Parent and Child Mental Health in Nontraditional Families: The Intersecting Roles

of Gender, Dyadic Support, and Communication

by

Danielle Nicole Shapiro

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Doctoral Committee:

     Professor Abigail J Stewart, Co-Chair
     Assistant Professor Julie Beth Kaplow, Co-Chair
     Professor Deborah Keller-Cohen
     Assistant Professor Robin Stacey Edelstein

Dedication

To my own nontraditional family and in particular, to my parents, whose strength and

enduring good humor have inspired this work

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Abstract

While families that deviate from traditional, nuclear, and biologically-based arrangements are increasingly common, relatively little work has adopted a systems-based approach to understand parents' experiences, and the psychological correlates of these experiences, in nontraditional families. To fill this gap, this dissertation employs a family systems and feminist model to examine the psychological outcomes, for both parents and children, associated with parenting in nontraditional or stressful contexts. In particular, this dissertation explores the role of dyadic support and communication among family members and the ways in which these two processes buffer both parents and children from depressive and other psychiatric symptoms. This dissertation also explores whether, and how, gender intersects with adopting a nontraditional parenting role. The first two of the three papers examine depression as an outcome of stepparenting, the ways in which social supports buffer stepparents against psychopathology, and gender as a potential moderator in stepparent well-being. To do so, the first of these studies used a sample of 75 step mothers and 60 biological mothers and the second study used a sample of 84 stepmothers and 41 stepfathers, all recruited online. Findings from these two studies suggest that low parenting stress (Chapter Two), high dyadic support (Chapters Two and Three), and more experience stepparenting (Chapter Three) are important buffers against depressive symptoms among stepparents. Importantly, these effects seem to matter

equally for stepmothers and stepfathers. The third study expands findings from Chapters Two and Three on the significance of dyadic support for parents in nontraditional families to children by examining relational correlates of depressive symptoms in 26 recently widowed mothers and their 38 children (45% female) between the ages of 3-12. Specifically, this study found that the quality of (observed) communication about the loss between parentally-bereaved children and their surviving mothers was associated with depression and maladaptive grief in children. Further, Chapter Four suggested that mothers' blunted emotional response to the loss, characterized by atypically low depressive symptoms, may prevent them from effectively communicating with their children about the loss. Implications for research and practice are discussed.

Chapter I

Introduction

Parenthood is perhaps the most common role that adults adopt (U.S. Census Bureau, 2010). However, individual experiences of parenthood are shaped by intersections between the parenting role with other roles, identities, and circumstances. Therefore, parenting may take on different meanings and challenges for women or for parents whose roles deviate from traditional, biological, married parenthood. The gendered, cultural prescriptions surrounding motherhood, which imply that mothers are unflappable, selfless, and naturally gifted in child-rearing, can be limiting for mothers even in traditional (i.e., nuclear, middle class) families (Douglas & Michaels, 2004). All mothers must contend with the dissonance between cultural portrayals of motherhood (as women's primary joy and purpose) and the realities of its emotional and logistical challenges (Douglas & Michaels, 2004).

These challenges may be amplified for women parenting outside of traditional, "intact" families such as, in the case of this dissertation, stepfamilies and parentally-bereaved families. Parents in nontraditional families may encounter a unique range of psychological, practical, and interpersonal complexities in addition to the challenges common to all parents. This dissertation examines the experiences and psychological correlates of two nontraditional family forms— stepfamilies and parentally-bereaved families—for both parents and children, as well as the ways in which gender may moderate these experiences.

Nontraditional families are becoming increasingly common as fewer Americans marry (United States Census Bureau, 2011), and children are increasingly born to and raised by unmarried couples and single mothers (United States Census Bureau, 2012). Research on these forms of nontraditional families provides insight into the challenges and outcomes associated with parenting outside of socially normative and legally-sanctioned family structures and illuminates different ways in which the cultural expectations associated with parenthood can put people, and women in particular, at psychological risk. For example, single mothers, particularly African American single mothers, have been documented to face a range of challenges, from unemployment and economic problems (McLoyd, Jayaratne, Ceballo, & Borquez, 1994) to low social support (Shook, Jones, Forehand, Dorsey, & Bordy, 2010), which contribute to lower parenting efficacy, worse child outcomes, and psychological problems like depressive symptoms and low self-rated quality of life (Wang, Wu, Anderson, & Florence, 2011; Landero Hernández, Estrada Aranda, & González Ramirez, 2009). While single and unmarried parenting are common forms of nontraditional parenting, other nontraditional family structures may also result in psychological risk for parents and their children, as well as more complex relationships among family members.

In three papers, this dissertation explores the relational and psychological consequences for both parents and children of two stressful family situations that may result in a change from a traditional to a nontraditional family structure—divorce and remarriage (Chapters Two and Three) and parental bereavement (Chapter Four). These family structures are common—approximately 9% of American families include at least one stepparent (Kreider, 2008) and 3.5% of American children have lost at least one

parent (Social Security Administration, 2000), with an estimated 25 million children orphaned in 2010 alone worldwide (UNAIDS, UNICEF, & USAID, 2004). While stepfamilies and parentally-bereaved families are distinct in many ways, stemming from fundamental differences in ways in which divorces/ remarriages and interpersonal losses are experienced psychologically, both involve a significant restructuring of the family environment and require family members to grieve the loss of the pre-death or pre-divorce family dynamic and adjust to a new one. This process of readjustment is experienced not only on the level of the individual, but also on the level of the family system. Therefore, the current dissertation focuses on the functioning of the family system, and in particular the dyadic relationships within that system, as they relate to stress, grief responses, and depressive symptoms.

Family Systems Theory and Social Support in Nontraditional Families

Family systems theory postulates that families function as social systems in which the dynamics of the system as a whole, as well as among individual members of the system, affect the health and well-being of both individuals and the group (Cowan & Cowan, 2002; Hargrove, 2009). Within the larger system, there are smaller subsystems comprised of interpersonal dyads: the parent dyad (comprised of the two parents in a traditional, nuclear family), the parent-child dyad, and sibling dyads (in families with multiple children) (Hargrove, 2009). The functioning of each of these dyads helps to determine the dynamics of the larger family system by setting relational norms and boundaries. At the same time, these dyadic relationships are important contributors to the well-being of individual members of the system as they are resources for support and emotion regulation or, in contrast, stress and dysfunctional coping. Thus, the health of

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relational dyads may be important in shaping outcomes for families and individuals following a major family transition or stressor, such as divorce and remarriage or the loss of one parent. Major disruptions to the family system, such as these stressors, can result in the dysregulation of the family system and individual symptom expression, particularly in the early phases of adjustment (Boss, 1980). Strong and healthy dyadic relationships may buffer individuals and families from the risks associated with major family stressors.

A large literature suggests that social support, particularly from family members, plays an important role in psychological symptom expression in general (e.g., Aneshensel & Stone, 1982; Grav, Hellzén, Romild, & Stordal, 2012; Stice, Ragan, & Randall, 2004) and depressive symptoms in particular (Grav et al., 2012; Slavich, O'Donovan, Epel, & Kemeny, 2010). More specifically, in times of stress, both the sum total of support individuals receive, as well as their ability to elicit support specific to their needs, can protect against the development and maintenance of psychological symptoms (Cohen & Willis, 1985). In times of high family stress, parents' ability to identify and use social supports can be an important buffer against psychological symptom expression. For example, among women with low birth weight infants, mothers' access to and effective utilization of social support mitigates psychological distress (Singer, Daviller, Bruening, Hawkins, & Yamashita, 1996). Family members are perhaps the most influential and available source of social support (Cowan, Cowan, & Pruett, 2007); for parents, support from partners, children, and other members may protect against depressive symptoms and for children, parental support may be similarly important.

First, spousal support has been found to mitigate a range of psychological symptoms (Syrotuik & D'Arcy, 1984), including depression (Dean, Kolody, & Wood,

1990). Among parents, functioning as a mutually-supportive and unified dyad promotes more effective parenting (Katz & Gottman, 1996) as well as psychological well-being (Malik et. al., 2007). Although spousal support serves in a protective capacity for both men and women (Syrotuik & D'Arcy, 1984), men generally provide less support to their wives than women do to their husbands (Schwarzer & Gutiérrez-Doña, 2005). Taken together, these findings suggest that spousal support may be an important source of resiliency for parents, but that access to spousal support may be variable or limited for women in heterosexual couples.

Second, and drawing from a family systems perspective, parents may benefit from supportive relationships with their children and other family members. A large psychological literature on parenting has shown that children's temperaments interact with parents' own disposition and parenting strategies to determine the health and well-being of parents, children, and families (e.g., Kochanska, 2008; Milliones, 1978; Putnam, Sanson, & Rothbart, 2002), suggesting that children's receptivity, engagement, and, as they grow older, relational supportiveness may be as relevant as parents' own behaviors in determining the health of the parent-child relationship and family system. In nontraditional families, however, children may struggle with shame, confusion, frustration, or distress about the family structure (Amato & Keith, 1991; Amato, 1993; Jeynes, 2007; Shapiro & Stewart, 2011), resulting in stress on the parent-child dyad and ultimately limiting the capacity of that dyad to provide a supportive context for both the parent and the child. Similarly, other family members (such as an ex-spouse in a stepfamily) may find it difficult to maintain positive and supportive relationships in the context of complicated and often contentious family dynamics. Thus, identifying the

forms of family support that facilitate parents' psychological well-being following a transition, as well as the constraints under which family members are, or are not, able to provide this support, is an important priority.

Finally, while parents, as the recipients of support, benefit from positive and validating relationships with other family members, they, and mothers in particular, are also primary providers of support and validation to their children. Maternal support, defined as sensitivity toward and validation of a child's experience, has been demonstrated to be an important buffer against psychopathology in children exposed to stressors or trauma—ranging from divorce (Wolchik, Wilcox, Tein, & Sandler, 2000) to sexual abuse (Morrison & Clavenna-Valleroy, 1998) and loss (Kaplow, Layne, Pynoos, Cohen, & Lieberman, in press). Supportive parenting in general, and through dyadic interactions in particular, not only provides children exposed to a stressful or traumatic event with a context in which to express their emotions related to the event, but also allows mothers to model effective emotion regulation and coping (Gottman, Katz, & Hoovan, 1996). While sensitive and validating parenting in the context of adversity may be protective for children, parenting after a major family stressor or transition can be complicated, especially for parents undergoing their own emotional processes related to these events. For example, parenting efficacy has been demonstrated to decrease in times of stress, such as the loss of a spouse (Schmiege, Khoo, Sandler, Ayers, & Wolchik 2006). For mothers, the stress of parenting through a major family transition or stressor may be exacerbated by social norms and expectations that emphasize their responsibilities as parents above all other objectives, including maintaining their own psychological health.

Gendered Norms and Parenting

Despite the obvious difficulty of maintaining high parenting efficacy in times of extreme stress, parents are incentivized, if not expected, to negotiate complicated new parenting dynamics without affecting their children's logistical and emotional life. These incentives—namely social veneration and freedom from being condemned as a "bad" parent—are powerful. As feminist activist Carol Hanisch first noted in 1969, "the personal is political" (Hanisch, 1970); parenting norms, like most norms, are enforced on many levels, ranging from the intimate domain of the family itself to society as a whole. Although men, especially those who are heavily involved in parenting, likely experience social pressures to parent effectively, the pressure to "do it right" may be particularly salient for mothers as a result of the uniquely gendered form that these expectations often take. Therefore, the experiences of mothers are the primary focus of this dissertation.

Unlike men, women are expected to be, and as a result generally are, the primary caretakers of children (Lachance-Grezla & Bouchard, 2010). Popular portrayals of this role often feature endlessly patient, domestic, and cheerful mothers with well-behaved children (Douglas & Michaels, 2004). Further, women are deemed, as a function of their biology, to be up to the challenge; the hegemonic norms surrounding motherhood suggest that all women are natural, unflappable, and instinctive mothers who navigate the stresses and challenges of parenting with ease and innate competence (Trebilcot, 1983). Per these norms, succeeding at motherhood is as important as it is natural; the popular discourse surrounding motherhood suggests that raising "healthy" children is the most important achievement a woman can claim (Held, 1983).

The emphasis placed on childrearing, and the narrowness of mothering ideals, set high stakes for mothers in general and for those faced with challenging circumstances, such as a divorce, remarriage, or loss. If it is challenging for mothers, even in traditional families facing few stressors, to live up to the ideals of motherhood, it may be even more difficult for mothers in nontraditional families, potentially contributing to the experience of stress-related psychopathology.

Stepmothering, Widowed Mothering, and the Intersection of Gender and Nontraditional Parenting Roles

While mothers in a range of nontraditional roles may be pressured by the normative expectations placed on them, here I focus specifically on the intersection of gender with two common forms of nontraditional parenting—stepparenting and widowed parenting. These two roles differ in meaningful ways, as a function of the fundamentally different experiences of the death of a spouse (e.g., existential distress related to mortality, longing for late spouse) and taking on a stepparenting role, even after a previous divorce or loss (e.g., ongoing, tense relationships with former partners). Thus, while both of these family restructurings increase risk for stress-related psychopathology, such as depression, the process by which symptoms develop may vary in meaningful ways. The distinction between these two family structures is also relevant on the level of the family system; while stepfamilies adjust to an expansion and must accommodate a new parent figure, parentally-bereaved families have constricted and must accommodate the new absence of a parent.

Despite these differences, stepfamilies and parentally-bereaved families have in common their deviance from a traditional family structure and the need for family

members to navigate new and complex interpersonal, logistical, and emotional territory. In other words, both stepfamilies and parentally-bereaved families are faced with processing the loss of one family structure and transitioning to a new one, making them interesting case examples for the purpose of examining the dyadic processes that facilitate these transitions.

In both the case of stepfamilies and parentally-bereaved families, the intersection of a challenging nontraditional parenting role with gender may result in a unique set of psychological and family dynamics. Both widowhood (as compared to widowerhood) and stepmotherhood (as compared to stepfatherhood) are defined by gendered social discourse and behavioral prescriptions. Women who lose a spouse, for example, may simultaneously be viewed as vulnerable and pitiable *and* expected to maintain high parenting efficacy for the sake of their children. For example, bereaved women have been found to remarry less often, and later, than bereaved men (Lister, 1991; Wu, 1995). While most work on this trend has been conducted on elderly widows and widowers, for bereaved parents a similar trend may suggest that men are pressured to find a mother-figure for their children (Burgess, 1994) while women are assumed to be capable of parenting alone. Similarly, stepmothers are often viewed as intruding upon another woman's mothering role, but at the same time, are expected to be natural, loving, and attentive mothers (Nielson, 1999). Meanwhile, although stepfathering can certainly be difficult, men are generally not expected to approach parenting with the enthusiasm and competence that women are, perhaps resulting in fewer contradictory demands. The contradictory norms and prescriptions faced by women in nontraditional families may

make difficult family transitions and adverse situations even more challenging, both for mothers and their children.

While these processes likely differ for stepmothers and widowed mothers, what is known more generally is that the experience of a family stressor is linked to women's mental health in general, and depressive symptoms in particular (Viana & Welsh, 2010; Étheir, Lacharité, & Couture, 1993). Feminist psychologist Susan Nolen-Hoeksema and her colleagues have suggested that the stress of gendered oppression, in and of itself, results in depressed mood and other psychological problems (Hatzenbuehler, Hilt, & Nolen-Hoeksema, 2010), which could indicate that merely as a function of being a mother, let alone one who occupies a nontraditional mothering role, women could be at an increased risk for mental health problems.

Depression as an Outcome of a Family Stressor or Transition

All three of the papers included in this dissertation focus on depressive symptoms as a consequence of facing a major family stressor or transition, either as a parent or a child. Depression, which is characterized by low mood, loss of interest in pleasurable activities, social withdrawal, and changes in appetite and sleep, among other potential symptoms, is debilitating for individuals and, by definition, results in functional impairment (American Psychiatric Association, 2000). Depression is one of the most common psychiatric disorders, affecting approximately 7% of adults per year (Kessler, Chiu, Demler & Walters, 2005) and 11% of children before they turn 18 (Merikangas et. al, 2010). Moreover, women are 70% more likely to experience depression over the course of their lifetimes than men (Kessler, Berglund, Demler, Jin, & Walters, 2005) and symptoms are often brought about by major life stressors (Caspi, et. al, 2003), making

depressive symptoms a particularly relevant outcome to study among parents in general, mothers in particular, and their children, in stressful circumstances.

While women's health and mental health, including depression, are popular topics in medical and psychological research (e.g., Gavin, Simon, & Ludman, 2010; Kendler, Neale, Kessler, Heath, & Eaves, 1993; Kendler, et. al, 1995) and despite the fact that most women have children (United States Census, 2009), relatively few studies are interested specifically in mothers' experiences of depression (outside of the postpartum period). Research focused on mental health, including depressive symptoms, among mothers has generally addressed the transmission of depressive symptoms from mothers to children through genetics, parenting behaviors, and modeling. This work has suggested that mothers who suffer from depression are less sensitive and attuned to their children and engage in more punitive and negative parenting behaviors, which can lead to symptom-expression in children (Jacob & Johnson, 1997; Dietz, Donahue-Jennings, Kelley, & Marshal, 2009). While limited by their lack of attention to women's own mental health outcomes and needs, these findings do reinforce the relational nature of the development and maintenance of psychopathology in families and in particular, among mothers and children.

Context may be a complicating factor in the documented associations among maternal depression, parenting, and children's psychological well-being. Mild-to-moderate depressed mood is normal, and in many cases healthy and emotionally-appropriate, among people who experience a significant life stressor, such as a divorce or a loss (Gersten et al., 1991). In fact, grief is currently listed as an exclusion criterion for the diagnosis of Major Depressive Disorder in the DSM-IVTR (American Psychiatric

Association, 2000). Thus, current models that emphasize the negative consequences of maternal depression for children may not uniformly apply to families facing adverse circumstances in which depressed mood among parents may be expected and healthy. Identifying the constraints under which depressed mood *does* negatively affect parenting, as well as the mediating and moderating factors that predict which women in nontraditional families develop relatively high levels of depression, may help to clarify the contextual contributors to, and consequences of, maternal depression.

The Current Dissertation

This dissertation aims to explore two broad research questions. First, this dissertation explores whether specific forms of dyadic support (or dysfunction) buffer (or put at risk) individuals during times of family stress or transition. Given the systemic nature of both divorce/ remarriage and parental bereavement, it is likely that psychiatric symptom expression is mediated by systemic processes, such as support, validation, and communication. Similarly, this dissertation investigates the role of systemic processes in symptom development for different members of the family system (namely, stepparents, biological parents, and children) as a means of exploring the ways in which family members' experiences differ from, or are mutually influenced by, one another. Second, this dissertation examines whether and how gendered identities, roles, and expectations intersect with nontraditional parenting roles, with a particular focus on the ways in which these processes affect women's and children's experiences of nontraditional families.

Specifically, the studies presented in Chapters Two and Three used online surveys to examine the factors that shape stepparents' mental health outcomes. The study presented in Chapter Two aimed to assess differences in parenting stress, perceived

regard from (step)children, and depressive symptoms in a sample of 75 stepmothers and 60 biological mothers, allowing me to examine not only *whether* stepmothers experience more depressive symptoms but also *why* this might be so. The study presented in Chapter Three followed up on the importance of perceived child regard identified in Chapter Two, using a sample of 84 stepmothers and 41 stepfathers by examining the role of dyadic supports (perceived child regard, partner support for parenting, and support for parenting from the ex-spouse of the current partner) in stepmother and stepfather depressive symptoms. This study allowed me to examine whether gender intersects with adopting a stepparenting role as well as whether certain forms of social support and validation are more effective at preventing depressive symptom expression than others.

Expanding even further on the idea that dyadic supports serve an important buffering role, and extending this finding to children, the study presented in Chapter Four used observational and interview methods to examine the role of mother-child communication in depressive and maladaptive grief symptoms in a sample of 38 parentally-bereaved children and their mothers. This study also examined the ways in which maternal depressive symptoms affect mothers' ability to effectively engage in communication with their children. Taken together, these three papers argue for the importance of dyadic relationships in both parents' and children's adjustment to a nontraditional family structure and examine the ways in which gendered roles and expectations may shape parents' experiences in these families.

Chapter II

Parenting, Perceived Child Regard, and Depressive Symptoms among Stepmothers and Biological Mothers[1]

The proportion of couples living with stepchildren has nearly doubled since 1991 (Teachman & Tedrow, 2008) and according to the 2004 census, of the 40 million households with children, 9% include at least one stepparent (Kreider, 2008). In addition, longitudinal research on divorcing families suggests that within 20 years following marital dissolution, 87% of divorced fathers remarry (Ahrons, 2007), reinforcing demographic research finding that men are more likely than women to remarry (South, 1991). The prevalence of remarriage among divorced men indicates that many families will eventually include a stepmother. Despite the prevalence of stepfamilies, relatively little is known about adults' well-being in stepfamilies. Research on stepfamilies has primarily focused on the experiences and mental health outcomes of children (e.g., Ahrons, 2007; King, 2007, Jeynes, 2007; Sweeney, 2007). In contrast, the experiences of stepparents, and particularly stepmothers, have received less attention despite suggestive evidence that stepparenting can be a challenging and stressful undertaking (Ceballo, Lansford, Abbey, & Stewart, 2004). Stepmothers, perhaps more than stepfathers, are subject to a range of negative stereotypes (Whiting, Smith, Barnett, & Grafsky, 2007) and face challenges such as difficult relationships with biological mothers, conflicted or

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[1] A version of this paper is published in *Family Relations*: Shapiro, D.N. (2011). Parenting stress, perceived child regard, and depression in stepmothers and biological mothers. *Family Relations, 60,* 533-544.

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limited support from spouses, and resistance from stepchildren (Hart, 2009). The unique challenges and stresses related to stepmothering may result in an increased risk for mental health problems, although this link has not yet been tested empirically.

