Comas d'Argemir, Dolors and Soronellas, Montserrat (2018) "Men as Carers in Long-Term Caring. Doing Gender and Doing Kinship", *Journal of Family Issues* published on line 14 November, 1-5. https://doi.org/10.1177%2F0192513X18813185 (Published-Ahead-of-Print)

Accepted version

Men as Carers in Long-Term Caring. Doing Gender and Doing Kinship

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Abstract

In this article, we examine men's involvement in long-term care for the elderly or sick relatives to locate changes in gender and kinship relations. Research on care has highlighted the role of gender, but has been blind as regards the link between care and kinship, which is taken as a given. We consider *care as work* and *care as kinship* by means of the concepts of "doing gender" and "doing kinship". We use data from the qualitative research we are undertaking in Catalonia (Spain) and this text is based on 49 interviews. We found that men are becoming new agents in care, due to social and cultural changes which are leading to a renegotiation of how care is allocated. Caring produces gender and produces kinship, and as such the involvement of men in care resignifies the contents of these relations and calls the nature of these changes into question.

Keywords: men as carers, doing gender, doing kinship, long-term care, care crisis

In this article, we analyze the involvement of men in long-term care for the elderly or sick relatives in Catalonia (Spain). Our aim is to analyze the changing role of gender relations and kinship. We will try to show that in a context of social change, a crisis of care and economic crisis, kinship becomes a primary factor in the attribution of care, while gender roles remain secondary. Our research focuses on three different kinship roles in care: husbands who provide spousal care, sons who provide filial care, and fathers who care for adult children with illness or disability.

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Care as work has been at the heart of feminist debates and the construction of academic approach to the study of gender. It has been problematized from various perspectives (domestic work, social reproduction, care as work, the ethics of care), and despite the complexity of its content and meanings, care has become an analytical category and has had a major impact in the academic sphere (Thomas, 1993). The research has emphasized not only the affective and moral relationships of care (Finch and Groves, 1983; Gilligan, 1982; Tronto, 1993), but also its social and material dimensions (Daly and Lewis, 2000; Glenn, 2010). There is a clear consensus that care as work is gendered and mainly undertaken by women, and the low social value of care and its impact on gender inequalities has been widely observed (Carrasco, Borderías, & Torns, 2011). Cultural diversity and historic dynamics provide an understanding of the specific forms of care and its transformations, as well as the variability of women's responses, negotiation and agency which take place in the context of generational changes and changes in socioeconomic conditions where they intersect with age, social class and ethnicity (Conlon, Timonen, Carney & Scharf, 2016).

Care is work and care is also kinship (Drotbohm & Alber, 2015). Women who provide care do so not just because they are women, but also because they are mothers, wives, daughters, or even relatives by marriage. Kinship is gendered and is a constituent element of care. Reciprocity, linked to the sense of duty, is present in the care provided within the family and in support networks as a whole. These aspects highlight the importance of kinship, which the academic literature on care work has ignored, taking it for granted. The idea of Yanagisako and Collier (1987) that gender and kinship require a unified analysis is still completely valid. Like gender, kinship is a social and cultural product that distributes roles and responsibilities and places them within a hierarchy. Not everyone with the same kinship relationship is equally involved in care, meaning that as in gender dynamics, it is necessary to understand how kinship roles are negotiated and transformed, changing the sense of duty and reciprocity attributed to them. Care as kinship leads us to consider the social mode of belonging, and like other forms of social belonging, kinship must be actively chosen, created and maintained. Care contributes to creating and maintaining kinship (Carsten, 2004; Drotbohm & Alber, 2015: 2).

We believe that focusing on men as caregivers allows us to understand the complex links between gender, kinship and care for three reasons. The first is that men who care are doing something "unusual" in terms of gender roles, and this allows us to examine the links between caregiving and masculinity. The second is that changes in gender and intergenerational relationships force a renegotiation of the roles of care in the family and contribute to men becoming involved in care. The third is that the economic recession makes having a job a priority, and some men are involved in providing care in the family because they are unemployed or have poorer working conditions than the women. In this case, the obligation arising from the gender structure is subordinated to kinship obligations for contextual reasons.

"Doing gender" has been a very fruitful approach to analyzing gender in its performative dimension, which models everyday human interaction based on what is considered appropriate as feminine or masculine (the accountability structure) (Butler, 1990, 2004; West & Zimmerman, 1987, 2009). As a performative act, gender is something that men

and women do in specific contexts. The power of the concept is what enables a variety of behaviors and practices which express gender identity in specific situations to be identified. In the same vein, we propose the concept of "doing kinship", which allows us to project the same conceptual outline in the sphere of kinship and to analyze how individuals negotiate normative conceptions regarding the obligations of kinship.

Our research was carried out in 2015 and 2016 in Catalonia (Spain) in the context of a twofold crisis: the crisis of care and the economic crisis. The crisis of care refers to the collapse of families and society to meet the growing need for care. The root of the care crisis lies in the increased longevity of older people, changes in gender and intergenerational relationships, and the reduction and fragmentation of family networks. All these factors have contributed to shrinking the pool of potential family carers. The economic crisis has aggravated problems for families who have to provide care. The reduction of state care services as a result of austerity policies has deeply affected families that lack the socioeconomic resources to access the services offered by the market. We believe that this dual crisis has contributed to the increased involvement of men in family care.

Gender, Kinship and Care: Negotiated Commitments

Gender Matters: Men in Long-term Caring

There are few men who care for adults within the family compared to the number of women, but their number is not insignificant and will increase in the coming years due to social and demographic trends related to the ageing of the population. Significantly, the percentage of men involved in providing care increases at advanced ages. In the United Kingdom, 15.1 percent of caregivers are men among the population aged over 65 years old, compared with 13.5 percent of women, and the gender balance is therefore changing among older caregivers (Milligan & Morbey, 2016). In Spain, men account for 41 percent of those caring for their spouse who suffers from Alzheimer (IMSERSO 2005), and estimates suggest that there are more men caring for their wives than vice versa among those aged over 80 years old (Abellán, Ayala, Pérez, Pujol & Sundtröm, 2018). A similar proportion has also been found in the United States (Kramer, 2005). The experiences of men as carers differ from those of women (Thompson, 2005), and as such further examination of the causes that lead men to care and how care is understood and organized is necessary. Men's involvement in family care has been observed to be related to the family structure, working conditions and gender ideology (Gerstel & Gallagher, 2001), and the probability of them providing unpaid care is higher among men who do not participate in the labor market or when wages are low (Carmichael, Charles, & Hulme, 2010).

