Gary L. Sanders

Blended Families: Issues of Remarriage

SUMMARY

Canada's divorce rate increased by 50% between 1968 and 1982. This has resulted in new family forms. One of these, the family which has been 'blended' through remarriage of a parent, has some unique developmental hardships and differences from traditional nuclear families. Blended families are subject to a number of myths that may adversely affect their formation. In addition, members of these families need more time and patience to form a stable and functioning family group than do traditional families. Family physicians can aid the blended family with frank discussion, preparation and specific information. (Can Fam Physician 1984; 30:1159-1163).

SOMMAIRE

Au Canada, le taux de divorce a augmenté de 50% entre 1968 et 1982. Il en est résulté de nouvelles formes de modèle familial. L'un de ceux-ci, qui est la famille fusionnée par le remariage d'un des parents, présente des difficultés de développement et des différences comparativement aux familles nucléaires traditionnelles. Les familles fusionnées sont soumises à un certain nombre de mythes qui contribuent à des difficultés d'implantation. De plus, les membres de telles familles nécessitent plus de temps et de patience pour former un regroupement familial stable et fonctionnel que ne l'exigent les familles traditionnelles. Les médecins de famille peuvent aider ces familles par une discussion franche, une préparation adéquate et des informations spécifiques.

Dr. Sanders is an assistant professor in the Department of Psychiatry of the Faculty of Medicine at the University of Calgary, and Associate Director of the Family Therapy Program and Director of the Human Sexuality Program at the University of Calgary Medical Clinic. Reprint requests to: University of Calgary Medical Clinic, 3350 Hospital Drive NW, Calgary, AB. T2N 4N1.

IMAGINE THAT 36-year-old Sheila M. visits your office with vague complaints of general malaise. On further questioning, she admits that her major concern is really her new family life. Specifically, she is most concerned about how her children are getting along with her new husband, Dirk. Brent, her 15-year-old son appears disinterested and occasionally resentful of any attention Dirk shows him. Brent's attitude is disheartening to Dirk, and Sheila is beginning to argue with Brent. Marion, Sheila's 13-year-old daughter, speaks increasingly of her biologic father and how she wants to see more of him. Sheila and her former husband, Eric, have been divorced for five years after a ten year marriage. The children visited him for a weekend every month until Sheila and Dirk decided to marry. When they married four months ago, both Sheila and her former husband decided it would be best for the children and the new family if he stopped seeing Brent and Marion regularly. Instead, it was decided that he would see them on special occasions such as Christmas and birthdays. When asked what Dirk thought about this arrangement, Sheila replies that he said it was up to Sheila and Eric, but that he would try hard to fill the role of father for Brent. Sheila then looks at you expectantly. What would you do?

There are many different avenues that the primary health care professional could take in trying to help Sheila and her family. Before examining these different directions, however, a more detailed look at remarriage and blended families is useful.

Remarriages are becoming numerous enough in our society to demand attention from all levels and sectors of the health care system. During the 1970s the divorce rate in the United States rose by 79% and there is now an expected 50% divorce rate for all new marriages.[1,2] In Canada, 20% of all marriages in 1975 included at least one person who had previously been divorced.[3] This proportion had increased to one third of all marriages by 1982. In fact, during the years between 1968 (the year the current Di-

vorce Act was last revised) and 1982, the Canadian divorce rate rose by 520%.[4] In the U.S., 75% of divorced women and 80% of divorced men remarry.[1,9] Sixty percent of these remarried couples have children.[1,2] That means that in the U.S., 20% of all children aged 18 or younger will be stepchildren at some point.[1,2] It is projected that 45% of all children born today will spend time in a blended family and/or a single parent family before they are 18 years old.[1]

Canadian statistics are not as detailed as the American ones. Statistics Canada does not have specific categories in the census data about numbers of stepchildren and blended families. However, with 75% of divorced Canadians subsequently remarrying,[5] the proportion of blended families is becoming larger. In fact, recent Statistics Canada figures[4] show that for ten percent of all those divorced in 1982, it was at least their second divorce.

Families constituted because of remarriage have been called various names in the literature. Terms such as reconstituted, stepfamilies, remarried, combined and blended families all have been used.[5-7,9] Despite the term used for the family unit, membership in these families is not defined in a straightforward way.[6] Vischer and Vischer gave one of the most useful definitions in 1979.[7] The most useful aspects of their definition are summarized in Table 1.

TABLE 1
Definition of a 'Blended' Family[7]

1. An adult couple is in the household but a biologic parent is elsewhere.
2. The relationship between one parent and a child predates the current marriage, and one adult (stepparent) is not legally related to a child.
3. Children may be members of more than one household.
4. Virtually all members have sustained a primary relationship loss.

