

Paper presented at the
4th Transforming Care Conference 2019
24–26 June 2019, Copenhagen, Denmark
Thematic panel “Inequalities and care needs in old age”

**The interrelation of class, ethnicity, gender, and employment in
coping with care: An intersectional analysis addressing
family caregivers in Germany**

Diana Auth (University of Applied Sciences Bielefeld)
Simone Leiber (University of Duisburg-Essen)
Sigrid Leitner (University of Applied Sciences Cologne)

Contact: simone.leiber@uni-due.de

Work in progress, please do not quote without authors' permission.

Abstract

This paper addresses inequalities in care for older people from the perspective of family caregivers. Not only older people in need of care, but also their caring relatives vary as far as their resources and needs are concerned. This is all the more relevant in a country like Germany, where almost 80 percent of older people in need of care are supported domestically – the majority of them by families without the additional help of professional services. We know that coping with the responsibilities of elderly care differs according to social structure categories such as socio-economic and educational background (e.g., ability to gather information or finance professional support); gender (e.g., societal expectations, opportunity costs); employment (e.g., requirement to reconcile work and care); or ethnicity (e.g., barriers according to language or familiarity with the welfare system). While the situation of particular groups of carers – female/male carers, carers from migrant families, carers whose relatives suffer from dementia, working carers etc. – has been studied in depth, the interrelation of such social structure categories in coping with elderly care has been largely neglected.

In how far does gender still matter today, when caring daughters or sons are well off and well educated? How do their coping strategies and needs differ, e.g. from low-earning migrant women? By applying an intersectional perspective, we examine interdependencies between socio-economic status, gender, ethnicity, and the employment status of family caregivers, as well as differences in their abilities to cope with providing care. Intersectionality is used as an analytic framework to identify how interrelated systems of power impact on those who are the most vulnerable. We present empirical results from the "PflegeIntersek" project funded by the German state of North Rhine-Westphalia. In this context, we have analysed 20 in-depth semi-structured qualitative interviews with caring relatives according to a pre-defined sample plan. Family caregivers who live in Germany and have Turkish backgrounds have also been included. Our analysis is theme-centred coding combined with an intersectional heuristic based on Christine Riegel's work.

The core result we wish to present is a typology. Five types of coping with care have been developed. Three of these types lead to 'rather successful' coping strategies and two types to 'rather precarious' coping situations. The types differ in the way social categories interact, with variations also in the ability of caregivers to self-care. We also identify specific needs for each type as well as the general problems experienced. Across all types, it is evident that their abilities to self-care as well as self-determination and control are central.

1. Introduction

Family caregivers have up to now been the mainstays of care provision in Germany and in North Rhine-Westphalia (NRW). According to the Federal Statistical Office, there are currently around 2.9 million people in Germany in need of care of whom almost three quarters are cared for at home and nearly all of these by relatives. Family carers will become an even more important factor in the future because of the ever increasing number of people in need of care and a socio-demographic leading to a continuous decline in the pool of potential carers and a shortage in skilled care staff (vgl. Afentakis/Maier 2010; Ehrentraut et al. 2015; for NRW: Cicholas/Ströker 2013). From a socio-political preventive perspective, it is therefore vital to support family caregivers in maintaining home-care arrangements for as long as possible and under the best possible conditions. This means maintaining high-quality care provision for those with long-term needs while avoiding risks to carers' health and living standards (poverty) (cf. Brüker et al. 2017).

A range of studies from different disciplines already exist on family caregivers. To support family caregivers in a socio-politically targeted and preventive way, many of these studies perceive this group as heterogeneous. Using analysis from the "PflegeIntersek" project¹, this paper goes one step further by not just examining group-specific requirements but also considering family carers from an intersectional perspective, i.e. the interrelations between various differentiating categories, in this case gender, social class, employment and the ethnicity of family caregivers. Such an approach not only enables investigating socio-political structures and processes in a way that is sensitive to power and inequality, but also serves to use intersectionality as a holistic "action-theoretical approach for the conceptualisation of help, support and social planning" (Fleischer 2014, p. 25, my translation [my translation]).

2. The current state of research and the research gap

Among studies on German care policy, only a few examine family caregivers according to differentiating categories and none of these take an explicitly intersectional research perspective. Theobald (2014, p. 349) has compared care policies in Sweden and Germany with regard to their "gendered and classed care arrangements". Leitner (2009;

¹ The "PflegeIntersek" project ("Family carers as the target group for a preventive care policy: An intersectional analysis") was carried out in cooperation with the Cologne University of Applied Sciences, the University of Duisburg-Essen and the Bielefeld University of Applied Sciences between September 2016 and August 2018 and was funded by the independent and non-profit German research institute *Forschungsinstitut für gesellschaftliche Weiterentwicklung* (FGW) NRW.

2013) also examined the gender and class effects of care regimes in conservative Western European welfare states. The only detailed account that explicitly addresses the topic of intersectional analyses of informal care of the elderly is from Appelt et al. (2014), which, however, refers only to Austria.

In both national and international care policy studies, it can be said that there is a general strong focus on gender as a category. Studies show that women provide care to a greater extent than men, especially as main caregivers, and thus with a higher amount time spent caring. The proportion of men providing care, especially sons, is however continuing to rise (cf. TNS Sozialforschung 2011, p. 27; Rothgang 2012, p. 80-90). The average age of male caregivers is higher due to them caring for their (married) wives mainly when they reach retirement age. When men care for their parents (or parent), they are more likely to be employed than women, often full-time (cf. TNS Sozialforschung 2011, p. 30), and their specific strategies for coping with giving care and their need for support are increasingly becoming the focus of research (cf. Klott 2010; Langehennig et al. 2012; Hammer 2014; on employed caring men: Auth et al. 2015). Women are more likely to organise their employment according to the care situation (cf. Keck 2012, pp. 38-40), while men arrange their care activities according to their employment (cf. Auth et al. 2016). A recent study from Ireland examined the relationship between socio-economic status and gender in respect of the expectations of women from different age cohorts to undertake the care of their parents, or to be cared for themselves by their daughters. It concludes: "[S]ocio-economic status shapes womens' capacity to negotiate the role of caring" (Conlon et al. 2014, p. 746).

In general, existing studies of family caregivers focus on lines of social class difference because attitudes to care and the resources of caregivers differ from class to class (cf. Blinkert/Klie 2004; 2008; Conlon et al. 2014, p. 746). Summarising the key findings of the literature on reconciling care and work, it can be seen that the social milieu, vocational qualifications and income situation have an impact on the providing care. Relatives with higher levels of education tend to be able to combine care and work, while those with a lower levels of education are more likely to stop working to provide care (cf. Klaus/Tesch-Römer 2014; Sarkisian/Gerstel 2004; Franke/Reichert 2012). Carers holding lower-grade occupational positions take on more extensive care tasks than those in middle and higher positions (cf. Keck 2012). Higher qualified people are also more likely to be able to free up time, e.g. by re-arranging their working times (cf. Spieß/Schneider 2003; Trukeschitz et al. 2009). It is easier for families with higher incomes to buy in professional help thus enabling them to go to work (cf. Kohler/Döhner 2012; Franke/Reichert 2012).