The barriers to men's involvement in care are cultural and opportunity-related, and are closely interlinked (Comas-d'Argemir, 2016). The cultural barriers are based on the assimilation of care as something that women do and on hegemonic masculinity (Connell, 1995; Connell & Messerschmidt, 2005). The barriers of opportunity are derived from wage and job differences for men and women. The gender pay gap makes it more costly for men to reduce their employment hours to cover care requirements (Himmelweit & Land 2011).. Deustch (2007) insists that gender operates at different levels, and in order to make changes

in the dismantling of gender systems, it is essential to consider the interaction between cultural and structural factors.

Men who provide family care are confronted with the dominant models of masculinity with which they were socialized, which did not include care in their life expectations. However, Calasanti and Bowen (2006) show that husbands who are caregivers cross gender boundaries, and perform tasks that their wives previously carried out. They also undertake emotional and practical activities which involve recognizing the other person as a gendered being. Interestingly, elderly husbands perceive their role as caregivers as an extension of their marital duty and conjugal reciprocity (Kluczyńska, 2015; Ribeiro, Paúl, & Nogueira, 2007; Russell, 2001). Campbell and Carroll (2007) analyze the ways in which sons care for their elderly parents. In this case, they are men of various ages and with varying employment situations. The authors show how these men, they have a style of care ("taking charge") that is consistent with hegemonic masculinity, but they also insist that it is their obligation and emphasize their duty of reciprocity to towards their elders. Prioritizing kinship over gender is a way of doing gender that means masculinity need not be called into question.

The different experiences of men providing care are a good example of the perspective of "gender-as-performance", as well as the various ways of understanding masculinities. They also show how kinship obligations are present in commitments for care.

Kinship Matters: Sons, Fathers and Husbands and Care

As Tatjana Thelen highlights, “care in public debates is often conceptualized as a given element of kinships or, more generally, of the private sphere” (2015: 498). Furthermore, the academic literature on care work has been surprisingly blind regarding the link between care and kinship. Most studies find that care takes place mainly within the family, and some have analyzed how care contributes to “doing family” (Blackstone, 2014; DeVault, 1991; Hertz, 2006; Nedelcu & Wyss, 2016), and may even describe the obligations of kinship and the cultural models on which they are based; however, these factors are not incorporated in the theoretical framework or as an analytical theme. This is the case of the considerable bibliography on husband carers and marital relations (Biltdgård & Öberg, 2017; Calasanti & Bowen, 2006; Kramer & Lambert, 1999; Kluczyńska, 2015; Milligan & Morbey, 2016; Milne & Hatzidimitriadou, 2003; Ribeiro & Paúl, 2008; Ribeiro, Paúl & Nogueira, 2007; Russell, 2001), and adult sons who care for their parents (Campbell, 2010; Henz, 2009; Horowitz, 1985; Matthews, 1987; Spitze & Logan, 1990; Tolkacheva, Broese van Groenou, & van Tilburg, 2014). Kinship is taken for granted, it is not problematized and is thereby naturalized. According to Drotbohm & Alber (2015), the proliferation of care research in several disciplinary fields explains this kind of neglect and the separation of the debates between care as work and care as kinship.

Anthropology has highlighted the role of care in social organization and the importance of analyzing forms of caring and being cared for as contexts for constructing socially significant links (Thelen, 2015). Feeding, nourishing, and spending time with someone - caring, in short - is not only based on obligations of kinship, but also in turn produces and confirms kinship relations (Borneman, 1997; Carsten, 2000, 2004). Other studies have analyzed the creation and recreation of kinship with carers from the extended family or the social networks (Allen, Blieszne & Roberto, 2011); the importance of care in

maintaining or affirming kinship in transnational families (Baldassar, 2008; Gregorio & Gonzálvez, 2008; Parreñas, 2001; Le Gall, 2010; Drotbohm, 2009); as well as the creation of pseudo-kinship links between professional carers and care receivers (Kay, 2013). Kinship is not something that is given, but is instead enacted through behavior and social action, as well as by subjective interpretations of social relations.

A distinctive feature of kinship relations compared to other social relations is the factor of morality, based on which duty, obligation and responsibility to care is established. This is what Sahlins (2013) has called mutuality of being. However, three aspects must be emphasized. First, the categories of kinship are simultaneously gender and generational categories which classify, give a hierarchical structure and assign roles and responsibilities in terms of care that vary in the life course (Drotbohm & Alber, 2015). Second, social, technological and legal changes make kinship a complex and differentiated universe. Apart from biological kinship, social perceptions and practices create relatedness. Kinship is experienced and created through care (Carsten, 2000). Third, in order to understand the factors contributing to certain people becoming responsible for caring, it is necessary to consider the tension between normative standards ("what is considered appropriate") and real behavior patterns ("what is done") based on the concept of "negotiated commitments" (Finch, 1989). Caregiving means complying with the behavior expected of a given kinship (and gender) role, but it is not prescriptive. Negotiated commitments are therefore heavily influenced by the material conditions in which people live, as well as by demographic structures, economic conditions, laws and public policies.

The concept of "doing kinship" refers to the performative dimension of kinship, and means that kinship and care can be linked based on social practices. What is important is "doing" as a relative, and care necessarily entails and confirms this kinship. "Doing kinship" also enables dialogue with the concept of "doing gender" and interrelates gender and kinship in the provision of care. The concept of "doing kinship" also means that kinship can be politicized. Kinship, like gender, is a social and cultural product and as such is subject to social change. Instead of essentializing kinship, it is necessary to understand how it takes place in social practices, and its relationship with other interaction and support networks. The family is an example of major changes in gender roles and the content of kinship, and is also an example of how these changes are linked to the institutional and political framework, as ultimately it is the state, by means of laws and public policy, which defines what a family is and what it is not.

Doing Gender and Doing Kinship: Men as Carers

Since the orders of gender and of kinship primarily involve women in care, we must ask under what circumstances men provide care. Is it when women are absent? Is it because of changes in gender relations? How are negotiated commitments regarding care established? Conlon *et al.* (2014) discuss the renegotiation of care between generations in Ireland, and show how young women are able to construct their life experiences because they are free from the obligation to care for their elders. In doing so, they have the support of their mothers, who do everything possible so that their daughters do not reproduce their personal histories dedicated to care. Socioeconomic status is a key factor, because women with low incomes cannot free themselves of the commitment to care, because they do not have

sufficient (cultural or economic) resources to outsource care, as Saraceno also notes (2010). Little is known as to what extent these changes in women's lives affect men in terms of their involvement in care. The examples mentioned above show that young women are not available to care for their elders because of their employment and social commitments. It is not therefore a question of there being no women, but rather of no women being available or not feeling committed to take care of their parents. This reflects a change in the order of gender and the obligations of kinship. More knowledge is required of the extent to which the involvement of men in care is related to these changes in the lives of women, and of the commitments negotiated between men and women, and between generations. This must all be considered in the context of socioeconomic conditions, and opportunities for access to public or commercial care services. Interaction between gender, class and life courses models different experiences of care. We aim to shed light on these issues with our research.

