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Underestimating gender-based violence in care: the silent burden of informal female caregiving

Lucia Landolfi [a*]

[a] *University of Salerno, Salerno, Italy*

Abstract
Informal female caregiving remains a deeply gendered phenomenon, embedded in cultural norms that perpetuate systemic violence against women. In Italy, caregiving continues to fall predominantly on women and is often framed as a moral duty rather than recognised as labour (Hochschild 1983). Drawing on Amartya Sen's (1993) capability approach, this study explores how informal caregiving, frequently imposed rather than chosen, affects women's well-being and sustains patriarchal structures. Specifically, it addresses the following research question: How do culturally embedded expectations regarding the caregiving role shape informal female caregivers' self-perceptions and contribute to forms of systemic micro-violence?

Using qualitative semi-structured interviews with informal female caregivers of people with Parkinson's disease (n=25), the research identifies three caregiving configurations emerging from the intersection of attitudes, behaviours, and role expressions: *"I am, therefore I care"*, *"I love, therefore I care"*, and *"I must, therefore I care"*. These types reveal the continuum between agency and coercion that shapes women's caregiving experiences.

The findings highlight two intertwined forms of violence: symbolic violence, which normalises caregiving as an inherent female duty, and structural violence, rooted in institutional neglect and inadequate welfare support.

By linking empirical insights to theoretical frameworks, the study demonstrates that informal caregiving operates as a subtle yet pervasive form of gender-based violence, sustained by cultural expectations and policy silence. It calls for a gender-sensitive welfare model capable of dismantling patriarchal norms, enhancing caregivers' capabilities, and promoting caregiving as a shared social responsibility rather than a naturalised female obligation.

Keywords: *women; care; capacity; symbolic violence; structural violence*

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[*] Corresponding author: Lucia Landolfi. *Email: llandolfi@unisa.it*

1. Introduction. Reasons for the research

This contribution arose serendipitously (Merton 1948) as part of a broader qualitative investigation focusing on life trajectories contexts of chronic illness and the configurations of informal care. During interviews with people with Parkinson's disease and their informal caregivers, the research question that emerged was: why does caregiving within the family continue to be predominantly carried out by women in Italy? More importantly, what motives lie behind the seemingly comforting guise of dedication, love or responsibility in assuming the role of informal caregiver?

At first glance, invoking the concept of *violence* in the analysis of family care may seem forced or excessive. It could be argued that such a perspective risks flattening the complexity of emotional relationships or reducing the ethical dimension of care – as proposed by authors such as Tronto (1993/2006) – to a rigid regulatory device. However, precisely because caregiving is often described in terms of a natural female vocation, it is urgent to question what happens when the narrative of care as a gift is intertwined with cultural devices that operate as forms of symbolic violence (Bourdieu 1998), normalising the unequal distribution of care work.

Care is a central hub for understanding the dynamics through which social order is reproduced (Di Nicola and Viviani 2020) and, as such, it is also a field traversed by potential forms of violence, both symbolic and structural. The inequalities that emerge in formal care work (Landolfi 2023) and the multiple shortcomings that characterise it – from institutional gaps to job insecurity and lack of recognition – reveal dynamics of systemic violence that are often normalised. Added to this is the historical association between women and care, the result of a process of differential socialisation that transforms a social function into a gender-based moral imperative. This association, which has its roots in the social reproduction of biological difference (Cersosimo 2023), has confined women to the private sphere, assigning them roles of emotional and relational responsibility and depriving them of public and rational legitimacy.

This cultural construct, supported by deeply internalised social expectations, tends to naturalise the act of caring, transforming it into a vocation, a mission or an innate duty of women (Hochschild 1983). However, the implications of this representation are significant, especially when the role of caregiver is assumed in the absence of real alternatives or as an automatic response to an internalised symbolic order, creating conditions that can lead to forms of invisible oppression. Help in the relationship between those living with illness and those who care for them informally cannot be considered an exclusively individual act, but should instead be interpreted as a social process involving strong moral, political and relational dimensions. When this help is asymmetrical, generating disadvantageous dynamics even without conscious intentions, it can become a means of oppression (Cabiati 2025) and, ultimately, lead to forms of violence. It is therefore not care itself that causes disrecognition, but the fact that it is culturally attributed to women (Tronto 1993/2006).

