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The Reconstituted Family

SUMMARY

The reconstituted or step-family is becoming more prevalent. The physician who cares for families should be acquainted with the different aspects of such family structure and family functioning. This will enable professionals to better understand and assist their patients, by anticipating the different stresses related to the new family formation, and supporting their adaptation. (Can Fam Physician 1981; 27:1803-1807).

SOMMAIRE

La famille reconstituée ou belle-famille est un type de famille de plus en plus répandu. Sa structure et son fonctionnement doivent être connus du médecin de famille si ce dernier veut être en mesure de bien comprendre les patients et leur venir en aide. Etre efficace auprès des patients signifie ici favoriser leur adaptation et prévoir les différentes tensions reliées à la formation de la nouvelle famille.

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IN CANADA, three main forms of family structure prevail. They are the intact nuclear family, the single parent family and the reconstituted family, often called the blended or step-family. For the purpose of this article, a reconstituted family is defined as a family in which at least one of the partners is acting as a step-parent. This definition includes families with or without custody of children as well as unmarried parents living in longterm couple relationships.

At the turn of the century, reconstituted families were mainly the result of remarriage after the death of a spouse, hence the expression step-families from the Old English prefix "steop", meaning bereaved or orphaned.[1] More recently, divorce gives rise to an enlarging proportion of reconstituted families: in 1979 there were approximately 59,000 divorces in Canada and of these, close to 15,000 occurred in Quebec.[2] This growth in the divorce rate, combined with a progressive decrease in age at divorce has resulted in the involvement of more and more children.[3-4] In 1975, remarriage accounted for 18.8% of marriages in Alberta, 23.6% in British Columbia, and 17.1% in Ontario.[5] Currently, at least one marriage in five has one previously married spouse, and one child in ten under age 18 (a total of 760,000) lives in a second-marriage family.[6] In the United States, the 1977 statistics estimated that 13% of families were reconstituted and 15% were single-parent.[7] Because of the number of common-law relationships not included in the census data, these statistics are clearly a gross underestimate of the actual number of reconstituted families. This omission has been rectified, however, and the 1981 census will provide a more accurate assessment of the number of such families.

Most of the popular literature about parenting and parent effectiveness is currently directed towards the natural family. Fairy tale literature abounds in myths about bad step-mothers or 'marâtres' who are never as good as natural mothers. Most cultural norms are also aimed at the natural family.[7] Children can be worried about knowing which set of parents they are supposed to invite to their graduation, what they should call this new man their mother is living with, and how they are going to introduce him to their friends. When filling out forms, the new step-parent may not know whether to write his or her name under 'father' or 'mother' or leave it all to the natural parent. All these subtle but powerful messages often put the step-parent in a relatively isolated position.

The family practitioner is often in the ideal position of having seen the progression of a family from the separation caused by divorce or the death of one of the spouses, through the single parent phase to the reconstituted family state following remarriage or common law arrangements. Such families often turn to the family physician as a source of support during the different stages of their adaptation. The family physician must therefore understand the different stresses inherent in the structural and functional elements

of such reconstituted families so that he or she may be able to provide anticipatory guidance, counselling or referral when needed.

Research

Despite the paucity of research data on reconstituted families, Visher and Visher summarize such results as are available in the following terms:[7]

1. There appears to be a positive correlation between socio-economic status and step-family success.[8-10] The higher the socioeconomic bracket, the more positive step-family interaction and functional characteristics were found.

2. Studies of adults indicate that individuals growing up in step-father families do not differ according to measurements of social functioning from individuals growing up in nuclear families.[11]

3. Step-mother/step-child relationships are more tentative and difficult than step-father/step-child relationships.[12]

4. Step-sibling relationships are relatively good, especially when there is a half-sibling to join the two groups together.[12]

5. Step-families experience more psychological stress than do intact families.[13]

6. Step-mothers have difficulties with the negative step-mother image.[7]

Visher concludes that research on step-families is plagued by methodological flaws and there is a need for more logical studies to assess the tensions, the strivings and failings, and the joys and successes of step-families. Research on the impact of divorce, single parent status and death of one spouse is also very relevant to research on step-families, because these past experiences are part of the adaptation that men and women carry with them to their new family experiences.