As a first investigation into these issues, this study examines the relation between family experiences and depressive symptoms in stepmothers and biological mothers. In particular, this study examines the contributions to depressive symptoms among biological mothers and stepmothers of parenting stress and maternal perceptions of children's regard for their family constellation in general and mother or stepmother in particular. Findings from the current study may help to identify the mental health needs of stepmothers and, as a result, improve the functioning and well-being of stepfamilies and stepchildren as well by serving as the foundation for a potential prevention/intervention.

Families in general (Hargrove, 2009) and stepfamilies specifically (Hetherington, 1992) have been described in terms of systemic models, including a series of dyads; each member of the family participates in multiple dyads (e.g., parent-parent, child-parent, child-child) simultaneously. The dynamics within and between these various dyads are determined by the specific roles (delineated by age and gender) of the people involved in them and affect the functioning of the family system as a whole as well as each individual within it. Family systems theory provides a useful framework to conceptualize how members of families, including stepfamilies, might be differentially affected by each other and the complexities of the dynamics within the family. Along these lines, family researchers have examined the effect of binuclear family arrangements (i.e. biological parents and their partners living in separate households with the children traveling

between them) on children and, to a lesser extent, on adults (Stewart, Copeland, Chester, Malley & Barenbaum, 1997).

Among children, adjusting to a stepfamily has been linked to a variety of internalizing and externalizing problems including relational, academic, and behavioral problems, poor self esteem, and substance abuse (Amato & Keith, 1991; Amato, 1993; Jeynes, 2007), highlighting the challenges posed by adapting to a new familial context. Despite the potential difficulty of binuclear family arrangements, identified outcomes for stepchildren are not universally negative (Yu & Adler-Baeder, 2007). This suggests that relational and cultural context may play a role in stepfamily functioning. For example, recent research has indicated that the negative childhood outcomes associated with living in a binuclear family may not extend to all racial and ethnic groups (Adler-Baeder, et. al, 2010; Moore & Chase-Lansdale, 2001), perhaps due to some cultures' reliance on more communal parenting norms that can accommodate family constellations involving more than two parenting figures.

Children's experiences in binuclear families may also depend on a range of relational variables, the most important of which is the quality of relationships among the children and their parents and stepparents (King, 2007; Schenck et. al, 2009; Yuan & Hamilton, 2006). While positive family relationships are likely to serve in a protective capacity for children, these relationships may be difficult to establish within the complex context of a binuclear family (Sweeney, 2010). Stepparents tend to be viewed by their families and communities as outsiders with ill-defined and less legally-legitimate parenting responsibilities (Sweeney, 2010). As a result of the complexity of stepparenting relationships, stepparents have been found to struggle in establishing positive stepparent-

stepchild relationships. For example, stepparents generally find parenting to be more difficult than do biological parents (Ceballo et. al, 2004). However, these experiences, and their mental health correlates, may vary as a function of gender and the norms associated with men's and women's participation in parenting. Such norms, which dictate that fathers are the dominant parents who have economic control of the household while mothers are the primary caregivers (Trebilcot, 1983; Collins, 2011), may affect stepfathers' and stepmothers' relationships with their stepchildren as well as their psychological outcomes.

Stepfathering is a complex role, perhaps made more difficult by stereotypes about men's inaptitude for parenting and cultural norms that undermine stepfathers' parenting (Marsiglio & Hinojosa, 2010). Despite these challenges, on the whole, stepfathers have been found to be involved and competent parents who in some, although certainly not all, cases are equally involved in their stepchildren's lives as the children's biological fathers (Adamsons, O'Brien, & Pasley, 2007). These positive relationships and investment in parenting, in addition to other factors such as stepfathers' ability to clearly define their family role, are associated with individual and interpersonal well-being for stepfathers and their families (Fine, Ganong, & Coleman, 1997; Marsiglio, 1992).

In contrast to stepfathers, stepmothers have been found to have greater difficulty consolidating their parenting role to fit within the broader family structure (Henry & McCue, 2009). Qualitative research has suggested that stepmothers struggle with role ambiguity and a lack of control over family dynamics and logistics (Weaver & Coleman, 2005). A study conducted in Spain found that strains placed on the stepparenting role were linked with poorer psychological functioning in both stepfathers and stepmothers,

although stepmothers were at considerably higher risk for the psychological consequences of role strain (Fellmann, Galán, & Lloreda, 2008). In addition to these risks, stepmothers also report higher levels of stress than do stepfathers or biological mothers (Dainton, 1993; Quick, McKerny, & Newman, 1994) which may be related to the unique roles they adopt in their families (Johnson et. al, 2008) and may in turn translate into personal and interpersonal problems.

Gendered norms about motherhood (and by extension stepmotherhood) may explain stepmothers' greater difficulty adapting to their parenting role (for review see Nielsen, 1999). For example, much like biological mothers, stepmothers tend to adopt a "kinkeeper" role that involves organizing family relationships that are, in stepfamilies, more complicated (Schmeeckle, 2007). Often stepmothers attempt to perform this role alongside biological mothers in a culture that assigns little value to shared mothering, which in turn can result not only in less social legitimacy for stepmothers but also strained family relationships (Nielson, 1999). These issues may be made even more complex and difficult by the residential status of the stepmother, her own marital and parenting history, and a range of other family variables (Weaver & Coleman, 2005). Comparatively, the mixed, and sometimes low, expectations often placed on fathers' and stepfathers' involvement in childrearing (Andrews, Luckey, Bolden, Whiting-Fickling, & Lind, 2004; Collins, Newman, & McKenry, 1995) may translate into more forgiving norms for stepfathers than those encountered by stepmothers, helping to explain stepfathers' better outcomes.

In a seeming contradiction to the expectation that stepmothers, as women, should maintain a high level of involvement in their new families, they are often subjected to a

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range of negative gendered stereotypes (Sweeney, 2010). Due to popular fables like *Cinderella* and *Hansel and Gretel,* a particularly salient stereotype is that of the "evil stepmother" (Whiting, Smith, Barnett, & Grafsky, 2007) who manipulates a benevolent, if slightly naïve, single man into allowing her into his home only to torture his children. Thus, stepmothers have to balance norms and expectations about motherhood alongside possible assumptions that they are selfish, financially motivated, unnatural, and even mean, all while their stepchildren, other family members, and society as a whole evaluate their adequacy as mothers (Nielson, 1999).

Given the potential challenges associated with stepmothering, it would be unsurprising if stepmothers were at a higher risk than biological mothers for mental health problems like depressive symptoms, although this possibility has not been adequately addressed quantitatively. In a recent qualitative study conducted in Australia, 10 nonresidential stepmothers described high levels of parenting stress and feelings of powerlessness, which in turn were associated with depressive symptoms (Henry & McCue, 2009), suggesting that stress combined with feelings of insignificance in the family may be associated with depressive symptoms in stepmothers. However, these connections have not been adequately addressed in a larger and more inclusive sample. In addition, no studies to date have directly compared depressive symptoms and other mental health outcomes in biological mothers and stepmothers, making it difficult to determine whether the risks associated with stepmothering are directly related to the stepmother role or motherhood more generally.

Higher levels of depressive symptoms are a particularly worrisome outcome, not only because of their debilitating effects on individuals, but also because of the well-

documented link between maternal depression and child psychological and behavioral outcomes (Ashman, Dawson, & Panagiotides, 2008; Berg-Nielsen, Vikan, & Dahl, 2002). This relation, while in part a result of genetics, is perhaps equally a consequence of decreased parenting efficacy among depressed parents, including lesser sensitivity and attunement to child emotional states (Garai, et. al, 2009). These parenting concerns are as relevant to stepmother depression as biological mother depression, making understanding and reducing stepmother depressive symptoms an important scientific and clinical issue.

Parenting stress and a lack of acceptance and support from other family members, especially stepchildren, may explain some of the potential differences in mental health outcomes and functioning in step- and biological mothers. Social validation has been linked to a range of mental health outcomes in adults and in particular it seems to play an important role in depressive symptom expression (Slavich, O'Donovan, Epel, & Kemeny, 2010). Stepchildren's regard may be an important source of validation for stepmothers, although the potential significance of the stepchild-stepparent relationship has been under-studied (Sweeney, 2010). For example, Lansford, Ceballo, Abbey & Stewart (2001) found that parent-child and marital conflict explained some of the variance in life satisfaction and well-being among parents in stepfamilies, adoptive families, and biological families. If low conflict with stepchildren is helpful to stepparents, it is likely that high regard and support from stepchildren is also a valuable asset to stepmothers. Therefore, we focus here specifically on biological mothers' and stepmothers' perceptions about their children's regard. In other words, we examine their experience (or lack thereof) of acceptance, approval, and high regard from their children or stepchildren

about their own parenting as well as family dynamics more broadly. While likely relevant for both biological mothers and stepmothers, concerns over children's adjustment to and comfort with family arrangements are likely more consequential for stepmothers, given their unique and more vulnerable position in the family. Likewise, the increased stress associated with stepmothering may result in depressive symptoms. Parenting stress (feeling overwhelmed and distressed as a result of both daily and chronic hassles of parenting) is correlated with maternal depression (e.g., Étheir, Lacharité, & Couture, 1995; Quittner, Glueckauf, & Jackson, 1990) and has been associated with maternal, child, and familial well-being more generally (for review, see Webster-Stratton, 1990).

In order to examine these possibilities, the current study examines two hypotheses. First, we hypothesized that stepmothers would report more parenting stress, replicating earlier research; we also expected them to perceive, less than biological mothers, that their children/ stepchildren hold them and the family constellation in high regard, and to report higher levels of depressive symptoms. Second, we hypothesized that perceptions of child regard and parenting stress would mediate the relation between biological/ stepparent status and depressive symptoms. In other words, while it is likely that stepmothers experience more depressive symptoms than biological mothers, it was also predicted that these outcomes would be associated with increased stress and concerns about childrens' regard, which are consequences of the more complicated and challenging stepparenting role.

Methods

Participants and Procedures

Thirteen mothers and stepmothers were recruited for a qualitative pilot study, used to inform the development of items measuring perceived child regard, using university email listservs prior to the initiation of the current study.

In contrast, for the larger, quantitative study we recruited a convenience sample through broad-based online social groups, forums, and listservs aimed at sharing resources and discussing parenting issues among parents in general or mothers in particular. All participants were invited to complete an online survey focusing on parenting and well-being. Surveys for biological mothers and stepmothers were identical except that stepmothers were asked additional demographic questions addressing the length and quality of their stepparenting relationships and were asked to answer about both children and stepchildren in parenting questions. All participants were guaranteed the confidentiality of their responses, provided their informed consent to participate in the study, and were compensated monetarily for their time. The resulting sample included 60 heterosexual biological mothers and 75 heterosexual stepmothers from the Midwestern United States. In order to be included in the study, participants had to identify themselves as parents or guardians, report their parenting role as either biological mother or stepmother of at least one child between the ages of 3 and 18, and provide identifying information indicating that they currently lived in the United States. Because the experiences of adoptive and lesbian mothers may be different in important ways, participants were excluded from these analyses and retained for separate analysis if their children were adopted or if they were currently in a lesbian relationship.

Table 2.1 provides demographic information for stepmothers and biological mothers. The stepmother and biological mother samples did not differ in age or

economic and racial composition. Both groups were predominantly European American and reported incomes consistent with middle or upper middle socioeconomic status (approximately 1/3 of both samples reported a family income above $100,000). The vast majority of participants in both groups reported being in a legally-recognized marriage. Stepmothers had significantly more children/ stepchildren than biological mothers (about one more on average) $t(133) = 4.60$, $p < .001$. Though the mothers' ages were equivalent, stepmothers' children were on average 6 years older than the children of biological mothers $t(131) = 7.85$, $p < .001$. Children in stepfamilies ranged in age from 0-36 and children in biological families ranged in age from 0-21, although all families had at least one child under the age of 18. The range of children's ages in stepfamilies was generally wider; although on average, stepmothers reported having older children, the youngest children in stepfamilies were significantly younger than the youngest children of biological mothers $t(131) = 6.231$, $p < .001$. In addition, while 34.7% of stepmothers had biological children, no differences were found in any of the outcome measures between stepmothers with biological children and those without. Each of these demographic variables was used as a covariate in preliminary analyses but they were not found to meaningfully influence results.

Table 2.1
Demographic Information

Variable	Biological Mothers (N = 60)	Stepmothers (N = 75)
Age in years	35.9 (5.57)	35.05 (7.17)
Number of children	1.7 (.81)**	2.6 (1.3)**
Average age of children	4.7 (3.62)**	10.54 (4.06)**
Legally recognized marriage	92.5%	85.3%
Annual Household Income		
> $40, 000	13.3%	10.9%
$40,000-60,000	16.7%	12.3%
$60,000-80,000	28.3%	21.9%
$80,000-100,000	10%	16.4%
< $100,000	31.7%	38.4%
Race		
White	80%	86.7%
Asian	5%	1.3%
Latina	3.3%	2.7%
African American	1.7%	0%
Unknown or other	10%	9.3%
Years step-parenting		4.73 (3.09)
Stepmothers with biological children		34.7%

Involvement in step-parenting

    A little involved   17.3%

    Moderately or Very involved   82.2%

Measures

All measures can be found in Appendix A.

 Demographics. Participants provided their gender, sexual orientation, age, and race/ethnicity. Participants identified their race or ethnicity in open-ended responses, which then were coded into one of five racial categories. In addition to individual demographics, participants provided information about a range of family demographics, including the number of children and stepchildren they have, the ages of their children, their relationship status, and their estimated household income. Stepmothers were also asked how long they had been stepparenting, the proportion of their stepchildren's lives for which they have been involved, and a self-rating of their level of involvement in parenting their stepchildren. Specifically, stepmothers rated their involvement on a four-point scale ranging from *Not at all involved* to *Very Involved*. All individual demographic information (e.g., race, age, gender) and family demographic information (e.g., family income, stepparent involvement in stepparenting).

 Perceptions of Child Regard. Participants were asked 9 questions about their perception of whether their children and/or stepchildren accept and value them and the family constellation as a whole. These questions were derived from qualitative pilot data in which it became clear that prominent concerns for stepmothers are: the degree to which their children and stepchildren accept them as parents, children's embarrassment about or discomfort with the family constellation, and children's adjustment to family changes. The thirteen mothers and stepmothers who participated in the pilot study were asked open-ended questions about their experiences with, and concerns about, parenting. For example, one stepmother we interviewed identified a concern that "the kids are

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embarrassed to talk about our family…the adults in my stepdaughter's life, like her teachers, sometimes have no idea that her youngest sister (her half sister and my biological daughter) exists." Questions about mothers' perceptions of children's regard were designed to capture the extent to which the mothers felt that their children or stepchildren appreciated them and were comfortable with the current family structure. These items were intended to measure the (step)mothers' understanding and interpretation of their children's feelings about them, *not* children's feelings themselves. Example items include "One or more of my children (or stepchildren) wishes our family was more 'normal'" and "All of my children (and/or stepchildren) accept me for who I am." The resulting scale was reliable both for stepmothers (α = .89) and biological mothers (α = .90). All items can be found in Table 2.2.

Participants rated their agreement with these items on a scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Items were reversed where appropriate so that higher scores represent higher levels of perceived child regard. Scores ranged from 1 to 45 with a mean of 35.56 (*SD* = 8.68).

Table 2.2

Perceived Child Regard Items

Item Number	Item Content
1	One or more of my children is embarrassed to talk about our family with their friends
2	One or more of my children disapproves of my life choices
3	All of my children are proud to be in our family
4	One or more of my children is ashamed of our family
5	All of my children are comfortable introducing me to their friends
6	One or more of my children wishes I was not their parent
7	All of my children accept me for who I am
8	One or more of my children wishes our family was more "normal"
9	One or more of my children does not fully accept me as their parent

Parenting Stress. Participants completed The Parental Stress Scale (PSS) (see Berry & Jones, 1995 for norming data and detailed description), which is a series of 18 questions designed to measure the level of stress a participant feels as a parent. Items are scored on a five-point scale ranging from "*strongly disagree*" to "*strongly agree.*" Stepmothers and biological mothers were administered identical versions of the questionnaire. Stepmothers were instructed to consider both their biological children (where appropriate) and stepchildren while responding. Preliminary analyses did not indicate any difference in parenting stress reported by stepmothers with and without biological children. The Parental Stress Scale was reliable in the current sample both for stepmothers (α = .91) and biological mothers (α = .88). Scores ranged from 20 to 86 with a mean of 45.53 (SD = 13.28) overall. In norming the scale for mothers of non-clinically diagnosable children, Berry and Jones (1995) reported a mean of 37.1 (8.1). The difference between this mean and the mean obtained in our sample results from the significant parenting stress reported by stepmothers. Stepmothers in the sample scored much higher (M = 50.89, SD = 13.55) than both the normed sample and the biological mothers in our sample (M =38.81, SD = 9.38).

Depressive Symptoms. Participants completed the CES-D (Radloff, 1977), a 20-item measure designed to measure depressive symptoms. Items are scored on a four-point scale ranging from "*Rarely or none of the time (less than 1 day)*" to "*Most or all of the time (5-7 days).*" CES-D scores in the present sample were reliable (α = .89) and the sum of the items ranged from 0-45 with a mean of 12.44 (SD = 10.05). A CES-D score of 16 or above is generally accepted as clinically relevant (Radloff, 1977) suggesting that, on the whole, the combined sample did not suffer from clinical levels of depressive

symptoms. However, 16.9% of biological mothers and 30.7% of stepmothers met this cut-off, highlighting the clinical significance of the depressive symptoms reported by stepmothers in this sample.

Results

All analyses were conducted using the scale or subscale scores of the relevant measures. We initially conducted all analyses including age, race, household income, age and number of children, years stepparenting, involvement in stepparenting, and whether stepmothers have additional biological children (from a previous relationship or current relationship) as covariates. None of the covariates, including the age and gender of children and whether stepmothers had biological children in addition to stepchildren, meaningfully affected results; they were therefore excluded from the final model.

Depressive Symptoms, Parenting Stress, and Perceptions of Child Regard in Stepmothers and Biological Mother

All means and standard deviations for parenting stress, perception of child regard, and depressive symptoms can be found in Table 2.3. Because it was hypothesized that perception of child regard and parenting stress would mediate the relation between parenting role (stepmother or biological mother) and depressive symptoms, as a first step we assessed the relation between parenting role and depressive symptoms. Results indicated that stepmothers reported significantly more depressive symptoms than biological mothers (t (132) = 2.0, p = .05).

A mediational analysis using bootstrapping (Preacher & Hayes, 2008) was used to assess the proposed meditational model. Bootstrapping is generally considered to be the most accurate measure of mediation available as it does not rely on often-problematic assumptions such as normality (Preacher & Hayes, 2008). Bootstrapping revealed that

stepmothers experienced significantly more parenting stress ($t(132) = 5.79$, $p < .001$) and significantly less perceived child regard ($t(132) = 7.59$, $p < .001$), as hypothesized. The direct effects of both parenting stress ($t (132) = 4.85$, $p < .001$) and perceived child regard ($t = 2.18$, $p < .05$) on depressive symptoms were also significant. Finally, bootstrap results indicated a significant indirect effect of parenting stress and a marginally significant indirect effect of perceived child regard on depressive symptoms, confirming the proposed mediational model. Specifically, the indirect effect of parenting role through parenting stress was significantly different from zero, with a point estimate of 0.20 and 95% BCa (bias-corrected and accelerated; see Efron, 1987) bootstrap confidence interval of 0.11 to 0.35. Similarly, the indirect effect of parenting role through perceived child regard was marginally significantly different from zero, with a point estimate of 0.12 and a 95% BCa of 0 to 0.26 although it should be noted that using a normal theory test (i.e. Sobel Test; Sobel, 1982), perceived child regard was a significant mediator ($z (132) = 2.11$, $p < .05$). In addition, the direct effect of parenting role on depressive symptoms was rendered non-significant ($t = 1.49$, $p > .1$) with the inclusion of the mediators. Figure 2.1 displays the final mediational model with the standardized coefficients associated with each pathway.

Table 2.3

Mean Scores for Parenting Stress, Perceptions of Child Regard, and Depressive Symptoms

Group	Mean Parenting Stress Score	Mean Perceptions of Child Regard Score	Mean Depressive Symptoms Score
Stepmothers	50.89 (13.55)	31.42 (8.48)	14.04 (10.54)
Biological Mothers	38.81 (9.38)	40.82 (5.55)	10.40 (9.08)
Mean Difference (*t*)	2.15*	6.06**	7.72**
Cohen's *d* (effect size)	-0.38	-1.08	1.36

Note. Standard deviations in parentheses; * indicates significance at $p = or < .05$; ** indicates significance at $p < .01$

Figure 2.1
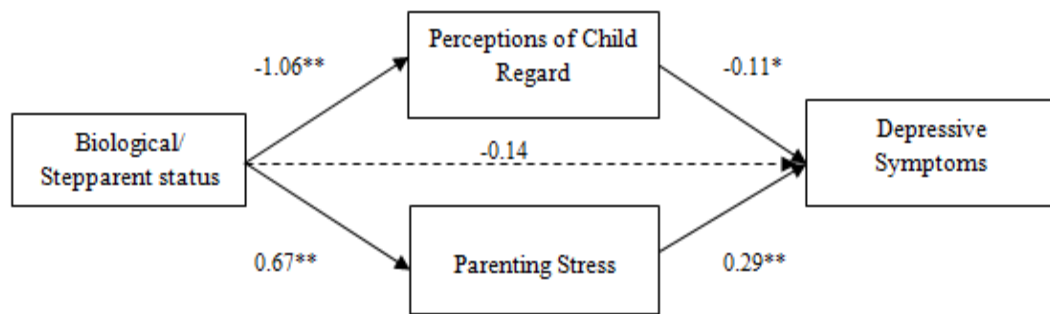
Note. *p < .05; **p < .001; dashed line represents non-significant relation

Perceptions of child regard and parenting stress as mediators of the relation between parenting status and depressive symptoms

Discussion

The findings of the current study, while based on a relatively small and homogeneous sample, suggest that stepmothers may experience significant levels of parenting stress, perceptions that their (step)children hold them and the family constellation in low regard, and high levels of depressive symptoms, confirming the first of our two hypotheses. Consistent with other research identifying the relational sources of depression (e.g., Slavich, O'Donovan, Epel, & Kemeny, 2010; Holt-Lunstad, Birmingham, & Jones, 2008) our second hypothesis was also confirmed: perceptions of child regard and parenting stress mediated the relation between being a stepmother and depressive symptoms. This finding is consistent with prior research showing that occupying parenting roles that fall outside of prescriptive norms may put mothers at increased risk for mental health problems (Shapiro et. al, 2009). Women occupying these roles must manage the shared stresses that all parents face alongside a range of additional possible stressors and concerns, including a lack of social validation both from members of their own families, as observed here, or from their broader communities (Nielson, 1999; Shapiro et. al, 2009). Given the already high (Sweeney, 2010; Kreider, 2008), and likely growing, number of stepmothers and the well-established association between maternal mental health and child mental health (Ashman et. al, 2008), identifying the implications of this unique mothering role and improving and maintaining stepmother well-being are important areas for future research and therapeutic intervention.

