



Original research article

Coping strategies of male informal caregivers

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Abstract

Introduction: The study aims to explore the specific experiences of men involved in informal care in the Czech Republic, with an emphasis on their coping mechanisms when adapting to mental, physical, and social stress.

Methods: A qualitative research design was employed, utilising thematic analysis of semi-structured interviews with eight men from the Moravian-Silesian region who assume roles as primary or secondary caregivers to varying degrees of intensity.

Results: The dominant coping strategy among men proved to be rationalisation and instrumentalisation of care, with caregiving redefined as a managerial and logistical task. This approach allows them to maintain their masculine identity and create emotional distance from the demanding situation. The analysis also identified major differences in the experience of stress depending on the caregiver's position; while secondary caregivers perceive caregiving more as external assistance, primary caregivers face extreme exhaustion, social isolation, and risk of burnout. Intimate personal hygiene is a significant barrier for men, especially in the son-mother relationship, which they therefore often delegate to others.

Conclusion: The study highlights the lack of systemic support for this growing group and emphasises the need for support for flexible job arrangements as well as the elimination of gender stereotypes that prevent men from seeking formal assistance.

Keywords: Anaesthesia; Nursing Care; Patient; Unpleasant Experiences

Introduction

Informal care, unpaid support provided by family or loved ones (Dvořáková, 2018; Jeřábek, 2009), is currently a key pillar of the long-term care system. Although it is not explicitly defined in Czech law, it is effectively enshrined in the care allowance and works as a complement to formal care, which is institutionally regulated (Act no. 108/2006 Coll.; Marešová et al., 2020).

In Europe and the Czech Republic, a significant increase in the number of people aged 80+ is expected, which, together with declining fertility and smaller families, is putting enormous pressure on the capacity of health and social systems (Hamanová et al., 2024; Langhamrová et al., 2018; Tragaki, 2024). Formal services are already struggling with staff shortages (OECD, 2020), which further increases the system's dependence on informal caregivers.

However, long-term care poses significant risks to caregivers (DiGiacomo et al., 2017; Berglund et al., 2015). The situation is exacerbated by the economic impact on family budgets and the failure to adequately meet the support needs of caregivers (Plöthner et al., 2019). Without systematic support and strengthening of formal services, there is a risk of caregiver exhaustion and destabilisation of the entire system (Kuhlmeier and Budnick, 2023).

Materials and methods

Gender aspects of informal care

Recently, the proportion of men involved in informal care has been growing. This trend is linked to the ageing population, the increasing need for long-term care, and changing gender roles in society (Eurofound, 2025). Despite these changes, the long-term care system remains predominantly female-oriented (EIGE, 2021). A study by Dudová and Volejníčková (2014) shows that women's decisions to provide care are affected not only by cultural norms (e.g., expectations that women are "naturally caring") but also by structural factors such as the availability of services, work conditions, and the labour division within the family.

Gender stereotypes pose a significant barrier for men as well. The persistent image of men as care providers who do not need any assistance leads to silent caregiving and refusal of support (Seidler et al., 2016).

Men's motivation to take on a caregiving role differs from that of women. While women more often cite emotional closeness, men list moral obligation, partner loyalty, and duty (Acicus, 2017; LeBlanc, 2021). Many men become caregivers because of certain circumstances rather than their own decision. They approach caregiving with a different mindset – dominated by rationality, task orientation, and technical and/or

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organisational skills (Fee, 2020; López-Anuarbe et al., 2019). Caregiving is a task to be mastered rather than a process of relational interaction (Dudová and Vohlídalová, 2018). Research shows that men prefer a practical approach to caregiving: focus on logistics, management, planning, and physical tasks (Fee, 2020; Milligan and Morbey, 2016). This approach can be effective, but it often leads to isolation and neglecting one's own needs (Fee et al., 2023).

