Fixation and Regression in the Family Life Cycle*

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In spite of the obvious fact that families differ significantly depending upon their current stage of the life cycle, most of the family therapy literature focuses on intervening in ongoing family interaction without specific attention to the dimension of family development. Family sociologists, on the other hand, while not dealing with modifying family functioning, have provided more detailed tools with which to understand variations in family functioning based on stages of family development. Our work with families in acute distress suggests the need to increase the specificity with which our assessments and interventions are tailored, by incorporating the family developmental view.

This paper explores the utility of the family developmental view using the concepts of fixation and regression in the family life cycle. These concepts were found to be relatively refined and quite pragmatic assessment devices that assist therapists in specifying developmental issues of the family. Case examples of actual families in crisis are presented in order to demonstrate the utility of these conceptual tools.

IN SPITE OF the obvious fact that families differ significantly depending upon which stage of the life cycle they are passing through, most of the family therapy literature focuses on intervening in ongoing family interaction without specific attention to family developmental issues. While it is understandable that general principles of family intervention needed to be developed before more specific variations and elaborations could be elucidated, our work with distressed families suggests the need to increase the specificity with which our assessments and interventions are tailored.

As an example of the state of the field, Weakland et al. in 1974 (16) discussed impasse points in family interaction and development. The concept is not a new one, being a formulation of principles that can be accepted by many family therapists. Briefly stated, the assumption is that the family can function adequately until it is stressed or forced to change; at that point the family can become "stuck" in rigid patterns. Outside intervention is often useful to upset the pathological pattern—thus allowing the flexibility needed for new problem-solving and growth (see also Haley [5] and Whitaker [17]). Once freed from

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stuck patterns and the resulting pessimism and pain, the family is able to cope relatively successfully with its problems. If a future "stuck point" emerges, the family can remobilize resources or seek further outside intervention (see also Camp [2]). Thus, rather than "curing" a family, a respectable goal of family therapy can be to loosen rigid patterns and thus to get the family problem-solving mechanisms working again. This approach is also quite compatible with the Family Crisis Intervention approach developed by Langsley and colleagues in Denver (8).

While this is an interesting and often useful paradigm for family intervention, it is clear that it is a general framework lacking details about how families differ according to their stage of development. Family sociologists, while not focusing on modifying family functioning, have provided more detailed tools with which to understand the differences, as well as general similarities, between families. Especially useful in family crisis therapy is the incorporation of the time dimension, as seen in the family developmental approach by Hill (6) and others. This perspective can provide additional details and clarity on the developmental needs and tasks of the family, the sequencing of roles, and the process of changing family norms.

> Any research (or clinical work, we'd like to add) which seeks to generalize about families without taking into account the variation due to the stages of family development . . . will have tremendous variance unaccounted for. . . . [6, p. 190]

Both Hill and Hansen (7) and Rodgers (11) have reviewed and critiqued various models in the family development approach. Hill (6 p. 192) cites Duvall's (4) nine stage schema as a widely used and relatively sound framework. The schema is based on three sets of readily available data: numbers of positions in the family, age composition of the family, and employment status of the father. The stages of the family life span, each of which then forms a "distinctive role complex," are as follows:

I. Establishment (newly married, childless)
II. New parents (infant—3 years)
III. Preschool family (child 3–6 years and possibly younger siblings)
IV. School age family (oldest child 6–12 years, possibly younger siblings)
V. Family with adolescent (oldest 12–19, possibly younger siblings)
VI. Family with Late Adolescent (oldest 16–20 until first child leaves home)
VII. Family as launching center (from departure of first to last child)
VIII. Postparental family, the middle years (after children have left home until father retires)
IX. Aging family (after retirement of father)

For our own clinical uses, we have modified stages V and VI to the following:

V. Family with Early Adolescent (oldest age 12–16, possibly younger siblings).
VI. Family with Young Adult (oldest 16–20 until first child leaves home)

This alteration was made in order to delineate more clearly the various family developmental tasks, specifically to take into account the increased freedom of youth sixteen years and older.

While numerous other family life cycle frameworks have been developed and are clearly possible, these nine stages have been found to be clinically useful as well as based on a wide survey of theoretical and empirical work. Perhaps of most practical clinical relevance is the concept of each stage as a "distinctive role complex" (6). This concept implies that the family must undergo considerable change in the transition from one life stage to another. Thus, the transitions have become thought of as "normal family developmental crises" (10).

