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Caregiving Relationships: A Gendered Perspective on Care Time in Italy

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Abstract

This contribution seeks to empirically explore the forms of informal caregiving in Italy, focusing on the relational dimensions and the gendered configurations that shape its sustainability and meaning. The study investigates how gender differences manifest in the distribution, experience, and narration of care, and examines the role played by family and friendship networks in supporting caregivers. Using a mixed-method design – structured in two phases, qualitative and quantitative – this article presents the findings of the qualitative research, conducted through dyadic interviews with caregivers of older adults and their reference persons. The study highlights a pronounced gender imbalance in the distribution of care work, with women bearing a heavier quantitative and emotional burden. Support networks, both formal and informal, play a decisive role in the sustainability of caregiving, yet they remain uneven in scope and quality. Male narratives tend to frame care as a functional and circumscribed intervention, whereas female narratives portray it as an all – encompassing and identity – defining experience. The integrated analysis shows that caregiving is not merely an assistive activity, but a situated relational process, in which identity, reciprocity, and recognition are deeply intertwined.

Keywords: caregiving, gender, family, care time, proximity networks, informal assistance.

1. Introduction: the centrality of caregiving in contemporary Italy

In the current Italian demographic and social landscape, the issue of care emerges as one of the most crucial nodes for understanding ongoing transformations in family structures, models of social cohesion, and welfare

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policies. Increasing life expectancy, disparities in healthy life years, the emergence of new vulnerabilities linked to disability, chronic illness or psychosocial fragility, as well as the persistent gender asymmetry in the organization of care work, all call for a critical reflection on how Italian society addresses the challenge of long-term care. In this context, caregiving represents a complex social practice that entails relational, emotional, and material responsibilities toward vulnerable individuals, carried out predominantly within families and informal networks.

Despite growing scholarly and policy attention, caregiving continues to be framed mainly in functional terms, as a form of assistance, or in economic terms, as a substitute for institutional care. The relational, transformative, and socially situated dimensions of this practice are less explored. This contribution aims to address this gap by adopting a relational and gender-sensitive perspective that observes caregiving from the standpoint of the actors themselves, as a dense biographical experience deeply intertwined with significant relationships that shape its sustainability, meaning, and effectiveness.

Italy represents a particularly emblematic context for analyzing caregiving: on the one hand, its welfare system largely delegates care responsibilities to families – and particularly to women; on the other, population ageing and transformations in family composition (smaller households, greater mobility, relational fragility) make caregiving both more burdensome and less sustainable. Given a system of services that remains highly uneven in terms of accessibility and quality, the care burden falls predominantly on family and informal networks, generating processes of strain and marginalization. The first report on innovation and change in the field of long-term care (Fosti & Notarnicola, 2018) identified a population of 8 million family caregivers who self-organize to respond to the needs of their dependent relatives, alongside nearly one million domestic care workers, both regular and irregular. These figures confirm that Italian families are heavily engaged in caregiving practices, both because of the growing number of oldest-old adults and the intergenerational breadth of family networks, with multiple generations coexisting: older adults today typically have both children and grandchildren (Istat, 2020, 2022).

Caregiving can be seen as a widespread but uneven practice: while some caregivers can rely on solid support networks or sufficient economic and informational resources to access public or private care services, others operate in conditions of isolation, facing significant psychological, economic, and social costs. Recent literature (Roth, 2020; Zygouri et al., 2021; Zwar et al., 2023; Kim, 2023; Pacheco Barzallo et al., 2024) further underlines that the caregiving role is neither static nor neutral: it is constructed over time, intertwined with processes of identity redefinition, and conditioned by gender, class, age, and social capital. From this perspective, caregiving must be understood as a multidimensional phenomenon, embedded in a complex network of supportive and close relationships, mediating between needs, resources, and social expectations.

Building on these premises, this study aims to empirically explore the forms of informal caregiving, focusing particularly on its relational dimensions and the gendered configurations that influence its sustainability and meaning. The contribution is based on a two-phase mixed-method design (qualitative and quantitative), adopting the dyad composed of caregiver and reference person as the primary unit of analysis to capture the complexity of relational networks and dynamics activated in care processes. The central research questions are: 1) *What gender differences exist in the distribution, experience, and narration of care? 2) What role do friendship networks and reference figures play in supporting caregivers' psychosocial well-being? 3) How are family, couple, and friendship relationships transformed in caregiving contexts?* Through these questions, the article seeks to contribute to a sociological reconceptualization of care, not merely as assistance, but as a situated relational process in which issues of identity, representation, reciprocity, and recognition are deeply at stake.

The article will first explore the meanings of caregiving and the gender differences highlighted in literature, through a sociological conceptualization that considers all dimensions of the care process. It will then present the results of the empirical research conducted on a sample of caregivers and their reference persons, leading to the identification of caregiving models shaped by gender and networks of proximity.

2. Theoretical perspective

2.1 Defining caregiving: beyond social support, within relationships

Regarding the process of caregiving, it is essential to conceptually situate it within the broader domain of social support. This term, frequently used in the scientific literature, refers to multiple forms of assistance (physical, task-specific, psychological, emotional, instrumental, relational), generally enacted within social networks (Heaney & Israel, 2008). Social support in all its forms, and provided by diverse social actors – public, private, third-sector organizations, or informal networks, has been the subject of extensive theoretical and empirical research, as documented by the vast available literature (Sarason et al., 1994). For the purposes of this study, which seeks to explore in greater depth the dynamics embedded in helping processes, social support is considered as a broader reference framework within which caregiving is to be situated, since the latter, in line with sociological literature (Bruhn & Rebach, 2014), is conventionally regarded as a subset of social support.

