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Social Support and Caregiving in Italy: The Specificities of Care Relationships

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Abstract

Informal caregiving is an invisible component of familistic welfare regimes, where the burden of care is predominantly delegated to primary networks. Drawing on a structural interactionist perspective, this article presents findings from an Italian national survey of 1,504 adults, analysed through personal network methods to investigate how network morphology shapes caregiving practices. Caregivers (19.8% of the sample) assist older people, persons with chronic illnesses, or persons with disabilities. Results show that caregivers belong to larger and denser networks than non-caregivers, reflecting strong bonding capital typical of familistic contexts; however, they display lower betweenness and ego-centric density, signalling limited brokerage capacity and reduced access to bridging ties. This structural closure reinforces the "total social fact" nature of caregiving, where mixed tasks of physical and administrative care predominate. The most significant of these is the fact that for all types of frailty, over a quarter of carers say they have no one to support them in their caregiving activities. Despite a certain uniformity across caregiving profiles, differences emerge: disability care is embedded in cohesive, inward-looking networks associated with higher burden; chronic illness care mobilises more open networks and higher satisfaction; elder care remains rooted in normative familial obligations. Across conditions, over one quarter of caregivers report lacking any support, while dissatisfaction with formal services highlights a dualised care regime unable to compensate for weak bridging social capital. These findings underscore the need for policies that expand caregivers' relational opportunities beyond primary networks. At the macro level, it does not seem necessary to distinguish policies by caregiver type. However, at the level of social intervention, it is considered appropriate to pay attention to some of the differences that emerged across the three profiles, such as the structure

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of their support networks, attitudes towards services, and respondents' future projections in their role as caregivers.

Keywords: caregiving, social support networks, social capital, structural interactionism, personal network analysis.

1. Introduction

In this article, we present the results of a national survey titled "Caregiving and social support in Italy". This survey was conducted as part of PRIN 2022 titled "Social capital as resource of care practice in Italy: Caregiving and social support in pandemic time"[1].

The survey presented here was conducted as part of the overall research project, following the structural interactionist sociological perspective (Degenne & Forsé, 2004; Tronca, 2013; Tronca & Forsé, 2022; Tronca & Sità, 2019). A key principle of this relational perspective is the need to interpret the actions of both individuals and groups as influenced by the social structure in which they are embedded. The social structure is viewed as the network of relationships that individuals are part of. The determinism associated with the actions of individual nodes in the network is considered "weak" because the network provides a range of possibilities for individual actions. People then choose how to act within these possibilities offered by the network. It should be noted that the range of possibilities defined by the network also includes the specific morphological qualities of the network itself. For example, a subject acting as a broker must be in a relational context where there are no relationships between some (or all) of the individuals with whom they interact. As Degenne & Forsé (2004, 10) point out, "une relation ne tire pas son sens du

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[1] Research Projects of Significant National Interest (RPNI) – "Social capital as resource of care practice in Italy: Caregiving and social support in pandemic time" – Prot. 2022B58JHF, Italia Domani – the National Recovery and Resilience Plan (NRRP) – Mission 4 "Education and Research" – Component C2, Investment 1.1, "Research Projects of Significant National Interest (RPNI)", Funded by the European Union – NextGenerationEU, Ministry of University and Research, CUP B53D23019350006 (Research Unit of the University of Verona). Principal Investigator: Prof. Donatella Bramanti (Università Cattolica del Sacro Cuore - Milano); Associated Investigator: Prof. Fabio Ferrucci (University of Molise); Associated Investigator: Prof. Luigi Tronca (University of Verona). Other members of the Research Unit of the University of Verona (Department of Human Sciences): Prof. Sergio Cecchi, Prof. Giorgio Gosetti, Dr. Giuseppe Grasso, Prof. Cristina Lonardi, Prof. Sandro Stanzani.

seul rapport entre deux individus" (a relationship does not derive its meaning solely from the relationship between two individuals). Ultimately, the social structure is the emergent effect of interactions among the individuals that comprise it.

From this perspective, the research aimed to describe the support networks of a sample of adults living in Italy, with particular focus on the help that becomes caregiving. The entire research project (Bramanti et al., 2025, in this issue), which includes the national survey presented here, aimed to investigate the relationship between social capital, social support, and caregiving, initially through qualitative methods and subsequently through quantitative methods. The qualitative surveys allowed researchers to explore issues such as caregiving for individuals affected by aging, chronic illness, or disabilities. As a result, the research team developed a strong foundation of methodological and empirical expertise related to the sociological perspective used here, which was essential to addressing the research topic. The qualitative investigations significantly contributed to the development of research tools for the quantitative study and informed the hypotheses guiding data analysis. After examining the concepts used in this survey (paragraph 2) and outlining the methodology (paragraph 3), the survey results will be presented (paragraph 4) and discussed (paragraph 5), with particular focus on the caregiving conditions for people experiencing aging, chronic illness, and disabilities.

2. From social capital to caregiving: the theoretical background

2.1 Social capital, social support and caregiving

In line with the structural interactionist theoretical perspective (Forsé & Tronca, 2005), social capital refers to network contexts capable of providing support (Burt, 2000; 2005; Chiesi, 1999; Degenne & Forsé, 2004; Di Nicola et al., 2011a; Forsé, 1997; Lin, 2001): in this sense, an individual's social capital is determined by the size, content, and shape of their personal support network. Social support, on the other hand, refers to "the aid – the supply of tangible or intangible resources – individuals gain from their network members" (Song et al., 2011, p. 118).

Social support, therefore, depends on social capital, as understood here, in the sense that it coincides with the content actually mobilised for support within the personal network. As clarified in Song et al. (2011, p. 119), "Social capital is a source of social support since network members' resources are drawn for various supportive purposes". Ultimately, social support can be seen as mobilised social capital: a social resource when it is utilised.

As we will see, caregiving is essentially social support, which is mobilised social capital provided with particular frequency to individuals in specific need. The concept of social support is closely linked to wellbeing and health: it especially highlights the connection between relationships, networks, and wellbeing and health (Meo, 1999; Song et al., 2011). This theoretical element also enables us to focus on its strong connection with the idea of social capital.

Since its appearance on the social science scene, the concept of social capital has been regarded as a resource for the proper functioning of organisations and social systems, as well as for promoting individual well-being.

The research discussed here focuses on the role that social relationships play in care and in the promotion of individual well-being, concentrating in particular on the support networks of people in specific situations of vulnerability (ageing, chronic diseases/illnesses, disabilities) and of their caregivers.

The adopted definition of caregiving in this work aligns with the approach used in the European Health Interview Survey (EHIS) conducted in Italy in 2019 by Istat (2022, Table 6.1.1). In the EHIS, a caregiver is defined as someone who provides care or assistance at least once a week to individuals with issues related to ageing, chronic diseases, or infirmity (Istat, 2022, table 6.1.1). In this study, "infirmity" is understood as "disability" to minimise confusion with aging and chronic illnesses, and to aid respondents in recognising persons with disabilities as those who receive assistance from them.

Research on the supportive role of social capital in relation to perceived well-being and health has developed within a well-established tradition, in which many scholars have reflected on the supportive functions of social relationships. As early as the 1970s, studies began to appear on social support (Cobb, 1976; Cohen & Syme, 1985; Lin et al., 1986; Di Nicola, 1986; Willmott, 1987; Sarason et al., 1990) and on the "buffering effect" (Lin et al., 1985) performed by social relationships. Building on this line of research – which, moreover, seemed to have lost some of its momentum – the concept of social capital considerably revitalised theoretical reflection and empirical research. To facilitate empirical investigation, the concept was elaborated internally, leading to a number of distinctions within social capital: collective/individual, community/individual, structural/cognitive, and others. At the same time, for an empirical study, the concept of well-being was also examined from several perspectives: physical/psychological/social well-being; organic well-being; and subjectively perceived well-being.

Many empirical studies have linked the constructs of social capital and well-being by combining these various analytical perspectives. Despite the complexity introduced by different angles of observation, much of the research identifies a positive correlation between social capital and well-being, regardless of the perspective from which the two concepts were operationalised. Some studies detect a positive correlation between well-being and collective or community social capital (Kawachi et al., 1999; Bjørnskov, 2003; Brown et al., 2006; Scheffler et al., 2008; Fujisawa et al., 2009), while others identify it between individual social capital and well-being (Fujisawa et al., 2009; Bolin et al., 2003; Fiorillo & Sabatini, 2011a; 2011b; Poortinga, 2006). However, studies find no relationship between social capital and well-being (Veenstra, 2002; Kennelly et al., 2003). Others do not find such a relationship for specific dimensions of social capital (D'Hombres et al., 2010; Mansyur et al., 2008; Rocco & Suhrcke, 2012). Still others identify negative associations between the two variables (Smith & Christakis, 2008; Scheffler et al., 2008; Brown, 2006; Moore et al., 2009). The survey presented in the following pages focuses on a specific form of social capital: care relationships within primary networks. In particular, it investigates the role of the caregiver as a source of support, the type of social support they receive from their support network, and the resulting impact on the caregiver's subjective well-being.

Caregiving is a complex social phenomenon that takes many forms and for which different definitions have been adopted. Eurocarer defines caregivers as "people of any age who assist (usually without remuneration) to those affected by chronic illness, disability or other health or ongoing care needs, outside of a formal or professional employment relationship" (Eurocarer, 2018). In Italy, there is currently no national legislation on this subject. However, the 2017 budget law defined the family caregiver as "the person who assists and cares for their spouse, partner in a same-sex civil partnership or cohabiting partner within the meaning of Law No. 76 of 20 May 2016, a family member or relative up to the second degree, or, in the cases indicated in Article 33, paragraph 3, of Law No. 104 of 5 February 1992, a family member up to the third degree who, due to illness, infirmity or disability, including chronic or degenerative conditions, is not self-sufficient and able to take care of themselves, is recognised as disabled as needing comprehensive and continuous long-term assistance pursuant to Article 3, paragraph 3, of the aforementioned Law No. 104 of 1992, or is entitled to a carer's allowance pursuant to Law No. 18 of 11 February 1980"[2]. This definition first identifies the subjects of the caregiving relationship: on the one hand, those who provide care and, on the other, those who receive care. The latter must be in a condition of non-self-sufficiency such that they are unable to take care of themselves. Secondly, the legislative measure identifies two characteristics of the caregiving relationship that imply assistance: i) "comprehensive", relating to the performance of activities of daily living, and

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[2] Law 27 December 2017, n. 205*, Bilancio di previsione dello Stato per l'anno finanziario 2018 e bilancio pluriennale per il triennio 2018-2020*, art. 1, comma 255.

ii) "long-term". This definition includes family caregiving relationships that take different forms and have different qualities. In part, the differences depend on how the various conceptual approaches adopted in the study of ageing and disability processes conceptualise phenomena such as dependence, autonomy and vulnerability. For example, while caregiving relationships for older people are usually interpreted within the framework of "frailty" and the end of the life cycle, caregiving relationships for young/adult people with disabilities are framed in terms of rights and participation throughout the life cycle (Era et al., 2024; Leahy, 2021).

2.2 Caregiving and the conditions of frailty

Greater longevity has become an established fact. However, the expanding elderly population, partly due to advances in medicine and the consequent increases in life expectancy, brings with it new social challenges. The ageing process inevitably involves a progressive loss of functional abilities and an increase in comorbidities (Dessi & Rusmini, 2015). Moreover, economic difficulties are increasingly becoming important limiting factors (Trabucchi, 2021). These aspects regard the individual, but inadequacies may also be present at the public administration level in relation to both meeting the present needs of an aging population and planning future policies (Maino, 2021).

