Stepparents participating in Couples Relationship Education and mental health: Differences at baseline and improvements over time

by

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Abstract

The current study involves a sample of 1,313 parents participating in couple relationship education (CRE) programs as part of a larger randomized control trial. Drawing on theoretical assumptions from Family Systems Theory and Family Stress Theory, the study examined baseline differences in levels of stress, depressive symptoms, and anxious symptoms between groups of parents, stepparents, and combination parents/stepparents and whether these groups benefit differently from CRE over time. In addition, pulling from the Stress Relief Hypothesis, this study examined a spillover of individual mental health functioning into couple/relationship quality. Findings from an analysis of variance revealed that stepmothers differ from combination mothers/stepmothers in levels of depressive symptoms at baseline. In addition, findings from a two way repeated measures analysis of covariance indicated a time x parent status interaction effect for stress for fathers, such that fathers and combination fathers/stepfathers report lower stress over time, and stepfathers report no changes. Findings from regression analyses revealed a spillover of stepmothers' own stress reduction predicting their own enhanced relationship quality six months later as well as a spillover of stepfathers' reduced depressive symptoms predicting their own relationship quality six months later; however, no spillover between partners was evident. Findings from this study support the need for continued examination into stepparent experiences, particularly between stepparents and combination parents/stepparents, in addition to potential gender differences within stepparent groups and the consideration of the role of mental health indicators in predicting positive relational outcomes following CRE.

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Introduction

Divorce and remarriage are a common occurrence for many families in the United States (Cherlin, 2010). As of 2009, the marriage rate was at 6.8% (rate per 1,000 population), and the divorce rate was at 3.4% (rate per 1,000 population; U.S. Census Bureau, 2009) As individuals divorce, recouple, and remarry, stepfamily formation may or may not become part of the experience. Stepfamilies may also be formed as first families with neither parent having been married or divorced previously. As such, many individuals reside in stepfamilies (Ganong & Coleman, 2017), with 15% of children living with a stepparent and parent (Pew Research Center, 2015) and 40% of a survey population reported having some form of step relationship (Parker, 2011).

A stepfamily can be defined as any family with at least one biological or adoptive parent, one non-biological adult fulfilling some role as a parent, and one child from a previous relationship (Ganong & Coleman, 2017). Therefore, a stepparent can be defined as an adult serving a parenting role for a non-adopted child to whom they are not biologically related, while also being romantically involved with the biological or adoptive child's parent, whether married or unmarried. Becoming a stepfamily is a significant transitional life event that many individuals in the United States are encountering, making it an important area to research and discuss to develop informed policies and practices to best serve these families (Ganong & Coleman, 2017).

Research on stepfamilies has primarily focused on relational and parenting aspects of the stepparenting role and on children's outcomes. With increased risks for relational dissolution (Ganong & Coleman, 2004), parenting challenges (Hetherington, 1999; Papernow, 2017), and role ambiguity (Favez et al. 2015) in stepfamilies, we would expect to see some effect on stepparent individual mental health functioning. Due to the additional structural and

developmental complexity inherent in stepfamilies, we would specifically expect stepparents to demonstrate a higher level of stress than parents at any given point in time (Ganong & Coleman, 2004).

While much is known about child mental health outcomes in stepfamilies only a few studies assess stepparent individual mental health functioning (Sweeney, 2010; Jensen, Lippold, Mills, & Fosco, 2018; Shapiro & Stewart, 2011). Evidence suggests that stepparents report higher levels of stress than biological parents (Shapiro, 2014). In addition, stepparents, particularly stepmothers report higher levels of depressive symptoms (Shapiro & Stewart, 2011) and anxious symptoms (Doodson & Davies, 2014) than biological mothers. Further, stepparent residential status influences rates of depressive symptoms such that non-residential stepparents report higher depressive symptoms than residential stepparents (Stewart, 2015).

Further, an area receiving increasing attention in stepfamily research is best practices to help parents and children be successful in becoming a stepfamily through both clinical and educational interventions. Of particular interest is how stepparents benefit from couple relationship education (CRE). Utilizing a family systems perspective, a growing body of evidence shows that stepcouples in CRE for stepfamilies experience simultaneous benefits in couple, parental, and family functioning (Lucier-Greer, & Adler-Baeder, 2012). Additionally, a comparative study found that remarried couples in CRE experience similar changes in measures of couple, parental, and individual functioning compared to first-married couples (Lucier-Greer, Adler-Baeder, Ketring, Harcourt, & Smith, 2012). Since these respondents may or may not have been stepparents (i.e., their partner is the stepparent), it is not known whether differences exist specifically between groups of parents and stepparents in changes in these same areas over time after CRE. Within groups of stepparents, evidence suggests that residential status of stepparents

influences outcomes, such that residential stepparents report greater improvements in individual and couple outcomes than non-residential stepparents (Stewart, 2015) and that gender influences outcomes, with stepmothers reporting improvements in coparenting agreement and stepfathers reporting no improvements (Garneau & Adler-Baeder, 2015). Other studies find evidence that all members of stepfamilies – children, the newly formed stepcouple, and the other biological parent outside of the immediate stepfamily – show improvements following CRE participation, with positive changes maintained at least one year post-program (Lucier-Greer, Adler-Baeder, Harcourt, & Gregson, 2014; Skogrand, Dansie, Higginbotham, Davis, & Barrios-Bell, 2011; Garneau & Adler-Baeder, 2015). While these results are encouraging and point to relational benefits of CRE for stepparents, little is known about benefits of participation in CRE for stepparents on indicators of individual mental health functioning and how these changes may influence the couple relationship. Therefore, this study will focus on mental health indicators among parents, stepparents, and combination parents/stepparents in a CRE program.

Differences in Individual Mental Health Among Parents and Stepparents

Some evidence indicates that stepparents may report higher rates of clinically significant symptoms at any given point, compared to parents (Shapiro, 2014; Shapiro & Stewart, 2011; Doodson & Davies, 2014). For example, Shapiro (2014) found that stepmothers and stepfathers report higher levels of parenting stress than both biological mothers and fathers. Shapiro and Stewart (2011) found that stepmothers experience higher levels of depressive symptoms compared to biological mothers. Additionally, it appears there may also be differences within stepparents groups. Within a study of stepparents participating in CRE, non-residential stepparents reported higher rates of depressive symptoms than residential stepparents (Stewart, 2015). In addition to within group differences at baseline, the literature suggests gender

differences. In a 2014 study, Doodson and Davies compared 4 differentiated categories of stepmothers and combination biological mothers/stepmothers to one another and to biological mothers. The study found support for stepmothers and combination stepmothers/biological mothers experiencing more depressive and anxious symptoms compared to biological mothers. A gap in the literature exists over indices of anxious symptoms for stepparents compared to parents within CRE at baseline, making this element of the proposed study novel and relevant. In the context of CRE, differences at baseline between stepparents and parents serve to inform CRE developers and facilitators about the needs CRE participants present with and reasons for electing to attend CRE.

Differences in how Individual Mental Health Changes Among Remarried Couples, First-Married Couples, Parents, and Stepparents in CRE

CRE has a goal of enhancing several aspects of couple, individual, and family functioning (Hawkins, A. J., Blanchard, V. L., Baldwin, S. A., & Fawcett, E. B., 2008) and research indicates that CRE is effective in enhancing couple and parenting functions (Adler-Baeder et al. 2013). For example, Adler-Baeder and colleagues (2013) found that participants in a couple's relationship education curriculum experienced positive changes in both parenting and couple functioning over time. In addition, when family structure and parental status was considered, CRE has been shown to be helpful for first family couples and stepcouples, alike (e.g., Lucier-Greer et al., 2012). In another study, Lucier-Greer and colleagues (2012) meta-analytically reviewed 14 CRE programs focused on stepfamilies and found improvements in family and parenting functioning. Other studies of CRE explore further the experiences of stepparents and parents in CRE (Lucier-Greer et al., 2014; Stewart, 2015. Garneau and Adler-Baeder (2015) explored changes in coparenting and parenting among stepparents after CRE and

found improvements in parenting efficacy regardless of gender and ethnicity in addition to gendered improvements, with stepmothers, alone, reporting improvements in coparenting agreement.

Spillover of Improvements After CRE Participation

While much is known about CRE's effectiveness in enhancing couple and parent functioning, less attention has been dedicated to examining whether CRE contributes to improvements in individual mental health functioning and if these changes lead to further improvements in couple and parent functioning, particularly among stepparents. Some evidence exists for a spillover of improvements from depressed affect into relationship quality following participation in CRE (Cooper, 2018; Bradford, Adler-Baeder, Ketring, Bub, Pittman, & Smith, 2014). Specifically, a study by Cooper (2018) found that immediate changes in individual mental health functioning following CRE participation predicted later changes in couple functioning. Additionally, Bradford and colleagues (2014) demonstrated how, among relationally-distressed couples improvements in one partner's depressed affect following CRE were found to predict improvements in the other partner's relationship quality. Because stepcouples have increased risks for relational dissolution, this is a relevant area to explore further (Ganong & Coleman, 2004). No research has focused on whether stepparent couples, in particular, experience this similar spillover of effects when stepparents' mental health symptomology is improved, which provides reason for this section of the proposed study.

Theoretical Assumptions

The current study draws on Family Stress Theory, Family Systems Theory, and the Stress Relief Hypothesis as the basis for empirical investigation. Family Stress Theory tells us that how families function when faced with challenges depends on the resources they have available to

them (Boss, 1992). When looking at risk vs. resilience, stepfamily structure is inherently stressful (Papernow, 2018). We would expect for an intervention in the couple domain to equip individuals with more resources for dealing with crises within the context of a stressful family experience. There is also an expectation for a link between individual well-being indicators and relationship functioning.

More specifically, family systems theory assumes that problems are systemic and interconnected, meaning what happens in one part of a family system will affect another (Bronfenbrenner, 1987, 1982). Per this conceptual framework, we would expect functioning in the child domain, the parenting domain, and the couple domain to influence the individual involved in the relationships. An ecological family systems approach provides a framework for the multi-level and comparatively complex challenges faced by stepfamilies. This framework guides our expectation that stepparents may report differing symptomology at baseline compared to parents.

In addition, per family systems theory, we would expect a spillover effect of improvements within the individual domain to improvements in the couple domain. Prior research has found support for a spillover of one partner's individual mental health functioning their partner's relationship quality (Bradford et al., 2014) While Family Systems Theory focuses on more general connections between family members, the Stress Relief Hypothesis is specific to the movement of stress within a family system (Wheaton, 1990). The stress relief hypothesis is a complementary assumption to both Family Systems Theory and Family Stress Theory and may be applied to understand the concept of spillover of mental health indicators into relationship functioning within the context of stepcouple relationships (Wheaton, 1990). That is, it informs

the specific assumption that if one partner is doing better individually within a couple, both they, themselves, and the other partner should perceive relationship enhancement.