The caregiving process may involve one or more family and/or informal caregivers, one or more professional caregivers, those who perform caregiving tasks in exchange for financial remuneration, or a combination of both. However, and this is a central point at both the theoretical-conceptual and operational levels, there exists an intermediate area, a kind of "buffer zone" between social support and caregiving proper, represented by informal support networks. These networks provide assistance to caregivers directly engaged in care tasks with recipients. This area, often socially unacknowledged, is in fact crucial for the caregiver's well-being and, indirectly, for the well-being of the care recipient. It encompasses the "reference" or supportive persons of caregivers and constitutes a fundamental support environment for those who bear the tensions and challenges of caregiving, both regarding direct care delivery and the significant responsibilities that caregiving entails.

How does such support operate, and who are the actors involved? Support unfolds through articulated dynamics engaging a multiplicity of actors: first and foremost, those who provide help directly to caregivers, but also the informal and professional caregivers themselves and the recipients of their care. These actors, in various ways, generate formal and informal relationships that develop within existing networks or give rise to new ones. In summary, those who act in this intermediate "decompression zone", though not directly engaged with the ultimate care recipient, play a crucial role in supporting the caregiver that is often decisive in preventing burnout.

Caregiving, therefore, must be contextualized within a broader area of support that is strategically important to consider when designing helping processes. Recognizing this dimension is also key to better understanding the caregiving process itself. The term caregiving, literally "to give care", could be more fully captured by integrating the notion of accompanying, i.e., "to care by accompanying." The etymology of accompany derives from "companion," meaning "one who shares bread with another," thus denoting a relationship of closeness. In caregiving, such proximity is connected to two further terms: *care* and *giving*. The first *care* connotes attentiveness, concern, and careful regard (Ingrosso, 2016). Sociological reflection has long underscored the necessity of shifting from a medicalized model of cure, focused solely on the removal of pathologies, to a broader model of care, attentive to relational dimensions and encompassing well-being from a multidimensional perspective, physical, psychological, relational, cultural, and social (Ingrosso & Mascagni, 2020). The second term *giving* refers to offering a relationship, a presence, and an empathic bond. Together, these dimensions highlight caregiving as a process of personal responsibility assumed by the caregiver within a relational framework, oriented toward fostering the well-being of others through recognition of their needs and a disposition (or necessity) to respond proactively (Oliner & Oliner, 1995).

Caring, then, is simultaneously an interpersonal and social process, encompassing both attachment factors (bonding, empathy, the internalization of caregiving norms, the assumption of personal responsibility) and inclusive factors (expanding relationships to include those who are different from oneself, networking, accompanying, conflict resolution). It is therefore a polysemic term – difficult to define, and even more difficult to enact – yet essential in contexts of illness, vulnerability, and fragility (Boccacin, 2024).

The English definition of the term directly refers to the caregiver as a person, either professional or informal, who supports a dependent individual's social, physical, and emotional needs (Ingersoll-Dayton et al., 2003).

In this perspective, emphasis is placed less on the process itself than on performing it, which is reasonable: for caregiving to take place, there must be actors who enact it. This explains the strong conceptual link between caregiving and the figure of the caregiver, i.e., the person offering care in its broadest sense. Yet, if the focus shifts too heavily either to the caregiver or to the recipient, the relational foundation of caregiving – the relationship established between caregiver and care-recipient – risks being obscured. Equally, the broader complexity of the caregiving process, embedded in a wider relational context where support for the caregiver is fundamental, may remain invisible (Boccacin, 2025).

2.2 The gender dimension of care practices

The figure of the caregiver is located at the intersection between the private and public spheres, where the distribution of tasks reflects both individual choices and long-term social processes. The predominance of women in caregiving is not a contingent fact, but the outcome of a historical stratification in which care work, often invisible and unpaid, has been naturalized as a "supposedly innate female competence" becoming embedded in a gendered habitus that continues to shape both family and institutional expectations (Bourdieu, 1991; Tronto, 1998). This configuration is sustained by a dual dynamic: on the one hand, the persistence of social norms that legitimize women's centrality in caregiving as a moral duty and primary responsibility; on the other, the inadequacy of welfare systems in equitably redistributing care burdens, effectively delegating to families, and especially to women, the role of a social safety net.

Within this framework, the feminization of caregiving is not merely a statistical picture, but rather an interpretive prism through which to understand how men and women experience, narrate, and organize care. Recent research has shown that caregiving entails significant emotional and physical costs (Sabo & Chin, 2021), particularly for women, who report higher levels of stress than men, especially under heavy caregiving loads (Willert & Minnotte, 2021). Moreover, the literature highlights a strong correlation between gender dynamics and caregiving models: men tend to focus primarily on practical tasks and show lower engagement with support services, whereas women adopt a more relational approach, closely monitoring services and making use of external supports to manage both practical and emotional aspects of care (Kokorelias et al., 2025). At the same time, the availability of formal and informal support networks shapes caregivers' competences and well-being: bonding social capital, grounded in dense and cohesive networks, provides immediate support but can restrict access to new information and alternative resources; whereas bridging social capital, rooted in weaker and more diverse ties, enhances access to innovative knowledge and facilitates the management of care relationships (Roth, 2020). Consistent with Baik et al. (2024), caregivers benefiting from stronger formal and informal social support, such as participation in religious or volunteering activities, tend to develop virtuous circles of reciprocity, improving both their psychological well-being and their overall social capital.

