BORN TO CARE: GENDER ROLES AND EMOTIONAL OVERLOAD AMONG INFORMAL FEMALE CAREGIVERS

NASCER PARA CUIDAR: PAPEL DE GÊNERO E SOBRECARGA EMOCIONAL DE MULHERES CUIDADORAS INFORMAIS

NACER PARA CUIDAR: PAPEL DE GÉNERO Y SOBRECARGA EMOCIONAL DE LAS MUJERES CUIDADORAS INFORMALES

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Amanda Cavalcanti Pinheiro Barbas[1], Bianca Lemos Cobra[2], Laleska Morais Ferreira[3], Lorena Lourenço Rosa da Silva[4], Mateus Henrique Oliveira Souza[5], Melissa Mendes Ferreira[6], Santiago de Matos Fernandes Perez[7], Tatiana Maria da Silva[8], Rosa Gouvêa de Sousa[9]

ABSTRACT

This is a study on understanding the impact of emotional and psychological overload on informal carers of home-based patients, with the aim of deepening this understanding based on determining factors such as the duration of care, the severity of the patient's pathological condition, as well as their limitations and demands, the social support available and the coping strategies used by carers. In addition, the study seeks to understand how gender affects the mental burden of informal caregivers, observing this phenomenon from a social and scientific perspective. The methodological design involved content analysis of narratives by women caregivers in a community affiliated with a health unit in the interior of Minas Gerais. The findings showed that informal care, although essential for sustaining life and supporting family and community networks, remains structured on profoundly unequal bases. The caregivers interviewed revealed in their narratives that the daily practice of care is marked by gender, loneliness, and symbolic and spiritual strategies that function both as support and as a way of reframing suffering. In view of this, this study reaffirms that caregiving

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[1] Medical student. Universidade Federal de São João del Rei (UFSJ). Minas Gerais, Brazil.
E-mail: amandacpbarbas@gmail.com
[2] Medical student. Universidade Federal de São João del Rei (UFSJ). Minas Gerais, Brazil.
E-mail: biancalcobra@gmail.com
[3] Medical student. Universidade Federal de São João del Rei (UFSJ). Minas Gerais, Brazil.
E-mail: laleskamf2001@hotmail.com
[4] Medical student. Universidade Federal de São João del Rei (UFSJ). Minas Gerais, Brazil.
E-mail: lorenalrs231@gmail.com
[5] Medical student. Universidade Federal de São João del Rei (UFSJ). Minas Gerais, Brazil.
E-mail: mat124578@gmail.com
[6] Medical student. Universidade Federal de São João del Rei (UFSJ). Minas Gerais, Brazil.
E-mail: melissamendesmf19@gmail.com
[7] Medical student. Universidade Federal de São João del Rei (UFSJ). Minas Gerais, Brazil.
E-mail: santiagomfperez@gmail.com
[8] Social Communication. Community Health Agent. Prefeitura Municipal de São João del Rei, Minas Gerais, Brazil. E-mail: tatthymary1905@gmail.com
[9] Dr. in Psychology, Medical Professor. Universidade Federal de São João del Rei (UFSJ), Minas Gerais, Brazil. E-mail: rosags@ufsj.edu.br

is also work, work that, when performed alone and continuously, causes illness. It is essential that care be understood as a collective responsibility and that progress be made.

Keywords: Caregiver. Health. Gender. Overload.

RESUMO

Trata-se de um estudo sobre a compreensão acerca do impacto da sobrecarga emocional e psíquica em cuidadoras informais de pacientes domiciliados, tendo por objetivo o aprofundamento de tal compreensão a partir de fatores determinantes como a duração do cuidado, a gravidade da condição patológica do paciente, bem como sua limitação e demanda, o suporte social disponível e as estratégias de enfrentamento utilizadas pelas cuidadoras. Além disso, o estudo busca entender como o gênero atravessa a carga mental de cuidadoras informais, observando esse fenômeno a partir de uma perspectiva social e científica. O desenho metodológico percorreu a análise de conteúdo por narrativas de mulheres cuidadoras de uma comunidade adscrita a uma unidade de saúde, no interior de Minas Gerais. Os achados evidenciaram que o cuidado informal, embora essencial para a manutenção da vida e para a sustentação das redes familiares e comunitárias, permanece estruturado sobre bases profundamente desiguais. As cuidadoras entrevistadas revelaram, em suas narrativas, que a prática cotidiana do cuidado é atravessada por marcadores de gênero, pela solidão e por estratégias simbólicas e espirituais que funcionam tanto como suporte quanto como forma de ressignificar o sofrimento. Diante disso, este estudo reafirma que cuidar é também trabalho, um trabalho que, quando desempenhado de forma solitária e contínua, adoece. É imprescindível que o cuidado seja compreendido como responsabilidade coletiva e que se avance na construção de estratégias que reconheçam, apoiem e protejam as cuidadoras informais.