It is clear that many other external and internal stresses (in addition to developmental changes) can lead to a request for treatment. A focus on these transition points, however, is useful and important in

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three ways. First, *most or all* families face such crises, so more information about them can have wide applicability. Second, these transitions *are* important in many clinical cases: the majority of families referred to our family treatment unit have appeared "stuck" at a particular stage or transition point. Third, even if a developmental transition does not appear to be the major factor in the disturbance, the life cycle stage nearly always *interacts* with the problem and thus becomes a relevant factor.

Fixation and Regression in the Family Life Cycle

In exploring the relevance of family life cycle transition points to identified family difficulties, we have found the psychodynamic concepts of fixation and regression to be useful. Here, however, we are not referring to individual psychological functioning but to the developmental stages of the family unit. Addressing the family unit from the perspective of the traditional concepts of fixation and regression is not difficult. Just as in the case of the individual, it is possible to hypothesize that families pass through and resolve the conflicts of each stage with varying degrees of success. Since one hundred per cent success at resolving the conflicts is rare, it can be assumed that there will be some partial fixation on unresolved issues at one or several of the life cycle stages. Growth and change proceed inexorably, however, and the family must continue to move on if it is to meet the new challenges ahead. The conflicts can then become sealed over, though vulnerable points can be left behind.

It is possible then to conceive that under a later situation of stress (internal, external, or both) the family can regress to previous levels of functioning. With the experience of stress, it becomes likely that old, unresolved conflicts from the partial fixation can become uncovered and alive again. Thus, as if it is not enough for the family to deal with one difficulty, an old conflict is reawakened, together with the old unsuccessful patterns of coping with the stress. The rigid, unsuccessful patterns are relived, leading to frustration, a sense of helplessness, and an increasing sense of urgency, until the family appears for help, quite "stuck." Concepts of family life cycle development then become important to the family worker who needs to be able to identify not only the *current difficulty* but also the *fixation* point issues that are being dealt with by the family at the same time.

It can be seen that such conceptualization utilizes crisis theory as well as psychodynamic and family dynamics concepts. It is a tenet of crisis theory that the therapist need not only deal with the current situation but also, to some extent, with whatever unresolved issue has turned a "stress" into a "crisis." Many such unresolved issues in individuals are well known, especially the importance of unresolved grief (9). Another point of crisis theory that appears relevant is Caplan's (3) hypothesis that dealing with the unresolved past issue as well as the current stress can leave the individual (and family) "better" than before. Thus, though the focus may be on the current difficulties, attention to the fixation point can leave the family at a higher level of functioning than before the crisis, in that the family may now be less vulnerable to future stress.

Some of our families have presented with a clear and overt stress as a precipitant, and we use problem-solving intervention around that issue. Many of our families, however, present with an internal family stress or a precipitant that appears merely to be the last straw before breakdown. These latter families we conceptualize as being involved in a family life cycle transition that has not been successfully managed as yet. Since they are in acute distress, however, and not just patiently working on their conflict, we assume also a significant regression to a previous level of functioning. This is called the "partial fixation" point, since it had been sealed over with some success for years.

It may be noted that the focus of our work is not generally on the stages per se but rather on the transition from one to the next. Rather than dealing with Duvall's basic stages, then, we have had to formulate the key principles of the *transition* points. It is clear that this approach (below) is just a beginning of the process of identifying the key issues in the transitions. The nine transitions, then, leading to the nine stages, we have tentatively conceptualized as follows:

0-I. *Commitment.* In the transition to stage I, we include late courtship, wedding, honeymoon, and preparenthood. The major process for the developing family is of breaking away from the family of origin and developing a life-long commitment to the new family. This commitment needs to change over time and is a fertile point for partial fixations: "I'll stay with you as long as . . ." being the actual contract as opposed to the stated one of "till death do us part" (13).

I-II. *Developing New Parent Roles.* In the transition from the husband-wife to mother-father roles, several new interrelated roles need to be developed. The shift from spouse to parent, within both the nuclear and the extended families, necessitates role transitions for numerous family members. Both dynamic and spatio-temporal issues are involved in the acceptance of the newborn in the family (1, 13).

II-III. *Accepting the New Personality.* As the child passes from the stage of infancy to that of childhood, the family needs to allow the development of the new individual personality as well as to accept the normal dependency of the newborn.

