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## OLDER HUSBANDS AS CARERS: CONSTRUCTIONS OF MASCULINITY IN CONTEXT OF CARE-GIVING

The main aim of the article is to describe how older men who are caring for their wives construct their masculinity in the face of their new role and tasks. My research draws on semi-structured, in-depth interviews with ten men between 64 and 90 years old who are the primary carers for their wives. The findings revealed four ways in which older care-givers talk about masculinity, and for all of them hegemonic masculinity was a point of reference. Masculinity was defined not only in relation to the carer's role, but also old age and the state of men's health. The ways of perceiving the activity of caring were crucial. Analysis allowed the main motives of providing care to emerge: obligation, love, and attachment. The research findings showed that an important factor in the way masculinity is constructed by older men caring for their wives was the definition of care. Men who perceive care as a masculine task feel less frustrated in the care-giver role, and sometimes gain satisfaction and a source of self-esteem from care-giving.

Keywords: masculinity, care, man as a carer, old men

### INTRODUCTION: MEN'S PARTICIPATION IN INFORMAL CARE

It is women, in particular middle-class, educated, and usually daughters, who most often care for family members (Sanders and Power 2009; Dahlberg, Demack and Bambra 2007; Martin-Matthews and Campbell 1995; Stoller 1994; Grotowska-Leder 2008; CBOS 2010, Błędowski 2002; McKee, Philp, Giovanni, Constantinos et al. 2003; Döhner and Kofahl 2005; Eurofarmcare 2006; Bień 2006; Bień, Wojszel and Doroszkiewicz 2008; Perek-Białas and Stypińska 2010; Golinowska 2010; Bettio and Verashchagina 2012). However, researchers have observed an increase in men's participation in this practice (Hirst 2001; Kramer and Thompson 2005; Döhner and Kofahl 2005; Russell 2007; Zierkiewicz and Mazurek 2015). In the USA and Canada, more than forty percent of men provide care for family members (Barker, Robertson and Connelly 2010). According to Betty Kramer (2005), thirty percent of carers for the elderly are men, usually husbands (45%), and less often sons (30%), or other unrelated men (25%).

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According to data from Great Britain (Dahlberg, Demack and Bambra 2007), nearly thirty percent of carers are older people, and about half of spouses living together act as carer for their partners. If we take into consideration statistical data showing that men are more likely to be married than women, we can deduce that men are the group that more often care for their spouse (Milne and Hatzidimitriadou 2003). Other British studies indicate that among the under-65s, men are just as likely to be a carer for their partner as women (Baker and Robertson 2008; Arber and Gilbert 1989). Furthermore, there is a clear trend in Poland for increased participation of men in caring. Researchers have observed a gender balance in terms of the care provided by older people to each other and equal proportions of male family carers in the 50+ age group (Döhner and Kofahl 2005: 25). There is, however, still a lack of statistical sources allowing estimates to be made of the number of men who care for their wives in Poland, because here, as in most European countries (Lamura, Mnich, Nolan, Wojszel et al. 2008), no country-wide register of family carers is available (Błędowski, Pędich, Bień, Wojszel and Czekanowski 2004).

In my analysis, I focused on a qualitative description of the situation of older men caring for their wives, because I wanted to investigate how men perceived themselves as carers, what their motivation is in taking care of partners, and how this role impacts on their definition of masculinity.

## OLDER MEN AS CARE-GIVERS

Research focusing on men in the role of carer for a family member developed in the 1990s. Research was mainly conducted in Europe, the USA and Canada and showed that men provide care for their wives, partners, parents, and children (Bytheway 1987; Kramer 2005; Döhner and Kofahl 2005; Eurofarmcare 2006; Dahlberg, Demack and Bambra 2007; Barker, Robertson and Connelly 2010; Golinowska 2010; Bettio and Verashchagina 2012). Some researchers claim that men provide care in a different way from women in the context of household and financial management, transport, shopping, and coordination of care (Keating, Fast, Frederick, Cranswick and Perrier 1999). Men also choose different coping strategies than women who care for their spouse, and also view the role of carer differently (Miller and Cafasso 1992). This point of view has come in for criticism, mostly from Kimmel (2003: 203), who stated that even if there are some differences between men and women in providing care, these are smaller than we assume.

According to Kaye and Applegate (1994), the role of carer might be a substitute for a paid job, because caring gives an opportunity to extend men's authority from the field of work to the home. Barusch and Spaid (1989) also support this assumption, and emphasize that retired husbands who care for their wives easily undertake the instrumental aspects of care, because they treat those activities as an extension of the man's role, also perceiving it as an extension of his power and authority, rather than just comprising nurturing and caring activities. It is also worth mentioning that men who continue to work and at the same time care for their wives experience role conflict and more often decide to use formal support

(Harris, Long and Fujii 1998: 196). Gutmann (1987) states that whereas women became more assertive, with their attitude becoming more instrumental with age, older men become more caring and expressive. What is more, women usually treat caring as a loss of autonomy (which is probably connected with previous experiences), whereas men perceive themselves as achieving a sense of control (Milne and Hatzidimitriadou 2003; Barusch and Spaid 1989). Davidson, Arber and Ginn (2000) indicate that men maintain a sense of control even if they are dependent; they very often manage the family budget and take a number of decisions, including those related to the caring process.

## OLDER MEN'S MOTIVES FOR CARE-GIVING

In Poland 29% of family carers are spouse carers (Döhner and Kofahl 2005: 17). The Eurofarmcare (Bień 2006) project, which evaluated the situation of family carers of older people in Europe, shows that the primary motivations for caring in Poland are the following: emotional bonds (love, affection), a sense of duty, and religious beliefs.

