THE UNIVERSITY OF CALGARY

THE FAMILY LIFE CYCLE: A SURVEY OF THE DEVELOPMENTAL CHARACTERISTICS OF CLIENTS ENGAGED IN RESIDENTIAL TREATMENT

BY

RICK WESTMAN

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF SCIENCE

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

CALGARY, ALBERTA

MARCH, 1986

ISBN 0-315-30020-5

THE UNIVERSITY OF CALGARY

FACULTY OF GRADUATE STUDIES

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled "The Family Life Cycle: A Survey of the Developmental Characteristics of Clients Engaged in Residential Treatment", submitted by Rick Westman in partial fulfillment of the requirements for the degree of Master of Science.

Chairman, Dr. L.W. West
Department of Educational Psychology

Dr. H.A. Altmann
Department of Educational Psychology

Mr. R.K. Tomlinson
Faculty of Social Welfare

Date March 19, 1986.

ABSTRACT

In this descriptive study the family histories of 100 recent clients of a residential treatment centre for children and adolescents were examined for useful generalizations about the clients' developmental experience. Several significant differences between male and female identified clients were uncovered. Consistent with previous research, intact nuclear families (29%) were heavily under-represented in this clinical sample. The overwhelming majority of clients (84%) had diverged in some way from the normative family life cycle (FLC) model, with accelerated marriage (17%), accelerated parenthood (9%), marital disruption (70%), single parenthood (71%), and remarriage (45%) characterizing their developmental history. From the obtained results it was inferred that the typical client at this centre will have experienced a relatively complex FLC history and that, accordingly, in order to address the client's particular treatment needs satisfactorily specialized programs reflecting an informed appreciation of alternative forms of family development will be required.

ACKNOWLEDGEMENTS

I wish to thank Dr. Lloyd West for encouraging me to embark upon a study of this nature and for the sensitive direction and insistence on quality that he maintained throughout the time that he supervised this project.

I also wish to express my sincere appreciation to my employer, the William Roper Hull Home, for enthusiastically supporting my request to conduct this research at the agency while I continued to work at the centre. In particular, I want to thank Gerry Fewster, Executive Director, for his strong support of this venture as well as George McBride, my immediate supervisor, for allowing flexibility in hours and work assignments while this research was in progress.

Finally, to my own family, to my wife Cindy and my daughters Jessica and Sarah, I express my deep gratitude for the unwavering affection which they have shown to me as well as their gracious willingness to sacrifice temporarily deserved time and attention during a very busy stage of our family life cycle.

CONTENTS

List of Tables

LIST OF FIGURES

CHAPTER ONE

INTRODUCTION

The present study examines a sample of clients engaged in residential treatment in order to determine whether there are useful generalizations that can be made about the developmental experience of these families. Are there commonalities of experience that can be identified across this clinical population? How much variability exists among these families in terms of their developmental history? As a descriptive study of clinical families, this research was designed to provide a detailed and comprehensive mapping of a single important dimension of the client's life: the family life cycle.

The family life cycle (FLC) construct provides an explicit normative schedule of the predictable stages of development experienced by the majority of contemporary North American families. As a heuristic device integrated with current demographic data, the FLC construct offers a useful means of tracking the life-course of nuclear families from formation to dissolution. Although in actual experience the family's history flows in a continuous, unbroken stream from one phase to the next, for analytical purposes the FLC formulation arbitrarily punctuates this

evolutionary process into a series of discrete developmental stages or milestones in each of which there is a predominant growth-related challenge, or developmental task, which must be mastered. According to this developmental formulation, there is a great deal of predictability not only in the content of these developmental stages but also in the timing and sequence of these life cycle transformations. Timing here refers to the pace at which developmental milestones occur (e.g. age at first marriage); sequence refers to the ordering of developmental events in relation to other developmental events (e.g. conception of the first child prior to marriage). By utilizing current census data, it is possible to plot the usual time at which particular developmental milestones are reached as well as identifying the predominant sequence of FLC stages. The family life cycle construct, then, provides a predictable schedule of the developmental experience of most contemporary families against which the experience of particular families, or as in this case a particular class of families can be compared and contrasted. The FLC construct facilitates an examination of such questions as: To what degree does the developmental experience of clinical families correspond to that of normal families who do not require the radical intervention of residential treatment? Are developmental

milestones reached by clinical families at approximately the same time and in the same sequence as nonclinical families? Are there FLC stages which are prolonged, truncated, or skipped over entirely by the majority of clinical families? Finally, do clinical families experience additional stages of alternative development which are generally not confronted by normal families?

In order to obtain a more accurate understanding of the developmental experience of clinical families, a survey was made of the family history of 100 recent clients of the William Roper Hull Home, a residential treatment centre located in Calgary, Alberta which serves the needs of emotionally disturbed young people and their families. Relevant developmental data were collected covering the period from inception of the family to the point of the symptomatic child's referral for residential treatment. Reference was made to information contained in existing files at the centre; thus the study was non-intrusive in that no direct contact was made with client families.

A strong case can be made for conducting a descriptive study of the developmental history of families in treatment. First of all, this remains largely uncharted territory. Not a great deal exists in the literature regarding the family life cycle characteristics of families in treatment--residential or otherwise. Even less

attention has been devoted to families engaged in residential treatment. The paucity of research on families in residential treatment is not, however, surprising. In the midst of providing intensive residential treatment to the individual family member who has been identified as the problem-bearer an orientation to the broader family context is easily lost. Because little research has been done on the historically-oriented developmental dimension of clinical families, it appeared timely to conduct a study of this important aspect of the family experience.

Secondly, much of the data necessary for this research project was already existing in fairly accessible, albeit raw, form. At the time of referral to residential treatment and subsequently, considerable developmental history is collected from clients. Although this background information was being utilized by agency staff on an individualized basis for the purposes of diagnosis and case planning, its potential usefulness as a source of more generalized knowledge of the developmental experience of agency clients had apparently been largely overlooked. It was insufficiently acknowledged that, if considered collectively, this same clinical information could serve the additional, broader purpose of revealing trends and commonalities in the developmental experience of agency clients. Because much relevant historical information is

contained in client files, the opportunity was afforded to collect and analyze these developmental data without a great deal of preliminary work. It appeared irresponsibly wasteful to not exploit fully this opportunity to extend the existing knowledge base concerning agency clients by means of generalizing about their developmental experience. Apart from the relative accessibility of the information, another significant advantage of examining existing files was that it allowed for a non-obtrusive research design. Because the necessary information had already been obtained at an earlier date for a different purpose, there was no need for the researcher to make direct contact with the families involved in the study and thereby potentially disrupt the course of their ongoing therapy.

A third important argument for conducting research on this clinical population, related to the first, is that it was believed that possessing more precise generalized knowledge of these client families would facilitate a fuller understanding of the historical context of the presenting problem and a more satisfactory addressing of their particular needs. Such descriptive analysis would provide agency staff with a clearer, more accurate image of the developmental history and current status of the typical client and would aid in the creation of therapeutic

programs carefully tailored to the unique needs of this population.

To summarize, then, this is a descriptive study of clinical families which utilizes information contained in existing files. The central purpose for this research project was to provide an accurate mapping of the developmental experience of these families, to construct a detailed and comprehensive representation of the family life cycle of clients engaged in residential treatment.

CHAPTER TWO

REVIEW OF THE LITERATURE

In family therapy literature Haley (1973) and Solomon (1973) were among the first to link the client's presenting problem (i.e. psychiatric or psychological symptoms) explicitly with difficulties in the area of family development. Haley asserts that symptoms signal a "dislocation or interruption" in the family's unfolding life cycle causing them to become stuck at a particular transition point. Solomon views the family life cycle construct as a "diagnostic base" from which to identify fixation in the family's development and to identify stage-appropriate intervention strategies. There is evidence, however, that this orientation was at least implicit in the work of family therapists prior to this time. For instance, nine years earlier, Satir (1964) recommended that a family chronology be compiled in the initial interview as an integral component in arriving at a full understanding of the client's difficulties.

In 1974 Minuchin offered a structural view of the family in which developmental stages occupied a central position. He noted that the family is subject to internal (i.e. developmental) pressure and external (i.e. social)

pressure which "require a constant transformation of the position of family members in relation to one another, so they can grow while the family system maintains continuity" (p. 60). The stress induced by family developmental transitions has the potential of triggering symptomatic behaviour.

> There are many phases in a family's own natural evolution that require the negotiation of new family rules. New subsystems must appear and new lines of differentiation must be drawn. In this process, conflicts inevitably arise. Ideally, the conflicts will be resolved by negotiations of transition, and the family will adapt successfully (p. 63).

When successfully resolved, family conflict serves as a growth opportunity for all members but when conflicts are not satisfactorily resolved the predictable difficulty inherent in negotiating normal family life cycle transitions may give rise to greater problems.

In a study of families engaged in outpatient counselling, Hadley, Jacob, Milliones, Caplan, Spritz (1974) found evidence to support the hypothesized link between symptoms and family life cycle disturbances. A significant correlation was found between the onset of symptoms and family developmental crises involving the loss or addition of family members. In their clinical experience, Barnhill and Longo (1978) found that the majority of families presenting themselves for treatment

appeared "stuck" at a particular family life cycle transition point. In those infrequent cases where developmental issues did not appear to be a major factor in the current disturbance, they found that "the life cycle stage nearly always interacts with the problem and thus becomes a relevant factor" (p. 471). In their landmark anthology, The Family Life Cycle, Carter and McGoldrick (1980) present a comprehensive treatment of the relationship between the developmental experience of the family and the presenting problems of its members. The developmental stages of the intact family are examined as well as the alternative developmental experience of the increasing proportion of families who depart from this normative evolutionary schedule.

FAMILY DEVELOPMENTAL TASKS

This orientation to viewing the presenting problem within the larger context of the client's current developmental experience owes its frame of reference to family sociologists who developed the family life cycle construct. This conceptualization focuses on the entire life cycle of the nuclear family and identifies the predictable timing, sequence, and duration of growth stages that are experienced from formation through to dissolution. By offering a normative model of the typical family's

development over the course of its history, the family life cycle (FLC) construct also provides a basis for differentiating forms of family development which diverge from this schedule. Duvall (1971) conceptualized the family unit as an organismic social system in constant interaction with its biological-social-historical context. Over time, in a fashion analogous to that of the individual, the dynamic character of the family's life together is continually transformed as the family passes through a series of growth stages. Discrete, observable milestones (e.g. marriage, birth of the first child, departure of the children, death of a spouse) herald the arrival of successive stages of development. At each of these stages it is incumbent upon family members (both individually and collectively) to master particular family developmental tasks related to their current level of development and prerequisite to their continued development.

These family developmental tasks are defined as arising from the biological pressure inherent in physical maturation, from the social pressure inherent in cultural imperatives, and from the personal aspirations of family members (Duvall, 1971). Thus, there are both internal and external sources for the emergence of family developmental tasks. Internal factors include all those intrinsic

pressures to advance developmentally which emanate from within individual family members and from within the family unit. External pressures refer to those forces for change imposed upon the individual family members and upon the corporate family unit from without. Neugarten (1976) coined the term "social time" to describe the phenomenon that, within any given social context, individuals are expected to reach particular developmental milestones and are accorded status in conformity with a normative schedule set by society. Just as biology functions as an inexorable internal regulator, so the social context exerts an equally powerful external influence on the individual's development.

> There exists a socially prescribed timetable for the ordering of major life events: a time in the life span when men and women are expected to marry, a time to raise children, a time to retire.... Age norms and age expectations operate as a system of social controls, as prods and brakes upon behavior, in some instances hastening an event, in others delaying it. Men and women are aware not only of the social clocks that operate in various areas of their lives but also of their own timing; and they readily describe themselves as "early", "late", or "on time" with regard to major life events. (Neugarten, 1976, p. 16).

Duvall (1971) asserts that the developmental tasks of the family are not merely an aggregation of the developmental tasks of its individual members, but rather

an organic composite of individual and corporate elements defined in part by individual developmental milestones and in part by developmental milestones applicable to the family as a corporate entity. At times individual tasks dovetail nicely with the predominant developmental task of the family; at other times there is incompatibility and conflict.

The succession of developmental tasks confronting the family provoke adaptations crucial to the family's physical survival and emotional wellbeing, and failure to master a particular task has dire consequences for the family as unresolved issues from an earlier stage will impede the family's future development (Duvall, 1971; Haley, 1973; Solomon, 1973). Barnhill and Longo (1978) note that, as with individuals (Erikson, 1963; Freud, 1960), if the issues pertaining to a particular developmental stage are not satisfactorily resolved, the family may become fixated at this stage and under stress may regress to an earlier, less difficult stage of development.

Levinson (1978) notes that developmental tasks are logically prior to developmental stages in that new developmental epochs are inaugurated by the emergence of a new developmental task.

> A period begins when its major tasks become predominant in a man's life. A period ends when its tasks lose their primacy and new tasks emerge to

> initiate a new period (Levinson, 1978, p. 53).

Terkelson (1980) concurs: "Each epoch is named for the principal second-order development that evokes the transformation" (p. 40).

Levinson differentiates between two categories of developmental tasks: those oriented toward homeostasis which are ascendant in stable periods of development and those oriented toward change which dominate in periods of transition. Levinson's dichotomy between developmental tasks directed to homeostasis and those directed to change is similar in some respects to Terkelson's (1980) dichotomy between first order and second order family development. Drawing heavily upon the notions of first order and second order change advanced by Watzlawick, Weakland, and Fisch (1974), Terkelson proposes that within the family life cycle there are two distinct orders of development. In first order developments, the pressure to <u>do</u> something new evokes moderate incremental changes in the behaviour of family members while the roles and status of family members and the basic structure and identity of the family remain intact. First order family development, like Levinson's category of homeostasis-seeking developmental tasks, is operative in plateau stages when the family is reinforcing the status quo following the disruptive influence of a

major second order developmental transition and the emphasis is upon the incremental integration of new roles, statuses, structures, and meanings. By contrast, second order developments are triggered by the need to be something new and the resultant change is more in the status of family members and less in their behaviour. Second order developments involve a discontinuous break with the status quo and a radical transformation in the status of family members as well as in the family's consensual reality. In the life cycle experience of families, second order development frequently stems from members' either entering or leaving the family.

FAMILY LIFE CYCLE STAGES

STAGE ONE: THE YOUNG ADULT BETWEEN FAMILIES

This stage begins with the individual's departure from the family of origin and the establishment of an independent existence which is physically and emotionally separate from parents and siblings. After approximately eighteen years of living in a dependent relationship with his/her parents, this transition to an independent existence outside the safety and familiarity of the home represents a highly discontinuous break with the past. This event signals an important milestone in the young person's passage from childhood to adulthood and is also a

very significant transition for the family. Although traditional FLC formulations skip over this preliminary stage, the developmental changes occurring during this critical period will have a very significant impact upon the young person's future family life. Dire consequences may ensue if the young person does not experience this hiatus between families and instead steps directly from the dependency of his/her family of origin to the manifold responsibilities of establishing his/her own nuclear family. Haley (1980) has devoted an entire book to conducting therapy with individuals and families stuck at the critical transition point of leaving home. In order to step confidently over the threshold from childhood into adulthood and competently assume adult responsibilities, it is necessary for an interim developmental stage in which the young adult can prepare himself/herself to take on this task. Effecting a physical separation from the family home launches the young adult into a radically new life situation and sets the stage for important transformations in status and meaning which will follow.

The primary developmental task of the young adult is to come to terms with his/her family of origin such that the process of individuation is complete but the two generations are not cut off emotionally (Carter & McGoldrick, 1980). Wald (1981) states that the primary

developmental dilemma confronting the parent-child subsystem during the launching transition is connection versus detachment and an appropriate balancing of these polarities must be attained. Meyer (1980) notes that there are three areas in which the young adult must effect individuation from parents: financially, emotionally, and functionally. According to Erikson's (1963) developmental formulation, this period includes the stages of Identity and Intimacy. Having begun the task of establishing a clear sense of one's own identity several years earlier while still a young adolescent living at home, the act of physically separating from one's family of origin heightens the saliency of this issue as it is now very meaningful for the individual to redefine who he/she is apart from his/her parents. Following upon this developmental task of redefining oneself as an individual is the highly discontinuous task of establishing intimate relationships with nonfamily members. Possessing a newly-defined sense of self, the individual must now unite in close affiliation with others. Lidz (1968) agrees with Erikson that in this stage the individual is confronted with the two most important decisions to be made in life: marital choice and occupational choice.

The precondition for tackling these two important decisions satisfactorily, Meyer (1980) asserts, is for the

young adult to have first attained the joint goals of effecting an appropriate degree of separation from one's family of origin and establishing a clear sense of one's personal identity. Otherwise, the individual's choice of a career and choice of a mate will hardly be an independent one. Rather, the dependent young adult will continue to make decisions either in overt compliance with, or in covert reactive opposition to, parental wishes.

STAGE TWO: ESTABLISHING A NEW FAMILY

This stage of family development extends from the couple's courtship to the conception of their first child. According to Wald (1981), the central developmental task of this stage is to achieve an appropriate balance between marital interest and self interest "so that the marital unit becomes a complementary and viable working relationship where accomodation, mutually supportive interactions, and positive bonding prevail" (p. 118). The key to successful mastery of this developmental task is to maintain a satisfactory balance between unity and engulfment. As McGoldrick (1980) puts it: "The basic dilemma in coupling is the confusion of closeness with fusion" (p. 96) wherein individuals abandon themselves in their marital relationship in the hope that the fused couple relationship will serve to complete what they

believe is lacking in their own personal identity and sense of worth. Both Satir (1967) and Bowen (1978) attribute this orientation toward fusion to the failure of the young adult in the previous stage to differentiate satisfactorily from his/her family of origin. Having never acquired an independent personal identity, the marital partner simply replaces one undifferentiated dependent relationship (with the family of origin) with another undifferentiated dependent relationship (with the spouse). This first order, "more of the same", substitution response (Watzlawick et al, 1974) is clearly maladaptive as what is required is a second order transformation to a radically new kind of relationship: interdependence between two equal partners. The discontinuity between the central developmental task of this stage and the preceding stage makes the adjustment to married life very challenging. Whereas the unattached young adult faces the task of arriving at personal conclusions about an array of significant issues, it is incumbent upon the new couple to compromise with one another in constructing a corporate lifestyle which reflects the personal philosophy of both individuals.

Singer (1980) notes that in the quest for intimacy in early marriage frequently differences are glossed over in a mythical "yearning for symbiosis" (p. 36). At the other

extreme, fear of losing one's identity in the oneness of marriage may result in a partner's overstating differences in the relationship. Bach and Wyden (1968) assert that marital fighting often serves the purpose of creating necessary distance in the marital system when one or both of the spouses is experiencing the threat of engulfment.

According to Satir (1967), learning to resolve differences satisfactorily is critical to the establishment of a successful marriage and the partners will be heavily influenced by the patterns of marital negotiation witnessed in their respective families of origin. Upon moving in together, the couple must reach agreement concerning a host of matters, both momentous and mundane. As Haley (1963) notes, negotiating rules for a specific situation frequently arouses strong emotions due to the fact that at a higher, largely implicit level, the marital couple is engaged in the process of deciding by precedent who will set the rules in the relationship, i.e. which partner is in charge.

A second developmental task for the marital partners in this stage is to continue the transformation being effected in their primary attachment structure. If development is proceeding on schedule, in the preceding stage the young adults will have made a significant shift away from the primacy of their families of origin. In this

stage the process is less one of moving away from the original family and more a matter of moving toward a new family system. The deepening couple relationship gradually eclipses family of origin relationships as the focal point of emotional allegiance and the primary source of emotional gratification. During this highly romantic period, the boundary between the young adults becomes increasingly diffuse while the boundary between the couple and outsiders becomes an increasingly isolating barrier. In Combrinck-Graham's (1985) terms, this is clearly a "centripetal" period in the couple's relationships wherein the couple's enmeshment is adaptive and nonpathological and functional in fostering the sense of being an intimate unit. Thus it increasingly evolves over time that the young adults' source of emotional gratification is one another. However, as McGoldrick (1980) notes, if this relationship becomes too exclusive and too intense--to the point that each partner's sole meaningful relationship is with the other--the relationship circuits will eventually become overloaded and the relationship will become untenable.

Ideally, the preparental stage will be of sufficient duration to facilitate the couple's mastery of these developmental tasks. Freedom from the responsibilities of parenting in this early phase of the couple's life together

appears to be a boon to present and future marital adjustment. Orthner (1975) notes that in critical transitional phases of the marital career, shared leisure activity eases the adjustment process, and this is particularily timely in the initial stage of marriage. Many couples radically foreshorten this preparental stage thereby intensifying the difficulties of early marriage and early parenthood.

Although couples, and especially women, report this initial period to be the happiest phase of marriage (Campbell, 1975), it is also one of the most challenging transitional periods in the couple's marital career. As McGoldrick (1980) notes, the prevailing romanticized view of early marriage as an idyllic time may, in fact, add to the couple's difficulty as cultural expectations cause them to minimize the difficulties inherent in beginning life as a married couple. As the couple colludes in denying conflict, marital problems are buried, only to intensify and resurface at a later date.

Demographic studies suggest that there is an optimum period in which to become a couple. Glick (1977) and Glick and Norton (1977) note that teenage marriages (i.e. those occurring prior to age 19) are twice as likely to fail than are marriages which occur when the spouses are in their twenties. Likewise, compared to those marrying in their

twenties, women who marry after age 30 are one and one-half times as likely to divorce. These statistical findings are consistent with Neugarten's (1976) contention that life cycle events are much more likely to be traumatic if they occur "off-time" rather than within the expected developmental timetable.

STAGE THREE: THE EXPANDING FAMILY

This stage begins with the conception of the couple's first child and extends until the departure of the first child from the home approximately twenty years later. The Expanding Family stage of development coincides with Erikson's (1963) Generativity versus Stagnation stage of individual development: that time in a person's life when producing progeny and guiding the next generation becomes a priority.

The arrival of the first child radically transforms the size, structure, and status of the family system. With the acquisition of an additional member there is a concomitant increase in the complexity of family relationships. The original emotional constellation of the couple must be expanded and re-aligned to make room for the new family member. With the arrival of the first child (as with the subsequent birth of additional offspring), the family is confronted with a new developmental task:

inclusion versus exclusion of family members (Wald, 1981). The addition of a third party upsets the established dyadic equilibrium and creates the precondition for triangulation and the potential for two members aligning against the third (Bowen, 1978; Bradt, 1980; Haley, 1973). Bradt (1980) notes that there are three possible family environments into which a child can be born: the family in which there is sufficient emotional space and the child is welcomed by the couple (i.e. inclusion); the family in which there is no emotional space for the child and the child is rejected (i.e. exclusion); and the family in which there is a vacuum in the marital relationship which the child is expected to fill (i.e. triangulation).