III-IV. *Introducing the Child to Institutions Outside the Family.* As the child becomes older, she or he needs to establish independent relationships to such institutions as school, church, scouts, sports, etc. The family needs to deal with the individual's adjustment and to cope with new environmental feedback (12).

IV-V. *Accepting Adolescence.* With the onset of puberty and early adolescence, numerous role transitions and developmental issues need to be faced. The necessity of developing a sexual identity for the adolescent, as well as the individual's integration into peer group culture, are some of the critical issues modifying family relationships.

V-VI. *Experimenting with Independence.* As the oldest child is moving into late adolescence and young adulthood, the family needs to allow independent, counter-dependent, and adult strivings to emerge. Increased mobility, sexual experimentation, and the need for making initial career plans require a gradual lessening of the primary ties with the family of origin.

VI-VII. *Preparations to Launch.* Acceptance of the independent adult role of the first child requires several role transitions in order to permit the child to leave the family nest and move toward developing his or her own family of progeny. This transition thus can overlap transition 0-I for the following generation.

VII-VIII. *Letting Go—Facing Each Other Again.* After many years of family focus on child-rearing, it is a major transition for the parents to let go of the children and to face each other as husband and wife alone again. This requires, as well, that the children be able to leave the parents to themselves. In addition, the development of the new roles of grandparent (for the parent) and parent (for the children) in a new three-generation arrangement is generally required.

VIII-IX. *Accepting Retirement and/or Old Age.* Retirement requires the married couple to cope with a role transition toward an entirely new life style excluding career plans, goals, and responsibilities. The second generation family, often freed by now from early childhood care of their own offspring, must begin to plan for caring for the older, as well as the younger, generation.

Case Examples

The families we wish to discuss are those that have presented with some difficulty in

managing a transition phase, concomitant with regression to an earlier stage of family development.

Family A

Family A came into treatment requesting assistance for their 18-year old daughter who had developed the symptom of banging her head with ashtrays and other hard objects or hitting her head against the wall or the floor if deprived of such objects. She was the youngest of three siblings; the other two children had left home and established their own families of progeny quite some distance from the parental home. She often had her "fits" or "spells" after arguments with her boyfriend, with whom she was living part time and who exploited her financially to support his developing business in illegal drug traffic.

Her father had developed an ulcer a few years previously and had recently recovered from a heart attack. He was due for retirement within three months after the family presented themselves at the medical center emergency room. Mrs. A, who seemed to be of an hysterical temperament, was in generally good health. In the last year, however, she had gradually increased her nightly beer consumption to nearly steady drinking from dinner to bedtime. The couple had no hobbies or joint activities except evening TV and a weekend drive.

The events precipitating the request for consultation were as follows: The daughter had sold her dental assistant's tools (bought by her parents for her training program) for money to give to her boyfriend. After using up the money, the boyfriend attempted to "throw her out" of his place, sending her back to the parental home. She became hysterical, throwing herself to the ground and repeatedly striking herself with objects. After several hours of attempting to calm her, the frightened parents called the family physician who recommended the emergency room. Shortly thereafter, the parents appeared with their bruised daughter quietly in tow.

Developmentally, the A family was having significant difficulty coping with two simultaneous life cycle transitions: VII-VIII, Letting Go and Facing Each Other Again, and VIII-IX, Accepting Retirement. While each of the individuals in the family had significant personal difficulties, it seems possible that some resolution could have been found by the family if they had been able to deal with the transition issues in a more ordered and sequential manner. That is, the two simultaneous transitions appeared to be more than the family could tolerate and the extreme symptoms appeared. It was not sufficient, however, to explore ways that the parents could "let go" and develop an interest in each other as well as explore means of structuring their

