Chapter 1

FAMILY THERAPY ACROSS THE LIFECYCLE

Family therapy is a term for a range of methods for helping families with various biopsychosocial difficulties. The terms marital and family therapy, couple and family therapy, and systemic therapy are often used interchangeably with the term family therapy. 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; the theories that underpin these practices; and the research supports the validity of family therapy.[1,2]

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

Some family therapists argue that problems addressed in therapy are defined by clients, that is, parents, children, or couples 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 is on an at-risk register or being an adolescent with antisocial behavioural problems involved with the juvenile justice system.

With respect to practices, some family therapists invite some or 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 and 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 and emotions,

family belief 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 great deal 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-30s 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' as gay or transgender.
- A family in which both parents are unemployed and have difficulty caring for their ageing parents and 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 misuse in a delinquent peer group.

These are all complex cases that 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 that 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 conceptualize 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 people from sexual and gender minorities, and diversity issues associated with gender, culture, and social class will also be discussed. The aim of the chapter is to sketch out some of the problem areas that 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, cohabitation, divorce, separation, remarriage, adoption, fostering, and same-sex marriage as common events, a narrow and traditional definition of the family is no longer useful.[3] It is more expedient to think of a person's family as a network of people in the individual's immediate psychosocial field. This may include household members and others who, while not members of the household, play a significant role in the individual'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 conceptualized as deviations from this norm.[4] McGoldrick's family lifecycle model is presented in Table 1.1. This model delineates the main transition processes and developmental tasks to be completed by the family at each stage of development. In the first stage, which is marked by young adult children leaving home, the main process is the emergence of a young person's emotional and financial autonomy. The principal tasks are differentiating from the family of origin and developing adult-to-adult relationships

Table 1.1 Stages of the family lifecycle

Stage	Emotional transition processes	Tasks essential for developmental progression
Leaving home	Developing emotional and financial autonomy	Differentiating from family of origin and developing adult-to-adult relationships with parents Developing intimate peer relationships Beginning a career and moving towards financial independence Establishing the self in community and society
Forming a couple	Committing to a long-term relationship	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 couples' relationships with families of origin and peers to include partners
Families with young children	Accepting children into the family 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 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 a couple take on the 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 a 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 the disabilities and death of a couple's ageing parents Realigning family relationships with community and society to accommodate new family structures 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	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

Based on McGoldrick, M., Garcia-Preto, N., & Carter, B. (2016). The expanding family lifecycle. Individual, family, and social perspectives. In M. McGoldrick, N. Garcia-Preto, & B. Carter (Eds.). *The expanding family lifecycle. Individual, family, and social perspectives* (5th ed., Figure 1.5, pp. 24–25). Pearson.

with parents, developing intimate peer relationships, beginning a career and moving towards financial independence, and establishing the self within the community and society. Problems in developing emotional and financial autonomy from the family of origin may occur at this stage of the family lifecycle. These may find expression in many ways, including depression, drug misuse, eating disorders, significant conflict between young adults and their parents, or criminality. Any of these issues may lead to a referral for family therapy.

Forming a Couple

In the second stage of the family lifecycle model in Table 1.1, the main process is committing to a long-term relationship. The principal tasks include selecting a partner and deciding to form a long-term relationship, developing a way to live together based on an appreciation of partners' real strengths and weaknesses rather than mutual projection, and realigning the couple's relationships with their families-of-origin and peers to accommodate partners.

Stage theories of mate selection, such as that proposed by Adams, conceptualize this process as relatively orderly and predicatable.[5] 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 the 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 couple and family therapist to address this complex issue.

However, stage theories like that just outlined were developed in the last century and within a Western culture. While supported by research within that context, they may not be valid for all cultures and contexts. For example, contexts in which arranged marriages, polygamy, polyamory, or 'friends with benefits' are commonplace; in the digital age, where online

dating and relationship formation are becoming the norm; or for sexual and gender-minority couples.[6]

An important task for young adult couples is developing routines for living together that are based on a realistic appraisal of the other's strengths, weaknesses, and idiosyncrasies rather than on the idealized 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 characterizes infatuation so common in the early stages of intimate relationships, is a particularly stressful task for many young couples and may lead to a drop in relationship satisfaction and a referral for couple therapy.[7]

Factors That Influence Relationship Satisfaction

When couples have formed a relationship, their satisfaction with that relationship has a very significant impact on whether or not it becomes long-lasting. Relationship satisfaction is influenced by the way partners interact with each other, the belief systems and feelings that underpin these interaction patterns, and personal and contextual factors in the couple's wider social system. Studies of interaction patterns, feelings, and belief systems of happy couples in stable marriages or long-term relationships show that these couples have distinctive features.[8–10] These include the following:

- More positive than negative interactions
- Predominantly positive feelings about each other
- Routines for rapidly repairing relationship ruptures and forgiving transgressions
- Routines for focusing conflicts on specific issues
- The capacity to address needs for intimacy and power
- A tendency to make dispositional attributions for positive behaviour
- A tendency to give partners the benefit of the doubt for negative behaviour
- Respect
- Acceptance
- Commitment
- Congruent goals, values, and expectations
- Sexual satisfaction

Regarding couple behaviour, the ratio of positive to negative exchanges has been found to be about five to one in stable couples.[9] Even though happy couples have disagreements, this is balanced out by five times as many positive interactions. Positive interactions include clear communication, appreciation, empathy, responsive behaviour, and behaviour that maintains the relationship. Partners with high levels of relationship satisfaction have predominantly positive feelings about each other and experience a close positive attachment to each other. They attribute their partner's positive behaviour to the fact that their partner cares about

them, rather than situational factors. When happy couples disagree, they tend to rapidly repair relationship ruptures arising from conflict. They focus their disagreement on a specific issue, rather than globally criticizing or insulting each other. This type of behaviour reflects a general attitude of respect which characterizes happy couples. Where transgressions occur and one partner is hurt, there is a willingness to forgive and prevent long episodes of non-communication, sulking, or stonewalling from occurring. Partners in stable, satisfying relationships tend to give their partners the benefit of the doubt, assuming that their partner is well intentioned, or that their negative behaviour is understandable. Sometimes, happy couples resolve conflicts by agreeing to differ. The process of agreeing to differ reflects a general attitude of acceptance. That is, accepting the inevitability that the needs, expectations, and priorities of partners in any relationship will not always be similar. 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 in therapy.[10] With respect to intimacy, usually males prefer greater psychological distance, while females prefer greater psychological intimacy. With respect to power, males tend to wish to retain the power and benefits of traditional gender roles, while females wish to evolve more egalitarian relationships. In happy, stable 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.[8] The goals, values, and expectations of partners in happy couples are compatible and have a good fit with each other. This applies to all areas of life, including sexuality. High relationship satisfaction is associated with high sexual satisfaction.

