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Caregivers and Their Support Networks. Who Supports Whom? Different Models of Informal Networks

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Abstract

Increases in life expectancy mean that more elderly people require care. This has significant implications for carers, who are typically women belonging to the so-called ‘sandwich generation’. This research, which formed part of a national mixed-methods study conducted in Italy between 2024 and 2025, aimed to identify the role of informal social relationships in supporting carers of older people. Data were collected from twenty caregiver-supporter dyads, in which the caregivers were aged between 50 and 65. In the first of two online interviews, the caregivers were interviewed using social network analysis tools to identify their support networks (i.e. the network structural data). In the second interview, qualitative data were gathered from the caregiver and their prime supporter (for example, a spouse, relative, or friend), and evaluated using thematic and template analysis. The results emphasise the variety of caregiving network models (for example, low-density large networks; high-density large networks; and low-density small networks) and the different roles caregivers can play within their networks. Their role depends on the type of support their receive. However, even caregivers situated within large functional networks may find that their resources are insufficient. These findings suggest that open networks and ‘bridging social capital’ contribute to greater well-being in both the caregivers and their supporters. Thus, promoting and preserving bridging social capital is crucial to enhancing the well-being of all actors involved in informal caregiving.

Keywords: caregiver, dyadic interview, social capital, social network, social relationships, social support.

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1. Introduction

This paper explores the function of caregiving, defined as a specific relationship within a network of informal relationships, at the centre of which we can hypothesise the presence of a dyadic relationship that supports the caregiver.

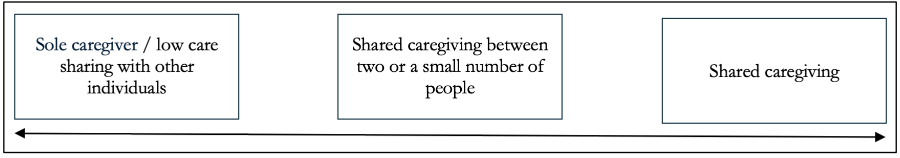
The topic of caregiving for older people is attracting increasing interest in the social sciences (Tur-Sinai et al., 2020), partly due to demographic changes that began several decades ago, resulting in a steady increase in the elderly population (Van Houtven & Norton, 2004; Yoo et al., 2004). This significant increase in life expectancy implies greater vulnerability and a substantial commitment to supporting and caring for the elderly (Ribeiro et al., 2021).

Welfare systems in Western countries are struggling to provide effective care and support for the most vulnerable elderly people in society. Italy is renowned for its strong culture of caring for the most vulnerable members of society, which is centred on the importance of family relationships (Bramanti, 2001; Bramanti & Donato, 2024; Carrà, & Moscatelli 2020). Although this model is often criticised for being traditional, outdated and having certain weaknesses, it is also acknowledged for its strengths such as the authentic expression of intergenerational solidarity (Bramanti & Garavaglia, 2016; Dykstra, 2010). Care – in the sense of taking care of others – is a distinctive feature of family relationships and characterises intergenerational solidarity. However, there is no doubt that society should offer individuals the freedom to choose, and to support those who provide informal care. For years, this task has almost exclusively been carried out by women, particularly middle-aged women who are likely having to juggle work and caring for their own children whilst facing the considerable difficulties inherent to caring for elderly parents (Pasquinelli, 2015; Pesaresi, 2021). This generation is often referred to as the 'sandwich generation' (Lei et al., 2023). Even today, women tend to carry the brunt of the care burden, being more involved than men, although the latter are certainly more becoming more involved than was typical in the past. Furthermore, an aspect that has been largely overlooked in social research, at least at a national level, is the impact of caring for a vulnerable person on the wider family network. In many cases, the impact is so widespread that it is described as a 'shared caregiving role'.

The objective of this paper is to explore the caregiving strategies adopted by adults who identify as fulfilling the role of caregiver. These strategies range from those involving low levels of sharing, where the caregiver performs most of the caregiving duties alone, to equal sharing, where the caregiving duties are shared equally with other individuals (Figure 1). These strategies can be attributed to various factors, such as the presence of solid and competent social capital and a formal network of services.

This paper essentially focuses on the different network configurations in which caregivers are involved, and on the presence of social capital (Tronca, 2016).

Figure 1. Different models of caregiving.



The article is divided into four sections. Section two presents an analysis of research conducted on the subject at the European and national levels; section three presents the research questions and methodology; section four presents the results, and section five discusses the study's findings and offers some concluding reflections.

2. Literature review

The term 'informal caregiving' for elderly people refers to "unpaid care provide by family, close relatives, friends and neighbours" (Li & Song, 2021, p. 1905), and it differs from 'formal caregiving', which means "paid care services provided by a healthcare institution or individual for a person need" (Li & Song, 2021, p. 1905).

As highlighted by Li and Song (2021), informal care involves "(1) routine activities of daily living (for example, bathing, toileting and eating); (2) instrumental activities of daily living (for example, housework, transportation, and managing finances); (3) companionship and emotional support; and (4) medical and nursing tasks, such as injections and colostomy care (p. 1906).

Therefore, informal care requires a significant level of commitment from those who dedicate themselves to it. As highlighted by Pesaresi (2021), caring for others is often considered a voluntary activity, driven by emotional and relational factors (Folgheraiter, 2011). However, in many cases, it is considered an obligatory role due to the perceived lack of alternatives. It is important to note that this does not happen by chance, but is the result of family dynamics (Cigoli, 2006), reflecting the family's particular social history and the individual's ability to negotiate which tasks are to be taken on; this may include some family members refusing to take on caregiving chores and the risk of work overload for those who do commit to providing care.

A multitude of international studies have been conducted on caregiving, mainly highlighting the role of caregivers and the consequences of caregiving on those providing care (Pasquinelli, 2015; Pesaresi, 2021). Furthermore, when considering the phenomenon within the European Union, it should be noted that formal recognition of care work varies between countries, meaning that it is treated differently depending on the country in consideration (Pesaresi, 2021; Phillips et al., 2022; Zarzycki et al., 2024).[1]

On the empirical level, research has shown a significant negative impact of the pandemic on the health of caregivers. This is a well-documented aspect of the research promoted by the European Association Working for Carers (Rosell, 2024), which investigated the conditions of informal carers of frail and disabled elderly people in more than ten European countries during the pandemic. The results revealed that, following the pandemic, the average number of care hours increased by over 15%, placing additional burden on women in particular. This increased care burden was exacerbated by difficulties accessing services, meaning that family networks became the primary source of support for caregivers during the pandemic, as they had been in the past.

Studies conducted at a national level prior to the pandemic crisis also highlighted the difficulties faced by people caring for others (Pasquinelli, 2015; Pesaresi, 2021). For example, research conducted in 2016 on a sample of 425 Italian caregivers highlighted the impact of caring for the elderly on caregivers. The study showed that caring for others affects not only the personal life of the caregiver but also their working life, often forcing them to take frequent leave from work or to opt for part-time work. This has negative repercussions for the economic situation of caregivers, who are predominantly women. In addition to the work-related aspects, the toil of caregiving may also impact the caregiver's own health. Providing care can cause fatigue, difficulty sleeping, anxiety, depression and an increased likelihood of illness, resulting in the use of medication (Pesaresi, 2021).

