Parenting and Depression in Stepfamilies: A Parental Roles Perspective

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Abstract

Despite the prevalence of stepfamilies in society, little is known about the mental well-being of (step)parents in stepfamilies. Following 1,561 men and women over time using NLSY79 data, we examined the association of children and parent depressive symptoms in post-divorce relationships (i.e., cohabitation and remarriage). Results from logistic regression revealed that having a new biological child while a stepchild was present in the home was associated with large odds of high depressive symptoms. Having a new biological child in the first year of a new relationship had a very low likelihood of depressive symptoms, and those who waited were at increased risk of symptoms with each additional year of waiting. Findings suggested that various parent-child relationships and the timing of having a new child together play important roles in the mental adjustment of adults to a new stepfamily.

Keywords: cohabitation; depression; divorce; remarriage; stepfamilies; stepparenting

While parenting may be a rewarding experience, it appears to have little positive impact on adult well-being (Evenson & Simon, 2005). Despite an advancing literature with increased methodological sophistication, the vast most research on parenting and psychological well-being makes broad comparisons within a general population and do not focus on a specific group of individuals. For example, few if any studies have addressed the role of parenting on depression among divorced men and women. This is unfortunate given the substantial negative impact divorce has on the well-being of most men and women who experience it. In fact, its adverse effects on psychological well-being may be most noteworthy. Divorcès tend to have higher alcohol consumption, hostility, and depressive symptoms than their continuously married counterparts (Amato & Keith, 1991; Johnson & Wu, 2002; Waite, Lewin & Lou, 2009). Divorced parents may experience these negative effects even more strongly than non-parents (Williams & Dunne-Bryant, 2006). Yet, not all divorcès experience depressive symptoms or other mental health issues, such as substance abuse or anxiety following marital dissolution (Helbig, et al., 2006). Men and women in particularly stressful marriages may actually see an increase in their mental well-being (Waite, Luo, & Lewin, 2009).

Some scholars have suggested that repartnering may re-confer some marital benefits lost at divorce, such as psychological well-being (Johnson & Wu, 2002). While there is some evidence that remarriage does, in fact, help ameliorate some divorce-related problems (e.g., M. E. Hughes & Waite, 2009; Waite, et al., 2009), little is known about what role children play in this process. Having (step)children in a repartnered (remarried or post-divorce cohabiting) family can be stressful. Stepparents are often viewed as illegitimate by children (Coleman, Fine, Ganong, Downs, & Pauk, 2001) and lack normative household roles (Stewart, 2007) which can

increase family conflict. Biological parents often report feeling caught between children, with whom they have pre-existing relationships, and their new romantic partners (Ganong & Coleman, 2004). Ultimately, both could impact well-being on their own. But, to complicate matters, adults in post-divorce unions can often have complex family arrangements—such as having a stepchild, biological child, and shared child with a new partner all in the same home. Thus, there may be significant variability in the effect of parenting on psychological well-being in stepfamilies. Furthermore, gender, relationship type (no relationship, cohabitation, remarriage), and relationship duration may moderate any relationship between parenting roles and psychological health after divorce.

In our study we address the lack of research findings about the role of children for psychological well-being among continuously divorced and repartnered divorcès. In particular, we address how various types of children affect depressive symptoms. We use data from the National Longitudinal Survey of Youth, 1979 cohort (NLSY79), a nationally-representative longitudinal study of adult participants to address this question. In the next sections we describe relevant research and theory concerning the link between parenting and psychological well-being, the unique nature of stepparenting, and variability in the association between stepparenting and psychological well-being.

Parenting and Depressive Symptoms

Although several studies have addressed the relationship between parenthood and depression, the results are far from decisive (Davies, Avison, & McAlpine, 1997; Evenson & Simon, 2005; Williams & Dunne-Bryant, 2006). Positive, negative, and null relationships between depression and parenting have been commonly found in various studies (Burton, 1998; Glenn & Mclanahan, 1981; M. Hughes, 1989; Kandel, Davies, & Raveis, 1985; Mclanahan &

Adams, 1987; Ross, Mirowsky, & Goldsteen, 1990; Umberson & Gove, 1989; Williams & Dunne-Bryant, 2006). The divergent conclusions of so many studies may be an artifact of methodological choices, such as inconsistent comparison groups, various time frames, different study designs, and different age ranges at observation. The definition of parenthood is also inconsistently applied. Some studies focus on individuals who have ever had a child and make comparisons to men and women who have no children. Others choose to operationalize parenthood as current parental status (Evenson & Simon, 2005). Recent research, most notably by Evenson and Simon (2005), has attempted to account for potential methodological artifacts by making several different comparisons. These studies find that parenthood does not reduce depressive symptoms, but not all parental roles (i.e., parent to non-residential children, empty-nester, etc.) are associated with poor mental health.

