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Who Should Take on Caregiving? Conditions for Assuming Long-term Care Responsibilities in the Family Context in Spain

¿Quién debe cuidar? Condicionantes para la asunción de la responsabilidad del cuidado de larga duración en el ámbito familiar en España

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Key words

- Care Crisis
- Long-term Care
- Gender Inequality
- Kinship
- Responsibility Redistribution

Abstract

This article analyzes the social factors influencing unequal involvement of family members in long-term care. Using a qualitative analysis, it explores caregiving responsibilities assigned differently based on gender and kinship, as well as the impact of factors such as marital status, family, economic, and employment situations, and residential conditions on caregiving predisposition. The results reveal a reactivation of the protective role of kinship and an increase in care negotiation conditioned by these factors. The need to redistribute care is highlighted, promoting an organization that extends beyond family responsibility in its provision. The study examines family caregiving dynamics, the distribution of responsibilities, and the social implications of the same.

Palabras clave

Crisis de los cuidados
- Cuidados de larga duración
- Desigualdad de género
- Parentesco
- Redistribución de responsabilidades

Resumen

Este artículo analiza los factores sociales que influyen en la desigual participación de los miembros de la familia en los cuidados de larga duración. A través de un análisis cualitativo, se exploran las responsabilidades de cuidado asignadas de manera diferenciada según el género y el parentesco, y el impacto de factores como el estado civil, la situación familiar, económica y laboral, así como las condiciones residenciales, en la predisposición al cuidado. Los resultados revelan una reactivación del papel protector del parentesco y un aumento de la negociación del cuidado condicionada por estos factores. Se destaca la necesidad de redistribuir socialmente el cuidado y promover una organización que trascienda la responsabilidad familiar en su provisión. Este estudio profundiza en las dinámicas familiares del cuidado, la distribución de responsabilidades y sus implicaciones sociales.

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INTRODUCTION[1]

Family care provision tends to be influenced by social structures that impose obligations based on gender and kinship, tending to attribute this task to women (Comas d'Argemir and Soronellas, 2019). According to data from the National Statistics Institute's 2020 Survey on Disability, Personal Autonomy and Dependency Situations, 20.5 % of all Spanish homes contained at least one individual with a disability or limitation. In 67.45 % of these cases, the main caregiver was a woman. The family (and women) continue to play a central role even in a model that seeks greater socialization of risk, with the approval of the Dependency Law (29/2006) (Rodríguez Cabrero, 2011; Martínez-Buján, 2014; Martínez-Buján, Jabazz and Soronellas, 2022).

Care is immersed in the context of social crisis that is characterized by a combination of demographic, economic, political and ideological factors. These factors place pressure on the capacity of traditional (family-based) models of provision to meet the growing needs of society and contribute to a transformation of the conditions in which care has traditionally been organized. This includes the debt and employment crisis of the first decade of the century, the health crisis, the housing access crisis, or the "care crisis" (Daly and Lewis, 2000), driven by an aging population, declining birth rates, changes in family structures, evolving norms regarding family and kinship responsibilities, as well as the role of women. This situation has been aggravated by the restructuring of welfare states within a framework of neoliberal globalization, based on policies of public spending containment and the individualization of risk (Rodríguez Cabrero, 2011). This crisis context has weakened various public and common structures that organize our society, increasing the unsustainability of the social organization of care, which requires a wide range of resources and material, spatial, and temporal possibilities for its distribution and organization.

This article examines the factors influencing family responsibility for long-term care of dependent adults necessary due to age or other circumstances. It analyzes how gender and kinship categories naturalize dedication to care and considers which social factors influence the willingness and ability of family members to take on this responsibility, as well as the possibilities for its redistribution.

Several studies have considered male participation in childrearing, but their involvement in family care for dependent adults has received less attention (Milligan and Morbey, 2016). Likewise, although some literature is available on kinship and care, few studies have examined the intersection between these categories and other social and circumstantial factors that shape and condition the predisposition to provide caregiving. This study addresses these issues in an integrated manner. The analysis of this intersection allows us to further understand the dynamics of family care and its social implications, in order to suggest a potential redistribution transcending the family sphere. This redistribution would include social co-responsibility as a fundamental pillar for the sustainability of well-being and equity in the distribution of care tasks (Fraser, 2013; Martínez-Buján, Jabazz and Soronellas, 2022).

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The objectives of this research will be explored in detail in four sections. The first presents some theoretical contributions to help frame the problem at hand, and to guide the analysis of the results. Second, the methodology section discusses the tools used and the procedures followed during the study. The results are presented in a third section, which is structured in subsections to facilitate understanding. Finally, the fourth section is devoted to the discussion and conclusions, based on an analysis of the results.