As highlighted by Pesaresi (2021), providing care to elderly people also affects the caregiver's relationships. Indeed, numerous studies confirm that caregivers often experience difficulties in their relationships with family members and friends, and that they feel compelled to abandon their free-time activities. In some cases, the caregiver is required to move into the elderly

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[1] The debate on this issue is ongoing in Italy. Despite legislative measures, such as Law No. 205 of 27 December 2017 and Bill No. 1461 of 2019, the role of informal carer has not yet been recognised at the legislative level.

person's home to provide care (Pasquinelli, 2015). These results emphasise the high level of commitment and risk associated with the role of carer.

The aforementioned studies did not look at how an individual's support network is configured or becomes reconfigured, or the number of people the network comprises.

The act of caring can be viewed as a process that occurs within a broader support framework, one that involves multiple individuals. This was clearly highlighted by Boccacin (2025, p. 243), who states that "the caregiving process may involve the presence of one or more family caregivers and/or members of informal networks, as well as one or more professional caregivers". From this perspective, the assumption of a caregiving role can be traced to a specific moment in the family life cycle. In many cases, this unfolds over a long period of time, during which a series of critical events occur. Some empirical evidence (Bramanti, 2023) documents a significant trend towards the reorganization of primary networks, which tend to include external individuals with a caregiving role belonging to friendship networks and paid networks (for example, family assistants).

According to this perspective, informal support networks – those positioned between social support and actual caregiving (Boccacin, 2025) – play a fundamental role in supporting caregivers. Given that the demand for care from non-self-sufficient elderly people is expected to increase in the coming years, while economic resources are predicted to dwindle and family structures are expected to become increasingly fragmented and reduced (Bramanti, 2023; Bramanti & Donato, 2024; Di Nicola, 2017), the burden of informal care is likely to intensify (Dessi & Rusmini, 2015), placing additional strain on caregivers' health, economic circumstances and employment conditions (Colombo et al., 2011).

Most studies on care and caregiving focus on the caregiver as 'the person who provides care', referring to anyone who provides assistance to a person with limited autonomy with whom they have an emotional and/or family bond. However, the importance of this role within family, primary and neighbourhood networks has overshadowed the fact that care is often a widespread function involving the entire network of the person in need of care, or at least a significant part of it. This multiplies the number of people effectively sharing the role of caregiver in relation to the same vulnerable person. Several studies at an international level have also focused on the importance of social relationships during the care process. For example, Roth (2020) highlighted that older adults who become caregivers are more likely to develop bridging social ties within their personal networks than non-caregivers, despite potential limitations on their personal freedom.

In light of these considerations, the informal resources that caregivers can rely on during the care process play an important role. As many questions on this issue remain unanswered at the national level (Bramanti & Bosoni, 2025), it is interesting to consider the phenomenon as a relational process involving more than just the caregiver and care recipient.

3. Objectives and methodology of the study

This study aims to understand the extent to which caregiving roles (Boccacin, 2025) are performed by a single person or shared among several individuals, and the strategies that caregivers and their networks implement to concentrate or distribute these functions. From this perspective, it is useful to consider the social capital of caregivers and their role in the network to which they belong.

Let us assume that the various strategies implemented for coping with the caregiving role are strongly influenced by i) the types of networks to which caregivers belong, with particular emphasis on their main supportive relationship: the carer-support dyad (i.e. the caregiver and their main source of support), and ii) whether their supporters are actively involved in caregiving or simply providing emotional and psychological support.

In particular, the presence of certain factors, such as the size and density of the network and its composition, differing in the number of family or non-family members, could lead to different outcomes in terms of the activation of high- or low-degree shared caregiving forms.

After the initial interview with the caregiver, they were requested to identify the person they felt most supported by with regard to the sharing of care tasks and the provision of emotional, psychological or informational support. This enabled us to apply the dyadic interview tool (in which the caregiver and support person are interviewed together) and thus extend the narrative to include the relational dimension inherent to the caregiving process. Furthermore, having the two subjects present during the interview helped us to guide the narrative to those figures present in the family scene who are often invisible yet much very involved, albeit in different ways.

The research questions are as follows:

RQ1: What motivates a person to become a caregiver?

RQ2: What roles do the caregiver (C) and support person (S) in the dyad play in the care network? Specifically, what kind of support does C seek from the S, and what kind of support is most important to C?

RQ3: In what ways do different caregiver network structures facilitate different caregiving practices?

RQ4: How do the different care strategies implemented impact the perception of well-being in the dyads?

The innovative aspect of this study's methodology lies in its use of two different data collection approaches: it combines the structural interactionist perspective (Tronca, 2007, 2013, 2021; Tronca & Sità, 2019) with the qualitative relational perspective (Bramanti et al., 2023).

To collect the data according to the first approach we applied network analysis, specifically three tools: the 'name generator', the 'name interpreter' and the 'name inter-relator' tool. The first tool collects information about the names of people (or 'nodes'). The 'name interpreter' tool collects the sociodemographic information related to the nodes identified in the first step (i.e. by the name generator); and the 'name inter-relator' tool was used to comprehend the relationships between the nodes identified.

To collect the data according to the second approach we used the open question applied in the dyadic interview (Caldwell, 2013; Eisikovits & Koren, 2010; Szulc & King, 2022). The dyadic interview entails both participants being interviewed together so that the participants can spontaneously interact with each other when responding to open ended questions being asked (Szulc & King, 2022). The advantages of this method are many; for example, the interviewees tend to encourage each other to respond to the questions, and it provides the opportunity to analyse the interactions between the two participants and the data generated from their interaction (Bramanti et al., 2023).

An initial small group of caregivers (n=5) aged between 50 and 65 years was identified through the network of local services and third-sector organizations operating in the local context of the province of Milan. We then employed the snowball method to generate the sample,[2] that is, by asking them to nominate other caregivers they knew. Caregiver identification stopped once we had identified a total of twenty caregivers willing to participate in the study.

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[2] Although a purposive sampling approach might have been more effective to ensure a balanced distribution of different types of caregiver network, given the absence of a national caregiver register (with detailed information on caregiver networks), on which we could have based such a selection, we instead adopted the more practical snowball sampling method to reach this demographic. We hypothesized that the word-of-mouth method would be the most practical, yet acknowledge its limitations; in particular, caregiver who are more socially isolated would be less likely to come into contact with the researchers, rendering the sample less representative.

Each caregiver was subjected to an initial remote interview using the network analysis tools mentioned above. This enabled us generate the caregiver's network and to identify the support person who could participate in the dyadic interview. In the dyadic interview, conducted at a later time, the caregiver and the support person had to be in the same room and connected to the same device (computer or tablet or cell phone) for the video-conference. Thus, the purposive sample for the qualitative study was composed of twenty dyads.[3] The interviews were held between March and July 2024.

