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Juggling Family Care Responsibilities and Personal Aspirations: The 'Invisible Care' Provided by Young Adults

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Abstract

This paper underscores the crucial role of personal networks and social capital in mitigating the stress young adults endure as a consequence of caregiving responsibilities. The study explores the experiences of young adult carers (YACs) aged 18–37 years who provide informal and ongoing care to family members with chronic illness, disability, or age-related conditions. Drawing on qualitative data from ten caregiver-supporter dyads in Italy, the research investigates how caregiving impacts personal development, relational dynamics and future planning during early adulthood. Using an innovative methodology combining personal network interviews and dyadic sessions, the study captures the structure and function of formal and informal support networks, as well as the subjective experiences of carers.

The findings revealed two caregiving configurations: "supportive dyads," where the supporter primarily provides emotional and organizational help to the carer; and "collaborative dyads," where both members are actively involved in direct caregiving. In both cases, the carer, who is central to the support network, acts as a bridge between family and external connections. Although supportive relationships, particularly with partners, play a protective role in buffering caregiver strain, the burden of care significantly constrains carers' autonomy, career progression, and relational well-being. However, the findings also point to the limitations of these networks when broader systemic support is lacking. The paper calls for enhanced policy recognition and targeted interventions to support young adult carers, whose roles still largely go unrecognized in public discourse and institutional practice.

Keywords: young-adult carers, dyad, social capital.

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1. Introduction

The exchange of care between generations characterises family life and daily experiences therein. The giving and receiving of care is generally solidaristic and can take on different forms, be it of a material, emotional, relational or economic nature (Bengtson & Roberts, 1991). This intergenerational exchange of care is normally distinguished by its gratuitous character; indeed, there is a normative expectation in family relationships that people will be there for each when someone is in need of care. In this sense, there is also an (often unsaid) family obligation to provide care (Attias-Donfut, 2001; Dykstra, 2010).

Caregiving implies an intensive form of caring for a family member. It can take on different connotations and involve different activities, which may be burdensome for the caregiver to varying degrees (Boccacin, 2025).

When the dimension of obligation is dominant, the relationship becomes distorted such that the needs of the caregiver are not taken into account, and dependency dynamics are created that can erode personal and family resources, generating processes of conflict, vulnerability and social exclusion. When this happens, the exchange becomes unbalanced and consumes the carer's physical, mental and relational resources.

In the literature, carers are defined as individuals who look after or provide help or support to a family member, partner or friend challenged with long-term physical or mental health problems, a disability and/or problems associated with old age. Young carers are usually defined as aged under 18 years, and young adult carers as aged between 18 and 25 years (Stamatopoulos, 2018; Brimblecombe et al., 2024).

The developmental phase of young adults (also referred to as emerging adulthood) involves critically important milestones, involving increasing levels of autonomy, identity formation and the development of careers and intimate relationships (Van der Werf et al., 2022; Landi et al., 2022). Young carers are often at an important physical, emotional and mental developmental stage where life plans are not yet set. Taking on caregiving responsibilities can interfere with the pursuit of developmental milestones and may cause the postponement of education and career development and even the progression of personal relationships.

Negotiating these milestones may be disrupted by the demands of caring for a family member. For many young adults, the family caregiving situation can dominate their daily living and lead to significant restrictions and disruptions, including less time for hobbies, leisure pursuits and social activities, interruptions to education or career development. The situation may also cause the individual to worry about the ill family member, lead to strained family relations, tension with respect to balancing the demands of establishing a career with those of caregiving, and decision-making conflicts regarding future life planning relative to their ongoing caregiving predicament.

The literature on caregiving and social support underlines the critical role of social networks for the well-being of caregivers. Caregiving, particularly for people with chronic illnesses, disabilities and dependency, can be an extremely challenging experience and negatively impact on the caregiver's social networks, especially if experienced as a young adult.

Studies show that perceived social support can significantly influence caregivers' mental health and overall quality of life. The dynamics of social support are complex and can vary significantly depending on the life stage of the caregiver and their role in care provision.

In this contribution we consider the experience of young adults (young adult carers) aged between 18 and 35 years who provide informal care and assistance to another family member on a continuous or regular basis (Bramanti & Bosoni, 2025).

The person receiving care is often a parent, sibling, grandparent or other relative. They may have a disability, suffer from a chronic illness, a mental health problem or some other condition necessitating the provision of care, support or supervision. Having to take on a caregiving role at this age has its risks, as caregiving may make it difficult for these young adults to do what is required to transition to adult life (build a family of their own, invest in their career, etc.) whilst performing the care responsibilities (Dearden & Becker, 2004; Warren, 2007; Casu et al., 2021). Indeed, the availability of formal and/or informal support networks to young carers plays a decisive role in facilitating their successful transition to adult life.

The study presented here is part of a larger research project[1] investigating how helping relationships, the networks and practices that result from them, enable further forms of social capital to be generated.

In this contribution, we discuss the results obtained from a qualitative study conducted on a non-representative group of ten young-adult caregivers aged between 18 and 37 years. The study aimed to understand the care burden of these carers and the types of formal and informal support they were receiving.

The study used an innovative methodology specifically designed to evaluate support relationships. The respondents underwent two online

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[1] Research project of major national interest (PRIN 2022) funded by the European Union - Next Generation EU - Project: Social capital as resource of care practice in Italy: Caregiving and social support in pandemic time – Prot. 2022B58JHF – CUP J53D23011290008. Mission 4 - Education and Research.

interviews: the aim of the first was to gain a clear understanding of the caregiver's personal support network; the second was a dyadic interview involving both the caregiver and the person the caregiver identified as supporting them (directly or indirectly) in the caregiving task.

This study does not intend to generalize its findings but to contribute towards deepening our understanding of how support networks can influence the caregiving experience of young adults.

2. Caregiving and social support: literature background

Experts report a general lack of awareness about young carers, who are distinguished from older adult carers by their necessity to reconcile their caregiving duties alongside their own development. This makes the role of social capital particularly important for their well-being. Public policies and support services are often fragmented and poorly coordinated, and countries have responded differently with regards to policymaking. Some have well-developed services, with the role of caregiving and social support clearly recognised by the law, whereas other countries are only just beginning to recognise the existence of the problem (Joseph et al., 2020).

