Chapter 2
Healthy Families and Their Development

What is a healthy family?

Is the family that is here with me today a healthy one?

What are their strengths and weaknesses that may help determine how healthy they are?

These are the kind of questions therapists ask themselves when a family comes seeking help.

As we have seen, families vary. There is no one type of 'normal' family.

But can we define a 'healthy' family? Perhaps, but well-functioning families also come in many forms. The most important consideration is the extent to which the family provides for the needs – material, emotional and spiritual – of its members. So how can we tell whether, and to what extent, the needs of the members of a family are being adequately met?

The first and second editions of this book, published in 1981 and 1986, respectively, had an outline on the front covers of a four-member family – a father, mother and two children, a boy and a girl – the archetypical nuclear family. But nowadays such families are in the minority in many cultures and societies. Twenty-three percent of UK families with dependent children are lone female-headed households (Gorell Barnes, 2004, p. 47).

In recent years I (PB) have rarely seen families in which the child or children are living with their two natural parents, neither of whom has been married previously. While this might be partly because such families have fewer problems and thus seek help less often, the statistical fact is that such families are becoming ever rarer and make up a smaller and smaller proportion of the population.

There have been substantial increases in the rates of divorce, of single, never-married women raising children on their own, of blended families and of other 'atypical', but not necessarily unusual, family constellations. In addition, increasing numbers of women work outside the home, so that many young children spend much of their time in day care.

Determining whether a family is 'healthy' is a challenge, probably greater than that of determining whether an individual is physically healthy. We can assess the health of individuals by measuring a variety of indicators: blood pressure, cholesterol levels, haemoglobin levels, fasting blood sugar, height

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and weight and body/mass index – to name just a few. But similar data are not available for use as indicators of emotional health.

There have been many suggestions as to what the criteria for normal families should be. These were addressed from various theoretical viewpoints in the original edition of the book *Normal family processes* (Walsh, 1982). A decade later, in the second edition of her book Walsh (1993, pp. 3–4) writes:

> Over the past decade, attempts to define family normality have become more complicated and more important—clinicians and family scholars have been further humbled in addressing normality by our increasing awareness that all views of normality are socially constructed, influenced by our own world view and by the larger culture.

So the time may have come for us to abandon the search for the 'normal' family and seek instead the 'healthy' family. Perhaps that is what Froma Walsh, the author of the above book, was really looking for when she discussed criteria for 'normality'. She distinguished families that function asymptomatically; those that function optimally; and those that function in a way that is statistically average. Normality may also be defined in terms of the processes occurring in the family of which Walsh wrote:

> Basic processes involve the integration, maintenance, and growth of the family unit, in relation to both individual and social systems. What is normal—either typical or optimal—is defined in temporal and social contexts, and it varies with the different internal and external demands that require adaptation over the course of the family life cycle. (Walsh, 1982, p. 6)

Thus the question of what is a normal – or a 'healthy' – family is not an easy one. Nevertheless Froma Walsh has soldiered on to provide answers, undeterred by the complexity of the subject, and the fourth edition of *Normal family processes* (Walsh, 2012) appeared while this chapter was being revised. It has proved to be a goldmine of information and will surely be a major resource for all who wish to get to terms with, and understand, the changes that have occurred, and continue to occur, in the lives of families. The emphasis is on the American scene, but much of the information surely applies to the white, English-speaking, middle class populations of many other countries.

At nearly 600 pages, this book may not be for everyone concerned with families, but all who aspire to work with families in any therapeutic setting would certainly gain much from reading at least the initial 'overview' (Chapter 1). This chapter is entitled 'The New Normal: Diversity and Complexity in 21st Century Families'. It has two sections. One is headed 'The Changing Landscape of Family Life: The Broad Spectrum of Normal Families' and the other 'Families in Transformation: A Pluralistic View of Normal Families'.

We cannot here go into this subject matter in any depth, but it is all there in this new edition of Walsh's book. It must suffice us to list the contents of the rest of the book:

Part 2: Varying Family Forms and Challenges
Part 3: Cultural Dimensions in Family Functioning
Part 4: Developmental Perspectives on Family Functioning
Part 5: Advancing Family Systems Research and Practice

Ethnic variations

The importance of ethnicity has long been recognized. What is acceptable and functional in one ethnic group may not be so in another. As therapists, most of us probably, at least at an unconscious level, tend to lean towards norms and values similar to those of the culture in which we have grown up. This may make it hard to engage families from other cultures and ethnic groups, and so lead to therapeutic failure. A good knowledge of the ethnic variations to be found in the population with which one is working is therefore important.

McGoldrick, in the first edition of *Ethnicity and family therapy* (McGoldrick & Carter, 1982), reviewed the relationship between ethnicity and family therapy. She pointed out that ethnicity is 'deeply tied to the family' and is transmitted by means of the family. She emphasized that family therapists should pay careful attention to the cultural influences on families. This is surely even truer now than it was when McGoldrick wrote these words.

