

**Comprendre les attentes et les exemptions
selon le sexe dont font l'objet
les aidants masculins à double emploi :
une analyse secondaire qualitative**

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De plus en plus de données montrent que les aidants naturels qui occupent aussi un emploi ont de la difficulté à équilibrer les multiples demandes associées à ce genre d'aide. On s'attend des professionnels de la santé qui sont des aidants naturels, ou aidants à double emploi (ADE) comme ils sont désignés dans cette étude, qu'ils utilisent leurs connaissances professionnelles dans la prestation de soins à leurs proches. La présente analyse secondaire qualitative avait pour objectif d'explorer comment les attentes et les exemptions selon le sexe ont un effet sur l'expérience en tant qu'aidant et la santé personnelle des infirmiers qui prodiguent des soins à des membres de leur famille. Être un ADE masculin créait un croisement des attentes et des exemptions selon le sexe. Ces attentes et ces exemptions qui coexistent et, parfois, se contredisent, forment le thème général des déterminants de soins et ont un effet direct sur la santé des ADE masculins, qui vivent des tensions en raison de leur double rôle. Les résultats de cette analyse ont des répercussions directes sur les politiques, les pratiques, la recherche et l'élaboration de théories en soins de santé.

Mots clés : aidant naturel, famille, aidant à double emploi masculin, infirmiers

Understanding Gendered Expectations and Exemptions Experienced by Male Double-Duty Caregivers: A Qualitative Secondary Analysis

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There is growing evidence that family caregivers who are also employed face challenges in balancing the multiple demands associated with family caregiving. Health professionals who are family caregivers, defined in this study as double-duty caregivers (DDCs), are expected to use their professional knowledge in the provision of family care. The purpose of this qualitative secondary analysis was to explore how gendered expectations and exemptions affect the caregiving experiences and personal health of male nurses caring for family members. Being a male DDC created intersecting gendered expectations and exemptions. These coexisting and at times conflicting expectations and exemptions, constituted by the overarching theme of the determinants of care, directly influenced the health of male DDCs as they experienced tension when negotiating their dual role. The findings have direct implications for health-care policy and practice, research, and theory development.

Keywords: caregiving, family, gender, home care, men's health, nursing roles

Introduction

It is expected that the number of individuals aged 85 or older in Canada will grow from approximately 430,000 to over 1.6 million by the year 2041. With the incidence of chronic illness rising among older adults (Health Canada, 2002), the increased need for family caregivers is unavoidable. In addition to these demographic trends, reforms in health care have led to increased cutbacks, shorter hospital stays, and increased community care, creating a greater reliance on and need for family caregivers (Armstrong, 2002). Ongoing health-care reforms and cutbacks, combined with other factors, have resulted in a large population of those who are required to provide familial care (Armstrong, 2002), a significant proportion of whom may be professional caregivers. Because of their professional knowledge and skills, those who are employed as nurses while also providing familial care are in the unique situation of being double-duty caregivers (DDCs) (Ward-Griffin, 2004). Female DDCs have reported that their familial and professional expectations are shaped

by gender norms (Ward-Griffin, Brown, Vandervoort, & McNair, 2005). However, little is known about male DDCs — whether they experience similar gendered expectations or whether gendered exemptions enter into their experience as DDCs. Although the literature on DDCs is informative, it does not address the possible coexistence of gendered expectations and exemptions experienced by male DDCs.

Literature Review

Familial Caregiving

In Canada, approximately three of every four family caregivers are women (Statistics Canada, 2006), as there is an underlying gendered expectation for women to assume traditional caregiving roles (Pavalko, Henderson, & Cott, 2007). Those who are family caregivers are likely to draw upon gender norms and use specific skills and strategies to affirm gendered expectations (Ussher & Sandoval, 2008). For example, male caregivers tend to focus on tasks that are consistent with traditional male roles, such as home maintenance and financial assistance, while being exempt from the tasks that are associated with the traditional female role, such as bathing and other physical hands-on care (Pinquart & Sorensen, 2006). When men occupy the role of primary caregiver, they tend to delegate tasks that are viewed as “feminine” to female family members (Campbell & Martin-Matthews, 2003). The differences in caregiving expectations and the predisposition to delegate or be delegated illuminates different gendered expectations of familial caregiving. Men may use gendered norms to exempt themselves from aspects of care, while the same gendered norms increase the expectations for women to provide care.