We believe that the increasing involvement of men in care is conditioned by three crucial factors. The first is cultural and is related to changes in family, in gender roles and in intergenerational relations, which modify the place that care occupies in the lives of men and women. The second is related to differences in socioeconomic status. Working-class families who cannot afford the care services available on the market are more likely to undertake care tasks themselves. The third is social and political and related to scant development of public policies in Mediterranean countries, which exacerbates the need for family care. The weakness of public policies for long-term care have strengthened the cultural traditional model whereby it is the obligation of families to provide the care for their neediest relatives (Roigé, 2006).

We will examine the motivations that lead men to provide care in the context of the economic crisis, the reduction of jobs available, the impoverishment of families and declining public resources in Spain. We also aim to understand the interrelationship between gender and kinship, and to identify the situations where gender boundaries are transferred and commitments arising from kinship become more relevant. We will focus on two basic aspects. How do men become involved in long-term care, based on kinship and their situation in the labor market? What are men's motivations for providing care?

Context

The system of care that operated in Spain during the twentieth century was based on the delegation of that care to the family. Women were the cornerstone of this system of deferred reciprocity, in which each generation cared for the previous one in their old age, and expected to receive the same treatment from subsequent generations. The moral foundations underlying this system still persist, although it is subject to criticism and desertion. As shown by Saraceno (2010) intergenerational solidarity is more necessary in countries with less generous welfare provisions and this creates an overload on families in terms of their resources, availability and time. This is the case in Spain, which has weak public policies and limited resources. In 2006, Spain passed the Dependency Act[2], which promoted the creation of economic benefits and care services as a public commitment to tackle the issue of long-

[2] Act 39/2006 of 14 December, on the promotion of personal autonomy and care of dependent persons.

term care. However, the economic crisis slowed down the application of the law. This led to a re-familiarisation of care, an expansion of market services, and growing inequalities.

The weakness of public policies exacerbates the crisis of care. Spain is one of the countries with the highest life expectancy levels in the EU (80.4 years for men and 85.7 years for women in 2017) and according to the OECD, in 2050 Spain will be the third oldest country in the world (after Japan and Korea). As well as this "ageing of ageing," there is an increase in the number of people with chronic illnesses, disabilities and mental disorders. Increased needs for long-term care have arisen at the same time as the massive presence of women in the labor market, limited involvement by men and cutbacks in public policy. Hiring immigrants (mostly women) to provide care has been the resource used by middle- and upper-class families, which entails a racialization and internationalization of care (Benería, 2008; Hoschchild, 2000; Pérez-Orozco, 2006).

The economic recession that Spain has experienced since 2008 has deeply affected the population and has led to the impoverishment of a large number of pensioners, workers and citizens. In February 2014, the unemployment rate reached 25.2 percent (54 percent among young people); there were almost 700,000 households with no income, and 30,000 families were evicted from their homes. The economic crisis has in turn been accompanied by liberalizing economic reform policies, with substantial cuts in public spending and benefits for long-term care (Deusdad, Comas-d'Argemir & Dziegielewski, 2016). The situation has been particularly serious for families with limited resources, which have to meet their basic needs and deal with care issues using their own resources.

Methodology

This article is part of broader research on men as carers conducted in Catalonia (Spain). The research focused on the long-term care of highly dependent adults, and excluded care in healthcare in the strictest sense, in order to focus on social care (Daly and Lewis 2000). We conducted 208 interviews with unpaid family caregivers (49), paid caregivers (84), social and economic stakeholders (32), persons receiving care (41), and focal groups (2), in order to evaluate the cultural and opportunity barriers that hinder men's involvement in care tasks and the emerging models. This is a Responsible Research and Innovation (RRI) study, which involved the collaboration of 43 institutions and associations involved in gender equality or the provision of care.

In this paper, we focus specifically on unpaid family caregivers and we use interviews with 49 men selected based on five criteria: age; employment situation; type of illness or dependence of the person cared for; kinship ties between the caregiver and the recipient of care; and self-perceived social class. Access to participants was a result of the cooperation of various organizations and institutions (relatives' associations, associations of ill or disabled people, self-help groups). The interviews were conducted in Catalan or Spanish, depending on the participants' preference.

By age group and employment status, 24 respondents were pensioners over 65 years old (4 were over 80), and 25 were under 65 and are of working age (5 of them were unemployed). In terms of type of care, 20 care for persons with mental health problems; 18 for people with Alzheimer's disease and frail elderly, and 13 care for chronically ill or

disabled people. As regards kinship ties, 20 are husbands; 15 are sons who provide care for their parents; 11 are fathers who care for disabled or ill adult offspring; and 5 have other kinship ties.[3] The final factor is socioeconomic status. We asked the participants to place themselves within a social class, and 42 of them answered with the following result: 15 said they were members of the working class; 26 placed themselves in the middle or lower-middle class; only one declared they were a member of the upper-middle or upper class.

The interviews were conducted between March 2015 and May 2016. They were conducted by the members of the research team, and transcribed by people trained in qualitative techniques and therefore aware of its methodological peculiarities. We entered the interviews into the Atlas-ti software, and classified the data into seven categories of analysis: 1) concept and social discourses on care; 2) development of the itinerary of care and strategies to adapt to the situation; 3) management and negotiation of care; 3) activities and decision-making; 4) types of support for the situation of care; 5) the impact of the economic crisis; 6) motivations for care; and 7) experiences and feelings about the situation of care.

Most people who we asked to be interviewed were interested in participating in the project. We realized that some participants did not recognize themselves as carers, and were even surprised at being classified as such. From the outset, we felt that unpaid caregivers perceive care as something that is intrinsic to the family relationship that links them to the recipient of care.

Results

Type of Kinship of Men Carers

What men become involved in family care? We aimed to ascertain which categories of kinship are the strongest driving force for men to provide care, the different commitments of kinship and marriage ties, and how the "duty of care" is embedded in the cultural models that govern relations between parents and children and between spouses, and between other kinship ties. Kinship is a regulatory system which assigns roles, and places roles of care in a hierarchy among members of the kinship group. Participation in the labor market, public policies, gender ideologies and personal availability to provide care help us to understand the situations in which kinship leads men to provide care. Caring is doing kinship, and for this reason we studied the participants' accounts to determine the kinship roles with the strongest influence on providing care; the employment circumstances; and finally, the reason that lead men to do kinship by caring.