Empirical research on stepfamilies has traditionally, although not exclusively, focused on the children within them (e.g. Amato & Keith, 1991; Amato, 1993; Higginbotham, Skogrand, & Torres, 2010). This study underscores, as others have (e.g.,

Coleman, Trolio, & Tyler, 2008), the need also to address the experiences of adults, and stepmothers in particular, in binuclear families. This research also highlights the potentially significant influence of the specific relational context of the stepfamily on its individual members. The stepfamily system may be fundamentally different from the dynamics observed in first marriage families (Sweeney, 2010) and therefore, the stepfamily system may have unique implications for the psychological well-being of individual family members. The findings of this study reiterate the importance of examining individual subsystems within the stepfamily and suggest that the stepmother-stepchild dyad may be particularly important for individual symptom expression. The dynamics of family dyads, such as the couple or parent-child dyads, have been identified as important markers for family and individual functioning (Hetherington, 1992) and emerge here as important for stepmother well-being. Therefore, it may not only be important for researchers to examine the stepfamily system as a whole, but also its smaller subsystems.

While these findings suggest that stepmothers have different experiences than biological mothers, researchers should be wary about generalizing these findings to stepfathers and biological fathers. While stepfathers face negative stereotypes and role ambiguity (Marsiglio & Hinojosa, 2010), these are likely different from those experienced by stepmothers as a result of gendered norms and expectations surrounding parenting (Coleman et. al, 2008). Women in general (Trebilcot, 1983) and stepmothers specifically (Coleman et. al, 2008) are subjected to a range of harmful gender norms and stereotypes. Unlike men, women are expected to be competent and natural mothers (Trebilcot, 1983), which may be particularly problematic for stepmothers who occupy

challenging and complex parenting roles. Therefore, it is likely that stepfathers experiences different levels and sources of stress than do stepmothers and this stress may differently contribute to mental health (Fellmann, Galán, Lloreda, & Psicothema, 2008).

Implications for Clinical Practice

In our sample, stepmothers reported higher levels of parenting stress than has been documented among mothers of children with ADHD (Berry & Jones, 1995) and almost double the rate of depression than that reported by biological mothers. In 1/3 of cases, stepmothers' depression was clinically-significant, This suggests that these findings are not only of theoretical significance, but also of potential clinical significance.

The mediational relations among parenting stress, perceived child regard, and depressive symptoms in the present study may indicate the need for targeted clinical interventions with stepmothers that recognize the difficulty of stepmothering and work to help stepmothers manage the stress and concerns that come with this role. While a certain amount of stress and adjustment may be common among stepmothers, intervention approaches aimed at preparing stepmothers for, and helping them to understand and manage the complexity and stress of, stepmothering might reduce the risk for depressive symptoms in this group. Such interventions should address the relational source of these stresses and work within the family system to improve individual and familial functioning. Systems-level approaches to addressing stepfamily functioning have been identified as beneficial for children (Higginbotham et. al, 2010) and this utility may extend to adults in binuclear families. In particular, it may be especially important for clinicians to facilitate partner and familial support for stepmothers as a means of reducing stepmothers' role ambiguity, stress, and depression. Marital and family therapies have

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been identified as useful for treating individual depression (for review see Beach, Jones, & Franklin, 2009) and given the relational sources of stepmother depressive symptoms identified here, relational interventions, particularly those that involve increasing spousal support and the facilitation of stepparent-child relationships, may be particularly relevant.

In general, clinical practitioners should be aware of the unique issues that stepmothers face, such as managing relationships with children and their biological parents, the gendered implications of adopting a non-normative mothering role, and the logistical and emotional challenges of stepmotherhood, as well as the psychological consequences associated with these issues, and aim to address them in their clinical work.

Limitations and Future Directions

The present study has several limitations worth noting. First, although many steps were taken to ensure that biological mothers and stepmothers were recruited in equivalent ways, this study used a convenience sample, recruited online, and therefore does not include women who did not have access to computers and may be subject to sampling or response bias. As a result, the sample obtained for the present study was relatively racially and economically homogeneous, suggesting that these findings may not be generalizable to a more diverse population of women. Because all of the women recruited for this study (both step- and biological mothers) were members of parenting or mothering listservs, they may represent a group specifically seeking social support, perhaps as a result of the experience of high levels of stress, adding another potential source of bias for both groups of mothers.

Second, additional factors outside of those addressed in the current study may influence the relations examined here. For example, in this study we were not able to

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examine the marital relationship, which has been shown to be related to other factors such as the quality of the stepparent-stepchild relationship (Fine & Kurdek, 1995). It is likely important for family and individual functioning more generally (Hetherington, 1992), but has not been examined in relation to stepmother depressive symptoms. The couple dyad should be examined as a possible contributor, or protective factor, to stepmother well-being. Nor were we able to examine stepmothers' relationships with their stepchildren's biological mothers. Although our results did not suggest a meaningful difference between stepmothers with biological children and those without, future research should address potential differences between these groups more thoroughly. Likewise, the lack of contribution from demographic variables, like the age of children and length of time stepparenting found in this study, merits investigation in larger, more representative samples and with a greater range of measures of mental health. In addition, the current study was limited by its inability to distinguish residential and non-residential stepmothers and the exclusion of stepfathers. Future research should investigate differences between residential and non-residential stepmothers, as well as relations among parenting stress, perceptions of child regard, and depressive symptoms in stepfathers. The latter would shed light on potential differences among families with either men or women in stepparenting roles. Another important direction for research may be the assessment of new clinical interventions aimed at reducing the stress associated with stepmothering and thereby improving both individual and family well-being and functioning.

Chapter III

Dyadic support in stepfamilies: Buffering Against Depressive Symptoms Among More and Less Experienced Stepparents[2]

Estimates of the prevalence of stepparenting indicate that it is an increasingly common parenting role (Teachman & Teadrow, 2008). Research suggests that major disruptions in social structures are often a source of stress, as new relationships must be formed and old relationships renegotiated (Ganong & Coleman, 2004; Sweeney, 2010). Indeed, stepparenting has been linked with increased stress and depression (e.g., Shapiro & Stewart, 2011). One major protective factor against depression is social support. We examine how various forms of social support buffer stepparents against depressive symptoms, whether these effects vary as a function of how long one has been stepparenting, and, because parenting roles may take on different meanings as a result of their intersection with gender, whether these associations are equally strong for stepmothers and stepfathers.

Stepparents face a range of relational challenges, such as difficult relationships with the other biological parent[3], conflicted or limited support from spouses, and resistance from stepchildren (Craig & Johnson, 2011; Lamb, 2007; Shapiro & Stewart, 2011). The unique relational challenges associated with stepparenting may result in an

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[2] A version of this paper is in press: Shapiro, D.N., & Stewart, A.J. (in press). Dyadic support in stepfamilies: Buffering against depressive symptoms among stepparents. *Journal of Family Psychology.*
[3] Throughout this paper we refer to the ex-spouse of the stepparent's current partner and the other biological parent of the stepchildren (e.g., in the case of a stepmother, the biological mother) as the "other biological parent."

increased risk for mental health problems, such as depression. Depression not only leads

to functional impairments in adults, but may also be passed intergenerationally to

children, even by non-biological parents (Tully, Iacono, & McGue, 2008) such as

stepparents, making the correlates of (step)parental depression an important concern.

The extent to which stepparents and their families are able successfully to

negotiate the challenges of stepparenting may have meaningful implications for their

psychological well-being. Drawing from a family systems perspective, which emphasizes

the systemic associations among family, dyadic, and individual well-being (Hargrove,

2009), as well as the extensive literature on the role of social support in preventing

psychological symptoms (e.g., Aneshensel & Stone, 1982, Grav, Hellzén, Romild, &

Stordal, 2012), we view positive dyadic relationships as a potential protective factor.

More specifically, in times of stress or transition, both the sum total of support

individuals receive, as well as their ability to elicit support specific to their needs, have

important roles in the prevention of psychological symptoms (Cohen & Willis, 1985).

Partners may be one of the more important sources of social support for parents

(Cowan, Cowan, Pruett, & Pruett, 2007). Partner support has been established as

contributing to parenting efficacy and psychological well-being (Katz & Gottman, 1996).

Among stepparents, marital satisfaction is associated with greater ease adjusting to the

stepparenting role (Whitsett & Land, 1992), and among stepfathers who identify strongly

with their parenting role, positive spousal interactions are associated with lower distress

(DeGarmo & Forgatch, 2002).

For stepparents, spousal support and facilitation of stepparenting may be

significant for at least two reasons. First, the challenges stepparents encounter may result

in a greater need for spousal support, and more severe psychological consequences if these needs are unmet. Second, because stepparents are relatively newer to the family, and lack the social legitimacy of biological parents (Ganong, Coleman, Fine, & Martin, 1999; Nielson, 1999), they may rely on their partners for help navigating and legitimizing their relationships with their stepchildren, particularly in the early years of stepparenting before these relationships have solidified. Some prior evidence has supported this link: marital conflict has been found to contribute to poorer mental health outcomes in stepfamilies and adoptive families (Lansford, et. al., 2001).

Similarly, as a result of the differential social, legal, and familial legitimacy and validation allotted to biological- and step-parents, relationships between stepparents and their stepchildren's other biological parent may be simultaneously strained and important. As biological parents, ex-partners are in a position to either facilitate, or undermine, the quality of stepparents' relationships with the children (Ganong, Coleman, Fine, & Martin, 1999).

A third source of relational support may be the stepchildren themselves, whose acceptance and regard for the stepparent is an often-ignored but potentially significant source of validation (Shapiro & Stewart, 2011; Sweeney, 2010). The research that does exist has suggested that parent-child conflict explains some of the variance in life satisfaction and well-being among parents in stepfamilies, adoptive families, and biological families (Lansford, et al., 2001) and that stepchildren's regard (defined as acceptance and support for the family constellation as a whole and the stepparent in particular) is an important determinant of stepmothers' mental health outcomes (Shapiro & Stewart, 2011). However, the link between stepchild acceptance and support and

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stepparent mental health has not been examined in conjunction with other relational supports or, to our knowledge, in stepfathers.

From a family systems perspective, the health of each of these dyads— the marital dyad, the other biological parent-stepparent dyad, and the stepparent-stepchild dyad—likely contributes to the success of stepparents' role negotiations and mental health outcomes. Further, because stepfathers may adopt different parenting roles than stepmothers (e.g., Clingempeel & Segal, 1986), face fewer, or qualitatively different (Lamb, 2007), domestic stressors, and be less likely to report depressive symptoms as a result of the stressors they do encounter (e.g., Olsson & Hwang, 2001), it is important to compare the experiences of social support and depression between stepfathers and stepmothers. Family roles are inherently gendered and, as a result, it is possible that gender intersects with these roles to the extent that stepmothers and stepfathers report different experiences.

Therefore, we predicted that partner support, other biological parent support, and child regard would all predict lower depressive symptoms independently, but we were interested in whether specific forms of support would emerge as more influential when these three sources of support were included in a single model. Further, while social support and validation are likely important for all stepparents, they may be particularly valuable for stepparents who are in the early years of stepparenting, as they adjust to their parenting roles and solidify relationships with stepfamily members. Family systems theorists have purported that stepfamilies go through a process of reorganization and role formation in the early years, but become more stable and settled over time (Hetherington & Clingempeel, 1992). Therefore, we predicted that having adequate social support

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would be particularly relevant for newer stepparents. Finally, we were interested in whether stepmothers and stepfathers would be equally vulnerable in their stepparenting role.

Methods

Participants and Procedure

All participants were recruited from internet groups and email listservs relevant to parenting and received an email inviting them to participate in a survey on parenting and well-being. Participants were compensated monetarily. The resulting sample included 125 stepparents (84 female). Table 3.1 provides demographic information for stepmothers and stepfathers. Stepmothers and stepfathers were similar on all demographic variables. The stepmother and stepfather samples did not differ in age or economic and racial composition. Both groups were predominantly European American (both samples were approximately 89% European American) and reported incomes consistent with middle or upper middle socioeconomic status (approximately 1/3 of both samples reported a family income below $60,000 and an equal proportion reported a family income above $100,000, with a third falling in between). Compared to stepmothers, stepfathers were both significantly older $t(123) = 3.10$, $p < .01$ and had been stepparenting for longer $t(109) = 2.93$, $p < .01$. Stepfathers were also more likely to have biological children $c^2(1, N = 125) = 9.28$, $p < .01$.

Table 3.1

Demographic Information

Variable	Stepmothers ($N = 84$)	Stepfathers ($N = 41$)
Number of children and stepchildren	2.44 (1.48)	2.68 (1.58)
Average age of children	9.70 (4.74)	11.41 (4.86)
Annual Household Income		
< $40, 000	12.0%	17.5%
$40,000-60,000	19.3%	15.0%
$60,000-80,000	14.3%	27.5%
$80,000-100,000	16.9%	10.0%
> $100,000	37.3%	30.0%
Percent European American	89.3%	89.7%
Years stepparenting*	4.26 (3.48)	6.49 (4.54)
Stepparents with biological children*	37%	64%
Perceived involvement in parenting	3.40 (0.70)	3.29 (0.75)
Partner Support	8.39 (1.91)	7.71 (2.43)
Biological Parent Support	4.76 (2.20)	5.11 (1.75)
Perceived Child Regard	29.76 (7.0)	28.03 (8.37)
Depressive Symptoms	12.28 (9.43)	9.20 (7.83)

Note. Variables on which there is a significant difference between stepmothers and stepfathers are notated with *

Measures

All materials used for the current study can be found in Appendix B.

Demographics

Participants provided their gender, age, and race/ethnicity. Because of the relatively low numbers of racial minority participants in the current study, race was coded to be either "European American" or "Not European American." In addition to individual demographics, participants provided information about a range of family demographics, including their estimated household income, the number of children and stepchildren they have, and the ages of their children/ stepchildren. In households with both biological and stepchildren, stepparents provided the number and ages of their stepchildren and biological children separately; for the purposes of analyses, the number of stepchildren and children were combined and child ages were averaged. Stepparents were also asked how long they had been stepparenting and to rate their level of involvement in parenting their stepchildren from 1 (Not at all involved) to 4 (Very Involved). Stepparents indicated very high levels of involvement; no stepparents indicated that they are not at all involved in parenting their stepchildren.

Partner and Biological Parent Support

Stepparents were asked about their sense of support and facilitation from their partners as well as from their stepchildren's other biological parent (i.e., their spouses' ex-partner). Specifically, they were asked to rate "the degree to which your partner has helped to facilitate or strengthen your relationship with your stepchildren" from 1 (Not at All) to 5 (A lot) and " how supportive has your partner been of your efforts to build a relationship with stepchildren" from 1(Very Unsupportive) to 5 (Very Supportive). These

two items were then summed into a single reliable measure of partner support (α = .86). Summed ratings of spousal support ranged from 2-10 (M = 8.16, SD = 2.11).

In reference to the stepchildren's other biological parent, stepparents were asked "how supportive has your stepchildren's other biological parent been of your efforts to build a relationship with your stepchildren?" and rated the supportivness on a 5 point scale from 1 (Very Unsupportive) to 5 (Very Supportive) and to rate the " quality of your relationship with your stepchildren's other biological parent" on a 5 point scale from 1 (Very Negative) to 5 (Very Positive). These two items were summed to create a reliable measure of other biological parent support (α= .79); summed ratings of other biological parent support ranged from 2-10 (M = 4.87, SD = 2.07).

Perceived Child Regard

Participants completed an eight items about the degree to which they perceive their stepchildren to accept and value them and the family constellation, derived from previous research on stepparenting and mental health (for a more detailed description of the items, see Shapiro & Stewart, 2011), which was highly reliable in the current sample (α = .91). Example items include "One or more of my children (or stepchildren) wishes our family was more 'normal'" (reversed) and "All of my children (and/or stepchildren) accept me for who I am." Participants rated their agreement with these items from 1 (Strongly disagree) to 5 (Strongly agree). Stepparents with multiple stepchildren were asked to report their agreement averaging across their stepchildren. Scores ranged from 8 to 40 (M = 29.09. SD = 7.52).

Depressive Symptoms

Participants completed the CES-D (Radloff, 1977), a 20-item measure designed to measure depressive symptoms. Items are scored on a 4 point scale ranging from 0 [Rarely or none of the time (less than 1 day)] to 3 [Most or all of the time (5-7 days)]. CES-D scores in the present sample were reliable ($\alpha = .76$) and the sum of the items ranged from 0-44 with a mean of 11.26 (*SD* =9.02). A CES-D score of 16 or above is generally accepted as clinically relevant (Radloff, 1977). Approximately one-quarter (26.4%) of the current sample reported a score above the clinical cutoff.

Results

All analyses were conducted using the scale or subscale scores of the relevant measures. We initially conducted all regression analyses including age, race, household income, and the average age and number of children as covariates. None of these covariates affected results nor did they differ as a function of gender. Therefore, for the sake of power and parsimony, they were excluded from the final model. Preliminary analyses also included interactions between the three forms of social support in order to explore whether support from one source might facilitate or reduce support from another. This alternate pattern of interactions was not supported and therefore these interaction terms were not included in the final model. Whether stepparents have biological children was included in the final regression model, as stepmothers and stepfathers significantly differed on this variable and previous research has suggested that stepparents with biological children may represent a different demographic group from those without (Lamb, 2007). Because of its potential impact on stepparents' need for and access to support, stepparents' involvement in parenting was also included in the model. Preliminary analyses did not indicate problematically high correlations (Aiken & West,

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1991) among predictor variables of interest (see Table 3.2), nor did they indicate the

presence of outliers exerting an undue effect on results.

Table 3.2

Intercorrelations Among Predictor Variables

	Perceived Child Regard	Other Biological Parent Support	Years Stepparenting	Stepparent Involvement
Partner Support	.51***	.21*	.02	.40***
Perceived Child Regard		.25**	-.06	.42***
Other Biological Parent Support			-.10	.21*
Years Stepparenting				.14

*Note: *p ≤ .05. **p ≤ .01. ***p ≤ .001.*

Depressive Symptoms, Social Support, and Years Stepparenting among Stepparents

Because some of our independent variables were correlated, independent variables were centered prior to analyses (Aiken & West, 1991). Before conducting the multivariate analyses, we assessed mean differences among the different forms of support; stepparents reported significantly more support from partners than from stepchildren t (118) = 4.41, $p < .001$ and their stepchildren's other biological parents t (113) = 13.97, $p < .001$. Next, we tested whether each form of support was associated with depressive symptoms using bivariate correlations. Partner support r (120) = -.39, $p < .001$, stepchild regard r (116) = -.34, $p < .001$ and support from the other biological parent r (110) = -.20, $p < .05$ were all negatively correlated with depressive symptoms suggesting that each of these may buffer against symptom expression.

In order to test the roles of social support from the three different dyads in relation to one another, as well as to examine hypotheses regarding gender and years stepparenting, we conducted a multivariate regression that included all main effects and two-way interactions between each form of social support and years stepparenting. Preliminary analyses did not suggest that gender or stepparent involvement interacted with any of the variables of interest; therefore, gender and stepparent involvement were included only as main effects, neither of which was significant. The regression model is summarized in Table 3.3. Main effects were entered into the first block $R^2 = .31$, $F(1, 92)$ = 5.38, $p < .001$. When included in a model along with partner support, neither other biological parent support $\beta = -.05$, $t(92) = -.50$, $p > .60$ nor perceived child regard $\beta = -.14$, $t(92) = -1.30$, $p > .10$ was significant predictors of depressive symptoms. Partner support, however, remained a significant predictor of depressive symptoms $\beta = -.39$, $t(92)$

= -3.49, $p = .001$. In addition, there was a marginally significant main effect of years

stepparenting $\beta = -.16$, $t(92) = -1.60.$, $p = .10$.

Interaction terms were entered as a second block $R^2 = .41$, $F(1, 92) = 5.70$, $p <$

.001; this improvement in the variance explained was significant $\Delta R^2 = 0.10$, $p < .01$.

The main effects of years stepparenting and partner support were qualified by a

significant two-way interaction $\beta = .30$, $t(92) = 3.01$, $p < .01$, modeled in Figure 3.1. The

simple slope measured at one standard deviation below the of mean years stepparenting

(approximately 1 year stepparenting) indicated that for newer stepparents, partner support

predicted lower symptoms $\beta = -2.99$, $t(92) = -4.73$, $p < .001$. In contrast, when measured

at one standard deviation above the mean of years stepparenting (approximately 9 years

stepparenting), partner support was not significantly associated with depressive

symptoms $\beta = -0.13$, $t(92) = -.21$, $p > .80$, and depressive symptoms were uniformly low.

