Stepfamilies as Patients

Anne Herndon, PhD, and Linda G. Combs, PhD
Winston-Salem and Charlotte, North Carolina

Census figures point out the increase in the population of stepfamilies, families in which one adult is a stepparent. Since it is likely that family physicians will have more stepfamilies in their patient populations than in previous times, it is important for physicians to be aware of the characteristics of stepfamilies that are not present in intact nuclear families. These characteristics are (1) the formation of the stepfamily out of loss, (2) a common history of some family members, (3) a parent-child bond that predates the couple bond, (4) a biological parent elsewhere, (5) children as members of two households, and (6) the legal limitations of the step relationship. Functions the physician might be able to serve for the stepfamily as its members work on the tasks associated with each characteristic are described. Recommendations for residency training and resources for physician and patient education are given.

Family physicians and others have been defining, refining, and debating the meaning(s) of *family* in family practice for a number of years. The standard definition of family given in "A Glossary for Primary Care" is "a group of persons sharing a common household. A relationship (not necessarily by blood or marriage ties) is implied."[1] The family has most frequently been depicted as a group of individuals sharing a common past and future and bound by emotional and/or blood ties. The biologically intact nuclear family and its life cycle stages are clearly described in the standard family medicine texts.[2-5] Recent reports from the US Bureau of the Census indicate, however, that at any given point in time, the majority of households in the United States are not intact nuclear family structures.[6] An increasingly prevalent family structure is the stepfamily. The stepfamily as a unique family structure with associated specific needs has not been reflected in the family practice literature.

The purpose of this article is to examine features that distinguish the stepfamily from the traditional intact (biological) nuclear family model and subsequently to clarify the physician's functions in constructively assisting individuals in such a family group. In addition, the inclusion of relevant information regarding stepfamilies as part of the residency program curriculum will be discussed.

Stepfamily Population

Blended, reconstituted, remarried, and recoupled are all terms which have been applied to the stepfamily structure. For this discussion a

From the Departments of Psychiatry and Behavioral Medicine and Family and Community Medicine, Bowman Gray School of Medicine, Winston-Salem, and the Department of Family Practice, Charlotte Memorial Hospital and Medical Center, Charlotte, North Carolina. Requests for reprints should be addressed to Dr. Anne Herndon, Department of Psychiatry and Behavioral Medicine, Section on Marital Health, Bowman Gray School of Medicine, 300 S. Hawthorne Road, Winston-Salem, NC 27103.

0094-3509/82/050917-06$01.50

stepfamily will be defined as a family in which one of the adults is a stepparent, regardless of the ages of the children.

The stepfamily structure is important to the family physician for at least two reasons. First, stepfamilies make up a numerically significant proportion of the patient population. By 1979 it was estimated that stepfamilies accounted for 10 to 15 percent of all households in the United States.[7] By 1978 at least 6.5 million children under the age of 18 years lived with a natural parent and a stepparent, a conservative figure, since children living with their natural father and a stepmother were not included in the figures. The 6.5 million also does not include children living with a single parent who visit a remarried noncustodial parent. Glick, who has long done the most careful assessments of family trends based on the census data, predicts that by 1990 the number of stepchildren will probably exceed 7 million and represent at least 11 percent of all children under the age of 18 years.[8]

The term *step* is a derivative of the Old English word *steop,* which denoted the bereaved or orphaned. The authors use the term *stepfamily* with full recognition that a minority of such families are now created following the death of a biological parent. Glick identified the years (1974 and 1975) in which the number of marriages disrupted by death was equalled and then exceeded by marriages disrupted by divorce. In fact, by 1979 only 12 percent of all the single-parent families in the United States were headed by widows or widowers.[9]

In addition to the numerical significance of stepfamilies in a patient population, stepfamilies are significant because they involve issues and developmental tasks that are in dramatic contrast to those of nuclear family units. The authors recognize that adoptive families are generally considered as nuclear families; however, the adoptive family is excluded from the definition of nuclear family in this article precisely because the adoption process gives rise to several characteristics in common with stepfamilies. Further treatment of this point can be found in the Vishers' comparison of stepfamilies and adoptive families.[10]

Current curricula of medical schools and residency programs appropriately focus on the intact biological family life cycle as a foundation for understanding family processes and development. In addition, however, curricula should include study of the typical issues facing alternative family structures such as the single-parent family and the stepfamily. It is inappropriate to study these alternative forms as aberrations of the nuclear family model.

