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Not Merely a Question of Work: Social Capital for Professional Carers, Between Reciprocity, Trust and Emotional Involvement*

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Abstract

The relationship between social capital and care work provides an invaluable area for research. Recently, researchers have focused on the relationship between social capital and the care work provided to those with long-term needs by individuals and family members. One such study focused on the social capital available to family carers (Ng et al., 2022). In this paper, we attempt to explore a different dimension. Firstly, we focus our attention on paid care work. At the centre of this is the figure of the professional caregiver. From here, we look at their relationship with the person for whom they are caring and also with a reference figure that the caregiver has identified as their support. We will closely examine these two relationships to see whether, and under what conditions, forms of social capital, in terms of trust, reciprocity and support within the caregiver network, are triggered and generated.

Keywords: social capital, caregiver, paid care work, care relationship.

1. Introduction

While in Cagliari, when presenting the preliminary results of this work[1], one of our group experienced a curious episode. We report it here first-hand.

* Although the work reflects the views of all the authors, sections 1, 2 and 3 were written by Roberta Teresa Di Rosa, sections 4, 4.1, 4.2, 4.3 by Gaetano Gucciardo and sections 4.4, 5 and 6 by Rita Affatigato.

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[1] The event was the Convegno della Società Scientifica Italiana di Sociologia, Cultura, Comunicazione (SISCC) which took place on June 20, 2025.

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I stop by a pharmacy in Largo Carlo Felice and overhear a conversation between a foreign lady and two young pharmacists. The woman says she is leaving in September. 'Are you going back to your own country?' 'No,' explains the lady, 'I'm going on a seven-day cruise'. The two pharmacists are surprised, congratulate her and hope she enjoys a rest and a good time. One asks her where she comes from. She comes from a country in Eastern Europe. She goes on to say she is always tired, that she can never get to sleep during the day, but she does not sleep at night either, because the lady she is looking after does not let her. The pharmacist then advises her to take care of herself, drink plenty of water and, when she gets home, have a nice shower. Before leaving, the woman in passing mentions the word "family", but I don't quite understand. So, when she leaves the pharmacy, I ask her if she is a caregiver; I explain that I am attending a conference on these issues, that I work in this field, and ask her to tell me more. Yesterday, the woman had gone to the pharmacy because she wasn't feeling well. She had been experiencing chest pains and, while standing at the counter, she had turned pale and lost consciousness. Help arrived immediately, an ambulance was called and took care of her.

The next day, the woman wanted to express her gratitude to the staff, and for this reason she was there at opening time. That is why, as she was leaving, she said that the people at the pharmacy had behaved "like family". The pharmacist then told me that many immigrants seek refuge in the pharmacy, where they can talk, share their stories, and sometimes sit and spend their time. A young man from Senegal, who often came there, the other day sent a three-minute audio message giving the latest news about himself. 'They are thirsty for family,' commented the pharmacist.

What we are describing and trying to explain in this article deals precisely with the social capital that is activated in care relationships, but, on examining the care work provided mainly by people with a marked lack of social capital, we will see how a wide variety of opportunities (such as, in this episode, the existence of a pharmacy) may become sources for building warm social relationships.

2. Social capital in long terms care relationships

Europe's population is ageing and the number of people requiring care is increasing. In addition, improvements in medical knowledge and treatment have led to a rise in longevity. As a result, there is a growing number of people with complex and multiple needs who require some form of significant care. For this underlying reason, support figures such as carers are increasingly important for the demands of long-term care. The European Commission explains that: 'Long-term care empowers people, who as a result of old age, illness and/or disability depend on help for daily activities, to maintain their autonomy and live with dignity' however 'for many people these services are still not affordable, available or accessible'[2].

They are important but insufficient, and those that do exist are under pressure. There are 30.8 million people in Europe who are dependent in this way, and this figure is expected to rise further by seven million by 2050[3].

It is also estimated, again in Europe, that one in three people are engaged in some form of care for people with problems due to ageing, chronic conditions or infirmity, and that the vast majority of these carers are women (CNEL, 2024). According to Istat data, in Italy there are almost eight million carers, of whom almost one million are receiving remuneration[4].

Providing support in situations of dependency requires some form of social capital. The person receiving care receives direct or indirect support thanks to a network of affection and help that may come from family members, neighbours, volunteers or associations. However, we believe that caregivers, whether voluntary or paid, should also receive support. This may come from various sources: they may be relatives of the person receiving assistance or even strangers to that person, belonging to the caregiver's own circle.