This occurs through socialisation processes which, although seemingly neutral, systematically reproduce the gender division of labour (Cersosimo and Landolfi 2024). This process is part of a broader patriarchal structure, historically rooted in the Italian Mediterranean family model (Ferrera 1996), which has made care not only invisible but also a service defined as a female task.

Therefore, this paper proposes an analysis of informal caregiving not based exclusively on the daily practice of care, but rather on the moment – explicit or implicit – when the role of caregiver is assumed. It is in this transition, too often taken for granted, that forms of symbolic and systemic violence take root, acting in the silence of family expectations, cultural representations and power asymmetries.

Discussing care through the lens of violence does not mean denying its ethical dimension, but rather highlighting its contradictions, revealing how behind a gesture of help there can lie a structure of violent male domination over female bodies, abilities and lives.

2. Care and coercion: violence in female caregiving relationships

The figure of the informal caregiver, often embodied by women who take care of a family member living with an illness on a daily basis, falls into a grey area between emotional duty and social imposition. The physical, psychological and emotional burden that accompanies continuous, unpaid care is particularly evident in the context of neurodegenerative diseases such as Parkinson's, where the quality of life of caregivers tends to decline dramatically, especially when the person being cared for is male and the caregiver is the female partner (Aamodt et al. 2024).

Lesley et al. (2025), in a systematic review, identify social isolation, lack of institutional support, emotional overload and the duration of the caregiving commitment as the main predictors of burden in informal caregivers of people with Parkinson's disease, as a prolonged burden, if unrecognised, can lead to burnout and depression, increasing the risk of exposure to psychological and physical violence. Sánchez-Guzmán et al. (2022) highlight how psychological violence, which is more prevalent in Parkinson's care settings, manifests itself through devaluation, hostility and daily microaggressions, often amplified by pre-existing dynamics of violence in intimate relationships. In most cases, it is women caregivers who bear the brunt of this violence. The element of gender-based violence is crucial in the context of care, suggesting an overlap between the levels of illness, intimate relationships and structural asymmetries, in which the variable of time emerges as a critical factor in the construction of violence in care relationships: the longer the period of caregiving, the more violent dynamics become entrenched, often internalised or normalised (Sánchez-Guzmán et al. 2022). The continuous availability required of the caregiver creates fertile ground for exercises of power, symbolic domination and emotional coercion, configuring a form of obedience to power, whose legitimacy is based on the condition of illness and vulnerability of the person being cared for, ultimately structuring the caregiving relationship as a system of normalised asymmetry. There are clear associations between depression, care burden and violence experienced by caregivers who care for adults with chronic illnesses (Pinyopornpanish et al. 2022). Verbal and physical aggression by people with Parkinson's disease and related disorders is not uncommon, especially in the advanced stages of the disease (Macchi et al. 2022).

Italian female caregivers are therefore exposed to violence that takes place in the privacy of their homes but is often silenced or ignored by social and health services. In this context, it is useful to recall that some forms of abuse, such as psychological and moral violence, although often invisible and difficult to recognise, have profoundly damaging effects on women's self-esteem, freedom and self-determination, even within apparently non-conflictual family relationships (Serban 2023).

Young women who are economically dependent and not in full-time employment are particularly vulnerable to violence perpetrated by people with severe mental disorders (Labrum et al. 2024), contexts in which the role of caregiver, determined exclusively by structural conditions, exposes them to an intrinsic risk of violence. The scarcity of resources, the lack of support during symptomatic crises and the absence of institutional alternatives, create an environment that favours the reproduction of violent dynamics.