There are also significant changes in the structure of the nuclear family. With the arrival of children, the dyadic single-generation family system is transformed into a multigenerational system comprised of two additional systemic components: the parent-child subsystem, which comes into existence with the birth of the first child, and the sibling subsystem, which comes into existence with the birth of the second child (Wald, 1981). In keeping with the expanded context of the family, the couple must open the borders of their exclusive adult relationship to admit a dependent third party. Minuchin (1974) notes that a clear boundary must be drawn around the couple subsystem

which "allows the child access to both parents while excluding him from spouse functions" (p. 57).

Becoming parents represents a momentous, irreversible transformation in the status of the couple. Henceforth, regardless of other changes in their lives, they will always be parents. Though marriage vows may be dissolved and though dependent children grow into adults, parenthood is a status which lasts a lifetime (Bradt, 1980; McGoldrick, 1980). Duvall (1971) notes that for many couples the transition to parenthood represents the last major step into the adult world, a realization which may create either consternation or a satisfying sense of closure in the couple. It is critical that the new role of parent not be permitted to eclipse the prior role of spouse. Becoming a parent is not simply a matter of substituting a new role for a former one nor simply appending an additional role to that which already exists. Rather, the arrival of the first child generates a second order, interactive amalgamation of the competing roles of spouse and parent. The couple is no longer a carefree and spontaneous adult twosome responsible only to each other. The privileges of "childfree" status must be relinquished and the often onerous responsibilities of caring for a dependent child must be assumed.

The challenge of collaborating on the task of raising the next generation will severely test the resiliency of the couple relationship, particularily if there is significant divergence in the childrearing orientation of the parents. If the couple has successfully mastered earlier developmental tasks (i.e. resolving differences satisfactorily, working collaboratively, providing mutual support), they will likely adapt to this new task with a minimum of difficulty. If, however, the couple has not sufficiently consolidated their relationship in the previous preparental stage, it is probable that differences encountered in the process of joint parenting will serve to reawaken earlier conflicts and exacerbate both parent-child and husband-wife relationships.

Le Masters (1957) and Dyer (1963) found that the addition of a child to a marital dyad necessitates a fundamental role re-arrangement which constitutes a "crisis" for the couple. But in the subsequent studies of Hobbs (1965; 1968) and Hobbs and Cole (1976), it was found that couples were much less likely to describe their becoming parents in terms of crisis, and it was contended that earlier studies had overstated the problematic aspects of this transition. Nonetheless, almost all researchers (e.g. Campbell, 1975; Hoffman & Manis, 1978; Lidz, 1968; Rollins & Cannon, 1974; Rollins & Galligan, 1978) agree

that this is a potentially challenging transition and, in the overwhelming majority of cases, with the arrival of children there is a noticeable drop in the level of marital satisfaction, especially for wives. The decisive, irreversible step into parenthood and the attendant role transformation inevitably creates disequilibrium in the couple's relationship system (Lerner & Spanier, 1978). It appears, however, that the transition to parenthood is much smoother when both partners want the child (Rollins & Galligan, 1978), as there is more likely a more realistic recognition of the mixed joys and challenges of parenting.

According to Wald (1981), the central developmental task of the Expanding Family stage is stabilization as a corporate family unit versus dissolution. Unless family members can adapt successfully to an array of challenging transformations and fashion a new structure commensurate with their changing size, structure, and status as a two generation family unit, it is unlikely that they will remain intact.

STAGE FOUR: THE CONTRACTING FAMILY

This stage begins with the launching of the first child from the family and extends through the postparental "empty nest" period to the eventual dissolution of the family unit upon the death of one of the spouses. With the

younger generation launched into the world of independent adulthood, the family system contracts to its original dyadic, single generation composition.

The primary developmental task of the couple subsystem during this stage is the relinquishing of the role of active parent and a "reworking of the marital bond" (McCullough, 1980, p. 191). With the children gone, the parent role recedes to the background and the role of spouse regains the ascendancy held during the preparental period. Depending upon the quality of the marriage maintained during the extended period of active childrearing, the couple will regard the new ascendancy of the marital relationship with joy or apprehension. If there has been a longstanding history of marital conflict that has been "detoured" through the children (Minuchin, 1974), the couple subsystem will likely impede the departure of the young adult whose presence is stabilizing their relationship (Haley, 1980). In this instance when the last child has finally departed and the couple are left alone with their unresolved conflict, there is a very high probability that major dissension and possibly divorce will occur. Often with the increased leisure time available to the couple in the absence of the children new satisfactions and deeper levels of intimacy are experienced. As Cleveland (1976) notes, recent research (e.g. Burr, 1970;

Rollins & Cannon, 1974; Stinett, Carter & Montgomery, 1972) has strongly challenged the conclusion of earlier researchers (e.g. Blood & Wolfe, 1960; Feldman, 1964; Pineo, 1961) that postparental marriages are a time of dissatisfaction. She contends that couples appear to become increasingly satisfied with their marriages over time. Deutscher (1964) concludes that, considering both the joys and stresses of this stage, it is generally a period of increased happiness. Lowenthal and Chiriboga (1972) report that the majority of couples regard the transition to the postparental family as a happy time in their marriage where they can regain some of the exclusivity and closeness in their relationship that had to be set aside due to parenting obligations. Rollins and Feldman (1970) and Campbell (1975) report that marital satisfaction begins a strong upward trend with the departure of the children and the return to life as a married twosome.

In structural terms, the transition to the empty nest is a period when "centrifugal forces" (Combrinck-Graham, 1985) are predominant. The orientation is toward increasing distance and clearly demarcated boundaries between the generations and increasing proximity among members of the same generation. By leaving home and individuating from the parent generation, the young adult

declares his/her allegiance to the younger generation. In their turning away from the task of parenting the younger generation and turning toward each other to establish a deeper connection between themselves, the couple, too, return to a predominantly single-generation focus.

According to Solomon (1973), during this stage, "integration of loss" is a primary task for the couple. No doubt the role of parent has been a major component in the identity of the couple and, although relief and satisfaction may accompany the completion of the parenting task, there may also be a sense of loss. The probability is that the mother may experience this loss more keenly, particularily if she is not involved in other meaningful roles, for instance a vocational career (Singer, 1980).

ALTERNATIVE FORMS OF FAMILY LIFE CYCLE DEVELOPMENT

It is evident, then, that the developmental career of the typical family is punctuated by a series of stressful adaptations. These radical second order transformations create stress both within and between family members (Terkelson, 1980). Depending upon the resiliency and problem-solving ability of the family, these stage-specific difficulties may be resolved satisfactorily within the acute transition period or they may become crystallized into chronic symptomatic behaviour requiring professional

intervention (Haley, 1973; Solomon, 1973). It is hypothesized that, if the family life cycle of the intact family is fraught with hazards, then there is a much higher potential for problems developing in families who depart significantly from this normative schedule. Within the idealized FLC model, periods of rapid, qualitative transformation are followed by longer periods of integration which allow sufficient time for these changes to be incorporated into the philosophy and lifestyle of family members. Family members not only come to act differently but they also perceive themselves in a different light. The general developmental flow through the family life cycle stages is orderly in that there is an optimal timing and sequence for the occurrence of particular developmental events and progressive in that the mastery of earlier developmental tasks facilitates the mastery of later developmental tasks. Such is not the case with the increasing proportion of families whose developmental career diverges sharply from the four-stage FLC model outlined earlier. It is postulated that departures from the normative family life cycle model are generally in the direction of greater complexity and greater stress. Clearly, there is a wide range of possible variations from the idealized developmental schedule.

These alternative family forms, however, can be organized into the three major categories examined below.

1. ACCELERATED FAMILY LIFE CYCLE DEVELOPMENT

Included in this category are those families who are significantly "ahead of schedule" due to the truncation of a previous developmental stage, usually the Unattached Young Adult stage. Consequently, without adequate preparation, these precocious family members must deal simultaneously with two or more major developmental transitions and an abundance of incompatible developmental tasks. Examples of accelerated family development include: teenage marriage, teenage parenthood, premarital conception, and premarital parenthood. These families share in common a truncation of developmental stages and an acceleration of the family life cycle. It is clear that the occurrence of conception and/or parenthood outside the context of marriage represents a departure from the idealized schedule of family development. When procreation precedes marriage or occurs shortly thereafter, the couple's development is speeded up, often to their peril. There is a very high probability that critical tasks (i.e. individuating from the family of origin, consolidating the conjugal relationship) will not be satisfactorily completed before the onset of the next

developmental challenge. Although premarital pregnancy is more likely to affect the timing of the marriage than the decision to marry (Furstenberg, 1976; Pietropinto & Simaneur, 1979), nonetheless advancing the wedding date may severely truncate the courtship stage and the premature pregnancy will certainly foreshorten, if not totally eliminate, the preparental establishment stage of marriage.

Unfortunately, there is very little information available concerning how frequently conception or birth occurs prior to marriage in Canada. However, Glick and Norton (1977) note that in the U.S. one in three births is conceived illegitimately and that 14% of all births occur out of wedlock. (Clearly, these figures include children conceived/born between marriages.)

The literature devotes greater attention to the phenomenon of early marriage and parenthood (i.e. occuring prior to age 19) suggesting that these are regarded as more serious FLC deviations. Bacon (1974) regards early parenthood as an "accelerated role transition" at variance with the socially-prescribed life cycle timetable. Because of the premature activating of adult roles, high levels of stress may be induced which are likely to result in "social pathologies" (e.g. marital dissolution, poverty, truncated education) being manifested in family members. Due to the foreshortening of the intermediate Young Adult stage, the

adolescent mother is confronted with adult tasks before she is sufficiently prepared to assume them. Bruce (1978) notes that a lengthy adolescence facilitates the acquisition of necessary social and educational/vocational skills and that precocious parenthood powerfully frustrates this normal developmental process.

Furstenberg (1976) asserts that, in regulating the formation of new families, society tries to "protect individuals from incurring obligations that they are not yet ready to assume" (p. 5). Being biologically capable of producing children is not regarded as a sufficient precondition for establishing a family. Individuals are generally not considered adequately prepared for assuming the adult responsibilities of marriage until their early twenties when vocational training and material resources have been acquired. When marriage occurs prior to this time it is viewed as a "violation" of the normative schedule and the couple may experience strong social disapproval. In a longitudinal study Furstenberg found that when the bride was less than 18-years-old pregnancy almost invariably preceded marriage. At the five year mark, he found that young women who had conceived premaritally were more than twice as likely to be separated from their husbands. This finding is consistent with that of previous studies (e.g. Bumpass & Sweet, 1972;

Christiansen, 1963; Coombs & Zumeta, 1970; Lowrie, 1965) which found that early parenthood is positively associated with marital disruption. However, Furstenberg's study did not support the finding (e.g. Bumpass & Sweet, 1972; Burchinal, 1965; Spanier & Glick, 1980) that age at marriage is a powerful determinant of the union's stability. Instead a curvilinear relationship was found between age at marriage and marital stability with mothers 18 years and older experiencing the highest level of marital disruption. Furstenberg also found that the children of these adolescent mothers were less well-equipped in cognitive skills than their contemporaries, but he acknowledged that these findings are very provisional due to the crudeness of the measures employed.

In a longitudinal study, de Lissovoy (1973) found that high school marriages were characterized by growing dissatisfaction and that parental knowledge of child development norms was sadly lacking and mothers tended to be impatient and intolerant with their children. Bartz and Nye (1970) found that, compared to those marriages which occur "on time", early marriage is more likely to be characterized by negative affect, marital disruption, and lower social class placement of the couple.

It is not clear which developmental event--early marriage or early parenthood--is more disruptive to the marital relationship, or whether they must both occur in order to exert a profound effect. On the basis of their multivariate study, Bumpass and Sweet (1972) concluded that it is the age of the young woman at marriage, not her age at the birth of the first child, which is more closely associated with marital disruption. Moore and Waite (1981) arrived at a similar conclusion. However, McCarthy and Menken (1979) concluded that "early childbearing appears to be the more restrictive and irreversible of the two" (p. 21). Teachman (1983) found that premarital parenthood had a significant effect on marital dissolution but this was not true for premarital pregnancy. Furthermore, unions in which marriage preceded conception were found to have the highest probability of remaining intact.

Finally, it is not only accelerated development that can have a deleterious effect on families. Developmental events which are significantly delayed can also be a source of difficulty. For instance, Haley (1973) has described the consequences of delaying courtship and Glick (1977) reports that divorce is more likely in couples who marry before the age of twenty or after the age of thirty.

2. DISRUPTIONS IN FAMILY LIFE CYCLE DEVELOPMENT

Included in this category are families who have experienced the highly disruptive event of marital disruption and the ensuing contraction to a single parent family. Whether the dissolution comes about through the death of one of the spouses or through separation and/or divorce, this major dislocation of the family life cycle radically destabilizes the system and has a profound effect on family members.

It is asserted by Beal (1980), McGoldrick and Carter (1980), and Wald (1981) that an additional developmental stage--extending from the final separation of the couple to the creation of a new marital subsystem through remarriage or unmarried cohabitation--is inserted into the life cycle of these families. Wald (1981) notes that upon entry to this stage of alternative family development, family members are confronted with normal developmental tasks of the childrearing period as well as new tasks unique to the fragmented single parent family. For families broken by death, the primary developmental task is to initiate a process of mourning versus denial. For families broken by divorce, the primary developmental task is decision versus ambivalence. The couple must arrive at a clear decision to separate and achieve an emotional as well as a physical separation. The children, on the other hand, must maintain

emotional bonds with both biological parents despite physical separation from the non-custodial parent. Irrespective of the precipitating event, the single parent family must acknowledge and mourn the "losses of significant persons, the marriage, and an idealized family structure" (p. 121). With the contraction from a two-parent to a single parent family system, a critical task for family members is coping versus disorganization. Beal (1980) identifies the primary developmental task of this new stage as the resolution of the emotional attachment of family members. Whiteside (1982) summarizes the primary tasks of separation and divorce as resolving the loss of intimate relationships, establishing an effective emotional divorce, developing a new basis for self respect and independence, and renegotiating parent-child relationships. Citing their own research indicating the benefits of the divorced child's maintaining contact with both biological parents, Wallerstein and Kelly (1980) emphasize that a critical task of the divorced couple is to work out satisfactory co-parenting arrangements rather than triangulating the children into residual marital conflict.

This is usually a time of great stress as family members must adapt to a new (usually reduced) standard of living, new rules and routines, and a new single parent

lifestyle. The difficulty is exacerbated by the fact that there is a lack of support and empathy from the larger society which views the single parent family as deviant from the ideal two-parent nuclear model of the family. Weiss (1979) notes three primary sources of stress for the single parent: "responsibility overload" (because the remaining parent must make all decisions and provide for all the needs of family members); "task overload" (because there is simply too much work for one person to do singlehandedly); and "emotional overload" (because the parent must always remain "on call" to give emotional support despite a short supply of personal emotional resources). Because there is only one parent in the household, roles formerly performed by the absent spouse must now be reassigned. Frequently an older child assumes the role of parent surrogate in order to assist in the parenting task, particularily when the custodial parent is at work.

In a five year longitudinal study, Wallerstein and Kelly examined the impact of divorce on family members at different stages of development. Irrespective of age, in the overwhelming majority of cases children experienced at least temporary interference in their developmental progress. However, by 18 months after the separation, most children had passed through the acute phase of the

dissolution crisis and, to an increasing degree, were mastering the developmental tasks of this critical event and resuming their developmental pace. Girls were generally coping better that boys at this point, although there were more similarities than differences between the sexes. The potential long term deleterious effects of divorce are evident in the fact that at five years after the separation almost 40% of the children remained moderately or severely depressed. The effects of marital dissolution on adult members of the family are no less profound. Wallerstein and Kelly (1980) found that during the acute phase there was a noticeable decline in the daily functioning of the custodial parent. Hethrington, Cox and Cox (1978) found important differences between divorced and intact families in the realm of the parent-child relationship with divorced parents demanding less maturity, demonstrating less affection, communicating more poorly, and maintaining less consistency in dealings with their children. In addition, Hethrington et al found that during the acute phase of the first year both divorced partners felt more angry, rejected, anxious, depressed, and incompetent than their married counterparts. These differences were found to have diminished markedly by the two year point. The divorced, non-custodial father underwent greater initial changes in self concept than the

mother but the effects were more persistent in the mother. Not surprisingly, changes in self concept and concerns about personal identity were greatest in older couples who had been married longest. Although divorced adults (especially males) frequently experienced an upsurge in their social life intially, by the end of the first year they were experiencing a pervasive desire for emotional intimacy that was not being satisfied by the social whirl and casual sexual encounters. Happiness, self esteem, and feelings of competency in heterosexual behaviour increased steadily over the two year period for both sexes but even by the end of the second year these feelings were not as high as those for married couples. Wallerstein and Kelly assert that, while divorce may sometimes be beneficial for adults, there is no evidence that divorce is better for the children than living within an unhappy marriage. Nor is there evidence that living within an unhappy marriage is better than divorcing. Neither unhappy marriages nor divorces, they conclude, are particularily congenial to children.

Utilizing an outpatient psychiatric population, Tuckman and Regan (1966) investigated the possible relationship between the intactness of a child's home and the manifestation of behaviour problems. It was found that within this clinical population, intact families were

underrepresented and broken (i.e. separated, divorced, widowed, unmarried) families were overrepresented compared to the general population. The authors conclude that any type of broken home bears potentially harmful consequences for the child's personal and social adjustment.

Examining a clinical population, McDermott (1970) found that the duration of the presenting problem was shorter for children from divorced families than for children from intact families and complaints were much more sharply defined--usually identifiable maladjustments specifically related to home and school. Depression was also found significantly more often in children from divorced families. McDermott concludes that these findings suggest that the disturbed child may be acting out in response to a specific, recent, acutely stressful event (i.e. parental separation and family break-up).

Morrison (1974) found that in over one-half of divorced families compared to one-quarter of intact families, at least one parent had a psychiatric disorder. Unlike McDermott's (1970) finding, however, it was children from intact families who had symptoms of shorter duration. Also, depression was found as often in children from intact families as in children from divorced families. Morrison concludes that there is no clear relationship between the marital status of parents and symptomatology in their

children. In view of his findings, he suggests that it is more reasonable to hypothesize a relationship between symptomatology in parents and symptomatology in children and to regard divorce not as a causative factor but rather a symptomatic feature of parental psychopathology.

Kalter (1977) found that divorced children were heavily overrepresented in an outpatient psychiatric population: the incidence of divorce was twice that of the general population. Non-intact families (i.e. either separated or divorced) comprised over 41% of the total clinical population. Stepparent households contributed significantly more girls than boys to this clinical population and in 82% of these cases the girl was living with her biological father and a stepmother. This finding suggests that this living arrangement is particularily stressful for girls. Compared to all other groups, children from intact families were found to be much less prone to antisocial acting-out behaviour such as involvement with sex and drugs and were much more likely to display subjective psychological symptoms. Kalter concludes that this study suggests that children of divorce may be particularily "vulnerable to the types of developmental conflict that eventuates in psychiatric referral", adding: "These parameters of divorce may well serve to increase substantially the vicissitudes of

adaptively negotiating the multitude of developmental tasks confronting a child" (1977, p. 47).

The majority of previously cited studies suggest that families which depart from the intact nuclear family form are more likely to experience psychological stress which may become manifested as psychiatric symptoms. Maratz-Baden, Adams, Brieche, Munro, and Munro (1979), however, offer a minority opinion on this matter. They assert strongly that it is incorrect to assume that the nuclear family is the ideal context in which to raise children and that alternatives to the nuclear family represent a "deficit". After reviewing the literature on alternative forms of family development, they conclude that there is little evidence directly linking divorce to negative developmental consequences for the children and that parental absence (i.e. single parent families) is not directly related to delinquent behaviour, sex role development, or general psychological adjustment. Finally, they conclude that there is little evidence to support the notion that divorce and/or remarriage "causes any lasting intrapsychic damage or major deviant social behavior in children" (p. 10), asserting that it is the process of the family, not its form, which is the most critical factor in a child's personal and social development.

3. HEIGHTENED COMPLEXITY: THE REMARRIED FAMILY

Included in this category are "remarried families" who, following marital dissolution and a period as a single parent family, become reconstituted as a two-parent, two-generation family system either through legal marriage or social marriage (i.e. unmarried cohabitation). One or both of the marital partners will have been married previously before being either divorced or widowed.

Remarriage is usefully viewed as another qualitatively different stage of family development (McGoldrick & Carter, 1980; Sager, Brown, Crohn, Engel, Rodstein & Walker, 1983; Wald, 1981). The remarriage of the divorced or widowed parent signals the onset of yet another highly discontinuous stage of family development. After having recently come to terms with the loss of the marital subsystem, and the contraction of the family structure to a single parent system, family members are precipitantly launched into an expanded two-parent family system which bears a superficial resemblance to the pre-dissolution structure of their former family. Although at first glance the two-parent, two-generation remarried family may appear to be very similar to the intact nuclear family, in reality the two family types are very different. The remarried family is a deviation from the normative model of the

nuclear family in the direction of increased complexity. The heightened complexity confronting members of the remarried family amplifies the stress experienced by the family and increases the probability that major difficulties will be encountered. Cherlin (1978) notes that, despite increasing visibility, the remarried family remains an incompletely institutionalized phenomenon in contemporary North American culture. Not only must remarried family members confront difficulties unknown to intact families but there is a lack of ritualized behaviour and institutionalized precedents for solving these problems. Also there is a paucity of kinship terms and a generally negative connotation to those in current usage. Finally, there is an absence of established customs and conventions to be called upon in the unique social situations faced by remarried families.

Sager et al (1983) identify four significant areas of difference between the nuclear and the more complex remarried family system: developmental tasks, structure, purpose, and bonding patterns. The remarried family that realistically acknowledges the uniqueness of its own situation and the irretrievable loss of the original nuclear family effectively removes one major obstacle to its survival. Wald (1981) attributes the greater complexity of the remarried family to the existence of a

prior parent-child attachment, step role ambiguity, and the increased vulnerability of family members due to previous traumatic losses. While some developmental tasks are unique to the remarried family, others are familiar in that they were encountered earlier (and, for the most part, unsuccessfully) when family members were part of an intact family system. However, in the remarried family, although the essence of these "old" tasks may be unchanged, the new context in which they must be performed transforms them into a much more difficult undertaking.