Milne and Hatzidimitriadou (2003) explain the motivation of older men to care for their partners in terms of a few factors: the structure of marriage (Thomson 1993), the will to reciprocate for care which they received earlier in their marriage (Fisher 1994), and also emotional closeness and love (Harris 1993). Husbands also decide to take on the role of carer through fear of separation, which is an effect of institutional care (Milne and Hatzidimitriadou 2003). Research shows that despite the fact that men indicate many different emotions accompanying the care-giving process, such as anger, frustration and sadness, the crucial motivation is love and respect for their wife and a sense of duty for her future (Siriopoulus and Brown 1999). Harris (1995, 1993) also indicates that the majority of men care for their wives out of duty and as a "labour of love". According to Cahill (2000), the main reasons to care for one's wife are love, marriage, duty and a combination of these factors, and, what is more, men's motivation in providing care is similar to that demonstrated by women (Cahill 2000). The results of Neufeld and Harrison's (1998) research show that the main motive is a sense of marital duty, hence care-giving is often an effect of social expectations.

## THE CONSTRUCTION OF MASCULINITY AND CARE

Caring is still treated as a female task (Gerstel and Gallagher 2001; Graham 1991; Kaye and Applegate 1990; Reskin 1991; Kramer 2000; Döhner and Kofahl 2005; Bień 2006; Perek-Białas and Stypińska 2010; Golinowska 2010). This is especially true when the care is given in an informal context and provided by family members. From the early years, women are socialized into the care-giving role, which is perceived as a "natural" female activity. Finch (1993) pointed out that the fact that care is gendered means something more than women carrying out most caring duties: it means that caring is connected with constructing women's identity in a way which is not appropriate for men. Researchers suggest

that whereas caring is a duty for women, for men caring is a matter of choice (Daly and Standing 2001).

Caring might be perceived as an unmanly activity, but on the other hand, men acting as carers achieve higher social recognition than women, because their behaviour is perceived as special, even heroic (Allen 1994). While women's care is stereotypically treated as "natural" and obvious, men's participation in care is treated as extraordinary, often more visible and appreciated than women's (Davidson, Arber and Ginn 2000).

Research findings have revealed that men are often "capable care-givers, able to manage, as well as nurture, innovate and adapt" (Russell 2001: 354). The majority of research focuses on perceiving the role of carer as an obligation (Neufeld and Harrisom 1998) or "labor of love" (Harris 1993; Harris 1995). Studies are also concerned with the instrumental aspects of care; expectations relating to the carer's role; emotional problems like depression, grief, stress, and burden (Kramer 1997; Kramer 2000); and formal or informal sources of support (Anders, Morano and Corley 2002; Russell 2004; Lilly, Richards and Buckwalter 2003; Butcher, Holkup and Buckwalter 2001; Coe and Neufeld 1999; Witucki, Brown, Chen, Mitchell et al. 2007). However, the problem of constructing masculinity and care is not often investigated (Riberio, Paúl and Nogueira 2007; Black, Schwartz, Caruso and Hannum 2008; Russell 2007). The lack of such research was signalled by Barker, Robertson and Connelly (2010), who used gender role conflict as a useful approach to investigate the negative consequences of traditional masculine roles in the caring process.

According to Connell's widely accepted theory of hegemonic masculinity, in every culture a form of masculinity exists which is highly valued and is connected with the most powerful position in the gender order (Connell 1995). Hegemonic masculinity is linked to power, domination, strength, heterosexuality and work. Although only few can achieve this pattern, for many it is a point of reference. There are also subordinate masculinities, which lie at the bottom of the masculinity hierarchy; these patterns are in opposition to hegemonic masculinity and are linked with limited access to power. Connell mentions homosexuals and ethnic masculinities as examples of subordinated masculinities. Such marginalized masculinities might be described in contrast to hegemonic masculinity, which means that older men, as a group which cannot be characterized through strength, work, and sometimes power, cannot achieve high status in the hierarchy of masculinities. It is important that not all older men lose the attributes which allow them to define themselves as dominant, and an intersectional perspective should be considered. However, there are groups of men who move down the masculinity hierarchy with age, especially if they are weak and ill, who stop working and lose their strength. It is worth emphasizing that not all men, even when they age, have to define their masculinity in relation to hegemonic masculinity; some of them might just redefine their masculinity, or deny the essential position of hegemonic masculinity in the construction of their masculinity. What is important to note is that the role of care-giver is not a part of the hegemonic masculinity pattern in our culture, which is why it seems important to check how older care-givers define their masculinities, and how important this role is in the context of constructing masculinity.

## METHOD AND SAMPLE

The author used a semi-structured in-depth interview as the research method, and thematic analysis coding as a mode of interpretation. The main aim of the research was to show how men perceived themselves as carers, what their motivation is in caring for their life partners, and how they construct masculinity in view of this care-giving. The interviews were carried out among ten older men who were primary carers for their wives and who provide unpaid care for a partner with a chronic illness, disability, or other care need. The participants were recruited via a local clinic in Poznan, where general practitioners and district nurses helped to select the interviewees, and facilitate contact with them. The crucial criteria when selecting the sample group were gender, age above 60, being the principal carer for a chronically ill or disabled wife, and living as the sole resident with their partner. The participants were informed about the research and agreed to take part. Nine of the interviews took place in the respondent's home and one in a local café (the respondent chose this venue). Nine of the interviews were recorded, although one respondent did not agree the conversation being recorded, so the researcher assiduously noted down his answers. All the recorded interviews were transcribed. The respondents were between 64 and 90 years old (the arithmetic mean was 80 years old). All respondents lived in a big city in Poland, but they are characterised by their diverse backgrounds, economic status, and various educational and occupational backgrounds (see Tab. 1). The study was completed in September 2014.

