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# How Can Companies Give Voice and Support Family Transitions That Risk Being Invisible and Silent?[*]

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## Abstract

In the contemporary social context, family transitions become increasingly challenging and affect not only the family life but also the whole social context. With the term "transition" we mean periods of crisis, resulting from an event that modifies in a very significant way personal and family life and requires a process of redefinition so that a new equilibrium can be found. Such transitions are often invisible, but inevitably impact on family and professional life. This topic was dealt within a broader mixed-method research project "Ageless Talents - An observatory on the condition of over 50 employed women and men" funded by Valore D (https://valored.it/), in Italy aimed at understanding personal and family transitions in the life of over 50 workers, in particular deepening personal experiences and motivations. By focus group methodology specific understanding of managing illness in the workplace has been done and it will be presented in this contribution. The participants gave a decisive contribution by putting themselves at stake, sharing their personal experience in an atmosphere of listening, interest, mutual respect, and gratitude for the possibility of being called to tell their experience. This fact immediately gave us back the urgency and importance of giving voice and a space of speech to topics that usually struggle to find a suitable time, space, and interlocutor.

Keywords: transitions, illness, Italy.

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[*] Paragraphs 1, 2, 3 and 6 are to be attributed to Sara Mazzuchelli, paragraphs 4 and 5 to Maria Letizia Bosoni.

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## 1. Introduction

This paper intends to analyze how a familiar transition, namely illness, is linked to the work experience. Over the life course, families encounter challenging events that require a process of adaptation as well as structural and identity changes.

Based on the Family systems theory perspective and family development framework (Duvall, 1957; Falicov, 1991; Hill & Rodgers, 1964) which contribute to highlight that families change in form and function, the concept of family transition was crucial in social psychology theory and social science, to understand mechanisms leading to adaptation and dysfunction, highlighting that families are always in a process of change. Here the focus is not only on the event that starts the transition, but for a change to be called transitional it must involve a qualitative shift in the family identity, moreover, family transition must be understood in the context of the cultural and historical periods in which they occur (Cowan & Hetherington, 1991; Hetherington, 1989).

Unlike the developmental perspectives that focus on individual (children or adult), the family transition goes beyond individuals as singles and there can be multiple trajectories: thus, changes in the life course of one family member implies a reorganization of the whole family system.

Since the first developments of the concept, many studies have focused on families' transitions: family formations, separation and divorce, parenting, aging, migration processes and more specific events that impact on family trajectories (Daniels, 1990; Demo et al., 2005; Carrà et al., 2014; Schoen et al., 2007).

The concept of family transition is relevant in Relational Sociology (Donati, 2011b), which is the theoretical background of the present paper. For family transition, Donati means "a phase of 'crisis' (in the etymological sense) that follows an event that significantly changes the family social system. The event requires a process of redefinition (adaptation) of family relationships, at the end of which the family must find a new balance, or rather a new *modus vivendi"* (Donati, 2011a, p. 13). These critical moments in the passage of family life can be triggered by the acquisition of new members (e.g., the birth of a child) or the release due to death or breakdown of the family unit following divorce and maybe connected to biological phenomena, such as adolescence or changes in the role or social position of family members (e. g. the transition to adulthood, oldness). The transitions then differ due to the predictability and the degree of choice: some are predictable, others less, some are choices, others are suffered (Scabini & Donati, 2003; Scabini & Rossi, 2006).

Each family, therefore, goes through a succession of different phases that mark its course, defining its life cycle. Each phase is also characterized by specific development tasks, which involve a continuous re-elaboration of the couple's relationships, the parent-child relationships and the relationship with the family of origin. However, it is worth emphasizing that every member of the family, being involved in more than one relationship, is involved, in every phase of the family life cycle, in the contemporary confrontation of multiple development tasks.

Donati immediately connects the concept of transition with the terms family, society, morphogenesis, and risk; he highlights how in today's society, as a result of a more chaotic social environment: (a) non-normative transitions increase their frequency with a higher rate than the normative ones; (b) the very characteristics of 'normativity' and 'non-normativity' change with the de-traditionalization of society; (c) both the number of transitions that families have to face and the number of families in transition are growing. These trends are the product of a society that is configured as unbound morphogenesis and that involves the family, forcing it to live in an internal and external environment characterized by increasing levels of risk and uncertainty (Donati, 2012).

In this frame, the present contribution intends to examine the family transitions, or rather those belonging to the subject-family, and not the transitions concerning individuals in their life course (i.e., the individual transitions in the family context). This clarification is mandatory because the very possibility of identifying the family transition depends on how we identify the family, what sense we attribute to it and how we conceive its changes[1]. With this, we want to observe the family as a reality of its order, or rather, as a *sui generis* social relation having a reality of a different order from that of individuals (Donati, 2011b) as a relational set with its own symbolic and communicative code.

But how do family transitions change in a society characterized by complex morphogenesis? Donati identifies three elements: (i) the family transition loses its institutionalized character - as the institutions that regulated it collapse - and becomes an individual and social risk; (ii) the transition is de-regulated; (iii) many families live in a sort of 'permanent transition'.

Briefly, 'the family no longer meets the single normatively defined transitions, but itself becomes an incessant transition' (Donati, 2011c, p.7). The family need to reorganize its functioning, using its own internal or external resources. All transitions with their destabilizing power shake the entire family organization and question its equilibrium, thus revealing the structure of

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[1] The different interpretative and intervention approaches on transitions differ greatly when it comes to defining what transitions consist of and the attitudes and orientations to be taken to address them.

relationships clearly: the transitions, therefore, show and at the same time test the relational pact of the whole family. It is therefore a family matter (Lewin, 1951) not of single individuals, which affects the relationship between generations and family identity. After an initial phase of confusion and disorganization, families look for new solutions and can exit this phase in a positive way, or - contrary to what Hill indicated - negative way by remaining in a critical phase or also breaking up. This means that transitions put people in an uncertain, ambiguous, and risky situation, where resources need to be activated to change (Rossi & Scabini, 2006). From an examination of the existing sociological literature, family transitions seem to be of difficult empirical variation. Several scholars have been interested in family transitions, focusing however on specific transitions, analyzed through secondary data: the transition to adulthood and life as a couple (Carrà, 2012); the transition to parenthood (Scisci, 2012); the transition to old age (Bramanti, 2004; Bramanti & Meda, 2012).

Within the 'Ageless Talents' project, and specifically in its first quantitative survey phase carried out in 2017 on a sample of 4962 workers aged between 50 and 69, an important presence of personal and family transitions was highlighted in the lives of over 50 working women: 73% of the interviewees report an event that has significantly negatively changed their lives, namely the loss of a loved one, their own or of a family member illness, separation/divorce.

This contribution is aimed to understand and analyse as illness impact of family transition, moreover as consequence of ageing population, often sever illness occur in the middle age when people are still working, so the contribution will consider the double impact of this transition of family life and professional life. Such transitions, often invisible, inevitably intertwine with professional life. We will now try to better clarify the characteristics of our object of study through a brief analysis of the literature on *illness*, to then deepen the meaning assumed by the aforementioned transition through the data of a quantitative and qualitative survey carried out by Valore D (https://valored.it/).

## 2. The disease: a brief analysis of the literature

Ageing population is a global social change with broad impacts on both the family and the labor market, thus generating an increased life expectancy but also consequences on people health.

The health of the population is monitored by European and Italian surveys: the aim is to analyze the main aspects of the population's health conditions[2] and the use of health services[3]; information is also collected on the level of perceived social support, as well as on the care provided to family and non-family members[4]. Given the population aging process, the data are mainly focused on the elderly (Istat, 2017); special attention is then paid to employees who have applied for severe handicap permits (low n.104/1992) (Istat, 2012b).