Relationship satisfaction is influenced not only by couples' behaviour, feelings, and beliefs within their relationship, but also by personal characteristics and contextual factors in the couple's wider social system. Several contextual and personal factors are associated with relationship satisfaction, quality, and long-term stability.[11–18] The following have a positive impact on couples' relationships:

- High level of education
- High socio-economic status (SES)
- Employment
- Early or late stage of the family lifecycle
- Secure adult attachment style
- Life satisfaction and positive mood
- High levels of agreeableness and conscientiousness personality traits
- Emotional intelligence
- Egalitarian role attitudes
- Religiosity and spirituality

In contrast, couple relationships are negatively affected by the following factors:

- High stress
- Poverty and social disadvantage
- Transition to parenthood
- Premarital pregnancy
- Partners are from different family cultures
- Alternatives to the relationship are available
- Unhappy childhood
- Parental divorce
- Insecure adult attachment style
- Depressed mood
- High level of personality trait neuroticism

A higher level of education, SES, and employment probably lead to greater relationship satisfaction because where these factors are present, couples have greater financial resources, better problem-solving skills, and therefore fewer chronic life stresses to cope with. Regarding lifecycle stage, for many couples, relationship satisfaction drops during the child-rearing years, particularly in the case of unplanned premarital pregnancy. In contrast, couple relationship satisfaction is highest before children are born and later when they become independent and 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 joint childcare. Where partners are from different ethnic, religious, or cultural backgrounds involving different norms, rituals, values, and practices, this may lead to chronic conflict between partners, which in turn may reduce relationship satisfaction, and lead to a referral for couple therapy. In contexts where more attractive alternatives are available, the comparison between these alternatives and the couple's relationship may lead to relationship dissatisfaction. Where partners have had an unhappy childhood or their parents have divorced, this may have led to them developing an insecure adult attachment style, which in turn may have made it more difficult for them to make and maintain a satisfying couple relationship. These intergenerational issues may emerge as a focus for couple and family therapy in some cases. A sunny personal disposition characterized by positive mood, life satisfaction, agreeableness, conscientiousness, emotional intelligence, and egalitarian role attitudes contributes to relationship satisfaction. In contrast, a dour personal disposition characterized by a depressed mood and a high level of neuroticism contributes to relationship dissatisfaction. Couple and family therapy is a useful intervention when a child or partner has such mental health problems.[19,20] Couples who conceptualize their relationship within a broader religious or spiritual context or tradition have more stable marriages. This may be because partners from the same religious or

spiritual tradition share similar values and expectations, and because their religious or spiritual community may provide them with social support, which is a buffer against stress.

Types of Couple Relationships

Not all couples with an acceptable level of relationship satisfaction who have stable long-term relationships have the same profile. Gottman[21] and Fitzpatrick[22] have both identified three types of stable couples or marital relationships in observational and questionnaire studies, respectively. I have termed these traditional, androgynous, and avoidant couples. Characteristics of these types of marriage are summarized 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 couples were identified in Gottman's research. 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 couples, the ratio of positive to negative verbal exchanges during conflict resolution was 5:1. For both unstable types of couples, the ratio of positive to negative exchanges was approximately 1:1. Gottman and Fitzpatrick's work highlights the fact that there are a number of possible models for a stable couple or marital relationship. Negativity is only destructive if it is not balanced out by five times as much positivity. Indeed, a low level of negativity may help couples balance the needs for intimacy and autonomy and keep attraction alive over long periods.

Relationship Distress

While Gottman's research showed that there are different specific types of distressed or unstable couples, epidemiological research supports the following general conclusions relevant to relationship distress.[23–25] In Western cultures, by the age of 50, about 85% of people have been married at least once. About a third to half of couples separate or divorce. About half of all divorces occur in the first 7 years of marriage. Of couples who remain married, about 20% experience relationship distress. Compared with distressed or separated couples, those who sustain mutually satisfying relationships have better physical and mental health, live longer, and have better financial prosperity. They also engage in better parenting practices, and their children have better academic achievement and psychological adjustment.

Table 1.2 Five types of couples

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 empathizes 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 express a high level of both positive and negative emotions
	Avoidant couples	• They adopt traditional sex roles • They have separate living space 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 • They accept differences about specific conflicts as unimportant compared with their shared common ground and values • Conflict-related discussions are unemotional

(*Continued*)

Table 1.2 (*Continued*)

Stability	Type	Characteristics
Unstable	Conflictual couples	• They engage in conflict without any constructive attempt to resolve it • Continual blaming, mind-reading, and defensiveness characterize their interactions • High levels of negative emotion and little 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, mind-reading, and defensiveness characterize 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. M. (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*(1), 6–15. https://doi.org/10.1037/0022-006X.61.1.6 and Fitzpatrick, M. (1988). *Between husbands and wives: Communication in marriage*. Sage.

Intimate Partner Violence

Intimate partner violence is an extreme expression of relationship distress. Epidemiological studies show that up to a third of heterosexual and sexual and gender-minority couples experience intimate partner violence.[26–30] The rates of violence by males against females are higher than those of females against males. Within couples, the rate of psychological violence is greater than the rate of physical violence, which, in turn, is greater than the rate of sexual intimate partner violence. About half of couples attending couple therapy have experienced an episode of intimate partner physical violence. Couple therapy interventions have been developed for mild to moderate context-dependent physical intimate partner violence.[31] Intimate partner violence has a severe impact on health and well-being and exacerbates relationship dissatisfaction.

Families with Children

The third stage of the family lifecycle model in Table 1.1 occurs when couples have children. The main process is accepting children into the family system. The principal tasks are making space within the couple's relationship

for children; arranging child-rearing, financial, and housekeeping responsibilities within the couple; realigning relationships with families of origin to include parenting and grandparenting roles; and realigning family relationships with the community and society to accommodate the new family structure. Each of these issues will be dealt with in more detail in the following section.

Division of Labour Within Couples

During the third family lifecycle stage, couples must arrange for a workable division of labour in terms of child-rearing, financial, and housekeeping responsibilities. Most research studies in Western industrialized countries show that this is an area marked by inequity.[32,33] 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, although there is an international trend towards increasing equality in the gendered division of childcare. Addressing inequity in childcare and housework may be the focus of intervention in couple and family therapy.

Parenting Roles

During the third family lifecycle stage, couples must work out how to engage in parenting roles. The development of parenting roles involves the couple establishing a co-parenting team with routines for meeting children's needs for

- safety,
- care,
- control, and
- cognitive stimulation.

This is a complex and demanding 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.[34–36] Routines for meeting children's needs for safety include protecting children from accidents by, for example, not leaving young children unsupervised and developing skills for managing frustration and anger, which the demands of parenting young children may 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 needs 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 cognitive stimulation also need to be developed if the child is to avoid developmental delays in emotional, language, and cognitive development.

Attachment

The establishment of parent–child attachments occurs during the third family lifecycle stage. Children who develop secure attachments to their parents or caregivers fare better in life than those who do not.[37] Children develop secure emotional attachments if their parents are attuned to their needs and if their parents are responsive to children's 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, who developed attachment theory, argued that attachment behaviour, which is genetically programmed and essential for the survival of the species, is elicited in children between 6 months and 3 years when faced with danger.[38] 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 in response to children's needs for proximity, comfort, and security. 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. The self and others may be viewed positively or negatively, and this in turn will impact the level of anxiety or safety felt in the relationship, and the inclination to approach or avoid the caregiver. In their groundbreaking text, *Patterns of Attachment*, Mary Ainsworth and colleagues described three patterns of mother–infant interaction (secure, avoidant, and resistant attachment), following a brief episode of experimentally contrived separation referred to as the strange situation.[39] Further empirical research with mothers and children led to the identification of a fourth category (disorganized attachment). About 52% of children develop secure attachments; the remainder develop insecure attachments: 24% disorganized, 15% avoidant, and 10% resistant.[40] 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, and they may sulk.
- Children with a **disorganized attachment** style following separation show aspects of both the anxious and avoidant patterns. Disorganized attachment is a common correlate of child abuse, 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.[37] Adult attachment styles in romantic relationships and patterns of family organization may be classified into four attachment categories, like those shown by children. These will be discussed further in Chapter 5 in the section on attachment-based therapies. Difficulties associated with insecure attachment may lead to referrals for couple or family therapy.