**Table 1.** Description of the respondents

Name	Age of carer	Age of cared-for wife	Causes of care need	Duration of care in years	Number of family carers who could help	Type of carer occupation/ Level of education
Bartosz	84	82	Alzheimer's, Diabetes	7 years	3 children	Director/ Higher education
Krzysztof	81	83	Sciatica, Cardiovascular diseases	Lack of data	1 daughter	Building worker/ basic vocational education
Franciszek	90	81	Rheumatoid arthritis	4 years	none	Worker of the post office
Maciej	78	75	Cardiovascular diseases, Diabetes	3 years	1 grandson	Toolmaker/ basic vocational education
Zenon	86	90	Dementia, Diabetes	Lack of data	none	Architect/ Higher education
Szymon	73	78	Chronic spinal pain	Lack of data	none	Technical secondary education

**Table 1** cont.

Szczepan	78	77	Stroke	3 years	1 son	Technical secondary education
Andrzej	64	59	No diagnosis – walking deficiencies	7 years	1 daughter	Toolmaker/ basic vocational school
Stefan	75	79	Parkinson's disease	9 years	none	Technical secondary education
Ryszard	87	78	Cancer, Diabetes	Lack of data	2 daughters	Higher education

## RESULTS. CONSTRUCTION OF MASCULINITY IN THE CONTEXT OF CARE-GIVING

### OLDER MEN'S MOTIVES FOR CARING FOR THEIR WIVES

Men most often declared that the main motive for caring for their wife was a sense of marital obligation: “We spent 50 years together [...] it's my duty, full stop!” [Stefan]; “That's my wife, I promised till death us do part” [Franciszek]. They were usually outraged when somebody suggested they give up caring for their wife: “There were people who said that they wonder whether I still took care of my wife, I could have got divorced long ago and stopped over-straining myself. But for me that is strange, because we made a vow not to send the other away somewhere, I don't think that's right” [Andrzej].

Some of the carers showed limits of providing care, mentioning strength and capabilities: “My conscience wouldn't allow me to act differently, as long as I can still do it” [Bartosz]. Faced with a lack of strength, a few respondents decided to hire a nurse or a home help to be able to provide care in the home, even if their wife agreed to institutional care: “My wife agreed to go to an old people's home, but we assume that as long as it's possible, she'll stay at home. It is just in case I couldn't cope with it [...]. They say that is immoral, why for God's sake, why is it immoral? What if I couldn't move tomorrow, what then?” [Stefan] Among the respondents, 24-hour care in a residential home was treated as a last resort in the event of the husband's lack of strength or even death.

Caring for a sick wife was defined not only as a marital obligation, but in wider terms as an obligation to care for others in need of help: “as a human being, you have to help one another [...]. I can't understand how one person can refuse to help” [Szymon]; “that's just a common sense of humanity” [Stefan].

Other men's motives for caring for their sick partners were love and attachment. Three of the respondents mentioned this kind of motivation, but they have difficulty speaking about love directly: “If I hadn't loved her, I wouldn't have done it” [Krzysztof]. One of the respondents also mentioned appreciation for the time they had spent together as being a motive for care-giving.

## HOUSEHOLD DUTIES AND WORK IN THE CONTEXT OF CARING AND THE CONSTRUCTION OF MASCULINITY

As an effect of the stereotypical belief in “natural” differences in our culture, some tasks are perceived as female, whereas others are treated as masculine. The public sphere is linked with masculinity, whereas the private sphere is associated with femininity. Among older couples, this stereotypical division is assumed to be the dominant one. We expect older men to define themselves mainly through their work, while women do so through the home. A wife’s chronic illness very often made it impossible for her to perform duties, and in such circumstances the man is faced with a new situation and new kinds of duties.

The traditional model of the family was dominant among the respondents. The men usually described themselves as the breadwinner (although sometimes the women had also had a paid job in the past), while the women were usually responsible for the home (some men declared that they participated in household duties to some extent when both partners were in paid employment). All respondents had worked in the past, and it was very often the case that they also decided to work during retirement if they felt healthy enough. Andrzej (the youngest interviewee at 64 years of age) stated that he would like to maintain occupational activity, but his wife’s illness had made it impossible. Almost all the respondents spoke with enthusiasm about their jobs; they usually emphasized that they derived satisfaction from work, and worked a great deal: “I worked a lot, about 16 hours a day for almost 4 years. I left home in the morning, and came back in the evening, in fact, I treated home like a hotel. But I always thought that you either want to become rich and achieve something or just do nothing and complain. [...] I did all the overtime, and after one week’s holiday I wanted to get back to work” [Andrzej]. Many of the respondents had continued to work despite being retired: “I took early retirement but I couldn’t sit at home, so I started working for a small business, and I have been working there for ten years. [...] The need to work and be active, with people, and anyway, money does not stink” [Maciej]. Work was treated as a crucial aspect in constructing men’s identity. The respondents usually related work to the role of breadwinner, but work was also defined as a source of status, the area of social life or self-realization. When faced with their wife’s illness, men have to cope with a new situation and take over her duties, some of which are completely new.