Multiple studies discuss the numerous circumstances that sons and daughters use to explain their involvement, or lack thereof, in filial care. The concept of “legitimate excuses” developed by Finch (1989) encompasses the reasons for or circumstances considered to be valid explanations for one’s limited involvement in familial care. According to this concept, such excuses absolve those who are seen as unable or unwilling to provide care. Lack of competence or skill is reported to be a major legitimate excuse for not providing care to ill family members. Women are regarded as “natural carers” and as somewhat more competent caregivers than men (Calasanti & King, 2007). However, the successful use of legitimate excuses does not apply in all situations and often diminishes with the degree of caregiving necessary when familial obligation begins to trump social expectations and exemptions (Campbell & Martin-Matthews, 2003; Matthews, 2002). Several researchers have suggested that sons’ caregiving involvement is dependent upon the parent’s condition

becoming unstable or reaching a higher level of need (Matthews, 2002). Still, in these circumstances female relatives continue to take on the majority of care (Campbell & Martin-Matthews, 2003). Family structure may also dictate the degree of male involvement in caregiving. In brother-only sibling networks, sons typically provide more care to parents, relative to mixed-sibling networks, and rely more on formal services for tasks perceived as “women’s work” (Matthews & Heidorn, 1998; St. Amant, 2008). Also, unmarried sons and daughters take on more parental care than married sons and daughters (Campbell, 2010). The difference may lie in perceived obligations; also, unmarried status may be associated with greater availability. In brief, it appears that men (and society) tend to assume and expect that women, when present, will be the main providers of care to family members.

Professional Caregiving

According to the 2006 Census, 94.2% of registered nurses in Canada are female and 5.8% are male (Statistics Canada, 2006). Still, women are increasingly employed in lower-paid nursing positions (Statistics Canada, 2006), while men are concentrated in positions of higher pay, prestige, and authority (Mullen & Harrison, 2008). The reasons behind this phenomenon may be gendered expectations and exemptions in a feminized profession. The feminization of paid caregiving can be linked historically to the identification of nursing as “women’s work” extending from women’s domestic and maternal roles (Huebner, 2007; Pavalko et al., 2007). Intimate physical care is one of the required and expected skills in the health professions; however, while female caregivers tend to provide this care while empathizing with and displaying friendliness and informality towards their patients, male caregivers tend to provide it in a somewhat sterile and emotionally detached way (Huebner, 2007). The results of multiple studies with men in nursing suggest a need to downplay feminine aspects of the profession in reaction to perceived social disapproval of their involvement in a feminized occupation (Cross & Baglihole, 2002), as well as to accommodate the gendered expectations of their colleagues (Calasanti & King, 2007). Men who do engage in “feminine” work are challenged to assert their “masculinity” in other ways, such as by downplaying the nurturing aspects of their job; highlighting the practical tasks, professional training, technical skills, and physical strength involved (Cross & Baglihole, 2002); and working in managerial positions (Mullen & Harrison, 2008). Such strategies enable men to redefine their work to conform to the gendered social expectations that shape their understanding of masculinity.

***Double-Duty Caregiving:
Combining Professional and Familial Caregiving***

Some researchers have begun to focus their investigations on nurses who are both professional caregivers and familial caregivers (Mills & Aubeeluck, 2006; Ross, Rideout, & Carson, 1994; Scott, Hwang, & Rogers, 2006; Ward-Griffin, 2004; Ward-Griffin et al., 2005, 2009; Ward-Griffin, Keefe, Martin-Matthews, Kerr, & Brown, 2010); these DDCs are in a unique position in that they experience the combined gendered expectations faced by both professional and family caregivers (Ward-Griffin, 2004). In general, little is known about DDCs. Most of the literature focuses on how DDCs navigate between the two caregiving domains (Barrett & Marshall, 1992; Ross et al., 1994; Ward-Griffin, 2004). Some researchers are of the opinion that professional caregiving is a separate domain, distinct from familial caregiving, and that one does not impact the other (Barrett & Marshall, 1992). Others believe that the uniqueness of nurses' familial caregiving experiences is embedded in the duality of the caregiving role (Ross et al., 1994; Ward-Griffin, 2004). Conceptualizing these two caregiving domains as separate may account for the dearth of research available on DDCs (Ward-Griffin, 2004).