During periods of stresses, patients tend to consult their physician for various ailments.[14-15] It is therefore important for the family doctor dealing with reconstituted families to understand the various aspects of family structure and their influence on the functioning of the reconstituted family. Such understanding will enable the clinician to help a new family in formation to anticipate and prevent the potential pitfalls associated with their new endeavor. It will also enable the physician to put the clinical problem (psychosomatic illnesses, behavior problems, depression, etc.) in its proper perspective since it could be the result of, or be influenced by, the stresses of step-family formation.

Reconstituted Family Structure

In a nuclear family, the structure is a spouse sub-system, a parent sub-system, and a sibling sub-system.[16] Each of these sub-systems is limited by a boundary indicating that groups of individuals are members of a family system distinct from other families or in-laws in their community. These boundaries can be clear, enmeshed or rigid.[16] Clear boundaries indicate that although the family will accept a certain amount of influence from outside it will retain its own independence. Enmeshed boundaries indicate a lack of distinctive identity in the family that allows large numbers of intrusions from outside (in-laws, service systems). The family with rigid boundaries will not allow any outside influence and functions as a closed system.

The structure of the step-family is often very ambiguous. There is often disagreement as to who belongs to which family and whether it includes the children of this one versus the other one or both. The reconstituted family is clearly not a classic nuclear family and is almost always a much more complex structure. It can include up to six sets of grandparents, four sets of parents, an unlimited number of step-siblings, and at least two households. The step-parents have no legal relation to the step-children, so they have functional responsibility but no legal power. Messenger[13] describes such families as having "permeable boundaries" that are different from the clear boundaries found in the nuclear family. Permeable boundaries may increase the susceptibility to conflict with the previous marriage relationship.

Vischer has summarized the potential problem areas resulting from the structural arrangements of the reconstituted family[7] as follows:

1. The presence of a biological parent outside the reconstituted family and of a same sex adult within the household commonly give rise to power struggles where the children are caught as the victims in between the two households. Such power struggles tend to increase when one of the two ex-spouses remarries. Room has to be made for a new set of values or perceptions on child rearing, for example.

2. Most children hold membership in two households, which gives rise to conflicts between the visitors and the members of the family. Lack of clear role definition and conflicts of loyalty are usually noted.

3. The role of the step-parent is ill-defined. When ex-spouses are involved, their roles are not clearly defined in relation to outside institutions like health services, schools, etc.

4. The fact that reconstituted families come together from at least two previous historical backgrounds accentuates the need for tolerance of differences.

5. Step-relationships are new and untested, not given as they are in intact families.

6. The children in step-families have at least one extra set of grandparents. Grandparents' acceptance of step-children and of the new spouse is very important. Coalitions can be formed, that undermine the child-rearing efforts of the blended family.

7. The final important characteristic concerns financial arrangements. If conflicts over money or alimony existed before the new marriage, they can easily be intensified. New marriages frequently upset a delicate balance, and alimony is well recognized as a fighting ground for couples who separate.

These structural characteristics represent potential pitfalls in the formation of reconstituted families. One cannot consider the step-family as a nuclear family; flexibility and good communication are major factors in the harmonious functioning of such families.

Functioning of the Reconstituted Family

The main function of the family is to integrate internal and external resources to foster the biopsychosocial growth of each of its members. Lewis in his book *No Single Thread* stresses the importance of couple cohesiveness as a main characteristic of healthy families.[17] For the reconstituted family this is even more important, since it will have to adapt immediately to a large number of events. The new

partners have to think of recoupling, parenting, dealing with ex-spouses when present, and new sets of in-laws. One could almost double, in a very short period, the number of adaptations that the reconstituted family has to undergo during the course of its development in comparison with a nuclear family.