Men often perceive asking for help as a failure (Fee, 2020; Seidler et al., 2016). They have weaker social support and tend to cope with stress on their own, increasing the risk of isolation (López-Anuarbe et al., 2019). Men often do not perceive themselves as "caregivers" and therefore do not expect to be entitled to support (Finn and Boland, 2021; Milligan and Morbey, 2016). According to a study by Nishio et al. (2023), more than 90% of older men caring for a partner with dementia do not actively seek help, even though they need it. There is also a lack of services tailored to men and low availability of gender-sensitive forms of support. Men often encounter information barriers, a feeling of being misunderstood by professionals, and difficult access to services. Key barriers to both formal and informal support include a lack of information, low levels of understanding among professionals, and gender-based differences in help-seeking. However, appropriately targeted interventions (e.g., peer support groups) can significantly improve the mental well-being of male caregivers (Greenwood and Smith, 2015).

Psychosocial and health impacts

Long-term care provision is associated with high physical and mental stress. According to AARP and National Alliance for Caregiving (2020), the strongest predictors of stress include loneliness (caregivers who feel lonely more likely to report high emotional stress (72%)), and the absence of choice in taking on caregiving, which significantly increases subjective burden. High stress is more often reported by caregivers who provide long-term, high-intensity care, or live with the care recipient in the same household (AARP and National Alliance for Caregiving, 2020). These characteristics are also typically found in men, who often take on technically demanding tasks and physically demanding care.

The health impacts on male caregivers often manifest as somatisation of psychological stress – back pain, sleep problems, or gastrointestinal problems (Fee, 2020).

Caring for a close person often leads to a loss of balance between helping others and caring for oneself. Therefore, a change in attitude is important: from performance-oriented care to care that is based on balance and mindfulness of one's own needs. This perspective is particularly important for male caregivers, as they tend to be less accustomed to discussing emotions and often neglect their own health (LeBlanc, 2021).

Methodological framework and research design

Understanding how men cope with informal caregiving is key to effective support; male caregivers often use problem-focused strategies and may challenge traditional masculinity norms, highlighting their potential for resilience and adaptation (Zygouri et al., 2021).

The study is a part of the Student Grant Competition project SGS04/FSS/2025: Gender Roles in Sandwich-Generation Families: A Comparison of Men's and Women's Roles. It is based on critical realism with elements of social constructionism.

Therefore, our research aims to interpret the data in the context of gender roles and structural conditions of social

care in the Czech Republic. We established two research objectives. The first was to identify the specific burdens that men face in the role of informal caregivers in the Czech Republic. The second was to determine which factors help male informal caregivers cope with the specific burdens associated with caregiving.

Research data was collected through semi-structured interviews conducted between March and June 2025. The recorded narratives were then transcribed in full.

For further work with the data, we chose thematic analysis (TA) following Braun and Clarke (2006). This allowed us to identify both manifest and latent patterns of behaviour and experiences in the informants involved in the research. The analysis focuses not only on explicit semantic content (what the informants say), but also on implicit meanings (what assumptions and norms are hidden behind their words). The analysis of latent meanings followed a multi-stage process: first, we identified recurring semantic patterns (explicit descriptions of care); second, we examined the specific vocabulary used by informants, such as managerial and technical metaphors; third, we interpreted these linguistic choices within the framework of gender theory to uncover underlying defensive mechanisms and the preservation of masculine identity, moving beyond what was explicitly said to why it was framed in such a way. Reflexivity was an integral part of the research process. We analysed data as a team, thereby minimising individual subjectivity. The resulting interpretations represent a collective consensus regarding both the manifest and latent meanings of the codes.

Adhering to the ethical standards of qualitative inquiry, all research interviews were fully anonymised. To protect participant confidentiality, any potentially identifying details were excluded from the citations. The SGS project was formally approved by the Ethics Committee of the Faculty of Social Studies at the University of Ostrava.

Characteristics of the research sample

The research sample consists of eight informants; men involved in informal care for a close person. We used the purposive sampling method, with the intention of capturing the variability in types of caregiving relationships (sons vs husbands) and intensity of care (from occasional assistance to 24/7 care). A detailed description is provided in [Suppl. Table S1](#). Theoretical saturation of the research sample was reached progressively as interviews were analysed. By the final interviews, no substantially new conceptual categories emerged, with recurring patterns already identified in approaches to instrumental care.

Results

During the analysis, three main themes were identified that structure the experience of male caregivers: the burden associated with caregiving in male caregivers, the caregiving limits among male caregivers, and primary vs secondary caregiving and its impacts. These themes are not isolated but intertwined, as can be seen in the following description.