Assignment of family caregiving responsibility

Families are institutions of power that hierarchize their members based on a structure in which gender, generation and genealogical position combine to distribute care responsibilities. The intersection between gender and kinship must be analyzed in order to understand the naturalization of the unequal distribution of care responsibilities among family members (Collier and Yanagisako, 1987).

Gender is a social category that organizes identities, roles, and social relations based on sexual differences. This category is relevant in the negotiation of the care work distribution, since a situation of structural inequality persists, is reproduced, and forces women to take on both paid and unpaid care and reproductive work (Durán, 2018). Serrano-Pascual, Artiaga-Leiras and Crespo (2019) found that cultural and moral norms surrounding caregiving affect not only the division of labor, but also emotional expectations. This consolidates the idea that caregiving is an essential aspect of female identity while presenting it as something that is alien or has been imposed on men.

Kinship is another social category that organizes responsibilities and relationships of reciprocity in everyday life, with care being a practice that becomes essential to the exercising of kinship (Comas d'Argemir and Soronellas, 2019). Human groups have used biology as a metaphor for developing kinship, which is actually a system of social relationships (Carsten, 2011). Shared body fluids, such as milk, semen or blood, reinforce family ties, but beyond biology, kinship is sustained and maintained through care. Feeding, protecting, and helping to sustain life are essential elements of kinship that become especially visible in non-biological relationships, such as kinship by affinity or adoption. Sahlins (2011) introduced the concept of "mutuality of being", explaining kinship relations as the intense participation in the existence of others, which links relatives in a network of mutual care, with or without biological ties.

According to Roussel (1995), family solidarity has evolved from a model based on statutory obligations to one in which emotional requirements and individual circumstances have an increasing importance. In statutory solidarity, intergenerational obligations are derived from defined family roles and duties. They, in turn, are linked to social and economic conditions. In contrast, unconditional solidarity is emerging as a more recent trend, especially in the relationship between parents and children, where support and care are provided regardless of circumstances and without expecting immediate reciprocity. This distinction, however, is not always reflected in practice, as the solidarity of adult children toward their elderly parents may not always be unconditional and may be influenced by various socioeconomic and personal factors. Increasing life expectancy leads to longer intergenerational cohabitation and increases both the time and complexity of the care required by

older adults. Furthermore, changes in the family and society contribute to the fact that care obligations are more selective in their application, although a moral conscience regarding the care of elderly parents may persist.

Comas d'Argemir (2017) and Martín Palomo (2013) argued that, in younger generations, there is a tendency to break the traditional cycle of reciprocity, delegating more care responsibilities to external resources. This process of change has also been reflected in the transition from a circular logic of reciprocity (where care is returned between generations) to a more linear logic, whereby each generation cares for the next (Comas d'Argemir, 2017). Thus, although the sense of filial responsibility may persist to some extent, expectations about the intensity and consistency of care provided by younger generations are changing. This may be due to factors such as women's experiences as caregivers, their desire for autonomy, and recognition of their children's independence (Bofill, 2018). This search for autonomy by older women, which questions the traditional model of intergenerational solidarity and the female role as primary caregiver, generates new expectations about self-care, redefining the rights and obligations of both the family and the State. Martin (2009) refers to this as the "cultures of discontinuity" when emphasizing how modern societies have undergone transformations that lead to ruptures in intergenerational relationships, affecting expectations of family solidarity and the role of the State.

As family models evolve, the organization of care is negotiated based on gender, kinship, and other factors influencing the distribution of family responsibilities. This limits time availability and the social and material resources of the different family members (Daly and Lewis, 2000). Some of the factors influencing the distribution of caregiving responsibility have been studied in the specialized literature, which has analyzed how they affect the availability of the different members involved in care provision. For example, unequal participation in the labor market affects the time available, with retirees being those contributing the most to intergenerational support (López, Faus and Gómez, 2021; Kahn, McGill and Bianchi, 2011). Similarly, marital status or having a family of one's own predisposes an individual to caregiving by conditioning the reproductive load level and, therefore, the time available. Single or unattached daughters are more likely to care for their parents, especially if they have not emancipated themselves (Rivera, Rivera and Zurdo, 1999; López, Faus and Gómez, 2021). Single males tend to assume more care responsibilities than their male siblings (Henretta, Soldo and Voorhis, 2011; Tolkacheva, Groenou and Tilburg, 2014). With respect to family composition, the commitment to care is greater amongst only children (Szinovacz and Davey, 2013). The time available also depends on the time required for mobility, so residential distance influences care decisions, especially when daughters or daughters-in-law live far away (Paoletti, 1999; Comas and Chirinos, 2017). On the other hand, the availability of social and material resources also influences the distribution of care. Some authors have suggested that in rural areas, family collaboration in long-term care is greater than in urbanized areas (Heady, 2012; Leutloff-Grandits, 2012; Chirinos, 2023). Employment status, precarious employment (Carmichael, Charles and Hulme, 2010) and social class also affect the distribution of care, since they condition the material resources to provide or outsource it (Cano, 2018). In addition, equitable distribution of care between siblings is more common when they share social status and available time

(Szinovacz and Davey, 2013; Tolcacheva *et al*., 2014).