However, it should be noted that even today, despite the efforts and progress made in data collection, the system is not able to define with a unique figure people whose gravity condition has been recognized so far. Significant information gaps remain, linked both to the failure to construct indicators capable of adequately capturing the phenomenon and to the unavailability or poor dissemination of administrative data. The outcome is a discrepancy between the data provided by the main sources: ISTAT and INPS (Bucci & Giacobini, 2015). The context is even more complex if we look at the subject of disability/invalidity - regulated by a legal point of view both as regards the sick person and the caregiver (Pavolini, 2002) - to that of chronic diseases which, according to the European Network for Workplace Health Promotion[5], affects 25% of the working-age population.

In international literature, a chronic disease is defined as a disease that has one or more of the following characteristics: it is permanent, leaves a residual disability, is caused by a non-reversible pathological alteration, requires a special

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[2] Concerning the health status of the population, information is analyzed regarding the presence of chronic diseases and comorbidities, the presence of depressive symptoms, the perception of physical pain and interference in daily activities, the presence of functional limitations (serious difficulties in sight, hearing, severe mobility difficulties), as well as impaired autonomy (severe limitations in personal care activities or ADL- Activities Daily Living; severe limitations in-home activities or IADL- Instrumental Activities of Daily Living).

[3] For the use of health services, information gathered on hospital admissions, medical examinations (general, specialist), home assistance, medication consumption, difficulty in accessing health care services, and benefits are made available.

[4] Istat (2016). *Condizioni di salute e ricorso ai servizi sanitari*, https://www.istat.it/it/archivio/5471; Istat (2017). *Condizioni di salute e ricorso ai servizi sanitari in Italia e nell'Unione Europea- indagine EHIS 2015*, https://www.istat.it/it/archivio/204655; Istat (2018). *Health for all – Italia*, https://www.istat.it/it/archivio/14562; Istat (2018). *Indagine europea sulla salute (Ehis): microdati ad uso pubblico*, https://www.istat.it/it/archivio/210557.

[5] European Network for Workplace Health Promotion (2012). *Promoting healthy work for workers with chronic illness: a guide to good practice*, 8, http://www.imp.lodz.pl/upload/english/english/promoting%20healthy%20work.pdf.

rehabilitation of the patient, or can be expected to take a long period of supervision, observation, or care (Conrad, 1990; Koch et al., 2013; Koolhaas et al., 2012; Timmereck, 1986).

The peculiar characteristics of the chronic disease seem to be therefore the absence of a definitive cure - the disease is destined to continue over time, possibly with phases of improvement, often with a progressive deterioration - being a consequence of the degenerative aggravation of 'risk factors, the non-transmissibility[6]. Beyond the stringent definitions, a series of pathologies are included under the umbrella of chronic diseases, although characterized by some traits of peculiarity and specificity:

- cardiovascular diseases;
- chronic kidney diseases;
- oncological diseases;
- liver diseases;
- mental health diseases, especially depression, but also anxiety or forms of psychological dependence;
- respiratory diseases (especially chronic bronchopulmonary obstructions, asthma, and allergies in the broad sense);
- rheumatic and arthritic diseases.

The condition of a worker suffering from chronic diseases is not simple, not only for the personal condition of the patient (Munir et al., 2005) but also for an anachronistic welfare system. A notion that in the context of the regulation and legal protection of chronically ill workers assumes undoubted importance is that of (partial) incapacity for work; it is often placed at the base of national social protection regulations: however, complex problems derive from the absence of a shared definition at international level[7].

Chronic diseases, therefore, represent a challenge for the sustainability of public health and welfare systems, impact the overall dynamics of the labor market, productivity, and work organization. How to face this challenge? With a change of direction in the intervention that moves from subsidies, reserve quotas, and passive protections to activation, conciliation, and retention

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[6] On the different definitions of chronic disease and non-transmissible disease in the World Health Organization, please see World Health Organization, *Chronic diseases, and health promotion. Part Two: the urgent need for action. Chapter One: chronic diseases, causes, and health impact. Terminology on chronic disease*, https://www.who.int/chp/chronic_disease_report/part2_ch1/en/.

[7] On the problem in Europe, please see Erhag T. (2011). *'Incapacity for work'; a National legal concept with cross-national functions*. In Devetzi S., & Stendahl S. (Eds.), *Too sick to work? Social security reforms in Europe for persons with reduced earnings capacity*. Kluwer Law International BV, The Netherlands, (pp.22-26).

policies, revisiting the conciliation and equal opportunities policies according to a work health-life balance perspective (Fernández Martínez & Tiraboschi, 2017; Tiraboschi, 2015).

As mentioned before, the disease is a challenge not only for the sick person but also for the caregiver (Osservatorio sulla condizione assistenziale dei malati oncologici, 2018).

In a Censis' research focused on the impacts of Parkinson's disease, it emerges that the care activity has brought about changes in working and social life, in the use of leisure time, and the health status of the interviewed caregivers (Censis, 2017)[8]. Help from family members is one on which people with functional limitations count most often (83.1%) (Censis Fondazione ISMU, 2013; Istat, 2012a; Istat, 2014). Families, therefore, face the lack of public services, but this entails significant social costs. It is not only a question of direct economic costs but also and above all indirect costs, in terms of impacts on the health of caregivers, failure to exploit care work, renouncing employment (Naldini et al., 2016). Especially for women: it is estimated that in 25% of families where there is a person to be assisted, and it is not possible to use the services of collaborators, there is a young woman who has given up her job: interrupting it (9.7%), significantly reducing the commitment (8.6%) or ceasing to look for it (6.7%) (Censis, Fondazione ISMU, 2013). Over one million people are inactive (24% of those with children under 15 years old or with other care responsibilities) who would be willing to work if they could reduce the time spent on assistance and care (Istat, 2011).

The sociological literature focuses mainly on the themes of disability, mental illness, and discrimination (McGonagle et al., 2016; Tausig, 2013; Weiss & Lonnquist, 2017), deepening the meaning of the disease in the life of the person and his family; the disease is studied as a biographical break, the experience of illness (Good, 1994; Pierret, 2003), the impact for the self-reorganization (Charon, 2006), the chronic illness and the course of life (Bury, 1991; Newby, 1996). Leaving the specific field of the sociology of health certainly deserves mention the reflection of Donati and Ferrucci. The first, although in a dated work (Donati, 1987), aims to outline health sociology oriented to re-establish the conception and the interventions for health in a wider picture than the medical one; in this perspective, health is defined not as a given psychophysical condition, but as a set of dynamic and complex social relations governed by a network and empowerment logic. Ferrucci (2004) proposes instead a critical review of the main sociological approaches - medical,

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[8] 36.9% state that care work has had consequences on their employment, ranging from problems due to repeated absences at work, the need to request part-time work, to the choice of retiring or losing the job.

structural-functionalist, and constructivist - trying to clarify the specific perspective of analysis of disability, but also the limits and reductionisms. The basic thesis is that disability must be analyzed and understood as a 'social relationship' and that the contributions of the different sociological approaches constitute the fragments of a conceptual framework that only in this perspective can consider the individual and social experience of the disabled person in all its factors and dimensions. Finally, Pavolini's reflection (2002) deserves to be mentioned: although with a different theoretical perspective from the authors mentioned above, introduces an interesting distinction between the emergency and chronic dimension as features of today's welfare; a distinction that we will be able to take up again in our analysis.

In the light of the outlined theoretical framework, we will therefore take into consideration, through both quantitative and qualitative data, the transition analyzed, trying to identify the complex connotation assumed by the family-work relationship.