While DDCs acknowledge their advantage in having nursing knowledge, nursing skills, and connections with the formal health-care system, many feel that they have no choice but to provide care to their family members (Ward-Griffin, 2004; Ward-Griffin et al., 2005). As well, some health professionals and family members expect health workers such as nurses to take on care that they may feel inadequately prepared for (Ward-Griffin et al., 2005, 2009). Furthermore, nursing practice standards do not adequately guide nurses in their familial care responsibilities. Indeed, when engaging in double-duty care, nurses experience a blurring of the boundaries between work and family life and are constantly challenged to find balance (Ward-Griffin, 2004; Ward-Griffin et al., 2005, 2009). Inherent in these challenges is the issue of the combined gendered expectations and exemptions associated with both professional and familial caregiving. Although expectations and exemptions are acknowledged separately in the familial and professional caregiving literature, questions about how the dialectic of gendered expectations and exemptions affect the health of DDCs remain unanswered. Therefore, a qualitative secondary analysis examining the caregiving experiences of male DDCs was conducted.

Theoretical Perspective

This study applied a social constructivist lens informed by the scholarly work of West and Zimmerman (1987). Gender typically refers to socially

constructed roles, behaviours, activities, and attributes expected or not expected of men and women (West & Zimmerman, 1987). West and Zimmerman provide a useful summary of how gender is socially constructed and “done.” They believe that gender should be understood as a “routine, methodical, and recurring accomplishment” that is constructed and deconstructed in everyday social interactions (p. 126). Men and women do not achieve a gender solely through a set of traits and norms; rather, gender is both a product and a process of social interaction (West & Zimmerman, 1987). In other words, individuals behave in response to what they perceive to be socially acceptable for their gender. Therefore, gender norms and expectations regarding femininity and masculinity, as well as individuals’ conformity with and resistance to them, are not fixed (Deutsch, 2007). However, in Western cultures gender norms are largely based on the dichotomous understandings of men and women. In addition, according to West and Zimmerman, individuals are constantly accountable to gender norms and consequently perceive that other individuals are also gendered and accountable.

The view of gender as a social construction highlights the role of the individual in creating, maintaining, or challenging gender through interactions with other individuals and with society (Deutsch, 2007; West and Zimmerman, 1987). Health is viewed as a co-creation through relationships (Hartrick, 2002). The ways in which men and women relate to socially constructed gender norms and their associated expectations and exemptions ultimately affect their health. Furthermore, one’s sense of identity and health is interrelated with and influenced by one’s relation to everyone and everything (Hartrick, 2002), including social norms. By examining the relationship between male DDCs’ experience of gendered expectations and exemptions, this study was intended to offer insight into the health experiences of DDCs.

Method

The present research is a qualitative secondary analysis derived from the study *Health Professionals Caring for Elderly Relatives: Investigating the Health Effects of Double Duty Caregiving* (Ward-Griffin et al., 2010). This analysis provides a more in-depth exploration of an issue that was not fully addressed in the original study (Heaton, 2004). That study was a sequential mixed-method investigation incorporating both quantitative (phase one) and qualitative (phase two) data. Specifically, phase two used constructivist grounded theory and its main objectives were to refine the conceptual knowledge of double-duty caregiving and further explore the health experiences of DDCs and the broader contextual factors that shape these experiences.

The 2009 study involved telephone interviews with registered nurses practising in the provinces of British Columbia, Ontario, and Nova Scotia who were also family caregivers. The participants were asked non-directive questions designed to trigger dialogue about their experiences as DDCs. The questions focused on familial care expectations, resources, strategies, and personal health experiences.

Although gender was examined in that study, the purpose of this secondary analysis was to explore how gendered expectations and exemptions enter into the caregiving and health experience of male DDCs. The research questions for this study were as follows: *What are the gendered expectations experienced by male DDCs? What are the gendered exemptions experienced by male DDCs? How do gendered expectations and exemptions enter into the health experiences of male DDCs?*

This secondary analysis involved 28 transcripts and field notes from interviews with male DDCs. The DDCs included in this secondary analysis ranged in age from 40 to 63 years. Seventy percent were currently living with a partner and 30% were divorced, widowed, or never married. Most were employed full-time in hospital or community management positions (such as patient case manager or nursing unit administrator) or in high-acuity departments (such as emergency or intensive care), with 72% working 30 to 49 hours per week. Sixty-one percent cared for one family member, while 28% and 11% cared for two and three family members, respectively. Familial care ranged from 1 to 21 hours per week, with 24% providing 2 hours per week. Most of the DDCs were sons or sons-in-law. The nature of the care provided was either hands-on, supervisory, or emotional.