Common outside pressures are moving into the neighborhood of one partner (most frequently the husband's), the attitudes of in-laws to the new marriage, the phase of puzzled neighbors when children and parents have different names, and the imbalance of power and responsibility between the custodian and the visitor. Not only do couples who remarry have to learn about the interactional style each has acquired from his or her family of origin, but also the carry-over from previous marital arrangements of at least one of the two members. Even within the family, the spouse who does not have children may feel excluded in some areas by the bonds already established between the partner and his or her children.

The relationship with the ex-spouse can generate a certain amount of stress on the new family in formation: a lack of clarity as to what should be discussed with the ex-spouse, as well as when and where, may have a variety of effects on the reconstituted family. Spouses recovering from a divorce may, for instance, react more sensitively to their new spouses' behavior.

Parenting presents some unusual challenges in reconstituted families. Since the number of involved parents can be as many as four, coordination and consistency of disciplining and of vocational expectations require a considerable expenditure of time and effort.

Parent-Child Relationship

Formation of a reconstituted family necessitates a whole process of negotiation, including an appraisal of the value of previous family arrangements in relation to those that the new family will attempt to create. When two households merge, previous functions, such as who takes care of the dog and who puts out the garbage, have to be renegotiated. Each group of children spends much time keeping track of "who is who's favorite?" The new parent cannot expect instant bonding from the children. He or she has to allow the children needed "space" to relate with their biological parents.

Studies on divorce[18-23] have shown that a good relationship with both sets of parents after divorce correlates with a much better outcome for the children. For some children, the remarriage represents the end of a reconciliation dream; the new family may appear tenuous and the risks of establishing a relationship with the new parent will be under constant test. Children are often the main link between the ex-spouse and the new family. They must not become the message carriers; parenting discussions must occur between the adults rather than through the children. This unduly powerful position is often uncomfortable for children and is not conducive to their optimal development, particularly because children often feel a conflict of loyalty between the two sets of parents even without this added burden.

Duberman's research indicates that step-mothers and step-daughters have more difficulties than step-fathers and step-sons and that the most difficult relationship is between step-mothers and adolescent step-daughters.[12]

Sibling Relationships

When two families merge, the age order of children may be changed so that a younger or older child could suddenly become the middle child. Rooms may have to reallocated, and a difference in status between the resident and the visiting children may become apparent. Chores and tasks may have to be renegotiated. When adolescents are involved, sexuality is more of an issue. Adolescents put together in the same household may be attracted to each other, or may be made uncomfortable at times by the increased sexual activity of the newlywed parents.

There are, then, a number of difficult areas in adaptation, emphasizing the great need for flexibility and effective communication in the formation of a reconstituted family. The family physician has a very important function in assisting the reconstituted family. He or she is often the one constant figure who has followed a family through its disintegration, its single parent phase and its reconstitution. In working with a reconstituted family, the physician must be aware, not only of his or her own values and attitudes towards divorce and remarriage, but also of his or her previous alliance and with one of the ex-spouses. These attitudes may color the physician's judgement and may interfere with his or her ability to be helpful to the new family.

Many communities do not provide adequate support for step-families. The family doctor may then become a front-line provider to whom the family will turn for help. His or her role is that of providing anticipatory guidance to the family in formation, counselling or facilitation to help the family solve current transitional problems, or referral to mental health workers when the family's lack of adaptive capacity prevents it from making necessary and appropriate changes.

Anticipatory Guidance

Reconstituted families are unusually willing, during the process of their formation, to discuss any question that is relevant to the success of their new union. The family physician is in a privileged position which allows him or her to offer the new couple the opportunity to sit down and review any questions they may have on parenting, relationships with ex-spouses and grandparents, and reactions of children to new members of the family, etc. By reviewing the various aspects of the new family structure and the functional adaptations required, the family and the physician can jointly anticipate and prevent some of the difficulties that commonly occur during the formation of the reconstituted family. The doctor should stress the importance of the roles to be played by each of the parental figures in bringing about a successful transition. In so doing, the physician will cover any areas pertinent to their life as a new couple or as new parents.

