Listening to Caregiving Sons: Misunderstood Realities

Phyllis Braudy Harris, PhD

Traditionally, the responsibility of caring for elderly adults has fallen on women, mainly wives and daughters (Abel, 1991; Brody, 1990; Horowitz, 1985). Even in the last two decades, as women have entered the workforce in unparalleled numbers, their commitment to caring for elderly family members has not decreased (Brody, Klaben, Johnsen, Hoffman, & Schoonover, 1987; Scharlach, Low, & Schneider, 1991). Yet there are men who are also involved in providing care to their elderly family members, going against traditional gender roles. Male caregivers are fewer in number, but also appear to be committed to their caregiving responsibilities (Harris, 1993; Harris & Bichler, 1997; Kaye & Applegate, 1990a; Montgomery & Kamo, 1989; Motenko, 1988).

Gender roles have been studied as an issue in caregiving since the early 1980s, but only recently have researchers expanded the focus of their studies to include men in caregiving roles (Arber & Gilbert, 1989; Kaye & Applegate, 1990a, 1990b). Arber and Gilbert (1989) estimated, based on the 1980 General Household Survey, that over one third of coresident caregivers are men. Stone, Cafferata, and Sangl (1987), using data from the 1982 National Long-Term Care Survey and Informal Caregivers Survey, found that 28% of caregivers were men. Their finding is supported by the National Alliance for Caregiving–American Association of Retired Persons National Family Caregiving Survey (1997). Most of the studies of male caregivers have focused on the role of husband caregivers, who, according to Stone and colleagues, comprise 13% of all caregivers. Husbands make up 36% of spousal caregivers (Stone et al., 1987) and provide long hours of consistent and dependable care for their wives (Chang & White-Means, 1991; Johnson, 1983), often without assistance from others (Kaye & Applegate, 1990a; Stone et al., 1987). Yet there are sons who are also actively involved in caregiving. Studies that make the distinction between primary and secondary caregivers have found that sons comprise 10–12% of primary caregivers and 52% of secondary caregivers to elderly adults (Stone et al., 1987; Tennstedt, McKinlay & Sullivan, 1989). Demographic and social trends, such as the growing elderly population, smaller average family sizes (resulting in fewer siblings available for elder care), greater sibling mobility, and changing gender roles, point to the probability that a growing number of sons will become caregivers to their elderly parents.

But what do we know about the caregiving experiences of sons? Research on sons has been limited, and survey research has focused primarily on gender task differences between sons and daughters. Horowitz (1985), in her sample of 32 sons, found that sons became caregivers only in the absence of available female caregivers; that sons were more likely than daughters to rely on the instrumental and emotional support of their spouses; and that sons provided less overall assistance, especially hands-on assistance, to their parents. Sons, though, are just as likely as daughters to provide financial and emotional support to their parents and to share their homes with parents. Montgomery and Kamo’s (1987) study of 64 sons, Stoller’s (1990) study of 60 sons, and Dwyer and Coward’s (1991) large multivariate comparison of 13,000 sons and daughters all found that sons provided intermittent assistance with occasional tasks, but were less involved in routine household chores than daughters were. As the parent’s level of functioning worsened over time, sons dropped out of the caregiving role. Chang & White-Means’s

In-depth interviews with 30 sons actively involved in caring for a parent with dementia expand the understanding of sons’ caregiving experiences. The within-group analysis revealed common themes that emerged from the narratives—duty, acceptance, taking charge, common emotions, and work flexibility—as well as common issues—loss, sibling relationships, role reversal, coping strategies, and positive outcomes. The interviews also generated a typology of son caregivers that included such types as the dutiful son, the son who goes the extra mile, the strategic planner, and the son who shares the care.

Key Words: Male caregiver, Alzheimer’s disease, Family relationships, Gender issues.
(1991) findings also support gender differences in the type of care provided, but in contrast to the other studies, did not conclude that men took on the caregiving role primarily because no one else was available. Based on the informal caregivers surveyed by the 1982–1984 National Long-Term Care Demonstration, Chang & White-Means concluded that, on average, male and female caregivers had the same number of other caregivers to help them on a regular basis. Lee, Dwyer, and Coward (1993), in one of the few studies on adult children caregivers that goes beyond gender role expectations in discussing reasons for task differences, examine same-gender preferences of the older adults and strength of kinship ties as possible variables. They propose that mothers do not select sons as primary caregivers because of their concern for modesty. These studies illustrate task differences between sons and daughters as caregivers, but do not provide an in-depth understanding of sons’ caregiving experiences.

Qualitative research on husbands has expanded our understanding of men’s caregiving processes and has demonstrated more variability among husband caregivers than previously reported. Such research has found that men orient to the caregiving process in different ways: from roles learned at work, out of a sense of duty, out of love, or as part of being a team with their ill wives (Harris, 1993; Harris & Bichler, 1997). Husbands feel a sense of satisfaction, personal achievement, and pride in their ability to care for ill wives, but they also experience a sense of despair (Motenko, 1988; Harris, 1993). Husbands experience social isolation and loss on multiple levels: loss of companionship and sexual intimacy, loss of former identity, and loss of control (Harris, 1993; Harris & Bichler, 1997; Motenko, 1988; Vinick, 1983). Caregiver stress is felt strongly by some men, particularly those in a “transition phase” of caregiving—husbands whose wives have been diagnosed with dementia recently or are moving into a new stage of the disease (Harris, 1995; Harris & Bichler, 1997). Some studies found men adapt a stereotypic stoic demeanor while others found men experience a fuller range of emotions caring for their ill wives, including love, despondency, frustration, and anger (Davies, Priddy, & Tinklenberg, 1986; Harris & Bichler, 1997; Motenko, 1988; Vinick, 1984). Quantitative research presents a more unidimensional, less complex picture of husband caregivers, indicating that they fare better emotionally, have lower caregiver burden (Barusch & Spaid, 1989; Fitting, Rabins, Lucas, & Eastham, 1986; Horowitz, 1985), have higher morale (Gilhooly, 1984), and are motivated more out of a sense of obligation than women (Pruchno & Resch, 1989; Fittings et al., 1986). Qualitative research has helped to further researchers’ understanding of the process of caregiving from the husband’s perspective.