Immersion and crystallization were used to elicit interpretive data (Borkan, 1999; Lincoln & Guba, 1985). Immersion consisted of simultaneously listening to audiorecordings and reading transcripts in detail. Initial coding, whereby data were condensed and categorized, was followed by focused coding (Lofland, Snow, Anderson, & Lofland, 2006). Concepts were identified and categorized until themes and patterns emerged (Borkan, 1999). Crystallization also involved the keeping of a reflective journal to capture questions and memos on the coding categories and the research experience. Ongoing immersion and crystallization helped to synthesize the data findings and interpretation (Borkan, 1999; Lincoln & Guba, 1985). NVivo software was used to manage the themes and codes and to support the identification of relationships within the data.

Findings

Extensive analysis of the transcripts and field notes provided insight into the male DDC caregiving experience, which was revealed by an over-

arching theme, *the determinants of care*, and three subthemes, *familial responsibility and relationships*, *nursing knowledge and skills*, and *access to resources*. The gendered expectations and exemptions experienced by the DDCs occurred within the context of the theme and subthemes. The health experiences of these DDCs were most visible at the intersection of their double-duty caregiving experiences — that is, at the point of overlap between their role as male family member and their role as male nurse. Pseudonyms are used for the participants.

Determinants of Care

For the purpose of this study, the determinants of care were the socially constructed factors that constitute the gendered expectations and exemptions experienced by individuals to provide care. Specifically, these gendered expectations and exemptions entered into the negotiation and distribution of tasks and affected the familial care that DDCs did or did not provide. Three determinants of care were identified: familial responsibility and relationships, nursing knowledge and skills, and access to resources.

Familial responsibility and relationships. The concept of reciprocity invoked and reinforced the familial expectations experienced by these male DDCs, as might be the case with many caregivers. For Jacob, reciprocity was a family value that played a large part in determining who provided familial care:

I feel because of the way we were brought up it's something that we want to do, make sure we have them around for a long time — because they're your parents and they helped you, so you help them back.

Constant interplay between birth order and familial responsibility was also evident. Some participants referred to birth order as an important factor in their caregiving experience. Fred explained that, in addition to his health-care knowledge and proximity to the care recipient, his status as the eldest sibling affected his caregiving:

I think my role would be more stressful, because they live just across town from us, so I have the geographical familiarity. I'm the oldest and I'm the only health-care-trained person.

However, Sam found that his youngest brother had a greater sense of obligation towards his parents and took on a more prominent role as power of attorney (POA). Sam seemed to resent this and decided to stop providing health-care advice:

My youngest brother announced that he was designated POA. So that frustrated me and I thought my observations were not being respected. And I said, "From this point on, you make all the decisions. It's up to you. I'll

be available to chat with you whenever you want, but don't ask me for any decisions." . . . [He] has a sense of obligation to Mom and Dad because he's the youngest and stayed with them for a long time.

The loss of control Sam felt by not having POA greatly influenced his familial relationships and the type of care he was willing to provide. This suggests that responsibility for familial care is negotiable and is influenced by the degree of power and control held by the DDC.

Familial responsibility and interpersonal relationships may play a role in the expectations placed on all family caregivers. However, in the case of male DDCs these expectations were related to the intersection of the socially constructed roles of male son and male nurse. The relationships between the DDC and his family changed to reflect his DDC position. The DDCs were often expected to take on the role of nurse instead of the role of family member, which likely caused tension between their gendered expectations as a son, husband, or father and their expectations as a nurse. This tension could affect relationships negatively, as exemplified by the case of Fred. Fred's marriage suffered greatly, even ending in divorce, as a result of his constant struggle to be a nurse to his mother-in-law and a supportive husband to his wife:

I believe as a son-in-law I tried to be almost professional about it and it was a positive end. The price that I paid was personal in that my wife wasn't looking for a professional — she was looking for emotional support, and that's sort of the bat I swung and missed with. . . . Basically, my wife was frustrated that I took on that role. I was being the family advisor and not being my wife's support.

