Knowledge of stepfamily culture and interventions: a look at the qualifications and characteristics of mental health professionals

Angela M. Thiesen

Iowa State University

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Knowledge of stepfamily culture and interventions: A look at the qualifications and characteristics of mental health professionals

by

Angela M. Thiesen

A thesis submitted to the graduate faculty

in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

Major: Human Development and Family Studies (Marriage and Family Therapy)

Program of Study Committee:
Marcia L. Michaels, Major Professor
Ron Werner-Wilson
Doug Bonett

Iowa State University
Ames, Iowa
2003
This is to certify that the master’s thesis of

Angela M. Thiesen

has met the thesis requirements of Iowa State University

Signatures have been redacted for privacy
TABLE OF CONTENTS

ACKNOWLEDGMENTS

ABSTRACT

INTRODUCTION

LITERATURE REVIEW

Unique Challenges
- Ambiguity of Roles
- Lack of Social Norms
- Boundary Ambiguity
- Loyalty Conflicts
- Unrealistic Expectations
- Alliances/Coalitions
- Lack of Shared History
- The Couple Relationship

Systemically Thinking about Stepfamilies
- Difference in Structure
- Systems Orientation
- Developmental Perspective

Clinical Recommendations
- Interventions
  - Normalizing and Validating
  - Education
  - Focus on the Couple Relationship
  - Re-defining Expectations
  - Grieving Loss
  - Clarifying Roles and Boundaries
  - Loyalty Conflicts
  - Identifying and Clarifying Problems
  - Flexibility versus Cohesion

Conclusion

METHODS
- Participants
- Instruments
- Procedure
- Analysis

RESULTS

DISCUSSION
- Limitations
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implications</td>
<td>57</td>
</tr>
<tr>
<td>APPENDIX A. SURVEY ON STEPFAMILY CULTURE AND PRACTICE</td>
<td>59</td>
</tr>
<tr>
<td>APPENDIX B. COVER LETTERS</td>
<td>68</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>72</td>
</tr>
</tbody>
</table>
I would like to express sincere thanks to all those individuals who have helped to make the completion of my Master's degree possible. I would like to say thank you to my major professor Dr. Marcia Michaels and my committee members Dr. Ron Werner-Wilson and Dr. Doug Bonett for their time, guidance, and knowledge. The completion of my thesis would not have been possible without you!

Special thanks to my wonderful mother and my amazing husband. To my mother, Thank you for planting the seeds of determination, aspiration, and love of knowledge. You taught me that anything is possible, not only through your words but through example. For this, I thank you. To my husband, Thank you for your encouraging words and unrelenting support through this journey. You have been my inspiration and my pillar of strength. You have sacrificed so that I could follow my dreams, and for this I thank you.
ABSTRACT

Based on the clinical and empirical literature it was hypothesized that mental health professionals who have training in systems theory and training specific to stepfamilies would be more knowledgeable in the areas of appropriate interventions and stepfamily culture. In addition, years of clinical experience and clinical practice with stepfamilies were assessed for their contribution to both knowledge of appropriate interventions and knowledge of stepfamily culture. The sample in this study consisted of 118 mental health professionals from three groups (Iowa Licensed Marriage and Family Therapists, Iowa Licensed Mental Health Counselors, and Stepfamily Association Affiliate Members located throughout the United States). Analysis of variance revealed that Stepfamily Association Affiliate Members were more knowledgeable in both stepfamily culture and appropriate interventions than other mental health professionals. Stepwise multiple regression analysis revealed that training specific to stepfamilies was the only variable predictive of both knowledge of stepfamily culture and knowledge of appropriate interventions. Implications and limitations of this study are discussed.
INTRODUCTION

Stepfamilies are rapidly becoming the most prevalent family form. In fact, it has been suggested that 33% of all children will live in a stepfamily before the age of 18, and stepfamilies will be the majority family form by the year 2010 (Visher, Visher, & Pasley, 1997). Thus, family therapists and other mental health professionals are bound to be dealing with these families in their daily practice. In fact, both the clinical and empirical literature overwhelmingly suggests that the therapist’s knowledge of stepfamilies is a major key to successful stepfamily therapy (Pasley, Dollahite, & Ihinger-Tallman, 1993; Pasley, Rhoden, Visher & Visher, 1996; Preston, 1984; Visher & Visher, 1991). Thus, in order for the professional to provide quality and effective interventions with stepfamilies they must be aware of the literature and the recommendations it offers for working with this type of family form (Pasley, Dollahite, & Ihinger-Tallman, 1993).

Stepfamilies are different from other family forms in both structure and the challenges that they face, as such, the literature suggests that the professional needs to have a thorough understanding of these differences before attempting therapy with this family type. The differences in structure, and challenges between nuclear and stepfamilies have been clearly stated in both the clinical and empirical literature and include, but are not limited to, the following: ambiguity of roles, lack of social norms, boundary ambiguity, loyalty conflicts, unrealistic expectations (Huntley & Carlson, 1995; Pasley, Dollahite, & Ihinger-Tallman, 1993; Visher, Visher & Pasley, 1997), alliances/coalitions (Visher & Visher, 1982), lack of shared history, lack of time for the couple to form a relationship (Papernow, 1993), and an increasingly complex family system (Preston, 1984; Visher & Visher, 1991). Accordingly, the literature suggests that a lack of knowledge and understanding of these differences make
professionals vulnerable to the mistaken belief that these family forms are identical to nuclear family forms. This lack of knowledge and mistaken assumptions can have detrimental effects on these families. Visher, Visher, and Pasley (1997) believe that these professionals may be unaware that they are not familiar with “stepfamily culture” and thus their picture of a “family” leads them to use the nuclear model rather than asking the needed questions and accepting, in a nonjudgmental manner, the answers provided. Visher and Visher (1982) state that the pervasive belief that this type of family form is the same as a biological or nuclear family leads to unrealistic and unattainable expectations, goals, and interventions that result in more pain and stress for those involved. The clinical literature also argues that the professional treat and view these families systemically (Berger, 1998; Preston, 1984; Visher & Visher, 1988) in order to provide the best possible treatment to this type of family form.