Table 3.3

Multivariate Regression Results

Variable	B	SE B	β
Step One			
Perceived Stepchild Regard	-0.17	0.13	-.14
Other Biological Parent Support	-0.22	0.45	-.05
Partner Support	-1.64	0.47	-.39***
Years Stepparenting	-0.38	0.24	-.16†
Gender	2.74	1.93	.15
Stepparent Involvement	-0.19	1.34	-.02
Whether Stepparent Has Biological Children	-1.88	1.74	-.10
Step Two			
Years Stepparenting X Perceived Child Regard	-0.04	0.03	-.14
Years Stepparenting X Other Biological Parent Support	0.21	0.14	.14
Years Stepparenting X Partner Support	0.36	0.12	0.30**

Note: $*p \leq .05. **p \leq .01. ***p \leq .001. \Delta R^2 = 0.10, p < .01$

Figure 3.1
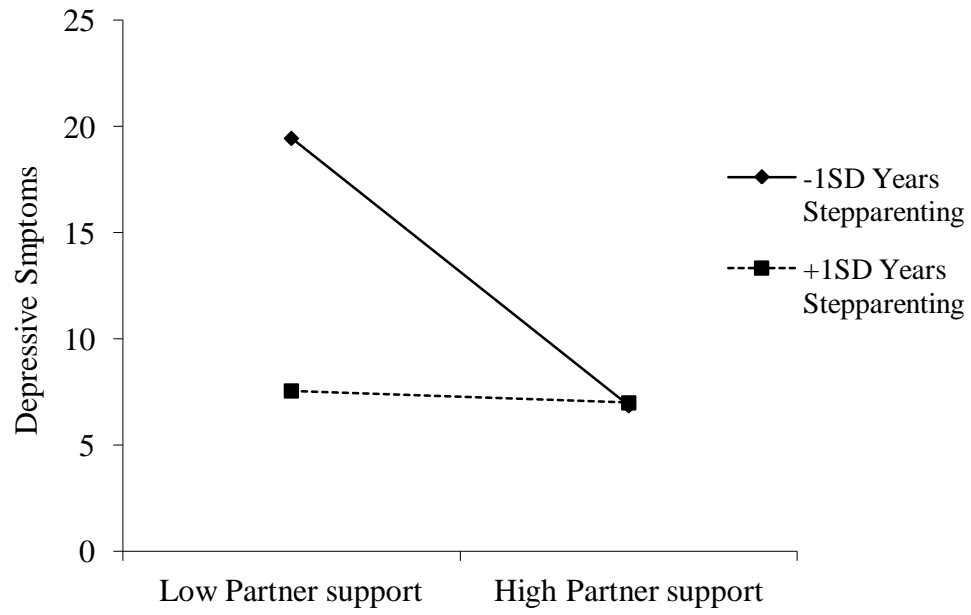
Interaction between years stepparenting and partner support predicting depressive symptoms.

Discussion

Results of the current study suggested that support, validation, and facilitation from multiple members of the family system—including a stepparent's partner, stepchildren, and stepchildren's other biological parent—were relevant to the expression of depressive symptoms among stepparents. However, stepparents reported receiving the most support from their partners and, when modeled together, partner support emerged as the strongest contributor to depressive symptoms, suggesting both that it may be the most available form of support and that its effects on stepparent well-being may eclipse those of other forms of social support. In addition, years stepparenting predicted (marginally) depressive symptoms such that the longer stepparents had been stepparenting, the less vulnerable they were to depressed mood.

These two main effects—of partner support and years stepparenting—were qualified by an interaction such that years stepparenting moderated the association between partner support and depressive symptoms. Among newer stepparents, a lack of partner support was associated with higher depression, while parental support mattered less for more experienced stepparents; in fact, for stepparents who had been stepparenting for nine years (one standard deviation above the mean) spousal support was unrelated to depressive symptoms, which were uniformly low.

Gender was not associated with any variable of interest, nor did it interact with any of these variables. One possible explanation for the lack of gender effects is that stepfathers and stepmothers did not differ on involvement in stepparenting, as might have been expected; decades of research findings suggest that women generally take on more active parenting roles (Lachance-Grzela & Bouchard, 2010). In the current sample, there

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was very little variance on the domain of involvement in stepparenting; no participants rated themselves as not at all involved and only 17 as a little involved. This perhaps suggests that the stepfathers in this study were uncharacteristically similar to stepmothers and that, at least in this sample of highly involved and engaged stepparents, stepfathers and stepmothers benefit from social support and experience—and suffer from their absence—in similar ways.

This study underscores the importance of adopting a systems approach to understanding stepparenting and centering the experiences of adults, in addition to the experiences of children, in research on stepfamilies. The dynamics of the family system, and in this case of individual dyads within the system, have important implications for the functioning for individuals (Hetherington, 1992) and while this relation is understood with regard to outcomes for children (Cowan & Cowan, 2002), less is known about how systemic factors affect stepparents.

This research also underscores the importance of the marital dyad in particular as a source of support and facilitation for parents (Cowan, et al., 2007; Katz & Gottman, 1996). In our data, in addition to exerting a greater influence on depression, partner support was, on average, higher than support from the other biological parent or stepchild, suggesting that in addition to providing more *effective* support, partners may provide more support overall. Taken together, these findings suggest that clinicians might best promote positive mental health outcomes by joining stepparents and their partners around the transition into a binuclear family arrangement, particularly in the early phases of adjustment to the binuclear family system.

The positivity of the relationship with, and support and facilitation from, the stepchildren's other biological parent and regard from the stepchildren themselves may also be important to stepparent well-being, although perhaps less important than partner support. In any case, researchers and clinicians should consider the functioning and health of each dyad within the stepfamily system, as well as the functioning and health of the system as a whole, when considering stepparent well-being.

These findings also suggest that stepfathers, or at least those who, as in our sample, are equally involved in parenting as stepmothers, may be similarly affected by stepparenting and benefit from the same kinds of social supports and years of experience as stepmothers. While some research on stepfamilies has suggested that gender does not play an important role in outcomes (Hetherington & Clingempeel, 1992) and that stepfathers who are particularly engaged may be more sensitive to some negative family interactions (DeGarmo & Forgatch, 2002), other research has suggested that stepmothers may be subjected to unique challenges, such as particularly damaging stereotypes and marginalization (Whiting, Smith, Bamett & Grafsky, 2007). Therefore, researchers and clinicians should continue to consider when and how gender matters in stepparents' adjustment and mental health.

Limitations

The present study has several limitations worth noting. First, this study made use of a cross-sectional, convenience sample recruited online and as a result, the sample may have been subject to sampling biases. Fewer stepfathers than stepmothers participated and, as a result, sampling bias may be particularly problematic for male participants. The sample was also relatively homogenous in terms of income, race, and perceived

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involvement as stepparents. Therefore, these results may not be generalizable to a population more diverse on these dimensions. Second, because the reports were drawn from a single source (the stepparent), ratings may be subject to source variance. Future research should address these shortcomings by engaging multiple family members in research studies or using observational methods to more directly and accurately examine family dynamics

Chapter IV

The Role of Parenting in Children's Grief Reactions: Associations among Mother-Child Communication Quality, Childhood Maladaptive Grief, and Depressive Symptoms[4]

The loss of a parent can be one of the most devastating events that a family may encounter and, unfortunately it is not an uncommon experience. In 2003, it was estimated that there were 143 million orphans in 93 countries across the world (UNAIDS, UNICEF, & USAID, 2005). Despite the seriousness of parental loss, existing studies on parentally bereaved youth suggest that only a minority of bereaved children in the general population (approximately 5 to 10%) experience clinically significant psychiatric problems (Dowdney, 2000). It seems that childhood bereavement alone (i.e., in the absence of other risk factors) is unlikely to lead to future psychopathology (Bebbington, Tennant, & Hurry, 1991; Harris, Brown, & Bifulco, 1986). Even among clinically-referred populations, most studies indicate that outcomes consist of sub-clinical symptoms rather than a full-blown diagnosis (Dowdney, 2000).

There are two notable exceptions to this finding. First, parentally bereaved youth may be at an increased risk for Major Depressive Disorder (Melhem, Walker, Moritz, & Brent, 2008). Second, bereaved children are at risk for developing a syndrome referred to as "complicated grief" (Melhem et al., 2011), "childhood traumatic grief" (Cohen, Mannarino, Greenberg, Padlo, & Shipley, 2002), or "maladaptive grief" (Kaplow, Layne,

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[4] A version of this paper is currently under review: Shapiro, D.N., Howell, K., & Kaplow, J.B. (under review). Associations among parent-child communication quality, maladaptive grief, and depressive symptoms among parentally bereaved children and their surviving mothers.

Pynoos, Cohen, & Lieberman, in press). Maladaptive grief i characterized by an atypically severe, lengthy, or symptomatic reaction to the loss of a close other and, for children, may include symptoms of traumatic stress (e.g., intrusive thoughts about the circumstances of the death), separation anxiety, and existential stress [e.g., feeling a lack of meaning or direction (Kaplow, et. al, in press)]. Because the construct of maladaptive grief was initially evaluated in adults and adapted for children secondarily, the symptoms, prevalence, and correlates of maladaptive grief among youth are difficult to pinpoint. However, this syndrome may represent a serious mental health problem as gauged by its links to developmental disturbances, associated psychological and behavioral problems, and functional impairment (Brown et al., 2008; Melhem et al., 2011; Spuji et al., 2011) and, as a result, childhood maladaptive grief is increasingly recognized as a significant clinical issue (Kaplow, et. al, in press). Both depression and maladaptive grief are problematic not only in the short term, but can also put children at risk for long-term impairment (Cerel, Fristad, Verducci, Weller, & Weller, 2006; Harrington, 1996).

Despite the prevalence and long-term risks associated with maladaptive grief and depression in the context of bereavement, little is known about which children are most at risk for developing these symptoms. Given that bereavement per se does not significantly increase risk for psychiatric disorders (Dowdney, 2000; Harris et al., 1986), efforts to elucidate the factors that produce clinical maladjustment among bereaved youth should address the role that children's broader ecologies might play in symptom development (Kaplow et al., in press).

In particular, children's immediate caregiving environments may either facilitate, or inhibit, their abilities to engage in adaptive grief processes and to achieve key

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developmental tasks following the loss. Compared to adults, children depend much more heavily on their immediate caretaking environment to help facilitate their mourning (Clark, Pynoos, & Goebel, 1994), suggesting that parent-child communication, particularly about the loss, may be an important factor in determining symptom severity. For example, when caregiver-facilitation of mourning is disrupted to a significant degree (e.g., by increased logistical or emotional demands placed on the parent) or disrupted altogether (by the subsequent loss of the surviving caregiver), the child is at substantially higher risk for experiencing clinically significant psychological distress (Brown et al., 2008; Lin, Sandler, Ayers, Wolchik, & Luecken, 2004) and derailment from a normal developmental trajectory (Lieberman et al., 2003).

Furthermore, and more generally, psychologists have long upheld communication as one of the most important contributors to relationship quality in families and dyads (Raush, Barry, Hertel, & Swain, 1974; Gottman, 1993; Sillars, Canary, & Tafoya, 2004). Research on communication in adult dyads such as couples, suggests that healthy communication involves mutual and engaged participation, displays of positive affect (such as humor), and validation of each person's feelings (Gottman, 1993). Some research has extended the methods and findings from studies on communication in marital relationships to parent-child dyads. We now know, for example, that parents' emotional responsiveness during communications with their children in a laboratory setting can predict important longitudinal outcomes including school performance, physiological reactivity, quality of peer relationships, and emotion regulation (Gottman, Katz, & Hoovan, 1996). The specific features of parent-child communication that seem to function in a protective capacity, particularly in times of familial stress, are openness,

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mutual disclosure (Lutz, Hock, & Kang, 2007), the parent's ability to engage the child (Stewart, et. al, 1997), positivity, validation (Brown, Fitzgerald, Shipman, & Schneider, 2007), and effective emotion-regulation (Gottman et. al, 1996).

Within the context of bereavement specifically, higher functioning and warmth of the surviving caregiver, better quality of parent-child communication, and the rate of stable, positive family routines may each buffer the adverse effects of parental death on children's adjustment (Lin et al., 2004; Melhem et al., 2008; Sandler, et al., 2003; Weller, Weller, Fristad, & Bowes, 1991). However, to our knowledge, observational studies of parent-child communication in bereaved populations have not been conducted.

While open and supportive communication may be an important resource for children, this level of engagement may be difficult to achieve for parents managing their own grief and the new logistical, social, and financial challenges of widowed parenthood and secondary adversities that complicate family grief processes (Clark et al., 1994; Layne, Warren, Saltzman, Fulton, Steinberg, & Pynoos, 2006; Silverman & Worden, 1992). Parents undergoing a sudden and extreme change in family structure, such as the loss of a partner, may not know how to parent a distressed child, parent alone, or communicate with a child about death and loss (Clements & Burgess, 2002). For example, parental discipline has been shown to suffer following the death of the other parent (Schmiege, Khoo, Sandler, Ayers, & Wolchik 2006; Wolchik, Tein, Sandler, & Ayers, 2006). The challenges of parenting in the context of bereavement may be particularly difficult for bereaved women who not only balance the logistics of parenting and their own grief, but also social norms dictating that they should be unflappable and selfless parents (Douglas & Michaels, 2004), even in difficult circumstances. Given the

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potential difficulty of parenting in the context of grief in general, and for women in particular, identifying mechanisms that can be employed to assist widows through communication and parenting processes following the loss of a spouse may be particularly relevant for intervention development.

A parent's emotional experience of bereavement may be one important factor in determining their ability to parent following the loss of their spouse and communicate with their children about the loss. Depressed mothers, in general, have been found to use a more negative and detached parenting style than non-depressed mothers, and these communication patterns can lead to symptom expression in children (Lovejoy, Graczyk, O'Hare, & Neuman, 2000; Jacob & Johnson, 1997; Dietz, Donahue-Jennings, Kelley, & Marshal, 2009). This association, however, may be more complicated in the context of bereavement, in which mild-to-moderate levels of depressive symptoms are considered to be normal (Gersten et al., 1991; American Psychiatric Association, 2000) and potentially necessary for bereaved children to observe and emulate during a period of mourning. In fact, in the DSM-IV TR, recent bereavement is listed as an exclusion criterion for the diagnosis of Major Depressive Disorder because of the high comorbidity between normal, healthy grief reactions and symptoms of depression (American Psychiatric Association, 2000).

It may be that any deviation from a healthy emotional response to the loss presents challenges for parents. In other words, it is not only possible that high levels of parental depressive symptoms are problematic for parent-child relationships, but that a blunted emotional response (i.e., very few, or no, depressive symptoms) may also affect parenting efficacy. Parents who are either not experiencing, or are suppressing the

expression of, negative affect following the loss of their spouse may have difficulty providing a context for their children to express their own loss-related emotions and may not model effective emotion regulation and emotional expression as effectively. Given the critical role the surviving caregiver plays in facilitating grief and mourning in his or her child (Kaplow et al., in press), the extent to which this process is disrupted by a parent's own symptoms is an important research and clinical concern.

Efforts to improve communication in the context of bereavement could help to prevent or alleviate mental health problems in widows and their children. However, in order to provide a foundation for the development of such interventions, we need research that specifically examines the dynamics and psychological correlates of parent-child communication in the aftermath of loss. Therefore, the purpose of this study is to examine patterns in the observed features of parent-child communication in the aftermath of parental bereavement, identify associations between maternal emotional functioning (in this case, depressive symptoms) and communication efficacy, and examine associations between parental communication efficacy and depressive and maladaptive grief symptoms in children. In order to achieve these objectives, this study examines two general hypotheses. First, mothers' abilities to effectively engage their children in a sensitive and productive conversation about the loss will be associated with lower depressive and maladaptive grief symptoms among their children. Second, mothers' healthy (and normative) emotional reaction to the loss, characterized by mild-to-moderate depressive symptoms, will be associated with increased communication efficacy.

Methods

Participants

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Our sample included 38 dyads comprised of 38 bereaved children between the ages of 3 and 13 ($M = 7.79$, $SD = 3.06$). Of these 38 children, 15 were under the age of 7 and 23 were aged 7 or older. Children aged 3-6 were excluded from all analyses of child mental health, as they are unable to reliably self-report symptoms. All 38 children who participated in the study recently (within the past six months) lost a parent; the sample also included their 26 surviving caregivers. In other words, 26 unique families participated in the study; the number of children per family ranged from 1-5 ($M = 1.61$; $SD = 0.93$). Nine of the families participating in the study had multiple children such that 21 children (55%) had siblings who also participated in the study and 17 were the only participating child.

All of the surviving caregivers were female guardians and 92% were biological mothers; 45% of the children were also female. Only four fathers completed the parent child interactoin and preliminary analyses suggested that their communication strategies might differ from those employed by the mothers in the sample. Because of these potential differences, and the lack of sufficient data to examine them, fathers were excluded from the current study and retained for future analyses. The majority of the sample (74%) described their race/ ethnicity as Caucasian. Most children lost their fathers to either an anticipated (31%) or sudden (33%) natural death and the mean days since the loss was 100 ($SD = 56.78$) days. Descriptive statistics for demographic and loss-related variables for mothers and children can be found in Table 4.1.

Table 4.1

Descriptive Statistics for Demographic and Loss-Related Variables

Child Age	7.79 (3.06)
Child Gender (% female)	45%
Parent Age	37.9 (8.43)
Race	
Caucasian	74%
African American	13%
Asian	5%
Hispanic	5%
Other	3%
Days since loss	100 (56.78)
Cause of death	
Anticipated natural death	31%
Sudden natural death	33%
Accident/ drowning	21%
Suicide	16%

Note. When means are presented, standard deviations are noted parenthetically.

Procedures

Following institutional review board (IRB) approval, participants were recruited through bereavement support centers, hospitals, and advertisements in three counties in the Midwestern United States to participate in interviews about their loss experience. Of the 39 female- headed families that were invited to participate in the study, 26 agreed, resulting in a 67% response rate. Parents provided written informed consent and children provided verbal assent prior to the interview. Parents and children participated in separate interviews, during which they completed all demographic and mental health measures. Children aged 3-6 completed an interview about their loss experiences only while children aged 7-13 completed measures of maladaptive grief and depression. Following the individual interviews, all parents and children participated together in a guided, video-taped communication task (described below) which took approximately ten minutes to complete. All participants were compensated monetarily for their time.

Measures

All measures can be found in Appendix C.

Child Depression. Child depressive symptoms among children aged 7-13 were assessed using the Short Mood and Feelings Questionnaire, which is a valid and reliable 13-item self-report measure (SMFQ; Angold et al., 1995). Using a three-point scale, each item is rated according to its frequency during the previous two weeks, with response options of not true, sometimes, and true ($\alpha = .78$). Responses are summed to create a total score ($M = 5.91$; $SD = 4.23$).

Child Maladaptive Grief. The Inventory of Complicated Grief – Revised [IGC-R (Melhem, Moritz, Walker, Shear, & Brent, 2007)] was used to assess evidence of

maladaptive grief ($M = 60.68$; $SD = 26.99$) in children aged 7-13 ($\alpha = .90$). Items are rated on a 5-point scale from 0 (almost never) to 4 (always). Responses for all 36 items were summed to create a total.

Maternal Depression. The Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) is a 21-item measure used to assess depressive symptoms in adolescents and adults. Items evaluate various aspects of depression, including somatic complaints, guilt, worthlessness, and indecisiveness ($\alpha = .88$). Participants rated their feelings of depression over the past two weeks using a 4-point scale from 0 (no evidence of symptom) to 3 (symptom experienced frequently and intensely). Scores ranged from 1-31 ($M = 13.84$; $SD = 6.73$). A score of 30 or above is typically accepted as indicative severe symptom expression.

Parent-Child Interaction Task. Parents and children participated together in a 10-minute videotaped communication task in which they were asked to discuss together positive memories of the deceased parent/spouse and ways in which the child is similar to the deceased parent. These questions were chosen to 1) maximize potential for content and behavioral coding; 2) impose as little psychological and relational stress as possible on participants; and 3) elicit positive responses from both parent and child.

Each dyad was coded for the quality of both parents' and children's communication strategies; therefore, although some mothers participated in multiple interaction tasks, each dyad had unique scores for communication quality. The coding scheme, which assessed both parents' and children's communication strategies, was adapted from the coding manual used in the first phase of the National Institute of Child Health & Human Development Study of Early Child Care and Youth Development

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[SECCYD (NICHD Early Childcare Research Network, 1993)], a longitudinal study of the developmental correlates of a range of childcare experiences conducted across 10 sites in the United States. Given the large-scale and multi-site nature of the study, the codebook was developed for use on a diverse, albeit Western, sample of parent-child dyads, making it particularly useful tool for this study. The codebook has been established as a valid and reliable tool for assessing parent-child communication in the SECCYD (NICHD Early Child Care Research Network, 2005) and related research studies (e.g., McElwain & Booth-LaForce, 2006). Despite this utility, the codebook does prioritize a style of interacting (e.g., child-focused, "hands-on") that may not be normative, or even desirable, across all cultural contexts.

The NICHD codebook was expanded from its original form to include codes specifically relevant to communication about interpersonal loss and was also modified for use with older children. The items included in the codebook are described below in relation to the factor reduction and are summarized in Table 4.2; the entire codebook, as well as the rater form used to code interactions, can be found in Appendix C.

All videotaped interactions were coded by the criterion observer (D.S.) and 84% were also coded by a second coder for the purposes of establishing reliability. Reliability was satisfactory; Pearson correlation coefficients ranged from .53 - .79 for individual items. The two questions that comprised the parent-child interaction task were coded separately. Scores for each item were averaged across the two questions to create a total item score; averaged scores were then used in all analyses.

Results

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Nine of the participating families had multiple children in the study, suggesting that data on both communication and mental health might not be independent. The small sample size available for these analyses limited our capacity to use statistical strategies, such as mixed modeling, to control for non-independence. However, preliminary diagnostics (e.g., scatter plot, comparisons of inter-family and intra-family correlations) did not indicate the presence of non-independent data on the variables of interest.