Nursing knowledge and skills. Nursing knowledge is possibly the main factor differentiating DDCs from other family caregivers. The participants were aware of the value of their nursing knowledge, and, although it appeared that the family expected male DDCs to provide answers and use their knowledge, DDCs also used their nursing knowledge as a means of being exempted from aspects of care. For example, John, who provided care to his mother-in-law, insisted on not providing hands-on care because he felt that this should not be expected of a male family member, especially a son-in-law.

I'd make sure she's looked after but I'm never doing hands-on care for this person. I'm not going to do it; she's my mother-in-law. She can get as sick as ever and I'm not, I'm not going to do it. You know, I'll just make sure the resources are there to look after her. . . . I'll help her find the people to do it, like CCAC [Community Care Access Centre] when she has a surgery, but I'm not going to do hands-on care, even though I probably could do it.

John's understanding of his socially constructed gendered expectations may have played a part in his refusal to provide hands-on care. The socially accepted boundaries between a man and his mother-in-law may have also determined the type of care John was willing to provide.

Due to their occupational status, the DDCs were expected to possess, use, and share health-care knowledge. For example, Ralph was expected to provide support for a full range of health-related concerns, regardless of the type or severity of health problems:

I'm the health go-to person in my family . . . when anyone has any problems they'll call me. I mean, they're all very intelligent, capable people, but when there's a specific health issue they phone the brother who's a registered nurse.

Consistent with their nursing role, the DDCs also took on the task of passing their knowledge and skills on to other family members. This was most notable when the care recipient's health was stable, which permitted the DDC to be excused and ultimately exempted from specific aspects of care. The tasks that were taught were often gendered in nature; physical and hands-on tasks, such as bathing, versus the more managerial tasks of advocating or organizing care, were taught and delegated to others. Specifically, the participants appeared to teach and delegate the tasks that were not "gender appropriate" for them. By doing so, they were exempted from some tasks while still maintaining expectations of others. In this sense, the occupational status of the male DDCs allowed them to keep their options open and decide which tasks could be delegated while maintaining control over other tasks. For example, Adam, an only child, had been expected to manage his father's care for more than 12 years; however, he taught his mother many hands-on "nursing" skills, which ultimately led to his exemption from hands-on tasks:

Personal care, like dressing changes, stuff like that, I guess normal folk would get home care to come in and do. I'm taking care of that. I'm teaching my mother how to do that as well. So my mother now is basically filling the role of the nurse.

Thus, due to their nursing status, the male DDCs tended to assume a managerial position within their familial care network; they had control over which tasks they were expected to perform and which ones they were exempted from.

Access to resources. Men in nursing typically occupy high-status positions within the profession (Mullen & Harrison, 2008), and many of the male DDCs demonstrated how their connections and positions within the health-care system had benefited the care they provided to their family member — and likely had positively impacted their own health.

However, they had the added burden of being *expected* to use their professional status to access resources for their familial care. Adam acknowledged his advantageous position in comparison to caregivers without a health-care background:

I'm an OR nurse so I've got contacts with all the different services . . . in my hospital. I was able to get him in to see the urologist. I jumped the line. So my professional work is helping with my private life. . . . I'm interacting with the surgeons on a daily basis. I know the urologists because I work in the rooms. If anything happens, I know the orthopedic guys, I know the general surgery guys. So if he needs to see a specialist, instead of waiting 6 months we might be able to get him in earlier.

In addition to accessing and navigating the health-care system with greater ease than other family caregivers, the DDCs had access to other health professionals and services. Furthermore, their awareness of available community resources meant that they were better able to obtain appropriate care for their family member. Due to his awareness of Community Care Access Centre (CCAC) services, John was able to arrange for the health care that his mother-in-law would need, thus decreasing the expectation that he would provide care:

She's always been independent, but suddenly she's had a knee replacement and she's expecting the daughter and the son-in-law and the kids to run home and look after her. The daughter is saying, "Okay, we got to go do this," and I'm saying, "No, we don't. When she has the surgery, we ask to speak to the CCAC coordinator at the hospital and we tell him, 'This is the situation. What does she need?' And 'This is what we think she needs'."

The participants also had the support of colleagues in the nursing profession. This support helped in the emotional and physical aspects of care. Ralph explained that his colleagues not only supported him at work, but were ready to provide nursing care to his mother if necessary:

With nurses, there's unofficial tact where, you know, "If you're in trouble we're here." They don't push — they're not pushy about stuff — but they're always there. My coworkers would deliver food to the house or other ways where they'd actually show up and send you home . . . The support things that really were helpful was coworkers offering to come and sit, do ADLs [activities of daily living], bathe her — all that kind of stuff.