The intersection of social capital – the resources, networks and relationships that can provide support – and the unique circumstances of young carers is pivotal for their social development and emotional resilience (Barry, 2011; Gough & Gulliford, 2020). However, many young carers face barriers in accessing these resources. Research indicates that young carers often struggle to engage in social interactions outside their home environments, hampering their ability to build social capital (Cunningham et al., 2016; Matzka & Nagl-Cupal, 2020). When they start this task as teenagers, they frequently miss opportunities central to social networking such as traditional schooling and extracurricular activities due to their caregiving responsibilities. These interruptions not only hinder their immediate social interactions but also leave a lasting impact on their psychosocial adjustment (Cunningham et al., 2016). Therefore, fostering a supportive environment within schools and communities that acknowledges the unique situation of young carers is essential for enhancing their social capital and overall well-being (Brimblecombe et al., 2024; Kaiser et al., 2024).

Furthermore, how carers engage with their peers and family networks can be significantly shaped by their social environments. Research demonstrates that friendships and informal social interactions contribute greatly to the resilience of young and adult carers. The experience of social bonding can help alleviate the emotional burdens often carried by these individuals (Matzka &

Nagl-Cupal, 2020; Leu et al., 2018). For instance, young carers who have access to supportive friendships are more likely to report higher levels of happiness and lower levels of stress. Conversely, isolation can exacerbate feelings of loneliness and vulnerability, creating a cycle that further diminishes their social capital (McDougall et al., 2018). This underscores an urgent need for policies and practices that not only recognize but actively support the social integration of young carers in various community and educational settings (Hanna & Chisnell, 2019).

The societal and familial expectations placed upon young carers can complicate their ability to seek help. Female carers may be particularly expected to manage their caregiving duties whilst fulfilling their own social needs, leading to a different yet similarly challenging set of expectations (Szafran et al., 2016). On the other hand, some young carers report developing stronger familial bonds and increased maturity due to their caregiving roles (Dharampal & Ani, 2019). Such developmental nuances highlight the paradox of being a young carer: while the responsibilities can lead to significant emotional burden, they can also foster resilience, empathy and a robust sense of identity linked to their caregiving experiences (Saragosa et al., 2022).

The integration of supportive structures within educational institutions is essential to facilitate the social inclusion of young carers. The establishment of peer support groups, adult mentorship programs and training for faculty members can create environments where young carers feel understood and valued. Indeed, such structures have shown promising results in their ability to provide academic support and enhance social capital through peer relationships and adult mentorship (Matzka & Nagl-Cupal, 2020; Chikhradze et al., 2017).

Technology also presents novel opportunities for enhancing the social capital of young carers. The use of social media and online platforms for connecting with peers can provide essential support mechanisms, especially during times of social isolation (Leu et al., 2018; Landi et al., 2022). Innovations in digital peer support networks can also facilitate connections between young carers who may feel isolated from their immediate social environments (Brimblecombe et al., 2024).

In summary, the interplay of social capital in the lives of young carers presents a complex scenario marked by resilience, isolation and developmental challenges. Recognising the importance of social networks, schools and community structures in supporting these individuals is critical for fostering a more inclusive environment. Policies that are sensitive to the needs of young carers while implementing practical measures to amplify their opportunities for building social capital are needed. The potential of young carers – when adequately supported – should not be underestimated as they transition through adolescence, contributing significantly to their families and communities (Cunningham et al., 2016; Barry, 2011).

3. Study objectives and methodology

Studies have shown that while social capital is a resource that enables families to overcome daily challenges, it can also be eroded when care burdens are excessive and inadequately supported.

The aim of this study was to gain insight into the personal experiences of a sample of young adult caregivers, in terms of the type of support being received and the impact that their caregiving tasks was having on their personal, family and professional lives. This information would allow us to ascertain whether, and to what extent, receiving informal support fosters resilience in caregivers and constitutes a protective factor for their own well-being. We hypothesised that the supporter and the presence of a support network around the carer, even a small one, would protect against the erosion of the caregiver's relational resources as it would allow for the care burden to be shared.

The methodological design was structured to enable the carers' relationships to be mapped out. It consisted of two online interviews: the aim of the first was to sketch out each carer's social support network; the second was a dyadic interview[2] carried out in the presence of a person whom the carer felt supported him/her in the caregiving task.

The support person (S) was identified by the carer, and their role in the caregiving task could be direct or indirect.

This method allowed us to map the support network on the one hand and, on the other, to gain an in-depth understanding of the experience of caring for a sick family member. In this sense, dyadic interviews could represent an important moment for narrating the experience, enhancing a deep understanding of illness and care experiences.

The therapeutic potential of illness narratives has been broadly documented, showing how storytelling is a means for reflection and dealing with chronic diseases (Riessman, 2015; Gucciardi et al., 2016; Grazzi et al., 2020). Such reflexivity allows people to construct meaning from their experiences, influenced by the other (in this case the support person involved in the interview), the context, and the personal significance assigned to events.

The overall objective of this study was to answer the following research questions related to the experience of each young adult caregiver:

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[2] This technique allows to grasp the helping relationship between the carer and the supporter. See also the contribution of Bramanti and Carradore (2025) in this volume.

- RQ1. What is the role of the carer in the support network?
- RQ2. To what extent is the presence of a support person a protective factor for the erosion of the caregiver's relational, mental and physical resources?
- RQ3. How does the caregiving process impact the perception of well-being and C's possibility to plan for the future?

The data used in this study were collected in 2024 and refer to ten dyads of young adult carers (C) and their respective supporters (S)[3] (for a total of 20 people). All individuals were living in Italy. The interviews were video recorded, transcribed and analysed using NVivo software.

The structural characteristics of the dyads interviewed are reported in table 1.

Table 1. Characteristics of the study dyads.