Husbands as caregivers. Most of the men providing long-term care are husbands of frail elderly wives. This is not surprising in a geriatrified society like Spain's. They are therefore caregiver husbands who are already in retirement, and therefore outside the labor market, and faced with the more or less unexpected situation of having to take care of a wife who has often been responsible for reproductive work and caring for members of their family throughout their shared lifetime. These men have been educated in a patriarchal model of conjugal and gender relations that they have contributed to reproducing. Their marriage ties, rather than their gender, are what lead them to care for their wives. In their new role, they

[3] Some participants care for two people at the same time so the numbers do not add up.

must cope with carrying out activities that they have never performed before, and for which they need guidance from the women for whom they provide care. Alfons, a pensioner aged 81, who cares for his wife who suffers from Alzheimer's disease, comments:

> ... I had to dress her, I had to accompany her, I had to watch her (...) when she goes to the day center, my work isn't finished. Then I begin the housework and put everything in order, and make the beds and do everything. (...) *I didn't know how to do any of that and I had to learn everything, all of it, everything. At my 80-odd years of age!* [our emphasis]

Another interesting aspect of husbands who care for their wives is their insistence that the obligation to care for their wife lies with them rather than with their own children. In this respect, the spousal relationship is more binding on the attribution of responsibilities for care than kinship by descent, as stated by Mikel, who is unemployed and whose wife suffers from a degenerative disease:

> The day I can't lift my wife up out of the chair... I'll ask where I have to go and see where they'll take us [referring to a nursing home]. I have no problems with that. *I can't give my daughter my wife's problems.* No, my daughter is married, she has her son, and wants to have another child, she'll have to work. I've more or less accepted that. [our emphasis]

Ethnography provides evidence that the marriage covenant entails a moral obligation to take care of one's wife, even in the difficult situation of mental illness. Simón, who is retired and cares for his wife with mental health problems, says:

> Yes, I'm taking care of my wife ... of course, of course ... because I'm the person who is at home. We're both retired, and so if one person is a little unwell, or a little poorly, the duty of the other one is to help as much as they can, I think. But between that and being a caregiver, I don't know. (...) *Of course, I feel obliged (...) This is an obligation, you have to learn to put up with it and that's it.* [our emphasis]

When the husband acts as the primary caregiver, this tends to highlight the difficulty of providing care, moving the focus away from help received from both offspring and employees. But in their accounts the following people gradually emerge: women hired to do the housework; family workers; daughters who wash and iron clothes; who invite the parents to lunch on Sundays; who perform personal hygiene tasks; who supervise the medication; and who accompany those receiving care to the doctor. A network of resources is activated around men providing care, and particularly retired husbands, which is often provided by the extended family, but also by institutions, organizations and the market. This must be taken into account in order to understand the strategy of care in the family environment.

Fathers as caregivers. Caregiver fathers have to cope with their children's illness and disability, which prevents them from leading an independent life. As in the cases above, the role of caregiver is activated and becomes visible particularly when they are outside the labor market; most caregiver fathers interviewed are retired, and some of them took early retirement. For them, parenthood is the bond which means that they have to do kinship and

care for their children. They are men who are deeply committed to care, even when there is a woman (the wife/mother) who shares responsibility for care that is very intensive and which is likely to continue after their deaths.

Ferran decided to retire to take care of his son and his wife. His son is 29 years of age, has serious health problems and needs constant and specialized care. His wife suffers from Alzheimer's disease and Ferran is the primary caregiver for both. In his account, he values the care he gives them differently. As a father he provides very technical (medicalized) but more emotional care; as a husband, he is a pragmatic caregiver who is operating on the basis of ageism.

> There is an additional problem in our family which to a certain extent determines the relationship. Why? Because as a father I have to make a decision based I don't know if it is on efficiency or logic, and all other things being equal, I must always prioritize my son rather than my wife. *What I mean in terms of effort, or the urgency of the need for help... for me the needs of my son, who has his young life ahead of him, always take priority over those of my wife.* And that also affects the relationship between the caregiver and the patient a little. It's a bit different. [our emphasis]

As in the case of husband caregivers, fathers who are caregivers also insist on relieving their other children of this responsibility. Laureano, who is retired, and the father of a son with mental illness, expresses it in the following terms, mentioning his other son who is married with a son of his own: "You don't have the problem, we have the problem." Once again, when doing kinship, the family of procreation takes precedence over the family of orientation.

Sons as caregivers. The relationship between emancipated adult children and their elderly parents is the one that has undergone the most significant changes in contemporary family relationships. Several generations living together, which was a very common phenomenon fifty years ago, now only occurs in very exceptional circumstances and instead, institutionalization and home care professionals are used more often. It is in these situations where the crisis is most visible, within a model of care which was based on the reproductive work of women, and for which Spanish society has not provided the alternatives to meet families' growing needs.

Son caregivers provide care for their parents by combining their own efforts with various healthcare resources: day centers, dining halls, nursing homes, employees, etc. When they are active in the labor market and have obligations towards their own families, the combination of resources is larger and more complex. Children often become partial caregivers with their siblings, among whom care shifts are established and specialized tasks are assigned. As has been shown, employment, gender, physical or geographic distance, partner status, family responsibilities, as well as affectual dimensions condition the relationship between filial caregivers and receivers of domestic help (Heady, 2012; Lawton, Silverstein, & Bengtson, 1994; Matthews, 1987). Siblings with similar characteristics and opportunities are more likely to share care (Tolkacheva *et al*., 2014).

Marcel, aged 51, is married and works as a university lecturer. With his two sisters, he cares for the needs of his ailing father and now his elderly and ailing mother. Despite having

performed the usual tasks involved in care, he does not consider himself to be a caregiver, as he feels that by taking charge of parents he is simply acting as a son.