The respondents usually described household duties as a task which must be done: “the laundry, cooking, shopping, cleaning, dusting, and everything that is needed. I look after the plants, and do everything in the house” [Maciej]; “I have never distinguished female tasks from male tasks. Work is work, and it’s got to be done. For me it wasn’t a problem if it was a woman’s job or a man’s. I washed nappies, I didn’t just sit around at home and only did it if they asked me. But I had mates who were waiting for their wife to do it. If somebody wants to display their masculinity in this way, well, go on then” [Szczepan]. Some of the respondents treated household duties as tasks which let them feel fulfilled, and, what is important, the fact of having shared household duties previously was not crucial: “I do everything by myself. I never did those things before, I hadn’t the foggiest about it! She did everything” [Stefan].

There were men who took over just some of the household chores. There was greater resistance connected to cooking. Although the men were aware that this an activity which

might be learnt, it was often too tightly connected with femininity, and therefore constitutes a boundary: “My wife still cooks, but when she feels really bad, I prefer to buy ready-cooked meals” [Andrzej]. Some men admit “I would prefer to have the male area, not all the household duties, but I don’t feel any negative pressure, no” [Ryszard], or emphasize that “I just can’t stand some of the household chores!” [Stefan].

Only one of the respondents sustains a very traditional model of sharing duties despite his wife’s illness. He was indignant at the question of sharing household duties: “I am not capable of doing this, how I can I do such things!! I have never done them. My wife was always the cook, not me!” [Zenon]. His way of coping with the situation was to hire domestic help.

Some men focused on their wife’s critical eye. They tried to meet the standards set by their wives, and feel proud of their own accomplishments or frustrated if they can or cannot manage: “My wife is very demanding, everything has to be just so... [...] We do the washing together, because she can still get in there in the wheelchair. Dirty laundry has to be arranged properly in the washing machine. She says “don’t do it like that, don’t do that”. Everything’s got to be just perfect”.

#### CONSTRUCTION OF CARE AND THE CARER’S ROLE

Most of the respondents defined care as a natural stage of life, and saw the fact that a man might become the main carer for his wife as natural: “I always took into account that anything might happen” [Krzysztof]; “as a human being you have to help another [...] It is natural”. [Szymon]; “It is obvious for people who have a sense of dignity, that’s right” [Maciej]; “It is a natural thing, duties and family commitments” [Szczepan]. Because of these assumptions, the respondents were indignant at the question of their motives in caring for their wives: “Who should do the job of caring? I’m supposed to get another person in to do it?” [Krzysztof]; “We are together, what can I do? Leave her in her old age? Move out of the flat?” [Szymon]. Those reactions confirmed the obviousness of caring for their wife.

There are two dimensions of care; we can draw a distinction between “caring for”, defined as a set of interrelated activities, and “caring about”, connected with feelings (Ungerson 1983). “‘Caring for’ is defined in practical terms as the provision of personal health service, nursing care and other work including domestic services central to the provision if interpersonal needs. ‘Caring about’ refers to the other-centered disposition or identity that caring work engenders” (Hanlon 2012: 31).

“Caring for”, as a more “technical” aspect of care, was performed by respondents through two groups of activities: nurturing and management. Management tasks were manifested by the interviewees making an appointment at the doctor’s, organizing transport to the doctor’s or hospital, organizing institutional help or care, planning the daily schedule, or planning a shopping trip. More often the men focused on making an appointment at the doctor’s and shopping, which were described as obvious tasks, and concentrate on technical aspects. It is worth emphasizing that these tasks might be the source of a sense of agency, and are connected with the public sphere. Nurturing was usually defined as “a job to do” [Stefan], where the only aim is to perform the task. The description of nurturing actions was frequently devoid of any emotional aspect: “it is a job to do [...]. I find a dirty bottom, so I have to clean it. The



aim is to clean it, and that's my attitude to life" [Szczepan]; "I have to help her out of the armchair, because she can't do it alone. I have to lower her legs from the bed or help her to go to the toilet, and such things [...] She can't dress and undress herself, so I have to help, too. I help her into the bathtub, so I suppose I can say that I bathe her" [Stefan]. Less frequently mentioned, but still present, was the emotional aspect of care. "Care about" manifests itself in providing support in difficult situations, and love is noticeable in the descriptions of an activity, especially in non-verbal communication: "My wife's legs swelled up, her cuticles had cracked and water was leaking, and yet I managed to care for her so well that even our GP was surprised that I could cope" [Maciej]. Although many couples decided to sleep in separate beds or rooms, Bartosz, regardless of his own comfort, decided not to do this: "For a long time I wanted to sleep separately [...]. She would have been offended, I would have hurt her, I feel it. She would like to be close, to have support, so I can't say 'no'" [Bartosz].

Many of the respondents emphasized that their wife's satisfaction is crucial for them. They are often frustrated if they cannot achieve the high standards of care-giving which they set for themselves: "It's not easy, I do what I can. There are many times when my wife won't be satisfied, I know, not just once ... It must be perfect. [...] I would like to do everything the best I can, and I get irritated. I would like everything to be perfect, but it seems that everything goes wrong, despite my efforts. But...well" [Franciszek]. In spite of providing care, several men declared that they cannot reach the level of female care-giving. They assume that women are better in this sense: "I plumped up the pillows, but it's still not good enough. After all, I am a man... and the nurse does it better" [Franciszek].

