then I could do the friend thing. I made arrangements not to be her nurse after that…but I think I play the role interchangeably. I remain her friend, but then sometimes, as a nurse, I give her advice about improving her health or the importance of taking medications.*

Although the participants considered it "natural" to be emotionally close to family members and "unnatural" to develop close ties to clients, there were remarkable similarities between the two kinds of care. They had gradually become attached to many clients, particularly those who were very old or who had no family. Although provision of care without emotional ties is highly valued in professional caregiving, many participants inevitably formed family-like nurse-client relationships. They also acknowledged that emotional involvement would jeopardize the care they provided to both family members and clients. In other words, they believed that they could not *care about* individuals and at the same time *care for* them. This dominant discourse caused tension as the women assumed their personal and professional caregiving responsibilities.

Caring for. The second set of story lines that emerged was associated with *caring for*: *caring for* as a nurse and *caring for* as a family member. Professional caregiving was a paid function that occurred in the public arena of the community, whereas unpaid family caregiving usually occurred within the private domain of the home. As nurses, the participants were expected to use their knowledge and skills in order to provide competent care to clients and their families. While some nurses were generalists, others specialized in acupuncture, palliative care, or geriatrics. However, regardless of their nursing specialty, a typical work day encompassed physical, emotional, and intellectual care, as described by Tina:

> *It can go from very clinical — you know, the technical provision of care when I'm running IVs — but even in wound treatment you're sometimes providing a lot of emotional care. I have a man now — and it's only been for a month and a half — but he's in tears because he doesn't think that it [the wound] is healing… So you just try to encourage them along at the same time…plus a lot of knowing what's out there in the way of services: the people and the liaison with the doctor.*

It is interesting to note that all of the participants viewed their family caregiving as a natural extension of their nursing duties. They felt obliged to use their nursing knowledge in the care of their relatives. Most participants declared that they were "the nurse in the family" and had little or no choice but to assume this role given their high expectations of themselves as well as the expectations of others, including health-care providers. Crystal, who had cared for her 80-year-old mother diagnosed with Alzheimer disease, explained:

> *I was expected to care [for my mother] because, one, I am a nurse, two, I am a daughter, and probably three, I am a mother. Also, you are supposed to know these things [as a nurse], so I did have an expectation of myself.*

Due to their nursing backgrounds, the participants were frequently expected to offer their caregiving services readily. Monique recalled that her mother chastised her for not seeing her ailing grandmother more often:

> *I find that because I work in palliative care, and I work as a nurse in my job...I hear my mom say: "You do it all the time. You care for other people. You could at least go and visit your grandmother."*

Although the participants felt an obligation to care for their elderly relatives, they found it particularly difficult to be the "nurse" for ill or frail family members. Annie's personal narrative reflects a common concern amongst participants, the expectation that they be daughter and nurse simultaneously:

> *In my family, I'm the only nurse and I'm the eldest and single...and because my brother and sister aren't in the health-care field I took care of Dad... I also tended to take on that job because I wanted my dad to have the best care that he could get, especially now when there have been so many [hospital] cutbacks... But the nurses actually expected a lot of me. I don't mind giving mouth care and I would help them lift him up in bed, but one time the nurse went to pull up my dad's hospital gown to fix his [urinary] catheter and I quickly turned my head and said, "I don't want to see the family jewels." Their expectation of me as a daughter being there... I mean, I'll help with back rubs and positioning but it was almost as if I did become unpaid help.*

Hazel spoke about a similar incident with her mother, who had dementia. She found it extremely awkward to be her mother's nurse, even though the situation called for her clinical expertise:

> *With my mother, I knew that her pill dispenser had been played with but it wasn't as easy to say to my mother, "These pills are mixed up in here. How did this happen?" because here I was a daughter telling my mother that things weren't right. So I felt that difficult. In the community [as a nurse], it's not.*

Other participants talked about a variety of instances when it was uncomfortable to be both nurse and daughter. Crystal commented:

> *They [health-care providers] were talking to me as a nurse, but how can I be clinical when this is my mother? I had difficulty with that because I felt that I wasn't allowed to be emotional, because I felt that I wasn't the nurse in this situation. I was the daughter, and I found that hard.*

However, as her mother's conditioned worsened, Crystal needed to make difficult decisions that required her nursing judgement:

> *My mother told me: "I am so mad at you. I thought you loved me but you don't love me if you put me in that [nursing] home." ...But I knew that I was doing the right thing. As a nurse, I knew in my head that I was doing the right thing. I wish in my heart I could have done things differently but there was no choice at the time.*

Many participants expressed concern that they were expected to assume too much responsibility for the care of their family member, particularly in situations where they lacked the necessary knowledge and skills. This caused tremendous guilt, especially if the person's health deteriorated under their care. Delila expressed tremendous guilt for missing key signs and symptoms of a bowel infection:

> *My biggest fear was that I would miss something... It was very exhausting, all that running around... I was beside myself. And then I think back. I wonder if I was so tired that I missed my dad's complaint about the abdominal pain. Like, why didn't I know that his sigmoid was going to blow? ...I will take that guilt with me to the day I die.*

Examination of the discourse of *caring for* in the women's professional and personal lives reveals two conflicting story lines. On one hand, they saw themselves as competent nurses, providing care for a variety of clients. On the other hand, they considered the care they provided to their relatives as inadequate. Even though they were seen, by themselves and others, as the most knowledgeable person when it came to family care, the intimacy of the relationship and a sense of powerlessness prevented them from providing full care within the family. Nonetheless, the participants felt accountable for the nursing care of their relative. Thus, the meanings associated with *caring for* were derived primarily from their professional frame of reference, which usually created stressful family-care situations. A strong sense of inadequacy is embedded in their stories. Further, they felt extremely guilty about making poor clinical decisions given their profession of nurse.