The third edition of *Ethnicity and family therapy* (McGoldrick, Giordano, & Garcia-Preto, 2005) reviewed some 47 ethnic groups and is by no means exhaustive. Its emphasis is on immigrants to America from other parts of the world. Thus the chapter dealing with 'Families of African Origin' does not consider in any depth African families that have remained on that continent. That may be because in much of Africa families are too poor and preoccupied with the tasks necessary for physical survival to seek help with family relationship problems. But in some parts of Africa, notably South Africa, family therapy is practised.

Yet another challenge is provided by the ethnically mixed marriage. Nowadays we may be confronted with families in which the partners come from families of origin with different cultural standards and values. The challenge can be even greater when they also come from different ethnic groups. It is usually helpful to approach such families with an attitude of respectful curiosity, valuing and validating the uniqueness each partner brings to the union.

The functions of families

Most of us who work with families would probably agree that the functions a family should serve include:

- Provision of the basic necessities of life for its members.
- The rearing and socialization of children.

- Provision for the legitimate expression of the marital couple's sexuality.
- Provision of mutual comfort and support.
- Reproduction and the continuation of the species.

The above do not all apply to every family. Some couples do not have children; in others the children have grown up and left home.

Societies, mostly in the 'developed' world, help with the rearing and socialization of children by providing schools, which socialize as well as educate, and sometimes other institutions – youth groups, boy and girl scouts, church groups, summer camps and so on – that supplement what the family does. They also wait in the wings for families to run into trouble, providing social service agencies to assist families or to take over the care of children, when families fail to do this properly. In varying degrees they may provide financial and material help to needy families.

In the past, and even today in some parts of the world, many of the functions now carried out by society's agencies were performed by the extended family. This consisted of a kinship network of grandparents, uncles, aunts, adult siblings, cousins and other relatives. Sometimes people unrelated by blood, but living in the same social network, also participated. But in industrial, especially large urban societies, a smaller role is generally played by the extended family and the neighbourhood community. Thus the parent or parents are faced with bigger tasks to perform than used to be the case. This is not to say that extended family networks no longer exist. They do, but they are fewer than they were, especially in large urban communities and where there is a high level of migration.

Family therapists are concerned with all forms of family life, whether traditional or not. All these forms aim, explicitly or implicitly, to meet the needs of their members, but what these are considered to be may vary. For example, pre-marital sex may or may not be considered acceptable; and the increasingly common practice of unmarried couples living together is no longer frowned upon in many societies. The family therapist must be sensitive to, and take into account, the standards and the moral and cultural values of the families coming to them for treatment.

AIDS has had devastating effects on family life. In sub-Saharan Africa, for example, there are millions of 'AIDS orphans'. Consequently many families are headed not by lone mothers but by children, some as young as 11 or 12 years.

Family development

Families are not static entities. They are continually changing, and there is a cycle of formation, growth, decline and dissolution that they all follow, with various diversions possible along the way.

Our therapeutic approaches must take into account the current developmental stage of the family. Nichols (1996) emphasized this, in *Treating*

people in families: An integrative framework, in successive chapters dealing with:

- Families in formation
- Expanding families
- Contracting families
- Postparental couples
- Families in transition due to divorce
- Families in transition due to remarriage

Previous descriptions of family development include those of McGoldrick and Carter (1982) and Duvall and Miller (1985). However, these seem increasingly outdated in that they assume, implicitly if not explicitly, that the normal process is that of a young couple meeting, courting, getting married, having and rearing children, then retiring and becoming grandparents. While this sequence of events still sometimes occurs, it is far from the current norm. It does not take account of the teenage girl who gets pregnant as a result of a casual sexual encounter; nor of 'arranged' marriages and other marriages that result from parental pressure; nor of gay couples who, in some jurisdictions, may be legally married and adopt children. And as we have seen, in some countries polygamy is still legal and practised.

The current reality is that families rarely develop in entirely smooth and predictable ways. Apart from situations such as those mentioned previously, development may be affected by the death of family members; the separation or divorce of the spouses; the late birth of a child or children after the others have grown up; the arrival of new children in a reconstituted family; chronic illness; financial setbacks; migration from one culture to another; natural disasters; military service; war; and many other circumstances.

The clinical importance of family developmental stages

Two main areas need to be considered when a family presents for treatment. One is the family's developmental stage. The other is the family's structure and way of functioning.

Many of the clinical problems with which families present are related to difficulties in making the transition from one developmental stage to the next. When this is the case the therapist needs to consider how the developmental process can be freed or assisted. Are there any road blocks, either in the family's social context or within the family itself, that can be removed with the help of the therapist?