Some respondents were ready to help and provide care at every moment. Ninety-year-old Frank had been sleeping on chairs close to his wife's bed for three weeks to be ready to help at any time, and some men wake up a few times each night to help their wife go to the toilet: "At night, I wake up four or five times. I have to get my wife's legs down off the bed and onto the floor" [Stefan]. Usually the men denied that they do something special, and downplayed their role. They also concealed their concerns: "There are times when I'm sitting on the sofa on the front of TV and pretending that I'm watching it. The TV is on because I want her to think I'm watching it... sometimes it's 3 a.m. But my wife knows that I did it so that I could keep my eyes on her, so she wouldn't fall asleep. You know, diabetes is awful" [Andrzej]. Caring is also linked with fighting for their wife's dignity. For example, to avoid having to use nappy pads, as long as their wife can control her urination, men are willing to wake up a few times a night to help her go to the toilet.

Some men hire qualified staff to look after their wife. They usually decided on such a move because of their own lack of strength: "nursing and washing my wife, I could do it by myself, but my fitness levels are too low" [Szczepan]. Using qualified care workers is treated rather as a failure, as an admission that they cannot cope with this duty. This meant that some men integrated nurturing and caring tasks into masculine ones, as being defeated by weakness might call their masculinity into question.

Men usually do not talk directly about any satisfaction connected with care-giving, but more often than not they deny such feelings: "It's a duty, not joy in the morning. I'm not making an altar out of this. [...] I don't feel satisfaction and I don't seek higher goals. I never counted on getting any satisfaction" [Stefan]. Men's satisfaction, which appeared in few

interviews, was linked with coping with care-giving, feeling proud of their knowledge related to illness or having a sense of control.

#### CONSTRUCTION OF MASCULINITY AND CARE

Masculinity was mentioned in relation to the men's current situation, thus in this context they most often emphasize a number of aspects: old age, the state of their health, and their role as carers. Analysis revealed four ways of talking about masculinity, and for all of these hegemonic masculinity was a point of reference.

The first description of masculinity was linked with a redefinition of the role of carer. Caring was perceived as a masculine task, although defined very broadly, as a responsibility for one's wife and managing the family, but household duties were excluded. Power was the core of the definition of masculinity. This way of "caring" was the source of a sense of "being where he should be" and "being a man".

In the second description of masculinity, care was perceived as a female task. The men emphasized that they feel masculine, but because they did not perceive care as masculine, they feel frustrated. The men from this group provide care, because they do not have a choice; they believe that is the best solution for their wives but not for themselves: "I do this, because I have no choice under the circumstances. If I bang my head against a brick wall, I can jump out of the window, and bugger all will come out of it, nothing... social workers will take her to an old people's home, they will give her Luminal or something like this, nappy pads and that's all the care she'll get!" [Stefan].

The third way of defining masculinity involved accepting changes and integrating care into every dimension as a masculine attribute. This redefinition of masculinity makes the men feel masculine, despite all the changes, and the effect of this metamorphosis of masculinity (Kluczyńska 2009) was calmness: "I'm sort of, well, you see, soft, but I didn't use to be, I was a tough person. [...] I think that there should be equality. I'm not set in my ways even in these traditional social matters, I don't have problem with this, but I'm surprised by people who are intolerant and don't accept progress" [Bartosz]. The integration of care as a masculine activity generates a higher level of satisfaction from care-giving, and social recognition might be perceived as an award. This way of defining masculinity was the most frequent: "Caring is a man's task. I couldn't imagine anybody saying that family is unimportant" [Ryszard]; "What the hell do you mean, can't take care of somebody?! For me, it's not as if it's something difficult or impossible" [Maciej].

The fourth and final way of constructing masculinity which emerged during the study was defining themselves through negation of "being a man". In the face of caring for their wife, which entails moving into the private sphere, and additionally acknowledging old age and body atrophy as an important factor influencing a decrease in the hierarchy of masculinity, some respondents felt sadness, and were resigned to not achieving hegemonic masculinity. For those men, the crucial factor was their physical weakness, which makes it impossible to provide a wide range of care, because they define masculinity mainly through strength and efficiency: "Because of my age I don't feel masculine, because I'm losing my strength" [Szczepan].