Despite the transformation of relationship spaces, intergenerational solidarity networks remain structural and functional in urbanized societies (Manceron and Segalen, 2012; Bazo, 2012; López, Faus and Gómez, 2021). Sociodemographic, economic and cultural changes affecting family structures and intergenerational roles have increased the need to share family care with other agents (the State, market and community). The combination of these actors varies according to the welfare model, as well as the availability of time and the resources of the families (Daly and Lewis, 2000). In Southern Europe, welfare systems are characterized by a strong family tradition of care, where the family members (especially women) have historically been the main providers. Public policies have tended to complement this model rather than replace it (Rodríguez Cabrero, 2011). According to Fraser (2015), the interaction between cultural values and the lack of public policies reinforces family responsibility in long-term care. Fraser argues that neoliberal policies encourage the privatization of home care, reducing government intervention in social justice. This dynamic, together with the values that traditionally assign care to the family, especially to women, increases the family burden due to the lack of public support.

Methodology

This study follows a qualitative methodological strategy based on ethnographic data taken from two research projects[2] conducted between 2014 and 2021. The projects focused on the analysis of long-term care for dependent adults. The first study focused on analyzing men's involvement in caring for dependent adults. The second project focused on the caregiving trajectories of men and women. Although this study also addressed the impact of COVID-19, this article exclusively considered the data describing the personal trajectories and caregiving experiences, without focusing the analysis on the effects of the pandemic. The use of data obtained from the two research projects is essential to addressing the study objective. It allows us to comprehensively observe the practices, representations and trajectories of caregivers within the context of the care crisis, while also identifying the social, cultural and structural factors that condition unequal involvement. The main data collection techniques were in-depth interviews and focus groups. Their purpose was to obtain qualitative data to capture the participants' perceptions, experiences and discourses, thereby providing a deep understanding of the care dynamics (Taylor and Bogdan, 1984).

Ninety-nine individuals (60 men and 39 women) were participants in this research. Eighty-seven of them were interviewed (59 men and 28 women), and 12 took part in two focus groups (one containing six women and one man, and the other consisting of five women). The following inclusion criteria were used for the sample creation: long-term care status; the interviewee was the primary caregiver for the dependent person; and a family relationship existed between the car-

[2] 1. "Homes cuidadors. Reptes i oportunitats per reduir les desigualtats de gènere i afrontar les noves necessitats de cura", financed by RecerCaixa (Obra social "La Caixa" amb la col·laboració de l'Associació Catalana d'Universitats Públiques (2014ACUP00045)). 2015-2018. IP: Dolors Comas d'Argemir; 2. "Care matters. The impact of gender on caregivers of elderly and dependent individuals in the times of Covid-19" (CUMADE). Fondo Supera COVID-19 Santander-CRUE-Spanish Universities. 2020-2021. IP: Dolors Comas d'Argemir.

egiver and the dependent person. Below is a table displaying the projects and their identification codes, which will accompany the verbatim results.

The sample was formed by convenience sampling, using data taken from previous research from which all interviews and focus groups related to family caregiving were selected. The final sample contained more men than women, since Project 1 focused on male caregivers, although a focus group with women was included to contrast the discourses and enrich the analysis from a gender perspective. Even so, we consider that the 28 interviews conducted with women, along with the participation of 11 women in the focus groups, offer a sufficient and relevant volume of information to understand their experiences regarding care. Furthermore, this article aims to analyze how kinship, in interaction with material and circumstantial factors, is articulated with gender in the distribution of caregiving responsibilities. Therefore, we worked with a diverse sample in terms of gender, kinship ties, and social, familial, and economic situations, allowing us to capture the complexity and multiple dimensions shaping caregiving practices in the family setting. Below is a summary table offering information on the participants and the variables considered.

Results: Factors conditioning relatives with respect to their involvement in caregiving

Gender and kinship

People provide care to family members due to a sense of moral obligation that is influenced by social norms of gender and kinship. When interrelated, these factors drive and structure caregiving within the family setting. For women, caregiving is assumed to be an unconditional obligation of mothers, wives, sisters, and daughters. In contrast, men, whose gender role often exempts them from family caregiving responsibilities, tend to engage in this task mainly when their kinship position demands it. This is especially the case in the absence of available women within the family setting.