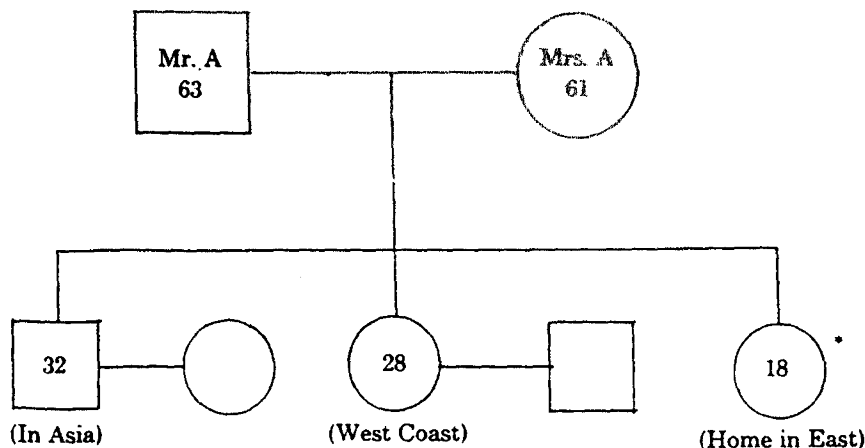


FIG. 1. The A Family

postretirement time, although it was necessary to cover these areas. First, some understanding and resolution of the dangerous acting-out needed to occur. Utilizing our own impressions of the interaction as well as some family historical data, we hypothesized that the behavior could be conceptualized as a regression to a fixation point in early childhood, Stage II, New Parents (with infant), or Stage III, Preschool Family (child making friends outside the family). We thus relabeled the "spells" as "tantrums" and encouraged the parents, especially the father, to insist upon certain orderly behaviors in the household. Once this pressing situation was altered, an effort was made to have the parents structure their own time together. The daughter's career plans were dealt with as if the problem had been a "temporary setback," which indeed it had become.

Lest this particular family seem "too easy," it might be worth noting that they initially dropped out of treatment immediately after symptom remission. It was not until the second time around, after a "relapse," that we were able to alter the marital structure. The second request followed a "suicide attempt" during which the daughter tried to strangle herself with a bath towel in the kitchen of the home. She was angry at her mother's drinking, which was then addressed more seriously in a marital session. Linking Mrs. A. to peers for increased social interaction provided alternative behaviors and allowed Mr. A. room to develop new interests of his own.

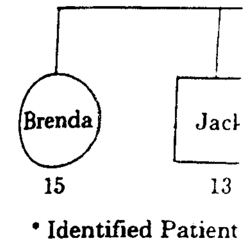
Family B

Family B came to the emergency room as their "last chance" after previous involvement with a family service agency and police. Their oldest boy, and second oldest child, Jack, 13, had taken the family car after an argument with his mother. He had picked up a friend and escaped from a pursuing neighbor in a 65-mile-an-hour chase by passing a truck on a curve. The parents felt they had little or no control over the boy and were hinting that the only solution would be placement and/or juvenile detention.

The only ally that Jack could muster in the sessions was his older sister Brenda, 15, who sided with him on adolescent freedom issues because the parents snooped on her every relationship with boys. Brenda, however, was quite irritated at Jack's behavior with her so she was quite willing to join in the attack upon him. There was also an occasional sense that his father, who grew up from age 8 in an orphanage, relished his son's daring escapades. Additional stress was placed on the family by Jack's poor school performance and a series of minor disciplinary problems at school. The school had suspended him, and he was currently in a home tutor program.

The other family stress that appeared to be a possible precipitant was the mother's hysterectomy two months previously. This appeared to be of greater significance when considered in the context of the family structure and life style. With the extreme emphasis placed on infant care in this family, the hysterectomy served notice that the parents could no longer experience the remnants of Stage II, New Parenthood (including child-bearing and infancy), at least with a natural child of their own. They had compensated somewhat by a series of temporary infant placements, but their own children were getting older and they needed to address new issues. This fixation point was clearly noted by Mrs. B when she stated she did "better" with infants and had "more difficulty" when the children "developed their own personalities."

In the family's struggle to accept and cope with adolescence, transition IV-V, the family had appeared to regress to Stage II coping techniques. That is, Jack was back in the home and was being watched "like a hawk" by the mother in order to protect him and the family. These coping techniques, however, were not successful with an adolescent and the pressure cooker exploded on a regular basis. Both family life