Theme 1: The burden associated with caregiving in male caregivers

Mental burden

The mental strain experienced by male caregivers is not primarily defined by "extra work" but rather by a state of permanent vigilance. This state is particularly exhausting in cases where the person being cared for has dementia. Informant BR

describes a life of constant tension, where even sleep is subordinated to his mother's needs: "So I often must sleep downstairs, next door, with my door open even at night. I'm just always on alert... If I hear a noise, I'm immediately up..." JB admits that caregiving is demanding and that he sometimes gets fed up with it, mainly because of his wife's constant chatter, "She talks all the time, but of course she talks nonsense", and her inability to recognise loved ones. JH, on the other hand, feels the mental burden of the constant need to "somehow constantly prompt his son and come up with ways to cope" and his "extreme mood swings" associated with ADHD. BR feels unappreciated, "She thinks everything is fine, that I'm just taking care of her and stuff. But I try to explain to her that she is in a difficult situation, but so are we as a family. That it's also mentally very stressful for us". BR also mentions the loss of privacy: "I always have to have the TV turned down, the door open, so I can hear if she goes somewhere, or needs something."

Rationalisation and instrumentalisation of care

For many informants, caregiving is primarily a series of activities that need to be organised and performed. Emotions are often pushed into the background in favour of functionality. One informant explicitly connects caring for his mother with caring for real estate, thereby transferring caregiving into a sphere where he feels competent: "In my case, it's about my mother being left alone in the home. She has a garden, which means the house needs maintenance...it needs some care, the same goes for the garden and the household. So, I help with that" (PP).

Another informant describes his role almost as that of a crisis manager who deals with administrative tasks that his mother cannot handle anymore. His approach to caregiving is rational, structured, and results-oriented: "Mostly electric bills, gas bills, postal orders, letters, and phone calls. All of that is waiting for me. I must come over, read it, explain it to her, and possibly arrange for some payments and errands" (JH).

This "managerial style" also shows in the provision of meals and catering. Informant BR takes on the role of "supplier", with cooking and meal preparation presented as a logistical task with clear rules (what the mother can and cannot chew): "So we agreed that I would take care of everything for my mum in terms of preparing meals, lunches, dinners, breakfasts... I take care of all that" (BR).

Instrumentalisation also serves as a defence mechanism. By focusing on "external" tasks, men protect themselves from the emotional impact of their parents' physical and mental decline. An informant caring for his 99-year-old mother describes his routine as matter-of-fact, without pathos. His emotions are "parked" so that he can function. He finds rest in manual labour (gardening), not in emotional sharing: "I just see it as something I owe the old lady, and I don't think about it" (MiBoh).

Balancing caregiving and work

Men often juggle three worlds: caring for their parents, caring for their own children, and the demands of their job. Informant JH is the prototype of the sandwich generation – he cares for his mother and his disabled son while having a demanding job. His strategy is "radical efficiency" – he combines his commute to work with visits to his mother: "I use a company car... That means that whenever I drive to or from work, I stop by to see her" (JH).

Informant BR had to exhaust his long-term care allowance and is facing losing his job, which would be devastating for his family: "That would mean I would have to quit my job. And since

we live in a family home... basically, we wouldn't be able to manage financially" (BR).

The issue of reducing the burden through formal care

Men often find themselves caught between "not being able to cope with care" and "not being able to end care" due to their parents' resistance to institutional care. Some informants encounter resistance from their mothers: "She doesn't want to hear about going to a retirement home or to any assistance flat. So right now, we're kind of struggling with that" (PP). Others may see institutional care as a rational solution to the crisis, while those near them (father, partner) resist it.

Theme 2: The limits of caregiving for male caregivers

While men accept instrumental care relatively easily, interventions involving intimate hygiene and bodily boundaries present distinct challenges. The interviews reveal a difference in approach to intimacy depending on the type of relationship (son vs husband).

Sons caring for their mothers

Sons caring for their mothers show a clear barrier to intimate hygiene (washing, showering). This activity disrupts the traditional boundaries of the mother-son relationship and is perceived as socially or mentally risky.