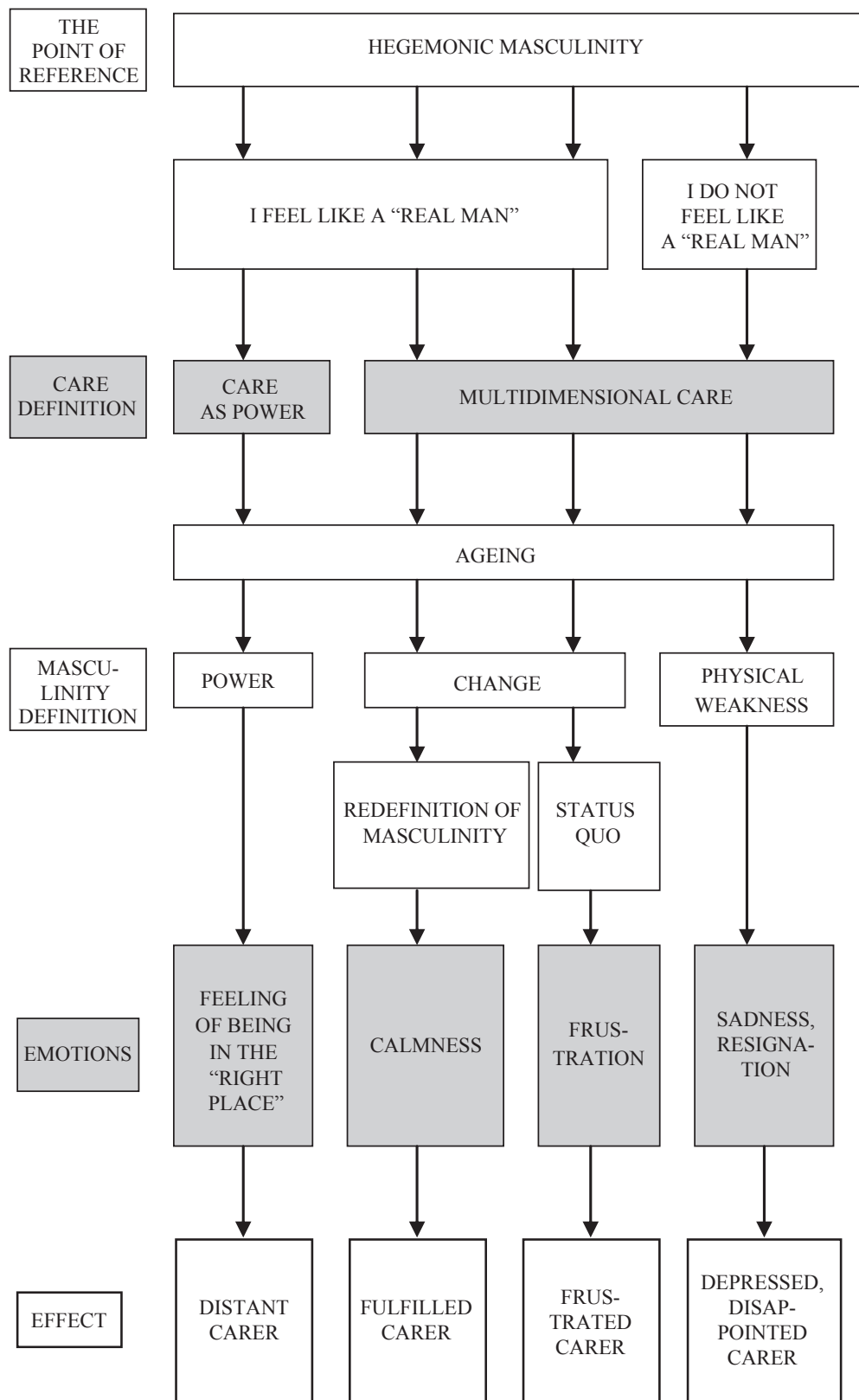


Figure 1. Construction of masculinity and care

For all respondents, masculinity is related to hegemonic masculinity, but just one respondent treated this model as a negation of everything connected with femininity and as a pattern which cannot be modified. This man rejected everything stereotypically defined as feminine, and described care in very wide terms, including such ideas as the breadwinner's role and managing the family. Despite admitting that hegemonic masculinity is a point of reference in constructing their masculinity, most of the interviewees treat this pattern as an area which might be modified. They usually integrated care as an attribute of masculinity. The way of defining care influences the way in which masculinity is constructed, because if it is not integrated as a masculine activity, men treat it as a burden and feel more frustrated because it hinders their chance to achieve hegemonic masculinity. Furthermore, Barker, Robertson and Connelly (2010) state that male care-givers with traditional beliefs about masculinity are more likely to feel a burden and a feeling of uncertainty about caring.

## DISCUSSION

In Polish society the family have always fulfilled the care functions for the elderly. Although recent years have brought some changes (Bojanowska 2012), informal caregiving is still the main source of care for older people in Poland (Pędich 2006; Bień, Wojszel and Sikorska-Simmons 2007, Golimowska 2010; Bojanowska 2012; Raclaw 2012; Drożdżak, Melchiorre, Perek-Białas, Principi et al. 2013, Stypińska and Perek-Białas 2014). The majority of Polish society (90%), with its traditional family model, states that the care of older people is the duty of family members (Kotowska and Wóycicka 2008), and 70% of the respondents express negative opinions about the institution of the nursing home. The Eurofamcare study (2005) showed that 87% of carers declared that they would not place an elderly person in a nursing home under any circumstances, and only 11% would consider such an option (Bień 2006; Stypińska and Perek-Białas 2014). There is a strong belief that it is crucial to enable elderly people to remain at home as long as possible (Bień and Doroszkiewicz 2006). One of the most important motivations for providing family care is not only emotional bonds, a sense of duty or obligation but also religious beliefs, which play a prominent role in Poland (Eurofarmcare 2006). In this country we can observe the powerful influence of Catholicism on society members, their care regimes, construction of gender order, and the still prevailing traditional gender roles.

The research findings revealed that the main motive for providing care for one's wife was marital duty. Many other studies support these findings (Neufeld and Harrisom 1998; Thomson 1993; Milne and Hatzidimitriadou 2003; Harris 1995; Harris 1993; Cahill 2000; Siriopoulus and Brown 1999; Miller and Kaufman 1996) and researchers emphasise that duty is one of the most frequently mentioned motives for caring for a wife as a consequence of the structure of marriage, social expectations regarding the spouse's role, and the commitment to marital vows.

The next motive declared by respondents, also identified in other studies (Cahill 2000; Harris 1993; Siriopoulus and Brown 1999), was love and attachment. Emotional closeness was an important factor, and according to Milne and Hatzidimitriadou (2003), husbands also

decide to care for their wives out of fear of separation as a consequence of institutional care. Interestingly, none of my respondents indicated this anxiety; in fact, they never mentioned such an emotion. Two men who connected the issue of separation with our conversation perceived it as an inevitable consequence of institutional care. One of the men stated directly that emotions connected with separation do not matter when it is necessary to put your wife in an old people's home for her sake.