Id.	**Interviewed Dyads**		**Person Assisted - PA (relationship with C, age)**	**Number of people in the caregiver's family**	**Caregiver lives with:**
	Caregiver - C (gender, age)	**Supporter - S** (relationship with C, age			
YC1	F, 37	C Partner, 36	Mother of C, 73, Alzheimer	2	Partner
YC2	F, 27	C Uncle, 45	Grandmother of C, 80	4	Grandparents and other relatives
YC3	F, 27	C Mother, 63	Brother of C with severe disability, 20	7	Partner, parents and siblings
YC4	M, 19	C Uncle, 47	Mother of C, 52 (Parkinson)	2	Mother
YC5	F, 18	C Father, 54	Mother of C, 51 (Parkinson)	3	Parents
YC6	F, 33	C Partner, 35	Mother of C, 63 (Parkinson)	3	Partner and own child
YC7	F, 31	C Partner, 35	Daughter of C, rare genetic disease, 3	6	Partner, own children and parents
YC8	F, 30	C Mother, 64	Daughter of C, rare genetic disease, 4	3	Partner and own child
YC9	F, 35	C Partner, 45	Son of C, rare genetic disease, 3	3	Partner and own child
YC10	F, 27	C Friend, 29	Uncle of C, 93	5	Parents and siblings

All carers were aged between 18 and 37 years. The supporter was often a partner; in some cases they were a parent or relative; and in one case they were

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[3] For more details on the methodology, see the introduction of this issue and the contribution of Bramanti and Carradore (2025) in this issue.

a friend. The person they were caring for was most frequently a parent (often the mother), but in other cases they were a grandparent, uncle, son, daughter or sibling.

With regard to the caregiving tasks being performed, all participants emphasised their role in providing emotional support, personal care and organisational activities. Often the caregiver did not carry this task out alone but together with other family members. In all cases, their caregiving role had a strong impact on the organization of their own life, including their work life, intimate relationships and their choices related to travelling and commuting. Many reported a sense of limitation and the inability to make long-term plans. The young carers reported being tired and worried about the future. They were often engaged in organisational and managerial tasks that led them to have disputes with the welfare system related to the activation of formal support. The complicated and slow nature of the welfare system was often mentioned.

In summary, we were able to distinguish two types of dyads related to the care burden:

- *Supportive Dyads*, in which the C was mainly involved in providing emotional support and organizational activities, and the role of the S was primarily directed towards C (and less so towards PA). Dyads YC1, YC2, YC4, YC5, YC6 and YC10 were considered in this predominant group.
- *Collaborative Dyads*, in which both C and S were involved in a practical manner in providing care to PA (in a complex mix of activities of a practical, emotional and organization nature). Dyads YC3, YC7, YC8 and YC9 were considered in this smaller group.

4. Results

In this contribution, two dyads, one from each group, are presented and discussed in depth. They differ with respect to the relationship between C and PA and the care tasks being provided. In line with the methodological framework discussed above, the 'structural' variables of the dyad are taken into consideration rather than classical variables such as gender and age to reflect on how these dyads fit into informal intra- and extra-family networks.

The first dyad (YC01) consists of a cohabiting couple, where the carer (C) is a 37-year-old young woman caring for her mother with Alzheimer's disease (PA), and her supporter (S) is her 36-year-old partner. The second dyad (YC07) also consists of a young couple, where the caregiver (C) is the mother of a 3-year-old girl (PA) with a rare and disabling genetic disease and her supporter (S) is her partner and father of her daughter. Thus, the first dyad is a childless cohabiting couple engaged in caring for an elderly and ill parent, whereas the second dyad consists of two parents engaged in caring for their own daughter.

These two dyads can be considered representative of the two groups identified above in terms of the differences in network structure (i.e. the roles played by C and S). In one case the PA is an elderly person and in the other it is a child.

4.1. Dyad YC1: supportive couple taking care of an elderly parent

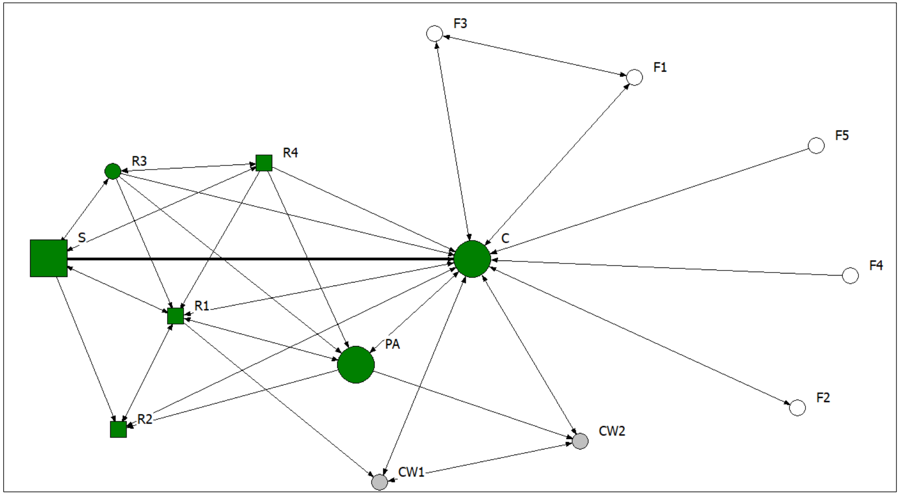
4.1.1 The care burden

C is a 37-year-old young woman, and since 2021 she has been caring for her 73-year-old mother (PA) who suffers from a fast-progressing form of Alzheimer's disease. At the time of the interview in 2024, PA's Alzheimer's was in an advanced state. PA lives with her husband, C's father (R1 in figure 1), who is also elderly but in good health, and who looks after PA daily. The PA can never be left alone due to her disease state. PA is unable to carry out normal daily activities, despite being physically able, due to the advanced phase of her cognitive impairment: *"I see that on some occasions she recognises me, she appears to be fully aware that I am her daughter, but in other moments… she isn't at all"* (C).

C is helped by her 36-year-old partner (S), with whom she is in a long-term relationship. They cohabit just a few kilometres away from her family of origin. C sees her partner as "the person who is closest to her and who can understand her the most". Even though he does not take care of C's mother directly, he always accompanies her to her parents' house and is always present, helping as much as he can. Moreover, S had previously experienced the illness and loss of his own father, albeit under different circumstances. The couple feel they have become more united due to performing these care experiences: *"we have supported each other in two very difficult situations; we have shared these difficult situations"* (C). C first became aware of her mother's illness during the pandemic, when she was living with her parents and working from home. She noticed that her mother was progressively forgetting things and not doing normal activities that she used to do on her own. The diagnosis was very difficult for C to hear: *"it was really hard finding out about my mum ['s illness], and I still struggle accepting it, especially now that it's at an advanced stage. I struggle finding a way to dialogue with and connect with her"* (C).