ISTAT data estimate that by 2050 the society aged 65 years and over could constitute 34% of the total Italian population (median scenario), while those aged 85 years and over could reach 7.2% (median scenario), representing an increase of over three percent with respect to 2024[3].

The role of the family caregiver (also known as an informal caregiver) is of great social importance. The care they provide is "informal" in the sense that it is given without any expectation of monetary compensation. Caregivers perform a wide range of tasks, from daily routine activities such as preparing meals, bathing, and helping the person being cared for to get dressed to instrumental activities including transport, financial management, and housekeeping. They also provide emotional support and companionship, as well as nursing and medical tasks such as administering injections and treating specific disorders (Li & Song, 2021).

Pesaresi (2021) profiled caregivers in Italy using ISTAT data and estimated there to be around 7.3 million informal caregivers in Italy, predominantly

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[3] https://www.istat.it/wp-content/uploads/2025/07/Report_Previsioni-della-popolazione-residente-e-delle-famiglie_Base-Base-112024.pdf (accessed 20th November 2025).

women aged between 45 and 64 years (53% of the total), although a significant proportion were also older (18.6%). A study performed by Pasquinelli in 2019 on caregivers in the Lombardy region of northern Italy found the average caregiver age to stand at 60 years. Subsequent research by Pesaresi (2021) revealed that the average age of caregivers had increased to 62 years.

The age difference identified in these two empirical studies indicates that caregivers are also ageing.

Caregivers need to exhibit considerable flexibility and adaptability, not only to meet the needs of the care recipient but also in order to balance personal economic and relational resources. Indeed, those who assume the role of caregiver are often compelled to work fewer hours or leave their jobs. Conversely, individuals who have to continue working while also caregiving, due to a lack of alternatives, may experience burnout (Cejalvo et al., 2025; Honda, 2025).

Caregivers may be able to receive formal support through welfare services, however, informal support arising from the caregiver's network tends to play a more central role, being far more immediate and flexible. Investigating the informal help that caregivers receive from their support networks offers an opportunity to understand the mechanisms that enable caregivers to cope with the daily challenges of informal caregiving.

Qualitative research, based on interviews held with dyads of caregivers and their supporter (Bramanti & Carradore, 2025, in this issue), demonstrated access to open networks and bridging social capital to be predictors of greater well-being in the caregiver. The study aimed to verify whether individuals who are part of bridging networks experience greater well-being than caregivers whose networks are predominantly bonding in nature.

2.3 Caregiving and people with chronic illnesses

There is a category of people who find themselves in a situation requiring informal caregiving very similar to that described in the previous paragraph. They are persons under the age of 65 suffering from chronic illnesses. Among the severely disabling chronic conditions, there are some which, although they do not give rise to recognition of disability status and although they are not elderly, require daily assistance and care within the family. These are for instance people with oncological, neurological (Parkinson's, multiple sclerosis, epilepsy), psychiatric and other conditions. They are considered in this research by asking the caregiver interviewed to classify the person they have cared for at least once a week over the course of a year as a chronically ill person who is not disabled or elderly.

There are no precise data quantifying how many people under the age of 65 need the support of family caregivers. Through monitoring conducted in the two-year period 2023-24, the Italian National Institute of Health found that 57% of people over the age of 65 had been diagnosed with a chronic condition, as had 18% of those aged between 18 and 65. However, it is not known how many of these people require support from family carers.

In projecting the quantitative survey, we referred to a qualitative stage of research which results are published in this issue (Lonardi & Tronca, 2025, in this issue). The qualitative research was conducted through eight in-depth interviews with eight individuals who provided support during the pandemic to people who contracted COVID-19 and had no other chronic conditions, and eight individuals who provided support during the pandemic to people with chronic conditions who did not contract COVID-19. From the content analysis emerged a number of working hypotheses that are relevant to the data analysis to be conducted here.

Firstly, the interviewees found it difficult to define themselves as carers, as the helping relationship within parental networks is not considered a specific role, but a common relational modality. It also emerged that help within support networks conveys many different resources: instrumental, emotional, informational, advisory, psychological support, recognition and self-esteem, to the extent that primary support networks can be considered a total social fact which, with regard to helping relationships, operates in the so-called area of non-uniform tasks (Litwak, 1985; Di Nicola, 1986). Furthermore, the interviews revealed that illness is capable of mobilising network resources even outside the family circle, involving relatives, friends and even neighbours, although it appears that this phenomenon was limited to the period of the pandemic.

2.4 Caregiving and persons with disabilities

Empirical psycho-social research has highlighted how care relationships involving young and adult persons with severe or very severe disabilities take on characteristics that differ from those of care relationships with older people who are not self-sufficient (Kittay, 2019, 1999; Freitag, 2018; Sanderson et al., 2017; Power, 2016; Talley & Crews, 2012). Among these, the protracted duration of the care relationship over many years is particularly significant. Parents – very often the mother – care for a child born with a congenital disability from infancy through to adulthood, giving rise to the phenomenon of perpetual parenting (Jenning, 1987; Kelly & Kropf, 1995; Seltzer et al., 2011; Seltzer et al., 2018). Within the framework of the present study, perpetual parenting can be understood as a relational phenomenon emerging from the intersection of micro-level dynamics (family ties, moral responsibilities), meso-level structures (social and community networks), and macro-level contexts (welfare models, disability policies, cultural norms).

In cases of particularly severe functional limitations, the activities associated with the growth and development of persons with disabilities require intensive and continuous care relationships, generating strong interdependence between those who assist and those who receive it (*linked lives*) (Bengtson et al., 2011). The pervasiveness of the care task and its continuity over time render the care relationship all-encompassing, often becoming burdensome for family caregivers (Resch et al., 2010). The relationship becomes particularly demanding at key points in the life-course transition of the person with a disability – from adolescence to adulthood and then to ageing. At each of these stages, social expectations of autonomy, available services, and the individual's rights change. It is at such junctures that social support becomes essential.

The qualitative investigation conducted with a sample of caregivers of adults with disabilities (Ferrucci & Monteduro, 2025 in this issue), confirms findings reported in similar research. On the one hand, caregivers experience chronic stress, social isolation, and financial strain; on the other, they recognise that the care relationship is also a source of gratification and existential meaning (Todd & Shearn, 1996). Furthermore, the future of their disabled sons and daughters once the parents who have cared for them over many years are no longer present – the so-called "after us" (*Dopo di noi*) – is a significant concern for the interviewed caregivers. The future represents a "sword of Damocles" that materialises whenever caregivers lift their gaze from the demands of the present (Walker & Hutchinson, 2018).

Perpetual parenting tends to consolidate into an all-encompassing identity role, limiting the caregiver's autonomy, undermining their well-being, and jeopardising both family balance and the long-term sustainability of the care relationship. Social support from others (emotional, instrumental, and informational) mediates the effects of stress and burden on caregivers of persons with disabilities, thereby enhancing their well-being (Sanderson et al., 2024). Seltzer et al. (2018) show that parents with strong support networks exhibit fewer depressive symptoms over time, maintain greater social engagement and decision-making autonomy, and are better able to delegate care tasks to services or to other members of their network. When the individuals providing support are other family members (spouse, children) or relatives, cohesive yet narrow networks may develop, reinforcing bonding social capital but limiting opportunities to generate bridging social capital by establishing relations with social worlds beyond the family or kinship network. At the same time, relationships with institutions and services are weak, being grounded in low levels of trust. When support networks are weak, the family tends to remain the only reliable agency. Low levels of bridging social capital make access to services more difficult, thereby increasing the care workload of parents of persons with disabilities. The all-encompassing nature of the care relationship reduces the caregiver's time to cultivate relationships – and relational networks – outside the family context, heightening isolation and reinforcing the role of perpetual parent.

The qualitative investigation also showed that bridging social capital generates more open and cooperative care networks, in which caregiving can become a collective process shared among the family, professionals, public services, and voluntary associations, rather than solely an individual obligation. In short, bridging social capital would not eliminate the need for perpetual parenting. However, it would change its form: from an all-consuming identity to a relational role supported by a community of care.

3. Method

Social support can be effectively studied using social network analysis research tools (Fernández-Peña et al., 2022; Song et al., 2011). Regarding the study of social support through SNA, the following points emerge, among others:

- The examination of social support for caregivers is of significant interest (Campana, 2004; Fernández-Peña et al., 2022);
- One of the limitations identified in the literature concerning social support is that it has been minimally studied from the perspective of those who provide it and in relation to its (possible) reciprocal nature (Song et al., 2011, p. 122): "the mainstream social support literature focuses on received support rather than providing support".

Social support was studied, focusing on the support actually provided or received from an individual's personal support network. Specifically, the study examined the size of the personal support network and its contents, such as social resources (Forsé, 1997; Lin, 1995; 1999; Van der Gaag & Snijders, 2004; Donati, 2007; Tronca, 2007; Di Nicola et al., 2011a; Tronca, 2013), the information conveyed by it, and its structure, which itself serves as a specific bonding or bridging support function (Forsé, 1997; Burt, 2000; 2005; Tronca, 2007; 2011; Wellman, 2007).

The quantitative research study "Caregiving and social support in Italy" was conducted on a sample of adults living in Italy, enabling the assessment of individuals' likelihood of providing social support and, when appropriate, assuming the role of actual caregivers. The characteristics of individuals' personal support networks, in terms of content and structure, were distributed nationally according to the parameters used to determine the sample quotas. The study enabled the testing of hypotheses related to specific aspects of personal life and areas of interest considered in the initial qualitative phase of the broader PRIN 2022 survey, through a process of confirmation or falsification. This research was carried out using personal network analysis (Tronca, 2013) on a sample of 1,504 adults residing in Italy (theoretical sample: 1,500). The research company SWG S.p.A. of Trieste, Italy, was responsible for constructing the sample, digitising the questionnaire developed by the PRIN 2022 research team, and collecting and organising the data. Based on data from the Italian National Institute of Statistics (Istituto Nazionale di Statistica – Istat) regarding adults living in Italy as of January 1, 2024[4], a sampling plan was created based on the following parameters (the percentage of cases in our sample are shown in brackets): (i) gender (males = 48.5%; females = 51.5%); (ii) age groups: 18-24 years (8.2%), 25-34 years (12.6%), 35-44 years (14.2%), 45-54 years (18.3%), 55-64 years (18.4%), over 64 years (28.3%); (iii) geographical area of residence: North-west[5] (27.3%), North-east[6] (19.3%), Centre[7] (20.0%), South[8] (22.7%), Islands[9] (10.8%)[10]; (iv) size of municipality: up to 5,000 inhabitants (16.5%), 5,001 to 10,000 inhabitants (14.0%), 10,001 to 30,000 inhabitants (24.6%), 30,001 to 100,000 inhabitants (21.7%), 100,001 to 250,000 inhabitants (7.8%), over 250,000 inhabitants (15.4%); (v) citizenship: Italian (90.6%), non-Italian (9.4%). While the first three parameters were cross-referenced with each other, the fourth and fifth were used solely to reference the totals of their respective categories to determine the sample quotas. We want to point out that the distribution of cases concerning the last two parameters generally appears balanced when cross-referenced with the first three parameters. Most importantly, they do not arise from the cross-referencing of variables associated with the parameters of the empty cells.

To ensure that particular attention was paid to the different segments of the sample regarding their potential IT skills, the questionnaire was administered using CAWI (Computer Assisted Web Interviewing) to subjects

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[4] The reference population includes 50,061,225 people (source: National Institute of Statistics – Istat, "Demo – Demografia in cifre", see https://demo.istat.it, last accessed: 21/11/2024).

[5] Regions in this area include Piedmont, Aosta Valley, Lombardy, and Liguria.

[6] Regions in this area include Trentino-South Tyrol, Veneto, Friuli-Venezia Giulia, and Emilia-Romagna.

