Roles and Coping Strategies of Sons Caring for a Parent With Dementia

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OBJECTIVE. Little is known about sons' roles in caring for a parent with dementia. To ensure that interventions and practices appropriately match sons' needs, we investigated their experiences.

METHOD. A qualitative descriptive approach was used; 20 sons of a parent with dementia participated in semistructured interviews.

RESULTS. Participants reported varied paths to becoming a caregiver, primarily undertaking a care management role and managing by using their own occupational experiences and receiving support from other family members, peers, and private and public community services. They experienced negative consequences such as participation restriction and stress and positive consequences such as feelings of satisfaction. Strategies used to cope included boundary setting and practicing self-care.

CONCLUSION. This study highlights the need to consider sons' role as care managers for their parent with dementia in community-based settings, as well as their need for education and intervention. Occupational therapy practitioners can use this information to inform their practices and support clients and their families.

cope with stress, and have different care experiences than female caregivers (Ducharme et al., 2011; Lin, Fee, & Wu, 2012; Mc Donnell & Ryan, 2013; Robinson et al., 2014). For example, men are more likely than women to assist with IADLs and to use a task-oriented approach to caregiving (Corcoran, 1992; Mc Donnell & Ryan, 2013; Robinson et al., 2014).

To date, most studies of men’s caregiving have focused on the experiences of husbands or have had mixed samples of men that included only a small percentage of sons (Mc Donnell & Ryan, 2013; Robinson et al., 2014). However, the limited available research indicates that sons may have different experiences and support needs than husbands. For example, in the study by Conde-Sala, Garre-Olmo, Turró-Garriga, Vilalta-Franch, and López-Pousa (2010), sons experienced greater feelings of guilt and burden and had more symptoms of depression and anxiety than husbands. In another study, son caregivers reported more burden than husband caregivers, despite spending less time providing care (Reed et al., 2014). Sons may also be more likely to consider institutionalization than other familial caregivers, further suggesting that they may need additional support to maintain caregiving at home (López, Losada, Romero-Moreno, Márquez-González, & Martínez-Martín, 2012).

Existing research indicates that although sons have difficulties caring for a parent with dementia (Conde-Sala et al., 2010; Reed et al., 2014), they rarely access dementia-specific caregiver supports, such as psychoeducational interventions (Houde, 2002; Kaye, 2005). Researchers and clinicians are uncertain as to why they do not access available supports and, therefore, need further information about their experiences to inform future interventions. To fill this gap in the literature, we undertook an exploratory qualitative study to understand the caregiving role from the perspective of sons caring for a parent with dementia. We had five guiding questions:

1. How do sons come to take on the caregiving role?
2. What is the scope of their caregiving role or roles?
3. What impact does caregiving have on their lives?
4. What strategies do they use to accomplish caregiving tasks?
5. How do they cope with the caregiving role?

Method

Design

Following the tradition of naturalistic inquiry (Lincoln & Guba, 1985), we used a qualitative descriptive design (Sandelowski, 2000) to explore sons’ perspectives and to understand their caregiving roles and support needs. Sandelowski (2000) described this type of design as a fundamental approach to description that seeks to present the phenomenon of interest “in everyday language” (p. 336) with minimal interpretation so as to bring forth study participants’ perspectives. The aim of this approach is to generate a thick description of a phenomenon (e.g., sons’ experiences of being a caregiver) rather than to create an encompassing analysis or theory. This type of approach allows the researcher to stay close to the data as reported, or “data near” (Sandelowski, 2010, p. 78); we chose it over other qualitative traditions (e.g., phenomenology, grounded theory) because our study was exploratory, and our overall goal was to describe how sons viewed their caregiving roles.

Participants

Participants were recruited through various sources. First, the second author (Nira Rittenberg), an occupational therapist who facilitates a psychoeducational group for dementia caregivers at a geriatric care center, distributed information about the study to group participants and to health care providers. Second, paper and online flyers advertising the study were distributed at various community agencies (e.g., Alzheimer’s Society) in one large urban city. Before the study, all participants were screened over the phone to ensure they met the inclusion criteria, which were as follows: a son (or son-in-law) who (1) is providing assistance to a parent with dementia with two or more daily activities per week (e.g., medication management, grocery shopping) and (2) speaks English. Care recipients could reside in the community or have recently (e.g., within the past 6 mo) moved to a residential care institution. Institutional review board approval was obtained from all relevant institutions, and all of the participants provided written informed consent.