Stepfamily Characteristics

There are six characteristics of stepfamilies that are different from those of biological nuclear families.[10] These characteristics have a strong impact on stepfamily development. Development, it is assumed, will be enhanced as the family accomplishes the tasks associated with each characteristic. The authors have suggested corollary functions for physicians as a way to stimulate and complement the family's tasks (Table 1).

It is important to remember that the characteristics of stepfamilies are mediated by ages of the stepchildren, life cycle stage of each blending family segment, and socioeconomic status of the family. A discussion of how these factors affect stepfamily development is beyond the scope of this article and must await careful research.

Loss

A stepfamily is born of loss. A stepfamily is formed because of the dissolution of the nuclear couple unit, either by death or divorce. Both the children and the biological parent have lost an important relationship. It is the remarriage of a biological parent that results in the stepfamily. In many cases, the stepparent has also been through a relationship loss. The implication of this characteristic of stepfamilies is that all members must go through a grieving process.

A second major loss for all of the family members is the loss or change of the original family relationship, with its traditional norms and clear expectations. The stepfamily, when it is formed, moves into largely uncharted territory. There are no clearly set rules, roles, or expectations for step relationships. The grieving process over the loss of the nuclear family relationship can be a subtle one. It is a very real process, however, since the general expectation is that one will live happily ever after in a nuclear family. (Does a child say he plans to be a stepparent when he grows up?)

The task for stepfamily members is completion of grieving for relationship losses and the loss of the nuclear family pattern. It will be difficult

Table 1. Physician's Function in Relation to Stepfamilies

Stepfamily Characteristic	Physician's Function	Stepfamily's Task
Loss	Gather information on previous family patterns: length of marriage(s), length of divorce or widowhood, situation of absent biological parent	Complete grieving over relationship and nuclear family losses
	Educate family members on the normal grieving process	
Common history	Establish record-keeping system to accommodate various last names within family	Negotiate differences
	Encourage couple planning of discipline strategy	Develop new patterns and traditions
	Encourage family creativity in developing new traditions	
Parent-child bond predates couple bond	Support couple bond	Establish a strong couple bond
Biological parent elsewhere	Encourage direct communication of adults	Establish direct communication between adults
	Arrange for transfer of medical records	
Children in two households	Determine visitation arrangements	Encourage children to enjoy both households
	Discuss implications of visitation for continuity of medical care	Establish ground rules for each household
No legal step relationship	Determine necessity of consent form for stepparent and noncustodial parent	Draw up legal agreements

for the family to accomplish other developmental tasks if this one is not finished.

The physician can facilitate this important family task first by gathering family history information that may pinpoint difficulty in the grieving process. The circumstances surrounding the dissolution of the original marriage(s), the ages of the children at the time of the original dissolution and remarriage, and involvement of biological parents, all need to be considered in assessing potential unfinished issues of grieving. An additional function for the physician can be educating family members about the normal grieving process they may experience in themselves and each other. The goal might be for the family to be tolerant of the process of grief resolution and foster a sense of cooperation as a result.

Common History

Some stepfamily members have a common history, whereas others do not. This characteristic is most evident in daily conflicts such as those that arise over the "correct" way of making a certain dish or in planning for holidays. A great deal of the initial tension in stepfamilies is the result of conflicts based on common histories.

One of the most frequent sources of tension within a stepfamily is the differing expectations each adult has regarding discipline of children. This is particularly a problem if both of the spouses are biological parents and both sets of children reside in the home. The adults have the choice of developing either a mutual system of discipline in which each will support the other or a system that supports the right of each biological parent to discipline his or her own children. The difficulty with the latter choice is that, inevitably, the stepparent will encounter situations that require immediate attention despite the absence of the biological parent. .