The Current Study

In sum, evidence indicates that differences exist between stepparents and parents on measures of stress, depressive symptoms, and anxious symptoms, but this comparison has not been examined within the context of CRE, making the current study relevant for stepfamily researchers and practitioners. While previous research finds comparable benefits of CRE for remarried couples vs. first married couples (Lucier-Greer et al. 2012), others suggest that variation within stepparent experiences may exist (Garneau & Adler-Baeder, 2015; Stewart, 2015). Limited attention in assessment of stepparents' experiences in CRE has been given to measures of individual mental health functioning and its effect on relationship quality over time. In addition, within samples of stepparents in CRE, few studies have distinguished stepparents from combination parents/stepparents. Further, no research has been conducted assessing for a spillover of improvements from a stepparent's individual mental health functioning into their partner's relationship quality, but research suggests that a spillover of improvements can occur for couples following CRE (Bradford et al., 2014).

Therefore, using family stress theory and family systems theory that considers the connection between individuals' well-being and the influence on their own and their partner's perception of the relationship, the present study will test the following hypothesis and explore the following research questions:

H1: Among parents, stepparents, and combination parents/stepparents at baseline, parents will report lower stress, anxious symptoms, and depressive symptoms than stepparents and combination parents/stepparents.

RQ1: Are there differences in how parents', stepparents', and combination parents'/stepparents' reports of stress, anxious symptoms, and depressive symptoms change across 6 months after participation in CRE?

RQ 2: Among stepfamily couples, do immediate reductions in stepparents' stress, anxious symptoms, and depressive symptoms predict later improvements in their own and their partners' reported relationship quality over time?

Literature Review

In the following review, I will further detail research on what is known about differences between stepparents and parents in indicators of individual mental health functioning, and I will also detail how stepparents and diverse types of couples experience change through participation in CRE. Additionally, I will describe the evidence of a spillover of improvements from one partner's individual mental health functioning and relationship quality following CRE participation and explicate the theoretical assumptions used in the study.

Differences in Individual Mental Health Between Parents and Stepparents

Research cites some links between stepparent status and individual mental health functioning. For example, Shapiro (2014) found support for stepparents reporting higher levels of parenting stress than biological parents. Using an analytic sample of 310 stepmothers, stepfathers, and biological mothers and fathers, the study examined measures of marital dyadic adjustment, gender views, and parenting stress. A General Linear Model of parenting role, dyadic adjustment, and gender views assessed for differences between stepmothers, stepfathers, and biological mothers and biological fathers. The study revealed that stepparents, regardless of gender, reported experiencing higher parenting stress than biological parents. Further, women, regardless of stepparent status, reporting higher parenting stress than men. Additionally, stepmothers reported the highest stress of any group, and stepfathers reported experiencing higher stress than both biological parent groups. High dyadic adjustment and nontraditional gender views were linked to lower stepparent stress.

Shapiro and Stewart (2011) examined differences between a convenience sample of 75 stepmothers and 60 biological mothers for self-reported parenting stress, perceived child regard, and depressive symptoms. To be included in the sample, women had to be either biological

mothers or stepmothers to children between the ages of 3 and 18. Participants answered a one-time online survey including measures of demographic information, a measure for stepmothers of how long they had been stepparents, what proportion of their stepchildren's lives they had been stepparents, and how involved they were in their stepchildren's lives. They also completed a scale developed by the researchers assessing perceptions of child regard, the Parental Stress Scale (Shapiro & Stewart, 2011), and the CES-D (Radloff LS, 1977; Eaton WW, Muntaner C, Smith C, Tien A, Ybarra M., 2004). Analyses were conducted using mean scores from each scale and subscale form administered surveys. Their study revealed that stepmothers reported higher levels of parenting stress, lower felt regard by stepchildren, and higher levels of depressive symptoms than biological mothers. An additional mediational analysis using bootstrapping assessed for mediation between parenting role and depressive symptoms by perception of child regard and parenting stress and revealed that perceptions of child regard and parenting stress mediated the relationship between parental status and depressive symptoms.

Other research indicates that differences arise between different groups of stepparents. For, example whether a stepparent is "residential" (i.e. residing with the stepchild) or "non-residential" (residing without the stepchild) has implications on stepparent functioning at baseline. Stewart (2015) examined differences between 324 (67 couples) residential and non-residential stepparents in a study participating in CRE. The study used pre- and postprogram surveys to measure indicators of individual and couple functioning, such as positive assertiveness, dedication, confidence, couple quality, depressive symptoms, and conflict management. To test for differences in measures of distress at baseline between residential and non-residential stepparents, an independent samples t-test was performed. Analyses revealed a significant difference in level of distress, with non-residential stepparents reporting feeling

significantly more distressed and more depressive symptoms at program start. These findings suggest that non-residential stepparents may present having greater needs at program entry than residential stepparents.

Doodson and Davies (2014) compared biological mothers to four categories of stepmothers on indices on mental health functioning: "full simple stepmothers," who have no biological children and serve as residential parental figures to their partners' children, " part simple stepmothers who have no biological children and serve as non-residential parental figures for their partners' children, "full complex stepmothers" who have both residential biological children and residential stepchildren, and "part complex stepmothers" who have residential biological children and non-residential stepchildren" (pg. 52). The study used the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) to measure indices of mental health functioning and the Kansas Marital Satisfaction (KMS; Schumm et al., 1986) scale to measure marital well-being on self-report questionnaires from a sample of 333 mothers. Separate one-tailed *t*-tests revealed that the mean levels of both depressive symptoms and anxious symptoms for biological mothers was significantly lower than all four categories of stepmothers combined. Analyses of variance revealed that full complex stepmothers and part simple stepmothers, specifically, reported significantly higher depressive symptoms than biological mothers. Analyses of variance also revealed differences in levels of depressive symptoms and anxious symptoms across the four categories of stepmothers were nonsignificant.

Differences in how Individual Mental Health Changes Among Remarried Couples, First-Married Couples, Parents, and Stepparents in CRE

A 2012 study by Lucier-Greer et al. found differential evidence for remarried couples' rates of depressive symptoms compared to first-married couples. Utilzing a sample of 1,542

participants in community-based relationship education, the study examined whether there were differences in individual, couple, and parental functioning between individuals in first marriages and those in diverse forms of remarriages at baseline. Those in remarriages may have married or remarried stepparents and may or may not have been stepparents, themselves. One of the measured indicators of individual functioning was self-reported depressive symptoms using 3 items from the CES-D. Separate one-way between-groups analyses of covariance analyzed for differences between first-married and remarried individuals at baseline. Data collected over a 4-year period found that there were no significant reported differences in depressive symptoms between individuals in first marriages and individuals in remarriages at baseline. Additionally, separate repeated measures analysis of covariance tests examined for changes over time in domains of individual, couple, and parent functioning. Individuals in first marriages and in remarriages demonstrated similar levels of marital functioning at least initially and benefitted similarly from CRE classes. Repeated measures analysis of covariance tests examined for differences in change over time for stepfamily-specific vs. general CRE classes. Whether the stepcouples attended stepfamily-specific or generalized CRE classes, they appeared to benefit similarly.

Stewart (2015) more specifically analyzed a sample of 324 (67 couples) residential and nonresidential stepparents participating in CRE. Using repeated measures mixed between-within analysis of covariance to test for differences in trajectory of changes post-program between non-residential and residential stepparents, the study found differences in positive assertiveness and dedication, with residential stepparents reporting greater improvements than non-residential stepparents. Regardless of residential status, all stepparents reported improvements in confidence and couple quality and no changes in depressive symptoms and conflict management skills.

In a program effictiveness study of *Smart Steps: Embrace the Journey,* Lucier-Geer et al. (2014) explored the experiences of relationally unstable couples participating in a stepfamily-specific RE program. From an overall sample of 196 stepcouples, the study compared relationally less stable couples in the program (n=97) to relationally less stable couples not receiving treatment (n=54). Using a quasi-experimental design, the study measured self-reported indicators of individual empowerment, couple quality, family harmony, and parenting efficacy. At baseline, individuals in stepfamilies participating in this study reported low levels of individual empowerment, couple quality, family harmony, and parenting efficacy. Paired samples *t*-tests examined for improvements in "perceived knowledge" of stepfamily experiences pre- and postprogram found that individuals in the treatment group experienced positive change in perceived knowledge in all areas of stepfamily-specific content. Separate mixed between-within groups repeated measures analyses of covariance tests examined change over time in each indicator pretest to posttest for the treatment and comparison groups. Results revealed time x group interactions for couple quality, family harmony, and parenting confidence with participants reporting desired increases in these areas and the comparison group reporting no change. These tests overall revealed that compared to a non-treatment less relationally stable group, less relationally stable stepcouples participating in stepfamily-specifc CRE tended to experience positive changes in their overall knowledge of stepfamily experiences, in individual empowerment, in couple quality, in family harmony, and in parenting efficacy.

In a 2012 meta-analytic review of couples relationship education specifically for stepfamilies, Lucier-Greer and colleagues assessed how effective stepfamily-specific CRE is for stepcouples in general and targeting specific domains of individual, couple, parenting, and family functioning and whether these programs have improved in effectiveness over time. The

study drew from a review of 14 CRE evaluation studies between 1982 and 2010 and used Comprehensive Meta Analysis (CMA) Version 2 to conduct analyses of self-reported data. An analysis of a measure of global functioning combining self-reports of family functioning, parenting functioning, the couple, and the individual as standardized scores after CRE revealed that participants did report significant improvements in global functioning overall. Separate analyses of each of these domains of outcome targets were conducted. Although one of the constructs that the study set out to test was measures of individual functioning using scales of depressive symptoms, self-esteem, ability to cope, and individual empowerment, there was not enough data to complete the analyses, so little is still known about how stepcouples in these studies benefited from stepfamily-specific CRE in individual functioning. In domains of family and parenting functioning, analyses revealed significant differences overall, and in couple functioning, no significant differences. In terms of the timing of studies, effectiveness over time showed that studies conducted in the 1980s and 1990s exhibited larger effects than recent studies.

In a study of 96 stepparents participating in CRE with an emphasis on coparenting between the stepparents, Garneau and Adler-Baeder (2015) measured changes in coparenting agreement, parenting efficacy, and parental involvement after program participation. Utilizing a family systems theory framework, the study looked at measures of coparenting agreement, parenting efficacy, and parental involvement. No indicators of individual mental health functioning were examined. Separate repeated measures analyses of covariance were conducted to examine changes from pre- to postprogam in reports of each measure. The study found significant improvement in coparenting agreement. A difference in change patterns between stepmothers and stepfathers was also observed, with stepmothers reporting better coparenting

agreement after program participation and stepfathers reporting no changes. All particpants experienced positive changes in parenting efficacy. Additionally, European-American participants experienced increases in parental involvement after program participation, while ethnic minorities did not. The study showed support for the idea of gendered expectations for stepparenting since stepmothers demonstrated greater change. While improvements in coparenting agreement were largely gendered, improvements in parenting efficacy occurred regardless of race, gender, residence (residential vs. non-residential stepparent), or curriculum.