However, gerontologists lack in-depth knowledge regarding sons in their caregiving roles. In order to obtain a clearer picture of caregiving sons, it is necessary to go beyond the focus on gender task differences of previous research and study son caregivers using a qualitative approach. To extend the knowledge about son caregivers, different questions need to be asked, such as: What is it like for a son to take on a major caregiving role? How does he adapt to and cope with his new role? What are his motivations for taking on this role? And what meaning, if any, does he derive from it? This study seeks to answer these four research questions about son caregivers, and attempts to give sons the opportunity to explain their caregiving experiences in their own words, to share their reflections on their changing roles. In previous caregiver research, the emphasis on comparing sons and daughters and the tasks they perform for their parents has lost the holistic understanding of how sons give care and the variability within that group. Sons may be dealing with unique caregiver strains due to gender socialization expectations that have limited their prior nurturing experiences, repressed their expression of emotions, and restricted the development of close friendships.

This study seeks to broaden the understanding of and provide perspectives on son caregivers, as well as to extend the qualitative research on men’s nurturing caregiving experience to include sons. When some of the issues and particular stresses faced by caregiving sons are better understood, services more sensitive to their needs can be designed.

Methods

Because so little is known about the day-to-day experiences of sons in caregiving roles, a qualitative research approach was chosen to gain insights into the issues and concerns sons face. This in-depth method will aid in identifying commonalities and differences within the sample of son caregivers. Findings from this study can identify some of the issues that need to be evaluated further by larger caregiver studies.

Sample Selection

A nonrandom, purposeful sample (N = 30) ensured the inclusion of a range of different types of son caregivers. The demographic characteristics that were included in the sample selections were race/ethnicity; providing care for parents in the early, middle, and late stages of dementia (based upon sons’ descriptions of parents’ symptoms and behavior); work status; marital status; being only children or having siblings; geographic location of siblings (in or out of town); socioeconomic status; and living arrangements of parents. The sample included sons who were primary caregivers (n = 13), as well as sons who were helping well parents care for their ill spouses (n = 17). The term secondary caregiver does not accurately reflect the extent of this latter group’s commitment and level of care. Such sons were secondary caregivers because their well parents were still living with their ill parents or their ill parents had moved into nursing homes, but these sons often saw their ill parents on a daily basis to assist in their care. For that reason, the terms primary caregiver and secondary caregiver are not used in
this article; rather, these men are all described as sons actively involved in their parents’ care. The caregiving tasks in which the sons were involved varied depending on the family situation and needs of the ill parents. Some of the sons provided hands-on, personal care to mothers or fathers, that included tasks such as bathing, dressing, cooking, and feeding. In instances when a healthy parent provided more of the hands-on care for the ill parent or when the ill parent had moved to a nursing home, the son provided emotional support, companionship, assistance in feeding, respite care, financial advice, transportation, and information seeking and advocacy functions. The parents of six of the sons had died within the year prior to the interviews, but the sons vividly recalled the active roles they took in their parents’ care. All of the sons were involved in the decision-making process for their parents, and many took leadership roles in their families.

The Cleveland Area Alzheimer’s Association chapter provided access to families for this study. Through placing ads in the chapter’s bimonthly newsletter, reviewing helpline calls received over two 3-month periods, and contacting support groups and other programs, the author recruited 30 sons who were caring for a parent with dementia. The sample ranged from sons who had made one call to the Alzheimer’s Association Helpline or just received the newsletter to a son who was a member of the chapter’s Board of Trustees.

Demographic Profile

The mean age of the son caregivers was 50 years. They ranged from a 32-year-old, White stockbroker who had cared for his mother with Alzheimer’s disease at home for 10 years to a 71-year-old, semi-retired, African American real estate agent whose 96-year-old mother had just entered a nursing home after a major stroke.

Seventeen percent of the sons were African American and 83% were White. Most of the sons were college graduates, but 26% were blue-collar workers. Participants were predominately middle class, with much income variation within that group. The sons’ occupations were diverse; sons were employed as construction workers, postal carriers, teachers, artists, college professors, sales representatives, business executives, and entrepreneurs. One son was unemployed and on disability leave; 23% of the sons were retired (see Table 1).

The majority of the sample (77%) had siblings, and most of the sons had sisters. Forty-three percent of their sisters lived locally, yet the sons were active caregivers. Fifty percent of the sons were the only child living in the same town as the parent, but 8 of these 15 sons had moved their parents to their towns to be near them. Thus, these sons did not take on their caregiving responsibilities because no one else was available. The sample contained relatively equal proportions of only, oldest, middle, and youngest sons. Fifty-seven percent of the sons were Catholic, and 60% of the sons were married.