Stepfamily members need to negotiate their differences and explore their various expectations. Stepfamilies have an opportunity for increased

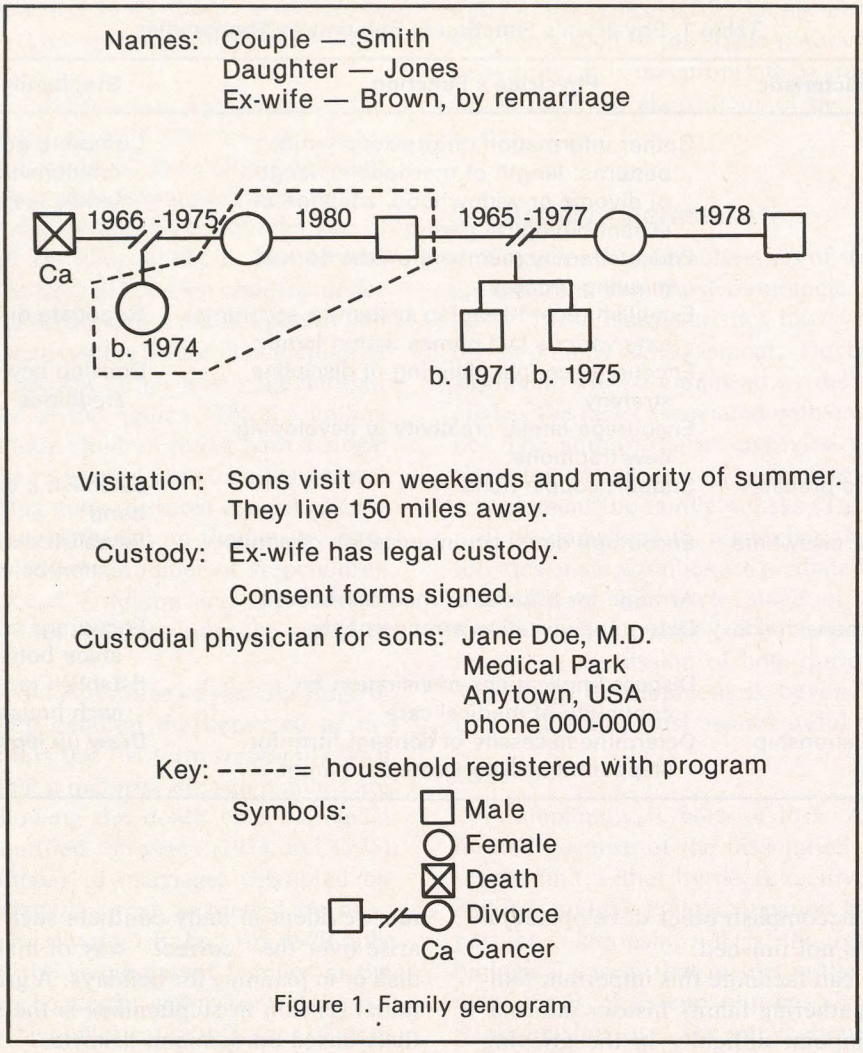

Figure 1. Family genogram

intimacy as a result of the negotiation of the differences that must occur. The various family members can develop creativity as they devise alternative plans for accomplishing desired goals.

The physician has several ways of dealing with the idiosyncrasies that arise from the common histories of family members. Initially the physician will need to determine whether the office record system allows for the variety of surnames possible in a stepfamily. A family genogram with the records might also be helpful as a quick reminder of the specific family arrangements (Figure 1).[11]

Healthy family functioning occurs most easily when the adults have clear executive roles in relation to the children.[12] The physician can encourage couple planning of discipline strategies that take into account the new family patterns. Opportunities may also arise to stimulate flexible attitudes among family members that will encourage creative ways of perceiving and developing family traditions.