Data Collection and Analysis

Participants completed a sociodemographic questionnaire, the results of which are summarized in Table 1. Data were collected through semistructured interviews either in person or over the phone, according to the participant’s preference. Interviews consisted of open-ended questions exploring how the participant became a caregiver, the challenges and benefits she experienced, and the strategies and supports she used to manage this role. Examples of interview questions are as follows:

- Can you please describe your caregiving situation?
- What kind of help does your family member need?
- Does anyone else help you or your family member (paid or unpaid)?
What are the changes that you have experienced over time as a caregiver?

How has providing care affected your own life? Good or bad?

Do you access any supports right now?

The interviews were conducted between 2011 and 2013, and each interview lasted an average of 49 min (range 528–79 min, median 544 min). All of the interviews were digitally recorded and professionally transcribed; the transcripts were checked for accuracy by the authors. The transcripts were uploaded to a qualitative software program (NVivo Qualitative Data Analysis Software, Version 10; QSR International Pty Ltd., Burlington, MA) that was used to manage and organize the material.

Interview data were analyzed using conventional content analysis (Hsieh & Shannon, 2005), which is a systematic method for interpreting and classifying textual data. It involves coding and identifying categories, or common patterns, in the data. This process involves the following steps: (1) becoming familiar with the data, (2) generating initial codes on the basis of study questions, (3) coding the data and identifying additional novel codes, and (4) analyzing and synthesizing codes into larger categories on the basis of the research objectives. All of the transcripts were first read and reread by all of the authors to identify key phrases and words that answered the guiding study questions presented earlier. Eight authors (Cameron, Rittenberg, Dick, McCann, Abbott, Kmielauskas, Estioko, and Kulasingham) identified preliminary codes and collaboratively discussed and refined them to develop the code book. Six authors (Dick, McCann, Abbott, Kmielauskas, Estioko, and Kulasingham) coded the data; the coded data were then examined and discussed by the first author (Grigorovich) and the study leads (Cameron, Rittenberg) to further supplement and refine the coding scheme and establish preliminary code clusters. This process resulted in a final set of codes that were then grouped into larger categories, or themes, and subthemes, which are discussed in the Results section.

The authors kept a written audit trail throughout the study, documenting every step of the research and analysis process, including field notes; data reduction, analysis, and synthesis products; and all other research-related decisions. Several strategies were also used to ensure the trustworthiness, credibility, and rigor of the analysis (Lincoln & Guba, 1985), including maintenance of an audit trail, use of a semistructured interview guide, multiple readings of the transcripts, and independent coding by multiple authors, followed by investigator triangulation of the codes and themes through collaborative discussion and consensus.

Results

Twenty men participated in the study (see Table 1). Of these, 19 were sons, and 1 was a son-in-law. Ten provided care to their father, and 10 provided care to their mother or mother-in-law. Our analysis revealed four themes and nine subthemes (Table 2) that describe how sons came to be caregivers and their caregiving roles, the ways in which they managed the care that their parent needed, the impact that caregiving had on their life, and the strategies that they used to cope with their caregiving role. The following is a summary of the themes using participant quotations as examples. The source of each quotation is indicated by Son Dementia Care Giver (SDCG) and a participant number (e.g., SDCG1).

Coming to Care

Participants discussed varied motivations for and pathways to becoming a caregiver to their parent. The
majority of them occupied the role of care manager for their parent.

**Path.** Most (n = 15) participants placed their motivation and current care roles within the larger context of their relationship with their parent and other family members’ involvement in the care of their parent. Many of them (n = 10) stated that they came to their current caregiving role gradually, and they viewed it as an expansion of their precaregiving familial role. For example, sons reported that they became caregivers because they already held (or shared) power of attorney for their parent or managed their parent’s finances before the parent’s diagnosis and gradually expanded these duties. Some sons also explained that they took on their specific care role because other family members were already assisting the parent with other care (e.g., personal care, social support). Three noted that they became caregivers because no other siblings were available to provide care (e.g., they were an only child, they were the closest child geographically, or they had a better relationship with the parent). As 1 participant explained, deciding which sibling took on caregiving was a gradual process and was “tied to who can help, who has the flexibility, who’s [the] closest, who notices what’s changing and what needs [to be done]” (SDCG6).