Many parents describe their maternal or paternal role as one of the most fulfilling parts of their lives, but there are various reasons why it may *not* lead to improved mental health. For one, the psychological costs of parenting may outweigh any benefits. This may help explain the substantial gender differences in psychological well-being among parents (CITES). Mothers are often expected to bear the brunt of childbearing tasks within a family—increasing the costs of parenting compared to fathers (Simon, 1998, 2002; Simon & Marcussen, 1999). Wider societal trends about the value of parenting may be another reason why there is little mental health benefit to parenting. Today, being a mother or father does not increase social capital to the extent it did in the past (Bianchi & Robinson, 1997). Furthermore, social support in the community and through organizations may be lacking (Caiazza & Putnam, 2005; Chiswick & Lehrer, 1990; Evenson & Simon, 2005; W. L. MacDonald & DeMaris, 2002). Changing norms about parenthood, such as reduced fertility, increased numbers of non-parents, and reduced desire to

marry may also reduce the positive social sanctioning provided to parents by social institutions, communities, and peer networks (Kelly, 2009).

Parental Role Perspective

The parental role perspective (Scott & Alwin, 1989) suggests that the negative psychological effects of parenting are directly correlated with the demands and stresses of childrearing expectations. While the majority of studies have addressed how parental roles and differential childrearing expectations can lead to disparate mental health outcomes between mothers and fathers, the parental role perspective can also provide context to why different parental roles (not necessarily associated with gender) can affect psychological well-being. For example, Purdovskia (2008) suggested that stepparents may experience fewer depressive symptoms than biological parents in stepfamilies because the expectations of residential non-biological parents are significantly different than biological parents. In line with this extension of the parental role perspective, we address how dissimilar childrearing responsibilities and combinations of roles *within* stepfamilies can contribute to variability in depressive symptoms. We discuss the application of the parental role perspective to our research questions in the discussion below.

Parenting in Stepfamilies and Depressive Symptoms

Some perspective about stepfamilies may prove helpful in understanding psychological well-being among divorcès who are stepparents, biological parents, or both. Most stepfamilies form after divorce and a subsequent remarriage. The negative effect of divorce on mental health is well-established in the literature (see Amato, 2000; 2010 for reviews). Much of this decline may be attributed to reduced social support after dissolution, continued stress from divorce, and the strain and stress associated with single parenting, economic concerns, and the like (Carlson &

McLanahan, 2010; Carlson, McLanahan, & England, 2004; E. M. Hetherington & Kelly, 2003; Johnson & Wu, 2002; McManus & DiPrete, 2001; Peterson, 1996). Notably, not all divorcès experience poor mental health following marital dissolution. In fact, individuals from unhappy first marriages often see an upturn in their psychological well-being following divorce (Paul R. Amato & Hohmann-Marriott, 2007). Notably, because not all divorcès want to or will remarry, we include a reference group of individuals who have not remarried or formed stepfamilies in our analysis.

As we noted earlier, the parental roles perspective could be used to suggest that stepparenting is not associated with poor psychological well-being (Purdovskia, 2008). One reason for this may be stepparents' perceptions of their role within the stepfamily. For example, Marsiglio (1992) found that nearly 50% of stepfathers felt that stepparents should be more a friend than a parent and one-third felt that they did not hold responsibilities akin to biological parents. Similarly, many stepchildren feel that their stepparents should be emotionally supportive (Kinniburgh-White, Cartwright, & Seymour, 2010), but find attempts to enforce rules and influence family values as off-putting and illegitimate (E. Hetherington & Kelly, 2002; Kinniburgh-White, et al., 2010). Biological parents also initially resist sharing full parental responsibilities with their new spouse (the stepparent), meaning that they take on the bulk of parental responsibilities (Weaver & Coleman, 2010).

On the one hand, these factors seem to support the parental roles perspective. By most accounts, the childrearing expectations of stepparents are substantially lower than those of biological parents. To the extent that these expectations are associated with psychological well-being, stepparenting should not be a risk factor for depressive symptoms. On the other hand, the ambiguity associated with non-biological parenting may but stepparents vulnerable to poor

psychological health. Stepparenting, especially what roles and boundaries exist for a stepparent, is an area of substantial conflict for many remarried couples (Coleman, et al., 2001; E. M. Hetherington, 1993). There is, quite simply, no normative roadmap for how stepparents should parent. Nearly all aspects of the stepparental role seem negotiable in most stepfamilies (Kinniburgh-White, et al., 2010; W. L. MacDonald & DeMaris, 2002). This stands in stark contrast to biological families, where boundaries and roles are, for the most part, clearly socially defined (A. Cherlin & Furstenberg, 1994; A. J. Cherlin, 2004).

