Chapter 1

GOALS OF FAMILY THERAPY ACROSS THE LIFECYCLE

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Family therapy is a broad term for a range of methods for working with families with various biopsychosocial difficulties. Within the broad cathedral of family therapy there is a wide variety of views on what types of problems are appropriately addressed by family therapy; who defines these problems; what constitutes family therapy practices; what type of theoretical rationale underpins these practices; and what type of research supports the validity of these practices.

Some family therapists argue that all human problems are essentially relational and so family therapy is appropriate in all instances. Others argue that marital and family therapy are appropriate for specific relationship problems or as an adjunct to pharmacological treatment of particular conditions such as schizophrenia.

Some family therapists argue that problems addressed in therapy are defined by clients. That is, parents, children or marital partners seeking help. Others argue that problems are best defined by professionals in terms of psychiatric diagnoses or statutory status, such as being a family in which child abuse has occurred and which is on an at-risk register, or being a person with an alcohol problem on probation.

With respect to practices, some family therapists invite all family members to all therapy sessions. Others conduct family therapy with individuals, by empowering them to manage their relationships with family members in more satisfactory ways. Still others have broadened family therapy so that it includes members of the wider professional and social network around the family; they may refer to this approach as systemic practice.

There are many theories of family therapy. Some focus on the role of the family in predisposing people to developing problems or in precipitating their difficulties. Others focus on the role of the family in problem maintenance. But all family therapists highlight the role of the family in problem resolution. There is also considerable variability in the degree to which theories privilege the role of family patterns of interaction, family belief

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systems and narratives, and historical contextual and constitutional factors in the aetiology and maintenance of problems.

With respect to research, some family therapists argue that case studies or descriptive qualitative research provide adequate support for the efficacy of family therapy. On the other hand, some family therapists highlight the importance of quantitative results from controlled research trials in supporting the degree to which family therapy is effective in treating specific problems.

Within this volume an integrative and developmental approach will be taken to family therapy, and where better to start than with a consideration of family problems across the lifecycle?

Family problems occur across all stages of the lifecycle. Here are some examples:

- A 6-year-old whose parents cannot control him and who pushes his sister down the stairs.
- A 13-year-old girl who worries her parents because she will not eat and has lost a lot of weight.
- A 19-year-old boy who believes he is being poisoned and refuses to take prescribed antipsychotic medication.
- A couple in their mid-thirties who consistently argue and fight with each other.
- A blended family in which the parents have both previously been married and have difficulties managing their children's unpredictable and confusing behaviour.
- A family in which a parent has died prematurely and in which the 13-year-old has run away from home.
- A family in which a child is terminally ill and will not follow medical advice.
- A family with traditional values in which a teenager 'comes out' and declares that he is gay.
- A family in which both parents are unemployed and have difficulty managing their children without getting into violent rows.
- A black family living in a predominantly white community, where the 16-year-old boy is involved in drug abuse in a delinquent peer group.

These are all complex cases which involve or affect all family members to a greater or lesser degree. A number of these cases also involve or affect members of the community in which the family lives. In some of the cases listed, other agencies including schools, hospitals, social services, law enforcement, juvenile justice or probation may be involved. Family therapy is a broad psychotherapeutic movement which offers conceptual frameworks for making sense of complex cases such as those listed here and entails approaches to clinical practice for helping families resolve complex problems.

The lifecycle is a particularly useful framework within which to conceptualise problems that may be referred for family therapy. In this chapter,

normative models of the family and individual lifecycles will be described. Gender development, lifecycle issues unique to lesbian and gay people and issues of culture and class will also be discussed. The aim of the chapter is to sketch out some of the problem areas which may be addressed by family therapy across the lifecycle.

THE FAMILY LIFECYCLE

Families are unique social systems insofar as membership is based on combinations of biological, legal, affectional, geographic and historical ties. In contrast to other social systems, entry into family systems is through birth, adoption, fostering or marriage and members can leave only by death. Severing all family connections is never possible. Furthermore, while family members fulfil certain roles which entail specific definable tasks such as the provision of food and shelter, it is the relationships within families which are primary and irreplaceable.

With single-parenthood, divorce, separation and remarriage as common events, a narrow and traditional definition of the family is no longer useful (Walsh, 2012). It is more expedient to think of a person's family as a network of people in their immediate psychosocial field. This may include household members and others who, while not members of the household, play a significant role in the person's life. For example: a separated parent and spouse living elsewhere with whom a child has regular contact; foster parents who provide relief care periodically; a grandmother who provides informal day-care; and so forth. In clinical practice the primary concern is the extent to which this network meets the individual's needs.

Leaving Home

Having noted the limitations of a traditional model of family structure, paradoxically the most useful available models of the family lifecycle are based upon the norm of the traditional nuclear family, with other family forms being conceptualised as deviations from this norm (McGoldrick *et al*., 2011). One such model is presented in Table 1.1. This model delineates the main developmental tasks to be completed by the family at each stage of family development. In the first stage, the principal concerns are with differentiating from the family of origin by completing school, developing relationships outside the family, completing one's education and beginning a career. Problems in developing emotional autonomy from the family of origin may occur at this stage and may find expression in many ways, including depression, drug abuse and eating disorders such as anorexia and bulimia. Problems in developing economic independence may also occur where young adults have not completed their education or where limited career options are available. In these circumstances some young adults become involved in crime.

Table 1.1 Stages of the family lifecycle

Stage	Emotional transition processes	Tasks essential for developmental progression
Leaving Home	Accepting emotional and financial responsibility for the self	Differentiating self from family of origin and developing adult-to-adult relationship with parents Developing intimate peer relationships Beginning a career and moving towards financial independence Establishing self in a community and society
Forming a Couple	Committing to a new system	Selecting a partner and deciding to form a long-term relationship Developing a way to live together based on reality rather than mutual projection Realigning couple's relationships with families of origin and peers to include partners
Families with Young Children	Accepting new members into the system	Adjusting couple system to make space for children Arranging child-rearing, financial and housekeeping responsibilities within the couple Realigning relationships with families of origin to include parenting and grandparenting roles Realigning family relationships with community and society to accommodate new family structure
Families with Adolescents	Increasing the flexibility of family boundaries to accommodate adolescents' growing independence and grandparents' increasing constraints	Adjusting parent–child relationships to allow adolescents more autonomy Adjusting family relationships as couple takes on responsibility of caring for ageing parents Realigning family relationships with community and society to accommodate adolescents' increasing autonomy and grandparents' increasing constraints

Launching Children and Moving into Midlife	Accepting many exits from and entries into the family system	Adjusting to living as a couple again Addressing couple's midlife issues and possibilities of new interests and projects Parents and grown children negotiating adult-to-adult relationships Adjusting to include in-laws and grandchildren within the family circle Dealing with disabilities and death of couple's ageing parents Realigning family relationships with community and society to accommodate new family structure and relationships
Families with Parents in Late Middle Age	Accepting new generational roles	Maintaining couple's functioning and interests, and exploring new family and social roles while coping with physiological decline Adjusting to children taking a more central role in family maintenance Making room for the wisdom and experience of the ageing couple Supporting the older generation to live as independently as possible within the constraints of ageing Realigning family relationships with community and society to accommodate new family structure and relationships
Families with Parents Nearing the End of Life	Accepting the constraints of ageing and the reality of death, and the completion of one cycle of life	Dealing with loss of partner, siblings and peers Preparing for death through life review and integration Adjusting to reversal of roles, where children care for parents Realigning family relationships with community and society to accommodate changing family relationships

Adapted from McGoldrick, M., Carter, B. & Garcia-Preto, N. (2011). The expanded family lifecycle. Individual, family and social perspectives (Fourth Edition). Boston: Allyn & Bacon. (p. 16–17).

Forming a Couple

In the second stage of the family lifecycle model, the principal tasks are those associated with selecting a partner and deciding to marry or cohabit. In the following discussion, the term 'marriage' is used to cover both traditional marriage and the more modern arrangement of long-term cohabitation. Adams (1995) views mate selection as a complex process that involves four stages. In the first phase, partners are selected from among those available for interaction. At this stage, people select mates who are physically attractive and similar to themselves in interests, intelligence, personality and other valued behaviours and attributes. In the second phase there is a comparison of values following revelation of identities through self-disclosing conversations. If this leads to a deepening of the original attraction then the relationship will persist. In the third phase there is an exploration of role compatibility and the degree to which mutual empathy is possible. Once interlocking roles and mutual empathy have developed, the costs of separation begin to outweigh the difficulties and tensions associated with staying together. If the attraction has deepened sufficiently and the barriers to separation are strong enough, consolidation of the relationship occurs. In the fourth and final phase, a decision is made about long-term compatibility and commitment. If a positive decision is reached about both of these issues then marriage or long-term cohabitation may occur. When partners come together, they are effectively bringing two family traditions together, and setting the stage for the integration of these traditions, with their norms, values, rules, roles and routines, into a new tradition. Decision-making about this process is not always easy, and couples may come to a marital and family therapist to address this complex issue.

Childless couples must develop routines for living together which are based on a realistic appraisal of the other's strengths, weaknesses and idiosyncrasies, rather than on the idealised views (or mutual projections) which formed the basis of their relationship during the initial period of infatuation. Coming to terms with the dissolution of the mutual projective system which characterises the infatuation so common in the early stages of intimate relationships is a particularly stressful task for many couples and may lead to a referral for marital or family therapy (Savage-Scharff & Scharff, 2008).

Contextual Factors Associated with Marital Satisfaction

The following demographic factors are associated with marital satisfaction (Conger *et al.*, 2010; Fincham & Beach, 2010; Gottman & Notarius, 2002; Newman & Newman, 2011):

- high level of education;
- high socioeconomic status;
- similarity of spouses' interests, intelligence and personalities;

- early or late stage of family lifecycle;
- sexual compatibility;
- for women, later marriage.

The precise mechanisms linking these factors to marital satisfaction are not fully understood. However, the following speculations seem plausible. Higher educational level and higher socioeconomic status probably lead to greater marital satisfaction because where these factors are present, people probably have better problem-solving skills and fewer chronic life stresses such as crowding. Although there is a cultural belief that opposites attract, research shows that similarity is associated with marital satisfaction, probably because of the greater ease with which similar people can empathise with each other and pursue shared interests. For many couples, marital satisfaction drops during the child-rearing years and satisfaction is highest before children are born and when they leave home. During these periods, it may be that greater satisfaction occurs because partners can devote more time and energy to joint pursuits and there are fewer opportunities for conflict involving child management. Most surveys find wide variability in the frequency with which couples engage in sexual activity but confirm that it is sexual compatibility rather than frequency of sexual activity that is associated with marital satisfaction. Couples may come to marital and family therapy to find ways to cope with marital dissatisfaction and sexual difficulties, often arising from incompatibility.

Belief Systems and Interactional Patterns Associated with Marital Satisfaction

Studies of belief systems and interaction patterns of happy couples from stable marriages show that they have distinctive features (Casey *et al*., 2010; Fincham *et al*., 2007; Gottman & Notarius, 2002; Gurman, 2008a; Ozer & Benet-Martínez, 2006). These include:

- respect;
- acceptance;
- commitment;
- spirituality;
- dispositional attributions for positive behaviour;
- more positive than negative interactions;
- ability to focus conflicts on specific issues;
- ability to rapidly repair relationship ruptures and forgive transgressions;
- ability to manage differing male and female conversational styles;
- ability to address needs for intimacy and power;
- emotional intelligence, emotional stability and agreeableness.