Many researchers (Fisher 1994; Pruchno and Resch 1989; Lobo-Prabhu, Molinari, Arlinghaus, Barr et al. 2005; Harris 1993; Harris 1995) indicate that one of the motives for husbands caring for their wives is reciprocation for the care they received earlier in their marriage, so "the care they currently provide to their spouses was due them in return for years of prior support and nurturing" (Pruchno and Resch 1989: 163). My analysis does not reveal such motivation; the respondents declared that caring for spouses is the natural order of things. Only one of the interviewees indicated that appreciation for time which they had spent together was one of his motives for care-giving.

The most common reason for providing care was duty, but this motivation was not one-dimensional. As Cahill (2000) claimed, motivation is a combination of the motives mentioned above. Other researchers (Daly and Standing 2001; Chappell and Kuehne 1998; Navon and Weinblatt 1996; Yee and Schulz 2000; Kim, Loscalzo, Wellisch and Spillers 2006) state that caring is defined as an obligation by women, whereas for men it is a matter of choice, hence women are perceived as the ones who are obligated to provide care, while men are not. All the respondents indicated that obligation was one of the main motives; for some this was marital duty, for others a duty which confirms humanity, but for all it was crucial in defining their care-giving situation.

There is some evidence to support the thesis that retired men increase their involvement in the running of the household, but it is usually women that are responsible for the majority of such tasks (Solomon, Acock and Walker 2004; Altschuler 2004). As long as wives are in a fit condition to manage the household work and take crucial household decisions, they usually do this, which is supported by the traditional division of power. The majority of couples shared the household duties in a very traditional way in the past (distinguishing women's household chores like cleaning, washing or cooking from men's, such as doing household repairs). However, illness suffered by women entails a change in the division of duties and also in areas of power. Men, who were previously oriented towards the public sphere, now felt fulfilled in the private sphere (household duties, everyday decisions), so we can observe a shift in the spheres of influence, which might be defined as an opportunity to gain a new sphere of power after retiring. This assumption is supported by Kaye and Applegate (1994), who state that caring and taking over the household chores gives men an opportunity to extend their authority from the field of work to the home.

The respondents very often defined household duties as "work", and in doing so adopted a task-oriented coping strategy, which is similar to the professional model of care-giving (Thompson 2002). Instrumental or problem-solving coping strategies are more effective in coping with interpersonal problems and health-related problems (Barusch and Spaid 1989).

Not all household duties were accepted by all men; sometimes tasks perceived as predominantly feminine, such as cooking, were not carried out. Sharing the household chores

with their wife in the past did not influence their current performance of these tasks. Only one respondent stated that he had never done any household chores and would never do any. Whereas Sanders and Power (2009) claim that men who had never helped women with the household duties before often experienced feelings of guilt, none of my respondents mentioned such emotions. More often they assigned household chores to women, as long as their wives could cope with these tasks.

Men often had to learn basic household and care-giving skills, but skilful performance of household chores was for some respondents a source of pride and an opportunity to experience a sense of achievement, which confirms Sanders and Power's (2009) results. Some respondents stated that they felt satisfied in the knowledge of their wives' illness and the reaction to its symptoms. As Stoller and Miklowski claim (2008: 119), "husbands are also more likely than wives to report that caring for their spouses bolsters their self-esteem – a positive outcome reflecting pride in their own accomplishments, gratitude of their spouse, and praise from both family members and professional care providers". Thus new duties and caring might become an important aspect of constructing older men's identity and masculinity. It is important to emphasize that satisfaction is declared by husbands who integrate caring and household duties as "masculine". Allen and Webster's findings (2001) show that a husband's involvement in household tasks might even influence marital happiness, but only if the men hold egalitarian attitudes towards gender and marital roles.

Some researchers state that while women focus on the practical dimensions of care (activities which allow needs to be fulfilled), men have a tendency to describe themselves as the person who cares by way of continuous commitment and responsibility, which is manifested through providing financial support (Hanlon 2012). This statement appeared in my analysis, and such care was also connected with the fight for their wife's dignity and protection as an important dimension of men's care, also mentioned by Sanders and Power (2009).

My research showed that men's activity is not limited to broadly defined care but includes many practical care tasks, and the respondents enumerated not only many household duties but also care activities. My analysis showed that men more often indicated the practical dimension of care, whereas the emotional one receded into the background. The practical dimension of care, being more visible and often more time-consuming, might be defined as the more important one. The analysis by Barusch and Spaid (1989) showed that men treat the instrumental aspect of care as something more than a set of activities; it is an extension of their power. However, the emotional dimension of care was more noticeable in further declarations during interviews. The practical dimension could be highlighted more by caregivers because this is in accordance with the social expectations of hegemonic masculinity (Connell 1995), which assume maintaining an emotionally safe distance.

All of the respondents stayed with their wives, but they had different perceptions of themselves in these caring relations. Men who integrated caring as a masculine attribute find in it a source of sense of agency and a sense of control. Barker, Robertson and Connelly (2010) state that men with less traditional beliefs about masculinity indicated the positive aspects of being their partner's carer, thus construction of caring masculinity is beneficial for older men. According to Ekwall and Hallberg's (2007) study, carried out among carers over 75 years of age, men highlight the satisfaction gained from the role of carer more often than women do.

What is more, the satisfaction from caring concerns individuals who chose coping strategies which were focused on problems. Research suggests that older men who take care of their partners might experience a number of benefits (Davidson, Arber and Ginn 2000). The role of carer might act as a source of identity, or bolster their self-esteem (Davidson, Arber and Ginn 2000; Fisher 1994). A group of researchers (Harris, Long and Fujii 1998) observed that despite a low level of satisfaction, male carers (both husbands and sons) indicated that the main benefit of this process was that they gained new insight and opportunities for personal growth. I suggest that integrating care as a masculine attribute and constructing a more caring masculinity allows men to find a sense of agency and control, or even satisfaction from fulfilling male roles. According to several academics (Barusch and Spad 1989; Milne and Hatzidimitriadou 2003; Marks, Lambert and Choi 2002), in contrast to women, who experience everyday care as a loss of autonomy (which might be connected with previous experience), men often gain a sense of control from this role.