THE MARITAL SUBSYSTEM

The couple must face those tasks incumbent upon all marital dyads: marital interest versus self interest; closeness versus fusion; transformation of the primary attachment structure; reconciling different backgrounds, values, preferences, etc; and resolving differences satisfactorily. But, for several reasons, the tasks confronting the remarried couple are much more complex and challenging than for the once-married couple.

First, the affective context in which these tasks must be mastered is quite different from that of a first marriage. Regardless of how optimistically the second marriage is entered into, it is very probable that vestiges of the previous marital failure will condition the spouses'

attitude and behaviour in the new relationship. McGoldrick and Carter (1980) note that "emotional baggage" from previous relationships is always carried into current relationships.

> This baggage makes us emotionally sensitive in the new relationships, and we tend to react in one of two ways: either we become self-protective, closed off, and afraid to make ourselves vulnerable to further hurt--i.e. we put up barriers to intimacy--or we become intensely expectant and demanding that the new relationships make up for or erase past hurts (p. 268).

Whereas, in the first marriage, the emotional baggage is from one's family of origin (i.e. unresolved feelings about parents and siblings), in remarriage there are at least three sets of emotional baggage: from the family of origin, from the first marriage, and from the process of dissolution and the period between marriages. Thus, the partners in a remarriage come to the relationship much more encumbered emotionally than is normally the case in a first marriage. This weight makes the task of marital consolidation much more difficult than when the partners have not been previously married. Beal (1980) suggests that childless couples divorcing in early marriage will have less unfinished business and less emotional baggage to be carried into a subsequent relationship. With no parent-child subsystem, there is less complexity in the

transition to a second marriage. When both spouses in a remarriage are childless, the couple's FLC situation much more closely approximates that of the intact nuclear family in that there is a preparental stage in which the couple can consolidate their conjugal relationship prior to the arrival of children. Duberman (1975) found that the length of the first marriage was a significant factor in the success of the remarriage with integration being more easily achieved by younger couples. In addition, remarriages following widowhood are generally more successful (Cherlin, 1978; Duberman, 1975).

Second, successful transition to remarriage remains largely contingent upon how completely the tasks from the previous stages of dissolution and single parenthood have been mastered. If the emotional divorce is far from being completed (i.e. the new couple are constantly tripping over the strewn baggage from previous relationships), intense, unresolved feelings will interfere with the establishment of the new intimate relationship. McGoldrick and Carter (1980) found that with clinical families a longer interval between marriages increased the probability of success in remarriage. Goldstein (1974) notes that while the remarrying couple is generally a little older and less naive regarding marriage, anxious doubts about their ability to sustain satisfying relationships may cause them

to react maladaptively when difficulties inevitably arise. The couple may resort to "pseudomutuality" denying all conflict out of the fear that any expression of discord signals the imminent demise of the marriage. Goldstein states that the denial of differences in remarried couples is quite different from that of the honeymooning once-married couple in that in the latter case the denial is based upon idealism and in the former case, it is based upon fear.

Third, the demands of an "instant family" conflict with the couple's need for time to consolidate as a marital unit. Wald (1981) notes that due to the immediate presence of children the couple experiences a shortage of the time, energy, and privacy necessary for early marital adjustment. Thus there is a telescoping of developmental tasks associated with the roles of spouse and parent. Under less than ideal conditions, marital and parenting responsibilies, each challenging in its own right, must be dealt with simultaneously by the remarried couple.

THE PARENT-CHILD SUBSYSTEM

Matching, if not surpassing, the complexity of the marital tasks faced by the couple subsystem is the challenge of jointly parenting the newly reconstituted family. For biological parents it is a challenge to

collaborate in presenting a united front to their children. These difficulties are notwithstanding the fact that in the nuclear family the husband and wife are "in a symmetrical position with each other vis-a-vis the ties to their mutual children in all four dimensions: biological, legal, developmental, and social" (Wald, 1981, p. 92). By contrast, in the remarried family the only basis of commonality is the social tie brought into being by the stepparent's joining the family. Lewis (1985) notes that power issues within the remarried family may run rampant due to the fact that the couple enter the new family as "unequal partners with regard to parenting functions and with an adult elsewhere who has more status as a parent than does one of the spouses" (p. 20). Biologically, legally, and developmentally the remarried couple stand in a very different relationship to the children, and this may become problematic. Depending upon the age of the children at remarriage, there may be great disparities between the couple in terms of their developmental history with the children. Due to the fact that multiple nuclear family systems are represented in the remarried family, there is the "lack of a shared developmental tie among all family members, because psychological bonds that grow from living together are there for some family members and not for others" (Wald, 1981, p. 124). Finally, the stepparent

frequently has no legal tie to, nor responsibility for, the spouse's children--unlike the noncustodial parent who remains symmetrical with the custodial parent in terms of the biological and legal (as well as, to a lesser extent, the developmental) ties with the children and who continues to wield influence over them. Unlike the nuclear family where children are the biological offspring of both parents and where marital and parental tasks are exclusive to the couple subsystem, in the remarried family, parental tasks are shared with the ex-spouse (Sager et al, 1983).

In the parent-child subsystem problems can arise either between the biological parent and child or between the stepparent and child. Because in the remarried family the parent-child subsystem(s) predate the couple subsystem, the strength of the emotional bond between the biological parent and child may pose a threat to the marital relationship. In particular, if during the previous single parent family stage generational boundaries were allowed to become blurred due to the mutual desire for a more enmeshed relationship, it may be very difficult for this parent-child relationship to be renegotiated and the new spouse to feel accepted. Related to this situation is the possibility that in the case of one or both of the adults, the previous marital failure may have shaped the belief that blood ties are stronger than marital ties and that

parent-child relationships persist over time whereas marital ties may by shortlived. This inappropriate cross-generational coalition may drive a wedge between the new couple. The custodial parent may feel guilty about the effect of the divorce and subsequent remarriage upon the children--especially if the children bitterly opposed both marital decisions--and overcompensate in maladaptive ways. Alternatively, if the child resembles the ex-spouse in appearance or behaviour, the biological parent may strongly reject the child as a bitter reminder of past failures.

Wald (1981) found that by far the most stressful problem in remarried families was the relationship between the stepparent and the stepchild. For both the parent-child and the husband-wife subsystems probably the most difficult issue is the question of the stepparent's assuming a position of authority with the stepchild. All attempts by the stepparent to provide nurturing or impose constraints upon the child may be strongly rebuffed out of resentment for the "outsider's" intrusion into the family or out of the concern that to enter into a positive relationship with the stepparent would constitute disloyalty to the noncustodial biological parent. In terms of parental power, the stepparent enters the remarried family at a disadvantage. As noted by Walker and Messinger (1979), in the intact family, the parental role is

ascribed; in the remarried family, the stepparent must achieve this role over time. The ideal arrangement is for the couple to agree that initially the stepparent will remain in the background while the biological parent is the primary parental authority.

THE SIBLING SUBSYSTEM

Whereas in the original nuclear family the ordinal position of siblings is fixed and evolves over time as new children are born, in the remarried family these positions may be abruptly altered. Fishbein (1982) notes that in the early stages of remarriage firstborn children are most vulnerable to feelings of loss, particularily the special status of parent-surrogate or spouse-surrogate which they enjoyed in the single parent family. Lastborn children are most likely to experience problems when they lose the status of being the youngest child upon the birth of a half-sibling to the remarried couple. Other possible sibling problems stemming from the complexity of the remarried family include: confusion in roles, increased sibling rivalry, alliances and coalitions among subgroups of the sibling subsystem, and the increased likelihood of sexual activity between members of this subsystem due to a loosening of the incest taboo (Sager et al, 1983).

THE WHOLE FAMILY SUBSYSTEM

The two most crucial tasks facing the remarried family system are inclusion versus exclusion of members and stabilization as a corporate family unit versus dissolution. According to Lewis (1980), it normally takes between eighteen months and three years for the remarried family to coalesce into a viable unit. Visher and Visher (1979) note that in the U.S. 40% of remarriages end in divorce within three years.

Because the remarried family includes at least two different families, there is a very high risk that as the family is reconstituted it will become stabilized along prior single parent family lines rather than as a new amalgamated family system. Whereas in the nuclear family the task of inclusion begins a year or so after marriage when the couple have established themselves as a marital unit, and the initial inclusion is between parent and child and later between siblings, in the remarried family this task is immediate and involves all subsystems and all family members simultaneously. Given the fact that at the point of remarriage a diverse group of individuals is faced with the challenge of being transformed into a primary group (i.e. where members are bound together by mutual affective concern), the normative developmental process of the small group is perhaps a better model for understanding the process of inclusion than is the normative experience

of the nuclear family. In Schutz's (1966) three-dimensional formulation, inclusion (i.e. whether one is "in" or "out" of the group) is a critical affective concern. Yalom (1975) concurs that the inclusion/exclusion question is a primary preoccupation of group members particularily in the early stages when the group is forming. Similarly, within the remarried family, family members remain very much preoccupied with whether they are accepted and whether they will accept or reject other family members and on what basis.

Much of the difficulty with the inclusion task can be attributed to the fact that, unlike the nuclear family, the boundaries around family subsystems are much less clear in the remarried family. It is often very unclear exactly who is "in" the family and indeed what "our family" defines. Sager et al (1983) note that, while the nuclear family is a relatively closed system wherein the boundary between members and nonmembers is biologically, legally, and geographically defined, the remarried family system is a relatively open system where there often is no consensus about who is a member of the family. The boundaries are necessarily much more open since parenting tasks and primary affective bonds are shared with former family members residing outside the domicile of the remarried family unit. In the extended family subsystem, the matter

of inclusion is even more complex given the presence of the original maternal and paternal kinship networks and the addition of a new step extended kinship network (Wald, 1981).

CHAPTER THREE

METHOD

Subjects

All 100 subjects included in this descriptive study were recent clients of the William Roper Hull Home, a residential treatment centre in Calgary, Alberta for emotionally disturbed young people and their families. The sample was composed of predominantly white families whose socioeconomic status ranged from middle class to lower class. In 72% of the cases the identified client (i.e. the family member referred for residential treatment) was male. This ratio of males to females was generally consistent with the 3 to 1 ratio of male to female children served by the agency at any given time.

The process for selecting subjects for the study involved an examination of the existing files of current and former clients of the treatment centre and including in the study the first 100 cases for which there was sufficient information available regarding the family development variables of interest. Because not all files contained a complete record of the family's developmental history, it was necessary to inspect 233 client files in order to collect 100 complete cases. All subjects selected

for the study were referred to the agency as recently as 1980.

Procedure

The design of this descriptive study was non-intrusive in that the data were collected from existing files of clients at the residential treatment centre and no direct contact was made with client families. The family development information contained in the agency files originated from the self-report of clients at an earlier date.

The variables of interest in this study were related to the developmental family life cycle characteristics of clinical families. Because of the complex developmental history of many of these clinical families, particularily those which become fragmented through marital dissolution and then are reconstituted through remarriage or unmarried cohabitation, it was necessary to designate arbitrarily two reference members to be focused on directly: the natural mother and the identified client. The mother was chosen as a reference point because in the great majority of cases, despite marital interruptions, she retained custody and/or primary responsibility for the child at the time of intake. The rationale for selecting the child referred for treatment as representative of the sibling generation was

that in the majority of cases, but not always, the identified client was the member of the sibling subsystem who was manifesting the greatest degree of disturbance at the time of referral to the agency. In order for a case to be selected as a subject to be included in this study it was necessary that the client file contain a complete record of the following family development variables: birthdate of the mother, the identified client, the firstborn child and the last born child; the dates of all marital (legal and social) unions and dissolution; the date of the family's first involvement with mental health professionals; and the date of the Hull Home intake conference at which the decision was made to admit the child for residential treatment. In addition, data were collected on the incidence of such developmental events as: the total number of marital unions and dissolutions; the number of children; the number of fathers and father figures; the number of previous placements of the identified client outside the home; and, in the case of reconstituted families, the number of different family units represented in the remarried household. From these data, it was possible to compute such family life cycle variables as: the mother's age at births of her children, at marital events (unions and dissolutions), at the first involvement with mental health professionals, and at the

child's admission to residential treatment; the identified client's age at the time of marital events, at the first professional involvement, and at admission to residential treatment; as well as the duration of such developmental epochs as the preparental period, the childbearing period, marital relationships, single parent family periods, and involvement with mental health professionals. Also, for each case it was noted whether the following deviations from the normative family life cycle model had been experienced by the family, namely: premarital conception, premarital parenthood, teenage (i.e. before 19 years) marriage, teenage parenthood, and intermarital conception.

Finally, in addition to these longitudinal data defining the client's history from the point of family formation to the point of intake, it was possible to compile cross-sectional data defining the family, the mother, and the identified client at this point in time. Accordingly, the following cross-sectional family life cycle variables were noted, namely: the current status of the family (intact, single parent, or reconstituted) at the time of intake; the current marital status of the mother (married, divorced, widowed, or never-married) at the time of intake; and the current living arrangement of the identified client (residing with his/her family or residing elsewhere) immediately prior to intake. It was possible to

extrapolate from this information a picture of the family life cycle experience of the families included in the study: the timing, sequence, and duration of developmental stages, and determine how closely this conforms to the idealized family life cycle model.

Following collection, these data were analyzed for the purpose of identifying areas of commonality and difference in the developmental history of this sample of clinical families. Descriptive statistical methods were employed to identify the basic distributional characteristics of the sample on each of the family life cycle variables under consideration. Consequently, this descriptive analysis yielded the mean age of the mother and the identified client at particular family life cycle milestones, the mean duration of particular family life cycle stages, and the mean incidence of particular alternative forms of family life cycle development (e.g. premarital conception and/or parenthood, teenage marriage and/or parenthood, etc.).

CHAPTER FOUR

RESULTS

As indicated in Chapter One, the goal of this research project was to generate a detailed and comprehensive profile of the most significant developmental characteristics of families engaged in residential treatment. A sample of 100 recent clients of a residential treatment centre for young people was carefully examined in order to develop a family life cycle profile. The intention was to identify the most salient developmental traits which characterize these families.

Due to the design of the project and the nature of the data that were collected, the findings of this descriptive study can be divided into two disparate yet complementary categories. First, the study provides a cross-sectional view of the families in terms of defining relevant developmental characteristics current at the time of intake. This cross-sectional category of findings includes such variables as: the age and birth order of the identified client; the age of the mother; the current marital status of the mother; the current family type (intact, single parent, or reconstituted); the current size and composition of the family; and the residence of the

identified client at the time of intake. Secondly, this same sample of families can also be viewed from a longitudinal perspective in terms of their cumulative developmental history from the point of family formation to the point of referral for residential treatment. The longitudinal category of findings includes such factors as: the number of years the family has been together as a corporate unit (i.e. the duration of their FLC history); the timing, sequence, and duration of FLC stages; the marital experience of the mother (i.e. number of marriages and dissolutions, duration of marital relationships, etc.); the experience of alternative family forms (e.g. unmarried cohabitation, single parent families, reconstituted families, etc.); and the duration of the family's prior involvement with professionals (including the ages of the mother and the identified client at the time that the initial contact was made with mental health professionals. Clearly, these two diverse viewpoints nicely complement one another and together provide a fully dimensional representation of the typical clinical family referred to this agency. Thus, what is provided is not only a distinct profile of the developmental traits most likely to characterize families at the point of intake, but also a comprehensive picture of what has generally transpired up to this point in their life together.

The analogy that springs to mind is that of the snapshot and the motion picture. Well executed, the snapshot clearly and succinctly provides a momentary glimpse of its subject. Without direct reference to past or future, the snapshot image simply records faithfully what is at a particular point in time. A clearly focused representation of the subject at this historical moment is thus rendered. By contrast, the motion picture is capable of introducing the notion of temporal process. Comprised of a sequential series of still photographs, motion picture images capture the sense of historical movement from an earlier point in time to a later one.

The snapshot view will be presented first. The following section provides a cross-sectional view of the life cycle characteristics of the clinical family at the time of referral residential treatment.

A. A CROSS-SECTIONAL VIEW OF FAMILIES AT THE POINT OF INTAKE

This section presents findings related to the current status of the family at the time of referral for residential treatment. What developmental traits characterize the typical clinical family at this point in time? The relevant cross-sectional data can be organized

around the three reference points of: the whole family system, the identified client, and the biological mother.

I. Developmental Characteristics of the Identified Client at Intake

Considering first the identified client, what does this sample reveal about the typical child referred for residential treatment? What were the most salient features comprising an accurate developmental profile of the child at this historical point in time? To be more specific: How old was the typical client at the time of intake? What was the proportion of males to females? What was his/her birth order in the family? Where was the identified client residing at the time of intake? Finally, on which of these developmental dimensions were there significant differences between male and female clients?

a.) Sex of the identified client.

Beginning with a consideration of the sex of the identified client and his/her age at the time of intake, Table 1 provides a representation of the proportion of clients from the total sample falling into each of the defined subgroups.

As indicated, males were heavily overrepresented in this clinical population: 72 males to 28 females. In

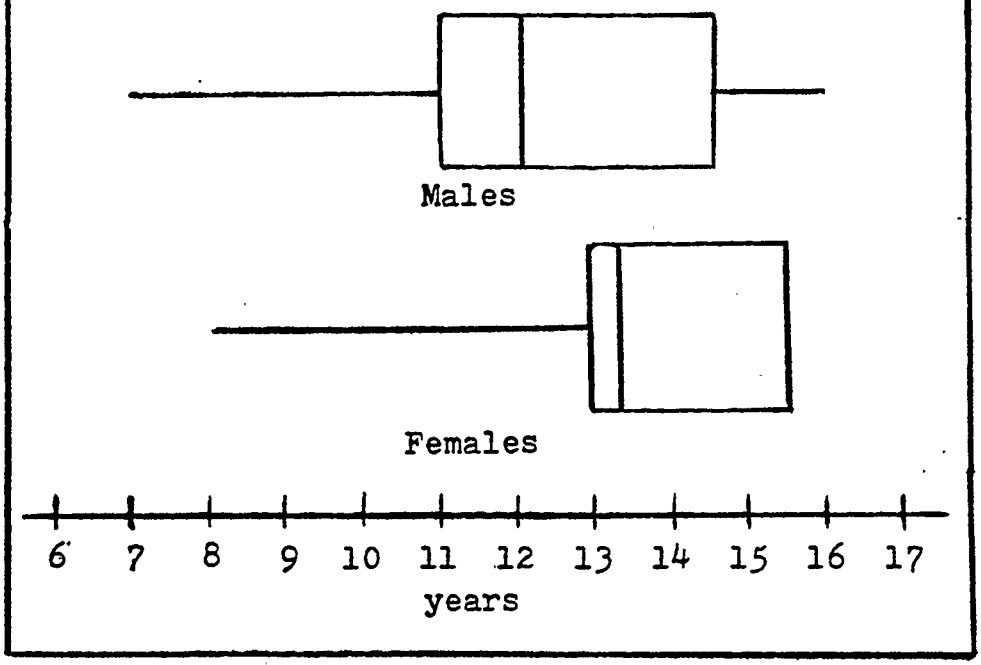
Table 1

Distribution of Clients According to Age and Sex

count row percentage column percentage total percentage	Sex: Male	Female	
Age: Pre-teen (7-12 years)	38 86.4% 52.8% 38.0%	6 13.6% 21.4% 6.0%	44
Adolesceent (13-16 years)	34 60.7% 47.2% 34.0%	22 39.3% 78.6% 22.0%	56
	72	28	100

Figure 1

Age of the Identified Client at Intake



other words, in the total sample of clinical families studied, a male child was two and one-half times more likely than his female counterpart to present as the identified client. Although this disparity was not as striking within the adolescent subgroup (61% males versus 39% females), the difference in gender representation was extreme among the preteens with 86% of this subgroup being comprised of male clients. Thus, it can be seen that within this clinical sample it was an extremely rare occurrence for the identified client to be a female under twelve years of age, whereas pre-adolescent males (by a slight majority) comprised the largest subgroup of identified clients.

b.) Age of the identified client.

The mean age for the total sample of clients at the time of intake was 12.4 years. For male clients the mean age was 12.1 and for females it was 13.3 years. One way analysis of variance indicated that this difference in the mean ages of males and females at intake is significant at $p<.01$.

The age of the identified client at intake ranged from 7 to 16 years. In Table 1 the age at intake is dichotomized into two broad categories: adolescents (13-16) and pre-adolescents (7-12). The box plots of

Table 2			
Birth Order of the Identified Client			
count row percentage column percentage total percentage	Sex: Male	Female	
Birth Order: First born	19 67.9% 26.4% 19.0%	9 32.1% 32.1% 9.0%	28
Last born	19 70.4% 26.4% 19.0%	8 29.6% 28.6% 8.0%	27
Middle child	19 70.4% 26.4% 19.0%	8 29.6% 28.6% 8.0%	27
Only child	15 83.3% 20.8% 15.0%	3 16.7% 10.7% 3.0%	18
	72	28	100

as the symptomatic member depends in part on his/her birth order. However, crosstabulation analysis indicated that, when controlled for sex and age, there was no significant association between a child's birth order and the role of identified client.

d.) Residence at intake.

At the time of admission, 57% of the total sample of clients were in the care of the larger community (e.g. residential treatment centres, group homes, temporary receiving homes, detention centres, hospitals, etc.) and 43% were residing at home with family members. Tables 3 and 4 provide a breakdown of this variable when controlled for sex and age respectively. It is evident that for this sample with increasing age there was a slightly higher probability of the identified client's not residing at home at the time of intake (55% versus 45%). With pre-adolescents the chances were almost fifty-fifty that the child would still be in the home, whereas for teenaged clients there was only a 38% chance that the youngster would be moving into the treatment centre from home. Also, males were more than twice as likely as females to be at home at the time of intake. However, neither sex nor age was found to be significantly associated with residence of the identified client at intake.

Table 3			
Effect of Sex on Residence at Intake			
count row percentage column percentage total percentage	Sex: Male	Female	
Residence: Home	30 41.7% 69.8% 30.0%	13 46.4% 30.2% 13.0%	43
Absent	42 58.3% 73.7% 42.0%	15 53.6% 26.3% 15.0%	57
	72	28	100

Table 4			
Effect of Age on Residence at Intake			
count row percentage column percentage total percentage	Age: Pre-teen	Adolescent	
Residence: Home	22 51.2% 48.9% 22.0%	21 48.8% 38.2% 21.0%	43
Absent	23 40.4% 51.1% 23.0%	34 59.6% 61.8% 34.0%	57
	45	55	100

II. Developmental Characteristics of the Mother at Intake

a.) Mother's age at intake.