Informant BR describes a sophisticated choreography that allows him to help his mother without crossing the boundary of intimacy: "It's up to my partner to help me with my mum, especially when it comes to hygiene, because my mum is a woman and my partner is also a woman. So, a woman should wash a woman, and I'm just there to make sure my mum doesn't fall. Like, I hold her..." (BR). Here, the man acts as a "gender-neutral" physical support (static element), while the woman performs the dynamic, intimate activity. MiBoh: "I don't think I could do that."

Spouses and partners

In contrast, husbands caring for their wives or partners overcome this barrier. Informant JB performs all hygiene tasks for his wife, who has dementia, including showering her. The intimacy of the marital bond probably neutralises any embarrassment: "She can hardly get dressed by herself anymore, I have to help her into the shower, she doesn't know how many times, she doesn't know where the toilet is" (JB).

Another informant concludes that "maybe at first it was a bit embarrassing" to provide care as a man, but "now everyone has got used to it" (VC). However, he indicates that caring for a man would be easier: "If it were a man, it wouldn't be so, let's say... restrictive, as when you care for an older woman who still has some kind of relationship with men."

Theme 3: Primary vs secondary caregiving and its impacts

The analysis shows that men's experience differs depending on whether they are primary (main) or secondary (supportive) caregivers. This is then reflected in the level of stress, the impact on their personal lives, and the perception of their own caregiver identity.

Care as "assistance" from secondary caregivers

For men in a secondary caregiver role, the main burden of care is borne by someone else – typically a woman (wife) or father. For them, care is something like an external assignment; they have an option to "leave" for work or for their hobbies. They retain their original identity (entrepreneur, employee). They

perceive caregiving as “just assistance” for the primary caregiver, not as their primary responsibility.

For example, informant MILA admits that care is his wife’s domain and he is only involved marginally when his work allows him to: *“And since it’s her responsibility, I leave it to her... I’m very busy, so I don’t really devote any time to the family”,* or *“From the very beginning, we agreed that the burden is on her when it comes to her mother... that she can’t ask me to do it, and if she can handle it, I’m fine with it. If it were to be my responsibility, it wouldn’t work”* (MILA).

Another informant sees his role as complementary to the care provided by his father and wife: *“We both help, but my wife more so. I tend to ‘babysit’, bring lunch, but more or less it’s up to my father and my wife”* (MBU).

Thus secondary caregivers often fulfil “the traditional model” where the man provides finances and logistics while the woman “cares”. This model is less threatening to men, but it can lead to overburdening their partners (as indicated by MILA). This group of men experiences a significantly lower level of stress from direct care; their burden arises from a “stifling atmosphere” in the family or from financial demands rather than from physical exhaustion.

Overburdening of primary caregivers

Men in the role of primary caregivers bear the main burden of responsibility. For them, caregiving is the central focus of their lives, around which everything else revolves. They exhibit higher levels of exhaustion and feelings of loss of freedom. They often live with the person they care for in the same household or in proximity. They cannot delegate care because: *“Most of the care is on me... basically, you tell yourself that you’re*

on your own anyway” (BR). These men have given up their careers (JB) or their jobs are at risk (BR). They have no room for escape; their home has become their workplace.

As a result of their situation, primary caregivers are forced to abandon the “traditional model” and accept a role that is socially coded as female. They often deal with this by hyper-instrumentalising care (managerial approach) to maintain a sense of control. While secondary caregivers have “some place to escape to” (work, hobbies), primary caregivers (especially only sons and husbands) are at risk of burnout and social isolation.