This scientific evidence converges on one essential point: informal care, far from always being a voluntary and affectionate act, can represent a space in which widespread, multifaceted and often invisible violence is exercised, linked to cultural, economic, psychological and emotional factors.

In light of these considerations, such a conceptual approach allows us to interpret the experiences of informal female caregivers from a perspective that brings together substantive freedom, systemic inequality and the forms of violence that lurk within social structures.

3.Lack of choice and structural violence

According to Galtung (1969), violence is not limited to physical or overt acts, but manifests itself whenever a human being is prevented, due to social conditions, institutional structures or symbolic relationships, from fully developing their physical and mental potential. From this perspective, violence is the cause of the difference between potential and actual, between what could have been and what is (Galtung 1969: 168). When this gap is avoidable and stems from modifiable systems, violence is present, even if silent, invisible or culturally legitimised. Galtung observes, for example, that death from tuberculosis in the 18th century would not have been defined as violence, whereas the same death today, with adequate resources and knowledge, is. In other words, 'when potential is greater than actual, it is by definition avoidable, and when it is avoidable, then violence is present' (ibidem).

Applying this perspective to informal caregiving, the assumption of the caregiving role by women – when it does not stem from a genuinely free choice but from normative, cultural or organisational pressures – can be interpreted as a form of structural violence. Although culturally represented as an affectionate and spontaneous gesture, care work can coincide with a systematic denial of alternative opportunities: an experience of silent deprivation, in which women see their possibilities for self-determination and development compromised.

In this theoretical context, Sen's (1993) capability approach offers a further insight. Unlike models that measure well-being based on available resources or subjective satisfaction, Sen proposes to assess well-being through substantive freedom: the real ability of people to make choices that they value and to engage in activities (doing and being) that they consider meaningful in relation to social and environmental factors that affect their capabilities (Naz 2016). Capabilities therefore represent actual possibilities, not just formal options. When women caregivers take on a role that involves giving up other dimensions of life – professional, relational, existential – not because these are considered worthless, but because they are unattainable, we could, and should, consider this condition as a form of structural violence. In this sense, informal caregiving is an ambivalent practice: on the one hand, it brings meaning and social recognition, and on the other, it can be a vector of systemic deprivation and denial of well-being. This interpretation fits into the broader theoretical framework that recognises gender and violence as social determinants of health (Cersosimo 2025). Recognising this ambivalence does not mean denying the emotional value of caregiving, but emphasising that, in the absence of real freedom, even the most socially valued practices can conceal subtle and pervasive forms of violence.

4. Research design

This study addresses the following research question: How do culturally embedded expectations regarding the caregiving role shape informal female caregivers' self-perceptions and contribute to forms of systemic micro-violence?

4.1 Data & Methods

This study addresses the following research question: How do culturally embedded expectations regarding the caregiving role shape informal female caregivers' self-perceptions and contribute

Between February and May 2023, 25 semi-structured interviews were conducted in Italy. The sample consisted of 25 informal female caregivers (average age 62.8 years), recruited through self-selection following a public call disseminated via local associations. Therefore, the sampling strategy was non-probabilistic and aimed at capturing a range of caregiving experiences rather than statistical representativeness. Interviews were carried out either individually (12) or jointly[1] (13), i.e., with the simultaneous presence of the caregiver and the care recipient[2]. Each interview lasted approximately one hour, was audio-recorded, transcribed verbatim, and anonymized in accordance with ethical and privacy standards.

The discursive analysis of the interviews and the analysis of the field annotations followed the iterative logic of Grounded Theory (Glaser and Strauss, 1967), adopting Strauss's concept–indicator model (1987) to ensure consistency between empirical data and emerging concepts. Coding was carried out through multiple readings and constant comparison, supported by NVivo software.

Three fundamental concepts guided the initial phase of open coding, the results of which will be presented in the following paragraph:

A) Attitudes: emotional dispositions and expressive modes through which the participants describe their caregiving role;
B) Behaviours: concrete care-related actions;
C) Expression of the role: discursive constructions through which caregivers attribute meaning to their experience.