The mean age of the mother at intake was 36.14 years. There was considerable variation in the age at intake: from 25.9 to 55 years. The distribution of mother's ages at the time of intake is represented in Figure 2.

b.) Mother's marital status at intake.

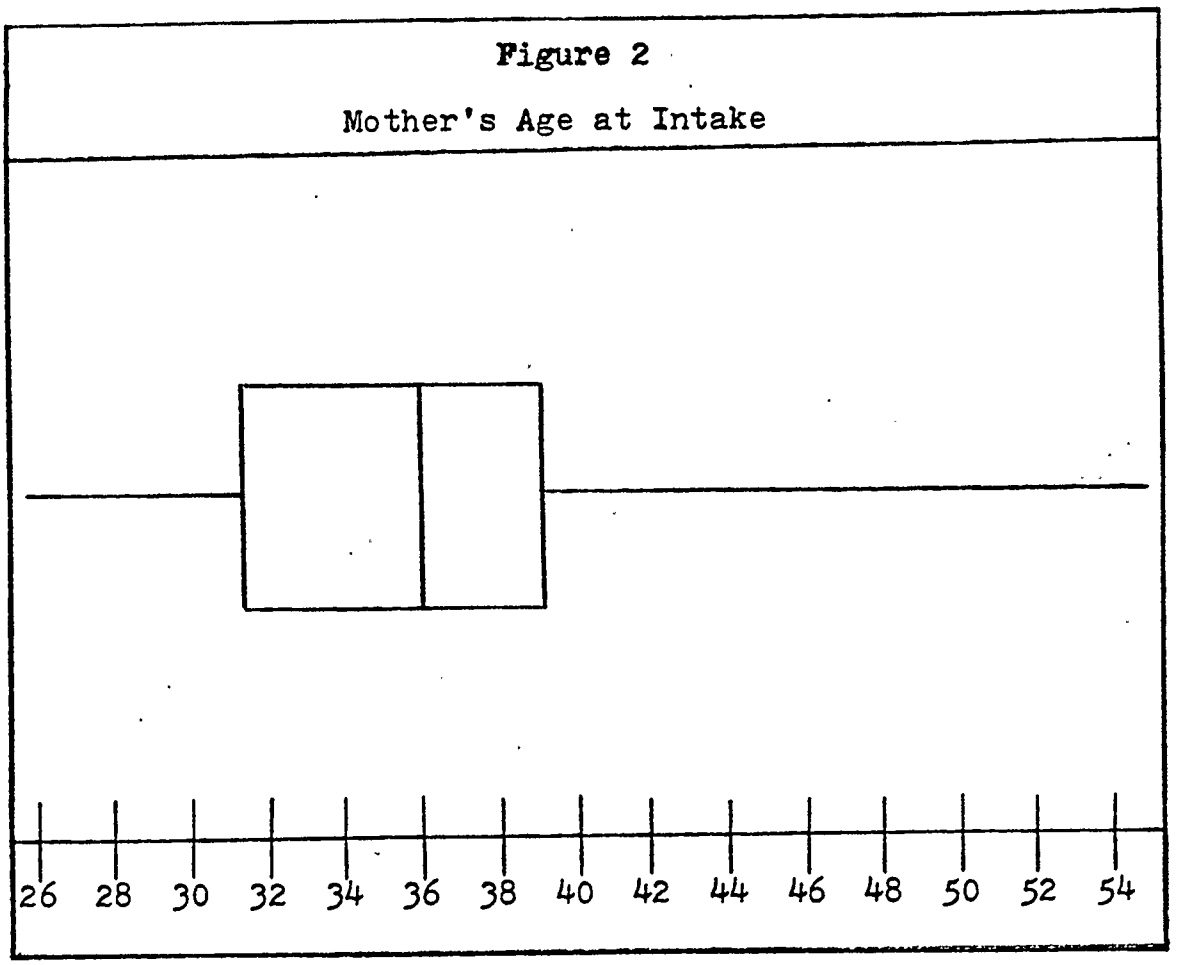
At the time of intake 48% of the mothers were legally married, 25% were currently divorced, 19% were currently separated, 2% were widowed, and 6% were never-married. Considering the functional marital status of the mothers (i.e. their conjugal living arrangement irrespective of legal status), the breakdown was as follows: 35% of the mothers were living without a marital partner and 65% of the mothers were functionally married, with 47% of these being legally married and 18% living common law.

III. Developmental Characteristics of Families at Intake

Finally, the developmental characteristics of the whole family system at the time of intake were considered in this study. This section presents findings related to the size and type of family and the number of different nuclear families represented in the current household at the time of intake.

Figure 2

Mother's Age at Intake



a.) Type of family at intake.

As indicated by Figure 3, the largest proportion (36%) of families was made up of remarried families. The remarried family group was evenly split between legally remarried stepfamilies and socially reconstituted families. This group was followed closely by the group of single parent families which comprised 35% of all families. In Canada, approximately one in ten families is a single parent family (Schlesinger, 1979). Finally, less than one-third of all families at intake were intact, once-married families.

Crosstabulation analysis was performed in order to explore the possible association between the gender of the identified client and the type of family at the time of intake. The results are displayed in Table 5. As indicated, female identified clients were equally distributed across all three categories of family types. This is a departure from Kalter's (1977) finding that a significantly lower proportion of female clients came from intact families and a significantly higher proportion came from remarried families. By contrast, males were considerably less likely to come from an intact family than to come from a remarried or single parent family.

Figure 3

Type of Family at Intake

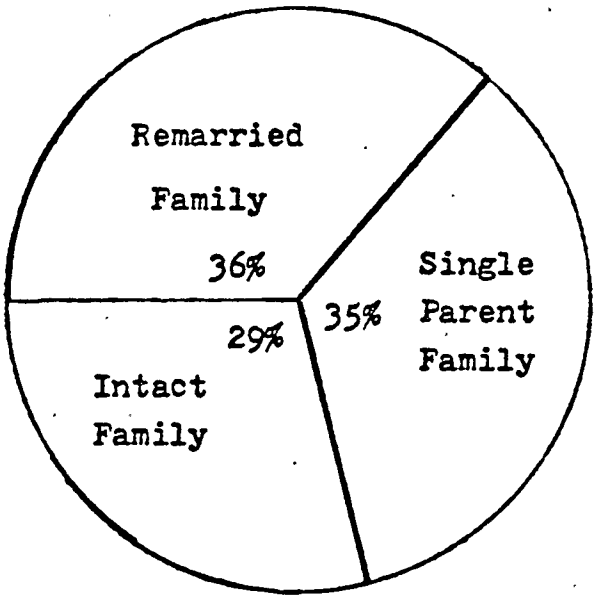


Table 5

Effect of Sex on Family Type at Intake

count row percentage column percentage total percentage		Sex: Male	Sex: Female	
Family type:	Intact	19 26.4% 65.5% 19.0%	10 35.7% 34.5% 10.0%	29
	Single Parent	26 36.1% 74.3% 26.0%	9 32.1% 25.7% 9.0%	35
	Remarried	27 37.5% 75.0% 27.0%	9 32.1% 25.0% 9.0%	36
		72	28	100

Crosstabulation analysis was also performed on the variables of the age of the identified client and the family type. Table 6 displays the results of this analysis. As indicated, in the pre-adolescent group of identified clients, intact families were under-represented, comprising only 22.2% of all families in this age group. By contrast, in the adolescent age group, there was a very even distribution across all three family types. Adolescents were almost twice as likely as pre-adolescents to come from an intact family. In the other two categories of families, pre-adolescents and adolescents were roughly equally represented.

b.) Number of different families in the household at intake.

Analysis was also made of the number of different nuclear families in the family at the time of intake. Fifty-three percent of the families were comprised of members from a single nuclear family, 37% of the families had members from at least two different families, and 10% had representation from three different families. In examining the sibling subsystems of the 36 remarried families included in this clinical sample, it became evident that 28 families (77.8%) included half-siblings while 3 families (8.3%) included stepsiblings.

Table 6

Effect of Age on Family Type at Intake

count row percentage column percentage total percentage		Age: Pre-teen	Age: Adolescent	
Family type:	Intact	10 34.5% 22.2% 10.0%	19 65.5% 34.5% 19.0%	29
	Single Parent	17 48.6% 37.8% 17.0%	18 51.4% 32.7% 18.0%	35
	Remarried	18 50.0% 40.0% 18.0%	18 50.0% 32.7% 18.0%	36
		45	55	100

c.) Size of the family at intake.

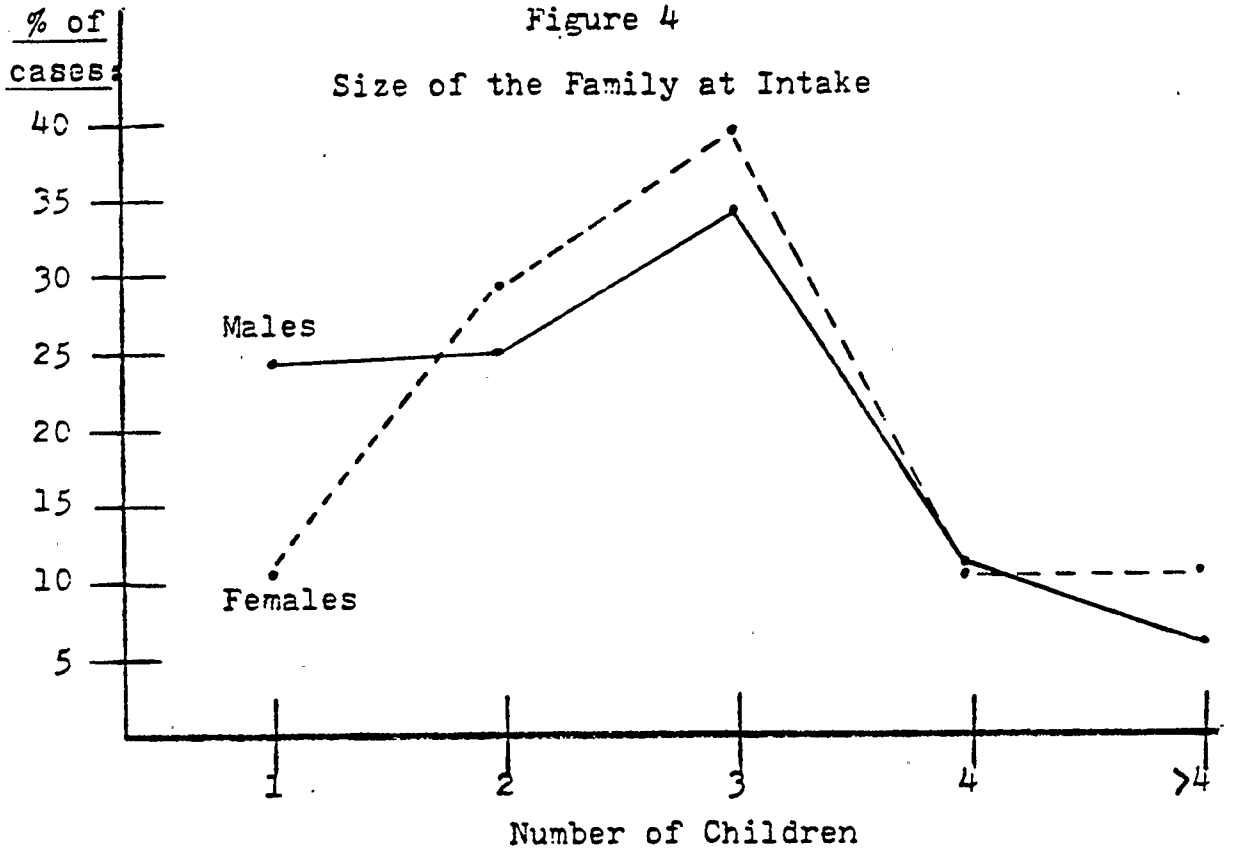
Figure 4 displays information relating to the size of the sibling subsystem at the time of intake. As indicated, over one-third of the cases were comprised of three-child families. Eighty-one percent of the families had between one and three children. The size of the sibling subsystem ranged from 1 to 12 children with the mean size being 2.8 children. In 1981, the average Canadian family contained 1.3 children (Statistics Canada, 1984). In this sample male identified clients were more than twice as likely as their female counterparts to be an only child. However, this sex difference was not found to be a significant one.

B. A LONGITUDINAL VIEW OF THE DEVELOPMENTAL HISTORY OF CLINICAL FAMILIES

In this section, findings related to the developmental history of this sample of clinical families up to the point of intake will be presented. Clearly, because this study was so designed to examine families midway through the family life cycle, it is not possible to present a complete life cycle history of these families. Nonetheless, although it is not possible to view the entire life cycle of these clinical families, the research design and the

Figure 4

Size of the Family at Intake



available information does present a fairly thorough picture of their developmental experience to this point.

What was the background history of the typical family presenting for residential treatment? How long had the family been together as a corporate unit by the time of intake? What had been the timing, sequence, and duration of family life cycle stages? How closely had the developmental experience of the family conformed to the idealized FLC model? To what degree had the family experienced alternative forms of family development? What had been the marital experience of the mother? What had been the family's prior experience with mental health professionals? These are the primary questions examined in this section. As with the previous presentation of cross-sectional data, the relevant longitudinal findings will be organized around the three reference points of: the whole family system, the biological mother, and the identified client.

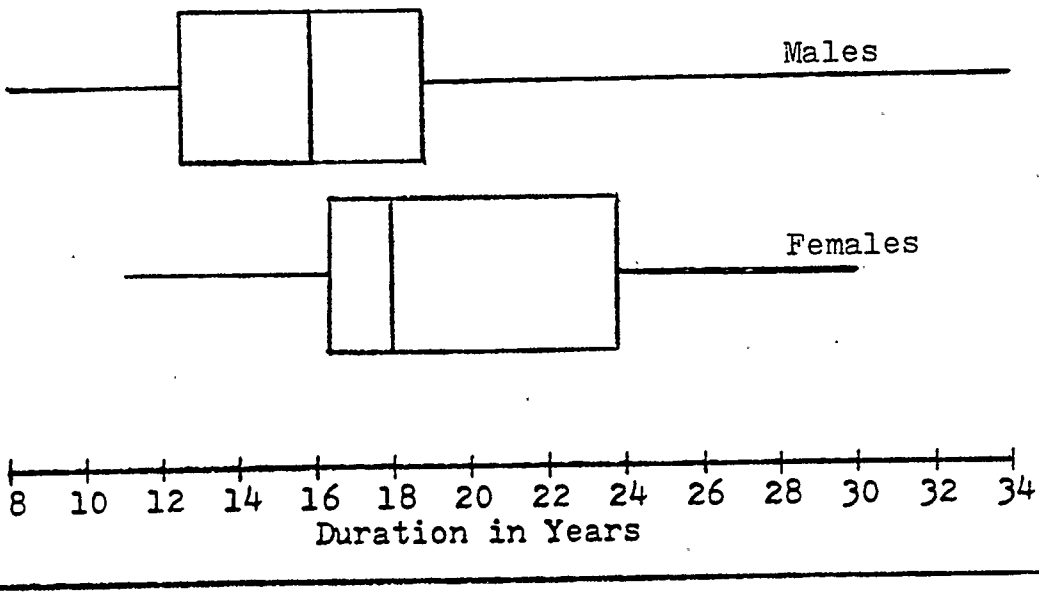
I. Developmental History of the Family

Considering first the whole family system, what does this sample reveal about the developmental experience of the typical family up to the point of intake? What was the background history of the average family being referred for residential treatment?

By the time they were referred to the residential treatment centre the average family had been together for a period of 16.75 years. There was, however, a great deal of variation in the length of time that particular families had been together. The duration of the family career ranged from as brief a period as 8 years to as long as 34 years. Figure 5 provides a representation of the distribution of the subsamples of males and females on this variable. The duration of the family's history was measured from the point that the biological mother entered a marital union (legal or social) or (if the marital union was preceded by parenthood) from the point that she bore her first child. In other words, the family career was considered to begin when the biological mother inaugurated a new family system: by joining either a marital subsystem or a parent-child subsystem. As this longitudinal examination will reveal, there was considerable variation, not only in the duration of the family life cycle career to the point of intake, but also considerable variation in the developmental experience of these families during their life together.

In terms of the normative sequence of developmental stages, the history of very few of these clinical families conformed to that of the idealized family life cycle model.

Figure 5
Duration of the Family Life Cycle



As noted earlier, at the time of intake, only 29% of all families fell into the category of intact, once-married families. In addition, the developmental experience of these intact families as well was often very different from that of the FLC model. For instance, in the history of this group of intact, once-married families: 7% of the mothers had conceived their first child premaritally, 2% had delivered the first child prior to marriage, 8% had married while still teenagers (i.e. prior to age 18), and 5% had delivered the first child while still a teenager. When these FLC-deviant cases were eliminated, only 16% of all clinical families (55% of this subsample of intact families) were found to conform to the sequence and timing of the family life cycle model. Thus, a full 84% of the families in this study departed in some significant way from the idealized model of the two-parent, once-married family.

In what ways and to what degree did this overwhelming majority of clinical families deviate from the normative model of the family life cycle? There are several important dimensions to consider.

The Marital History of the Family.

As indicated earlier, only a tiny minority of the families studied had a normal, uninterrupted marital

experience. In this section, the marital experience of these clinical families will be presented in detail.

a.) Number of legal marriages and marital unions.

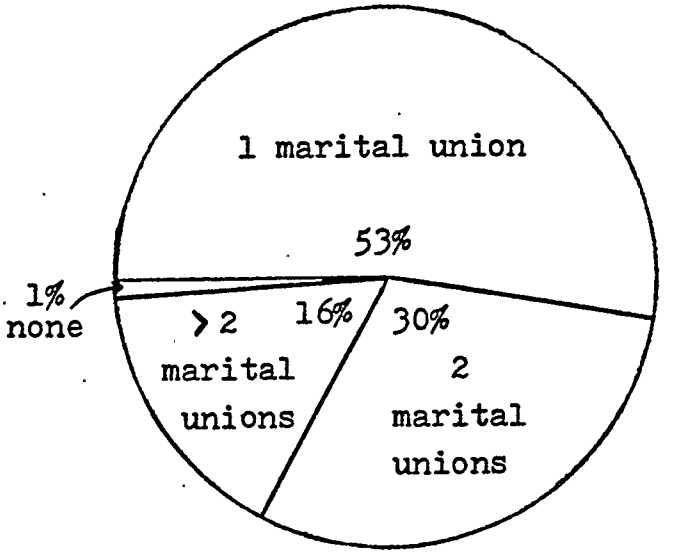
In this sample, 6% of the mothers never married, 67% were married once, 23% were married twice, and 4% were married three times. In all but 1% of the cases, the mother had been involved in at least one conjugal relationship (legal or otherwise) up to the point of intake. As indicated in Figure 6, in the majority of cases there was only one legal marriage and/or marital union experienced by the family by the time they were referred for residential treatment. However, in 46% of the cases there were at least two unions, and in 27% of the cases there was more than one marriage. Although there was a fairly high incidence of social marriages or commonlaw unions within the experience of these families (35%), 74.9% of all conjugal unions were legally sanctioned.

b.) The experience of marital disruption.

Figure 7 provides a graphic representation of the incidence of marital disruption in the experience of these families prior to intake. As indicated, 70% of these families experienced marital dissolution at least once and in 25% of the cases marital disruption was experienced more than once. The incidence of legal divorce was also very high.

Figure 6
Marital Experience of the Family

a.) Number of Marital Unions:



b.) Number of Legal Marriages:

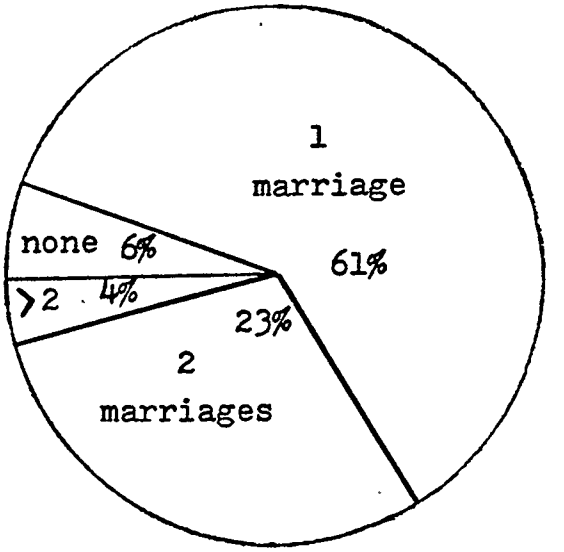
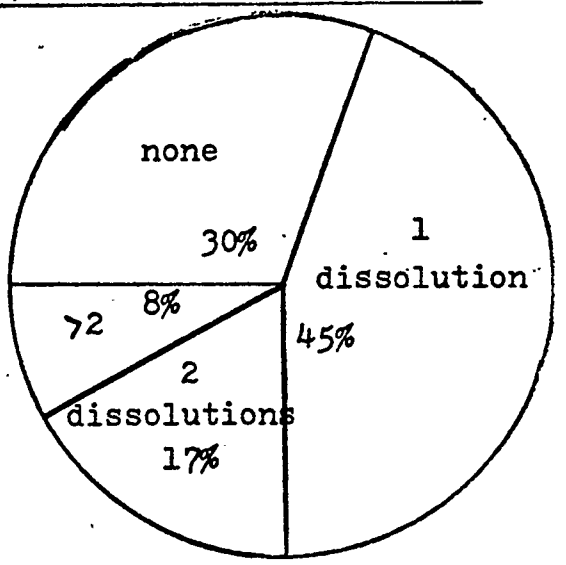
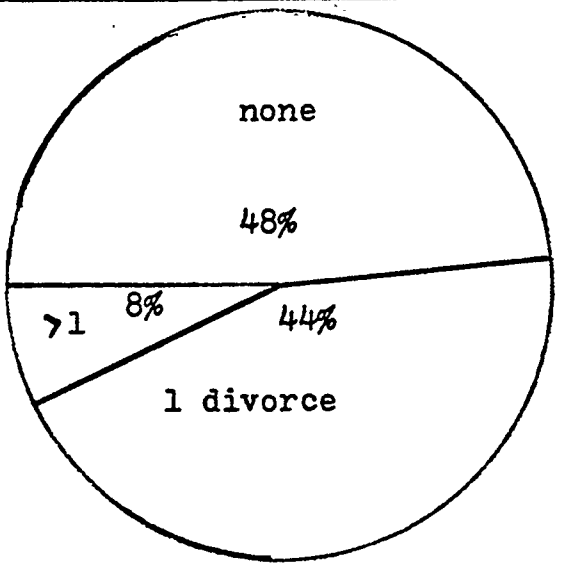


Figure 7
Experience of Marital Dissolution

a.) Number of Dissolutions:



b.) Number of Legal Divorces:



Over half of the first marriages (52%) were terminated by divorce.

c.) Duration of marital unions.