[7] Regions in this area include Tuscany, Umbria, Marche, and Lazio.

[8] Regions in this area include Abruzzo, Molise, Campania, Apulia, Basilicata, and Calabria.

[9] Regions in this area include Sicily and Sardinia.

[10] Because of rounding, the total percentages might vary slightly from 100.0%.

aged 18 to 64 and using CAPI (Computer Assisted Personal Interviewing) to those over 64. The 1,078 subjects under 65 interviewed were selected from a random sample drawn from the SWG S.p.A. online research community, which includes over 60,000 profiled members. Respondents aged 65 and older (426) were identified using the random walk technique. Data collection occurred between December 4 and December 19, 2024[11].

As expected, besides collecting data on individual respondents' characteristics, the survey employed tools for gathering and analysing relational data typical of social network analysis, specifically in the form known as personal network analysis (Di Nicola et al., 2011b; Tronca, 2013; Tronca & Secondulfo, 2023)[12]. The personal network analysis conducted in this survey aligned with those used in qualitative studies and followed the cognitive network detection approach (Chiesi 1999; Tronca 2013). It involved administering a name generator to respondents (egos) to identify the list of alters they had assisted at least once in the past 12 months, as well as an additional integrative name generator to complete the survey of each respondent's personal support network over the last year – identifying the alters from whom they received support but to whom they did not provide support. Here is the first name generator's text: "In everyday life, we sometimes have to deal with needs or solve problems. Very often, it is essential to rely on the help and support of the people we are in a relationship with. Let us now talk about the people to whom you provided free support or help in the past 12 months and whom you may no longer support or help today. Could you indicate below how many people you provided support or assistance to in the past 12 months, even for a short or very short period, when they needed it in their daily lives? (N.B.: also consider your family members)". Here is the text of the second name generator: "How many people, other than those we have mentioned so far, have provided you with support or help, in the past 12 months, even for a short or very short period, when you needed it in your daily life? (N.B.: also consider your family members)".

For technical reasons, a maximum number of alters to be indicated had to be set for both name generators. Multiplying the average number of alters useful in case of need, which is 2.86 as identified in the latest survey of this type

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[11] To reach 1,504 interviews, a total of 6,290 contacts were required. Along with the interviews, this resulted in 4,368 refusals – including uninterested individuals and community members who did not open the email invitation to participate – and 418 out of quota.

[12] Data collection was conducted in Italian. For each question, the options "I don't know" and "I prefer not to answer" were always available. Unless otherwise specified, the data shown exclude these responses, which are considered missing.

conducted on a sample of adults residing in Italy in 2022 by the Household Consumption Monitoring Centre of the Department of Human Sciences at the University of Verona (Tronca, 2023), by four, a maximum value of 11 alters was determined for each of the two name generators (maximum identifiable total: 22 alters). These amounts were also found to be sufficient in the qualitative research conducted during PRIN 2022, as per this model (Lonardi & Tronca, 2025; Cecchi et al., 2025). Moreover, an even higher number of alters would have made data collection with the name interrelator too complex, which will be discussed shortly.

Each name generator was followed by a number of name interpreters, i.e., questions useful for collecting personal data on alters and additional relational data on ego-alter bonds. For practical reasons, we present only the name interpreters related to the first name generator, but we would like to point out that the name interpreters used for the second name generator were identical, with the only difference being that those related to caregiving were not used, as they were only used for the first name generator, since we were interested in identifying respondents who were caregivers. The name interpreters were preceded by this text: "We now ask you to indicate some of the characteristics that these people have or had (if they are deceased), whose number you have just mentioned and whom you have helped by providing them with support or assistance when needed in their daily lives". Here is the information collected with the relevant name interpreters and related to the alters or the relationship between the ego and each of its alters: a) Gender[13]; b) Age in years[14]; c)

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[13] Valid values: 1) Male; 2) Female; 3) Other.

[14] For individuals identified with the second name generator, the minimum age that could be selected was 14, in accordance with research conducted by the Household Consumption Monitoring Centre of the Department of Human Sciences at the University of Verona (Tronca, 2023).

Educational qualification[15]; d) Social circle[16]; e) Help during this period[17]; f) "In the past 12 months, were you the caregiver for this person? A caregiver is the main person who provides care or assistance, at least once a week, to a person with problems due to ageing, chronic conditions or disabilities"[18]; g) (if applicable) "Are you the caregiver for this person during this period?"[19]; h) (if applicable) "What kind of problems does/did the person you are/were the caregiver have? (multiple answers possible)", followed by the responses: 1) Problems due to ageing; 2) Problems due to chronic conditions; 3) Problems due to disability.

Both name generators were then provided with name interpreters designed to identify the content of social support, in line with the adopted theoretical approach. Here is the general wording of the question: "In particular, what kind of support or help have you provided or are you providing to each of these people? (more than one type of support per line)". To identify the different types of assistance provided by the ego or obtained from the alters identified with the second name generator, we used the relational version of Parsons' AGIL scheme, which includes symbolic and generalised means of exchange (Donati, 1991), used for the study of social capital (Tronca, 2007), in this case in terms of social resources actually mobilised, i.e., social support. Here are the contents of the help detected. The reference to the AGIL schema, in its relational version, is indicated in brackets: Money [A]; Other material assistance,

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[15] 1) No educational qualification; 2) Primary school certificate; 3) Middle school certificate; 4) 2-3 year upper secondary school vocational qualification (level II) that does not allow enrolment at university; 5) 4-5 year upper secondary school leaving certificate (level II) that allows enrolment at university; 6) Non-university tertiary diploma (academy of fine arts, conservatory, etc.); 7) Degree (all types including the university diploma); 8) Level I or II Master's degree, Specialisation diploma; 10) PhD.

[16] Name interpreter's text: "This person is/was (if deceased), for you (if, in theory, you can indicate more than one answer, indicate the one that appears first in the list: for example, if, for one person, you could indicate both 'Relative not living with you' and 'Neighbour', indicate 'Relative not living with you'). Valid values: 1) Partner living with you; 2) Partner not living with you; 3) Relative/family member other than your partner, living with you; 4) Other person, not a relative and other than your partner, living with you (in the corresponding name interpreter connected to the second name generator: 'Other person, not a relative and other than your partner and not a professional helper, living with you'); 5) Relative not living with you; 6) Friend; 7) Neighbour; 8) Work colleague; 9) Association colleague; 10) Other (specify: ___).

[17] Name interpreter's text: "Are you still assisting this individual during this period?". Valid values: 1) No; 2) Yes.

[18] 1) No; 2) Yes.

[19] 1) No; 2) Yes.

e.g., personal care (cooking, personal hygiene, etc.), accompanying to a medical appointment, etc. [A]; Information [A]; Reputation and credentials (the fact that you know them has increased the attention, esteem and/or consideration that this person has enjoyed/enjoys from others and therefore the possibility of achieving their goals: for example, this person has contacted a professional on your behalf who has helped them) [G]; Contacts and interpersonal connections (introduced this person to someone who could help them: for example, introduced this person to someone who became part of their support network and helped them) [I]; Did you provide this person with the most appropriate strategies to achieve their goals (e.g., in terms of advice, moral or psychological support, reassurance, an opportunity to vent, etc.) [L]; Other (specify: ___).

Finally, the morphology of the personal support networks identified using the two name generators was examined with a name interrelator. This question allowed each personal support network to be reconstructed as a directed graph centred on the ego. Thanks to this, support links were recorded over the past 12 months between all the alters identified and those indicated by the first name generator ego: "Overall, in the past 12 months, were there any bonds of support or help, in case of need in daily life, between the people you mentioned and towards you from those you helped? Answer, indicating for each person you mention, considering them in the row, whether they have provided support or help, in case of need in daily life, to each of the others listed in the columns. Consider that a person CANNOT have helped themselves".

Regarding personal support networks, we will examine the following structural characteristics of egos (i.e., respondents) or their graphs, in addition to the overall size, which is the total number of alters (Chiesi, 1999; Wasserman & Faust, 1994)[20]:

(i) Outdegree and indegree: These refer to the outgoing and incoming degrees of nodes, respectively. Outdegree is the number of alters that ego helps, while indegree is the number of alters from whom ego receives help.

(ii) nOutdegree and nIndegree: These are the normalized versions of the two measures just seen, obtained by dividing each measure by the total number of alters that make up the graph of each ego. These measures range from 0 to 1.

(iii) nBetweenness: This is the normalised Freeman's betweenness index (Freeman, 1979). It is a global centrality measure, also calculated for egos, which

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[20] Along with the authors, Giuseppe Grasso (University of Verona) and Giuseppe Monteduro (University of Molise) contributed to analysing the data received from SWG S.p.A., helping to determine structural measures. The data for individual respondents were processed using IBM SPSS Statistics version 23 (Release 23.0.0.0). The relational data, which were then assigned to respondents, were obtained using Ucinet 6 software (Borgatti et al., 2002).

considers their ability to occupy the shortest paths connecting all pairs of alters and, therefore, to act as mediators. This measure can be calculated if there are at least two alters in the personal support network. We will present the normalised version of this index as a percentage.

(iv) Density and ego-centric density: density is a characteristic of the entire graph, defined as the ratio of actual direct ties to all possible direct ties. This measure can be calculated if there is at least one alter in the personal support network. Its ego-centric version is calculated by removing the ego (i.e., the respondent) and their ties from the graph (Scott, 2000), providing insight into how connected the alters are to each other independently of the ego's mediating role. This measure can be calculated if there are at least two alters in the personal support network. The density and ego-centric density range from 0 to 1.

This section concludes with clarification regarding the identified caregivers. It notes that different conditions of need – such as aging, chronic illness, and disabilities – can apply to different alters, and sometimes to the same alter. This creates overlaps among the three caregiver groups based on these conditions. To address this, comprehensive analyses were performed on all individuals who identified as caregivers, followed by comparisons among the three subgroups. The caregiver analyses focused on a specific part of the questionnaire dedicated solely to those who reported being caregivers.

4. Results

4.1. Social support in Italy

As shown in Table 1, overall, outgoing and/or incoming personal support networks have an average size of 2.98 individuals. We should add that the mode is 2, with 26.3% of respondents, while we note that 11.6% of them do not have any support links. Before going into detail about the relationships between this variable, the other social support indicators, and the variables used to identify the sample quotas, we provide some general information about these networks as a whole.

First, let's present the characteristics of alters (for egos that, obviously, have at least one). From a gender perspective, we observe that, on average, egos with at least one alter have 1.36 males[21], 2.00 females[22], and 0.01 others[23] in their personal support network. The alters around the egos have an average age

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[21] Min=0; max=10; SD=1.42; n=1,153.

[22] Min=0; max=15; SD=1.77; n=1,153.

[23] Min=0; max=1; SD=0.07; n=1,153.

of 55.67 years[24]. To carry out a summary analysis of the alters' educational qualifications, they were grouped as follows: (1) No educational qualification/Primary school certificate/Middle school certificate; (2) 2-3 year upper secondary school vocational qualification (level II) that does not allow enrolment at university/4-5 year upper secondary school leaving certificate (level II) that allows enrolment at university; (3) Non-university tertiary diploma (academy of fine arts, conservatory, etc.)/Degree (all types including university diploma); (4) Level I or II Master's degree/Specialisation diploma/PhD. The first category has an average of 1.02[25] alters, the second 1.20[26], the third 0.78[27], and the fourth 0.13[28].

Let's now examine the social circles to which alters belong. The most common circle in personal support networks is that of relatives not living with the ego, averaging 1.01 alters[29]. This is followed by friends, with 0.89[30], relatives/family members other than partners living with the ego, with 0.43[31], partners living with the ego, with 0.23[32], neighbours, with 0.20[33], partners not living with the ego, with 0.11[34], work colleagues, also with 0.11[35], other persons who are not relatives or the ego's partner (and not professional helpers), living with the ego, with 0.04[36], association colleagues, with 0.02[37], and finally, other persons again with 0.02[38].