After the onset of the illness, C decided to move in with her partner to get some distance from her family and the situation she was beginning to experience. C visits her parents every weekend, with the help of her partner (S), in order to support her father as much as possible. C experiences this situation with a sense of fatigue and tiredness that she openly declares: "*even though I mainly only go on weekends, it's not easy for me to be there with my parents, also because I find it very stressful and tiring even though it's my dad who takes care of my mum's daily needs*" (C).

Figure 1. YC1 Dyad support network (support given and received).



Legend: C = caregiver; PA = person assisted; S = supporter; R = relative; F = friends; CW = co-worker; square = male; circle = female; green = family member; white = non-family member; thickest line = dyadic relationship.

4.1.2 *Structure of the dyad support network*

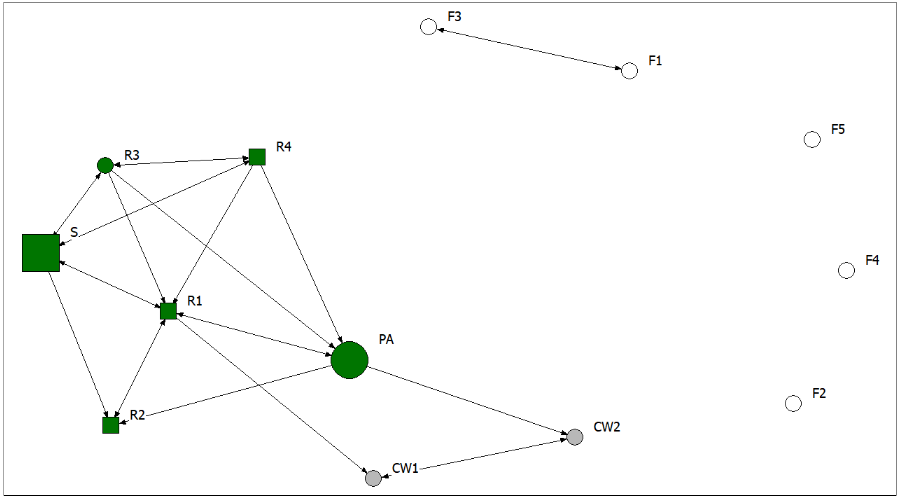
By reconstructing the personal support network, which indicates the help being given and received by all members, we can see how the dyad fits into this network (Chiesi, 1999; Scott, 2002; Tronca, 2005). The network consists of 14 individuals (nodes), including family and non-family members in equal numbers (7 relatives, 5 friends and 2 colleagues). The network contains 10 females and 4 males (Figure 1). The average age of the individuals in the network (C excluded) to which C provides help is 51.4 (S.D. 14.8), and the average age of the individuals in the network providing support to C is 49 (S.D. 16.9). The modal value of the educational level of both networks (C excluded) is 'university degree', indicating high cultural capital of both networks.

PA lives at home with her husband (C's father), who takes care of her on a continuous basis. C's brother (R2 - 44 years old, married) lives close to his parents, but he does not make a significant contribution to providing support to PA: *"My brother has always taken… let's say… a bit more of a back seat, especially at the beginning, even if he lives very close to mum and dad"* (C). This makes C the main point of reference for her parents when they need help, especially because PA can never be left alone and has to be monitored constantly.

Both C and her partner report their wish for C's brother to be more involved, both for logistical reasons (he lives in the same building) and because C feels overloaded such that she requires the support of a (private) psychologist.

Referring to some network measures, we can see that the *density* of the network (i.e. the number of actual relationships divided by the maximum number of theoretically possible relationships) is 0.27, indicating a very loosely meshed (i.e. not very dense) network (Trobia & Milia, 2011); the *ego-centric density* (the density of the network excluding Ego) is 0.15. These two measures (*density* and *ego-centric density*) indicate a bridging shape of the network; i.e. an open network in which C performs a bridging function from within the family to the outside (Tronca, 2021). Furthermore, in this network, C is the subject with the highest level of broker ability (the *effective size* being 11.17, one of the highest values of all the interviewed dyads; and the value of *Constraint* is 0.21) (Burt, 1992).

Figure 2. Network of the YC1 excluding C.



Legend: C = caregiver; PA = person assisted; S = supporter; R = relative; F = friends; CW = coworker; square = male; circle = female; green = family member; white = non-family member; thickest line = dyadic relationship.

This role of C is evident from the figure 2: if we remove C, the family network around PA remains intact as C's friends and work colleagues are disconnected from PA. We can also note that S is well connected to the PA family network.

With respect to C, the *in-degree* measure has a normalised[4] value of 1, indicating that all the members of the network have a direct relationship with the carer. The *in-degree* is the incoming degree, i.e. the support that the other members of the network offer to the caregiver,[5] the *out-degree* (outgoing degree), i.e. the relationships that originate from the caregiver and are directed towards the others in the network, has a normalised value of 0.62 (Table 2).

Table 2. Out-degree and in-degree for all the nodes.

	Outdeg	**Indeg**	**nOutdeg**	**nIndeg**
C	8	13	0.615	1.000
PA	4	4	0.308	0.308
R1	5	6	0.385	0.462
R2	2	4	0.154	0.308
F1	2	2	0.154	0.154
F2	1	1	0.077	0.077
F3	2	2	0.154	0.154
CW1	2	3	0.154	0.231
CW2	2	3	0.154	0.231
R3	5	2	0.385	0.154
R4	5	2	0.385	0.154
F4	1	0	0.077	0.000
F5	1	0	0.077	0.000
S	5	3	0.385	0.231

Focusing on the role of the caregiver in relation to the network: the *betweenness centrality of C* is high at 92.92 (normalized value: 59.56), indicating that the ability of C to influence the relationships between the pairs of nodes is high; for example, by controlling the resources transferred between other members of the network. Thus, the network supporting the dyad also consists of some relatives. In addition, there is a reciprocal relationship of support between C and friends and colleagues. This is mainly material, informative and strategic help, where PR is particularly important for moral, emotional and informational support.

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[4] The normalised value is given by the ratio between the value of the in-degree and the maximum value the degree could reach. The same is for the out-degre value (Tronca, 2005).

[5] This was investigated with the following question: 'Overall, in the last 12 months, have you received any support or help from other people (friends or colleagues)?'