Palavras-chave: Cuidadora. Saúde. Gênero. Sobrecarga.

RESUMEN

Se trata de un estudio sobre la comprensión del impacto de la sobrecarga emocional y psíquica en las cuidadoras informales de pacientes domiciliados, con el objetivo de profundizar en dicha comprensión a partir de factores determinantes como la duración de los cuidados, la gravedad de la condición patológica del paciente, así como sus limitaciones y demandas, el apoyo social disponible y las estrategias de afrontamiento utilizadas por las cuidadoras. Además, el estudio busca comprender cómo el género atraviesa la carga mental de las cuidadoras informales, observando este fenómeno desde una perspectiva social y científica. El diseño metodológico se basó en el análisis de contenido de las narrativas de mujeres cuidadoras de una comunidad adscrita a una unidad de salud, en el interior de Minas Gerais. Los resultados evidenciaron que el cuidado informal, aunque esencial para el mantenimiento de la vida y el sostenimiento de las redes familiares y comunitarias, sigue estando estructurado sobre bases profundamente desiguales. Las cuidadoras entrevistadas revelaron en sus narrativas que la práctica cotidiana del cuidado está atravesada por marcadores de género, soledad y estrategias simbólicas y espirituales que funcionan tanto como apoyo como forma de resignificar el sufrimiento. Ante esto, este estudio reafirma que cuidar también es trabajo, un trabajo que, cuando se realiza de forma solitaria y continua, enferma. Es imprescindible que el cuidado se entienda como una responsabilidad colectiva y que se avance

Palabras clave: Cuidadora. Salud. Género. Sobrecarga.

1 INTRODUCTION

The dynamic process of illness is inherent to the human condition and makes it essential to build a network of support and care around the sick individual, since he himself becomes limited to perform the basic activities of daily life. In this sense, the figure of the caregiver is urgent, who, in many contexts, is a female figure of the family or community (Conceição et al., 2021), especially in Brazil, whose data point to the existence of approximately 47.5 million people involved in care, 78% of whom are women (Institute of Applied Research, 2024).

Thus, an informal caregiver is defined as one who provides care, but who does not receive any remuneration or sign any type of contract for the purpose of caring (Barbosa et al., 2009). Such people usually have some affective bond with the patient, usually being friends, family or neighbors, and are responsible for mediating the physical, affective, social, psychological and spiritual well-being of those who receive care (Sales et al., 2022).

Within this context, the right to care has been widely recognized and incorporated as one of the pillars of social citizenship, along with social security, health, and education (Brasil, 2022). However, what is the look given to caregivers? There are several studies on sick patients, but little is said about the caregiver. Thus, understanding care as a fundamental right, it is expected that it will be extended to those who care as well, and not only to those who are cared for. From this perspective, informal care support can cause physical and emotional exhaustion, anxiety, and overload in caregivers, since they do not receive adequate preparation to meet the complex demands that involve care (Diniz et al., 2018; Fernandes et al., 2013).

Thus, when talking about overload, two dimensions must be considered: the objective and the subjective. The first refers to the negative and resulting consequences of the caregiver role, including the frequency of daily tasks, the supervision of problematic behaviors, interruptions in the social and professional life of caregivers, and financial losses. The second dialogues with the emotions and perceptions of the caregiver regarding his own function, including uncomfortable feelings and the impacts resulting from the changes that occur in his social and professional life, as well as encompasses the concerns with the patient (Batista; Bandeira; Oliveira, 2015).

