*Examining the support needs of older male spousal caregivers of people with a long term condition: a systematic review of the literature.*

Corresponding author: Anne Fee, School of Nursing and Institute of Nursing and Health Research, Ulster University, Shore Road, Newtownabbey, BT37 0QB Northern Ireland, United Kingdom. Phone: 00 (4) 7097579875

Email: a.fee@ulster.ac.uk

Professor Sonja McIlfatrick, School of Nursing and Institute of Nursing and Health Research, Ulster University, Shore Road, Newtownabbey, BT370QB, Northern Ireland, United Kingdom

SJ.mcilfatrick@ulster.ac.uk

Professor Assumpta Ryan, School of Nursing and Institute of Nursing and Health Research, Ulster University, Northland Road, Londonderry, BT48 7JL Northern Ireland, United Kingdom

AA.ryan@ulster.ac.uk

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Abstract

**Aim**: The aim of this review was to identify and synthesise literature reporting on support needs of older male caregivers, who are providing care for a chronically ill spouse/partner at home.

**Background:** Traditionally, informal caregiving has been perceived as a feminised activity. Consequently, caregiving research has been dominated by female samples, and male caregivers are grossly under-represented. Given the growing recognition of caregiving as a gendered concept, and the rise in number of male caregivers, particularly in later life, the need for better understanding of the needs of male caregivers is important in order to plan effective support for this population.

**Design:** A systematic literature review.

**Methods:** Four electronic databases and grey literature were systematically searched.

**Results:** The systematic search resulted in 3,646 papers, eligibility criteria were applied to the full texts of 104 papers, and eleven papers met the inclusion criteria. Two core themes were identified: the need to maintain masculinity; the provision of social support.

**Conclusion:** Findings suggestthatmen may have a gendered approach to caregiving based on dominant masculine norms. This can be manifested in a reluctance to ask for or accept help and a desire to retain control over caregiving. Findings also revealed isolation and loneliness experienced by older male caregivers, along with a preference for support to address this within a male specific context. It is suggested that healthcare professionals should be cognisant of the male caregiver approach and should have an increased awareness of male caregivers support preferences, and of their own gendered assumptions, in order to provide effective support for this population.

**Implications for practice:** Nurses have a key role in providing family support. Findings from this review suggest that nurses should be aware of the specific needs of older male spousal caregivers if they are to provide effective care and support to this population group.

**Key words:** caregiver, masculinity, support, spousal, gerontological nursing

Summary Statement of Implications for Practice

**What does this research add to existing knowledge in gerontology?**

* The research advances understanding about support for older male spousal caregivers by identifying and synthesising literature reporting on support needs for this population who are under-represented in caregiving and gerontology literature.
* Findings indicate that the provision of support from nurses and other healthcare providers which aligns with dominant masculinity norms may be appropriate for many older male caregivers.

**What are the implications of this new knowledge for nursing care with older people?**

* Earlier identification of support needs of older male caregivers may avoid crises, through appropriate signposting and tailored information using a collaborative approach.
* Given that caregiving is a gendered phenomenon, formal assessment of caregivers should include consideration of potential gender related influences on attitudes to support, such as male caregivers reported reluctance to seek help.

**How could the findings be used to influence policy or practice or research or education?**

* The review draws attention to issues such as ‘gendered assumptions’ about caregiver needs. Addressing this within nurse education may reduce reported stereotypical views of male caregivers from healthcare support providers.
* Findings of this review could inform policy or nurse education by aligning the concept of support for older male caregivers with the concept of support in the wider field of mens’ help-seeking in healthcare.

**Introduction**

There is increasing evidence that older malecaregivers have a different approach to their caregiving role from their female counterparts (Russell *et al.* 2008; Petorious *et al.* 2009; Hong & Coogle 2016) and consequently, may require different forms of support to sustain this role.

A global ageing population (WHO, 2018) and increased prevalence of chronic long-term conditions (WHO, 2018) have been noted in literature. Defined as ‘*conditions for which there is currently no cure, and which are managed with drugs and other treatment’* (Department of Health, United Kingdom, 2012*)*these conditions can include dementia, cancer, heart disease, and Multiple Sclerosis (US National Library of Medicine). Evidence suggests that the needs of caregivers who are caring for older people with chronic conditions are poorly understood and remain largely under-recognised by community healthcare services (Ploeg *et al.* 2017). Moreover, long-term chronic conditions are reported to be a more significant predicator of caregiver burden than short term illness (Garlo *et al.* 2010).