Happy couples tend to attribute their partners' positive behaviours to dispositional rather than situational factors. For example, 'She helped me because she is such a kind person', not 'She helped me because it was

convenient at the time'. The ratio of positive to negative exchanges has been found to be about five to one in happy couples (Gottman, 1993). So even though happy couples have disagreements, this is balanced out by five times as many positive interactions. When happy couples disagree, they focus their disagreement on a specific issue, rather than globally criticising or insulting their partner. This type of behaviour is a reflection of a general attitude of respect which characterises happy couples. Happy couples tend to rapidly repair their relationship ruptures arising from conflict. Where transgressions occur and one partner is hurt, there is a willingness to forgive, and to prevent long episodes of noncommunication, sulking or stonewalling from occurring (Fincham *et al.*, 2007). Sometimes happy couples resolve conflicts by agreeing to differ. The specific process of agreeing to differ reflects a general attitude of acceptance. There is good evidence that men and women have different conversational styles, and these differences are probably determined more by social than biological factors (Cameron, 2010). Men use conversation predominantly to convey task-focused information and to resolve task-related problems. Women use conversation predominantly to make and maintain relationships. In their communication with each other, happy couples find ways to manage these differing conversational styles so that psychological intimacy may be fostered rather than compromised. So males in such relationships make efforts to use conversation to make and maintain their relationship with their partner and females are tolerant of the challenge that this poses. Difficulties and disagreements about communication and intimacy on the one hand, and the power balance or role structure of the relationship on the other, are central themes for distressed couples (Gurman, 2008a). With respect to intimacy, usually males demand greater psychological distance and females insist on greater psychological intimacy. With respect to power, males commonly wish to retain the power and benefits of traditional gender roles, while females wish to evolve more egalitarian relationships. In happy couples, partners' needs for intimacy and power within the relationship are adequately met, and partners have the capacity to negotiate with each other about modifying the relationship if they feel that these needs are being thwarted. This process reflects a commitment to place the long-term viability of the relationship ahead of personal concerns (Fincham *et al.*, 2007). Marital stability is associated with religious or spiritual affiliation. Couples who conceptualise their relationship within a broader religious or spiritual context or tradition have more stable marriages (Fincham *et al.*, 2007). Emotional intelligence, emotional stability and agreeableness are personality characteristics that are associated with marital satisfaction (Casey *et al.*, 2010; Ozer & Benet-Martínez, 2006). This may be because stable, agreeable people with high emotional intelligence select partners who also have these attributes. It may also be because stable, agreeable people with high emotional intelligence are better equipped to perceive and understand their own and their partners' emotions; to use this information to enhance their relationships and solve relationship problems; and to regulate their emotions so as to maximise relationship satisfaction.

Types of Marriage

Fitzpatrick (1988) and Gottman (1993) have both identified three types of stable marriage, in questionnaire and observational studies respectively. I have termed these 'traditional', 'androgynous' and 'avoidant' couples. The characteristics of these types of marriage are summarised in the first part of Table 1.2. Traditional couples adopt traditional sex roles and lifestyles and take a low-key approach to conflict management. Androgynous couples strive to create egalitarian roles and take a fiery approach to conflict resolution. Avoidant couples adopt traditional sex roles but live parallel lives and avoid conflict. Two types of unstable couple were identified in Gottman's study. In Table 1.2, I have labelled these 'conflictual' and 'disengaged' couples. The former engage in conflict but without resolution and the latter avoid conflict much of the time. Gottman found that in all three stable types of couple the ratio of positive to negative verbal exchanges during conflict resolution was five to one. For both unstable types of couple the ratio of positive to negative exchanges was approximately one to one. Gottman and Fitzpatrick's work highlights the fact that there are a number of possible models for a stable marital relationship. Their work also underlines the importance of couples engaging in conflict with a view to resolving it, rather than avoiding conflict. Negativity is only destructive if it is not balanced out by five times as much positivity. Indeed, negativity may have a prosocial role in balancing the needs for intimacy and autonomy and in keeping attraction alive over long periods.

Marital Violence

Violence within marriage is common. In a review of international community surveys, Alhabib *et al*. (2010) found that while there was considerable variability in rates of domestic violence across countries and ethnic groups, the average rate was about 30%. Marital violence is a multifactorial phenomenon and characteristics of the abuser, the victim, the marital relationship and the wider social context have all been found to contribute to the occurrence and maintenance of the cycle of violence (Frude, 1990; Holtzworth-Munroe *et al*., 2002; O'Leary, 2008). A personal history of abuse, a high level of the personality trait of aggressiveness, strong conservative attitudes, beliefs in traditional sex roles, low self-esteem, poor social skills, depression, antisocial personality disorder, alcohol abuse and morbid jealousy have all been found to characterise abusers. Victims, quite understandably, have been found to be retaliative and to use verbal and physical abuse during conflict resolution. The majority of couples who seek therapy for domestic violence have engaged in reciprocal violence, but the negative physical and psychological consequences of domestic violence are greater for women than for men. Marriages in which domestic violence occur are typically characterised by a history of multiple separations, a low level of commitment and little marital satisfaction. There is commonly conflict about intimacy, with women demanding more psychological

Table 1.2 Five types of couple

Stability	Type	Characteristics
Stable	**Traditional Couples**	• They adopt traditional sex roles • They privilege family goals over individual goals • They have regular daily schedules • They share the living space in the family home • They express moderate levels of both positive and negative emotions • They tend to avoid conflict about all but major issues • They engage in conflict and try to resolve it • At the outset of an episode of conflict resolution, each partner listens to the other and empathises with their position • In the later part there is considerable persuasion
	Androgynous Couples	• They adopt androgynous, egalitarian roles • They privilege individual goals over family goals • They have chaotic daily schedules • They have separate living spaces in their homes • They express high levels of positive and negative emotions • They tend to engage in continual negotiation about many issues • Partners disagree and try to persuade one another from the very beginning of episodes of conflict resolution • They have a high level of both positive and negative emotions
	Avoidant Couples	• They adopt traditional sex roles • They have separate living spaces in their homes • They avoid all conflict • They have few conflict-resolution skills • Partners state their case when a conflict occurs but there is no attempt at persuasion or compromise

Table 1.2 (*Continued*)

Stability	Type	Characteristics
		• They accept differences about specific conflicts as unimportant compared with their shared common ground and values • Conflict-related discussions are unemotional
Unstable	**Conflictual Couples**	• They engage in conflict without any constructive attempt to resolve it • Continual blaming, mindreading and defensiveness characterise their interactions • High levels of negative emotion and low levels of positive emotion are expressed • They have an attack–withdraw interaction pattern
	Disengaged Couples	• They avoid conflict and have few conflict-resolution skills • Brief episodes of blaming, mindreading and defensiveness characterise their interactions • Low levels of negative emotion and almost no positive emotion are expressed • They have a withdraw–withdraw interaction pattern

Based on Gottman, J. (1993). The roles of conflict engagement, escalation and avoidance in marital Interaction: A longitudinal view of five types of couples. Journal of Consulting and Clinical Psychology, 61, 6–15; and Fitzpatrick, M. (1988). Between husbands and wives: Communication in marriage. Newbury Park, CA: Sage.

intimacy and men demanding more physical intimacy. Many rows are about not enough 'talking and empathy' from the woman's perspective and not enough sex from the man's. There is also conflict about power, with the woman having higher status than the man and the man believing in a model of marriage where the male has more power. Many marital disagreements are about money, and this reflects the disagreement about power. Poor communication and negotiation skills characterise these couples, so they cannot resolve their conflicts about intimacy and power. Because they cannot communicate about what they want from each other, they make negative inferences and assumptions about their partners' intentions and respond to their partners as if these inferences were accurate. This results in a blaming stance rather than an understanding stance. They also believe

that arguments must involve winners and losers and therefore in all conflicts they escalate the exchange so that they can win. They believe in a win–lose model of conflict resolution, not a win–win model. They work on a short-term quid-pro-quo system, not a long-term goodwill system. This results in attempts to control each other by punishment, not reward.

This destructive relational style is more likely to escalate into violence if certain broader contextual factors are present. Violence is more likely where couples live in crowded living conditions, are unemployed, live in poverty, have a low educational level, are socially isolated and have experienced many life changes and stresses recently. With crowding, unemployment and poverty, couples struggle for access to their own limited resources and displace aggression towards societal forces that have trapped them in poverty with each other. Better-educated couples use more sophisticated negotiation skills to prevent conflict escalation. Social isolation increases stress and reduces social support. This stress may lead to heightened arousal and so increase the risk of violence. Also, abusive families may deliberately isolate themselves so that the abuse is not uncovered or may inadvertently become isolated, which reduces the chances of the abuse being detected. Major life changes may lead to increased cohesion in some families and increased conflict in others. Moving house, the birth of a baby and redundancy are examples of transitions that can lead to marital violence. Family therapy for couples involved in violence focuses on both risk assessment and helping couples evolve alternatives to violence (Cooper & Vetere, 2005; Holtzworth-Munroe *et al.*, 2002; O'Leary, 2008). Multicouple therapy, a recent innovation for the treatment of violent couples, is particularly effective (Stith *et al.*, 2005).

Families with Young Children

In the third stage of the family lifecycle model given in Table 1.1, the main tasks are for couples to adjust their roles within their relationship in order to make space for young children; for couples' parents to develop grandparental roles; for children as they move into middle childhood to develop peer relationships; and for families to arrange day-care, preschool and school placements for their children in their communities. Each of these issues will be dealt with in more detail in this section. During this lifecycle stage, couples must also arrange for a workable division of labour in terms of child-rearing, financial and housekeeping responsibilities. In this domain, most research studies in Western industrialised countries show that this is an area marked by inequity. Men tend to do more paid work outside the home than women; women tend to do more housework and childcare, even when they work outside the home; and men have more leisure time than women (Bianchi & Milkie, 2010).

Parenting Roles

The development of parenting roles involves the couple establishing routines for meeting children's needs for:

- safety;
- care;
- control;
- intellectual stimulation.

Developing these routines is a complex process. Difficulties in meeting each of these needs may lead to specific types of problems, all of which may become a focus for family therapy (Reder & Lucey, 1995; Reder *et al.*, 2000, 2004). Routines for meeting children's needs for safety include protecting children from accidents by, for example, not leaving young children unsupervised, and also developing skills for managing frustration and anger, which the demands of parenting young children often elicit. Failure to develop such routines may lead to accidental injuries or child abuse. Routines for providing children with food and shelter, attachment, empathy, understanding and emotional support need to be developed to meet children's needs for care in these various areas. Failure to develop such routines may lead to a variety of emotional difficulties. Routines for setting clear rules and limits; for providing supervision to ensure that children conform to these expectations; and for offering appropriate rewards and sanctions for rule-following and rule violations meet children's need for control. Conduct problems may occur if such routines are not developed. Parent–child play and communication routines for meeting children's needs for age-appropriate intellectual stimulation also need to be developed, if the child is to avoid developmental delays in emotional, language and intellectual development.

Attachment

Children who develop secure attachments to their caregivers fare better in life than those who do not (Cassidy & Shaver, 2008). Children develop secure emotional attachments if their parents are attuned to their needs and if their parents are responsive to their signals that they require their needs to be met. When this occurs, children learn that their parents are a secure base from which they can explore the world. John Bowlby (1988), who developed attachment theory, argued that attachment behaviour, which is genetically programmed and essential for survival of the species, is elicited in children between 6 months and 3 years when faced with danger. In such instances, children seek proximity with their caretakers. When comforted, they return to the activity of exploring the immediate environment around the caretaker. The cycle repeats each time the child perceives a threat and their attachment needs for satisfaction, safety and security are activated. Over multiple repetitions, children build internal

working models of attachment relationships based on the way these episodes are managed by caregivers. Internal working models are cognitive relationship maps based on early attachment experiences which serve as a template for the development of later intimate relationships. Internal working models allow people to make predictions about how the self and significant others will behave within relationships. In their groundbreaking text *Patterns of Attachment*, Mary Ainsworth and colleagues (1978) described three patterns of mother–infant interaction following a brief episode of experimentally contrived separation, and further research with mothers and children led to the identification of a fourth category (Cassidy & Shaver, 2008). The four attachment styles are as follows:

- **Securely attached** children react to their parents as if they were a secure base from which to explore the world. Parents in such relationships are attuned and responsive to the children's needs. While a secure attachment style is associated with autonomy, the other three attachment styles are associated with a sense of insecurity.
- **Anxiously attached** children seek contact with their parents following separation but are unable to derive comfort from it. They cling and cry or have tantrums.
- **Avoidantly attached** children avoid contact with their parents after separation. They sulk.
- Children with a **disorganised attachment** style following separation show aspects of both the anxious and avoidant patterns. Disorganised attachment is a common correlate of child abuse and neglect, and early parental absence, loss or bereavement.