Given the complexity of care practice, family caregivers should also be the target of attention, since long-term exercise can bring physical, psychological, material and social overload, limiting caregivers' self-determination and freedom to "be", "be" and "participate" in the community. In view of this, it is crucial to identify the needs of caregivers in the psychological, financial, and social spheres, as well as to recognize community resources, caregiver's level of education, caregiver support, or temporary care, and promote actions to ensure the sustainability of care. When the perspective is focused on gender, women are the majority in the provision of care, reflecting a gender configuration associated with this practice, which is socially constructed as a feminine task. Thus, it is urgent that the discussion of gender be considered when addressing the demands of caregivers, in order to recognize social asymmetries and break with stigmatizing practices.

Thus, the objectives of this study went through the understanding of the impact of emotional and psychic overload on informal caregivers of home-based patients, deepening this understanding based on determining factors such as the duration of care, the severity of the patient's pathological condition, as well as its limitation and demand, the available social support and the coping strategies used by the caregivers. In addition, this study sought to understand how gender crosses the mental load of informal caregivers, observing this phenomenon from a social and scientific perspective.

2 METHODOLOGY

This study addressed, based on a qualitative and cross-sectional research, the understanding of the impact of emotional and psychic overload on informal caregivers of patients living in the city of São João del Rei - Minas Gerais. There is then an open-ended individual interview with the triggering question "How do you feel about the role of caregiver?". From there, the interviewer in charge will conduct with other questions to understand the context and state of the interviewee's psyche. The research group is composed of seven students, whose information was taken to ensure peer evaluation. This group was divided into research areas, and the interviews were done in pairs. Eight interviews were conducted, and the interviewees were selected because they were informal caregivers, female, who were relatives or had some degree of proximity to the patient, who were domiciled, bedridden or not, who required care and who had most of their activities restricted to the home. Those who receive payment for care and people of the male gender were excluded. The selection of participants was carried out through people enrolled in the Family Health Strategy (FHS) type 2 of the city of São João Del-Rei, indicated by the community health agents of the São Geraldo locus, a region suggested due to the demands necessary for the current research.

The family health strategy unit (FHS) chosen as the territory for the construction of the narratives, has been a health center since the 2010s (name withheld to ensure confidentiality). Within the team of professionals who work in the unit, inserted in the Community Agents Program (PAC), there is the presence of twelve agents, divided between the two teams that make up the ESF (Brasil, 2025). The author of this article participates in one of the teams and is responsible for a micro-area that is farther from the post and with socioeconomic conditions of high vulnerability (Brasil, 2024).

Her long-standing work as a health agent is in line with her own history in the community, as the author has lived in the neighborhood for a long time, since her childhood (the name of the region was withheld to ensure the anonymity of all those involved). The community agent leads coordinated health care in her micro-area, intertwining her territorial community knowledge with the individualized care of people, taking into account the history of all those involved, of the territory itself and of the community itself.

With regard to the community, for a better understanding of this study, it is highlighted that the territorial beginning took place as "the place of residence of some families, which grew and stayed in the same territory, contributing to a community relationship constituted by family relationships" (author's report, 2025). The community knows and supports each other, building support networks that promote dialogue and exchange, which enable knowledge about demands and thus the production of actions that act in favor of family health care.

Community strength is based on women, exemplified in the presence of the caregivers highlighted here, as well as in religious and cultural festivals when they are the leaders, such as the festivities of the Congado, for Nossa Senhora do Rosário and for São Dimas (author's report, 2025). The city, where this community is located, is located in a rural area of the State of Minas Gerais, in the southwest region, being a health center of the region. It has approximately 90 thousand inhabitants and has a municipal and regional SUS network.

The data were filtered to identify caregiver-patient pairs who met the inclusion and exclusion criteria of the research. The selection and interviews were carried out in the first half of 2025, from March to June, only after approval by the ethics committee, CAAE (85787524.5.0000.5151). After approval by the Ethics Committee, contact was made with the indicated people and explained to them the nature of the research, the context of the investigation and the procedures of the narrative interview, so that the indicated person could choose whether or not to accept to be interviewed and participate in the study.

The approach included an initial stage dedicated to creating a bond between the interviewers and the participating informal caregivers. This stage, which lasted approximately 20 minutes, was conducted before the formal start of the interview and was not recorded, aiming to provide a welcoming and trusting environment. During this moment, the interviewers introduced themselves, explaining their roles in the project and the general objectives of the research. Next, the caregiver was given the opportunity to talk about herself, her challenges and motivations, promoting a space for initial dialogue.