Women feel the obligation to care more intensely than men do. This is also normalized by the people being cared for and the rest of the family members, such as Elisabeth's father (EP2), who assumes that his daughters will care for him, both because of the filial relationship and because they are women:

> Because if he has four daughters... he doesn't need anyone to take care of him, other than us. And, what's more, two of them are retired! We have nothing else to do in life but take care of him!

TABLE 1. *Project identification*

Projects	Period of the field work	Techniques	Sample by sex	Identification code
Project 1	February-December 2015	48 interviews	48 men	EP1
		1 focus group	5 women	GFP1
Project 2	May 2020- February 2021	39 interviews	11 men 28 women	EP2
		1 focus group	6 women 1 man	GFP2

Source: Author's own creation.

TABLE 2. *Sample characteristics*

	Interviews		Focus groups[3]		Total
	Men	Women	Men	Women	
Total	59	28	1	11	99 participants
Kinship[4]	Father [11] Brother [3] Son [20] Spouse [25] Brother-in-law [1] Friend [1] Nephew [1] Grandson [3]	Mother [4] Sister [2] Daughter [18] Spouse [1] Daughter-in-law [4]	Son [1]	Spouse [2] Daughter [7] Sister [1] Niece [1]	Father/Mother [15] Sibling [6] Child [47] Spouse [28] Son/daughter-in-law [5] Niece/nephew [2] Grandchild [3] Friend [1]
Age	25-44 [6] 45-64 [24] 65-84 [26] +85 [3]	25-44 [3] 45-64 [22] 65-84 [3]	65-84 [1]	45-64 [2] 65-84 [9]	25-44 [9] 45-64 [48] 65-84 [39] +84 [3]
Self-perception of class	Low [9] Middle [32] Middle-upper [18]	Low [6] Middle [12] Middle-high [11]	-	-	Low [16] Middle [44] Middle-high [29]
Marital status	Single [7] Married [43] Separated [9]	Single [4] Married [22] Separated [1] Widow [1]	-	-	Single [11] Married [65] Separated [10] Widow [1]
Work situation	Working [16] Unemployed [2] Not working [1] Quit job [2] Retired [37] Student [1]	Working [18] Unemployed [2] Not working [2] Quit job [3] Retired [3]	-	-	Working [34] Unemployed [4] Not working [3] Quit job [5] Retired [40] Students [1]
State of health of the care recipient[5]	Alzheimer's [14] Old age/fragile [14] MD [18] FD [19]	Alzheimer's [5] Old age/fragile [14] FD [9] Dementia [2]	Alzheimer's [1] Old age/fragile [1]	Alzheimer's [5] Old age/fragile [6]	Alzheimer's [25] Old age/fragile [34] MD [18] FD [28] Dementia [2]
Forms of co-existence[6]	Co-residence [43] Does not co-reside [8] Lives close by [3] Sporadically co-resides [5]	Co-residence [16] Does not co-reside [2] Lives close by [9] Sporadically co-resides [1]	Co-residence [1]	Co-residence [8] Does not co-reside [2] Lives close by [1]	Co-residence [68] Does not co-reside [12] Lives close by [13] Sporadically co-resides [6]
Autonomous community	Catalonia [49] Valencia community [8] Andalusia [1] Madrid [1]	Catalonia [7] Valencia community [10] Andalusia [9] Castile and León [1] Castile-La Mancha [1]	Catalonia [1]	Catalonia [11]	Catalonia [68] Valencia community [18] Andalusia [10] Madrid [1] Castile and León [1] Castile-La Mancha [1]

Source: Author's own creation.

[3] In the focus groups, information on certain variables is either unavailable or is only available for some participants. Therefore, certain fields in the corresponding table are empty.

[4] Eighteen people simultaneously cared for two people (11 men and 7 women). Therefore, the values for the variables "kinship" and "health status" exceed the total number of respondents. This is because some caregivers care for more than one family member with different kinship ties and different health conditions. Specifically, seven interviewees (1 woman and 6 men) have dual kinship, and eight interviewees (6 men and 2 women) care for dependent family members for different health reasons.

[5] MD= Mental Disorder; FD= Functional diversity.

[6] Sporadic coexist = lives sporadically (for example, on weekends) with the person.

Women's dedication to caregiving is naturalized by appealing to personality traits that are considered characteristically feminine. Mari (EP2) cares for her father-in-law since her husband and brothers-in-law "don't have the spirit to perform these duties". Loinaz (EP2) considers her brother capable of performing caregiving activities, but not of putting the same emotional energy into these tasks that she does:

> He also cares for him [...] but he doesn't quite have the... shall we say, the empathy, to consider that my mother needs to go outside or to stay a while chatting with my father.