> For me, providing care is either a professional sacrifice or personal sacrifice, and there has been no such sacrifice in my case. (...) It is a shared family responsibility. I haven't had to stop working, I haven't had to ask for time off, I haven't had to sell the house to pay for a very expensive treatment (...) So in our Catalan family and social environment, in particular, *I haven't had to give up anything that makes me think I'm a caregiver*. [our emphasis]

Most of the son caregivers interviewed describe themselves as taking charge of their parents rather than as caring for them, especially when they are in full employment. Care is assumed based on a role of managing the multiple resources mentioned above, and is often shared with other siblings. This is also true of Sergi, whose mother has a degenerative disease and who emphasizes that his sisters play their gender role and prefer to have control of the situation:

> This female empowerment of the family is part of the sexist tendency in our family. They have adopted this role. Then they complain that other people don't do it! But when the time comes to take decisions, they don't like people to give their opinions, and they have to be the ones who decide. I don't let them. Since I'm helping with everything, *I'd like these important decisions to be taken by all of us together*. [our emphasis]

Daughters do not always demand control over care based on their gender role. The gender system has changed, and we observed situations in which daughters were not available or did not feel obliged to take care of their parents. This is true of José María, who is unemployed, and takes care of his mother who suffers from Alzheimer's because his sister has a job and she does not want to renounce her professional activity to care for her. He finds it difficult to have to provide care and although as a man he feels less equipped to do so, he does not think his sister should have to give up her job as she is the one who provides the income to live on. A different case is that of Cesc and Joel, who are a gay couple who take charge of Cesc's mother and aunt on alternate weekends and during the holidays. His siblings live closer, but they have accepted hardly any responsibilities because their priority is to care for their own children. José Maria and Cesc are caregivers despite the fact that they have female siblings. Joel is also involved in the care for his mother-in law. All three do kinship, and all three are undoing gender. The nature of doing gender and doing kinship have changed.

Care strategies vary depending on changes in the personal or work situation, or even because of the loss of healthcare resources. The economic recession has reduced government benefits for long-term care, which has contributed to care once again being provided by the family and becoming more unstable. Tomás is 67 years old, and is currently responsible for managing the care of his elderly parents. His wife used to provide the care, but with the economic downturn the social benefit was cut and he became unemployed. To cut back on expenses, the two spouses became personally involved in the care, dispensing with the caregivers who they used to employ, until the parents, aged 96 and 93 years old, were recently admitted to a public nursing home.

The Motivation for Caring

Caring does not have the same meaning for retired men as it does for those who are of working age. Among elderly husbands, caring builds up their self-esteem and gives a new meaning to this period of their lives, by embodying their commitment to their wives. For many of them, providing care is an option (even if it is determined by the lack of resources) motivated by responsibility and affection. Insofar as they perform a role that is not normative, their contribution is highly valued by those around them (Milne & Hatzidimitriadou 2003). However, younger men who provide care because they are unemployed experience their situation with some dissatisfaction, and consider it as temporary. In the hypothetical event that they obtained a job, they would ideally return to their normal situation, free of responsibilities for care (Hanlon, 2012). It is not having a job that makes them uncomfortable, rather than providing care. Sons who provide filial care, and fathers who care for adult children and have a job strike a balance between their employment and providing care in the home by using a mosaic of care resources that they carefully try to fit together with great difficulty in order to meet all their needs (day centres, dependency aids, home help services, home help for cleaning, telephone alarms, help from neighbours, visits by relatives, catering services and very importantly, establishing periods and responsibilities for care among siblings). They are "care managers" who are often also involved in providing direct care.

Jan is the youngest in a family of five middle-class siblings. He is heavily involved in care for their frail elderly mother and father with his four siblings (in total they are three brothers and two sisters); he lives near to his parents and remains single, and as such does not have the responsibility of a family of his own. Jan organizes the care shifts among the siblings and manages the three people hired to complete the mosaic of the care resources for his elderly and ill mother, and his father who has been unable to assume any responsibility and who is also a recipient of care:

> We have a lady that comes in at 7:00 - which is when we go to work - until 10:00 or 11:00, depending on the day. Then Marta, who is the lady who has been our home help for years, is there from 9:00 - when she starts work - until 2:00. At 2:00 she leaves them their dinner ready, and my father is there. (...) Someone else comes in just to clean. She only comes in one day a week in the afternoon. (…) My father pays because fortunately we don't have any problems in that respect. But coordinating all those people who come in and out certainly isn't easy.

Male caregivers with a low socioeconomic status have to provide care directly, while trying to access public resources, which is difficult nowadays in view of the fact that welfare spending cuts. Under these circumstances, it is much more difficult to reconcile care with work, and the family or community network must be used on a much more intensive basis.

The people interviewed who care for their relatives expressed a sense of moral obligation to those who they care for. It is an "obligation" expressed in terms of kinship that is based on the strict need to perform some tasks (in the operative sense) and on the emotions that lead them to perform them. Until recently men did not feel involved in caring because it was a job done by women so this sense of obligation is new for them. Family members are

relatives, but to build this relationship they must do kinship, and in this article we argue that providing care is the most important way of expressing kinship. Caring is undoubtedly doing kinship, as is stated by Alfons in relation to his wife with Alzheimer's disease, and also by Bernat who cares for his wife who suffered a stroke:

> When you look at the moral side, you think of how she's a person who you've lived with for 60 years in my case. And of course, you know who she is, she's the mother of my children, and you've lived with her through good and bad times and you've been through everything. (...) Then comes the moral, or we could say sentimental aspect. *You have to do it because your feelings tell you that you have to do your utmost, and you have to think that she's your wife and you have to do it... And you convince yourself.* And so you do it, but it's difficult, very difficult. [our emphasis] (Alfons).
>
> *I think what I do is a natural thing and that it's my duty*; it's not like I'm forced to do it reluctantly. [our emphasis] (Bernat).

As shown in the above quotation, there is an assimilation of care, which is something that is unquestionably associated with kinship. Men caregivers clearly state that care is related to a range of activities, attitudes and emotions that are assumed based on reciprocity. Care circulates like gifts (Mauss, trans. 2002): family members provide care, they receive and return it in a circuit of generalized reciprocity in which the fact that there should be compensation for the gifts (care) received is not explicitly mentioned. However, care is not always reciprocated, particularly care provided by women which may be rendered invisible because it is so taken for granted (Ashwin, Tartakovskaya, & Lytkina, 2014; Comas-d'Argemir, 2017). Valentí, a retired husband wo cares for his wife who suffers from Alzheimer's disease, comments:

> When I do something for her, I think: would I like people to do this for me? And that's why I do it for her. (...) *I do it out of obligation. The fact that we have always lived together since we were 14 years old makes me do it*. [our emphasis]

Mutual care builds kinship ties. This is what Marshall Sahlins calls mutuality of being. "Relatives live each other's lives and die each other's deaths." (2013: 28). In Western cultures, a blood relationship is often a symbolic reinforcement of the importance of kinship and the power of mutuality. This is mentioned by Fèlix, a father who is employed and who cares for his son with mental health problems.