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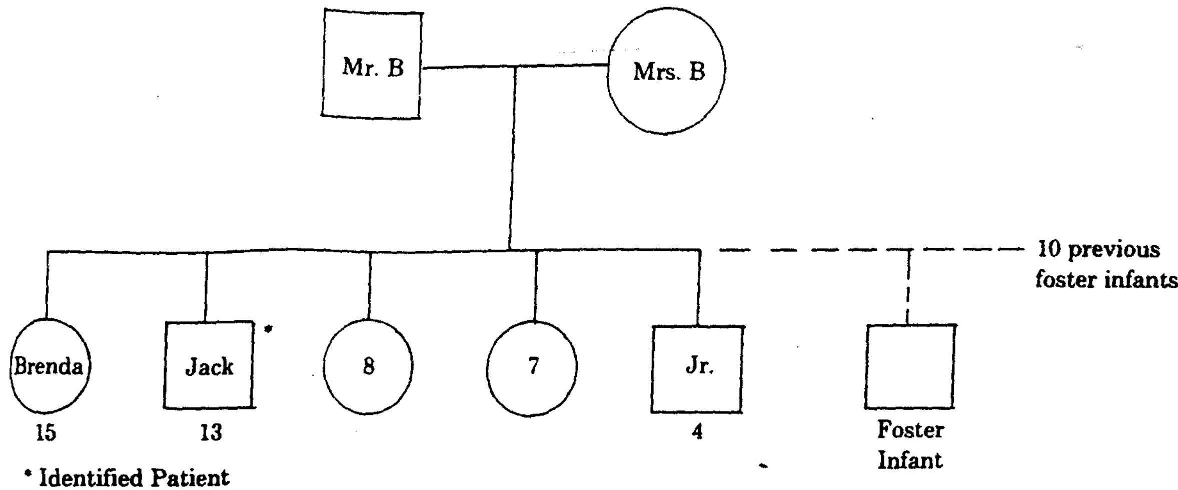

FIG. 2. The B Family

cycle transitions of "weaning" the parents from infants and allowing adult striving in the older children needed to be dealt with simultaneously. Since Jack's attempts at independence were too frightening to the family, the easiest way of achieving conflict resolution of adolescent issues was by focusing on the older daughter. Once addressed, she was quite willing to accept the focus, and both parents were given tasks related to facilitating her adolescence, such as shopping trips, planning driving lessons, negotiating boy-girl contacts, etc. Parallels to the son were brought up wherever possible, and the assistance of the school was sought to get Jack out of the house and back in school during the day, giving everyone more breathing room. An additional necessary focus of treatment in this family was a consideration of the father's difficulties in dealing with an adolescent son, since he went through this period himself without a father.

Family C

Addressing stages still earlier in the family life cycle, Family C presented with the husband arriving at the Information Desk seeking psychiatric hospitalization for his wife. Upon referral to the Emergency Room, Mr. C's request for hospitalization was found to be related to: (a) Mrs. C's "nerves"—she was on a minor tranquilizer for anxiety in public situations, and (b) Mr. C's discovery that Mrs. C was seeing another man. Mr. C's family of origin had known of the contact for several months, and his brother eventually told Mr. C when Mrs. C did not respond to the brother's insistence that she end the extra-marital contact. Though the shocked husband accepted the wife's story that the relationship was platonic—just "coffee and talk"—thoughts of divorce nevertheless arose and precipitated a struggle for position with regard to possible custody of their 3-year-old child. A complicating factor and additional precipitant was Mr. C's vasectomy one year previously, which could leave him childless for life if Mrs. C obtained custody in a divorce.

Conceptualizing the dominant issue of Stage II as New Parenthood (including childbearing and infancy), it became clear that the C family was in transition II-III, with an abrupt end to Stage II interaction patterns being inevitable. The vasectomy became a significant problem to this family as they faced this transition, because both now felt they wanted another child of their own. The reasons for Mrs. C's drift away to a male friend were never clearly expressed during treatment. With the life cycle stress and the "other man" precipitant, however, both partners became so isolated that we were clearly struggling with the 0-I Com-

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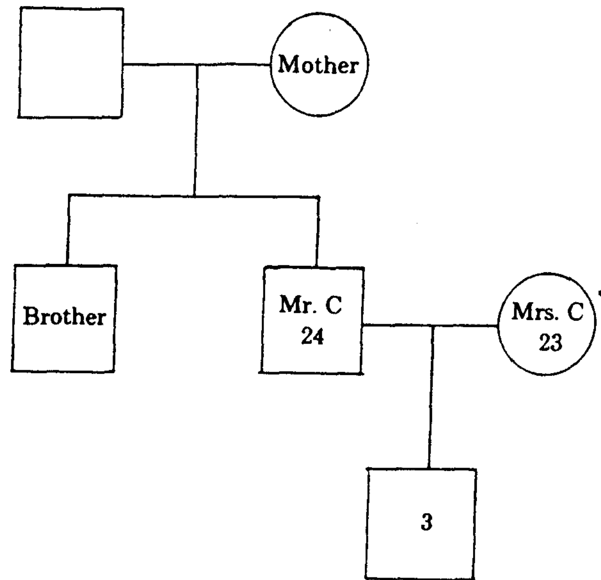

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FIG. 3. The C Family

mitment transition as well. There was no indication of problems in the I-II Accepting Parenthood transition, as both spouses were more than willing to assume parenting responsibilities.