This descriptive overview of personal support networks ends with some information on the homophily of relationships with others, concerning gender, age, and educational qualifications.

45.1% of respondents have a personal support network where same-gender relationships are more common than different-gender ones[39].

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[24] Min=4; max=98; SD=17.64; n=1,086. This is the mean of the average ages of the alters associated with each ego.
[25] Min=0; max=8; SD=1.25; n=1,007.
[26] Min=0; max=12; SD=1.48; n=1,007.
[27] Min=0; max=9; SD=1.26; n=1,007.
[28] Min=0; max=4; SD=0.45; n=1,007.
[29] Min=0; max=10; SD=1.26; n=968.
[30] Min=0; max=13; SD=1.50; n=968.
[31] Min=0; max=5; SD=0.86; n=968.
[32] Min=0; max=2; SD=0.42; n=968.
[33] Min=0; max=6; SD=0.59; n=968.
[34] Min=0; max=3; SD=0.35; n=968.
[35] Min=0; max=4; SD=0.43; n=968.
[36] Min=0; max=5; SD=0.29; n=968.
[37] Min=0; max=3; SD=0.17; n=968.
[38] Min=0; max=2; SD=0.15; n=968.
[39] n=1,153.

Considering, for age, a variability range of +/- 10 years relative to ego's age (Warde & Tampubolon 2002)[40], we see that the average age of alters falls within this range for 37.9% of egos, while in 37.8% of cases the alters are older, and in 24.2% they are younger[41]. When we narrow the range to +/- 5 years (Di Nicola et al. 2011b), 23.8% of egos have a homophilic network based on age, with 46.2% having alters older than themselves, and 30.0% having alters younger[42]. The analysis of homophily based on educational qualifications – comparing the educational levels of egos and alters using the four-category version of this variable (see above) – shows that 33.9% of egos have a network mostly composed of alters with the same educational qualification. In 28.3% of cases, alters with lower qualifications are more common; in 15.2%, alters with higher qualifications prevail; and finally, in 22.6% of cases, there is no clear majority in the educational qualifications among alters[43].

Let us now examine the social support indicators, beginning with size and morphological indicators. Regarding the relationship between outdegree and indegree, we observe that outgoing support links are reciprocated by ego links an average of 1.49 times[44].

Table 1 presents the relationships among these indicators and the variables used to determine the sample quotas, along with their overall distribution. Specifically, ANOVA[45] and Pearson correlation analyses were conducted.

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[40] Please note that the age range of respondents is 18-91 years old.

[41] n=1,086.

[42] n=1,086.

[43] n=1,002.

[44] Min=0; max=11; SD=1.91; n=1,088.

[45] When Levene's test was statistically significant, the Brown-Forsythe test was used instead of the F-test. When there were at least three groups in the independent variable, post hoc tests were also considered: Tukey's HSD post hoc test, with equal variances across groups, or Tamhane's T2 post hoc test, with unequal variances across groups. The results of these tests were not reported due to the length of the text, but the observations derived from them were included in the table notes.

Table 1. Structural measures of personal support networks by quota-defining variables: ANOVAs and Pearson correlations.

	Variables used for sample quotas										
	Gender			**Age (years)**		**Geographical area of residence**					
	Males	**Females**	**Sig.**	**Pearson's *r***	**Sig.**	**North-west**	**North-east**	**Centre**	**South**	**Islands**	**Sig.**
Size	2.96	2.99	ns	-0.27	$p < 0.001$	2.95	3.23	2.97	2.94	2.72	ns
Outdegree	2.13	2.29	ns	-0.18	$p < 0.001$	2.26	2.40	2.19	2.06	2.13	ns
Indegree	1.95	2.17	ns	-0.29	$p < 0.001$	2.01	2.45	2.07	1.97	1.61	ns
nOutdegree	0.75	0.74	ns	0.15	$p < 0.001$	0.73	0.75	0.76	0.73	0.81	ns
nIndegree	0.58	0.62	ns	-0.17	$p < 0.001$	0.60	0.64	0.60	0.62	0.48	ns
nBetweenness	29.63	31.80	ns	-0.09	$p < 0.05$	31.11	31.51	30.18	31.67	27.32	ns
Density	0.51	0.48	ns	0.03	ns	0.49	0.49	0.50	0.50	0.49	ns
Ego-centric density	0.27	0.21	$p < 0.05$[1]	-0.06	ns	0.25	0.25	0.25	0.22	0.18	ns

	Size of municipality (inhabitants)							**Citizenship**			**Total**				
	Up to 5,000	**5,001 to 10,000**	**10,001 to 30,000**	**30,001 to 100,000**	**100,001 to 250,000**	**Over 250,000**	**Sig.**	**Italian**	**Non-Italian**	**Sig.**	**Min.**	**Max.**	**Mean**	**SD**	**n**
Size	2.97	3.47	3.11	3.17	2.63	2.21	$p < 0.001$[2]	3.00	2.59	ns	0	22	2.98	2.64	1,316
Outdegree	2.17	2.34	2.20	2.46	2.23	1.84	$p < 0.05$[3]	2.24	1.76	ns	0	11	2.22	1.75	920
Indegree	2.14	2.32	2.10	2.12	1.97	1.64	ns	2.07	1.96	ns	0	22	2.06	2.30	920
nOutdegree	0.69	0.71	0.74	0.77	0.79	0.79	$p < 0.01$[4]	0.75	0.69	ns	0.00	1.00	0.75	0.26	920
nIndegree	0.66	0.65	0.59	0.57	0.59	0.55	ns	0.60	0.61	ns	0.00	1.00	0.60	0.43	920
nBetweenness	38.69	27.39	31.69	27.96	33.80	26.64	$p < 0.01$[5]	30.64	32.93	ns	0.00	100.00	30.75	28.39	711
Density	0.46	0.50	0.48	0.51	0.50	0.54	ns	0.50	0.49	ns	0.08	1.00	0.50	0.23	920
Ego-centric density	0.16	0.27	0.21	0.28	0.21	0.28	$p < 0.05$[6]	0.24	0.22	ns	0.00	1.00	0.24	0.34	711

Notes: [1] Brown-Forsythe test=4.69; df1=1; df2=681.15; [2] Brown-Forsythe test=5.96; df1=5; df2=1151.61 (from the post hoc tests it emerges that the categories Up to 5,000, 5,001 to 10,000, 10,001 to 30,000, and 30,001 to 100,000 have significantly higher average values than the Over 250,000 category); [3] Brown-Forsythe test=2.49; df1=5; df2=777.67 (the 30,001 to 100,000 category has a significantly higher average value than the Over 250,000 category); [4] $F(5,914)=3.65$ (the 30,001 to 100,000 and Over 250,000 categories have significantly higher average values than Up to 5,000 category); [5] $F(5,705)=3.10$ (the Up to 5,000 category has a significantly higher average value than the 5,001 to 10,000, 30,001 to 100,000, and Over 250,000 categories); [6] Brown-Forsythe test=2.46; df1=5; df2=544.47 (the 30,001 to 100,000 category has a significantly higher average value than the Up to 5,000 category).

Table 2. Contents of outgoing support ties by quota-defining variables: ANOVAs and Pearson correlations.

	Variables used for sample quotas										
	Gender			Age (years)		Geographical area of residence					
	Males	Females	Sig.	Pearson's r	Sig.	North-west	North-east	Centre	South	Islands	Sig.
Money [A]	0.71	0.49	$p < 0.001$[1]	-0.00	ns	0.65	0.56	0.53	0.61	0.68	ns
Other material assistance [A]	1.33	1.39	ns	-0.05	ns	1.25	1.30	1.46	1.49	1.36	ns
Information [A]	1.85	1.73	ns	-0.17	$p < 0.001$	1.79	1.80	1.87	1.75	1.67	ns
Reputation and credentials [G]	0.71	0.63	ns	-0.03	ns	0.57	0.57	0.74	0.82	0.67	ns
Contacts and interpersonal connections [I]	0.83	0.76	ns	-0.11	$p < 0.001$	0.69	0.78	0.82	0.92	0.75	ns
Most appropriate strategies [L]	1.61	1.81	ns	-0.10	$p < 0.001$	1.71	1.72	1.74	1.77	1.51	ns
Other	0.03	0.04	ns	-0.04	ns	0.04	0.03	0.04	0.03	0.02	ns

	Size of municipality (inhabitants)							Citizenship			Total				
	Up to 5,000	5,001 to 10,000	10,001 to 30,000	30,001 to 100,000	100,001 to 250,000	Over 250,000	Sig.	Italian	Non-Italian	Sig.	Min.	Max.	Mean	SD	n
Money [A]	0.49	0.65	0.58	0.65	0.46	0.71	ns	0.60	0.64	ns	0	6	0.60	0.94	1,236
Other material assistance [A]	1.18	1.35	1.40	1.48	1.42	1.33	ns	1.36	1.41	ns	0	11	1.36	1.34	1,214
Information [A]	1.76	1.72	1.82	2.09	1.70	1.46	$p < 0.05$[2]	1.79	1.82	ns	0	11	1.79	1.96	1,229
Reputation and credentials [G]	0.72	0.66	0.59	0.81	0.62	0.58	ns	0.68	0.47	ns	0	11	0.67	1.29	1,146
Contacts and interpersonal connections [I]	0.83	0.72	0.85	0.89	0.74	0.63	ns	0.79	0.86	ns	0	11	0.79	1.37	1,221
Most appropriate strategies [L]	1.48	1.67	1.73	2.04	1.57	1.58	$p < 0.05$[3]	1.73	1.41	ns	0	11	1.71	1.84	1,205
Other	0.03	0.03	0.03	0.04	0.02	0.04	ns	0.03	0.01	ns	0	2	0.03	0.19	1,241

Notes: [1] Brown-Forsythe test=16.93; df1=1; df2=1148.87; [2] $F(5,1223)=2.34$ (the 30,001 to 100,000 category has a significantly higher average value than Over 250,000 category); [3] $F(5,1199)=2.57$ (the 30,001 to 100,000 category has a significantly higher average value than Up to 5,000 category).

Table 3. Contents of incoming support ties by quota-defining variables: ANOVAs and Pearson correlations.

	Variables used for sample quotas										
	Gender			**Age (years)**		**Geographical area of residence**					
	Males	**Females**	**Sig.**	**Pearson's *r***	**Sig.**	**North-west**	**North-east**	**Centre**	**South**	**Islands**	**Sig.**
Money [A]	0.41	0.34	ns	-0.27	$p < 0.001$	0.33	0.39	0.30	0.40	0.61	ns
Other material assistance [A]	0.80	0.73	ns	0.05	ns	0.75	0.82	0.77	0.76	0.66	ns
Information [A]	1.01	0.93	ns	-0.16	$p < 0.001$	0.86	1.08	1.09	0.92	0.85	ns
Reputation and credentials [G]	0.48	0.41	ns	-0.11	$p < 0.01$	0.42	0.36	0.39	0.60	0.42	ns
Contacts and interpersonal connections [I]	0.44	0.41	ns	-0.13	$p < 0.001$	0.40	0.47	0.43	0.45	0.34	ns
Most appropriate strategies [L]	0.96	1.12	ns	-0.15	$p < 0.001$	0.95	1.20	1.11	1.04	0.83	ns
Other	0.01	0.01	ns	-0.01	ns	0.01	0.01	0.00	0.01	0.00	ns

	Size of municipality (inhabitants)							**Citizenship**			**Total**				
	Up to 5,000	**5,001 to 10,000**	**10,001 to 30,000**	**30,001 to 100,000**	**100,001 to 250,000**	**Over 250,000**	**Sig.**	**Italian**	**Non-Italian**	**Sig.**	**Min.**	**Max.**	**Mean**	**SD**	**n**
Money [A]	0.36	0.38	0.41	0.34	0.51	0.30	ns	0.37	0.47	ns	0	7	0.38	0.76	687
Other material assistance [A]	0.66	0.90	0.74	0.74	0.71	0.89	ns	0.78	0.56	ns	0	6	0.76	0.94	685
Information [A]	0.90	0.98	0.98	1.07	1.05	0.79	ns	0.98	0.72	ns	0	9	0.97	1.09	690
Reputation and credentials [G]	0.50	0.34	0.49	0.43	0.38	0.49	ns	0.45	0.42	ns	0	9	0.44	0.86	676
Contacts and interpersonal connections [I]	0.50	0.36	0.43	0.35	0.36	0.56	ns	0.41	0.67	$p < 0.05$[1]	0	9	0.43	0.84	679
Most appropriate strategies [L]	0.87	0.98	1.02	1.25	1.10	1.11	ns	1.06	0.87	ns	0	9	1.04	1.20	676
Other	0.02	0.00	0.00	0.01	0.00	0.00	ns	0.00	0.02	ns	0	1	0.01	0.07	716

Note: [1] $F(1,677)=4.01$.