In light of the unique structure and challenges faced by stepfamilies, the clinical and empirical literature has provided strategies that are beneficial in treating them. While the literature categorizes these strategies differently they fundamentally include, but are not limited to, the following: normalizing (Burt & Burt, 1996; Papernow, 1993; Pasley, Dollahite, & Ihinger-Tallman, 1993; Visher, Visher, & Pasley, 1997), validating, education (Burt & Burt, 1996; Papernow, 1993; Visher, Visher, & Pasley, 1997), focusing on the couple relationship (Pasley, Dollahite, & Ihinger-Tallman, 1993; Visher, Visher, & Pasley, 1997), re-defining expectations (Burt & Burt, 1996; Huntley & Carlson, 1995; Papernow, 1993; Pasley, Dollahite, & Ihinger-Tallman, 1993; Visher, Visher, & Pasley, 1997), clarifying roles (Burt & Burt, 1996; Huntley & Carlson, 1995; Pasley, Dollahite, & Ihinger-Tallman, 1993; Visher, Visher, & Pasley, 1997), clarifying boundaries, (Huntley & Carlson, 1995; Pasley, Dollahite, & Ihinger-Tallman, 1993), grieving loss (Burt & Burt, 1996; Papernow, 1993;
Pasley, Dollahite, & Ihinger-Tallman, 1993), loyalty conflicts (Huntley & Carlson, 1995; Pasley et. al., 1993), identifying and clarifying problems (Burt & Burt, 1996; Pasley, Dollahite, & Ihinger-Tallman, 1993; Visher, Visher, & Pasley, 1997), and flexibility versus cohesion (Pasley, Dollahite, & Ihinger-Tallman, 1993).

These therapeutic strategies that have been recommended by both clinicians and researchers should be utilized with an understanding of the stepfamily process of development. Perhaps the most well known and accepted process of development in regards to the stepfamily is that which was outlined by Patricia Papernow. Based on her clinical work, Papernow (1993) identified the following developmental stages through which stepfamilies progress: Fantasy, Immersion, Awareness, Mobilization, Action, Contact, and Resolution. Papernow (1993) suggests that the therapist must have an understanding of these developmental stages in order to provide the most appropriate intervention strategies and goals. Papernow (1993) also suggests that the professional not only be knowledgeable about the stages but also knowledgeable in regards to the range of time each of these stages takes to complete. A lack of understanding and knowledge will lend to therapeutic failure.

The clinical and empirical literature has identified common issues these families face in becoming a stepfamily, as well as strategies found to be helpful in working with these family forms. In addition, it has been made abundantly clear that the professional’s knowledge of these family forms is absolutely crucial to the therapeutic process. There is, however, a lack of empirical data on several key recommendations. That is, it is not known how much professionals really know about dealing with the different structures and unique challenges these families face. It is also unknown whether professionals are aware of the appropriate therapeutic strategies to be utilized when working with stepfamilies. There has
been no research exploring the characteristics of the therapist, such as, years of doing therapy, amount of experience in working with this family form, or special training and how that may impact their success with stepfamilies (Pasley, Rhoden, Visher, & Visher, 1996). Finally, the empirical literature is very limited in regards to exploring the validity of the recommendations that the therapist be knowledgeable in “stepfamily culture” and that the therapist treat these families using a systems orientation. Therefore, this study will test the following hypotheses: 1) Stepfamily Association of America Affiliate Members and Licensed Marriage and Family Therapists will have more knowledge of stepfamily culture (i.e., the unique challenges, structures, and developmental processes that stepfamilies experience) than Licensed Mental Health Counselors. Since Stepfamily Association of America Affiliate Members have specialized training in working with stepfamilies it is expected that they will have more knowledge because of this training. Since Licensed Marriage and Family Therapists have training in systems theory it is expected that this training will lead to a greater understanding of stepfamily culture. 2) Stepfamily Association of America Affiliate Members and Licensed Marriage and Family Therapists will have a greater knowledge of appropriate interventions than Licensed Mental Health Counselors. Since Stepfamily Association of America Affiliate Members have specialized training in working with stepfamilies it is expected that they will have more knowledge because of this training. Since Licensed Marriage and Family Therapists have training in systems theory it is expected that this training will lead to a greater understanding of appropriate interventions. In addition, this study will: 3) Examine the qualities of the mental health professionals in this study that may be the best predictors of knowledge of stepfamily culture. The predictors include: specialized training in working with stepfamilies, systems training, percentage of stepfamilies seen in the
professionals clinical practice, and years of clinical experience. 4) Examine the qualities of the mental health professionals in this study that may be the best predictors of knowledge of appropriate interventions. The predictors include: specialized training in working with stepfamilies, systems training, percentage of stepfamilies as clients in clinical practice, and years of clinical experience.
LITERATURE REVIEW

The literature was reviewed to gain an understanding of the stepfamily form. This was done so that an adequate and informed understanding could be gained of the difference in structure, unique challenges, and the process that this type of family encounters. It was also done so that knowledge could be gained in regards to the recommended ways of treating this family form. While we know that the stepfamily structure differs from other family forms, are aware of unique challenges, have a general sense of what characteristics the therapist should possess, and have recommendations, both clinical and empirical, of how to appropriately intervene with these stepfamilies, it is still unclear and unstudied whether the general professional is aware of all of these components. In addition, it is suggested that the therapists knowledge of the stepfamily form and the therapists ability to view this family form systemically is important to the success of treatment. However, it is still unclear what role these components play in the therapists ability to successfully treat this family form. Thus, through this review of the literature one can begin to develop a way in which to ask the question of whether professionals are qualified to work with this family form. In this research the empirical and clinical literature will be examined to explore what we know about the unique challenges faced by this family form. Systems theory will be discussed along with the process and structure of this family form. Finally, the clinical recommendations will be examined.