Biological parents in stepfamilies may be at greater risk for poor mental health than stepparents, however. Unlike the majority of first married couples, biological parents in stepfamilies are often the only residential biological parent (Stewart, 2007). In fact, many times they may be the only biological parent with whom a child has contact, given the high rate of absent fatherhood among divorcès (Sweeney, 2010). Because parent-child ties predate relationships with a new spouse, many biological parents feel considerable role strain and conflict. For example, reports of feeling caught between a new spouse and children are commonplace (Weaver & Coleman, 2010). Complicating matters, many biological parents choose to back their children in arguments with their new spouse (Ganong & Coleman, 2004). Another common strategy employed by newly remarried couples can also create difficulty for stepfamilies. They often attempt to legitimate their relationship in a way that signals to stepchildren that their stepmother or stepfather is, in actuality, their *new* mom or dad. This often has very negative effects. Conflict and familial disharmony are customary when (step)parents do this (Coleman, et al., 2001). Ultimately, these problems may lead to lower levels of psychological well-being.

Variability by Stepfamily Structure

Birth of a new child. One distinguishing feature of stepfamilies is that adults often have a number of parental roles which they take on at the same time. For example, it is not uncommon for men and women to have biological children from a prior relationship and non-biological stepchildren in the same home. Particular family difficulty can arise from having a new biological child with a remarriage partner. In fact, fertility is quite common among remarried couples. Recent estimates indicate that at least 25% of remarried couples have a child together (Manlove, Logan, Ikramullah, & Holcombe, 2008) and that number may be higher (Guzzo & Furstenberg, 2007)This complexity raises questions about the impact of these combined roles on psychological well-being through conflicting familial roles.

Simply put, it is not well-known how somewhat conflicting roles within the same family affect adults. As we noted earlier, stepparenting on its own could have positive, negative, or null effects on depressive symptoms. However, having a new child creates a family structure where non-biological and biological children are now in the household. While many remarried couples see having a child with a new partner as reflecting the couple's commitment to one another (Bulanda & Brown, 2007; Schoen, Kim, Nathanson, Fields, & Astone, 1997), it can also change family dynamics in profound ways. For example, MacDonald and DeMaris (1996) report that remarried adults are less satisfied parenting stepchildren than new biological children. Similarly, Stewart (2005) found that involvement with a stepchild declined with the birth of a new child. Because these changes can complicate family dynamics, the birth of a new child may lead to lower levels of psychological well-being for stepparents.

The birth of a new child within a stepfamily may also lead to role strain and conflict for adults with biological children. As we noted earlier, many biological parents report feeling caught between their new spouse and their children—a feeling which could be exacerbated by

the presence of a new biological child (or a shared child) with a new spouse. For example, these adults may now have multiple people pulling at them: a new spouse, children with an ex-partner, a new child, and stepchildren. Such patterns appear to be evident in the fact that having a child with a new partner reduces investment, monitoring, and control with biological children with an ex-spouse (E. M. Hetherington & Jodl, 1994; Stewart, 2005, 2007). Interestingly, this is counter to the expectations of many adults, who believe that the new child will cement the stepfamily together as a nuclear unit (Ganong & Coleman, 1994). As a result, many biological children feel that shared children have privileged status, generating considerable conflict within the family (Beer, 1992; Stewart, 2007). These factors may contribute to poor psychological well-being in new parents with a biological child from a prior relationship in the home (Stewart, 2007).

Remarriage and cohabitation. Relationship formation can mitigate the psychological consequences of divorce. For example, Johnson and Wu (2002) found that the effect of divorce on psychological well-being was moderated by repartnering. Yet, not all new relationships may have the same effect on psychological well-being. Remarriage can positively impact subjective well-being in divorcès. Many remarried men and women report more satisfaction with their second marriages than their first marriages (Hawkins & Booth, 2005), happiness, and lower levels of depression (Waite, et al., 2009). While lower relationship commitment among cohabiters may diminish the positive impact of repartnering on psychological well-being (P.R. Amato, 2010; Hilton & Kopera-Frye, 2004), some studies show that cohabitation can reduce the risk of depression (Johnson & Wu, 2002). Given this context, how might the effect of children on well-being differ for remarried and cohabiting stepparents? Using the parental roles perspective, remarried stepparents may see more negative impact from being a stepparent than cohabiting stepparents because of higher relationship commitment in marriage than cohabitation.