The interview explored five key areas: (i) the care relationship (example question: please describe your relationship with the care recipient); (ii) the carer's relationship with care services (example question: what is your experience with public and private social and health care services?); (iii) trust in institutions and other people (example question: during your caregiving experience, or that of supporter, has anything happened to increase your trust in the services available and in other people?); (iv) participation in voluntary associations (example question: please describe any collaborations you have engaged in with voluntary associations); and (v) the interviewees sense of the future and own well-being (example question: with regard to your roles of caregiver and supporter, how do you see yourself in the future?). Through these questions, we aimed to assess: the experience of the caregiver, the role of supporter and their interaction in the process of caregiving.

The interviews were conducted in the Italian language by a researcher from the team involved in the project. All interviews were audio recorded. All recordings were transcribed by the same researcher who conducted the interviews in their original language in order to preserve linguistic nuances.

The data related to the caregiver networks were analysed using UCINET 6 (Borgatti et al., 2002); meanwhile the qualitative data collected via the dyadic interview were analysed by thematic analysis (Nowell et al., 2017) using NVivo 14 (Jackson & Bazeley, 2019).[4] The two methods were performed sequentially.

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[3] The majority of the caregivers interviewed resided in Lombardy, while one case was based in Veneto. However, we do not claim the sample to be representative of subnational diversity.

[4] No ethical approval was required for the study, in accordance with Italian law, since the nature of the research not clinical, and all data were anonymized before publishing the results. Nevertheless, informed consent was obtained from each participant before starting the interviews.

4. Results

4.1. *Who are the caregivers? And why them?*

The caregivers interviewed were primarily the adult children of those receiving the care: in thirteen cases they were the daughters and in two cases they were the sons. In three cases the caregiver was the husband or wife of the care recipient, and in the two cases the carers were other female relatives. The sample confirms the situation predominant in the Italian context where care is primarily being provided by family members, especially adult children and most commonly daughters (Brenna, 2020; Crespo & Mira, 2014).

In most cases the caregivers were still employed (only three of them were retired). The average age of carers was 58.5 years (SD: 6.03). The average caregiver status, assessed as a combination of educational level and professional activity, was medium-high. In only one case was the status low, while the majority of the cases had a medium level (12 cases). In one case the caregiver lived alone, while all others lived in families in which other relatives were present or with their partner and children. At the time of the interview, five caregivers were single, and the remainder were in a relationship.

The majority of cases involved the caregivers providing informal care to one (and in four cases both) of their parents due to the latter's advanced age and/or inability to live independently. Three assisted their partners who were suffering from ill health. The average age of the assisted was 84 years (SD: 11.42).

The sociodemographic data of the caregivers (C), supporters (S) and persons being assisted (PA), and the nature of their relationships are presented in Table 1.

The dyadic interviews revealed some of the reasons why the caregiver had taken on the role. They ranged from the lack siblings with whom to share the role, *"I am the only child"* [C_06], to the notion of mutual recognition: *"I often think that my mum and dad helped me a lot in life, especially as a married woman with children. So, in a sense, I feel grateful to them"* [C_05], and *"Well, how can I put it? It's love. It's the love she gave me when I needed it at the beginning of our marriage, and it's my way of giving something back in return"* [C_04].

In dyads in which the S was the brother of a female sibling performing the role of C, practical motivations, such as residential proximity, and gender aspects were cited: *"She does ninety-nine per cent of the things, either because she's closer or because her job probably allows her more time. She's a woman, after all"* [S_07]. The concept of 'residing nearer' also emerged in some interviews: *"I live in the same house as my mum, so I am necessarily more present."* [C_08]; *"She has a more regular daily routine, partly because she lives closer."* [S_11].

Table 1. Characteristics of caregivers, supporter and person assisted and their relationship.

Caregiver - C			**Social supporter - S**				**Person assisted - PA**		**Dyadic relationship between:**		
ID_C*	**Gender**	**Age**	**Status**	**ID_S**	**Gender**	**Age**	**Gender**	**Age**	**C and S**	**C and PA**	**S and PA**
C_02	F	50-55	High	S_02	M	50-55	M	81-85	S is C's husband	C is the daughter of PA	S is the son-in-law of PA
C_05	F	61-65	High	S_05	M	61-65	M	≥ 96	S is C's husband	C is the daughter of PA	S is the son-in-law of PA
C_06	F	56-60	High	S_06	M	61-65	F	86-90	S is C's husband	C is the daughter of PA	S is the son-in-law of PA
C_16	F	50-55	High	S_16	M	56-60	F	86-90	S is C's husband	C is the daughter of PA	S is the son-in-law of PA
C_01	M	50-55	Medium	S_01	F	46-50	F	76-80	S is C's wife	C is the son of PA	S is the daughter-in-law of PA
C_07	F	56-60	Medium	S_07	M	56-60	F	86-90	S is C's sister	C is the daughter of PA	S is the son of PA
C_08	F	61-65	High	S_08	F	56-60	F	≥ 96	S is C's sister	C is the daughter of PA	S is the daughter of PA
C_11	F	61-65	Medium	S_11	M	56-60	F	91-95	S is C's sister	C is the daughter of PA	S is the son of PA
C_14	F	61-65	Medium	S_14	F	61-65	F	91-95	S is C's sister	C is the daughter of PA	S is the daughter of PA
C_18	F	61-65	Medium	S_18	F	56-60	F	91-95	S is C's sister	C is the daughter of PA	S is the daughter of PA
C_12	M	61-65	Medium	S_12	F	26-30	F	56-60	S is C's daughter	C is the husband of PA	S is the daughter of PA
C_19	F	61-65	Low	S_19	F	46-50	M	86-90	S is C's daughter	C is the daughter of PA	S is the granddaughter of PA
C_13	F	56-60	Medium	S_13	M	18-25	M	≥ 96	S is C's son	C is the daughter of PA	S is the grandson of PA
C_15	F	56-60	Medium	S_15	M	31-35	M	61-65	S is C's son	C is the wife of PA	S is the son of PA
C_17	F	50-55	Medium	S_17	F	76-80	M	76-80	S is C's mother	C is the granddaughter of PA	S is the sister-in-law of PA
C_04	F	56-60	Medium	S_04	F	61-65	F	81-85	S is C's friend	C is the daughter-in-law of PA	Not a relation
C_20	F	50-55	Medium	S_20	F	41-45	F	71-75	S is C's friend	C is the daughter of PA	Not a relation
C_03	M	56-60	High	S_03	F	56-60	F	56-60	S is employed by C	C is the husband of PA	S is the person who helped C to care for PA
C_09	M	56-60	Medium	S_09	F	56-60	F	91-95	S is employed by C	C is the son of PA	S is the person who helped C to care for PA
C_10	F	56-60	High	S_10	F	50-55	F	91-95	S is employed by C	C is the daughter of PA	S is the person who helped C to care for PA

* The cases are ordered according to the type of relationship between C and S.