Globally the number of informal/family caregivers is rising (van Groenou & De Boer, 2016). In the United States it is estimated that there are 65.7 million unpaid family caregivers. An increasing number of these caregivers are reported to be male, with numbers rising from 28% in 1997 to 35% in 2018 (Family Caregiver Alliance, 2019). In Europe, the Organisation for Economic Co-operation and Development (OECD) reported that there were more male caregivers within the over 75 age group than any other age (Colombo *et al.* 2011). This finding is also reflected in the United Kingdom with an estimated 6.5 million caregivers, 42% of whom are reported to be male, with the number rising to 59% within the over 85 age group (Carers UK, 2015).

The increase in numbers of older male caregivers is not surprising, since older men are more likely than older women to live with a spouse, (Poysti *et al.* 2012; Stepler, 2016). Evidence suggests that spousal caregivers provide a greater number of caregiving hours, and more intense caregiving tasks than grown up children caregivers (Litwin *et al.* 2014; Tremont & Davis, 2014). Older spousal caregivers have to adapt to the gradual decline of their marital relationship (O’Shaunessey, Lee & Lintern, 2010) and older male spousal caregivers are reported to experience deterioration of their own health (Haley *et al.* 2010), increased loneliness (Pretorius *et al*., 2009), and declining intimacy (Fee *et al.* 2019). Research about male caregivers remains under-developed (Sharma *et al.* 2016; Dickinson *et al.* 2017), with little understanding about the experience of caregiving husbands and their support needs.

Although some research suggests that support measures such as information, training and practical support are crucial for sustaining caregiving within the general caregiving population (Silva *et al.* 2013; McCabe *et al.* 2016; Fernandes *et al.* 2016), these studies have mainly been with female samples, and male caregivers are under-represented in the literature (Dickinson *et al.* 2017). However, it has been reported that male caregivers are less likely than female caregivers to report caregiver strain and burden or have a limited perception of available support (Robinson *et al.* 2014; Greenwood & Smyth, 2015). This raises the question about whether male caregivers’ approach to support is influenced by gender, as suggested by previous research (Morgan *et al.* 2016; Swinkles *et al.* 2019). However, the focus of the current review is not on a comparison between male and female caregivers, in relation to negative outcomes. Rather, that the *approach* of male caregivers should be examined more conclusively. This subtle but important difference has implications for healthcare professionals in terms of how they assess need for support and provide services for older male caregivers.

Research is beginning to recognise gender-related issues for caregivers, and particularly for older male caregivers (Robinson *et al.* 2014; Rollero, 2016). Evidence indicates that even though men and women may have similar caregiving experiences, they tend to have a different approach to caregiving, and a different way of accessing support (Morgan *et al.* 2016). It has been suggested that female caregivers have higher levels of stress, lower levels of well-being, and more depressive symptoms than male caregivers (Akpinar *et al.* 2011; Lee *et al.* 2015; Kim *et al.* 2016). An explanation for this could be that traditionally, caregiving has been dominated by females (Glauber *et al.* 2017), resulting in all female research samples; or that men who have traditional beliefs about masculinity are less likely to admit to feeling burdened in their caregiving role (Baker *et al.* 2010; Hong & Coogle, 2016). Moreover, questions have been raised about the appropriateness of measurement scales, including using the same tool to measure depression/anxiety/stress in male and female caregivers (Sullivan *et al.* 2015; Yousaf *et al.* 2015). These authors maintain that certain tools can be more ‘female friendly’ leading to self-report bias, as female participants may be more comfortable articulating their stress/burden than male participants. This is supported by Seidler and colleagues who emphasise that tools such as ‘The Masculine Depression Scale’ (Magovcevic & Addis, 2008) would be more appropriate with males (Seidler *et al.* 2016). Seidler goes further to raise the issue of help-seeking behaviour with males and poses questions about how best to engage men in support, given their reticence to seek professional help for healthcare (Seidler *et al.* 2018). Findings from previous studies examining male caregivers’ use of support within caregiving have revealed some inconsistencies. It has been reported that male caregivers are reluctant to make use of formal support services, and when they do it is when a crisis has arisen (Milligan & Morbey, 2016). However, there is also some evidence to indicate that male caregivers frequently used formal support (Greenwood & Smyth, 2015). Thus, a need for further research about male caregivers’ use of support is important not only to clarify such inconsistencies, but also to address the lack of studies with all male samples (Dickinson *et al.* 2017).