Spillover of Improvements

Only one study can be found that considers mental health and relationship quality following CRE participation while also examining direction of effects. Bradford et al. (2014) conducted a study of 250 ethnically diverse, relationally unstable couples participating in CRE examining depressed affect and relationship quality. The goal of this study was to examine for improvements in depressed affect and relationship quality following participation in CRE in addition to looking for linkages between these improvements. The study applied an ecological family systems perspective, the stress generation model, and the marital discord model to look for direction of effects. If either partner in a couple responded "yes" to an item on the pre-program questionnaire asking if either partner had ever seriously considered a divorce, the couple met criteria for inclusion in the analytic sample. Researchers controlled for relationship length, SES, marital status, and ethnicity to examine how much improvements in depressed affect and relationship quality predicted each other for each partner and self. Measures of socioeconomic status, relationship length, ethnicity, marital status, relationship quality, and depressed affect were included in the study.

Paired sample *t*-tests of mean scores of depressed affect and relationship quality revealed a significant decrease between pre- and postprogram for men's and women's depressed affect and for men's and women's relationship quality. Further, a structural equation model (SEM) analyzed for linkages between postprogram measures. Results of the SEM of postprogram latent constructs on preprogram latent constructs for men and women revealed that preprogram relationship quality predicts postprogram relationship quality for men and women, and preprogram depressed affect predicts postprogram depressed affect for men and women. To analyze for effects of one partner's improvements onto another partner's improvements, an actor-partner independence model was tested, and postprogram depressed affect was found to be predictive of partner's relationship quality, but this linkage was not found to be bidirectional. These results lend support for the idea that improvements in one partner's individual mental health functioning following CRE participation could predict improvements in the opposite partner's relationship quality.

Theoretical Assumptions

In the proposed study, we combine assumptions from Family Stress Theory, Family Systems Theory, and the Stress Relief Hypothesis (Boss, 1992; Bronfenbrenner, 1987 or 1982; Wheaton, 1990). Family Stress Theory assumes that how families function when faced with challenges depends on the resources they have available to them (Boss, 1992). This theory is relevant in this study and helps explain 1) why stepparents may present to CRE with poorer individual mental health functioning at baseline, and 2) why CRE may provide stepparents with increased resources for coping with stressors specific to stepparent status. We would expect for an intervention in the couple domain to equip individuals with more resources for dealing with crises within the context of a stressful family experience.

Family systems theory assumes that problems are systemic and interconnected, meaning that what happens in one part of a family system will affect another (Bronfenbrenner, 1987 or 1982). Per this conceptual framework, we would expect functioning in the child domain, the parenting domain, and the couple domain to influence each other. An ecological family systems approach provides a framework for the multi-level and comparatively complex challenges faced by stepfamilies. This framework also guides our expectation that stepparents may report differing symptomology at baseline compared to parents, given the complexity of multiple family relationships (Sweeney, 2010).

In addition, per family systems theory, we would expect a spillover effect of improvements within the individual domain to improvements within the couple domain. More specifically to the movement of stress within family systems, the stress relief hypothesis, derived from Family Systems Theory, may be applied to understand the concept of spillover within the context of stepcouples across relationships (Wheaton, 1990). This theory frames the assumption that if one partner is doing better within a couple, the other partner should be doing better as well. Within the context of this specific study, we assume improvements in one partner's individual mental health functioning would lead to improvements in the other partner's relationship quality.

In conclusion, clear associations have been found between stepparent status and individual mental health functioning, but little is known about these differences within the context of CRE participation. Research has shown CRE to be effective in improving couple, parental, and family functioning both in stepfamilies, diverse types of remarriages, and non-stepfamilies and first married families. However, we have limited information on stepparents' experiences in CRE, particularly in regard to their mental health indicators. Based on the

previous literature and assumptions from family systems theory and family stress theory, and the stress relief hypothesis, we hypothesized (H1) that among parents, stepparents, and combination parents/stepparents at baseline, parents will report lower stress, depressive symptoms, and anxious symptoms than stepparents and combination parents/stepparents. We will explore (RQ1) whether there are differences in how stepparents, combination parents/stepparents, and parents reports of stress, depressive symptoms, and anxious symptoms change across 6 months after participation in CRE. Finally, based on family systems theory and the stress relief hypothesis, I will analyze whether immediate reductions in stepparents' stress, depressive symptoms, and anxious symptoms predict later improvements in their own and their partners' reported relationship quality.

Methods

Procedure

This study involves participants in a southeastern state participating in program efficacy studies of *ELEVATE: Taking Your Relationship to the Next Level* and *Couples Connecting Mindfully* (*CCM*). Family resource centers and other community agencies served as recruitment sites for the programs. Methods used to recruit participants included social media posts, web page advertisements, passing out flyers, emails and word of mouth across the 10 program sites. Informed consents were provided to participants. Baseline surveys collected information on demographics as well as individual, couple, parenting, and family functioning information. After completion of the baseline survey, random assignment into one of three groups occurred: 1) a control group receiving no treatment, 2) Couples assigned into ELEVATE, and 3) Couples assigned into Couples Connecting Mindfully. All participants received payment for completing program surveys, regardless of treatment group.

CRE curricula specific to the current study are derived from The National Extension Relationship and Marriage Education Model (NERMEM). NERMEM serves to provide a conceptual framework for essential elements of relationships which can include: care for self, choosing the relationship daily, knowing one another intimately, caring for one another, sharing with one another, managing conflict within the relationship, and connecting to others who support the relationship (Futris & Adler-Baeder, 2013). The curricula used in the current study include two programs derived from NERMEM that are specifically designed for enhancing couple relationships, *ELEVATE: Embrace the Journey,* and *Connecting Couples Mindfully* (*CCM)* (Futris & Adler-Baeder, 2014; McGill, Ketring, and Adler-Baeder, 2015). *ELEVATE* is a skills-based curriculum developed to enhance several key aspects of couple quality (Futris and

Adler-Baeder, 2014). *ELEVATE* is a 6-week curriculum with individual lessons represented by each letter: (E) Empower Yourself, (L) Lay the Foundation, (E) Enlighten, (V) Value, (A) Attach, (T) Tame, (E) Engage (Futris & Adler-Baeder, 2014). This curriculum was developed to educate couples on qualities essential to relationship maintenance, satisfaction, and quality. *CCM,* also a research-informed, NERMEM-derived CRE curriculum, has a basis in mindfulness-based stress reduction practices with an emphasis on mindfulness within the context of couples for increasing individual emotion regulation ability and enhancing healthy couple relationship practices (McGill et al., 2015). This curriculum was developed in response to growing evidence that couples needed help beyond basic skills training to improve individuals' management of stressful daily stimuli and addresses topics such as how mindfulness is beneficial for mental, physical, and relational health, how stress and touch affect intimacy within relationships, how stress affects the body, how to mindfully manage conflict, and empathy skills training (McGill et al., 2015).

Both the *ELEVATE* and *CCM* groups had the opportunity to complete 6 separate lessons spanning 6 weeks of classes. Each session lasted two hours. Participants were provided dinner and free childcare. Two facilitators trained in *ELEVATE* and/or *CCM* curricula lead the lessons and discussions each week. Immediately at the end of the 6 weeks of classes, each participant completed a post-program survey identical to the pre-program survey except for additional questions about class facilitation. Individuals additionally completed surveys at a 6-month follow-up.

The control group completed a demographic questionnaire and pre-program questionnaire in a similar timeframe as both treatment groups. At the end of the 6 weeks of program facilitation, the control group also completed the post-program questionnaire and a 6-

month follow-up questionnaire. Questions about facilitators were the only difference in surveys between the treatment and control group post-questionnaires. Overall response rates to the surveys across the treatment and control groups were 100% at time 1, 89% at time 2, and 80% at time 3.

Participants

Selection criteria for inclusion in this study were that participants report being a parent, stepparent, or combination parents/stepparents. From an overall study sample of 1,814 participants, 1,313 met these criteria and will be included in the study. The analytic sample consists of 30 individuals who are stepparents only (2%), 284 who are combination parents/stepparents (22%), and 999 who are parents only (76%). Participants range in age from 17 years old to 90 years old (median=37). The sample is balanced in gender (53% female). The sample is mostly European-American (58%); another 38% report their race as African-American and 4% other. In terms of ethnicity, 5% of the sample identify as Hispanic. In regards to level of education, 37% of participants report having a Bachelor's degree or higher, 20% report some college, 23% report having a high school education or equivalent, 14% report a vocational/technical or associate's degree, and 6% of participants report having no degree or diploma. For employment status, 62% of participants report working full time, 22% report not currently being employed, 10% report working part-time, and 7% report working variable hours or temporary, occasional, seasonal employment. For yearly household income, 10% of participants report a total household income before taxes of less than $7,000 per year; 19% report making $7,000 to $24,999; 16% report making $25,000 to 39,999; 29% report making $40,000 to 74,999; 13% report $75,000 to 99,999; 13% reported $100,000+. Regarding marital status, 76% report being married, 16% report being in a committed relationship, 7% report being

engaged, and less than 1% report being separated. The average length of relationship is 6 years, with 59% reporting being married once, 19% twice, and 5% three+ times, and 17% reporting this question did not apply. The full sample was used to test Hypothesis 1; the sample of participants in the two programs (n = 874) was used to test the question related to change following program participation; the sample of stepparents and combination parents/stepparents participating in the program (*n* =314) was be used to test the question concerning spillover.

M**easures**

Parent status was measured categorically by asking "are you a parent" and answering "yes" or "no." Parents were coded as "1." If participants answered that they were a parent at time 1, they were included in the analyses. **Stepparent status** was measured by asking "how is your child related to you?" for each child listed. If participants answered "stepchild" or "my partner's child," they were coded as stepparents (2) in the sample regardless of child age and residential status. **Combination parent/stepparent status** was measured by participants reporting serving as a parent to at least one child and a stepparent to at least one child. Combination parents/stepparents were recoded (3) from stepparent status to include participants reporting at least one child related to them as a "stepchild" or "my partner's child" and at least one child related to them as "biological, adopted, foster, grandchild, and/or other."