> *It is very difficult to live with someone who is sick. We put up with him because he is our son*. Because if he was from another family, he would be *unbearable. If it isn't someone who's own blood it's very hard*. [our emphasis]

Blood is undoubtedly the most important of metaphor for kinship and the main argument for the assimilation of the relationship between relatives and the mutual ties that require them to exchange the gifts of care and withstand the difficulties of the situations experienced. Relatives who do not become involved in care are therefore sanctioned for their failure to fulfil their obligations, and this is especially true of women. Camilo, a working-class man of 61, is married to a woman who has had mental health problems for the last twenty years and

who recently has suffered more intense and frequent crises. He complains about the lack of commitment from his wife’s siblings and relatives:

> The only people who I wish were suffering the way I am suffering is *my wife's family*. It's wrong to say it, but I would like them to have the same thing that I have. It is painful to say it, *but they haven't done the right thing by my wife*. [our emphasis]

Emotions are clearly key factors among the motivations that the men caregivers expressed in interviews. It is marital, filial or paternal love, which is often sublimated, and which is closely related to the commitment of caring. It is expressed in these terms by some husbands and even some sons, such as Fermín, unemployed, who went to live with his elderly mother when she started having health problems that limited her autonomy, explains:

> I've always loved my mother very much, I've always had a special relationship with her. (...) (I care for her) Because I'm more relaxed, you can see she's happy and content and that makes me happy.

The responsibility for caring is not only rational, and is not only the result of necessity and strict obligation, or even pragmatism. Caregiving is hard, it involves major sacrifices, it leads to personal conflicts, it weakens social relations and ties you down, and changes the caregiver's life. Accordingly, some participants say that caring cannot be defined only by pragmatism, but rather that it also needs a certain mood. That is how Laureano, a pensioner whose son suffers from mental illness, expresses it when he says that "the situation has changed my life."

> You have to spend a lot of time with them (...) I think that if someone is to take responsibility for the family, *it has to come from the heart* and they have to be very prepared. [our emphasis]

Conflict is also present in caregiving situations. It is not usually addressed directly or clearly expressed in the interviews, but it is latent, appears between the lines and is sometimes also very explicit. The respondents talk about the life changes they have suffered and the intensity of the work involved. However, they find it difficult to discuss their personal conflicts, doubts and weaknesses which are caused by a situation of care that is clearly stressful and exhausting, and which leaves little space for their personal freedom, or for them to spend their time as they please. Miguel is 63 years old, who decide to retire to care for his wife who has been affected by a stroke. He feels a prisoner of his situation, and has even mentally planned how he could "abandon" his wife, but the guilt puts the idea out of his mind:

> Sometimes I think of a plan, which maybe *would make me feel guiltier if I left her*. I'd collect my pension, she has her pension. We wouldn't get divorced, we would separate. She could have the house and I'd hire someone to be with her 24 hours a day (...) But what would happen? *I'd feel bad. I'd do that and then I'd feel worse than I do now*. [our emphasis]

Care as kinship is expressed in terms of an obligation that creates kinship mutuality and reciprocity. People feel responsible for the life and death of their relatives. Kinship relations are socially effective because they create a circuit of reciprocally exchanged gifts, and care is

one of the most precious and most valuable gifts. Emotions and feelings are embedded in the duty of care, and are part of it; this is in addition to the personal conflict and doubt about the possibility of being released from a responsibility that exhausts caregivers. However, the care provided by men may have a better chance of return, not because of some neutral social effectiveness but because of the way reciprocity is gendered.

Discussion and Conclusions

This article has analyzed the involvement of men in long-term care based on their experiences and perceptions. We aimed to explore how the dynamics are established between gender and kinship in the provision of care, based on the idea that care is work and is also kinship. Care as work has traditionally been provided by women, and as such our analysis focused on the reasons that lead men to care. Care as kinship is also gendered, and we attempted to establish the circumstances in which men feel subject to the moral obligation to provide care. Our analysis has shown that the conditions resulting from the social and demographic context, and changes in the family and in public policy, modify the roles and responsibilities in the family and put pressure on men to become involved in long-term care. Their socioeconomic situation and life course in turn shape how they accept care. Under these conditions, kinship obligations take precedence over the gender order, and men provide care for their relatives despite this not having been part of their expectations and their lack of socialization for doing so. At the beginning of this article, we mentioned that in the case of women, the importance of gender in the allocation of care has been so important that the academic literature about care work has obscured kinship and it has therefore become naturalized. The role of kinship in care becomes more visible to analysis when it is men who provide care, because when the boundaries of gender are crossed, care as kinship becomes more evident.

We have shown that unemployment, retirement and having low-skilled, poor quality or low-paid jobs make it more likely for men to take the decision to become primary caregivers in the family environment. By the same token, the economic recession has enhanced the value of employment. That means that the scarcity of job places much greater emphasis on securing and maintaining those jobs that are in place, to detriment of other considerations. For this reason, if men are unemployed and a need for care arises in the family, it is they who meet this need rather than jeopardizing the women's employment. Gender and kinship roles are renegotiated.

Our research has found that men provide unpaid long-term care when there are no women available. There are a few exceptions to this statement, but some qualifications to it are necessary. We are not arguing that men provide care due to the absence of women in the family (meaning that gender roles would be fulfilled in the strictest sense), but instead that they do so because the women are unable to provide care or do not feel involved. There is therefore a lack of availability of women due to social and cultural changes. Many women do not want to or cannot provide care because they have a job; because they live far away; or because they do not feel committed to care. As indicated by Conlon *et al.* (2014) we observed changes in the system of intergenerational reciprocity and a renegotiation of care in the lives

of women. This is consistent with the older generations insisting that they do not want to depend on their children, and wish to resolve their care needs themselves by using public and private services. These are changes that express new negotiated commitments, and contribute to men becoming involved in long-term care, as husbands, sons or fathers. They are changes that affect families unevenly, since families with fewer resources cannot purchase services on the market.

Care is not only involved with gender roles, but also with kinship. Moral obligation, reciprocity and affection permeate care and reveal the importance of kinship ties. Studying men who provide care at home sheds light on the situations in which kinship becomes prevalent in the attribution of care and in which gender roles are of secondary importance. Marriage takes precedence over kinship and over gender in care for spouses in old age and reciprocity is mentioned as a reason to provide care. It is interesting to note that this was not the case a few years ago: when the woman-wife-mother became ill, daughters and even daughters-in-law were expected to provide the care for her. Husbands, sons and sons-in-law did not feel involved in direct care, although they did contribute to resolving its material aspects. Being a woman prevailed when it came to providing care, and the gender role predominated over kinship. The family relationship (conjugality in the case of spouses) currently creates the primary relationship of obligation. Kinship remains important in commitments between parents and children. The role of fatherhood can be activated when children have significant disabilities or mental disorders that prevent them being autonomous. Reciprocally, sons take responsibility for the care of their elderly parents in various ways depending on whether or not they live with them. The "just-do-it approach" predominates in care (Thompson, 2005), based on which sons take charge of care, and outsource direct caring to third parties.