Males have personal support networks with a higher average ego-centric density than females, making their support networks more bonding, even though, overall, these networks remain relatively low in density. As people age, personal support networks tend to shrink, and their ability to act as brokers decreases. No link is found between the geographical area of residence and network characteristics, but a connection does emerge with the size of the municipality. People living in very large cities (over 250,000 inhabitants) generally have smaller support networks and support fewer people. Interestingly, those in smaller cities (up to 5,000 inhabitants) tend to have more bridging support networks, indicated by higher average nBetweenness, and are often at the center of networks with lower ego-centric density. The comparison between Italians and non-Italians shows no statistically significant difference, highlighting a strong structural similarity between these groups in terms of help given and received.

Let's now examine the content of helping relationships, which are the social resources exchanged between the ego and alters within the personal support network. Table 2 displays data on resources flowing from the ego. Consistent with previous findings, no significant links are found between the geographic area of residence or the citizenship of respondents. Men tend to be more likely to assist others financially. As respondents age, their capacity to help others through information, contacts, and interpersonal connections, as well as the most appropriate strategies to achieve their goals, declines. Information and strategies are also influenced by the size of the city where respondents live. Specifically, those residing in medium-sized cities, with populations between 30,001 and 100,000, tend to help more people with information compared to those in larger cities (over 250,000 inhabitants), and they also help more people with strategies compared to those living in smaller cities (up to 5,000 inhabitants).

Finally, in Table 3, examining the social resources flowing to the ego, we still observe negative relationships with age, which can be considered the personal characteristic of the ego most closely linked to the structural features of its support networks at this point. As respondents age, the average number of alters who help them without getting help in return decreases, providing resources such as money, information, reputation and credentials, contacts, and interpersonal connections, as well as strategies. Additionally, a correlation with citizenship appears, with non-Italians receiving help from a higher average number of alters in terms of contacts and interpersonal connections.

This information, related to personal support networks in the Italian context, sets the stage for the subsequent analyses, which focus on respondents who identified as caregivers.

4.2. The caregivers

The survey found that 298 respondents (19,8% of the sample) stated that they were caregivers at the moment of interview, as they were providing care or assistance to one or more vulnerable people (aged, chronically ill, with disabilities). The majority, 52.7%, are male, with an average age of 52.4 years and a standard deviation of 15.8 years. Just over a quarter are elderly (27.2%), but there is a significant proportion of young people under the age of 35 (16.8%), and a large proportion (56%) are adults. The geographical distribution of the sub-sample is similar to the distribution by macro-area of the research sample, which reflects that of the Italian population (Table 4). Caregivers in the North-east are slightly under-represented and those in the South are over-represented. This may be a consequence of the geographical distribution of social and health services, with a greater presence of social and health facilities and higher social welfare expenditure in the North than in the South.

Table 4. Geographical distribution of caregivers (n 298) and Italian adult population (%).

	Caregivers	**Our representative sample of Italian adult population**
North-west	27.5	27.3
North-est	16.8	19.3
Centre	18.8	20.0
South	26.2	22.7
Islands	10.7	10.8
Total	100.0	100.0

Table 5. Distribution of caregivers (n 298) by number of inhabitants of the municipality (%).

	Caregivers	**Our representative sample of Italian adult population**
Up to 5.000 inhabitants	15.4	16.5
From 5.001 to 10.000 inhabitants	12.1	14.0
From 10.001 to 30.000 inhabitants	26.2	24.6
From 30.001 to 100.000 inhabitants	24.5	21.7
From 100.001 to 250.000 inhabitants	6.7	7.8
Over 250.000 inhabitants	15.1	15.4
Total	100.0	100.0

The distribution by municipality size of residence (Table 5) shows that most caregivers are located in medium-sized and small municipalities. 26.2% are in municipalities with between 10,000 and 30,000 inhabitants, and 24.5% are in municipalities with between 30,001 and 100,000 inhabitants, totaling 50.7%. This is followed by approximately 15% of carers in small municipalities with fewer than 5,000 inhabitants and the same percentage in large municipalities with more than 250,000 inhabitants. The overall distribution does not differ significantly from the population distribution.

Furthermore, among those interviewed, a large proportion of caregivers (46.3%) have a secondary school diploma, followed by 18.7% with a university degree and 15% with a middle school diploma (Table 6).

Table 6. Distribution of caregivers (n 294) by qualification (%).

	%
Primary school	5.8
Middle school	15.0
2-3 year upper secondary school vocational qualification	8.2
Upper secondary school	46.3
Non-university tertiary qualification (academy of fine arts, conservatory, etc.)	0.3
Bachelor's degree	18.7
First or second level master's degree, specialisation diploma	4.1
PhD	1.7
Total	100.0

Finally, about employment status and occupation (Table 7), we note that 31.8% of the sample are private sector workers, 23.6% are retired, 13.7% are employed in the public sector, 11.4% are self-employed, and there is also a proportion of homemakers (8.2%) and students (5.1%). With regard to occupation, the number of respondents drops to 164. It can be noted that 83 carers, i.e. the absolute majority (50.6%), are white-collar or executive employees. The remaining 81 respondents are distributed across other professional areas. 15.2% are manual workers, 14% are entrepreneurs or freelancers, 11% are managers, and 4.9% are traders.

Table 7. Distribution of caregivers (n 292) by employment condition (%).

	%
Homemaker	8.2
Student	5.1
Unemployed	2.4
On temporary layoff/redundancy	0.7
Seeking first job	0.7
Unable to work/disabled/invalid	1.0
Employee in the private sector	31.8
Employee in the public sector	13.7
Self-employed	11.6
Atypical worker (occasional collaboration, work without a contract or unregulated work, etc.)	1.0
Retired or withdrawn from work	23.6
Total	100.0

4.3. Caregiving in Italy

4.3.1 Caregivers for the ageing

In relation to carers providing assistance to elderly individuals, it should be noted that the majority, specifically 82.5%, reported to be caregiving for a single person, whereas 17.0% were caregiving for two people, and in just one case was a caregiver supporting three elderly individuals (Table 8). The mean number of people being looked after by a single carer was 1.18 (SD, 0.40).

Table 8. Percentage of caregivers for people assisted.

Number of people assisted	**Condition**		
	Ageing	**Chronic illness**	**Disability**
1	82.5	84.0	91.6
2	17.0	14.4	6.5
3	0.6	1.6	0.9
4	0.0	0.0	0.9
Total	100.0	100.0	100.0
n	171	188	107

The average age of the people receiving care (as reported by the carers) was 82.1 years, implying an age-range of approximately 74 to 90 years (Table 9).

The data concerning the type of help being provided to the elderly person (Table 10)[46] showed that almost half of the carers (49.4%) provided both 'administrative management' and 'physical care and assistance' to the elderly person, while 29.5% provided 'physical care and assistance' only, 16.3% primarily deal with 'administrative management', such as paying bills, and 4.8% fulfilled a coordinating role.

Table 9. Average age of people assisted by the caregiver.

Condition	**Min**	**Max**	**Average value of the average age of the alters that the ego currently assists as a caregiver**	**SD**	**n**
Ageing	65.0	98.0	82.1	7.3	168
Chronic illness	8.0	98.0	69.2	20.4	180
Disability	8.0	93.0	68.4	21.7	102

Essentially, the data show that half of the respondents were responsible for both the care and administrative aspects of the elderly people they assist,

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[46] Only caregivers were invited to respond to the question: "Which tasks do you primarily perform for the people you care for?". The response options are reported in Table 10.

while those responsible for just one of these two tasks made up the majority of the remainder (45.7%).

Table 10. Primary duties performed by the caregiver (%).

Primary duties	**Condition**		
	Ageing	**Chronic illness**	**Disability**
Mainly administrative management (e.g. paying bills)	16.3	11.9	14.0
Physical care and assistance only	29.5	27.0	27.1
Both administrative management and physical care and assistance	49.4	56.2	51.4
Solely a care coordination role	4.8	4.9	7.5
Total	100.0	100.0	100.0
n	166	185	107

Considering the characteristics of the caregiver network for elderly people, the average network size is 3.36, and caregivers support an average of 2.44 people and receive help from an average of 2.07 people. The number of people the caregivers help, and the number of people who help the caregivers, differ because caregivers help between one and eight people, while receiving support from between zero and thirteen people (Table 17). The betweenness values are around 31, with a similar variation value. The mean density value of the caregiver network is 0.53, whereas the ego-centric density value is 0.27, indicating that caregivers have more bridging social capital (Tronca, 2021).

4.3.1.1 The subjective perception of the caregiving role

The questionnaire also explored caregivers' perceptions about the level of commitment caregiving requires[47]. While more than half of the respondents (58.0%) considered it to be a demanding task, they also saw it to form a normal part of family relationships and/or relationships with loved ones. Although the role of caregiver is challenging, 15.4% regarded it to be a commitment that gave meaning to their lives, and 11.7% saw it as an opportunity to learn the value of dedication and commitment to family members and/or loved ones. The view that caregiving is an experience that fosters personal growth was further supported by 6.2% of carers, who considered it to offer them the chance to appreciate the value of relationships, such as those with a partner, parents, relatives, or friends. Finally, fewer than 10% found being a carer to be a burden that exceeded their capabilities and, as a consequence, was causing them to experience significant difficulties (Table 11).

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[47] Question: "What is your perspective on the care that you provide to the person you are assisting?". The answer options are reported in Table 11.

Table 11. Perception of the level of care commitment towards the person assisted (%).

Level of care commitment	**Condition**		
	Ageing	**Chronic illness**	**Disability**
A condition that exceeds an individual's capacity and causes considerable difficulty	8.6	6.6	10.5
A challenging condition, yet one that offers a deeper sense of purpose and meaning in life	15.4	23.8	26.7
A challenging situation, but one that is typical in families and relationships with loved ones	58.0	50.8	47.6
A condition through which the carer learns the value of dedication and commitment to family and loved ones	11.7	12.2	9.5
A condition in which the carer values their relationship with a partner, parents, relatives, or friends	6.2	6.1	5.7
Other	0.0	0.6	0.0
Total	100.0	100.0	100.0
n	162	181	105

The informal support that carers receive from others in their network was viewed positively by most participants in the survey, with 36.6% and 49.3% considering themselves very and fairly satisfied, respectively[48]. Meanwhile, 8.5% considered themselves somewhat dissatisfied and 5.6% not at all satisfied with the support they received from their network (Table 12).