The sons participating in this study were caring for fathers (33% of the care recipients) and mothers (67%). The average age of the parent with dementia was 77 years (range 63–96 years). The majority of the demented parents were in the early or middle stages of the disease process, based upon the sons’ descriptions of their behavior. Twenty-three percent of the parents were living with their sons, 23% were living in nursing homes, and 27% were living in their own homes.

Data Collection

Instrument Construction.—An interview schedule was developed using a general interview guide approach derived from the research questions and the literature review. In this type of approach, the researcher outlines a set of major issues to be explored in each interview, but the order and exact wording of the questions vary depending on the context of the interview (Patton, 1980). The topics included in the interview schedule were divided into four main categories, listed below.

1. Role as caregiver—caregiver history, tasks performed, commitment, new roles learned, difficulties, satisfactions, losses, and effect on lifestyle and work
2. Stress and coping—caregiver burden, coping strategies, social supports, financial and caregiver health issues, and formal service usage
3. Interpersonal and family relationships—relationship with parent(s), sibling(s), wife or significant other, the impact of illness on these relationships, and the role of the son’s children
4. Meaning and motivation—motivations for taking on a caregiver role, meanings derived from the experience, and personal growth

The interview guide was pretested on two caregiving sons, one of whom suggested adding a question regarding the response of service providers to male caregivers; this was added to the stress and coping category.

Interviews.—Data were collected through in-depth personal interviews between May 1994 and January 1995. The interviews lasted an average of 1.5 hours to 2 hours and were conducted at locations selected by the sons. Most of the sons chose locations other than their homes, such as the author’s university office, their own offices, or restaurants and libraries. All of the interviews were audiorecorded and then transcribed and compared with the field notes for accuracy. Sons were contacted by telephone for clarification if there were inconsistencies.

Because the participating sons viewed this interview process as research to help other caregivers rather than as an opportunity to receive social/emotional support, they were willing to open up to the author and to discuss very personal, and often very emotional issues. Once the interviews started, there were rarely breaks in the flow of information.

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### Table 1. Demographic Profile of Son Caregivers

<table>
<thead>
<tr>
<th>Demographic Category</th>
<th>Sons (N = 30)</th>
<th></th>
<th>Sons (N = 30)</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean = 50 yrs</td>
<td>18</td>
<td>60</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td>Range = 32–71 yrs</td>
<td>12</td>
<td>40</td>
<td>20</td>
<td>67</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>8</td>
<td>27</td>
<td>13</td>
<td>43</td>
</tr>
<tr>
<td>Not married</td>
<td>16</td>
<td>53</td>
<td>17</td>
<td>57</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>25</td>
<td>83</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>African American</td>
<td>5</td>
<td>17</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school graduate</td>
<td>13</td>
<td>43</td>
<td>23</td>
<td>76</td>
</tr>
<tr>
<td>College graduate</td>
<td>16</td>
<td>53</td>
<td>17</td>
<td>57</td>
</tr>
<tr>
<td>Advanced degree</td>
<td>6</td>
<td>20</td>
<td>12</td>
<td>40</td>
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<tr>
<td><strong>Employment status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td>23</td>
<td>77</td>
<td>23</td>
<td>76</td>
</tr>
<tr>
<td>Retired</td>
<td>7</td>
<td>23</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
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<td></td>
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<tr>
<td>Blue collar</td>
<td>8</td>
<td>27</td>
<td>11</td>
<td>36</td>
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<tr>
<td>Middle management/sales</td>
<td>6</td>
<td>20</td>
<td>8</td>
<td>27</td>
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<tr>
<td>Professional</td>
<td>8</td>
<td>27</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td>Entrepreneur/business executive</td>
<td>8</td>
<td>26</td>
<td>2</td>
<td>7</td>
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<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under $10,000</td>
<td>2</td>
<td>7</td>
<td>2</td>
<td>7</td>
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<tr>
<td>$11,000–$20,000</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>$21,000–$40,000</td>
<td>9</td>
<td>30</td>
<td>11</td>
<td>36</td>
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<tr>
<td>$41,000–$60,000</td>
<td>7</td>
<td>23</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Over $60,000</td>
<td>12</td>
<td>40</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td><strong>Religious affiliation</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Catholic</td>
<td>17</td>
<td>57</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>Jewish</td>
<td>3</td>
<td>10</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Protestant</td>
<td>8</td>
<td>27</td>
<td>8</td>
<td>27</td>
</tr>
<tr>
<td>None</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>7</td>
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<tr>
<td><strong>Siblings in family</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Son only child</td>
<td>7</td>
<td>23</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td>Has sisters</td>
<td>8</td>
<td>27</td>
<td>7</td>
<td>23</td>
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<tr>
<td>Has brothers</td>
<td>6</td>
<td>20</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td>Has sisters and brothers</td>
<td>5</td>
<td>17</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td><strong>Geographic location of sibling(s)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Son only child in town</td>
<td>15</td>
<td>50</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>Sister(s) in town</td>
<td>6</td>
<td>20</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Brother(s) in town</td>
<td>2</td>
<td>7</td>
<td>2</td>
<td>7</td>
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<tr>
<td>Both in town</td>
<td>7</td>
<td>23</td>
<td>7</td>
<td>23</td>
</tr>
</tbody>
</table>

**Notes:** AD = Alzheimer's disease; I & R = information and referral.
*One respondent retired to take care of his mother.
*Based on sons' descriptions.
*Some respondents chose more than one.
*Attended more than two sessions.

