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## article

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# “You have got to get off your backside; otherwise, you'll never get out”: older male carers' experiences of loneliness and social isolation

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Loneliness is framed as an enduring problem for carers of all ages, including older carers; however, there is little examination of older men's experiences of caring, loneliness and social isolation. Based on interviews with 25 men (aged 68–92 years), we discuss findings from a study of older male carers' experiences of loneliness in England. Within their accounts, loneliness is framed as a future, rather than present, problem as caring provides a time-limited buffer to loneliness while concurrently increasing social isolation. Further, the findings shed light on how male carers seek and benefit from carers' support groups while also maintaining autonomy.

**Key words** carers • male caring • loneliness • social isolation

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## Introduction

In England, the UK government's *Carers action plan 2018–2020* identifies carers as ‘susceptible to loneliness’ (Department of Health and Social Care, 2018: s 4.14) and seeks to better understand carers' experiences. In this article, we set out to expand current understanding about older male carers' experiences of loneliness and social isolation. Loneliness is a social phenomenon of policy, practice and research concern in the UK and in other Global North nations. Recent data from the Office for National Statistics (2018) indicates several notable trends among England's adult population: 5 per cent of adults report feeling ‘often’ or ‘always’ lonely; and carers are 37 per cent more likely to report loneliness than those without caring responsibilities.

Loneliness and social isolation are reported concerns for people of all ages with caring responsibilities as the caring role restricts time available for social contact with friends and family, and as the associated costs of caring can make social activities less affordable and more restricted. In a recent UK survey of carers, over 80 per cent reported feeling lonely or isolated as a result of caring (Carers UK, 2015).

Ageing in place is a prominent social policy stream in European (including in the UK), American and Australasian nations through which the continuation of older citizens, and their carers, residing in their homes and local neighbourhoods is promoted and care in institutional settings is avoided (Means, 2007; Hillcoat-Nallétamby and Ogg, 2014). As well as reflecting aversion to institutional care, this policy stream also reflects neoliberal economic and political drivers, including: the presumption of the cost-effectiveness of care markets; state bodies limiting public responsibility for meeting the care and support needs of older adults; and the premise that individuals are responsible for their own care needs and welfare in old age (Hudson, 2016; Martens, 2018). These trends in policy implementation and service delivery may inadvertently further isolate older service users and carers with limited social networks and financial resources, including those residing in rural areas that are geographically isolated (Winterton and Warburton, 2011). In England, problems with accessing local support services have been compounded by nine consecutive years of government-imposed austerity measures, which have led to the closure or withdrawal of carer support services (Brimblecombe et al, 2018).

The landscape of caring has typically been couched as a feminine activity by health and social care professionals, as well as in the research literature (Greenwood and Smith, 2015; Milligan and Morbey, 2016). This is partly explained by the majority of carers being female. However, for older people, this gender balance changes. While women have longer life expectancy, they may also live a greater proportion of their senior years with serious illness or disability. Consequently, if their spouse has survived with them, they may end up in a caring role. Around half of all carers aged between 75 and 84 years in the UK are male, and above age 85 years, male carers are in the majority (59 per cent of carers over 85 years old are male) (Slack and Fraser, 2014).

International studies comparing female and male caring roles reveal distinct differences in the ways in which men and women experience caring, most notably, with men finding caring less burdensome or stressful than woman (Pruchno and Resch, 1989; Miller and Cafasso, 1992). Work carried out in Finland by Kirsi et al (2000, 2004) examined husbands' narratives as carers to their wives experiencing dementia. In their later study, husbands described their caring in a passive voice that reflected duty and responsive agency, and was also indicative of masculine practices. Furthermore, male participants' narratives of their experiences of care were diverse and dependent on individual life experiences and caring histories, challenging previous interpretations of men as either ineffective or capable carers.

In this article, we provide a nuanced examination of older men's (aged 65+ years) experiences of caring, loneliness and social isolation. Scarce attention has been given to men's experiences of loneliness and social isolation in later life through a qualitative lens, including older male carers as a 'seldom-heard' group. Our research questions were: (1) 'How do older male carers experience loneliness and social isolation?'; and (2) 'In what ways do caring responsibilities shape these experiences?' Our overarching aim is to develop a deeper understanding of how caring responsibilities intersect with and impact on older men's experiences of social engagement with others outside the caring

relationship. We present findings from a larger, qualitative study of older men's experiences of loneliness and social isolation across marginalised and seldom-heard groups in England (2016–19). We contend that caring for a significant other can act as a time-limited buffer to loneliness while concurrently impacting on social contact with others outside the caring relationship. In our findings, emotional loneliness is framed as a future problem that is occasionally glimpsed and experienced in current caring relationships, while social loneliness is more tangible through diminished social contact with others. Our findings shed new light on how older male carers seek and benefit from carers' support groups while also maintaining a sense of autonomy and coping with caring responsibilities.