Empirical indicators were associated with each concepts, including non-verbal cues (pauses, hesitations, silences), which were treated as integral elements of meaning construction.

5. Results

The results of the discursive analysis of the interviews and field annotations were organised into three macro categories, referring to the guiding concepts used in the coding

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[1] The difference between individual and joint interviews was initially assessed as a potential source of analytical imbalance, considering that the presence of the person being cared for may influence the caregiver's discourse. However, the subjective choice to participate alone or in pairs was itself treated as significant analytical data, capable of providing insights into the representation of the caregiving role and the underlying relational dynamics.

[2] Although characterised by the presence of people with Parkinson's disease in order to maintain consistency with the research question, the analysis only took into account the narratives of informal caregivers, in order to focus on their subjective representations and the emotional and relational dynamics implicit in non-professional care.

process: attitudes, behaviours and role expression. Each of these is divided into three subcategories (Table no. 1), which emerged from an in-depth analysis of the codes.

Table no. 1. Categories emerging from the analysis

A. ATTITUDES		
1) Reticence	2) Catharsis	3) Internalisation
B. BEHAVIOURS		
1) Resilience	2) Redemption	3) Sacrifice
C. EXPRESSION OF ROLE		
1) Recognition	2) Aversion	3) Acquiescence

5.1 Attitudes

The attitudes category includes the initial ways in which caregivers related to the interview experience and, more generally, to the opportunity to talk about their caregiving situation. These attitudes – reticence, catharsis and internalisation – are not fixed but dynamic: they often intertwine and change during the dialogue. They are important indicators of the cultural and relational context in which care is experienced and communicated.The subcategory *reticence* indicates an attitude of caution, doubt or suspension, especially evident at the beginning of the interview. Informal caregivers tended to ask for clarification on the content of the interview, the role of the researchers and the use of the information collected. This hesitation also translated into implicit resistance towards the tape recorder, the presence of the interviewer or the choice of location.

> *First of all, I said: who knows what sociologists want to know about a chronic illness. We know about it because we have lived it ourselves. So, I was a little surprised... I insisted a little to ask what the interested party was. Then I understood better* (Luisa,[3]_71)[4].

> *I sincerely thought it was something more clinical... at the level of the disease. That's how I understood it, but obviously I misunderstood* (Rosaria_45).

On the contrary, the attitude defined as *cathartic* expresses an active and positive willingness to narrate, often already present at the time of recruitment. The participants expressed the feeling of finally being listened to, of giving voice to an often invisible condition and of contributing to a process of knowledge and social recognition.

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[3] The names used in this work are fictitious to ensure anonymity and protect the privacy of the participants, in line with the ethical principles of sociological research.

[4] Legend: Pseudonym of the informal caregiver interviewed_age

> *It's a beautiful thing. I never thought anyone would want to interview me. When they told me about the thesis on Parkinson's, I thought, 'Wow, they chose us!'* (Federica_44).

> *Every drop helps. It helps patients, but also the people close to them. There are difficulties, so anything that can improve our lives is welcome* (Aurora_70).

Finally, the *self-internalisation* subcategory includes cases where participation in the interview was seen as inevitable or necessary, a habit or a sense of duty. In these situations, involvement appears passive, often accompanied by a sense of fatalism.

> *It could have been a way of sharing the journey we are on. Which, unfortunately, we are on. As I always say to him: 'We're in this boat together, so we have to keep going* (Luigia_64).

> *Let's say I have to participate with my mother, because she's not someone you can leave alone* (Serena_ 44).

5.2 Behaviours

The first subcategory identified in the area of behaviours is resilience, which manifests itself as an attitude of control and limitation of communication, both externally (towards the researcher) and within the dyad with the person being cared for. This behaviour highlights a need for protection, but also a selective exercise of communicative and interpretative power. Caregivers often show reluctance to allow their own experiences or those of their loved ones to emerge fully, interrupting or correcting what is said during the interview. When it was not possible to exercise this control by correcting directly during the joint interview, some caregivers explicitly requested to be interviewed first, with the aim of anticipating, filtering or defining the narrative framework.