As indicated in Figure 8, the mean duration of the first marriage was 10.5 years with the duration of particular cases ranging from one year to 30 years. The mean duration of the first marital union (legal or social) was 9.8 years with the range extending from 2 months to 30 years. Over 13% of first marriages had been dissolved within three years. Also, over 28% of first marital unions were terminated within the first three years.

Figure 9 provides a representation of the duration of the 70% of first unions which ended in dissolution. In over 25% of the cases the union had ended before 3 years had elapsed; in 60% of the cases the first union had ended by the sixth year; and in slightly over 21% of the cases the union had lasted more than 10 years before being dissolved. The most likely time for a marital disruption to occur was between 3 and 6 years.

The Single Parent Family Experience.

A full 71% of the families studied had experienced life in a single parent family. In this sample, marital breakdown was the predominant cause of transformation to

Figure 8

Duration of Marital Unions

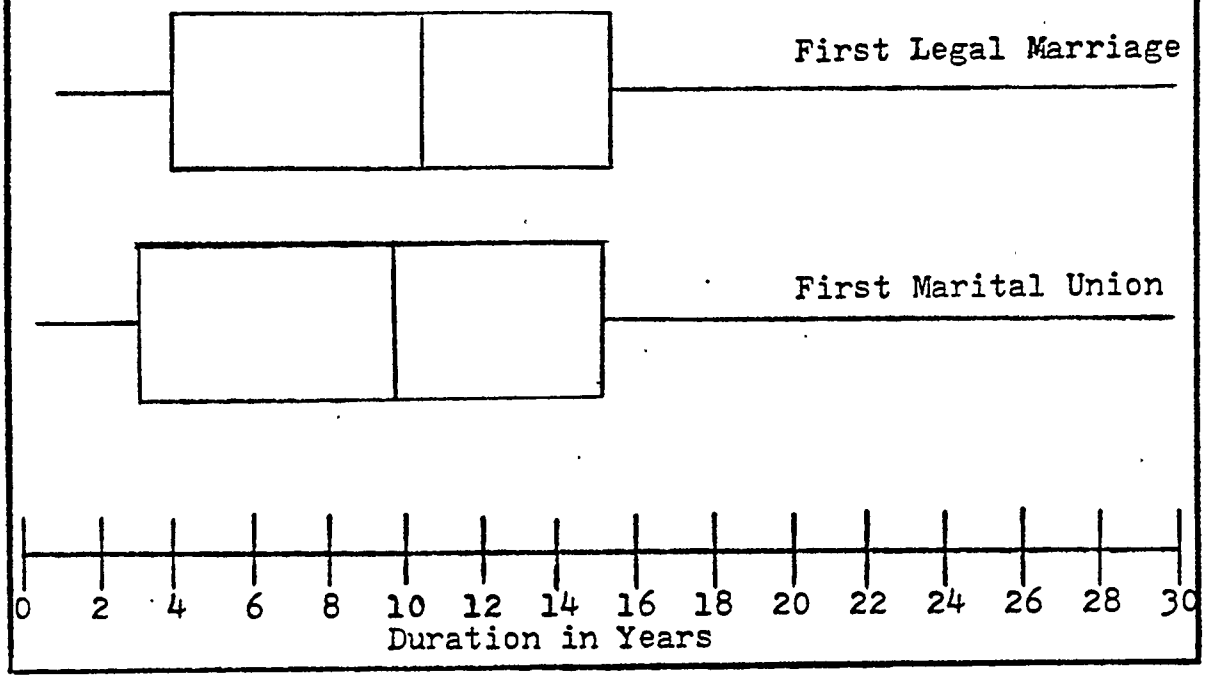
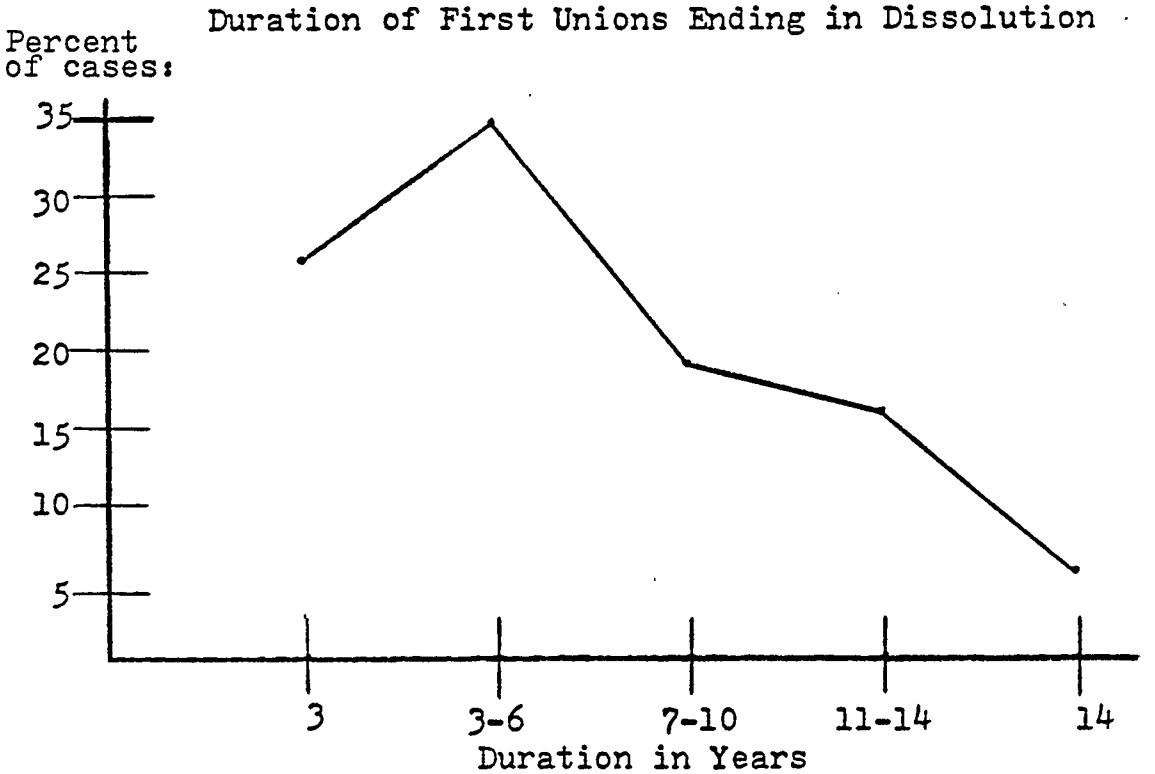


Figure 9

Duration of First Unions Ending in Dissolution



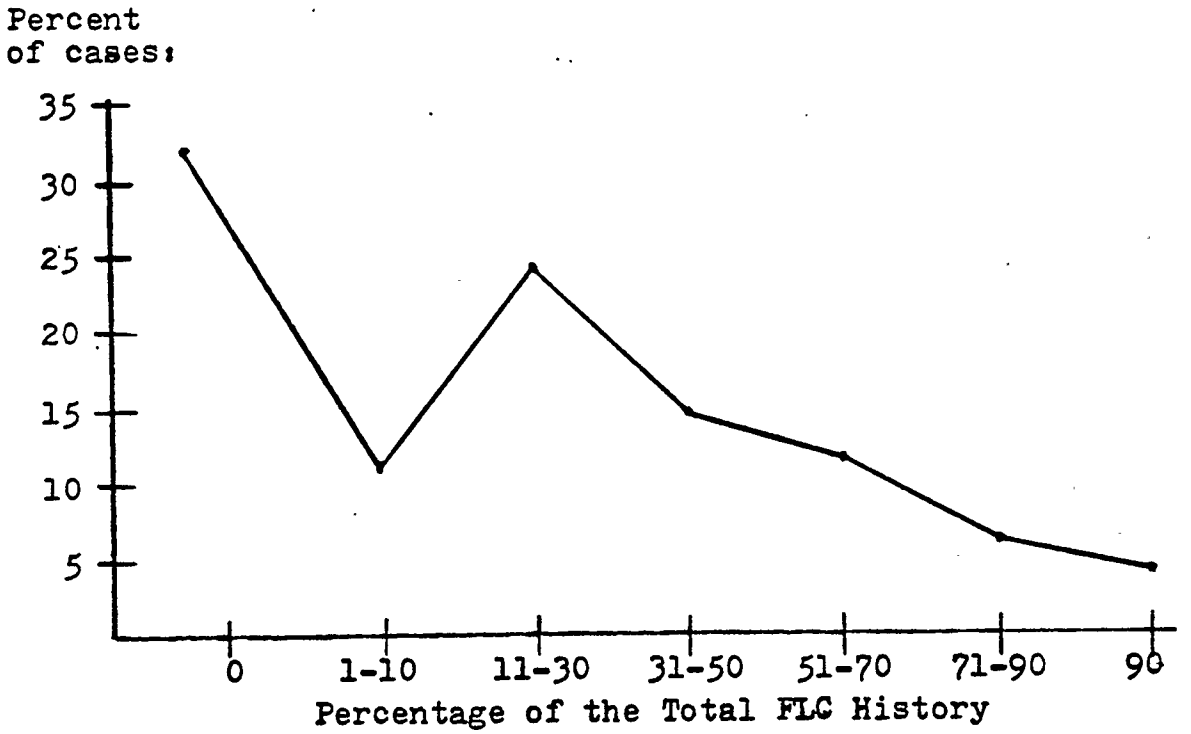
the state of the single parent family. In 94% of the cases the single parent family status was the outcome of a broken marriage; in the remaining cases it was preceded by the death of a parent.

One interesting variable noted in this study was the proportion of the total history of the family that was spent as a single parent family. Figure 10 portrays the distribution of cases for different proportions of the family's historical experience with single parenthood. As indicated, of those families with experience in this alternative family form, the highest proportion (23.7%) lived as a single parent family for between 11% and 30% of their total history as a family. Almost 20% of these clinical families had spent more than half of their life together as a single parent family. Of those families with experience as a single parent family, 66% were transformed to this state only once, 28% became a single parent family on two separate occasions, and 4% had more than two experiences with this alternative form of family development.

II. Developmental History of the Biological Mother

In this section, attention will be given to those aspects of the developmental experience of the natural

Figure 10
Single Parent Family Duration as a Proportion
of the Total Family Life Cycle Experience



mother not already addressed in the previous section. What does this study of clinical families reveal about the developmental experience of the typical mother up to the point of intake?

Age of the Mother at Critical Events

a.) Mother's age at the first marital union.

The mean age of mothers at the time of the first marital union was 20.0 years. All of the mothers had their first marital union between the ages of 15 and 37 years. Figure 11 provides a visual representation of the distribution of the mother's age at the first marital union. In the highest proportion of cases, the first union occurred in the 18 to 19-year-old age group; in over 10% of the cases, the first marital union occurred before 16 years; and over 75% of the unions occurred between 16 and 21 years.

The mean age for mothers at the point of the first marriage was 20.1 years. This compares with the Canadian national average age of 23.7 years (Statistics Canada, 1984). In all cases, the first legal marriage occurred between ages 15 and 37 years. The distribution of this variable is also displayed in Figure 11. Eighty-four percent of first marriages had occurred prior to age 24; over 22% of the mothers married while still teenagers

Figure 11

Mother's Age at First Union

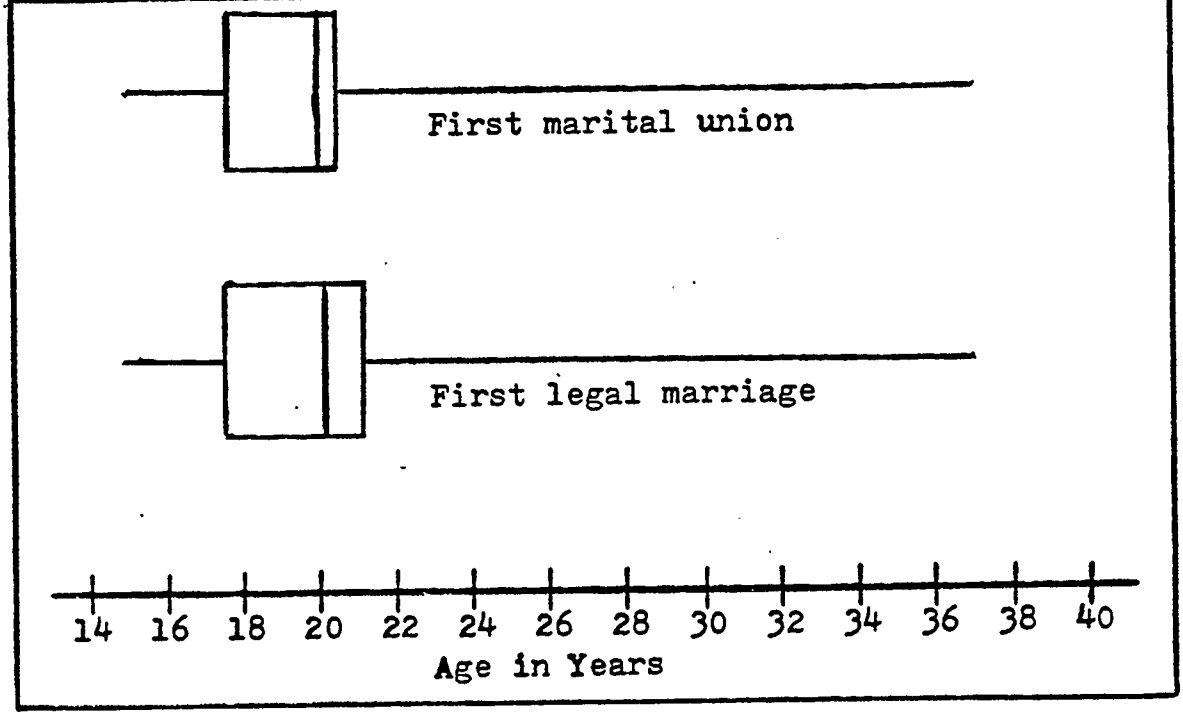
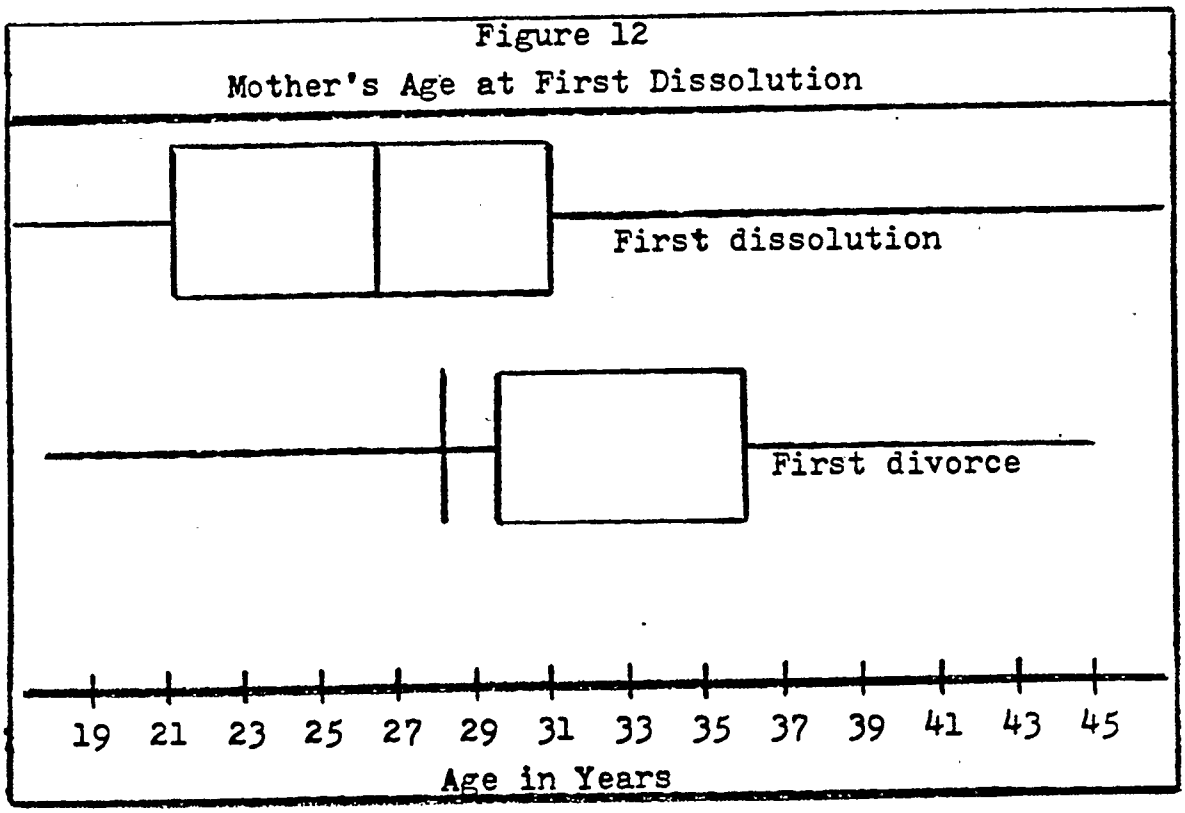


Figure 12

Mother's Age at First Dissolution



(i.e. prior to age eighteen) and half of the mothers married between 18 and 20 years of age.

b.) Mother's age at marital dissolution.

How old was the average mother at the time of marital disruption? The mean age of mothers at the point that the first marital union failed (i.e. the couple separated decisively for the last time) was 26.4 years. The age of the mother at this critical juncture ranged from 17 years to 47 years. The distribution of this variable is represented by Figure 12. For the 69 mothers who experienced marital failure, the most likely time for dissolution to occur was between ages twenty and thirty-one. Thirteen percent of the mothers in this study experienced the dissolution of a marital union prior to age twenty.

By contrast, the mean age of mothers at the time of the first divorce was 28.3 years, with the age ranging from 18 to 45 years. It was rare for divorces to occur before the mother's twentieth birthday; almost 70% of the divorces occurred between ages 20 and 31 and were equally distributed throughout this period; and slightly over one-quarter of the divorces occurred when the mother was 32 or older.

c.) Mother's age at second marital union.

Forty-two percent of the mothers in this study experienced a second marital union. Slightly over half of these second unions were legal marriages. The mean age of mothers at the time of remarriage (legal or social) was 25.9 years. All mothers entered the remarried family state between the ages of 18 and 36 years with 85% of the second unions occurring between 20 and 34 years. Figure 13 provides a representation of the distribution of this variable. In almost 10% of the cases the mothers had entered the second union before the age of twenty.

d.) Mother's age at the birth of the first child.

The mean age of mothers at the birth of their first child was 21.1 years with the age ranging from 14.3 to 36.3 years, and with 89% of first births occurring to mothers between the ages of 16 and 25. Twenty percent of first births were to teenaged women under the age of eighteen. Half of the first children were born to women between the ages of 18 and 21 years. Seventy percent of first children were born before the mother turned twenty-two.

The median age of mothers at the birth of their firstborn was 19.9 years. This compares with a national Canadian median age of 24.6 years (Statistics Canada, 1984).

Figure 13

Mother's Age at Second Marital Union

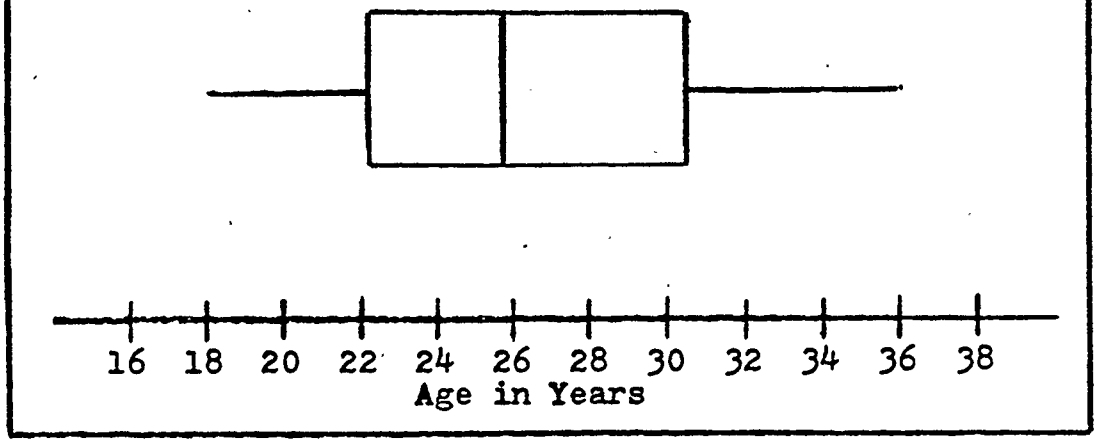
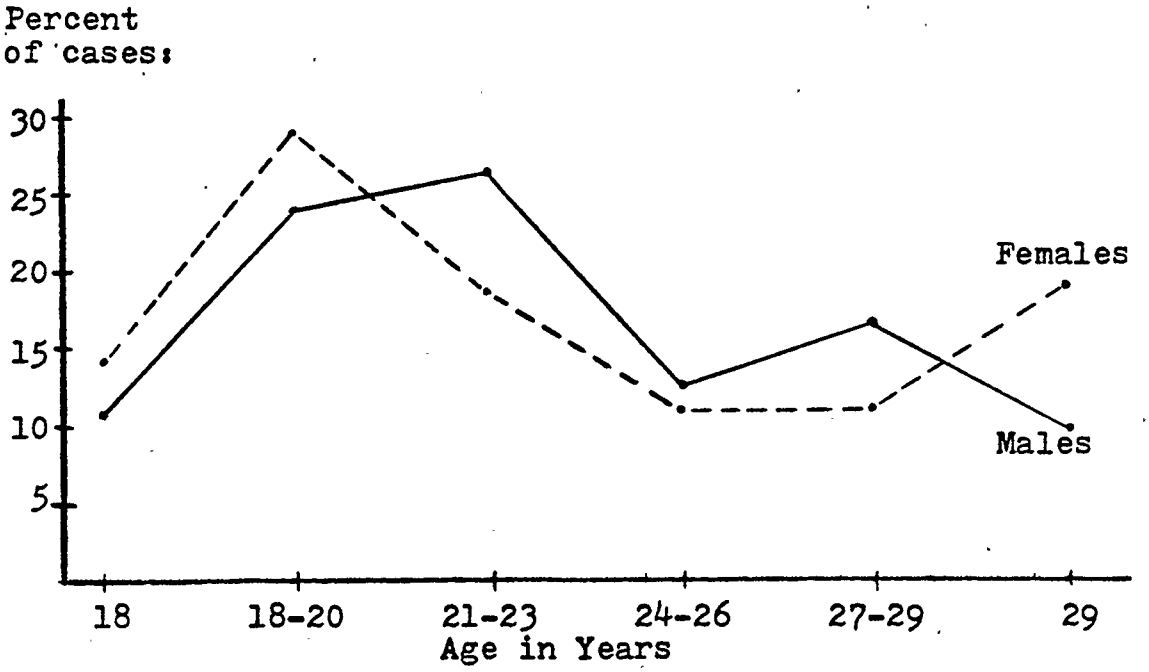


Figure 14

Mother's Age at Birth of Identified Client



e.) Mother's age at the birth of the last child.