## Background literature

### *Conceptualising loneliness and social isolation*

The definition of loneliness varies across the literature, with a unifying theme of loneliness as a subjective experience: an individual experiences loneliness when they perceive a discrepancy between the number and/or quality of relationships that they have, and the number and/or quality that they would like to have (De Jong-Gierveld, 1987: 120). Loneliness can have both emotional and social dimensions. Emotional loneliness is more closely aligned with the loss of meaningful relationships (such as being widowed or separated from partners) and a desire for fulfilling relationships with others (Weiss, 1973; Tiilikainen and Seppanen, 2017). In contrast, social loneliness refers to the perceived absence of engagement with social groups and dissatisfaction with one's social network (Weiss, 1973; De Jong Gierveld and Van Tilburg, 2006). More recently, a third type – 'existential loneliness' – has been developed to capture the sense of social separation, alienation and disconnection that older people experience from social life around them (Bolmsjö et al, 2018).

As a related but separate construct, social isolation refers to the absence of contact with other people (De Jong Gierveld et al, 2009). It is a social phenomenon measured by criteria such as lack of social contact with others, living alone and diminished involvement in social activities (Gale et al, 2018). Loneliness and social isolation often coexist as isolation can trigger experiences of loneliness (Buffel et al, 2015). However, being socially isolated is not synonymous with loneliness. Equally, individuals may experience regular contact with members of their social network but still feel lonely, depending on the quality of those relationships. Loneliness can be experienced irrespective of the size of an individual's social network (De Jong Gierveld et al, 2009).

Gender matters to the ways in which older adults experience loneliness and social isolation. There are some indications that older men may be at greater risk of social isolation than older women in the UK (Beach and Bamford, 2013; Durcan and Bell, 2015). More recently, survey research from England indicates that women report loneliness more often than men (Office for National Statistics, 2018). A similar trend has been identified among a large sample of respondents aged 65 years and over in European nations (Vozikaki et al, 2018). Victor et al (2006) offer two explanations for this: first, women may be more likely than men to discuss and report experiences of loneliness; and, second, older women have a higher likelihood of experiencing widowhood than men. However, the relationship between gender and loneliness disappears once other factors such as marital status, age and household size are accounted for.

### *Caring in later life: why focus on male carers?*

Caring in later life is associated with a number of adverse circumstances and outcomes impacting on carers' financial, physical and social well-being. Older carers in England report financial burdens (a reduction in income, financial costs associated with caring and so on), deteriorations in health (including the stressors associated with caring) and diminished social networks, which are all factors that exacerbate the responsibilities of caring (Jopling, 2015). The combined impacts of caring and ageing include a weakened immune system, tiredness and physical inactivity, which can all lead to a decrease in social activity (Durcan and Bell, 2015). Older adults caring for a spouse experience greater psychological distress, more difficulties with cognitive functioning and reportedly more loneliness than non-carers (Lavela and Ather, 2010). Caring has been identified as a chronic stressor that is burdensome and stressful, placing carers at risk of psychological health problems (Chang et al, 2010). Evidence as to whether caring among older men leads to increased mortality remains contested (Shu et al, 2019). There are some indications from Canadian survey data that women carers (inclusive of older women) report lower levels of physical health compared to male carers, and male carers are less likely to experience burden associated with caring (Williams et al, 2017).

Older men are more likely to be reliant on their (female) partner for maintaining social networks and are therefore at higher risk of social isolation when widowed (Davidson, 2004; Ruxton, 2006). The tendency of men to rely on their spouse for the maintenance of social networks also risks disadvantaging men whose partner becomes ill or disabled in later life. From their survey of older adults (64–92 years), De Jong-Gierveld et al. (2009) found that both social and emotional loneliness were greater if the spouse experienced health problems, and social loneliness was higher in men when their spouse was disabled. Among Dutch couples aged over 65 years, social loneliness was correlated with spousal disability for men, whereas for women, it was correlated with their own disability (Korporaal et al, 2008). Other studies of older carers suggest a relationship between being a male carer and social isolation (Neri et al, 2012).

There is evidence that older male carers may find it more difficult (or be less willing) to access formal help and support, increasing the risk of social isolation. Men may be less likely than women to self-identify as carers (Greenwood and Smith, 2015; Jopling, 2015; Milligan and Morbey, 2016), and may prefer to remain independent of formal service support (Baker and Robertson, 2008). In their review of the barriers and facilitators of male carers accessing services, Greenwood and Smith (2015) also found that men may feel guilty about seeking help. Older male carers may also be less likely to know about available services and support, and/or perceive services as less appealing to men and therefore unlikely to meet their needs (Greenwood and Smith, 2015; Milligan and Morbey, 2016).