In addition, the conversation sought to better understand the context of the care provided by the participant. At this point, spontaneous reporting of her perceptions of the caregiver role was encouraged, including how she defines and interprets her responsibilities and the impact of this role on her life. This stage was also used to briefly introduce the main themes that were addressed in the subsequent formal interview. As a way to increase knowledge and awareness, at the end of each interview, a booklet was delivered with relevant points of the Informal Caregiver Statute (Law No. 100/2019, of September 6), highlighting information about the rights guaranteed and the responsibilities attributed to caregivers. The interviews were confidential and anonymous under the parameters of the ethics council. The recordings were later transcribed, and the names collected were changed to fictional names, thus preserving the privacy of the interviewee and reinforcing the confidentiality and care with the material collected.

Table 1

Interview questions

Issue:
1. How do you feel about the role of caregiver?
2. How does this feeling impact your life?
3. What does caring mean to you?
4. Since you started taking care of the patient, how is your mental health?
5. What does taking care of the patient require of you?
6. Is there anything else you want to talk about this?

Source: The authors archive.

Table 2

Phases of the Narrative Interview

Phases of the narrative interview	Rules for the interview
Preparation	Exploring the Question Formatting field
Initiation	Formulation of the initial topic for narration Use of visual aids
Central Narration	Do not interrupt Only non-verbal or paralinguistic encouragement to continue Narration Wait for signs of completion

Question Phases	Only "What happens then" Not giving opinions or asking questions about attitudes Do not argue about contradictions Not asking "why?" questions Going from exmanent to immanent questions
Concluding speech	Stop recording Are "why" questions allowed? Take notes immediately after the interview

Source: Jovchelovich and Bauer (2002)

2.1 THE ANALYSIS OF NARRATIVES

The method adopted for the analysis of the narrative interviews initially consisted of transcribing the material and then dividing the work into two parts. The first contains the rational, concrete and scientific content, with the description, in an objective way, of individual actions and functions. The second part encompasses information that transcends the facts narrated, including values, ideas and personal perceptions, linked to the wisdom and subjectivity of the participants. In the next stage, the events were organized chronologically for each interviewee, allowing the evaluation of their respective individual trajectories. Then, the trajectories of the caregivers were studied and compared, allowing the identification of similarities between the reports, finally allowing the formation of collective trajectories with the sharing of common characteristics inherent to the context of these women.

To analyze the mental state of informal caregivers, the material was progressively condensed, using reduction and generalization techniques. This process was divided into three stages: the complete transcription of the narratives; a first reduction, in which the most prominent passages were summarized; the third stage, with the definition of keywords that captured the central concepts addressed in the highlighted excerpts. Based on this, initial categories were created for each narrative and, later, organized in a common system, applicable to all interviews, allowing a final interpretation that considered both the relevant aspects for the caregivers and for the researchers.

In order to deepen the analysis, the question proposed by Erving Goffman was used: "What is happening here and now?". This question helps to identify contextual and temporal indicators, enabling a better understanding of the environment and the emotional dynamics of caregivers. The "frames" and "contextualization clues" are fundamental in this process, helping to structure the understanding of the situation. The frames reflect how the context should be interpreted, while the clues refer to both the local context and the broad context, of an institutional, cultural and social nature.

To create and organize the categories, both data-based and concept-driven coding methods were used. The literature on the mental state of informal caregivers and the focus of the research allowed the definition of some preliminary categories. However, the material obtained in the field allowed the construction of new categories, adapted to the specific experiences of the caregivers. The objective was to extract from the data their real meaning, avoiding interpretations based on preexisting theories.

Finally, it was essential to explore both the "said" and the "unsaid" in the caregivers' narratives, favoring a contextualized analysis. This allowed them to capture implicit meanings in their speeches, as well as to identify how the individual context influences their expressions. With this approach, it was possible to carry out a deeper and more accurate analysis of the psychological challenges faced by caregivers, considering both their explicit statements and the emotional aspects not directly verbalized.