4.1.3 Care challenges and risks

After PA's diagnosis during the pandemic, her need for assistance increased rapidly, requiring the constant presence of a care-giver, which is generally C's father: *"the disease has advanced quickly and she started to become rather limited in her speech and mobility, so she needs to be looked after once she gets up as she might fall and hurt herself"* (PR). The open RSA[6] service was recently activated, which enables an individual to receive specific treatment by specialists at home (e.g. by OSS[7] and physiotherapists). C's role in the network is to support and alleviate her father's burden as much as possible, especially during weekends, and she also takes care of the organisational aspects of PA's medical-health pathway and, with the help of her partner, all the bureaucratic aspects of PA's care, such as the activation of the open RSA.

Despite the volume of the burden and feeling tired, C is happy to look after her mother and is grateful for the help she has received: *"I see myself in this role, I feel that I am predisposed for this [role] as my mother was before she got sick; she has always been there for me and my brother, and she has dedicated herself so much to our family"* (C); C's commitment is recognised and much appreciated, especially by her father, but less so by her brother.

The dyad identifies both benefits and drawbacks of the care experience. One of the advantages C mentions is the improvement in her relationship with her father: "*I had a very limited relationship with my dad, I had a hard time talking to him, and my mum's illness made me re-evaluate my relationship with him and it enabled me to get a lot closer to him*". She discovered unexpected personal resources as well as the ability to manage critical situations. S also reported how the situation with C's family provided him with the possibility to experience positive reciprocal and authentic relationships, despite the fatigue.

The difficulties reported concern the level of commitment and emotional burden associated with the weekly visits to PA (*"It's really hard for me to go there alone,"* C), their concern for the health of C's elderly father, the rapid progression of PA's illness, and low level of involvement of C's brother (*"her brother lives upstairs [in an apartment on the floor above], but if PA needs help it is usually us who he calls"* S). The caregiving load also has some negative repercussions on the couple's (C and S) relationship, as their time and plans are tied to the caring

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[6] RSA (Residential Care Home) is a non-hospital social and healthcare facility that provides care for elderly or disabled people who are not self-sufficient. In this case, the service is provided in the patient's home by practitioners.

[7] The Italian OSS (Operatore Socio Sanitario) is a "Social Health Care Worker", a professional figure trained to provide assistance to individuals (the elderly, ill or disabled) in different settings (in hospitals or other care facilities as well as at home).

needs of PA: "*To be honest, it's more of an obligation ....*" (S). "*He experiences it as an obligation .... we spend a lot of time discussing this situation, and I realise that I am asking a lot from him … that we have less time for ourselves, because in the end we are pretty much trapped in this situation*" (C). "*… The main disadvantage regards time, in the sense that we do not have the freedom to decide how we spend our time, this is a disadvantage for me*" (S).

4.1.4 Reconciling work and care

At the time of the interview, C was able to balance her work and caregiving responsibilities; however, this was mainly thanks to the working conditions of the couple. S was self-employed so it was easy for him to organize himself in a way that was functional to the family, even though he was not involved in caring for PA directly. C, on the other hand, was employed by a private company and reported difficulty in being able to use the statutory leave to which she was entitled. Whilst C reported feeling supported by those she worked closely with (i.e. colleagues and team leaders), she felt that her employer's HR department did not adequately recognise or value her right to request statutory leave for caregiving reasons.

Thus, C's perception of support from her employer was closely linked to specific people involved: *"Fortunately, I have a direct manager who is a bit more sensitive about this, she knows about my family situation, and she told me that I needn't worry about asking for leave. But the person we had before, who was responsible for the whole structure, on the other hand, was not very sensitive to this type of issue"* (C).

C gave her opinion that corporate organisations in Italy offer very little support to individuals trying to manage these types of problems, and statutory leave was only considered in relation to childcare: *"in my opinion, the attitude about certain issues is still a bit backward ... it [the caregiving role] needs to be recognised and shared more and today it is not, but I think it's the same in many companies...."* (C).

4.2. Dyad YC7: collaborative couple facing hard parenthood

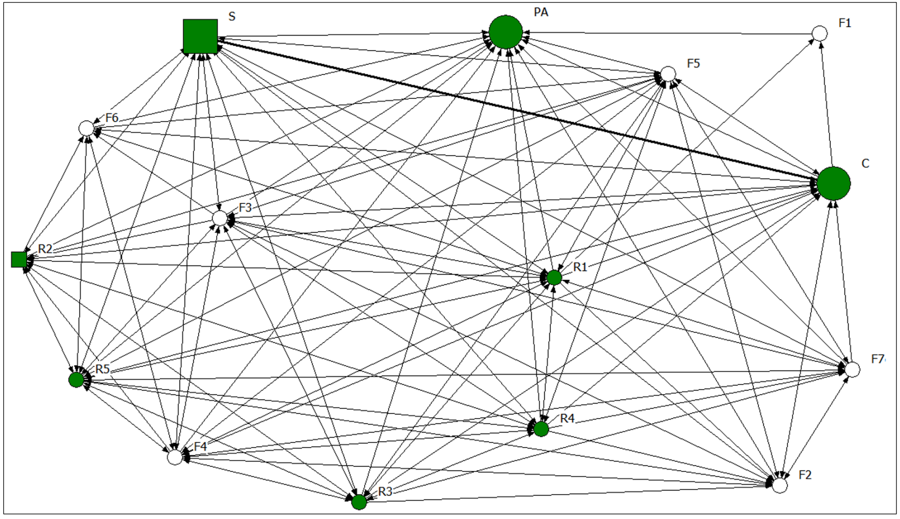
4.2.1 The care burden

C is a young (31-year-old) mother of two children aged three (the PA) and one. C lives with her 35-year-old partner (S), and together they take care of their children. The older child is affected by a rare genetic skin disorder characterized by fragile, blistering skin. The condition was diagnosed at birth, after a normal pregnancy, and requires continuous care, monitoring and treatment. The mother and father were immediately separated from the newborn, who had to be transferred to a specialised paediatric hospital: "*the first year was devastating, people tell you that when you give birth they put the baby on you and this indissoluble bond is created... but my daughter was taken away from me immediately, I didn't even have the chance to see her*" (C). In the first few weeks after the birth, the parents, assisted by the medical staff, had to learn special manoeuvres for handling the child and dressing her wounds before they could take her home. The child's nutrition was also an issue and required the learning of specific procedures. "*We were in hospital for two or three weeks, we didn't know how to touch her, how to change her nappy, how to dress her, then after two weeks we were discharged, we went home for the first time all three of us together and we didn't really know how to do it, we were alone and we didn't know how to touch her...*" (C).