These elements suggest that understanding the gender dimension of caregiving requires shifting the focus from the mere distribution of tasks to the daily negotiation of roles within complex family and community systems. Such negotiation does not occur in a social vacuum, but is influenced by entrenched gender norms, the availability and accessibility of services, work–life balance policies, and the forms of symbolic and material recognition attributed to care. In this sense, gender operates both as a lens that filters the caregiving experience and as a structure that shapes its possibilities, constraints, and trajectories, determining the quality of relationships, the sustainability of commitments, and the opportunities for caregivers' empowerment.

It thus becomes evident that, in order to fully grasp caregiving practices, it is essential to observe how gender roles are negotiated not only within the care context itself but also within the broader social fabric in which caregiving is embedded.

3. Research design and methodology

This contribution is part of the project "Social capital as resource of care practice in Italy: Caregiving and social support in pandemic time", funded by PRIN, and developed through a mixed-method research design that integrates qualitative and quantitative approaches[1]. In this paper, we present the results of the first, qualitative phase, with a specific focus on caregiver dyads engaged in the care of older adults.

The analytical unit of reference is the dyad composed of the caregiver and the "reference person," highlighting the relationship between those performing caregiving tasks and those who accompany or support them, whether materially, psychologically, emotionally, or symbolically. This device makes it possible to explore not only the individual experience of care, but also the relational dynamics that sustain caregivers in their daily management of care responsibilities, that intermediate zone between social support and caregiving, formed by the informal support networks discussed earlier.

The interviews were conducted in co-presence between 2023 and 2024, following the methodology of the narrative dyadic interview (Bramanti et al., 2023), and were accompanied by the compilation of egocentric network charts designed to map the personal support networks activated in caregiving management. During dyadic interviews, interviewers were attentive to potential asymmetries of voice. They actively encouraged both members of each dyad to express their perspectives freely, using follow-up questions to balance conversational turns and mitigate hierarchical dynamics.

Based on verbatim transcripts, a content analysis was carried out using NVivo (QSR International), adopting a constructivist grounded theory approach (Charmaz, 2006). This approach is characterized by the inductive construction of analytical categories from the data, through an iterative interpretive process that acknowledges the active role of the researcher in the production of meaning (Strauss & Corbin, 1998). The analytical process unfolded in three main stages: in the first stage, units of meaning were identified and coded descriptively, staying as close as possible to interviewees' words (in vivo codes); in the second stage, the generated codes were grouped into broader conceptual categories and organized into a hierarchical map of macro-areas, codes, and subcodes; finally, in the third stage, the categories were integrated

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into a coherent interpretive framework, linking the empirical dimensions with the research questions and theoretical references (Glaser & Strauss, 2017).

The sample analyzed here consists of a subset of 20 dyads (40 participants), selected through purposive and maximum variation sampling, to capture the diversity of family configurations and relational trajectories. The sample size was determined according to the principle of data saturation (Guest et al., 2006) and information power (Malterud et al., 2016), balancing thematic depth with variability across cases. Although the majority of caregivers were women, this distribution mirrors the empirical prevalence of female caregiving in the Italian context, rather than representing a sampling bias.

Table 1. Summary of participants' characteristics.

Variable	Description / Range
Number of dyads	20 (Caregiver–Reference Person)
Gender (Caregiver)	16 females, 4 males
Gender (Reference Person)	12 females, 8 males
Gender (Assisted Person)	14 females, 6 males
Age (Caregiver)	Range 49–67 years (Mean ≈ 59)
Age (Assisted Person)	Range 58–96 years (Mean ≈ 85)
Relationship type	Mainly intergenerational family ties (spouses, parents–children, in-laws, siblings); a few non-kin dyads (friends, paid caregivers)
Living arrangement	9 caregivers live with the assisted person; 11 do not cohabit but are in daily contact.

The dyads include Italian caregivers aged between 49 and 67 years, engaged in providing care to parents, in-laws, spouses, or older siblings with limited autonomy. The sample is strongly feminized: 80% of the caregivers are women, and even among the reference persons there is a female prevalence, with a significant incidence of female–female dyads. Male caregivers, when present, are in the minority and are always paired with a female reference person. From a geographical perspective, the cases involve participants living in different Italian regions, encompassing both urban and rural areas. Participants were identified through a snowball sampling process activated by an invitation to participate in the research, which included social media channels and targeted invitations. The selection criteria prioritized long-term caregiving situations (over six months), with varying levels of care intensity, in order to analyze the role of broader social relationships in supporting informal caregiving. Table 1 presents a summary of the main sociodemographic and relational characteristics of the participants (gender, age, relationship type, and living arrangement).

4. Results

4.1 Gender asymmetries and forms of responsibility

Caregiving within the families analyzed emerges as strongly feminized, not only quantitatively, as reflected in the composition of the sample, but also symbolically and practically, through the attribution of caregiving responsibility. The analysis of interviews confirms that the orchestration of care is predominantly entrusted to women, both in everyday practices and in the language used to describe them.

Female narratives highlight presence and the maintenance of relational bonds, which in some cases translate into a socialization of renunciation:

C: "It's all renunciations… we were educated this way… there is never full enjoyment." (INT. 8: caregiver of mother, woman, 64 years old – RP, sister).

In this frame, the "female orchestration" lies in holding together organization and relationship:

C: "…in addition to the care worker, one of us is always present… it's an intense caregiving." (INT. 8: caregiver of mother, woman, 64 years old – RP, sister).

Even clinical strategy becomes a matter of family coordination:

C: "We are aligned: we do what is necessary, avoiding the emergency room and long waits… this way we extend her life." (INT. 8: caregiver of mother, woman, 64 years old – RP, sister).