3 RESULTS AND DISCUSSIONS

For the analysis of the content collected, all researchers read the interviews in full, identifying significant passages related to the experience of care. These excerpts were initially organized into preliminary categories - family support, mental overload, physical overload, coping and informal care - which allowed us to capture different dimensions of the caregivers' daily lives. The next stage involved the grouping and systematic comparison of these contents, enabling the emergence of more comprehensive interpretative axes. From this process, three central analytical nuclei were derived: gender, understood as the symbolic and material structure that shapes expectations, inequalities and the naturalization of care as a female task; loneliness, understood as the experience of affective and practical isolation, in addition to silencing, which permeates prolonged care; and religiosity, defined as the set of practices, beliefs, and spiritual meanings activated to support, justify, or resignify the daily burden of care. These axes worked as lenses to understand the way in which women elaborate their experience and attribute meaning to emotional and psychic overload in the context of informal care.

3.1 PATRIARCHAL ROLE OF WOMEN, DIVISION OF LABOR AND THE BURDEN ASSOCIATED WITH CARE

The social role of women has historically been constructed through cultural, social and economic dimensions that, over the centuries, have attributed to the feminine the responsibility for domestic and care work. Federici (2019) highlights that there is a particular combination of physical, emotional, and sexual services that make up the figure of the "housewife", a fundamental character whose work remains invisible. This naturalization of care as a feminine practice becomes evident in the narratives of the interviewees, such as when Orquídea states: *"I have to be on her own"* and *"I am not alone",* revealing how this responsibility is interpreted as an individual and inevitable obligation.

In this sense, the romanticization of love and its link to marriage function as mechanisms to legitimize this inequality. As Federici (2019) discusses, the idea of love operates in order to mask the exploitation of female labor in the domestic space, sustaining the belief that caring is a natural expression of affection. Such a dynamic appears when Bárbara reports: *"I don't like to be too stubborn. I do what he says",* revealing the maintenance of relationships that reinforce female submission. Jasmin also evidences this process when she comments: *"They don't care how my marriage is",* indicating the social disregard for the emotional and marital impacts of the overload.

These individual experiences are part of an organization defined by Walby (1990) as patriarchal, in which the subordination of women is structured in different spheres of life. In Brazil, this heritage is marked by a colonial past that consolidated the patriarchal family as the dominant model of social organization (Narvaz; Koller, 2006). The consequences of this configuration emerge when Rosa says: *"The rest is just us here, right?"* and *"Before it was me, just me, just me, only me",* pointing out the centrality of care in the hands of women and the absence of support from other family members.

In this way, the sexual division of labor, as systematized by Kergoat (2003), is based on two principles: the separation between "men's" and "women's" jobs and the hierarchization that devalues everything that is assigned to the feminine. This structure remains evident in the reports of the interviewees. Orquídea points out: *"We are 8, but the women who were left with the greatest overload, we are 4. Men don't...",* explaining how the burden falls exclusively on them. At the same time, Jasmin reveals her father's abandonment in motherhood when she reports: *"It was a lot of responsibility, that's not what he wanted",* demonstrating how fatherhood is still socially treated as optional, while motherhood is compulsory.

From this perspective, care goes beyond conjugality and is distributed among mothers, daughters, sisters and grandmothers, consolidating a female support network (Gonçalves; Sena, 2001; Rosa, 2003; Pegoraro; Caldana, 2006). This appears in the lines of Orquídea: *"My sisters come in the afternoon, so my sisters stay more in the bath part",* Azaleia: *"My girls help me"* and Rosa: *"Then we got a girl, at least for the girl to stay here to help me".* On the other hand, the absence of men is a constant: *"No one can ever stay", "There's no one, there's only me, you know?"* and *"Nobody helps",* report Orquídea and Jasmin, evidencing the persistence of this unequal division.

It is also evident that the overload resulting from this structure produces significant impacts. The theories of Fonseca (2000) and Saffioti (1979) describe how the expropriation of women's time, body and energy constitutes a fundamental pillar of gender inequality. Pegoraro (2006) highlights that this overload contributes to psychological illness, with anxiety, depression and chronic stress. The interviewees reinforce this dimension: Rosa reports that *"Only us, only us, we really get desperate",* while Jasmin summarizes inequality by stating: *"With the overload only for one"* and *"People close their eyes to this".* These statements show not only the emotional exhaustion, but also the social invisibility of the work they do.