### *Caring as a gendered activity*

Caring is a gendered practice predominately undertaken by women and is often naturalised as a feminine practice attached to female roles and expectations, which masks gender inequalities in the distribution of caring activity between men and women (Pease, 2018). As a 'feminine' activity that is unpaid, caring is often located in the private sphere of the home and family life, and is attributed less social value

compared to participation in the public sphere of paid employment and civic participation. [Robinson \(2006\)](#) argues that as a form of work performed mostly by women, caring is undervalued, and claims that a relational understanding of care is needed to strengthen appreciation of the interdependency of caring as a morally charged activity. Pease contends that when men carry out caregiving roles, they often emphasise the bureaucratic and technical aspects of the role as they are under normative pressures 'to do so in ways that do not challenge their masculinity' ([Pease, 2018: 190](#)). This chimes with [Russell's \(2004\)](#) finding that older male carers tend to focus more on instrumental tasks when seeking support and give less attention to the affective experience of caring. Others have echoed the managerial approach that men take to caring in contrast to women's focus on the emotional and experiential dimensions ([Davidson et al, 2000; Ribeiro et al, 2007](#)).

Sex-role stereotypes can impact on older male carers' experiences. One study of 53 older men caring for spouses found that almost all were affected by the perception that caring was primarily a female role and presented themselves as doing 'women's work'. Others were positive about their caring role, though it challenged the stereotyped 'masculine' persona ([Ribeiro et al, 2007](#)). A UK study of male carers (aged 50+ years) found that they experienced isolation from others as their gender influenced the impact that the caring role had on their identity, particularly because of the change that this represented from men's previous roles and relationships ([Milligan and Morbey, 2013, 2016](#)). The support often offered to male carers is influenced by their gender, assuming that men would need support with cooking and cleaning rather than the tasks associated with men, such as DIY and practical work ([Milligan and Morbey, 2013, 2016](#)). Gendered stereotypes around care are reflected in surveys about the caring role, with men's feelings couched around a sense of pride, and women's around a sense of affection ([Baker and Robertson, 2008; Milligan and Morbey, 2013](#)). US research suggests that men understate the strains of caregiving ([Fromme et al, 2005](#)), which can further complicate attempts at seeking help.

It is important here to acknowledge [Connell's \(1995\)](#) critique of sex-role theories, first, the ways in which sex-role theories can downplay social inequalities and power relations; and, second, the linking of sex roles with biologically defined differences (male/female) rather than approaching gender as a basis for configuring social relations. Through [Connell's \(1995: 71\)](#) sociological lens, gender is a social process (or 'configuring practice') through which social life is organised and 'not a fixed set of biological determinants'. In this context, gender relations intersect with the social dynamics of caring, and gendered practices can shape men's approaches to and understanding of caring responsibilities. The aforementioned research on male carers and gender differences throws helpful light on how caring practices are socially configured and the different outcomes that can manifest for male and female carers. However, these roles should not be assumed to be naturalised, context-neutral or universal.

In summary, previous literature indicates loneliness as a perennial problem for carers of all ages, including older carers, and caring practices heighten the risk of social isolation. There are some indications that older men are at higher risk of social isolation than women, though women are more likely to self-report as lonely. As a gendered practice, caring is often framed as conflicting with masculine roles and expectations; however, gender-based social roles are context-specific and permeated by other social and cultural differences. This leads us to our current enquiry into the

self-reported experiences of loneliness and social isolation for older men who are carers for significant others.

## Research design

We present findings from a cross-sectional study of older men's experiences of loneliness, social isolation and social participation across seldom-heard or marginalised groups. The overarching aim was to develop an in-depth understanding of the ways in which men (aged 65+ years) seek to maintain social engagement and social participation in later life. Across the larger study, we interviewed 111 men living in the South-West and West of England, who belonged to five distinct sample groups, including: male carers; men who were single and living in urban or rural areas; men who identified as gay and were single or living alone; and men with hearing loss. The study was conducted in partnership with Age UK. Ethical approval was received from the National Health Service (NHS) Social Care Research Ethics Committee (Ref. 17/IEC08/0004).

Purposive sampling was used to recruit male carers through notices circulated through groups and voluntary organisations aimed at older adults, as well as groups and organisations specific to carers, such as dementia support and carers' support services. We advertised for the interest of older men who self-identified as a carer for a significant other (including partners, other family members or close friends), adopting the Care Act 2014's definition of a carer as 'an adult who provides or intends to provide care for another adult' (s 10[3]). One limitation of this approach is that not all carers associate their caring relationships with the term 'carer', and men even less so. Hence, we also sought to emphasise 'men who care for others' when advertising the study.