This data should prompt us to reflect on the importance of the support provided by the caregiver's network of relationships. Therefore, supporting caregivers in creating and maintaining these relationships could enable them not only to rely on informal help when needed but also to perform their caregiving role with greater peace of mind.

Table 12. Degree of satisfaction with the relationship with the person who has provided you with the most support in your caregiving activities over the preceding twelve months (%).

Satisfaction level	**Condition**		
	Ageing	**Chronic illness**	**Disability**
Not at all	5.6	1.3	0.0
A little	8.5	5.2	11.5
A lot	49.3	44.2	34.6
Very much	36.6	49.4	53.8
Total	100.0	100.0	100.0
n	71	77	52

As highlighted in the literature, informal caregiving can be a burdensome task, often negatively impacting the carers' professional and personal lives. We

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[48] "How satisfied have you been with your relationship with the person who has been most instrumental in your caregiving activities in the preceding twelve-month period?". The answer options are reported in Table 12.

sought to explore this aspect in greater depth through quantitative analysis, asking respondents who were still working or studying about the consequences of their caregiving role on their work or studies (Table 13)[49].

Table 13. Statement best describing the impact of caregiving responsibilities on the carer's work or studies (%).

Statements	**Condition**		
	Ageing	**Chronic illness**	**Disability**
My role as a carer does not affect my work or studies	26.3	29.6	26.8
My role as a carer affects my work and studies, but I still manage to balance them	52.5	51.9	53.5
My role as a carer affects my work and studies, and I have yet to find a way to balance them	12.1	12.0	7.0
It is difficult to be a carer while working or studying simultaneously	9.1	6.5	12.7
Total	100.0	100.0	100.0
n	99	108	71

More than half of the sample (52.5%) indicated the role of carer to be impacting their work or studies, although they were still able to manage both of these life spheres. According to 26.3% of respondents, the role of carer had no impact on their work or studies, whereas the opposite was true for 12.1% of respondents, who were still trying to find a way of balancing these commitments. Just over 9% found it difficult to be a carer while fulfilling their job or study responsibilities. For most respondents, it appears that although caregiving affects their work commitments, they are able to balance both caregiving and work.

4.3.1.2 Knowledge about, access to, and satisfaction with the support provided by public services

Receiving support from local services remains essential for many individuals who provide informal care and assistance. Therefore, we wanted to investigate caregivers' awareness of and satisfaction with the available medical and health services, social welfare services (e.g. home care, meals on wheels, and transport services), and social security services (Table 14)[50].

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[49] "Considering your caregiving responsibilities, with which of the following statements do you feel most aligned in terms of its impact on your professional or academic pursuits?". The answer options are reported in Table 13.

[50] "With regard to public and affiliated healthcare services, social welfare services, and administrative and social security services: 1) How familiar are you with the local

Considering welfare services in the medical and healthcare sector, more than half of respondents (63.2%) reported having fairly good or very good knowledge about these services, while 36.7% believed their knowledge about them to be very limited to non-existent. Regarding usability, however, more than half of caregivers (52.1%) believed it to be difficult to gain access to the services, and a similar proportion of respondents (55.9%) reported being neither very nor entirely satisfied. Only 7.4% said they were satisfied, while 12.5% of carers reported being not at all satisfied.

Regarding social care services, the frequency distribution of responses was similar to that of medical and health services: the majority of carers (57.3%) were aware of the services and their functions, but a smaller proportion (44.3%) considered them to be fairly or very usable. Once again, around 12% of carers said that they were unable to gain access to them in terms of proximity.

As for the medical/healthcare and social care services, the majority of respondents (55.6%) reported having sufficient knowledge of the functions performed by administrative and social security services. However, a higher proportion (61.0%) of carers rated their usability and satisfaction levels as low or non-existent. In summary, most of the carers who took part in the survey had a fairly sufficient, albeit incomplete, knowledge of local support services. However, usability and satisfaction appeared to be lacking or non-existent in all cases.

Those who indicated a certain degree of satisfaction with medical, social, and welfare services were also asked about their level of trust in these services (Table 15). Regarding medical services, just over 60% of carers had a fair amount or a great deal of confidence in them. In contrast, only 41.9% said they had a great deal or a fair amount of confidence in the local social care services. The smallest proportion of carers expressing a great deal of confidence is found in relation to social security services: only 3.5% reported having a great deal of confidence in this service compared with 15.6% who had no confidence in it at all. Therefore, the data show that while carers place a certain degree of trust in the healthcare system, they have very little trust in social assistance and social security services.

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services that could help you? 2) Overall, do you find these services easy to access? 3) Are you happy with how you use them?". The answer options are reported in Table 14.

Table 14. Knowledge of, usability of, and satisfaction with the local services that could be useful to the caregiver.

Services		**Condition**								
		Aging			**Chronic**			**Disability**		
		Knowledge	**Usability**	**Satisfaction**	**Knowledge**	**Usability**	**Satisfaction**	**Knowledge**	**Usability**	**Satisfaction**
Welfare services in the medical and healthcare sector	Not at all	6.0	14.1	12.5	5.4	14.0	10.1	7.5	10.1	9.8
	A little	30.7	38.0	43.4	27.4	36.3	42.3	24.3	48.5	41.3
	A lot	54.2	40.5	38.8	55.9	43.6	42.3	56.1	33.3	44.6
	Very much	9.0	7.4	5.3	11.3	6.1	5.4	12.1	8.1	4.3
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	n	166	163	152	186	179	168	107	99	92
Social-assistance welfare (e.g. home care)	Not at all	11.6	11.9	14.4	7.6	10.0	12.7	9.5	7.6	12.3
	A little	31.1	43.7	43.9	30.8	42.4	37.3	32.4	40.2	35.8
	A lot	48.2	37.7	34.8	51.4	40.0	44.7	49.5	42.4	44.4
	Very much	9.1	6.6	6.8	10.3	7.6	5.3	8.6	9.8	7.4
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	n	164	151	132	185	170	150	105	92	81
Administrative and social security welfare services	Not at all	9.8	14.6	16.9	5.7	11.7	14.3	6.9	8.5	15.7
	A little	34.6	46.5	44.1	33.7	44.4	40.3	33.3	48.9	42.7
	A lot	46.4	34.7	30.9	51.4	39.5	36.4	49.0	38.3	36.0
	Very much	9.2	4.2	8.1	9.1	4.3	9.1	10.8	4.3	5.6
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	n	153	144	136	175	162	154	102	94	89

Table 15. Trust in services according to caregiver experience.

Trust on	**Welfare services in the medical and healthcare sector**			**Social-assistance welfare (e.g. home care)**			**Administrative and social security welfare services**		
	Ageing	**Chronic illness**	**Disability**	**Ageing**	**Chronic illness**	**Disability**	**Ageing**	**Chronic illness**	**Disability**
Not at all	5.2	8.2	6.5	11.8	9.8	10.7	15.6	12.9	18.0
A little	33.1	24.6	23.9	46.3	44.4	36.9	48.2	49.0	42.7
A lot	51.9	56.7	59.8	35.3	37.9	45.2	32.6	35.5	34.8
Very much	9.7	10.5	9.8	6.6	7.8	7.1	3.5	2.6	4.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
n	154	171	92	136	153	84	141	155	89

Table 16. Caregiver's future perception (projection in 3-5 years) (%).

Future conditions	**Condition**		
	Ageing	**Chronic illness**	**Disability**
Worse	41.0	32.1	39.4
Essentially the same as the current one	51.4	54.9	48.9
Better	7.6	13.0	11.7
Total	100.0	100.0	100.0
n	144	162	94

A question was posed to caregivers to investigate their perceptions about the future. More than half of respondents (51.4%) thought that the situation would be essentially the same in three to five years' time, while just under half (41.0%) believed things would get worse. The remaining proportion (7.6%) thought that their situation as carers will improve. Thus, most carers predicted no changes in the medium-term (Table 16).

4.3.2 Caregivers of people with chronic illnesses

Those who were providing regular assistance to people in frailty due to chronic illness at the time of the interview numbered 188; 158 supported only one person, 27 supported two people, and 3 supported three people. Even in relation to chronic illness, the data show that caregivers, on average, assist only one person (mean value 1.17), with limited variation. The average age of those receiving help from caregivers, who are in a specific form of vulnerability associated with chronic illness, is high: 69.24 years, with a standard deviation of 20.49.

Among the sub-sample of caregivers of people with chronic illnesses, 56.2% provide help with both administrative management and physical care and assistance. A smaller proportion, 27.0%, provides "only" physical care and assistance; 11.9% mainly deal with administrative management, and a tiny proportion (0.9%) perform a coordinating function for the help provided (Table 10). In their care activities, caregivers of people with chronic illnesses receive support from public services and from the primary support network. The average size of the network is 3.5. Within the network, caregivers receive help from an average of 2.08 people and provide help to an average of 2.29 people. Thus, the number of people they help exceeds the number from whom they receive help. The minimum number of people from whom they receive help is 0, as is the case for other caregivers in the sample, while the maximum is 13, as also observed among caregivers of older people. The interviewed caregivers likely serve as a point of reference for the entire support network surrounding the person with a chronic condition, since many relationships between the network's nodes pass through them, as indicated by the nBetweeness value of 29.13. These networks are nevertheless characterised by a relatively high frequency of relations among nodes, as shown by a density of 0.51, within a range of 0 to 1. Furthermore, the value of ego-centric density (0.29) indicates that the caregiver serves as a brokerage role between the other nodes in the network.

From this point onwards, commentary on the data in this paragraph will refer exclusively to the sub-sample of caregivers of people with chronic illness, and percentages will be calculated with reference to the 188 respondents just described.

4.3.2.1 Subjective perception of the care task

The majority of respondents (50.8%) consider the care they devote to the vulnerable person as demanding, yet view it as a typical consequence of existing bonds with family members and loved ones (Table 11). A further 23.8% hold a particularly optimistic view because, although they recognise it as demanding, they believe it gives their lives greater meaning. In a similar vein, which reflects a favourable view of the caregiving experience, 12.2% state that they are learning the value of dedication and commitment, while 6.1% shift the focus from a general axiological perspective to a more concrete one, declaring that taking care of the person enables them to experience the value of interpersonal ties. A relatively small proportion (6.6%) considers the caregiving role to be very burdensome, beyond their strength, and a source of significant difficulty. The data convey a view of supportive care as an activity taken for granted, inherent in proximate human relationships, rather than as a social role marked by civic relevance and deserving recognition in the public sphere. Among caregivers of people with chronic illness, the proportion of those who emphasise solely the difficulty of the role they perform is particularly low – lower, in fact, than among caregivers of older people and of people with disabilities.

Although respondents generally display a positive attitude towards their role as caregivers of chronically ill people, it remains true that care relationships require effort that may detract from other aspects of caregivers' lives. The questionnaire explored caregivers' subjective perception of the impact of caregiving tasks on other life domains (work/study) (Table 13). A majority of respondents (51.9%) recognise that caregiving affects their work or study, yet state that they can reconcile both spheres of commitment. About one third (29.6%) report that caregiving has no consequences for their work/study obligations. Conversely, 18.5% experience considerable difficulty reconciling the two areas; an additional 12% report that they have not yet found a way to balance them; and finally, 6.5% consider them altogether irreconcilable in a satisfactory manner – although this latter percentage is the lowest among the other vulnerability categories.

Turning to the help received, the vast majority of respondents (93.6%) report being satisfied: 49.4% are delighted, and 44.2% fairly satisfied (Table 12). In essence, satisfaction with the help received is higher among caregivers of people with chronic illnesses than among other caregivers.

