Family Rehabilitation in Chronic Illness

U. Gerhardt

The sociological literature on chronic illness focuses on the issue that a "re-designing of life-styles" is essential for successful rehabilitation. My main proposition is that rehabilitation is a family process which leads to changes in a family's role composition and way of life. The hypothesis is raised that differences in family rehabilitation are conducive to differences in the quality of life with chronic illness and, moreover, that the prospect of survival depends on the quality of the newly found equilibrium, or disequilibrium, in the family's role structure.

The hypothesis is discussed here on the basis of data procured from the total group of male married patients with end-stage renal failure in the south-east of England who were between the ages of 20 and 50 years at the onset of their dialysis treatment and who had not been patients for more than three years at 1 January 1978. Of the total study population of 76 cases, 68 were interviewed once, and 56 twice, after a 1-year interval, yielding a total of 234 interviews from husbands and wives, amounting to over 600 hours of tape-recorded material. As may be seen from Table 1, the original distribution of treatment types in our study population was similar to that of the general United Kingdom treatment population 1 year previous to the study. Over time, the distribution of treatment types among the surviving cases reversed the proportion of transplant and dialysis cases. The figures under III are based on the data of a 5-year follow-up completed in 1983.

Through an elaborate procedure of data processing using a technique of qualitative interpretation adapted from Max Weber's idea of an "ideal type", four idealized typified versions of the division of labour between the spouses were found to characterize the occupational side of the patient careers:

1. traditional family rehabilitation where the husband remains the sole or main breadwinner despite his severe disability
2. A similar situation with male dominance but with the husband's being unemployed
3. A dual-career marriage where both spouses secure the family's income
4. An arrangement where the wife alone secures the livelihood, often in "rational" anticipation of the family's need to survive after the husband's eventual death.

In our sample, the tendency is remarkably stable to stay with one of two composite types, namely, either a male-centred type of family structure with
Fig. 1. Proportion of surviving patients by treatment group, social class and long-term type of family rehabilitation, at interview 1 and 5 years later, in percentages (n = 68, n = 52). * Percentages calculated after omission of social class V and cases that were unclassified in British social class terms.

sexual role differentiation (1 and 2), or a companionship type of family structure with role blurring between the sexes (3 and 4). Among the 77% of our study population who survived, only 5% changed from one of the two composite types to the other, and the proportion of male-centred cases rose slightly from 42% to 45% while that of companionship-type families dropped from 35% to 32%.

The picture of stability does not prevail in the figures relating to survival and treatment over time (see Table 1). However, the marked decline in the proportion alive on home dialysis and the increase in the proportion alive with a transplant are not only due to differences in mortality rates but also to frequent transplantation of dialysis patients, often after years of treatment on the machine. It emerges that, over time, social class and type of family rehabilitation acquire a prominent role as relevant factors connected with type of treatment among the surviving patients (Fig. 1).

Returning to the initial statement that chronic illness requires a “re-designing of life-styles”, a concluding remark may be in order. It ought to be mentioned that our data give answers regarding *survival*; not, however, death rates