Social capital is a polysemic term that has, since the 1990s, acquired striking prominence in social and economic research and publiions. It has been used in many ways for descriptive and explanatory purposes. It has served to explain socio-economic development disparities (Putnam et al., 1993) such as inequalities in opportunity for academic achievement (*Coleman Report*, 1966 cit.

[2] https://employment-social-affairs.ec.europa.eu/news/european-care-strategy-caregivers-and-care-receivers-2022-09-07_en#navItem-relatedDocuments.
[3] https://employment-social-affairs.ec.europa.eu/policies-and-activities/social-protection-social-inclusion/social-protection/long-term-care_en#:~:text=Long%2Dterm%20care%20consists%20of,of%20some%20permanent%20nursing%20care.
[4] https://www.istat.it/tavole-di-dati/condizioni-di-salute-e-ricorso-ai-servizi-sanitari-in-italia-e-nellunione-europea-indagine-ehis-2019/: tavola 6.1.1.

in Fukuyama, 1999, p. 154). It has also made it possible to bring together under a single term elements such as associationism, volunteering, the extent and intensity of friendships, neighbourly relations and community relations, trust, civic participation and civic awareness. It thus provides a basis for a theory of synthesis. Since its first appearance (Hanifan, 1916, as cited in Putnam, 2004), social capital has been defined as a resource inherent in social relationships that individuals can rely on for a variety of purposes, or simply as a feature emerging from a social context that is propitious for the pursuit of one's goals.

Despite all the ambiguities documented in literature (Lin, 2003; Portes, 1998), the concept of social capital has led one to think of the structure of social relations as a potential resource that benefits individuals and communities. Therefore, social capital may be thought of as an *individual resource* or as a *collective attribute*. In the first case, it consists of relationships that individuals may rely on for their needs, aims and objectives (Bourdieu, 1980). In the second case, it consists of resources of reciprocity, solidarity and trust, which enhance collective outcomes (Putnam et al., 1993; Putnam, 2004).

There is a third view, the relational one, according to which social capital is specifically embedded in social relations and is, more precisely, an *attribute of social networks*, which needs to be activated. This view is consistent with the assumption that, in society, relationships come first and individuals second; it sees social capital as a resource that resides in the network and not in the nodes of the network. Social capital is not the domain of individuals but exists and is activated in relationships. And not only. It should also be emphasised that, from this perspective, social capital is not a commodity, which means that it cannot be owned, either by individuals or by the community. Rather, it emerges from social interactions and is triggered solely by the characteristics and quality of those interactions (Bertani, 2010; Di Nicola et al., 2010; Donati, 2007; Donati & Tronca, 2008). Individuals may interact and even be in a relationship, but this is not sufficient to activate social capital as a resource of trust, reliability, cooperation, and reciprocity. Precisely because of the central role that the relational perspective attributes to a certain quality of the network (as the key to activating social capital), this perspective seems particularly suitable for examining the relationships between caregivers, care recipients, and figures of reference. Examining care relationships from a relational perspective will bring some order to the data, while allowing one to 'see' elements that different perspectives might not grasp.

Care relationships can show how specific interactions, such as those between caregivers and care recipients, between an individual who provides care and one who is dependent, fragile, vulnerable, and receives care, can generate social capital. Here, by social capital we mean primarily relational resources of trust, reciprocity and solidarity. These are non-instrumental

resources that cannot be appropriated in the abstract by the components of the network, but can be implemented within the network, and because of the actual specific nature of the network itself.

One of the essential conditions for enabling and accessing social capital, as pointed out by Coleman (1988), is the time during which social capital can be accessed. Using terminology that was perhaps a little too economy-oriented, Glaeser et al. (2002) showed that maintaining social capital demands investment, and that the main investment lies in nurturing relationships. On the other hand, when we talk about social capital, we are dealing, as Hirschman (1984) explained, with a moral resource that, if not employed, will decay.

The mere passing of time is a source of entropy for social capital if that social capital is not deployed: over time, it diminishes. Based on data from the German Socio-Economic Panel (GSOEP) relating to the German population and covering a fairly long period (1984-2015), Eberl (2020) was able to verify that people who care for family members in need of assistance have less time to devote to maintaining social ties.

The data shows that actual caregiving, in the form of informal assistance to a family member, has a depressing effect on the caregiver's social capital. In particular, participation in cultural events, cinema, sports, and volunteering decreases, and opportunities to nurture so-called weaker ties (Granovetter, 1985) are reduced. On the other hand, in caring activities, it is strong ties that are triggered; from this point of view, care work can be a resource for strengthening strong ties if, for example, family members enter into forms of shared care.