4.2.2 Structure of the dyad support network

The personal support network shows how the dyad is embedded within the network. The network consists of 15 people (nodes), with a strong presence of family members (8 relatives) as well as 7 friends (Figure 3).

Figure 3. YC7 Dyad Support Network (support given and received).



Legend: C = caregiver; PA = person assisted; S = supporter; R = relative; F = friends; CW = coworker; square = male; circle = female; green = family member; white = non-family member; thicker line = dyadic relationship.

Thirteen nodes are female (including C), and two are male. The average age of the network receiving help from C (C excluded) is 28.6 years (SD 11.5), whereas the average age of the network supporting C is 48.9 years (S.D. 12). The modal value related to the educational level (C excluded) is 'high school diploma' (the certificate allowing enrolment at university) for both networks (help given and received), implicating an average level of cultural capital.

Figure 4 shows the composition of the network help given (figure 4), which includes seven predominantly extra-familial people (in addition to PA) and their relationships. It represents the people to whom C provides help. These people were identified with a specific item in the questionnaire. C may also receive help from these people, so the arrows indicate a reciprocal relationship.

Figure 4. Network of help being given.

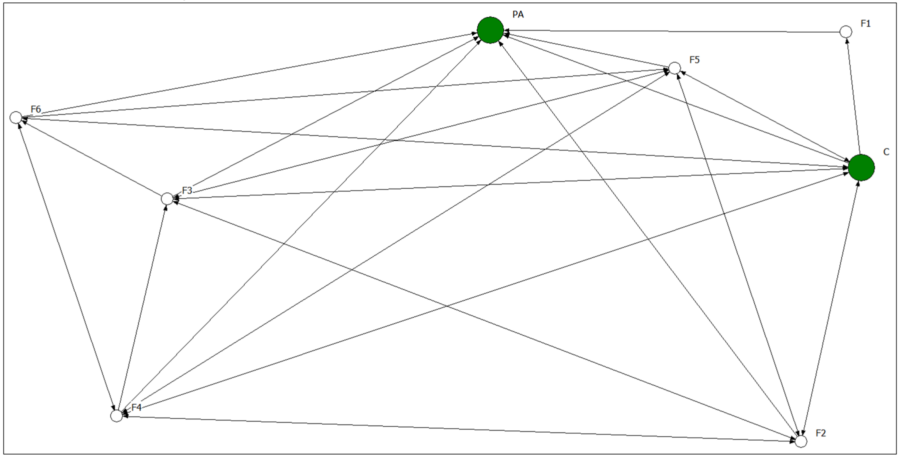


Figure 5 shows the network of help received (including the dyadic relationship) also made up of seven nodes, all of which are family members. In both cases, the help being provided is predominantly non-material, and includes the provision of information, contacts and moral support. The figure includes the people whom C has indicated as people from which she receives help. In this case too, C receives help and can reciprocate.

C looks after the PA on a full time basis and is almost always present at home since she was not working at the time of the interview. Due to the specialised nature of care the child requires, and the absence of any appropriately trained professionals, the parents cannot obtain help in the form of babysitters, paid or unpaid. Instead, the couple can only rely on help from by family network; for example, from C's parents who live close to the couple and who have learnt how to handle the child appropriately. In addition to the technical competence required to touch and handle the child, there is also the issue of trust, which must be very high for the parents to be able to leave the child with anybody. This is why the couple only seek help from close relatives: "*regarding her management, I can only have help from family members I trust, like my sister or my mother, because no one else has the preparation that is required, not even the national health system*" (C).

Figure 5. Network of help received.

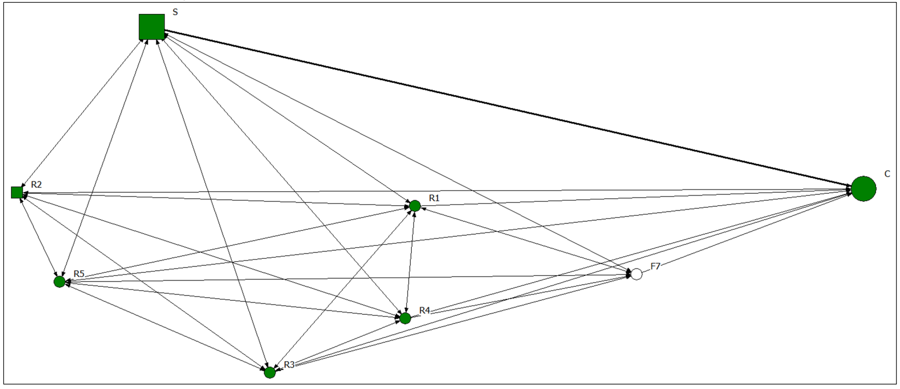
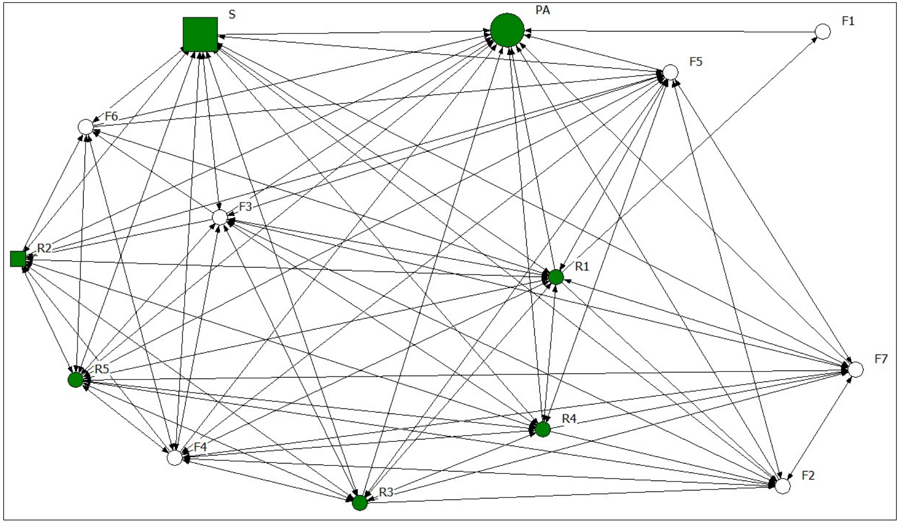


Figure 6. The network of YC7 without C.