> *Let's say you didn't accept it. I think you're starting to understand what this disease is now. [...] He didn't really understand what kind of disease it was, even though we tried to explain it to him, sometimes gently, sometimes harshly* (Anna_ 45).

The second subcategory concerns a behaviour of redemption, aimed at constructing an autonomous space for both the caregiver and the person being cared for. In some cases, this stems from a clear negotiation of roles; in others, it represents a strategy for coping with the fatigue of caregiving. Autonomy is claimed as a means of mutual protection and manifests itself in the balanced distribution of responsibilities, the management of boundaries and a relational attitude that avoids excessive fusion. This behaviour represents a form of non-violent resistance to the potentially destructive symbiosis of the care relationship, in which the identity of one risks being annihilated in the other. The narratives also reveal an implicit reflection on the risks of domination, which can manifest itself, even unintentionally, in the overlapping of caregiving roles. In this sense, redemption becomes a tool for protecting the vulnerable person from the possible invasiveness of their caregiver.

> *I avoid passively accepting delegation. [...] It's your commitment. Invest in your situation* (Laura_65).

> *If I see that he really needs it, I help him. Otherwise, I pretend everything is fine* (Giovanna_62).

Finally, the third subcategory includes behaviours explicitly oriented towards active, daily sacrifice, both material and emotional. Female caregivers interviewed show their presence in small gestures, in mediating with health services, in promoting the autonomy of the person being cared for whenever possible, and in managing family organisation. Sacrifice is thus a practical response to the impact of the disease, but also a form of mediation with regard to the conditions of vulnerability that can lead to isolation, feelings of inadequacy and stigmatisation, to the detriment of well-being. Sacrifice is part of a delicate balance between protection and control, between care and absorption.

> *If it weren't for us (meaning informal caregivers), they would have been left alonein the silence of their homes (Serena_44).*

> *I am at your service as a driver. (Maria _ 75)*

5.3 Expression of the role

The last area that emerged from the analysis concerns the ways in which informal caregivers express and negotiate their role in the care relationship. The three subcategories that make up this section – recognition, aversion and acquiescence – represent discursive and pragmatic attitudes that reflect subjective adaptation to the caregiving task, as well as the different ways in which women caregivers deal with more or less overt forms of symbolic, systemic and relational violence.

The subcategory *recognition* includes narratives in which the role of caregiver is assumed with awareness and declared in terms of responsibility, competence and active presence. However, this recognition is rarely spontaneous or free of ambivalence: it is often the result of prolonged exposure to fatigue, overload and the normalisation of female sacrifice. In many testimonies, caregiving is described as natural, but it is precisely this naturalisation that outlines a form of invisible violence, which presupposes an unlimited, non-negotiated availability of women's time and energy. In this context, recognition does not come from outside – institutions, social or family networks – but is constructed by the caregivers themselves in an attempt to make sense of an often precarious and exhausting position.

> *I felt involved from the very beginning. It was normal for me to take care of it. No one asked me, it just happened* (Giulia_70).

> *We are the ones who keep everything going. We know it, but no one recognises it.* (Emma_72).

On the other hand, the subcategory of aversion includes experiences in which the role of caregiver is perceived as imposed, unfair or even hostile. In these cases, caregiving is perceived as a form of coercion that generates anger, frustration and a sense of imprisonment. The violence here is direct and explicit: it is the violence of an asymmetrical burden, of time taken away, of identity reduced to the function of care. These voices express the rejection of a role taken for granted and denounce the violence implicit in social expectations that prevent people from naming their discomfort or escaping the role of caregiver.

I didn't want this life. I didn't choose it. And now I can't back out (Gina_80).