If social capital needs constant nurturing of relationships in order to be maintained, what about social capital in caregiving relationships? This could be a sort of wordplay to sum up the essence of our investigation via ten interviews with professional carers; there can be no caring relationship without caring for the actual relationship, not only between the caregiver and the assisted person, but also towards the caregiver. More specifically, our interviews bear witness to the triggering of fundamental relationships of trust that have a strong emotional component and, in effect, serve to remind us how trust (and social capital) is a cognitive disposition; it is accompanied by a specific emotional component that emerges and thrives within the relationship.

3. Methodology

In our analysis[5], we sought to focus, especially, on the support that caregivers receive from other figures. We therefore observed the relationships between professional caregivers (CG), care recipients (CR) and a reference person (RP) indicated by the caregiver as their support figure. Through the analysis of this triangle, we examined the relationship between care work and social capital. We carried out ten dyadic interviews (Bramanti et al., 2023) with paid caregivers working in several towns and cities in Sicily and one city in northern Italy.

The subjects of our dyadic interviews were nine women and one man, who work as carers for elderly people. They were selected by matching the recommendations provided by an association for the protection of domestic workers (Apicolf) with personal knowledge on the part of the research team members, and by asking the caregivers interviewed to themselves recommend any colleagues who might be available. The requirements were that they had at least one year of experience working as caregivers and that they spoke Italian sufficiently well.

Nine of these caregivers are foreign nationals and two are Italian. Each of them was asked to name a reference person by whom they would like to be interviewed and who represented a source of support for them in their work caring for the person they assisted. Three of these reference persons are men and seven are women. In six cases, they are relatives of the person being cared for (husband, son/daughter, daughter-in-law); in two cases they are children of the CG, and in a further two cases they are colleagues of the CG with whom they share the caring.

First of all, an interview was carried out with the caregiver as part of the broader research for the project. During this individual interview, the caregiver was asked to indicate who actually provided support in their work, by answering the following question: 'I would now like to ask you to name the people, other than those we have mentioned so far, who have provided you with support or assistance in the last 12 months, even for a short or very short period, when you needed help in your daily life, and the type of assistance you received from

[5] Our research is part of a project devoted to social capital in healthcare services in Italy, funded by the Ministry of University and Research (PRIN2022). The project is coordinated by the Università Cattolica del Sacro Cuore in Milan, in collaboration with the University of Molise and the University of Verona. The project, following the COVID-19 pandemic, explores the different forms of social capital, in Italy, with regard to care work and, in particular, in active social support in the form of caregiving (family and paid, for the elderly or people with disabilities).

each of them'. The CG was then free to choose with whom to conduct the dyadic interview.

Analysis of the interviews was undertaken using a method that could be likened to analytical induction. According to Katz (2001), this consists of a process that proceeds from the actual data, in order to work out provisional explanations, which, as the data is being examined, are adapted or replaced by new ones that can summarise all the data previously examined. However, we cannot ignore the fact that, even during the interview phase, we began contemplating an explanatory hypothesis and proceeded to examine the interviews on the basis of this hypothesis. The similarity with the analytical induction method lies in the openness to adapting a hypothesis to the evidence that emerges from the interviews as they are being analysed.

During the interviews, something specific seemed to emerge regarding the relationship between the caregiver, the person receiving care, and the caregiver's reference person. This particularity seemed to be linked specifically to the generation and use of a specific type of social capital. The dyadic interviews in which we spoke to a caregiver and a person whom he or she considers a source of support, revealed an exchange of concern, attention and trust that flowed not only from the caregiver to the person receiving care, but also from the person receiving care to the caregiver. In short, there is a support network that benefits not only the person receiving care, but also the person providing it.

The first model on which we worked suggested that the triggering of this social capital between CG and PA or between CG and PR, might be linked to the relational deficiencies of the CG (mostly foreigners with few local ties) or to all-consuming working conditions that 'force' them to forge relationships wherever they are offered, i.e. in the workplace itself with people from the PA's family circle. In other words, we explored the extent to which social capital can be generated in fairly extreme conditions, such as those experienced by foreigners, who are also isolated, or workers who are on call 24 hours a day.

The other model we constructed, as we proceeded with the analysis of the interviews, focused on the nature of the exchanges between CG and PR. We noted frequent mentions of help, trust, ethical and religious motivations, and emotions (especially affective ones) as characterising the relationships. The model anticipated that these elements could be the ones necessary in paid care relationships, essentially in the form of in-home nursing. The limited number of interviews conducted prevents us from presenting our results as definitive. They need to be subjected to further checks and verifications.