## 3. The quantitative survey

The research presented here is part of a large project started in 2017 and funded by Valore D[9]. The first phase, at the request of the Client, focused on a sample of 4962 working women, aged between 50 and 69 and a twofold objective is set:

1 - provide a first representative photograph of the population of over 50 working women in Italy

2 - identify intervention strategies useful to support the presence at work of women in this age group.

This was followed by a qualitative survey aimed at contextualizing the evidence that emerged from the first quantitative survey (2017), helping to deepen personal experiences and motivations, as well as orienting the second quantitative survey (2018) by providing useful indications for the revision of the tool used.

This second phase of the quantitative investigation was carried out in 2018[10] on a sample of 12912 participants (64% M, 36% F); of these, 5906

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[9] The first corporate association promoting gender balance and an inclusive culture to foster companies and country growth (https://valored.it/en/).

[10] The questionnaire used in the first wave (2017) was revised based on the stimulations that emerged from the qualitative survey, which allowed us to investigate the most critical aspects in combining experience and meaning of work within the transitions of life after 50 years.

reports a significant event that has changed their lives in recent years: 13.4% (N = 789; 414 M and 369 F) the illness of a close family member/relative, 10.2% (N=602; 348 M and 251F) an own disease. Comparing the data of the 2018 edition with the previous one (2017) - although with caution due to the difference in the sample - within the challenges encountered in the various phases of life transition, an increase in the disease event and/or death of close family members are confirmed, as well as the greater presence of health problems for workers. This data, combined with the changes brought about by the reform of the pension system and by the family structure and extended parental network of workers, prefigures an imminent scenario on which companies should certainly reflect and where a supportive intervention is more decisive than ever.

In the participants' perception, these events produce a worsening of the following life conditions for most respondents (about 59%) and are characterized as negative transitions[11]; however, it is above all the illness of a relative/family to be seen as a pejorative event by about 74% of the participants, followed by their illness (56.3%). These assessments are similar for male and female respondents. More than 70% of interviewed stated that they had communicated to the company - in the person of direct/responsible leader or HR figure - the criticality of the situation when linked to the illness event (own, 79.8% or relative, 71.8 %).

However, it should be noted that a high percentage (over 50%) declares that they have not received support in the company following the critical event. The presence of support is more frequent for own illness, even if it is mainly informal support (respectively family member illness, 28%, and own illness 29.9% of cases). Forms of formalized support are instead declared only by 14.5% and by 16% of those who have faced the illness of a family member or their illness[12].

We then asked the workers what kind of reaction this personal affair had caused in the company: the picture that emerges is not encouraging. While

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[11] We have defined as negative the transitions that led the over 50s to a significant deterioration in life, while the changes perceived as neutral or as positive improvements for one's life have been defined as positive transitions.

[12] A precise analysis of different types of received support confirms the scarce use of formalized supports.

colleagues[13] and the boss for the most part react by showing support[14], the company[15] and HR[16] remain mostly indifferent. It, therefore, seems that corporate resources struggle to become active for those who have a life change perceived as negative.

It is also interesting to highlight how work remains an important aspect of life for most respondents (men and women) through those facing the event of illness must more often put the work in the background (49% and 51.1% of those who respectively face the illness of a family member or their illness).

Lastly, for workers who have had a negative life change, the probability of staying active increases almost once when the number of company figures offering support increases. Moreover, it is almost four times more likely to be active workers who have been able to put the work in the critical phase of the event, while it is once less likely to be active workers who have continued to invest as much as possible in the work in the critical phase of the event. Finally, the likelihood of being an active worker decreases if one receives indifference in the workplace while increasing if one receives support from the family.

## 4. The qualitative survey

### *4.1. Methodology*

As mentioned in the previous paragraph, the first (2017) and second waves (2018) of the quantitative investigation were interspersed with a qualitative survey having a dual aim:

1. to contextualize the evidence that emerged from the first wave of quantitative investigation (2017) contributing to deepening personal experiences and motivations and shed light on numerical data, with both women and men to make gender differences evident and allow more in-depth reflections;

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[13] It is necessary to distinguish between colleagues in general and the closest colleagues, who offer more support; while the former is more supportive in the face of the employee's illness (68.1%) compared to illness of a relative (67.6%); the closest colleagues offer greater support for the illness of a relative (86.3%), or own illness (84.2%).

[14] The direct boss is more supportive towards the illness of relatives (71.8%) and own illness (65.7%).

[15] The company appears less indifferent to those who are sick (60.4%) or have a sick relative (63.6%) than to those who are separated (83.1%).

[16] Greater indifference is towards the separated (85.5%) and those who have sick relatives (61.3%).

2. to orient the second wave (2018) providing useful indications for the revision of the instrument used.

The key tool of this qualitative phase was the focus group. The choice of the tool was dictated by the objectives of the research: the focus group foresees a main theme (focus) and some stimulating questions regarding it to encourage the participants to tell their experiences; it offers the possibility of a comparison of positions, resulting useful in the exploration of experiences and the understanding of behaviors and subjective experiences. The discussion is favored by the moderator(s), which allows highlighting both the specificity and richness of the individual subjects' paths and solicits, through comparison with the experience of others, further space for reflection and judgment.

11 companies associated with Valore D (https://valored.it) have joined the qualitative phase. Company involvement took place through e-mails presenting the project to the Company's Referents. All the organizations (managers, executives, office workers, manual workers) have been involved in the working groups. The participants' engagement took place in different ways: some companies decided to send a call to the over 50 population and therefore the participants were self-nominated; others preferred the direct engagement of the participants because of the experience of transition.

For this qualitative exploration, it was decided to investigate what happens to over 50 workers during some transitions that may occur during their lifetime: the urgency to manage the disease in the workplace (the disease as a transition).

A Focus Group with 15 employees, lasting approximately 3 hours, was performed. Participants, 10 females and 5 males, all aged between 50 and 65, mostly reported they have experienced a disease (tumors, neurodegenerative and autoimmune diseases and disabling genetic syndromes) and in a few cases their family members (children or relatives). The discussion - articulated starting from some stimulus questions - was moderated by two members of the research team and audio-recorded to allow the recovery of the data and the analysis of the emerged contents.

The collected material was analyzed with specific techniques aimed at grasping the main themes and significant links, or the specific way in which the participants give meaning to the lived experience through their story. Once the verbatim transcription of the recordings was concluded, a first thematic analysis of the transcripts was carried out using the paper-pencil method (content analysis, Ghiglione, et al., 1980) [17] - with the aim of capturing thematic areas and

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[17] The paper-pencil method consists of an analysis of the qualitative data through reading grids provided by the analysis categories. It aims to detect the occurrence of themes in complex texts, such as those produced within a group discussion. The categories of analysis can be established a priori, for a specific theoretical interest, or in

co-occurrences - and subsequently the T-lab software (lexical and correspondence analysis)[18] was used.

The two different instruments allow the articulation of a complementary analysis. The richness of the designated corpus has allowed us to carry out analyzes of different types and complexity. We will report only a few for reasons of brevity.

We will now present the focus group analysis with this structuring scheme: first, the data emerging from the paper-pencil analysis will be presented, inserting, where appropriate, graphs and comments relating to the T-LAB software analysis and then concluding with a summary and some operational indications useful to the companies interested in intervening on these topics.

### *4.2. Results from focus groups analysis*

The thematic analysis of the focus groups highlighted four large thematic areas around which the participants' narrative revolves:

1. the transition experience and implications,
2. what helped/made it difficult to cope with the transition,
3. how the relationship with work and in work relationships has changed,
4. useful suggestions for companies.