The mean age of mothers at the birth of their last child was 26.3 years. There was great variation on this variable with the age of mothers at this critical event ranging from 16.5 to 43.2 years. The peak period for the occurrence of the last child's birth was between 24 and 25 years. There was a fairly even distribution of cases between the ages of 20 and 31 years. The median age of the mothers in this study at the birth of their last child was 25.3 years. By comparison the national median age for all Canadian mothers was 26.3 years (Rodgers & Witney, 1981).

f.) Mother's age at the birth of the identified client.

The mean age of the mother at the time that the identified client was born was 23.2 years. The age of mothers at this event ranged from 14 to 41 years with the most likely time for the identified client to be born being when the mother was between 19 and 27 years of age. Twelve percent of the identified clients were born to teenaged mothers. Also, in an equal proportion of cases (12%) the birth of the identified client occurred when the mother was relatively older (i.e. after the age of 29). For purposes of comparison, Figure 14 includes distributions for mothers of female identified clients and mothers of male identified clients. Whereas for the full sample, in 24% of the cases

the identified client was born outside the usual time frame of the childbearing period, in the case of female identified clients this occurred in almost one-third of the births. Only 20.8% of male identified clients were born outside the usual time frame.

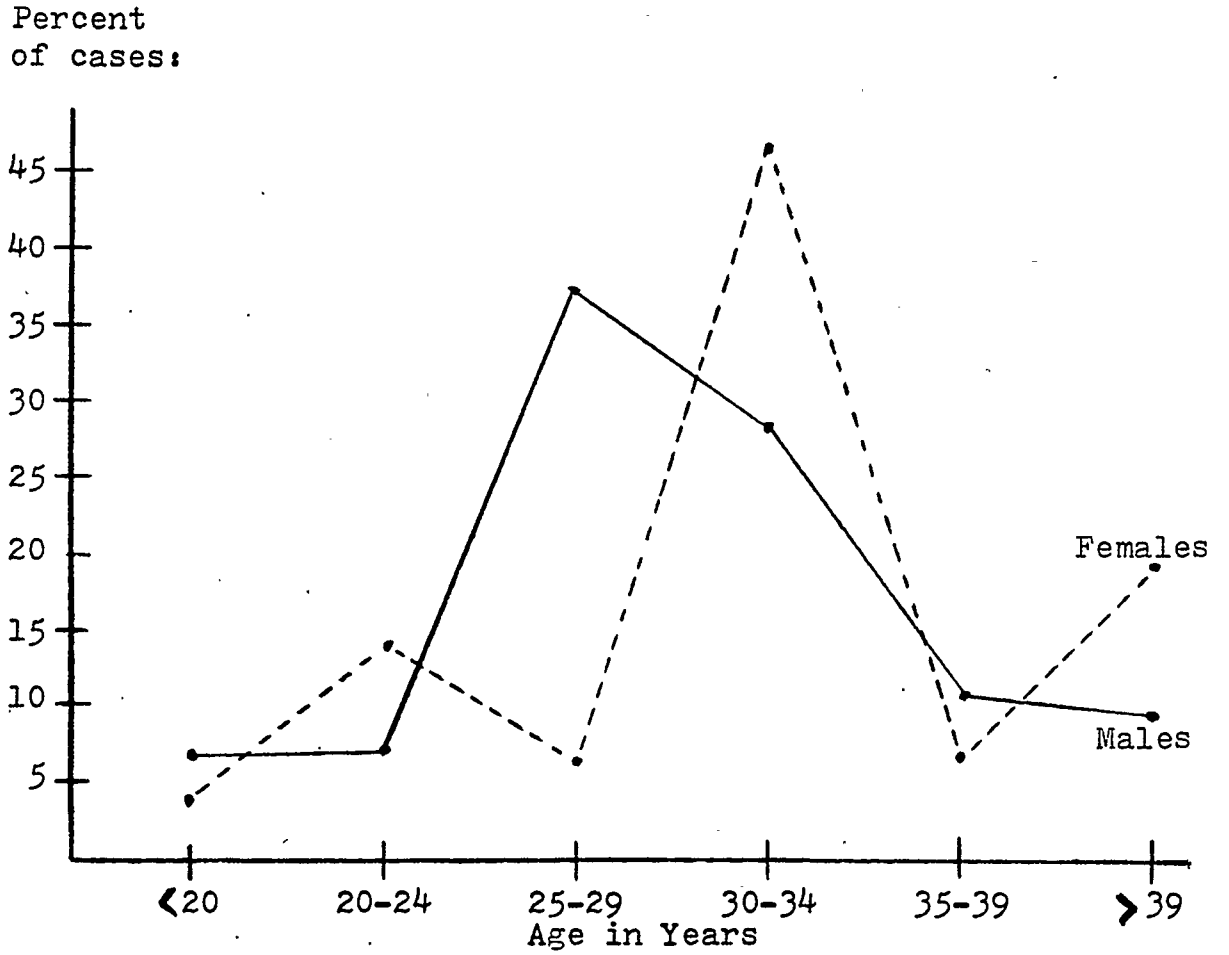
g.) Mother's age at the time of the first involvement with professionals.

The mean age of mothers at the point that the first involvement with mental health professionals was established was 31.2 years. However, in the most extreme cases, the mother was as young as 17.8 years or as old as 49.7 years. Figure 15 provides a representation of the distribution of cases on this variable for the subsamples of male and female identified clients. As indicated, the majority of cases fall into the age group of 25 to 34 years. For the subsample of female identified clients there are two interesting points to be noted. First of all, in almost half of the cases the mother was between 30 and 34 years when contact with helping professionals was first established. Secondly, in over 21% of the cases, the first professional contact did not occur until the mother was forty-years-old or older.

Duration of Family Life Cycle Stages

Figure 15

Mother's Age at First Professional Involvement



a.) The young adult stage.

Attention was paid in this study to whether the mother of the identified client had had a normal experience as a young adult. Because information was not generally available on when the young woman departed the family of origin, this assessment could only be less than precise. On the basis of the information that was available (i.e. the age of the mother at the formation of the family), however, it was possible to determine in which cases the young adult stage was truncated due to the premature assumption of family responsibilities: marriage or parenthood. In this sample, 29.3% of all mothers had entered their first marital union before the age of eighteen and 65.7% before the age of twenty. Twenty percent of all mothers had become mothers before the age of eighteen and 47% before the age of twenty.

b.) The preparental establishment stage.

The mean duration of the period between the inauguration of the marital union and the arrival of the first child was 9.5 months. The timing of the first birth ranged from 13.8 years prior to the marital union to 10.25 years after the couple came together. Figure 16 indicates the point at which the first birth occurred relative to the couple's union. In over 16% of the cases, the first child

Figure 16
Timing of First Birth

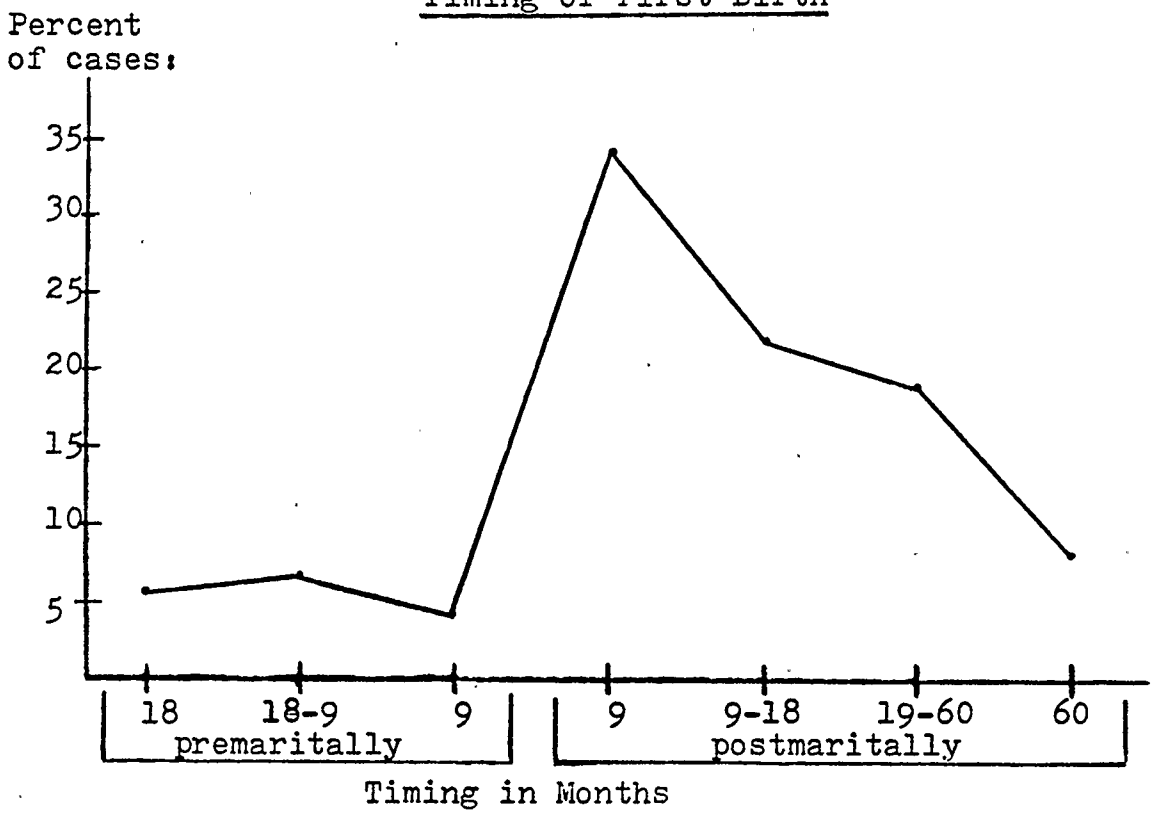
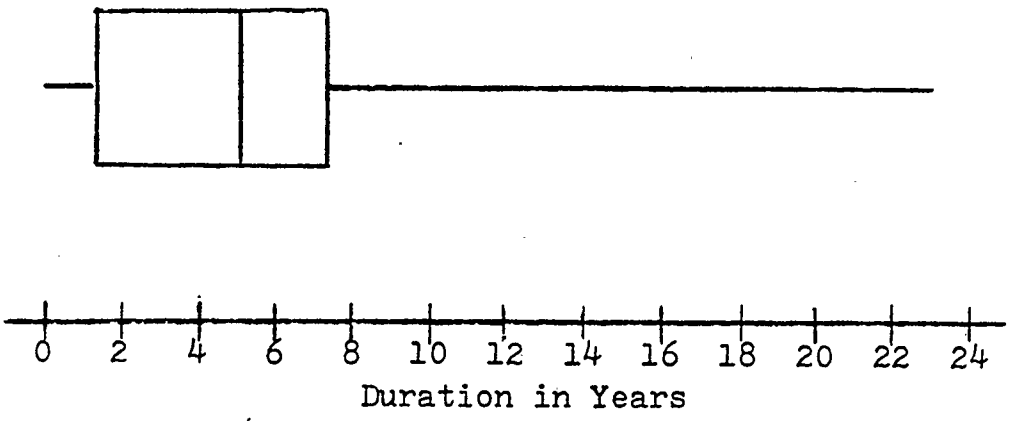


Figure 17

Duration of Childbearing Period



arrived prior to the marital union of the couple. Thirty-four percent of first children were born within the first nine months of the couple's marital relationship. Over half (51%) of the first children in this sample were conceived premaritally. The average Canadian couple has approximately one "child-free" year after marrying (Statistics Canada, 1984).

c.) The childbearing period.

The average period between the birth of the first child and the birth of the last child was 5.2 years. The range extended from 0 (in the case of single child families) to 23 years between the first and last child. As indicated in Figure 17, there was considerable variation in the length of the childrearing period. The median duration between the arrival of the first and last child was 5.94 years compared to 2.4 years for the Canadian population (Rodgers & Witney, 1981).

d.) Duration of involvement with mental health professionals.

The average family had been involved with mental health professionals for a period of 5.3 years prior to the identified client's being referred for residential treatment at this agency. However, there was great variation in the length of time which individual families

had been involved with professionals: from less than 1 year to 20 years of involvement. Figure 18 represents the distribution of cases for this variable. It is a bimodal distribution with the peak duration of professional involvement being 1-2 years and 7-8 years. When one way analysis of variance was employed to compare the duration of prior professional involvement for families with males or females as the identified client, no significant differences were detected.

III. Developmental History of the Identified Client

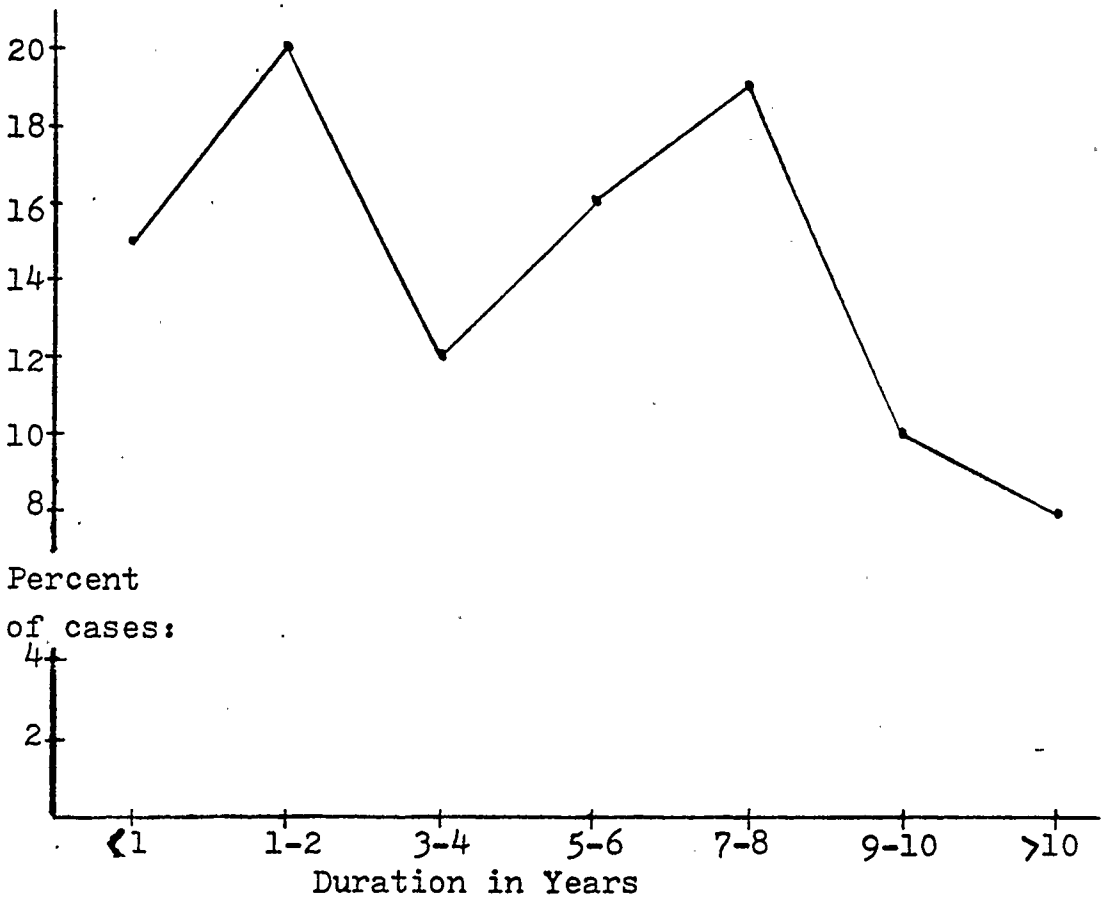
Considering, finally, the identified client, what does this sample reveal about the developmental experience of the typical child up to the point of his/her referral for residential treatment? What commonalities exist in the background histories of these children? How many placements outside the home preceded this current referral? How old was the child when his/her family first became involved with helping professionals? What has been the child's experience with marital disruption and alternative forms of family development? How old was he/she when critical events occurred?

Number of Previous Placements.

The average number of previous placements experienced

Figure 18

Duration of Professional Involvement



by the client prior to referral to this agency was 2.3 placements. For male clients the number of previous placements extended from 0 to 9; for female clients the range was from 0 to 7 previous placements. Figure 19 offers a representation of the relative frequencies of previous placements of the identified client for subsamples based upon sex and subsamples based upon age. As indicated, only about one-quarter of these children had never been placed outside the home. The proportion of clients who had never been previously placed was essentially equal for clients regardless of age or sex. Over three-quarters (76%) of all children had experienced at least one placement outside the family home by the time of referral to this agency. One way analysis of variance revealed no significant differences between these subsamples on this variable.

Age of the Identified Client at the First Professional Involvement.

Information was sought concerning the age of the identified client at the point at which involvement with mental health professionals was first inaugurated. Involvement with mental health professionals was defined to include contact with all professionals engaged in addressing personal difficulties (e.g. psychologists,

Figure 19

Previous Placements of Identified Client

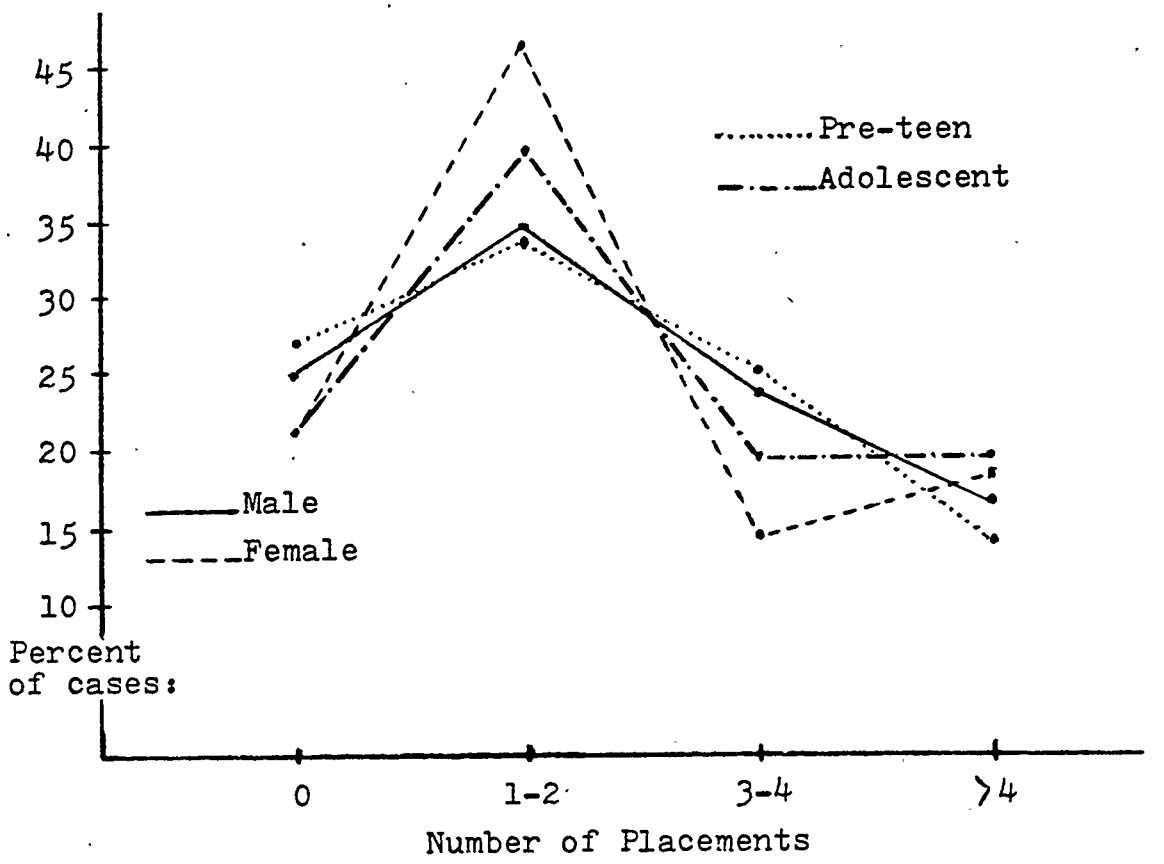
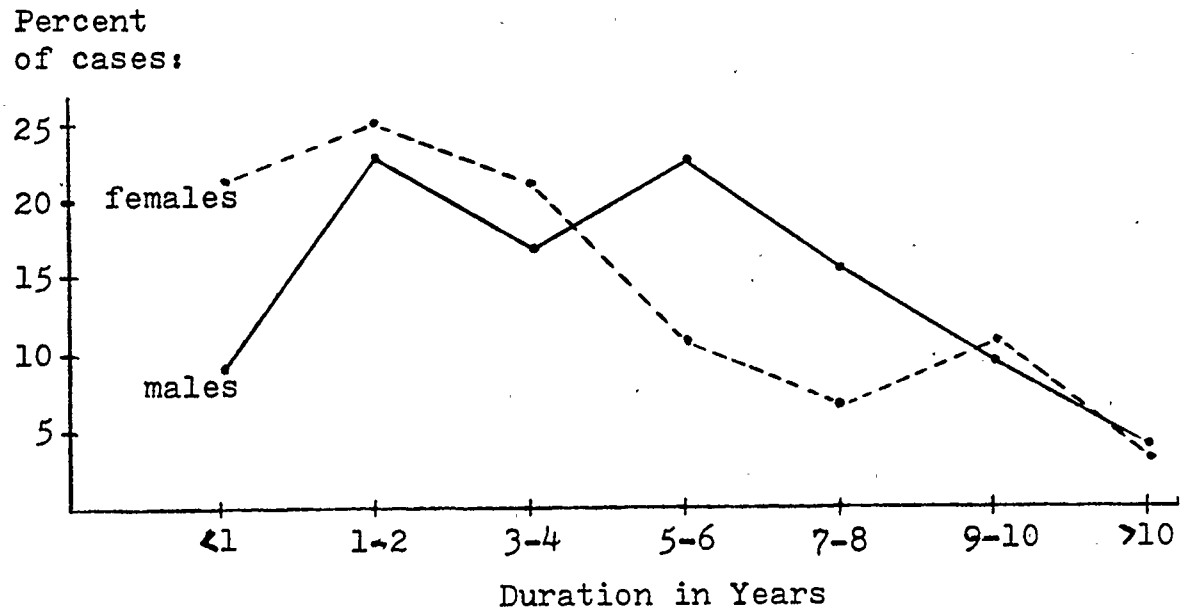


Figure 20

Duration of Identified Client's Professional Involvement



psychiatrists, counsellors, therapists, etc.). Although the problems of delinquency, academic underachievement, and medical symptoms frequently accompany personal difficulties in children and frequently it is the case that personnel from the criminal justice system, the school system, and the medical community are the first professionals to become involved with a troubled family, it was specifically the date of the first involvement with mental health professionals that was noted in this study. Also, in acknowledgement of the systemic inter-relatedness of the difficulties of family members, professional involvement was considered to begin at the point that any member of the nuclear family, not only the identified client, sought the assistance of mental health professionals.