**Primary Role.** The majority of participants (n = 16) described their primary role as being that of a care manager. Typically, this role meant that they coordinated and took their parent to medical appointments and managed other aspects of their parent’s care (e.g., direct personal care provided by personal support workers, care provided by other family members). Other common activities included grocery shopping and management of the parent’s finances. Four participants also reported providing personal care (e.g., bathing, toileting, dressing) or cooking for their parent; 2 of the 4 shared these responsibilities with another caregiver (e.g., sibling, spouse of parent or son). The care manager role was most commonly cited, regardless of the sex of the parent, the stage of dementia, or whether the parent had a spouse (or another child) who also provided care. For example, as 1 participant explained, “I’m a case manager, so I’m in charge of all her appointments, doctors’ appointments . . . various tests. . . . I’m [also] getting her into a day program” (SDCG6).

Participants also stated that they actively chose this specific care role because they felt that they were best suited for it as a result of their educational and professional training and occupational history in white-collar workplaces (i.e., managerial, professional, or administrative work). In particular, participants explained that they had the experience of managing their own businesses and supervising employees and could apply these skills to securing care, delegating care tasks, and managing care for their parent. For example, 1 participant stated, “I’m a good researcher, I’m a good planner, I’m a good manager, and I’ve taken all of those skills that I would otherwise use in other parts of my life, and I’m using them here” (SDCG6).

**Managing the Care**

Participants reported relying on a variety of supports to manage their parent’s care needs, including other familial caregivers, formal caregiver services, and commonly available technologies.

**Other Family Members.** Fourteen participants stated that the care responsibilities for their parent were shared with other familial caregivers (e.g., siblings, parent’s spouse, their own spouse, other extended family members). Eight of these participants reported that their sisters and wives (and ex-wives) were primarily responsible for providing assistance with day-to-day activities, including emotional support and personal care, and for responding to care crises during the work week. For example, as 1 participant explained:

So you asked me what my sister’s role is. Her role is probably the softer role of visiting a little more frequently, speaking to [mother] on the phone very regularly, and providing that very regular contact that I don’t do as well. . . . She’s probably more of a friend to my mom, and I’m probably more like a parent. (SDCG2)

**Formal Care Services.** Regardless of whether participants lived with their parent or the level of care the parent needed, everyone whose parent needed daily support reported relying heavily on the formal health care system for assistance. Formal supports accessed through this system

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Table 2. Results of Data Analysis

<table>
<thead>
<tr>
<th>Theme and Description</th>
<th>Subthemes</th>
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<tbody>
<tr>
<td>Coming to care: How sons came to occupy their caregiving role and the scope of their role</td>
<td>Path, Primary role</td>
</tr>
<tr>
<td>Managing the care: How sons perform their caring role and the resources they draw on for support</td>
<td>Sharing role with family, Using formal care services, Using technology</td>
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<tr>
<td>Impact of providing care on sons: The impact of caregiving role on son’s life and well-being</td>
<td>Negative impact, Positive impact</td>
</tr>
<tr>
<td>Coping with role: How sons coped with their role and its impact on their own life</td>
<td>Boundary setting, Participation in valued activities</td>
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included the services of formal caregivers (e.g., personal support workers, nurses) who assisted the parent with daily activities and provided respite care for the participant and other familial caregivers. Participants also accessed the services of other health professionals—such as geriatric psychiatrists, social workers, and occupational therapists—for their parent and assisted the parent with accessing community day programs. Although some of these care services were provincially funded (i.e., paid for by the province of Ontario), participants and their parents also paid privately for additional support, such as aides to provide their parent with social and emotional support, personal care, and housekeeping on top of what was provided publicly. One participant, whose mother lived alone in the community explained that she could do so despite needing daily care because she was able to afford to supplement her publicly funded care services with privately funded care: “Between [publicly funded community care services] and some extra hours . . . that she hired for herself . . . we had most weekdays . . . covered” (SDCG8).

Thirteen participants reported accessing in-person psychoeducational supports and services for themselves (e.g., in-person support group, educational sessions, counseling). For many, the Internet was an initial starting point through which they first educated themselves about the disease and its progression and the types of assistance that their parent might require. However, participating in an in-person psychoeducational group or session for caregivers was seen as especially helpful in finding out about local support services and for learning about strategies others have used to secure services and to cope with their parents’ symptoms and behaviors. For example, 1 son stated that this type of support was useful because it allowed for both information sharing and camaraderie with other caregivers:

[1 learned] material facts about what services and processes were out there. And also . . . to sit in a room with a bunch of other people who were in exactly the same situation [makes] you feel less . . . isolated. . . . The information that was provided . . . I’m sure it’s all available on the Internet. But it’s different when it’s presented to you and shared with you in an organized way. (SDCG2)