Based on this emerging evidence it could be argued that there is a need to identify support requirements of older male caregivers as a precursor to meeting these needs. This is especially timely given the rising numbers of male caregivers, reported evidence of gendered care styles (Hong & Coogle, 2016); and the male approach to caregiving (Robinson *et al.* 2014). A recognition of support needs of older male spousal caregivers and a deeper understanding of how they could be addressed is also necessary in order to add to the limited knowledge base in the area, and to develop tailored, sustainable support for this population.

**Aim**

The aim was to identify and synthesise literature reporting on support needs of older male spousal caregivers. The specific research question was: ‘*What do we currently know about the support needs of older male caregivers who are caring for a chronically ill spouse/partner at home?’*. The following definitions were applied for the purposes of this review: ‘*support needs’* refers to the need for emotional, instrumental, and informational resources needed to sustain caregiver well-being within the caregiving role (Ostberg & Lennartsson, 2007); ‘male caregivers’ were defined as men who undertook a primary role, without remuneration, in the care of their chronically ill spouse/partner; ‘older’ was defined as caregivers aged over 65 years as this is the definition of ‘older’ in western societies (World Health Organisation, 2014).

**Methods**

A systematic review of the literature was undertaken in order to address the research question. Thematic synthesis was applied to findings (Thomas & Harden, 2008) due to its appropriateness for synthesising qualitative studies to provide deeper understanding of a research phenomenon from the perspective of participants. Search findings were listed in accordance with Preferred Reporting Items for Systematic Reviews and Meta Analysis (Moher, 2010). The Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) framework guided the reporting of review findings (Supp File 1). The ENTREQ framework (Tone *et al.* 2012) aims to encourage transparency, through a checklist of 21 items to guide synthesis and reporting of qualitative research.

*Search Strategy*

The search strategy was pre-planned and primarily developed for Medline using medical subject headings (MeSH) terms, and text words. Searches that had been adapted for other databases were then conducted on 16th April 2019. The term caregiver included informal/family/unpaid caregivers. MeSH and keyword terms are outlined in Figure One. Electronic databases were systematically searched in April 2019, using the specified search terms. Choice of database was guided by study aims; relevance to caregiver support - such as medicine (Medline), nursing (CINAHL), psychology (PsycINFO) and more generally (Scopus/Google Scholar); and for their international perspective. The limits applied to searches were: written in English and involving participants over 65 years. Given the dearth of literature in this area, no date limits were applied. To enhance rigour, grey literature was searched iteratively, and included google.com, Google Scholar, OpenGrey, OpenDOAR, Systematic reviews register (PROSPERO) University Repositories, community-based organisations websites (including Alzheimer’s UK, Alzheimer’s Disease International); and relevant government department websites from English speaking countries (including United Kingdom, United States and Australia).

*<Insert Figure One About Here>*

*Article Screening*

After removal of duplicates, articles were screened by title and abstract. Next, eligibility criteria (Table One), were applied to the full text by the review author (AF). Remaining articles were scrutinised and peer validated by the research team. Finally, reference lists of included papers were analysed for other relevant studies.

*<Insert Table One About Here >*

*Methodological Quality Assessment*

Even though some authors dispute the usefulness of methodological quality assessment for qualitative studies in systematic reviews (Lucas *et al.* 2007), Thomas & Harden would advocate for quality assessment. Therefore, studies in the current review were assessed using the Critical Appraisal Skills Programme Qualitative Checklist (CASP, 2018). Two authors (AF, AR) assessed selected studies independently. Specifically, CASP comprises checklists of ten questions to enable a systematic consideration of the methodological approach of the study. Studies were not weighted on the basis of this assessment (Thomas & Harden, 2008), and since all studies met the initial two screening two criteria (CASP, 2018) none were excluded (Supp File 2).