Race was measured categorically by asking "which of the following best describes your race?" and answering from a selection of 8 items (1=Caucasia/White, 2=African-American/Black, 3=Hispanic/Latino, 4=Asian American, 5=Native-American/Alaskan Native, 6=Native Hawaiian/Other Pacific Islander, 7=Biracial, and 8=Other). Due to literature citing some differences by race, it served as a control variable in analyses (Garneau & Adler-Baeder, 2015).

Stress was measured using 10 items from the Perceived Stress Scale (PSS) on a Likert-type scale (1=never; 5=very often; Cohen, S., Kamarck, T., and Mermelstein, R., 1983). Sample questions include "In the past month, how often have you been upset because of something that happened unexpectedly?"; "Felt that you were unable to control the important things in your life?" A mean of the responses was created with higher scores indicating higher stress. The Cronbach's alpha coefficient of internal consistency for women in the study sample was $\alpha = .90$ at baseline, $\alpha = .88$ at immediate follow up, and $\alpha = .88$ at six month follow up, indicating acceptable reliability. For men in the study sample, the alpha coefficient of internal consistency was $\alpha = .87$ at baseline, $\alpha = .89$ at immediate follow up, and $\alpha = .87$ at six month follow up, indicating acceptable reliability.

Women's and men's **depressive symptoms** were measured using 3 items from the Center for Epidemiologic Studies Depression (CES-D) scale (Radloff LS, 1977; Eaton WW, Muntaner C, Smith C, Tien A, Ybarra M., 2004). Items were answered on a Likert-type scale [0=rarely or none (less than 1 day); 1=some or little (1-2 days); 2=occasionally or moderately (3-4 days); 3=most or all of the time (5-7 days)] and include "How often have you felt or behaved in each of the following ways in the last week?: I felt sad that I could not shake off the blues even with the help from my family and friends; I felt depressed.; I felt sad." A mean of the responses was created with higher scores indicating greater depressive symptoms. The Cronbach's alpha coefficient for internal consistency for women in the study sample was $\alpha = .91$ at baseline, $\alpha = .92$ at immediate follow up, and $\alpha = .92$ at six month follow up, indicating good reliability. The alpha coefficient of internal consistency for men in the study sample was $\alpha = .87$ at baseline, $\alpha = .90$ at immediate follow up, and $\alpha = .91$ at six month follow up, indicating good reliability.

Women's and men's **anxious symptoms** were measured using the Generalized Anxiety Disorder 7-item scale (GAD-7) (Spitzer, R.L., Kroenke, K., Williams, J.B., & Lowe, B. 2006). Items were answered on a Likert-type scale (0=Not at all; 3=Nearly every day) using the prompt "Over the last 2 weeks, how often have you been bothered by the following problems?" and sample items include "feeling nervous, anxious, or on edge," and "not being able to stop or control worrying." A mean of the responses was created with higher scores indicating higher anxious symptoms. The Cronbach's alpha coefficient of internal consistency for women in the study sample was $\alpha = .94$ at baseline, $\alpha = .94$ at immediate follow up, and $\alpha = .94$ at six month follow up, indicating excellent reliability. For men in the study sample, it was $\alpha = .94$ at baseline, $\alpha = .94$ at immediate follow up, and $\alpha = .94$ at six month follow up, indicting excellent reliability.

Couple quality/relationship quality was measured using 3 items from the Quality of Marriage Index (QMI) (Norton, R., 1983). Items were answered on a Likert-type scale (1=very strongly disagree; 7=very strongly agree). Items include "we have a good relationship"; "our relationship is strong."; "my relationship makes me happy. A mean of the responses was created with higher scores indicating higher relationship quality. The Cronbach's alpha coefficient of internal consistency for women in the study sample was $\alpha = .96$ at baseline, $\alpha = .97$ at immediate follow-up, and $\alpha = .97$ at six month follow up, indicating excellent reliability. For men in the study sample,, it was $\alpha = .95$ at baseline, $\alpha = .97$ at immediate follow-up, and $\alpha = .97$ at six month follow up, indicating excellent reliability.

Analytic Plan

In order to test H1 regarding potential differences between parent status groups at baseline, I compared differences in means of stress, depressive symptoms, and anxious symptoms at startpoint between the three groups using a one-way analysis of variance (ANOVA) including the full sample and controlling for race. In order to deal with the dependence in the couple data, I ran the ANOVAS separately for men and women.

In order to test RQ1 which focuses on differences in patterns of change over time after program participation, I conducted a two-way repeated measures analysis of covariance (RMANCOVA) with just the program participants (n = 874) to compare patterns of change over 6 months between the three parent groups in reports of stress, depressive symptoms, and anxious symptoms. Because of dependence in the data, these tests were run separately for men and women.

In order to test RQ2 which focuses on spillover of improvements from stepparents' individual mental health functioning to their own and their partner's relationship quality, I used regression analyses. A difference score for stress, anxious symptoms, and depressive symptoms from Time 1 to Time 2 will be entered as predictors of relationship quality at T3, controlling for Time 1 levels of relationship quality. This was only tested for stepparents and combination parents/stepparents (n = 314) and their partners and was run for men and women separately, predicting their own relationship quality and their partner's reports.

Results

Descriptive statistics of all variables across the three parent groups in program participant and control groups for men and women are reported in Tables 1, 2, and 3. The variables in the overall sample are normally distributed, as the kurtosis and skewness statistics fall between -2 and +2 (George & Mallery, 2010). Within the subsample group of stepparents some variables were not normally distributed in both the groups of stepfathers and stepmothers. Because the leptokurtosis variables are only in one group and at one time point, and because the group is so small, I proceeded with recommendations that the variables not be transformed (Osborne, 2002).

H1: Baseline differences between parent groups.

To test hypothesis 1, I used an analysis of variance to check first for differences between stepparents and combination parents/stepparents in levels of stress, depressive symptoms, and anxious symptoms at baseline for men and women separately. This was to determine if the two groups should be combined for baseline comparisons. Comparing the three parent groups for women on differences in depressive symptoms at baseline, results indicated a marginally significant difference between the three groups [F(2)=2.585, p=.076]. As a post hoc analysis to further explore this difference, I compared stepmothers and combination mothers/stepmothers for baseline differences in depressive symptoms. There was a significant difference in baseline depressive symptoms between the two groups [F(1)=5.231, p=.024], with stepmothers reporting higher depressive symptoms at baseline (M= 1.29, SD=1.29) than combination mothers/stepmothers (M=.62, SD=.78). No significant differences between these 2 groups for women were found for stress [F(1) =.278, p=.599] or for anxious symptoms [F(1)=1.152 p=.285], therefore the two stepparent groups were combined for further baseline analyses for these 2 variables. Note: race was originally included but was not a significant covariate for any

of the indicators, so it was removed, and these analyses were conducted and reported excluding it.

Comparing the two parent groups for women (i.e., mothers and stepmothers) at baseline, there were no significant differences for stress [F(1)=.424, *p*=.515] or anxious symptoms [F(1)=.691, *p*=.406]. Race was a significant covariate for anxious symptoms in women [F(1)=6.479, *p*=.011], but not for stress [F(1)=3.633, *p*=.057] or depressive symptoms [F(1)=.288, *p*=.592], so it is included in the reports of anxious symptoms only. Hypothesis 1 was partially supported for stepmothers' baseline depressive symptoms.

For men, there were no significant differences between stepfathers and combination fathers/stepfathers in levels of stress [F(1)=1.109, *p*=.294], depressive symptoms [F(1)=1.443, *p*=.231], or anxious symptoms [F(1)=.220, *p*=.639] at baseline; thus, the two stepparent groups were combined for further baseline analyses. Note: race was originally included but was not a significant covariate for any of the indicators, so it was removed, and the analyses were conducted excluding it and those statistics are presented here.

For men, comparing the two parent groups (fathers and stepfathers), there were no significant differences at baseline on measures of stress [F(1)=.077, *p*=.781], depressive symptoms [F(1) =.007, *p*=.934], or anxious symptoms [F(1) =.312, *p*=.577]. Hypothesis 1 was not supported for men's baseline differences.

RQ1: Between group comparisons of change.

In order to test for differences in change across Time 1, Time 2, and Time 3 between the three parent groups, two-way repeated measures ANCOVAS were run separately for men and women. Although there was only one difference found between the stepparents only group and the combination parent/stepparent group at baseline, it is still possible that the groups could

differ in patterns of change over time; therefore, the original research question regarding the difference in change patterns between the three groups was tested.

There were main effects for time for men for stress [F(1)=4.447, *p*=.036]; however these results are interpreted with caution, given the interaction effects of time by parent group for stress [F(1)= 3.35, *p*=.036]. Post-hoc paired samples *t*-tests revealed differences from time 1 to time 3. For fathers, there was a significant change in stress from time 1 to time 3 [*t*(219)=2.539, *p*=.012], such that stress decreased ($\underline{M_1}$=2.54, SD_1=.63; $\underline{M_2}$ =2.44, SD_2=.64). Similarly, for combination fathers/stepfathers, there was a significant change in stress from time 1 to time 3 [*t*(82)=4.056, *p*=.000] such that stress decreased ($\underline{M_1}$=2.63, SD_1=.59; $\underline{M_2}$ =2.35, SD_2=.59). For stepfathers only, there was no significant change in stress from time 1 to time 3 [*t*(10)=.127, *p*=.902].

There were no significant time by parent group interaction effects in fathers/stepfathers' changes from time 1 to time 3 for depressive symptoms [F(1)=.022, *p*=.978] or for anxious symptoms [F(1)=.017, *p*=.983] using three groups, indicating all groups changed similarly. There also were no main effects for depressive symptoms, [F(1)=.142, *p*=.707] or anxious symptoms [F(1)=1.720, *p*=.191], indicating the group of parents and stepparents did not change significantly from baseline to 6 months.

For women, there were no significant time by parent group interaction effects in changes from time 1 to time 3 between the three parent groups for stress, [F(1)=1.042, *p*=.354], depressive symptoms [F(1)=.075, *p*=.928], or anxious symptoms [F(1)=.247, *p*=.781], indicating all groups changed similarly. There also were no significant main effects for time for stress [F(1)=.069, *p*=.792], depressive symptoms, [F(1)=.166, *p*=.684], or anxious symptoms

[F(1)=1.322, *p*=.251], indicating the group of parents and stepparents did not change significantly from baseline to 6 months.

RQ2: Predictors of change in relationship quality.

To test research question 2, I created a couple dataset from the stepparent and combination parent/stepparent participants from the program participant group only, indexed the couples by sex, and deleted out same sex couples (*n*=2) for a final sample of 171 paired couples. Difference change scores were calculated for perceived stress, depressive symptoms, and anxious symptoms for both stepfathers and stepmothers in each paired couple by subtracting the time 1 score from the time 2 score. In separate analyses, I regressed self and partner's relationship quality at time 3 onto stepparents' change scores, controlling for partner race and relationship quality at time 1.