Strategies for Managing Family Caregiving Responsibilities: Choices Within Constraints

The nurses engaged in the following personal strategies to manage their family caregiving responsibilities: setting limits; coordinating, delegating and supervising care; and assuming complete caregiving responsibilities. Strategies ranged from refusing to provide specific types of care to doing it all without any assistance from other family members or health professionals.

Those individuals whose personal narratives were more firmly grounded within the discourse of *caring about in family care* tended to set specific limits on the care they provided. Monique, a new nursing graduate, described a tendency to separate the role of family member from that of nurse:

> *I think that when emotions are involved, sometimes we forget about what each person is in our professional life... When my dad had surgery, and it was quite serious surgery, I wasn't thinking about being a nurse; I was thinking about my dad. My dad was going to be at my wedding and be able to walk me down the aisle. I was worrying. When he came out of the surgery, I wasn't thinking about his vital [signs] and I wasn't assessing — I guess you always assess, you don't lose that — but I was just hoping that everyone else was doing their job and I would do my job. I would just be my dad's daughter and be there for him. I didn't want to be the nurse in charge of his care.*

To safeguard their own health, some participants also tended to set limits on the care provided if the situation was not considered life-threatening. Delila had refused to provide care to her mother-in-law:

> *She was very demanding for hands-on care when she thought she needed some attention. I can recall one incident where she was suffering a lot with heartburn and wanted me to run to the store to get her something over-the-counter, and I said no. I felt that if the heartburn was as severe as she had said it was, she needed to be seen and assessed by the physician.*

It is interesting to note that in these situations the participants tended to be in the early stages of family caregiving, when the need for formal nursing care was limited.

In direct contrast, women whose personal narratives were situated more within the *caring for* dimension of family care tended to take on major elder-care responsibilities. In fact, they assumed other caregiving roles within the family, such as coordinator, and delegated certain tasks, especially during times of crisis or to avert a crisis. Since many participants were the most qualified health-care person within the family unit, they believed they had no choice but to assume the bulk of care for their relative, in spite of the consequences. Paula drew on her extensive nursing knowledge while caring for her mother post-surgery:

> *When my mom had some surgery we all said we would take turns staying with her, and I tried to work my days off so I would have the first night or two, thinking if she came home from surgery she should have a nurse… It would be hard not to use some of your nursing knowledge, to make sure they are getting the best care they can, but it was emotionally and physically exhausting at times.*

Those who had workplace supports, such as an understanding manager or flex time, considered themselves fortunate. A few others worked only part-time in order to be available for their unpaid family caregiving responsibilities. For Annie, the boundaries between family care and nursing care became blurred as she was required to provide more and more care for her father-in-law in hospital:

> *[His] nephrostomy would be leaking from his site. He needed a bed change. Well, they were so busy, run off their feet. I would say, "That's something I can help you with…" Sometimes we're not even conscious of when we're being the nurse or when we are the daughter, or the daughter-in-law in my case… I don't think that it is separate.*

In summary, the participants engaged in a variety of personal strategies to contain the stress they experienced as double-duty caregivers. The *caring about in family care* discourse supported the idea of setting limits — that is, if one cares about an individual, one cannot, and should not, provide professional care for them. The belief that one should separate family care from nursing care was clearly evident in some of the narratives. For other participants, however, the alternative story line, *caring for in family care,* supported the idea of assuming the bulk of care because they possessed the necessary nursing skills. For those who were grounded in this discourse, the boundaries between family caregiving and nursing care virtually disappeared.

Discussion

Examination of the interface between personal and professional caregiving amongst nurses revealed four story lines associated with *caring about* and *caring for* (see Figure 1, Part A). Two of these provided congruent frameworks for interpreting the nurses' experiences as double-duty caregivers: *caring about in family care* and *caring for in nursing care.* Both story lines upheld the dominant belief that emotional attachment clouds clinical judgement, hence one should not *care about* clients nor *care for* family members. However, two other story lines, *caring about in nursing care* and *caring for in family care,* offered an alternative set of assumptions, values, and beliefs with which to interpret their experiences. Participants provided examples of nursing care and family care situations that supported their claim that it is possible, and sometimes preferable, to *care about* someone while *caring for* them. This alternative discourse suggests that the boundaries between *caring about* and *caring for* in family care and nursing care are permeable. Thus, not only do individuals who are both health professionals and family caregivers use multiple, sometimes contradictory, story lines to interpret their caregiving experiences, but for them the boundaries between *caring about* and *caring for* cease to exist (see Figure 1, Part B).