Factor Reduction

Parent-child communication items, using data from all 38 dyads, were entered into a principal components analysis using a varimax rotation, the results of which are summarized in Table 4.2. Factors in the rotated solution with eigenvalues over 1.0 were included. Each item was included in the factor on which it had the highest loading and no item was allowed to load on more than one factor. The results indicated a two-factor solution. The first factor was identified as "Parent Communality," included five items, had an eigenvalue of 3.45, and accounted for 38.31% of the variance. The items that loaded on the Parent Communality factor were 1) parent sensitivity and attunement toward the child (e.g., parents' ability to modulate the conversation based on the child's needs and interests); 2) parent engagement in, and attentiveness to, the conversation; 3) parent comfort and ease (in contrast to anxiety and discomfort) discussing the loss; 4) parent positivity and warmth toward the child and conversation (e.g., smiling at the child, displays of physical affection, enjoyment of the interaction); and 5) emotional depth of the conversation (e.g., describing content in detail or discussing emotions).

The second factor was identified as "Child Communality." The Child Communality factor had an eigenvalue of 2.84, accounted for 31.60% of the variance,

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and included four items: 1) Child comfort and ease discussing the loss (in contrast to anxiety and discomfort); 2) Child positivity and enjoyment of the conversation (e.g., smiling, playfulness, use of humor); 3) Child attentiveness (e.g., ability to sustain focus on the conversation within age-appropriate limits); and 4) Child engagement with the parent and in the conversation, such as the child's initiation of topics or ratification of the parent's disclosures.

Factor scores were created by summing the scores of the items on each factor. Summed factor scores were then used in all further analyses. Scores on the Parent Communality factor ranged from 12.50 to 24.00 (M = 18.51, SD = 3.11) and were reliable (α = .88). The Child Communality factor was also reliable (α = .84); scores ranged from 5 to 20, with a mean of 14.55 (SD = 3.21). Parent Communality and Child Communality were not significantly correlated with one another (r (30) = .28, p > .10).

Table 4.2

Factor Loadings for Observed Parent-Child Interaction Items

Item	Factor 1 Parent Behaviors	Factor 2 Child Behaviors
Parent sensitivity and attunement	**.90**	.14
Parent engagement	**.93**	-.03
Parent warmth and positivity	**.82**	.03
Parent ease	**.70**	.007
Conversational depth	**.70**	.34
Child positivity	.31	**.72**
Child ease	.00	**.92**
Child attentiveness	.04	**.70**
Child engagement	.00	**.92**
Eigen-value	3.83	2.46

Note. N = 38 children and 26 adults; For the ease of presentation, items have been arranged so that, for each component, loadings appear according to the strength of their loading.

Only children aged 7-13 (N = 23) were available for analyses of the associations between parent and child communality and mental health outcomes. Of these 23 children, 10 (43%) had at least one sibling who was also eligible for inclusion in these analyses. Preliminary analyses showed that the demographic (i.e., race, gender of the child, age of parent or child) variables and circumstances of the death were not significantly associated with any of the variables of interest; therefore, we did not control for these variables in further analyses. The amount of time that had passed since the death was positively correlated with Child Communality and therefore was included as a covariate for analyses involving child outcomes.

Parent Communality and Depressive and Maladaptive Grief Symptoms

Parent Communality and Child Communality were correlated with child maladaptive grief and child depressive symptom scores, controlling for time since the loss. Results indicated that Child Communality was not correlated with either mental health outcome. However, Parent Communality was associated with lower childhood maladaptive grief symptoms *partial r* (19) = -.44, *p* < .05 and marginally associated with lower depressive symptoms in the child *partial r* (19) = -.41, *p* < .07. Correlations between parent and child communality and child mental health outcomes are described in Table 4.3

Table 4.3

Partial Correlations among Parent and Child Communality and Child Symptoms

	Child Communality	Child Maladaptive Grief	Child Depressive Symptoms
Parent Communality	0.44*	-0.44*	-0.41[†]
Child Communality		-0.19	0.07
Child Maladaptive Grief			0.59***

*Note:* [†]$p \le .10$. *$p \le .05$. **$p \le .01$. ***$p \le .001$.

Given the apparent importance of Parent Communality, post-hoc partial correlations assessed associations among items on the Parent Communality factor and children's mental health outcomes. These analyses indicated that mothers' positive regard toward the child (i.e., warmth, physical affection, and enjoyment of the child and the conversation) was significantly associated with lower symptoms both in the case of maladaptive grief symptoms *partial r* (19) = -.55, *p* = .01 and depressive symptoms *partial r* (19) = -.49, *p* < .05. In addition, mothers' sensitivity and attunement toward the child was marginally associated with lower childhood maladaptive grief *partial r* (19) = -.42, *p* < .l0 and depressive symptom scores *partial r* (19) = -.37, *p* < .10. Finally, conversational depth was marginally associated with lower childhood maladaptive grief symptoms *partial r* (19) = -.38, *p* < .10 and mothers' engagement in the conversation was marginally associated with lower depressive symptoms in the child *partial r* (19) = -.38, *p* < .10. Taken together, these findings suggest that in dyads where mothers convey Communality in general, and warmth and positivity in particular, children demonstrate fewer symptoms of depression and maladaptive grief following the loss of the other parent. In contrast, children's own communication strategies were not, in and of themselves, significantly related to their own grief reactions.

Maternal Depressive Symptoms and Communication Efficacy

In cases in which mothers participated in dyadic interactions with multiple children, their parent communality scores were averaged so that each participant contributed a single parent communality score for the purposes of analysis. Using regression curve estimation, we then assessed the relation between maternal depressive symptoms and Parent Communality. Curve estimation identified this association to be

logarithmic $R^2 = .24$; $F(1,25) = 7.81$, $p = .01$, suggesting the necessity for a log

transformation. The loglinear curve estimation as well as the scatter plot data for this

association can be found in figure 4.1. After the log transformation, Parent Communality

was regressed onto depressive symptoms using linear regression, revealing that the

loglinear association between these two variables was significant $\beta = .49$, $t = 2.80$, $p = $

.01.

Figure 4.1
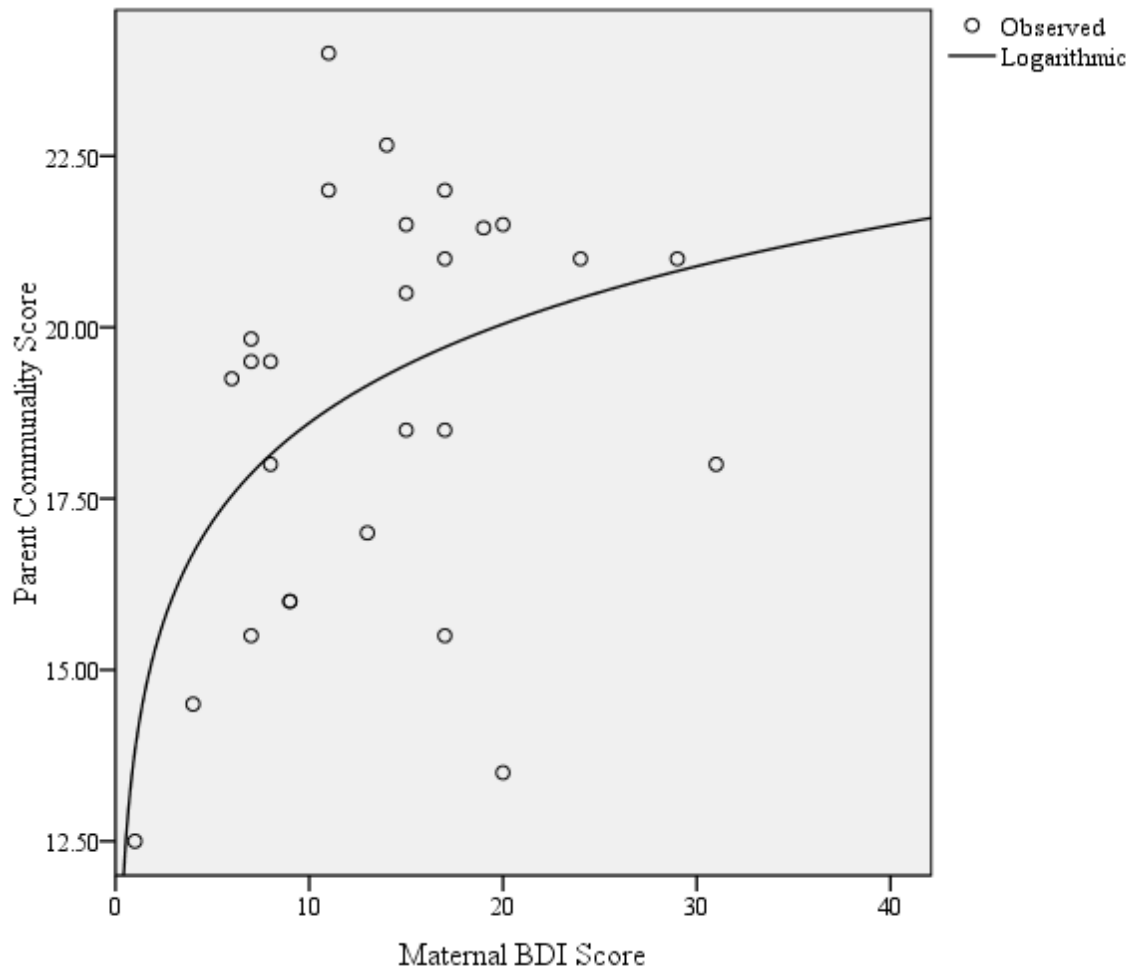
Logarithmic association between maternal depressive symptoms and parent communality

In order to explore this association further, we split the sample of mothers into three groups: minimal depressive symptoms (defined as below ½ standard deviation below the mean; corresponding to a score of 0-10 on BDI), mild depressive symptoms (defined as between ½ standard deviation below and above the mean; corresponding to a score of 10-17 on the BDI), and moderate depressive symptoms (defined as above ½ standard deviation above the mean; corresponding to a score of 17-31on the BDI). Mean Parent Communality scores for each of these groups are noted in Table 4.4. Planned contrasts compared the use of effective communication strategies between mothers with *mild* levels of depression to those with *minimal* (F (1, 24) = 8.57, $p < .01$) and *moderate* (F (1, 24) = 1.40, $p > .20$) symptoms. These findings suggest that women with little or no depressive symptoms were less likely to use effective communication strategies than those with mild symptoms. Mothers with mild and moderate symptoms were equally like to employ these strategies. Because there was an insufficient sample of women with severe symptoms in the current sample, differences between women with severe symptoms and mild, moderate, or no symptoms were not assessed.

Table 4.4

Parent Communality among Mothers with No/ Minimal, Mild, and Moderate Depressive

Symptoms

	No/minimal symptoms (< ½ standard deviation below the mean)	Mild symptoms (between ½ standard deviation below and above the mean	Moderate symptoms (> ½ standard deviation above the mean)
Mean Parent Communality Score	17.05	20.90	18.90

Discussion

While the findings of the study are limited by the size, and potential non-independence, of the sample it presents several findings of possible importance. The findings of this study suggest that, in the context of bereavement, parent-child communication strategies fall into two broad categories: Parent Communality and Child Communality, and that the former of these two factors is associated with a reduction in children's depressive and maladaptive grief symptoms. Further, findings from this study suggest that among grieving mothers, an expected level of depressive symptoms, falling in the mild or moderate range, is associated with the most frequent use of effective communication strategies relative to mothers who report minimal or no symptoms.

This work contributes to a clarification of the mechanisms that may distinguish the minority of children who develop psychiatric symptoms following the loss of a parent from the majority who do not (Dowdney, 2000), pointing, in particular, to the importance of the family system in symptom development and expression. Specifically, these findings highlight the potential role that parenting plays in shaping a child's psychological experience of a major loss and suggest that a parent's own psychological functioning affects her ability to effectively engage her child in communication about the loss.

It is noteworthy that the surviving parent's communication patterns, and not the child's, are associated with child mental health outcomes. Because parent-child interactions are typically parent-driven, children's communication strategies in this context may be more reactionary and, therefore, less diagnostic of their overall emotional well-being. This also points to the powerful role of parent communication strategies, as

their effects may be relevant to child well-being in a way, or to an extent, that a child's own strategies are not.

The context of the family system in general, and the parent-child dyad in particular, shapes children's grieving responses through modeling, fostering the exploration and expression of emotions, and providing a safe and warm environment for grief processes to develop over time (Kaplow et al., in press; Lin et al., 2004; Melhem et al., 2008; Sandler, et al., 2003; Weller et al., 1991). The findings presented here expand upon these ideas by identifying that warm, sensitive, and engaged communication may be one underlying mechanism in these general links and suggesting constraints (i.e., parents' own healthy emotional response) under which parents might be most effective at communicating with their children.

Implications for Research and Clinical Practice

Identifying the constraints under which grieving parents communicate effectively with their children, as well as the childhood outcomes associated with parents' communication strategies, may indicate pathways through which communication can be employed as a therapeutic tool for bereaved families. Clinical studies have linked parent-child communication quality, frequency of child expression, and a child's attitudes toward communication with a parent to the success of family therapy (e.g., Durrett & Kelly, 1974). Improving parent-child interactions therapeutically can also reduce risk for child maltreatment (Timmer, Urquiza, Zebell, & McGarth, 2005) and depression (Liu, 2003). As a result of its therapeutic utility, facilitating more effective parent-child communication is a central feature of several efficacious therapies for children, including

Child-Parent Psychotherapy (CPP) and Parent-Child Interaction Therapy (PCIT) (Lieberman & Inman, 2009; Werba, Eyberg, Boggs, & Algina, 2006).

Our findings suggest that interventions for parentally bereaved children should focus on strategies to increase parents' use of warm, positive, and affectionate communication strategies when engaging the child in discussions about the loss. Highly stressful experiences in childhood (including the death of a loved one) may activate attachment proximity seeking. The availability of a warm, positive, and affectionate attachment figure helps to reduce fear and other negative emotions related to a traumatic experience, helps to re-establish normal routines, and serves as a biobehavioral regulator (Shear et al., 2007). In the context of such a relationship, children may feel safer exploring the complicated emotions surrounding a loss experience.

In addition, researchers and clinicians interested in children's grief processes should assess and address parents' own psychological symptom expression, as these may be important predictors of a parent's ability to engage with their child about the loss. In non-bereaved samples, depressive symptoms have been linked with reduced parenting efficacy (Cummings & Davies, 1994) such that mothers with higher levels of depression are more negative and less engaged (Field, 1995; Lovejoy, et al., 2000). However, in a bereaved sample, mild or moderate levels of depressive symptoms may be indicative of a "healthy" grief response; for example rates of depressive symptoms following the loss of a spouse are six times higher than in a comparable married, but not bereaved, sample (Harlow, Goldberg, & Comstock, 1991). Our findings suggest that mothers who experience, and are willing to express, more normative levels of sad emotions surrounding their loss may be better able to model, relate to, and elicit their child's own

grief-reactions. Future research should explore this association among bereaved mothers with more severe depressive symptoms; in addition to suppressed or blunted emotions, a severe or dysregulated emotional response might also be problematic for the purposes of engaging in effective communication with children.

Limitations and Future Directions

This study has several limitations worth noting. First, the study's small sample size limits our power to conduct more complex statistical analyses, including optimal assessment and management of non-independence; the sample was also a convenience sample, which may preclude generalizability of the findings. Future research should aim to replicate these findings using a larger and more representative sample of parentally-bereaved children and should more directly address potential issues of non-independence, providing an adequate sample size to do so. Second, this study was limited by a lack of longitudinal data, precluding our ability to infer causality; future research should address how parent-child communication changes throughout the grief process and whether effective parent-child communication is associated with a long-term reduction in psychiatric symptoms. Third, this study did not have enough fathers to compare strategies and outcomes of communication between parents of different genders and no differences were found on Parent or Child Communality or mental health outcomes between male and female children. Future research should explore the ways in which cultural expectations about motherhood, as compared to fatherhood, affect the communication strategies employed by bereaved mothers and fathers as well as the effectiveness of these strategies. Future research should also explore whether parents in same-gendered parent-child dyads employ different forms of communication than those

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in opposite-gendered dyads as well as whether certain communication strategies, such as warmth or sensitivity, are more effective for some combinations of parent and child genders than others. Fourth, the childhood maladaptive grief measure used in the current study was originally developed for adults, and patterns of maladaptive grief are likely to differ in children (Nader & Layne, 2009). Future studies would benefit from assessment tools grounded in developmental theory and designed to capture age-related and multidimensional manifestations of childhood grief.

Similarly, this study did not compare behaviorally-coded parent-child communication against existing, self-report measures of parent-child communication quality, leaving the possibility that items coded as indicative of effective communication here could, in reality, reflect other psychological processes. Future research should work to address these distinctions and provide additional evidence for the validity and reliability of observational measures of parent-child communication. The codebook used to assess parent-child interactions may also have prioritized White and Western family values. It is important to note that expectations about both parents' and children's roles in communication are not pan-cultural or, perhaps, equally relevant to both fathers and mothers. As a result, "parent communality" might embody different behaviors for different families as a function of cultural backgrounds and gender. Future research should be sensitive to these distinctions when assessing the quality of dyadic communication.

Finally, future research should explore additional mechanisms that might distinguish children with healthy grief responses from those with pathological grief responses. This theory-building work should encompass potential mediators of the links

between the death and ongoing adjustment including *secondary adversities* (adverse life events and circumstances generated or exacerbated by the death and loss), *loss reminders* (cues such as the deceased's name, pictures, or belongings that call attention to his/her ongoing absence), and *trauma reminders* (distressing cues linked to the traumatic circumstances of the death) (Kaplow et al., in press; Layne, et al.,2006). in addition to psychobiological factors, coping strategies, and social support.

Chapter V

Discussion

To summarize, these three papers highlight that i) relative to parents in traditional families, parents in nontraditional families undergo unique challenges that can result in depressive symptoms (Chapter Two), ii) in general, dyadic supports protect family members from the potential psychological consequences of family transitions (Chapters Two, Three, and Four), and iii) in particular partner support and facilitation of parenting is important for parents' adjustment (Chapter Three) and maternal support, at least as expressed through communication, is important for children's adjustment (Chapter Four). Notably, these patterns were largely consistent for both women (Chapters Two, Three, and Four) and men (Chapter Three) in nontraditional parenting roles; in addition, parenting strategies did not differ as a function of child gender (Chapter Four), suggesting that the stress and psychiatric symptoms associated with nontraditional parenting roles may apply to both men and women with similar levels of investment in parenting and, perhaps, regardless of the gender of children.

More specifically, Chapter Two identified that relative to biological mothers, stepmothers may be uniquely at risk for depressive symptoms, in large part as a result of the uniquely high parenting stress they experience. Stepmothers and biological mothers both experienced a base level of stress associated with the logistical and emotional challenges of parenting, but compounding the stress common to all parents, stepmothers

reported additional stress resulting from their more relationally and psychologically complex parenting role. Chapter Two also suggested that acceptance and support from stepchildren may be an important buffering factor for stepmothers; perceived child regard was a mediator in the association between being a stepmother and experiencing depressed mood.

Expanding on these findings, Chapter Three compared experiences of social support and depression between stepmothers and stepfathers. While there were no significant differences by gender, all stepparents benefited from support and acceptance from their stepchildren, a positive and supportive relationship with the other biological parent, and, most importantly, support, specifically for parenting, from their partners. Stepparents who had been parenting longer also experienced (marginally) fewer symptoms, suggesting that adjusting to a stepparenting role is difficult, but that the psychological consequences of this difficulty may nevertheless abate over time. Further, years stepparenting moderated the association between partner support and depression such that partner support was particularly important in stepfamilies that had remarried more recently. Like Chapter Two, the findings from Chapter Three indicate that social support may be crucial for stepparent adjustment, especially in the early years of this transition.

Building on the apparent significance of dyadic support structures identified in Chapters Two and Three, and in order to examine the potential benefits of dyadic support for children in nontraditional families, Chapter Four assessed dyadic communication between widows and their children by observing them interact directly. Chapter Four identified that Parent Communality, or a mother's ability to emotionally engage her child

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in a conversation about the loss of the other parent, was associated with lower child depressive and maladaptive grief symptoms. This link may be attributable to the sense of comfort, safety, and connection that warm and sensitive communication both represents and fosters. In other words, children may find it easier and more helpful to express their grief-related emotions with a parent who responds openly and positively and, in turn, this communication pattern may help to build a warm and sensitive parent-child relationship more generally.

Further, Chapter Four suggested that among grieving mothers, the experience of mild or moderate depressive symptoms (relative to no or minimal symptoms), which are consistent with a healthy grief response, were most conducive to engaging in effective communication strategies. In other words, previously documented associations between depressive symptoms and parenting inefficacy (e.g., Lovejoy, et al., 2000) may not universally apply to all families; in families facing major stressors and transitions, low-grade depressive symptoms may indicate healthy levels of emotional reactivity and actually serve to facilitate the communication about the loss.

These findings expand on the findings from Chapters Two and Three by suggesting that a strong parent-child dyad is not only protective for parents, but also for children, in families facing a transition or stressor. The findings from these three papers highlight that i) support and communication are reciprocal and mutually affect all family members and ii) dyadic support processes are important contributors to psychological well-being following the stressors and transitions that result in the formation of nontraditional families. These findings have several important implications for research and clinical intervention.

Transitions and Stressors in Family Systems: the Important Role of Dyads

Taken together, these dissertation findings reinforce the idea that major family stressors and transitions, such as divorce, remarriage, and parental bereavement are experienced both on the level of the individual and the level of the family. From a family systems perspective these two levels of experience mutually influence each other, such that the family's functioning as a whole depends on the functioning of its individual members and vice versa (Hargrove, 2009). Only by taking the multiple levels of the family system (the family as a whole, dyads, and individuals) into account can we begin to understand the psychological processes related to being a member of a nontraditional family.