The gender aspect that emerged from the interviews appeared to be linked to the cultural perception that care is more of a feminine role: *"I think NAME grew up in a traditional Southern [Italy] family where, if there was a son and a daughter, certain things land on the daughter, that's just how it is."* [S_16]; *"...I've talked to other female friends who've faced similar problems, and it's as if they [their brothers] don't want to recognise [the problem], my brother doesn't want to hear about it"* [C_20].

An aspect underlined by an unmarried male caregiver was that he had taken on the carer role because of his lack of own family commitments: *"The context matters. I'm able to make this choice serenely because I've never married. It's not to say that this is the solution for caring for the elderly in life, it would be more appropriate to marry, start a family, have children, but I didn't do that. I've failed in that sense, but at the moment my situation allows me to do what I am doing"* [C_09].

4.2. *The composition of the dyads: what does the caregiver look for in the support they receive?*

The supporters (S) can be classified as belonging to three different social networks: a family network; a friendship network; or a network of professionals.

The first group concerns the relatives of the caregivers, for example, a husband or wife, brother or sister, son or daughter. These supporter types typically live with the carer and are well acquainted with the challenges the carer encounters and are aware of the needs of the person receiving care. A husband supporting his wife who cares for her parents emphasizes the significance of his role in shouldering the daily hardships that the family faces: *"Yes! Firstly, we've been together for over forty years and gone through a lot together. I hope we can continue to do so in the future, health permitting. Secondly, because in delicate situations like these… there are always delicate situations like these to manage within a family, within a couple."* [S_05]. Another female caregiver looking after for her mother underlined the relevant role of her husband in supporting her: *"A year ago, I reached breaking point. With the help of my husband, I realised that I couldn't go on like this because my life was falling apart, and that I wouldn't be able to save either my mother or myself."* [C_06]. Others cited support from brothers and/or sisters. One caregiver, talking about her brother, said: *"The first person I talk to about big decisions, or if something happens, well it's my brother, that's obvious"* [C_07]. One S confirmed her role in supporting her sister: *"Well, my sister and I both act as caregivers. My sister lives with my mother, and I live upstairs. When she's not there, I am. We share the hard work and the joy."* [S_18]. In some cases, where more than one brother or sister is present, it is conceivable that the level of support may vary among them. A female caregiver taking care of her mother, and who had both brothers and sisters, reported being able to rely more on one particular sibling: *"My sister is a great support to me, because even* *when there are difficult moments, she is the first person I want to talk to or exchange ideas with, or... because it's also tiring sometimes, [...], but when I turn to my sister, she listens to me, we understand each other, and I have more strength to go back to my mother."* [C_14]. Sons and daughters were also identified by some of the cares as fulfilling the supporter role. A female caregiver of her parents stated, regarding her son: *"If he hadn't helped me in certain situations, I wouldn't have had the physical strength. More than once in the evening, he had to lift his grandfather up. I am so grateful to him for doing it, because it's not something to be taken for granted."* [C_13]. Also, a caregiver of her husband emphasized the important role played by her son and daughter in supporting her: *"[I can reply on] both my children, they are absolutely identical, absolutely interchangeable, so to say, when it comes to this kind of thing."* [C_15].

The caregiver cannot always rely on family members for support. Some caregivers have highlighted how families can sometime fail to step up and collaborate in the care process. This can create challenges and make it difficult for caregivers to provide the best possible care. For example, *"I would have liked a little more support from my sister. I asked her for it a while ago when I was really tired. I suggested we agree on a couple of days when she would come, so I would know I was free on those days. But she replied, 'I'll come when I feel like it"* [C_13]. Another caregiver said: *"my brother is completely absent"* [C_16], and another: *"sometimes, the person closest to you – whether they're your husband or your father – simply won't listen to you."* [C_20].

In some cases, although caregivers had a family network to turn to, they actually considered someone from their friendship group as the important source of social support. During the dyadic interview with her friend, one supporter said: *"We are old friends and, although we don't talk often, I must say that in times of difficulty or need, we seek each other out."* [S_04]. The C in this dyad confirmed this aspect: *"me and my friend, I found [...] her to be my reference point, because she has already been through this, she knows how to act, where to go, what to do, and so she was a great source of support for me."* [C_04]. Another supporter, who was the friend of the carer, provided a detailed account of the origins of the support relationship: *"For almost three years now we have been very close, ever since we found ourselves in a particular situation at work together. She began to have a series of problems with her mother. She had already mentioned the situation to me in the past, but then, well, the situation started to get worse."* [S_20]. The carer confirmed that the supporter, who was her friend and colleague, had listened to her in that difficult time: *"I realised that many people didn't want to hear about these things, but perhaps my friend, who was a colleague, well, we were stuck in these two situations [that at work and that with my mother], which were very different, but ultimately a bit similar."* [C_20].

In other cases, the C turned to a professional network for support. This was the case for a male caregiver employing S for their professional assistance: *"Let's say that the work aspect also coincides with the moral support aspect, so to speak, so that the two are integrated."* [C_03]. Another caregiver spoke about the professional who cared for his mother *"It's a huge help for me, because I already have to keep track of all the mess at work, [...] and I also have to look after my mum [...] and the fact that there's someone who tells me, 'Look, the medicines are running out', great, and then maybe even gives me the list, great, it's all support [...], right?"* [C_09].

Thus, from the dyadic interviews it emerged that friends and professionals also played an important role in providing social support to the caregiver in addition to practical assistance, and the processes underlying the establishment of the dyadic relationship varied. In dyads where the S was a family member, the support process is usually based on the reciprocity of family relationships, as underlined by one S: *"I think it's important, because it's important not to run away from the things that happen and it's part of the pact, let's say, of love that we exchanged, so it's part of that"* [S_16]. The reciprocity of family relationships was also underlined by a caregiver who stated: *"I think that, in any case, the family is the place where you have to face problems together. If there is love and a willingness to work things out, you can manage to overcome anything. I believe that, even within a family, if people truly love each other, they will work together to overcome challenges in the best possible way"* [C_01]. In the case where friends fulfilled the role of S, the friend's previous experience of caregiving was often stated: *"I had just lost my mother."* [S_20]; similarly, C_04 emphasised how her supporter had gone through a similar caregiving experience. In cases where S came from the professional sphere, 'trust' was often cited as the important aspect of the relationship: *"We discovered our sensibilities to be similar, by that I mean that I could confide in NAME, and they could confide in me"* [C_09].