There are also several studies that focus on the issue of migration and caring for relatives. These mainly refer to Turkish or Russian (ethnic German repatriate) populations. Hubert et al. (2009) or Olbermann (2013) demonstrate that there are barriers to migrant access to local elderly care services and that these can be explained by education levels. But there are also indications that the low take up of in-kind benefits from long-term care insurances, as well as discrimination in assessment processes, which Okken et al. (2008) found among Turkish persons in need of long-term care, cannot be explained solely by socio-economic status, but also by cultural and religious influences (cf. Mogar/Kutzleben 2015). Tezcan-Güntekin and Breckenkamp (2017, p. 21) determined that families with migrant backgrounds are inadequately informed about how care assessment works. Families of Turkish origin perceive an expert from the medical services of German health funds (MDK) as a visitor to be welcomed and therefore present their home environments in such a way as to avoid any sense of shame (Tezcan-Güntekin/Breckenkamp 2017, S. 15). Across the different migrant groups, it has been shown that same-sex care is highly regarded and that sensitivity is required towards cultural attitudes to the physical body and the privacy of parents (cf. Neumayer et al. 2014, p. 169; Schnepf 2002, p. 237; Tezcan-Güntekin et al. 2015, p. 25-26).

Most of these studies are based on analysis using one or two categories. Studies taking intersectional approaches using more than two categories of difference are located predominantly in the area of "24-hour care" by migrant care workers (cf. Lutz/Palenga-Möllenbeck 2015; Beckmann 2011; Näre 2013; Weicht 2014; Bachinger 2014). An exception is the Austrian study by Neumayer et al. (2014) which specifically examines gender, class and migrant background in relation to the needs and networks of informal carers. This study comes to the conclusion that "the more lines of difference overlap, the greater the discrimination against informal carers [my translation]" (Neumayer et al. 2014, p. 174).

This study examines caring for relatives from an intersectional perspective because of the gap in research evident here. Intersectionally based research work theoretically and empirically analyses the "significance of a range of categories of difference in phenomena and processes of various kinds [my translation]" (Degele/Winker 2010, p. 11). However, the analysis is not based on a cumulative understanding of multiple discriminations using a range of categories of difference, but rather an analysis of *interactions between the categories* (Walgenbach 2012, p. 1). This is where the benefit of an intersectional approach. With regard to the group of family caregivers, the approach can reveal the diversity and variety in meeting care needs and any risk of homogenizing can be countered.

3. Family caregivers and intersectionality: Conceptual and methodological framework

The *PflegeIntersek* research project examined the power and dependency relationships in which family caregivers find themselves and how they cope with care situations under such conditions². It is assumed that carers differ in their coping strategies – i.e. the way in which they are able (or unable) to act – according to categories of social difference. A central question was the role of existing instruments and service structures of care policy in such coping strategies. In addition to examining support options for family caregivers, the research also focused on existing hurdles to accessing services. This raised the following questions:

- How do interactions between the differentiating categories of socio-economic status (SES), gender, employment and ethnicity develop in a care situation?
- To what extent are there differentiated needs for advice and support depending on the combination of characteristics? To what extent are there structural gaps in provision?
- What coping strategies can be identified?

The interview participants were selected according to a qualitative sampling plan (Table 1). The starting point for this was an intra-categorical approach (cf. McCall 2005). To create the sample plan, the category social class/SES is central. This is because the current state of research on the various groups of family caregivers clearly shows that those with a low SES have practically been ignored as an explicit target group despite there being clear indications that SES (seen here in dimensions of income and educational status) has a strong influence on coping with providing care. It was therefore decided from the start that family caregivers with a high or a low SES would be central when examining interactions with other categories of difference of gender, ethnicity and employment status. The resulting sampling plan is as follows:

² Using the concept of *Lebensbewältigung* [Life Management] by Lothar Böhnisch (2016), we understand the challenge of caring for those in need as a coping task for family caregivers which they must confront, and to cope have recourse to a range of personal and social resources.

Table 1: Qualitative sampling plan

Social class	Low SES								High SES							
Gender	Female				Male				Female				Male			
Ethnicity	NM		M		NM		M		NM		M		NM		M	
Employed	E	NE	E	NE	E	NE	E	NE	E	NE	E	NE	E	NE	E	NE
SES = socio-economic status																
NM/M = No migration background/Migration background																
NE/E = Not employed/Employed																

Source: authors

Using the sampling plan, 2 interviews per category aimed at gaining a total of 32 semi-structured interviews for the intersectional analysis of coping by family caregivers.

Family caregivers who also work are becoming increasingly significant so the group of respondents is limited to family caregivers caring for their (in-law) parents and it can be assumed that most carers in this target group are still of working age. To ensure coping strategies were being examined in high-level care situations, a further restriction was made relating to the level of care (prerequisite: dementia or at least Germany's 3rd level of care).

The 'ethnicity' category focuses on family caregivers of Turkish origin because these represent the largest migrant group in Germany and findings from existing studies have been ambiguous. The study also limits interviewees to urban areas to keep interviewee conditions more or less comparable. Variations along the categories of difference described above can then be focused on. Persons were contacted in the areas of Cologne, Düsseldorf³, and Bielefeld, 3 regions within the participating universities. When interpreting the results, the possibility of other mechanisms in rural areas should be considered.

No limits were placed to the time and duration of care. This means that relatives were interviewed who were either in an ongoing homecare situation or for whom such care was in the past. The transition from homecare to inpatient care and/or the death of the person in need of care therefore also became an issue in individual interviews.

A pragmatic approach was taken to gaining interviewees in the regions (Cologne, Düsseldorf and Bielefeld) of the participating universities. Specialist advisory centres for family caregivers and those requiring care, and institutional facilities for senior citizen

³ The PflegeIntersek project began at the Düsseldorf University of Applied Sciences and transferred to the University of Duisburg-Essen only in the autumn of 2017.

support were approached as well as general advisory and support facilities, GPs and neurologists, and inpatient and outpatient care facilities/-services. Interviewees were also sought via the press in the form of newspaper adverts in the local press and via a radio appeal. At a later stage in the project, major companies were also contacted who provide social support services to their employees. As a result, employed and non-employed women with high socio-economic statuses and no migrant background became over-represented. To access more male and/or Turkish-born family caregivers, social services for men and support services for Turkish-born migrants were included.

In this way, 36 guideline-based interviews were conducted. Despite a lot of effort, all 16 planned characteristic groups were not equally represented. Women without migrant backgrounds and with a high socio-economic statuses are therefore strongly represented in the study sample. Two characteristic groups were not represented at all: non-employed men with a low SES and no migrant background; and non-employed men with a high SES and no migrant background.

Qualitative data was collected by means of guideline-based interviews. (cf. Helfferich 2014, p. 560).

The guideline was drawn up along four phases of care. These are based on the Lindgren *caregiver career* concept⁴ (1993, p. 214-219). Phases three and four, however, were not experienced by all interviewees:

1. The decision to undertake care
2. How daily care is organised and carried out
3. The transition from home care to inpatient care
4. The dying and post-death phase

Focusing on these four phases of care characterises the basic approach of the study: to examine family caregiving as a dynamic process that requires coping with changing needs over time. The first phase focuses on factual information and the setting up of the care to be provided at home. The second phase focuses on the established structures of the respective care situation as well as the burdens and coping strategies of family caregivers. In the third phase, the limits of home care arrangements become clear with a transition to inpatient care becoming important. When the fourth phase is reached,

⁴ Lindgren (1993, pp. 214-219) considers caring tasks to be a specific stage in a person's life in which caring for a person in need becomes the focus of daily life. She names three phases: (1) *Encounter Stage* – confrontation with the care situation, (2) *Enduring Stage* – care routines and coping with care, (3) *Exit Stage* – leaving the caring role (on the person being cared for entering a care-home or post-death).

the coping strategy is additionally challenged by the emotionally highly stressful situation of caring for the dying. After the death of a relative, with the task of caring for a relative then over, caregivers must then develop strategies to continue their own life plans which may have been temporarily postponed.