Parenting Styles

The establishment of parenting styles occurs during the third family lifecycle stage. Reviews of the extensive literature on parenting suggest that by combining the two orthogonal dimensions of warmth or acceptance, and control or demandingness, four parenting styles may be identified, and each of these is associated with particular developmental outcomes for the child.[41] 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 which is maximally beneficial for children's development as autonomous, confident individuals.[42] Children of parents 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 warm and accepting but 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 that may become a focus for family therapy. This is particularly the case with corporal punishment.

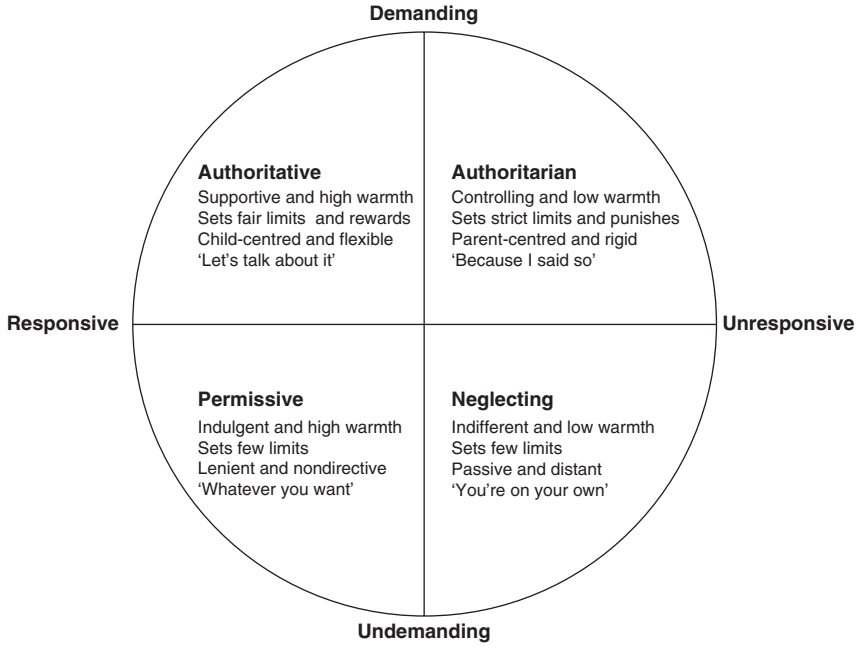

Figure 1.1 Patterns of parenting

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 violent behaviour and becoming involved in bullying.[43]

Grandparental Roles

The establishment of grandparental roles occurs during the third family lifecycle stage. Grandparental roles in providing childcare and economic support when their children become parents vary from non-involvement through a moderate level of involvement to a high level of involvement, for example, where grandparents provide kinship care for grandchildren. Grandparental roles are influenced by grandparental personal characteristics and circumstances, the quality of their relationships with their children and grandchildren, and the availability of social services they may require to fulfil their grandparental roles.[44] Grandparental personal characteristics and circumstances include, for example, their state of health or illness, childcare skills, financial resources, motivation to support their children and grandchildren, and the size and proximity of their home to that of their children. Contemporary grandparental roles are also influenced by recent demographic trends.[45] For example, the increasing prevalence of dual-earner families, divorce rates, and

single-parent families creates opportunities for many grandparents to actively contribute to childcare. Their availability to do so is increasing because older people are living longer and are healthier than in the past. Grandparental roles have benefits for grandparents and grandchildren when the demands of these roles do not exceed the grandparents' psychological and financial coping resources. However, where the demands of the role are too great, for example, in the case of kinship care, then grandparenting may adversely affect the health and well-being of both grandparents and grandchildren.[46–49] This may lead to a referral for family therapy.

Day Care

During the third family lifecycle stage, parents may place their children 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 3–54 months); and when high-quality day care is provided.[50,51] In this context, high-quality day care is characterized by continuity in the relationship between the infants and day-care staff; responsivity in staffs' reactions to infants' needs for safety, care, control, and cognitive stimulation; positive relationships between day-care staff and the group of children in their 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.[52] 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 buffer against risk factors associated with problematic home environments characterized 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 for from 3 to 54 months, they are more likely to develop aggressive behavioural problems, which may become a focus for family therapy.

Preschool

During the third family lifecycle stage, parents may 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.[53] 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 up to the start of primary school. A central factor is a good working relationship between the parents and 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 that incorporates the elements of planning activities, doing 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

During the third family lifecycle stage, children start school. School plays a central role in the lives of families of children between 5 and 18 years old. 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 schools are especially conducive to academic achievement and prosocial development. In their seminal study of secondary schools, Rutter and colleagues 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.[54] These features include the following:

- Authoritative leadership of the staff team by the school principal.
- Authoritative management of classes by teachers with high expectations of success, clear rules, and regular homework, which is routinely graded.
- A participative approach to decision-making among the staff about curriculum planning and school management, which fosters cohesion among the staff and the school 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 and the arts.
- Teachers model good behaviour.
- Teachers regularly appreciate, reward, and praise academic and non-academic 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.[55–58] This type of approach to teaching requires moderate class sizes, a variable that has been consistently associated with pupil performance.

Children's Peer Group Roles

During the third family lifecycle stage, children develop peer relationships, which are important for adjustment across the lifespan.[59–61] 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 for family therapists. Over the first 5 years, with increasing opportunities for interaction with others and the development of language, interaction with other children increases. Co-operative 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 co-operative 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 characterized 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 non-romantic 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 children 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 the group's activities. Unpopular children, particularly the aggressive type, do not tune in to group activities. They tend to criticize 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 children miss out on important opportunities for learning about co-operation, teamwork, 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 developing 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

The fourth stage of the family lifecycle model in Table 1.1 occurs when children make the transition to adolescence. At this stage, the main developmental process is increasing flexibility of family boundaries to accommodate adolescents' growing independence and grandparents increasing constraints. The principal tasks at this stage are adjusting parent–child relationships to allow adolescents more autonomy, adjusting family relationships as the couple takes on the responsibility of caring for ageing parents, and realigning family relationships with the community and society to accommodate adolescents' increasing autonomy and grandparents' increasing constraints. This is a complex and stressful lifecycle stage, not least because the demands of grandparental dependency may compromise parents' abilities to meet their adolescents' needs for increasing autonomy.

Facilitating the Growth of Adolescent Autonomy

In the fourth stage of the family lifecycle, good parent–child communication, joint problem-solving skills, and accurate information about adolescent development may facilitate the renegotiation of parent–child relationships and the growth of adolescent autonomy. Skills deficits in these areas, or lack of accurate information about adolescent development, may underpin referrals for family therapy. Results of research on adolescent relationships with parents, peers, and partners contradict some commonly held misconceptions about adolescent development. In family therapy, it may be useful in some cases to provide parents and adolescents with the following information. The ideas that very permissive or very strict parenting is what is best for adolescents are widely popularized. A vast body of research shows that these views are unfounded, and that authoritative parenting, mentioned above in the section on parenting styles and in Figure 1.1, is the best approach to take with teenagers.[62] With this approach, parenting is characterized by both warmth and reasonable discipline. Parents appreciate their teenagers, listen to them, empathize with them, take their views seriously, and support their autonomy. However, they also negotiate clear, fair boundaries and set limits in a consistent way. Authoritative parenting leads to adolescents having greater academic success, mental health, and social relationships.