Another central aspect is the limitation of female autonomy. Orquídea reports, *"My husband has been out four times, and I can't get out of here,"* demonstrating how care restricts her freedom while male mobility remains unchanged. Even when there is some male participation, it is punctual and perceived as a favor, as when she says: *"There's my husband too, sometimes he washes dishes for me."* This type of collaboration reinforces, rather than disrupts, the logic of unequal division.

It is also possible to identify the construction of co-dependent bonds, as discussed by Gonçalves (1999). Jasmin expresses this dynamic by saying: *"I'd rather deprive myself of things, than leave her alone."* At another point, she reinforces the feeling of inevitability of care: *"If I don't help her, who will?"* and *"If I don't help her... no one will give it."* In contrast, some experiences are crossed by the feeling of affective retribution, as Peônia reports: *"For us to take care of her, it is a satisfaction. Because she already took care of us when we were children, right?"*, demonstrating that care can also be experienced as an extension of the family bond.

Therefore, the articulation between prolonged responsibility, isolation and intense emotional load demonstrates that informal care, when unevenly concentrated, produces profound effects on women's lives, compromising their autonomy, well-being and their ability to insert themselves in other social and professional spheres. Thus, in patriarchal societies, to be born a woman is, symbolically, to be born destined to offer the care indispensable to life, although such care remains systematically invisible and devalued.

3.2 SILENCING OF WOMEN'S SUFFERING AND WOMEN'S LONELINESS IN SOCIETY

The caregivers' testimonies show a pattern of silencing suffering, which permeates their physical and emotional experiences. Such silencing, far from being just an individual perspective, constitutes a social and historical phenomenon rooted in the patriarchal structures that shape care work in the domestic sphere (Federici, 2019). The suffering that emerges from this daily and continuous function tends to be minimized, interpreted as inevitable, and often seen as intrinsic to the female role (Lugones, 2019).

The silencing occurs because care is socially constructed as an extension of the woman's identity. The idea that the ability to care derives from characteristics considered "natural" or "biological" underpins the sexual division of labor and reinforces the association between femininity, selflessness, and sacrifice (Lugones, 2019). In this context, a mechanism of symbolic subordination is manifested that transforms the physical and emotional exhaustion of caregivers into something morally acceptable and expected, and, therefore, little questioned. Dedication to care is perceived as a moral duty, which makes it difficult to express fragility, fatigue or suffering, often interpreted as personal failures or lack of commitment (Pereira, 2003; Pegoraro and Caldana, 2006). Bernardo (2021) highlights that this process functions as a mechanism of symbolic subordination and silencing, fundamental to sustain colonial and patriarchal relations that hierarchize gender roles, and thus legitimize the exploitation of the female body and labor as something "moral" or "expected".

In this way, informal care, exercised predominantly in the domestic space, operates far from the public sphere, which contributes to its invisibility (Federici, 2019). Although it involves complex activities, whether physical, cognitive or emotional, it continues to be socially recognized as a private and affective task, and not as work. As Jasmin said in the excerpt "*People close their eyes to this*", translating that the devaluation reinforces the idea that the suffering of these women is not worthy of attention, institutional support or specific policies. Consequently, caregivers internalize the need to remain strong, resilient, and emotionally stable, even in the face of overload. This scenario also stems from social structures marked by gender hierarchies and historical patterns that legitimize the unequal distribution of work (Lugones, 2019). The expectation that women alone assume the responsibility for care maintains the logic in which their pain must remain invisible so that the social organization continues to operate without ruptures.

Silencing works, therefore, as a device of social control, which prevents the problematization of the conditions in which care is exercised, as well as prohibits the possibility of claiming support, redistribution of tasks or public recognition. In these circumstances, suffering is no longer seen as a consequence of an unequal system, but is then interpreted as an individual characteristic, which prevents the construction of adequate social and institutional responses.

Thus, the loneliness experienced by the informal caregiver is a dense experience crossed by emotional, social and symbolic layers far beyond the simple "being alone". According to Dornelas (2007), this loneliness is not only born from the exhausting routine of care, but from the way society inscribes in the body and subjectivity of women the expectation of silent sacrifice. It is a loneliness woven into daily life by those who dedicate time, attention and affection to others, often at the expense of their own existence. As Orquídea expresses: *"My husband has left four times, and I can't leave here",* revealing the symbolic and material confinement that structures this experience.