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**Data Analysis.**—The content analysis consisted of a six-step process completed by the author and a colleague (who was not involved in the data collection) with extensive clinical social work experience working with Alzheimer's patients and their families. The author and clinician each read each transcript in its entirety, then reread each transcript a second time to develop substantive codes for each of the 30 narratives, as suggested by Glaser and Strauss (1967). The codes were then grouped into themes that emerged from the narratives and common issues that were identified through the interview guide questions. Then a master list of themes and issues was developed from each interview to allow for easy cross-interview examination. During the fourth step, the author and clinician reexamined each narrative, looking for quotations that summarized the essence of each son's experience as a caregiver. These quotations were compared for consistency with the themes and issues that had been identified for that caregiver. In the fifth step of the analysis, the author and clinician met and compared their separate findings. In areas of disagreement, portions of the transcripts were reread and discussed until agreement was reached.
reached. The final step was a content analysis of the transcripts using features of WordPerfect word-processing software.

Findings

This section is divided into two parts: common themes and common issues. Common themes among the 30 caregivers emerged naturally from the sons’ narratives during the course of the interviews. Common issues were topics identified through the interview schedule that the author used as an interview guide.

Common Themes

Duty.—One of the most common themes among these 30 sons was their sense of duty to care for their ill parents; the sense of filial obligation was paramount in the interviews. Twenty-two of the sons discussed this issue. Many sons used almost the same words, “You got to do what you got to do.” It was a 60-year-old son who perhaps said it most poignantly:

What kept me going was my devotion to her. I saw how they [his parents] treated me over my lifetime, the loyalty they felt. I learned. I learned that’s what you do with family. You don’t moan and groan about them; you take care of them. You do what you have to do.

Acceptance.—Eighteen sons perceived themselves as being more readily able to accept the diagnosis of dementia in their parents at earlier stages in the illness than other family members were. This did not mean that these sons were not upset, but they accepted the reality and started to make plans. One 58-year-old son said:

You remember how sweet and compassionate your mom was and you look at the disease and it’s totally out of character, but you might as well come out of your denial you’re in. You have to recognize the fact that she has a serious problem and begin to help her and help yourself by dealing with it.

Taking Charge.—One of the major roles sons played was that of taking charge of the situation, pushing their families to make the necessary decisions. It was a theme that occurred over and over again in the interviews of 17 sons. A 55-year-old son stated: “There always seems to be a family captain in a situation like this and no one else was doing it, so I just did it. I called a family meeting. And I said, if you want me to take the responsibility, fine.”

Many of the sons viewed taking charge or control of the situation as a natural extension of their roles as sons. However, one of the most frustrating aspects of trying to “take charge” of dementia, as voiced by a number of sons was, “There are no good answers.”

Common Emotions.—Twenty-five sons expressed some combination of these five common emotions: love, pain and anguish, anger and/or resentment, sadness mingled with compassion, and guilt. Fifteen sons also expressed caregiver stress and burden, including all 7 sons who had their parents living with them. One 57-year-old son voiced the experience shared by many sons when he described his emotions as he cared for his mother in the late stages of dementia: “It’s like being on an emotional roller coaster, and in a 24-hour period, you experience just about every emotion known to mankind.”

Another 41-year-old son expressed his feelings about his parents (both of whom had Alzheimer’s disease) this way: “The emotional sense of sadness . . . it’s just overwhelming. I can’t describe it. It’s just so sad to see these very competent capable people—they were so successful.”

One son eloquently expressed his love for his mother in this way:

The last month [of his mother’s life] was really not too good for her. She had her eyes closed and was not responding to very much, but I did get one response out of her. I was telling her one night how much I loved her and I appreciated everything she had done for me in my lifetime. I said, “But more importantly than that, I guess I know more than anything in my life is that you loved me, and that means a lot to me.” And she opened her eyes and tried to talk, you know like confirming what I was saying, and I said, “I know. I understand.” And that was the last gesture of recognition she made.

But the emotions of anger, resentment, and guilt were also present in the interviews. One 46-year-old son admitted his feelings of guilt, saying, “There was never enough time to do what I felt I should have done. I let my mother carry too much of it [the caregiving responsibility for his father], because she was strong, and so in my case I went to the point of the path of least resistance.”

“I hollered at her! I hollered at her! Because she’d forget,” another son regretfully admitted about his outbursts of anger at his mother. And one 35-year-old son voiced his sense of burden and stress, saying, “I’m putting so much in here, that I am losing myself, you know? I’m really losing myself. I’m so stressed out.”

As their words show, these sons experienced a wide range of emotions as they took on caregiving roles for ill parents. They were emotionally invested and involved in this caring process.

Work Flexibility.—A key factor that allowed 14 out of the 23 working sons in this study to participate actively in caring for their ill parents was the control and flexibility they had over their work hours. Because of seniority or the nature of their work, they could take time off during the day to assist their ill parents. One son who headed a family business stated, “I would have to take weeks off to resolve this [problem for his father who had dementia],

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but in my position I don’t need to worry about that because I am covered, but I can see where control over your hours is necessary because there’s no way you can run a job and deal with this at times.”

Over half of the sons participating in this study had some flexibility in choosing the hours they worked.

### Common Issues

**Loss.**—Loss was a common issue acknowledged by 17 sons during the interviews. For some men it was a loss of a person they loved. For others, it was a loss of personal space and freedom or the loss of job opportunities. Some sons experienced combinations of these losses and struggled to overcome their compounded sense of loss. One son put into words what he felt was the most difficult thing for him to deal with in the process of his mother’s Alzheimer’s disease: “I miss the person she was; she was a loss of a person they loved. For others, it was a loss of personal space and freedom or the loss of personal space and freedom or the loss of personal space and freedom.”