Controlling for female partners' relationship quality at time 1, I regressed female partners' relationship quality at time 3 onto stepfathers' changes in stress, depressive symptoms, and anxious symptoms. I originally controlled for race, but it was not significant for stress, depressive symptoms, or anxious symptoms, so I removed it. The analysis revealed no significant findings for immediate decreases in stepfathers' stress [ß = -.189, *t*=-1.230, *p*=.227], depressive symptoms [ß =-.157, *t*=-1.125, *p*=.268], or anxious symptoms [ß = .107, *t*=.742, *p*=.463] predicting improvements in female partners' relationship quality at time 3, controlling for time 1 relationship quality. The model accounted for 50.9% of the variance in female partners' relationship quality at time 3.

Controlling for male partners' relationship quality at time 1, I regressed stepmothers' changes in stress, depressive symptoms, and anxious symptoms onto male partners' relationship quality at time 3. I originally controlled for race, but it was not significant, so I removed it. This

analysis revealed that stepmothers' immediate reductions in stress [ß =-.117, *t*=-.782, *p*=.440], depressive symptoms [ß =.092, *t*=.559, *p*=.579), and anxious symptoms [ß =.064, *t*=.366, *p*=.716] were not significantly linked to changes in male partners' relationship quality at time 3, controlling for time 1 relationship quality. The model accounted for 25.7% of the variance in men's relationship quality at time 3.

I then conducted a regression using changes in stepparents' own stress, depressive symptoms, and anxious symptoms at time 2 to predict their own changes in relationship quality at time 3 using difference scores subtracting time 1 from time 2. Immediate reductions in stepfathers' depressive symptoms at time 2 significantly predicted improvements in their own relationship quality at time 3, [(ß = -.341, *t*=-2.745, *p*=.007). Neither immediate change in stress (ß =-.042, *t*=-.387, *p*=.700) nor anxious symptoms (ß =-.026, *t*=-.207, *p*=.836) were significantly related to stepfathers' relationship quality at time 3, accounting for all else in the model. The model accounted for 40.4% of the variance in stepfathers' relationship quality at time 3.

For stepmothers' changes in stress, depressive symptoms, and anxious symptoms at time 2 predicting their own relationship quality at time 3, controlling for time 1 relationship quality, the results were significant for immediate reductions in stress (ß=-.213, *t*=-2.085, *p*= .041) predicting later improvements in stepmothers' reported relationship quality at 6 months, accounting for all else in the model. Immediate change in stepmothers' depressive symptoms (ß =.056, *t*=.495, *p*=.622) and anxious symptoms (ß =.146, *t*=1.270, *p*=.208) did not significantly and uniquely predict change in their reported relationship quality at time 3, controlling for time 1. The model accounted for 40% of the variance in relationship quality at time 3 for stepmothers.

Discussion

While a few studies have explored the experiences of stepfamilies in CRE, only one focused on indicators of individual mental health functioning; and none have distinguished stepparents and combination parents/stepparents, nor compared these measures to parents within the context of CRE. Becoming a stepparent is a unique experience and the current study added some novel contributions to stepfamily literature by finding some differences between groups of parents at baseline and overtime.

The first goal of this study was to examine baseline levels of individual mental health functioning in parents, stepparents, and combination parents/stepparents participating in CRE using indicators of stress, depressive symptoms, and anxious symptoms. I found that there were differences at baseline between stepmothers and combination mothers/stepmothers only, with stepmothers reporting higher depressive symptoms at baseline and only marginally significant differences between all three groups. Otherwise, there were no significant differences between each of the groups. The second goal was to examine for differences in change patterns over time between the three groups. I found one significant difference in change patterns for men on measures of stress, indicating that those who are stepfathers only did not experience the significant stress reduction that the others did. The third goal was to examine for a spillover of improvements in indicators of individual mental health functioning into self and partners' relationship/couple quality. While no cross-over spillover was evident between partners, I found some evidence of spillover for stepmothers' and stepfathers' own reports of change in relationship quality. For stepmothers, immediate reductions in stress between time 1 and time 2 predicted improvements in relationship quality at time 3, and for stepfathers, immediate

reductions in depressive symptoms between time 1 and time 2 predicted improvements in relationship quality at time 3. I discuss here the implications of these findings

H1: Baseline differences between parent groups.

Due to previous findings about individual mental health symptomology and stepparent status, I had reason to propose that baseline differences would arise between parents, stepparents, and combination parents/stepparents (Doodson & Davies, 2014; Shapiro, 2014; Shapiro and Stewart, 2011). My analyses revealed one significant difference between these parent groups at baseline. Baseline depressive symptoms were different between stepmothers and combination mothers/stepmothers only, with stepmothers reporting higher depressive symptoms at baseline. Although this finding is different from Doodson and Davies's (2014) finding that complex and simple stepmothers reported similar levels of depressive symptoms, a potential reason I explored for this difference is that stepparents in their study differed by residential status in addition to bioparent/stepparent (complex) vs. stepparent only (simple) status. Stewart's (2015) study comparing residential and nonresidential stepparents found higher depressive symptoms among non-residential stepparents. However, in my sample, 100% of those in the stepmother only group were residential and 88% of the combination mothers/stepmothers group were residential, so resident status does not explain this difference. Parent status remains the more likely explanation of this difference rather than residential status.

Stepmothers' higher depressive symptoms could be telling of additional challenges faced by stepmothers who are not also biological parents. In stepfamily literature there is a noted dynamic of "insider-outsider" status within stepfamilies, such that biological parents typically hold "insider" status between both their partner, the stepparent, and their child(ren), and stepparents typically hold "outsider" status with the child(ren), at least initially (Papernow,

2017). Outsider status presents inherent challenges, particularly if there is no simultaneous "insider" role held as a combination stepmother/biological mother and could have a direct effect on stepparent mental health and potentially explain higher depressive symptoms in stepmothers in this sample. From a Family Systems Theory perspective, one particular challenge of being an outsider is struggling to simultaneously feel supported by one's spouse and accepted by one's stepchild all within one family system. Stepmothers may feel reluctant to disclose their feelings of frustration with stepchildren to their partners and struggle with isolation. Feeling like an outsider is an inherently isolating experience, especially when feeling excluded from pre-existing parent-child subsystems, and feelings of loneliness are one of the items measured on the CES-D.

Although previous studies found evidence supporting stepparents having higher levels of stress and anxious symptoms than bio parents (Doodson & Davies, 2014; Shapiro, 2011), we did not find similar results in our sample of participants in CRE, with baseline levels of stress and anxious symptoms being similar across parent groups for both men and women. Men's depressive symptoms did not differ by parent group. An additional factor that was not examined in the analyses and that may lend more understanding to these findings is that this sample consisted of individuals reporting relatively lower resources overall. It is possible that level of resources rather than parent status could account for the similarities in individual mental health functioning across parent groups. In other words, economic strain across parent groups may contribute more to reports of mental health symptomology than parent status (Wadsworth et al., 2005). Future studies exploring the interaction of parent status and income are recommended.

While these results did not fully support Hypothesis 1 that there would be differences between these parent groups, an alternative view of the findings can be suggested from a strengths-based approach. It may be simply that stepparents are not disadvantaged in regards to

mental health symptomology and risks by virtue of being a stepparent and that other conditions and variables better predict mental health among parents. Finding that parents, stepparents, and combination parents/stepparents report similar levels of stress and anxious symptoms is an important piece in fighting the stigma associated with being a stepparent.

Scholars note the long-term approach to stepfamily research from a deficit perspective (Ganong & Coleman, 2017). The story depicted over various media for several years has been that stepparenting is overwhelmingly more difficult than being a first-parent. Several articles detail the "myth" associated with being a stepparent. Claxton-Oldfield's (2000) exploration into the cultural transmission of stepfamily myths framed overcoming the portrayal of stepparents as "wicked" as an additional challenge stepparents must face, describing how this myth is based in folklore and continuously propagated in popular media. Further, Miller and colleagues' (2018) study of stepparent perceptions of stereotypes found that a sample of stepmothers living in New Zealand reported a felt experience of the "wicked stepmother" stereotype by individuals both inside and outside of the stepfamily. Additionally, the study found that these stepmothers adaptively engaged in coping behaviors to minimize this stereotype's relevance. In a 2003 article seeking to minimize stigma against stepfamilies, Jones detailed the institutionalized privileging of nuclear families that often excludes stepparents, along with views of stepfamilies as "inferior" that are continuously reinforced by several factors. The article highlighted how micro-level stigmas, like the language used to describe stepfamilies as "reconstituted" or "blended," influence larger level family policy that paradoxically perpetuate the stigma against stepfamilies. Jones (2003) argued for promotion of "kinship ties" as a measure of family cohesion rather than "biology" as a means of combatting this stigma on both informal and institutional levels. These findings suggest that the modern context in which stepparents exist demonstrates more

acceptance or that the stigma of being a stepparent, at least, is not as severe as in previous generations.

While there are important differences in being a stepparent and a first-parent, and stepparents may endure a felt experience of stigma, my findings indicate this may not necessarily manifest in greater mental health symptomology. While the difference in depressive symptoms was found for women between those who are stepmothers only and those who are combination mothers/stepmothers, the mean levels are still relatively low (M=1.29; R=1.67) and the overwhelming evidence from the 3 indicators of mental health is no differences between parent groups. This is important information for potential stepparents, stepfamilies, policy makers, and practitioners and relationship educators working with stepfamilies. It appears that looking for other predictors of mental health functioning, in addition to parent status is warranted.

RQ1: Between group comparisons of change.

To understand whether parents, stepparents, and combination parents/stepparents benefit differently from CRE participation in levels of stress, depressive symptoms, and anxious symptoms, we examined changes in these outcomes over time. Similar to findings from the baseline comparisons, analyses for research question 2 showed no differences in change patterns over time except for one. Importantly, only one mental health indicator demonstrated significant change after program participation at the 6 month mark – stress reported by men. Further, the interaction effect clarifies that this was driven by the biological fathers and the combination father/stepfather groups who demonstrated change, while stepfathers did not. This finding suggests that fathers and combination fathers/stepfathers may receive different benefits from CRE participation than stepfathers only. This study is the first to examine change patterns for these indicators of individual mental health functioning in stepparents and combination

parents/stepparents and the first to find a significant difference in change patterns for stepfathers for reported stress.

Overall, however, the findings indicate no differences in change patterns for the groups and the main effects demonstrate no significant change in the other measures for men and any of the three measures for women at the 6 month mark. It is unclear why mental health indicators are not largely improved by the CRE experience in our sample. It could simply be a "floor" effect, in that the groups reported relatively low levels of symptomology at baseline and there is limited room for improvement. This is common in nonclinical samples (Kendall, P. C., Marrs-Garcia, A., Nath, S. R., & Sheldrick, R. C., 1999). Future research with a larger sample with more variability in mental health symptomology could yield different results. It is also possible that mental health indicators are not directly addressed enough in CRE.