The core question in all four phases is how family caregivers cope with the care situation. This not just about ensuring care is provided to those in need, but also importantly about ensuring respite for family caregivers and what options for self-care are available to caregivers and/or what options they take advantage of.

The interviews were evaluated in a two-phase process: firstly by thematic coding of the text material (cf. Flick 2012, p. 245; Hopf/Schmidt 1993; Schmidt 2012) and secondly by intersectional analysis of 20 selected interviews.⁵ The thematic coding served to break down the text material and provide a structural basis for the subsequent intersectional analysis.

In a second step in the analysis, case studies were performed on 20 selected interviews.

The intersectional analysis of the selected individual cases with regard to a) identity construction (cf. Winker/Degele 2010) and b) the conditions of care was carried out along two core heuristic questions conceived by Christine Riegel for intersectional analysis (cf. Riegel 2010, p. 77). The research follows Riegel's proposal to use an intersectional perspective as an instrument for analysis and reflection. In this respect, the approach is "not a research or evaluation method with clear methodological steps [my translation]", but should rather be seen as a *regarding strategy* (cf. Riegel 2010, p. 77), i.e. a critical view of the material with regard to relationships of dominance, attribution, exclusion, revaluation and devaluation, hierarchization, hegemonic structures, etc.

Riegel therefore proposes four dimensions of question which are to be repeatedly addressed to the phenomenon being investigated as part of a qualitative evaluation. For this research project, two questions were posed:

1. Which social categories and dominance relationships become relevant and how do they interact?
2. How are social differences and inequalities produced and reproduced?

⁵ The 20 cases selected for closer analysis was a sample of seven male caregivers and thirteen female caregivers including one granddaughter. Eight of the caregivers have a migration background. Ten of the interviewees were employed at the time of the interview. Twelve of the caregivers had a high socio-economic status.

The questions focus on the significance of the categories of difference and their interaction and were initially addressed to the individual codes, i.e. the relevant categories of difference and their interaction were examined, for example, according to the stress experienced in a care situation and with regard to the reasons given for caregiving or with regard to the reasons given for using social services and the experience of such services (etc.).

The results of this evaluation step were recorded in a "one sheet of paper" (according to Ziebland/McPherson 2006) exercise. This is a clear summary, usually two to three pages long, of the case in its entirety with regard to the categories and interactions that were evident. Focus is given to identity constructions as well as a summary of the general conditions of care. This was done against the background of Winker and Degele's multi-level approach (2010).

Identity constructions refer to how family caregivers presented themselves in the interview, how they wish to be seen and the attitudes they revealed. From a methodological aspect, it can be assumed that the interviewees do this using categories of difference (Winker/Degele 2010, pp. 81-83) and that the level of identity construction via the social practices of all individuals is interwoven with the level of representations and the level of structures. Especially at the level of identity construction, subjective, i.e. individually perceived opportunities emerge because action orientation enables or limits the care given.

After evaluating the individual cases, a case comparison analysis was carried out. Similarities and differences in care were sought, together with the question of how far these can be related back to the initial categories of SES, gender, employment status and ethnicity.

4. Findings: The coping strategies of family caregivers

A core finding of the evaluation was that, in an intra-categorical approach, the SES was not the dominant category. While SES is very important, it can be superposed as well as compensated for primarily from family resources utilised according to an accepted sharing of care. And when dependencies exist (e.g. responsibility for care being imposed on the caregiver by third parties, specific expectations of care from the person being cared for, aggravating framework conditions), a high SES may not have an enabling effect.

Furthermore, ethnicity as a dichotomous category of difference was not borne out by the empirical analysis. The heterogeneity of family caregivers with migration

backgrounds meant no uniform or dominant differences could be discerned when compared to caregivers without migration backgrounds. This would have justified differentiating caregivers with migration backgrounds from the other family caregivers with regard to their care-relevant identity constructions. The different interactions between SES, gender and employment (see section 3) were found to be independent of the migration status of family caregivers, i.e. a migration background as a category of difference was strongly overshadowed by other categories of difference. The migration background of the person in need of care was however important in arranging care. Migrant background was therefore only indirectly relevant for caregivers – via the person in need of care – especially when it involved accessing culturally sensitive care services. Families of Turkish origin were similar to families without a migration background by also being characterised by heterogeneous family cultures (which are by no means reduced to religion). Turkish-origin families are subject also to tensions between first and second generation migrants with regard to expectations and the provision of care (cf. Tezcan-Güntekin et al. 2015, S. 11-13).

The ability of family caregivers to self-care was an important finding which had major significance in the process of inductive analysis. In the interaction between the categories of difference, the ability of family caregivers to self-care was either enabling (when they have a high ability to self-care) or limiting (with little or no ability to self-care) in coping with providing care. The ability to self-care therefore represented a key extra line of difference in the ongoing analysis.

The cases then underwent further analysis examining the ability of caregivers to self-care. This ability reveals itself in different life contexts and ways of acting, e.g. staying in gainful employment, having a social support network, ensuring one has leisure time, using family resources to share care tasks and/or actively using services (possibly even against the will of the person in need of care)⁶

Evaluation of the interviews showed that the higher ability of caregivers for self-care in care situations substantially reduces stress and contributes to 'rather successful' coping strategies in providing care. On the other hand, a low or absent ability to self-care or a persistent struggle for self-determination and the opportunities for self-care, increase stress and lead to 'rather precarious' coping strategies in providing care. The ability to self-care therefore becomes effective in the care process as a central line of difference.

⁶ We assume that all interviewees are sufficiently able to provide care because they have undertaken the care at home when the need arose, regardless of their general circumstances. The decisive factor for this study must therefore be the *extent* to which family caregivers supplement their general ability to provide care orientation with an ability to self-care.

Through this analysis, five different types of family caregivers could be identified and developed into a *typology of coping behaviour of family caregivers*.

When comparing cases, similarities and differences in coping with providing care could be identified. Based on the concept of *Lebensbewätigung* [Life Management] by Lothar Böhnisch (2016), family caregivers are faced with taking on responsibility for family members in need of care and they will question their ability to act in a situation in which their psycho-social balance in terms of self-esteem, social recognition and self-efficacy is endangered. The ability for individuals to do this depends on their personal and social resources such as their family, their work situation, the availability of social services, etc. The extreme cases of a lack of recognition and low self-efficacy may create a sense of helplessness could lead to a separation from society and to antisocial and self-destructive behaviour, e.g. violence towards the person in need of care and depression.

From the qualitative interviews, which – to again clearly state – have no claim to being representative, a typology has been developed with five types of family caregivers with similar strategies for coping with care and providing care. The names given to the individual types refer to the key characteristic of the respective coping strategy, which is common to all family caregivers assigned to a type. A comparative analysis of the sample reveals that coping with a care situation can be assessed as 'successful' in some cases and 'precarious' in others. Three types of family caregivers could be assigned to the 'successful' coping strategy group, and two types were assigned to the 'precarious' coping strategy group (cf. Table 2). The typology's dimensions are based on a further development of the categories of difference⁷. The characteristics of the dimensions were derived from the analysis. Table 2 below gives an overview of the five types of caregivers.