*Data Synthesis and Analysis*

Data were analysed using a thematic synthesis approach (Thomas & Harden, 2008). Data in the results/findings/conclusions section of selected papers were electronically extracted and entered into QSR Nvivo 12 qualitative software for management and coding. Next, the first researcher (AF) inductively coded data line-by-line to identify key categories and concepts from the first study, based on the research question. Data from subsequent studies were added to the original, or new concepts and categories where required, in order to develop descriptive themes (based on findings in the primary studies). Codes and themes were discussed and checked for reliability through continuous peer review within the research team. A conceptual map was developed to visualise and compare themes, and to assist with ongoing interpretation of data. The final stage of analysis involved further interpretation and refinement of descriptive themes in order to generate more abstract analytical themes.

**Findings**

A total of 3,646 articles were identified and exported to Refworks Reference Management system. Duplicates were removed, and 2,725 articles were screened by title and abstract. Finally, eligibility criteria were applied to 104 studies, resulting in a final eleven for review (Figure Two). All eleven studies were assessed for methodological quality assessment. The methodological quality varied. All eleven studies met the two screening criteria of ‘Statement of Research Aims’ and ‘Qualitative Methodology Appropriate’. However, only four showed clear ethical approval, and six showed rigour in data analysis. Nine studies reported appropriate research design and ten presented a clear statement of findings.

*<Insert Figure Two about here>*

*Study Characteristics*

Characteristics of selected articles are summarised in Table Two. All eleven articles were qualitative, and were drawn from Scandinavia (2), United States of America (7), United Kingdom (1), and South Africa (1). Eight articles used semi-structured interviews with older male caregivers, one study used focus groups, one study used a psychoeducational support group, and one study used narrative correspondence from older male caregivers and interviews with service providers to collect data. A total of 504 male caregivers participated. All participants were married in heterosexual relationships. Although most were retired or had given up work to care, a range of previous employment was described including GP, taxi driver, accountant, farm labourer and teacher. It is acknowledged that some study participants were outside the age inclusion criterion (of over 65 years). However, we decided to include studies with a mean age of 65 or over, to ensure that we did not exclude studies where most of the participants met the age criterion. Although all studies included care recipients living with dementia, nine studies listed this as the primary health condition, and some had additional health conditions (either physical or mental). Sample characteristics are detailed in Table Three.

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*Themes*

Two themes were identified: ‘the need to maintain masculinity’; and ‘the provision of social support’.

Theme 1: The Need to Maintain Masculinity

 This theme was identified in all studies, to a greater or lesser extent. It related to the concept of masculinity, how it influenced the approach to caregiving by many older male spousal caregivers, and the perception of caregiving as ‘gendered’ by families and institutions. Maintaining masculinity involved, for some, ‘re-framing’ their identity to maintain masculine traits and societal expectations. This was mainly achieved through the ‘professionalisation’ of caregiving tasks by applying skills from previous employment, such as management or technology (Russell, 2007; Milligan & Morbey, 2016; Hellström *et al.* 2017). Hellström *et al.* (2017) referred to using such strategies *‘to maintain a sense of a preserved orientation as a man’*, including a ‘take charge’ attitude related to previous occupations. In their study Sandberg & Eriksson (2009) explained that maintaining masculinity was ‘*The urge to be in control and manage the care without professional involvement’.* Others also referred to cognitive strategies to maintain control (Pretorius *et al.* 2009; Milligan & Morbey, 2016).

Maintaining masculinity through a protective approach towards their partners was evident in eight studies. This was exemplified through statements such as *‘Being responsible for their wives’ wellbeing and protecting them from harm’* (Sandberg & Eriksson, 2009). However, authors noted that this sense of protection was often detrimental, as protectiveness ‘*combined with the desire to maintain their own independence, eventually became too demanding’*, and that seeking external support was ‘*tantamount to failing in his role as husband and primary carer’ (*Sandberg & Eriksson, 2009)*;* or the inability to maintain a protective environment for their spouse, was also described as *‘a devastating blow to the men’s self-image’* (Sandberg & Eriksson 2009*)*. Sandberg & Erikson further emphasised that ‘*what men regard as important in the formal support they receive, diverges sharply from what they are offered’* (Sandberg & Eriksson, 2009). In other words, participants viewed their spousal and caregiving expertise as crucial in their partners’ ongoing care, and had the expectation that healthcare professionals would take this into account, however participants often felt excluded when care services ‘*took over’* and did not consider the men’s knowledge of their spouse. Thus, men tended not to accept the help that was offered. In a similar veinMilligan & Morbey (2016) concluded that the urge to take responsibility led to negative outcomes when participants had to ask for help, often resulting in help only being requested at crisis point. According to the care providers in their study, asking for help *‘may be seen as indicative not only of an inability to cope, but as a perceived failure, as husbands, to provide for their wives’* (Milligan & Morbey, 2016). Findings in several other studies also indicated a reluctance to seek or accept help (Coe & Neufeld, 1995; Russell, 2004; 2007; Hellström *et al.* 2017).