In some cases, they have to simultaneously care for children and parents. This is the so-called "sandwich generation". It has been trapped within the provision of intergenerational care provision, in both ascending and descending directions (Burke and Calvano, 2017). These are women who have been socialized in caregiving tasks, since they have seen their mothers taking care of their grandparents, and may have even helped them. Then they have gone on to be chained to the caregiving cycle. "My mother-in-law, my father-in-law, and my husband have all passed through my hands", says Assumpta (EP2). Generally, they receive support from other relatives and in some cases, they are beneficiaries of economic subsidies for family care, as provided by Law 39/2006.

However, there are also situations in which it is the man who provides the caregiving. Driven by the bond of kinship, he crosses gender barriers and decides to provide care. This is when gender roles take a backseat, and the protective role of kinship is activated, conceptualizing care as an obligation. According to Pedro (EP2), who, along with his brother, cares for his mother, "it is our thing, our obligation". Luis Miguel (EP1) explained that "family ties" are responsible for his caring for his mentally ill sister.

Men who take on caregiving roles, especially of their children and spouses, emphasize an initial estrangement from the task. Pedro explains it as follows (EP2):

> I had to do things that I thought I would never in my life do, like changing her, cleaning her (laughs), diapers... I thought that this was not for me, it wasn't going to be part of my life.

In many cases, these are men who, during their childhood, were socialized in a caring environment since they lived in extended family units with elderly or fragile relatives or those having early-stage illnesses who were being cared for at home. Cesc (EP1), for example, who cares for his wife who suffered from a stroke, explains that "almost all of my life we have had someone at home who was disabled. So, what I am experiencing now is nothing new for me".

In terms of kinship, the nuclear family is more likely than the extended family to assume caregiving responsibilities. When the caregiver is a sibling, grandchild, or nephew, they usually provide care because there are no other close relatives who can care for the dependent person. They do so because of the bond that they have established with their relatives, or because they are available to do so. Cesc (EP1) does not have children and cares for his grandmother because "they are people who were really good to you".

Unlike care for parents or siblings, the care that parents provide to their children is not questioned. Félix (EP1) justifies that, together with his wife, he takes care of his adult son who has a mental disorder, "because he is our son. If we had to do it with a boy from another family, I don't know if we could bear the situation". Although care is concentrated in the core formed by the two parents,

mothers tend to be more involved in daily and essential care within the home, while fathers are usually more involved in activism and activities related to their children's sociability (Soronellas *et al.*, 2022).

Spouses who care for their husbands or wives prefer not to delegate care to their children, arguing that they have their own family and work responsibilities. Mikel (EP1), who is the main caregiver of his wife, explains that his daughter helps him, but he resists burdening her with more work because he feels it is not her responsibility. However, children are allowed to participate by supporting their parents or taking on the management of care. The handling of paperwork for an external service is usually delegated to children, who are considered more capable of handling the situation: "My son was there, and he took care of it, otherwise I wouldn't have understood anything", explained Toni (EP2), caregiver of his wife with functional diversity. Parental responsibility is also questioned by those currently caring for their families. Nina (EP2), for example, states that, when she grows up, she does not want to "sacrifice" her children.

Children usually share the caregiving responsibilities with their sisters, but less so with their brothers. Therefore, daughters are more likely to provide care. In the case of women who care for their in-laws, they usually do so without the help of their spouses since, in accordance with the gender mandate, these men do not agree to devote time to their care. For example, Josefina (EP2) explains that when her mother-in-law had a stroke, none of her husband's brothers wanted to take on the responsibility of sharing the care. In these cases, these are men who have had no experience with family care. However, there are also cases in which children assume direct care for their parents, renouncing the involvement of their wives, prioritizing the obligation of blood kinship over that of gender. Pedro (EP2), who is retired, does not involve his wife in the care of his father, who lives alone in his own home. However, he delegates the responsibility for housework and care of his own family to his wife, thus reproducing the gender system. He justifies this as follows:

> In their position as homemakers, they are willing to collaborate with their obligations to us, to make things easier for us. But we clearly understand that it is our responsibility, being our father's children (Pedro, EP2).

The sense of obligation perceived by caregivers and those cared for, derived from family responsibility and gender roles, can make it difficult to delegate care to external supports. Dolores (EP2) resists receiving help for the care of his mother: "We are here. We bathe her. Why would we ask for help? Why would they come and take her for walks? No, we will walk her ourselves". They consider professional care to be more distant and value the family bond and trust. For example, Mikel (EP1), who cares for his wife with disabilities, believes that hiring an external individual would be "worse" because "she won't be comfortable. She'd have to start getting used to it". Whenever possible, however, caregiving is shared with other family members or external support, even if only sporadically. In these cases, men tend to delegate the most feminized caregiving tasks, such as housecleaning, and take on the more masculinized ones, such as medical visits, household repairs, and errands. This strong sense of obligation, although an important driver of family caregiving, comes into tension with the growing demand for (and shortage of) external support and the need to socially redistribute the responsibility for caregiving.