Unique Challenges

Stepfamilies are inherently different from that of the intact nuclear family and the single-parent family for the simple fact that they differ in structure. However, these families also differ from each other in their family configurations. While each stepfamily is different
from the next, there are common challenges that are unique to the stepfamily form. Based on clinical experience, Preston (1984) states that it is crucial for therapists who work with these families to be aware of, and knowledgeable of, this complex structure and the unique challenges that arise as a result. It is also important to know that while these family forms do face unique challenges because of their differing structure they are not destined to function in a dysfunctional manner as the literature has previously suggested (Coleman, Fine, Ganong, Downs, & Pauk, 2001).

**Ambiguity of Roles**

The ambiguity of roles that all members of this family form experience is just one indicator of the complexity of this family form. The roles in which each family member plays in a biological family is more clearly defined. The expectations, rights, and responsibilities each member of the biological family form anticipates is simply less complex than that of the stepfamily form. Pasley, Rhoden, Visher, and Visher (1996) state that the inherent complex structure of this family form serve to create the ambiguity of roles experienced within the stepfamily. In fact, after examining responses from 267 adults who sought out therapy because of stepfamily issues, they found that the primary concerns expressed by respondents at the initiation of therapy were stepfamily functioning, and parenting and stepparenting; the latter of which includes confusion about the stepparent role. Findings also suggest that the most common challenge resulting from ambiguity of roles was disciplining of the child(ren). Similar findings were found in a qualitative study by Golish (2003). This study consisted of face-to-face and phone interviews of 90 family members from 30 stepfamilies. The purpose of this study was to examine the communication strategies that differentiate strong stepfamilies from those experiencing more difficulties. Strong stepfamilies were those in
which all members of the stepfamily reported that they had a strong stepfamily. Stepfamilies experiencing more difficulty were those in which at least one of the members of the stepfamily reported a negative experience, and thus, did not indicate that they had a strong stepfamily. This was based on the systems perspective, which states that if one family member has negative feelings about the family, the family as a whole is influenced. Golish (2003) found from this qualitative study that ambiguity of roles was a familiar challenge to this type of family form. In fact, ambiguity of roles was identified as a problem in both strong stepfamilies and stepfamilies experiencing more difficulty; with 100 percent of the strong stepfamilies reporting ambiguity of roles and 88 percent of the stepfamilies experiencing difficulty reporting ambiguity of roles.

Role ambiguity is not only an issue for the adults involved, children can also experience this confusing issue. Obtaining stepsiblings through their parents remarriage can, in turn, change the child’s status in the family and thus lead to confusion. Pasley et al. (1993) gives the example of a first-born becoming a middle child in the sibling hierarchy after the remarriage, resulting in a less defined, less clear, sibling hierarchy. Thus, the child’s sense of where and how they fit into this new family becomes unclear.

Lack of Social Norms

The ambiguity in regards to the stepparent role is compounded by the fact that there seems to be no social expectations or rules for the role of stepmother or stepfather. In fact, Booth and Edwards (1992) completed a national study of 2,033 married persons 55 years and younger who were interviewed by telephone in 1980, 1983, and again in 1988. Cases were coded in which both partners were in their first marriage, one person was in a remarriage, or both were in a remarriage. This study looked at specific factors that may contribute to the
instability of second marriages, and concluded that one of the reasons that remarriages are more fragile than first-time marriages is because they lack social support and clear norms to follow. Based on recent reviews of the literature, Fine and Kurdek (1994) also report that part of the stress that many stepparents face is caused by the lack of clear norms in regards to what is proper behavior in stepfamilies. This should not be surprising given that society still views the biological family as the ideal and stepfamilies as, at the very least, less than desirable.

Given that society does not have clear expectations of what a stepparent should be, the stepparent is left to depend on what society does tell us about parenting. In fact, after interviewing 20 stepfamilies, Kelley (1995) found that stepmothers often fall prey to the societal expectation of them taking the mother role, and thus, that of the nurturer and caregiver. "...this expectation comes from men and women alike, who have been raised to see the woman's role chiefly as mother and nurturer. In a stepfamily, however, this expectation sets the woman up for failure" (p. 30). Kelley also reports that stepmothers are not the only ones who fall prey to these societal expectations. Stepfathers are also exposed to societal views. The traditional view of the father as the disciplinarian becomes the guide for stepfathers to follow.

**Boundary Ambiguity**

The sense of where and how one fits into this new family is compounded by what is often referred to as boundary ambiguity. Boundary ambiguity can surround the family as a whole or the subsystems within the family. These boundaries that exist between households and between individuals within these households are more complex than those of nuclear families (Crosbie-Burnett, & Ahrons, 1985). Unlike the more impermeable boundaries of an
intact nuclear family, stepfamily forms must experience permeable boundaries in order to facilitate the exchange of children, money, decision making, custody, visitation, and resources (Coleman, Fine, Gangong, Downs, & Pauk, 2001; Crosbie-Burnett, & Ahrons, 1985). For example, it is not uncommon for a child in the steppfamily to have membership in two households which decreases the clarity of boundaries and thus increases boundary ambiguity for the child and adults involved (Pasley, 1987). In fact, Pasley (1987) found that an increase in the complexity of structure of the family also tended to lead to an increase in boundary ambiguity. This study consisted of 272 remarried couples, who were categorized into six types of remarried families. The types of remarried families ranged from simple to complex. The simplest remarried family type was defined as a husband and wife with common children. The most complex remarried family type was defined as a husband, wife, both with children of their own and common children. In the simplest family form only 5 percent experienced high boundary ambiguity. The families with stepchildren ranged from 24 percent to 77 percent who experienced high boundary ambiguity.