Barnhill and Longo (1978) defined nine *transition points* which need to be negotiated as the family passes from stage to stage. Despite the changes

in families and the wide variety of family forms we encounter nowadays, the concept of transition points remains useful. Those suggested by Barnhill and Longo were:

0–1: Commitment of the couple to each other.
1–2: Developing new parental roles, as husband and wife become father and mother.
2–3: Accepting the new personality, as the child grows up.
3–4: Introducing the child to institutions outside the family, such as school, church, scouts, guides and sports groups.
4–5: Accepting adolescence, with the changed roles associated with this, and the parents' need to come to terms with the rapid social and sexual changes occurring in their son or daughter.
5–6: Allowing the child to experiment with independence in late adolescence and early adulthood.
6–7: Preparations to launch, the term used by Barnhill and Longo for the process whereby the parents come to accept their child's independent adult role, which includes starting his or her own family.
7–8: Letting go – facing each other again, when child-rearing is finished and the couple face each other as husband and wife alone again.
8–9: Accepting retirement and/or old age, with the changed lifestyle involved.

While accepting that many families are headed by single parents rather than couples and that family forms are more variable now than when Barnhill and Longo (1978) put forward the concept of transition points, the fact remains that any family is faced with the need to negotiate transitions.

Just as an individual's development may be fixated at a particular stage – when it has failed to proceed beyond that stage at a time when it normally would have done so – so may a family fail to make one or more of the needed transitions. A family may also regress, that is, go back to an earlier transition point, usually when faced with some stress. Barnhill and Longo also put forward the concept of 'partial fixation', when a family life cycle transition has not been successfully achieved, although a partial and even superficially satisfactory, though often precarious, adjustment has been made.

Optimal family functioning

Kirschner and Kirschner (1986, Chapter 2) introduced the concept of 'optimal functioning'. They considered the marital transactions; the rearing transactions; and the independent transactions. The latter refers to the functioning of the individual family members in their own activities, be they vocational, educational, social or recreational.

In two-parent families, the *marital transactions* are the foundation on which everything else rests. The marital couple first needs to meet each other's needs. As 'reparental' figures for each other, each spouse can provide inputs that were lacking in the partner's family of origin. A spouse may programme the other for self-confidence and success through suggestions and directives regarding productive behaviours. Education, modelling, confrontation, validation, encouragement and inspiration may also be provided (Kirschner & Kirschner, 1986, p. 30).

If the marital relationship is a poor one, the foundations for a successful, well-functioning family unit are lacking, or at least shaky. It is hard for a couple who do not get along well together to function effectively as a parental team. An important part of the assessment of a family, therefore, is the assessment of the quality of the marital relationship.

The essential question is whether the marital partners get satisfaction out of their relationship. Ideally, they nurture, affirm and support each other, and the relationship should be one of mutual trust and respect. Elements of romance and intimacy are involved in this, and the couple needs also to have effective ways of recognizing and resolving conflict.

Nowadays many families are headed by single parents. Such parents need to perform the same tasks as couples, but must find the support they need elsewhere than in the marital relationship. An important part of the process of working with one-parent families is identifying the sources of support, and the social networks, available to such families, and involving those supports, directly or indirectly, in the treatment process. The estranged parent of the children may be important in this regard.

The *rearing system* comprises the way the parental couple work together to rear and care for their children. The parents should be agreed on the principles to be used in doing this, and the care provided according to these principles should meet the needs of their children and foster their healthy development. It is the transactions, or the network of relationships, between the parents and the children, and also those between the children, that largely determine how the children develop.

Finally, the therapist should consider the relationships that exist between the members of the family and the wider community of which the family is a part. In the terminology of the 'comprehensive family therapy' of Kirschner and Kirschner (1986), these are the *independent transactions*. In an optimally functioning family these enable family members to function autonomously outside the family. A successful outcome of child-rearing is one which produces children who can do this.

In view of the enormous variety of family forms and ethnic variations with which therapists may be called upon to work, and the fragmentation of families that occurs in many of the troubled areas of our planet, the above considerations may be somewhat simplistic. Moreover, the ethnic variations are legion and only a few are discussed in McGoldrick et al. (2005).

Summary

Families vary greatly in their composition. Healthy family functioning can take many forms and the variety of forms has been increasing. The cultural values of families, and their ethnic backgrounds, are also relevant factors.

Families pass through a series of developmental stages as they are formed, bear and rear children, then launch the children into the world, leaving the marital couple alone again, although usually with the new role of grandparents. The family therapist must always consider the stage that has been reached by a family presenting for treatment and whether the family is having, or has had, difficulty surmounting a particular developmental hurdle.

The concept of 'optimal family functioning' is helpful. It is concerned not just with the absence of problems, but also with whether the needs of the marital couple and the children are being met as well as they might be.

A family should both meet the current emotional and psychological needs of all its members and prepare the children for an autonomous existence in the wider world into which it will, at the appropriate time, launch them.

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