#### *4.2.1. The transition experience and implications*

The experiences that people bring about, compared to a work transition due to the field of physical health, are very different (tumors, neurodegenerative

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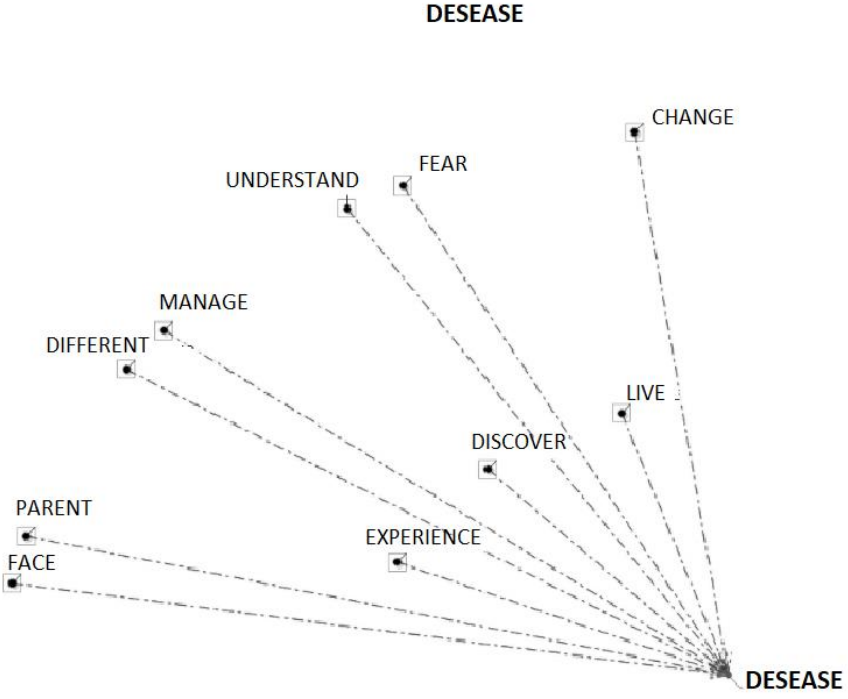
retrospect, searching for them within the analyzed text. For this research, a qualitative approach was used that left room for interpretative moments, generating hypotheses and semantic links starting from the conversations developed in groups.

[18] T-LAB is a software consisting of a set of linguistic and statistical tools for content analysis and text mining. There are several valuable elements of this program: its interface is particularly user-friendly and allows the application to very different fields and objects as well as an automatic lemmatization available in different languages (Italian, English, French, German, Spanish and Portuguese). T-LAB also uses automatic and semi-automatic processes that quickly highlight significant patterns of words, themes and variables; finally, all software processes are transparent and can be easily customized using a wide and flexible range of analysis tools. The richness of the designated corpus has allowed us to carry out analyzes of different types and complexity: Word associations, Radial diagrams, Sequence Analysis, Multidimensional Scaling (MDS).

and autoimmune diseases, disabling genetic syndromes), and concern both the participants as well as their family members. The story of the experience during these transitions emerges with strong emotional tints as can also be seen from the analysis of the sequences[19] with T-lab (fig. 1 and 2).

*Fig. 1 - Predecessors of Disease.*



The lemmas *experience, change, fear* and *manage* appear both as predecessors and as successors of the lexical unit *disease*, and this is an indication of their strength and relevance.

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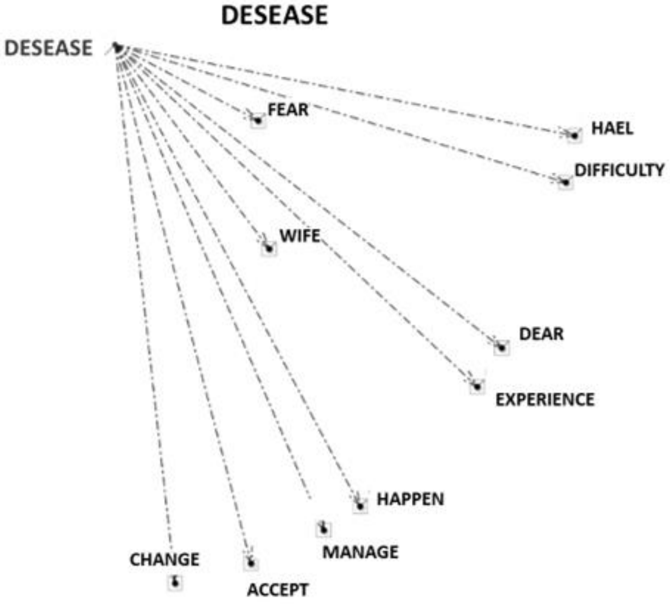
[19] T-LAB allows to carry out a Markovian analysis of sequences and to export the relative outputs for a Network Analysis. Starting from a matrix where all the predecessors and all successors of each item (lexical unit or theme) are recorded, T-LAB calculates the transition probabilities (Markov chains) between the various units of analysis. In the graphs, the lexical units less distant from the one selected are those that are more likely to precede it (predecessors) or follow it (successors).

The focus group generates a great desire to share details of personal trajectories, aspects that have affected people's lives, and ways of thinking. Narratives assume great importance, in these species.

*Fig.2 - Successors of Disease.*



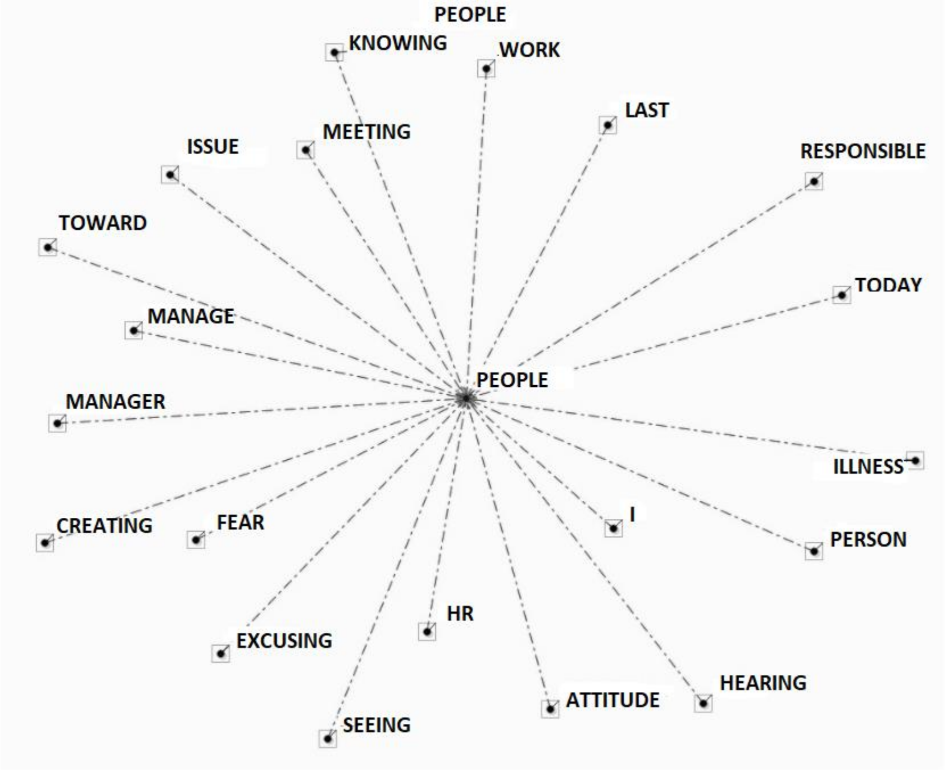
### 4.2.2. *What helped/made it difficult to cope with the transition*

In the experience of illness, family networks and the support from the law are helpful. Participants reported that continuity at work has served as a supportive and empowering aspect because being engaged in work diverted attention from the issue of illness.