Stepfamilies often struggle with forming these new boundaries which can result in overly rigid or overly permeable boundaries, both of which can lead to such issues as coalitions both within the family system and across boundary lines (Preston, 1984). Golish (2003) found evidence of this in her qualitative study. This study consisted of both phone and face-to-face interviews with 90 family members from 30 stepfamilies. Golish found that 64 percent of the strong stepfamilies and 81 percent of the families having difficulties reported experiencing boundary ambiguity. Golish reported that the boundary ambiguity these families faced involved relationships between the children's biological parents homes and between children and their stepparents. A study by Coleman et. al. (2001) consisted of 34 adults and
24 children from 17 families and looked at perceived conflicts and resolution strategies in stepfamilies. They found that the conflicts identified were diverse (i.e., conflicts over resources, loyalty conflicts, conflict with extended family) but that family boundaries were at the root of most disagreements.

**Loyalty Conflicts**

The boundary ambiguity that these family forms experience often leads to problems such as loyalty conflicts and feelings of guilt. While the very structure of the stepfamily form sets the stage for loyalty conflicts, this issue is heightened and made more intense when the relationship between parents and former spouses is unfriendly (Pasley et al., 1996). A hostile relationship between former spouses often occurs when one or both parents attempt to triangle the child, thus, once again increasing the problem of loyalty conflicts. This is especially stressful to adolescents (Pasley, Dollahite, & Ihinger-Tallman, 1993). Based on their readings of the clinical literature Ihinger-Tallman & Pasley (1987) suggest that from a child’s view, the remarriage of their parent not only ends hope that their parents will reunite but also introduces loyalty conflicts particularly if they experience the stepparent in a positive manner. In fact, Bray and Harvey (1995) also report from their review of the clinical and empirical literature that children may act out or even withdraw after visitation with their biological parent because of loyalty conflicts. The qualitative research conducted by Golish (2003) supports the above statements. After data analysis of the 1,015 single-spaced pages of transcribed data gathered from interviews, Golish reported that a common theme was “feeling caught.” While both adults and children reported feeling caught it was most often reported by the children in the stepfamily. In addition, it was found that children in families having difficulties were more likely to report “feeling caught” than children in families that were not
experiencing difficulties. Most often these children reported feeling caught between their custodial and non-custodial parent.

However, children are not the only ones to experience loyalty conflicts. Clingempeel, Colyar, and Hetherington (1994) suggest that biological parents also experience conflicting loyalties. The experience of conflicting loyalties for biological parents is a result of feeling torn between commitment to their new partner and commitment to their biological children. The question they ask themselves is “Am I supposed to be a wife/husband first or a mother/father first?” Crosbie-Burnett and Ahrons (1985) discuss this in terms of “role overload,” stating that the biological parent often feels caught in the middle when their spouse’s needs conflict with their children’s needs. In addition, the parent can also feel torn between their biological children and their stepchildren (Clingempeel, Colyar, & Hetherington, 1994). This study by Clingempeel et al. (1994) also demonstrates the impact of loyalty conflicts in regard to the stepfather experience. This study consisted of a subset of the data collected in Hetherington and Clingempeel’s (1992) longitudinal study. The sample included 26 Caucasian, middle-class stepfather families. These stepfather families were interviewed in their homes at 4 months and 17 months following their remarriage. During the in-home interviews both the stepfathers and their spouses independently completed questionnaires and participated in structured and unstructured family interaction tasks which were video taped. One of the findings suggests that more intense loyalty conflicts were associated with a greater likelihood of stepfathers experiencing negative emotions, accusations by family members of favoritism, and higher dissatisfaction with relationships with their biological children.
Unrealistic Expectations

Many people enter into the stepfamily using the biological family form as the model for how to operate as a stepfamily. Based on her clinical experience, Papernow (1993) states many evaluate parenting with a biological parenting model, and then utilize this model to determine what is to be expected, and to gauge what is right and proper between stepparents and children. Papernow also states that when fantasies or expectations give way, usually within the first four years of remarriage, the family may feel like they have failed again. Stress and frustration can increase significantly during this time.

Based on published literature and observations Papernow (1993) and Crosbie-Burnett and Ahrons (1985) identify six unrealistic expectations often held by parents and stepparents. One, the biological parent looks to the new spouse to relieve the demands of being a single parent. Two, the parent views the formation of this new family form as the second chance to get it right. Three, the expectation is held that everyday living in this newly formed family will be similar to that of an intact family. Four, the parent believes that their child will love, or at least grow to love, their stepparent and see what a wonderful person they are. Five, the stepparent expects to come in and rescue their new partner and children and then expects to be appreciated for doing so only to later find that some members do not desire and even resent the attempt to rescue. Finally, many stepparents often expect to love their stepchildren as if they were their own and when this does not happen, they feel guilty. Fine, Lawrence, and Kurdek (1994) also discuss “low expectations” stating that the stereotypes of the wicked stepmother, the abusive stepfather, and the neglected stepchild may play a role in family interactions by impacting the families thoughts of what a stepfamily is. In fact, a meta-analysis of 26 studies published during the period of 1978-1989 on family structure
stereotypes found that people perceive stepfamily roles, particularly the stepparent role, more negatively than similar positions in intact families (Ganong, Coleman, & Mapes, 1990). These low expectations may negatively affect family interaction by influencing family members' thoughts about stepfamily life, possibly leading to low expectations, and thus, a sort of self-fulfilling prophecy.

Findings from a study by Pasley, Rhoden, Visher, and Visher (1996) are indicative of the experience of unrealistic expectations by this family form. Of the 267 adults involved in this study, 73 percent of the sample sought out therapy within the first three years of their remarriage. The first three years is a time when Papernow (1993) suggests that fantasies and expectations may collapse. Thus, families come to the realization that their family will be different than they had expected.