Relationship duration. Finally, we consider the interaction of relationship duration and children on psychological well-being. Stepfamilies become substantially more stable, roles become clearer, and boundaries better defined with time. For example, after an initial period of hesitancy, many children see their stepparent as a legitimate authority figure after several years (Coleman, et al., 2001). Most childrearing disagreements or difficulties with children diminish substantially after loving and supportive bonds, a shared identity, and new rules and boundaries are established (Stewart, 2007). Similarly, after a period of adjustment, biological child-biological parent and new children should be integrated into the home. As a result, we expect that the negative effects of parental roles will reduce with additional years in a relationship (which we define as years of continuous cohabitation and/or marriage).

The Current Study

We focus on the role of stepchildren, biological children, and newly born children as stressors to post-divorce relationships, as measured by depressive symptoms. We also consider the role of moderators and adjustment to stepfamily life by focusing on changes in depressive symptoms from being divorced (at T1) to their new union (at T2). Further, we address potential variability in the relationship between children and depressive symptoms by gender, stepfamily structure, relationship type, and relationship duration. Finally, our paper builds on earlier studies by using nationally representative longitudinal data over a significant period of time (1992-2008).

Method

Data

We used the National Longitudinal Survey of Youth, 1979 cohort (NLSY79), a nationally-representative sample of 12,686 men and women born between 1957 and 1965. NLSY

data were collected annually between 1979 and 1994 and biannually since. Data are publically available from the 1979-2008 waves and includes a full marital history, sociodemographic information on spouses and children, and various other measures. Our analysis began in 1992, when questions on depressive symptoms were first introduced in the survey, and ended in 2008. The analytic sample was limited to individuals who were divorced and not remarried or cohabiting in 1992 or 1994 (depression questions were also asked in 1994). Depressive symptoms were measured again at either age 40 or 50. Due to these limitations, 1,561 respondents of the 3,695 divorcès in the NLSY79 data are included in our analyses.

Depressive Symptoms

Our dependent variable, self-reported depressive symptoms, was assessed using a 7-item CES-D scale, which is reliable across gender, race, and age (Radloff, 1977). The measure includes items which assess the frequency respondents felt depressed or sad, had problems eating or sleeping, could not focus on tasks, and required extra effort to complete tasks in the past week. Responses were given on a 4-point Likert scale (0-3) with scaled scores ranging from 0-21 and higher scores indicating more depressive symptoms. Importantly, we dichotomize this variable into high and low depressive symptoms. The original 20-item CES-D scale uses a cutoff score of 16 out of a possible 60 points to indicate high depressive symptoms (Comstock & Helsing, 1976). We used a similar proportion with our 7-item scale for a cutoff score, but as a conservative estimate we rounded up to 6 points as the cutoff for high depressive symptoms.. This approach with the 7-item scale has been used in prior research (Cseh, 2008) and more closely approximates clinical diagnoses of depression than continuous scales.

Baseline depression was measured in 1992 or 1994, when respondents were 27-37 years old, while T2 depression was measured at age 40 or 50. This was based off the NLSY health

evaluation, starting in 1998, which was given at age 40 and 50 for respondents. Because using the 40 year old evaluation would have produced a very small time gap between T1 and T2 for the oldest divorcès, we used the 50 year old health evaluation for some respondents. Most T2 evaluations took place between 2000 and 2006, a difference of 8 to 12 years from baseline. Cronbach's alpha at baseline was excellent (α= 0.97) and good at age 40 (α= 0.86). Individual items on the scale were not available for 50 year olds in an effort to protect respondent anonymity, as few respondents had reached age 50 in 2008. Cronbach's alpha was not provided by NLSY, either. Nevertheless, screening efficacy and reliability of the CES-D has been established for 50 year olds in other samples (e.g., Lewinsohn, 1997).

Key Independent Variables

We focus on two key independent variables: children and relationship status at T2. We used several child variables describing the type of relationship the respondent had with a co-residential child. We chose to focus on co-residential children because the parental role is significantly stronger and more defined in such situations than with non-residential children (Evenson & Simon, 2005). The presence of a stepchild is measured with a dichotomous variable indicating if a new partner's child (non-biological child to the respondent) regularly lived in the home. The presence of a residential biological child and a new biological child (shared, if in a relationship) were also measured with dichotomous variables. Relationship status at T2 was measured with dichotomous variables for a cohabiting or remarital relationship, with no current relationship as the reference category.