4.3. *The different caregiver network morphologies and their caregiving practices*

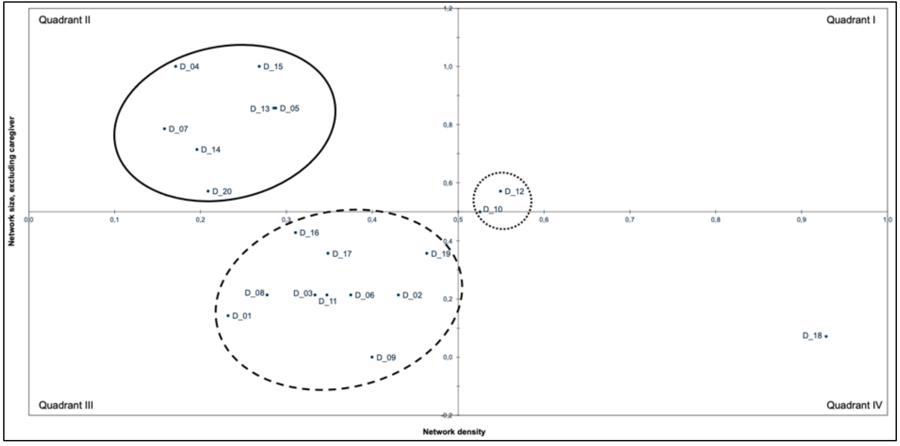
Here, we consider the difference types of caregiver support networks in which the dyadic relationship is embedded.

To attempt to identify some common functional models in the sample by combining certain structural network dimensions with information emerging from the dyadic narratives. Regarding the structural dimension, we initially examined the density and the size of the network. Figure 2 shows the distribution of dyads with respect to these two characteristics. Three groups emerged as shown.

Among low-density networks, we find both broad and more restricted configurations. One group includes dyads positioned exclusively in the quadrant II of Figure 2. These cases are characterised by low-density, large networks. The non-family component is more prevalent in these networks, meaning they include friends, neighbours, work colleagues and professionals.

These networks are characterised by their low density (which measures the ratio of actual ties in a network to the total possible connections), for example, as reflected by the fact that the caregivers' S figures were not always connected to their family network. Table 2 shows some of the main characteristics of these networks.

Figure 2. Distribution of dyads according to network density and breadth.



Note: Each dyad was identified according to the name of the C and the S. The numbers following the letter D correspond to the code numbers used for C in table 1.

Table 2: Characteristics of networks located in quadrant II of Figure 2 (extensive network size but low-density networks).

ID_D	Network			Caregiver - C			Supporter - S		
	Size	**Density**	**Type**	**nBetweenness** (%)	**Eff. Size**	**Constraint**	**nBetweenness** (%)	**Eff. Size**	**Constraint**
D_15	19	0.27	Mainly non-family-based	28.36	14.84	0.21	3.34	3.45	0.41
D_04	19	0.17	Mainly non-family-based	44.98	16.38	0.18	0.00	1.25	0.60
D_13	17	0.29	Mainly non-family-based	44.34	13.20	0.20	13.04	5.74	0.31
D_05	17	0.29	Mainly non-family-based	37.83	13.11	0.18	11.67	5.88	0.30
D_07	16	0.16	Mainly non-family-based	57.71	14.52	0.14	5.83	2.36	0.50
D_14	15	0.20	Mainly non-family-based	27.06	12.36	0.24	0.32	1.78	0.51
D_20	13	0.21	Mainly non-family-based	44.55	10.97	0.19	0.00	1.83	0.51

These are networks in which caregivers have a high degree of centrality, i.e. the ability to act as intermediaries between two nodes in their network. The centrality values of this group of caregivers are higher than the average value for all caregivers. Caregivers in these networks also demonstrate good brokering skills, as evidenced by their high effective size values – i.e. the number of people they are connected to minus a degree of redundancy, as defined by Burt (1992) and Tronca (2007) –, while their constraint values (i.e. the extent to which their relationships are with people who are in turn connected to other subjects in the same network) are low (Tronca, 2007). Effective size represents a caregiver's ability to bridge structural gaps (Burt, 2000) and has a positive relationship with social capital in these cases, enabling caregivers to reap greater benefits from the network (Tronca, 2007). On average, the ability of the supporters to mediate between two nodes was good.

From the dyadic interviews, we can ascertain how the caregiver perceived their role and the responsibilities of the various individuals in the network in terms of both the support provided to the caregiver and care being given to the person being assisted. Furthermore, the interviews allowed us to gather information on the roles of the various subjects, revealing a considerable division of tasks and functions. For example: *"My husband, he mostly gives her a lift [...] then there's NAME, who is our daughter. She either picks her up or has her over for lunch"* [C_04]. The division of tasks may also be shared with professional and/or friend networks: *"I mentioned NAME, NAME, NAME, and NAME, and all the people we met, either through the association or, as in the case of NAME, because her daughter went to nursery with NAME [...], there was that harmony, that way that when you talk about something, when you talk about a problem or a situation, a state of mind, there is understanding, they understand!"* [C_15]. Other family members were also cited, as the supporter in one particular dyad claimed: *"My mother mentioned many people, but I don't know if you mentioned [...] my aunt NAME too"* [S_15], as well as the caregiver himself: *"They are cousins, but they are those who are very close, perhaps older too, but closer, so since my parents are no longer here, they are my point of reference, and a bit more mature, you know!"* [C_15].

Another carer emphasised the importance of support from friends: *"Yes! Yes, my brother, but not only him. Other people I confided in, who were there for me, definitely made things easier,"* [C_07] and *"when I'm sick, I have friends who think about going shopping for me. It's a bit like that. Sometimes there are friends of my mum's who are a bit younger and come to visit her"* [C_07].

Another caregiver also emphasised the importance of friends outside the family: *"Yes! My mum and I sometimes argue because she doesn't understand why [...] I don't speak with my sister anymore. When I was unwell, I was supported by my son, my ex-husband and my friend [not C's sister]. Fortunately, I realised that I have a lot of [other] people who care about me"* [C_13]. The supporter also tries to enlist the help of the caregiver's friends, encouraging the caregiver to go out with them. *"Let's say I push her to go out with her friends, who then help her relax"* [S_13].

Other carers also emphasised the importance of support from people outside the family network: *"I remember when I met her [referring to S], after... that I told her I couldn't do it; I couldn't go on. And she said, 'No! No! You have to go on because life goes on. You have to go on and nothing else."* [C_04].

Another type of caregiver emerging from the analysis were those in which the dyads still lay within a large network, but the network's density value was higher than that for whole set of cases examined: namely, those lying in quadrant I of Figure 2. The data relating to these networks is summarised in Table 3. In these cases, the support network was predominantly family-based.

Table 3. Characteristics of the networks located in quadrant I of Figure 2 (very dense and extensive networks).

ID_D	**Network**			**Caregiver - C**			**Supporter - S**		
	Size	**Density**	**Type**	**nBetweenness** (%)	**Eff. Size**	**Constraint**	**nBetweenness** (%)	**Eff. Size**	**Constraint**
D_10	13	0.53	Both family-based and non-family-based	11.74	6.32	0.30	2.20	2.78	0.37
D_12	14	0.55	Mainly family-based	29.49	7.13	0.23	3.97	4.12	0.33

The degree of centrality of the caregivers of this type was generally lower than that in the previous cluster (in quadrant II), albeit still higher than that for the entire sample. The low constraint and effective size values suggest that the caregivers have little need to build bridges between individuals as they are already in contact with each other. The centrality of the supporters of these caregivers is generally lower than those supporting other types of caregiver, and their ability to act as brokers also appears to be limited.