Participants ( $n = 25$ ) ranged in age from 68 to 92 years (mean age of 77). One participant was from a Black Caribbean background; the majority (24) were White British. All identified as heterosexual. Nineteen men were caring for their spouse. Two men cared for a close female friend, four were caring for their adult children (including one man caring for his spouse *and* adult child) and one man co-cared (with his wife) for their grandson. All participants had been providing care for a minimum of two years and described themselves as the main carer. [Table 1](#) provides a detailed breakdown of participants' characteristics.

All men took part in a single interview lasting 1.5–2 hours in duration; these typically took place in participants' homes, dependent on their preferences. Through standardised, open-ended questions, we invited participants to discuss: their current social networks and levels of social contact with network members; their experiences of loneliness and isolation (both in current and earlier life); and their participation in group interventions and social activities. When seeking to initiate discussion about loneliness as a highly sensitive topic, questions from the University of California Los Angeles (UCLA) three-item Loneliness Scale ([Hughes et al, 2004](#)) were used, for example, 'How often do you feel that you lack companionship?' and 'How often do you feel isolated from others?' Questions were asked about social connections and social network membership (currently and ten years ago) to identify personal and situational characteristics, as well as sources of instrumental and affective support. Specific to carers, participants were asked to share their experiences of caring, including the person they cared for, their role and responsibilities, and the formal and informal help and support received.



**Table 1: Key characteristics of participants**

ID	Age at interview	Person being cared for and health concerns	Primary location of care	Sources of informal support
M17	79	Spouse – physical health and pain management	Home	Considering seeking extra help
M20	70	Spouse – disabled (physical)	Home – housing scheme	Other residents in same housing scheme
				Adult daughter
M23	87	Spouse – mental health	Home	None identified
M25	71	Spouse – disabled (physical)	Home	None identified
M29	82	Spouse – Alzheimer's	Home	Adult daughter and son
				Accesses support from carers' services/groups
M30	76	Adult daughter – disabled (physical and learning)	Home	Attends weekly social club, people help there
				Adult daughter
M31	92	Spouse – Alzheimer's	Home	Adult daughter
				Accesses support from carers' services/groups
M32	79	Spouse – dementia	Home	Church friends and neighbours
				Accesses support from carers services/groups
M34	82	Spouse – physical health problems	Home	Friends
M35	83	Spouse – disabled (physical)	Home	Accesses support from carers services/groups
M36	71	Spouse – disabled (physical) and mental health	Home	Accesses support from carers services/groups
		Daughter – mental health		
M42	76	Spouse – dementia and physical health problems	Care home (spouse only)	Support from care staff on site
M43	80	Spouse – disabled (physical)	Home	None identified
M44	76	Spouse – dementia	Home	Neighbours
				Adult son and daughter
M45	76	Spouse – Parkinson's disease	Home – housing scheme with care	Support from care staff on site
M47	82	Two adult children – mental health	Various places	None identified
M48	88	Spouse – dementia	Spouse recently moved from home into care home	Support from care staff on site
				Adult daughters

*(Continued)*



**Table 1: (Continued)**

ID	Age at interview	Person being cared for and health concerns	Primary location of care	Sources of informal support
M49	68	Adult child – disabled (learning)	Special support school	Accesses support from carers services/groups
M53	72	Spouse – dementia	Home	Neighbours and family members
				Accesses support from carers' services/groups
M54	70	Spouse – mental and physical health/pain management	Home	Sister and local authority social worker
M55	73	Adult grandchild – mental health	Home	Adult daughters
				Accesses support from carers' services/groups
M56	70	Long-term female friend – dementia	Care home (where friend lives)	Support from care staff on site
				Accesses support from carers' services/groups
M57	81	Spouse – Alzheimer's and physical health	Home	Neighbours and friends
				Accesses support from carers' services/groups
M59	68	Female friend – dementia and stroke recovery	Home	None identified
M60	83	Spouse – dementia	Home – extra care housing	Friends
				Accesses support from carers' services/groups

Note:  $n = 25$ .

Interviews were recorded and transcribed, and interview data were thematically analysed using framework analysis for managing and coding the data (see [Gale et al, 2013](#)). A sample of transcripts were read by three team members in order to develop the initial coding framework. This incorporated a priori categories identified in the literature and interview schedule, and was supplemented with categories arising inductively. One member of the team charted a small selection of transcripts across the devised framework to ensure that it worked effectively. Charted data were organised around identified categories and categories relating to caring experiences and practices, with categories being coded separately using an initial line-by-line approach. This was followed by selective coding, where initial codes were clustered together to formulate larger, coherent themes that encompassed multiple 'cases' (that is, participants). Four central themes are presented in the following: (1) caring as a buffer against loneliness; (2) caring as a trigger for loneliness; (3) being cut off from others; and (4) gaining social and emotional connections. Data extracts are presented using participant numbers to protect anonymity, along with their age at the time of interview.