Research on intimate relationships in adulthood confirms that these four relational styles show continuity over the lifecycle (Cassidy & Shaver, 2008). Significant adult relationships and patterns of family organisation may be classified into four equivalent attachment categories, which will be discussed further in Chapter 5, in the section on attachment-based therapies. Difficulties associated with insecure attachment may lead to referrals for marital or family therapy.

Parenting Styles

Reviews of the extensive literature on parenting suggest that by combining the two orthogonal dimensions of warmth or acceptance and control, four parenting styles may be identified, and each of these is associated with particular developmental outcomes for the child (Darling & Steinberg, 1993). These four styles are presented in Figure 1.1. *Authoritative parents*, who adopt a warm, accepting, child-centred approach coupled with a moderate degree of control, which allows children to take age-appropriate responsibility, provide a context that is maximally beneficial for children's development as autonomous, confident individuals. Children of parents

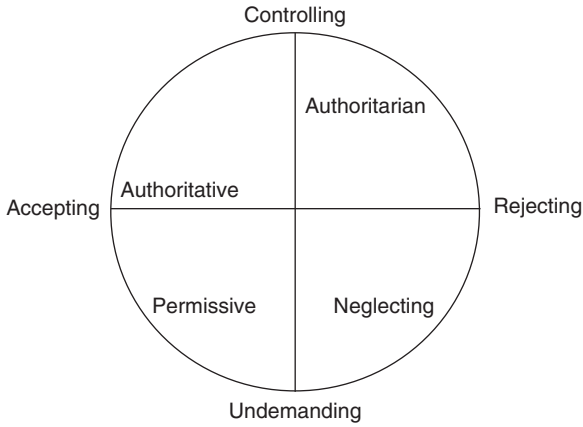

Figure 1.1 Patterns of parenting

who use an authoritative style learn that conflicts are most effectively managed by taking the other person's viewpoint into account within the context of an amicable negotiation. This set of skills is conducive to efficient joint problem-solving and the development of good peer relationships, and consequently the development of a good social support network. Children of *authoritarian parents*, who are halfway along the continuum from accepting to rejecting, but quite controlling, tend to develop into shy adults who are reluctant to take initiative. The parents' disciplinary style teaches them that unquestioning obedience is the best way to manage interpersonal differences and to solve problems. Children of *permissive parents*, who are warm and accepting but lax in discipline, in later life lack the competence to follow through on plans and show poor impulse control. Children who have experienced little warmth or acceptance from their parents and who have been either harshly disciplined or had little or inconsistent supervision develop adjustment problems, which may become a focus for family therapy. This is particularly the case with corporal punishment. When children experience corporal punishment, they learn that the use of aggression is an appropriate way to resolve conflicts and tend to use such aggression in managing conflicts with their peers. In this way, children who have been physically punished are at risk for developing conduct problems and becoming involved in bullying (Knox, 2010).

Grandparental Roles

In addition to developing parental roles and routines for meeting children's needs, a further task of this stage of the family lifecycle is the development of grandparental roles and the realignment of family relationships that this entails. In their wide-ranging review, Thiele and Whelan (2006) concluded that the grandparental role is typically

meaningful and satisfying, probably because it provides an avenue for individuals to meet their needs for generativity. There is considerable variability in the way different grandparents fulfil their roles. This has led to a range of different typologies. For example, Neugarten & Weinstein (1964) identified five types of grandparental role. First, there were those that adopted a formal role and were not involved in childcare but were loving and emotionally involved with the grandchildren. The second role was essentially fun-seeking, with these grandparents acting as playmates for the grandchildren. The third type of grandparental role was that of a distant figure who had little contact with grandchildren. The fourth role type was that of parental surrogate, with these grandparents assuming the role of parent to the grandchildren so that the mother could work outside the home. The final grandparental role was that of a reservoir of family wisdom, who occupied a powerful patriarchal or matriarchal position within the extended family. Where grandparents adopt roles that are supportive of parents and grandchildren, they contribute to family resilience. Where they adopt roles that greatly increase the demands on parents and grandchildren, without offering support, they may contribute to the development of adjustment problems that become a focus for family therapy.

Day-care

Families with children may involve their offspring in day-care. Children benefit most from day-care when they have developed secure attachments to their parents and have positive interactions with them in their homes; when they are not placed in day-care at too early an age; when they do not spend excessive amounts of time in day-care (under 30 hours per week from 3 to 54 months); and when a high quality of day-care is provided (Lamb & Ahnert, 2006; Vandell, 2004). In this context, high-quality day-care is characterised by continuity in the relationship between the infants and day-care staff; responsivity in the staff's reactions to infants' needs for safety, care, control and intellectual stimulation; positive relationships between the day-care staff and the group of children in its care, which creates a positive group dynamic; positive peer relationships between children within the day-care setting; a low ratio of infants to staff; and a safe, spacious and well-equipped physical facility. Where day-care placements meet these criteria, children show better cognitive, language and social development compared with children who have had poorer day-care placements. Where parents have difficulty in meeting their children's needs, high-quality day-care can help children develop school readiness before entering elementary school and can buffer against risk factors associated with problematic home environments characterised by poverty and poor parenting. There is also a dark side to day-care. Where children are placed in day-care for more than 30 hours per week from 3 to 54 months, they are more likely to develop aggressive behavioural problems which may become a focus for family therapy.

Preschool

Many families with young children place their children in preschools. Preschool placement is particularly important for disadvantaged children. Preschool early-intervention educational programmes for socially disadvantaged or low-birth-weight children can have beneficial long-lasting effects on psychosocial adjustment, cognitive development and school attainment, particularly if certain conditions prevail (Carr, 2002). In effective early-intervention programmes, families are engaged very early in the child's life. Effective programmes involve long-term supportive and educational home-visiting in addition to preschool placement. Child-stimulation, parent training and support, and conjoint parent–child sessions to promote secure attachment all typify good preschool programmes. Family therapy may be offered by preschool staff to provide these essential attributes of effective preschool placements for vulnerable families. Effective programmes extend right up to the start of primary school. A central factor is a good working relationship between the parents and the preschool staff. Children and parents must also have access to positive role models who, by their example and success, show the value of schooling. Finally, a teaching method which incorporates the elements of planning activities, performing these activities and reviewing performance (plan–do–review) is vital to success. Four life skills, the foundations of which are laid by successful preschool programmes, distinguish those children who have positive outcomes. The first is the development of a goal-orientated and planful approach to solving scholastic and social problems. The second is the development of aspirations for education and employment. The third is the development of a sense of responsibility for one's own actions. The fourth is a sense of duty and responsibility towards others.

School

School plays a central role in the lives of families of children between 5 and 18 years. In many cases referred for family therapy, contact with the children's schools is essential. Typically the aim of such contacts is to involve school staff in contributing to the resolution of child-focused problems. In this context it is useful to note that particular types of school are especially conducive to academic achievement and prosocial development. In their seminal study of secondary schools, Rutter *et al*. (1979) found that a series of features of the secondary school environment had a favourable influence on behaviour and attainment, and these factors were independent of child and family characteristics. These features are:

- Authoritative leadership of the staff team by the principal.
- Authoritative management of classes by teachers, with high expectations of success, clear rules and regular homework that is graded routinely.

- A participative approach to decision-making among the staff about curriculum-planning and school management, which fosters cohesion among the staff and the principal.
- Many opportunities for pupils to participate in the running of the school, which fosters pupil loyalty to the school.
- A balance of emphasis on both academic attainment and excellence in other fields such as sport.
- Teachers modelling good behaviour.
- Teachers regularly appreciating, rewarding and praising academic and nonacademic achievements.
- A balance between intellectually able and less-able pupils.
- An attractive, comfortable and pleasant school environment.

Subsequent research on both primary and secondary schools has supported and extended Rutter's original findings and shown that the following attributes are also associated with high attainment: presenting pupils with clear predetermined goals or standards, creating an expectation of success, structuring material so that it is easily interpretable, using sufficient repetition to keep the pupils on task, presenting information clearly, providing extra help if necessary to ensure that goals are reached and providing feedback. This type of approach to teaching requires moderate class sizes, a variable which has been consistently associated with pupil performance (Sylva, 1994).

Children's Peer-group Roles

Peer relationships in childhood are important for adjustment across the lifespan (Rubin *et al*., 2009). Child and adolescent peer relationships are the context within which skills for making and maintaining relationships are learned. Peer-relationship problems are therefore a concern of family therapists. Over the first five years, with increasing opportunities for interaction with others and the development of language, interaction with other children increases. Cooperative play premised on an empathic understanding of other children's viewpoints gradually emerges and is usually fully established by middle childhood. Competitive rivalry (often involving physical or verbal aggression or joking) is an important part of peer interactions, particularly among boys. This allows youngsters to establish their position of dominance within the peer-group hierarchy. There are important sex differences in styles of play adopted, with girls being more cooperative and relationship-focused, and boys being more competitive and activity-focused. Boys tend to play in larger peer groups, whereas girls tend to play within small groups characterised by emotionally intimate exclusive friendships. Sex-segregated play is almost universal in middle childhood. In adolescence, the amount of time spent with peers gradually increases. Peer groups that involve both boys and girls form. Romantic friendships develop and nonromantic friendships deepen. Within adolescent peer groups, 'popularity hierarchies' develop.

Peer friendships are important because they constitute an important source of social support and a context within which to learn about the management of networks of relationships. Children who are unable to make and maintain friendships, particularly during middle childhood and early adolescence, are at risk for the development of psychological difficulties which may be a focus for family therapy. Children who have developed secure attachments to their parents are more likely to develop good peer friendships. This is probably because their experience with their parents provides them with a useful cognitive model on which to base their interactions with their peers. Children reared in institutions have particular difficulty with peer relationships in their teens.

Popular children are described by their peers as helpful, friendly, considerate and capable of following rules in games and imaginative play. They also tend to be more intelligent and physically attractive than average. They accurately interpret social situations and have the social skills necessary for engaging in peer-group activities. About 10–15% of children are rejected by their peer group. In middle childhood, two main types of unpopular child may be distinguished – the aggressive youngster and the victim – and both may be referred for family therapy. Victims tend to be sensitive and anxious, have low self-esteem and lack the skills required to defend themselves and establish dominance within the peer-group hierarchy. They are often the targets for bullies. Unpopular aggressive children are described by peers as disruptive, hyperactive, impulsive and unable to follow rules in games and play. Their aggression tends to be used less for establishing dominance or a hierarchical position in the peer group and more for achieving certain instrumental goals. For example, taking a toy from another child.

Popular children are effective in joining in peer-group activities. They hover on the edge, tune in to the group's activities and carefully select a time to become integrated into them. Unpopular children, particularly the aggressive type, do not tune in to group activities. They tend to criticise other children and talk about themselves rather than listening to others. Warmth, a sense of humour and sensitivity to social cues are important features of socially skilled children. Unpopular children, particularly the aggressive type, are predisposed to interpreting ambiguous social cues negatively and becoming involved in escalating spirals of negative social interaction.

Unpopularity is relatively stable over time. A child who is unpopular this year is likely to remain so next year and this unpopularity is not wholly based on reputation. For the aggressive unpopular child, inadequate cognitive models for relationships, difficulties in interpreting ambiguous social situations and poor social skills appear to be the main factors underpinning this stability of unpopularity. For the unpopular victim, the continued unpopularity is probably mediated by low self-esteem, avoidance of opportunities for social interaction and a lack of prosocial skills. Also, both types of unpopular child miss out on important opportunities for learning about cooperation, team work and the management of networks of friendships. While unpopularity is not uniformly associated with long-term difficulties, it appears to put such youngsters at risk

for academic problems, dropping out of school, conduct problems in adolescence, mental health problems in adulthood and criminality. Family therapy coupled with school-based consultations and social-skills training is a useful approach when working with unpopular children.

Families with Adolescents

In the fourth stage of the family lifecycle model, which is marked by children's entry into adolescence, parent–child relationships require realignment to allow adolescents to develop more autonomy. Concurrently, the demands of caring for ageing grandparents may occur. This is an extremely complex and demanding stage of the family lifecycle, particularly for parents, where there is a need to realign family relationships to accommodate adolescents' increasing independence and grandparents' increasing constraints.