The dyadic interviews revealed the caregiving tasks to be almost equally divided between the caregivers and support persons. The roles of other network members were largely unseen.

The carer of an elderly woman emphasised how her supporter, who was a professional outside the family network, was always available to provide care, even when unexpected problems arose. *"In fact, we have a problem at the moment, and she said she would stay every other weekend. Today, when there was a problem, she said she would stay."* [C_10]. The supporter confirmed what the carer said, reiterating that she tries to fulfil her caregiving role to the best of her ability and treat the person she assists as if they were a member of her own family: *"I have been with the lady for many years and consider her like a mother to me [...] I try to take good care of her, dress her well and take her out socialising [...] I treat her like my own mother!"* [S_10]. In addition, the supporter highlighted how the caregiver she assists takes care of more specific tasks that are not so much related to the elderly person's material care – which the supporter instead takes care of – but rather to aspects related to their relationship with the health services. In fact, he states that *"the caregiver is with them every day, always helping mum and doing everything for the doctor when needed, such as getting medicines and making appointments [...] She does everything"* [S_10].

The caregivers of other dyads belonging to this type were also able to see that they essentially shared the care function with their supporter, who was often a family member able to pay more attention to the needs of the person being cared for than the caregiver themselves: *"NAME, is definitely the most sensitive. There's no doubt about it! She is much more attentive to PA's posture and more empathetic than I am. She often looks into PA's eyes and reads her mind, and she certainly understands PA's difficulties regarding her posture or movement"* [C_12]. Another element that characterises this type of shared care function is continuous presence: *"From lunch through to the afternoon, NAME is always present, except when she has to go to work, but she works remotely a lot. There is this integration which, so far, has been fortunate for us in that we have not had to draw on outside help"* [C_12]. A shared division of time is created between the caregiver and the supporter of this type, for example: *"The afternoon is almost entirely NAME's [...] the morning or evening are mine."* [C_12], as well as care tasks, as the same caregiver stated: *"NAME is 100% responsible for lunch and dinner and feeds PA." Or even with regard to personal hygiene: "[...] NAME or NAME comb and style her hair"* [C_12]. The supporter of this dyad also highlighted the division of time and the amount of time dedicated to care, which allowed her to understand better the person being cared for: *"I think I probably understand her better sometimes [...] because, given the number of hours we spend together during the working week, I am at home more"* [S_12].

The networks characterised by smaller dimensions may have either a low or a high density. The group of dyads present in quadrant III of Figure 2 stands out from the rest because they are all part of networks characterised by low density and small size. These networks are primarily composed of individuals belonging to the family sphere. Table 4 shows some of the main characteristics of these networks.

The average value of centrality for this group of caregivers is slightly lower than the overall average. This could be because these are predominantly family-based networks, meaning that the members are directly related to each other. The average effective size of the networks for this set of cases is lower than that for the caregivers located in the quadrant II (Figure 2). On the other hand, the constraint values show the opposite trend, indicating a lower ability of the caregivers to bridge structural gaps and thus enjoy the resources that could be derived from the network. The average degree of intermediation (nBetweenness) of the support persons for these caregivers is similar to that of the overall set of cases.

The dyadic interviews clearly demonstrated the importance of the family-based network in task allocation: *"There is a brother, my mother's youngest brother, who definitely feels it more and therefore tries to be very present"* (C_01); *"Yes, my brother. Even yesterday, for example, he came"* (C_09) to support me in the care process. One supporter also emphasised how the family-based network had been mobilised: *"I've seen three siblings who really collaborated and tried to get things done together, each in their own way, but they are all there, in a way that I think is normal, they get things done, so it's the strength of a coalition"* [S_19]. *"However, I would say that we have divided up the work, which we did in the past too. I... it was always me who took on more of the care, including the housework, and since my father's death, I have taken care of the administrative and bureaucratic side too, while NAME, thanks to her skills, takes care of the medical side"* [C_08].

Table 4. Characteristics of the networks located in quadrant III of Figure 2 (low-density networks of modest size).

ID_D	Network			Caregiver - C			Supporter - S		
	Size	**Density**	**Type**	**nBetweenness (%)**	**Eff. Size**	**Constraint**	**nBetweenness (%)**	**Eff. Size**	**Constraint**
D_16	12	0.31	Mainly family-based	39.21	8.32	0.31	2.58	2.89	0.49
D_19	11	0.46	Mainly family-based	8.24	5.68	0.36	3.43	4.14	0.39
D_17	11	0.35	Mainly family-based	52.78	7.97	0.24	0.00	1.50	0.59
D_02	9	0.43	Mainly family-based	22.62	5.64	0.39	1.79	2.71	0.51
D_06	9	0.38	Mainly non-family-based	18.15	5.25	0.39	17.26	5.00	0.42
D_11	9	0.35	Mainly family-based	39.88	5.82	0.37	0.60	2.50	0.58
D_03	9	0.33	Mainly family-based	10.71	5.56	0.44	10.71	2.00	0.61
D_08	9	0.28	Mainly family-based	25.89	5.94	0.35	9.82	2.57	0.54
D_01	8	0.23	Mainly family-based	17.86	5.64	0.40	0.00	2.50	0.64
D_09	6	0.40	Mainly non-family-based	0.00	3.17	0.73	0.00	1.00	0.85

One carer mentioned that focusing on their role as a helper could result in all their energy being absorbed and eliminate any room for a relationship outside this commitment. *"We are people who give spontaneously, as does our brother. When this mechanism kicks in and we feel obliged to help, everything becomes more difficult and burdensome: 'I have to call her', 'I have to visit her', 'I have to do this', 'I have to do that'. Often, our phone calls begin with us exchanging these things, and then, at a certain point, we try to say, 'Enough is enough!' We talk about other things and our lives because we need to let off steam, and that's what we do!"* [S_11]. *"The problem is that half the time we* *talk about her, and that's frustrating because we can't be creative or proactive due to this burden, this mess that takes up so much of our time. But never mind!"* [C_11]. Another caregiver noted how she managed to find the resources she needed through the network, including the family-based network: *"I found her through the network, through my cousin. She's the one who gave me her name. For now, the prospects are good. The person seems nice, although she has her difficulties, including linguistic ones and integration"* [C_16].

Lastly, we noticed that only one case was characterised by being a small but highly dense network, as shown by its location in quadrant IV of Figure 2. The values for this dyad's network are shown in Table 5. The network is mainly made up of individuals from outside the family sphere.

Table 5. Characteristics of networks located in the fourth quadrant of Figure 2 (high-density, small-scale networks size).