Some male carers may perceive care as a feminized activity, which may hinder their performance of this role in the context of the traditional masculinity model. Bowers (1999) observed that widowed men who had been care-givers for their wife describe themselves in more “feminine” terms than men who did not care for their wife before becoming a widower. That is why it seems important to understand “how men think about themselves as care-givers and how they perceive possible supports may contribute to strategies that will optimally engage older male carers and reduce their burden” (Barker, Robertson and Connelly 2010: 326).

This study contained several limitations that should be considered in the interpretation of its findings and in planning future research. Firstly, the small sample does not allow results to be generalized, but does allow us to set new directions for further research. What is more, the analysis concerns the situation where men decided to care for their wives and omitted those husbands who decided, for different reasons, to send their wife to a care home. The study does not take into consideration the nature of the wife’s illness or disability, which might be a crucial factor in the level of burden or stress experienced during the process of caring. It would also be interesting to consider the construction of masculinity and care in relation to such factors as social class, ethnicity or financial status. Furthermore, analysing institutional and informal sources of support could contribute to a more in-depth description of the situation. I am sure that the age of the carers also plays a crucial role in constructing masculinity, which is why I think it would be interesting to carry out research among younger men who are primary care-givers of their wives.

## CONCLUSIONS

This analysis presents the main motives of elderly men caring for their wives. The most common motivation was marital duty, as the men wanted to fulfil their wedding vows and be perceived as reliable and solid. Sometimes this obligation was defined in a wider sense as providing care to others who need help, hence it was an obligation which confirmed their humanity. The men also highlighted love and attachment as motives for providing care, but they had difficulty talking about love in direct terms. Moreover, appreciation for time spent

together was mentioned as one of the motives. Even though duty was the most common reason for providing care, motivation was not one-dimensional, but was a combination of the motives mentioned above.

It is difficult to separate household duties from caring, because these are closely connected. Household duties might be treated as one aspect of caring. Therefore, in the context of masculinity, it is important to analyse how men cope with a situation where they are responsible for the household, and how they define or redefine those tasks. They feel less frustrated when they integrate housework and caring as masculine activities. This might be a difficult process, because caring is culturally constructed as woman's work and is linked with low-status activities. But if older men cope with this obstacle, they can find a new field of influence because household duties and the role of carer might provide an opportunity to extend men's authority from the area of work to the home, and become an important aspect of constructing older men's identity and masculinity.

All respondents defined masculinity in relation to hegemonic masculinity. For some men, the discrepancy between the hegemonic pattern and the contemporary situation was impossible to cope with, leading them to feel frustrated or "not a real man". For other men, the solution was to redefine masculinity and integrate care as a masculine attribute. This redefinition allowed men to feel masculine and find a sense of agency and control. Men who had to care felt frustrated, despite this activity contradicting hegemonic masculinity, which was a point of reference for them. All the respondents have stayed with their wives, but they differ in perceiving caring as a greater or lesser burden. In the light of this analysis, the most beneficial course of action for carers seems to be to redefine masculinity as an effect of individuals integrating caring and new duties as masculine activities, rather than as a necessity and the impossibility of achieving hegemonic masculinity. Frustrated men have a sense of failure; they feel that they have dropped down the masculinity hierarchy, whereas men who redefine masculinity in the face of their new situation and welcome change, feel a sense of self-efficacy. Hegemonic masculinity as a point of reference in constructing masculinity might be linked with a high level of burden in the context of care-giving and the ageing process, and that is why a reconstruction of masculinity, which entails constructing a more caring masculinity, might be beneficial for them.

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STARSI MĘŻCZYŹNI JAKO OPIEKUNOWIE:

KONSTRUOWANIE MĘSKOŚCI W KONTEKŚCIE SPRAWOWANIA OPIEKI

Celem analizy jest opis sposobu, w jaki starzy mężczyźni definiują opiekę nad swoimi schorowanymi żonami oraz jak konstruują męskość w kontekście nowej roli i zadań. Badania z wykorzystaniem częściowo ustrukturalizowanego wywiadu jakościowego zostały przeprowadzone wśród dziesięciu mężczyzn w wieku od 64 do 90 lat, którzy określili się jako główni opiekunowie swych przewlekle chorych żon. Badania ukazały cztery sposoby opowiadania przez starszych opiekunów o męskości, w których męskość hegemoniczna zawsze była punktem odniesienia, a kluczową kwestią było postrzeganie się przez mężczyzn jako osób aktywnych. Definiowanie męskości nie ograniczało się wyłącznie do kontekstu opieki, ale w dużym stopniu wiązało się z wiekiem i stanem zdrowia mężczyzn. Badania ukazały również, że istotnym elementem wpływającym na sposób definiowania męskości był sposób definiowania opieki. Mężczyźni, którzy postrzegali opiekę jako męskie zadanie, odczuwali mniej frustracji, a czasem uzyskiwali satysfakcję i źródło poczucia własnej wartości dzięki realizowanej roli opiekuna. Analizy pozwoliły wyłonić główne motywy przyświecające mężczyznom w realizowaniu roli opiekuna chorej żony: obowiązek oraz miłość i przywiązanie.

Słowa kluczowe: męskość, opieka, mężczyzna jako opiekun, starsi mężczyźni