There was also some evidence of caregiving as ‘gendered’ from others such as families and healthcare professionals. Russell described reactions from friends and family to work that was considered ‘*men’s work’* such as building shelves or gardening, as opposed to the invisibility of care work, regarded by the relatives of some study participants as ‘*women’s work’* (Russell, 2007). Potential gender stereotypes with healthcare professionals were also evident in findings in Sandberg & Eriksson, where the perception of one support service manager was described as being ‘*highly influenced by stereotyped views of men’s ability (or, rather lack thereof) to provide care’* (Sandberg & Eriksson, 2009).

Theme 2: The Provision of Social Support

Findings in this theme described the emotional and instrumental support needed by older spousal male caregivers.

Nine of the eleven studies highlighted aspects of the caregiving role that impacted negatively on caregivers’ emotional well-being. Studies commonly referred to men’s sense of isolation and loneliness due to the ‘*declining ability to engage in social activities with other older men as a result of their caring role’* (Milligan & Morbey, 2016); or ‘*As they developed their skills as carers, they were almost entirely isolated in the role’* (Sandberg & Eriksson, 2009). This was further compounded by a profound sense of loss at the closeness and companionship that they had once shared with their partner, as described by Michael (Brown *et al.* 2007):

 *‘I said, ‘I can’t get in there with you. I know you’re in there somewhere and I can’t bring you out here with me and I miss you so much’… She’s been everything to me. She took care of everything. She’s all I’ve got, the only woman, all I want. She’s my companion… Alzheimer’s took away my wife… ‘cause she’s not my wife anymore. I just miss her so’.* (Brown et al. 2007)

This experience of loss, grief, and deep sadness were also emphasised by Sanders & Power (2009); Harris (1993); Sandberg & Eriksson (2009) and Hellström *et al.* (2017). Not only did Harris (1993) report that ‘*social isolation from family and friends’* was the second most common theme in their study, but Hellström *et al.* (2017) concluded that:

 *‘a diminishment of social life that included social isolation, feelings of loneliness and a reduction of social and bodily contact were explicit in all the men’s narratives’* (Hellström *et al.* 2017).

Six studies reported that there was a pressing need amongst participants for more opportunities to have someone to talk to(Harris, 1993; Russell, 2004; Sanders & Power, 2009; Pretorius *et al.* 2009; Milligan & Morbey, 2016, Hellström *et al.* 2017). Milligan & Morbey (2016) noted that for their participants:

*‘The narratives also revealed that many of the OMCs (older male caregivers) felt a real need and desire to have someone to talk to about the issues, but for this to be delivered through professional services (such as a mental health worker or counselling service) rather than friends or relatives’* (Milligan & Morbey, 2016).

When participants talked about the type of emotional support that would be beneficial they generally referred to a need for male specific support. This was highlighted by five studies (Harris, 1993; Lauderdale & Gallagher-Thompson, 2002; Russell, 2004; Pretorius *et al.* 2009; Sandberg & Eriksson, 2009), as described by a participant in the study by Harris (1993):

*"I need to express my feelings with people who have experienced the same thing and understand. You just don't talk about those kind of things with women of our generation"* (Harris, 1993).

Instrumental support was reported to a lesser extent than emotional support. Five studies noted the importance of respite (Harris, 1993; Brown *et al.* 2007; Pretorius *et al.* 2009; Milligan & Morbey, 2016; Hellström *et al.* 2017). For some study participants, respite provided through agency staff allowed important time away from the caregiving role to pursue leisure/ social activities, personal appointments, or part-time employment. Other studies referred to more informal ‘*personal time’*, which was described as time watching television, or in the garden while the care recipient was in bed. This personal time away seemed to provide stress relief and was referred to by participants in Sanders & Power (2009) as ‘*the only factor that was going to ensure their survival as a caregiver’.*

**Discussion**

For this systematic review eleven studies were identified that discussed support for older male spousal caregivers.