The purpose of this paper is to help physicians become more familiar with the particular characteristics and challenges facing blended families in contemporary Canadian society. The paper will outline clinically relevant information about blended families and their functioning and then briefly outline intervention strategies.

Myths About Blended Families

There is a growing body of literature[1,7] outlining a number of myths that can strongly influence the way blended families see and feel about themselves. These myths may interfere with the performance of difficult developmental tasks facing a blended family in its attempt to become an integrated and successful family unit. Vischer recently[1] wrote about seven such myths. A summary of these myths follows.

Stepmothers are wicked.

Although this myth seems almost too obvious to have impact on blended family formation, the fact that it is so widely known and held is what is most important. Indeed, it is recited in fairytales and nursery rhymes (e.g., *Cinderella, Snow White*) for each new generation in their formative years. Health care professionals should make a great effort to remember that it is seldom the individual who is 'wicked', but rather the relationships of these individuals which make them appear so.

Love occurs instantly.

Although this myth seems to be more widely held by the public than by health care professionals, it still has the potential for a negative impact on blended family formation. It seems that many adults who fall in love and develop a relationship with another adult expect to instantly love their mate's children. Conversely, they may expect their new mate to instantly love their own children. Unfortunately, this belief can easily generate high levels of guilt and personal condemnation by adults and children alike.

A blended family can and should duplicate a biologic family.

Historically, in North American society, the nuclear family (i.e., biologic family), has been seen as the normal family unit. For generations, helping resources and cultural rituals have been built around the nuclear family. Many blended families try to recreate the nuclear family that they have had before divorce or indeed the one in which they grew up. Because of the unique structure of blended families (i.e., biologic parents outside and inside the home, step-parents in and outside the home, and at least two households), they require more permeable boundaries or methods of entering and exiting than do nuclear families.[8]

Children of divorces and remarriages are forever damaged.

This myth stems from society having most experience with the traditional nuclear family and its values. The primary belief in the past was that a marriage lasted until the death of one partner. However, in today's society, people no longer remain married solely for the purpose of raising children. The belief that the children of blended families and single parent families are damaged stems from this old cultural belief and not from relevant clinical research.[1]

It is helpful for children's adjustment if their biologic fathers withdraw from them.

This has been called "folk wisdom"[1] which can have negative effects. Mothers may attempt to legislate biologic fathers away from their children or biologic fathers may withdraw in the belief that this would be better for their offspring. More recent research, however,[8] shows that the most disturbed children are those who had little or no contact with their noncustodial parent.

Remarriage after a spouse's death goes more smoothly than after a divorce.

The traditional reasoning underscoring this myth is that death eliminates one person in an already complex blended family structure. However, it is useful to realize that change is change, whether it is caused by death or divorce. In fact, in some ways remarriages after death may be more difficult because of the post-death idealization of the dead parent or the different rates of mourning in various family members.

Blended family integration occurs quickly.

This myth is commonly held by both the public and a large group of helping professionals. It arises from the larger belief that once a hurdle is crossed, it is left behind forever. In the case of blended families, this hurdle may be remarriage, settlement of custody issues, or any host of other issues. Once these large hurdles are

passed, the expectation that integration should now occur readily is frequently met with frank disappointment and resentment. In fact, blended family integration occurs rather slowly; most clinicians[1, 3, 4, 6-8] point out that families require three to five years before stable, cohesive interaction occurs. The stability of the blended family will most often be different than members' expectations.

The health care professional can use these myths to highlight information that will probably be required by blended families.

Developmental Tasks And Clinical Implications

It is often useful to conceptualize the process of family integration over time by thinking of various developmental tasks that will face the family.

Beginning

The degree of mourning the loss of the previous relationship(s) depends on the degree to which strong emotional involvement, whether positive or negative, has been resolved and allowed a more neutral emotional state. Some authors[9] believe this task is the most important determinant for the future outcome of the remarried family. The professional needs to help the adults confine their concerns and conflicts with the previous mate to the context of the former marriage, and thereby avoid these old issues spilling over into relationships with the children.

Letting go of the previous relationship always occurs to some extent upon separation and eventually divorce. When one partner moves out, two single parents are created. In all likelihood, one will be the major custodial parent but, increasingly, parents are asking for and getting joint custody. At some point in the life of a single parent family, the parent will most likely become emotionally involved with another adult. As this relationship progresses, the new mate moves from a position of 'helping out' to sharing responsibility[10] in what is increasingly becoming a form of blended family. The new level of responsibility provides children with an excellent opportunity to establish relationships with potential stepparents or stepsiblings, through participation in low demand activities. These activities could include group outings, shared hobbies or even group projects.