Male caregiving, by contrast, is framed mainly in technical–organizational terms, aiming not to "break" the rhythm of work and family. Support is described in terms of engineering flows and activating "third parties":

C: "…the lady who supports me reminds me of the medicines, we shop online, so I avoid interrupting the working day." (INT. 9: caregiver of mother, man, 60 years old – RP, domestic worker and care assistant).

Emotional distance is often portrayed as a normative resource by male reference figures:

RP: "For me, being less emotionally involved, it is easier to keep distance and rebalance relationships." (INT. 16: caregiver of mother, woman, 49 years old – RP, husband).

The practices reflect these differentiated semantic frames. Women combine direct care and advocacy:

C "I moved heaven and earth to find a doctor who would come home." (INT. 13: caregiver of parents, woman, 60 years old – RP, son).

C "…we share this caregiving." (INT. 8: caregiver of mother, woman, 64 years old – RP, sister).

Men, on the other hand, emphasize coordinated delegation and compatibility:

RP: "Cooking, taking my mother-in-law during Covid, staying 12–13 days… relieving my wife emotionally." (INT. 16: caregiver of mother, woman, 49 years old – RP, husband).

C: "Esselunga home delivery… saves two hours." (caregiver of mother, man, 60 years old – RP, domestic worker and care assistant).

For women, entry into the caregiving role is rarely the subject of explicit negotiation; it is more often internalized as "natural," in continuity with long-term family habitus and cultural scripts. This translates into a markedly asymmetric division of labor: women take on the overall orchestration of care (organization, bureaucracy, health/relational management), while men provide more episodic support, often legitimized by status categories (husband/father/brother) or by constraints preventing others from assuming the role. One caregiver puts it emblematically:

C: "I come from a family where care was never optional… it was deeply part of the family experience, as if it were already part of me" (INT. 5: caregiver of parents, woman, 61 years old – RP, husband).

Family histories of care thus signal the internalization of a cultural norm that associates domestic commitment, sensitivity, and availability with women. In several cases, women manage care without material support from brothers, who limit themselves to providing emotional or directive input:

RP: "…ninety-nine percent of things are done by her… she's closer… she has a job that allows it… she's a woman…" / C: "…for major decisions the first discussion is with my brother." (INT. 7: caregiver of parents, woman, 60 years old – RP, brother).

At the same time, women themselves often reinforce the definition of greater female involvement by narrating episodes and patterns from their own lives:

C: "It's more of a male trait, as if they don't want to see… my brother didn't want to see, didn't want to hear." / RP: "Yes, it's masculine, because my uncle too, when my grandmother's condition worsened, we had to take shifts, but he never showed up." (INT. 20: caregiver of mother, woman, 49 years old – RP, friend and colleague).

By contrast, male caregivers tend to describe their role in functional terms or as a response to an abstract, non-relational duty. This difference also emerges in the quality of the relationship with the care recipient: women frequently evoke intense emotional bonds and a "relational" caregiving, while men describe their function in more technical or detached terms. In one emblematic case, the role of caregiving is hardly recognizable:

I: "…do you recognize yourselves in this caregiving role?" / RP: "I think so, for me yes!" / C: "Recognize in what sense, sorry?" / RP: "That maybe we can be helpful, something?" / I: "Yes, let's say if you are aware that you are providing help, support (to the care recipient)." / RP: "I think so!" / C: "Me, a little less, but…" / RP: "Really? Not easy, not easy." / C: "And it's hard work." (INT. 1: caregiver of wife, man, 59 years old – RP, domestic worker/care assistant).

However, the polarization between male and female caregiving responsibilities does not provide an exhaustive interpretive key. On the contrary, the experience of a son caring for his mother – sacrificing time with his family and work – shows that caregiving also responds to strictly familial dynamics:

C: "Being close to her makes me feel good… knowing I can be useful to her and accompany her in this part of her life… I believe that in families where people truly love each other, they network and try to cope in the best possible way" (INT. 1: caregiver of mother, man, 50 years old – RP, wife).

From this analysis it emerges that caregiving responsibility is structurally gendered, following a tacit norm that assigns women the daily and symbolic–relational orchestration of care, often with disproportionate and invisible workloads (organization, bureaucracy, coordination of ties). Male voices remain in the minority and tend to legitimate their contribution in functional or duty-bound terms, confirming the persistence of cultural models that hinder a truly equitable distribution. Nevertheless, there are hybrid zones where men fully invest emotionally in caregiving. Some trajectories, such as that of the fifty-year-old son reducing work and family time to accompany his mother, motivated by an ethos of affection and closeness, show that caregiving also responds to situated and relational logics. These cases do not negate the gendered matrix of care but nuance it, pointing to spaces of negotiation where availability, the quality of ties, and resources matter, and where men too can assume emotionally intensive caregiving responsibilities when conditions and social recognition make it possible.

4.2 Care time between suspension and biographical transformation

The "time of care" takes shape as both suspended and highly structured, often experienced as a subtraction from life itself. As one reference person remarked about cohabiting with a non-autonomous mother-in-law:

RP: "it feels like something that robs your life, that sucks it away" (INT. 16: caregiver of mother, woman, 49 years old – RP, husband).