⁷ As described at the beginning, the category 'ethnicity' was abandoned after the first analysis and a line of difference according to the ability to self-care was added. Table 2 does not therefore include 'ethnicity' as a typology dimension. In sections 4 and 5, however, the relevance of the ethnicity of the person in need of care is discussed in more detail.

Table 2: The coping strategies of family caregivers: A typology

	'Successful' coping			'Precarious' coping	
	Type 1 'Care organised around gainful employment'	Type 2 'Active use of family resources'	Type 3 'Sense of purpose'	Type 4 'No alternative'	Type 5 'Struggling for control'
Socio-economic status (SES)	High SES	Low SES	High or low SES	High or low SES	High SES
Employment status	Stays in gainful employment	Stays in gainful employment/life plan choice	None or minor gainful employment	None or stressful gainful employment	Stays in gainful employment
Ability to self-care	High ability to self-care	Family resources enable practising of a high ability to self-care	High ability to self-care is achieved through experiencing care as a sense of purpose	Hardly any ability to self-care, cannot be practised	Ability to self-care available, but unstable
Gender	Includes both sexes, gender as a category of difference not very relevant	Includes both sexes, gender as a category of difference not very relevant	Includes both sexes; gender-specific identity constructions become evident	Comprises women only	Comprises women only
<i>Case Studies in Sample*</i>	<i>Mr Kaya, Ms Keller, Ms Demir, Mr Otten, Mr Stelter, Ms Cordes (I)</i>	<i>Ms Uenal, Mr Aydin, Ms Herbst</i>	<i>Mr Behrens, Mr Münster, Mr Yildirim, Ms Heinrich, Ms Goder</i>	<i>Ms Kessler, Ms Aslan, Ms Jakobi, Ms Bührmann</i>	<i>Ms Meierjohann, Ms Yüksel, Ms Cordes (II)</i>

* All names have been changed

Source: authors

The following outlines how the terms 'successful' and 'precarious' coping with care are understood in the study.

The material shows that 'rather successful' coping is characterized by the ability to provide care according to one's own ideas which also means high-levels of care effort is more likely to be accepted and psycho-social stress is lower⁸ Adapting life plans to the needs of care situations is self-determined as far as possible, so a high level of self-efficacy is experienced. There is an objective perception that the personal and social resources required for coping are mainly available as well as a subjective perception of having options to act.⁹

In contrast to 'successfully' coping family caregivers, caregivers from the 'precarious' coping group mainly subordinate their life plans to the needs of the person in need of care. Accordingly, heteronomy is high and options to act are clearly limited. Coping with the task of care is experienced as being minimally or not at all controllable, social recognition by the family or the person in need of care is generally absent, and the situation is subjectively perceived as being more or less inescapable. Personal and social resources are not sufficient to enable a 'successful' coping strategy.

The individual types of family caregivers are presented in the following. It should be noted here that the care-coping type assigned can change, both positively and negatively, when the personal and/or social resources in the care process change.

4.1 Type 1 – Care organised around gainful employment

"It's not my goal to become a carer. Of course I want to develop personally and want to make sure that my plans are somehow realized" (Mr Kaya, line 1013–1015 [my translation])

Coping with care identified as "care organised around gainful employment" applies to persons with the following characteristics:

- High socio-economic status (SES)
- Staying in gainful employment
- High ability to self-care

All family caregivers assigned to this type have a high SES. All persons are also gainfully employed. The type includes both females and males as well as a variety of migration backgrounds.

The 'success' of this type of care is characterised by the preservation of one's own life plan. (Full-time) employment is considered to be of central importance here. Providing care is

⁸ However, this does not mean that stress does not exist objectively.

⁹ In our study, 'success' or 'precariousness' refers primarily to the well-being of the caregiver. We could not test the extent to which the provision of care to the person in need of care was actually 'successful' or not. We have only the descriptions from the viewpoint of family caregivers about the care arrangements, and information only on issues that they themselves considered as problems.

subordinated to staying in gainful employment and the wishes of persons being cared for may come secondary. Such a pronounced ability to self-care significantly contributes to 'successfully' coping with care. Staying in gainful employment is a particularly successful coping strategy by giving family caregivers opportunities to compensate and temporarily withdraw from the care situation. Staying in gainful employment is complemented by working conditions that are sensitive to employees providing care (cf. also Reuyß et al. 2012).

The specific care arrangements are individually very different. Care services are to a large extent used as support. Where family resources are available, these are also used as a way of keeping to one's own life plan. This group also has no common approach in the decision to move to inpatient care. This decision represents, however, an opportunity to ensure one's own life plan is not disrupted. Regardless of the specific conditions, it remains central for the affected family members that care decisions are made with a view to the caregivers' own needs and limits, and that self-determination is key in the provision of care process. Family caregivers therefore have a high level of control over their lives which helps them to cope 'successfully' with providing care.

Mr Kaya as an exemplary Type 1 case

The above quote from 'Mr. Kaya' classifies him in this typology. Mr Kaya is 39 years old, married, has a migration background and is in full-time employment. He describes himself as career-oriented. Nevertheless, caring for and supporting his father is important to him due to a background where providing care from within the family is important. Mr Kaya undertakes all care tasks because he wants to protect his mother and siblings due to several of them being unable to provide support due to health reasons. His father is 83 years old and has been in need of care since 2010. Dementia became evident in 2014 and he is currently classified at Germany's 3rd level of care. Even though Mr Kaya has registered with a care service, Mr Kaya must undertake many tasks himself, including personal hygiene, because the father refuses an outpatient care service. The options for respite for Mr Kaya here are therefore limited. Mr Kaya would like the care service to undertake more tasks but is sensitive to the needs of his father. The father's rejection of the care service means Mr Kaya is located within the socialization framework of the father who had migrated from Turkey. For Mr Kaya, it is important for him to consider both his own needs as well as those of the person in need of care. Staying in gainful employment during the caring phase is a priority. The focus here is not financial but primarily personal career aspirations. Mr Kaya is not losing sight of his own life plan. For him, gainful employment also offsets a stressful care situation, even though scarce time resources cause him high-levels of stress. An important factor in his case is the negotiating position he holds at work. As he works in a smaller business and has management responsibility, Mr Kaya can make relatively self-determined decisions. In this respect, Mr Kaya's category of employment status, and in particular the way in which he organises his working life in conjunction with his seniority, is effective in enabling him to cope with care¹⁰

¹⁰ Such a pattern of "Care organised around gainful employment" was also found in an earlier study related to employed male caregivers (Auth et al. 2016). Our analysis, however, sees it more as a general coping strategy for the better qualified and is found in both males and females.

4.2 Type 2 –Active use of family resources

"We always keep together. When there are appointments, we talk agree them in advance.... Who is going? Who does what? Who stays at home? One of us is always at home. From the youngest to the oldest" (Ms Uenal, line 540 – 543 [my translation])

Family caregivers assigned to the type 'Active use of family resources' are characterised by the following:

- Low socio-economic status
- Staying in gainful employment/life plan choice
- Ability to self-care s supported by family resources (which create options)

Family caregivers of this type are have a low SES. Similar to the first type, the carers here are employed, both male and female, and with and without migrant backgrounds. According to the four categories of difference relevant to this study (SES, gender, migration status and employment status), the two types differ only in SES. With regard to coping with care, it can be stated that a low SES does not represent a relevant limitation in the ability of caregivers to provide and (self-) care because it interacts with a facilitating family network.