Using Technology. The respondents stated that they used a variety of technologies to manage their role as care manager and to help them oversee their parent’s care. For example, 3 reported using online banking to manage their parent’s finances and investments remotely. Three also used low-tech and easily available monitoring technologies such as cameras, baby monitors, and Skype to keep in touch with their parent and to monitor their parent for problem behaviors. As 1 participant explained,

She [mother] had a tendency to wander in the house, upstairs at night . . . so we put the safety gate in so she couldn’t fall down the stairs. . . . We also installed, just recently, . . . a baby monitor. We put the [transmitter unit with a microphone] in her room, and . . . I have a speaker next to me in my room so I can hear if she’s in distress or anything, or if she’s getting up [during the night]. (SDCG20)

To manage the work of caregiving, participants relied on assistance from family members, formal caregivers, psychoeducational supports, and technology.

Impact of Providing Care

Providing care had both negative and positive effects on participants’ well-being and lives.

Negative Impact. Fourteen participants stated that caregiving had an adverse impact on their lives and well-being. The most commonly cited impact was difficulty maintaining participation in valued activities (e.g., employment, leisure, exercise) and social relations with their own family and friends. As 1 participant explained,

I used to be much more physically active. I still do some fitness . . . but the additional time burden [from caregiving] has prevented me from being able to do that. . . . So it’s negatively influenced my health. . . . Insofar as work goes, yeah, I mean, I’m self-employed, so the additional time that I’m devoting to my mom is lost [work] time. (SDCG6)

Eleven participants also indicated that they experienced negative emotional consequences, such as relationship stress with their partner, frustration over their parent’s problem symptoms or behaviors (e.g., wandering, apathy) or other family members’ limited involvement in caregiving, guilt over not spending enough time with their parent, and feelings of sadness and grief over the loss of the parental relationship: “[Caring for my mother is] a little . . . depressing . . . and you feel sad about it. . . . To see one’s parent . . . degenerate somewhat . . . is not pleasant. (SDCG8)

Positive Impact. Although most cited negative consequences, 4 participants also described a positive impact as a result of providing care, such as experiencing satisfaction or personal growth and developing a closer relationship with their parent and with other family members. For example, 1 participant stated that he felt “a certain element of pride and self-achievement . . . from
the work that I do for my mom” (SDC6). Another participant who had been estranged from his mother since childhood explained that caregiving enabled him to develop a closer relationship with her as an adult:

Sometimes the relationship has been trying for me on an emotional basis, [but] . . . I think that with my mom it’s become a . . . deeper relationship based on the fact that [we] know each other better. (SDCG18)

Caregiving had a variable impact on participants’ lives and well-being, with most reporting that they experienced stress, participation difficulties, and negative emotions.

**Coping With the Caregiver Role**

Participants reported that they used several strategies to cope with the caregiver role or limit the impact that providing care had on their own well-being and participation in life roles (e.g., work, relationships, leisure). The use of these strategies was informed by both the type of care role that they took on (e.g., primarily care manager) and the ways in which they approached this role (e.g., participants’ perceptions of their abilities and the scope of their responsibility to their parent).

**Setting Boundaries.** Participants primarily coped with caregiving by placing boundaries on the types of care they provided and the time that they spent in this role. For example, they described undertaking specific care activities that they could do as needed (e.g., activities that they could do on the weekends or remotely). These activities typically demanded less time and allowed them to maintain their participation in other activities. However, participants’ ability to restrict their time was also enabled by the fact that they were primarily care managers and thus expected to facilitate rather than provide direct care. For example, as 1 participant explained,

I don’t see myself as the caregiver for my mother, because to me a caregiver is a person who gives care. And I’m the person who’s like the administrator. Like I deal with the problems and stuff. But as far as going there and giving her a hug and a kiss every day, that’s not me . . . that’s more my sister. (SDCG2)

Four participants also expressed the belief that they, and men in general, were better suited to help with these types of instrumental care activities than to provide other types of care, such as social or emotional support or ongoing personal care. These beliefs also facilitated their ability to set boundaries and thus cope with the caregiving role. For example, as 1 explained, “Men . . . in my mind are not natural caregivers. They don’t have the empathy that the average woman has” (SDCG10).