The labor market situation

Gender and kinship structures intertwine in different ways to define the moral senses of responsibility, determining who should take on the caregiving responsibilities. These variables are also linked to other social spheres, such as the labor market, which conditions participation in the same, determining the time availability of each member. Thus, the possibilities for socially organizing caregiving are differentially configured and limited. Family members who are not in the labor market, whether due to unemployment, inactivity, or retirement, are often the most suitable to assume the caregiving duties. In the case of the women interviewed, they have either not held a job because they have taken care of the home and cared for children, or they left their job to care for children when they got married or had children. They often leave work due to gender norms and the prioritization of their husband's employment, due in part to the barriers to opportunity resulting from the wage gap and differences in job categories between men and women. These inequalities make reducing men's working hours economically less viable, leading women to assume caregiving responsibilities. For example, Patricia (EP2), who cares for her disabled daughter, quit her job to prioritize her husband's salary, arguing that:

> Ultimately, who earns less? Well, I was the one who earned less, so I decided to stay and do the caregiving, because she was almost always in the hospital [...] and since there is no assistance...

The decision to leave their job to take on caregiving responsibilities is less common among men and is more frequent in cases of unemployment. One example is José María (EP1), an unemployed attorney who, during the years of the economic crisis, cared for his mother who suffered from Alzheimer's while looking for work. However, he said that the responsibility of caring for his mother limited his job opportunities. His case reveals a correlation between the economic crisis and the increase in the participation of unemployed children in caregiving tasks (Zueras, Spijker and Blanes, 2018).

In mixed family networks, employment status can motivate gender differences, since employment and professional responsibilities are frequently used as an argument to free brothers from caregiving obligations. Nina (EP2), for example, explains that she prefers to care for her parents because her brother has more obligations in his job:

> My brother's job is also much more complicated. It requires not twenty-four hours a day, but twenty, and with this situation, he has even more work. I know he's going to have a harder time trying to be a caregiver.

While quitting work is less common for men, it is also a possible strategy in certain circumstances. This is the case of Mikel (EP1), the husband of a woman who suffers from a neurodegenerative disease that left her quadriplegic 16 years ago. He was granted a severe disability pension that exceeded his salary. Therefore, he decided to leave his job, which was lower paying, to care for his wife because "thinking things through, it was more profitable for me to stay home than to go to work. And that's why we decided to stay home" (Mikel, EP1).

Those who balance paid work and caregiving attempt to organize their schedules, frequently working double shifts. Strategies to balance work and caregiving are activated, such as sacrificing their careers or seeking support from family members or external resources. Continuing to work during a caregiving process is perceived positively and, in some cases, is presented as an escape route

that allows one to cope better with the burden associated with caregiving. For this reason, many people choose to continue working and hire outside help, as in the case of Fermín (EP1): "I prefer to go to work and have someone else be with her and I continue working". Manoli (EP2), for her part, stopped working to care for her mother with Alzheimer's, although she clearly expressed that she would have preferred to continue working rather than face the hardships of caregiving. She explains that "you don't choose that, it comes to you".

As for retired individuals, the variables leading them to dedicate themselves to caregiving is not only the availability of time, but also the need to care for a close relative (in this case, a spouse) due to illness or disability. Often, this is combined with factors such as emotional bonding and commitment, the limitations of formal care systems, and social and cultural dynamics (Chirinos, 2023). Some people of working age even choose to retire early to take on caregiving responsibilities, often after having juggled caregiving with their work for years. Paco (EP2) decided to retire in order to devote more time to his mother's care: "It's true, I'll tell you, I retired thinking about that a bit".

Marital status and family situation

The distribution of family responsibility for caregiving depends on both the ability to care for others and on the perceived duty to do so. Time availability is a key factor, influenced by marital and family status. Therefore, single, divorced, or otherwise dependent individuals tend to assume more responsibilities. Single individuals who have yet to leave home are especially likely to take on the care of an aging parent. This is the case with José María (EP1), who normalizes caring for his mother with Alzheimer's disease: "If I had gotten married, had my children, and had other living conditions, of course it wouldn't be the same. I wouldn't be able to be with my mother". In sibling groups, those who remain single tend to provide more assistance to their parents. Despite having siblings, Éric (EP1) assumes the sole caregiving of his father who suffers from cancer. He has been living with him since his divorce. He has no children and his sister lives far away. He is an example of those who take on caregiving responsibilities due to a lack of other available family members: only children, or children with a widowed or divorced parent, or when the person no longer has other family responsibilities. In many cases, the availability of time resulting from being single, widowed, not having children or other family circumstances weighs more in the organization of care than gender mandates, although it reinforces those of kinship. When there is a relative with no other reproductive burdens, they are expected to assume this responsibility. Many of the men interviewed justify their involvement in family caregiving based on their life circumstances, suggesting that they use this argument to explain a perceived atypical involvement, or that they only assume the caregiving role when permitted by material conditions of time and resources. In contrast, women tend to assume caregiving responsibilities even without these circumstantial advantages.