The 'success' of care from this type is based on the active use of existing family resources. The personal freedom it creates enables family caregivers to continue to shape their own ongoing life plans. This life plan can include enabling and staying in gainful employment as well as a chosen educational path. In this way, self-care options can be practised and are made available both by an agreed sharing of tasks and roles within the family as well as by a mainly conflict-free family network. Family caregivers in this group are able to reconcile the values that are strongly oriented towards providing care from within the family, with self-caring for their own lives. They then see personal opportunities to be only slightly limited. The family share tasks and are able to either fully replace care services or perceive such services as an extension of the family. This system of providing care from within the family, which is a core component in the action orientation of family caregivers in this type, can then be sustained. The family caregivers demonstrate a high level of being in control of their lives, and the care activities of this type can be evaluated as 'successfully' coping with care.

Ms Uenal as an exemplary Type 2 case

Ms Uenal emphasises the cohesion of her family in the above quote and already at a young age undertook the care of her mother, who needs to be cared for and monitored around the clock. Her ability to provide care is part of her family socialisation. Ms Uenal undertook the the role of a caregiving daughter at the age of 17, but has been able to benefit from a caring family network because the providing care is shared by all family members. In this way, Ms Uenal has managed, despite caring for her mother, to complete school and then vocational training. She chose geriatric nursing as a profession, thereby remaining in a care context. Her employment status therefore corresponds closely to her role as a caregiver and is both enabling and limiting. While gainful employment limits Ms Uenal's availability for home care tasks, she can use her professional skills for the benefit of her mother's care. She also benefits herself from being able to coordinate appointments with the care services to enable difficult

care tasks to be performed together, e.g. bathing of the mother. Comparable to the Kaya case study where he is able to exploit a high degree of flexibility in his day-to-day work, the flexibility for Ms Uenal to adapt her work times is also important.

The family's low SES makes the care situation more difficult because the financial scope for action is small and for every purchase the family is dependent on prior approval from the health insurance. To cope with caring, however, it is central that there is interaction between a low SES and a family network. According to Ms Uenal, an alternating provision of family care and an agreed spreading of roles lead to low stress and enable her to pursue her own life plan in addition to her caring activities.

4.3 Type 3 – Sense of purpose

"Whenever it was possible, I was always there, wasn't I. Because for me there was a need" (Mr Behrens, line 121 [my translation])

The following key characteristics have been determined for Type 3:

- None or minimal gainful employment
- The ability to self-care is incorporated into the 'sense of purpose' of the caring task

This type includes people with both low and high SES's, as well as different migration statuses and genders. In contrast to the first two types, none of the family caregivers here is gainfully employed (minor employment excluded).

The SES is not directly relevant to coping with care. Nevertheless, all caregivers have in common that the financial framework at their disposal provides sufficient means of subsistence. It is crucial for coping with care that the decision to undertake care is part of the life plan and constructed as an important task. Self-care is thus made possible mainly by the care activity that is seen as having a sense of purpose. In line with the discourse on the *employment-centred normal biography*¹¹ (vgl. Kohli 1988), the task of care takes on a 'substitute function' for gainful employment.

Reasons for non-employment vary, but a common feature in all cases is that non-employment is linked to the biography of the family caregiver and therefore the caregiver does not see care as a compulsion but as a conscious choice. Caregiving may then be constructed as a stage in one's working life – in which case gainful employment is temporarily given up – or is an occasion to give up gainful employment altogether and take early retirement. This type of family caregiver may also include carers who were not in employment when entering the care situation due to incapacity to work or a previous role as a caregiver. The construction of caring as a substitute for gainful employment/a *normal biography* to obtain a recognised subject position is exclusively male in connotation here. For the women in the group, however, the undertaking of care activities as a sense of purpose is constructed more as an *alternative role*

¹¹ This is understood to mean a standardised life-course model which traditionally provides for continuous full-time employment especially for men.

*concept*¹² (cf. Offe/Hinrichs 1977) than an alternative role to gainful employment with a female connotation. In this respect, gender is relevant for family caregivers of the 'sense of purpose' type.

Because caregiving is perceived as being a negligible burden by the family caregivers and the 'sense of purpose' is made a genuine part of identity construction through the care activity, this type of coping with care is seen as 'successful'.

Mr Behrens as an exemplary Type 3 case

Mr Behrens, 59 years old, has no migration background and lives in a partnership, points out in the above quotation that he felt there was a "need" to care for his father-in-law who has very high care needs. Behrens feels that providing care is primarily a task with a sense of purpose rather than a burden. He also ascribes the undertaking of care as socially a matter of course, which for him also has a religious association. Mr Behrens cared for his 81 year old father-in-law, who suffered from dementia and died in 2015. The father-in-law qualified for Germany's 3rd level of care (with hardship provision) of up to 30 hours a week. For Mr. Behrens, everything other than his caregiving was of secondary importance including his (minor) gainful employment. It is relevant, however, that Mr Behrens became unable to work long before his father-in-law required care that he had only minor employment at the beginning of care. Reconciling care and gainful employment therefore posed no difficulties for Mr Behrens. Unlike his partner, who is dependent on earned income, his livelihood was secured by a reduced-capacity pension. His status of being minimally employed pushed him towards the role of carer because he had the time. However, in maintaining the care arrangement, such availability of time also had a facilitating effect, and by interacting with his ability to self-care by perceiving caregiving as having a sense of purpose, he was able to experience a high degree of satisfaction. For Mr Behrens, to cope with care it was important that the care activity, rather than putting his own life plan at risk, became a part of it. It is a life plan which Behrens continues to follow through voluntary work after the death of his father-in-law. That Mr Behrens has re-interpreted caregiving as a 'substitute task' can be seen as a coping strategy. It could be reconstructed from the interview that Mr. Behrens' ability to provide care is strongly based on his own biographical experiences.

4.4 Type 4 – No alternative

"Two or three years ago, I was given the alternative of either caring for my mum or letting my mum die." (Ms Kessler, line 21-23 [my translation])

The following key characteristics were determined for the 'no alternative' type:

- None or essential employment

¹² In labour market research, the alternative role concept explains the discrimination of certain groups who are ascribed a meaningful existence outside of gainful employment, e.g. in the case of women the alternative role of housewife, mother and family caregiver.

- Very low ability to self-care
- Comprises women only

The 'no alternative' type is comparable to the 'sense of purpose' type in that it includes family caregivers with both low and high SES's, the former being predominant. Migration statuses also vary. It is also comparable due to the majority of family caregivers of this type not being in gainful employment. In the study sample, only female caregivers were found in the 'no alternative' group so that the gender category of difference appears relevant here.

It is evident in this type that a high SES does not bring advantages for coping with care because other factors that cause a high level of stress overshadow the effectiveness of a high SES. Family caregivers assigned to this type refer to (forced) action orientations that are not only influenced by religious belief but also by individual family constellations and attitudes, and always being a question of conscience. Self-caring is not possible for the family caregivers of this type and the ability to self-care is low. What is striking here is a perceived dependence in the relationship to the person being cared for which reveals itself either financially and/or emotionally. There is also a narrow value set which does not permit any kind of other alternative. For example, additional services to gain respite from providing care cannot be procured due to the specifics of the situation and the care relationship, even though sufficient financial resources are available. This dependency and narrow value set severely limits the ability of caregivers to self-care to the point of complete negating any other options.