Facilitating the Growth of Adolescent Autonomy

Good parent–child communication and joint problem-solving skills facilitate the renegotiation of parent–child relationships and the growth of adolescent autonomy. Skills deficits in these areas may underpin referrals for family therapy. The results of empirical studies of adolescent relationships with parents, peers and partners contradict many commonly held beliefs (Collins & Steinberg, 2006; Jackson & Goossens, 2006). Misconceptions about adolescence abound. There is a widespread idea that parent–child conflict is the norm in adolescence. Epidemiological studies show that this is not the case. While one in five families experience some parent–child conflict, only one in twenty experience extreme conflict. A traditional view of adolescence is one where a visionary adolescent confronts conservative parental values. Epidemiological studies show that in most families, parent–adolescent quarrels are about mundane topics like untidiness, music, clothing and curfew time. They are rarely about values or ethics. A traditional view of adolescence posits a gradual erosion of the quality of parent–adolescent relationships with a complementary increase in the quality of the adolescent–peer relationships. Studies of attachment suggest that this is not the case. Secure attachments to parents are correlated with secure attachments to peers.

Promiscuity in adolescence is not the norm. Most surveys show that a majority of older teenagers view premarital sex between committed partners as acceptable. Premarital sex with multiple partners is viewed as unacceptable. Teenage pregnancy is a risk factor for later adjustment, primarily because it may interfere with education and compromise the career prospects of the teenager. Adolescent marriages resulting from unplanned pregnancies run a high risk of dissolution, and these young families often develop multiple life problems and require particularly intensive multisystemic intervention.

Resilience in Adolescence

Adolescence is a risky period for some young people (Jackson & Goossens, 2006). During the second decade of life there are many opportunities for developing a variety of psychological problems.

A central concern for family therapists working with adolescents is knowing the degree to which the dice are loaded in favour of the adolescent emerging into adulthood relatively unscathed despite exposure to risk and adversity. Factors which characterise resilient adolescents are summarised in Table 1.3 (Masten *et al.*, 2009; Rutter, 2006). Adolescents are more likely to show good adjustment if they have an easy temperament and a high level

Table 1.3 Factors associated with resilience in adolescence

Domain	Factors
Family factors	• Absence of early separation or losses • Secure attachment • Authoritative parenting • Father involvement
Community factors	• Positive educational experience • Good social support network (including good peer relationships and involvement in organised religious activity) • High socioeconomic status
Psychological traits	• High ability level • Easy temperament
Self-evaluative beliefs	• High self-esteem • Internal locus of control • Task-related self-efficacy • Optimistic attributional style
Coping skills	• Planning skills • Sense of humour • Empathy skills • Skill in detaching from deviant attachment figures and peer groups • Skill in finding or creating a social supportive network • Skill in using unique talents (e.g. sport or music) to create a social supportive network and avoid deviant networks

Based on Masten, A., Cutuli, J., Herbers, J., Reed, M. (2009). Resilience and development. In S. Lopez & C.R. Snyder & (Eds.), Oxford handbook of positive psychology (Second Edition, pp. 117–132). New York: Oxford University Press, and Rutter, M. (2006). The promotion of resilience in the face of adversity. In A. Clarke-Stewart, & J. Dunn (Eds.), Families count: Effects on child and adolescent development. The Jacobs Foundation series on adolescence. (pp. 26–52). New York: Cambridge University Press.

of intellectual ability. A high level of self-esteem and optimistic attributional style, a general belief in control over one's life and a specific belief that factors related to specific stresses can be controlled (high self-efficacy) are all associated with good adjustment. These traits and positive belief systems probably render youngsters less vulnerable to becoming overly physiologically aroused and aggressive or demoralised and depressed when faced with life stresses. Adolescents are less adversely affected by life stresses if they have good planning skills, a sense of humour and the capacity to empathise with others. All of these coping skills can help youngsters detach from deviant or incapacitated attachment figures (such as criminal or incapacitated parents) and deviant peers and seek out more resourceful and prosocial attachment figures and peers. Selecting or creating a positive social network (through marriage, positive school experiences, good friendships or talented performance in sports or arts) can halt negative chain reactions or start positive chain reactions that facilitate personal development. Better adjustment to life stress occurs when adolescents come from higher socioeconomic groups, have good social support networks comprising family members and peers, and attend schools that provide a supportive yet challenging educational environment. Secure attachment relationships to primary caregivers who adopt an authoritative parenting style and the involvement of both mothers and fathers in parenting are the major positive family factors associated with adolescents' adjustment to life stress. The absence of childhood separations, losses, bereavements, parental mental health problems, criminality and marital discord also characterise the families of children who are resilient in the face of stress.

Grandparental Care

Increasingly, as the average lifespan lengthens, the responsibility of caring for ageing parents is becoming routine for men and women in midlife (Connidis, 2010). The responsibility of caring for ageing parents typically coincides with the responsibility of rearing adolescent children and helping them make the transition to adulthood. It is therefore not surprising that people with these dual responsibilities are sometimes referred to as the 'sandwich generation'. For this generation it is undoubtedly a challenging period in the lifecycle. Social support from family and friends and periodic relief-custodial care are important coping resources in dealing with these issues. Family therapists have a role to play in helping families manage the joint challenges of rearing adolescents and supporting ageing parents (Lambert-Shute & Fruhauf, 2011).

Launching

The fifth stage of the family lifecycle model is concerned with the transition of young adult children out of the parental home. For young people and their parents this can be a very positive process that creates the context for developing less hierarchical relationships. When adult children leave

home, for parents there are both challenges and opportunities. There are opportunities to reevaluate their lives, reinvest in the marital relationship and celebrate the expansion of the family if their adult children marry and procreate. There is also the challenge of dealing with disabilities and death in their families of origin.

Midlife Reevaluation

As adolescents grow up and begin to leave home, parents have the opportunity to engage in a midlife reevaluation, to consider their life priorities, their marital relationship and their career aspirations. This process, which may have begun in the previous lifecycle stage, takes on considerable momentum as the family home empties. Just as the notion of the universality of adolescent rebellion has not been supported by the results of carefully conducted community-based surveys, so the popular conception of the midlife crisis has been found to be a relatively rare phenomenon (McAdams & Cox, 2010). Longitudinal studies show that many men and women in their forties become more introspective and reevaluate their roles within the family and the world of work. For men, there may be a shift in values, with an increased valuing of family life over work life. For women, there may be an increased emphasis on work over family. However, these changes in values rarely assume crisis proportions.

Gould (1978) has shown in an extensive study of clinical and nonclinical populations that the assumptions and belief systems learned within the family of origin are challenged in a gradual way over the course of adulthood and that this process reaches a resolution in midlife. Gould's findings are summarised in Table 1.4. The assumptions of childhood give a sense of safety and security. They include a belief in omnipotent thought, a belief in omnipotent protective parents, a belief in the absoluteness of the parents' world view and defences against a rage reaction to separation. Adult consciousness, on the other hand, is governed by an acceptance that we create our own lives according to beliefs and values that are different from those internalised in childhood.

In the late teens, if the adolescent is to be liberated from the family, the parents' world view must be appraised. The parents' role as protectors must be evaluated and their command over the youth's sexuality and body must be challenged. The conflict is between retaining a childhood role and trying out new roles. In the twenties, within the work arena, the idea that life is fair and if you stick to the rules you will win is challenged. With relationships, the idea that our partners can make up for our deficiencies and we can make up for theirs is also challenged. The idea that love can cure personal deficiencies must be given up during the twenties. For example, a talkative partner can't make up for a quiet partner's style, nor can a nurturant partner fulfil all their partner's dependency needs. When these assumptions have been challenged, the person is in a position to differentiate sufficiently to establish a family separate from the family of origin.

The assumptions that are challenged up to the twenties relate to the outer world. In the thirties, assumptions about our inner selves or our

Table 1.4 False assumptions challenged in adulthood

Period	False assumption	Belief systems
Late teens	**'I will always belong to my parents and believe in their world'**	• 'If I get any more independent it will be a disaster' • 'I can only see the world through my parents' assumptions' • 'Only they can guarantee my safety' • 'They must be my only family' • 'I don't own my body'
Twenties	**'Doing it their way will bring results and they will guide me through difficulties'**	• 'If I follow the rules, I will be rewarded' • 'There is only one right way to do things' • 'Rationality, commitment and effort will always prevail over other forces' • 'My partner will do those things for me that I cannot do for myself (i.e. give me a love cure)'
Thirties	**'Life is simple and controllable. There are no significant coexisting contradictory forces within me'**	• 'What I know intellectually, I know emotionally' • 'I am not like my parents in ways that I don't want to be' • 'I can see the reality of those close to me clearly' • 'I can realistically identify and deal with threats to my security'
Forties	**'There is no evil in me or death in the world. The sinister has been expelled'**	• 'My work or my relationships grant me immunity from death and danger' • 'There is no life beyond this family' • 'I am innocent'

Based on Gould, R. (1978). Transformations: Growth and change in adult life. New York: Simon Schuster.

relationships with ourselves are challenged. The person realises that one can know something intellectually, such as 'this row with my partner can be resolved through patient negotiation', and yet lack the emotional knowledge to work through the process of negotiation. In their thirties, people realise that they have many characteristics of their parents which they dislike. For example, they may treat their children unfairly. This has to be recognised if patterns are not to be repeated across generations. There must be an acceptance of a partner's evolution and growth and of the fact that we cannot assume that we see their point of view today just because we saw it a year ago. There are many threats to security in midlife within both marriage and the workplace. Perceived threats within marriage are often projections, rather than realistic threats. People in their thirties assume that the feelings of being mistreated or taken for granted are real threats from their partners, rather than projections on to their partners of ways in which they were treated as children by their parents or significant others. The belief that we can always identify and deal with threats accurately must be challenged in midlife.

In the forties, illusions of safety are challenged. For men, the most common illusion is, 'If I am successful, I will never be frightened again'. For women, the most widespread illusion is, 'I cannot be safe without a man to protect me'. When these illusions are challenged, both men and women are freed from slavish adherence to career or marital roles to make the best use of their remaining years with an awareness of their mortality in mind. Within marriage, both husbands and wives must challenge the belief that there is no life outside the marriage. This may lead to them choosing to separate or choosing consciously to live together. The choice to remain married enriches the marriage. In midlife there must be a reappraisal of the idea that we are innocent, since this is usually a defence against the childhood tendency to label certain emotional states as bad or unacceptable. There is an examination of how we label these emotional experiences, rather than a continued attempt to try to deny them.

For example:

- Anger need not be labelled destructiveness.
- Pleasure need not be labelled as irresponsibility.
- Sensuality need not be labelled as sinfulness.
- Wicked thoughts need not entail wicked actions.
- Dissatisfaction need not be labelled as greed.
- Love need not be labelled as weakness.
- Self-concern need not be labelled as selfishness.

When these aspects of the self are relabelled rather than denied, and integrated into the conscious self, a process of liberation and increased psychological vitality occurs. For Gould (1978), at the end of the midlife period the adult experiences a consciousness wherein the guiding belief is 'I own myself' rather than 'I am theirs'. The sense of self-ownership gives life meaning.

As described by Gould, couples who seek marital and family therapy in midlife are often preoccupied with the consolidation of an adult consciousness.

Later Life

In the penultimate and final stages of the family lifecycle model in Table 1.1, families are concerned with parents' physiological decline and approaching death (Connidis, 2010; Stroebe *et al*., 2001). On the positive side, these stages of the lifecycle afford ageing parents an opportunity to review all they have done in their lives, to receive care and attention from their children and grandchildren, and to savour the simple pleasures that each new day brings. For children and grandchildren there is an opportunity to benefit from the wisdom and experience of the elderly. However, there are also many difficult challenges in these final stages of the lifecycle, associated with loss. Loss in this context refers to the loss of ageing parents' youth, health, vitality, resources and ultimately life. A parallel issue for families is the process of caring for parents as disability and illness compromise their capacity for self-care, and developing new roles and relationships after their death. During these lifecycle stages, when dealing with terminal illness or bereavement, families may be referred for therapy because one or more of their members displays adjustment difficulties such as those listed in Table 1.5. These types of problem typically reflect involvement in the following grief processes:

- shock;
- denial or disbelief;
- yearning and searching;
- sadness;
- anger;
- anxiety;
- guilt and bargaining;
- acceptance.