There is a widespread idea that extreme parent–child conflict – the adolescent rebellion – is the norm in adolescence. Research shows that

disagreements between parents and offspring increase with the transition to adolescence. This is a normal part of developing autonomy. However, most parents and adolescents have minor disagreements about day-to-day issues, not major conflicts about basic values or life goals.[63] There is little support for the idea that adolescent rebellion is the norm.

A traditional view of adolescence posits a gradual erosion of the quality of parent–adolescent relationships and a complementary increase in the quality of the adolescent–peer relationships. Research shows that it is normal for adolescents to spend less time with their parents and more time with their peers than they did in childhood. However, the basic quality of relationships between parents and offspring is not adversely affected by the young person's peer relationships. There is a positive correlation between the quality of adolescent–parent and adolescent–peer relationships. Adolescents who have good relationships with their parents tend to have good relationships with their peers.[64] It is not the case that, as part of an adolescent rebellion, adolescents cut ties with their parents and replace formerly close relationships with their parents with close peer relationships.

A traditional myth is that promiscuity in adolescence is the norm and part of adolescent rebellion. This is not supported by research. Frequent, risky, promiscuous sex with multiple partners is viewed by most adolescents as unacceptable, and a majority of older teenagers view safe sex between committed partners as acceptable.[65] Teenage pregnancy, an outcome of risky or promiscuous sexual behaviour, is a risk factor for social disadvantage because it may interfere with education and compromise the career prospects of the teenager.[66] Adolescent marriages resulting from unplanned pregnancies run a high risk of dissolution, and these young families may develop multiple life problems and require particularly intensive family therapy.

Risk and Protective Factors in Adolescence

When working with families in the fourth stage of the family lifecycle, account must be taken of adolescents' vulnerability to developing long-term difficulties. Adolescence is a risky period for some young people. During the second decade of life, there are many opportunities for developing a variety of 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. The adverse childhood experiences (ACEs) and protective and compensatory experiences (PACEs) framework is one way for considering risk and protective factors in childhood and adolescence. ACEs is the acronym for adverse childhood experiences.[67] PACEs stand for protective and compensatory experiences.[68] ACEs include child abuse or maltreatment; parental death, separation, or divorce; living in a family where a member has mental health or substance use problems

or has been imprisoned; and witnessing or experiencing intrafamilial or extrafamilial violence. ACEs are risk factors for physical and mental health problems and social adjustment difficulties. In contrast, PACEs are 10 specific experiences that children and adolescents require for optimal development. These experiences fall into two categories: relationships and resources. The relationship factors include unconditional love from a primary caregiver, having a best friend, volunteering in the community, being part of a group, and having a mentor. The resource factors include having a safe, clean home with enough food, getting a good education, having a hobby, getting plenty of physical activity, and having rules and routines. Research shows that PACEs are protective factors that may attenuate the effects of ACEs.[67–69] PACEs provide young people with supportive relationships and necessary resources in childhood and adolescence for optimal neurobiological, cognitive, and social development. Successful early development leads to engagement in health-promoting behaviour and positive relationships later in life. These factors, in turn, promote health and longevity.

Caring for Ageing Parents

When working with families in the fourth stage of the family lifecycle, the demands on middle-aged parents caring for their ageing parents are often a central issue. Increasingly, as the average lifespan lengthens, caring for ageing parents is becoming a routine responsibility for men and women in midlife.[70] 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'.[71] For this generation, while rewarding, it is undoubtedly a challenging period in the lifecycle associated with considerable burden.[70–73] Social support from family and friends, social and medical services, and periodic relief-custodial care are important coping resources in dealing with these issues.[74] Family therapists have a role to play in helping families manage the joint challenges of rearing adolescents while supporting ageing parents.

Launching Adult Children and Parents in Midlife

The fifth stage of the family lifecycle model in Table 1.1 is concerned with the transition of young adult children out of the parental home and the parents' progression into midlife. The main process during this stage is accommodating exits from, and new entries into the family system. For young people and their parents this can be a very positive process that creates a context for developing less hierarchical adult-to-adult relationships. When adult children leave home, for parents there are both

opportunities and challenges. There are opportunities to re-invest in the couple relationship, re-evaluate their lives, address midlife issues, develop new interests and projects, and celebrate the expansion of the family to include in-laws and grandchildren if their adult children procreate. Parents are also faced with the challenges of adjusting to living as a couple again, to dealing with disabilities and death in their families of origin, and realigning family relationships with the community and society to accommodate changes in the family structure. Where entry into this stage becomes blocked or delayed by significant obstacles to adult children leaving home, this may reduce quality of life, and lead to a referral for family therapy. Entry into this stage may be blocked where children or parents have significant disabilities, physical or mental health problems, or significant financial constraints.[75–77]

Midlife Re-evaluation

In the fifth stage of the family lifecycle model in Table 1.1, parents have the opportunity to engage in a midlife re-evaluation to consider their life priorities, their relationship, and career aspirations. This re-evaluation occurs within a context where middle-aged adults become aware of their declining energy and vitality and increased risk of health problems and are faced with multiple responsibilities at home, work, and in the community. However, midlife re-evaluation also occurs when many adults are at a peak in many areas, including decision-making skills, self-confidence, and control beliefs; earnings and financial security; and leadership in work, family, and community settings. The midlife re-evaluation process 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 also the popular conception of the midlife crisis, characterized by profound changes in mood and behaviour, has been found to be a relatively rare phenomenon.[78,79] For most people, the transition that occurs in midlife is a subtle process. Many men and women in their 40s become more introspective and re-evaluate their roles within the family and the world of work, as they realize that death is not an abstract fact of life, but a personal event that will happen to them. 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 lead to changes that assume crisis proportions.

In an extensive study of the clinical and non-clinical population, Gould found that inaccurate or false assumptions and belief systems learned within the family of origin are gradually challenged over the course of adulthood, and this process reaches a resolution in midlife.[80] Gould's findings are summarized in Table 1.3. The inaccurate or false 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

Table 1.3 False assumptions and beliefs challenged in adulthood

Period	False assumption	False beliefs
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 (e.g., 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 one 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*. Simon Schuster.

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 internalized in childhood.

In the late teens, if the adolescent is to be liberated from the family, the parent's worldview must be appraised. Their parents' roles 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 20s, within the work arena, the belief that life is fair and if you stick to the rules you will win is challenged. With relationships, the belief that our partners can make up for our deficiencies and we can make up for theirs is also challenged. The belief that romantic love can cure personal deficiencies must be challenged during the 20s. For example, a talkative partner can't make up for a quiet partner's style, nor can a nurturing partner fulfil all their partner's dependency needs. When these beliefs have been challenged, the person is in a position to differentiate sufficiently to establish a family separate from the family of origin.

The assumptions and beliefs that are challenged up to the 20s relate to the outer world. In the 30s, beliefs and assumptions about our inner selves or our relationships with ourselves are challenged. The person realizes that they can know something intellectually, such as 'this row with my partner can be resolved through patient negotiation', and yet lack the emotional competencies to work through the process of negotiation. In their 30s, people realize that they have many characteristics of their parents which they dislike. For example, they may treat their children unfairly. This must be recognized if patterns are not to be repeated across generations. There must be an acceptance of a partner's evolution and growth and 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, both within marriage and in the workplace. Perceived threats within marriage are often projections, rather than realistic threats. People in their 30s assume that the feelings of being mistreated or taken for granted are real threats from their partners rather than projections onto their partners of ways in which they were treated as children by their parents or significant others. The belief that we can always accurately identify and deal with threats must be challenged in midlife.