Although preliminary, the results of this research afford several insights concerning family caregiving. First, they suggest that the dynamics of care are extremely complex when the family caregiver is a health professional. Since any two or more of the four story lines may be used simultaneously, the complexity of double-duty caregiving issues is clear. Because of personal and familial expectations, the nurses struggled with the challenges of family caregiving, yet because of their knowledge and ability to "work the system" they could access information and services not normally available to family caregivers. Thus, the findings reveal how the professional occupation of the caregiver affects the caregiving experience, as well as how the presence or absence of suitable workplace supports influences caregivers' appraisal of and response to their situation. It is important that future studies on professional caregiving pay particular attention to the type and extent of the caregivers' employment, and examine how this may, over time, be advantageous or disadvantageous to the caregiver.

Second, the socialist-feminist perspective used in this study differs from the approach taken generally in examinations of caregiving by employed family members. What distinguishes this research is its focus on the connection between the occupational and domestic spheres, and particularly its questioning of the traditional dichotomy between paid nursing care and unpaid family care. As well, a feminist lens helps to shed light on the difference between feeling affection and providing emotional support. The findings suggest that both elements are present in nursing care and family care but tend to be linked only in family care. Future investigators might consider using a feminist framework since this perspective has the potential to encourage health-promoting critical reflection among research participants. In the present study, nurses had the opportunity to identify specific areas requiring change (workplace support) and, during the focus group session, to offer mutual support.

Third, the recognition that caregiving is a fluid activity that crosses the public-private divide is critical to our understanding of women's family and work lives and the impact of their dual role on health and well-being (Armstrong et al., 2003; Hooyman & Gonyea, 1995; Long & Kahn, 1993; Walters et al., 1996). The findings are consistent with previous observations regarding the difficulty of juggling work and family responsibilities (Guberman & Maheu, 1999; Phillips et al., 2002). However, the findings of this study and others (O'Connor, 1999) indicate that the caregiving role is not experienced uniformly. The double-duty caregivers interviewed in the present study appeared to experience challenges not faced by other employed caregivers. The expectation that they provide competent nursing care while functioning in the role of family caregiver frequently placed them in a no-win situation. The participants felt obliged to apply their nursing knowledge yet their expertise was rarely acknowledged. Consequently, many expressed feelings of helplessness, inadequacy, and guilt, which had a negative impact on their health. Although they used personal strategies to alleviate stress, the findings suggest that we need to go beyond short-term recommendations designed to help women cope with their caregiving roles, to long-term policy recommendations that challenge the gendered nature of caregiving (Morris, 2001).

Fourth, the findings lend support to the growing body of research on the macro-micro linkages between individuals and society. Although personal values and beliefs are used in constructing the meaning of caregiving at the individual level, these values and beliefs are constructed within a socio-political context (O'Connor, 1999). The comments of the participants in the present study reflect traditional values. For instance, the nurses' notions of who should provide care were shaped by a gender ideology in which female family members are regarded as "natural" caregivers. Moreover, the onus on them to provide care was strengthened by their position as "the nurse in the family" and the current climate of fiscal restraint in health care. Consistent with other aspects of our gendered world, these women rarely questioned their obligation to provide care to elderly relatives. However, a limitation of this study is that it focused on a small number of female nurses. It would be worthwhile for future investigations with employed caregivers to examine and compare the double-duty experiences of male and female health professionals over time. Given the structural basis of gender inequities and the magnitude of the changes required, there is a clear need for a broad policy shift.

The results of this study point to the need for a critical examination of policies and programs that address the paid work and family life of double-duty caregivers. There is an urgent need for health-care institutions to consider the special needs of double-duty caregivers and to institute flexible work arrangements. In addition, managers' attitudes and behaviours are key to the implementation of workplace policies (Phillips et al., 2002). However, as noted by Hooyman (1990), the overriding issue is not how to relieve caregiver stress but how to organize society to achieve social justice for all — both men and women — so that the care of frail elders is more equitable for both providers and recipients. Recognition of the broad political context of caregiving can foster a new discourse that encourages a health-promoting approach to care.

Conclusion

This exploratory study examined the ways in which nurses manage their dual role when providing care in both their professional and their personal lives. The findings reveal that nurses providing care to elderly relatives must constantly negotiate the boundaries between their professional and personal caregiving roles. Located at the juncture of private and public domains of care, the participants used multiple, sometimes contradictory, story lines to analyze their caregiving experiences. Gender ideologies about caregiving, both professional and personal, had a direct impact on the women's lives.

A feminist perspective on caregiving allowed this study to move beyond the dichotomies of work and family and to recognize the interconnections between the public and private spheres and the health effects of double-duty caregiving. Health promotion strategies, such as supportive practices and policies in the workplace and in society, are essential. Only when such practices and policies are in place will we be assured that the health of caregivers and those who rely on their care is not compromised.

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