Control Variables

We include numerous control variables in our analyses. Because time can have various effects on our results, we included a dichotomous variable for T2 depression measured at age 40

(compared to age 50) and continuous variables for years since divorce at T1, duration of first marriage, and duration of the new relationship (which equaled zero if they were not in a new relationship). We also controlled for various personal characteristics associated with divorce (Amato, 2010), remarriage (Sweeney, 2010), and childbearing decisions after divorce (Stewart, 2002). These include dichotomous variables for gender and race (Hispanic, Non-Hispanic Black, and Non-Hispanic White). Socioeconomic differences in depressive symptoms (Evenson & Simon, 2005) and repartnering behavior (Sweeney, 1997) are also noted in prior research. As a result, we control for employment, income, and education. Employment status was measured by a set of time-varying control variables indicating if the respondent had full-time employment (more than 35 hours a week, 50 weeks a year), part-time employment (less than 35 hours a week and/or less than 50 weeks a year), or no employment. Family income was the sum of household income adjusted to 2008 dollars and logged to adjust for positive skew. Measures of educational attainment at baseline with dichotomous variables for less than 12 years of schooling (less than high school graduate), 12 years (high school graduate), 13-15 years (some college), and 16 or more years (college graduate) were also included.

We also controlled for residence in the South or an urban area—places where divorce and remarriage are significantly more common (United States Census Bureau, 2008). Since religious involvement is associated with somewhat fewer depressive symptoms, and acts as protective factor among individuals undergoing psychosocial stress (Smith, McCullough, & Poll, 2003), religious affiliation was measured by dichotomous variables for Mainline Protestant, Conservative Protestant, Catholic, and Other religious affiliation.

Analytic Method

We used logistic regression with a change score that estimated the difference between depression at T1 (age 27-37) and depression at T2 (age 40 or 50) in Stata 12.0. As a result, we could estimate the effect of repartnering and children on depression among the previously married. We converted the logits to odds ratios, which range from 0 to ∞ for ease of interpretation. Odds ratios may be interpreted as percentage increases or decreases in the odds of an outcome in the following manner: $1\text{-}e^{\beta}$. We also tested for a number of potential interactions with children. These include interactions between children and years in a new relationship, children and gender, interactions testing for differences rooted in combinations of children, and between children and being married. We also tested for an interaction between children and cohabitation, but found no significant effects.

Results

Descriptive Statistics

Table 1 shows the means and standard deviations of the predictor variables for respondents depressed and not depressed at T2. Nearly 23% of the respondents (358/1558) exhibited a high number of depressive symptoms. Three hundred fifty eight of the 1,558 respondents (23%) in the data exhibit a high number of depressive symptoms. We tested for differences in the likelihood of having high depressive symptoms by each characteristic. In each case we compared individuals with that characteristic against individuals who do not. For example, respondents with a biological child are more likely to exhibit high depressive symptoms than those without a biological child present in the home. Likewise, women, urban residents, and Catholics all had higher risk for depression. The presence of a new child, remarriage, and full-time employment appear to be protective factors for depression. Blacks and Conservative Protestants have fewer depressive symptoms, as well. Individuals with high

depressive symptoms at T2 had depression scores approximately two higher at T1 than respondents with low depressive symptoms at T1. Further, respondents with depression measured at age 40 were more likely to report low depressive symptoms.

Main Effects Model

The results of our main effects model, which includes no interactions, may be found in Table 2. This model shows that having a stepchild or biological child present in the household has no effect on depression when compared to not having a child. However, the birth of a new child reduces the odds of high depressive symptoms by nearly 39%, compared to respondents with no children ($p < .01$). Cohabiting and marital relationships also negatively impact depressive symptoms. Compared to individuals who are not in a relationship, cohabiting respondents saw a nearly 37% decrease ($p < .10$) in the odds of high depressive symptoms and remarried respondents a 38% decrease ($p < .05$). Many of our control variables also had significant effects on depressive symptoms. Respondents depressed at T1, women, urban residents, and Catholics all had higher odds of depressive symptoms. Conversely, longer first marriage duration, graduating from college, being Hispanic, and identifying as Conservative Protestant appear to be protective factors. Finally, respondents with T2 depression measured at age 40 were significantly less likely to report high depressive symptoms than their 50 year old counterparts.

Interactive Models

The results of four interactive models are reported in Table 3. These models include interactions with child (stepchild, biological child, or new child) and four different variables: female, new biological child, remarriage, and relationship duration. We report truncated results

in Table 3 because the effects of other variables included in each model are substantively similar to those reported in Table 2.

Child-female interactions. Earlier, we noted that women may feel particularly high levels of stress in stepfamilies because of greater parental roles and expectations. Many women with stepchildren may feel more pressure to take on motherly roles than stepfathers do to act as a father-figure. Further, because many women are the primary post-divorce caregiver for biological children (Goldscheider & Sassler, 2006), more women will feel caught in stepparent-stepchild conflicts than men. Our interactions, however, only show that women without children (as noted by the main effect of female) have a significantly higher likelihood of depressive symptoms (OR = 1.846; $p < .01$). Having a new biological child seems to be protective for women, however—reducing the odds of high depressive symptoms by some 44% ($p < .10$).