## Findings

### *Caring as a buffer against loneliness*

A total of 14 men described experiences of loneliness in their previous and current life, and the impact that this had on their social connections with others. Across these accounts, loneliness was often framed as a fleeting experience rather than a constant concern. For some, caring brought with it the constant companionship of the care recipient, which helped mitigate feelings of loneliness. A total of 11 men identified that caring and the caring relationship acted as a buffer to loneliness: "Well, the fact that we have each other, that takes the loneliness away and I can, if I was left on my own, I could imagine that I could feel lonely" (M43, 80, cares for spouse). Although M43 talks of how being with his wife can impede loneliness, he also conveyed awareness of the potential for future loneliness should anything happen to his wife. Other male carers were also attuned to the potential for loneliness to become a future problem: "I would feel lonely if [name of friend] passes away. I said to my best friend the other day, actually, on Saturday. I had to get it out" (M59, 68, cares for long-term friend).

From this perspective, the caring relationship and the companionship that it brings is a time-limited buffer against loneliness. Some men conveyed their awareness of how loneliness 'bubbled away' in the background as a potential, future problem if their circumstances changed, such as their partner moving into long-term care or dying. These concerns were expressed among a number of wider concerns about the future being uncertain and their relationship with the person receiving care being highly likely to change. The majority of carers discussed their future-oriented concerns, with discussions mostly relating to financial issues regarding the cost of care and support they require, and the sources of and standards of care provided by health and social care services. Seven men voiced concerns about the need for more professional help and support with caring in the future as their partner's health deteriorated, and where this help would come from. In discussion of this, two men suggested that they had been unable to express their anxieties about likely future deterioration and indicated that they would like to be listened to more in order to enable them to be more prepared for the future.

### *Caring as a trigger for loneliness*

Caring and its responsibilities did not completely inhibit loneliness as some men situated loneliness as fleeting moments in their everyday lives. For some men, changes in their living situation with their spouse triggered experiences of loneliness. Two men missed their spouses who were now living in a care home:

'It's strange being here on your own when, for years, we had children, me and my wife. Now, the place is a bit empty and lonely. It's different. I don't know how this affects you or anything else, or how you look at things, but it's different. It must have some effect but God knows what, other than what I'm telling you. I certainly miss my wife.' (M48, 88, cares for spouse)

Seven men described fleeting moments of loneliness, and for some, it was the responsibility and caring duties that triggered these feelings, as M53 discusses:

'I think my loneliness comes from the total responsibility.... Yes, because you've got to do everything, so whether that confuses your brain to say that, you know, well, you're on your own, you're basically on your own. When there are people here, it's fine; if they come and look after her, I go away, but I come back to it.' (M53, 72, cares for spouse)

M53 notes that such feelings of loneliness are heightened on the days when his wife's condition is poor and the caring strain is high. He highlights how feelings of loneliness are lessened when other people are present to share caring responsibilities.

Where loneliness was discussed as a more familiar and constant experience, it was often associated with a lack of both companionship and social contact with others. A total of 11 men described a lack of companionship, including the companionship of their spouses/partners, evoking a sense of emotional loneliness. Participants talked about missing conversations with their partner, which had become increasingly challenging due to their spouses' illness or due to the care recipient relocating to a care home. One man describes missing conversations with his wife and shared time together with friends:

'Yes, at mealtimes because there is no conversation about things. I sometimes think it would be nice to be out at the pub having lunch with another couple. I do that from time to time. I can't do it any longer because [wife's name]'s table manners are not good enough to do it.' (M57, 81, cares for spouse)

For men who lived with the care recipient, mealtimes and evenings were emphasised as acutely difficult times when conversation was lacking (because partners were no longer able to converse) or the first part of their day when they had time on their own (because the care recipient often went to sleep before them).

Some men were cautious about describing their experiences of loneliness as they were mindful of ageist and gendered stereotypes about 'lonely, old men':

'Loneliness, I wouldn't say it's a big item with me, Jon [interviewer]. I mean, I wouldn't like to give you an impression of a poor old sod who's lonely all the time. I'm not, but it isn't a thing that's not here occasionally because we've been married over 60-odd years. Loneliness is a minor feature but to disregard it completely would be quite wrong.... I hope I don't give the impression that I'm desperately lonely because I'm not, but I have experienced it.' (M48, 88, cares for spouse)

The participant just quoted stresses that he is not "desperately lonely", seeking to distance himself from the social stigma attached to loneliness, while recognising that loneliness does feature in his day-to-day life since his wife relocated to long-term care. Equally, some men discussed loneliness in association with missing friendships.

### *Being cut off from others*

Male carers described how caring had a detrimental impact on interaction with others in their social network as they discussed missing time spent with adult children, other family members and friends. The majority (21) of male carers recounted difficulties

in being able to socialise with friends and in attending and being part of different social activities and groups, for example, social clubs or group sports. Several men described their social life as shrinking due to being unable to leave the care recipient for extended periods of time and having to withdraw from social activities such as going to the pub with friends.