However, in many experiences reported, the company appeared closed to this: an alliance was made with the boss in terms of work organization and based on a more relational and fiduciary plan; communications and dialogues with other colleagues concerning aspects related to the illness were scarce. The fear linked to the socialization of one's condition with the widest group of colleagues concerns the fear of being stigmatized and the awareness that people (who have not gone through an illness) are not able to calmly accept dialogue on the condition of the sick.

This aspect also appears in the analysis of radial diagrams[20] carried out with T-lab.

*Fig.3 – Radial diagrams with People.*



The lemma *People* is associated with the personal dimension (I), the workplace (*work*), and the *illness*, which calls into question the themes of *fear*, of *attitude* towards the *person* (*sick*). In this, central is the figure of the HR manager and the manager is called to take a position with very concrete actions: *hearing, seeing, knowing, excusing, creating, and managing*. The theme of the *meeting* emerges and the relevance of the temporal dimension (*today*) (fig. 3).

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[20] In the radial diagrams, the selected lemma is placed in the center. The others are distributed around it, each at a distance proportional to its degree of association. All the relations are therefore significant according to a one-to-one relationship between the central lemma and each of the others.

### *4.2.3. How the relationships with work and at work have changed*

The disease necessarily generates a rethinking and rebalancing of personal life spheres as evident in Figure 4.

*Fig.4 – Radial diagrams with Desease.*

*Desease* is often defined as something that happens to the subject (*I*), to the loved ones (*dear, parent*), to the others (*people*). It is associated with *fear*, particular *attention* to be had, changes (*change, before*) - even at work it can give rise to transfers or changes of position (*transfer, place*), corrective actions or side effects (*chemo, sclerosis*) yet it is strongly associated with life (*live, life*).

The request for part-time or the use of flexible hours contributes to reshaping the relationship with work.

Thus, from such transition experiences, it is also possible to learn new attitudes towards work and colleagues. Towards work, understood as a classification of work within life, as a redefinition of priorities, better ability to assess the circumstances and the investment dedicated to it but also as optimization of time, the desire to get involved and contribute positively.

Concerning the relationship with people within the company, the fear of speaking, on the part of colleagues, with those who are sick, and of facing closeness with the pain of others emerges. Participants suggest that in the workplace there is a lack of a specific language, a real literacy, and acculturation to stay close to the suffering or uncertainty of life. Thus, there is a subtle line between protection and discrimination, concerning a condition or illness: in some cases, episodes of severe discrimination or unpreparedness are reported to manage the return of the sick person in the workplace; if the disease does not concern the person himself, those who choose to dedicate time to take care for others could be perceived as 'foreign'.

However, the experience of managing such transition can provide new skills and help manage others differently. The responsibility of those who have passed from an illness, and the fatigue of people to talk about it, generates a situation of greater responsibility for the sick: they act as a resource for those who face similar situations, remove the discomfort to others about the way to manage the suffering of others, but are called to live their condition through autonomous paths of survival.

#### *4.2.4. Useful policies and attentions, made available by the company*

It appears urgent for companies to develop a culture of communication and listening concerning the issues of personal discomfort and illness. In general, illness and suffering are scary issues, and not being trained or sensitized to approach these situations creates barriers in communication and relationship between people.

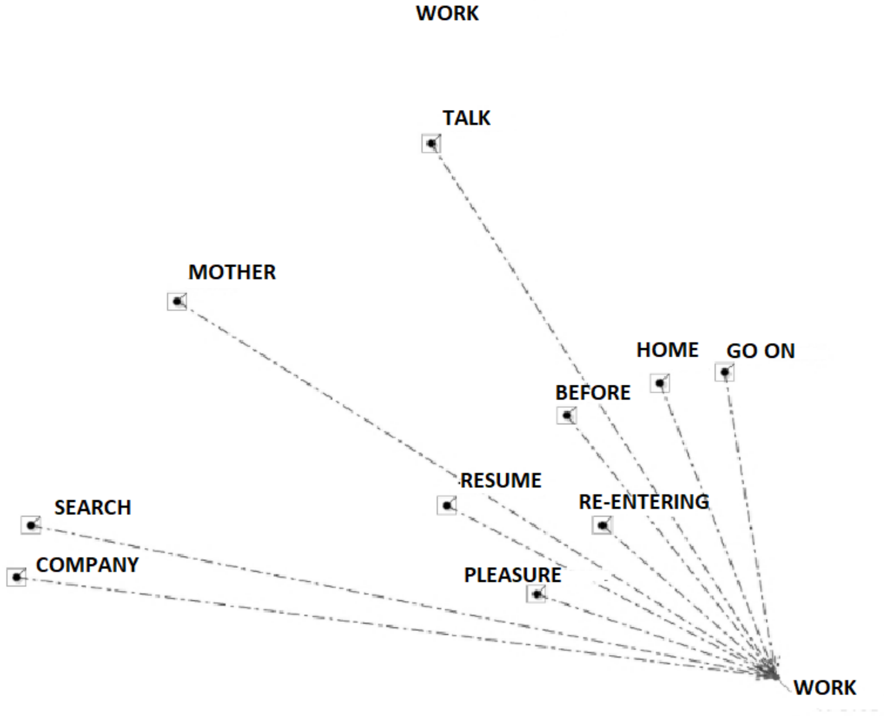
Policies that help to make symbolic and cultural, as well as material, attention to discomfort and disease are detected in measures such as flexible time, smart working, the psychologist in the company, but also the discourses circulating in the company and the attentions of HR managers toward human dimension.

The company is seen as supportive whenever it proposes policies and careful discourses on illness and disability, as well as when it proposes health prevention policies. These attentions contribute to creating a culture attentive to the different needs of the person, making it natural to refer to health or illness as physiological parts of life to be guarded, all together.

Time management (managing the healing phase or the rest period when the person is on a care path) is a crucial variable on which some companies are trying to focus on with concrete practices, such as flexible working and the time-based solidarity bank. To the needs of the person facing a disease, it is possible to identify a need linked to the immediate confrontation of the situation, and a need linked to a long-time phase (welfare linked to the criticality, and welfare tied to the chronicity of the need).

This theme of time also emerges in the analysis of T-lab sequences (Fig. 5 and 6).

*Fig. 5 – Predecessors of Work.*



It is interesting to highlight the relevance of the temporal dimension (*before*) and the theme of the return to work (*re-entering*): they appear both as predecessors and as successors of the lexical unit *Work;* noteworthy is the juxtaposition of this lexical unity with the lemmas *pleasure* and *home*.

Multidimensional Scaling (MDS)[21] allows us to identify relationships between lexical units (Co-Word Analysis), thus synthesizing the main themes present in the narration (Fig. 7).