Parent-Child Bond Predates Couple Bond

One of the most striking characteristics of the stepfamily is that the parent-child bond predates the couple bond. The typical nuclear family has a period of time during which the couple bond becomes established prior to the arrival of children.

This is not true for the stepfamily. Consequently, jealousy and resentment may arise between a stepparent and stepchild who feel that they are in competition for the favor of the spouse who is the biological parent. The stepparent may feel guilty about his or her jealousy of stepchildren. The biological parent often feels caught in the middle between his or her own children and the spouse.

Establishment of a strong couple bond within the stepfamily is the central task related to this characteristic. This bond is essential for the survival of the stepfamily. The physician can support the couple bond by encouraging the couple to plan time and activities together.

Biological Parent Elsewhere

There is another biological parent elsewhere. Whether the absent biological parent is living or dead, the concept of that parent has an impact on the stepfamily. If the biological parent is living, then there is another adult who influences the activities of the stepfamily, since often visitation schedules have been arranged. The stepfamily either sends the children to visit the noncustodial parent or it receives visits from the stepchildren who reside primarily with the other biological parent. Stepfamilies' plans for vacation and holidays must take into account the children's need to see both biological parents as well as their grandparents. For this reason, such plans usually cannot be made solely by the couple unit in the stepfamily alone.

If the remarriage has occurred following the death of a spouse, the reality of the deceased parent must still be considered by the stepfamily. In addition to having time to work through the grieving process, the children also need to know that their original parent is remembered appropriately. The grandparents and extended family of the deceased parent may be living and may still need to have some role in the children's lives. Many stepparents find that confronting memories of the deceased parent is more difficult than working with a living parent. As one stepmother put it, she had the feeling that she was "competing with an angel."

Ideally, all adults involved with the children would make plans directly with each other. For joint custody cases in which the biological parents put the welfare of their children and their parenting responsibilities above and separate from their previous marital difficulties, this arrangement has been worked out satisfactorily.[13] Realistically, however, in most families this attitude does not occur. The physician may be able to encourage one or more adults to assume the responsibility for communicating with other family members. It is important to emphasize that the child's welfare is facilitated when adults communicate directly and avoid using the children as message-bearers.

Children in Two Households

The children are members of two households or extended families. This characteristic is especially applicable if both biological parents are living. The majority of custody agreements provide for some visitation arrangements, which means that children will be switching households on a variable schedule. Stepfamilies have to deal with "culture shock" as the stepchildren shift from one living environment to another. While most children are able to make the adaptation and learn what is appropriate in each environment, it is not unusual to find that at some point they will test the limits of discipline.

Also, children may feel some confusion about where they belong and may have some conflicts over loyalty. A common concern voiced by children of divorced parents is that they want to give equal time and attention to both parents.

Adults and stepfamilies can help the children adjust to the confusion of membership in two households by establishing clear ground rules within their own household. The adults can then encourage the children to enjoy both households and to see the differences between them as an opportunity for an increased variety of experiences. Such an approach relieves the child of having to label one household as "good" and the other as "bad."

The physician's functions related to this fifth characteristic of stepfamilies center around visitation. Part of the basic information necessary for treating stepfamilies is the visitation arrangements. If the primary patients are the noncustodial parents/stepparents, care of the children may be episodic or crisis oriented. If the patients are the custodial stepfamily, the physician may want to suggest that some health information on the children be sent to the noncustodial parent's family physician. These points need to be discussed with the adults prior to an emergency.

No Legal Step Relationship

There is no legal relationship between the stepparents and stepchildren. Their relationship ends when the marriage ends unless a legal adoption has taken place. One important factor of the step relationship for the medical setting is that the stepparent is not a legal guardian and therefore in many cases is not able to sign consent forms for nonemergency procedures. In some states the noncustodial parent also does not have the legal right to sign consent forms.

Because of the lack of a legal relationship, the important task the stepfamily must accomplish is the development of legal agreements such as wills and (possibly) consent forms. The physician's function is to learn what local laws apply regarding medical treatment of stepchildren.