I don't feel free. I'm angry. Not with him, but with everything else. As if it were normal for me to keep quiet and do what I'm told (Eleonora_51).

Between recognition and aversion lies the subcategory of *acquiescence*. This represents a form of passive adaptation to the role, lacking both full identification and open opposition. Caregivers in this position seem to give up the possibility of negotiating or critically reworking their experience, accepting the caregiving task as inevitable. Violence, in this case, is expressed in a more subtle way: it manifests itself in the suspension of conflict, in resignation, in the gradual erasure of individual needs.

That's just the way it is now. There's no point in getting angry (Tiziana_68).

Sometimes I feel like a spectator. Things happen, I'm there (Gabriella_67).

Acquiescence is probably the most insidious and pervasive form of symbolic violence, because it blends into everyday life and is consolidated through a sense of duty. The renunciation of conflict thus becomes an effect of power that asymmetrically structures care relationships, rendering subjective fatigue silent – and therefore even more profound.

6. Discussion

Results led to the identification of three types of informal caregivers, which emerged from the intersection of categories constructed on three empirical dimensions: attitudes, behaviours and modes of expression of the role. Each type represents a specific configuration of the position taken by caregivers with respect to the care relationship, their role and the illness. In all the types analysed, elements of structural violence emerge – in a more or less explicit form – which manifest themselves both in the naturalisation of care expectations and in the tension between individual agency and moral duty:

1) I am, therefore I care

This type includes caregivers who define themselves based on their family relationship: 'I am a wife, therefore I care', 'I am a daughter, therefore I care'. Caregiving is experienced not as a choice but as an identity obligation, inscribed in gender roles that are assumed passively and rarely questioned. The prevailing attitude is reticence: the interviewees speak cautiously, motivated by a desire to protect the sick person, but also by a profound difficulty in claiming a subjective space. The behaviours observed reveal forms of communicative resistance and control – particularly during joint interviews – where caregivers try to manage or filter the content expressed by the other. The role is assumed fully, but conformist and automatic, as if it were a non-negotiable continuation of the emotional bond. This stance reveals a subtle but pervasive form of symbolic violence: care is not imposed by an external authority, but by an internalised social order that assigns women the task of 'being there' unconditionally, without recognition and without alternatives.

2) I love, therefore I care

This type includes caregivers who participate enthusiastically in the interview, expressing a desire to talk about themselves and an awareness of their role. The main motivation behind their actions is emotional: care stems from love, not from a social obligation. However, this very 'love that cares' can prove to be ambiguous. The line between freedom and obligation becomes blurred, and the relationship risks producing a form of invisible emotional bond. At the behavioural level, these caregivers alternate gestures of support with strategies to safeguard their own independence and that of the sick person. The role is taken on critically, with forms of selective aversion: not towards the loved one, but towards the logic that transforms love into systemic fatigue, denying its spontaneity. In this configuration, violence is less evident, but it creeps into the emotional pressure and the continuous redefinition of the self in relation to the other, in a dynamic of adaptation that leaves little room for self-determination.

3) I must therefore care

The third type is where systemic violence (Žižek, 2007) manifests itself most explicitly. Caregivers who fall into this category experience caregiving as an inevitable fate, with no alternatives. The attitude with which they participate in the interview is often marked by resignation: they feel stuck in a role they did not choose, but which they must fulfil due to a lack of resources and support. The behaviours observed revolve around continuous sacrifice, which leaves little room for recognition or self-care. The role is expressed through acquiescence: the interviewees adapt, support, mediate, but in doing so they dissolve. In this configuration, violence is invisible but systemic, because it is produced by the absence of services, loneliness, the inadequacy of institutional responses and the lack of recognition. Their role becomes functional in filling the gaps of a deficient system, and for this very reason it is unavoidable. Their voices are marked by silent endurance, which prevents them from even naming their discomfort, the result of a context that makes care an invisible but all-encompassing obligation.