Child-new biological child interactions. We expected that family structure would affect the psychological well-being of divorced men and women. We were particularly interested in the effect of having a new biological child in remarried families. As such, we interacted stepchild present and biological child present with the birth of a new child in this model. Our results show that having a new child significantly increases the odds of depression in adults with stepchildren. In fact, having a new child increases the odds of depressive symptoms by 4.614 times for stepparents. Interestingly, stepparents without new children (as noted by the main effect) have low odds of depression, as do adults with new children.

Child-remarriage interactions. We were also interested in potential differences in the effect of children in remarriages, cohabitations, and no relationship. Although we had interactions between children and cohabitation, they yielded no significant effects. However, our results do show that men and women in remarriages who have a new child experience

significantly higher levels of depressive symptoms than individuals who are not in marital relationships (as noted by the main effect). This suggests the possibility that there are greater levels of stress associated with remarriages because of its higher level of commitment and lack of clear norms—a point we return to in our discussion.

Child-relationship duration interactions. Finally, we introduce interactions between children and years in a new relationship. We have one significant interactive effect in the model—between new biological child and years in new relationship. The main effect indicates that respondents who had a new child in the first year of their post-divorce relationship had a very low likelihood of depressive symptoms (*OR* = 0.541). However, the interactive effect shows that the odds of depressive symptoms increase by 10.4% for each year they wait to have a child.

Discussion

We used a parental roles perspective to understand the possible association of stepchildren, biological children, and new biological (shared) children with the depressive symptoms of divorcès. Prior studies on parenting, broadly defined, are inconclusive about its influence on psychological well-being (see Evenson & Simon, 2005 for a full discussion). Importantly, little research has addressed stepparenting's influence on mental health and has not focused on variability in parental roles within the same household. This issue is central to adults in stepfamilies, who may have biological children, stepchildren, and new children all under the same roof. As a result, there may be conflicting, unique, and combined parental roles that can lead to poor psychological well-being. Additionally, we also considered possible variability in the effect of children on depressive symptoms by gender, marital duration, the birth of a new child, union status, and relationship duration. Because parental roles can vary across these

characteristics, we expected substantial differences in the effect of children on psychological well-being.

Our paper has several key findings. First, stepchildren are not risk factors for high depressive symptoms. This is somewhat surprising given that many stepparents and stepchildren report significant conflict, role ambiguity, and unclear boundaries (Coleman, et al., 2001). Yet, it is clear that stepparents and stepchildren view the parental role of non-biological adults quite differently than they do biological parents. Namely, stepchildren expect that their stepparents will be supportive, but will not try to enforce rules or influence family culture (Coleman, et al., 2001). Similarly, stepparents often see themselves more as friends than as adult authority figures (Marsiglio, 1992). As a result, the weak parental roles and expectations of stepparents have little effect on well-being. Second, biological children are not associated with psychological well-being after divorce. While this finding was unexpected it may be due to a lack of difference between divorcès and repartnered individuals. For individuals who do not remarry, financial strain, time commitment, issues associated with single parenting, etc. can create significant psychological stress. Biological parents who repartner feel stress as well, such as split loyalties are split between their new partner and their children (Ganong & Coleman, 2004). Third, we found that a new biological child increases psychological well-being when there is not a stepchild present in the household. Men and women with a new child have lower odds of high depressive symptoms than individuals without children. This suggests that new relationships may be solidified by the birth of a new and/or shared child.

Although female stepparents and biological parents may have more expected of them when it comes to parenting (Shapiro & Stewart, 2011), it appears to have no negative effect on psychological well-being. In fact, women without children are at a high-risk for depression.

Conversely, the birth of a new child seemed to be a protective factor for divorced women. Yet, various parent-child relationships were found to be associated with increased risk of high depressive symptoms among respondents. Those who had a new biological child with their new partner, while a stepchild was already present in the home, were much more likely to have high depressive symptoms than those without children. However, giving birth to a new child when the respondent had no stepchild in the home was associated with a substantial decrease in the odds of high depressive symptoms. Similarly, individuals who acquired a stepchild, but did not have a new biological child, tended to have much lower odds of depressive symptoms. These findings provide evidence that stepparents have difficulty negotiating a relationship between a stepchild and a new child. We speculate that relationships with stepchildren may be particularly strained by the presence of a new child which, in turn, increases conflict and depressive symptoms. Interestingly, we found no significant evidence to suggest that other tested combinations of children (i.e., biological-new child, biological-stepchild) were associated with an increased risk of a depressive outcome.

In assessing differences across marital statuses among parent-child relationship structures, our results indicate that remarried individuals who have a new child are significantly more likely to experience higher levels of depressive symptoms than individuals who are not in marital relationships, while cohabiters did not exhibit such an effect. This may be due to the high levels of commitment, but lack of clear norms to regulate family functioning inherent to stepfamilies (P.R. Amato, 2010; Stewart, 2007; Sweeney, 2010).