In the 40s, illusions of safety are challenged. For men, the most common illusion is 'If I am successful, and 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 couple relationship roles to make the best use of their remaining years with an awareness of their mortality in mind. Within couple relationships, both husbands and wives must challenge the belief that there is no life outside the couple relationship. This may lead to them choosing to separate or choosing consciously to live together. The choice to remain within a couple relationship enriches it. 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, at the end of the midlife period, the adult experiences a consciousness where the guiding belief is 'I own myself' rather than 'My parents own me'. The sense of self-ownership gives life meaning.

The consolidation of an adult consciousness, as described by Gould, may be a theme for couples referred for therapy in midlife.

Families with Parents in Late Middle Age and End of 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. The acceptance of new generational roles arising from ageing parents' physiological decline is the main developmental process in the sixth stage of the family lifecycle. This stage is marked by ageing parents moving into late middle life. The principal task for ageing parents is to maintain functioning and interests and accept help and support from their adult children. The principal task for adult children is to take a more central role in family maintenance, which includes arranging appropriate supports for their ageing parents so that they can live as independently as possible within the constraints of ageing. At this lifecycle stage, families must also make room for the wisdom and experience of ageing parents and realign family relationships with community and society to accommodate the new family structure. The acceptance of the constraints of ageing and the inevitability of death is the main developmental process in the seventh stage of the family lifecycle, which is marked by parents nearing the end of life. The principal tasks include preparing for death through life review and integration, adjusting to the reversal of roles where adult children care for parents, dealing with loss, and realigning family relationships with the community and society to accommodate changing family relationships. The family must cope with ageing parents' physiological decline and approaching death while at the same time developing routines for benefiting from their wisdom and experience.

The last two stages of the family 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. However, these stages also entail difficult loss-related challenges. Loss in this context refers to the loss of ageing parents' youth, health, vitality, resources, and ultimately loss of life. A parallel issue for their adult children 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 final two lifecycle stages, when dealing with terminal illness or bereavement, families may be referred for therapy because one or more of their members display adjustment difficulties such as those listed in Table 1.4. These types of problems typically reflect involvement in the following grief processes:

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

There is no clear-cut progression through these processes from one to the next.[81–83] Rather, at different points in time, one or another process predominates when a family member has experienced a loss or faces death. 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 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 were 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 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

Table 1.4 Behavioural expressions of themes underlying grief processes following bereavement or facing terminal illness

	Bereavement		Terminal illness	
Grief process	**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	• Non-compliance 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 schoolwork	• 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 schoolwork

(*Continued*)

Table 1.4 (*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	• Non-compliance 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 remaining time

or being visited by them. Some children carry on full conversations with what are presumably hallucinations of the deceased person. Mistaking other people for the deceased is also a common experience during the denial process. With a 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 realization 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 may 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 misuse are some of the common ways that grief-related anger finds expression. With terminal illness, the anger may be projected onto family members or members of the medical team. Destructive conflicts within these relationships may occur, such as refusal to adhere to medical regimes, to take medication, or to participate in physiotherapy.

Anxiety

The expression of such anger may often be followed by remorse or fear of retribution. Children or grandchildren 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, health anxiety, 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, surviving family members reconstruct their view of the world so that the deceased person is construed as no longer living in this world, but 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 evolve as part of the process of accepting the death of a family member, and the family is reorganized 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. A summary of the grief processes and related adjustment problems that may lead to referral for family therapy is presented in Table 1.5.

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.[81–88] First, grief processes, either anticipatory or grief following loss, do not occur as an ordered and invariant sequence

Table 1.5 Extra stages in the family lifecycle entailed by separation or divorce and remarriage

Phase	Stage	Attitude	Developmental task
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	• Co-operatively developing a plan for custody of the children, visitation, and finances • Dealing with the extended family's response to planned separation
	Separation	Committing to continued co-operative co-parenting and joint financial support of children Beginning to break attachment to partners	• Mourning the loss of the intact family • Adjusting to the change in parent–child and parent–parent relationships • Adjusting relationships with, and staying connected to, ex-partners' extended family
	Divorce	Establishing emotional divorce: processing emotions such as hurt, anger, and guilt	• Letting go of hopes of reunion • Grieving unfulfilled hopes from the marriage that has ended • Maintaining extended family connections
Post-divorce family	Establishing single-parent custodial and non-custodial households	Engaging in co-operative 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 • Re-establishing peer relationships and a social network

(*Continued*)

Table 1.5 (*Continued*)

Phase	Stage	Attitude	Developmental task
Remarriage	Entering a new relationship	Recovering from emotional divorce and loss of first marriage	• 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 arrangements for continued co-operative financial and co-parental relationships with ex-partners within the context of new family relationships • Planning to deal with children's loyalty conflicts involving natural and step-parents • Realigning relationships with extended family and ex-partner's extended family to include new partner and children
	Remarriage and reconstruction of the family	Breaking attachment to previous partners Giving up the ideal of an 'intact family' and accepting a different family model	• Realigning multinuclear family relationships, relationships with extended family, and finances to facilitate new family members • Sharing memories and histories to allow for integration of all new family members
	Renegotiation of family relationships at lifecycle transitions	Accepting evolving relationships in a multinuclear family	• Adapting to lifecycle changes as children graduate and marry, as members become ill or die, and as ex-partners form new couple relationships

Based on McGoldrick, M., & Carter, B. (2016). The remarriage cycle. Divorced, multi-nuclear, and recoupled families. In M. McGoldrick, N. Garcia-Preto, & B. Carter (Eds.), *The expanding family lifecycle. Individual, family, and social perspectives* (5th ed., Figure 22.1, pp. 413–414). Pearson.

of stages. There is a progression from shock through a variety of emotional reactions, including anger, depression, anxiety, and guilt, to acceptance. However, there is wide variability in the way this progression occurs, and not everyone experiences all processes. 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 are inevitable. 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 it. Those that effectively use the former coping strategy may not show emotional distress. Fourth, extreme distress following bereavement commonly occurs in those who show prolonged grief reactions. Fifth, not everyone needs to work through their sense of loss through immediate intensive conversation about it. Some people who apparently work through their sense of loss early have later problems. Sixth, a return to normal functioning does not always occur rapidly. While most people approximate normal functioning within 2 years, a substantial minority of bereaved people continue to show adjustment difficulties even several years after bereavement. Seventh, the resolution and acceptance of death do not always occur. For example, parents who lose children or those who lose a loved one in an untimely fatal accident may experience prolonged grief reactions. Eighth, detachment from the bereaved person does not always occur. Some people form an internal representation of the deceased and continue to have a relationship with them. Ninth, grief may have a marked effect on physical functioning. Infections and other illnesses are more common among the bereaved. This is probably due to the effect of loss-related stress on the functioning of the immune system. However, with the passage of time, the immune system's functioning returns to normal. 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, adults bereaved as children have double the risk of developing depression when faced with a loss experience in adult life compared with their non-bereaved counterparts.

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

LIFECYCLE STAGES ASSOCIATED WITH SEPARATION AND DIVORCE

Divorce is no longer considered to be an aberration in the normal family lifecycle, but a normative transition for a substantial minority of families.[89,90] Family transformation through separation, divorce, and remarriage may be

conceptualized as a process involving a series of stages. McGoldrick's model of the extra stages in the family lifecycle entailed by separation or divorce and remarriage is presented in Table 1.5. 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 referrals for couples or family therapy.