The type described here is characterised by having an ability to self-care that is at best weak, and a general perception that any self-care activities are impossible. Family caregivers see no alternatives due to the circumstances and therefore abandon their own life plans to care for the person in need. The caregiver's own needs are fully subordinated to the needs of the person requiring care. The 'no alternative' caregiver provides care mainly without the support of external care services because the caregiver either rejects them themselves, does not consider them an option (e.g. due to the challenging behaviour of the person being cared for), or refuses them, for example, because the person in need of care rejects them. In contrast to the 'active use of family resources' type, these family caregivers have no functioning family network to fall back onto (due, among other things, to intra-family conflicts) and are predominantly solely responsible for the care and support of the person in need. The resulting extremely high level of stress in providing care is tolerated with resignation. The dependencies and a high focus on providing care means no options can be perceived for respite through changing the care arrangements. In providing daily care, these family caregivers sense of a loss of control over their lives. Coping with care is therefore to be classified as 'precarious'.

Ms Kessler as an exemplary Type 4 case

An example of this type is Ms Kessler. She has no migration background, is 55 years old, single and was already very close to her mother prior to the care situation. The mother has been in need of care for five years and, at the time of the interview, suffered from advanced dementia requiring Germany's 5th level of care. Ms Kessler has never lived anywhere other than her parents' house. Accordingly, her sense of self is shaped by the role of a caring daughter who is able to go to extremes to provide care. She fulfils this role against the background of a powerful construction of dependence, because Ms Kessler has neither a partner nor children. She cares for her mother around the clock in their own household. To do this, she gave up her

gainful employment and thus became financially and "psychologically dependent on her mother", as she claims. Ms Kessler's sense of self as a caring daughter is marked by a religiousness. Faith gives her strength but primarily places her under a (no-alternative) obligation to care.

For all caregivers of this type, the situations are compounded by a lack of social and family support, which, as in the case of Ms Kessler, can lead to social isolation. With a few exceptions, she is limited to the contact with her mother, who requires high-level care and suffers from dementia. Her low SES makes the situation considerably more difficult because she is unable to establish any compensatory opportunities due to her lack of funds. For Ms Kessler, not having the opportunity of gainful employment has a high social opportunity costs because it excludes her from participating in society. Despite the highly stressful situation, she tolerates it with resignation, a common feature of this type of caregiver. In Mrs Kessler's case, the mother accepts no form of extra-familial care. Many of the daily care tasks that could actually be performed more adequately by outpatient care services are therefore carried out by Ms Kessler. Because of the mother's extremely negative attitude towards caring staff, Ms Kessler experiences no respite and instead is massively restricted in her ability to act because of the mother's expectation of care. The excessively high level of stress experienced goes hand in hand with a loss of control over the caregiver's own life plan and a suppression of the caregiver's own needs.

4.5 Type 5 – Struggling for control

"I often thought that I might lose my job because of my grandmother, especially when I was looking for a new caregiver and became desperate because I couldn't find a woman suitable to care for her" (Ms Yüksel, line 334-337 [my translation])

The following key characteristics were determined for this type:

- High socio-economic status
- Staying in gainful employment
- Good ability to self-care but self-care actions unstable and overshadowed by heteronomy
- Comprises women only

The 'struggling for control' types have a high SES and are gainfully employed. Caregivers with and without migration backgrounds are found here. From the study sample, only female family caregivers were found in this type.

Gender as a category of difference is relevant in both types with 'rather precarious' coping strategies because they comprise only women. However, due to the study's qualitative approach, no premature generalisations should be made about the pattern and requires further examination.

In contrast to the 'no alternative' type, caregivers here do have a certain degree of options within a persistent struggle to maintain control over their own life plans. This type of care

mainly differs from the 'no alternative' type in that caregivers, despite the 'struggle for control', keep their own needs in mind and actively practise self-care, expressed predominantly in staying employed even though they are not compelled to do so. However, specific conditions mean family caregivers are exposed to a very high and involuntary burden of care, which was often described emerging in a slow, gradual process. In a context that has been mainly forced upon them, they perceive their options for coping with care as very limited and they are at risk of losing control over their own life plans. Support from external care services is possible due to a high SES but can be only partially applied to the person in need and therefore provides only minor respite. Although the family caregivers consider their ability to self-care to be severely restricted, the struggling for control reveals itself in persistent attempts to (re)create the desired options. This struggle takes place either with third parties imposing care responsibilities (often in a conflictual relationship with other family members) or when dealing with the expectations and needs of the person being cared for.

Against this background, staying in gainful employment is considered to be particularly important. However, this does not always succeed to the desired extent and employment as a key aspect in structuring life becomes threatened. The family constellation does not – as in the 'actively used family resources' type – contribute to helping but makes coping more difficult. The key feature of this type of care is the care arrangement remaining unstable, repeatedly being disrupted, or subjectively regarded as fragile and at risk. Expectations from the person in need of care and conflicts with siblings make gainful employment a necessary time-out and respite from relationship conflicts in day-to-day care. In contrast to the 'no alternative' type, caregivers here repeatedly weigh up their alternatives. A high SES can be effective here, for example, because of the option to finance care services (e.g. a "24-hour carer"). This permanent 'struggle for control' in coping with care while at the same time experiencing high stress leads to this group being described as 'precarious' in coping with care.

Ms Yüksel as an exemplary Type 5 case

For Mrs. Yüksel, 43 years old and single, undertaking the care of her grandmother (who suffers from dementia and is severely restricted in her mobility and entitled to Germany's 4th level of care) is closely related to the position she holds within her family. The willingness to provide care revealed explicitly and implicitly in the interview is ambivalent. Mrs. Yüksel refers on the one hand to the close relationship with her grandmother and the family responsibility she takes as a given. On the other hand, she does not describe undertaking the care as being actively sought by her, but sees it as assigned by the family (among others by her own father, the grandmother's son). It becomes clear that the task was attributed to her by the family because she lives alone and has no children, and is also the only university-educated member of the family and therefore can be entrusted with professional competence. Yüksel's high SES becomes relevant within the family. As the grandmother's need for (physical) care increases, the gender category in interaction with the migrant background also appears to become relevant. Here both Ms Yüksel's brother and her father withdraw almost completely from the care tasks that they had performed only occasionally anyway. To use family resources for respite is therefore practically impossible for Ms Yüksel. In contrast to the 'actively used family resources' type, she has been assigned a task that is not seen as one to be shared. Conflicts in family negotiations make coping with care more difficult and result in the caregiver's 'struggle' for control over her own life.

Maintaining gainful employment is of central importance for Ms. Yüksel, regardless of her willingness and ability to provide care. It makes up a genuine part of her ability to self-care and is not negotiable. In contrast to the 'care organised around gainful employment' type, combining work and care is perceived as stressful. In the above quote, for example, there appears to be concern that she could lose her job because Mrs Yüksel, despite a "24-hour carer" financed by the entire family, has primary responsibility for the care. The bargaining position a family caregiver has within the job or, as in the Yüksel case, doesn't have is relevant here. The family as well as the position Mrs. Yüksel holds at work reveals a permanent struggle for control, which leads to a highly stressful situation. In contrast to the 'no alternative' type, it is however always possible to achieve a certain stability in care arrangements through the practice of self-care.