Research has shown that caregivers (regardless of gender) who receive support experience better health outcomes, and physical/psychological wellbeing than those who do not (Ablitt *et al.* 2009; Dam *et al.* 2016). However, a lack of conceptual clarity about ‘support’ has previously existed within nursing research. This has been addressed by various authors (Stolz *et al.* 2007; Ostberg & Lennartsson, 2007). Langford *et al.* (1997) provided a more specific definition of social support in their conceptual analysis and concluded that defining attributes of social support were: emotional, instrumental, informational and appraisal.

Addressing the research question: *‘What do we currently know about the support needs of older male caregivers who are caring for a chronically ill spouse/partner at home?’* the findings of this review highlighted themes of: ‘the need to maintain masculinity’, and ‘the provision of social support’. Maintaining masculinity included strategies whereby male caregivers sought to take responsibility or display a task oriented approach (Pretorius *et al*. 2009; Hellström *et al.* 2017). Re-framing masculinity involved approaching new caregiving tasks in a way that aligned with masculine ideals, or ‘professionalisation’ of caregiving tasks by applying skills from previous employment (Russell, 2007; Milligan & Morbey, 2016; Hellström *et al.* 2017).

Connell’s hegemonic masculinity theory (2005) characterises ‘normal’ masculine behaviour as independent, stoic, and self-reliant (Donaldson, 1993). These ideas become societal gender role expectations, and internalised gender norms, but complicity is often difficult for men. Gender norms can be restrictive to men when they are in a position of having to navigate through family, social and community life. Caregiving is an example of this and can pose a conflict for males as it is viewed by society as ‘women’s work’ (Glauber, 2016), and performed in a ‘*feminised landscape of care, from which they often feel excluded’* (Milligan & Morbey, 2016). This conflict was described by O’Neil (1981b) as Gender Role Conflict (GRC). A unifying theme within GRC is ‘fear of femininity’, whereby men associated negative emotions with stereotypical female behaviour and values. This resulted in them distancing themselves from behaviour that is commonly associated with feminine traits. Tendencies to under-report caregiver stress, or limited perceptions of support (Fromme *et al.* 2005; Baker *et al*. 2010), have also been linked with GRC. An awareness of these factors amongst healthcare professionals may improve caregiver assessment or increase the likelihood of timely caregiver support interventions to avoid crisis.

A protective approach to caregiving among older male spousal caregivers was evident in findings. Selected studies reported that participants felt a sense of duty, as husbands, to provide care. Sandberg & Eriksson (2009), argued that the reluctance of older male spousal caregivers to use formal support was due to their difficulty in obtaining support which enabled them to continue to provide a protective environment. Often, they felt that when care services became involved, they ‘took over’ and ignored the men’s spousal expertise. This often resulted in men feeling excluded from caregiving and from their spousal relationship (Sandberg & Eriksson, 2009). This is an important point as it sheds light on the consequences, in terms of support, for some older male caregivers when caregiving intersects with their masculine identity.

Studies depicted a range of emotions in relation to the caregiving role which included anger, frustration, sadness, grief and loss. Despite this, there was evidence of reticence to discuss such emotions. Milligan & Morbey (2016) pointed out that even though their narratives were *‘strewn with references to stress, distress, self-doubt, worry, struggle’* participants were reluctant to discuss these aspects of their role. Consistent with previous findings about male caregivers minimising emotion or under-reporting stress (Robinson *et al.* 2014.; Spendelow *et al.* 2018), other authors described how interview participants made efforts to suppress strong emotions. This was particularly apparent in Sanders & Power (2009), when a participant described feeling sorry for himself as a ‘*brief moment of weakness’*. Also, Hellström *et al.* noted a tendency to block emotions as a coping strategy, and explained that interview participants were *‘Keeping the discussion on a rational level was a way of keeping their emotions at bay’* (Hellström *et al.* 2017).