Caring was not always a solo activity. The majority of men (19) mentioned others who assisted as they described the informal help received from friends and family and formal support organisations. Some men mentioned family members such as adult children or siblings who would sometimes help out. Typically, the majority of participants did not explicitly talk about accessing support from their immediate family. Men tended to speak more of support from neighbours and care organisations. Some men were able to call on informal support from neighbours and close friends to 'sit in' with the person they cared for while they attended a group or social activity. However, this was often time-limited and occasional:

'Well, if I wanted to go off for the day or something like that, I'd have to think, "Well, no, I can't do it." It is restricting but sometimes I can get over it by, perhaps, going out for an hour in the morning and an hour in the afternoon, or something like that.' (M32, 79, cares for wife)

Feeling overwhelmed with the responsibilities of caring and lacking time away from the caring role were recurring issues for participants. One participant in our study shared his longing for more freedom from caring duties: "I think since the Alzheimer's has kicked in, whether it is loneliness or whether it is a feeling of, 'I don't want to do this anymore. I wish I could go out and have a pint.' That happens more frequently" (M57, 81, cares for wife). His comments convey an overlap between isolation from others and feelings of loneliness. Another participant described feeling "cut off" from others: "Very cut off at times; very much left to my own devices. If a crisis evolves, I more or less feel that I'm more or less just left to get on with it myself, with no one I can really safely reach out to, if you like" (M54, 70, cares for wife).

In a similar vein, two men discussed how they sought to manage caring responsibilities on their own. For those caring for spouses with dementia, health deterioration (mentioned by three men) was of particular concern because of the implications of not being able to cope with increased caring responsibilities at home alone. M29 expressed concern for his wife's deterioration and how difficult caring may become: "By the end of the year, I suspect that my [name of wife] won't be walking at all. That's going to make things a little bit more difficult for us but we'll cope, as we always have coped" (M29, 82, cares for spouse). In this quote, the participant emphasises his capacity to cope in the face of increasingly difficult circumstances, without clarity on how they will manage to cope; the future holds high degrees of uncertainty, as discussed earlier. Five men had concerns about the end of life, in particular, a dual concern about how their partner would cope without them and how they would cope without their partner: "It's a worry, what would happen if I was to pass on first. I really worry how she would manage" (M54, 70, cares for wife).

## *Gaining social and emotional connections*

### *Group engagement and participation*

While some male carers acknowledged caring as an isolating activity, this did not prevent them from accessing groups. The majority of participants were involved in some group or shared, social activity. Just under half (12) of the male carers were involved in activity-based or shared interest groups (for example, art societies, book clubs, skittles and croquet clubs, walking groups, men's sheds and so on), and 16 men were involved in a civic-based organisation (for example, local Probus groups, the University of Third Age and so on). A total of 12 men attended specific groups for carers, such as carers' support meetings, dementia cafes (inclusive of carers) or Alzheimer's support groups. Support settings like carers' groups and meetings provide a supportive space of mutual, empathetic understanding that validates the normalcy of emotional responses to the strains of everyday caring (Thoits, 2011).

Participants acknowledged the benefits of group participation as a way to inhibit feelings of loneliness and to provide short-term respite from caring responsibilities. For the majority of men involved in groups, having social interaction, keeping occupied and getting out of the house were the main benefits:

'As I say, I think, really and truly, you've got to get out and he's got to get out and find these clubs. They are about. You have got to get off your backside; otherwise, you'll never get out and I think it's terrible when you're just sat there day in, day out, doing nothing or watching that square box.' (M30, 76, cares for daughter)

A number of men were attending carers' support groups and these groups were described as beneficial in providing emotional support. These groups were viewed as a safe space where they could share problems and 'let off steam' about their caring experiences. Within this space, they felt understood by other group members (men and women) who were in similar caring situations and had experienced common challenges:

'There are some lovely people there, everybody is lovely. They are very sympathetic. There are some of us who can get to grips with the labyrinth of social services and things better than others.... It is also quite useful to hear that other people are doing the same things. That is the main thing, in a way, you are not the only one.' (M57, 81, cares for spouse)

M57's comment suggests that carers' groups help reduce social isolation through harbouring connections with other carers. Alongside sharing the 'burden', carers' groups were also a place to receive information and advice:

'So, information is available, and that keeps us up to date. Then it's a case of going around the room, and if you've got anything that you want to ask, or something to get off your chest, I think, with a lot of people because, probably, like me, they don't really talk to anybody. So, it is a case of being able to just unburden, I suppose.' (M29, 82, cares for spouse)