Alliances/Coalitions

Stepfamilies are typically formed after experiencing the single-parent form for some time. Whether this occurs during the course of a "bad marriage" or after the marriage has ended, there may be alliances and coalitions already formed due to the structure of the single-parent family. Crosbie-Burnett and Ahrons (1985) report that members of the single-parent family become extremely cohesive because they have shared especially difficult times. Because of this intense cohesiveness, new stepparents often report difficulty in becoming a part of and feeling accepted into the pre-established biological parent-child relationship. This often results in the stepparent feeling like an outsider. It is no mystery that these stepparents feel like outsiders as they are entering into a preformed family with its own culture, set of norms, and ways of doing things. Visher and Visher (1982) also discuss the challenge of alliances and coalitions, reporting that the parent-child relationship that has been
previously established often leads to insiders and outsiders with all struggling for positions and power within the newly formed family.

Compounding this issue is that biological parents feel loyalty to their children and a strong desire to protect them from any further hurt or loss. The clinical literature suggests that the biological parent can play a pivotal role in bridging the gap between insiders and outsiders (Crosbie-Burnett & Ahrons, 1985). However, parental figures are not the only ones to experience the outsider position. The outsider position can also be experienced by the children of the family. Preston (1984) suggests, from his clinical work, that when this occurs the child often establishes a coalition with the non-custodial biological parent. The coalition established can be against the custodial biological parent, the new stepparent, or both.

These clinical observations are supported by Golish’s (2003) qualitative study which examined communication strategies of strong stepfamilies and those experiencing difficulty. Golish found that 63 percent of mothers and daughters in stepfamilies experiencing difficulties formed such a cohesive bond postdivorce that the daughter became a peer and confidant to the mother. The shift in power (from child to peer) became problematic when the stepparent entered the family and assumed the power position that was once held by the child. The same was true of strong stepfamilies with 57 percent experiencing the same situation.

**Lack of Shared History**

The clinical literature also suggests that a common and unique challenge to this type of family form is lack of shared history and/or middle ground (Papernow, 1993; Visher & Visher, 1982). These families come together with pre-established cultures, traditions, rituals, and ways of functioning. To complicate matters, the formation of a stepfamily often brings together persons of various ages in various stages of development with differing
backgrounds. Each member of the family brings ideas of how the family should operate. Thus, the problem is that there is no agreement, partially because there is a lack of shared history and middle ground (Visher & Visher, 1982). As Papernow (1993) states when these families come together each brings "...its own separate history and its own shared rhythms, rules, and ways of operating, built over years of connection and often intensified in the single-parent stage" (p. 51). Pasley, Rhoden, Visher and Visher (1996) report that the middle ground (the area of common experience and understanding) enables a family to know each other, to function more easily and cooperatively, and offers a sort of sanctuary. The new stepfamily form lacks this shared history and middle ground. Family members come with pre-made ideas of how a family should function ranging from when the dishes should be done to how to handle conflict. In new stepfamilies the middle ground is strongest between the biological parent and his or her children so it contributes to the already mentioned loyalty conflicts, alliances and coalitions, and ambiguous boundaries. The fact that these families come together with differing backgrounds and lack of middle ground not only calls for tolerance of differences but emphasizes the need to gain history and middle ground for the new family. As Visher and Visher (1979) state while the nuclear family develops slowly with continuous compensation and negotiation of individual differences, the stepfamily experiences these differences much more abruptly creating not only additional differences but additional stress as well. The importance of a shared middle ground is demonstrated in Golishs' (2003) qualitative study. After examining the transcripts of the interviews Golish found that 93 percent of strong stepfamilies participated in creating a common ground compared to only 50 percent of the stepfamilies experiencing difficulties.
The couple relationship also presents a unique challenge to these family forms. In these families the normal adjustment period is lacking. This normal adjustment period consists of gradual changes in the family’s development such as the honeymoon period, children being born, and then slowly developing and maturing as a family unit. Instead, the couple encounters instant chaos with little or no chance to adjust as a couple before children are brought into the family (Visher & Visher, 1982). The couple has little time to focus on the couple relationship as they must also focus on the relationships of this newly formed family. Visher (1994) reports, based on clinical experience, that this is the relationship of greatest importance to the development and integration of the stepfamily and must be given time to develop. Papernow (1993) reports that the couple relationship is of great importance, noting that this is the relationship that others depend on for stability, and should be given individual time away from other members of the family. She also makes clear that it is important that this is not done at the expense of the adult-child relationships. The couple relationship obviously presents a challenge to this family form as it becomes a balancing act between the happiness of the couple relationship and the good of the family.

In summary, both the clinical and empirical literature have provided ample evidence of the unique challenges faced by stepfamilies. It is not clear, however, that the professionals working with this family form are aware of these unique challenges. It is not clear because there has been no research inquiring about the professionals knowledge of the unique challenges identified by the literature. Therefore, one purpose of this study is to examine the professionals level of knowledge.
Systemically Thinking about Stepfamilies

It should now be clear that stepfamilies differ in many ways from other family forms. Stepfamilies not only differ in the challenges that they face but they also differ in structure, and in the process of developing as a family. The complex structure of the stepfamily along with the unique developmental process that stepfamilies experience has led many to argue for a systemic way of thinking when working with this family form, as well as, a developmental perspective unique to this family form. This section discusses the complex structure of the stepfamily, the benefits and reasoning behind utilizing systems thinking when working with stepfamilies, and the unique developmental process that has been proposed in helping one understand the process that this family form travels through.

Difference in Structure

The literature, both clinical and empirical, provides clear evidence that stepfamilies differ from nuclear and single-parent families in that their structures are fundamentally different and more complex. For example, Berger (1998) argues that the structure is more complex because: stepfamilies are composed of two previously separate families, they include children who belong to two households, they consist of multiple parental figures, they consist of numerous relationships, and there is a collection of full-time and part-time family members. Just the number of interactions these families encounter are far greater than what family members of an intact nuclear family experience. For example, a nuclear family with two parents, two children, and four grandparents have a total of 28 interactional pairs and a total of 247 possible interactional groupings as opposed to an astonishing 136 interactional pairs and a total of 131,054 possible interactional groupings, that would occur, if this same couple divorces and only one of the spouses remarries and does not produce any children in
the new relationship (Visher & Visher, 1979). Compounding this already complex structure are differences in divorce and custody arrangements, leading stepfamilies to contain a variety of subsystems and relationships (Berger, 1998).