Residential conditions

In the broadest scope, residential conditions significantly influence the distribution of family care responsibilities. In interaction with gender and kinship mandates, this variable affects both the time available (through proximity, co-residence

with the person being cared for, or residing in urban or rural settings) and material resources (depending on the living conditions of the home, such as size or accessibility). Co-residence with a person receiving care encourages the assumption of the caregiving role from the outset of the caregiving situation. This is the case with José María (EP1) and his sister, who, in addition to being single, previously lived with their father and took over his care when he developed Alzheimer's. This was due in part to this co-residence situation: "When my father was getting older, we didn't want to leave, you know? We saw that he needed us a little bit". Residential proximity is another factor that determines the taking on of the caregiver role. Those living far from the home of the dependent person are less likely to assume care responsibilities. Rogelio (EP1) noted that his sister was less active in the care of her father, sick with Alzheimer's, due to the distance and architectural barriers of her home. This questions the gender mandate and highlights the influence of available time and material resources linked to residence. "My sister's problem is that she lives very far away, in a semi-detached house with stairs [...] necessary for everything. And my mother is losing her sight a bit".

The availability of space in the home makes it easier to accommodate dependent family members when circumstances so require. Assumpta (EP2) cares for her frail elderly parents on weekends at their home because "it is in a very good state to accommodate them; it has a garden." This quote also reveals the relationship between the conditions and size of the home and the economic situation of the caregiving family member, a factor which we will discuss further in the following subsection.

Changes in the types of living arrangements and housing sizes can make it difficult to assume family care, as explained by young Amal (EP2), when asked about the future possibility of hosting her elderly parents in her home:

> I said to my parents: "well, of course, you all used to live together"... Now everyone has their own home, and they also noted this. Before, you went to a family member's house without calling and they asked you to spend the night. But not anymore.

Furthermore, living in rural or urban settings influences how the burden of care is shared with external support. In rural areas, it is more difficult to travel and access home care services, but stronger social support networks often remain, facilitating informal care.

Economic situation

As mentioned in the previous section, economic situation is another factor influencing the organization of family care, since it determines the material resources available to distribute the reproductive burden. Family members from lower social classes usually assume care responsibilities because it is cheaper than hiring outside support. They often stop working in order to take on the care duties. This is the case with Patricia (EP2), a caregiver for her disabled daughter. She explains: "I had to stop working [...], I could have kept working, but I didn't earn enough to say... 'Hire someone'".

Another finding related to social class is that there are fewer beneficiaries of public resources among lower-class families: misinformation or difficulties in accessing the complex bureaucracy may be reasons for this. Simón (EP1), who cares for his wife with a mental disorder, explains that "I have no idea what the range of possibilities is". Thus, difficulties in ac-

cessing public resources reinforce family involvement in caregiving, deepening kinship mandates, as in the case of Simón (EP1) and gender mandates, as in many other cases. Both of these are main factor conditioning the distribution of care. In contrast, the presence of external resources in the organization of caregiving increases greatly in middle- and upper-class families, which tend to combine private and public resources, particularly making use of home care services. Thus, although gender and kinship roles remain relevant, they are not the only factors determining the organization of family care.

Social class is one factor determining the redistribution of care through the market or public services. Another determining factor is the inadequacy of public policies. Participants express indignation and despair in the face of a lack of support from public authorities. Ignacio (EP1), who cares for his wife, states that he is "very sacrificed", and that "you need to get help from the administration. At least a few hours so that you can escape from the problem". So when home care reaches its limit due to the shortcomings of the public system, the family's economic capacity becomes a decisive factor in accessing private resources and negotiating its involvement in care.

Discussion and conclusions

Given the results obtained, the proposal of Yanagisako and Collier (1987) of analyzing gender and kinship as dynamic social and cultural systems, in which the roles, obligations and hierarchies are built, negotiated and transformed, remains fully valid. Not everyone with the same kinship bond are equally involved in care. Therefore, it is essential to understand how these roles are redefined, altering the sense of obligation and reciprocity that is traditionally attributed to them.