**Sibling Relationships.**—Having parents with dementia affected the sons’ sibling relationships. A parent’s illness brought some siblings closer together. They talked more over the phone and saw each other frequently, sometimes daily. One son remarked, “I am talking to my brother more than I ever did before.” In other cases, the tensions brought on by the parent’s illness reawakened old sibling rivalries, often accompanied by a sibling’s refusal to accept responsibility in the parent’s care, pushing the siblings even further apart. One 67-year-old son related this situation:

> Finally I got hold of him [his brother who lived out of town] late one evening and I told him, “I need help.” He said, “Yes, yes, I’ll be there.” Wednesday, Thursday, Friday went by, and I would call him every night. Saturday morning I called him and I said to him, “What in God’s sake is wrong with you? I’ve been asking you to come and help with Mom and you told me you’re gonna come.”

Some siblings were able to put past relationships behind them for the sake of the parent; others could not let go. Only three sons with siblings reported that their relationship seemed unaffected by the experience of caring for an ill parent.

**Reversing Roles**—Sons often expressed difficulty in accepting the fact that they now had to take on many of the roles and tasks that their parents had performed for them as children. The issues of bathing and driving were the most difficult to handle for 16 sons. The driving issue, particularly when the parent was a father, was difficult. Taking the keys away from his father, who had taught him to drive, and creating dependence through that act, was a traumatic event for both father and son. “He hated me, just hated me,” said one 40-year-old son. “He saw me as the bane of his entire existence, the root of all his troubles.”

**Coping Strategies.**—To deal with all of the concerns and issues of caregiving, sons seemed to rely on four major coping strategies: using a problem-solving approach (n = 19), immersing themselves in their work (n = 11), confiding in their wives (n = 10), and finding solace and support in their religious convictions (n = 10). A problem-solving approach was the most common coping strategy used by the sons; similar findings have been reported in husband caregiver studies (Harris, 1993; Miller, 1987; Zarit, 1982). This approach is exemplified by a statement one son made about the method he would encourage other sons to use as they consider placing their parents in nursing homes. “I would encourage people who are definitely going to be faced down the road with a nursing home to start checking them out right now. Talk to other people that have had relatives in nursing homes and just find out what the problems are, and get accustomed to the idea.”

Referring to his approach to dealing with his father’s illness, another son stated, “I did the research, proposed the solutions, and then guided the decisions, but the problem with this disease is there are no good answers.”

One 46-year-old son confided that he used his work as an escape: “Being able to get lost into the pressures of work, work with nothing else to distract you; it’s all consuming. It’s this great sucking tunnel—and if you like it, you don’t pull that hard away from it. You can fill all your available time with work.”

Men in the study relied on their wives or significant others to be their confidants. One man in his early 50s spoke about the important role his wife played in helping him cope with his father’s dementia. Throughout this difficult time and his conflicts with his siblings, his wife had been his main source of support. He stated, “She acted as my sounding board and safety valve when I needed to release some pressure.”

Many of the sons relied upon their strong religious beliefs to help them cope. When asked what helped him cope, one son answered, “My religion more than anything else. I think it reduces stress, because anytime I’ll just go over to the cathedral near my office and sit there for 15, 20 minutes and think about things.” Another son, who was caring for his 96-year-old mother, said, “When things are going bad, I say, ‘Hey, it’ll come and the Lord will guide me whichever way it goes.’”

**Positive Outcomes.**—Yet, as difficult as the caregiving process was for the sons in this study, 11 sons could step back from their experiences and discuss the positive outcomes of caregiving. Sons talked about three positive outcomes: a chance to pay their parents back for their care, a sense of purpose and personal growth, and the importance of being a role model for their children. “Payback” was the phrase that occurred many times in the dialogues with the sons. This was best exemplified by a 60-year-old son who shared these thoughts: “It’s just that I was pleased that I was able in some small way to be able
to pay her back. I think if she had died of a heart attack, I would never have had the chance to say to myself in some small way I had repaid her for what she did. Not that she ever made me feel like I had to, but I did.” Another son exemplified the sense of meaning some sons expressed regarding their caregiving experiences. He stated, “After being in this for a while, you start thinking what is the purpose [in life], and maybe the purpose is giving instead of getting. And so you give in some small way to somebody else who’s important to you.”

One 60-year-old son summed up the thoughts of other sons about being a role model when he said, “I have a responsibility to my father, and I think we all have responsibilities to one another, I guess I am being as responsible as I can in a bad situation. And I think another thing is I am setting an example for my kids. My kids have told me, ‘Dad, you are doing a great job.’”

A Typology of Son Caregivers

Four types of son caregivers emerged from the data collected in this study. Each type had the common characteristics discussed in the Findings, but each also had unique characteristics and behaviors that oriented the men to the new caregiving role differently. These orientations helped them cope with the difficulties of caring for parents with dementia and provided them with direction and a sense of mission as they carried out their caregiving tasks. These four types of son caregivers are the dutiful son, the son who goes the extra mile, the strategic planner, and the son who shares the care.

The Dutiful Son

Dutiful sons felt an overwhelming sense of duty toward their parents, and this feeling was the driving force that motivated them to become involved. Their words and actions expressed their sense of obligation and responsibility, and they integrated caregiving duties into their present lifestyles. They either shouldered total responsibility for their ill parents or were the moving forces that spurred siblings to work together and action to take place. Some of the men in the dutiful son category combined their sense of duty with their love for their parents with dementia; others just accepted this new role as a matter of fact, as one son explained, “Why do I take on this responsibility? I just do it. That’s it.”