The structure is so complex that some have allocated specific terms to discuss it. For example, Visher and Visher (1988, 1982) refers to this complexity of structure as the “suprafamily system” and speak of a family forest rather than a family tree. Preston (1984) and Sager et. al., (1981) refer to the family as a “meta-family.” All of which are an attempt to convey the importance of viewing the system as a whole. Berger (1998) suggests that experts advocate working with the whole stepfamily as a unit which includes all relevant members such as: biological parents, stepparents, half and stepsiblings, all types of grandparents, and those members of the family who do not reside in the home such as children who only visit on weekends.

It is obvious that the suprasystem involves a much more complex set of relationships than that of a first-time or nuclear family form. This very structure creates different experiences from that of the nuclear family form (Papernow, 1993). Papernow (1993) suggests that therapists and families who attempt to function as if they are separate and can ignore the presence and influence of the non-custodial parent are neglecting the fact that the children are part of two households. In fact, the research suggests that the relationship between the custodial and non-custodial parent is critical in the development of the child (Crossbie-Burnett & Ahrons, 1985). It is important, when working with this type of family, to be aware of these characteristics so that one does not misinterpret them as dysfunctional (Papernow, 1993).
Based on the stepfamilies complex structure and set of relationships clinical recommendations have largely suggested that the therapist think systemically when working with this family form. Visher and Visher (1991) believe, because of the complexity of structure, that the therapist must be required to think in terms of the supra-family system in order to successfully treat this family form. Bray (1995) also suggests that a systems orientation in treating stepfamilies is useful. Bray states that this approach allows the therapist to understand the multiple family systems and subsystems involved and the interactional processes that produce both positive and negative experiences. In addition, a systems view allows for a better understanding of the interaction between the developmental changes and the unique challenges of this family form which can produce a complex set of relationships.

While Kelley (1996) states that some modifications should be made, she also suggests that a systems perspective is useful when working with stepfamilies. Kelley states that the idea of problems resulting from interactions between people and between people and their environment is useful when working with stepfamilies. Kelley further states that many of the systems theory concepts are beneficial when working with stepfamilies. Systems concepts discussed by Kelly are: an emphasis in looking for and pointing out of strengths, the view that problems are intertwined in behavioral patterns and can be interrupted, and the life-cycle view of families.

Pasley, Rhoden, Visher, and Visher (1996) suggest that most clinicians suggest helping stepfamilies view themselves from a family systems perspective because it provides a useful framework for understanding that each individuals needs, emotions, and behaviors
affect all other members of the family system. Thus, this family form is more likely to consider the perspective of other family members and then reciprocal influences can be explored. This suggests that the therapist herself need be informed in regards to systems theory. However, as O'Connor, Hetherington, and Clingempeel (1997) point out, that while systems theory is extensively cited in the clinical and developmental research for understanding family relationship influences, there has been no research to affirm these suggestions. In addition, there has been no research done to suggest that knowledge of systems theory is any more beneficial when working with stepfamilies. Therefore, one purpose of this study is to examine if training in systems theory does, in fact, play a role in the professionals preparedness in working with this family form.

**Developmental Perspective**

As previously stated, the stepfamily developmental process is unique from other family forms. As such some have put forth ways in which to view this unique developmental process. While the literature differs in the names and number of stages that this family form must pass through in order to become a stepfamily it is consistent in stating that it is a process that differs from other family forms. Based on clinical experience, Preston (1984) laid out those differences identifying the development of nuclear, single-parent, and stepfamily forms. Preston identified the developmental stages of the stepfamily form as: de facto relationship, secondary feelings of grief for the first family, remarriage, restructuring family roles and function, and re-divorce.

While Preston (1984) did not discuss the time it takes to progress through these stages, others (Fine, Kurdek 1994; Papernow,1993) have provided more definitive time frames. Fine and Kurdek (1994) break their model of stepfamily adjustment down into five
phases in which they report can take up to a total of 12 years to complete. These developmental stages are as follows: dating and courtship, cohabitation (if it occurs), early remarriage, middle remarriage, and late remarriage.

Based on her clinical work, Papernow (1993) breaks down the stepfamily cycle of development into seven stages and states that the average family takes seven years to complete the entire cycle, with faster families completing it in four years and slower families in twelve. While there seems to be several developmental models in regards to the stepfamily process of integration, Papernow's model is the most widely cited and discussed throughout the literature. It also appears to be the most in depth as it includes aspects of these other models as well as aspects that are unique. Papernow (1993) identifies the major stages in the stepfamily development cycle as Early, Middle, and Late. The Early Stage of stepfamily development includes the individual stages of fantasy, immersion, and awareness; the Middle Stage of family development includes the individual stages of mobilization and action; and Late Stage of family development includes the individual stages of contact and resolution. Papernow states that faster families complete the Early Stage in about a year, with average families taking two to three years, and slower moving and stuck families remaining in the Early Stage for four or more years. In regards to the Middle Stage, faster families take about a year or two to complete this stage, with the average-paced families taking about two or three years to complete, and slower or stuck families either breaking apart or retreating back to the Early Stage. In regards to the Late Stage, Papernow suggests that all families complete this stage in about one to two years. Following is a description of the seven stages of individual development which are embedded within and interact with the three stages of stepfamily development.
During the fantasy stage members may still be grieving over loss created by death or divorce. Biological parents may be hoping for a new spouse who will be a better husband and/or wife and parent than their previous partner. The biological parent may also believe that adding another parent will ease the burden of being a single parent. Stepparents hope to provide what had been missing and to be appreciated for it. Both adults may hope and think that since they love each other and want to be married that the children will also want this. In contrast, children often continue to have a powerful and enduring investment in seeing their parents back together again or at the very least reclaim their exclusive relationship they once had with the single parent, thus they fantasize about the family that used to be.