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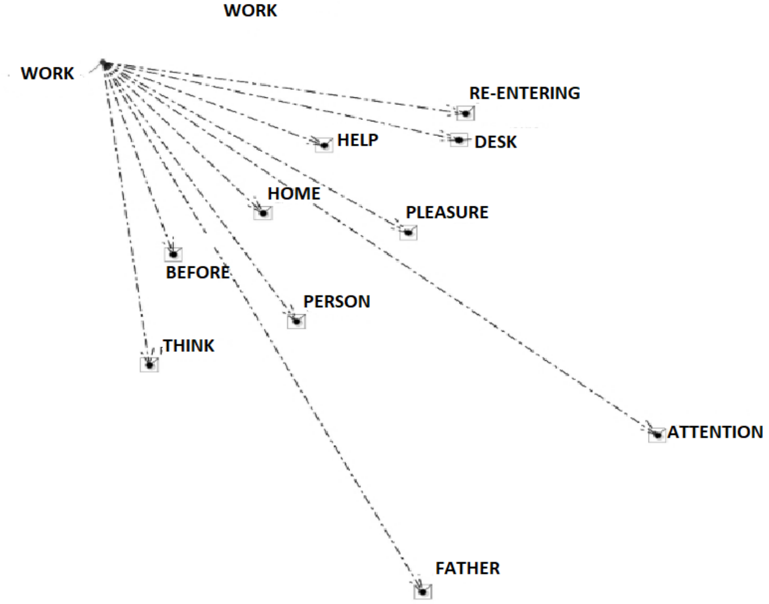
[21] It is a set of statistical techniques that allow analyzing similarity matrices and representing the relationships between data within a small space. In T-LAB a type of MDS (Sammon method) is used to represent the relationships between lexical units (Co-Word Analysis) or between thematic nuclei (Modeling of Emerging Themes). The

*Fig.6 - Successors of Work.*



Predominant are the two quadrants on the right strongly connected to the theme of work: in the upper quadrant, the management of people[22] (to *understand, succeed, put, see, find*) is discussed by the manager while in the lower one the return to the company and the experience of moving from home to work. The lower left quadrant focuses more specifically on the relationship with colleagues, while the upper left shows the issue of illness of family members - *parent, child, boy* - and the difficulties connected to it (*accept, look, fear, time*).

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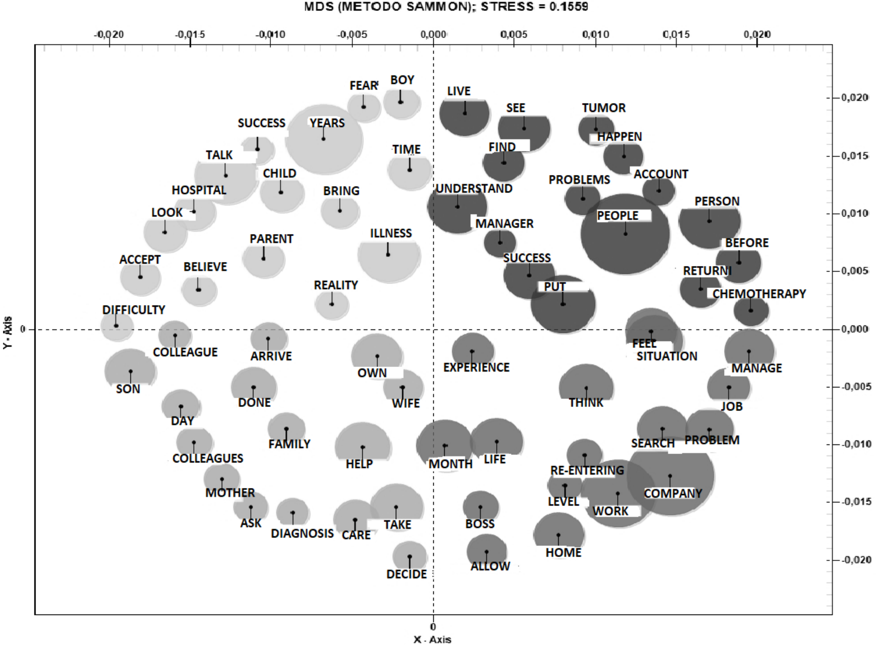
data consist of square matrices where there are values of proximity (dissimilarity) derived from the calculation of an association index (Jaccard, Dice, Cosine, Equivalence, Inclusion, or Mutual information). The obtained results, similarly, to those of correspondence analysis, allow us to interpret both the relationships between the "objects" (proximity/distance), and the dimensions that organize the space in which they are represented.

[22] These people have problematic situations (cancer) and are facing therapies (chemotherapy).

*Fig.7 - MDS (Sammon method).*



## 5. Discussion

We can certainly highlight some elements for improving the analysis, an analysis that is certainly interesting but deserves to be expanded in the reference sample to allow a more structured and complex reflection.

One of the most delicate aspects concerns the use of the focus group as an investigation tool: only the conduct of experienced moderators with solid psychological training can avoid the risk of an excessive homogenization effect of the group at the expense of an enhancement of the individual experience. In our case, this risk has been kept under control, but it is appropriate to warn anyone who believes they are using a qualitative survey with too much ease.

Summarizing the results,–we can therefore highlight how companies are faced with very different situations (such as tumors, neurodegenerative and autoimmune diseases, disabling genetic syndromes) that can directly affect the worker or one of his family members.

In both cases, we can distinguish two temporalities or phases: an emergency phase - close to the disease event and requiring immediate confrontation and a detachment from work - and a chronicity phase - at a distance from the event, with the most extended and nuanced temporal boundaries where the worker can resume work even with some precautions and modulations.

In the light of the carried-out analysis, we can identify some actions or interventions that companies can implement to accompany or support the transition (Table 1).

*Table 1. Actions or interventions implemented by companies to support the transition.*

| *For those who have faced or are facing their disease* | |
|---|---|
| *Suggested measures to face the emergency can be:* | - investing in a humanized management culture and education (management awareness and cultural change: events, training / educational and informational activities on diseases and disabilities);<br>- guarantee the required permits or set up special permits;<br>- support a solidarity time bank (make available hours of your time to help people in need);<br>- create backups to be able to buffer emergencies;<br>- establish economic contributions in case of need. |
| *Supportive measures in chronicity phase can be:* | - pay more attention to the transition to return (balance of skills and motivations and perceived security to face the work carried out before the illness; ensure over time the support by another person who can guarantee the support in case of need);<br>- create a personalized help desk for professional repositioning; introduce the figure of the psychologist in the company; identify reference persons who are aware of illness situations and become support for specific requests;<br>- guarantee the continuity of work and role; pay attention to the mobbing after a long illness; continue to value people both professionally and humanely, and provide continuous work incentives;<br>- introduce rewarding policies even for those who have suffered periods of illness;<br>- promote a corporate culture that allows, and incentives dedicated spaces for dialogue about diseases and disabilities (examples: enhancement of concrete examples, preparation of ad hoc assistance figures, as well as training in the sensitivity of management ...);<br>- invest in training for staff and management for personal care;<br>- offer support for managing children, guaranteeing permits;<br>- support a solidarity time bank (make available hours of your time to help people in need);<br>- allow and promote smart working and organizational flexibility. |
| *For those who are responsible for and manage the illness of loved ones (children, elderly or dependent family members)* | |