However, sometimes nursing colleagues expected the DDC to be a nurse rather than a son when the family member's care happened to be in their work environment. For example, Ralph intervened in his father's

care in the emergency room, despite the possibility of being reprimanded for his actions:

All of a sudden all of the nurses disappeared. He was doing poorly and he just needed to be cared for now. . . . having said that, I recognize that I wasn't in the best position to determine that at the time, because of emotional attachment coupled with stress. But then what I did was hook up his oxygen, started an IV, drew his blood work, [and] at the same time did a blood gas. Now, that's what I would have done if I was assigned to him as his nurse, but that was completely inappropriate for me to do.

In addition to accessing the health-care system and health professionals, the DDCs often accessed and deployed family members as resources in the provision of care. Usually female family members took on the role of primary caregiver, while male DDCs maintained the roles of health-care advisor, educator, and liaison as a result of the combination of their gender and occupational statuses. These male DDCs tended to deploy family members in accordance with socially constructed gendered tasks: female relatives for “female” tasks such as bathing and male relatives for “male” tasks such as yard work. For example, Tom specifically stated that bathing his mother would be a female task and that as a male he was exempted from this aspect of care. He deployed female family members for this task:

We used my sister-in-law for a couple [of] months because I didn't think it was right to bathe my mother. I also used my daughters when they were home. Otherwise my mother [wouldn't] bathe herself— she'd go months without bathing— so we basically used nieces and nephews and daughters to make her bathe, because as a guy I'm not going to bathe my mom.

Tom may also have felt the need to have female relatives provide care for his mother as a way of helping her to “do” her own gender. By providing his mother with personal care such as bathing, Tom would perhaps have caused discomfort due to his mother's gendered expectations of herself and of him. The DDCs may have sensed a need to protect and reinforce the gendered expectations of the care recipient.

Gendered Expectations and Gendered Exemptions

The participants experienced gendered expectations and gendered exemptions from many sources, such as family members, the health-care system, and even themselves. Being a nurse as well as a son added another dimension to typical familial caregiving. The DDCs felt pressure to provide care beyond the traditional expectations of male family members. At times they felt obligated to fill the gaps left by other family members, which resulted in resentment and anger. John observed that the increased

family expectations he experienced were due to his being a nurse; thus familial expectations became intersected with expectations related to his status as a member of the nursing profession:

When Mom got really ill, my father couldn't handle it. My sister couldn't deal with it. Dad would ask, "Can you come and help me bathe her?" "Okay, Dad, I'll be right there." How do you think I felt about bathing my mother and resenting the fact that my sister wouldn't help me? I remember when my dad got sick — he had cancer — and my sister wouldn't help with that, nor my brothers, because "You're a nurse — deal with it." When he got sick I had to bring him into my house and I had to deal with it all.

The uniqueness of the male DDC experience was shaped by the interface between gendered expectations and exemptions. As explained by Darren, this entwining of expectations as a nurse and as a son led to confusion and frustration:

You provide care to family members and that's just the way it is, whether you're a nurse or you're not a nurse. I think it's the expectation in life, but because I'm a nurse, then I'm the one who's qualified and therefore should do it. I'm constantly having to tell people, "You know, it doesn't take . . . a nurse to be able to make somebody a sandwich or bring them food."

The participants had some control over the expectations and exemptions they encountered when delegating and teaching care tasks. They used their gender status to exempt themselves from certain tasks. Their gender status within their family network exempted them from "female" tasks. However, their status as a nurse meant that they were often expected to provide care that fell within "female" gender norms. As male DDCs they apparently had the advantage of being able to choose when to be a nurse and when to be a family member, and they often acted on the gendered expectations or exemptions associated with each role. The concept of choice is best illustrated with respect to the managerial role of male DDC, as the participants chose which aspects of care to become involved in and which to be exempted from. Although the concept of choice and control may have advantaged these male DDCs, tension frequently arose when they negotiated the intersection of being a male family member and being a male nurse, and this tension could lead to a lack of control and ultimately negative personal health experiences.