4.3.2.2 Knowledge, access and satisfaction with support provided by public services

The caregiver undoubtedly acts as a "hinge" between the person they care for and the assistance services that societies guarantee to their citizens. As noted above, the survey assessed caregivers' levels of knowledge of health and medical services, socio-assistance services, and administrative and social security services, as well as their perceived accessibility and satisfaction with their use (Table 14).

Regarding health and medical services, a substantial proportion of caregivers (67.2%) report good knowledge of them (knowing them fairly well or very well). Slightly below the majority (49.7%) are those who consider such services relatively or very easy to use. Also, below the majority (47.7%) are those who report being satisfied with this type of service.

Turning to socio-assistance services, the percentage of caregivers who say they know them reasonably well or very well declines, though it remains a solid majority (61.7%). As for ease of use, fewer than half rate it positively (relatively/very). Satisfaction with these services rises again to the threshold of a majority (50.0%).

Finally, for administrative and social security services, the percentages of positive evaluations (relatively/very) are generally lower. Knowledge is reported by 60.5% of respondents, though fewer consider it easily accessible (43.8% evaluate it as reasonably/very accessible). Nevertheless, the proportion of respondents expressing satisfaction with this type of service rises slightly to 45.5%.

Overall, for caregivers of people with chronic conditions, health and medical services are the most well-known and easily accessible. However, although satisfaction with health services is generally high, the services receiving the highest number of positive evaluations for satisfaction are not health services but socio-assistance services. Caregivers dealing with chronic illness also report greater knowledge of these services and consider them more accessible than other caregiver groups do. The administrative and social security sector shows the lowest percentages across all evaluation types (knowledge, accessibility, satisfaction). However, it nevertheless receives higher positive evaluations from caregivers of chronically ill people than from caregivers of older people or people with disabilities.

The survey also assessed the degree of trust placed in services across the three areas (health and medical, socio-assistance, administrative and social security). From an overall perspective, among caregivers of people with chronic illness who expressed some degree of satisfaction with services, trust decreases progressively from health and medical services to socio-assistance services and then to administrative/social security services, following a pattern similar to that found among caregivers of older people and of people with disabilities (Table 15).

Finally, as noted earlier, the survey shed light on caregivers' outlook over the next three to five years. For those caring for people with chronic health difficulties, and in line with the outlook of the other caregiver groups, the clear majority (54.9%) envisage a future similar to their current situation. A comparative analysis, however, reveals a larger share of responses (13%) predicting a better future (Table 16). For most caregivers, medium-term prospects resemble the present, with somewhat greater hope of improvement among caregivers of people with disabilities and especially among those caring for chronically ill patients.

Table 17. Structural measures of the caregiver's network.

Condition	**Ageing**					**Chronic illness**					**Disability**					**Non caregivers**				
Structural measures	**n**	**Min**	**Max**	**Mean**	**SD**	**n**	**Min**	**Max**	**Mean**	**SD**	**n**	**Min**	**Max**	**Mean**	**SD**	**n**	**Min**	**Max**	**Mean**	**SD**
Size	159	1	15	3.36	2.57	177	1	15	3.50	2.71	99	1	13	3.57	2.81	1,033	0	22	2.90	2.67
Outdegree	130	1	8	2.44	1.77	143	1	8	2.29	1.72	83	1	7	2.13	1.54	691	0	11	2.22	1.77
Indegree	130	0	13	2.07	2.38	143	0	13	2.08	2.28	83	0	8	1.94	1.93	691	0	22	2.10	2.33
nOutdegree	130	0.33	1	0.83	0.21	143	0.25	1	0.78	0.23	83	0.25	1	0.78	0.23	691	0	1	0.73	0.27
nIndegree	130	0	1	0.58	0.45	143	0	1	0.58	0.43	83	0	1	0.60	0.43	691	0	1	0.61	0.43
nBetweenness	95	0	100	30.93	31.05	108	0	100	29.13	30.64	58	0	100	28.17	31.48	547	0	100	31.72	28.01
Density	130	0.13	1	0.53	0.24	143	0.11	1	0.51	0.24	83	0.14	1	0.56	0.24	691	0.08	1	0.48	0.23
Ego-centric density	95	0	1	0.27	0.36	108	0	1	0.29	0.36	58	0	1	0.33	0.37	547	0	1	0.22	0.33

4.3.3 Caregivers of persons with disabilities

The respondents who regularly assist persons with disabilities number 107. Almost all – 96 – regularly assist only one person, while 7 assist two people. There are, however, two individuals who care for three persons and, remarkably, one who cares for 4.

For 83 of them, we have the primary network measures (Table 17). On average, caregivers provide help to 2.13 people and, in turn, receive help from 1.94. In both cases, these values are slightly lower than those recorded for caregivers of older people and of those with chronic illnesses. When we compare the normalised values of the two measures, we observe that the help provided is identical to that of caregivers of persons with chronic diseases (0.78). In contrast, the average help received (0.60) is slightly, though only marginally, higher than that of caregivers of older people and of people with chronic illnesses (0.58). Caregivers' networks appear to be relatively well-connected. Average values do not show significant differences, although the network of caregivers of persons with disabilities displays the highest value (0.56). The average normalised betweenness value of the sub-sample of caregivers of persons with disabilities (28.17%) is considerably lower than the averages observed in the other sub-samples. In summary, the networks to which caregivers of persons with disabilities belong appear cohesive and collaborative, organised around the caregiver – who performs a coordinating function – but not entirely dependent on them.

The mean age of the people assisted by caregivers is just over 68 years, ranging from 8 to 93 years (Table 9).

Of this sub-sample of caregivers, 51.4% take care of both the person's physical care and assistance and administrative matters (Table 10). Some 27% perform only care and physical assistance tasks, while 14% are mainly engaged in administrative management. A total of 7.5% of caregivers coordinate the help provided exclusively. Although this is a comparatively small share, it is slightly higher than that recorded in the sub-samples of caregivers assisting older people (4.8%) and those assisting people with chronic illnesses (4.9%). This noticeable difference may be due to the greater range of support needed by persons with disabilities, not only in relation to healthcare.

4.3.3.1 Subjective perception of the care task

A total of 47.6% of caregivers consider their situation demanding yet regard it as partly typical of family bonds or relationships with loved ones (Table 11). Some 26.7% are aware of the commitment required but emphasise its positive aspects, believing it gives greater meaning to their lives. For 10.5% of respondents, the caregiving role is challenging because it exceeds their strength. A slightly lower percentage, 9.5%, acknowledges that, by being caregivers, they are learning the value of dedication and commitment to their family members and loved ones. A small proportion of respondents regard their situation as an opportunity to experience the value of the relationship with the person they care for (5.7%). Respondents' assessments are likely influenced by the support they receive from those who help them with their caregiving activities.

In response to a specific question concerning the degree of satisfaction with the relationship with the person who most supports them in their care work, 52 respondents answered (Table 12). Of these, 53.8% reported being very satisfied, while 34.6% were pretty satisfied. Only 11.5% expressed low satisfaction. The effectiveness of the support received by the caregiver is likely one of the factors that enables them to make care work compatible with other activities, particularly paid employment.

The widespread sense of moral obligation towards family members or loved ones with disabilities, which leads respondents to undertake care tasks, has repercussions for their work activities (Table 13). Of the 71 respondents to this question, the majority (53.5%) report being able to reconcile the two commitments, whereas 26.8% believe that the caregiving role has no impact on their work. Reconciling productive work and care work is difficult for 12.7% of the sample, while 7% report still searching for a way to balance both demands. Overall, a large majority of respondents appear able to combine the demanding tasks of caregiving with their work roles.

4.3.3.2 Knowledge, access, and satisfaction with public services

Respondents were asked questions regarding their relationship with certain welfare services in the medical and healthcare, social-assistance, and social security/administrative sectors. The questions aimed, in particular, to determine the degree of knowledge caregivers had of these locally available services that could support them, and how easy they were to use in terms of proximity. Those who had used them were also asked to indicate their level of satisfaction and trust in these services.

The majority of respondents (56.1%) state that they know the local medical and healthcare services fairly well, while 12.1% say they know them "very well" (Table 14). Just under a third of respondents (24.3%) know them little, and 7.5% not at all. Knowledge of social-assistance services is less widespread. While 49.5% report knowing them reasonably well and 8.6% very well, 32.4% say they know them little, and 9.5% say they know them not at all. As for administrative and social security services, a non-negligible proportion of the sample (11.2%) cannot answer these questions. Compared to other services, fewer respondents report using administrative or social security services fairly well (38.3%) or very well (4.3%). In comparison, limited use is more common: the majority (48.9%) know them little, and 8.5% use them not at all.

Overall, knowledge of services that can support caregivers in their care work tends to decrease as one moves from more locally grounded services – such as healthcare and social-assistance – to those managed at the national level, such as social security services (e.g., pension benefits). It is noteworthy that almost 42% of respondents report limited or no knowledge of social-assistance services, which in principle should be the most locally accessible, as municipalities or municipal associations typically provide them.

Knowledge of available services is a necessary precondition for usability, but not sufficient. Spatial proximity – and therefore ease of access – are other factors influencing service use. A relative majority of respondents (48.5%) consider healthcare services little accessible in terms of territorial proximity, while 33.3% consider them a lot accessible and 8.1% very much accessible. However, 10.1% of respondents state that medical and healthcare services are not accessible at all. A relative majority (42.4%) believe that social assistance services are relatively accessible, while 40.2% deem them not very accessible and 7.6% not accessible at all. For 9.8%, these services are very accessible. Assessments of administrative and social security services mirror those of medical and healthcare and social-assistance services. First, around one tenth of respondents cannot express an opinion. Among those who do, a relative majority (48.9%) considers these services not very accessible; 38.3% find them reasonably accessible; 4.3% very accessible; and 8.5% consider them not accessible at all.

Regarding service usability, it becomes even clearer that positive evaluations vary with territorial proximity. Overall, positive evaluations ("fairly" and "very") decrease from social-assistance services (52.2%) to administrative/social security services (42.6%) and medical and healthcare services (41.4%).

Not all respondents expressed an opinion on satisfaction and trust concerning service use. Most often this was due to not having used the services (medical and healthcare 13.1%; social-assistance 16.6%; administrative and social security 15.0%), while in fewer cases respondents were unable or unwilling to answer.

Among those who responded, 44.6% reported being satisfied with healthcare services, a slightly higher proportion than those who were slightly dissatisfied (41.3%), followed by 9.8% who were not satisfied at all. A tiny share (4.3%) declared themselves very satisfied. The situation worsens for social-assistance services. Although a relative majority (44.4%) declared themselves fairly satisfied, 38.5% were only a little satisfied, and as many as 12.3% were not at all satisfied. Only 7.4% reported being very satisfied. Administrative and social security services have the highest dissatisfaction levels: 42.7% reported being only slightly satisfied and 15.7% not at all satisfied. Some 36% were fairly satisfied, while only 5.6% expressed entirely positive evaluations.

A relative majority of respondents report high trust (Table 15) in medical and healthcare services (59.8%) and social-assistance services (45.2%), while distrust is more widespread regarding administrative and social security services (42.7%). These services also record the highest percentage of respondents with no trust at all (18%), followed by social-assistance services (10.7%) and health/social care services (6.5%).

Taken as a whole, these data illustrate certain aspects of the relationship between caregivers and the services they rely on when performing their care tasks.

To simplify analysis and enhance interpretability, variables can be recoded as dichotomous by grouping categories into two main classes: low levels ("none" and "little") and high levels ("fairly" and "very") of knowledge, accessibility, satisfaction, and trust. Medical and healthcare services are those best known to caregivers and those in which the majority express trust. Most caregivers regard social-assistance services as accessible and are those with which they are most satisfied. Although administrative and social security services are known to an absolute majority of respondents, they are also the ones respondents most often consider not very accessible, and they express dissatisfaction and distrust about them. None of these services reaches the levels of satisfaction that almost all caregivers express regarding the relationship with the person who supports them in their care work.