Mr. Brown personifies the dutiful son. Mr. Brown is a slender, unmarried, 41-year-old African American. After living out of town for a number of years, he returned home to be near his aging parents. He is a man of strong, complex emotions, and he has a certain philosophical proclivity. He is a systems analyst and recently changed jobs; he had to take a cut in pay, but the new position gave him more flexibility in his work hours. He lives downtown in an old house that he is renovating slowly. His rooms are filled with antiques, a passion he shared with his mother.

His mother is in the middle stages of dementia. She still recognizes him and his sister, but she has difficulty communicating. Mr. Brown has recently moved his mother out of the nursing home where his father had placed her, because his father had not wanted the responsibility of caring for her. She is now staying with neighbors of Mr. Brown who live across the street. Mr. Brown explained how this living arrangement happened:

My mother was dying there [in the nursing home]. I couldn’t look at her. She was just giving up. I could see it in her eyes. I knew I had to just get her out of there. I was sitting on my back porch one day explaining my situation to a neighbor, not knowing what to do and she said, “Well I’ll help you; I’m not working now. I’ll do it.” This arrangement is a lot better. My sister helps a lot [his sister is a nurse], but since I live so much closer, I will often relieve the caretaker and check on my mother.

As he described his feelings toward his mother, Mr. Brown confided, “My mother nurtured me. She made very big sacrifices for us and she is not going to be here forever. So, I don’t want her to leave this earth and not do my best for her. She made me who I am.”

He offered advice to other sons involved in caring for their ill parents:

Things aren’t always as bad as they feel. The main thing is we all have our ways of accepting it, but the sooner you can accept it, the better you can deal with it. You’ve got to come to that realization. And realize you are not God. You’re going to need people. And it’s just unbelievable some of the good people that have been put into our lives.

The Son Who Goes the Extra Mile.—The sons typical of this group went a step beyond the roles and actions of those of the “dutiful son” group. Sons who go the extra mile have brought their parents into their own households or have moved back to their parents’ homes to deliver hands-on care. They have made multiple sacrifices in their lives to care for their parents and have put their own personal lives on hold. In essence, they have taken on the role typical of a spouse caregiver. They speak of devotion to their parents, as well as an overwhelming sense of duty and of the guilt that would have surfaced had they not taken on this role. Like husband caregivers (Harris, 1993), they mention feelings of social isolation, but they acknowledge the stress more openly. They use little outside help; they care for their parents by themselves or in conjunction with their siblings. Interestingly, the six sons who fell into this category all had Catholic upbringings, and five were still quite religious.

Mr. Giavonni is a good example of this type of son caregiver. He is a 57-year-old, White marketing executive with a very business-like manner. He is an only child, and he and his wife returned from the Western United States to care for his 81-year-old mother. She had been diagnosed with multi-infarct...
dementia, and each of a series of strokes has left her increasingly impaired, both physically and cognitively. He always knew that when the time came, he would assume the responsibility for her care. Mr. Giavonni stated simply:

My mother has a need, and I will do it for her. I think there is a time and place when you do it. At least that's my feeling and maybe my Catholic upbringing. We [he and his wife] were at a point when we had to make some commitments and help my mom, her urgency was critical and a priority. We decided to move back. We wanted to give her every opportunity to have as normal a life as possible.

He explained it had been a time in his life when he could make a life change. His children had finished college, so he sold his business, and he and his wife moved into his mother's home. Because he did not have any business contacts in his new location and his marketing career would not allow him the flexible hours he needed to provide care to his mother, he has started a new career in porcelain and Formica repair, which he can operate out of his home.

Mr. Giavonni provides total care for his mother. He says:

I'm her chief caregiver. We get up around eight o'clock and I lift her out of bed and put her on the toilet. Then we come in and have breakfast, take her back and give her a complete sponge bath and brush her teeth. Then I bring her into the living room or do some exercises. When she watches TV or dozes off, I clean things up. I get her completely dressed after lunch. I'm with my mom seven days a week.

He is the only one his mother would really allow to care for her. As Mr. Giavonni remarked, he has reversed roles with his wife, who stayed home to care for their children. His relocation has resulted in sacrifices for his wife, who continued her career and her marketing career would not allow him the flexible hours he needed to provide care to his mother, he has started a new career in porcelain and Formica repair, which he can operate out of his home.

Mr. Giavonni provides total care for his mother. He says:

The Strategic Planner

These sons orient to their caregiver roles by using the management and planning skills they acquired in their work worlds. The central theme of their intervention was their strategies and plans for obtaining care for their parents. They took charge, which was reflected in their words and actions. The parent's care became a special project to oversee, but one with which they were emotionally involved. A son of this type stated, "As I keep a file of all the other projects I work on, I keep my father's file on my desk and work on that daily also."

Mr. Malloy is a White, tall, physically fit, married man in his early 50s, and his demeanor shows traces of his military background. He recently took advantage of an early retirement offer from his company to start his own business. He is one of three sons from a large family of seven children. His father is moving into the middle stages of Alzheimer's disease, but is still living at home with his wife and receives much support from Mr. Malloy, his other children, and his grandchildren. It is a very supportive and devoted family: Mr. Malloy moved his parents across town into a condominium he owns to have them closer to him and visits them daily.