### *The trouble with carers' groups*

Not all participants were invested in participating in carers' groups, for various reasons. These included finding the structure and content of the sessions unappealing, being frustrated by continual changes in staff and group facilitators, or because of more personal views about sharing concerns with other group members, as discussed by one man:

'It just doesn't appeal to me. I am quite happy as I am. If I have a problem of some sort, then I can find somebody to go to sort it, be it the doctor or one of my sons. No, I find – this sounds terribly snobbish, perhaps – but I find I'm bored with the often-inane chatter that goes on in those sorts of meetings, you know, where ... I mean, we're going to have one on Thursday, it's the quarterly site meeting, and yes, I'll go to it but probably won't make much of a contribution, and be glad when it's all finished.' (M42, 76, cares for spouse)

The respondent's comments emphasise his independence in managing his caring responsibilities alone alongside his low tolerance for "inane chatter" in groups. Another participant found the group's focus on enjoying activities together highly frustrating as he sought advice rather than shared activity and companionship:

'I want to be able to understand more the difficulties and how to deal with them. Well, that part of it seems to have dropped off a bit and it just seems now that some of it is just concentrated on giving you a pleasant hour or so away from your responsibilities, where I'd rather be learning all the time about how to adapt and how to make things a little easier.' (M55, 73, cares for grandson)

One main difficulty in attending and being actively involved in groups was the caring role, which was discussed by eight men. Lack of time combined with continual worry about the care recipient amplified difficulties in regularly attending groups:

'And they, every so often, run a meeting where we can go along but I can't go and leave [name of wife]. So, I can only go to the ones where we both go. And now she's not, it's not so good. If I take her somewhere, she's has her head down on the table within five minutes and that's it.' (M35, 83, cares for spouse)

M35's comments convey the social and emotional challenge of attending meetings when accompanied by the care recipient. A related practical challenge was the timing and location of groups. For example, one participant stated that he would prefer carers' meetings to be during the daytime rather than evenings, when he needed to be with the care recipient. Another man spoke of the "hassle" of getting to the group when it clashed with tasks he had to undertake during morning times, highlighting that there is no optimum time for group meetings.

Perhaps unsurprisingly, the majority of carers' groups and meetings attended by our participants consisted mostly of women. For some, being the only man in a group of

women was not a problem and some men enjoyed the company. However, one man found it difficult to contribute to the group, despite acknowledged attempts by the facilitator to involve him: “At the other meeting, the ladies don’t always chat about their husbands – they do a lot – or fathers, etc, so I don’t really get involved in that kind of chat” (M29, 82, cares for spouse). Discussions within the group were perceived to be focused on topics of interest to women and of less interest and appeal to men.

## Discussion

While loneliness and social isolation are reported problems for carers, including older carers, there is limited evidence available on older men’s experiences and the meanings that they construct from experiences of diminished social contact and isolation from others. Survey-based reports highlight loneliness as a distinct problem for carers ([Carers UK, 2015](#); [Office for National Statistics, 2018](#)). Our findings provide a more nuanced understanding of how older male carers perceive and experience loneliness in caring relationships. The first prominent finding is the framing of loneliness as a prospective problem, partly buffered by the current caring relationship and the company that this affords, albeit under challenging conditions. For over a third of the men interviewed, loneliness was not identified as a major problem; however, male carers were aware of diminished social contact with others outside the caring relationship and the ways in which the everyday challenges of caring were accompanied by fleeting moments of loneliness.

For some older men, providing care acts as a buffer to loneliness as the company and presence of the care recipient counteracts feelings of loneliness. We acknowledge that such a condition is relationship-specific: some carers may be in antagonistic or abusive relationships that severely compromise the quality of companionship shared. Equally, deterioration in the care recipient’s health can lead to a lack of conversation and companionship, and further restrict social contact with members of one’s social network. Some participants were reflexively aware that this was a short-term inhibitor and were attuned to the potential for future loneliness should the care recipient’s condition deteriorate, or should they die. Caring, then, might delay emotional loneliness in old age, rather than alleviating it completely.

The conceptual distinction drawn between emotional and social loneliness in the literature ([De Jong Gierveld et al, 2009](#)) is tangible in older men’s accounts in our study. When discussing loneliness, some men conflated it with diminished social contact with others, such as family and friends, and they missed former social rituals such as going to the pub with friends. From this perspective, diminished levels of social contact with others, such as friends and family members, is a more palpable challenge as a form of social loneliness rather than emotional loneliness. [Neri et al. \(2012\)](#) note similar trends among older male carers in Brazil, being evident by their withdrawal from participation in social activities and events. Our findings suggest two differing experiences of loneliness: emotional loneliness is lessened by the responsibilities of caring and partly by the company of the care recipient; while carers experience social loneliness in tandem with their social networks shrinking.