Participants reported limiting the amount of time they visited their parent or deciding to not live with their parent, which enabled them to cope. Four stated that institutionalizing their parent when the parent required 24-hr supervision also reduced the impact that caregiving had on their life. In fact, most participants (n = 16) reported that they did not live with their parent at the time of the interview or before their parent’s institutionalization. As 1 explained, choosing not to live with his parent helped him to cope:

Some of these fellows [in the support group] were living with their mother, and I knew that I probably wouldn’t survive that. . . . I felt badly, [but] I knew in my heart that I couldn’t. I wouldn’t be able to cope with that. (SDCG5)

Similarly, another participant whose mother lived on her own in an apartment nearby added, “[I don’t] feel compelled to go visit her every single day and make sure that her, you know, her toes are cleaned and her shirt is pressed” (SDCG2).

**Practicing Self-Care.** Finally, participants also coped by proactively practicing self-care and making efforts to maintain their participation in leisure activities and own valued interests. They described going out to see friends, traveling, and enrolling in educational courses. Participants were aware that caregiving might affect their own health and well-being and viewed their participation in these activities as providing a necessary distraction and stress reduction that enabled their coping. As 1 participant explained,

I saw my friends less, no doubt about that, but I was aware that this stuff [caregiving] would be a threat. . . . Enrolling in school, that was a strategy to kind of fight these things [impact of caregiving on well-being] and dig my heels in so I wouldn’t get totally swallowed into the caregiving. (SDCG19)

Participants coped with the impact that caregiving had on their lives by placing boundaries around their care time and role and by practicing self-care.

**Discussion**

This study adds to the limited available literature on male caregivers (Mc Donnell & Ryan, 2013; Robinson et al., 2014) and extends the knowledge about sons’ involvement in the care of a parent with dementia. In particular, the findings suggest that sons’ experiences and support needs are different from those of other familial caregivers (e.g., wives, daughters, husbands). Participants in this study cited a variety of motivations and paths to providing
care, and many viewed their caregiving as an extension of already established familial and professional roles.

Most participants were care managers and typically delegated and facilitated other types of care that their parent needed. Many also stated that they actively chose this caregiving role and felt that they were best suited to it. To manage their parents’ care needs, they relied on their work-related and personal knowledge, sought additional information by participating in caregiver support groups, and received support from other family members. They also accessed publicly funded formal care services (e.g., adult day programs) and paid for additional private care.

Most participants stated that they experienced negative personal consequences as a result of caregiving, such as difficulties in maintaining employment and social relations and negative emotions (e.g., frustration, guilt). However, 4 also stated that providing care had a positive impact on their life, for example, they experienced feelings of satisfaction and a closer relationship with their parent. Finally, sons primarily coped by setting boundaries and proactively using self-care strategies.

Consistent with our study, existing research that has primarily focused on spouses and daughters has suggested that men may prefer certain caregiving tasks and may hold gender-specific attitudes with respect to caregiving. For example, men—and sons in particular—may be more likely than women (e.g., wives or daughters) to perform IADLs and to delegate housekeeping and ADLs to other caregivers (Corcoran, 1992; Kramer & Thompson, 2002; Robinson et al., 2014). Men may also believe that they are less able than women to perform emotional and social types of caregiving (Campbell & Carroll, 2007; Kramer & Thompson, 2002).

In our study, sons primarily performed a care manager role and felt that this role was best suited to their emotional and relational skill set. Moreover, participants stated that they thought that men, in general, were better at providing managerial and instrumental types of care support than ongoing psychosocial support. Our study adds to the available literature in that participants also stated feeling more comfortable with the care manager role because it allowed them to use existing professional-based skills and knowledge, such as their research and managerial skills.

Research with caregivers of spouses with dementia has also suggested that men may be more likely than women to use task-focused coping strategies (e.g., information gathering, seeking assistance) to deal with caregiving-related stress (Baker & Robertson, 2008; Mc Donnell & Ryan, 2013; Robinson et al., 2014). Our findings suggest that sons, like husbands, may also be more likely to use task-based strategies. Participants in this study described seeking information about the disease, accessing public and private care services (e.g., respite, home care), and using low technology to facilitate caregiving. However, a unique finding was that participants also coped with stress through anticipatory and proactive strategies. In particular, because participants anticipated experiencing stress and role strain from taking on caregiving in addition to their other social roles, they placed boundaries on their caregiving tasks to protect their time and emotional well-being and engaged in personally valued activities (e.g., socializing, education) to reduce stress.