Personal Health Experiences

The personal health experiences of the participants were central to their overall caregiving experiences and were shaped by the determinants of care. They were able to use their professional knowledge and training to

manage any negative personal health effects and prepare themselves for familial caregiving:

I guess you just have to figure it out. Being in the psychiatric end of it — with stress — with all the training that we've gone through, we all know stress can cause a lot of problems, so it's best to try and minimize any types of stress. (Jacob)

However, even though their backgrounds may have prepared them for familial care, they still experienced stress when providing health-care support to family members:

As a nurse it's rewarding caring for people, so it sort of continues on from your job and it's a rewarding although a frustrating experience, as it can be at work. You feel the pressure, too, because you're the knowledgeable one and so family sort of looks at you as the one that has the right answers for things. (Mike)

Although the participants appreciated the sensitive nature of being a DDC, the expectations they experienced often greatly changed the dynamics of their social relationships. George used the metaphor of “stepping in a minefield,” with everyone watching and expecting him to deliver. He had to be cautious in navigating his way:

It feels a lot like first-year clinical when your preceptor is watching you, over your shoulder, except that there's a lot more emotional hooks. So you're kind of stepping in a minefield, especially in my role as the son-in-law. I guess that's kind of unique, but I would think it's the same thing as a daughter-in-law working on a relative. It's kind of like dancing through a thorn bush — you have to be really careful because the things you see coming, you have to negotiate how you're going to present them to the family.

The DDCs tended to focus on the health of their family member at the cost of their own health. For instance, Ralph described how he would ignore his own health when providing care to his mother. He felt pressured to be a family caregiver and a working nurse simultaneously. The multiple expectations made him feel that he was burning out and not fulfilling all of the roles expected of him:

You ignore your personal needs and, unfortunately, your immediate family needs . . . working all those shifts because you still have to pay the mortgage or this or that. So if you can fit everything in and still get it done in a day, I'll work and do that and I'll do everything else. . . . emotionally, for the health of myself and my family, I would have been better off [taking] a leave of absence, with or without pay. I think nurses have to be

careful, because if you're everything to everybody all the time you're burning a candle from both ends sometimes and it's a tough balancing act.

The participants believed that nurses are always expected to provide care. The expectations associated with nursing constantly shape the life experiences of all nurses, including familial care experiences. Ralph likened the caregiving experience to a rollercoaster ride, with crises and periods of calm. During the crises he would be aware of the effects on his health but not be able to address them. Only upon reflection was he able to see the stress he endured and the health consequences he suffered:

When you're in an acute thing, and my dad's illness ran for 3 years, it's like a rollercoaster, so you run for 6 months and then . . . you'd be really busy for a while and in your busy time you notice you're run down, weight loss, blood pressure would go up, things like that. When things would smooth out you relax a little bit more, back to normal. You fool yourself into thinking it's normal and wait for the next wave or the next high point down the rollercoaster or whatever. . . . But 3 years ago when my dad wasn't doing well it was very hard, it's very hard to cope. People are very generous, you take a lot on yourself, you feel this obligation and it's a lot of work at the time, but later it comes out . . . you don't realize the stress you were under until a year later, 3 years later.

As male DDCs, the participants appeared to be in an advantageous position with respect to familial care. However, they constantly felt pressured to attend to the needs of others while disregarding their own health. When they finally took note of the toll on their health, they tended to either cope with their concerns or simply deny their existence.

Discussion

Three main insights can be gleaned from the findings of this research. First, the caregiving experiences of male DDCs are shaped by the determinants of care: familial responsibility and relationships, nursing knowledge and skills, and access to resources. Consistent with other findings (Bedard, Koivuranla, & Stuckey, 2004; Marshall, 2006; Pavalko et al., 2007; Ussher & Sandoval, 2008), gender and social norms shaped both expectations and exemptions in the provision of care. In line with the findings of Matthews and Heidorn (1998) in their study with brother-only siblings, the participants, as male DDCs, tended to engage in tasks based on traditional male roles, such as yard work or home maintenance, while delegating tasks that are considered "women's work" to female family members or formal services. However, the care provided by these male DDCs was shaped by additional factors, such as the knowledge and resources afforded by their profession. Specifically, their nursing knowl-

edge and skills affected their typical filial responsibilities. As members of a feminized profession, these male familial caregivers were sometimes expected to perform tasks traditionally viewed as female. The addition of the nursing role to their filial role transformed the gendered expectations and exemptions associated with their familial care.