Decision to Divorce

In the first stage, the decision to divorce occurs, and accepting one's own part in relationship failure is the central task. However, many contextual factors contribute to divorce, including age, socio-economic and employment status, educational level, parental marital status, premarital cohabitation, prior marital status, prior parental status, ethnic similarity, marital harmony or conflict, and fidelity.[89] Couples are less likely to separate or divorce if they marry after the age of 20, are of high SES, have a high educational level, are employed, have grown up in a family where their parents did not separate, if they have not cohabitated prior to marriage, if they have not previously been married or had children, if they are from similar ethnic backgrounds, and if they have no history of relationship conflict or infidelity. In contrast, divorce is more common among those from lower socio-economic 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, are from different ethnic groups, and have a history of marital conflict, domestic violence, and infidelity. The economic resources associated with high SES, 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 non-divorced 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.

Planning, Separation, and Divorce

In the second stage of the lifecycle model of divorce, plans for separation are made. A co-operative plan for custody of the children, visitation, finances, and dealing with families of origin's response to the plan to separate must be made if a positive adjustment is to occur. Mediation may facilitate this process.[91] The third and fourth stages of the model are separation and divorce, respectively. In the third stage, committing to continued co-operative co-parenting, joint financial support of children, and beginning to break attachment to partners are major themes

in the lives of parents. Mourning the loss of the intact family, adjusting to the change in parent–child and parent–parent relationships, and staying connected to the partner's extended family are the principal tasks of the third stage. A major challenge is preventing couple relationship disagreements from interfering with interparental co-operation. In the fourth stage, establishing emotional divorce and processing emotions such as hurt, anger, and guilt are central concerns for parents. Letting go of hopes of reunion, grieving unfulfilled hopes from the marriage that has ended, and maintaining extended family connections are the main tasks of the fourth 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.[89,92] 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 care for children and work outside the home. Non-custodial parents experience all these changes apart from 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 most 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 initiated divorce.

Post-divorce Period

The fifth stage of the family lifecycle model of divorce is the post-divorce period. Parents' primary concern is engaging in co-operative co-parenting and joint financial support of both households. The main tasks are maintaining flexible arrangements about custody, access, and finances without deterring conflict with the children; retaining strong relationships with the children; managing changed financial circumstances; and re-establishing peer relationships and a social network. 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 co-operate in meeting their children's needs for safety, care, control, education, and relationships with each parent.[89,90] 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 non-custodial 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.[93] With *co-operative parenting*, a unified and integrated set of rules and routines about managing the children in both the custodial and non-custodial households is developed. This is the optimal arrangement, but it only occurs in about one in five cases. With *parallel parenting*, each parent has their 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 couple often does not communicate directly with each other. Many messages from one parent to another are passed through the child. This go-between role, forced upon the child, 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 long-term adjustment reactions.[89–93] During the 2-year period immediately following divorce, most children show some adjustment problems. Boys tend to display conduct or externalizing behaviour problems, and girls tend to experience emotional or internalizing 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 effect on children. 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 socio-economic level in comparison with adults who have grown up in intact families.

Certain characteristics of children and certain features of their social contexts influence the effects of parental divorce on their adjustment.[89–99] 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 a difficult temperament 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, relationship distress, intimate partner violence, family disorganization, and a history of previous separations and reunions, also places children at risk for post-separation adjustment problems. Early life stresses, such as child abuse or bereavement, may also compromise children's capacity to deal with the 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. 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 non-custodial 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-operative co-parenting environment that minimizes 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, realistic beliefs about their parents' separation and divorce, and good problem-solving and 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. Children show better post-separation adjustment when parents cope well with post-separation grief, have good personal psychological resources, and have a high level of satisfaction within their new couple relationships. 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 child-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 begins in the sixth stage of the divorce lifecycle model. For this to occur, emotional divorce from the previous relationship must have progressed, and a commitment to a new marriage must be developed. The seventh stage of the model is planning a new marriage. Central issues are accepting concerns about forming a new family and being patient about the slow pace at which adjustment to the complex new family arrangements occurs. Key tasks in this stage are planning for co-operative financial and co-parental relationships with ex-partners and planning to deal with children's loyalty conflicts involving natural and step-parents. It is also important to adjust to the widening extended family. In the eighth stage of the model, remarriage and reconstruction of the family are the central themes. Central concerns are relinquishing attachments to previous partners, letting go of the ideal of an 'intact family', and accepting a new family model. Realigning relationships and finances within the family to accommodate new members and sharing memories and histories to allow for integration of all new members are the principal tasks of this stage. The final stage involves the renegotiation of family relationships at lifecycle transitions. The main task is adapting to lifecycle changes as children graduate and marry, as members become ill or die, and as ex-partners form new couple relationships.

Stepfamilies have unique characteristics, which are, in part, affected by the conditions under which they are formed.[93,100] On the positive side, surveys of stepfamilies 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, stepfamilies are less cohesive and more stressful. Stepparent/child relationships, on average, tend to be more conflictual than parent–child relationships in intact families. This is particularly true of stepfather/daughter relationships and may be due to the daughter's perception of the stepfather encroaching on a close mother–daughter relationship.

Children's adjustment following remarriage is associated with age, gender, and parents' satisfaction with the new marriage. Good adjustment occurs when the custodial parent remarries while the children are preadolescent or in their late adolescence or early adulthood. Most children in divorced families resist the entry of a stepparent. 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. Couple relationship satisfaction in the new relationship has a protective effect for young boys, and it is a risk factor for preadolescent girls. Young boys benefit from their custodial mothers forming a satisfying relationship with a new partner. Such satisfying relationships lead stepfathers to behave in a warm, child-centred way towards their stepsons 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 mothers is threatened by the development of a new and satisfying marital relationship. They may respond with increased conduct problems and psychological difficulties. In adolescence, when remarriage has occurred while the children were preadolescent, a high level of couple relationship satisfaction is associated with good adjustment and a high level of acceptance of the stepparent 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 conceptualize problems. However, it is also useful for therapists to conceptualize 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 and Newman's modification of Erik Erikson's model of identity development[101] is presented in Table 1.6. 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 that affords an opportunity to develop a personal strength or virtue, on the one hand, or a vulnerability or pathology on the other, depending on the supports and skills available to the individual during that stage. The ease with which successive dilemmas are managed is determined partly by the success with which preceding dilemmas were resolved.

Table 1.6 Newman's revision of Erikson's model of the stages of the individual lifecycle

Stage	Dilemma main process (Main parental role)	Virtue or strength	Pathology or vulnerability
Infancy 0–2 yrs	**Trust versus mistrust** Mutuality with caregiver (Parental responsiveness)	**Hope** I can attain my wishes	**Withdrawal** I will not trust others
Toddlerhood 2–4 yrs	**Autonomy versus shame and doubt** Imitation (Parental patience)	**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
Early school age 4–6 yrs	**Initiative versus guilt** Identification (Parental permission to explore & safe limits)	**Purpose/curiosity** I can plan and achieve goals	**Inhibition** I can't plan or achieve goals, so I don't act
Middle childhood 6–12 yrs	**Industry versus inferiority** Education (Parental encouragement to develop skills)	**Competence** I can use skills to achieve goals	**Inertia** I have no skills, so I won't try
Early adolescence 12–18 yrs	**Group identity versus alienation** Peer pressure (Parental support for peer group membership)	**Affiliation** I can be loyal to the group	**Isolation** I cannot be accepted into a group

Later adolescence 18–24 yrs	**Identity versus identity confusion** Role experimentation (Parental support for role experimentation)	**Fidelity to values** I can be true to my values	**Confusion** I have uncertainty about my values and role
Early adulthood 24–34 yrs	**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 adulthood 34–60 yrs	**Generativity 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
Later adulthood 60–75 yrs	**Integrity versus despair** Introspection	**Wisdom** I am committed to life and have a deep flexible understanding of it, but I know I will die soon	I am disgusted at my frailty and my failures and express this as disdain for others
Elderhood 75-Death	**Immortality versus extinction** 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

Based on Erikson, E., & Erikson, J. (1998). *The lifecycle completed* (extended version). Norton; Newman, B., & Newman, P. (2018). *Development through life: A psychosocial approach* (13th ed.). Cengage.