The exclusivity of the bond between caregiver and care recipient generates a relational fabric that tends to crystallize and reconfigure the caregiver's network, leaving few margins of autonomy for those in charge of care. This suspension materializes in routines scheduled minute by minute, reorganizing daily life while compressing the caregiver's scope for independence. One daughter describes her mother's day in detail:

C: "not before 7:30 I bring her a coffee in bed, so she can take the first pills… around 10 she gets up… I help her get dressed… tea… then together we decide what to cook… after *lunch a reclining chair, rosary, nap 14:30–16:30" (INT. 13: caregiver of parents, woman, 60 years old – RP, son).*

Similarly, another caregiver outlines his wife's daily routine, punctuated by micro-acts of care and multiple "rounds" of medication:

C: "breakfast and pills, repositioning, lunch around one, afternoon snack, then the night pills… positioning in bed, on the side, in safety… two or three awakenings to be turned" (INT. 12: caregiver of wife, man, 61 years old – RP, daughter).

In female narratives, time appears other-directed, absorbed by a presence that admits no spontaneity, framed in a lexicon of renunciation and guilt. The rhythm of care is embedded in presence and relational orchestration ("putting her to bed," sharing shifts with sisters, mediating with paid caregivers), with emphasis on compressed life margins. Two sisters put it starkly:

RP: "They're all years in some way…" / C: "Lost forever!" / RP: "Lost forever… Demanding work, free time is dedicated to our mother" / C: "Almost exclusively!" / RP: "Almost exclusively to our mother, more for her than for me, but in the end, I don't know how to say it, it's a bit like having children, you always carry it inside you" (INT. 8: caregiver of mother, woman, 64 years old – RP, sister).

Yet the difficulty is not only organizational. The erosion of social life and the impossibility of planning beyond a few hours produce relational consequences:

C: "relationships fray… you live half a day at a time, at most" (INT. 5: caregiver of parents, woman, 61 years old – RP, husband).

When the burden exceeds a threshold, families often turn to professional support, yet without relinquishing control:

C: "I realized I could not go on like this, because my life was collapsing and I wouldn't have been able to save either my mother or myself. I had to find another solution so that I could take back my life, but without depriving my mother of anything" / I: "So you identified support services?" / C: "Yes, exactly, supports that help us, because in any case I haven't let go completely…" / RP: "She hasn't let go entirely" (INT. 6: caregiver of mother, woman, 57 years old – RP, husband).

Male narratives, in contrast, frame time as a resource to be protected from interruptions, preserved in the face of heavier physical or mental care burdens. Their descriptions are procedural and detailed (medications by time slots, hygiene and physiotherapy cycles), often distributed across micro-family networks (daughters, in-laws) or professional help (domestic workers, live-in aides), producing a "fluid" day. One son explains:

C: "For me, not being interrupted is essential; having all these supports in place helps. We do online shopping every week… Carla helps too, because if something is missing in the morning, she picks it up on her way here. These are all supports, because otherwise I would have to do them myself, but that would mean my head is never in my work" (INT. 9: caregiver of mother, man, 60 years old – RP, domestic worker, live-in aide).

Delegation of specific tasks (shopping, medical supplies) thus preserves work and life-course continuity. Even when family life is especially demanding (three small children), the dominant frame remains one of compatibility:

C: "it takes away a lot of time from our things… we struggle to plan… we have to stay nearby" (INT. 1: caregiver of mother, man, 50 years old – RP, wife).

Alongside suspension, however, paths of transformation and reconfiguration emerge. A son (PR) reflects on "*greater closeness, greater unity*" with his mother, forced into deeper conversations about his father's choices and prognosis (INT. 15: caregiver of husband, woman, 56 years old – RP, son). For a husband caregiver and his daughter, the supportive network beyond the family serves as a symbolic resource *"the parish priest… the neurologist… we feel part of a mesh… people who love us and help us*" (INT. 12: caregiver of wife, man, 61 years old – RP, daughter). Suspended time can thus open transformative spaces, where the care network is aligned, and the time of assistance becomes also time of proximity: "*we see each other more than before" (INT. 8: caregiver of mother, woman, 64 years old – RP, sister).* In other cases, post-care time must be re-learned:

C: "It's a mess…" / RP: "In the end you get used to it, you go on, but when it's all over it's hard to get your life back, because in the end you cut everyone else out. So, returning to normal life is not easy" (INT. 4: caregiver of mother-in-law, woman, 58 years old – RP, friend).

From this perspective, one caregiver reflects on his mother's care within the broader economy of his life, underscoring how the management of time is anchored to life-course positioning and the interplay of parental, work, and caregiving roles:

C "if we were in another phase of life, surely we would have much more time to dedicate to these things" (INT. 1: caregiver of mother, man, 50 years old – RP, wife),

In female trajectories, transformation often passes through friendships and micro-breathing spaces ("finding someone who listens," selectively investing in ties). In male narratives, it emerges through "flow engineering" (digital tools, deliveries, shifts) and operational alliances with trusted figures (RP/domestic aides), which ensure continuity without "breaking" work routines. Yet ambivalence runs through all dyads: the same time that "steals" life is also when practices are learned, boundaries negotiated, and relationships rewritten, provided that supportive networks and micro-spaces of self-determination exist within everyday life.

4.3 Couples, friendships, families: the variety of networks and their meaning

As highlighted by the suspension and reconfiguration of biographical time, caregivers' relational networks emerge as dynamic matrices, marked by emotional continuity, ruptures, and new adaptations of social bonds. Caregiving thus becomes both a prism through which to read the quality of family and community relationships, and a transformative agent capable of strengthening or weakening pre-existing ties.

For some caregivers, care becomes an opportunity for renewed closeness with family members or partners, opening spaces for emotional reconnection:

C: "We three siblings divided the tasks: one took the night, another the day… there was always one of us" (INT. 19: caregiver of father, woman, 64 years old – RP, daughter).