Similarly, the participants' access to health-care resources affected their familial relationships. As male nurse in the family, the participants typically adopted a managerial role and became responsible for all aspects of care. They were able to do this because, as male nurses, they could call upon a multitude of resources and strategies, including the delegation of care tasks to other family members. Consistent with findings reported in the literature (Ingersoll-Dayton, Neal, Ha, & Hammer, 2003), conflict within sibling relationships appeared to emerge and change as a result of inequities, specifically in relation to the power associated with task delegation. The participants, as male DDCs, tended to manage and control the activities of care. These coexisting determinants of care entered into their own health experiences. Caregiving is a complex process, with many factors playing a part and shaping the health of caregivers. All caregivers cannot be treated the same: The uniqueness of the care provided by male DDCs and other caregivers must be acknowledged and appropriate support offered by means of community and workplace initiatives. Specific workplace policies must be put in place to address the needs of employed caregivers such as DDCs.

The second insight gleaned from this study concerns the interface between expectations and exemptions associated with double-duty caregiving. Although caregiving expectations and exemptions are well documented, few studies have acknowledged their simultaneity and the coexistence of multiple caregiving expectations or exemptions. While Matthews (1995) uses the concept of legitimate excuses to highlight the exemptions experienced by caregiving sons, the present study reveals how expectations and exemptions associated with the nursing and filial roles of male DDCs are intertwined and experienced simultaneously. The male DDCs used the expectations that guided their actions to determine the consequent exemptions, and exemptions similarly guided expectations. For example, when they lived up to their caregiving expectations related to nursing, the male DDCs would exempt themselves from some of their filial care expectations. Thus, not only did expectations and exemptions occur simultaneously, but the DDCs appeared to at times control and determine movement between expectations and exemptions — to their advantage.

Future research could further examine the coexistence of gendered expectations and exemptions and its role in health experiences. Specifically, investigations that focus on the gendered power relations

associated with controlling and delegating familial care may help to identify and address potential health and care inequities.

The third insight gleaned from this study is that male DDCs experience both gendered advantages and disadvantages. The participants were able to use gender as a resource, which allowed them to choose which “gendered” care tasks to take on themselves and which to delegate. However, although their nursing background afforded advantages with regard to resources and skills, they were disadvantaged in terms of conflicting expectations, which ultimately caused them to lose their sense of control. For example, at times siblings would step back from making a filial contribution because the nurse in the family was seen as the ideal caregiver. Similarly, it became incumbent upon the male DDC to ensure that the gendered expectations of the care recipient were met. The DDCs’ nursing background intensified caregiving expectations and challenged the exemptions they typically experienced as sons. They consequently encountered coexisting gendered expectations and exemptions, which simultaneously advantaged and disadvantaged them. Thus the advantages and disadvantages encountered by the participants were often influenced and shaped by social gender norms constructed in their everyday social interactions.

Gender is not viewed as an individual attribute based on the dichotomous understandings of men and women, but, rather, is defined as one of the social determinants of health (Raphael, 2009), which creates inequities within multiple social contexts (Keheler, 2004) and cuts across all aspects of social life (Raphael, 2009). According to Deutsch (2007), since gender is “done” or constructed, it can also be “undone” or deconstructed. Theoretical development aimed at deconstructing gender norms could help to address some of the challenges and health compromises faced by caregivers. Additionally, it should be recognized that the social construction of gender is complex and is shaped by other social relations, such as culture and sexual orientation. For instance, the health experiences of homosexual male DDCs may be different from those of heterosexual male DDCs. Further research into the gendered expectations and exemptions of male DDCs representing various sexual orientations is warranted.

Conclusion

This qualitative secondary analysis explored the caregiving and personal health experiences of male double-duty caregivers. Determinants of care were found to play a role in the gendered expectations and exemptions experienced by male DDCs. Some participants reported negative health experiences at the intersection of the gendered expectations and exemp-

tions associated with their roles as nurse and as son. A number of implications for health-care policy and practice, research, and theory development have been identified. Health and social services as well as workplace policies need to be refined if they are to support the growing number of family caregivers. Research that links professional and familial caregiving would have the added value of increasing our understanding of employed caregivers, specifically how double-duty caregiving plays a role in health experiences and care provision. Finally, theory development should aim to deconstruct the gender ideologies associated with caregiving. Challenging gender ideologies within caregiving and their associated social norms would help to ensure that responsibility for the health of both family caregivers and care recipients is assumed by society as a whole rather than by family caregivers alone.

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