When taking care of a dependent family member, many women report a progressive distancing from their professional lives, social ties and even their own identity. We observe this when Jasmin states, *"Everyone has life. Except me."* This movement echoes what Dornelas describes as a symbolic erasure of women. They become "invisible presences", always available, but little noticed; they support the daily lives of others, but have their own needs disregarded. Thus, the loneliness they experience is not limited to the lack of company, but to the absence of reciprocity, because they care, but are not cared for, just as they speak, but are not listened to.

This scenario is deepened by a social structure that, as Dornelas (2007) points out, romanticizes female suffering and abnegation, naturalizing both isolation and emotional overload. Care, when seen as a destination and not as work, takes away from caregivers the right to rest, recognition and their own desire. Bárbara, for example, synthesizes this invisibility when she narrates: "*I went to look for it, there was no one to go get the salt*", showing how basic tasks become solitary responsibilities. Breaking this cycle requires support networks, public policies, and a cultural transformation that gives women back the right to exist beyond the function of care. The loneliness of these caregivers, therefore, is not a personal failure, but an expression of a structural inequality that limits their possibilities of sharing the weight and meaning of care.

This perspective is also directly intertwined with two central elements that emerged in the narratives: the fear of the woman cared for and the social recognition of those who should care. Some caregivers exposed that the dependent person feared being abandoned or being alone, as reported by Jasmin: *"If... if I don't help, if I don't... give her a hand... no one will give it".* This fear intensifies the pressure on caregivers and reinforces the expectation of constant presence, an expectation deeply crossed by gender. As Dornelas (2007) discusses, this fear reveals the complexity of the relationships of emotional dependence that fall on women, who end up being responsible not only for physical care, but also for the affective security of the family member.

At the same time, the understanding of "who should care" appears marked by family discourses that assign women this naturalized role, as an inevitable extension of their identity, which Jasmin expresses forcefully when she says: *"If I don't help her, who will?"*element. This combination between the fear of care and the naturalization of feminine destiny deepens the loneliness pointed out by Dornelas: a loneliness that is not born of absence, but of obligatory presence, that is, a loneliness produced by bonds that ask too much and by structures that give too little.

3.3 GRATITUDE AND DUTY ASSOCIATED WITH THE IDEA OF DIVINE PROVISION

Religiosity is configured as a fundamental interpretative axis to understand how informal caregivers signify, support and re-elaborate the emotional overload associated with care. The contents collected by the interviews dialogue in a consistent way with the contemporary literature on religious confrontation, Marianism and gratitude.

The presence of a strong feeling of divine provision, which is exemplified in Barbara's lines "*everything I'm going to do, everything is fine. Thank God, you know?*", "*Today the rice fell to the ground... I hope God has more to give me*" and Azalea "*as long as God gives me health, strength there, to walk and I'm there helping her*", aligns with the concept of perceived divine control. According to DeAngelis & Ellison (2017), when individuals believe that God is directly involved in everyday events, they tend to reinterpret stressors in a more positive way, understanding them as part of a larger plan. This mechanism is observed among the interviewees, who transform exhausting experiences into expressions of faith, reinforcing their ability to endure care.

The articulation between mission, burden, and self-sacrifice speaks directly to the core elements of Marianism, as developed by Mendez-Luck & Anthony (2015). Jasmine's speech: "*His cross was heavy, He took care of it, why won't I give it?*", exemplifies the symbolic alignment between suffering, devotion and feminine morality, classic elements of the ideal of the "selfless mother". The idea that care is a sacred responsibility, as explained by Jasmin "*it's in God's hand, He gave me this mission*", reinforces the notion that care is not only a social obligation, but a spiritual expression of submission, surrender and moral duty, fundamental characteristics of the gender construction analyzed by the authors.