The findings from these dissertation studies reinforce this theoretical premise, while also suggesting that in times of stress or transition, certain dyads, namely the parent dyad for adults and the parent-child dyad for children, may be particularly crucial in protecting against individual psychopathology, at least relative to the other dyadic relationships measured here. Further, when and how these dyadic supports are useful may vary as a function of contextual factors; the findings of this dissertation highlight that a monolithic model of the family system may not universally apply to all families all of the time. For example, we identified that mothers in stepfamilies and biological families experienced different relational stressors and differentially benefited from support and validation from their children (Chapter Two). Even within stepfamilies, dyadic supports were more or less important as a function of contextual factors, namely the length of time since the family formation (Chapter Three). When and how dyadic support is helpful may vary even beyond what is suggested by the findings presented here; for example, we only

assessed partner support for *parenting* specifically. It is possible that other forms of spousal support or support from other family members are relevant in different ways or at different times in a family's developmental trajectory. For children, in particular, the role that parental (or sibling) support plays in mental health may vary highly as a function of age and family environment.

In light of these distinctions, a single all-encompassing model of family functioning may neglect important complexities in the role and significance of dyads both across different types of families and within individual families over time. Therefore, researchers interested in the outcomes associated with nontraditional family structures should adopt a nuanced and participant-driven stance toward the role of family and dyadic support in individual psychopathology and avoid applying a homogeneous theoretical structure to what are, in reality, complex and dynamic systems.

If researchers and clinicians can adopt a nuanced view of the role of dyadic relationships in individual and family well-being, dyads may be an important level at which to study the psychological consequences of family transitions and stressors and to remediate them therapeutically. A wide range of therapies, namely couples therapies for adults and parent-child therapies for children, employ dyads in treating families, couples, and individuals. While the breadth of theoretical and empirical supports for these treatments is beyond the scope of this dissertation, there is strong evidence that dyadic treatments can help alleviate marital problems (e.g., The Marriage Survival Kit, Gottman, 1999; Imago Relationship Therapy, Luquet, 2007), individual adult psychopathology (e.g., Cognitive Martial Therapy, Teichman, et al., 1995; Behavioral Marital Therapy, Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky, 1991), and individual child

psychopathology (e.g., Child-Parent Psychotherapy, Leiberman & Inman, 2009; Parent-Child Interaction Therapy, Werba, et al., 2006). Despite their differing objectives, these therapies share an emphasis on effective and supportive communication as a means of promoting empathy, sensitivity, and thoughtful interpersonal processes.

Specifically, for couples, fostering partners' ability to listen to one another, understand the emotional experiences that underlie conflict both for themselves and their partner, and engage in more self-regulated, deliberate, and supportive communications generally improve both marital and individual well-being (Emanuels-Zuurveen & Emmelkamp, 1996; Luquet, 2007). The findings from this dissertation suggest that for parents in nontraditional roles, such as stepparents, their partners' ability to express support and attunement regarding parenting efforts, specifically, and facilitate positive interactions with the children may help mitigate the stress and depression associated with adopting a stepparenting role. Interventions aimed at aiding parents, and families, to adjust to major transitions might benefit from working to strengthen the parent dyad, in particular, and from encouraging parents to support and affirm each others' parenting efforts.

Similarly, therapies based in the parent-child dyad have been demonstrated to be efficacious in treating a range child psychiatric symptoms— from behavioral dysregulation (Werba, et al., 2006) to PTSD (Lieberman & Inman, 2009). These therapies use play to help children and parents communicate with one another and generally focus on helping parents to take a developmentally-appropriate and empathetic approach toward their children's behavioral and emotional reactions (Lieberman & Inman, 2009). Expanding on this foundation, the papers that comprise this dissertation suggest that

improved parent-child interactions may benefit parents, in addition to children, and that at least for families facing a recent transition or loss, facilitating open, sensitive, and direct communication about the event, and modeling appropriate or "normative" emotions surrounding the event, may buffer against risk for psychiatric morbidity.

Overall, the findings of this dissertation highlight the importance of adopting a systemic approach to intervention in which the experiences of all family members, including parents, are an explicit focus of treatment. Further, they emphasize the important role that dyads might play in family interventions and suggest that fostering supportive, sensitive, and attuned communication between parents and between parents and children may help reduce barriers to both individual and family well-being.

Gender and Nontraditional Families

Although we did not find parent (or child) gender differences in these three studies, feminist scholars have identified gender as a "linchpin" in family and social structures (Lorber, 1996). The foundational role that gender plays in family dynamics may mean that men and women occupying nontraditional parenting roles benefit from different types of clinical and relational supports. The social roles and expectations associated with motherhood vary in important ways from those associated with fatherhood; namely, mothers are generally expected to be [and in reality, usually are (for review, see Lachance-Grezla & Bouchard, 2010)] more involved in caregiving. For women in nontraditional parenting roles, the expectation that they are naturally adept at motherhood may reduce the visibility of the struggles associated with adopting a difficult or new role and prevent adequate attention toward mothers' own mental health needs in stressful circumstances. In other words, because others may assume that, as women,

mothers in nontraditional parenting roles are natural parents and enjoy all aspects of parenting, they may not provide them with the necessary level of support, attention, or guidance. The findings from this dissertation suggest that women in these roles may benefit from familial and societal support and validation and that without support, the stress of undertaking a nontraditional mothering role can be psychologically taxing.

In contrast, because women are socialized to be more attuned to others' needs, they may in fact *be* more adept at communicating and managing relationships with their children, spouses, and other family members in times of stress and transition. Men, in contrast, may have fewer skills and less practice to draw from in these circumstances. For example, although there were only four men available for analysis in Chapter Four of this dissertation, preliminary analyses suggested that fathers may have been less sensitive and warm in their communication strategies, perhaps because they have not had to occupy the role of the primary communicator prior to the loss of their wives. At the same time, in Chapter Three, we did not find that stepfathers were more robust than stepmothers to the relational stress associated with becoming a stepparent. The stepfathers in Chapter Three reported themselves to be equally involved in stepparenting as the stepmothers (although perhaps more-so than typical stepfathers would). Thus, these particular stepfathers may have had a similar relational investment, and therefore suffered from similar relational pressures and their psychological consequences, as stepmothers. In other words, parenthood may be a complex role that is at least in part shaped by gendered roles and expectations, but also determined by relational experiences, parental engagement, and other values and identities.

Both mothers and fathers may also adopt different parenting strategies, and have different parenting experiences, with same-gendered and opposite-gendered children. In Chapter Four, we did not find that mothers engaged differently, or to a different effect, with their male and female children. However, as a social role, gender is only significant in the context of a social environment and in relation to other people (e.g., femaleness is determined, in large part, by its comparison to maleness). Therefore, in families, the genders of all family members as well as the meanings assigned to gender within the family may help to determine parenting experiences and their mental health correlates.

Taken together, the findings of this dissertation reinforce that any individual's experience of parenting cannot be reduced to their gender alone, but that gender may be one of several important factors. Individual experiences of parenting may be best understood within the context of the full range of parents' experiences, beliefs, and roles. Researchers and practitioners should adopt a contextual view of the ways in which the genders of both the parent and child intersect with nontraditional parenting roles and continue to examine how gendered roles and expectations shape the psychological consequences of nontraditional parenting.

Future Directions

The work presented in this dissertation suggests several directions for future research. First, in these three papers, similar processes were identified as important across stepfamilies and parentally-bereaved families. Specifically, in all three studies, dyadic support emerged as an important correlate of psychological well-being and was identified as a valuable asset for both parents and children in nontraditional families. However, these studies did not directly evaluate whether the nature and function of dyadic support

varies across different kinds of nontraditional families. Stepfamilies and parentally-bereaved families face distinct relational and psychological challenges and these differences may impact the ways in which members of dyads communicate with and support one another. For instance, Chapters Two and Three identified that despite the importance of support and validation from children, for stepparents, partner support was especially influential, a finding that cannot be generalized to widows. For widows, whose partners have died, it is unclear whether support and validation from children takes on a different and more significant role, parents seek out support from others in the absence of their partners, or other psychological or relational processes apply. Therefore, it will be important for future research to distinguish the dyadic processes common across nontraditional families from the processes that are specific to families facing only certain stressors or transitions.

Second, future research should continue to pursue the ways in which gender, parental involvement, and parental role salience intersect to determine individual experiences of nontraditional parenting roles, as well as whether children's genders also relate to communication and support processes. Although we did not find differences as a function of parent gender in Chapter Three or child gender in Chapter Four, we were unable to assess all family members' genders together and were limited by the lack of fathers in Chapters Two and Four. Therefore, many questions remain about the ways in which gender relates to parenting processes and outcomes, particularly in nontraditional families. For example, it may be that under certain conditions, communication processes function differently in same-gendered parent-child dyads (e.g., father and son or mother and daughter) than in opposite-gendered parent-child dyads. Similarly, a family's values

and beliefs about gender may influence the extent to which their communication and support patterns are moderated by gender; for example, fathers who identify strongly with the stereotype of emotionless and independent masculinity may not elicit the amount or quality of support they need to successfully adopt a nontraditional parenting role, such as stepparenting or bereaved parenting. These possibilities are important areas for future research.

This research also addressed only a limited set of dyadic relationships and only certain forms of social support. Other dyads, such as sibling dyads or relationships with friends or relatives outside of the immediate family environment may be equally important in family and individual functioning. Further, only specific forms of support and engagement were measured here, namely positive regard, acceptance, support and facilitation of parenting, and emotional connectedness. Other forms of support, such as instrumental support (i.e., the provision of resources), may also allow for smoother adjustment following a major stressor or transition. These events can have significant implications on a family's logistical and financial functioning; for example, a study comparing widowed and married women found that widows were more likely to experience economic hardship (Zick & Smith, 1991). The financial and logistical burden of family stressors and transitions may compound their psychological consequences and a family's access to support that mitigates these problems may reduce stress and stress-related psychopathology. Future research should examine with greater breadth the sources and types of supports that are helpful for nontraditional families.

Last, future studies should aim to translate findings on the dyadic and family processes that determine psychological outcomes following a major family stressor or

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transition into clinical approaches aimed at promoting individual and family well-being following these events. While nurturing positive, supportive communication between family members and encouraging partners to facilitate and support nontraditional parents are important clinical objectives, researchers should also investigate the ways in which other variables (e.g., family and personal histories, secondary or individual stressors, supports available from outside of the family) intersect with dyadic functioning to support, or undermine, adjustment to a nontraditional family structure. Along these lines, family therapists and researchers have begun to incorporate cultural (e.g., gender, race) and contextual (e.g., community environment) factors into their understanding and application of family therapy (for review see McGoldrick & Hardy, 2008). Researchers should continue to explore the ways in which family therapies can be modified to take advantage of dyadic supports and best aid families that do not conform to traditional family arrangements. By adopting a holistic and systemic view of individual and family well-being, interventional approaches may be more effective and generalizable.

Methods: Strengths and Limitations

The methods employed in these three papers have strengths and limitations that are worth noting. Chapters Two and Three used online surveys to assess stepparents' experiences of their social relationships and mental health. In doing so, we were able to reach large numbers of stepparents through listservs, online groups, and networks across the country. Second, stepparents were able to participate in the study from home or work, without having to come into the lab, the convenience of which may have led to a more robust response rate. These two features allowed us to gather sample sizes large enough to evaluate our hypotheses. Surveys, online or otherwise, also allow participants to

provide information about themselves and intimate relational or emotional experiences without having to openly discuss them with a researcher. Because we were interested in stepparents' *own* perspectives and experiences and because we wanted them to feel as comfortable as possible disclosing these, the survey format was particularly useful.

However, surveys, particularly those conducted online, have important limitations. First, both Chapters Two and Three relied on convenience samples and are therefore not generalizable to a larger population of parents who do not have access to the internet or choose not to connect with others online through email listservs and groups. Indeed, the samples obtained in Chapters Two and Three were both relatively homogeneous with regard to race, income, and educational obtainment. Second, it can be harder to ensure the quality of data collected online; participants may be distracted while completing the survey, attempt to participate in the study multiple times, or misrepresent themselves for the monetary incentive. In both Chapters Two and Three, steps were taken to minimize these risks. We eliminated participants with suspicious IP addresses, who completed the survey multiple times, who took either too short, or too long, a time to complete the survey, and who did not provide coherent responses to open-ended questions. However, it remains possible that error was introduced by the online collection method. Finally, it is also possible that responses were biased because they were self-reported; a large literature in survey methodology suggests that individuals often misremember or misreport information about themselves on surveys (for review, see Tourangeau, Rips, & Rasinski, 2000).

Because of the interpersonal nature of the research questions addressed in Chapter Four, we used observational and interview methods to assess parent-child communication

and parent and child mental health. Observational methods reduce the bias introduced by self-report and provide researchers with a broader range of information, including data on behavioral and relational processes. They also allow for data to be drawn simultaneously from multiple people in a social situation, such as a communication task, and thus better characterize the ways in which families and dyads function in natural settings. Similarly, interviews allow for the researcher to note emotional reactions to the content being described (e.g., sadness, discomfort) or the interview itself (e.g., fatigue) and assess for information that is conveyed nonverbally (e.g., crying, smiling), providing a more accurate understanding of the information that is provided in interview responses.

Although observational and interview methods provide the kind of high quality, rich data that allowed us to evaluate a broad range of interpersonal and psychological processes in Chapter Four, there are tradeoffs to these strengths that should be addressed. First, although biases based on self-report are reduced by relying on researcher evaluations, researchers themselves may introduce bias in their evaluations of observational data. In order to mitigate this potential problem, multiple raters rated observed phenomena until satisfactory reliability was reached. Still, even the selection of which processes are important enough to be evaluated relies on value judgments that may neglect important variables or differ from what participants themselves would identify as representative of their experiences. Second, we were not able to observe families together, meaning that we do not have data on the functioning of the sibling dyads or of the parent engaging with multiple children simultaneously, which may more accurately reflect the natural environment of the family.

Conclusions

This work highlights the importance of taking a systemic and contextualized view of individual and family functioning in general, and after a major transition or stressor in particular. Individuals exist within, and are inextricable from, their social and cultural contexts. Any role, including parenthood, is shaped by one's immediate social context (in this case, the family) and the norms and expectations set by one's larger cultural context (in this case, related to gender). To the extent that these contexts can be supportive, validating, and flexible, families may adjust to even the most significant and devastating events, including a divorce, remarriage, or parental loss, with little risk for psychiatric morbidity. However, when family members are rejecting and unsupportive, and cultural norms are imposing and rigid, parents and children may be at an increased risk for developing stress- and loss- related psychopathology. Thus, as researchers and practitioners, we might best support nontraditional parents and their children by adopting a nuanced view of the ways in which social and cultural systems intersect to inform their experiences and by helping them to identify and foster flexible, positive, and reliable support systems within their family environment.

Materials Used in Chapter Two

Eligibility Filters

First, we would like ask you some questions about your family.

Are you currently parenting or step-parenting at least one child under the age of 18?

__ Yes

__ No

What kinds of parenting are you currently doing? Please check all that apply.

__ Parenting at least one child born in your current relationship

__ Parenting at least one child born in your previous relationship

__ Step-parenting at least one child born in your partner's previous relationship

__ Other: _____

Are you currently parenting or step-parenting children who you did NOT give birth to?

__ Yes

__ No

Have any of your children been adopted?

__ Yes

__ No

IF YES: What was the nature of the adoption(s)? Please check all that apply.

__ My partner and I adopted child(ren) who neither of us gave birth to

__ I adopted child(ren) as a single parent

__ I adopted child(ren) who my partner gave birth to

__ My partner adopted child(ren) who I gave birth to

IF STEPMOTHERING: In years, how long have you been parenting your stepchildren ?
_____-

IF STEPMOTHERING: For what proportion of your stepchildren's lives have you been parenting them?

___ less than half of their lives

___ about half of their lives

___ more than half of their lives

___ their entire lives

IF STEPMOTHERING: How involved are you in parenting your stepchildren?

___ Not at all involved

___ Somewhat involved

___ Quite Involved

___ Very Involved

Demographics

How many children and stepchildren do you have in all?

___ 1

___ 2

___ 3

___ 4

___ 5

___ 6 or more

How old are each of your children? Please record their ages in the space provided.

Now, we would like to ask you some questions about you.

What is your gender _____

How old are you in years? _____

What do you consider to be your sexual orientation?

__ Lesbian

__ Gay

__ Bisexual

__ Heterosexual

__ Other

What is your currnet relationship status?

__ Unpartnered or singled

__ Partnered with a man

__ Partnered with a woman

Do you have a legally recognized marriage or civil union?

___ Yes

___ No

What do you consider to be your race or ethnicity?

What is your annual household income?

__ under $20,000

__ $20,000- $40,000

__ $60,000- $80,000

__ $80,000- $100,000

__ more than $100,000

Perceived Child Regard

Every parent has conflicts with their children. Below is a list of issues that your children or stepchildren may have had. Please indicate your agreement to the following statements about your family. A rating of 1 means you do not agree with the statement while a rating of 5 means you strongly agree with the statement.

	1-- Strongly Disagree	2-- Disagree	3—Neither Agree nor Disagree	4-- Agree	5— Strongly Agree
One or more of my children or stepchildren is embarrassed to talk about our family					
All of my children and stepchildren are proud to be in our family					
One or more of my children or stepchildren is ashamed of our family					
All of my children and stepchildren are comfortable introducing me to their friends					
One or more of my children or stepchildren wishes I was not their parent					
All of my children and stepchildren accept me for who I am					
One or more of my children or stepchildren wishes our family was more "normal"					
One or more of my children or stepchildren disapproves of my life choices					

Depression (CES-D)

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of the time (3-4 days)`	Most of all of the time (5-7 days)
I was bothered by things that don't usually bother me				
I did not feel like eating; my appetite was poor				
I felt that I could not shake off the blues, even with help from my family or friends				
I felt I was just as good as other people				
I had trouble keeping my mind on what I was doing				
I was depressed				
I felt that everything I did was an effort				
I felt hopeful about the future				
I thought my life had been a failure				
I felt tearful				
My sleep was restless				
I was happy				
I talked less than usual				
I felt lonely				
People were unfriendly				
I enjoyed life				
I had crying spells				
I felt sad				
I felt that people dislike me				
I could not get going				

Parenting Stress

Next we would like to ask you about the kinds of things that are stressful to you as a parent. Please rate your agreement to the following statements. A rating of 1 means that you strongly disagree with the statement. A rating of 5 means that you strongly agree with the statement.

	1-- Strongly disagree	2-- Disagree	3-- Neither agree nor disagree	4-- Agree	5-- Strongly agree
I am happy in my role as a parent					
There is little or nothing I wouldn't do for my children or stepchildren if it was necessary					
Caring for my children and/or stepchildren sometimes takes more energy than I have to give					
I sometimes worry whether I am doing enough for my children and/or stepchildren					
I feel close to my children and/or stepchildren					
I enjoy spending time with my children and/or stepchildren					
My children and/ or stepchildren are an important source of affection for me					
Having children and/ or stepchildren gives me a more certain and optimistic view for the future					
The major source of stress in my life is my					

children and/ or stepchildren				
Having children and/ or stepchildren leaves little time and flexibility in my life				
Having children and/ or stepchildren has been a financial burden				
It is difficult to balance different responsibilities because of my children and/ or stepchildren				
The behavior of my children and/ or stepchildren is often embarrassing or stressful to me				
If I had it to do over again, I might decide not to have children and/ or stepchildren				
I feel overwhelmed by the responsibility of being a parent and/ or stepmother				
Having children and/ or stepchildren has meant having too few choices and too little control over my life				
I am satisfied as a parent and/ or stepmother				
I find my children and/ or stepchildren enjoyable				

Materials for Chapter Three

Eligibility Filters

Are you currently parenting or step-parenting at least one child under the age of 18?

- ○ Yes
- ○ No

What kinds of parenting are you currently doing? Please check all that apply.

Parenting at least one child born in your current relationship
Parenting at least one child born in your past relationship
Step-parenting at least one child born in your partner's past relationship
Other: _____

Are you currently parenting children who you did NOT give birth to?

- ○ Yes
- ○ No

Are any of your children adopted?

- ○ Yes
- ○ No

IF YES THEN: What was the nature of the adoption(s)? Please check all that apply.

My partner and I adopted child(ren) who neither of us gave birth to
I adopted child(ren) as a single parent
I adopted child(ren) who my partner gave birth to
My partner adopted child(ren) who I gave birth to
Other: _____

IF ADOPTED THEN: Currently, adopted parents are not the focus of this study. As a result, we will not be able to pay you for your participation. However, if you would like, you are welcome to complete the survey. Would you like to continue?

Yes
No

Demographics

IF STEPPARENT THEN: In years, how long have you been parenting your stepchildren?

IF STEPPARENT THEN: For what proportion of your stepchildren's lives have you been parenting them?

- ❍ less than half of their lives
- ❍ about half of their lives
- ❍ more than half of their lives
- ❍ their entire lives

IF STEPPARENT THEN: How involved are you in parenting your stepchildren?

- ❍ Not at all involved
- ❍ a little involved
- ❍ moderately involved
- ❍ Very involved

IF STEPPARENT THEN: On average, how much of the time do your stepchildren currently live in your household?

- ❍ 0 days per week
- ❍ 1-2 days per week
- ❍ 3-4 days per week
- ❍ 5-6 days per week
- ❍ 7 days per week
- ❍ If these options do not capture to your situation, please describe your arrangement below: _____

IF CHILDREN FROM PAST RELATIONSHIP THEN: You told us that you are parenting children born in a previous relationship of yours. Was this relationship with a man or a woman?

man
woman

How many children and stepchildren do you have in all?

- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6 or more

In the spaces provided below, please record the ages of each of your biological and/or stepchildren in the correct space. Please separate the ages with commas.

Stepchildren:

Biological Children

Now, we would like to ask you some questions about you.

What is your gender

- ○ Male
- ○ Female
- ○ Other (please describe) _____

How old are you, in years?