There is not a clear-cut progression through these processes from one to the next (Stroebe *et al*., 2001; Walsh & McGoldrick, 2004). Rather, at different points in time one or other process predominates. There may also be movement back and forth between processes.

Shock and Denial

Shock is the most common initial reaction. It can take the form of physical pain, numbness, apathy or withdrawal. The person may appear to be stunned and unable to think clearly. This may be accompanied by denial, disbelief or avoidance of the reality of terminal illness or bereavement, a process that can last minutes, days or even months. During denial, people may behave as if the illness is not fatal or the dead family member is

Table 1.5 Behavioural expressions of themes underlying grief processes following bereavement or when facing terminal illness

Grief process	Bereavement		Terminal illness	
	Underlying theme	**Adjustment problems arising from grief processes that may lead to referral**	**Underlying theme**	**Adjustment problems arising from grief processes that may lead to referral**
Shock	• 'I am stunned by the loss of this person'	• Complete lack of affect and difficulty engaging emotionally with others • Poor concentration	• 'I am stunned by my prognosis and loss of health'	• Complete lack of affect and difficulty engaging emotionally with others • Poor concentration
Denial	• 'The person is not dead'	• Reporting seeing or hearing the deceased • Carrying on conversations with the deceased	• 'I am not terminally ill'	• Noncompliance with medical regime
Yearning and searching	• 'I must find the deceased'	• Wandering or running away • Phoning relatives	• 'I will find a miracle cure'	• Experimentation with alternative medicine
Sadness	• 'I am sad, hopeless and lonely because I have lost someone on whom I depended'	• Persistent low mood, tearfulness, low energy and lack of activity • Appetite and sleep disruption • Poor concentration and poor school work	• 'I am sad and hopeless because I know I will die'	• Giving up the fight against illness • Persistent low mood, tearfulness, low energy and lack of activity • Appetite and sleep disruption • Poor concentration and poor school work

(*Continued*)

Table 1.5 (*Continued*)

Grief process	Bereavement		Terminal illness	
	Underlying theme	**Adjustment problems arising from grief processes that may lead to referral**	**Underlying theme**	**Adjustment problems arising from grief processes that may lead to referral**
Anger	• 'I am angry because the person I needed has abandoned me'	• Aggression • Conflict with family members and others • Drug or alcohol abuse • Poor concentration	• 'I am angry because it's not fair. I should be allowed to live'	• Noncompliance with medical regime • Aggression • Conflict with medical staff, family members and peers • Drug or alcohol abuse • Poor concentration
Anxiety	• 'I am frightened that the deceased will punish me for causing their death or being angry at them. I am afraid that I too may die of an illness or fatal accident'	• Separation anxiety, agoraphobia and panic • Somatic complaints and hypochondriasis • Poor concentration	• 'I am frightened that death will be painful or terrifying'	• Separation anxiety and regressed behaviour • Agoraphobia and panic
Guilt and bargaining	• 'It is my fault that the person died, so I should die'	• Suicidal behaviour	• 'I will be good if I am allowed to live'	• Overcompliance with medical regime
Acceptance	• 'I loved and lost the person who died and now I must carry on without them while cherishing their memory'	• Return to normal behavioural routines	• 'I know that I have only a short time left to live'	• Attempts to live life to the full for the time remaining

still living, albeit elsewhere. Thus, the bereaved may speak about future plans that involve the deceased. Terminally ill people may talk about themselves and their future as if they are going to live indefinitely.

Yearning and Searching

A yearning to be with the deceased, coupled with disbelief about their death, may lead younger family members to engage in frantic searches for the dead person, wandering or running away from the home in a quest for the person who has died. Children or grandchildren within the family may phone relatives or friends, trying to trace the person who has died. During this process, those who have lost family members may report seeing them or being visited by them. Some children carry on full conversations with what presumably are hallucinations of the deceased person. Mistaking other people for the deceased is also a common experience during the denial process. With terminal illness, the yearning for health may lead to a frantic search for a miracle cure and to involvement in alternative medicine.

Sadness

When denial gives way to a realisation of the reality of death, family members may experience profound sadness, despair, hopelessness and depression. The experience of sadness may be accompanied by low energy, sleep disruption, a disturbance of appetite, tearfulness, an inability to concentrate and a retreat from social interaction. Young children or grandchildren experiencing the despair process may regress and behave as if they were a baby again, wetting their beds and sucking their thumbs, hoping that by becoming a baby, the dead person will return to comfort them. With terminal illness, despair, hopelessness and depression find expression in an unwillingness to fight the illness.

Anger

Complementing the despair process, there is an anger process associated with the sense of having been abandoned. Aggression, conflict within the family and the wider social system, and drug and alcohol abuse are some of the common ways that grief-related anger finds expression. With terminal illness, the anger may be projected on to family members or members of the medical team. Destructive conflicts within these relationships may occur, such as refusal to adhere to medical regimes, take medication or participate in physiotherapy.

Anxiety

The expression of such anger may often be followed by remorse or fear of retribution. Children may fear that the deceased family member

will punish them for their anger and so it is not surprising that they may want to leave the light on at night and may be afraid to go to bed alone. For adolescents and adults, anxiety may be attached to reality-based threats. So, where a family member has been lost through illness or accident, those grieving may worry that they too will die from similar causes. This can lead to a belief that one is seriously ill and to a variety of somatic complaints, such as stomach aches and headaches. It may also lead to a refusal to leave home lest a fatal accident occur. Referral for assessment of separation anxiety, recurrent abdominal pain, headaches, hypochondriasis and agoraphobia may occur in these cases.

Guilt and Bargaining

The guilt process is marked by self-blame for causing or not preventing illness or the death of the deceased. Family members may also find themselves thinking that if they died this might magically bring back the deceased. Thus, the guilt process may underpin suicidal ideation or self-injury, which may result in a referral for family therapy. With terminal illness, ill health may be experienced as a punishment for having done something wrong. This sense of guilt underpins the bargaining process in which people facing death often engage. The bargaining process may be carried out as imagined conversations with a deity, where the dying person makes promises to live a better life if they are permitted to live longer.

Acceptance

The final grief process is acceptance. With bereavement, the surviving family members reconstruct their view of the world so that the deceased person is construed as no longer living in this world. A benign and accessible representation of them is constructed which is consistent with the family's belief system. For example, a Christian may imagine that the deceased is in heaven. Atheists may experience the deceased as living on in their memory or in projects or photographs left behind. In terminal illness, acceptance involves a modification of the world view so that the future is foreshortened and therefore the time remaining is highly valued and is spent living life to the full, rather than searching in vain for a miracle cure. For bereaved families, new lifestyle routines are evolved as part of the process of accepting the death of a family member and the family is reorganised to take account of the absence of the deceased person. With terminal illness, once the family accepts the inevitability of imminent death, routines which enhance the quality of life of the dying person may be evolved.

Variability in Grief Responses

Reviews of empirical studies of bereavement confirm that there is extraordinary variation in grief processes, and the following points have been well

substantiated (Kissane & Bloch, 2002; Shackleton, 1983; Stroebe *et al.*, 2001; Walsh & McGoldrick, 2004; Wortman & Silver, 2001). First, not everyone needs to work through their sense of loss with immediate intensive conversation about it. Second, depression following bereavement is not universal. Only about a third of people suffer depression following bereavement. Third, failure to show emotional distress initially does not necessarily mean that later adjustment problems will follow. It appears that different people use different coping strategies to cope with loss. Some use distraction or avoidance, while others use confrontation of the grief experience and working-through. Those that effectively use the former coping strategy may not show emotional distress. Fourth, extreme distress following bereavement commonly occurs in those who show protracted grief reactions. Fifth, many people who work through their sense of loss early have later problems. Sixth, a return to normal functioning does not always occur rapidly. While the majority of people approximate normal functioning within 2 years, a substantial minority of bereaved people continue to show adjustment difficulties even several years after bereavement. Seventh, resolution and acceptance of death does not always occur. For example, parents who lose children or those who lose a loved one in an untimely fatal accident show protracted patterns of grief. Eighth, grief may have a marked effect on physical functioning. Infections and other illnesses are more common among bereaved people and this is probably due to the effect of loss-related stress on the functioning of the immune system. However, with the passage of time, immune-system functioning returns to normal. Ninth, children's grief reactions tend to be similar in form to those of adults but to be briefer and less intense, probably because in comparison with adults, children do not tend to focus for a protracted time period on memories or lost possibilities concerning the bereaved person. Tenth, the quality of family relationships may change in response to bereavement or terminal illness, with discordant relationships becoming more discordant and supportive relationships remaining so. Finally, bereavement, particularly loss of a parent, leaves young children vulnerable to depression in adult life. Adults bereaved as children have double the risk of developing depression when faced with a loss experience in adult life compared with their nonbereaved counterparts. Bereaved children most at risk for depression in adulthood are girls who were young when their parents died a violent or sudden death and who subsequently received inadequate care associated with the surviving parent experiencing a prolonged grief reaction.

LIFECYCLE STAGES ASSOCIATED WITH SEPARATION AND DIVORCE

Having considered a family lifecycle model which assumes lifelong monogamy, a lifecycle model that addresses other types of family arrangement deserves attention, particularly one that evolves when separation, divorce and remarriage occurs.

Divorce is no longer considered to be an aberration in the normal family lifecycle, but a normative transition for a substantial minority of families (Amato, 2010; Fine & Harvey, 2006). Family transformation through separation, divorce and remarriage may be conceptualised as a process involving a series of stages. McGoldrick *et al*.'s (2011) model of the extra stages in the family lifecycle entailed by separation or divorce and remarriage is presented in Table 1.6. This model outlines tasks to be completed during various stages of this process. Failure to complete tasks at one stage may lead to adjustment problems for family members at later stages and to referrals for couple or family therapy.

Decision to Divorce

In the first stage, the decision to divorce occurs, and accepting one's own part in marital failure is the central task. However, many contextual factors contribute to divorce, including age, socioeconomic and employment status, educational level, parental marital status, premarital cohabitation, prior marital status, prior parental status, ethnic similarity, marital harmony or conflict, and fidelity (Amato, 2010). Couples are less likely to separate or divorce if they marry after the age of 20, are of high socioeconomic status, have a high educational level, are employed, have grown up in a family where their parents did not separate, have not cohabitated prior to marriage, have not previously been married or had children, are from similar ethnic backgrounds and have no history of marital conflict or fidelity. In contrast, divorce is more common among those from lower socioeconomic groups with limited education who are unemployed, whose parents separated while they were growing up and who married before the age of 20. Divorce is also more common where partners have children, have been married previously, where they are from different ethnic groups and where they have a history of marital conflict, domestic violence and infidelity. The economic resources associated with high socioeconomic status, education and employment; the psychological resources associated with maturity; the relationship resources associated with marital harmony and fidelity; the model of marital stability offered by nondivorced parents; and the stresses associated with prior marriages and children and ethnic dissimilarity are probable explanations for links between these factors and divorce. The relationship between these various factors and divorce, while consistent, is moderate to weak. That is, there are significant subgroups of people who show some or all of these risk factors but do not divorce.