These changes in gender roles and in kinship as regards care show that relational and contextual aspects matter, as well as the substance of the relationships. Being a relative is not enough. It is necessary to do kinship, and men who care incorporate new obligations in their kinship roles. The same is true with regard to gender. Being a man does not preclude providing care, and doing so changes the content of gender roles. Social and cultural conditions mean that certain relationships must be mobilized and certain types of care must be reformulated based on obligations, reciprocity and affection, which are not without some tensions, contradictions and conflicts. There are therefore many ways of “doing gender” and “doing kinship” based on renegotiating what is considered appropriate to meet the needs of care. This diversity is compounded by the intersection with socioeconomic conditions and the life course, which determine experiences of providing care.

Caring produces gender and produces kinship. The inclusion of men in care resignifies the content of gender and kinship. From this perspective, we wonder if the involvement of men in care means that changes are taking place in gender differences not only at an interactional level, but also at an institutional level and in the social structure. We also wonder to what extent the changes in kinship roles and content can lead to the perception that care needs are not only an individual and family problem, but also a social and political issue.

References

Abellán, A., Ayala, A., Pérez, J., Pujol, R. & Sundtröm, G. (2018). Los nuevos cuidadores [The new caregivers]. In *Vejez y cuidados. ¿Cómo viviremos y nos cuidaremos cuando seamos mayores?* [Ageing and care. How will we live and care for ourselves when we are old?] (pp. 25-31). Barcelona, Spain: Observatorio Social de "la Caixa".

Allen, K. R., Blieszner, R., & Roberto, K. A. (2011). Perspectives on extended family and fictive kin in the later years: Strategies and meanings of kin reinterpretation. *Journal of Family Issues*, 32(9), 1156-1177.

Ashwin, S. Tartakovskaya, I., Ilyina, M., & Lytkina, T. (2013). Gendering reciprocity: Solving a puzzle of nonreciprocation. *Gender & Society,* 27, 396-421.

Baldassar, L. (2008). Missing kin and longing to be together: emotions and the construction of co-presence in transnational relationships. *Journal of intercultural studies*, 9(3), 247-266.

Benería, L. (2008). The crisis of care. International migration and public policy. *Feminist Economics,* 14(3), 1-21.

Bildtgärd, T., & Öberg, P. (2017). New intimate relationships in later life: Consequences for the social and filial network? *Journal of Family Issues*, 38, 381-405.

Blackstone, A. (2014). Doing family without having kids. So*ciology Compass*, 8(1): 52-62.

Borneman, J. (1997). Caring and being cared for: Displacing marriage, kinship, gender and sexuality. In J.D. Faubion (Ed.*), The Ethics of Care. Ethnographic Inquiries* (p. 29-46). Oxford: Rowman and Littlefield Publishers.

Buttler, J. (1990). *Gender trouble*. New York, NY: Routledge.

Buttler, J. (2004). *Undoing gender*. New York, NY: Routledge.

Calasanti, T., & Bowen, M.E. (2006). Spousal caregiving and crossing gender boundaries: Maintaining gendered identities. *Journal of Aging Studies,* 20, 253-63.

Campbell, L.D. (2009). Sons who care. Examining the experience and meaning of filial caregiving for married and never-married sons. *Canadian Journal of Aging,* 29, 73-84.

Campbell, L.D., & Carroll, M.P. (2007). The incomplete revolution. Theorizing gender when studying men who provide care to aging parents. *Men and Masculinities,* 9(4), 491-508.

Carmichael, F., Charles, S., & Hulme, C. (2010). Who will care? Employment participation and willingness to supply informal care. *Journal of Health Economics,* 29, 182-90.

Carrasco, C., Borderías, C., & Torns, T. (2011). Introducción. El trabajo de cuidados. Antecedentes históricos y debates actuales [Introduction. Care work. Historical background and current debates]. In C. Carrasco, C. Borderías, & T. Torns (Eds.), *El trabajo de*

cuidados, Historia, teoría y políticas [Care work. History, theory, and policies] (pp. 13-95). Madrid, Spain: La Catarata.

Carsten, J. (2000). Introduction: cultures of relatedness. In J. Carsten (Ed.), *Cultures of relatedness, New approaches to the study of kinship* (pp. 1-20). Cambridge: Cambridge University Press.

Carsten, J. (2004). *After kinship*. Cambridge: Cambridge University Press.

Comas-d'Argemir, D. (2016). Hombres en los trabajos de cuidados: Barreras culturales y modelos emergentes [Men in care works: Cultural barriers, and emerging models]. *Psicoperspectivas. Individuo y Sociedad*, 15(3), 10-22.

Comas-d'Argemir, D. (2017), El don y la reciprocidad tienen género: las bases morales de los cuidados [Gifts and reciprocity have gender: the moral bases of care], *Quaderns-e,* 22(2), 17-32.

Conell, R.W. (1995). *Masculinities*. Berkeley, CA: University of California Press.

Conell, R.W., & Messerschmidt, J.W. (2005). Masculinity: Rethinking the concept. *Gender & Society,* 19, 829-859.

Conlon, C., Timonen, V., Carney, G., & Scharf, T. (2016). Women (re)negotiating care across family generations. Intersections of gender and socioeconomic status. *Gender & Society*, 8, 729-51.

Daly, M., & Lewis, J. (2000). The concept of social care and the analysis of contemporary welfare states. *British Journal of Sociology,* 51(2), 281-298.

Deusdad, B., Comas-d'Argemir, D., & Dziegielewski, S.F. (2016). Restructuring long-term care in Spain: The impact of the economic crisis on public policies and social work practice. *Journal of Social Service Research,* 42, 246-62.

Deutsch, F.M. (2007). Undoing gender. *Gender & Society,* 21, 106-127.

Drotbohm, H. (2009) Horizons of long-distance intimacies. Reciprocity, contribution and disjuncture in Cape Verde. *History of the Family*, 14 (2), 132-149.

Drotbohm, H. & Alber, E. (2015). Introduction. In E. Alber & H. Drotbhom (Eds.), *Anthropological perspectives of care, Work, kinship, and the life-course* (pp. 1-19). New York, NY: Palgrave MacMillan.

DeVault, M.L. (1991). *Feeding the family*. Chicago, IL: University of Chicago Press.

Finch, J. (1989). *Family obligations and social change.* Cambridge: Polity Press.

Finch, J. & Groves, D. (Eds.) (1983). *A labour of love. Women, work and caring*. London: Routledge.

Gerstel, N., & Gallagher, S.K. (2001). Men's caregiving: Gender and the contingent character of care. *Gender & Society,* 15, 197-217.

Gilligan C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Glenn E.N. (2010). *Forced to care. Coercion and caregiving*. Cambridge, MA: Harvard University Press.