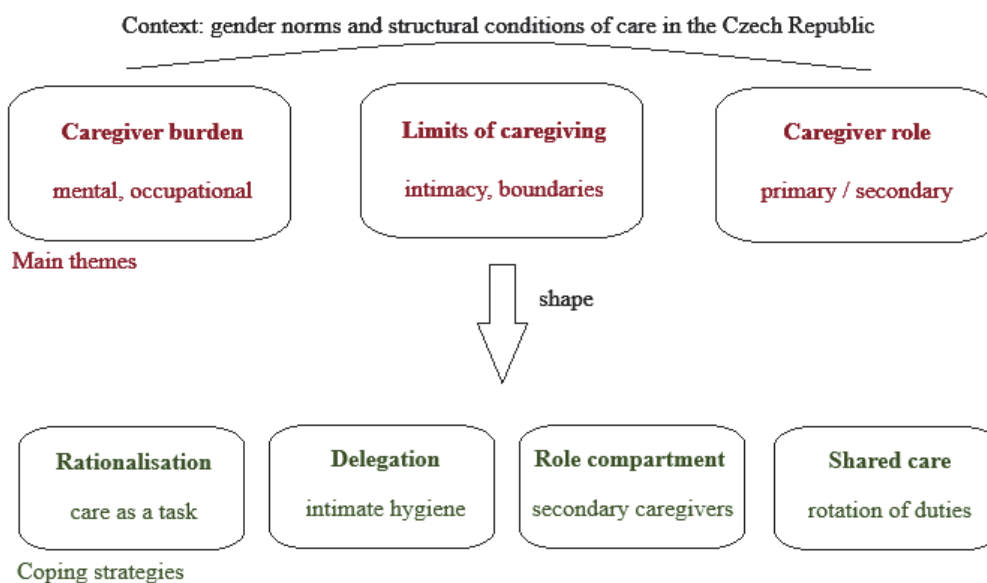
Shared and remote care

A specific subgroup consists of men who are the main organisers of care but do not live with the parent (PP, JH) or share care equally (VČ).

PP and JH are “remote managers”. They are the primary caregivers in terms of responsibility (no one else is there to do it), but their care is episodic (visits, shopping). This allows them to maintain a distance that men like JB or BR do not have: *“In my case, it’s about that my mother stayed alone in the house. ... So, I help with that”* (PP). Similarly, BR states, *“Well, there’s not much time, ... I’m in a gardening club, so I find some time for that.”*

Informant VČ presents a model of “shared care”. This model seems to be the most psychologically sustainable, because it allows for rotation of duties and mutual support. *“Whoever is available... We agree... Whoever can do it at the moment”* (VČ).

The results of the thematic analysis are summarised in Scheme 1.



Scheme 1. Thematic structure of male caregivers’ coping strategies

Discussion

First, we will summarise the results concerning the two research objectives.

The first research objective was to identify the specific burdens faced by men in the role of informal caregivers in the Czech Republic

The burden associated with informal care provided by men is multifactorial. In addition to the psychological and emotional demands associated primarily with the deteriorating condition of a close relative they are caring for, the difficulty of balancing work responsibilities and caregiving also plays an important role.

A specific form of burden for male caregivers is the pressure associated with concerns about disrupting the “traditional masculine role”. Caregiving activities and professions tend to be perceived as low prestige (except for medicine), even though they are essential to the functioning of society. This low status is linked to a high degree of feminisation of these professions, which correlates with systemic inequalities in pay, lower prestige, and poorer work conditions (Shannon et al., 2019). At the same time, the devaluation of care work discourages men from entering these professions (Puzio and Valshtein, 2022). This, in turn, exacerbates existing inequalities, contributes to the neglect of the importance of female-dominated professions, and reduces society’s willingness to address the problems these professions face. It is therefore not surprising that men are often reluctant to take on the care of their close relatives. On the other hand, greater involvement of men in caregiving may help society pay more attention to the challenges associated with caregiving professions and informal care.

Research findings indicate that the strategy of care instrumentalisation corresponds with the conclusions provided by Fee (2020) and Milligan and Morbey (2016), who likewise depict a preference for a hands-on, task-oriented concept of care. However, our data suggests that this approach is mainly characteristic of secondary caregivers, while for primary caregivers, it functions more as a defensive mechanism against burnout.

Another specific form of burden for male caregivers is tasks related to the intimate hygiene of the women they care for. This is particularly true for sons taking care of their mothers, where there is a risk of disrupting the mother-son relationship boundaries. Sons, therefore, often actively delegate this part of care to women – partners, wives, and/or professional caregivers.

A key factor in terms of the level of burden is whether the man is the primary or secondary caregiver. For primary caregivers, the burden associated with caregiving is much higher and more complex, and there is a risk of more serious consequences than for secondary caregivers. Primary caregivers face great exhaustion, feelings of loss of freedom, risk of burnout and social isolation, risk of job loss, and even a threat to their masculinity (Fee et al., 2023; Jahodová, 2021). They then tend to address this with a managerial approach to caregiving (instrumentalisation of care) to retain at least some sense of control over what is happening.