In this sense, Marianism also operates as a cultural matrix that organizes not only behaviors, but above all emotional and spiritual experiences associated with the act of caring. According to Mendez-Luck and Anthony (2016), this normative ideal constructs the female figure as naturally destined for sacrifice, renunciation and devotion, establishing that the moral value of women is deeply linked to their ability to "suffer for love" and to put the needs of others above their own. This model does not act only as an abstract reference, as it is lived in a concrete way in the narratives of the caregivers, who often translate care as a divine mission, a gesture of love and an expression of religious obedience. Bárbara's speech "*To care, to take care of him, I do feel that I like him, that I'm helping the person I like. E... for love* *of God too*" synthesizes the intertwining between affection, devotion and moral responsibility. By stating that she cares "for the love of God", Bárbara mobilizes exactly the pattern described, in which care becomes a space for spiritual fulfillment and identity affirmation. Thus, Marianism not only legitimizes self-sacrifice, but also offers an interpretive framework that allows wear and tear to be re-signified as a virtue, reinforcing the sense of purpose and the conviction that suffering associated with care has moral and religious value.

In addition, many reports express care as a form of affective retribution, as Peônia puts it: "*she already took care of us when she was a child*". This relational logic echoes the findings of Mendez-Luck & Anthony, which show that caregivers often interpret their role as returning the care received, reinforcing family bonds and legitimizing self-sacrifice as a gesture of love and commitment.

On the psychosocial level, religious involvement works as a protective factor, consistent with what Koenig et al. (2016) identify: religious beliefs and practices can reduce depressive symptoms, facilitate adaptation to the role of caregiver, and offer cognitive mechanisms that produce meaning to daily tasks. The participants' statements, especially the constant thanks, ("*I thank God very much*"), and the perception of spiritual support, reinforce that faith not only provides emotional support, but organizes the coping narrative.

A particularly relevant fact is the presence of gratitude as a central attitude, which not only softens the experience of overload, but also produces a sense of purpose. Jasmine's statement "*So, like this, I thank God very much*" shows how gratitude works as a resource for resignification, allowing caregivers to interpret daily life beyond immediate difficulties. This finding speaks directly to McGee et al. (2024), who demonstrate that higher levels of gratitude in caregivers are associated with a greater sense of life, even in the face of high stressors.

Thus, the core of religiosity observed in the study participants functions simultaneously as a cultural structure, an emotional coping system and a moral mechanism for legitimizing care. It is in this triple spiritual, psychological and sociocultural movement that faith is transformed into a practical resource, sustaining both the "burden" and the "mission", allowing caregivers to continue performing their functions, often with less subjective suffering and a greater sense of purpose.

4 FINAL CONSIDERATIONS

The findings of this study show that informal care, although essential for the maintenance of life and for the sustenance of family and community networks, remains structured on profoundly unequal bases. The interviewed caregivers reveal, in their narratives, that the daily practice of care is crossed by gender markers, loneliness and symbolic and spiritual strategies that work both as support and as a way to resignify suffering. Far from being just a set of practical tasks, care emerges as an emotionally dense experience, marked by individual responsibility, social invisibility, and an overload that unfolds at physical, psychic and material levels.

From the analytical dimensions of gender, loneliness and religiosity, it was possible to understand how these women elaborate meanings for their performance and how they internalize social expectations that naturalize their position as caregivers. The statements reveal a constant tension between the desire to meet family demands and the need to preserve their autonomy, often restricted by the sexual division of labor and the absence of effective support. Loneliness, not only as the physical absence of others, but as a structural silencing, is a central element of this experience, and contributes to the intensification of the mental load, reinforcing feelings of exhaustion and impotence.

At the same time, religiosity appears as an axis of emotional support, offering comfort, meaning and a symbolic horizon that allows one to endure the harshness of everyday life. However, although faith represents an important resource, it does not replace the urgency of specific public policies, structured support networks and community processes that redistribute care and recognize its social value.

In view of this, this study reaffirms that care is also work, a job that, when performed in a solitary and continuous way, makes people sick. It is essential that care is understood as a collective responsibility and that progress be made in the construction of strategies that recognize, support and protect informal caregivers. This includes both the strengthening of assistance and support policies and the transformation of the cultural bases that sustain the naturalization of care as a female destination. To recognize care as a right is to also recognize the right of those who care to be cared for. And it is only in this ethical, political and social movement that it will be possible to guarantee the sustainability of care practices in the home context and promote justice and dignity to women who have carried, for centuries, the centrality of this invisible work.

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