5. Conclusion

The PflegeIntersek study has once again shown the extremely important role played by family caregivers in the provision of care in Germany. As to the question of social inequality, very different arrangements and conditions can form the basis for coping 'successfully' with care and that there are no simple dividing lines or solutions. It is particularly important that family caregivers manage in their own way, to undertake care in a mainly self-determined way, to bring it into line with their personal ideas of life, and to have sufficient opportunities for self-care. Functioning family relationships (mainly in the form of a conflict-free sharing of responsibilities) continue to be an important resource in many situations but can by no means be taken for granted everywhere. This makes it all the more important to have a flexible, tailored public and corporate support system that places the needs of family caregivers on an equal footing with those of those in need of long-term care.

References (to be completed)

- Appelt, Erna/Fleischer, Eva/Preglau, Max (Hrsg.) (2014): Elder Care. Intersektionelle Analysen der informellen Betreuung und Pflege alter Menschen in Österreich, Innsbruck: Studien-Verlag.
- Auth, Diana/Dierkes, Mirjam/Leiber, Simone/Leitner, Sigrid (2016): Trotz Pflege kein Vereinbarkeitsproblem? Typische Arrangements und Ressourcen erwerbstätiger pflegender Söhne. In: *Zeitschrift für Sozialreform*, 62 (1), S. 79–110.
- Bachinger, Almut (2014): „24-Stunden-Betreuung - ganz legal?: Intersektionale Regime und die Nutzung migrantischer Arbeitskraft“. In: Aulenbacher, Brigitte/ Dammayr, Maria (Hrsg.): Für sich und andere sorgen. Krise und Zukunft von Care, Weinheim: Beltz, S. 127-137.
- Beckmann, Sabine (2011): „Intersektionale Perspektiven auf Care in Frankreich: methodologische Überlegungen zu migrantischer Sorgearbeit in der feministischen Wohlfahrtsstaatsforschung“. In: *GENDER Zeitschrift für Geschlecht, Kultur und Gesellschaft*, 3(3), S. 24-38.
- Blinkert, Baldo/Klie, Thomas (2004): Solidarität in Gefahr? Pflegebereitschaft und Pflegebedarfsentwicklung im demografischen und sozialen Wandel, Die "Kasseler Studie", Hannover: Vincentz.
- Böhnisch, Lothar (2016): Lebensbewältigung: ein Konzept für die Soziale Arbeit, Weinheim Basel: Beltz Juventa.
- Brüker, Daniela/Leiber, Simone/Leitner, Sigrid (2017): Vorbeugende Pflege- und Sorgepolitik. Herausforderungen und (kommunale) Gestaltungspotenziale in NRW, Düsseldorf: Forschungsinstitut für Gesellschaftliche Weiterentwicklung (FGW), http://www.fgw-nrw.de/fileadmin/user_upload/FGW-Studie-VSP-05-Leiber-Leitner-A1-komplett-web.pdf (Zugriff: 30. Sep. 2018).
- Brüker, Daniela/Kaiser, Petra/Leiber, Simone/Leitner, Sigrid (2017a): Die Rolle der Kommunen in der Pflegepolitik. Chancen und Grenzen einer vorbeugenden Perspektive. In: *Zeitschrift für Sozialreform*, 63 (2), S. 301–332.
- Cicholas, Ulrich/Ströker, Kerstin (2013): Auswirkungen des demografischen Wandels. Modellrechnungen zur Entwicklung der Pflegebedürftigkeit in Nordrhein-Westfalen (Statistische Analysen und Studien Nordrhein-Westfalen).
- Conlon, Catherine et al. (2014): „Women (Re)Negotiating Care across Family Generations: Intersections of Gender and Socioeconomic Status“. In: *Gender & Society*, 28(5), S. 729-751.
- Eggert, Simon/Sulman, Daniela/Teubner, Christian (2018): Unternehmensbefragung Vereinbarkeit von Beruf und Pflege – 2018. Forschungsbericht . Berlin: Zentrum für Qualität in der Pflege, https://www.zqp.de/wp-content/uploads/ZQP_Analyse_BerufPflegeDemenz_vf.pdf (Zugriff: 30. Sep. 2018)
- Fleischer, Eva (2014): „Intersektionalität als unverzichtbare Forschungsperspektive im Bereich informeller Pflege, Betreuung und Begleitung alter Menschen“. In: Appelt, Erna et al. (Hrsg.): Elder Care: Intersektionelle Analysen der informellen Betreuung und Pflege alter Menschen in Österreich, Innsbruck: Studien-Verlag, S. 13-31.
- Flick, Uwe (2012): Qualitative Sozialforschung. Eine Einführung, Reinbek: Rowohlt.
- Fleischer, Eva (2014): „Intersektionalität als unverzichtbare Forschungsperspektive im Bereich informeller Pflege, Betreuung und Begleitung alter Menschen“. In: Erna Appelt et al. (Hrsg.), Elder

- Care: Intersektionelle Analysen der informellen Betreuung und Pflege alter Menschen in Österreich, Innsbruck, S. 13-31.
- Franke, Annette/Reichert, Monika (2012): Carers&Work. Zwischen Beruf und Pflege: Konflikt oder Chance? - Ein europäischer Vergleich-, Analyse der internationalen Forschungsliteratur, Dortmund.
- Hammer, Eckart (2014): Unterschätzt: Männer in der Angehörigenpflege, Was sie leisten und welche Unterstützung sie brauchen, Freiburg im Breisgau: Kreuz-Verlag.
- Helfferich, Cornelia (2014): Leitfaden- und Experteninterviews. In: Baur, Nina/Blasius, Jörg (Hrsg.): Handbuch Methoden der empirischen Sozialforschung, Wiesbaden: Springer VS, S. 559-574.
- Hopf, Christel/Schmidt, Christiane (Hrsg.) (1993): Zum Verhältnis von innerfamiliären Erfahrungen, Persönlichkeitsentwicklung und politischen Orientierungen. Dokumentation und Erörterung des methodischen Vorgehens in einer Studie zu diesem Thema (vervielfältigtes Manuskript), Hildesheim: Institut für Sozialwissenschaften.
- Hubert, Sandra et al. (2009): Soziodemographische Merkmale und psychophysisches Befinden älterer türkischer Migrantinnen und Migranten in Deutschland. Eine Untersuchung auf Basis der Haupt- und Zusatzbefragung des Generations and Gender Survey der ersten Welle (Schriftenreihe des Bundesinstituts für Bevölkerungsforschung 39), Berlin.
- Keck, Wolfgang (2012): Die Vereinbarkeit von häuslicher Pflege und Beruf (Studien zur Gesundheits- und Pflegewissenschaft), Bern: Huber.
- Klaus, Daniela/Tesch-Römer, Clemens (2014): Pflegende Angehörige und Vereinbarkeit von Pflege und Beruf: Befunde aus dem Deutschen Alterssurvey 2008 (DZA-Fact Sheet).
- Klott, Stefanie (2010): "Ich wollte für sie sorgen". Die Situation pflegender Söhne: Motivation, Herausforderungen und Bedürfnisse, Frankfurt am Main: Mabuse.
- Kohler, Susanne/Döhner, Hanneli (2012): Carers@Work. Carers between Work and Care. Conflict or Chance?, Results of Interviews with Working Carers, Hamburg.
- Langehennig, Manfred et al. (2012): Männer in der Angehörigenpflege, Weinheim: Beltz
- Leitner, Sigrid (2009): „Von den Nachbarn lernen? Care-Regime in Deutschland, Österreich und Frankreich“. In: WSI-Mitteilungen, 62(7), S. 376-382.
- Leitner, Sigrid (2013): Varianten von Familialismus. Eine historisch vergleichende Analyse der Kinderbetreuungs- und Altenpflegepolitiken in kontinentaleuropäischen Wohlfahrtsstaaten (Sozialpolitische Schriften 91), Berlin: Duncker & Humblot.
- Lindgren, Carolyn L. (1993): The Caregiver Career. In: Image: the Journal of Nursing Scholarship, 25 (3), S. 214–219.
- Lutz, Helma/Palenga-Möllenbeck, Ewa (2015): „Care-Arbeit, Gender und Migration: Überlegungen zu einer Theorie transnationaler Migration im Haushaltssektor in Europa“. In: Meier-Gräwe, Uta (Hrsg.): Die Arbeit des Alltags: Gesellschaftliche Organisation und Umverteilung, Wiesbaden, S. 181-200.
- McCall, Leslie (2005): „The Complexity of Intersectionality“. In: Journal of Women in Culture and Society, 30(3), S. 1771-1800.
- Mogar, Medlin/Kutzleben, Milena v. (2015): „Demenz in Familien mit türkischem Migrationshintergrund: Organisation und Merkmale häuslicher Versorgungsarrangements“. In: Zeitschrift für Gerontologie und Geriatrie, 48(5), S. 465-472.