Once more definite plans are established to cohabit or remarry, the focus of development may revert back to concerns centring on personal identity, roles of the partner with respect to children, finances, custody, etc.[4] McGoldrick[11] predicted that the family showing difficulty in making this transition from sharing single parenthood to cohabitation or remarriage, would show symptoms of failure to separate emotionally from the first family; holding expectations that the blended family form would be similar to the last family form, and lack of appreciation for the complexity of the emotional issues involved in blended family life, for both adults and children. Most authors[1, 7-9] suggest open, direct planning should occur around the issues of remarriage.

Family co-creation

The new family unit will be a blend of expectations and styles of all the members. Of course, the adult members may have the most to say about how the blended family is supposed to work, but children inevitably have a large say in how it actually will work.

Usually each family member has strong beliefs about what is 'normal' and 'correct' for a family. However, frequently members' notions differ.

Blended families must be more permeable than nuclear families, because of former spouses' rights to visit the children, etc.

It is in this area of family cocreation that many of the myths become most operable and therefore hinder the development of the blended family. The key to success for this stage of development is *time*. The first few years of family formation may in fact be ones of 'stable instability'. It seems as if the family lurches from one crisis to another, and yet the overall composition of the family is developing and integrating over this time. Whiteside[6] developed the notion of the 'ours' child as the beginning of the concrete cocreation of the new blended family unit. Up until this point, which may be marked by the birth of a child, a new home, a new business or some other concrete cocreational event, much of the energy has gone toward stabilizing what amounts to two family units in one home.

If adolescents are a part of the new family, care must be taken in order to create even more freedom to come and go than that needed by younger children. Adolescents are in the process of defining their independent identity and they may show a longing to become closer to or get to know the non-custodial parent.

Remarriage in later years

Remarriage of adults whose primary families may have grown and left home has its own unique set of difficulties. Not only do these adults have a longer family history prior to their remarriage, but they have a more solid and extensive series of family ties and future expectations. These expectations may include such things as a will, inheritances, grandparenting rites, etc. Even if their children are fully grown, they will continue to have surprisingly strong reactions to parents' decision to remarry.

Clinical Intervention

Primary health care professionals often are the first professionals directly or indirectly contacted about concerns of blending families. There is much that such professionals can and, indeed, should do to aid patients with their concerns.

Information and permission

Information on the myths about blended families is often particularly useful in helping such families adjust to crises. Further, the family physician can give family members permission to act and feel how they are at that moment, whether it be upset or concerned, fearful of the future, struggling to integrate, etc. This permission giving helps to normalize much of what the family sees as abnormal crises, but which are, in fact, normal developmental tasks that take time and patience to resolve.

Professional neutrality

The importance of not taking sides nor even using a concept of blame cannot be overstressed. In order to be of most use to the new family, the health care professional must be able to take a neutral stance. As long as the individual members of the new family feel they have the opportunity to exercise some freedom of choice, then that family's developmental tasks are being

fulfilled. The role of the professional is helping them get beyond periods of developmental hardship that constrain their choices and personal freedoms. In order to do this, it is most useful to see personal symptoms as indicators of relationship messages, rather than as individual psychological states. For instance, a newly constituted family in which one child shows behavioral disruption at home and at school, may most usefully be examined from this 'message' perspective. If one looks at the message of the child's symptoms, rather than for a defect in the child, it could be discovered that each parent is attempting to define the new family according to different views of how a family should be. The child's misbehavior may unite the parents in an attempt to solve the behavior problems, even though their wished-for solutions may be different. Here the message may be the need for marital agreement about how the family and children should be. Such a view of people's symptoms can help prevent the professional from assigning blame to the missing parent or the stepparent, and lecturing.

Resolution of first relationship

In order to give the newly forming family as much opportunity as they wish to build the kinds of relationships they want, previous relationships should be worked through. Any intense emotion, whether it be joy, love or anger, requires continued interaction with another person. As such, those partners who may no longer cohabit but are still angry and involved in litigation, in a sense do not live at home but in the court house. Physicians can help by encouraging patients to direct these strong emotions towards the marital relationship, not the parent-child relationship. In addition, giving the family members permission to have and work at these intense emotions sets up opportunities for progress.

Preparation for blending

Physicians can help a blended family prepare for living together and remarriage. The couple will need to know that they require lots of preparation. Such preparation can include frank discussion about each partner's expectations for the blending of the families. It can also include planning for every day living. Partners may discuss where money will come from, how visits to the biologic parents, chores and home management will be handled.

Planning may also include preparation for potential difficulties, such as discipline. Often the biologic parent is of two minds. On the one hand, they want the step-parent to borrow authority to discipline the stepchild, but on the other hand, they don't want the step-parent to have responsibility for that discipline. This may result in the natural parent resenting either the withdrawal of the step-parent or, paradoxically, the step-parent's attempts to help with discipline. Arguments may ensue, or the children may show symptoms of maladjustment. Planning for such differences will help the family deal with them when they arise and decrease the chances of overreaction or escalation of problems.