The dyadic interview is a distinctive data collection technique, on which it is necessary to reflect. As we have said, the pair to be interviewed was chosen by the caregiver. As mentioned, he or she was asked to indicate a person who was a point of reference for them as a support figure.

This method of generating dyads may have had consequences in terms of what was revealed. For example, it is almost inevitable that a strong relationship of trust between the two people in question emerged from the interviews. This was almost implicit in the way the pair selected each other.

In most cases, the contact person selected is either part of the care process, or a relative of the person receiving care, or a relative of the caregiver involved in the caring in some way (in two cases, it was the caregiver's child who replaced them when necessary). This seems to imply that all that was found was implicit from the outset, in the very way in which the object of investigation, or at least a significant part of it (the dyad), was selected. However, as we shall see when analysing the results, it is possible to invert the perspective and observe the conditions that enabled it to be established and function, in the characteristics singled out in the relationships between the protagonists of the care relationship.

4. Research results

Before presenting the results, it is worth clarifying a few points regarding the limitations of our study. Naturally, the relatively small number of cases examined does not enable us to draw general conclusions that could be considered even minimally representative. However, it does allow us to provide food for thought and pathways for further research. Furthermore, having interviewed mainly foreign caregivers, who are not fully proficient in Italian, the accounts they gave seem to have been heavily influenced by the presence of the reference person, who often ends up dominating the narrative. This situation had the unintended effect of resulting in the caregivers talking less about their direct relationship with the person they care for, and rather more about their relationship with the reference person.

In this regard, the last detail that needs to be mentioned is that whoever is interviewed tends to present a positive image of themselves. In this case, the image that the caregiver tended to project was naturally that of being caring and affectionate, while the image that the reference person aimed to project, in cases where they were also the caregiver's employer, was that of being respectful of the caregiver's work, ready to appreciate it and willing to help them. It may also be assumed that, in the presence of the interviewer, both had some motivation to foster a positive image of their relationship.

We are well aware of these trends and, in fact, we found many statements consistent with this picture. On the other hand, however, the interviews reveal occasionally that the caregivers have had negative experiences of care, in which they did not feel respected, while the cases we have observed offer no evidence

whatsoever to suggest that such situations exist. In fact, we might assume that the cases we have identified are examples of successful care work. Sticking to this definition, we can conclude that what we have identified is not solely the result of a spontaneous desire to make a good impression but contains a kernel of truth that could help to indicate the reasons or conditions that determine whether the care work is successful or not.

4.1. Social capital

Care work is very demanding and often exhausting. It requires a high degree of mental effort and leaves little free time. For the family member providing care, it might feel like living in a prison camp.

> *We don't always manage it, because it's a heavy commitment, also because I'm in a situation that you don't know about. When you go out, you take your phone with you, you wonder if everything is OK, you're not free to do anything... I feel very lonely... psychologically lonely, being left alone.*

We did not ask questions about working conditions (including contractual conditions) because the focus of the survey was elsewhere, but it is clear from the interviews that pay is unsatisfactory and the work is very demanding.

A CG:

> *For me, it's a job, even from a humane point of view. It's a big sacrifice, but it has to be made, in the sense that I have to be grateful, in the sense that I've been doing this job for nine years; speaking from an economic point of view, not great in terms of quality of life, but it has allowed me to get by, to have a certain peace of mind.*
>
> *As far as I'm concerned, psychologically, it destroys us a bit.*

The all-encompassing nature of care work emerges from the words of this caregiver:

> *There was a lady who also worked as an in-home nurse, but she was off duty that day and was actually out for a walk. She approached me... she was sitting on one of those benches in the park, and she said to me: "Madam, unfortunately they eat up half of our lives". And it's true... This job engages you so much that it becomes sort of.. that I go home and talk about this lady.*

These people, unknowingly, in those conditions, kind of... I can't find the word... they suck your energy dry.

Our interviews reveal that care relationships entail a great deal of social capital in the form of mutual trust, reciprocal exchanges, mutual assistance and support. We find this both when there is a direct relationship between the CG and the PR (kinship or friendship) and when it is mediated by the person receiving care (in cases where there is a kinship between the PA and the PR). The CG provides care but often receives assistance in return from the PA, the PR and the family of the person being cared for. There are various forms of support that go beyond helping to care for the person being treated. They range from cash loans and help with bureaucratic matters to psychological comfort. Many CG are immigrants and need guidance in dealing with paperwork, for example, to apply for renewal of residence permits. However, precisely because they are immigrants, they often lack a social network within which to find support and so look for it in the family network of the person they are caring for. Often, in fact, the person they designate for dyadic interviews, and who provides them with support, belongs to the family network of the person being cared for (it may be the husband, daughter, or daughter-in-law). However, if they are assisted by other carers, they form a relationship with them that goes beyond the workplace.