*Continue to the next page.*

| | |
|---|---|
| *Suggested measures to face the emergency can be:* | - investing in a humanized management culture and education (management awareness and cultural change: events, training/educational and informational activities on diseases and disabilities);<br>- guarantee the required permits or set up special permits (i.e., a solidarity time bank);<br>- create back up to be able to buffer emergencies;<br>- establish economic contributions in case of need;<br>- investing in an effective information and communication policy-focused and systematized on the opportunities provided by the law or by welfare policies already present in the company (benefits, services, leave ...). |
| *Supportive measures in chronicity phase can be:* | - maintain the transition to return (motivational balance and sustainability in dealing with the same job that was performed before the illness of the family member; ensure over time the support by another person who can guarantee the support in case of need);<br>- create a personalized listening and support desk; introduce the figure of the psychologist in the company; identify reference persons who are aware of illness situations and become support for specific requests;<br>- guarantee the continuity of work and role; continue to value people both professionally and humanely, and provide continuous work incentives;<br>- introduce rewarding policies even for those who find themselves remodeling their work time to look after a family member;<br>- promote a corporate culture that allows, and incentives dedicated spaces for dialogue about diseases and disabilities (examples: enhancement of concrete examples, preparation of ad hoc assistance figures, as well as training in the sensitivity of management ...);<br>- invest in training for staff and management to personal care;<br>- offer support for the care of children and family members to be looked after (eg. company nurseries; facilitated agreements; on-demand babysitters; on-demand caregivers ...);<br>- guarantee special permits to look after the family member and the possibility of recovering the hours of leave;<br>- support a solidarity time bank (make available hours of your time to help people in need);<br>- allow and promote smart working and organizational flexibility;<br>- investing in an effective information and communication policy-focused and systematized on the opportunities provided by the law or by welfare policies already present in the company (benefits, support services, leave ...);<br>- establish economic contributions in case of loss of wife/husband and case of need. |

These suggestions can certainly be further implemented using ad hoc analyzes that make it possible to identify, by segments, the needs, and resources of the workers to identify further measures responding to the real condition of people. It is also useful that the company continues to promote and invest in health prevention policies - free check-ups, workplace innovation, care of the canteen service -; this helps to create an attentive culture to the different needs of the person and to make the reference to health or disease natural as physiological parts of life; that could break down the existing barrier between health and illness which results in a difficulty in looking, treat and deal with ever-increasing cases of *illness*.

Finally, as mentioned regarding the concept of family transition, it is important to support people to see the transition as a family question, understanding that changes that impact a single member impact all family relationships and the various aspects of life in which people are involved, such as work.

## 6. Conclusion

From the carried out analyzes it emerges how, despite the specific nature of each transition, the impact that life changes have on the work organization follows a very similar timing.

Two temporalities or phases can be distinguished: an emergency phase and a chronicity phase. The emergency phase is close to the event (illness) and requires immediate confrontation and, in some cases, a separation from work. The chronicity phase is located at a distance from the initial event, representing a phase with more dilated and nuanced temporal boundaries.

To support people facing a life transition, it is possible and necessary to invest in these different levers:

-*guarantee time:* permits, time bank, allow and promote smart working and organizational flexibility

-*guarantee support and help*: backups, economic contributions, personalized help desk, personalized support, support for managing children and family members to be looked after

-*communication*: investing in an effective information and communication policy-focused and systematized on the opportunities provided by the law or by welfare policies already present in the company (benefits, services, leave ...)

-*invest in management culture and cultural change*: guarantee the continuity of work and role, continue to value people both professionally and humanely, provide continuous work incentives, introduce rewarding policies, promote a space for discussion and speech so that the disease is not experienced as a taboo but as part of life, invest in training for staff and management for personal care.

To support people facing a life transition, we need to invest in a humanized management culture and education. This is particularly urgent as regards the negative transitions that are received with less support and solidarity in organizational contexts.

This managerial training (events, training/educational and informational activities on life transitions and their phases) must be aimed at a cultural change that promotes a vision of the transition as "normalized" and a longer-term vision towards workers who cross phases of change, that is, that can sustain periods of minor work commitment aimed at restoring the work-life balance.

It is confirmed what emerged in other surveys (Mazzucchelli, 2011): a supportive corporate culture, which shows to hold to the employee well-being, leads to having more satisfied workers.

What are the ingredients of a supportive corporate culture? The careful availability of the company and the willingness to meet the employees need when they arise[23]; the ability to manage work flexibly and the willingness to negotiate needs allow workers to maintain the right concentration, reducing the incidence of personal/family concerns on work performance; the work climate, based on mutual trust, in a negotiating and informal perspective, ensures that each case could be assessed individually in its entirety, with attention and enhancement of the family dimension; this allows people to look to the future without concern, certain of the company's unconditional support.

A pivotal role is undoubtedly represented by the figure of the management who has to decline the values of the corporate culture and has greater proximity and involvement with the workers.

Management has an important and delicate task: it protects and favors work, which allows continuity of one's dimension of life and identity, despite the illness; helps fight the fear of being stigmatized, by colleagues, which leads to silence own situation; favors a rethinking and rebalancing of personal life spheres that can be an opportunity to acquire new managerial and relational skills.

This figure plays a key role as it supports the narration and reconstruction of a life story - an element considered decisive by the interviewees.

Nevertheless, while recognizing a decisive role for management and companies, we cannot fail to note that in the current welfare context, the latter play a decisive social role but increasingly and hopefully, in partnership and / or network with other subjects. (PA, nonprofit). It is therefore important to

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[23] Here is confirmed what was noted by Ganster, Fox, Dwyer (2001): Greater autonomy and control in the work management are elements that reduce stress to a greater extent than a reduction in the number of hours spent at work.

open up space for reflection on what could be the concrete initiatives and measures activated by companies in a network with other subjects.

## References

Bramanti, D. (2004). *Passaggi di consegne. La transizione all'età anziana in una prospettiva relazionale.* Milano: Vita & Pensiero.

Bramanti, D., & Meda, S. (2012). I grandi anziani: l'ultima transizione familiare. In G. Rossi & D. Bramanti (Eds.), *La famiglia come intreccio di relazioni. La prospettiva sociologica* (pp. 113-142). Milano: Vita&Pensiero.

Bucci, D., & Giacobini, C. (2015). *Persone con disabilità in Italia, fra dati ufficiali e luoghi comuni*, www.condicio.it.

Bury, M. (1991). The sociology of chronic illness: a review of research and prospects. *Sociology of health & illness*, 13, 451–468. https://doi.org/10.1111/j.1467-9566.1991.tb00522.x.

Carrà, E. (2012). La Transizione all'età adulta e i percorsi alla vita in coppia. In G. Rossi & D. Bramanti (Eds.), *La famiglia come intreccio di relazioni. La prospettiva sociologica* (pp. 59-79). Milano: Vita&Pensiero.

Carrà, E., Lanz, M., & Tagliabue, S. (2014). Transition to adulthood in Italy: An intergenerational perspective. *Journal of Comparative Family Studies*, 45(2), 235-248.

CENSIS Fondazione ISMU (2013). *Elaborazione di un modello previsionale del fabbisogno di servizi assistenziali alla persona nel mercato del lavoro italiano con particolare riferimento al contributo della popolazione straniera.* Maggio, http://www.condicio.it/allegati/130/Sintesi_2013.pdf.

CENSIS (2017). *La gestione della cronicità: il ruolo strategico del caregiver. Il quadro generale ed un focus sul Parkinson.* Novembre, http://www.condicio.it/allegati/323/Caregiver_Parkinson_Sintesi2017.pdf

Charon, R. (2006). *Narrative Medicine. Honoring the Stories of Illness*. New York: Oxford University Press.

Conrad, P. (1990). Qualitative research on chronic illness: A commentary on method and conceptual development. *Social Science & Medicine*, 30, 1257–1263. https://doi.org/10.1016/0277-9536(90)90266-U.

Cowan, P. A., & Hetherington, E. M. (Eds.) (1991). *Family transitions* (Vol. 2). Hillsdale: Psychology Press.

Daniels, J. A. (1990). Adolescent Separation-Individuation and Family Transitions. *Adolescence*, 25(97), 105-121.

Demo, D. H., Aquilino, W. S., & Fine, M. A. (2005). Family composition and family transitions. In V. L. Bengtson, A. C. Acock, K. R. Allen, P. Dilworth-Anderson & D. M. Klein (Eds.), *Sourcebook of family theory & research* (pp. 119–142). Thousand Oaks, California: SAGE Publications, Inc.