Soon after his father's diagnosis, Mr. Malloy became the main planner of his father's care. He asked his mother to write a letter to the other family members suggesting he take on this role because of his management expertise and close proximity to his parents. Mr. Malloy explained:

I suggested this to my mom early on. All my siblings suffer from the same frustration of, how do we deal with this thing? How do we help Dad? They do what they can, but they don't have the accessibility that I have or the knowledge of how to get things done. I am in the process of modifying the bathroom and I've been attempting to hire a person to come and help bath my father. There is a waiting list, and what I have done, I've picked one intake screener at the agency and I leave her a message every two days. I say, "Hi, how are you today? I don't think you probably have any change, but our need is just as critical as it was before and I just want to give you an update."

Mr. Malloy works with his mother "to plod her along," as he says, so she can see what needs to be done next. He stated:

I sat down with my mother and explained to her what needs to be done. I'm trying to plod her along to make some decisions and once they're done, go on to the next one. The issues down the road are obviously a nursing home with an Alzheimer's wing. How do we do that? How do we get on a waiting list? Whether they are willing to take that step? I think though, it starts with me, because I asked for that responsibility.

The Son Who Shares the Care

These were the sons who, as teams with their wives or other siblings, "shared the care" of demented parents. They were equal partners in the provision of care and the decision making; sometimes partners...
providing hands-on care and at other times supportive services. The two family members often brought complimentary skills to caregiving and often completed each other's sentences. Each person was aware of and acknowledged the contribution his or her "partner" made to the care of the ill parent.

Mr. Irvine, who is an example of this type, is a tall, African American man in his late 50s with a quick wit, a wonderful sense of humor, and a panache for telling stories. He has held a number of jobs over the course of his life, from security guard at a large corporate headquarters to owner of a clothing store. He is an only child, and as his mother's Alzheimer's disease became progressively worse and there was question of her safety, he brought her from her home in the South to live with him and his wife. As a child, he had promised his mother that he would care for her when she grew old, and he was determined to honor that commitment out of love and duty, even though his mother fought the move all the way.

His wife was involved from the day he drove his mother from her home in Alabama straight to his home in Ohio. Mr. Irvine described it as a very harrowing ride; his mother became more and more agitated as she saw the signs to Cleveland. She said to him, "If I wanted to go to Cleveland, I would have driven myself." He admitted:

I finally said, "Dammit Mother! If you don't shut up!" She pulled herself up in her seat and said in that voice, "I remember a time when kids respected their elders!" I knew I had better be quiet and thought, "The Lord's gonna get me now."

When I got into town, I pulled my car into my fiancée's driveway [Mr. Irvine and his wife were engaged to be married at the time]. I got her out of the car and told my fiancée, "My mother's outside. If you want her, go and get her, because she is driving me crazy. I can't stand it. I have to go home and get some sleep." She took her out the car and kept her that night for me.

Mr. Irvine reflected back on the role his wife played throughout the 5 years they cared for his mother in their home. He stated:

The relationship with my wife to the present time has been one of two people coming together and shouldering responsibility. When I am not at my best, my wife is. It's like having an alternator on your car to take care of the pressure when the battery is getting low. Once you get it started, now you have to keep it running. That's the effect my wife has on me.

Discussion

This analysis, which focuses on commonalities and different caregiving orientations that emerged from the 30 interviews, illustrates the complexities and diversity among sons caring for parents with dementia and demonstrates the need for more in-depth within-group analyses.

However, this study has many limitations. The information is based on interviews with 30 middle-class sons who have accepted the responsibility for caring for a parent with dementia. These men identify themselves as having been involved in the caregiving process; they may indeed represent a unique group of sons. Also, the sample is biased toward service users. This study uses a cross-sectional collection of data to examine a dynamic process such as caregiving, and, as a preliminary investigation, it did not conduct repeated interviews to verify participants' perceptions. And a small group of the sons' parents died within the year prior to the interviews, which could affect these sons' recall of details surrounding their caregiving experiences.

Yet the voices of these sons emerge from this qualitative research. This article provides a more in-depth, diverse, and complex understanding of son caregivers than has been previously reported. This study increases researchers' knowledge of the effects of the caregiving process on sons and therefore advances the research on male caregivers. It also has implications for future research and practice.

As discussed earlier, a review of the previous research on son caregivers (which primarily compares sons with daughters), indicated that sons are seen as somewhat reluctant, intermittent caregivers who become involved only because no one else is available (Dwyer & Coward, 1991; Horowitz, 1985; Montgomery & Kamo, 1987; Stoller, 1990). However, this study contradicts some of these findings and shows that there may be more variability among son caregivers than previously reported. Sons in this study were committed to caring for their ill parents and were motivated out of a sense of love and/or obligation that did not depend upon the availability of a sister. These sons were the ones providing the care, and they oriented to their caregiving roles in different ways. The role of most of the sons' wives was to support them emotionally.

Other studies have shown men (husbands) fare better emotionally than women as caregivers (Barusch & Spaid, 1989; Fitting et al., 1986; Horowitz, 1985). However, this study demonstrates the degree of emotional and caregiver stress that sons feel when caring for demented parents. Twenty-five of 30 sons demonstrated a wide range of emotions. Though this study cannot compare men and women as caregivers or discuss their respective emotional responses, it does clearly illustrate that the gender stereotype of "the stoic man," may not always be the norm.