When invited to reflect on their future as caregivers, just over one tenth of the sub-sample (12.1%) are unable to imagine it. A relative majority (48.9%) believe their situation will remain substantially unchanged, but over one third (39.4%) believe it will worsen, while only 11.7% show some optimism, expecting it to improve.

5. Discussion

Comparing the structural characteristics of the networks associated with the three categories of caregivers (aging, chronic diseases, disabilities) and survey respondents who reported not being caregivers revealed significant differences in the mean network sizes at the time of the survey. On average, those in the role of caregiver appeared to be part of larger networks than those who are not (3.36, 3.50, and 3.57 for the three caregiver groups, resp., vs 2.90 for non-caregivers), although the maximum network value reported in the non-caregivers far exceeded that of caregivers. A comparison of the amount of help given and received by caregivers and non-caregivers indicates that caregivers provide more help than non-caregivers. Furthermore, of the three types of caregivers, those providing care to aged people were also those providing help most frequently to other network members. With regard to assistance received, the disparities are less pronounced than those observed for assistance provided, with non-caregivers tending to be those receiving the most support from their network. However, larger variation values are observed in the network density, particularly between caregivers and non-caregivers. The networks of the former demonstrate higher values (respectively: 0.53, 0.51, and 0.56) compared with those of the latter (0.48), indicating that caregiver networks exhibit greater connectivity than those of individuals who do not fulfil a caregiving role. This phenomenon may be attributed to the caregiving process, which necessitates continuous interaction with other network members. Finally, comparing the ego-centric density shows that caregiver networks – having higher average values than non-caregiver networks (specifically 0.27, 0.29, and 0.33 vs 0.22) – possess a lower level of bridging social capital (Tronca, 2021). We might hypothesize that the caregiving commitment, which necessitates continuous interaction within one's reference network, seldom permits the caregiver to establish bridging ties to those outside their network – ties which might offer the caregiver novel resources, including information, knowledge, and personal well-being.

The comparison between the three caregiver profiles will begin with the characteristics of the helping relationship. In all three sub-samples, the majority of caregivers assist a single person (over 80% of caregivers in each profile). However, in the case of caregivers of people with disabilities, the proportion of those who assist only one person is significantly higher (91.6%). This fact may indicate a greater level of caregivers' commitment required by the care relationship with people with disabilities than that required by the relationship with an older person or a person with a chronic illness. This "totalising" commitment makes it difficult to care for others as well.

Differences in the average age of those assisted are significant, leading us to believe that, overall, respondents' self-placement is reasonably reliable. The older people assisted by caregivers are aged 65-98, with a mean age of 82. In this case, frailty is closely linked to the life course and the consequent functional decline. The people with chronic illnesses who are assisted are between 8 and 98 years old, with a mean age of 69. Very similar values are recorded for people with disabilities who receive assistance. Indeed, chronic conditions can arise at any point in the life course, while disabilities may be congenital or develop later.

In all caregiver profiles, a mixed form of care predominates, combining physical care with the management of administrative matters. The highest values for these mixed forms are found among caregivers of people with chronic illnesses and of people with disabilities. The higher average age of older people accounts for the greater weight of physical care (29.5%) on their caregivers. Caregiving for people with disabilities shows the highest proportion of caregivers who are exclusively engaged in coordinating the help provided, a need that stems from the markedly greater complexity of the social support networks in which they are embedded.

The care task is primarily perceived as a moral and family obligation across all three caregiver profiles, though there are significant differences. Care for older people is most frequently perceived as "natural" (58%) and thus linked to a familistic model. In contrast, the care of people with disabilities (26.7%) and of people with chronic illnesses (23.8%) is more often considered, compared with care for older people, as an identity-based and long-term relationship. Once again, it is caregivers of people with disabilities who, to a relatively greater extent than others, regard the care commitment as a condition that exceeds their strength (10.5%).

In all three caregiver sub-samples, there is widespread ability to reconcile caregiving with work or study (52-54%). However, the totalising nature of the care relationship is reflected in the responses of caregivers of people with disabilities, for whom, to a relatively greater extent than for other caregivers, there are severe difficulties and even an inability to reconcile the two activities (12.7%).

Caregivers of people with chronic illnesses express the highest levels of satisfaction with informal support. This may be due to greater mobilisation of the networks available to these caregivers, which may, in turn, be facilitated by the fact that chronic illness is less stigmatising and less totalising than disability.

We now turn to some characteristics of caregivers' relationships with certain key service types that are particularly relevant to their care relationships. All three caregiver sub-samples have moderate knowledge of services. Caregivers of people with chronic illnesses display greater familiarity with social care services and health services; caregivers of older people, meanwhile, are well acquainted with health services but less so with social care services, while caregivers of people with disabilities report that they know little or nothing about administrative and social care services.

Service usability, understood in terms of territorial proximity, is a factor that significantly shapes the care relationship. A large majority of caregivers, across all three sub-samples, consider administrative and social security services the most difficult to use. These are followed by social care services, which the majority of caregivers of older people and of people with chronic illnesses regard as "not very" or "not at all" usable, unlike caregivers of people with disabilities. Health and medical services are also considered by the majority of respondents in the three sub-samples to be "not very" or "not at all" usable. In this case, the most critical evaluations come from caregivers of people with disabilities.

The three caregiving profiles show very similar patterns in terms of satisfaction. In general, most respondents express dissatisfaction, particularly with administrative and social security services, as well as with health and medical services. Dissatisfaction is less widespread regarding the use of social care services, probably because these are the most easily accessible to respondents and the people they assist. Within this generally dissatisfied picture, differences emerge between caregiver sub-samples. Caregivers of older people and caregivers of people with disabilities are those most dissatisfied with administrative and social care services. The dissatisfaction may be explained by the cumbersome procedures for accessing social security benefits available to those they care for. Among caregivers of older people, dissatisfaction with social care services is also more widespread, whereas, regarding the use of these same services, the majority of caregivers of people with disabilities express predominantly positive evaluations. Similarly, although dissatisfaction with health and medical services remains prevalent overall, it is less widespread among caregivers of people with disabilities. Taken as a whole, within the sub-sample of caregivers of older people, dissatisfaction with the various types of services is clearly more widespread than in the other two sub-samples.

In general terms, based on their personal experience, a large majority of caregivers in all three sub-samples place "fairly" or "a great deal" of trust in health and medical services.

The highest levels are expressed by caregivers of people with disabilities and by those of people with chronic illnesses. It is likely that the quality of the services they use, which are used more frequently than those of caregivers of older people, meets their expectations to a greater extent. By contrast, a certain degree of distrust prevails towards care services, except among caregivers of people with disabilities, the majority of whom have confidence in this type of service. The field of social care services encompasses a range of respite services that can alleviate caregivers' burdens (e.g., day centres, home care), as well as services that support social inclusion for people with disabilities, including young and adult individuals. The lowest levels of trust are recorded, this time uniformly across all three sub-samples, in relation to administrative and social security services.

Caregivers share a similar horizon of expectations concerning the future, as the majority believe that their situation will remain the same as it was at the time of the interview. Caregivers of older people and caregivers of people with disabilities are those who, to a relatively greater extent, foresee a worsening of their condition. In contrast, a relatively higher proportion of caregivers of people with chronic illnesses expect an improvement. Differences in expectations for the future may be linked to the greater care commitment required as functional decline increases with age among older people and people with disabilities. In contrast, a chronic illness may instead remain stable over time.

6. Conclusions

The research was conducted on a sample of the adult Italian population, identifying those who work as informal caregivers ex post. This methodology allowed us to provide a snapshot of the caregiving phenomenon in Italy and observe it against the background of the characteristics of the entire population. The analyses were conducted by examining the profiles of caregivers, representing 20% of the sample, their opinions on caregiving, and the personal support networks to which they belong.

Personal network analysis shows that caregivers' personal support networks are, on average, broader than those of other citizens. They are also characterized by greater connectivity and a lower propensity to connect with external networks. Therefore, confirming one of the hypotheses, caregiver networks have fewer opportunities to engage in brokerage activities that could enable them to gather support resources for the caregiver and/or the vulnerable individual.

This evidence supports the suggestion that caregivers who struggle to develop new support relationships, distinct from their existing ones, should be supported by external initiatives for the development of formal/institutional networks. The development of this type of bridging social capital would allow us to conceptualize assistance for vulnerable citizens by shifting *from caregivers to caregiving*, creating forms of assistance that take on a collective character, involving families, professionals, public services, and third-sector organizations in a more comprehensive manner.

The research project also aimed to distinguish caregivers based on the type of vulnerability of the individuals they care for, to identify their specific characteristics, opinions, and needs.

The comparison between different caregiver profiles – of older people, of people with chronic illnesses, and of people with disabilities – makes it possible to highlight both the common elements of informal caregiving in Italy and the specific characteristics of each profile and of the social support network available to them, in relation to the condition of fragility of the person they assist. The distinction between the three sub-samples results from respondents' self-placement and, therefore, from their subjective assessment. This methodological choice, while facilitating the administration of the questionnaire, has, on the other hand, led to some overlap between the three caregiver categories. This is a limit of the research that is difficult to overcome in a survey on a sample of the general national population.

Nevertheless, the comparative analysis reveals a certain degree of uniformity among carers, regardless of the characteristics of the people they assist. The most significant of these is the fact that for all types of frailty, over a quarter of carers say they have no one to support them in their caregiving activities.

At the same time, the size of personal networks does not differ significantly among the three sub-samples, nor does the type of help provided, which, for most carers, is comprehensive, involving aspects of personal care and administrative matters. As hypothesized, this can be considered a total social fact. At the same time, the opinions provided by respondents regarding formal health, welfare, and administrative/security services are very similar. In all cases, nearly half of the respondents believe they have a good knowledge of these services. However, when it comes to assessing their accessibility and satisfaction, positive assessments account for only 40% of the responses. The exception is social care services, which receive satisfactory ratings in half of the cases from carers of people with disabilities and chronic conditions. The case is different when it comes to opinions on the trust enjoyed by the three types of services, which always show a certain degree of agreement among respondents in the three sub-samples, but health services enjoy the trust of 60% of all three sub-samples, while the other types of services rank well below 50%.

Some differences emerge between the three sub-samples regarding their opinions about the care work they do and the future prospects of their status as caregivers.

Given that, taken as a whole, respondents consider caregiving to be a typical part of family relationships, it is noticeable that carers of people with disabilities emphasise the difficulties associated with their role more than carers of other vulnerable people. Caregivers of persons with disabilities consider their situation to be very demanding, beyond their strength, and difficult to reconcile with their study or work commitments. At the same time, more than other carers, they consider it a condition that gives more meaning to life. Meanwhile, those who care for people with chronic conditions consider caregiving a condition from which they learn the value of dedication and commitment to the person in need, and, at the same time, they are more satisfied than other caregivers with the help they receive from family members. Those who care for older people are more likely to view caregiving as a typical part of family ties and relationships with loved ones.

Finally, the research showed that, when asked to look to the future, half of all three sub-samples saw it as essentially similar to the current situation. However, caregivers of older people were the most pessimistic about the future, while caregivers of people with chronic illnesses were the most optimistic.

Overall, the evidence that has emerged can provide valuable support for the design of policies in favour of vulnerable people and their caregivers. At the macro level, it does not seem necessary to distinguish between policies based on the type of caregiver. In many respects, the caregiver profile is uniform. However, at the level of social intervention, it is considered appropriate to pay attention to some of the differences that emerged between the three profiles, such as the structure of their support networks, the attitudes towards services, and the respondents' future projections in their role as caregivers.

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