ID_D	**Network**			**Caregiver - C**			**Supporter - S**		
	Size	**Density**	**Type**	**nBetweenness** (%)	**Eff. Size**	**Constraint**	**nBetweenness** (%)	**Eff. Size**	**Constraint**
D_18	7	0.93	Mainly non-family-based	0.00	1.00	0.59	0.00	1.27	0.57

The degree of intermediation exercised by the caregiver and the support person between the two other nodes in this network was zero. There was limited ability for either the caregiver or their support person to act as a broker. These factors suggest the network to be interconnected, suggesting strong synergy in the care process. Indeed, the centrality value and structural holes[1] measure for this dyad were much lower compared with those in the other network types. Furthermore, this dyad was a special case since the carer was entering a new phase of life, having recently retired and thus needing to reorganise her day-to-day life. The life stage in which the need to become involved in a care process arises is another factor that complicates this experience: this case demonstrates how the care process can affect different stages of people's lives. *"Until a month ago, I was working, and my sister works mornings, so we needed two carers to take turns being with our mother during the day. We also have a brother who helps us when needed, for example, with household repairs. Then there is my brother-in-law, my sister's husband, who also helps us. So yes, we have other people who can take care of my mother's health: My brother, my brother-in-law and two carers, […]. Now that I'm retired, I'm trying to figure out how much support is needed. We still have the carers, for some of the time"* [C_18] The support person confirmed the aspect regarding reorganising life: *"Right now, my sister has taken charge because she's retired.*

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[1] A structural hole implies the lack of a direct tie between two or more entities (Burt, 1992).

Since she retired, she's taken on a lot. [...] and now she has really taken charge, but she too is trying to understand how she can help… together with the carers. It's a time of transition" [S_18].

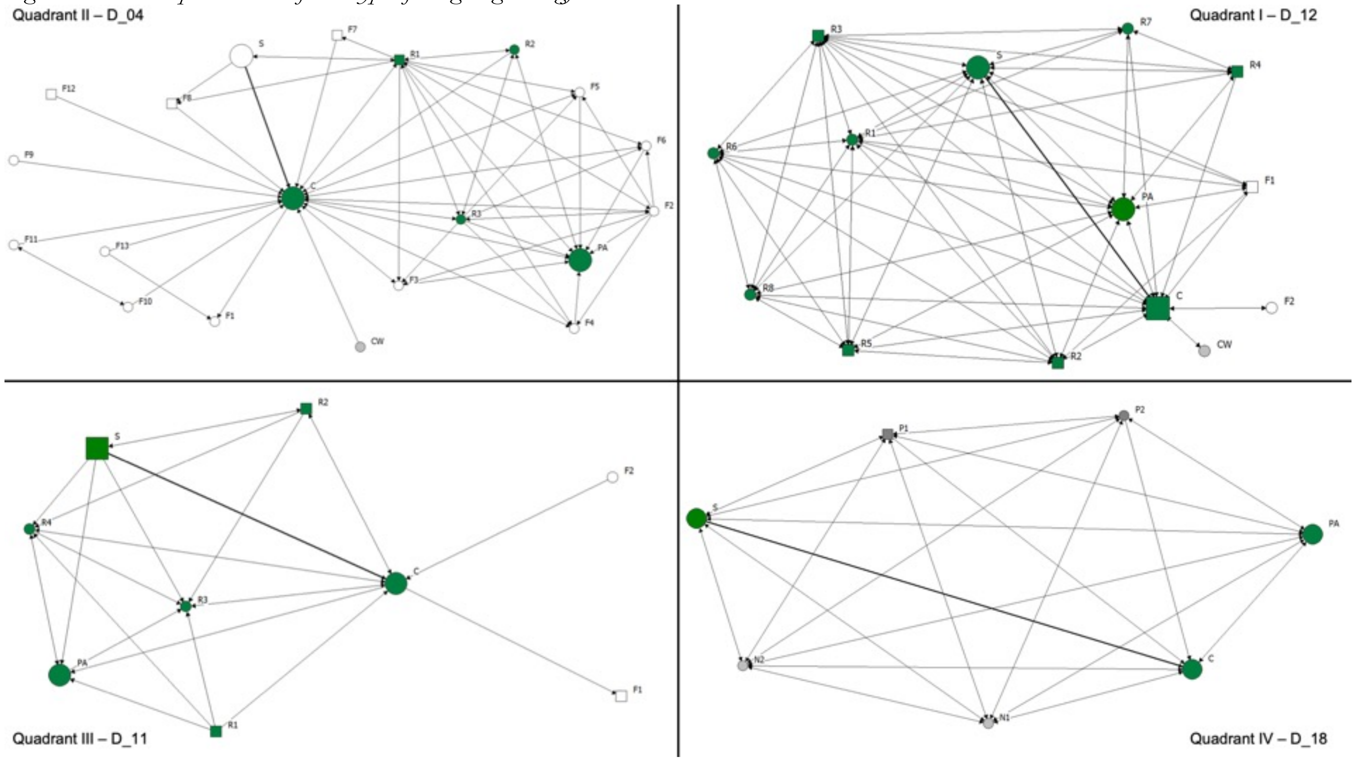
5. Discussion and conclusion

From the analysis of the empirical evidence, we can attempt to answer the questions we posed at the outset and demonstrate how help and support in the form of caregiving is being provided within informal networks today.

Let us now revisit the questions posed at the beginning of this paper from the analytical perspective. With regard to taking on the role of carer (RQ1), several recurring themes emerge from the interviews, confirming the existence of the so-called 'sandwich generation', which is predominantly female, with some contextualisation. The presence of long-living generations (Bramanti, 2025) is pushing the average age of our target group forward, standing at around 58 years. The dyadic interviews revealed that decision-making processes tend to occur within a network of relationships, where intervening factors are linked to various circumstances unique to the social history of each family. However, some recurring reasons for taking on the caregiving role did emerge relating to feelings of affection and gratitude for the elderly person (Scabini & Cigoli, 2012), as well as to a series of contingencies that made it necessary for the caregivers to take the role on.

Although the decision to take on the role of carer is often characterised by obliging circumstances, we observed more flexibility in the choice of the person they turned to for support. Interestingly, support either involved the provision of tasks for the person assisted or regarded the caregiver's need for a confidant, someone who could understand and listen to what they were experiencing or offer them advice (RQ2); in other words, the supporter role was fulfilled by someone who could offer them direct and/or indirect support in performing their tasks. Some sought an effective substitute in the form of a professional figure or other person (including a family member) with whom they could share the work equally. In these cases, the caregiving role was equally divided between two people, making it difficult to identify a single caregiver. Those who sought someone with whom to talk to about the caregiving experience, to receive a sympathetic ear and spend some free time together, always referred to someone who was not directly involved in caring for the person assisted. In other cases, the person identified for the dyadic interview was from a family or friendship network whose presence was seen as crucial. This supported the hypothesis that the caregiving role is increasingly being fulfilled in a shared manner rather than by a single individual.

Figure 3. An example network of each type of caregiving strategy.