These cases might suggest a general rule; when there is relative relational poverty, caregivers compensate for it by drawing on the social capital of the people they care for, the network of the person being cared for, and the caregivers with whom they are sharing the care work. This somehow demonstrates the self-generating capacity of social capital.

The rich network of people served by PRs is particularly evident in the assistance they offer in dealing with public administration and bureaucratic requirements related to foreign national status.

A PR on the subject of CG:

I put her in touch with Casa dei diritti (lit. House of Rights) for anything that might be useful in managing her affairs; or, for example, with the municipal social services, the social housing agency, now known as the "inclusion agency", to get help paying her rent. In other words, I shall also try to put her in touch with resources that may help and support her in her family. For her own sake, also because, if she is personally stable, she may continue to work as a carer... There is this important reciprocity.

A CG:

When there were problems, the relatives of the PA were there for me, and all the grandchildren helped me, including Mrs Irene's.

The rootedness in the neighbourhood engendered by the inclusion of the person being cared for in the family also generates forms of social capital.

There is a priest here that I know. When I am not working, I go to see him and he gives me groceries.

A foreign CG, via her uncertain Italian, explains that, in her relationship with the person with whom she shares caring duties for the person assisted:

... first and foremost, there is friendship... [when you are feeling unwell] you want someone who will listen to you ... who will say 'don't worry'... I found that in her, because my family is far away, my mother, my father, everyone, so if something happens and I am feeling unwell ... she is there for me.

In the only case involving an Italian caregiver, there is a greater amount of social capital than foreign CG in terms of knowledge of the area, integration into social networks and information on procedures for accessing resources and services for PA care. This greater endowment seems to be reflected in the quality of the relationship with the PR, which is less marked by dependence and exclusivity, as well as in greater clarity of roles and a different distribution of care tasks between CG and PR with respect to the PA.

These considerations suggest the need for future research aimed at broadening the empirical base to allow for a more systematic comparison between foreign and Italian CG in terms of social capital and its impact on care-related relationships.

4.2. The relationship with the services

One section of the dyadic interview was reserved for services. We asked our dyads to tell us about their experience with services, understood as the range of social and health care available in the local area. It is particularly significant that on numerous occasions the question was not even understood.

A caregiver:

What do you mean? ...ah...someone who comes to help us?...

Another:

I don't understand this question. From whom, sorry?

Another carer:

I don't know if I understand... the question.

Those who do not understand the question at first, when they do understand it, seem to be all alone in their work and with the person they are caring for. They say they only rely on their own forces.

Thank God my shoulders support me…

says one caregiver.

Others misunderstand and think of services related to the migrant situation and, therefore, how to obtain a residence permit or forms of support during critical periods when they are not working. As in this case.

Interviewer: *Who helps you the most?*
Caregiver: *I don't know.*
Interviewer: *None of the services help you?*
Caregiver: *No, none of them.*
Interviewer: *What kind of help would you like from services to be able to do your job well? From external services, what we were talking about earlier, the network. What kind of help would you like?*
Caregiver: *To do my paperwork.*

Some might mention the public transport network, which penalises them due to inconvenient timetables and connections.

One says that she would like psychotherapy for herself.

If services are being ignored, it is probably because they are not perceived as being available. When the person being cared for is under 24-hour supervision by in-home nurses, services are not needed but, on the other hand, it is like a dog chasing its tail: they are not needed because private arrangements have been made and the burden falls on the family. Our impression, as suggested by the interviews, is that if there were many more 'accessible and tangible' services, such as a general practitioner, families would be more inclined to seek additional support to supplement the caregiver's assistance.

In the organisation of services, there are no substantial forms of home care that can adequately relieve the burden of round-the-clock care. In the case of the city of Palermo, where most of the interviews were conducted, home care

(which includes housekeeping and administrative tasks based on a defined plan) is assigned for a limited period of time and for only a few hours compared to the needs of elderly people with specific economic and/or clinical and care requirements.

There are also fragmented welfare services (home rehabilitation, INPS home care premium only for state pensioners, etc.) that do not cover the family's need for 24-hour care. This is why some CGs say that the services are there, that doctors and physiotherapists come and do their part, and that they trust them (this is what family members say).

For the most part, when we think of services, we think of health services, not social services. In only one case does a respondent mention that a social worker came to see her. One respondent is particularly satisfied with the coordination between her doctor and the pharmacy, which means she can get her medication promptly and does not even have to leave her home. Others say that 'there is no need because the person being cared for is not that ill'. This is precisely why services are thought of in terms of healthcare. These statements tell us about the infrequent presence of services, especially social services, which are poorly considered and acknowledged.