Separation

In the second stage of the lifecycle model of divorce, plans for separation are made. A cooperative plan for custody of the children, visitation, finances and dealing with the families of origin's response to the plan to

Table 1.6 Extra stages in the family lifecycle entailed by separation or divorce and remarriage

Phase	Stage	Emotional transition processes	Tasks essential for developmental progression
Divorce	**Decision to divorce**	Accepting that the couple's problems are not resolvable	Accepting one's own part in marital failure
	Planning separation	Supporting viable living arrangements for all family members following separation	Cooperatively developing a plan for custody of the children, visitation and finances Dealing with the extended family's response to planned separation
	Separation and divorce	Committing to continued cooperative co-parenting and joint financial support of children Beginning to break attachment to partners	Mourning the loss of the intact family Managing doubts about separation and becoming committed to divorce Adjusting to the change in parent–child and parent–parent relationships Staying connected to partners' extended families
Post-divorce	**Establishing single-parent custodial and noncustodial households**	Engaging in cooperative co-parenting and joint financial support of both households	Maintaining flexible arrangements about custody, access and finances without detouring conflict through the children Ensuring both parents retain strong relationships with the children Managing changed financial circumstances Reestablishing peer relationships and a social network

(*Continued*)

Table 1.6 (*Continued*)

Phase	Stage	Emotional transition processes	Tasks essential for developmental progression
Remarriage	**Entering a new relationship**	Recovering from emotional divorce and loss of first marriages	Developing commitment to a new marriage
	Planning a new marriage and family	Accepting concerns about forming a new family Being patient about the time required to adjust to the complexity of the new family arrangements	Planning to deal with children's loyalty conflicts involving natural and step-parents Planning arrangements for continued cooperative financial and co-parental relationships with ex-partners within the context of new family relationships
	Establishing a new family	Breaking attachment to previous partners Giving up the ideal of an 'intact family' and accepting a different family model	Realigning family relationships to allow space for new members Sharing memories and histories to allow for integration of all new members Continuing cooperative financial and co-parental relationships with ex-partners within the context of the new relationship

Adapted from McGoldrick, M., Carter, B. & Garcia-Preto, N. (2011). The expanded family lifecycle. Individual, family and social perspectives (Fourth Edition). Boston: Allyn & Bacon. (p. 320–321).

separate must be made if positive adjustment is to occur. Mediation may facilitate this process (Folberg *et al.*, 2004). The third stage of the model is separation and divorce. Mourning the loss of the intact family, adjusting to the change in parent–child and parent–parent relationships, preventing marital arguments from interfering with interparental cooperation, staying connected to the extended family and managing doubts about separation are the principal tasks at this stage.

Divorce leads to multiple life changes which affect parental well-being, and the impact of these changes on parental well-being is mediated by a range of personal and contextual factors (Amato, 2010). Divorce leads custodial parents to experience major changes in their lives, including a change in residential arrangements, economic disadvantage, loneliness associated with social-network changes and role strain associated with the task overload that results from having to both care for children and work outside the home. Noncustodial parents experience all of these changes with the exception of role strain. Changes in divorced couples' residential arrangements, economic status, social networks and role demands lead to a deterioration in physical and mental health for the majority of individuals immediately following separation. Mood swings, depression, identity problems, vulnerability to common infections and exacerbation of previous health problems are all common sequelae for adults who have separated or divorced. However, for most people these health problems abate within 2 years of the separation. Better post-divorce adjustment occurs in couples who had very distressed marriages (presumably because separation leads to relief) and in partners who initiate divorce.

Post-divorce Period

The fourth stage of the lifecycle model of divorce is establishing single-parent custodial and noncustodial households during the post-divorce period. Here couples must maintain flexible arrangements about custody, access and finances without detouring conflict through the children; and must retain strong relationships with the children and reestablish peer relationships. The stresses and strains of residential changes, economic hardship, role changes and consequent physical and psychological difficulties associated with the immediate aftermath of separation may compromise parents' capacity to cooperate in meeting their children's needs for safety, care, control, education and maintaining relationships with each parent (Amato, 2010; Fine & Harvey, 2006). Authoritarian-punitive parenting, lax laissez-faire or neglectful parenting and chaotic parenting, which involves oscillating between both of these extreme styles, are not uncommon among both custodial and noncustodial parents who have divorced. Couples vary in the ways in which they coordinate their efforts to parent their children following divorce. Three distinct co-parenting styles have been identified in studies of divorced families (Bray & Hetherington, 1993). With *cooperative parenting*, a unified and

integrated set of rules and routines about managing the children in both the custodial and noncustodial households is developed. This is the optimal arrangement but only occurs in about one in five cases. With *parallel parenting*, each parent has his or her own set of rules for the children and no attempt is made to integrate these. Most children show few adjustment problems when parallel parenting occurs and this is the most common pattern. When *conflictual parenting* occurs, the parents do not communicate directly with each other. All messages are passed through the child and this forced go-between role is highly stressful and entails sustained adjustment problems.

Parental separation and divorce are major life stressors for all family members. For children, the experiences of separation and divorce may lead to short- and longer-term adjustment reactions (Amato, 2010; Amato & Gilbreth, 1999; Fine & Harvey, 2006; Hetherington & Kelly, 2002; Kelly, 2000; Leon, 2003; Reifman *et al*., 2001; Rogers, 2004; Wallerstein, 1991). During the 2-year period immediately following divorce, most children show some adjustment problems. Boys tend to display conduct or externalising behaviour problems and girls tend to experience emotional or internalising behaviour problems. Both boys and girls may experience educational problems and relationship difficulties within the family, school and peer group. The mean level of maladjustment has consistently been found to be worse for children of divorce in comparison with those from intact families on a variety of measures of adjustment, including conduct difficulties, emotional problems, academic performance, self-esteem and relationships with parents. This has led to the erroneous conclusion by some interpreters of the literature that divorce always has a negative long-term effect on children. In fact, when the impact of divorce on children is expressed in terms of the percentages of maladjusted children, it is clear that divorce leads to maladjustment for only a minority of youngsters. A small proportion of individuals from families where divorce has occurred have difficulty making and maintaining stable marital relationships, have psychological adjustment difficulties and attain a lower socioeconomic level in comparison with adults who have grown up in intact families.

Certain characteristics of children and certain features of their social contexts mediate the effects of parental divorce on their adjustment (Amato, 2000, 2001; Amato & Gilbreth, 1999; Anderson, 2012; Faust & McKibben, 1999; Greene *et al*., 2012; Hetherington & Kelly, 2002; Kelly, 2000; Leon, 2003; Pasley & Garneau, 2012; Reifman *et al*., 2001; Rogers, 2004; Visher *et al*., 2003; Wallerstein, 1991). In terms of personal characteristics, males between the ages of 3 and 18 are particularly at risk for post-divorce adjustment problems, especially if they have biological or psychological vulnerabilities. Biological vulnerabilities may result from genetic factors, prenatal and perinatal difficulties, or a history of serious illness or injury. Psychological vulnerabilities may be entailed by low intelligence, a difficult temperament, low self-esteem, an external locus of control or a history of previous psychological adjustment problems. Specific features of children's families and social networks may render

them vulnerable to adjustment difficulties following parental separation or divorce. Children are more likely to develop post-separation difficulties if there have been serious difficulties with the parent–child relationship prior to the separation. Included here are insecure attachment, inconsistent discipline and authoritarian, permissive or neglectful parenting. Exposure to chronic family problems, including parental adjustment problems, marital discord, domestic violence, family disorganisation and a history of previous separations and reunions, also places children at risk for post-separation adjustment problems. Early life stresses, such as abuse or bereavement, may also compromise children's capacity to deal with stresses entailed by parental separation. In contrast to these factors that predispose children to post-separation adjustment difficulties, better post-separation adjustment occurs where youngsters have a history of good physical and psychological adjustment and where their families have offered a stable parenting environment.

Following parental separation, adjustment difficulties may be maintained by a variety of psychological factors within the child and a range of psychosocial factors within the child's family and social network (Amato, 2000, 2001; Amato & Gilbreth, 1999; Anderson, 2012; Faust & McKibben, 1999; Hetherington & Kelly, 2002; Greene *et al.*, 2012; Kelly, 2000; Leon, 2003; Reifman *et al.*, 2001; Pasley & Garneau, 2012; Rogers, 2004; Visher *et al.*, 2003; Wallerstein, 1991). At a personal level, adjustment problems may be maintained by rigid sets of negative beliefs related to parental separation. These beliefs may include the view that the child caused the separation and has the power to influence parental reunification, or a belief that abandonment by parents and rejection by peers is inevitable. Within the child's family and social network, adjustment problems following separation may be maintained by sustained parental conflict and routine involvement of the child in this ongoing parental acrimony. The use of non-optimal parenting styles, a lack of consistency in parental rules and routines across custodial and noncustodial households, a lack of clarity about new family roles and routines within each household, and confused family communication may all maintain children's post-separation adjustment problems. These parenting and co-parenting problems which maintain children's adjustment difficulties are in turn often a spin-off from parents' personal post-separation adjustment problems. The degree to which parental post-separation problems compromise their capacity to provide a co-parenting environment that minimises rather than maintains their children's adjustment reactions is partially determined by the stresses parents face in the aftermath of separation. These include the loss of support, financial hardship and social disadvantage.

In contrast to these factors that maintain post-separation adjustment difficulties, better post-separation adjustment occurs in youngsters who have psychological strengths such as high self-esteem, an internal locus of control, realistic beliefs about their parents' separation and divorce, good problem-solving skills and good social skills. In terms of the child's family and social network, better adjustment usually occurs after a

2-year period has elapsed, where parental conflict is minimal and not channelled through the child and where an authoritative parenting style is employed. Where parents cope well with post-separation grief, have good personal psychological resources and have a high level of satisfaction within their new relationships, children show better post-separation adjustment. Parental commitment to resolving child-management difficulties and a track record of coping well with transitions in family life may be viewed as protective factors. The availability of social support for both parents and children from the extended family and peers and the absence of financial hardship are also protective factors for post-separation adjustment. Where the school provides a concerned student-centred, achievement-orientated ethos with a high level of student contact and supervision, children are more likely to show positive adjustment following separation. The factors discussed above have a cumulative effect, with more predisposing and maintaining factors being associated with worse adjustment and more protective factors being associated with better adjustment.

New Relationships

Establishing a new relationship occurs in the fifth stage of the divorce life-cycle model. For this to occur, emotional divorce from the previous relationship must be completed and a commitment to a new marriage must be developed. The sixth stage of the model is planning a new marriage. This entails planning to deal with children's loyalty conflicts involving natural and step-parents and planning for continuing cooperative financial and co-parental relationships with ex-spouses. It is also important to adjust to the widening of the extended family. In the final stage of the model, establishing a new family is the central theme. Realigning relationships within the family to allow space for new members and sharing memories and histories to allow for integration of all new members are the principal tasks of this stage.

Step-families have unique characteristics which are, in part, affected by the conditions under which they are formed (Pryor, 2008; Sweeney, 2010). On the positive side, surveys of step-families have found them to be more open in communication, more willing to deal with conflict, more pragmatic and less romantic, and more egalitarian with respect to childcare and housekeeping tasks. On the negative side, compared with intact first marriages, step-families are less cohesive and more stressful. Step-parent–child relationships on average tend to be more conflictual than parent–child relationships in intact families. This is particularly true of step-father–daughter relationships, which may be due to the daughter's perception of the step-father encroaching on a close mother–daughter relationship.

Children's adjustment following remarriage is associated with age, gender and parents' satisfaction with the new marriage (Greene *et al.*, 2012; Hetherington & Stanley-Hagan, 2002; Pasley & Garneau, 2012; Visher *et al.*, 2003). Good adjustment occurs when the custodial parent remarries

while children are preadolescent or in their late adolescence or early adulthood. All children in divorced families resist the entry of a step-parent. But during the early teenage years (10–15) this resistance is at a maximum. Divorced adults with children in middle childhood and early adolescence who wish to remarry should try to wait until after the children have reached about 16–18 years, if they want their new relationship to have a fair chance of survival. Remarriage is more disruptive for girls than for boys. Marital satisfaction in the new relationship has a protective effect for young boys and is a risk factor for preadolescent girls. Young boys benefit from their custodial mother forming a satisfying relationship with a new partner. Such satisfying relationships lead step-fathers to behave in a warm, child-centred way towards their step-sons and to help them learn sports and academic skills. These skills help young boys become psychologically robust. Preadolescent girls feel that the close supportive relationship they have with their divorced mother is threatened by the development of a new and satisfying marital relationship. They usually respond with increased conduct problems and psychological difficulties. In adolescence, when the remarriage has occurred while the children were preadolescent, a high level of marital satisfaction is associated with good adjustment and a high level of acceptance of the step-parent for both boys and girls.