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. A sensitivity to these themes relevant to individual development may inform family therapy.

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 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 move 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 and a sense of self-esteem develop. As adults, such children are patient with themselves and have confidence in their abilities 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 criticize or humiliate failed attempts at mastery, the child will develop a sense of self-doubt and shame. The lack of patience and parental criticism will become internalized. Children will evolve into adults who criticize themselves excessively and who lack 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 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. The child finds 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, by lighting matches, taking toys apart, or playing doctors and nurses. The initiative versus guilt dilemma is resolved when the child learns how to channel the need for investigation into socially appropriate courses of action. This occurs when parents empathize 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 empathizing with the child's need for curiosity and curtail experimentation unduly, children may develop a reluctance to explore untried options as adults 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, autonomy, and 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. Unfortunately, not all children have the aptitude for skills that are valued by society. Youngsters who have low aptitudes for literacy and numeracy 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 school need to avoid over-restriction of opportunities for making and maintaining peer relationships. This must be balanced against the dangers of overpermissiveness since a lack of supervision is associated with conduct problems and drug misuse in adolescence.

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 found that adolescents may achieve one of four identity states.[102] With identity diffusion, there is no firm commitment to personal, social, political, or vocational beliefs or plans. Such individuals are either fun-seekers or people with 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 several roles before settling on an identity. Some of these roles may be negative (delinquent) or unconventional (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 being trapped, which may occur with foreclosure. During this developmental stage, adolescents need parental support for role experimentation. 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 move to an isolated position. People who do not achieve intimacy experience

isolation. Isolated individuals have unique characteristics.[103] 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 on 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 be overwhelmed by 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 that allows them to face death without fear develop a sense of despair. The process of integrating failures, disappointments, conflicts, growing incompetencies, and frailty into a coherent life story is very challenging. It is difficult to do unless the first psychosocial crisis of trust versus mistrust has been resolved in favour of trust. The positive resolution of the later adulthood 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; through 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 that brings 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, become 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 it challenging to accept their physical mortality while at the same time evolving a sense of immortality.

Erikson's model has received support from many studies and offers a useful framework within which to conceptualize individual psychosocial development across the lifespan.[104] However, it appears that the stages do not always occur in the predicted 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 couple and family therapy. The individual lifecycle model presented in Table 1.6 offers a framework within which to comprehend such personal dilemmas.

GENDER-ROLE DEVELOPMENT

One important facet of identity is gender-role.[105] This area deserves particular consideration because a sensitivity to gender issues is essential for the ethical practice of family therapy. From birth to 5 years, children go through a process of learning the concept of gender. They first distinguish between the sexes and categorize themselves as male or female. Then they realize that gender is stable and does not change from day to day. Finally, they realize that there are critical differences (such as genitals) and incidental differences (such as clothing) that 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. Based on these scripts, they develop gender schemas, which are cognitive structures used to organize 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. 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 nurturing 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 that 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. Girls show more rapid language development than boys and earlier competence in maths. In adolescence, boys' competence in maths exceeds that of girls, and their language differences even out. Males perform better on spatial tasks than girls throughout their lives.

While an adequate explanation for gender differences in 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). Numerous studies show that parents expect different sex-role behaviour 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 co-operative and relationship orientated. A problem with traditional gender roles in adulthood is that they have the potential to lead to a power imbalance within couple relationships, an increase in couple relationship distress, 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. The androgynous youngster develops both male and female role-specific skills. Gender stereotyping is less marked in families where parents' behaviour is less gender-typed, where both parents work outside the home, and in single-parent families. Gender stereotyping is also less marked in families with high SES.

SEXUAL AND GENDER MINORITY LIFECYCLES

Sexual and gender minorities include people who self-identify as lesbian, gay, bisexual, transgender, queer, questioning, intersexual, and other non-heterosexual orientations, or as LGBT, LGBTQI+, or other similar acronyms. In what follows, the term LGBTQI+ will be used. In 2024, the prevalence of LGBTQI+ individuals across 26 countries in an Ipsos survey was 11%, with a higher prevalence among younger people.[106] When LGBTQI+ individuals engage in family therapy, it is important that frameworks and research findings that take account of their sexual and gender identity be used to conceptualize their problems.[107]

LGBTQI+ Identity Formation

Research on LGBTQI+ sexual and gender identity formation has provided useful information on developmental milestones. In a review and meta-analysis of 30 studies of lesbian, gay, and bisexual people, Hall and colleagues found the following average ages for sexual orientation identity milestones[108]:

- Attraction to same-sex partners: 12.7 years
- Questioning one's orientation: 13.2 years
- Self-identifying as gay, lesbian, or bisexual: 17.8 years
- Sexual activity with same-sex partners: 18.1 years
- Coming out: 19.6 years
- Romantic relationship with a same-sex partner: 20.9 years.

However, there was considerable variability in the timing and developmental sequence for reaching these milestones. In all studies, attraction was the first milestone, and commonly occurred at puberty. Self-identification or 'coming out to the self' typically occurred before coming out to others.

In a review of research on transgender identity formation, Doyle found that gender incongruence and gender dysphoria typically reach a critical point between 10 and 13 years.[109] Gender incongruence is a mismatch between the gender assigned at birth and the felt gender identity. Gender dysphoria is distress due to gender incongruence. The timing of this milestone coincides with biological changes associated with puberty, and peer pressure to conform to gender roles associated with the gender assigned at birth. Feelings of gender incongruence and dysphoria motivate self-identification, or 'coming out to the self' as transgender. Coming out to others usually occurs later in adolescence or young adulthood. However, there is considerable variability in the timing of these milestones. For transgender people, 'passing' refers to successfully concealing their transgender identity so that others view them as cisgender. Passing may be used to avoid discrimination and violence in social situations where transgender people feel threatened by prejudiced cisgender people. In some jurisdictions (e.g., England), failing to disclose transgender identity to a cisgender romantic partner, in some circumstances, is a punishable crime. When transgender individuals successfully pass as cisgender, some find that they are excluded from the LGBTQI+ community and lose this important source of support. Family and friends may demonstrate support for transgender individuals by using appropriate pronouns and using a transgender person's current name rather than their birth name. Using their birth name is referred to as 'deadnaming'.