4.3. Trust

In the case of care provided by 'paid outsiders' (Folgheraiter, 2011, p. 63), the trust required is not impersonal; it is not generalised trust linked to a formal role and therefore to professionality and professional ethics in the traditional sense or according to the canons of the classical professions. Instead, it requires focused trust (Roniger, 1992). The job offer that appears on the market is seen as inextricably linked to a demand for human reliability.

We were saying that dyadic interviews, as a means of assessing the relationship between CG-PA and PR, reveal a social reality characterised by strong elements of mutual aid, reciprocity and trust. It should be emphasised that trust is not to be understood solely as the employer's conviction, in the wider sense, that the CG is reliable and capable of taking care of the PA. There must be reciprocity: the CG must also be able to trust the employer who, in our own cases, is frequently (six cases out of ten) the CG's contact person. A PR on the subject of the CG:

> *So, I think that also from what you've told me... the problem... is that... in fact, you've met people you felt you couldn't trust. You're definitely at ease here because you know you can trust us, because here we have total and utmost respect for you as a person, for your work, your time and your peace of mind.*

A CG:

I chose [to be a CG for this person] the moment I met the family.

And another:

I always felt like I was part of the family.

A PR, daughter of a CG, recounts how her mother was once deceived by a colleague who aimed to replace her totally when she needed someone with whom to take turns, and explains:

Simply trusting another person to replace you... you need to have a lot of trust because there are so many responsibilities.

And then she adds that

... her mother gave herself the opportunity to ask for her help precisely because of a question of trust ... for her mother, it was certainly an important step to take to trust a family member.

In short, she had to turn to her daughter when needing to be replaced in her caregiving work.

It is also worth remembering that the caregiver takes on a responsibility, feels entrusted, feels that the vulnerable person being cared for has placed their trust in them. A caregiver who gets help from their offspring, the only person to whom they feel they can entrust the person they care for, says:

You can't take a day off ... because you're looking after a human being, out of necessity, not as a job. You send your son or daughter, because it's a help, it's something more for me.

But he himself points out, with regard to the person being cared for,

This person treats me like a son, not like a caregiver, because you know how it is... you give and you receive... he really lives [participates] with me, with my family [he knows] how my children are doing, how this one is doing, how he is feeling during the day, we also talk about my family... you understand... he is close to me, just as I am close to him, he is also close to me.

Trust must also exist between the individuals who care for the person receiving assistance, in their relationship with each other. One caregiver told us that another caregiver, hired to work with her, was scheming to get her fired and take her place:

> *A few years ago, they were looking for someone to help me, and that person came and tried to somehow convince them that they had to fire me so that she could stay on.*

4.4. Emotional involvement

For our interviewees and interviewers, the work is extremely demanding both physically and emotionally. 'It eats away at you,' as one of them told us. However, a strong sense of dedication and emotional involvement emerges, binding together the key figures in care work.

This is emphasised by the PRs when they talk about the relationship they observe between the CG and the PA, and it is confirmed by the reciprocal comments made by the CGs and PRs when they talk about their relationship with each other.

The son of a caregiver who helps him in his work

> *My father... taught me [to consider him] as one of the family. When you go... you mustn't feel it's a heavy burden, you must do it with pleasure first and foremost, otherwise it's pointless.*

The daughter of a person receiving care, speaking about the caregiver:

> *She has infinite patience. With my mother, infinite patience.*

Above and beyond social capital support, there is human and emotional capital that comes into play. Without this, even social capital would not function in the specific context of the caregiver's unique caregiving relationship.

It is as if care had its own intrinsic logic, whereby it involves the ability 'to become sensitive, permeable, vulnerable and responsive to others (human or non-human) and their needs for well-being' (Centemeri, 2021, p. 83). With the acuity and sensitivity of a great writer, Saul Bellow wrote that 'those on the front line [for him, nurses facing death] are more open to pure feelings than those in the rear' (2000, p. 227).

Not that instrumental relationships are lacking, nor can it be excluded that certain expressions of affection are self-interested. In some cases, the reference

persons who are relatives of the cared-for individual have a very strong dependence on the selflessness of the caregiver and thus have a strong motivation to recognize the quality of the caregiving work, also beyond its actual merits. However, for us, the emergence of this sort of relational social entity is unquestionable, consisting of something that goes far beyond caregiving activities carried out by strangers and remunerated (Barazzetti, 2006, p. 89).