Adjustment problems arising from difficulties with managing the developmental tasks associated with family transformation through separation, divorce and remarriage may lead to a referral for family therapy.

THE INDIVIDUAL LIFECYCLE

In practising family therapy, the lifecycle of the family offers one important developmental framework within which to conceptualise problems. However, it is also useful for therapists to conceptualise the dilemmas faced by each individual at various lifecycle stages. For this reason, a cursory review of a model of the individual lifecycle follows. Newman & Newman's (2011) modification of Erik Erikson's (1959) model of identity development is presented in Table 1.7. The model has been selected because it pinpoints personal dilemmas that must be resolved at various stages of development which have particular relevance for participating in family life. In this model it is assumed that at each stage of social development the individual must face a personal dilemma. The ease with which successive dilemmas are managed is determined partly by the success with which preceding dilemmas were resolved and partly by the quality of relationships within the individual's family and social context.

Trust versus Mistrust

The main psychosocial dilemma to be resolved during the first 2 years of life is trust versus mistrust. If parents are responsive to infants' needs in

Table 1.7 Newman's revision of Erikson's psychosocial-stage model

Stage	Dilemma and main process	Virtue and positive self-description	Pathology and negative self-description
Infancy 0–2	**Trust versus mistrust** Mutuality with caregiver	**Hope** 'I can attain my wishes'	**Detachment** 'I will not trust others'
Early childhood 2–4	**Autonomy versus shame and doubt** Imitation	**Will** 'I can control events'	**Compulsion** 'I will repeat this act to undo the mess that I have made and I doubt that I can control events and I am ashamed of this'
Middle childhood 4–6	**Initiative versus guilt** Identification	**Purpose** 'I can plan and achieve goals'	**Inhibition** 'I can't plan or achieve goals, so I don't act'
Late childhood 7–11	**Industry versus inferiority** Education	**Competence** 'I can use skills to achieve goals'	**Inertia** 'I have no skills so I won't try'
Early adolescence 12–18	**Group identity versus alienation**[a] Peer pressure	**Affiliation** 'I can be loyal to the group'	**Isolation** 'I cannot be accepted into a group'

Adolescence 19–22	**Identity versus role confusion** Role experimentation	**Fidelity** 'I can be true to my values'	**Confusion** 'I don't know what my role is or what my values are'
Young adulthood 23–34	**Intimacy versus isolation** Mutuality with peers	**Love** 'I can be intimate with another'	**Exclusivity** 'I have no time for others, so I will shut them out'
Middle age 34–60	**Productivity versus stagnation** Person–environment fit and creativity	**Care** 'I am committed to making the world a better place'	**Rejectivity** 'I do not care about the future of others, only my own future'
Old age 60–75	**Integrity versus despair** Introspection	**Wisdom** 'I am committed to life but I know I will die soon'	**Despair** 'I am disgusted at my frailty and my failures'
Very old age 75–death	**Immortality versus extinction**[a] Social support	**Confidence** 'I know that my life has meaning'	**Diffidence** 'I can find no meaning in my life, so I doubt that I can act'

Adapted from Newman, B. & Newman, P. (2011). Development through life (Eleventh Edition). Belmont, CA: Wadsworth; Erikson, E. (1959). Identify and the life cycle. New York: International University Press.

[a] These stages were added to Erikson's model by Newman & Newman.

predictable and sensitive ways, the infant develops a sense of trust. In the long term, this underpins a capacity to have hope in the face of adversity and to trust, as adults, that difficult challenges can be resolved. If the child does not experience the parent as a secure base from which to explore the world, the child learns to mistrust others, and this underpins a view of the world as threatening. This may lead the child to adopt a detached position during later years. Difficulties with making and maintaining peer relationships may occur.

Autonomy versus Shame and Doubt

The main psychosocial dilemma in the preschool years is autonomy versus shame and doubt. During this period, children become aware of their separateness and strive to establish a sense of personal agency and impose their will on the world. Of course, sometimes this is possible, but other times their parents will prohibit them from doing certain things. There is a gradual movement from the battles of the terrible twos to the ritual orderliness that many children show as they approach school-going age. Routines develop for going to bed or getting up, mealtimes and playtimes. The phrase 'I can do it myself' for tying shoelaces or doing their buttons is an example of the appropriate channelling of the desire to be autonomous. If parents patiently provide the framework for children to master tasks and routines, autonomy develops, along with a sense of self-esteem. As adults, such children are patient with themselves and have confidence in their ability to master the challenges of life. They have high self-esteem and a strong sense of will and self-efficacy. If parents are unable to be patient with the child's evolving wilfulness and need for mastery, and criticise or humiliate failed attempts at mastery, the child will develop a sense of self-doubt and shame. The lack of patience and the parental criticism will become internalised and the child will evolve into an adult who criticises themself excessively and who lacks confidence in their abilities. In some instances, this may lead to the compulsive need to repeat their efforts at problem-solving so that they can undo the mess they have made and so cope with the shame of not succeeding.

Initiative versus Guilt

At the beginning of the school-going years, the main psychosocial dilemma is initiative versus guilt. When children have developed a sense of autonomy in the preschool years, they turn their attention outwards to the physical and social world and use their initiative to investigate and explore its regularities with a view to establishing a cognitive map of it. Children find out what is allowed and what is not allowed at home and at school. Many questions about how the world works are asked. Children conduct various experiments and investigations, for example lighting matches, taking

toys apart or playing doctors and nurses. The initiative versus guilt dilemma is resolved when a child learns how to channel the need for investigation into socially appropriate courses of action. This occurs when parents empathise with the child's curiosity but establish the limits of experimentation clearly and with warmth. Children who resolve the dilemma of initiative versus guilt act with a sense of purpose and vision as adults. Where parents have difficulty empathising with a child's need for curiosity and curtail experimentation unduly, the child may develop a reluctance to explore untried options as an adult because such curiosity arouses a sense of guilt.

Industry versus Inferiority

At the close of middle-childhood and during the transition to adolescence, the main psychosocial dilemma is industry versus inferiority. Having established a sense of trust, of autonomy and of initiative, the child's need to develop skills and engage in meaningful work emerges. The motivation for industry may stem from the fact that learning new skills is intrinsically rewarding, and many tasks and jobs open to the child may be rewarded. Children who have the aptitude to master skills that are rewarded by parents, teachers and peers emerge from this stage of development with new skills and a sense of competence and self-efficacy about these. Unfortunately, not all children have the aptitude for skills that are valued by society. Youngsters who have low aptitudes for literacy skills, sports and social conformity are disadvantaged from the start. This is compounded by the fact that in our culture, social comparisons are readily made through, for example, streaming in schools and sports. In our society, failure is ridiculed. Youngsters who fail and are ridiculed or humiliated develop a sense of inferiority and in adulthood lack the motivation to achieve.

Group Identity versus Alienation

The young adolescent faces a dilemma of group identity versus alienation. There is a requirement to find a peer group with which to become affiliated so that the need for belonging will be met. Joining such a group, however, must not lead to sacrificing one's individuality and personal goals and aspirations. If young adolescents are not accepted by a peer group, they will experience alienation. In the longer term, they may find themselves unaffiliated and have difficulty developing social support networks, which are particularly important for health and well-being. To achieve group identity, their parents and schools need to avoid over-restriction of opportunities for making and maintaining peer relationship. This has to be balanced against the dangers or overpermissiveness, since lack of supervision is associated with conduct problems and drug dependence.

Identity versus Role Confusion

While the concern of early adolescence is group membership and affiliation, the establishment of a clear sense of identity – that is, a sense of 'who I am' – is the major concern in late adolescence. Marcia (1981) has found that adolescents can achieve one of four identity states: diffusion, foreclosure, moratorium or achievement of a stable identity. With identity diffusion there is no firm commitment to personal, social, political or vocational beliefs or plans. Such individuals are either fun-seekers or have adjustment difficulties and low self-esteem. With foreclosure, vocational, political or religious decisions are made for the adolescent by parents or elders in the community and are accepted without a prolonged decision-making process. These adolescents tend to adhere to authoritarian values. In cases where a moratorium is reached, the adolescent experiments with a number of roles before settling on an identity. Some of these roles may be negative (delinquent) or nonconventional (drop-out/commune-dweller). However, they are staging posts in a prolonged decision-making process on the way to a stable identity. Where adolescents achieve a clear identity following a successful moratorium, they develop a strong commitment to vocational, social, political and religious values and usually have good psychosocial adjustment in adulthood. They have high self-esteem, realistic goals, a stronger sense of independence and are more resilient in the face of stress. Where a sense of identity is achieved following a moratorium in which many roles have been explored, the adolescent avoids the problems of being aimless, as in the case of identity diffusion, or trapped, as can occur with foreclosure. Parents may find allowing adolescents the time and space to enter a moratorium before achieving a stable sense of identity difficult and referral for family therapy may occur.

Intimacy versus Isolation

The major psychosocial dilemma for people who have left adolescence is whether to develop an intimate relationship with another or to move to an isolated position. People who do not achieve intimacy experience isolation. Isolated individuals have unique characteristics (Newman & Newman, 2011). Specifically, they overvalue social contact and suspect that all social encounters will end negatively. They also lack the social skills, such as empathy or affective self-disclosure, necessary for forming intimate relationships. These difficulties typically emerge from experiences of mistrust, shame, doubt, guilt, inferiority, alienation and role-confusion associated with failure to resolve earlier developmental dilemmas and crises in a positive manner. A variety of social and contextual forces contribute to isolation. Our culture's emphasis on individuality gives us an enhanced sense of separateness and loneliness. Our culture's valuing of competitiveness (particularly among males) may deter people from engaging in

self-disclosure. Men have been found to self-disclose less than women, to be more competitive in conversations and to show less empathy.

Productivity versus Stagnation

The midlife dilemma is that of productivity versus stagnation. People who select and shape a home and work environment that fits with their needs and talents are more likely to resolve this dilemma by becoming productive. Productivity may involve procreation, work-based productivity or artistic creativity. Those who become productive focus their energy into making the world a better place for further generations. Those who fail to select and shape their environment to meet their needs and talents may become overwhelmed with stress and become burnt-out, depressed or cynical on the one hand, or greedy and narcissistic on the other.

Integrity versus Despair

In later adulthood, the dilemma faced is integrity versus despair. A sense of personal integrity is achieved by those who accept the events that make up their lives and integrate these into a meaningful personal narrative in a way that allows them to face death without fear. Those who avoid this introspective process or who engage in it and find that they cannot accept the events of their lives or integrate them into a meaningful personal narrative develop a sense of despair. The process of integrating failures, disappointments, conflicts, growing incompetencies and frailty into a coherent life story is very challenging and is difficult to carry out unless the first psychosocial crisis of trust versus mistrust was resolved in favour of trust. The positive resolution of this dilemma in favour of integrity rather than despair leads to the development of a capacity for wisdom.

Immortality versus Extinction

In the final months of life the dilemma faced by the very old is immortality versus extinction. A sense of immortality can be achieved by living on through one's children, by a belief in an afterlife, by the permanence of one's achievements (either material monuments or the way one has influenced others), by viewing the self as being part of the chain of nature (the decomposed body becomes part of the earth, bringing forth new life) or by achieving a sense of experiential transcendence (a mystical sense of continual presence). When a sense of immortality is achieved, the acceptance of death and the enjoyment of life, despite frailty, becomes possible. This is greatly facilitated when people have good social support networks to help them deal with frailty, growing incompetence and the possibility of isolation. Those who lack social support and have failed to integrate

their lives into a meaningful story may fear extinction and find no way to accept their physical mortality and evolve a sense of immortality.

Summary

Erikson's model has received some support from a major longitudinal study (Vaillant, 1977). However, it appears that the stages do not always occur in the stated order and often later life events can lead to changes in the way in which psychosocial dilemmas are resolved.

It is important for therapists to have a sensitivity to the personal dilemmas faced by family members who participate in marital and family therapy. The individual lifecycle model presented here and summarised in Table 1.7 offers a framework within which to comprehend such personal dilemmas.