The density of the network is 0.66, indicating a close-meshed network (Trobia & Milia, 2011), and the ego-centric density is 0.37. In this case, even once the caregiver (ego) is removed, we can see that the nodes remain connected to PA and S, with no isolated or disconnected nodes (figure 6).

With respect to C, the normalised *in-degree* value is 0.86, indicating that almost all members have a relationship with C, be it direct or indirect; the normalised *out-degree* value is 0.50, indicating that C mainly focuses on specific nodes within the network (the effective size is 4.89, and the constraint value is 0.27). As we can see in Table 3, C's mother is the person with the greatest capacity to mediate between two nodes, i.e., between the different nodes (nOutdeg= 1)

Table 3. Out-degree and In-degree of all nodes

	Outdeg	**Indeg**	**nOutdeg**	**nIndeg**
C	7	12	0.500	0.857
PA	0	14	0.000	1.000
F1	1	2	0.071	0.143
F2	6	10	0.429	0.714
F3	12	10	0.857	0.714
F4	13	9	0.929	0.643
F5	12	12	0.857	0.857
F6	7	7	0.500	0.500
R1	14	10	1.000	0.714
R2	9	8	0.643	0.571
R3	12	8	0.857	0.571
R4	12	8	0.857	0.571
R5	13	9	0.929	0.643
S	13	10	0.929	0.714
F7	7	9	0.500	0.643

Focusing on C's role in the network: C's *Betweeness* measure (normalised value) is 4.43, meaning that C has little ability to mediate between two network nodes. So, the role of C here differs from that in the previous dyad (YC01).

4.2.3 Care challenges and risks

The child (PA) in this network needs constant supervision and care to prevent her from hurting herself and to immediately medicate any injuries that may occur. Her medical condition also necessitates the use of specialised clothing and skin products, which can only be obtained through specific channels (treatment plans), meaning that they sometimes have difficulty getting hold of the products they need when they need them.

The PA is followed by a specialist healthcare centre for skin diseases located far away from the family's home (outside the region). However, contact with these doctors is necessary since paediatricians or normal medical personnel (e.g. from the emergency services) are often not adequately familiar with the pathology or adequately trained in how to manage the child's lesions. In addition to this, the PA undergoes some specific therapies, such as psychomotricity and swallowing rehabilitation (close to her place of residence), for which she must be accompanied by a parent.

PA's illness has a high impact on the lives of the young couple, who have nevertheless managed to remain united while coping with the difficulties, as recounted by the child's father: "*I was obviously stressed, there was a time when I got given a lot of responsibility at work, so I was working a lot, when I came home there was always something I had to do for my daughter, it was stressful, so we [my wife and I] often had fights. Then, fortunately, we started to find a bit of balance and so our relationship improved until we reached the state we have now*" (S); "*at the beginning it was difficult, because we were so angry and we each took it out on each other, also because it was a recessive disease [so we felt to blame]*" (C).

The couple also have another child, aged one at the time of the interview. They recount their experience of having a second child with joy: *"the first year with our daughter was very difficult, but I must say that we found our balance with our second son"* (S); "*he really put many things back into balance, he was born when our first daughter was 14 months old and who was not yet walking, because she walked late, for us it was like... a redemption I think, our personal redemption, as parents. He really gave us the right balance in not being pathologically attached to the disease*" (C).

The PA attends kindergarten, and the parents are very happy with their daughter's situation now, who is looked after by trained educators at school. The biggest difficulties the parents must contend with are: the constant risk of their daughter getting hurt (of having new lesions), the time-consuming nature of every activity that a normal family performs on a daily basis (from dressing to eating), and the presence of the pain they perceive on the child's face: "*After four years we have become very good at handling the wounds, we can treat them even if she moves a lot, but she always feels pain. And what she says to me, 'you're hurting me, go away, I don't want you' …, well, for a mother it's never pleasant to hear that; but we know that it is the only way to keep her safe, so we have to do it even if it hurts her*" (C).

4.2.4 Reconciling work and care

C was not working at the time of the interview. After the first two years of extraordinary leave, she was forced to leave her job because it was not possible to reconcile it with caring for her daughter: "*they would not accept any part-time* *agreement in any way. I asked if I could work in the afternoons and evenings only so that I would be available in the morning for the therapies... they did not accommodate me at all... I was forced to resign, and I am looking for a job here near where I live because it is the only way to guarantee both work and taking care of my child*" (C).

S, on the other hand, found a very supportive environment that allowed him to change his place of work to be closer to his family: "*I used all my holidays and leave of absence, and the director told me not to worry if I needed time, that is, whatever happened with my daughter, I could get away, I had no problems, they were always much more empathetic and much more understanding than in other workplaces... even my colleagues gave us a supply of a very expensive cream that we were using but not provided by the national health system, and they helped us in that way*".

4.2.5 The experience of founding an association

C and her family founded an association to help other families and other children with the same pathology. The association is mainly active with legal assistance and material support (sending medical supplies or other materials to families that for various reasons are unable to receive adequate supplies). This activity, above all others, allowed for the creation of a network of families, which, by staying in close contact, support each other and exchange advice: "*it offers support, let's say, in the form of information on how to dress the wounds, what to do, and by sharing knowledge about products... a wide exchange between families, 'I use this', 'I tried this,' 'I tried this cream and it works'... no doctor tells you these things*" (C).

The experience of the association has enabled the dyad to engage in constructive exchanges with a very wide network of families, although the couple pointed out that the association is sometimes used in a one-way manner: "*it is difficult to create a true sense of membership among the associates, as some only interact with the association when they need something, but they don't really feel part of it … 'membership' means we are part of a team, we all contribute and benefit from the association…, if we want to achieve something we have to move as a group... but this is easier said than done*" (C).

5. Discussion and conclusion

The experience of young and young adult carers is often associated with great loneliness, stress and a high risk of burnout. We hypothesized that this stress can be reduced by informal networks and social capital. The aim of this study, conducted on a sample of ten dyads of young adult carers (C) and their respective supporters (S) (aged between 18 and 37 years), was to understand the type of support the carers were receiving and the impact caring was having on their private, family and professional lives.

The study used an innovative approach to understand supportive relationships. It involves two interviews designed to evaluate the support relationships around carers and how the characteristics of networks were able to help the care burden being shared. The goal of the first interview with C was to gain a clear understanding of their personal support network. The second interview was a dyadic interview conducted in the presence of the carer's prime supporter. This second interview was specifically designed to understand the helping relationship from the dyad's point of view.