The peculiarity of the social capital activated or generated in these relationships is that it seems to emanate from the affective and emotional world of the people involved. Although these are paid care relationships, social capital and trust do not seem to be activated here due to an expectation of reciprocal convenience as a reasoned view might suggest (in other words, it is beneficial for me to hire and pay you, and it is beneficial for you to be reliable in order to ensure the continuity of the position and the retribution). Even though these relationships involve paid strangers (Folgheraiter, 2011, p. 63), in these cases, the bond of affection seems to be what not only establishes mutual trust but also suggests that it has influenced the selection of the caregiver. In other words, the 'employers', essentially the relatives of the care recipient, have chosen the caregiver guided by that peculiar form of ethical discernment (Nussbaum, 2009) which is the emotional dimension of trust.

Let us imagine trust in action as a form of ethical discernment. Suppose that the reference person for the caregiver is the husband of the person being assisted: when he chose the caregiver, she obviously inspired trust. Now, this trust was not established based on a calculation, meaning that the person who had to hire her did not say to himself: since it is in your interests to do your job well, I shall hire you. No, this cannot have been enough. We can easily imagine that the choice was sparked off by an emotion (which accompanies trust) triggered by the caregiver in the person who is taking her on, or in the actual assisted person; furthermore, this emotion corresponded to a similar emotion in the other party. Do not entrust a loved one to strangers if you do not trust them, but trust would not be activated if it were not accompanied by some positive emotion regarding the relationship with the caregiver on the part of the person being entrusted and by the relative who will be entrusting them.

It is important to emphasize this aspect. Trust is linked to vulnerability and the ability to rely on others and is inseparable from the emotional dimension of relationships. One might even consider it an emotion in itself. Solomon, in Not Passion's Slave: Emotions and Choice (2003) and Martha Nussbaum, in The Intelligence of Emotions (2009), highlight the

emotional and moral nature of trust. Nussbaum sees it as a form of ethical discernment, as a component of ethical reasoning.

Considering trust from this perspective, the conditions for its generation cannot simply be traced back to a utilitarian outlook (the mutual expectation of convenience, benefit, or advantage). Certainly, this is not the case in the parent-child relationship, but what is notable for our investigation is the emergence of the emotional component of trust in a working relationship, in a rapport that could be viewed entirely from the perspective of mutual utility (the caregiver provides a service in exchange for remuneration that the assisted person or someone acting on their behalf has an interest in providing).

We believe that integrating the emotional component into the vision of trust (and social capital) allows us to go beyond an individualistic perspective (Coleman, 2005) and clarifies the specificity of the emphasis on the relational dimension referred to by Donati (2007). When it comes to the specifics of the interviews, if we use PR as evidence of the relationship between CG and PA, the dimension of emotional involvement is always present.

Focusing specifically on the interviews, when we employ PRs as eye-witnesses to the relationship between CG and PA, the dimension of affection is always present. It is a constant. The presence of affection in the relationship between PR and CG, on the other hand, is subject to some variability. Of course, if PR is related to CG, this goes without saying (in two cases, it is a parent-child relationship); if this type of relationship does not exist, affection, i.e. the fact that CG and PR are linked by a recognised and declared relationship of affection, is combined with the presence and declaration of strong ethical-religious motivations.

In the words of the protagonists:

> *At Mr. NAME's, I am doing very well... thank God, his behaviour towards me is as if I were their daughter... the first person I found to be good …*

A CG who comforts the daughter of the PA:

> *... you mustn't cry because Jesus doesn't want you to cry. He knows that you love your mother and has left me beside your mother. Go rest.*

And she explains that

> *...this is a house where my spirit wants to be... to work with Stefania, with sister, with brother, they treat me like a sister, in fact, I am happy.*

and the daughter replies:

Finally, I have by my side the sister I needed in taking care of my mother...

Another caregiver, after the death of the assisted person, goes to the cemetery with the assisted person's niece to visit the grave. She has continued to see the lady's family and brings 'ice creams' for the niece's children. She has emotionally bonded with the family, and for her, the death of the assisted lady is a reason for mourning.

A young PR, son of the caregiver, says, regarding his relationship with the assisted person:

Having a relationship with Mr. NAME is a nice thing, also because I talked a lot with him, like a grandfather, especially since I haven't been fortunate enough to know them all, especially the grandfathers.

A PR wants the CG that is currently taking care of the mother-in-law (once the mother-in-law is no longer there) to take care of the brother who is not self-sufficient.

I want you as a caregiver for my brother, because I see you as so humane, the right term is humanity... I get emotional because I'm already thinking about my brother, because no one loves him like I do, but Dalinda is an exceptional person for me.