Couple

1. How much time have you scheduled for yourselves, as a couple? The parental figures in reconstituted families are suddenly confronted with a large number of responsibilities to children and to community; it is easy for them to be left without the couple time that is essential to their longterm bonding.

2. How have your previous experiences changed your perspectives on this marriage? This question may

allow the couple to deal with some of the fears they may have about repeating previous patterns; mothers who have come through a single parent phase may have increased their activities during the process and may not wish to return to a more traditional role assignment.

Parenting

1. How are the children reacting to the new marriage? This question may provide the opportunity to discuss some of the fears the parents may have about the effect remarriage might have on their children. Children will react differently according to their own stage of development. For example, school age children or preschoolers may resent the new marriage, since it terminates their fantasies of a reunion; an adolescent who may have enjoyed a more adult status during the single parent phase may resent becoming one of the children again. An attitude of not rushing or pushing and of providing ample time for the children to develop their relationship with the new parent is usually more conducive to a successful transition. By not making too many demands on the children for affection, the new parents will alleviate the loyalty problems some children may have about biological parents and the step-family.

2. How are you planning to work out the sharing of child-rearing responsibilities? This broad area covers everything from disciplining to flexibility in adapting to a difference of values and approaches to child-rearing. The biological parent may often assume disciplining responsibility at the beginning, followed by a progressive transfer to a shared responsibility with the step-parent as his or her relationship with the child becomes consolidated. Step-parents should, nevertheless, be aware of the playmate trap that may have developed during the courting phase of their relationship. The support of the biological spouse will help the step-parent to feel comfortable in establishing his or her role as a parent.

3. What plans have been made for the necessary contacts and relationships with an ex-spouse? This allows the couple to examine their attitudes, flexibility and comfort in dealing with such things as visiting and financial arrangements with the other biological parents. The more courteous and flexible the visiting arrangements, the more the children will be able to benefit from contact with the different adults involved. The parenting relationship within and between the families must remain at the parental level, so that the children are not ensnared as message carriers between the families.

Facilitation

Although anticipatory guidance is preferable as a form of prevention, patients more commonly present themselves when a specific problem arises. When the family physician is aware that his patient is part of a family in transition, he should elicit data pertinent to the different stresses generated by the transition. Whether one deals with the symptoms of one of the spouses or a behavior problem with one of the children, seeing the couple will allow a better grasp and understanding of the problem.

We have found that telling each patient how much importance we attach to the family as a unit in our practice facilitates their acceptance of the benefits to be derived from participating in such meetings. Even in dealing with the problems of a child, we find an interview with the couple very advantageous. During such an interview, the different points mentioned under anticipatory guidance are reviewed in order to give the clinician a better understanding of the specific structure and functioning of this particular reconstituted family. Couples welcome these discussions when they realize that their concerns are not at all uncommon to families in their situation. Under these circumstances the family physician's role is that of a facilitator in the transitional process.

Referral

Finally, there are situations where the family system does not have the flexibility required to adapt to unavoidable changes. Biological parents and children may be so close as to exclude the new step-parents; children can be caught between the two families as message carriers when there is virtually no other channel of communication, and situations may develop where the family cannot adopt simple suggestions, or the problem is of such long duration (over six months) that the family doctor should enlist the help of a mental health worker. We prefer to use consultants with a family orientation. Even if the consultant may need to spend more time with different members of the family, his or her competence with the overall family system will be more efficient in the long run. Ex-spouses may need to be seen together in order to clarify various issues of visiting and child-rearing. Occasionally both families may need to be seen together to point out to the children that they need not be involved with adult matters. The physician's main contribution in such situations is his or her ability to clarify the problem for the family and to negotiate such interventions as may be necessary. If the physician is to play as constructive a role as possible, he or she must transfer the trust that the family will have developed in him to the consultant.