Donati, P. (1987). *Manuale di sociologia sanitaria*. Roma: Carocci.

Donati, P. (2011a). Tutela dei minori e nuove transizioni familiari. In P.Donati, F.Folgheraiter, M. L. Raineri (Eds.), *La tutela dei minori. Nuovi scenari relazionali* (pp. 13-15). Trento: Erickson.

Donati, P. (2011b). *Relational Sociology. A New Paradigm for the Social Sciences*. London and New York: Routledge.

Donati, P. (2011c). Family Transitions in a Morphogenetic Society: How Can We Treat Them? *Interdisciplinary Journal of Family Studies*, 1, (16) 1–19.

Donati, P. (2012). How to Cope with Family Transitions When Society Becomes an Unbound Morphogenesis. In E. Scabini, G. & Rossi (Eds.), *Family Transitions and Families in Transition* (pp. 29–47). Milano: Vita& Pensiero.

Duvall, E. M. (1957). *Family development*. Philadelphia: J. P. Lippincott.

Falicov, C. J. (Ed.) (1991). *Family transitions: Continuity and change over the life cycle*. New York: Guilford Press.

Ferrucci, F. (2004). *La disabilità come relazione sociale. Gli approcci sociologici tra natura e cultura*. Soveria Mannelli: Rubbettino.

Fernández Martínez, S., & Tiraboschi, M. (Eds.) (2017). *Lavoro e malattie corniche,* ADAPT University Press – Online publication of the ADAPT Series. https://moodle.adaptland.it/pluginfile.php/29887/mod_resource/content/3/vol_64_2017_tiraboschi_fernandez_malattie_croniche.pdf.

Ganster, D. C., Fox, M. L., & Dwyer, D. J. (2001). Explaining employees' health care costs: a prospective examination of stressful job demands, personal control, and physiological reactivity. *Journal of Applied Psychology*, 86, 954-964. DOI: 10.1037//0021-90 10.86.5.954.

Good, B. J. (1994). *Medicine, Rationality, and Experience. An Anthropological Perspective.* Cambridge: Cambridge University Press.

Hetherington, E. M. (1989). Coping with Family Transitions: Winners, Losers, and Survivors. *Child Development*, 60(1), 1–14.

Hill, R., & Rodgers, R. H. (1964). The developmental approach. In H.T. Christensen (Ed), *Handbook of marriage and the family* (pp. 171–211). Chicago: Rand McNally.

Istat (2011). *La conciliazione tra lavoro e famiglia. Anno 2010,* dicembre, https://www.istat.it/it/archivio/48912 .

Istat (2012a). *Inclusione sociale delle persone con limitazioni dell'autonomia personale.* Anno 2011, dicembre, https://www.istat.it/it/files//2012/12/Inclusione-sociale-delle-persone-con-limitazioni-dellautonomia-personale_14_12_2012.pdf.

Istat (2012b). *Lavoratori che hanno richiesto permessi per handicap grave (L 104/1992),*https://www.istat.it/it/archivio/76451.

Istat (2014). *Disposizioni in materia di assistenza in favore delle persone affette da disabilità grave prive del sostegno familiare. Audizione dell'Istituto nazionale di statistica.* Ottobre, https://www.istat.it/it/archivio/184190 .

Istat (2017). *Anziani: le condizioni di salute in Italia e nell'unione europea*, http://www.istat.it.

Koch, L. C., Rumrill, P. D., Conyers, L., & Wohlford, S. (2013). A narrative literature review regarding job retention strategies for people with chronic illnesses. *Work*, 46, 125-134. DOI: 10.3233/WOR-131668.

Koolhaas, W., Van der Klink, J., Groothoff, J. W., & Brouwer, S. (2012). Towards a sustainable healthy working life: associations between chronological age, functional age, and work outcomes. *European journal of public health*, 22, 424–429. https://doi.org/10.1093/eurpub/ckr035.

Lewin, K. (1951). *Field theory in social science: selected theoretical papers* (Edited by Dorwin Cartwright.) https://doi.org/10.1177/000271625127600135

Mazzucchelli, S. (2011). *Reconciling family-work: the role of Corporate Citizenship,* Saarbrücken: LAP LAMBERT Academic Publishing GmbH & Co.

McGonagle, A., Roebuck, A., Diebel, H., Aqwa, J., Fragoso, Z., & Stoddart, S. (2016). Anticipated work discrimination scale: a chronic illness application. *Journal of Managerial Psychology*, 31, 61–78. https://doi.org/10.1108/JMP-01-2014-0009.

Munir, F., Leka, S., & Griffiths, A. (2005). Dealing with self-management of chronic illness at work: predictors for self-disclosure. *Social Science & Medicine*, 60, 1397–1407, https://doi.org/10.1016/j.socscimed.2004.07.012.

Naldini, M., Pavolini, E., & Solera, C. (2016). Does Caring for the Elderly Affect Mid-Life Women's Employment? Differences across Care-Work Regimes. *Economia & lavoro, Rivista di politica sindacale, sociologia e relazioni industriali*, 3, 79-96. DOI: 10.7384/85921.

Newby, N. M. (1996). Chronic illness and the family life cycle. *Journal of advanced nursing*, 23, 786-791. https://doi.org/10.1111/j.1365-2648.1996.tb00052.x.

Osservatorio sulla condizione assistenziale dei malati oncologici (2018). *10° Rapporto sulla condizione assistenziale dei malati oncologici*, https://www.favo.it/osservatorio/decimo-rapporto/10-rapporto-download/file/357-decimo-rapporto-2018-integrale.html.

Pavolini, E. (2002). Il Welfare alle prese con i mutamenti sociali: rischio, vulnerabilità, frammentazione. *Rassegna Italiana di Sociologia*, 4, ottobre-dicembre, 587-618. DOI: 10.1423/8193.

Pierret, J. (2003). The illness experience: state of knowledge and perspectives for research. *Sociology of Health & Illness*, 25, 4–22. https://doi.org/10.1111/1467-9566.t01-1-00337.

Rossi, G., & Scabini, E. (Eds.). (2006). *Le parole della famiglia*, Milano: Vita&Pensiero.

Scabini, E., & Donati, P. (Eds.). (2003). *Tempo e transizioni familiari*. Milano: Vita&Pensiero.

Scabini, E., & Rossi, G. (Eds.). (2006). *Le parole della famiglia*. Milano: Vita&Pensiero.

Schoen, R., Landale, N. S., & Daniels, K. (2007). Family transitions in young adulthood. *Demography*, 44 (4), 807–820.

Scisci, A. (2012). La transizione alla genitorialità. In G. Rossi & D. Bramanti (Eds.), *La famiglia come intreccio di relazioni. La prospettiva sociologica* (pp. 81–112). Milano: Vita&Pensiero.

Tausig, M. (2013). The Sociology of Work and Well-Being. In C.S. Aneshensel, J. C. Phelan & A. Bierman (Eds.), *Handbook of the Sociology of Mental Health, Second Edition* (pp. 433–455). Berlin: Springer.

Timmereck, C. (1986). *Dictionary of Health Services Management Hardcover*, National Health Publishing.

Tiraboschi, M. (Ed.). (2015). *Occupabilità, lavoro e tutele delle persone con malattie croniche*, ADAPT University Press – Online publication of the ADAPT Series, https://moodle.adaptland.it/pluginfile.php/20511/mod_resource/content/5/ebook_vol_36.pdf.

Weiss, G. L., & Lonnquist, L. E. (2017). *The Sociology of Health, Healing, and Illness*. New York: Routledge.