And, in responding, the CG:

Thank you, I thank God because I have seen her as an angel for me and for the lady, also because I was unwell for a while, a month, my mother was in hospital, I feel that she is something more for me... she has a feeling when talking to the lady, if there is trouble, that I am not well, there is a very humane emotion, it is important that she is there.

Finally, a reference person who, however, is a caregiver:

You cannot do this job without having something inside, a feeling, a feeling of help, of support, of being useful, let's say, because I am not self-interested, I could never live only for myself; therefore, I like what I do…

5. Social capital in professional care relationships

Paid caregiving seems to be a good test of the conditions in which the constitutive elements of social capital are triggered. The person being assisted is 'entrusted' to the caregiver, and the certainty that they will receive adequate care cannot depend solely on their remuneration. On the other hand, even those who care for others in exchange for payment need support that is not only material. Caregiving can be particularly burdensome and can put a strain on the caregiver's nerves as well as their stamina. But, as we have seen, in some way motivational resources are activated, which draw on a sphere regarding sociality, affectivity, ethics, and religion.

We have seen that there is an activation of social capital where the caregiver acts as the activating agent. In the cases we examined, when the caregiver has little social capital, essentially because he/she is a foreigner, he/she uses the social relationships available to him/her, starting from the workplace, that is to say, from the family of the person he/she is looking after, to create social capital, meaning a network that is supportive, helpful, and comforting.

This is an aspect that we think should be emphasized. Studies show that caring for non-autonomous individuals can lead to a loss of social capital, especially if they are relatives. In our cases, although they are not relatives, caregivers who have little social capital strive to create it, but also find an environment, that of the family of the assisted person, receptive and willing to help.

We have said that there is no caregiving relationship without caring for the relationship itself. This should be understood in the sense that it is the system of relationships around the person being cared for that is nurtured. In our case, what we have found and learnt from our reports is that care concerns the relationship between the caregiver and the assisted person, as well as the relationship between the caregiver and the employer (who is often also a person with whom they share the work).

An initial manifestation of this care is, as mentioned previously, the generation of social capital from the scarce resources available at the grassroots level. Paid caregiving (i.e. caregiving as a job) is all-consuming, while eroding social capital, of which those who do it will most likely possess little. Consequently, social capital can be built up, starting from the relationships it can rely on, beginning with the network of the assisted person. Our small number of cases does not allow for any empirical verification, but it seems that caregivers who live in a condition of relative relational poverty, mainly due to their immigrant status, might seek in relationships activated by work, the opportunity to build up these relationships, in order to access new social capital.

The other manifestation of this care lies in the direction of the relationship with the reference person. As we said, the fact that strong elements of trust and affection emerge from this relationship, is implicit in the actual way the dyads of the interviews were created. Yet, inverting the perspective, we might consider that these components emerge because we are faced with care relationships that actually work. The reference persons indicated by the caregivers are also support figures for the caregiver in looking after the assisted person; we do find here, in this system of relationships that entail the remunerated care of a person, strong elements of trust, strong ethical and religious motivations, strong emotional bonds, and this is, most likely, because these are successfully functioning care relationships. And we thus return to our wordplay in which care relationships need to be cared for in order to be what they are.

6. Final considerations

In the network of relationships in paid care work for elderly people, social capital is triggered to support the caregiver. This is the result of a certain mobilisation on the part of the caregivers, who seek to build their own support network based on the relationships they have in a city or country where they are foreigners. They build relationships with employers, with the family of the person being cared for, and also with colleagues who assist them in their care work, from whom they receive assistance, guidance, and moral support. This form of social capital is complemented by another of a different nature, often linked to the relationship with the person indicated by the caregiver. In this case, care work is accompanied by, and perhaps engenders, the establishment of bonds that go far beyond the workplace.

There are evident forms of emotional attachment to the person being cared for and forms of attachment between the people who care for them. We also find strong ethical and religious motivations which, when shared, strengthen the bond: 'in order for people to cooperate with one another, they must be well disposed to do so; or, to put it another way, they must feel that they have something in common that motivates them to do so. If they share the same values, for example, they will be more inclined to cooperate to achieve a common goal' (Field, 2004, p. 9).

As previously stated, the number of our cases is far from comprising a basis for empirical verification, but we believe it is sufficient to put forward general hypotheses for future research. Care work, precisely because it is care work, is not merely a job. It is undoubtedly particularly demanding, but at the same time it requires extra motivation that draws on an area comprising deep

sociability, emotions and ethics, and which finds sustenance and support in the quality of the collateral relationships in which it develops.

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