Legend: C= caregiver; PA=person assisted; S=supporter; R=relative; F= friends; CW= Co-worker; N = neighbour; A= acquaintance.
Square=male, circle=female; green=family member, white and grey scale= non-family member.
Thicker line = dyadic relationship between C and S.

The evidence gathered from the network data and the dyadic interviews allowed us to profile the different strategies (Figure 3) employed by informal care networks for elderly people (RQ3), and to understand which strategies are related to a perceived higher or lower level of well-being by the caregivers and their supporters (RQ4).

A first general observation concerns evidence for the elderly person's own direct networks, which, according to their caregivers, were large and 'well-equipped', i.e. composed of a variety of actors. This can be explained by referring to the fact that the persons assisted had a 'lifetime of relationships behind them', so to speak. These relationships were formed with people who, in different capacities, constituted their social capital. Although this social capital was often weak, it was never absent, and formed the basis of the new network. This was particularly well documented in some of the interviews: *"There are some of Mom's friends who are a little younger, so then she has someone a little younger who maybe tells her 'I'm coming round to see you'"* [C_07].

In other cases, however, the elderly person had never formed relationships outside their family or had become withdrawn and closed off towards others upon retirement. *"My parents really stopped 'living' when my father retired. Life was: wake up, have breakfast, watch TV, eat, and 'what are we doing this evening?' They only went out once a month, and that was just to go to the markets. My mum didn't have a life of her own or any of her own relationships"* [C_01]. It was in these situations that the dyad faced the greatest challenges to sustain and activate a support network.

Let's start by analysing the networks identified characterised by a low density and large size. The first observation is that they appeared to be decidedly innovative compared with the Italian family-based solidarity stereotype. Indeed, these networks comprised a large number of individuals and, notably, included non-family members. The role of the dyad was decisive in maintaining and involving the different individuals in the network as indicated by the high degree of centrality and the good values for structural holes.

Furthermore, our data confirm the existence of highly collaborative caregiving, with tasks being divided up between relatives and friends. This could be labelled as a postmodern network, as it is inclusive yet of low-density, enabling caregivers to find support in unconventional ways, such as through friends who have gone through similar caregiving experiences. Therefore, much depends on the dyadic relationship that supports and confirms the coordinating function of a complex network of support and a marked bridging attitude.

Overall, these dyads demonstrate a moderate level of well-being, which can be attributed to a sense of gratification obtained from the commitment undertaken, as well as the ability to feel part of a supportive network, which is sometimes even of an associative nature. One participant stated, *"I feel good now because I am gratified. Yes, I'm not the perfect housewife or mother, but I'm committed to this* *cause. It's a bit like a mission, like the Alzheimer's Café (a voluntary association [the carer is involved in]). I focus on that because I got a lot out of it before [when C attended the association with her father, who passed away a few years ago] and it can still offer a lot to many people"* [C_04].

The context also allows us to view the problem in perspective and compare it with more dramatic situations. *"I wouldn't change anything about the situation, because it is what life has presented me with right now. Today, I visited a mother whose son was seriously injured in an accident. He has come out of a coma, but we don't know what his condition is like, so I think we should talk about well-being instead. Really!"* [C_07]. Carers also presented a high level of motivation: *"I think I'm satisfied with what I do because I'm motivated, and also because I'm still caring for my mum. Yes, I think so."* [C_14].

However, there was also evidence of a proactive energy and desire to invest in the experience they were going through: the sense of 'room for improvement'. *"[It's certainly] improveable! We have lots of room for improvement, especially during this more complicated period, but we're making progress"* [C_15].

In the large, high-density networks, probably reflecting a greater presence of family members and relatives, we found a slightly different scenario. In these cases, tasks were mainly being divided between the carer and the support person, although there was also an extensive family network and other friends or professionals were also involved. However, although the network was present, it tended to remain in the background and, even though it was often discussed, it was not perceived as effective support. In these cases, there was evidence of great fatigue in the carers: *"Yes, well, honestly, it's important because she's my mother and she's passed on her values to me. However, I am beginning to feel overwhelmed. At this time of year, when everyone is talking about their summer plans, I can't make any plans, and after twenty years, I'm fed up with it!"* [C_10]. *"I have always considered myself a very lucky person because I found the woman of my life [...] Now, I definitely struggle more, but I have to find a way through these difficulties, and more than anything else, I have to find a way with my wife"* [C_12]. In these cases, caregiving was being divided within the dyad, with each member of the dyad taking responsibility for different elements of the caregiving.

Now, let us observe what happens in small, low-density networks. Here, the network appeared to operate independently of the caregiver and their supporters. These networks mainly comprised individuals who belonged to the same family. The family network was entirely focused on caregiving, to the extent that normal relationships between family members were affected. Everything revolved around the caregiving, almost as if it were a mechanism that, once triggered, functions mechanically or continues behaviours established prior to the onset of the elderly person's frailty. These situations appear to be quite stressful for couples: *"It has definitely impacted our lives as a couple. There's no question about that. I mean, even finding moments of peace and tranquillity at home is far* *more difficult."* [C_01]; and on the overall perception of the impact on the family: *"I think that, for someone with a sick person at home, maintaining an acceptable level of well-being is difficult. Either there is really strong support, or it's difficult!"* [SC_03]; and on dyadic relationships: *"I can't remember the last holiday we took together. We try to be there for one another, so taking a short break, a trip or a weekend away is difficult. It limits us in this sense too"* [C_08]. Although subjective perceptions varied, for instance, *"for now, I am content with my level of well-being, even though it is tiring and a burden, and there are negative aspects, I am still confident"* [C_02], in situations where institutional care was required, it seems that if the network was almost exclusively family-based, even if it was large, there were still signs of reduced well-being; for example, *"It's bad because you don't have peace of mind from knowing that both mum and dad are there. I don't know. Personally, even though I am convinced of our choice for dad, who is being cared for, I think it was worse at home."* [C_19].

In summary, different caregiving models demonstrate that caregiving involves many individuals, and that those who identify as caregivers may fulfil different roles depending on their position within their support network and the type of support they have chosen or are able to receive. Clearly, not everyone has extensive and functional networks. As our analysis shows, the caregiving task can be overwhelming, so even when resources are available, they are never sufficient. Nevertheless, it is evident that access to open networks and bridging social capital predicts greater well-being for caregivers and their supporters. The complexity of care requires specific knowledge and intervention techniques, and therefore access to information and practical knowledge that family networks are unlikely to possess. Therefore, bridging social capital appears to be a valuable resource for Italian caregivers, as Roth (2020) has already highlighted at an international level. This is a resource from which those who provide care can benefit.

In conclusion, our research supports the predominance of shared caregiving models. However, further research should be conducted to take into consideration the networks surrounding both the supporter person (S) and the recognised caregiver (C) of the person receiving care (PA), and the family dynamics underlining the choice of caregiver within a family network. Further studies should also endeavour to identify a representative sample of caregivers in order to deal with the sampling limitations of present study.

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