C: "…together… the happiest period of all ten years of cohabitation… we had a wonderful time… Grandma was happy" (INT. 8: caregiver of mother, woman, 64 years old – RP, sister).

These cases show how, in certain contexts, care may function as a catalyst for proximity, transforming distant relations into new forms of complicity or co-responsibility. However, for a significant share of respondents, relational trajectories are marked by disappointment, leading to rupture, isolation, or mistrust. In such cases, relationships progressively disintegrate, leaving caregivers vulnerable both emotionally and in terms of organization.

C: "Friends are no longer there!" / PR: "It's all tied to time, to care! By caring for one person, you no longer have time for yourself; in fact, you can't manage to do anything else" (INT. 6: caregiver of mother, woman, 57 years old – RP, husband).

C: "I just wish some friend would come more often to visit, to talk with [care recipient], to spend time with her… I wish that some of our friends, and we had many, not few, even very special ones, would every so often come by, spend time with her, have an ice cream together" (INT. 3: caregiver of wife, man, 59 years old – RP, domestic worker, live-in aide).

Many interviews also describe networks that are reconfigured under the weight of care, becoming less extensive but more selective and reliable. Here care acts as a symbolic filter, distinguishing those who are "truly present" from those who are merely nominally close:

C: "If he hadn't helped me in certain moments, I wouldn't have even had the physical strength, because more than once in the evening he had to go and lift grandpa, or just the other night grandma couldn't manage the alarm and was in a panic. I'm grateful because it's not something you can take for granted" / PR: "I, on the other hand, did take it for granted" (INT. 13: caregiver of parents, woman, 60 years old – RP, son).

C: "We found ourselves on the same wavelength; sometimes I confide in Mrs. Carla, and sometimes she confides in me" / PR: "Yes!" / C: "It's true that we tend to take this for granted, but not everyone does it" / PR: "Not everyone does it!" / C: "Indeed. For me, this *really helps" (INT. 9: caregiver of mother, man, 60 years old – RP, domestic worker, live-in aide).*

These examples illustrate how the reconfiguration of care networks generates recognition of support as something "non-obvious," whether it comes from close relatives or external professionals. Care thus operates as a powerful selective device, redrawing relational hierarchies where concrete reliability outweighs formal proximity. In this process, traditional boundaries between family and non-family blur, and trust becomes anchored less in role than in effective availability.

In women's trajectories, family networks function best when daily coordination and oversight are present; often sisters organize shifts and sustain relational "cohesion":

C: "We are two, and we both take care of our mother… I do a little more because I live with her… it's intense and long-term caregiving" (INT. 8: caregiver of mother, woman, 64 years old – RP, sister).

When family networks are misaligned, requests for timely support remain unanswered, and caregivers turn to alternative networks:

C: "I would have liked more support from my sister. I asked some time ago: 'Can we agree on a couple of days when you come, so I know I am free?' But she said, 'I'll come when I feel like it.' And that means once a week, at best." / PR: "About that! Rounded up generously!" / C: "Even just hearing, 'if you need it, ask me and I'll go,' made me happy. Once I had to run an errand, and a friend went instead." (INT. 13: caregiver of parents, woman, 60 years old – RP, son).

In cohesive configurations, by contrast, siblings share daily co-responsibility:

PR: "My sister and I are both caregivers; we're both equally involved. She lives with my mother, I live upstairs… so when she isn't there, I am… we share both the fatigue and the joy" (INT. 18: caregiver of mother, woman, 62 years old – RP, sister).

In women's networks, proximity is maintained through daily monitoring (calls, visits, shifts) and relationship maintenance, while men more often play intermittent or consultative roles, stepping in during crises or peaks of demand.

When men are the primary caregivers, partners tend to recognize their role in freeing up time rather than providing direct care:

PR: "We have three young children, so life is complicated enough. I work, I manage everything, and I must say I don't do much in terms of caring for my mother-in-law" / C: "No! Well, yes, but even just the fact that you free up time for me to take care of her myself makes a difference, in terms of organization" (INT. 1: caregiver of mother, man, 50 years old – RP, wife).

In such cases, the affective-instrumental network activates in cascade – mother-in-law, search for a live-in aide, information-sharing.

For women, friendships often function as emotional containers and informational bridges. One telling exchange between a caregiver and her friend illustrates this:

C: "The few times we met, she [the RP, friend] would share her difficulties, and I treasured them when my turn came" / PR: "Her strength is that she knows how to listen, and I probably felt comfortable with her because she never got tired of listening to me" (INT. 4: caregiver of mother-in-law, woman, 58 years old – RP, friend).

Here, friendship operates as both a reflective network (listening) and a competent network (practical knowledge).

Men, by contrast, rarely cite friendship as a source of emotional support; instead, male friendship networks are invoked mainly for functional or organizational purposes (information, contacts), while emotional support is more often attributed to partners or paid caregivers.

In several cases, for both men and women, live-in aides become de facto family members or key reference figures, often serving as the caregiver's primary reference point:

C: "She's not an employee, she's family… after eleven years" (INT. 10: caregiver of mother, woman, 58 years old – RP, live-in aide).

Here, the network becomes hybrid, with the aid as both emotional and operational node. In men's trajectories, this dimension is reinforced by a strong emphasis on organizational efficiency, with aides integrated into care routines: 24/7 shifts, Sunday coverage, and coordination with family logistics.