- Näre, Lena (2013): „Migrancy, Gender and Social Class in Domestic Labour and Social Care in Italy: An Intersectional Analysis of Demand“. In: *Journal of Ethnic and Migration Studies*, 39(4), S. 601-623.
- Neumayer, Clara et al. (2014): „Bedürfnisse und Netzwerke von informell Pflegenden - Überlegungen zu gender-, schicht- und migrationsspezifischen Unterschieden und Gemeinsamkeiten“. In: Appelt, Erna/Fleischer, Eva/Preglau, Max (Hrsg.): *Elder Care: Intersektionelle Analysen der informellen Betreuung und Pflege alter Menschen in Österreich*, Innsbruck: Studien-Verlag, S. 163-178.
- Okken, Petra-Karin/Spallek, Jacob/Razum, Oliver (2008): „Pflege türkischer Migranten“. In: Büscher, Andreas/Bauer, Ullrich (Hrsg.), *Soziale Ungleichheit und Pflege: Beiträge sozialwissenschaftlich orientierter Pflegeforschung (Gesundheit und Gesellschaft)*, Wiesbaden: VS, S. 396-422.
- Olbermann, Elke (2013): *Das Alter wird bunter. Lebenslagen älterer Menschen mit Migrationshintergrund und Handlungsbedarfe für Politik und Gesellschaft (WISO direkt, Analysen und Konzepte zur Wirtschafts- und Sozialpolitik)*, Bonn: Friedrich-Ebert-Stiftung.
- Riegel, Christine (2010): *Intersektionalität als transdisziplinäres Projekt. Methodologische Perspektiven für die Jugendforschung*. In: Riegel, Christine/Scherr, Albert/Stauber, Barbara (Hrsg.): *Transdisziplinäre Jugendforschung. Grundlagen und Forschungskonzepte*, Wiesbaden: Springer VS, S. 65-89.
- Sarkisian, Natalia/Gerstel, Naomi (2004): „Explaining the Gender Gap in Help to Parents: The importance of Employment“. In: *Journal of Marriage and Family*, 66(2), S. 431-451.
- Schmidt, Christiane (2012): „Analyse von Leitfadeninterviews“. In: Flick, Uwe/Kardorff, Ernst von/Steinke, Ines (Hrsg.): *Qualitative Forschung: Ein Handbuch*, Reinbek: Rowohlt, S. 447-456.
- Schnepp, Wilfried (2002): *Familiale Sorge in der Gruppe der russlanddeutschen Spätaussiedler. Funktion und Gestaltung (Reihe Pflegewissenschaft)*, Bern: Hogrefe.
- Schroeder, Wolfgang (2014): *Vorbeugende Sozialpolitik weiter entwickeln - Weiterdenken ...*, Diskussionspapier des Landesbüros NRW der Friedrich-Ebert-Stiftung, Bonn.
- Spieß, Christa K./Schneider, Ulrike (2003): „Interactions between care-giving and paid work hours among European midlife women, 1994 to 1996“. In: *Ageing and Society*, 23(1), S. 41-68.
- Statistisches Bundesamt (2017): *Pflegestatistik 2015 - Pflege im Rahmen der Pflegeversicherung – Deutschlandergebnisse*, https://www.destatis.de/DE/Publikationen/Thematisch/Gesundheit/Pflege/PflegeDeutschlandergebnisse5224001159004.pdf?__blob=publicationFile (Zugriff: 30. Sep. 2018).
- Stiegler, Barbara/Engelmann, Dirk (2011): *Zeit und Geld für pflegende Angehörige : Eckpunkte für eine geschlechtergerechte Gestaltung der Vereinbarkeit von Beruf und Pflege*, <http://library.fes.de/pdf-files/wiso/08192.pdf> (Zugriff: 03. Okt.2018).
- Tezcan-Güntekin, Hürrem (2017): *Türkeistämmige Menschen mit Demenz: pflegende Angehörige stärken*. In: *NDV-Nachrichtendienst des deutschen Vereins für öffentliche und private Fürsorge e. V.*, 97. Aufl. Berlin, 2017, S. 408-410.
- Tezcan-Güntekin, Hürrem/Breckenkamp, Jürgen (2017): *Die Pflege älterer Menschen mit Migrationshintergrund*. In: *G+G Wissenschaft (GGW)*, 17(2), S. 15-23, https://www.wido.de/fileadmin/wido/downloads/pdf_ggw/wido_ggw_0217_tezcan-guentekin_breckenkamp_0617.pdf (Zugriff: 05. Jul. 2018).
- Theobald, Hildegard (2014): „Care Policies and the Intersection of Inequalities in Care Work Germany and Sweden Compared (Care-Politiken und Intersektionalität in der Care-Arbeit: Ein Vergleich der

Situation in Deutschland und Schweden)“. In: Soziale Welt, Zeitschrift für sozialwissenschaftliche Forschung und Praxis (Sonderband), (20), S. 345-341.

Trukeschitz, Birgit/Mühlmann, Richard/Schneider, Ulrike/Ponocy, Ivan/Österle, August (2009): Arbeitsplätze und Tätigkeitsmerkmale berufstätiger pflegender Angehöriger. Befunde aus der Wiener Studie zur informellen Pflege und Betreuung älterer Menschen 2008 (VIC 2008) (Forschungsberichte des Forschungsinstituts für Altersökonomie), Wien.

Walgenbach, Katharina (2012): „Intersektionalität - eine Einführung“, <http://portal-intersektionalitaet.de/uploads/media/Walgenbach-Einfuehrung.pdf> (Zugriff: 13. Sept. 2018).

Winker, Gabriele/Degele, Nina (2010): Intersektionalität. Zur Analyse sozialer Ungleichheiten, 2. unveränd. Aufl., Bielefeld: Transcript.

Ziebland S./McPherson A. (2006): Making sense of qualitative data analysis: an introduction with illustrations from DIPEX (personal experiences of health and illness). In: Med Educ. 40 (5), S. 405-414.