What do you consider to be your sexual orientation?

- ○ Lesbian/ gay
- ○ Heterosexual
- ○ Bisexual
- ○ Other _____

What is your current relationship status? Please note that being "partnered" means being in a committed relationship or marriage.

- ○ Unpartnered or single
- ○ Partnered with a man
- ○ Partnered with a woman
- ○ Other (please describe) _____

IF SINGLE: Currently, our study is focused on parents in relationships. While we are certainly interested in your experiences as a parent, we cannot pay you for your participation at this time. Would you like to continue?

- ○ Yes
- ○ No

Do you have a legally recognized marriage or civil union?

- ○ Yes
- ○ No

What do you consider to be your race or ethnicity?

What is your annual household income?

  ○ under $20,000
  ○ $20,000-$40,000
  ○ $40,000-$60,000
  ○ $60,000-$80,000
  ○ $80,000-$100,000
  ○ more than $100,000

Partner Support/ Facilitation

Please identify the degree to which your partner has helped to facilitate or strengthen your relationship with your stepchildren

  ○ Not at all
  ○ A little
  ○ Somewhat
  ○ Moderately
  ○ A lot

How supportive has your partner been of your efforts to build a relationship with your stepchildren?

  ○ Very unsupportive
  ○ Somewhat unsupportive
  ○ Neither supportive or unsupportive
  ○ Somewhat supportive
  ○ Very supportive

Biological Parent Support

How supportive has your stepchildren's other biological parent been of your efforts to build a relationship with your stepchildren?

  ○ Very unsupportive
  ○ Somewhat unsupportive
  ○ Neither supportive or unsupportive
  ○ Somewhat supportive
  ○ Very supportive

How would you rate the quality of your relationship with your stepchildren's biological mother?

  ○ Very negative

❍ Negative
❍ Neutral
❍ Positive
❍ Very positive

Perceived Stepchild Regard

	1—Strongly Disagree	2--Disagree	3--Neither Agree nor Disagree	4--Agree	5--Strongly Agree
One or more of my stepchildren is embarrassed to talk about our family					
All of my stepchildren are proud to be in our family					
One or more of my stepchildren is ashamed of our family					
All of my stepchildren are comfortable introducing me to their friends					
One or more of my stepchildren wishes I was not their parent					
All of my stepchildren accept me for who I am					
One or more of my stepchildren wishes our family was more "normal"					

One or more of my stepchildren disapproves of my life choices					
One or more of my stepchildren does not accept my partner as a parent					

Depression (CES-D)

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of the time (3-4 days)`	Most of all of the time (5-7 days)
I was bothered by things that don't usually bother me				
I did not feel like eating; my appetite was poor				
I felt that I could not shake off the blues, even with help from my family or friends				
I felt I was just as good as other people				
I had trouble keeping my mind on what I was doing				
I was depressed				
I felt that everything I did was an effort				
I felt hopeful about the future				
I thought my life had been a failure				
I felt tearful				
My sleep was restless				
I was happy				
I talked less than usual				

I felt lonely				
People were unfriendly				
I enjoyed life				
I had crying spells				
I felt sad				
I felt that people dislike me				
I could not get going				

Appendix C

Materials Used for Chapter Four

Child Demographics

I'M GOING TO START BY ASKING YOU SOME QUESTIONS ABOUT THE PEOPLE WHO LIVE WITH YOU. How many people, in total, including adults and children, relatives and non-relatives currently live with you and have no other home? Include college students who aren't here right now, but come home for breaks and in the summer.

1. Number of children:

2. Number of adults:

3. Children's first names:

4. Adults' first names:

LET'S START WITH ___. (specific child being interviewed that day)

5. Your relationship to _____ (child1):

6. Relationship of deceased (WRITE NAME OF DECEASED HERE:) to _____ (child1):

7. Child's birthdate:

8. Child's current age:

9. Child's gender:

10. Child's race/ethnicity:

11. Child's religion:

12. Child's current grade in school:

Parent Demographics

NOW I'M GOING TO ASK YOU SOME QUESTIONS ABOUT YOU AND YOUR FAMILY.

13. Your relationship to the deceased:

14. Can you tell me how your _____ died?

15. What was the date of your _____ death?

16. Your birthdate

17. Your age:

18. Your own race/ethnicity:

19. Your religion:

20. Are you currently employed?

21. If yes, what do you do?

Child Depression (Short Mood and Feelings Questionnaire

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way in the *past two weeks.*

If a sentence was true about you most of the time, check TRUE.

If it was only sometimes true, check SOMETIMES.

If a sentence was not true about you, check NOT TRUE.

	TRUE	SOMETIMES	NOT TRUE
1. I felt miserable or unhappy			
2. I didn't enjoy anything at all			
3. I felt so tired I just sat around and did nothing			
4. I was very restless			
5. I felt I was no good any more			

6. I cried a lot			
7. I found it hard to think properly or concentrate			
8. I hated myself			
9. I was a bad person			
10. I felt lonely			
11. I thought nobody really loved me			
12. I thought I could never be as good as other kids			
13. I did everything wrong			

Child Maladaptive Grief (The Inventory of Complicated Grief – Revised)

DIRECTIONS: Please tell me the answer that best describes how you have been feeling since your _____ died. Tell me how true each sentence is for you: never, a little, sometimes, pretty much, or a lot.

1. **The death of my mom/dad feels very upsetting to me.**
    A. never

    B. a little

    C. sometimes

    D. pretty much

    E. a lot

2. **I think about my mom/dad so much that it can be hard for me to do the things I normally do.**
    A. never

    B. a little

    C. sometimes

D. pretty much

E. a lot

3. **Memories of my mom/dad upset me.**
   A. never

   B. a little

   C. sometimes

   D. pretty much

   E. a lot

4. **I can't face the fact that my mom/dad died.**
   A. never

   B. a little

   C. sometimes

   D. pretty much

   E. a lot

5. **I miss my mom/dad very much.**
   A. never

   B. a little

   C. sometimes

   D. pretty much

   E. a lot

6. **I feel like going to places and doing things that I used to do with my mom/dad.**
   A. never

   B. a little

   C. sometimes

   D. pretty much

   E. a lot

7. **I feel angry about my mom/dad's death.**
   A. never

   B. a little

C. sometimes

D. pretty much

E. a lot

8.   I cannot believe my mom/dad is dead.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

9. I feel shocked over my mom/dad's death.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

10. Ever since my mom/dad died, it is hard for me to trust people.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

11. **Ever since my mom/dad died, I feel like I don't care about other people as much as I did or I don't feel as close to people I care about as I used to.**

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

12. I have pain in the same area of my body as my mom/dad used to have before his/her death or I have some of the same symptoms as my mom/dad used to have before his/her death.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

13. I have some of the same behaviors or personality traits as my mom/dad.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

14. Are there any things you used to do before the death of your mom/dad that you no longer do? Or are there people you used to see that you no longer see?

No   Yes

14a. If yes, how upsetting is it for you not to be doing these things or seeing these people?

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

15. I avoid reminders of my mom/dad.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

16. I avoid reminders that my mom/dad is dead.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

17. Sometimes, people who lose a loved one feel that they can't go back to normal life and make new friends or do new things. Do you think making new friends or doing new things would be difficult for you?

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

18. I feel that life is empty or has no meaning without my mom/dad.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

19. I hear my mom/dad's voice speak to me.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

20. I see my mom/dad stand before me.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

21. I feel like I have become numb or don't have any feelings at all since the death of my mom/dad.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

22. I feel that it is unfair that I should live when my mom/dad died.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

23. I feel jealous of others who have not lost someone close.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

24. I feel like the future has no meaning or purpose without my mom/dad.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

25. I feel lonely ever since my mom/dad died.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

26. It is hard for me to imagine living a happy life without my mom/dad.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

27. I feel that a part of myself died with my mom/dad.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

28. I feel that the death made me see the world differently.

    A. never

    B. a little

    C. sometimes

    D. pretty much

    E. a lot

29. I don't feel safe since the death of my mom/dad.

    A. never

    B. a little

    C. sometimes

    D. pretty much

    E. a lot

30. I feel that I don't have control over things since the death of my mom/dad.

    A. never

    B. a little

    C. sometimes

    D. pretty much

    E. a lot

31. I think that these feelings have really affected how I act with friends, how I am at school, or how I act during other activities.

    A. never

    B. a little

    C. sometimes

    D. pretty much

    E. a lot

32. I have been jumpy or easily startled since the death.

    A. never

B. a little

C. sometimes

D. pretty much

E. a lot

33. Since the death, I haven't been sleeping as well.

A. never

B. a little

C. sometimes

D. pretty much

E. a lot

34. How soon after your ___ died did these feelings begin (referring to any of the above feelings that the child endorsed)? (in days, weeks, or months)

35. How long have you been having these feelings? (provide number, e.g., every day since, once per week, etc.)

36. Have there been times when you did not have these feelings and then these feeling began to bother you again?

No   Yes

36a. If yes, can you describe how your feelings have changed over time?

Parent Depression (BDI)

This questionnaire consists of 21 groups of statements. Please read each group of statements carefully and then pick out the one statement that best describes the way you have been feeling IN THE PAST TWO WEEKS, including today. If several statements in the group seem to apply equally well, select the highest number for that group.

Sadness

 0 -- I do not feel sad.

1 -- I feel sad.

2 -- I am sad all the time and I can't snap out of it.

3 -- I am so sad and unhappy that I can't stand it.

Pessimism

 0 -- I am not particularly discouraged about the future.

1-- I feel discouraged about the future.

2 -- I feel I have nothing to look forward to.

3 -- I feel the future is hopeless and that things cannot improve.

Past Failure

0 -- I do not feel like a failure.

1 -- I feel I have failed more than the average person.

2 -- As I look back on my life, all I can see is a lot of failures.

3 -- I feel I am a complete failure as a person.

Loss of Pleasure

 0 – I get as much pleasure as I ever did from the things I enjoy

1 – I don't enjoy things as much as I used to

2 – I get very little pleasure from the things I used to enjoy

3 – I can't get any pleasure from the things I used to enjoy

Guilty Feelings

0 – I don't feel particularly guilty

1—I feel guilty a good part of the time

2 – I feel quite guilty most of the time

3—I feel guilty all of the time

Punishment Feelings

0—I don't feel I am being punished

1—I feel I may be punished

2—I expect to be punished

3—I feel I am being punished

Self-Dislike

0—I don't feel disappointed in myself

1—I am disappointed in myself

2—I am disgusted with myself

3—I hate myself

Self-Criticalness

0—I don't feel I am any worse than anybody else

1—I am critical of myself for my weaknesses or mistakes

2—I blame myself all the time for my faults

3—I blame myself for everything bad that happens

Suicidal Thoughts or Wishes

0—I don't have any thoughts of killing myself

1—I have thoughts of killing myself, but I would not carry them out

2—I would like to kill myself

3—I would kill myself if I had the chance

Crying

0—I don't cry any more than usual

1—I cry more now than I used to

2—I cry all the time now

3—I used to be able to cry, but now I can't cry even though I want to

Agitation

0—I am no more restless or wound up than usual

1—I feel more restless or wound up than usual

2—I am so restless or agitated that it's hard to stay still

3—I am so restless or agitated that I have to keep moving or doing something

Loss of Interest

0—I have not lost interest in other people or activities

1—I am less interested in other people or things than I used to be

2—I have lost most of my interest in other people or things

3—It's hard to get interested in anything

Indecisiveness

0—I make decisions about as well as ever

1—I put off making decisions more than usual

2—I have greater difficulty in making decisions more than I used to

3—I have trouble making any decisions

Worthlessness

0—I do not feel I am worthless

1—I don't consider myself as worthwhile and useful as I used to

2—I feel more worthless as compared to other people

3—I feel utterly worthless

Loss of Energy

0—I have as much energy as ever

1—I have less energy than I used to have

2—I don't have enough energy to do very much

3—I don't have enough energy to do anything

Changes in Sleeping Pattern

0--I have not experienced any change in my sleep pattern

1a--I sleep somewhat more than usual

1b--I sleep somewhat less than usual

2a--I sleep a lot more than usual

2b--I sleep a lot less than usual

3a--I sleep most of the day

3b--I wake up 1-2 hours early and can't get back to sleep

Irritability

0--I am no more irritable than usual

1--I am more irritable than usual

2--I am much more irritable than usual

3--I am irritable all the time

Changes in Appetite

0--I have not experienced any changes in my appetite

1a--My appetite is somewhat less than usual

1b--My appetite is somewhat greater than usual

2a-- My appetite is much less than before

2b--My appetite is much greater than usual

3a-- I have no appetite at all

3b-- I crave food all the time

Concentration Difficulty

0--I can concentrate as well as ever

1-- I can't concentrate as well as usual

2-- It's hard to keep my mind on anything for very long

3-- I find I can't concentrate on anything

Tiredness or Fatigue

0-- I am no more tired or fatigued than usual

1-- I get more tired or fatigued more easily than usual

2-- I am too tired or fatigued to do a lot of things I used to do

3-- I am too tired or fatigued to do most of the things I used to do

Loss of Interest in Sex

0--I have not noticed any recent change in my interest in sex

1-- I am less interested in sex than I used to be

2-- I am much less interested in sex now

3-- I have lost interest in sex completely

Parent Child Communication Task

Parent-child observation.

ID number: Date:

Start time: End time:

We'd like to learn more about how parents and kids talk to each other after one parent has died. I'm going to give you a topic to talk about and then you can talk about it together. There are no right or wrong answers. Do either of you have any questions right now before we get started?

Can you talk together about your favorite memories of mom/dad? They could be of things you remember about mom/dad, things you did together as a family, or anything else that comes to mind.

If under 5 minutes, continue to next question. If over 5 minutes, stop here.

Can you talk together about what each of you think (child's name) had in common with dad/mom? They could be personality traits, physical traits, behaviors, or anything else that comes to mind.

Coding Manual for Parent-Child Communication Task

Qualitative Ratings for Parent-Child Interactions During Bereavement Interview

I. General Instructions for Applying The Qualitative Ratings Of Parent-Child Interaction

Each set of qualitative rating is to be based on videotaped semi-structured observation of the parent and her/his child. Ratings will be given for each category during the episode. The procedure for structuring the parent-child interaction is one in which the mother / father is instructed to discuss their favorite memories of the deceased parent as well as traits that the child has in common with the deceased parent.

In determining the ratings it is helpful for the coder to take longhand notes of parent and child behaviors as they relate to each scale and organize the notes by coding category on the worksheet titled "Qualitative notes." In assigning a rating, the coder should use a two-step process (borrowing from the logic used by Harter). The first step is to ask, "Is this dimension 'characteristic' (a 4 or 5 rating) or 'not characteristic' (a 1 or 2 rating) of the person being rated?" Once this decision is made, then the rater needs to make a finer discrimination between 4 or 5 and 1 and 2 ratings. A rating of 3 would be given to those that fall mid-range or demonstrate inconsistent tendencies throughout the episode.

Rating for most of these scales should be based on both the quality and quantity of the observed behaviors in relation to the proportion of the item they were observed. Ratings of 1 and 5 should be reserved for those observations that could be considered either problematic or exceptionally advantageous, depending on the specific scale.

II. Parent Ratings

A. Sensitivity / Responsiveness (adapted from Fish, 1990)

This scale focuses on how the parent observes and responds to the child's social gestures, verbal and nonverbal expressions, and signals. The key defining characteristic of sensitive interaction is that it is child centered. The sensitive parent is tuned in to the child and manifests awareness of the child's needs, moods, interests, and capabilities, and allows this awareness to guide his/her interaction. This also includes sensitivity to the child's own agenda, his needs from the conversation, and the child's ideas and opinions. The sensitive parent structures the conversation so that it is **age-appropriate, engages the child, and prioritizes the child's needs and objectives**. The sensitive parent also offers praise and encouragement, where appropriate, withholds criticism, and provides the right mix of support/ prompting and independence for the child's age and ability, so the child can express his or her thoughts effectively but with the guidance of the parent.

If the child initiates social gestures verbally or nonverbally (e.g., smiling at the parent, initiating physical touch, hugging the parent, making eye contact with the parent), the sensitive parent responds appropriately, based on the child's cues.

If the child appears disengaged in the conversation or distracted, the sensitive parent takes time to re-engage the child in a manner that demonstrates awareness of and sensitivity to the child's mood and preferences for how the conversation should take place (e.g., being more gentile and probing with a shy child, using humor or more sophisticated approaches with an adolescent).

A sensitive parent provides prompting where appropriate and is **responsive to the child's needs**. He/she acknowledges the child's feelings, elaborates on the content the child shares, and seems genuinely interested in what the child is saying, rather than being listless, age-inappropriate, detached. In addition to being relatively unresponsive to the child, the insensitive parent could be overstimulating/intrusive and might continue in his/her attempts to engage the child even when the child is providing clues that he/she is seeking to end the interaction.

A sensitive interaction is well timed and paced to the child's responses as a function of its child-centered nature. Such an interaction appears to be "in sync." The parent paces the conversation to keep the child engaged and interested, but also allows the child to disengage and end discussion of the topic naturally. A good indication that an interaction is not well-paced, indicating a lack of sensitivity, is if it comes across as **awkward or halting.**

The sensitive parent is flexible in supporting and responding to the child. The sensitive parent demonstrates knowledge about how the child is different from other children and responds accordingly. For example, the parent may structure the conversation differently depending on how distractible, emotional, or shy he/she knows the child to be. The sensitive parent will also respond effectively to child misbehavior. (e.g., rather than directing child to sit down and listen, offering choices and engaging the child in a positive way). The parent does not rely on commands or criticism when child misbehaves, nor does the parent disengage from the child when he or she is misbehaving. Rather the parent offers choices and focuses on positive alternatives to distracted or inappropriate behavior. The sensitive parent recognizes and encourages the child's independent ideas and opinions, but does not demand them. At the same time she or he permits the child to be dependent when the child needs it.

To be noted is that excessive talking on the part of the parent can reflect insensitive-intrusive caregiving rather than sensitive caregiving. Long-winded talking on the part of the parent often reflects the parent's lack of awareness of the child's developmental level. A parent who dominates the conversation without providing an

opportunity for the child to engage or awareness of what is inhibiting a child from engaging would be considered insensitive.

Markers of sensitivity include (a) **acknowledging the child's affect**; (b) **the parent is responsive to the content of the child's discussion** (i.e. what the parent says is in service of what the child is sharing) (c) **facilitating, but not over controlling the discussion** (d) **evidence of good timing paced to the child's interest and arousal level**; (e) **changing the pace when the child appears to become distracted, disengaged, or disinterested** (f) **picking up on the child's interest in specific topics, and developing and expanding that interest;** (g) **shared positive affect**; (h) **encouragement, in an age-appropriate way, of child's participation in the discussion**; (i) **sharing topics that the child can understand and relate to given his or her age and experiences with the deceased parent**; (j) **general flexibility in determining the nature of the discussion and managing child's (mis)behavior where relevant**

Thus, the sensitive parent demonstrates the ability to adapt her/his behavior to the child's mood, needs, and developmental stage. The parent neither over- nor underestimates the child's capacities to participate in the conversation or understand the content of what is being said. The parent knows when it is time to increase or reduce the amount of stimulation the child is experiencing.

Consideration is also given to how the parent responds to the child's expressions of negative affect (including anger, becoming sullen or withdrawn, crying, seeming anxious or uncomfortable). This includes the following three markers:

1)   Proportion of distress signals responded to. What proportion of distress is responded to? The sensitive parent responds to all signals of distress.

2)   Latency of response. How long does it take the parent to respond? The sensitive parent responds to distress quickly.

3)   Appropriateness of response. Appropriateness of the adult's behavior might be inferred by its effectiveness in soothing the child as well as the completeness of the response. Responses to child distress generally involve speaking sympathetically to the child, hugging child or engaging in other physical contact, distracting child, making child laugh or engaging with the child positively. Any of these or other behaviors can be considered sensitive if they appear to have the effect of soothing the child. If the parent's first response to the distress does not soothe the child, the sensitive parent should offer a "fuller" response or adapt a different strategy (i.e., more proximal soothing behaviors).

Ratings on this scale should be based on both quality and quantity of parent

behavior. For example, in relation to child distress, the proportion of signals responded to and the latency of response time should be evaluated in relation to the quality of the response. For example, if a parent responds very slowly or not at all to child distress, s/he should receive a rating of 1. A parent might receive a 3 if full responses are delayed or immediate responses are somewhat "shallow" or if there is a combination of response types, some being more effective than others. A rating of 5 should be given to those parents who exhibit immediate and exceptionally sensitive *and* appropriate responses.

1 = Not at all characteristic. This rating should be given to parents who are **very insensitive and unresponsive** to the child's needs and expression. The parent's interactional style is predominantly intrusive and/ or detached. The parent rarely responds appropriately to the child's cues and does not manifest an awareness of the child's needs, discomfort, or conversational interests. **Interactions are characteristically ill timed, inappropriate, or awkward**. When the child is upset, the parent responds not at all, or very slowly or inappropriately. Redirection of the child's misbehavior is negative or punitive. Parent's interaction with the child seems shallow, passive, or ingenuine.

2 = Minimally characteristic. This rating should be given to parents who display **infrequent or weak sensitivity / responsiveness or, the parents attempts at engaging or relating the child are unsuccessful**. While the parent is sometimes sensitive, the balance is clearly in the direction of insensitivity. The parent responds rarely or slowly to the child's distress signals or inappropriate behavior. The responses tend to be minimal or perfunctory or otherwise inappropriate. These parents generally appear attentive and observant of child but may offer infrequent verbal responses and/or evidence of sensitivity is not particularly striking or can be characterized as minimal. The parent may be somewhat passive or poorly attuned to child's needs and behave in a way that results in the child becoming disengaged or distressed. **The parent may also "leave the child out" of the conversation by discussing content that is age-inappropriate or directed primarily at the interviewer**.