In the immersion stage the reality of the stepfamily structure begins to become evident. The stepparent may experience such feelings as: jealousy, resentment, confusion, and inadequacy. The biological parent may, in turn, interpret the stepparents feelings as an unwillingness to commit to the family. However, the biological parent may be somewhat less uncomfortable at this stage as he or she can seek support from his or her children. During this stage members of the new family begin to have a sense that something is wrong but are not sure what it is.

Stepfamily members may start to make sense out of this confusion during the awareness stage. For example, stepparents may start to put names to their painful feelings, and there begins to be a greater understanding in regards to the power of the biological parent-child bond. Thus, stepparents are able to see that their feelings are not unjustified but rather a result of being in the role of the outsider. As the stepparent becomes clearer about his or her feelings as an outsider, the biological parent begins to feel the stress of the insider position. The insider position creates a sense of feeling caught between his or her biological


children and his or her partner. The members of this family form now begin to relinquish their fantasies of an instant family. Papernow (1993) states that the developmental tasks of the awareness stage are: dealing with the reality of the early stepfamily experience without giving up, start to identify and understand the challenges the stepfamily structure creates for all members of the family, and relinquish fantasies of how the family should be.

The mobilization stage is often a chaotic and intense stage. In this stage the family begins to communicate the differences between step and biological family members needs. While Papernow (1993) reports that the stepparent feels some relief now that they have voiced their feelings, the biological parent begins to feel more pressure as they feel torn between the needs of their partner and that of their children. Papernow (1993) states that while arguments seem trivial they are most likely about “...whether the biological subsystem will be able to meet its needs for some stability and continuity after a series of losses and changes, or whether the steppeople in the family will be able to generate enough change to make themselves comfortable” (p. 15).

In the action stage negotiation of new agreements about how the family will function take place. The decisions of this stage will actually change the family structure as boundaries are drawn around the step relationships in the family. In this stage the stepfamily form is able to begin to function without constant attention to step issues as the struggle between insiders and outsiders decrease.

In the contact stage the family finally has areas of agreement which allows them to function with more ease. Due to the decisions and behaviors in the action stage, triangulation has faded and made way for one-to-one relationships. The children have been removed from the marital relationship and the biological parents from the stepparent-stepchild relationship.
The stepparent role finally becomes defined as the structural changes are made allowing the marital relationship to be utilized as a haven even in regards to step issues. The family is finally allowed to experience a honeymoon like period.

In the resolution stage the family has developed solid and reliable step relationships, norms have been established, and there has now been several years together allowing for a common history to form. Members of the family are clear about their roles and the position of insiders and outsiders. However, Papernow does state that the family continues to deal with loss, step issues do continue to arise, and the family may re-cycle through the stages particularly during stressful events. Papernow (1993) also states that just as a biological family does not move through developmental stages in a neat and orderly fashion neither do these family forms. For example, this family form may develop in one area but fail to progress in others. Stepfamilies may be able to openly communicate their concerns, needs, and wants and still be grasping onto such fantasies as a second chance to get it right.

The literature strongly suggests that in order for the professional to successfully intervene and treat stepfamilies the professional must possess an understanding of the unique developmental process of this family form, as well as the ability to view stepfamilies from a systemic orientation. However, there is no empirical support for these recommendations. Thus, this study will attempt to discover the validity of these recommendations, by examining the professionals knowledge of the developmental process and by determining if therapists trained in the systems approach are more prepared to intervene and treat stepfamilies.

**Clinical Recommendations**

The clinical literature is abundant with recommendations in how to best intervene when working with stepfamilies and while some of the recommendations have been
supported by empirical research others have not. This section will discuss the clinical recommendations and the supporting empirical research where available. A brief overview in regards to the recommended ways of intervening with stepfamilies will be offered followed by a discussion of specific interventions.

**Interventions**

Both the clinical and empirical literature agree that it is crucial that the professional posses an understanding for what is normal for stepfamilies and be aware that it is unrealistic to assess this family type by standards used for non-stepfamilies (Berger, 1998). In fact, Pasley et al. (1996) found that the most unhelpful aspect of therapy from the clients perspective was the therapists lack of understanding and knowledge about stepfamilies. Papernow (1995) suggests that an accurate assessment of this type of family form requires the professional to attend to both step and clinical dynamics, which involves both separating and weaving together these dynamics.

In order to understand and then be able to successfully intervene, Papernow (1995) suggests that the professional be knowledgeable of the following dimensions: the structural challenges that this type of family form must face, and a sense of where this particular family is in the developmental process. An understanding of the stepfamily structure and the pattern of development will allow the professional to ask the appropriate questions during assessment (Papernow, 1995). Without an understanding of these dimensions, common to the stepfamily form, the professional may treat these normal dilemmas as dysfunctional which can have disastrous results and cause unneeded pain and stress for all members involved (Papernow, 1995; Visher & Visher, 1982).
There has been empirical research in regards to what stepfamily members consider most beneficial to them and for their family in terms of interventions used by the professional. For example, Pasley et. al., (1996) found the following to be ranked as most beneficial to these family forms: affective support, clarification of issues, and the therapy process and structure. Also reported was what members of this family form found to be unhelpful in therapy. Pasley et. al. found that most of the respondents felt that the professional’s lack of training, skill, and knowledge about stepfamily issues was the least helpful in the therapy process. This suggests that there is a need for professionals who wish to work with this type of family to seek out training specific to the unique experiences of the stepfamily form and ways in which to treat them successfully.