Discussion

Clearly, the physician has a unique set of opportunities to foster the positive growth and development of stepfamily members who are in his or her clinical practice. In addition, there are important issues to be considered when the legal custody of a minor is a crucial factor.

The *Essentials for Residency Training in Family Practice* state that the "family practice resident must understand the importance of communication and interaction within the family under his care." It goes on to say that the resident "must have enough exposure to recognize stages of stress in the family life cycle."[14] Current family medicine literature has only recently begun to pay attention to normative patterns of family structures other than those of the nuclear family. Since census figures indicate that stepfamilies are on the increase, it seems advisable for family medicine educators to prepare residents who are able to work with the types of families they are likely to encounter. The intact nuclear family is not a sufficient model for norms within stepfamilies or other nonnuclear family structures. Residency training needs to provide data on normative family interaction and development, not only for stepfamilies, but for all types of family structures.

Family physicians now in practice may have had little exposure to information on stepfamilies and also may not know what to suggest to their families for patient education on this subject. Listed below are resources the physician may find helpful for continuing education. These resource references are also appropriate to suggest for patient education. They are commonly available as paperbacks in bookstores and in public libraries.

Suggested Reading

Nonfiction

Maddox B: The Half-Parent. New York, Evans, 1975

Roosevelt R, Lofas J: Living In Step. New York, Stein & Day, 1976

Visher EB, Visher JS: Step-Families: Myths and Realities. Secaucus, NJ, Citadel, 1979

Fiction

Klein N: Taking Sides. New York, Avon, 1976
A preteen describes her adjustment to her parents' divorce and to the possibility of a stepmother.

Oppenheimer JL: One Step Apart. New York, Grosset & Dunlap, 1978
A book for young people that describes stepchildren's feelings well.

Thayer N: Stepping. New York, Doubleday, 1979
Written from the stepmother's viewpoint, this book depicts the evolution of family relationships with visiting stepchildren over time. The portrayal of the stepchildren's reactions to their stepmother's pregnancy is well done.

References

1. A glossary for primary care. Report of the North American Primary Care Research Group (NAPCRG) Committee on Standard Terminology. J Fam Pract 5:633, 1977

2. Baider L: Introduction to the sociology of the family. In Medalie JH (ed): Family Medicine: Principles and Applications. Baltimore, Williams & Wilkins, 1978, p 29

3. Geyman JP: Family Practice: Foundation of Changing Health Care. New York, Appleton-Century-Crofts, 1980, pp 225-248

4. Rakel RE: Principles of Family Medicine. Philadelphia, WB Saunders, 1977, pp 249-278

5. Ransom DC, Massad RJ: Family structure and function. In Rakel RE, Conn HF (eds): Family Practice, ed 2. Philadelphia, WB Saunders, 1978, pp 20-31

6. Population characteristics; household and family characteristics: March 1978. Bureau of the Census (Suitland, Md): Current Population Reports, series P-20; No. 340. Government Printing Office, 1979

7. Espinoza R, Newman Y: Stepparenting, with annotated bibliography. Center for Studies of Child and Family Mental Health, National Institute of Mental Health (Rockville, Md). DHEW publication No. (ADW) 78-579. Government Printing Office, 1979

8. Glick P: Remarriage. J Fam Issues 1:455, 1980

9. Bernard J: Afterword. J Fam Issues 1:561, 1980

10. Visher EB, Visher JS: Stepfamilies: A Guide to Working With Stepparents and Stepchildren. Secaucus, NJ, Citadel, 1979

11. Jolly W, Froom J, Rosen MG: The genogram. J Fam Pract 10:251, 1980

12. Haley J: Leaving Home. New York, McGraw-Hill, 1980

13. Steinman S: The experience of children in a joint-custody arrangement: A report of a study. Am J Orthopsychiatry 51:403, 1981

14. Special requirements for residency training in family practice. In Directory of Residency Training Programs, 1979-80, Chicago, American Medical Association, 1979, pp 34-36