5. Discussion

The empirical material confirms what the literature has already highlighted regarding care practices, namely that the dichotomy between "informal" and "professional" care does not fully capture the burdens involved in supporting and accompanying older people (Miele, 2021). More precisely, when focusing on the caregiver's experience, care emerges as a relational infrastructure: a work of coordination aligning people, time, space, and practices; holding together emotions and bureaucracies; connecting homes, clinics, service counters, and networks of family and neighbors. The interviews reveal a complex system of care that is not a residual form of public or private provision but the very mechanism that enables the entire care system (both formal and informal) to function.

This approach resonates with theories that conceptualize care as a process of network maintenance (Keating et al., 2021) and as social capital embodied in interactions (Lin et al., 2001), showing how the caregiver's orchestration is the condition for the functioning of the entire care system, whether formal or informal. In the data, this orchestration is visible in small but constant everyday gestures – phone calls, shifts, micro-agreements, anticipating crises, managing frictions – which confirm the idea of care as a high-intensity relational practice, where the value lies not only in the quantity but especially in the manner and the social configurations of caregiving.

Table 1 translates the hypothesis of care as relational infrastructure into operational terms, organizing results along observable dimensions – role frames/lexicon, practices, subjective temporalities, support networks, management of paid caregivers, and transformations of social bonds – distinct the prevalent styles of female (C_f) and male (C_m) caregivers. This analytical reworking makes it possible to see immediately:

(a) the gender asymmetries in the orchestration of care (continuous and relational for women, functional and compatibility-oriented for men), consistent with the centrality of cultural codes and meanings that shape the integration and actual division of tasks;

(b) the role of the intermediate area of support (aligned friends/relatives, proximate figures, care workers) as a buffer that transforms networks and meanings into social capital (bonding/bridging), thus preventing burnout;

(c) the transformative nature of caregiving on couple, family, and friendship ties over time.

The prevailing caregiving styles among women (C_f) and men (C_m) are structured along four empirical axes – role frame/lexicon, practices, subjective temporality, and legitimation – which together delineate a gendered asymmetry in the governance of care[2]. Among women, caregiving tends to take the form of continuous orchestration: direct responsibility, advocacy (selection of specialists, avoidance of inappropriate service use), and the daily stitching together of alliances (sisters, friends, paid caregivers), with a temporality often experienced as suspended and saturated by rigid routines. Among men, caregiving appears more functional: coordinated delegation, flow engineering (online shopping, deliveries), protection of work and family time, with an optimized temporality aimed at minimizing interruptions. This polarization, however, does not exhaust the possible configurations: hybrid forms emerge (women adopting managerial postures; men fully investing emotionally) when ties, resources, and recognition open spaces for negotiation. Theoretically, this pattern can also be understood through the AGIL schema reinterpreted in a

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[2] The observable dimensions reported here refer to the empirical indicators employed in the study; they are derived from the dyadic interview guide for family caregivers, which specifically explored care relationships, perceived well-being, interactions with services, trust resources, associative participation, and future perspectives.

relational key (Donati, 2013)[3]: the latency or cultural function (L), codes of meaning defining who "should" coordinate what, shapes integration (I) and, consequently, the concrete distribution of tasks; when meanings are explicit and shared, asymmetry decreases, and caregiving orchestration can be redistributed.

Table 2. Care as relational infrastructure: styles of orchestration and support networks among caregivers (C_f vs. C_m) across the analytical dimensions of: RQ1: gender differences in the distribution, experience, and narration of care; RQ2: friendship networks and reference figures in sustaining caregivers' psychosocial well-being; RQ3: transformations of family, couple, and friendship relations in caregiving contexts.

Analytical Dimension (RQ - Research Question)	Prevalent Style C_f	Prevalent Style C_m
Role framing / Lexicon (RQ1)	Continuous orchestration; emphasis on presence, sacrifice, and guilt; lexicon of relational endurance.	Functional orchestration; lexicon of efficiency/objectivity; compatibility with work.
Concrete practices: who does what (RQ1)	Direct caregiving and advocacy (with doctors/institutions); coordination among sisters; care for meaning.	Coordinated delegation (care workers/services); rationalization of flows; reduction of interruptions.
Subjective temporality (RQ1)	Suspended time: rigid routines, reduced spontaneity, feelings of guilt.	Optimized time: tools and micro-networks to avoid "disrupting" work/rhythms.
Support networks: bonding/bridging (RQ2)	Mixed networks woven into daily life (sisters, friends, "family-like" care workers); caregiver oversees alliances.	Networks as logistical mediation (professionals/services) cushioning the main caregiver's load.
Management of care workers (RQ2)	Quasi-familial integration; contractual orchestration and domestic micro-solutions.	Focus on coverage/shifts and sustainability; evaluation of task adherence.
Transformations of relationships (RQ3)	Consolidation among sisters/children when co-orchestration works; selective friendships.	Functional reconfiguration (family/service arrangements), with possible reconnections.
Couple dynamics (RQ3)	24/7 cohabitation as a test of endurance; relief when spaces reopen.	Partners often provide time/space rather than direct care; operational alliances.
Hybridizations and negotiation spaces (all RQs)	Female managerial postures with strong orchestration and instrumental use of networks.	Full emotional investment when strong ties/recognition are present.

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[3] For the purposes of the present analysis, particular emphasis is placed on the connection represented by the L-I axis, while a detailed examination of all four dimensions and their interrelations is not undertaken, for reasons of conciseness.