The mean age of the client at the point that the assistance of mental health professionals was first sought was 7.4 years. For males the mean age was 6.6 years and for females it was 9.3 years. There was, however, considerable variation in the time at which professional assistance was first sought. One way analysis of variance indicated that this sex difference in the mean age of clients at the point of the first involvement with professionals is significant at $p<.01$. Utilizing the identified client as a reference point, the age at which

the family first became involved with professionals ranged from 11 years prior to his/her birth to age 14.

Figure 20 portrays the age distribution of the identified client at the point of the first professional involvement. In the case of 80% of the male children, the first professional involvement occurred between ages 3 and 11. For female clients, in 82.1% of the cases the first professional contact occurred between ages 6 and 14 with 71.4% of these involvements occurring between 9 and 14 years.

Duration of Professional Involvement

Related to the previous variable is the matter of the duration of the identified client's involvement with mental health professionals. At the point of intake, how long had the typical client been involved with members of the helping profession?

The mean duration of involvement with professionals was 5.2 years. For families with a male identified client the mean duration was 5.65 years and for families with a female identified client the mean was 4.18 years. T-test analysis revealed no significant differences between these two groups.

Figure 21 represents the distribution of the variable of the duration of professional involvement for the subsamples of male clients and female clients. It is evident that very few of the clients referred for residential treatment had been involved with professionals for less than one year. In this distribution the highest frequency was in the 1 to 2 years duration category. Almost three-quarters of the cases fell in the range from 1 to 8 years involvement with professionals. Only a minimal proportion of children had been involved with professionals for more than 10 years. In comparing males and female clients on this variable it is interesting to note that females were over two and one-half times as likely as males to have had less than one year's involvement with professionals prior to this current referral for residential treatment. Over 21% of female clients had had less than a year's professional involvement and over 46% had had 2 years or less professional involvement.

In addition to calculating the duration of previous professional involvement, the question was asked: For what proportion of the client's lifetime have professionals been involved with his/her family? Figure 22 portrays the distribution of this proportion. A particularily striking observation is the fact that in almost one-third of these

Figure 21
Duration of Professional Involvement
for the Identified Client

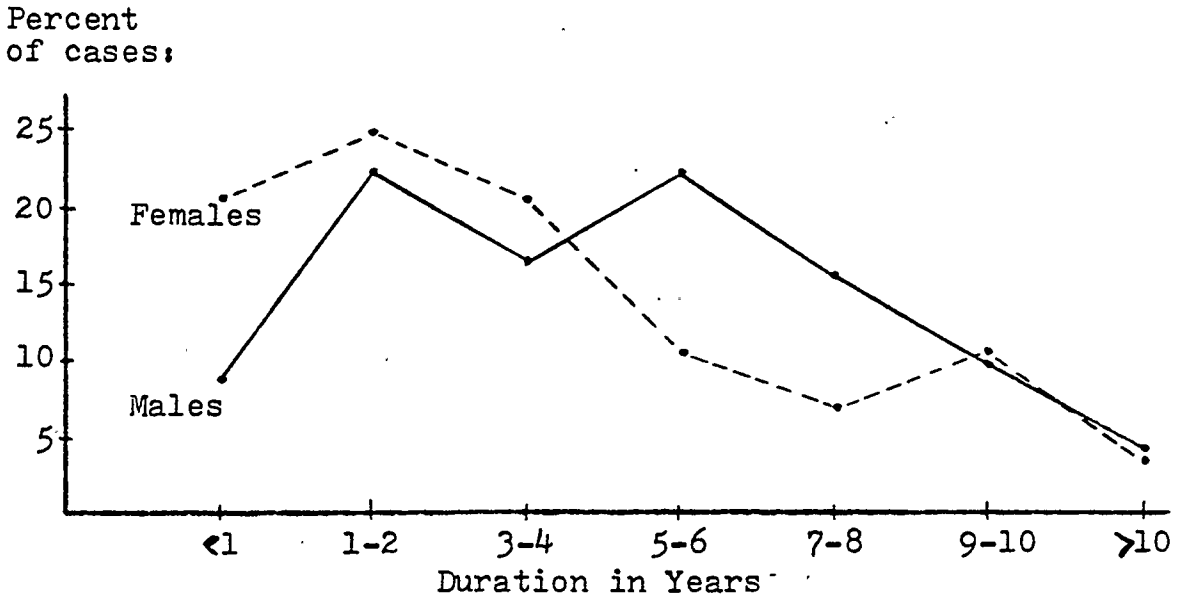
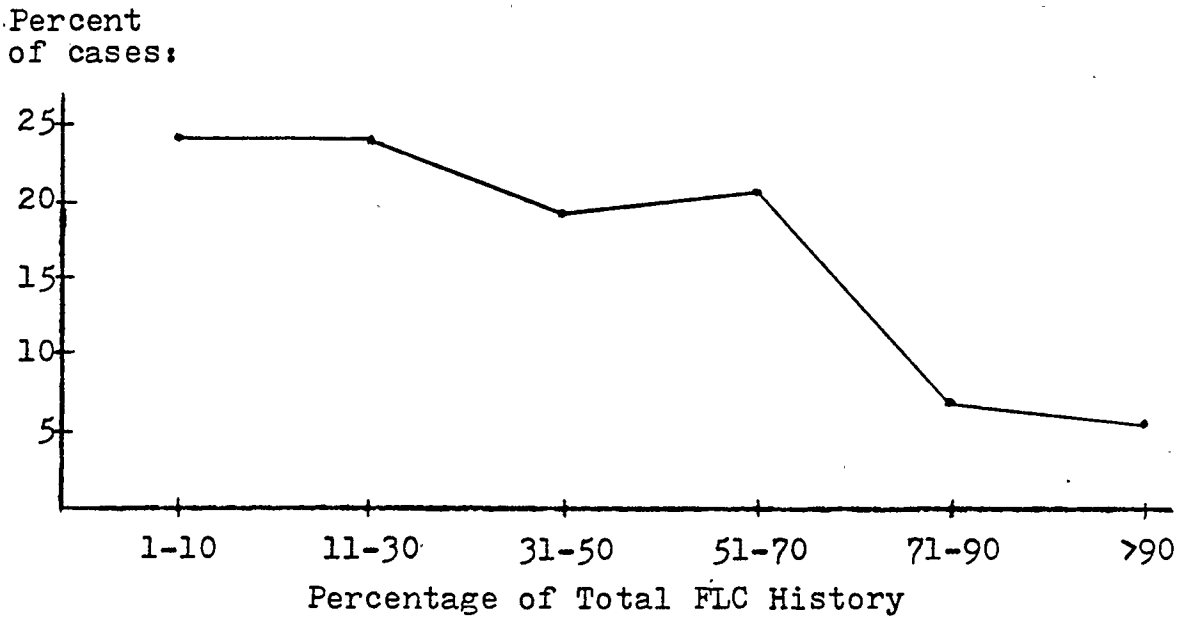


Figure 22
Proportion of the Client's Lifetime in Which
Professionals Have Been Involved

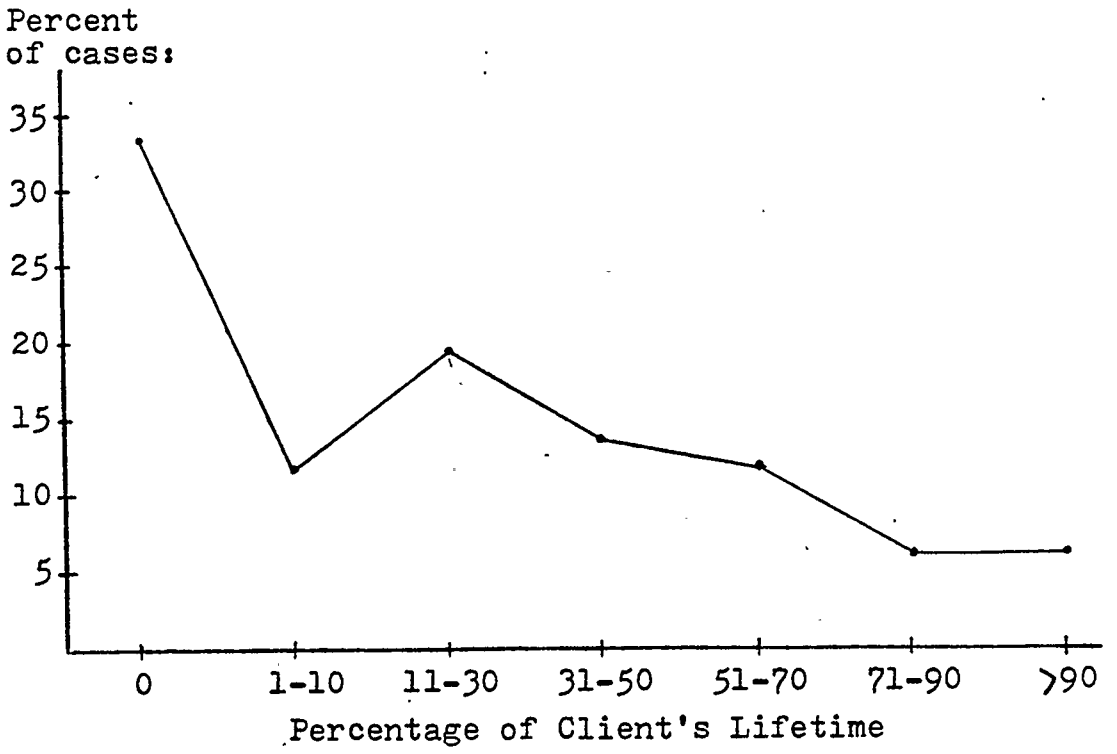


cases (32.4%), over one-half of the client's lifetime was spent in contact with helping professionals. While the proportion was slightly higher for male clients (35.1%), the ratio of professional involvement to total life experience was this high for only 25% of female clients. Female clients were much more likely to have spent a smaller proportion of their lives involved with professionals. For example, the largest percentage of female clients (35.7% versus 19.7% of males) had spent 10% or less of their lives in involvement with professionals and over 67% of female clients had been involved for one-third of their lives or less. The largest percentage of male clients (23.9% versus 7.1% of female clients) had spent between 31% and 50% of their lives involved with professionals.

The Identified Client's Experience of the Single Parent Family

As noted previously, 68% of the families studied confronted the experience of the single parent family at some point in their history. For all cases, the mean duration spent by the identified client in a family with only one parent was 3.3 years. The duration ranged from 0 to 15 years. Figure 23 provides a picture of the percentage of the client's total life spent in a single

Figure 23
Proportion of the Client's Lifetime Spent
in a Single Parent Family



parent family. As indicated, over half of the identified clients had spent at least 10% of their lives in a single parent family and in almost one-quarter of the cases the child had spent over half his/her life with only one parent.

The Identified Client's Experience of the Remarried Family

As indicated earlier, 70% of all families studied had experienced marital dissolution at least once prior to being referred for residential treatment at this agency. Slightly less than two-thirds of these fragmented families subsequently became part of a (legally or socially) remarried family system. This group constituted 45% of all families in the study. Within this subsample of remarried families, in 65.7% of the cases the identified client entered a remarried family system only once; in 21.4% of the cases the child went through this experience twice; and in 12.9% of the cases the child experienced this alternative form of family development on more than two occasions prior to intake.

Related to this variable is the matter of the number of father figures that the identified client had been exposed to in his/her family history to the point of referral. In the great majority of cases (59%), there had been a single father figure in the family. However, in 3%

of the cases there had been no adult male presence in the home with whom the child could identify. Thirty percent of the children referred for treatment had had two father figures and a further 8% had experienced more than two different individuals in this parental role.

SUMMARY

On the basis of the results obtained in this study it is possible to construct a developmental profile of the typical client at the point of admission to residential treatment as well as identifying the predominant developmental pathways traversed by families up to this point in their FLC career.

a. Developmental Profile of the Client at Intake

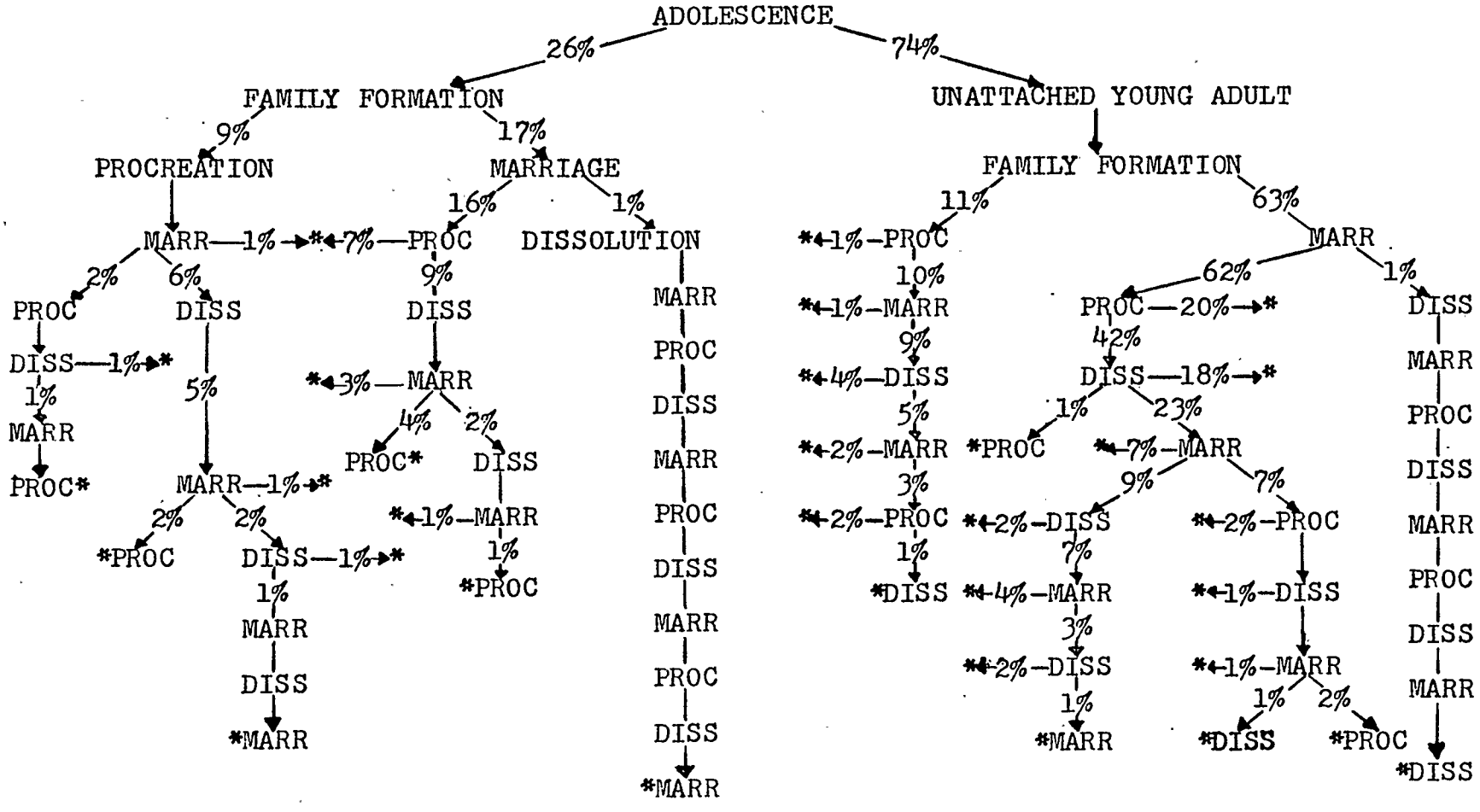
The typical child referred for residential treatment was a male between the ages of 10 and 15 years (mean age=12.4 years) who was not currently living with his family. Although almost two-thirds of the children were members of a two-parent family system, less than one-third of these were from an intact, once-married family. Due to marital disruption, the largest subgroup of clients (slightly over one-third) was comprised of children from (legally or socially) remarried families. Almost one-half (47%) of the clients were part of a family system comprised

of members from at least two different nuclear families. (The difference between these two percentages is reflective of the fact that some children were part of a remarried family system that had subsequently broken down and contracted to a single parent family system.) Also, clients tended to come from families larger than the national average: 2.8 versus 1.3 children (Statistics Canada, 1984). The child's ordinal position in the sibling subsystem was not found to be a predictor of eventual referral for residential treatment. In most instances, the identified client had been placed outside the home on at least one occasion prior to the current referral to this agency and his/her family had been involved with mental health professionals for 5.3 years, or 20% of their FLC history. Finally, due to an accelerated attainment of the childbearing milestone, the mothers of clients tended to be considerably younger than their nonclinical peers.

b. Developmental Pathway of Families Up To Admission

This study also examined the sequence, timing, and frequency of the occurrence of particular second order FLC transformations in order to identify the predominant developmental pathway or career of clinical families. Figure 24 represents the developmental pathway of the 100 families included indicating the respective percentage of

Figure 24: Developmental Pathway of Clients Up To Admission

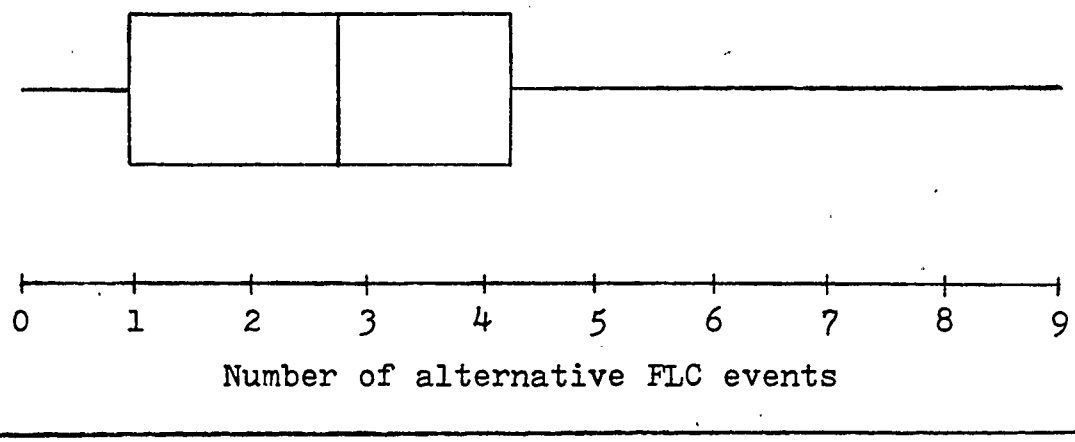


* Remained at current developmental stage with no further FLC transitions.

families who followed a particular course. The left hand side of the figure provides a representation of the 26% of families who inaugurated their FLC career before completing the Unatttached Young Adult stage (i.e. prior to age 19). The right hand side of the figure depicts the FLC career of mothers who delayed family formation (i.e. marriage or parenthood) until at least age 19. Similarly, Figure 24 indicates whether parenthood preceded the marital (legal or social) union and whether this union ended in dissolution or remained intact.

In addition to mapping the developmental pathway followed by families up to the point of admission (Figure 24), it was possible to measure the degree of deviation of each family from the idealized family life cycle model (Figure 25). To this end, the following FLC events were identified as major deviations from the developmental experience of the majority of contemporary North American families, namely: truncation of the Unattached Young Adult stage (i.e. first marital union and/or procreation occurring prior to age 19); truncation of the Preparental Couple stage (i.e. less than 9 months between marriage and procreation); first marital union occurring later than age 30; marital dissolution; single parent family; and remarriage. The frequency of these alternative

Figure 25
Degree of Deviation From the FLC Model



developmental events in the experience of each family was then calculated and families were rated accordingly. Figure 25 provides a representation of the degree of deviation from the idealized FLC model for the clinical families examined in this study. The range extended from total conformity with the FLC model (i.e. no deviations) to 9 alternative developmental events, with the average family experiencing between 2 and 3 deviant family life cycle events.

CHAPTER FIVE

DISCUSSION

Chapter Four offered a developmental profile of the typical client at the point of admission to residential treatment and identified the predominant developmental pathways taken by clinical families to this point in their family life cycle. As such, this developmental information contributes to a contextual understanding of agency clients.

As an exploratory study, there was not, strictly speaking, a hypothesis to be tested concerning these clinical families. Although, for comparison purposes, reference was made to the wider population, the goal of this research was not to ascertain whether families in residential treatment are significantly different in their developmental history from the majority of contemporary Canadian families. Rather, the purpose of the study was to obtain a precise, comprehensive description of the developmental context of young people referred for residential treatment at the William Roper Hull Home. This research was undertaken on the assumption that increased awareness of pertinent developmental characteristics of agency clients would facilitate a deeper appreciation of

their total life situation and contribute to the generating of treatment interventions more appropriate to the particular treatment needs of the child and his/her family. It was also hoped that, by more clearly defining the developmental profile of agency clients, this study would aid in identifying those children and families who are at greatest risk of experiencing difficulties of the magnitude that residential treatment will be required.

The results reported in Chapter Four would appear to suggest that particular segments of the population are at greater risk of requiring residential treatment than are others. In the clinical sample studied, boys were heavily overrepresented in every age group. The concentration of females in the 13-15 years age group suggests that the early adolescent years are a particularily difficult developmental period for the teenager and her family and the most likely time at which residential treatment will be indicated. By contrast, on the basis of the obtained results it is much more difficult to predict when male children will display serious difficulty. Boys appear to be at risk over a much more extended period.