Findings of general similarity between groups is consistent with a previous study that found support for individuals in first marriages and remarriages demonstrating similar change patterns after CRE participation (Lucier-Greer & Adler-Baeder, 2012). While these groups were separated as marital groups rather than parental status (i.e., a biological parent was categorized as part of the remarried group if married to a stepparent or individuals or couples may not have had children but one was married more than once), findings in the study may be considered complementary as expectations in that study also were for potential disadvantage of those in remarried couples. Our study refines these findings by more specifically documenting limited differences in the CRE experience on indicators of mental health for stepparents but does find a slight disadvantage in program effects on stress for stepfathers who are not also biological fathers. The difference in levels of stress may lie within the parenting domain rather than the

couple domain, with individuals who are stepparents rather than individuals who are remarried facing different stressors.

This finding is of note particularly since stepfathers have received little attention in stepfamily research and even less attention in CRE literature. Shapiro (2014) found support for stepfathers reporting higher stress than fathers only. While our finding was not that stepfathers experience higher stress, the finding was related to stepfathers experiencing no significant changes in stress levels through CRE participation. This finding could underscore a difference in needs or curricula from parents and combination parents/stepparents. There is reason to believe these results might look different in a stepfamily-specific CRE curriculum, with stepfathers benefitting more from a targeted program. Although this is in contradiction with Lucier Greer and colleagues' (2012) study that found first-married and remarried individuals benefitted similarly from stepfamily-specific CRE and general skills-based CRE, the fact that the groups were separated by marital status rather than parental status suggests this recommendation deserves further exploration. Jones (2003) details the many levels of exclusion stepparents may inherently experience, and exclusion within a CRE setting could be a possibility for stepfathers. Stepfathers may inherently feel excluded or disconnected from the facilitation and program contents if the curricula does not address them directly or acknowledge the different challenges they face from first parents, particularly if they are not also biological fathers. Adler-Baeder and Schramm (2010) describe a conceptual framework for designing CRE programs specific to stepfamilies and highlight the lack of studies comparing the experiences of stepcouples in general and stepfamily-specific CRE. It is suggested that the vicarious "normalization" that occurs through shared similar experiences with others is an important part of the CRE experience for stepcouples.

RQ2: Predictors of change in relationship quality.

Finally, to explore the potential for a spillover of effects for stepparents from change in mental health to change in relationship quality over time for oneself and crossover from stepparents' changes in individual mental health functioning into their partner's relationship quality within a sample of stepparents and combination parents/stepparents participating in CRE, we examined for relatedness among these variables. This element of the study is a novel addition to stepfamily literature for its examination of the concept of spillover within a stepparent and combination parent/stepparent population and the use of sequential rather than concurrent data. True process studies are virtually nonexistent in studies of CRE in general. Whereas I found no evidence of a crossover from stepparents' symptomology to their partner's experience of the relationship, analyses supported a spillover between stepparents' own symptomology after CRE participant and their relationship quality at 6 months. Both stepmothers' immediate decreases in stress and stepfathers' immediate decreases in depressive symptoms predicted their own improvements in relationship quality 6 months after participating in CRE curricula. These findings underscore the impact of individual mental health functioning on one's own experience of relationship, particularly for a sample of stepparents participating in CRE. This is particularly noteworthy since there were not significant improvements documented over time for depressive symptoms in men and stress for women; however, what change that did occur in these was related to later changes reported in relationship quality in cascade fashion.

These findings differ from Bradford and colleagues' (2014) documented significant spillover of depressed affect into partner's relationship quality; however, this is likely due to an important difference in selection criteria for the study. Whereas Bradford and colleagues' (2014) study selected a sample of relationally unstable couples, my sample consisted of parents and

stepparents in CRE who may or may not have reported relationship dissatisfaction at baseline. While previous studies do support stepcouples being at greater risk for relational dissolution (Ganong & Coleman, 2004) and this provides reason to presuppose that my sample would report similar levels of instability, this was not a variable I initially examined in my analyses. Post-hoc analyses revealed there were no differences at baseline on reports of relationship quality between the three parent groups, confirming this difference in my sample from Bradford and colleagues' (2014) study sample.

These findings present the possibility for a gender difference in individual mental health functioning. That men experienced improvements in relationship quality with reductions in depressive symptoms and that women with reductions in stress suggests symptomology could affect men and women differently. In men, depressive symptoms have been recorded as manifesting more frequently as withdrawal and aggression (Schudlich, Papp, & Cummings, 2004), while for women they tend to manifest more frequently as symptoms measured on the CES-D like sadness and low energy. This points to stress in women playing a large role in their enjoyment and perception of their intimate partner relationship. With men, perhaps the tendency to withdraw or anger more easily as depressive symptoms contributes to their enjoyment and perception of their intimate partner relationship when these symptoms improve. I did not examine for potential bidirectional relationships among each mental health indicator and relational health, and there is potential for different findings.

Limitations

This study aimed to highlight the needs stepparents present to CRE with and their experiences in CRE compared to parents. While this study adds many novel contributions to

stepfamily literature using 3 timepoints and a diverse sample of parents, limitations exist. First, the sample was derived from a larger sample of couples participating in CRE, so there is limited generalizability in the results to all stepparents. This sample may not be considered representative of all stepparents and combination parents/stepparents. In addition, the small sample size of stepparents compared to combination parents/stepparents was a limitation. While the proportion of the overall sample consisting of parents was large, the analyses lost statistical power when separating this parent population into smaller subgroups, so effects could be masked. Because the data were also collected from self-report measures, social desirability bias is a possibility, and the survey responses may not be completely reflective of accurate participant experiences. The sample is also low in LGBTQ+ diversity. Same-sex couples were excluded from the final research question due to the nature of the analyses, so the results on spillover in same-sex stepparent couples cannot be generalized to these populations. Finally, limited variability was found among the indicators of mental health functioning. A sample containing the three parent groups with more variability in mental health indicators may find more differences between groups.

Conclusions and Future Directions

This study presented relevant findings concerning how stepparents and combination parents/ stepparents participating in CRE compare to parents on indicators of individual mental health functioning, how they experience change over time, and whether a spillover of individual mental health functioning exists within stepcouple relationships. We find some indication of differences for stepmothers in baseline depression and change for stepfathers in stress. We also find that change in depressive symptoms for men and change in stress for women predicts their relationship quality six months later. Overall, however, we find more commonality among

parent groups at baseline and over time than differences. This study leaves several opportunities for further investigation into the links among parent status, individual mental health functioning, and CRE participation. First, this study needs to be replicated with a larger sample of stepparent participants to enhance variability and the power to detect differences if they exist. Additionally, we encourage future studies to continue to distinguish stepparents from combination parents/stepparents due to differences that arose and their distinct contexts as parents. We encourage the use of more complex models of predicting relationship quality that examine the interaction of parental status and other demographic and contextual conditions, such as economic strain. And we encourage the continued attention to multiple mental health indicators of participants in CRE and to the distinction of each owing to the established links with relationship functioning and the evidence found here for the links between shifts in mental indicators and improvements in relationship quality over time. Further, this study did not examine for a bidirectional relationship between mental health and relational health. A marital discord model perspective could be applied for further investigation of the effects of relational health on mental health (Beach, Sandeen, & O'Leary, 1990). These efforts will serve to inform both the CRE evaluation research base and practitioners offering CRE programming for diverse populations of couples.

Tables

Table 1. *Descriptive Statistics for Key Variables in Parents*

		Program Participants					
Variable		*N*	*M* (SD)	Min	Max	Skewness (SE)	Kurtosis (SE)
Stress	Time 1	365	2.78 (.72)	1	5	.30 (.13)	.22 (.26)
		277	**2.58 (.64)**	**1**	**4.9**	**.35 (.15)**	**.45 (.29)**
	Time 2	327	2.60 (.68)	1.1	4.5	.07 (.14)	-.32 (.27)
		237	**2.40 (.64)**	**1**	**4.5**	**.12 (.16)**	**-.27 (.31)**
	Time 3	290	2.59 (.68)	1	4.4	.03 (.14)	-.25 (.29)
		220	**2.44 (.64)**	**1**	**4.4**	**.06 (.16)**	**-.13 (.33)**
Depressive Symptoms	Time 1	363	0.67 (.83)	0	3	1.37 (.128)	1.09 (.26)
		276	**0.45 (.71)**	**0**	**3**	**1.88 (.15)**	**3.05 (.29)**
	Time 2	326	0.57 (.80)	0	3	1.56 (.14)	1.70 (.27)
		237	**0.39 (.68)**	**0**	**3**	**2.00 (.16)**	**3.56 (.32)**
	Time 3	288	0.53 (.77)	0	3	1.75 (.14)	2.53 (.29)
		220	**0.37 (.60)**	**0**	**3**	**1.93 (.16)**	**3.81 (.33)**
Anxious Symptoms	Time 1	364	0.97 (.83)	0	3	.89 (.13)	-.14 (.25)
		276	**0.69 (.73)**	**0**	**3**	**1.19 (.15)**	**.84 (.29)**
	Time 2	326	0.84 (.81)	0	3	.98 (.14)	.13 (.27)
		236	**0.60 (.71)**	**0**	**3**	**1.57 (.16)**	**2.19 (.32)**
	Time 3	290	0.79 (.80)	0	3	1.17 (.14)	.67 (.29)
		220	**0.58 (.69)**	**0**	**3**	**1.58 (.16)**	**2.43 (.33)**
Relationship Quality	Time 1	353	5.42 (1.41)	1	7	-.85 (.13)	.36 (.26)
		271	**5.63 (1.18)**	**1**	**7**	**-.81 (.15)**	**.73 (.30)**
	Time 2	320	5.63 (1.31)	1	7	-.96 (.14)	.68 (.27)
		237	**5.84 (1.09)**	**1**	**7**	**-1.07 (.16)**	**1.98 (.32)**
	Time 3	284	5.69 (1.34)	1	7	-1.10 (.15)	1.17 (.29)
		223	**5.82 (1.06)**	**1.33**	**7**	**-.77 (.16)**	**.67 (.32)**