Kinship operates unequally within the family network, prioritizing the nuclear family. The observed patterns of solidarity align with Roussel's (1995) distinction between the unconditional solidarity of parental care and the more negotiated and conditional solidarity of filial care, which depends on other social factors such as marital status or family situation, among others. The way in which sibling cohorts coordinate with parents to establish the conditions of care can be understood as a negotiation process, although significantly influenced by gender expectations. These expectations often assign greater responsibility to women, as evidenced by previous research (Rivera, Rivera and Zurdo, 1999; López, Faus and Gómez, 2021).

The results reflect a transition from a circular logic of reciprocity to a linear logic (Comas d'Argemir, 2017), in which the current generations tend to release their children from the obligation of paying back the care that they have received (Bofill, 2018). The husband's role in caring for their elderly wives reveals a shift in filial duty and a revival of the protective role of kinship, sometimes challenging gender roles in an aging context (Comas d'Argemir and Soronellas, 2019; Chirinos, 2023). This growing, albeit less common, male involvement demonstrates how, under certain circumstances (such as retirement), kinship obligations can be negotiated and may even prevail over traditional gender expectations, reinforcing the idea that these systems are malleable and can transform (Yanagisako and Collier, 1987).

The social and circumstantial factors influencing the predisposition to care, such as marital status, family, economic and employment situation, or residential conditions, intersect with gender and kinship structures, playing a key role in the negotiation and distribution of re-

sponsibilities. Situations such as retirement, unemployment, or being single (in the case of men), as well as women's position in the labor market, favor their involvement in caregiving tasks. Thus, the family members who are most involved in caregiving tend to be those who are not in the labor market (or those holding part-time or dispensable jobs), those without other significant family responsibilities, those living close to or cohabiting with the person being cared for, those with adequate housing, those lacking the resources to afford external care, or those without access to public care services. Therefore, these material and spatial factors, in addition to gender and kinship, condition the availability of time and resources, and influence the negotiation and distribution of care responsibilities within the family.

Men often cite specific circumstances (such as their work, family, or financial situation) to justify their involvement in caregiving. This attitude may be interpreted as a strategy to break away from traditional gender norms or as a means of legitimizing behavior perceived as "atypical". Women, on the other hand, more frequently resort to traditional gender expectations, presenting care as an unconditional obligation linked to their role as mothers, wives, sisters or daughters. This consolidates the idea that care constitutes an essential aspect of the feminine identity (Serrano-Pascual, Artiaga-Leiras and Crespo, 2019). This difference reinforces the notion that gender remains a determining factor in shaping family caregiving dynamics (Durán, 2018), despite some progress that has been made towards greater co-responsibility (Hanlon, 2012). This finding reinforces the need to incorporate gender norms into strategies developed to redistribute responsibilities and address the care crisis. This involves not only improving care and work-life balance policies but also transforming perceptions that normalize women's dedication to caregiving (Hanlon, 2012). Measures such as paid leave to care for family members or educational programs on gender co-responsibility from an early age are key to encouraging increased male involvement (Milligan and Morbey, 2016).

Finally, the results suggest an evolution towards less predictable and possibly more conditioned forms of solidarity (Roussel, 1995). This is related to the idea of discontinuity (Martin, 2009) and a change in the logic of intergenerational reciprocity and a redefinition of the rights and obligations of both the family and the State (Bofill, 2018). This break with traditional models of family solidarity contributes to the debate on the need to socially redistribute care responsibilities beyond the family sphere in the context of the care crisis (Daly and Lewis, 2000). However, we observe that tension exists between the moral obligation to care and the difficulty of delegating this responsibility to external supports, either due to issues of trust or the perception that family care is inherent to the emotional bond. Furthermore, the scarcity of public services and the difficulty of accessing market resources underscore the need for public policies to guarantee a social redistribution of care and to overcome the neoliberal logic that promotes the privatization of care in homes and families (Fraser, 2015).

In short, the results reveal how gender and kinship structures, although still fundamental in the organization of care, have been strained by social and demographic changes. This highlights the unsustainability of the predominantly family-based care model in Spain. At the same time, the results suggest that these structures, although transformed, continue to naturalize dedication to care and are an essential component in the pro-

vision of the same. This makes it necessary to reconsider public policies and implement cultural changes that permit a more equitable and socialized redistribution of caregiving responsibilities. Furthermore, a structured political approach is needed to address broader issues such as wealth redistribution, support for alternative models of coexistence, review of the wage-labor model, and guaranteed access to housing. The ultimate aim is to prevent the accumulation of the various social factors mentioned above from becoming a determinant that forces people to assume care. Instead, it is necessary to promote conditions that enable the negotiation and redistribution of care between different actors, spaces and areas.

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