Finally, we looked at the role of new child timing within a relationship. Respondents who had a new child in the first year of their new relationship had a very low likelihood of high depressive symptoms; however, the odds of high depressive symptoms increased substantially

for each year they waited to have a new child with their partner. Although depressive symptoms stay stable and stepfamily conflict tends to decrease with time, waiting to have a new child leads to worse psychological well-being. The homeostasis achieved by many stepfamilies takes several years to establish (Hetherington & Kelly, 2002; Stewart, 2007) and may be upset by the addition of a new child. Thus, solid stepfamily functioning may be established, but may also be fairly fragile and not resilient to "family shocks."

Limitations and Future Directions

Our study has implications that need to be taken into account. Depression was only measured at two time points—divorce and cohabitation/remarriage. It would have been beneficial to measure symptoms more frequently. Also, our data has CES-D scores for only one partner, rather than both. Though there was no significant interaction effect for having a biological child from a previous relationship and giving birth to a new child with the new partner, this is precisely the family structure with high odds of depressive symptoms for respondents' partners who were not measured. While stepfamily structures can be complex, the relationship dynamics, individual behaviors, and internal processes among members are certainly more complex, and understanding depressive symptoms from the perspective of both partners (e.g., actor-partner models), among other outcomes, may be a direction for future research. It is important to note that we used depression as the only measure for mental health, while mental health is actually a much broader construct measured in a number of ways in adults (e.g., anxiety, self-esteem, substance abuse).

In NLSY79, a child, or stepchild, whose primary residence was not the respondent's home but who visited or stayed over regularly was coded as being a residential child; thus, leaving only several respondents with very minimal contact with children who were not included

in our analyses; thus, limiting our ability to separately assess the influence of non-residential children on parental mental health. Also, we did not factor in the child characteristics in predicting depressive symptoms. This will be a direction for future research to contrast with Evenson and Simon (2005) who found that parents living with minor stepchildren are less depressed than parents living with adult stepchildren. Despite these limitations, our study possesses strengths. We were able to improve upon past methods by increasing the longitudinal increment to be 6 to 16 years (compared to 12 years, e.g., Johnson & Wu, 2002), for a nationally-representative sample, while holding time constant. We incorporated rigorous methodology and explained key findings with theory.

Implications for Clinical Practice

While all adults in stepfamilies will face varying degrees of challenges, such as depression, the stability of the unit is better explained by how challenges are met rather than their prevalence (Saint-Jacques, et al., 2011).

Our findings have implications for mental health professionals who work with all types of diverse families in society—including stepfamilies, which are found on many caseloads in some form. Practitioners who work with stepfamilies can take into account the increased likelihood of depressive symptoms among stepparents who have a new child with their partner. Particularly, clients of mental health services who are in remarital relationships are at-risk of symptoms and might benefit from this emphasis. Professionals might choose to reassess the mental health of clients in these situations to help determine therapeutic direction or need for services. They might choose to normalize and validate the challenges experienced by clients. As practitioners take this awareness into the field, they may strengthen the resilience and resolve of stepparents to endure challenges and remain together, reducing the risk of further divorce and

avoiding potential negative short-and long-term outcomes for adults and children. But, above all, practitioners need to be aware of the complexity of stepfamily life and how various challenges can combine to affect the well-being of not only adults, but also their children and family relationships.

Being divorced can be a difficult and life-changing experience; nevertheless, post-divorce relationships may be a solution to restore lost-benefits—including mental health. Despite the benefits of forming a new relationship, there are obstacles to address and overcome. Parenting in a new stepfamily brings added challenges and risk factors to mental health. However, there are protective factors, such as the timing of having a new child while considering stepchild relationships. As individuals navigate new family structures, with help from the theoretically and empirically informed perspective and counsel of practitioners, stepparents can increase their resilience and resolve to carry on through individual and family challenges.

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Table 1. Descriptive Statistics of the Sample

	Variable Range		High Depressive Symptoms (n= 358)		Low Depressive Symptoms (n= 1,200)	
Children	Minimum	Maximum	$\bar{X}$	SD	$\bar{X}$	SD
Stepchild present	0	1	0.05		0.07	
Biological child present*	0	1	0.50		0.46	
New child born*	0	1	0.33		0.43	
Relationship status at T2						
Cohabiting relationship	0	1	0.12		0.14	
Remarriage*	0	1	0.61		0.65	
Depression at T1	0	18	5.98	4.95	4.09	3.48
Depression measured at age 40*	0	1	0.45		0.78	
Female*	0	1	0.70		0.59	
Years since divorce	0	21	7.14	4.87	6.70	4.20
Duration of first marriage	1	17	6.93	3.91	7.34	3.65
Duration of new relationship	0	16	2.30	3.87	2.29	3.65
Full-time employment*	0	1	0.79		0.81	
Educational attainment						
Not high school graduate	0	1	0.15		0.14	
Some college educaiton	0	1	0.15		0.16	
College graduate	0	1	0.12		0.12	
South	0	1	0.21		0.21	
Urban*	0	1	0.89		0.78	
Race and ethnicity						
Non-Hispanic Black*	0	1	0.07		0.12	
Hispanic	0	1	0.01		0.03	
Religious affiliation						
Catholic*	0	1	0.57		0.42	
Conservative Protestant*	0	1	0.13		0.20	
Other religious affiliation	0	1	0.10		0.09	