The previous studies also defined most of the participating sons as secondary caregivers. This study does not categorize the men as primary or secondary caregivers; rather, based on their narratives, all sons are described as actively involved in the caregiving process. An effort was made to discontinue the gender construction that defines men's caregiving roles as mostly secondary; instead, the data were used to define their actual caregiving activities, because gendered assumptions can obscure men's actual caregiving contributions. Even the sons (n = 17) who had well parents living with their demented parents or who had parents in nursing homes did not easily fit...
into the definition of “secondary caregivers,” defined here as caregivers providing a supplementary pattern of assistance, who are not regularly involved in care, and who more often provide intermittent help (e.g., shopping, transportation, financial assistance, and home repairs; Tennstedt et al., 1989). These 17 sons provided hands-on care, often feeding, dressing, and toileting their parents and providing emotional support, activities they would not be expected to be involved in by virtue of the image of the “secondary caregiver.” Thus, by not conforming to the accepted jargon and by examining sons’ roles more fully, the variability and depth of the male caregiving experience can be observed more clearly. Therefore it is important for researchers to define the extent of the caregiving involvement carefully and not to assume that sons are just secondary caregivers.

As mentioned earlier, the parents of a small subsample of the sons (n = 6) had died during the year prior to the interviews. As one might logically think, given the impact of a parent’s death, these sons’ responses and experiences could be affected and thus color the recall of their experiences; however, this did not appear to occur. These sons represented all four types of the typology, and they expressed no more guilt, love, resentment, anger, sadness, or compassion than any of the other sons within their respective types. The only common theme among these six sons was that they appeared to feel more at ease in expressing their emotions, as if grieving gave them legitimate social approval to express their feelings more freely and deeply. This lack of distinction between the sons with living parents and the sons whose parents had died may be due to the “loss of self” associated with demented patients, as noted by other researchers (Cohen & Eisdorfer, 1987). Therefore, the demented parent is no longer who he or she once was; thus, the sons whose parents had not yet died may have already begun a less intense grieving process.

Work commitments were beneficial and acceptable escapes that helped the men cope with the caregiving process. Unlike most caregiving research, which argues that competing roles add stress to the caregiving relationship (Brody, 1985), this study supports Stoller and Pugliesi (1989), who concluded that other roles could act as buffers for the stress and bolster the caregiver’s self-concept and well-being.

This study also confirmed previous findings that indicated that sons were as likely as daughters to provide emotional and financial support and to share their homes with parents (Montgomery & Kamo, 1987). In addition, the problem-solving approach as a positive caregiving coping strategy supports the findings of other caregiving research (Miller, 1987; Zarit, 1982). Further, this study supports other caregiver studies that have found that there are positive gains associated with the caregiving experience (see Kramer, 1997, for a review of this literature).

This qualitative research on sons goes beyond a discussion of gender task differences and begins to examine sons in the nurturing role of caregiver. However, these findings raise more questions than they answer. There are many more questions about son caregivers that need to be addressed, including:

- What motivates certain sons to assume caregiving responsibility, while other siblings are unmotivated?
- What roles do social class and ethnicity play with son caregivers?
- What role does religion play for caregiving sons?
- Would the typology of son caregivers hold true if the study were replicated with a larger sample and/or parents with another illness besides dementia?
- How different are the caregiving experiences of sons and husbands?

This study offers a starting point for future research by suggesting variables and issues that need to be considered.

**Practice Implications**

The interviews described in this article offer some service and program suggestions that should be considered by practitioners as they explore the needs of the son caregiver population. Service suggestions break down into four major areas: (a) information, (b) care management, (c) support, and (d) respite. The sons were most often the information gatherers for the family, the ones who initiated the plans and implemented the decisions, and thus they were interested in educational services rather than social support groups. The sons spoke consistently of the need for up-to-date information. A simple guide book that would summarize the major terms used in dementia care, list the service options, and explain how to evaluate the quality of services was very much in demand. Sons also wanted information on Medicare, Medicaid, power of attorney, and living wills. Workshops and literature on these topics held great interest for these men.

Sons without any prior caregiving experience often found themselves taking over the enormous task of managing their parents’ every need. Sons, like most other caregivers, also found themselves dealing with health care and social service systems that were confusing, expensive, and difficult to access. A written care management plan detailing the strengths of the family unit, the problems or goals that need to be handled in the parents’ dementia care, specific tasks that need to be accomplished to handle the problems, and ways to delegate specific tasks to various family members would be of much help to these son caregivers. It would place the information in a format similar to plans encountered in their world of work.

Sons, in general, did not have strong friendship networks. Many confided in their wives or significant others, but they did not have any other outlets for the multitude of feelings with which they were dealing. Sons expressed that work was a place they went to escape their caregiving concerns, so it was not a place they shared emotions with others. They did not have time for or feel comfortable in traditional
support groups. Therefore, for sons, a computer network with a listserv specifically for son caregivers might provide a unique opportunity for them. Such a listserv could provide them with an emotional outlet without having to identify themselves, with a chance to expand their friendship network to other people who understand their situation, and with helpful caregiving hints and the most up-to-date information. Such a computer-based support center has been developed for all caregivers (Smyth & Harris, 1993).

Finally, sons reiterated the need for more affordable, flexible, high-quality respite services. The availability of respite care was a critical issue that influenced whether they could keep their parents living in the community, because most of the sons who participated in the study were working. The sons especially needed adult day care that had extended hours and could provide weekend services. Vacation care was also needed. Such services must be developed to further aid and encourage caregiving sons.

Gerontologists and health care professionals need to expand their understanding of the roles of sons as caregivers. They must listen to sons' concerns, identify sons' strengths, and recognize sons' diversity. Going against gender stereotypes, some sons are deeply involved in caring for a parent with dementia. As the baby boomers come of age, more sons will find themselves in caregiving roles, and services to aid, support, and encourage this care need to be in place.

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