Children will frequently 'act up' at the news or event of a parent's recommitment. Frank discussion on what to do in these instances may be particularly helpful. Planning for permeable boundaries so visits from one household to another can occur easily may be necessary. Discussion about loyalty to both biologic parents being permitted, even though the child may live in only one household, could be suggested.

Frequently, blended families suffer a negative social reaction. This may be particularly marked in areas where the traditional family is touted as most normal, usual and expected. Therefore, more negative social reaction is often seen in rural settings where higher emphasis is placed upon traditional values. This may be particularly hard for rural farm owners, where blending of families involves not only emotional bonds but financial, legal and property bonds as well. Supportive discussion around such issues should be encouraged.

Another difficulty for many blended families is the frequent attempt to avoid conflict. In family therapy, this is called 'pseudomutuality'. New marital pairs are often exquisitely aware of the frequent arguments and fights that occurred in their previous relationships. They may try, at almost any cost, to avoid these painful events in their new marriage. Unfortunately, some couples avoid all areas of conflict and as a result settle these differences inadequately. By helping make the family aware of this as a potential problem, and through modelling open discussion, keys to solving such problems before they occur can be given to new families.

Finally, help should be offered in planning for difficulties that may arise because of extended family (i.e., grandparents, aunts, uncles, etc.) becoming involved.

TABLE 2
'Key Words' for Health Professionals Helping Blended Families

Time	Expect blending to take months to years, not days to weeks.
Preparation	Anticipate and plan for various instrumental and emotionally charged issues. This can do much to defuse these issues before they appear.
Difference	Blended families will and should be different from traditional nuclear families; they are neither worse nor better, simply different.
Acceptance	As a health care professional, one must be neutral and accept the blended family's goals, needs and expectations.

Case Discussion

The question 'What would you do?' about Sheila, Dirk, and their new family was asked at the beginning of this article. Within a very short time, the family physician could give Sheila specific permission to be concerned, telling her that such concerns are a normal part of starting a family. Specific information could also be given to help discount some of the myths that are operable in this new family. These would include the myths that love should occur instantly, that a blended family should be like a nuclear family, that it is helpful to the children if the biologic father withdraws, and that integration occurs instantly.

However, information is seldom enough. If the clinician feels confident, he or she could meet with the spouses and/or the whole family to

openly help them, through discussion, to prepare for possible future problems such as visitation issues, loyalty, discipline, etc. Suggestions for meetings at home would be helpful. If the clinician does not feel equipped to provide such counselling on his or her own, or if the problems become persistent or severe, referral for family therapy is indicated.

Conclusions

Blended families are rapidly becoming a new and large family form—a form without much historical tradition or many role models for solving developmental problems.

The key words for health professionals dealing with blended families are shown in Table 2.

If health care professionals remember these key words, much will be done to decrease the possibility of future hardship and pain for newly formed families. ◉

References

1. *Visher JS: Seven myths about stepfamilies. Med Aspects Hum Sex 1984; 18:52-88.*
2. *Roosevelt R, Lofas J: Living in Step. New York, McGraw Hill, 1976.*
3. *Walker K, Messinger L: Remarriage after divorce: Dissolution and reconstitution of family boundaries. Fam Process 1979; 18:185-192.*
4. *Marriages and Divorces Vital Statistics: Volume II—1982. Ottawa, Statistics Canada, Health Division, Vital Statistics and Disease Registry Section, 1983.*
5. *Messinger L, Walker K, Freeman S: Preparation for remarriage following divorce: The use of group techniques. Am J Orthopsychiatry 1978; 48:263-272.*
6. *Whiteside MF: Families of remarriage: The weaving of many life cycle threads, in Hansen JC (ed): Clinical Implications of the Family Life Cycle. Rockville, MD., Aspen Systems Corporation, 1983, pp 100-119.*
7. *Visher EB, Visher JS: Stepfamilies: A Guide to Working with Step-parents and Stepchildren. New York, Brunner/Mazel, 1979.*
8. *Wallerstein J, Kelly J: Surviving the Break Up. New York, Basic Books, 1980.*
9. *Wolpert-Zur A, Bross A: The formation of the reconstituted family system: Processes, problems, and treatment goals, in Bross A, Papp P (eds): Family Therapy: Principles of Strategic Practice. New York, Guilford Press, 1982, pp 114-127.*
10. *Weiss RS: Going it Alone: The Family Life and Social Situation of the Single Parent. New York, Basic Books, 1979.*
11. *McGoldrick M: Forming a remarried family, in Carter EA, McGoldrick M (eds): The Family Life Cycle: A Framework for Family Therapy. New York, Gardner Press, 1980.*