‘Permission’ to discuss caregiving stress or the emotional impact of caregiving appeared to be important to study participants. One study noted how a participant only discussed his caregiving stress because he was taking part in a research project (Milligan & Morbey, 2016). Previous studies have highlighted a tendency for men to receive more emotional support from spouses than women, and for men to have ‘permission’ for an emotionally close relationship only with their spouse (Liao *et al.* 2018). Therefore, the declining spousal relationship was felt acutely by many study participants. Discussing emotion seemed to be more permissible if it took place in a certain setting. Several authors emphasised that although study participants experienced caregiver stress, they were more accepting of support to address this, if it was within a male-centred context such as men only discussions, activities or support groups (Harris, 1993; Coe & Neufeld, 1999; Lauderdale & Gallagher-Thompson, 2002; Russell, 2004; Milligan & Morbey, 2016). Findings from the present review and other evidence indicates that men do seek and accept support in certain circumstances (Fogarty *et al.*, 2015; Harris *et al.*, 2015; Seidler *et al.* 2018). However, despite the growing interest in the development of man-centred support initiatives, there is still very limited understanding about what facilitates men’s engagement with emotional support. Emerging research such as the scoping review about engaging men in psychological treatment, conducted by Seidler *et* *al.* (2018), have shed some light on the most effective strategies to engage men, by focussing on the ‘how’ of providing support for men (as opposed to specific support measures). Authors suggested underlying prerequisites needed to engage and work with men, based on an acknowledgement of masculine socialisation leading to support which was goal-focused and action-orientated. They also highlighted current fundamental limitations in support service provision for men, including *‘inadequate clinician training in gender socialisation*’ (Mellanger & Lui, 2006), and *‘clinicians bias toward or against masculinity’* (Owen, Wong & Rodolfa, 2009). Seidler *et al.* (2018) further identified four key themes: ‘Building in Gender Socialisation; Clarifying Structure; Building Rapport and a Collaborative Relationship; and Tailoring Language’. Themes not only acknowledged how gender role socialisation informed men’s alignment to masculine norms, but also the importance of collaborative work with men, and an awareness of clinician’s own gender role stereotypes, and biases regarding masculinity. Such gender role stereotypes and biases regarding masculinity have already been recognised in male caregiving literature (Sandberg & Eriksson, 2009; Milligan & Morbey, 2013).

In summary, this review has employed a novel thematic synthesis in reviewing the current literature about the support needs of older male spousal caregivers, and has highlighted how masculinity may impact on support for this population. Consequently, there is a need to increase our understanding about the connection between men, caregiving and identity; and what this means for healthcare professionals. If ‘support’ is explored within the context of men’s help seeking behaviour in healthcare (Seidler *et al.* 2018), this may help to inform a process of sustained engagement with older male caregivers, and the design and provision of support for this population group.

**Limitations**

It could be suggested that the aims of reviewed studies were somewhat disparate, ranging from help-seeking processes, to formal support, or experiences of caregiving. Nevertheless, all selected studies referred to significant support needs of older male caregivers, and therefore were included in the review. Studies included in the review related mainly to dementia, findings may have been different if studies had focussed on a range of chronic conditions. Given that the current review did not consider other influencing factors on older male caregiver support (such as sociodemographic factors, or stage in caregiving trajectory), this remains an area for future research.

**Conclusion**

This review can add to existing knowledge about support for older male caregivers. Healthcare professionals should be aware of how caregiving can impact on some men’s masculinity, in what has traditionally been seen as ‘women’s work’, whilst maintaining their masculine identity. Findings revealed a gendered approach to caregiving where men endeavoured to maintain their masculine identity though adherence to masculine ’norms’ such as a protective approach in their caregiving role, or a reluctance to seek help or to discuss emotions. Findings also revealed a need for social support to address the isolation, loneliness and lack of companionship experienced by older male spousal caregivers, and for this to be provided within a male specific context. If healthcare professionals are aware of the gendered approach of some male caregivers, then this can be taken into consideration when assessing male caregivers’ support needs. The identification of appropriate support for this population is important for future policy for several reasons. Firstly, greater emphasis on providing care in the community in western societies places additional responsibility on family caregivers. Secondly, an increasing population of people over the age of 85, suggests a continuing rise in the number of male caregivers, who are currently under-represented in the caregiving literature.

**Nursing Implications**

* Nurses should be aware of the gendered approach to caregiving highlighted in this review. This knowledge is essential if nurses are to provide effective care and encourage the early uptake of support, potentially avoiding crisis, for this population group.
* As many men have demonstrated a protective approach to caregiving, it is important for nurses to acknowledge older male spousal caregiver’s expertise in this area and plan the delivery of support collaboratively.
* Given that men often feel excluded from a ‘*feminised landscape of care*’, nurses should be aware of isolation, and be equipped with information that could address this.

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