Support networks operate in gender-differentiated ways: female caregivers more often activate mixed networks woven into daily life (sisters in co-caregiving, friends as emotional containers and informational bridges, domestic workers integrated as affective–operational nodes), whereas male caregivers rely more heavily on instrumental/logistical networks (professionals, services, digital solutions) as buffers ensuring compatibility with everyday rhythms. This configuration confirms the link between the density of primary ties and the capacity to access services and resources – both necessary for psychosocial sustainability and the prevention of burden/burnout. The literature shows that adequate perceived support reduces subjective burden and levels of distress, with beneficial effects on caregivers' health; our qualitative evidence clarifies that such outcomes depend not only on the availability of support, but on its integration into the caregiver's orchestration of care: routines of coordination, family briefings, protocols with domestic workers, and clear communication channels aligning expectations, roles, and boundaries.

Caregiving also acts as a transformative agent of social ties, highlighting two recurrent trajectories: (a) consolidation/reconnection when co-caregiving arrangements are clear and the network "holds" (greater proximity, trust, and complicity among siblings or children, alliances with reference figures); (b) unraveling/selectivity when alignment is lacking (erosion of sociability, isolation, reliance on a few dependable relationships that "truly remain"). Both trajectories are sensitive to temporality, which can test, weaken, or consolidate precarious balances, and they confirm that relational outcomes depend on the quality of interactions over time.

Overall, the findings indicate that caregiving processes are not merely containers of relationships, but productive mechanisms that generate, transform, or consume social capital, depending on the combination of material and immaterial resources, roles and positions, concrete support, and symbolic mediations (trust, reciprocity, cooperation). The theoretical challenge, therefore, is to recognize caregiving not as a residual appendage of the welfare system, but as a relational infrastructure central to social cohesion and community resilience.

At the same time, care practices are deeply embedded in cultural meanings and normative expectations that define, along gendered lines, who is expected to assume coordination and emotional responsibilities (Nocenzi & Crespi, 2025; Sartori, 2009). The predominance of female caregivers reveals how care remains deeply embedded within gendered cultural expectations. The narratives collected highlight not only the unequal distribution of caregiving tasks but also the emotional labour and identity work attached to them. These findings resonate with sociological perspectives on the social construction of care as a feminised moral duty rather than a shared social responsibility, suggesting that gender still shapes both the lived experience and the symbolic representation of caregiving (Fraser, 1996).

This study presents several limitations: the gender imbalance, predominantly female caregivers, and the limited age range reflect the actual composition of the Italian caregiving population, yet they reduce the potential for broader comparative interpretation; furthermore, the reliance on self-reported narratives may have introduced biases linked to social desirability and the interactional dynamics of the interviews. Although the small and context-specific sample restricts the transferability of the findings, it enhances their contextual depth, enabling a nuanced interpretation of the relational that sustain family care.

6. Conclusions

The analysis confirms that family caregiving constitutes a structural and indispensable component of the welfare system, whose contribution goes beyond providing assistance and extends to safeguarding and reshaping affective bonds, directly shaping care recipients' quality of life. As widely discussed in the literature (Colombo et al., 2011), this function manifests itself as a relational infrastructure operating at the intersection of the private and public spheres, where coordination skills, advocacy capacities, and integrated resource management converge.

The first research question highlighted that gender differences do not merely concern the amount of time devoted to care but deeply affect its organizational architecture and narrative construction. Women tend to assume a global and continuous orchestration role, in which responsibility for care is interwoven with the daily management of the household and relationships, producing a narrative lexicon marked by obligation and, at times, sacrifice. Men, by contrast, are more likely to situate care within episodic actions or arrangements compatible with other priorities, constructing accounts oriented toward functionality and the preservation of their personal and professional trajectories. This dichotomy, consistent with findings from Daly and Lewis (2000) and Saraceno (2011), is rooted in persistent cultural codes that legitimize female responsibility as "natural" and male responsibility as "occasional," though some cases reveal hybrid trajectories that partly unsettle traditional models.

Regarding the second research question, the findings confirm that caregivers' psychosocial resilience depends not solely on the availability of support, but on the quality and structure of the connections they can mobilize. Friendships operate as spaces of emotional decompression and normalization of experience, while reference figures, often other women in the family or trusted professionals, serve as anchors for decision-making. Their effectiveness is proportional to the degree of integration into the everyday life of care, through arrangements that combine effective and functional dimensions. This perspective resonates with Fine and Glendinning (2005), who argue that caregiving competences, when adequately supported and valued, can become a strategic social asset, strengthening the welfare mix and promoting participatory forms of co-design.

The third research question showed that caregiving triggers significant transformations in family, couple, and friendship relationships. The management of care tends to redefine the hierarchy and priority of social ties: in some cases, it consolidates proximity and intrafamilial solidarity, while in others it reduces the space for relationships perceived as less meaningful, generating a gradual filtering of relational capital. Within friendship networks, ties concentrate around a smaller core of reliable people, while weaker relationships tend to dissolve. This process, while limiting the variety of social interactions, simultaneously reinforces the density and reliability of the ties that endure, reconfiguring relational patterns according to criteria of reciprocity, trust, and emotional closeness.

Despite the limitations previously discussed, the evidence illustrates that caregiving should not be understood as ancillary to formal services, but rather as a structuring device of the entire care ecosystem, whose effectiveness depends on integrating formal and informal resources within a dynamic and negotiated balance. The qualitative analysis of dyads of senior caregivers engaged in supporting older family members clearly documents that care must be interpreted as a relational infrastructure: a form of orchestration with high symbolic, emotional, and organizational intensity that interconnects biographies, gender roles, networks, and institutions. Far from being a mere domestic appendage, caregiving functions as a mechanism of coordination that can generate proximity or, conversely, produce fractures, suspend biographical projects, or reconfigure them. This leads to a conception of the family not as a cohesive unit, but as a dynamic field of relations marked by asymmetries, implicit obligations, and often unnegotiated expectations.

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