Source: National Longitudinal Survey of Youth, 1979 cohort. Note: * indicates that a t-test shows difference in depression at $p<.05$

Table 2. Logistic Regression for Main Effects of Depressive Symptoms After Divorce (n= 1,561)

	e^{β}	β (s.e.)		e^{β}	β (s.e.)
Children[a]			Model, continued		
Stepchild present	0.759	-0.276			
		(0.242)			
Biological child present	1.185	0.169	Educational attainment[d]		
		(0.192)	Not high school graduate	1.178	0.164
New child born	0.614	-0.488 **			(0.248)
		(0.092)	Some college education	0.937	-0.065
Relationship status at T2[b]					(0.188)
Cohabiting relationship	0.635	-0.454 †	College graduate	0.582	-0.542 *
		(0.148)			(0.140)
Remarriage	0.619	-0.480 *	South[e]	1.106	0.100
		(0.119)			(0.196)
Depression at T1	1.125	0.118 ***	Urban[f]	3.035	1.110 ***
		(0.019)			(0.709)
Depression measured at age 40	0.228	-1.478 ***	Race and ethnicity[g]		
		(0.034)	Non-Hispanic Black	1.519	0.418
Female[c]	1.742	0.555 ***			(0.457)
		(0.273)	Hispanic	0.239	-1.433 *
Years since divorce at T1	1.008	0.008			(0.139)
		(0.019)	Religious affiliation[h]		
Duration of first marriage	0.953	-0.048 *	Catholic	1.399	0.336 †
		(0.020)			(0.253)
Duration of new relationship	0.982	-0.018	Conservative Protestant	0.461	-0.775 **
		(0.020)			(0.118)
Full-time employment	0.940	-0.062	Other religious affiliation	1.294	0.258
		(0.163)			(0.358)
-2 log likelihood			286.71		
Pseudo R^2			0.170		

Source: National Longitudinal Survey of Youth, 1979 cohort; *Note*. [a] Reference= no children; [b] Reference= continuously divorce;

[c] Reference= male; [d] Reference= high school graduate; [e] Reference= non-South; [f] Reference= non-urban; [g] Reference= non-Hispanic White; [h] Reference= Mainline Protestant

† $p < .10$, *** p< .05, **p< .01, ***p< .001.

Table 3. Logistic Regression for Interactive Effects of Depressive Symptoms After Divorce (n= 1,561)

	e^{β}	β	s.e.
Child-female interactions			
Stepchild present	0.982	-0.018	0.469
Biological child present	0.824	-0.193	0.232
New child born	1.015	0.015	0.261
Female	1.846	0.613	0.416 **
Stepchild * female	0.667	-0.406	0.410
Biological child * female	1.587	0.462	0.503
New biological child * female	0.563	-0.575	0.179 †
Child-new biological child interactions			
Stepchild present	0.485	-0.724	0.183 †
Biological child present	1.086	0.083	0.211
New child born	0.478	-0.737	0.111 **
Stepchild * new child	5.614	1.725	3.589 **
Biological child * new child	1.345	0.297	0.406
Child-remarriage interactions[a]			
Stepchild present	1.573	0.453	0.574
Biological child present	1.496	0.403	0.427
New child born	0.365	-1.008	0.098 ***
Remarriage	0.510	-0.672	0.121
Remarriage * stepchild	1.573	0.459	1.914
Remarriage * biological child	0.664	-0.409	0.221
Remarriage * new child	2.595	0.954	0.842 **
Child-relationship duration interactions			
Stepchild present	1.022	0.022	0.553
Biological child present	1.202	0.184	0.232
New child born	0.541	-0.615	0.098 **
Duration of new relationship	0.968	-0.033	0.034
Stepchild * duration	0.954	-0.048	0.080
Biological child * duration	0.989	-0.011	0.040
New biological child * duration	1.104	0.099	0.045 *

Note. [a] child-cohabitation interactions were tested, but produced no statistically significant results

† $p < .10$, *** p< .05, **p< .01, ***p< .001.