GENDER-ROLE DEVELOPMENT

One important facet of identity is gender-role (Blakemore *et al*., 2009). This area deserves particular consideration because a sensitivity to gender issues is essential for the ethical practice of family therapy. From birth to five years of age, children go through a process of learning the concept of gender. They first distinguish between the sexes and categorise themselves as male or female. They then realise that gender is stable and does not change from day to day. Finally they realise that there are critical differences (such as genitals) and incidental differences (such as clothing), which have no effect on gender. It is probable that during this period they develop gender scripts, which are representations of the routines associated with their gender roles. On the basis of these scripts they develop gender schemas, which are cognitive structures used to organise information about the categories 'male' and 'female'.

Extensive research has shown that in Western culture, gender-role toy preferences, play, peer-group behaviour and cognitive development are different for boys and girls (Blakemore *et al*., 2009). Boys prefer trucks and guns. Girls prefer dolls and dishes. Boys do more outdoor play, with more rough and tumble and less relationship-orientated speech. They pretend to fulfil adult male roles such as warriors, heroes and firemen. Girls show more nurturant play, involving much relationship conversation, and pretend to fulfil stereotypical adult female roles such as homemakers. As children approach the age of five they are less likely to engage in play which is outside their sex role. A tolerance for cross-gender play evolves in middle childhood and diminishes again at adolescence. Boys play in larger groups, whereas girls tend to limit their group size to two or three.

There are some well-established gender differences in the abilities of boys and girls (Blakemore *et al*., 2009). Girls show more rapid language development than boys and earlier competence at maths. In adolescence, boys'

competence in maths exceeds that of girls and their language differences even out. Males perform better than girls on spatial tasks throughout their lives.

While an adequate explanation for gender differences on cognitive tasks cannot be given, it is clear that sex-role behaviour is influenced by parents' treatment of children (differential expectations and reinforcement) and by children's response to parents (identification and imitation) (Blakemore *et al*., 2009). Numerous studies show that parents expect different sex-role behaviours from their children and reward children for engaging in these behaviours. Boys are encouraged to be competitive and activity-orientated. Girls are encouraged to be cooperative and relationship-orientated. A problem with traditional gender roles in adulthood is that they have the potential to lead to a power imbalance within marriage, an increase in marital dissatisfaction, a sense of isolation in both partners and a decrease in father involvement in childcare tasks.

However, rigid gender roles are now being challenged and the ideal of androgyny is gaining in popularity (Blakemore *et al*., 2009). The androgynous youngster develops both male and female role-specific skills. Gender stereotyping is less marked in families where parents' behaviour is less sex-typed, where both parents work outside the home, and in single-parent families. Gender stereotyping is also less marked in families with high socioeconomic status.

GAY AND LESBIAN LIFECYCLES

A significant minority of individuals have gay or lesbian sexual orientations. When such individuals engage in family therapy, it is important that frameworks unique to their sexual identity be used to conceptualise their problems, rather than frameworks developed for heterosexual people and families (Laird, 2003).

Gay and Lesbian Identity Formation

Lifecycle models of the development of gay and lesbian identities highlight two significant transitional processes: self-definition and 'coming out' (Green, 2012; Laird, 2003; Laird & Green, 1996; Malley & Tasker, 1999; Stone-Fish & Harvey, 2005; Tasker & McCann, 1999). The first process – self-definition as a gay or lesbian person – occurs initially in response to experiences of being different to or estranged from same-sex heterosexual peers, and later in response to attraction to and/or intimacy with peers of the same gender. The adolescent typically faces a dilemma of whether to accept or deny the homoerotic feelings he or she experiences. The way in which this dilemma is resolved is in part influenced by the perceived risks and benefits of denial and acceptance. Where adolescents feel that homophobic attitudes within their families, peer groups and society will have severe negative consequences for them, they may be reluctant to accept

their gay or lesbian identity. Attempts to deny homoerotic experiences and adopt a heterosexual identity may lead to a wide variety of psychological difficulties, including depression, substance abuse, running away and suicide attempts, all of which may become a focus for family therapy. In contrast, where the family and society are supportive and tolerant of diverse sexual orientations, and where there is an easily accessible supportive gay or lesbian community, the benefits of accepting a gay or lesbian identity may outweigh the risks, and the adolescent may begin to form a gay or lesbian self-definition. Once the process of self-definition as gay or lesbian occurs, the possibility of 'coming out' to others is opened up. This process involves coming out to other lesbian and gay people, to heterosexual peers and to members of the family. The more supportive the responses of members of these three systems, the better the adjustment of the individual.

In response to the process of 'coming out', families undergo a process of destabilisation. They progress from subliminal awareness of the young person's sexual orientation to absorbing the impact of this realisation and adjusting to it. Resolution and integration of the reality of the youngster's sexual identity into the family belief system depends upon the flexibility of the family system, the degree of family cohesion and the capacity of core themes within the family belief system to be reconciled with the youngster's sexual identity. Individual and family therapy conducted within this frame of reference aim to facilitate the processes of owning homoerotic experiences, establishing a gay or lesbian identity and mobilising support within the family, heterosexual peer group and gay or lesbian peer group for the individual.

Gay- and Lesbian-couple Lifecycles

While there is huge variability in the patterns of lives of gay and lesbian couples, a variety of models of normative lifecycles have been proposed (Laird, 2003). Slater (1995) has offered a five-stage lifecycle model for lesbian couples. In the first stage, couple formation, the couple is mobilised by the excitement of forming a relationship but may be wary of exposing vulnerabilities. The management of similarities and differences in personal style so as to permit a stable relationship occurs in the second stage. In the third stage, the central theme is the development of commitment, which brings the benefits of increased trust and security and the risks of closing down other relationship options. Generativity through working on joint projects or parenting is the main focus of the fourth stage. In the fifth and final stage the couple learns to jointly cope with the constraints and opportunities of later life, including retirement, illness and bereavement on the one hand and grandparenting and acknowledging life achievements on the other.

McWhirter and Mattison (1984) developed a six-stage model for describing the themes central to the development of enduring relationships

between gay men. The first four stages, which parallel those in Slater's model, are blending, nesting, maintaining and building. McWhirter and Mattison argue that the fifth stage, which they term 'releasing', in the gay-couple lifecycle is characterised by each individual within the couple pursuing his own agenda and taking the relationship for granted. This gives way to a final stage of renewal, in which the relationship is once again privileged over individual pursuits.

Research on children raised by gay and lesbian couples shows that the adjustment and mental health of such children does differ significantly from that of children raised by heterosexual parents (Laird, 2003).

Difficulties in managing progression through the lifecycle stages may lead gay and lesbian couples to seek family therapy (Coyle & Kitzinger, 2002; Green & Mitchell, 2008; Laird & Green, 1996; Stone-Fish & Harvey, 2005).

CLASS, CREED AND COLOUR

The models of family and individual development and related research findings presented in this chapter have all been informed by a predominantly Western, white, middle-class, Judeo-Christian sociocultural tradition. However, in Westernised countries, we now live in a multicultural, multiclass context. A significant proportion of clients who come to family therapy are from ethnic-minority groups. Also, many clients are not from the affluent middle classes, but survive in poverty and live within a subculture which does not conform to the norms and values of the white, middle-class community. When such individuals engage in family therapy, a sensitivity to these issues of race and class is essential (Falicov, 2003, 2012; Hardy & Laszloffy, 2002; Ingoldsby & Smith, 2005; McGoldrick & Hardy, 2008).

This type of sensitivity involves an acceptance that different patterns of organisation, belief systems and ways of being in the broader sociocultural context may legitimately typify families from different cultures. Families from different ethnic groups and subcultures may have differing norms and styles governing communication, problem-solving, rules, roles and routines. They may have different belief systems, involving different ideas about how family life should occur, how relationships should be managed, how marriages should work, how parent–child relationships should be conducted, how the extended family should be connected and how relationships between families and therapists should be conducted. Most importantly, family therapists must be sensitive to the relatively economically privileged position that most therapists occupy with respect to clients from ethnic minorities and lower socioeconomic groups. We must also be sensitive to the fact that we share a responsibility for the oppression of minority groups. Without this type of sensitivity, we run the risk of illegitimately imposing our norms and values on clients and furthering this oppression.

CONCLUSION

Families are unique social systems insofar as membership is based on combinations of biological, legal, affectional, geographic and historical ties. In contrast to other social systems, entry into family systems is through birth, adoption, fostering or marriage and members can leave only by death. It is more expedient to think of the family as a network of people in the individual's immediate psychosocial field. The family lifecycle may be conceptualised as a series of stages, each characterised by a set of tasks family members must complete in order to progress to the next. Failure to complete tasks may lead to adjustment problems. In the first stage of family development, the principal concerns are with differentiating from the family of origin by completing school, developing relationships outside the family, completing one's education and beginning a career. In the second stage, the principal tasks are those associated with selecting a partner and forming a couple. In the third stage, the main task is for couples to adjust their roles as marital partners to make space for young children. In the fourth stage, which is marked by children's entry into adolescence, parent–child relationships require realignment to allow adolescents to develop more autonomy. The demands of grandparental dependency and midlife reevaluation may compromise parents' abilities to meet their adolescents' needs for the negotiation of increasing autonomy. The fifth stage is concerned with the transition of young-adult children out of the parental home. During this stage, the parents are faced with the task of adjusting to living as a couple again, to dealing with disabilities and death in their families of origin and to adjusting to the expansion of the family if their children marry and procreate. In the final two stages of this lifecycle model, the family must adjust to new roles in late middle age and then cope with the parents' physiological decline and approaching death, while at the same time developing routines for benefiting from the wisdom and experience of the elderly.

Family transformation through separation, divorce and remarriage may also be viewed as a staged process. In the first stage, the decision to divorce occurs, and accepting one's own part in marital failure is the central task. In the second stage, plans for separation are made. A cooperative plan for custody of the children, visitation, finances and dealing with the families of origin's response to separation must be made if positive adjustment is to occur. The third stage of the model is separation. Mourning the loss of the intact family, adjusting to the change in parent–child and parent–parent relationships, preventing marital arguments from interfering with interparental cooperation, staying connected to the extended family and managing doubts about separation are the principal tasks at this stage. The fourth stage is the post-divorce period. Here couples must maintain flexible arrangements about custody, access and finances without detouring conflict through the children, retain strong relationships with the children and reestablish peer relationships. Establishing a new relationship occurs in the fifth stage. For this to occur, emotional divorce from the previous

relationship must be completed and a commitment to a new marriage must be developed. The sixth stage of the model is planning a new marriage. This entails planning for cooperative co-parental relationships with ex-spouses and planning to deal with children's loyalty conflicts involving natural and step-parents. It is also important to adjust to the widening of the extended family. In the final stage of the model, establishing a new family is the central theme. Realigning relationships within the family to allow space for new members and sharing memories and histories to allow for integration of all new members are the principal tasks of this stage.

The development of individual identity, within a family context, may also be conceptualised as a series of stages. At each stage the individual must face a personal dilemma. The ease with which successive dilemmas are managed is determined partly by the success with which preceding dilemmas were resolved and partly by the quality of relationships within the individual's family and social context. the dilemmas are: trust versus mistrust; autonomy versus shame and doubt; initiative versus guilt; industry versus inferiority; group identity versus alienation; identity versus role confusion; intimacy versus isolation; productivity versus stagnation; integrity versus despair; and immortality versus extinction.

Lifecycle models of the development of gay and lesbian identities highlight two significant transitional processes: the process of self-definition as a gay or lesbian person and the process of coming out to other lesbian and gay people, to heterosexual peers and to members of the family. The more supportive the responses of others, the better the adjustment of the individual. Stage models for the development of lesbian- and gay-couple relationships have been developed which take account of a gay or lesbian couple's unique life circumstances.

When working with individuals from ethnic minorities and lower socioeconomic groups in family therapy, a sensitivity to issues of race and class is essential if the illegitimate imposition of norms and values from the dominant culture is to be avoided.

FURTHER READINGS

McGoldrick, M., Carter, B. & Garcia-Preto, N. (2011). *The Expanded Family Lifecycle. Individual, Family and Social Perspectives* (Fourth Edition). Boston: Allyn & Bacon.

Walsh, F. (2012). *Normal Family Processes* (Fourth Edition). New York: Guilford.