The analysis was conducted on all 10 dyads, and it indicated the presence of two main types of dyad relationship: supportive and collaborative. This work analysed in detail the experiences of a representative dyad from these two types.

To address RQ1, 'What is the role of the carer in the support network?', we performed network analysis on the two representative dyads, and found the presence of a wide support network in both. The networks included both males and females, family members and non-family members. The educational level of the first dyad was high, whereas that of the second was medium. The carers are the active nodes in the network, meaning that they are in the position to mediate between the network of family members and that of non-family members.

In both dyads examined, it is interesting to note that the network of people to which C provides help comprises both family and non-family members, whereas C primarily (or exclusively) receives help from family members only. This was very evident in dyad 2 (figures 4 and 5). The role of C differed in the two dyads analysed: when we removed C in the first dyad ('supportive'), friends and work colleagues were shown to be disconnected from PA (figure 2), whereas in the second dyad ('collaborative'), the family network around PA remained and included the role of S (figure 6), indicating that although caring may often be performed to a large degree by a single person (C), it can also be organised as a broad relational process to involve others.

While this study revealed a relatively extensive network of actors around the carer in both cases, we can see that in both cases C primarily received help from family members, and in particular by the supporter (S) who, in all cases except one (see table 1) was a family member.

In addition to confirming the family dimension of caregiving, this study highlights a further detail of the caregiving experience. Not only does the caregiving experience concern the carer plus various members of the family network (although the roles and the level of direct contact with the PA may vary) but it is also an experience that concerns relationships. In our opinion, this is an interesting piece of evidence which, without claiming to be representative, highlights the relational dimension of caregiving in this specific phase of the life cycle (Boccacin, 2025).

In a previous study carried out in Italy aimed at capturing the caregiving experience of young, young adult and former carers, the presence of a sense of deep loneliness emerged. Some reported having to take on caregiving roles as children and/or adolescents and that they found it difficult to talk about their experiences with others (including their peers and adults of reference such as teachers); they appeared to perceive their role as a secret not to be talked about. The difference between the representation of caregiving as an experience of loneliness, as found in the previous study (Bramanti & Bosoni, 2025), and that of sharing, as found here, can probably also be explained by the higher age of the interviewees in this study, who have already transitioned to adulthood. Their accumulated experience in other life spheres (work, social life, etc.) would have given them the possibility to generate higher levels of social capital as well as the personal agency to act on it.

RQ2 asked 'to what extent is the presence of a support person a protective factor against the erosion of the caregiver's relational, mental and physical resources?' We can see that although the role played by S may vary – from primarily providing emotional and organisational support in the case of 'supportive dyads' (first dyad) to the provision of more practical support in the case of 'collaborative dyads' (second dyad) – the benefit that C gains from their presence is clearly important.

Both dyads analysed were characterised by extended social capital, which appeared to be very efficient and contributed towards both the practical aspects of caring as well as non-practical help.

RQ3 asked 'How does the caregiving process impact the perception of well-being and the C's possibility to plan for the future?' However, since S is often the partner of C, it is important to mention that both members of a couple risked feeling that the caregiving role was impacting their individual wellbeing and limiting the possibility to plan for the future. Indeed, the ability to 'move beyond caregiving and plan for the future' has been discussed in several studies. For example, while young and adult carers may express their desire to start their own families or to move abroad for work opportunities, they also reported feeling torn between relief and guilt at the idea of diminishing their caregiving duties (Saragosa et al., 2022; Stamatopoulos, 2018).

A difference between the two dyads concerns their attitude towards caregiving and acceptance of the role of carer. As noted in previous studies, the first step in 'encountering the disease' phase includes accepting the role, referring to filial obligation, religious reasons or an unexpected diagnosis. Many young carers accept the role without question, reporting that they "just do it", adjusting to a new day-to-day reality entailing more responsibilities (Saragosa et al., 2022). In the present study, while supportive dyads reference 'family solidarity' and accept their caregiving duties, in collaborative dyads where caregiving is associated to a disease or disability this phase of accepting the role is more complex and challenging.

In conclusion, despite the limitations of a non-representative sample, this study shows that the caregiving experience in young adults is wide and complex, and can involve relatively large support networks, mainly made up of family members. This also highlights the potential positive and preventive role of social capital in this phase of life.

However, the study also shows a lack of policy and intervention to support carers in their caregiving duties, confirming the previous literature. Obtaining welfare services requires the activation of complex bureaucratic procedures, often entailing long time scales and so failing to meet the immediate needs of families. Moreover, welfare professionals are not always made aware of the caring roles being fulfilled by young and adult people. Instead, carers are often pushed to fall back on their family networks to meet their care needs. To change this, some studies suggest: i) the need for carers to be formally recognised by national and local policies, which are still absent in Italy (Casu et al., 2021); ii) the need for good-practice tools, such as family questionnaires, to help welfare professionals identify young carers and get them in touch with the appropriate support services (Saragosa et al., 2022) such as training and mutual support groups.

In addition, the role of corporate welfare also emerges as a crucial point, while still limited: the interplay between caregiving responsibilities and work-life balance is increasingly recognized as a significant issue affecting both personal well-being and organizational productivity. Workplace policies (such as flexible work arrangements and supportive welfare culture) play a critical role in influencing how caregivers manage their dual roles. However, despite the growing recognition of the need for such policies, many organizations still do not provide adequate support for caregivers. Some family-friendly workplace policies do exist, yet they often fall short of adequately addressing the complexities associated with caregiving.

In conclusion, this study highlights how young adult carers often play a pivotal role within their support networks, frequently acting as bridges between family and external contacts. The presence of a supporter – most often a close family member – emerges as a key protective factor, particularly for emotional and organizational support. However, the caregiving burden significantly affects carers' well-being, limits long-term planning and impacts couple dynamics. While support networks exist, they are often limited to the family sphere, increasing the risk of isolation. Social capital appears to buffer some of the strain, yet remains insufficient without formal recognition and systemic support. Thus, there is an urgent need for structured interventions that formally acknowledge and assist young carers in navigating transitions to adult life. Although based on a small sample, the study reveals the relational and complex nature of caregiving in young adulthood, and it calls for integrated approaches combining informal and formal resources to truly support these invisible caregivers.

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