Another important finding was the emphasis that men gave to the social and emotional gains of participating in carers’ groups. This stands in contrast to previous literature emphasising the managerial, task-oriented approach that older men adopt towards caring responsibilities ([Russell, 2004](#); [Ribeiro et al, 2007](#)), and is out of



kilter with prior discussions about male carers' reluctance to seek help and support (Milligan and Morbey, 2016). Our findings on group engagement and participation suggest a more complicated picture and indicate some reflexive recognition of being 'not the only one' immersed in caring. In Russell's (2004) US study, the construction of masculinity inhibited older male carers from discussing emotional responses to caring, while in our study, the emotional gains are more tangible for these men. Participants pointed to instrumental gains in attending carers' groups, such as staying occupied and getting out of the house, in parallel with emotional benefits garnered from having a protected space to 'let off steam', express caring-related problems and connect over shared experiences.

Based on their review of the literature, Greenwood and Smith (2015) indicate that male carers feel guilty about seeking help and seek to remain independent of support services. Our findings show how older men seek to both manage caring responsibilities on their own while equally engaging with groups socially and emotionally, particularly groups targeted at carers. Based on their Portuguese study, Ribeiro et al. (2007) argue that older male carers seek social recognition as a reinforcement of their perceived duty and responsibility as providers for their spouses. Participation in carers' groups may bring some element of social recognition and role validation for men undertaking what is customarily perceived as a gendered role associated with femininities. However, the centrality of shared experience and connection suggests a process of validation as mutual carers first, and men doing caring second.

Aside from these social and emotional gains, a small number of men did not easily connect with others involved in carers' groups, as evidenced by frustrations aired about the direction and focus of group meetings and the construction of group discussion as 'inane chatter'. The importance of self-sufficiency, coping and maintaining autonomy – attributes associated with hegemonic masculinity and identified as shaping other male carers' experiences (Russell, 2004; Ribeiro et al, 2007) – may filter some men's expectations of carers' support groups and interrupt their attempts to engage with other carers through group forums and services. However, seeking to manage and maintain autonomy does not preclude older male carers from also engaging with carers' groups and support services. As evident in our findings, some older men may struggle with participation in carers' groups that they perceive to be focused on women's interests and experience as feminised spaces.

Our findings shed new light on how male carers seek and benefit from carers' support groups while also maintaining a sense of autonomy and coping. In part, this may reflect the recruitment of older male carers through existing carers' services running group interventions. However, this does not diminish the core messages that men convey about the engagement of male carers when planning and developing suitable interventions. Service providers face the dual challenge of: first, men recognising themselves as carers (which they may only realise through contact with services); and, second, men recognising experiences of loneliness and diminished social contact as problematic. Both experiences carry social stigma and unhelpful connotations of older age as a typically negative social experience. Marketing carers' groups and services as tackling loneliness and providing support may be counter-intuitive and hold less appeal for older men. Following on from the preceding findings, there may be more successful engagement through promoting services as opportunities to meet and connect with other carers or as social opportunities to 'get out of the house' and enjoy other company. When planning supportive interventions, service providers also need

to look beyond static representations of older male carers as practical/task-focused and less invested in sources of affective support. Finally, group facilitators need to plan how to manage the gendered dynamics of carers' groups while not compromising this supportive space for other members.

There are several limitations to our study. We have drawn on a small, non-representative sample and the findings have limited transferability to other older carers' lives as we have not captured the perspectives of male carers who are not involved in groups and services, and may therefore be at greater risk of loneliness and social isolation as a result. The sample is homogeneous across social characteristics of ethnicity and sexual identity; this limits scope to examine the ways in which these social identities intersect with and shape older men's experiences of caring, and how social networks may differ according to sexual identity and ethnicity. This study is cross-sectional and has not captured changes in the caring relationship over time. Further longer-term exploration into life after caring for older male carers and the impact of this on loneliness and social isolation would be beneficial for health and social care providers in assisting them to provide continuous support for men who may find themselves in this situation.

## Concluding comments

Findings from this study reiterate the value of carers' groups for older men as a source of information, a place for mutual, affective support, and a safe space to connect with others in similar situations who can offer empathetic understanding. These groups help alleviate social isolation while providing brief periods of respite from caring responsibilities. Equally, service providers for carers may need to engage men in future-oriented conversations when there are pivotal changes to the caring relationship, such as one party moving into long-term or end-of-life care. Older men need to consider life after caring, and this includes re-forging social connections with others. This may entail reconnecting with members of their social network or building new networks – a daunting social activity in later life when coupled with experiences of grief, loss and bereavement. Older male carers' accounts speak to the importance of services ensuring consistency in who facilitates groups for carers, flexibility in the scheduling of groups and recognition that men benefit in different ways from these forums, including obtaining emotional support, information and advice.

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## Conflict of interest

The authors declare that there is no conflict of interest.

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