The family physician may wish to use other resources in the community in his or her efforts to help a reconstituted family through any formative difficulties. Support groups or couples of reconstituted families are one of these resources. Such groups are often available through community agencies like the YMCA or social service agencies. The physician can also provide a list of relevant books or other helpful literature for step-families. The book by Visher and Visher is an excellent reference work for both professionals and step-families.[7]

Conclusion

Major changes are occurring in the structure of the Canadian family. Step-families are becoming more prevalent. Step-family formation presents a challenge to the creativity of couples who embark on it. The physician who cares for families in the process of reconstitution should know about the different phases through which they will pass. Such knowledge will enable the family physician to more readily perceive and more fully understand the different stressors that may impel some of the patients who arrive in his or her consulting room.

References

1. Living Webster Encyclopedic Dictionary of English Language. Chicago, The English Language Institute of America, 1971, p 957.

2. Statistics Canada: Divorce and Marriage Rate for 1979. Ottawa, Government of Canada, 1980.

3. Maddox B: The Half Parent. New York, Evans, 1975.
4. National Council of Welfare: One in a World of Two's. Ottawa, Government of Canada, 1976.
5. Roy L: Les remarriages, de plus en plus nombreux au Québec. Cahier québecois de démographie 1979 Avr; 8:30-40.
6. Carson S: Don't expect to be instant pals with stepchild. Montreal Gazette, Dec 20 1980, p 69.
7. Visher EB, Visher JS: Step-Families: A Guide to Working with Stepparents and Stepchildren. New York, Brunner Mazal, 1979.
8. Bowerman CE, Irish DP: Some relationships of stepchildren to their parents. Marriage Fam Living 1962 May; 24:113-131.
9. Bernard J: Remarried: A Study of Marriage. New York, Russell and Russell, 1971.
10. Langner T, Michael ST: Life Stresses and Mental Health. New York, Free Press, 1963.
11. Wilson KL, Zurcher LA, McAdams DC, et al: Stepfathers and stepchildren: An exploratory analysis from two national surveys. J Marriage Fam 1975; 37:526-536.
12. Duberman L: Step-kin relationships. J Marriage Fam 1973; 35:283-292.
13. Messinger L: Remarriage between divorced people with children from previous marriages: A proposal for preparation for remarriage. J Marriage Fam Counselling 1976; 2:193-200.
14. Gallin R: Life difficulties, coping and the use of medical services. Cult Med Psychiatry 1980; 4:249-269.
15. Mechanic D: Response factors in illness: The study of illness behavior, in Jaco EG (ed): Patients, Physician and Illness. New York, Free Press, 1972, pp 118-130.
16. Minuchin S: Families and Family Therapy. Massachusetts, Harvard University Press, 1975.
17. Lewis J, Beavers WR, Gosset JT, et al: No Single Thread: Psychological Health in Family Systems. New York, Brunner Mazel, 1976.
18. Hetherington EM, Cox M, Cox R: Divorced fathers. Fam Coordinator 1976 Oct; pp 417-428.
19. Hetherington EM, Cox M, Cox R: The aftermath of divorce, in Stevens JH Jr, Matthews M (eds): Mother-Child, Father-Child Relations. Washington, DC., NAEYC, 1978.
20. Hetherington EM: Family interaction and the social, emotional and cognitive development of children after divorce, in Brazelton TB, Vaughan VC (eds): The Family: Setting Priorities. New York, Science and Medicine Publishing Co., 1979, pp 71-87.
21. Wallerstein JS, Kelly JB: The effect of parental divorce: Experience of preschool children. J Am Acad Child Psychiatry 1974; 14:600-616.
22. Wallerstein JS, Kelly JB: The effect of parental divorce: Experience of the child in early latency. Am J Orthopsychiatry 1976; 46:20-37.
23. Wallerstein JS, Kelly JB: The effect of parental divorce: The adolescent experience, in Koupernik C, Anthony J (eds): Child in the Family. New York, John Wiley, 1974, vol 3, pp 479-505.