Bold = men

Table 2. *Descriptive Statistics for Key Variables in Stepparents*

		Program Participants					
Variable		*N*	*M* (SD)	Min	Max	Skewness (SE)	Kurtosis (SE)
Stress	Time 1	4	2.65 (.93)	1.3	3.4	-1.67 (1.01)	3.11 (2.62)
		15	**2.42 (.75)**	**1.2**	**3.6**	**-.01 (.58)**	**-1.15 (1.12)**
	Time 2	4	2.79 (.28)	2.4	3	-1.29 (1.01)	.92 (2.62)
		12	**1.88 (.65)**	**1.1**	**3**	**.53 (.64)**	**-1.04 (1.23)**
	Time 3	4	2.93 (.30)	2.5	3.2	-1.38 (1.01)	2.60 (2.62)
		11	**2.33 (.66)**	**1.2**	**3.2**	**-.56 (.66)**	**-.46 (1.28)**
Depressive Symptoms	Time 1	4	0.50 (.79)	0	1.67	1.80 1.01	3.14 (2.62)
		15	**0.38 (.67)**	**0**	**2**	**1.72 (.58)**	**1.87 (1.12)**
	Time 2	4	0.42 (.50)	0	1	.37 (1.01)	-3.90 (2.62)
		12	**0.11 (.26)**	**0**	**0.67**	**2.06 (.64)**	**2.64 (1.23)**
	Time 3	4	0.5 (.58)	**0**	**1**	.00 (1.01)	-6.00 (2.62)
		11	**0.27 (.51)**	**0**	**1.67**	**2.39 (.66)**	**6.04 (1.28)**
Anxious Symptoms	Time 1	4	0.96 (1.42)	**0**	**3**	1.56 (1.01)	2.17 (2.62)
		15	**0.55 (.72)**	**0**	**2.14**	**1.45 (.58)**	**1.08 (1.12)**
	Time 2	4	1.07 (.66)	**0.43**	**2**	1.190 (1.01)	2.12 (2.62)
		12	**0.23 (.35)**	**0**	**1**	**1.68 (.64)**	**1.76 (1.22)**
	Time 3	4	0.79 (.58)	**0**	**1.29**	-1.09 (1.01)	.30 (2.62)
		11	**0.39 (.39)**	**0**	**1.14**	**.75 (.66)**	**-.50 (1.28)**
Relationship Quality	Time 1	4	6.25 (1.50)	**4**	**7**	-2.00 (1.01)	4.00 (2.62)
		14	**5.9 (.80)**	**4**	**7**	**-.82 (.60)**	**1.31 (1.15)**
	Time 2	4	6.33 (1.33)	**4.33**	**7**	-2.00 (1.01)	4.00 (2.62)
		12	**5.86 (.94)**	**4.33**	**7**	**-.43 (.64)**	**-.65 (1.23)**
	Time 3	4	5.00 (1.41)	**4**	**7**	1.41 (1.01)	1.50 (2.62)
		10	**5.57 (1.19)**	**3.33**	**7**	**-.54 (.69)**	**-.32 (1.33)**

Bold = men

Table 3. *Descriptive Statistics of Key Variables for Combination Parents/Stepparents*

		Program Participants					
Variable		*N*	*M* (SD)	Min	Max	Skewness (SE)	Kurtosis (SE)
Stress	Time 1	99	2.71 (.72)	1.2	4.5	.28 (.24)	-.25 (.48)
		112	**2.68 (.59)**	**1.6**	**4.4**	**.31 (23)**	**.20 (.45)**
	Time 2	88	2.43 (.68)	1.4	4.8	.90 (.26)	1.03 (.51)
		96	**2.46 (.64)**	**1**	**4.8**	**.62 (.25)**	**1.58 (.49)**
	Time 3	78	2.46 (.61)	1.2	3.9	.20 (.27)	-.31 (.54)
		83	**2.35 (.59)**	**1**	**3.8**	**-.11 (.26)**	**-.14 (.52)**
Depressive Symptoms	Time 1	99	0.63 (.82)	0	3	1.34 (.24)	1.12 (.48)
		111	**0.55 (.74)**	**0**	**3**	**1.67 (.23)**	**2.58 (.46)**
	Time 2	88	0.42 (.67)	0	3	1.82 (.26)	2.90 (.51)
		95	**0.47 (.78)**	**0**	**3**	**1.87 (.25)**	**2.68 (.49)**
	Time 3	78	0.47 (.73)	0	**3**	1.59 (.27)	1.64 (.54)
		83	**0.39 (.76)**	**0**	**3**	**2.45 (.26)**	**5.55 (.52)**
Anxious Symptoms	Time 1	99	0.89 (.85)	0	**3**	.93 (.24)	-.14 (.48)
		112	**0.72 (.76)**	**0**	**3**	**1.31 (.23)**	**1.33 (.45)**
	Time 2	88	0.64 (.74)	0	3	1.57 (.26)	2.03 (.51)
		96	**0.60 (.80)**	**0**	**2.86**	**1.50 (.25)**	**1.16 (.49)**
	Time 3	78	0.71 (.83)	0	3	1.20 (.27)	.48 (.54)
		83	**0.52 (.68)**	**0**	**3**	**1.78 (.26)**	**2.95 (.52)**
Relationship Quality	Time 1	97	5.62 (1.29)	1	7	-.99 (.25)	1.10 (.49)
		109	**5.47 (1.36)**	**1**	**7**	**-.79 (.23)**	**.17 (.46)**
	Time 2	87	5.79 (1.24)	2	7	-1.01 (.26)	.40 (.51)
		96	**5.79 (1.42)**	**1**	**7**	**-1.46 (.25)**	**2.01 (.49)**
	Time 3	76	5.93 (1.14)	1	7	-.86 (.28)	-.07 (.55)
		79	**5.74 (1.26)**	**1**	**7**	**-.99 (.27)**	**1.23 (.54)**

Bold = men

Table 4.

Differences at baseline between stepmothers and combination mothers/stepmothers

	Stepparents		Combination		
Variable	N	M (SD)	N	M (SD)	*F*
Stress	8	2.89 (.75)	139	2.75 (.72)	0.559
	22	**2.47 (.70)**	**145**	**2.62 (.64)**	**1.109**
Depressive Symptoms	8	1.29 (1.29)	139	.62 (.78)	5.231*
	22	**.33 (.61)**	**144**	**.52 (.70)**	**1.443**
Anxious Symptoms	8	1.21 (1.47)	139	.87 (.78)	0.285
	22	**.61 (.70)**	**145**	**.68 (.73)**	**0.312**
Relationship Quality	8	5.79 (1.41)	136	5.50 (1.37)	0.56
	21	**5.92 (.81)**	**141**	**5.48 (1.31)**	**0.14**

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

Bold=men

Table 5.

One Way ANOVAS of Stress, Depressive Symptoms, and Anxious Symptoms by Step vs. Combo

Variable	F	DF	P
Stress	0.278	1	0.559
	1.109	**1**	**0.294**
Depressive Symptoms	5.231	1	0.024*
	1.443	**1**	**0.231**
Anxious Symptoms	1.152	1	0.285
	0.22	**1**	**0.639**
Relationship Quality	0.34	1	0.56
	2.18	**1**	**0.14**

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

Bold=men

Table 6.

One Way ANOVAS of Stress, Depressive Symptoms, and Anxious Symptoms by Parent, Step, and Combo

Variable	F	DF	P
Stress	0.424	1	0.515
	0.077	**1**	**0.781**
Depressive Symptoms	2.585	2	0.076
	0.007	**1**	**0.934**
Anxious Symptoms	0.691	1	0.406
	0.312	**1**	**0.577**
Relationship Quality	1.01	1	0.75
	1.53	**1**	**0.22**

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

Bold=men

Table 7.

Time x Parent Status Group Interaction Effects and Main Effects

	Time x Parent Status			Main Effects		
Variable	F	DF	P	F	DF	P
Stress	1.042	1	0.354	0.609	1	0.792
	3.35	**1**	**0.036***	**4.447**	**1**	**.036***
Depressive Symptoms	0.075	1	0.928	0.166	1	0.684
	0.022	**1**	**0.978**	**0.142**	**1**	**0.707**
Anxious Symptoms	0.247	1	0.781	1.322	1	0.251
	0.017	**1**	**0.983**	**1.72**	**1**	**0.191**

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

Bold=men

Table 8.

Paired Sample T-Tests of Stress, Depressive Symptoms, and Anxious Symptoms for men

		Fathers			Stepfathers			Combination		
Variable		*M*	*SD*	*t*	*M*	*SD*	*t*	*M*	*SD*	*t*
Stress	Time 1	2.54	0.63	2.539*	2.35	0.77	0.127	2.63	0.59	4.056***
	Time 3	2.44	0.64		2.33	0.66		2.35	0.59	

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

Table 9.

Regression of Relationship Quality onto Stress, Depressive Symptoms, and Anxious Symptoms

	Partner					Self				
Variable	*B*	*SE B*	**β**	*t*	*p*	*B*	*SE B*	***β***	*t*	*p*
Stress	-0.332	0.424	-0.117	-0.782	0.44	-0.492	0.236	-0.213	-2.085	0.041*
	-0.405	**0.329**	**-0.189**	**-1.23**	**0.227**	**-0.09**	**0.232**	**-0.341**	**-2.745**	**0.7**
Depressive Symptoms	0.203	0.362	0.092	0.559	0.579	0.102	0.205	0.056	0.495	0.622
	-0.249	**0.222**	**-0.157**	**-1.125**	**0.268**	**-0.583**	**0.213**	**-0.042**	**-0.387**	**0.007****
Anxious Symptoms	0.177	0.482	0.064	0.366	0.716	0.243	0.191	0.146	1.27	0.208
	0.235	**0.317**	**0.107**	**0.742**	**0.463**	**-0.05**	**0.239**	**-0.026**	**-0.207**	**0.836**