Another striking feature of this clinical population is the degree of deviation from the traditional family life cycle: a mere 16% of the families studied had not diverged in some way from the idealized FLC model with marital

disruption being the predominant source of deviation. Clearly, the rate of broken families is extremely high in this sample of clinical families with 70% of the identified clients having experienced marital dissolution at least once prior to referral for residential treatment. In Kalter's (1977) study, by comparison, it was found that only 41.4% of the children had experienced marital dissolution. How can this striking difference in the proportion of non-intact families be explained? It could possibly be accounted for in part by the earlier point at which Kalter conducted his study on the assumption that in these few intervening years the state of families in North America has deteriorated markedly. But perhaps a more credible explanation of the discrepancy between these two findings is that in investigating the situation of outpatient clients Kalter was dealing with a less disturbed, less problematic population than clients engaged in residential treatment. Given that residential treatment is a much more drastic intervention than outpatient counselling it is reasonable to assert that generally clients at the point of admission have experienced more longstanding difficulties that have not been satisfactorily remediated by less intensive methods. Thus, the clients seen in an outpatient setting and those in residential treatment may be quite different. Unfortunately, in the

literature there is a dearth of studies of the FLC characteristics of clients in residential treatment so there is little basis of comparison for the current study.

UNEXPECTED FINDINGS

Although (as noted earlier) there was not a central hypothesis guiding this exploratory research, clearly there were some strong hunches regarding the results that were likely to be obtained. Based upon a review of the literature and direct clinical experience, there were some established expectations at the outset about what this research would reveal about the families studied. In this regard, the obtained results served to fulfill some expectations while at the same time providing some surprises.

For instance, the finding of significant differences between the developmental experience of male and female clients was anticipated. It was also expected that within this sample of clinical families there would be a predominance of families whose developmental career diverged from the idealized FLC model. However, the magnitude of this deviation--i.e. the fact that only 16% of these families conformed to the normative model--was quite unexpected.

It was expected that in this study the phenomenon of accelerated family development would be evidenced as a more striking feature of the FLC profile of clinical families than was in fact the case. When age eighteen was employed as the minimum termination point for the Unattached Young Adult Stage (in accordance with the conventions of the literature), it was found that approximately one-quarter (24%) of the families studied had experienced a truncation of this stage and commenced their family life cycle--with marriage and/or parenthood--at an early date. However, given the critical developmental tasks faced by the young adult and considering recent demographic information (e.g. Statistics Canada, 1984), perhaps it is more reasonable to propose that beginning a family prior to age twenty constitutes a truncation of the Unattached Young Adult stage. When age twenty is substituted for age eighteen as the minimum cut-off point for this stage, it is found that a striking 65% of the families studied fall into the category of experiencing accelerated development. Table 7 provides a comparison of the results obtained when ages 18 and 20, respectively, are employed as the termination point for the Unattached Young Adult stage.

On the basis of informal clinical observation coupled with theoretical speculation, it was expected that single child families would be over-represented in this clinical

Table 7

Accelerated Family Formation: Two Alternative Formulations

		Occurring prior to: Age 18	Age 20
Family Formation:	Either marriage or parenthood	24%	65%
	Both marriage and parenthood	16%	42%
	Marriage only	21%	62%
	Parenthood only	19%	44%

sample. It may be argued that because the single child family lacks a sibling subsystem, the child may have fewer opportunities to develop cooperative social skills with his/her agemates. In addition, as an only child, the boy or girl may experience greater pressure to succeed in order to meet the expectations held by the parents. Finally, being the only family member outside of the marital subsystem, the only child may be at greater risk of being drawn into a triangulated relationship with the couple. However, contrary to expectations, being a single child was not found to be a significant variable in this study.

Another interesting finding was that adolescent clients were almost twice as likely as preadolescents to come from intact families. Given the likelihood that adolescent families will have had a relatively longer FLC history and thus a longer period of exposure to the risk of family dissolution than their pre-adolescent counterparts, it is not unreasonable to expect that among the adolescent subsample fewer families would be intact. However, perhaps this finding suggests that intact families are more self-sufficient and are able to maintain a problematic member's presence in the home longer than is the case with fragmented families. Perhaps what is untenable in a single parent family or a remarried family is more tolerable when the family unit is intact.

LIMITATIONS OF THE STUDY

There are several limitations to the current study which must be acknowledged. First, the developmental information collected on clients originated largely from self-report. Given this primary source, it is reasonable to assume that, due to clients' memory lapses and/or deliberate hedging about embarrassing aspects of their personal history, the information may not be entirely accurate. Secondly, significant developmental information that would have enhanced the current study was simply not available. For instance, although client files contained a record of the births of children, there was no consistent record of miscarriages, abortions, or children surrendered at birth--despite the fact that these are major FLC events having great impact upon family members. Also, knowing at what age the mother left home and what the interval was between separating from her family of origin and establishing a new nuclear family would have enriched the developmental profile immeasurably. Similarly, it would be useful to have more precise information on the length of the courtship stage and whether a period of unmarried cohabitation preceded legal marriages. In addition, it would be helpful to have more information on the other siblings. For instance, the current information is not

clear whether the identified client is the only child with a treatment history or whether he/she is carrying on a family tradition of different members requiring major professional intervention.

IMPLICATIONS OF THE STUDY

What implications can be drawn from the results of this exploratory study? What specific recommendations can be offered in the realm of treatment and future research?

Beginning with the area of treatment, what can be inferred from the developmental profile of these families concerning the stresses likely to be impinging upon them at the time of admission? What are the most effective means of addressing their particular needs in the residential treatment setting?

It is important, first of all, to recognize that the family situation of agency clients is likely to be substantially different from that of their nonclinical counterparts. For only a tiny minority (16%) of the subjects studied had the family's developmental history conformed closely to the idealized FLC model. In the vast majority of cases, family histories were characterized by a great deal of disruptive second order change triggered by the arrival and departure of various family members and the

concomitant transformation of the family structure. Frequently, major life cycle transitions had occurred prematurely and/or on the heels of the previous FLC transition thereby adding immeasurably to the normal stresses associated with these events. In addition to the extra stress generated by accelerated development and the telescoping of incompatible developmental tasks from successive stages was the extra stress experienced by families who confronted additional FLC transitions and alternate stages of family development as the result of marital disruption. Thus, in entering residential treatment the typical client was likely to be struggling with developmentally-related issues more complex than those confronted by the population at large. Given the incidence of disruption and change characterizing the history of the majority of these families, it is not unreasonable to assume that individuals in these circumstances will have evolved particular attitudes about themselves in the context of their family. It is likely that the themes of insecurity, loss, and failure will pervade their consciousness of themselves in human relationships in general. It is likely that the rapid succession of major FLC transitions and the concomitant incompletion of stage-specific developmental tasks will have left family members feeling a lack of control and self determination in

satisfactorily managing their lives. Furthermore, this deficient sense of personal competency and autonomy may have been inadvertently reinforced by the relatively lengthy involvement of helping professionals with the family. Experience with alternate forms of family development as well as extended involvement with mental health professionals may have left family members feeling stigmatized as social deviants who are heavily dependent upon the ongoing support of others.

The overrepresentation of non-intact, alternative family forms (i.e. single parent and remarried families) suggests that there may be an association between deviations from the normative FLC model and the etiology of difficulties requiring professional treatment for a family member. It appears reasonable to hypothesize a circular interaction between these two phenomenon with psychological and behavioural difficulties both stemming from and contributing to deviations from the family life cycle. Although it is not possible on the basis of this study to comment conclusively on the relationship between these two variables, the fact remains that the overwhelming majority of agency clients arrive with a developmental history characterized by deviations from the norm. It is incumbent upon agency staff to respond appropriately to the unique situation of this clinical population.

Considering the developmental profile of agency clients rendered by this study, what are the specific implications for staff of the residential treatment centre? First of all, it is evident that to empathize and work effectively with these clients, agency personnel must be thoroughly acquainted both with normal family development and with alternative forms of family development. A knowledge of normal family development is essential, first of all, because despite the fact that intact families conforming to the idealized FLC model are very much a minority, they are nonetheless represented in this group of clinical families. It is evident that even families who are "normal" in developmental terms can run into serious difficulty with a symptomatic member. Second, a knowledge of normal family development is necessary because many of the normal developmental tasks remain relevant to single parent and remarried families. Finally, being familiar with the normative FLC model is necessary because this is the benchmark against which most families--normal and exceptional--measure themselves. It is equally critical for clinicians to possess a thorough knowledge of alternative forms of family development: the predominant ways in which families depart from the normative FLC model and the unique developmental tasks and particular stresses experienced by these families. If treatment staff lack an

appreciation for the unique circumstances faced by members of developmentally different families, they will demonstrate a lack of empathy in their dealings with clients and may inadvertently compound their distress. Given the extremely high incidence of families broken by marital dissolution, particular attention should be paid to the impact of separation and divorce on family members and how this distress may manifest itself in psychological and behavioural symptoms. Also, in light of the large proportion of clients who at some point in their history have been part of a single parent family and/or remarried family, the particular complexities of these two alternative forms of family development must be thoroughly comprehended.

In order to ensure that treatment staff are prepared to respond constructively to the particular life situation of each and every agency client, it is recommended that in the training offered to agency staff greater attention be given to the area of development over the family life cycle. In particular, it is recommended that a unit on alternative forms of family development--which details the predictable crises of these alternative FLC stages--be added to the existing curriculum. As well, staff members should be encouraged to attend workshops and conferences whose theme is the developmental context of the family.

Not only must clinicians possess a solid background of developmental information in order to deal effectively with the diversity of clients referred to the residential program, it is also necessary to consider carefully the family situation of each client. Upon admission, a complete family chronology should be compiled for each client family as an integral part of the formal assessment process. The obtained developmental information will foster a deeper appreciation of the client's current situation as well as suggesting particular areas to be addressed in treatment.

A treatment recommendation based upon the findings of this study is that specific therapy groups be conducted for children who share a common experience with alternative forms of family development, e.g. a group for recently divorced children, a group to discuss the difficulties of being part of a single parent family, a group for stepchildren, a group for single parent mothers, etc. Such groups would foster a sense of identification among group members and facilitate constructive dialogue on the predictable difficulties of these alternative forms of family development thereby providing support for individuals in these circumstances. It is asserted that gathering a more detailed developmental history on clients would be a benefit both for the purposes of treatment

planning in individual cases and, more globally, for creation of new agency programs. To this end, it is recommended that the "Family Information Sheet" currently completed by clients at the point of intake be modified and expanded to include more specific queries regarding the biological mother's marital and childrearing history as well as the treatment history of the family, particularily the residential placement of siblings. In the interests of corroboration and elaboration--and because it should not be expected that embarassing or complex developmental details will be reported on the "Family Information Sheet"--it is recommended that this questionaire information be followed up by the careful compiling of a family chronology conducted by a family therapist during the formal assessment period.

Finally, what implications flow from this exploratory study concerning future research?

As noted in Chapter One, very little research has been conducted on the family life cycle characteristics of children engaged in psychotherapy. Thus, this remains fertile ground for further study. In particular, it would be useful to have the current study replicated in other residential treatment centres in order to the ascertain the generalizability of the results obtained. It would also be

interesting to conduct a study examining significant differences between children in residential treatment and children in outpatient psychotherapy in terms of their developmental characteristics and their presenting problems. Also, if the formidable difficulties inherent in obtaining an adequate control group could be overcome, it would be valuable to compare the FLC characteristics of clinical families with that of normal families.

The significant sex differences uncovered in this study suggest another area for further research. Although it was beyond the scope of the present study, it would be interesting to investigate significant differences in the predominant presenting problem associated with different age and gender subsamples of this clinical sample. From informal clinical observation it is predicted that the key presenting problems of early school age male clients would be aggression and hyperactivity whereas for adolescent females the presenting problems would be running away, sexual promiscuity, and substance abuse, with academic underachievement characterizing both groups. Finally, a study examining significant differences in the presenting problem of residential treatment clients according to their particular family type at admission--analogous to Kalter's (1977) examination of outpatient clients--might produce some interesting results.

In summary, then, the current exploratory study renders a clearly-focused profile of the salient family life cycle characteristics of clients engaged in treatment at the William Roper Hull Home. From this developmental profile can be derived important recommendations concerning the treatment provided to these clients as well as suggestions for further research.

REFERENCE LIST

Bach, G., & Wyden, P. The Intimate Enemy: How to Fight Fair in Love and Marriage. New York: William Morrow, 1968.

Bacon, L. Early motherhood, accelerated role transition, and social pathologies. Social Forces, 1974, 52, 333-341.

Barnhill, L., & Longo, D. Fixation and regression in the family life cycle. Family Process, 1978, 17, 469-478.

Bartz, K., & Nye, I. Early marriage: A propositional formulation. Journal of Marriage and the Family, 1970, 32, 258-268.

Beal, E. Separation, divorce, and single parent families. In E. Carter & M. McGoldrick, (Eds.). The Family Life Cycle. New York: Gardner Press, 1980.

Blood, R., & Wolfe, D. Husbands and Wives. New York: Free Press, 1960.

Bowen, M. Family Therapy in Clinical Practice. New York: Jason Aronson, 1978.

Bradt, J. The family with young children. In E. Carter & M. McGoldrick, (Eds.). The Family Life Cycle. New York: Gardner Press, 1980.

Bruce, J. Adolescent parents: A special case of the unplanned family. The Family Coordinator, 1978, 27, 75-78.

Bumpass, L., & Sweet, J. Differentials in marital stability: 1970. American Sociological Review, 1972, 37, 754-766.

Burke, R., & Weir, T. The relationship of wives' employment status to husband, wife, and pair satisfaction. Journal of Marriage and the Family, 1976, 38, 279-287.

Burr, W. Satisfaction with various aspects of marriage over the life cycle. Journal of Marriage and the Family, 1970, 32, 29-37.

Campbell, A. The American way of mating. Psychology Today, 1975, 8, 37-43.

Carter, E., & McGoldrick, M. The family life cycle. In E. Carter & M. McGoldrick, (Eds.). The Family Life Cycle. New York: Gardner Press, 1980.

Cherlin, A. Remarriage as an incomplete institution. American Journal of Psychology, 1978, 83, 634-650.

Combrinck-Graham, L. A developmental model for family systems. Family Process, 1985, 24, 139-150.

de Lissovoy, V. High school marriages: A longitudinal study. Journal of Marriage and the Family, 1973, 35, 245-255.

Deutscher, I. The quality of postparental life. Journal of Marriage and the Family, 1964, 26, 52-59.

Duberman, L. The Reconstituted Family: A Study of Remarried Couples and Their Children. Chicago: Nelson-Hall Publishers, 1975.

Duvall, E. Family Development (Fourth Edition). Philadelphia: Lippincott, 1971.

Dyer, E. Parenthood as crisis. Marriage and Family Living, 1963, 25, 196-201.

Erikson, E. Childhood and Society. New York: Norton, 1963.

Feldman, H. Development of the Husband-Wife Relationship. Ithaca: Cornell University Press, 1964.

Fishbein, H. The identified patient and the stage of family development. Journal of Marriage and Family Therapy, 1982, 8, 57-61.

Freud, S. A General Introduction to Psychoanalysis. New York: Washington Square Press, 1960.

Furstenberg, F. Unplanned Parenthood: The Social Consequences of Teenage Childbearing. New York: Free Press, 1976.

Glick, P. Updating the life cycle of the family. Journal of Marriage and the Family, 1977, 39, 5-13.

Glick, P., & Norton, A. Marrying, divorcing, and living together in the United States today. Population Bulletin, 1977, 32, 5 (Population Reference Bureau Inc, Washington, D.C.).

Goldstein, H. Reconstituted families: The second marriage and its children. Psychiatric Quarterly, 1974, 48, 433-440.

Hadley, T., Jacob, T., Milliones, J., Caplan, J., & Spritz, D. The relationship between family developmental crisis and the appearance of symptoms in a family member. Family Process, 1974, 13, 207-214.

Haley, J. Marriage therapy. Archives of General Psychiatry, 1963, 8, 213-234.

Haley, J. Uncommon Therapy. New York: Norton, 1973.

Haley, J. Leaving Home: The Therapy of Disturbed Young People. New York: McGraw-Hill, 1980.

Harry, J. Evolving sources of happiness for men over the life cycle: A structural analysis. Journal of Marriage and the Family, 1976, 38, 289-296.

Hethrington, E., Cox, M., & Cox, R. Family interaction, and the social, emotional, and cognitive development of children following divorce. In V. Vaughn & T. Brazelton, (Eds.). The Family: Setting Priorities. New York: Science and Medicine Publishing, 1979.

Hobbs, D. Parenthood as crisis: A third study. Journal of Marriage and the Family, 1965, 27, 367-372.

Hobbs, D. Transition to parenthood: A replication and an extension. Journal of Marriage and the Family, 1968, 30, 413-417.

Hobbs, D., & Cole, S. Transition to parenthood: A decade replication. Journal of Marriage and the Family, 1976, 38, 723-731.

Hoffman, L., & Manis, J. Influences of children on marital interaction and parental satisfactions and

dissatisfactions. In R. Lerner & G. Spanier, (Eds.). Child Influences on Marital and Family Interaction. New York: Academic Press, 1978.

Kalter, N. Children of divorce in an outpatient psychiatric population. American Journal of Orthopsychiatry, 1977, 47, 40-51.

Le Masters, E. Parenthood as crisis. Marriage and Family Living, 1957, 19, 352-355.

Lerner, R., & Spanier, G. Child Influences on Marital and Family Interaction. New York: Academic Press, 1978.

Levinson, D. The Seasons of a Man's Life. New York: Knopf, 1978.

Lewis, H. Family therapy with stepfamilies. Journal of Strategic and Systemic Therapies, 1985, 4, 13-23.

Lidz, T. The effect of children on marriage. In S. Rosenbaum & I. Alger, (Eds.). The Marriage Relationship. New York: Basic Books, 1968.

Lowenthal, M., & Chiriboga, D. Tranition to the empty nest. Archives of General Psychiatry, 1972, 26, 8-18.

Maratz-Baden, R., Adams, G., Brieche, N., Munro, B., & Munro, G. Family form or family process? Reconsidering the deficit family model approach. The Family Coordinator, 1979, 28, 5-14.

McCarthy, J., & Menken, J. Marriage, remarriage, marital separation, and age at first birth. Family Planning Perspectives, 1979, 11, 21-30.

McCullough, P. Launching children and moving on. In E. Carter & M. McCullough, (Eds.). The Family Life Cycle. New York: Gardner Press, 1980.

McDermott, J. Divorce and its psychiatric sequelae in children. Archives of General Psychiatry, 1970, 23, 421-427.

McGoldrick, M. The joining of families through marriage: The new couple. In E. Carter &

M. McGoldrick, (Eds.). The Family Life Cycle. New York: Gardner Press, 1980.

McGoldrick, M., & Carter, E. Forming a remarried family. In E. Carter & M. McGoldrick, (Eds.). The Family Life Cycle. New York: Gardner Press, 1980.

Meyer, P. Between families: The unattached young adult. In E. Carter & M. McGoldrick, (Eds.). The Family Life Cycle. New York: Gardner Press, 1980.

Minuchin, S. Families and Family Therapy. Cambridge:Harvard University Press, 1974.

Moore, K., & Waite, L. Marital dissolution, early motherhood, and early marriage. Social Forces, 1981, 60, 20-40.

Morrison, J. Parental divorce as a factor in childhood psychiatric illness. Comprehensive Psychiatry, 1974, 15, 95-102.

Neugarten, B. Adaptation and the life cycle. The Counselling Psychologist, 1976, 6, 16-20.

Orthner, D. Leisure activity patterns and marital satisfaction over the marital career. Journal of Marriage and the Family, 1975, 37, 91-102.

Pietropinto, A., & Simaneur, J. Husbands and Wives. New York: Times Books, 1979.

Pineo, P. Disenchantment in the later years of marriage. Marriage and Family Living, 1961, 23, 3-11.

Rodgers, R., & Whitney, G. The family life cycle in twentieth century Canada. Journal of Marriage and the Family, 1981, 43, 727-740.

Rollins, B., & Cannon, K. Marital satisfaction over the life cycle: A re-evaluation. Journal of Marriage and the Family, 1974, 36, 20-28.

Rollins, B., & Feldman, H. Marital satisfaction over the family life cycle. Journal of Marriage and the Family, 1970, 32, 20-28.

Rollins, B. & Galligan, R. The developing child and marital satisfaction of the parents. In R. Lerner

& G. Spanier, (Eds.). Child Influences on Marital and Family Interaction. New York: Academic Press, 1978.

Sager, C., Walker, E., Brown, H., Crohn, H., & Rodstein, E. Improving functioning of the remarried family system. Journal of Marriage and Family Therapy, 1981, 7, 3-13.

Sager, C., Brown, H., Crohn, H., Engel, T., Rodstein, E., & Walker, L. Treating the Remarried Family. New York: Brunner/Mazel Publishers, 1983.

Satir, V. Conjoint Family Therapy. Palo Alto: Science and Behavior Books, 1964.

Schlesinger, B. One in Ten: The Single Parent in Canada. Toronto: Guidance Centre, Faculty of Education, University of Toronto, 1979.

Schutz, W. The Interpersonal Underworld. Palo Alto: Science and Behavior Books, 1966.

Singer, L. Stages: The Crises That Shape Your Marriage. New York: Grosset & Dunlop, 1980.

Solomon, M. A developmental, conceptual premise for family therapy. Family Process, 1973, 12, 179-188.

Statistics Canada. Marriages and Divorces. Ottawa: February, 1985, Catalogue 84-205.

Teachman, J. Early marriage, premarital fertility, and marital dissolution: Results for whites and blacks. Journal of Family Issues, 1983, 4, 105-126.

Terkelson, K. Toward a theory of the family life cycle. In E. Carter & M. McGoldrick, (Eds.). The Family Life Cycle. New York: Gardner Press, 1980.

Tuckman, J., & Regan, R. Intactness of home and behavioral problems in children. Journal of Child Psychology and Psychiatry, 1966, 7, 225-233.

Wald, E. The Remarried Family: Challenge and Promise. New York: Family Service Association of America, 1981.

Walker, K., & Messinger, L. Remarriage after divorce: Dissolution and reconstruction of family boundaries. Family Process, 1979, 18, 185-192.

Wallerstein, J., & Kelly, J. Surviving the Breakup: How Children and Parents Cope With Divorce. New York: Basic Books, 1980.

Watzlawick, P., Weakland, J., & Fisch, R. Change: Principles of Problem Formation and Problem Resolution. New York: Norton, 1974.

Weiss, R. Going It Alone: The Family Life and Social Situation of the Single Parent. New York: Basic Books, 1979.

Whiteside, M. Remarriage: A family developmental process. Journal of Marriage and Family Therapy, 1982, 8, 59-68.

Yalom, I. The Theory and Practice of Group Psychotherapy (Second Edition). New York:Basic Books, 1975.