The second research objective was to determine which factors help male informal caregivers cope with the specific burdens associated with caregiving.

Data analysis shows that male caregivers’ coping strategies are multifactorial and do not consist solely of common relaxation

activities such as sports, work, and hobbies. The key stress coping mechanisms are deeply connected to the gender identity management and the type of caregiver role that the informant performs.

The dominant and most frequently identified strategy is the rationalisation and instrumentalisation of caregiving. Men tend to redefine care from emotional and relational work to a project or a set of managerial and logistical tasks. By transferring care to a sphere where they feel competent – such as property management (PP), handling paperwork (JH), and/or providing supplies (BR) – they maintain their identity as “problem solvers”. This approach allows men to create emotional distance from the psychologically demanding aspects of care, such as watching a close person’s decline, while protecting their masculinity in an activity traditionally perceived as feminine.

Another important strategy is the active establishment of boundaries and the delegation of specific tasks. This mechanism is most evident in intimate hygiene, which is taboo for sons caring for their mothers. The burden associated with disrupting the mother-son relationship boundaries is addressed by strictly delegating these activities to partners and/or both professional and non-professional caregivers.

The caregiver role fundamentally affects the choice of strategy. While secondary caregivers (MILA, MBU) cope with the burden through compartmentalisation of roles – they define caregiving as “help” and maintain their primary identity at work or in the family – primary caregivers (BR, JB) do not have this option. For them, instrumentalisation becomes a defensive mechanism against burnout and loss of control. The most sustainable model appears to be shared care (VČ), where taking turns and mutual support with a partner function as a primary coping mechanism. The ability to find time for oneself and maintain personal activities is, therefore, more a consequence of the successful application of these strategies than the actual strategies.

Overall, men are usually able to find/make time for themselves. They often set clear and unbreakable boundaries, such as informant MILA (“*If it’s supposed to be my responsibility, it won’t work*”), and women usually accept them. Men’s position in arrangements of care is still more advantageous than that of women, who are traditionally associated with this activity and are more burdened with care (Zygouri et al., 2021).

The specific coping strategies that informants used to cope with the emotional burden helped them come to terms with their role as caregivers without having to transgress their gender role.

Several limitations of this study should be acknowledged. The research sample was limited, and it was purposively selected to capture variability in caregiving relationships rather than representativeness. The transferability of the findings is limited by the specific socio-cultural and institutional context of the Czech Republic. Participants were recruited from a network accessible to the research team, which may introduce selection bias. Finally, the interpretations reflect the researchers’ analytical positionality and conceptual framework, and alternative readings of the data remain possible.

Recommendations for practice

It is important to work with instrumental framing of care, not against it. Men tend to frame care as a managerial/logistical task. Emotional or nurturing language creates a barrier. Task-oriented support is more effective: care planning, coordinating respite services, and advice on benefits and employment.

Primary caregivers should be proactively identified before a crisis. Primary caregivers – especially single sons and husbands caring for a partner with dementia – carry heavy burdens but seek help late. Social workers should identify them early (e.g., through contact with the care recipient) instead of waiting for them to ask.

It is also important, to routinely ask about intimate hygiene. This often-overlooked area can be a breaking point, especially for sons caring for mothers. Without timely support, men either shift the burden to partners or withdraw from care. A simple routine question can surface issues early.

Finally, shared care should be promoted as the norm. A sustainable model involves sharing responsibilities without fixed roles. Social workers should actively support families in negotiating shared-care arrangements rather than defaulting to a single primary caregiver.

Conclusion

Informal care provided by men is complex, dynamic, and strongly influenced by gender norms and structural conditions. Although the number of men involved in caregiving is gradually increasing, their experiences and needs remain insufficiently reflected in professional and political debate.

Systemic support for male caregivers is needed: more flexible forms of employment, expansion of formal service capacities, greater awareness, and, particularly, a change in social discourse, which still views caregiving primarily as a female domain. Overcoming these stereotypes can not only ease the burden on women but also enable men to take on caregiver roles without the need for complex strategies of self-identification.

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Conflict of interest

We are not aware of any conflict of interest relating to the publication of this article.

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