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

Bold = men

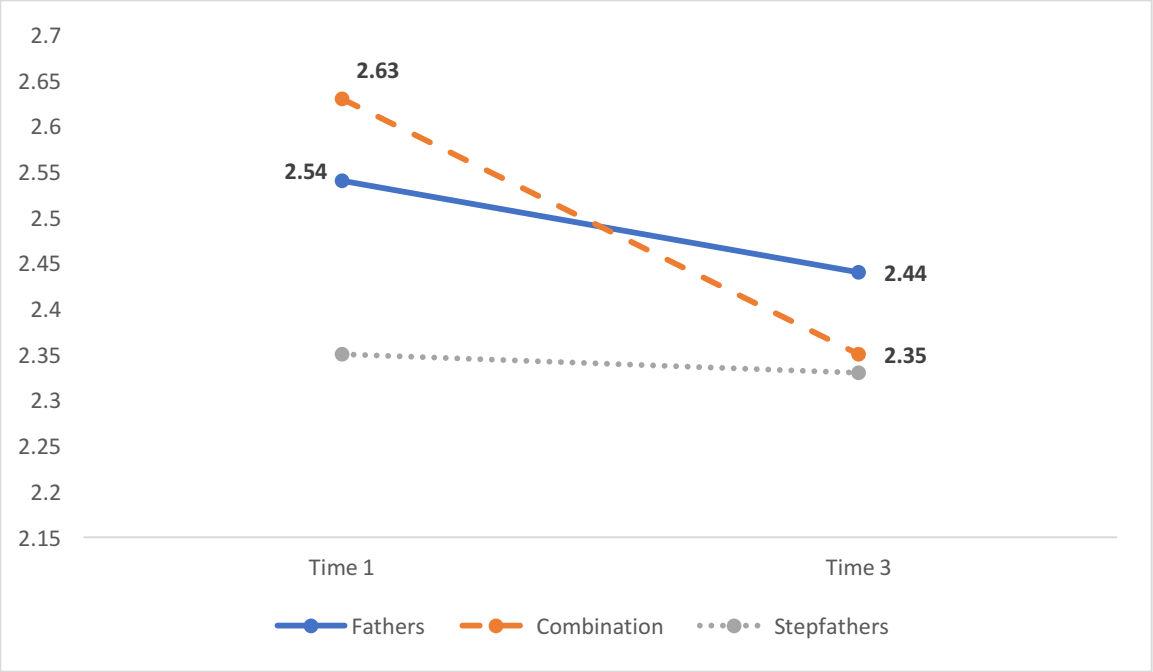

Figure 1. Means for men's stress from time 1 to time 3

References

Adler-Baeder, F., Calligas, A., Skuban, E., Keiley, M., Ketring, S., and Smith, T. (2013). Linking Changes in Couple Functioning and Parenting Among Couple Relationship Education Participants *Family Relations 62*, 284-297

Beach, S. R. H., & O'Leary, K. D. (1992). Treating depression in the context of maritaldiscord: Outcome and predictors of response of marital therapy versus cognitive therapy. Behavior Therapy, 23, 507–528.

Boss, P. (1992). Primacy of perception in family stress theory and measurement. *Journal of Family Psychology, 6*(2), 113-119.

Bradford, A.B., Adler-Baeder, F., Ketring, S. A., Bub, K. L., Pittman, J. F., & Smith, T. A. (2014). Relationship quality and depressed affect among a diverse sample of relationally unstable relationship education participants. *Family Relations, 63,* 219-231. DOI:10.1111/fare.12064

Bronfenbrenner, U. (1987). The Ecology of Human Development. Barcelona: Polity Press.

Cherlin, A. (2010). Demographic trends in the United States: A review of research in the 2000s. *Journal of Marriage and Family, 72*(3), 403-419. doi:10.1111/j.1741-3737.2010.00710.x.

Claxton-Oldfield, S. (2000). Deconstructing the myth of the wicked stepparent. *Marriage & Family Review*, *30*(1-2), 51-58. DOI: 10.1300/J002v30n01_04

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24*(4), 385-396. http://dx.doi.org/10.2307/2136404

Cooper, E. Individual Mental Health and Couple Functioning: Exploring Changes among Couple Relationship Education Participant Outcomes (2018)

Doodson, L. J. & Davies, A. P. C. (2014). Different challenges, different well-being: A comparison of psychological well-being across stepmothers and biological mothers and across four categories of stepmothers, *Journal of Divorce & Remarriage, 55*(1), 49-63. DOI: 10.1080/10502556.2013.862094

Eaton, W. W., Smith, C., Ybarra, M., Muntaner, C., & Tien, A. (2004). Center for Epidemiologic Studies Depression Scale: Review and Revision (CESD and CESD-R). In M. E. Maruish (Ed.), The use of psychological testing for treatment planning and outcomes assessment: Instruments for adults (pp. 363-377). Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers.

Favez, N., Widmer, E., Doan, M.-T., & Tissot, H. (2015). Coparenting in Stepfamilies: Maternal Promotion of Family Cohesiveness with Partner and with Father. Journal of Child & Family Studies, 24(11), 3268–3278. https://doi.org/10.1007/s10826-015-0130-x

Futris, T. & Adler-Baeder, F. (Eds.). (2014). The National Extension Relationship and Marriage Education Model. National Extension Relationship and Marriage Education Network. University of Georgia Extension. http://www.nermen.org/NERMEM.php

Futris, T., Adler-Baeder, F. et al., (2014). ELEVATE: Taking Your Relationship to the Next Level. 8-module curriculum. Leader guide, facilitation and implementation guide, power points, handouts, background materials, videos. http://www.nermen.org/ELEVATE.php

Ganong, L.H., & Coleman, M. (2004). *Stepfamily relationships: Development, dynamics, and interventions*. New York, NY: Springer US

Ganong, L.H., & Coleman, M. (2017). Studying stepfamilies: Four eras of family scholarship. *Family Process, 57*(1), 7-24. doi: 10.1111/famp.12307

Garneau, C. L. & Adler-Baeder, F. (2015). Changes in stepparents' coparenting and parenting

following participation in a community-based relationship education program. *Family Process, 54*(4), 590-599. doi: 10.1111/famp.12133

Hawkins, A. J., Blanchard, V. L., Baldwin, S. A., & Fawcett, E. B. (2008). Does marriage and relationship education work? A meta-analytic study. *Journal of Consulting and Clinical Psychology, 76*(5), 723-734. DOI: 10.1037/a0012584

Hetherington, M. E. (1999). Family Functioning in nonstepfamilies and different kinds of stepfamilies: An integration Malden, MA : Blackwell Publishers, Inc., 1999.

Jensen, T. M., Lippold, M. A., Mills, K. R., & Fosco, G. M. (2018). Stepfamily Relationship Quality and Children's Internalizing and Externalizing Problems. *Family Process, 57*(2), 477–495. https://doi.org/10.1111/famp.12284

Jones, A. C. (2003). Reconstructing the Stepfamily: Old Myths, New Stories. *Social Work, 48*(2), 228-236. 10.1093/sw/48.2.228

Kendall, P. C., Marrs-Garcia, A., Nath, S. R., & Sheldrick, R. C. (1999). Normative comparisons for the evaluation of clinical significance. *Journal of Consulting and Clinical Psychology, 67*(3), 285-299. http://dx.doi.org/10.1037/0022-006X.67.3.285

Lucier-Greer, M., Adler-Baeder, F., Harcourt, K. T., & Gregson, K. D. (2014) Relationship education for stepcouples reporting relationship instability - evaluation of the *Smart Steps: Embrace the Journey* curriculum. *Journal of Marital and Family Therapy 40*(4), 454-469. doi: 10.1111/jmft.12069

Lucier-Greer, M., & Adler-Baeder, F. (2012). Does Couple and Relationship Education Work for Individuals in Stepfamilies? A Meta-analytic Study. Family Relations, 61(5), 756–769. https://doi.org/10.1111/j.1741-3729.2012.00728.x.

Lucier-Greer, M., Adler-Baeder, F., Ketring, S. A., Harcourt, K. T., & Smith, T. (2012). Comparing the Experiences of Couples in First Marriages and Remarriages in Couple and Relationship Education. Journal of Divorce & Remarriage, 53(1), 55–75. https://doi.org/10.1080/10502556.2012.635970

McGill, J., Ketring, S., & Adler-Baeder, F. (2015) Couples Connecting Mindfully: A Couple Relationship Education Program

Miller, A., Cartwright, C., and Gibson, K. (2018) Stepmothers' perceptions and experiences of the wicked stepmother stereotype. *Journal of Family Issues*, *39*(7), 1984-2006. DOI: 10.1177/0192513X17739049

Norton, R. (1983). Measuring marital quality: A critical look at the dependent variable. *Journal of Marriage and the Family, 45*(1), 141–152.

Papernow, P. L. (2017) Clinical guidelines for working with stepfamilies: What family, couple, individual, and child therapists need to know. *Family Process, 57*(1), 25-51. https://doi.org/10.1111/famp.12321

Parker, K. (2011). A portrait of stepfamilies. Pew Social & Demographic Trends. Retrieved from http://www.pewocialtrends.org/2011/01/13/a-portrait-of-stepfamilies/

Pew Research Center. (2015). The American family today [Data file and code book]. Retrieved from http://www.pewsocialtrends.org/2015/12/17/1-the-american-family-today/

Radloff L.S., (1977) The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*(3), 385-401. https://doi.org/10.1177/014662167700100306

Schudlich, T. R., Papp, L. M., & Cummings, E. M. (2004). Relations of Husbands' and Wives' Dysphoria to Marital Conflict Resolution Strategies. *Journal of Family Psychology, 18*(1), 171-183. doi:10.1037/0893-3200.18.1.171

Schumm, W. R., Paff-Bergen, L. A., Hatch, R., Obiorah, F. C., Copeland, J. M., Meens, L. D., & Bugaighis, M. A. (1986). Concurrant and discriminant validity of the Kansas Marital Satisfaction Scale. *Journal of Marriage and the Family, 48*, 381–387.

Shapiro, D. N. & Stewart, A. J. (2011). Parenting stress, perceived child regard, and depressive symptoms among stepmothers and biological mothers. *Family Relations, 60*, 533-544. DOI:10.1111/j.1741-3729.2011.00665.x

Shapiro, D. (2014) Stepparents and parenting stress: The roles of gender, marital quality, and views about gender roles *Family Process. 53 (1),* 97-108. DOI: 10.1111/famp.12062

Skogrand, L., Dansie, L., Higginbotham, B. J., Davis, P., & Barrios-Bell, A. (2011). Benefits of stepfamily education: One-year post-program. Marriage & Family Review, 47(3), 149–163. https://doi.org/10.1080/01494929.2011.571634

Spitzer, R.L., Kroenke, K., Williams, J.B., & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166(10), 1092-7. DOI: 10.1001/archinte.166.10.1092

Stewart, S. C. Exploring the Influence of Residential Status of Stepparents on Program Effects of Couple and Relationship Education (2015)

Sweeney, M. M. (2010) Remarriage and stepfamilies: strategic sites for family scholarship in the 21st century. *Journal of Marriage and Family, 72*, 667-684. DOI:10.1111/j.1741-3737.2010.00724.x

U.S. Census Bureau. (2011, May). *Number, Timing, and Duration of Marriages and Divorces: 2009* (Report No. P70-125). Retrieved from https://www.census.gov/prod/2011pubs/p70-125.pdf

Wadsworth, M. E., Raviv, T., Compas, B. E., and Connor-Smith, J. K. (2005) Parent and adolescent responses to poverty-related stress: Tests of mediated and moderated coping models. *Journal of Child and Family Studies, 14* (2), 283-298. DOI: 10.1007/s10826-005-5056-2

Wheaton, B. (1990). Life transitions, role histories, and mental health. *American Sociological Review, 55*(2), 209-223. Retrieved from http://www.jstor.org/stable/2095627

Zigmond, A. S., & Snaith, R. P. (1983). The Hospital Anxiety and Depression Scale. Acta Psychiatrica Scandinavica, 67, 361–370.