In conclusion, the three types of caregivers identified in this study perform a social buffer function (Costa 2022), embodying the role formally introduced into Italian legal discourses by Law No. 205 of 27 December 2017, Art. 255, which recognised the figure of the “family caregiver” for the first time. However, this legal definition recognises the role without specifying rights, protections or structural support, thus reinforcing a gender-connoted and gender-oriented configuration of care.

This absence translates into an implicit form of institutional violence, which is intertwined with the symbolic violence described by Bourdieu (1998): a cultural mechanism that, under the rhetoric of dedication and love, legitimises the moral obligation of women to take on the responsibility of care. In this sense, the structural violence theorised by Galtung (1969) manifests itself in the gap between what women could be and what they are socially and institutionally allowed to be, a gap that limits their capacity for self-determination. Sen's (1993) capabilities approach allows us to interpret this gap as a denial of substantive freedom: when care is taken on out of necessity rather than choice, it becomes a form of systemic coercion that deprives women of the possibility of planning their own lives. Bridging the gap between theoretical reflection and policy design, and recognising care as an area of social justice, is therefore essential to transform a field currently marked by invisible violence into a space of freedom, recognition and equal opportunities.

7. Conclusion

Reading the phenomena of informal caregiving through the lens of structural violence represents a fundamental epistemological operation for revealing and deconstructing the invisible forms of oppression that permeate the daily lives of women caregivers. As theorised by Galtung (1969), structural violence does not necessarily take the form of an act performed by an agent, but rather a systemic mechanism that produces inequalities of power and opportunity, making the pain and suffering of victims the result of an unequal and deeply unjust social order. Farmer (2013) broadens this perspective, denouncing how such mechanisms are often hidden beneath the surface of institutions, not attributable to individual blame but to a self-perpetuating system of oppression that imposes disproportionate burdens on vulnerable individuals, in this case informal female caregivers.

The qualitative evidence presented here highlights how, across different configurations of attitudes, behaviours and role expression, caregivers reproduce and internalise social norms that naturalise care as a gendered duty. Whether motivated by identity, affection, or moral obligation, their experiences converge in exposing the tension between agency and constraint, and the systemic nature of the micro-violences they endure.

However, for the purposes of this contribution, it is crucial to emphasise that this violence is not perpetrated by the sick person, nor by the act of care itself, but by a socio-cultural and political system which, by failing to take responsibility for caring for sick people, delegates and obliges women to take on unsustainable burdens. The absence of effective public intervention, the lack of a fair support network and patriarchal cultural inertia thus translate into a form of oppression that is as psychological as it is material.

Defining gender-based violence to include these structural and systemic dimensions means breaking with the narrow view that confines violence to its visible manifestations, and recognising how it operates in subtle, everyday and institutional forms. Sociology has the task not only of revealing these hidden mechanisms, but also of informing political and institutional action capable of addressing them. At different levels, this requires coordinated responses: at the micro level, supporting caregivers' recognition and well-being; at the meso level, improving inter-agency collaboration and the inclusion of caregivers in service design; and at the macro level, promoting policies that redistribute care and challenge the cultural norms that naturalise women's responsibility for it. The study attempts to offer analytically transferable insights into how structural and gendered violence is reproduced through everyday care practices. Future research should further examine these dynamics in comparative and institutional terms.

Only through an integrated approach that links empirical understanding with policy innovation can a model of care be built that is equitable, sustainable and respectful of dignity and rights. Otherwise, women will remain bound to roles of sacrifice and silence, perpetuating the structural and gendered violence that undermines social and gender justice for all women born and living in Italy.

8. Limitations

The main limitation of this research lies in the non-representativeness of the self-selected sample, which does not allow for statistical generalisation. In addition, the analysis did not systematically consider possible socio-demographic or contextual variations that may influence caregivers' experiences and these constraints limit the scope of inference.

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ORCID ID

Lucia Landolfi https://orcid.org/0000-0001-8940-7998

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Author biography

Lucia Landolfi is Research Fellow at the University of Salerno.

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