While there are distinct differences between issues faced by lesbian and gay individuals and transgender individuals outlined above, both groups, and indeed others within the LGBTQI+ community, share certain common identity formation processes.[107,110] The LGBTQI+ adolescent typically

faces a dilemma of whether to accept or deny the homoerotic feelings or gender incongruence and dysphoria they experience. 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 prejudiced attitudes within their families, peer groups, and society will have severe negative consequences for them, they may be reluctant to accept their sexual or gender identities. Attempts to deny homoerotic or gender incongruence and dysphoria experiences and adopt a heterosexual or cisgender 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 and gender orientations, and where there is an accessible, supportive LGBTQI+ community, then the benefits of accepting their LGBTQI+ identity may outweigh the risks, and the adolescent may begin to form an LGBTQI+ self-definition. Once the process of self-definition as LGBTQI+ occurs, the possibility of 'coming out' to others is opened up. This process of coming out involves coming out to other LGBTQI+ people; to heterosexual and cisgender 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 destabilization. They progress from subliminal awareness of the young person's sexual or gender orientation to absorbing the impact of this realization and adjusting to it. Resolution and integration of the reality of the youngster's sexual or gender identity into the family belief system depend 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 or gender identity. Compared to their heterosexual and cisgender peers, LGBTQI+ young people (especially transgender youth) experience less support and more strain from their families of origin, and this is linked to negative mental health outcomes.[111] Individual and family therapy conducted within this frame of reference aims to facilitate the processes of owning homoerotic or gender incongruence and dysphoric experiences, establishing an LGBTQI+ identity, and mobilizing support within the family, heterosexual or cisgender peer group, and LGBTIQ+ peer group for the individual.

LGBTQI+ 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. Slater has offered a five-stage lifecycle model for lesbian couples.[112] In the first stage of couple formation, the couple are mobilized 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 learn 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 developed a six-stage model for describing the themes central to the development of enduring relationships between gay men.[113] 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 characterized 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 same-sex couples support the following conclusions.[111] They are older and more educationally heterogeneous than their different-sex counterparts. They report relatively similar relationship quality, although their functioning is strongly influenced by external factors, notably homophobia and stigma. Same-sex couples are more likely to have an egalitarian household division of labour than heterosexual couples. Similar to heterosexual couples, same-sex couples who are married have better health than those who are cohabiting but not married.

For transgender individuals who are already in a heterosexual, gay, or lesbian relationship, coming out destabilizes the couple and leads to a new relationship phase for about half of couples, and for the other half, it leads to the dissolution of the couple's relationship.[114]

LGBTQI+ Parents

LGBTQI+ couples pursue a variety of pathways for family formation, for example, including children from a previous heterosexual relationship, adoption, surrogacy, and the use of reproductive technologies.[111] In addition to the family lifecycle tasks for heterosexual couples with children, same-sex couples who have not come out to their families of origin have this additional developmental task to address if they decide to have children. Despite these additional complexities, extensive research reviews conclude that compared with children residing in different-sex parent households, children in same-sex parent households fare just as well in terms of cognitive development, academic performance, social development, mental health, substance misuse, and early sexual activity.[111,115,116]

LGBTQI+ Families in Midlife and Later Life

In midlife and later life, LGBTQI+ families must address the same developmental tasks as other families. There are, however, additional complexities and opportunities. LGBTQI+ families must deal with a society in which the LGBTQI+ community is still marginalized, stigmatized, and oppressed. However, they have the opportunity to act as role models for younger generations of LGBTQI+ individuals by coming out and living authentically in the face of societal oppression.

Difficulties in managing progression through the lifecycle stages may lead couples and families of LGBTQI+ individuals to seek couple or family therapy.

DIVERSITY

The models of family and individual development and related research findings presented in this chapter have all been informed by a predominantly patriarchal, Western, White, middle-class, Judeo-Christian sociocultural tradition. However, in Westernized countries, we now live in a multi-cultural, multi-class context. A significant proportion of clients who come to couple and 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, ethnicity, gender, and class is essential.[117]

This type of sensitivity involves an acceptance that different patterns of organization, 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 socio-economic 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. Guidelines for socioculturally attuned family therapy are given in Chapter 6.[118]

SUMMARY

The family lifecycle may be conceptualized as a series of stages, each characterized by a set of tasks family members must complete to progress to the next stage. Difficulty in completing tasks may lead to adjustment problems for one or more family members and to a referral for family therapy. Problems young adults experience in developing emotional and financial autonomy from the family of origin may occur in the 'leaving home' stage of the family lifecycle. These may find expression in a variety of ways, including educational problems, work-related difficulties, depression, drug misuse, eating disorders, significant conflict between young adults and their parents, or criminality. In the couple formation stage of the family lifecycle, couple relationship distress and intimate partner violence may lead to referrals for couple therapy. For families with young children, referrals for family therapy may occur when parents have difficulty establishing effective parental teamwork routines for meeting children's needs for safety, care, control, and cognitive stimulation, and children present with emotional, behavioural, or developmental problems. For families with adolescents, referrals for family therapy may arise when parents are challenged by meeting their adolescents' needs for increasing autonomy, while also meeting the demands of supporting their ageing parents. Entry into the launching stage of the family lifecycle may be blocked where children or parents have significant disabilities, physical or mental health problems, or significant financial constraints, all of which may lead to a referral for family therapy. In the final two stages of the family lifecycle, covering late middle age and families in which parents are nearing the end of life, referral for family therapy may involve loss-related problems associated with grief processes. A series of extra stages in the family lifecycle occur in a significant minority of families who experience transformation through separation, divorce, and remarriage. Difficulties completing the complex tasks associated with these extra family lifecycle stages may lead to parents and children experiencing physical and mental health problems and adjustment difficulties, which may lead to a referral for family therapy.

The development of individual identity, within a family context, may also be conceptualized as a series of stages, each of which entails a dilemma that affords an opportunity to develop a personal strength or virtue, on the one hand, or a vulnerability or pathology on the other, depending on the supports and skills available to the individual during that stage. The ease with which successive dilemmas are managed is determined partly by the success with which preceding dilemmas were resolved. 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. A sensitivity to these themes relevant to individual development may inform family therapy.

In the development of LGBTQI+ identities, two significant processes are self-definition or coming out to the self and coming out to others. The more supportive the responses of others during these coming out processes, the better the adjustment of the individual and the family. In response to the process of 'coming out', families undergo a process of destabilization, and this may lead to a referral for family therapy. Where LGBTQI+ individuals form new families, their passage through the stages of the family lifecycle may be more challenging than for heterosexual couples and prompt them to request a referral for couple or family therapy.

When family therapists work with individuals from ethnic minorities and lower socio-economic groups, 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.

GLOSSARY

ACEs. Adverse childhood experiences, including child maltreatment; parental death, separation, or divorce; family members having mental health or substance use problems or imprisonment; and witnessing or experiencing intrafamilial or extrafamilial violence.

Family lifecycle. A sequence of family developmental stages, involving processes and tasks. McGoldrick's model has seven stages: leaving home, forming a couple, families with young children, families with adolescents, launching children, moving into midlife, families with parents in late middle age, and families with parents nearing the end of life.

Gender dysphoria. Distress due to gender incongruence.

Gender incongruence. A mismatch between the gender assigned at birth and the felt gender identity.

LGBTQI+. Acronym for sexual and gender minorities, including lesbian, gay, bisexual, transgender, queer or questioning, intersex, and others.

PACEs. Protective and compensatory childhood experiences include unconditional love from a primary caregiver; having a best friend; volunteering in the community; being part of a group; having a mentor; having a safe and clean home with enough food; getting a good education; having a hobby; getting plenty of physical activity; and having rules and routines.

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Australian Association for Family Therapy: https://www.aaft.asn.au.
European Family Therapy Association: https://europeanfamilytherapy.eu.
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