Research with husbands has also suggested that men may be less likely to know about, seek out, and use formal care services (e.g., community services, psychoeducational interventions) and may have difficulty securing social support (Coe & Neufeld, 1999; Kaye, 2005; Neufeld & Kushner, 2009; Stommel, Collins, Given, & Given, 1999). In contrast, in our study, most sons had multiple sources of social support and provided care within networks of family members. In fact, some participants reported being able to choose their specific care roles because other family members were involved in the care of their parent and already occupied other roles. Participants were also aware of, and made use of, a variety of formal care services for themselves and for their parent (e.g., adult day programs, home care services), including publicly and privately funded services.

In part, these findings may be explained by our recruitment strategy, which included recruiting participants who participated in caregiver support groups. In line with this involvement, participants highlighted the benefits of participating in in-person support groups for obtaining information about available community services and for peer support. Nonetheless, our findings suggest that sons do find in-person dementia support groups useful and may benefit from increased access to these types of psychoeducational interventions. In particular, access to these interventions may be crucial in facilitating sons’ use of community services and for supporting their long-term well-being.

Limitations

This study was an exploratory descriptive study with a homogeneous sample of participants who were primarily recruited in one geographic urban location in which dementia-specific services and other community supports (e.g., adult day programs, publicly funded home care) were available. As a result, our findings may not be generalizable to the larger population or reflect the experiences...
of sons providing care in rural environments or in areas with more limited access to community supports. We also included sons who cared for parents in different stages of dementia and interviewed them once. Consequently, we could not delineate caregivers’ experiences at specific points in the illness trajectory or assess changes over time (Cameron & Gignac, 2008; Cameron et al., 2014). We also relied on only one type of data, sons’ self-report, which may not have provided an accurate representation of their involvement in the care of their parent or of the assistance provided by others. Despite these limitations, this research contributes to a gap in the literature about caregiving sons and suggests the need for further research in this area.

Implications for Occupational Therapy Practice

Just as occupational therapy practitioners support clients living with dementia, they also need to support the client’s family caregivers. As more sons assume the caregiving role, practitioners can use the results of this study to inform their practice concerning sons. Our study describes sons’ approaches to care, the strategies that they find beneficial, and the challenges they face in their caregiving roles. In particular, our findings suggest that sons may benefit from dementia-specific education in community service use. Encouraging sons’ participation in leisure and other meaningful activities may also be especially useful given sons’ preference for this coping strategy.

Finally, our findings suggest that many sons provide care as part of a group of familial caregivers. Integrating a team-based approach to support dementia caregivers, whereby the unique contributions of multiple caregivers are recognized and affirmed, may increase the capacity of families to provide care at home. Our findings thus have the following implications for occupational therapy practice:

- Occupational therapy practitioners focus not only on caregivers’ roles in ADL and IADL care but also on their roles in assisting with managerial and organizational tasks.
- Occupational therapy practitioners working with families should consider sons’ care roles and assess their needs by investigating their existing skills or abilities.
- Occupational therapy practitioners can support son caregivers’ well-being by providing them with dementia-specific information and education about community services, management of problem behaviors, and the use of activity participation as a coping strategy.

Conclusion

Our study findings have implications for clinicians, future dementia caregiving research, and intervention development. Evidence has shown that existing interventions, developed on the basis of research with women, may not appropriately match sons’ experience and support needs. Gitlin, Corcoran, Winter, Boyce, and Hauck’s (2001) occupational therapy intervention increased wives’ self-efficacy and reduced both wives’ and husbands’ feelings of upset but had no effect on sons. Similarly, another psychosocial intervention reduced spousal caregivers’ strain but had no effect on sons (Signe & Elmstähl, 2008).

Our research findings could be used to develop interventions that are more inclusive of sons’ needs in both content and delivery of information. For example, interventions for dementia caregivers often emphasize emotional support and relational skill training and offer them alongside practical education about disease management and use of community services. Our findings suggest that sons who primarily occupy a care manager role may prefer task-oriented information, such as guidance on accessing community services from health care professionals as well as from peers who have practical experience in providing care to a parent.

This research contributes to a gap in the literature by shedding light on caregiving sons and their role in providing care to a parent with dementia. Our findings highlight the need for occupational therapy practitioners in their development and provision of support, to consider sons’ roles as care managers in community-based dementia family care, their preference for receiving task-focused information, their need for education, and the challenges and benefits that they experience as a result of taking on the caregiving role. ▲

Acknowledgments

We thank all of the study participants for sharing their experiences and Elaine Khon, Baycrest Health Sciences; the Alzheimer’s Society of Toronto; and the Toronto Dementia Network for their assistance with participant recruitment. This research was supported by a Canadian Institutes of Health Research New Investigator Award to Jill I. Cameron.

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January/February 2016, Volume 70, Number 1