3 = This rating should be given to parents who are **not particularly sensitive or insensitive**. If the parent does display an instance of insensitivity or unresponsiveness, it is brief and never striking / not enough to warrant a 2. For instance, the parent demonstrates predominant responsivity to the child's cues, moods, and conversational directivity but shows instances of mistimed or half-hearted sensitivity. The parent responds to child's needs more often than for a rating of 2 and responses are not inappropriate, and do not appear to distress or lead to the disengagement of the child.

4 = Moderately characteristic. This rating should be given to parents who are

predominantly sensitive / responsive. The parent typically responds effectively to child distress or disengagement, verbal and nonverbal cues, and child attempts at engaging or participating in the conversation. Some of the parent's responses are mixed, i.e., some are half-hearted or perfunctory, but the majority are full responses after which the observer feels like "that was a good episode." The parent is available and responsive to child's needs but some (although very few) responses are more adult-driven than child-driven or **responses are more subtle and less obvious than in a rating of 5**. The conversation seems to flow well.

5 = <u>Highly characteristic</u>. This rating should be given to caregivers who are **exceptionally sensitive and responsive**. The caregiver responds quickly and appropriately to the child's distress. If the child is upset, the caregiver takes time to soothe and calm the child. **Interactions are characteristically well timed and appropriate and parent displays exceptional awareness of child's affect, mood, and signals**. Parent responds very well to child's interests or discomfort with the conversation. Content is all age-appropriate and directed at the child rather than the interviewer. The conversation seems to flow extremely well and feels natural and comfortable.

B. Detachment/disengagement

The detached / disengaged / undercontrolling / understimulating parent appears **emotionally uninvolved or disengaged**, unaware of the child's needs to facilitate the conversation, and as a result, it may fall to the child or interviewer to guide the conversation. This parent does not react contingently to what the child says (i.e. does not vary his or her reaction based on what the child does) or provide a scaffold from which the child can help guide the conversation. Thus, there is little joining in the child's interests or conversation and instead there is an incomplete, superficial, or non-expansive set of responses. Detached caregivers "miss" the child's bids to them, signals of discomfort or interest, or need for engagement, comfort, or sharing of experiences not because they are *insensitive* to them (i.e. unaware of *how* to respond), but because they are not paying enough attention and are "somewhere else," distracted, or disinterested. **Responses are delayed or superficial and seem to suggest that parent is not paying very close attention**. **The parent provides too little structure for the conversation and relies too much on the child or interviewer to direct the content and tone**. The detached / disengaged / undercontrolling parent lacks the emotional involvement that characterizes a sensitive parent. S/he appears uninterested in the child and what s/he is saying.

Detached / undercontrolling parenting is sometimes evident in the disciplinary or redirective behaviors that do NOT take place or in the insufficiency of those that do occur. Detached / under-controlling parents often fail to act when the child becomes distracted or acts inappropriately. The parent may also be inconsistent in which behaviors s/he responds to, i.e. sometimes redirecting child distractibility but not at other times.

Detachment can be marked by (a) **providing too little content or structure to the conversation**; (b) **failing to respond effectively to the child's social bids, attempts to direct the content of the conversation, or displays of discomfort or disinterest** (c) **lack of awareness or responsiveness to what child says**; (d) **failing to respond to behavior and content that call for regulation or responding half-heartedly and inconsistently**, (e) **not attempting to continue the conversation or bring up new topics;** (f) **ignoring child's discomfort or distress**; (g) **attending to other issues in the environment (e.g., straightening child's clothing or the room, talking to interviewer) rather than attending to child** (h) **relying on the child or the interviewer to guide the conversation and set its tone**

This scale contains both qualitative and quantitative components. **A parent who is indifferent or shows little or no emotional involvement would be rated high on detachment**.

1 = <u>Not at all characteristic</u>. This rating should be given to parents who display no signs of detachment or under-involvement. When interacting with the child, the parent is **clearly emotionally involved and attentive.** These parents can be sensitive or intrusive, but it is

clear that they are emotionally involved in the conversation, paying close attention, and provide structure.

2 = Minimally characteristic. This rating should be given to parents who display minimal detachment. While the parent is sometimes noninvolved, he/she is clearly more involved than not. Evidence of detachment is not particularly striking and not extensive. The parents' involvement may be lacking in some instances but they can mostly be characterized as fully responsive and engaged.

3 = This rating should be given to parents who are still more involved than not, *but* displayed detachment is more striking and pronounced and slightly more frequent than would warrant a 2. For some parents, engaged responses to and interactions with their child may not be particularly striking and/or full responses occur less frequently. A 3 rating may be given to a parent who is very quiet and understimulating, but who generally seems engaged. There may be brief periods during which the parent may appear to be emotionally uninvolved.

 4 = Moderately characteristic. This rating should be given to parents who are mostly detached. The parent is generally emotionally disengaged, to the point that it is somewhat striking. The parent consistently responds when child explicitly demands it (e.g., "Mom, do you remember when…") but is otherwise mostly disinterested in the conversation and/ or does not attempt to continue or facilitate the conversation.

5 = Highly characteristic. This rating should be given to parents who are highly detached. The parent is clearly not emotionally involved with the child or conversation and appears to be "just going through the motions." The parent does not seem to be invested in the conversation, responds shallowly to the child, and does not attempt to facilitate, structure, or guide the conversation in a way that is helpful or effective. The parent appears to be completely "tuned out".

C. Positive Regard for the Child

This scale rates the parent's positive feelings toward the child, expressed during interaction with him/her. Positive feelings are shown by (a) **speaking in a warm tone of voice**; (b) **hugging or other expressions of physical affection**; (c) **smiling**; (d) **making good natured and appropriate jokes**; (e) **enthusiasm about the child and what s/he is sharing**; (f) **praising the child**; (g) **general enjoyment of the child and the activity**. (h) **makes and maintains good eye contact**

Ratings on this scale are based on both quality and quantity of positive regard.

1 = <u>Not at all characteristic</u>. This rating should be given to parents who display no positive regard. The parent may be expressionless or flat, or negative and does not appear to be enjoying the activity.

2 = <u>Minimally characteristic</u>. This rating should be given to parents who display infrequent and/or weak signals of positive regard. Positive regard and affection are generally ingenuine or mostly lacking. Generally, the parent does not seem to be enjoying the activity.

3 = This rating should be given to parents who display subtle and less frequent signals of positive regard. Instances of positive regard are not particularly striking and are sometimes inconsistent or not well timed with the child's expressions or gestures. Some instances of clear cut indicators of positive regard occur but they are not particularly spectacular and/or lack elaboration or believability. The parent seems neutral to the activity.

4 = <u>Moderately characteristic</u>. This rating should be given to parents who typically and consistently display positive regard. More frequent and intense positive affect is shown than in the 3 rating, but displays of positive regard are not spectacular or particularly striking as would be the case with a 5. The parent seems to enjoy the activity.

5 = <u>Very characteristic</u>. This rating should be given to parents who are exceptionally positive and warm, in terms of facial and vocal expressiveness, and behavior. Affect is positive, spontaneous, and frequent. The parent shows a range of expressions and behaviors which are all clearly positive. S/he is warm, affectionate, and positive toward the child and creates a comfortable and genuinely positive and enjoyable tone. The parent seems to greatly enjoy the activity.

D. Negative Regard for the Child

This scale rates the caregiver's negative regard for the child. Both frequency and intensity of negative affect toward the child are considered. Some markers of negative regard include (a) **disapprova**l **or insinuation that the child's expressed content is silly, weird, or wrong**; (b) **tense body**; (c) **abruptness**; (d) **tense facial muscles**; (e) **sarcastic or mocking comments to/about the child**; (f) **using a patronizing tone**; (g) **roughness** and (h) **a cold/ cool tone toward child.** In general, the parent appears not to be enjoying the activity.

Note: crying should not be considered to be evidence of negative regard

Ratings on this scale are composed of both qualitative and quantitative evaluations. The amount and intensity of negative regard exhibited is evaluated in relation to the duration of the observation period.

1 = <u>Not at all characteristic</u>. This rating should be given to parents who do not display negative regard for the child either in words or in expressions. No evidence of anger, frustration, impatience, general dislike, threatening the child or punishing the child's expression, sarcasm, annoyance, harshness or other indicators of negative regard is observed in the parent's face or voice.

2 = <u>Minimally characteristic</u>. This rating should be given to parents who display minimal negative regard. There is some evidence of low-intensity negative regard (e.g., instances of impatience), but it is more often completely absent than present (i.e. present only 1-3 times). Negative regard is not striking.

3 = This rating should be given to parents who display more striking instances or clear indicators of negative regard than what warrants a 2, but negative regard is still more absent than present. Displays more striking example of negative regard (e.g., being harsh, critical, or patronizing toward child) in at least one instance and shows more subtle negative regard (i.e., frustration, impatience, or negative facial or vocal expressions) in a couple other instances. Has a harsh style of interacting sometimes, but not generally.

4 = <u>Moderately characteristic</u>. This rating should be given to parents who regularly display negative regard. Multiple instances of low-intensity negative regard and/ or some (i.e. more than once) evidence of more-intense negative regard is observed. Has a generally harsh, cool, or annoyed style of interacting, but not always

5 = <u>Highly characteristic</u>. This rating should be given to parents who are consistently and very negative<u>.</u> Feelings of negative regard are expressed strongly and repeatedly, or persistent moderate levels of negative regard are expressed. The overriding affect influencing the parent-child interactions is negative.

E. Parent Comfort and Anxiety

This scale assesses parents' comfort and/or anxiety level with regards to the conversation. Parents receiving a 5 on this scale appear completely at ease and comfortable while those receiving a 1 appear ill at ease, anxious, and unsure about how to approach the task. Example markers of comfort include : (a) **a casual, easy approach to the conversation, (b) no demonstrable discomfort, even during moments of silence or transition, (c) relaxed body posture, facial expression, and voice tone (d) little or no effect of discussing loss (note: in terms of anxiety only, not affective reactions such as tearfulness) or being observed (i.e. parent seems to be acting naturally).** Examples makers of discomfort and anxiety include (a) **tense body, face, or voice tone (b) nervous laughter or fidgeting (c) difficulty maintaining conversational fluency (i.e. talks in a halting way, word-finding difficulties) (d) "stiffness" or lack of ease (e) attempts at self-soothing (e.g., deep breathing, taking breaks to calm down)**

1= Very Comfortable. The parent displays no signs of discomfort or anxiety and is completely at ease with the conversation. The parent appears very relaxed, calm, and natural (i.e. as if having an everyday conversation with their child).

2= Moderately Comfortable**.** The parent displays no strong signs of discomfort or anxiety, but does not seem as fully at ease as would merit a 1. The parent is at least somewhat (although not very) affected by the context or content of the conversation.

3= Parent displays some signs of discomfort (e.g., some stiffness or nervous laughter) but is more at ease than not.

4 = Moderately Uncomfortable. The parent displays several signs of discomfort such as stiffness, nervous laughter or grimacing, fidgeting, or tense body posture or tone. The conversation does not appear to be natural for the parent and s/he appears to be "working hard" to keep it going.

5 = Very Uncomfortable**.** The parent appears very ill at ease, uncomfortable, or anxious. The parent appears to be unable to "act naturally" and displays little or no instances of feeling at ease or comfortable

III. Child Ratings

A. Positivity

This scale assesses the extent to which the child is satisfied, content, and pleased with the conversation overall. Measures of child positivity include smiles, laughter, and positive tone of voice, as well as **enthusiasm for the conversation**. Lack of positive affect may be manifested by a neutrality or negative mood. Ratings on this scale should be based on quality and quantity of behavior, as well as the age of the child since older and younger children manifest their positivity in different ways. Attempt to balance both the intensity of the child's positive affect and the relative amount of time positive behavior is shown. A rating of 1 should be given to those children who exhibit no positive affect and give no evidence of feeling good, enjoying **the conversation, or feeling satiated by the conversation**. A rating of 5 should be given to those children who regularly display positive affect and seem to greatly enjoy the activity.

Note that in order to be considered positive, the **expressions must be appropriate and natural**. For example, laughter or silliness should not be avoidant, signify attempts at distraction, or anxious. Positive behavior should be appropriate given the content of the conversation.

1 = <u>Not at all characteristic</u>. This rating should be given to children who display no signs of positive mood. The child provides no real indication of being happy, content, or in a pleasant state or enjoying the interaction. The child does not seem to find the conversation useful or feel satiated by it.

2 = <u>Minimally characteristic</u>. This rating should be given to children who display infrequent or weak positive affect or seems somewhat content but does not seem to be particularly enjoying the activity. The child may show brief instances of strong or moderately strong positive affect (e.g., smiles or laughs).

3 = This rating should be given to children who display a few strong indictors of positive mood and can mostly be characterized as pleasant and content. Some children may appear to be enjoying the interaction, but the instances of obvious positive affect (such as smiling, laughing, telling jokes) are infrequent or occur only on a few occasions and are not extensive.

4 = <u>Moderately characteristic</u>. This rating should be given to children who frequently display positive affect and seem to enjoy the activity. The child exhibits several instances of strong positive affect (expresses enthusiasm, playfulness, smiling, and laughter) and is often pleasant and shows consistent enjoyment of the activity

5 = <u>Highly characteristic</u>. This rating should be given to children who are exceptionally positive, in terms of physical and vocal expressiveness. The child displays multiple instances of strong positive affect (smiling, laughing, telling a joke) and is characteristically "pleasant" for most of the remainder of the observation period. The child should truly "radiate" or "sparkle." For this rating, a child can have no strong distress.

B. Discomfort and discontent

This code includes signs of anxiety or discomfort (e.g., nervous laughter, discomfort, stiff body posture) and/or discontent (the child withdraws from conversation, is frustrated or impatient with the parent and/or conversation) The child does not enjoy the activity.

Ratings on this scale should be based on both qualitative and quantitative assessments, as well as the age of the child.

1 = Not at all characteristic. This rating should be given to children who display no discomfort or discontent. There are no signs of strong (whining) or weak (mild discomfort or anxiety) negative affect from the child during the observation period.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak discomfort or discontent. The child displays brief instances of mild negative affect (anxious laughter, frowning, signs of discomfort) which may last for a single prolonged period or short bursts. Overall, the child seems to enjoy the activity.

3 = This rating should be given to children who display infrequent but moderately strong discomfort or discontent. Some children may display instances of fairly striking negative affect (e.g.,withdrawal from the activity), but they do not persist with their negative affect. Other children may show more prolonged, milder discomfort or discontent. The negative mood typically is observed for about half of the time and the child seems, generally, neutral to the activity.

4 = Moderately characteristic. This rating should be given to children who display strong and/or frequent discomfort and discontent. The child displays one or two instances of moderately strong affect or is moderately discontented (whining, withdrawn) throughout most of the observation period.

5 = Highly characteristic. This rating should be given to children who display high levels of discomfort and discontent. The child displays several instances of strong negative affect (crying, anger, withdrawal) during the observation period and appears to be rarely contented. The child does not like the activity at all and appears very uncomfortable; wants to end his/her participation in the conversation.

C. Sustained Attention

This scale assesses children's ability to **demonstrate age-appropriate**, sustained involvement with the conversation without becoming distracted, fidgety, or losing interest. The child's attention does not jump from one topic to another quickly. The child is able to sit in his or her chair without spinning, kicking, or squirming. He/she sustains his or her focus on the parent and what the parent is saying. The inattentive child may appear apathetic, bored, distracted, distressed, or aimless. For older children, distractibility may include looking away, playing with clothing, losing track of the conversation or being tangential, tapping foot or hands, etc. For younger children, squirming, getting out of the chair, running around, jumping, or being very "silly" are all indicators of distractibility.

The focus of this scale is primarily quantitative. Ratings are based primarily on the duration of attention to the activity.

1 = Not characteristic. This rating should be given to children who display very little sustained attention. The child is consistently distracted, squirmy, tangential and/or unable to sustain an interaction about a given topic.

2 = Minimally characteristic. This rating should be given to children who can sustain attention for only brief periods or for only a limited proportion of the observation period. Attention is scattered and unfocused during the session.

3 = This rating should be given to a child who displays regular sustained attention but sometimes appears half-hearted or not appear fully engaged in the conversation. The child is at least somewhat distracted or fidgety.

4 = Moderately characteristic. The child spends most of the time focused on the topics being discussed with only a few periods of distracted behavior. The child is generally focused.

5 = Highly characteristic. This rating should be given to the child who is clearly involved, interested, and focused all or almost of the time. No clear instances of being distracted or fidgeting are noted.

*D. **Engagement (adapted from Booth, 1991)**

This scale assesses the extent to which the child is connected and engaged with the parent and engages in an effective, mutual dialogue with the parent. Behaviors indicative of engagement include (a) **positive and engaging responding to the parent's initiation of a conversational topic;** (b) **initiating conversational topics without prompting from the parent**; (c) **positioning / orienting body toward the parent,** (d) **sustained interest, involvement, and emotional investment during the conversation** (f) **ratifying what parent says** (e.g., saying mmmhmm, smiling, nodding, asking follow-up questions) (g) **makes and maintains good eye contact**. Behaviors indicative of disengagement include (a) **active rejection of parent's overtures** (b) **creating a conversation that is notably "one-sided" (not being interested in what the parent says/ asks/ shares** (c) **positioning / orienting body away from the parent**.

*Note: even if children appear to be "engaged" in the conversation, they may be disengaged with the parent. Children who fit this description may appear to be trying to entertain, engage, or "get the right answer" for the interviewer but are not necessary engaging in an effective **dialogue with the parent.**

Ratings on this scale should be based on both quality and quantity of behavior.

1 = <u>Not at all characteristic</u>. This rating should be given to children who display no engagement with the parent. Children given this rating seem clearly disconnected and disengaged. They actively reject or ignore the parent's efforts to engage them and/or initiate no such efforts on their own. **They are uninterested in or avoidant of the activity.**

2 = <u>Minimally characteristic</u>. This rating should be given to children who display infrequent or weak engagement. These children are responsive to a few prompts from the parent, but are **generally disengaged and quiet**. They do not make attempts to continue the conversation spontaneously.

3 = This rating should be given to children who display inconsistent engagement with the parent. There are no striking instances of the child disengaging, but neither is the child fully engaged. There are few to none or very weak instances of the child initiating a topic of conversation or ratifying what the parent says. This code is for children who show instances of both engagement and disengagement.

4 = <u>Moderately characteristic</u>. This rating should be given to children who are more engaged with the parent than not. The child ratifies what the parent says relatively frequently, although not with the striking quality that would justify a rating of 5. The child initiates topics of conversation, asks questions of the parent, or otherwise attempts to keep the conversation going.

5 = <u>Highly characteristic</u>. This rating should be given to children who are very engaged with the parent. The child has a high frequency of initiations of conversational topics or questions and is very clearly emotionally invested in the activity. The child is strikingly adept at ratifying what the parent says.

IV. General conversational Quality

A. Depth of Content

This scale assesses the depth of the content discussed during the parent-child interaction. Content ranges from superficial to deep. Superficiality (a rating of 1) is defined as touching on only surface memories or traits that **do not hold much emotional significance** for either the parent or the child. Superficial content is described **without much detail or valence attached to it** and is not expanded upon or **elaborated beyond the essential facts** of the memory or trait. Superficial "similar traits" may be physical in nature (rather than based on personality). Superficial content does little to increase the connection between parent and child or help process emotions and experiences related to the loss. **Rather the purpose of superficial content seems to be completing the task itself rather than communicating about the loss or loss-related emotions**. This content may seem to suggest that the dyad is "just going through the motions" or not taking the task seriously/ making good use of the task. In contrast, deep content (a rating of 5) expresses some sort of emotional valence or holds a great deal of emotional significance for the dyad, helps consolidate experiences or emotions, and is aimed at increasing the connection between the parent and child or providing the child with information that could help him/her maintain a positive connection with the deceased. In other words, deep content serves a broader purpose than simply completing the parent-child interaction task. The parent and/or child are affected by the memories and traits shared and seem to **gain something from the experience of having discussed the content**.

Emotionally-valenced implies some discussion of how the participant felt or feels…for example "that was really fun" or "I miss Daddy's jokes" Nonverbally-expressed emotions should also be considered, such as smiling at a memory or crying.

If one participant is engaging in "deep content" but the other is not, please note that here:

_____

_____

_____

1 = Very Superficial = Almost no emotionally-valenced content is discussed and the content seems to hold very little emotional significance for the dyad. Memories and traits are almost purely factual in nature, are not elaborated upon, and are discussed only briefly. The dyad seems to "miss the point" of the interaction and do not seem to discuss content of particular importance to them.

2= <u>Moderately Superficial</u> = Very little emotional valence is expressed and content is elaborated occasionally, but not consistently or with much detail. Overall, the conversation occurs at a surface-level.

3= The content is somewhat superficial, but several moments of emotional valence, elaboration, or connection occur.

4= <u>Moderately Deep</u> = The content is mostly "deep" in that it generally seems to serve a purpose for the dyad beyond completing the task, includes emotional expression, and is elaborated beyond essential facts. Some moments of more surface-level discussion may take place but these are brief not and not striking.

5= <u>Very Deep</u> = The dyad delves into content with striking depth, elaborating on almost every memory or trait, describing and/ or experiencing emotions related to the content, and consistently sharing in a way that suggests connection and consolidation of loss-related experiences.

Parent-Child Interacting Coding Rater Form

Rater:

Date:

ID:

Time (initial, 6 mo, 12 mo):

Memories Portion of Video

Parent Ratings

Sensitivity	
Detachment/ Disengagement	
Positive Regard	
Negative Regard	
Discomfort and Anxiety	

Child Ratings

Positivity	
Discomfort and Discontent	
Sustained Attention	
Engagement	

General Conversational Quality

Depth of Content	

Traits Portion of Video

Parent Ratings

Sensitivity	
Detachment/ Disengagement	
Positive Regard	
Negative Regard	
Discomfort and Anxiety	

Child Ratings

Positivity	
Discomfort and Discontent	
Sustained Attention	
Engagement	

General Conversational Quality

Depth of Content	

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