Further indications of a regression to the Commitment phase were evidenced by the family's move to Mr. C's parents' home and his regressive shift of primary alliance to his family of origin. His brother had threatened Mrs. C's life if she sought custody of the child, though Mr. C defended his brother saying that it "was just a joke." Our first step was to encourage the couple to move back to their own home in order to limit the conflict as much as possible to the marital couple. This was not easy as even after the move, Mr. C's mother continued surveillance of the trailer until stopped by Mr. C. This allowed a less complicated consideration of the transition toward a recommitment. Effective problem-solving was not possible, however, until their pattern of mutual recrimination for the vasectomy was eased by shared mourning for the lost potential of future children. This latter experience provided the first closeness observed between the couple and allowed them to focus on other normative marital conflicts.

Family D

The D family provides some variation on our theme. Although they were in a transition phase (III-IV), the transition appeared unrelated to their difficulties. The couple presented to the emergency room with the stated difficulty of Mr. D's being unable to handle work stresses and of his self-depreciation. The family physician played some role in their referral as he had recommended evaluation for hospitalization of Mr. D owing to either "paranoid schizophrenia" or "manic-depressive psychosis." Both spouses, in fact, were working so hard to identify Mr. D as the patient that a more traditional view would likely have been an "acute schizophrenic episode," or worse. While Mr. D was indeed confused, depressed, and exhausted, we were hopeful that brief outpatient contact might be helpful, especially since similar therapy had been beneficial to them three years previously just before the birth of their second child.

Mr. D's work stresses were, indeed, at least partly real as his coworker had just quit and Mr. D was trying to do the work of both to keep his shipping and receiving room in order. Why he had worked himself to exhaustion did not become clear until late in the second session after a good night's sleep and a couple of days off from work. The precipitant appeared to be a casual flirtation at work that apparently

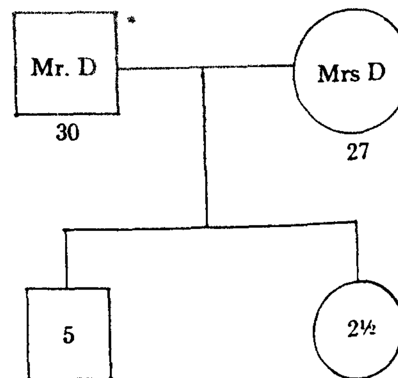

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FIG. 4. The D Family

got an eager response from a female co-worker of Mr. D. Since he had quite traditional values, Mr. D became guiltridden (and apparently frightened by the response) and told his wife, who became upset and turned to her parents for support. Mr. D began working "like a demon," returning exhausted from work and full of self-recriminations. As the pair became further isolated, Mr. D began to speak of "not deserving" to be married to his wife, to the point of asking his father-in-law to beat him and of considering leaving his family. This frightened Mrs. D further, and she became more dependent on her own family of origin and, eventually, the family physician.

Consideration of the family of origin of each spouse yielded numerous conflicting and rigid expectations of the spouses for themselves and for each other. This focus allowed renegotiation and reaffirmation of their commitment to each other (0-I transition). After dealing with this regression, the life cycle transitions, II-III (Accepting the New Personality) and III-IV (Child Contacts with Outside World), emerged as relevant to the family. As the younger child, age 2½, began to develop more independence and the older child, age 5, was about to begin school, the parents could no longer focus their interactions on a dependent infant and preschooler. They needed to renegotiate their marital relationship and develop new goals. Consideration of these latter transition points led the therapists to focus on other ways for Mrs. D to spend her time and use her increased freedom, as well as on ways for her to support her husband in relation to his work stresses.

Conclusions

Watzlawick, et al. in their book, *Change* (15), persuasively argue that students of human behavior can learn much about change in human behavior by observing naturally occurring changes in human relationships. Our team has found the structured family crisis therapy approach to be an excellent vantage point from which to observe and study, as well as intervene in, relationships in a state of flux. Of significant theoretical utility in such study is the concept of family life cycle stages and transitions as explored by family developmental theorists. Family life cycle transitions are important not only because of their frequent intersections with family crisis but also because they are issues that all families face. Thus, the knowledge to be gained from them can have wide applicability.

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