Gregorio, C. & Gonzálvez, H. (2012), Las articulaciones entre género y parentesco en el contexto migratorio: más allá de la maternidad transnacional [The relationships between gender and kinship: going beyond the transnational maternity]. *Ankulegi*, 16, 43-57.

Hanlon, N. (2012). *Masculinities, care, and equality, Identity and nurture in men's live*. London: Palgrave MacMillan.

Heady, P. (2012). European kinship today: Patterns, prospects and explanations. *Ethnologie française*, 42(1), 93-104.

Henz, U. (2009). Couples' provision of informal care for parents and parents-in-law: Far from sharing equally? *Ageing & Society,* 29, 369-395.

Hertz, R. (2006). Talking about "doing" family. *Journal of Marriage and Family*, 68(4), 796-799.

Himmelweit, S., & Land, H. (2011). Reducing gender inequalities to create a sustainable care system. *Kurswechsel*, 4, 49-63.

Horowitz, A. (1985). Sons and daughters as caregivers to older parents: Differences in role performance and consequences. *The Gerontologist,* 25(6): 612-617.

Hochschild, A. (2000). Global Care Chains and Emotion Surplus Value. In W. Hutton & A. Giddens (Eds.). *On the Edge: Living with Global Capitalism* (pp. 130-146). London: Jonathan Cape.

IMSERSO (2005). *Cuidados a las personas mayores en los hogares españoles El entorno familiar* [Caring for elderly people in Spanish family settings: The home environment]. Madrid, Spain: Author.

Kay, R. (2013). "She's like a daughter to me": Insights into care, work and kinship from rural Russia". *European Asia Studies*, 65(6), 1136-1153.

Kluczyńska, U. (2015). Older husbands as carers: Constructions of masculinity in context of care-giving. *Studia Humanistyczne* AGH, 14, 73-94.

Kramer, B.J. (2005). Men caregivers: an overview. In B.J. Kramer & E.H. Thompson (Eds.), *Men as caregivers: Theory, research and service implications* (pp. 3-19). Amherst, NY: Prometeus Books.

Kramer, B., & Lambert, J. (1999). Caregiving as a life course transition among older husbands: A prospective study, *The Gerontologist*, 39(6), 658-667.

Lawton, L., Silverstein, M., & Bengtson, V.L. (1994). Affection, social contact, and geographic distance between adult children and their parents. *Journal of Marriage and the Family*, 56, 57-68.

Le Gall, J. (2010). La ayuda a distancia: el caso de las mujeres musulmanas en Montreal. [Long-distance help: the case of Muslim women in Montreal]. In M. Soronellas (Ed.), *Familias en la migración. Emociones, solidaridades y obligaciones en el espacio transnacional* [Families in migration. Emotions, solidarities and obligations in the transnational space] (pp. 29-56). Barcelona, Spain: Icaria.

Matthews, S.H. (1987). Provision of care to old parents. Division of responsibility among adult Children. *Research on Aging*, 9, 45-60.

Mauss, M. (trans. 2002). *The gift. The form and reason for exchange in archaic societies*. London: Routledge.

Milligan, C., & Morbey, H. (2016). Care, coping and identity: Older men's experiences of spousal care-giving. *Journal of Ageing Studies,* 38, 105-14.

Milne, A., & Hatzidimitriadou, E. (2003). 'Isn't he wonderful?' Exploring the contribution and conceptualization of older husbands as carers. *Ageing International,* 28(4), 389-407.

Nedelcu, M., & Wyss, M. (2016). 'Doing family' through ICT mediated ordinary co-presence: transnational communication practices of Romanian migrants in Switzerland. *Global Networks*, *16*(2), 202-218.

Parreñas, R. (2001). *Servants of globalization. Women, migration and domestic work.* Palo Alto, CA: Stanford University Press.

Pérez-Orozco, A. (2006). Amenaza tormenta. La crisis de los cuidados en la reorganización del sistema económico [Threat of storm. The crisis of care in the reorganization of the economic system]. *Revista de Economía Crítica,* 5, 7-37.

Ribeiro, O, & Paúl, C. (2008). Older male carers and the positive aspects of care. *Ageing and Society*, 28, 165-183.

Ribeiro, O., Paúl, C., & Nogueira, C. (2007). Real men, real husbands: Caregiving and masculinities in later life. *Journal of Aging Studies,* 21, 302-313.

Roigé, X. (2006). De la familia troncal a las nuevas familias. Continuidades y cambios en la familia catalana [From the stem family to the new families. Continuities and changes in the Catalan family]. In X. Roigé (Ed.) *Familias de ayer, familias de hoy. Continuidades y cambios en Cataluña [Families yesterday, families today. Continuities and changes in Catalonia*] (p. 9-23). Barcelona, Spain: Icaria.

Russell, R. (2001). In sickness and in health. A qualitative study of elderly men who care for wives with dementia. *Journal of Aging Studies,* 15, 351-67.

Sahlins, M. (2013). *What kinship is - and is not*. Chicago, IL: The University of Chicago Press.

Saraceno, C. (2010). Social inequalities in facing old-age dependency: A bigenerational perspective. *Journal of European Social Policy,* 20, 32-44.

Spitze, G., & Logan, J.(1990). Sons, daughters, and intergenerational social support. *Journal of Marriage and Family*, 52, 420-430.

Thelen, T. (2015) Care as social organization. Creating, maintaining and dissolving significant relations. *Anthropological Theory*, 15(4), 497-515

Tolkacheva, N., Broese van Groenou, M., & van Tilburg, T. (2014). Siblings similarities and sharing the care of older parents. *Journal of Family Issues*, 35, 312-330.

Thomas C. (1993). De-constructing concepts of care. *Sociology*, 27, 649-669.

Thompson, E.H. (2005). What's unique about men's caregiving? In B.J. Kramer, & E.H. Thompson (Eds.), *Men as caregivers, Theory, research and service implications* (pp. 20-47). Amherst, NY: Prometeus Books.

Tronto J.C., (1993). *Moral boundaries: A political argument for an ethic of care*. London, Psychology Press.

West, C., & Zimmerman, D.H. (1987). Doing gender. *Gender & Society,* 1, 125-51.

West, C., & Zimmerman, D.H. (2009). Accounting for doing gender. *Gender & Society,* 23, 112-22.

Yanagisako, S.J., & Collier, J.F. (1987). Toward an unified analysis of gender and kinship. In J.F. Collier, & S.J. Yanagisako (Eds.), *Gender and kinship, Essays towards a unified analysis* (pp. 14-50). Stanford, CA: Stanford University Press.

The author keeps the recordings and transcriptions of the interviews