Based on her clinical experience Papernow (1993) suggests that the developmental stage of the stepfamily should influence the therapeutic approach. She suggests that depending on the stage the family is currently in, certain strategies are more beneficial in helping the family progress through the remaining stages of integration. For example, she recommends that in the early stages interventions should focus on: drawing attention to longings for something that cannot be, providing information in order to place fantasies in perspective and normalize feelings, explore losses involved in giving up fantasies and provide empathetic support for the necessary grief work. In the middle stages she suggests such interventions as: providing feedback on what the family is doing well, providing empathy for both the insider and outsider positions, helping the family to slow down and listen to each other, looking for unexpressed losses or family of origin issues, helping members recognize that there experiences differ from one another even in regards to the same event, and teaching problem solving and communication skills. In the later stages she
suggests such interventions as: helping families normalize regression and place challenges in the context of sound stepfamily ties, and assess level of completion of awareness tasks and if necessary complete earlier stage tasks for this issue.

Both the empirical and clinical literature have provided strong recommendations on the types of interventions that seem to be most beneficial to stepfamilies. These interventions include the following but are not limited to: normalizing and validating of feelings and experiences, education, focusing early interventions on the couple relationship, re-defining expectations, resolving grief over loss and change, clarifying roles and boundaries, resolving loyalty conflicts, identifying and clarifying problems, and increasing family flexibility rather than family cohesion (Pasley, Dollahite, & Ihinger-Tallman, 1993; Pasley, Rhoden, Visher & Visher, 1996).

Overall, the literature recommends that the professional help stepfamilies understand the differences between the stepfamily and the nuclear family form, as well as the unique challenges that the stepfamily form encounters. The literature also strongly emphasizes that learning about the structure unique to this family form is integral to achieving stepfamily integration (Papernow, 1993; Visher & Visher, 1979, 1988). Thus, the professional must be knowledgeable of these differences and unique challenges and ways of successfully intervening.

**Normalizing and Validating.** It is here that an understanding and knowledge of the stepfamily form is so important. Without knowledge of the empirical and clinical literature it is impossible for the professional to normalize and validate the clients feelings and experiences which has been reported to be of utmost importance in implementing successful treatment to this family form (Pasley, Dollahite, & Ihinger-Tallman, 1993). Burt and Burt
(1996) report, from their clinical work, that many couples find normalization of the stepfamily process to relieve and decrease stress and tension dramatically. They go on to state that the members of this family form find that the issues and challenges they are struggling with are common and expected when normalized and validated by the professional. One scenario a professional might encounter is a new stepmother who expected to feel appreciated for her efforts of taking care of the children, but instead felt hurt and angry when she was not; particularly when her spouse failed to recognize her efforts. The professional should inform the stepmother that what she is experiencing is normal and that her feelings are valid and that the adjustment takes longer than a few months; in fact, it can take years.

The professional must also be aware and make the family aware that what is considered normal in a nuclear family is not always so in the stepfamily form. Burt and Burt (1996) state that, as professionals, we must give the fundamental message that what they are experiencing is normal and a healthy part of becoming a stepfamily. Thus, in order to assist clients in tolerating this discomfort the professional must utilize the basic interventions of validating and normalizing the stepfamily’s experiences and feelings. In fact, Visher and Visher (1991) suggest, based upon years of clinical experience, that in order for this family form to reach internal validation, they must receive external validation and normalization. Visher and Visher further state that this validation and normalization can easily come from the professional because of their relationship with the family. Visher and Visher also offer the following ways in which the professional can provide this support: accepting and empathizing with the feelings that occur in stepfamilies, and emphasizing the viability and positive values of stepfamilies.
In fact, Pasley, Rhoden, Visher, and Vishers' (1996) study provides support for the clinical recommendations. Pasley et al. found that 21.9 percent of 267 stepfamily members receiving therapy stated that affective support was the most helpful aspect of their therapeutic experience. Those who identified affective support as most beneficial were frequently referring to validation of feelings (33.9%), gaining a sense of control (39.7%), and gaining a sense of acceptance (25.6%). As an example, respondents remarked that realizing their feelings were normal was a great relief and restored their feelings of self-esteem. In addition, a study completed by Michaels (2000) also supports these clinical recommendations. Michaels study consisted of eight remarried couples participating in a group stepfamily enrichment program. Results from interviews found that participants, by listening to other stepfamily experiences, became aware of how similar their situation was to others, and thus, made them feel normal.

**Educating.** Many clinicians (Burt and Burt, 1996; Papenow, 1993) also advocate that the professional utilize referral of reading material. Visher and Visher (1991) state that books can be a helpful tool to stepfamilies as they help them learn about the stepfamily form, and thus gain insight into their experiences. As such, they suggest bibliotherapy as an effective therapy intervention.

A study done by Pasley et. al. (1996) reported that clients found the following educational information the most helpful: information on the time it will take to feel like a family, clarification about stepparent roles, advice to move slowly, and information about the biological parents feeling of being trapped in the middle. Since many members in this family form do not themselves know or understand what is to be expected during the course of forming this new family, information and education can be very helpful.
The intervention of education can also be a useful tool in administering other recommended interventions. For example, Visher, Visher, and Pasley (1997) report that education can clarify issues, validate feelings and normalize experiences, aid members of the family to become more realistic in regards to their expectations, and can reduce the sense of helplessness by providing information and suggestions for ways to deal with the challenges unique to stepfamilies.

**Focus on the Couple Relationship.** The clinical literature often recommends that the couple relationship be of primary focus (Papernow, 1993; Visher & Visher, 1985) in the early stages of therapy. By focusing on the couple relationship the couple will be able to build a stronger sense of cohesion and a strong parental front. The couple must be encouraged to spend time developing their couple relationship by spending time together, getting to know one another, emotionally bond, discuss issues and concerns, and develop a satisfactory relationship (Pasley et. al., 1993; Visher & Visher, 1985). By developing a strong marital relationship a strong parental relationship will be allowed to develop.

This is of importance as the relationship bond between the parent and their biological children is often stronger than that of the couple because of the longer duration of the biological parent-child relationship. Pasley et. al. (1993) reported that coalitions between the parent and their biological child, if continued, can cause harm to the parental dyad and result in children taking on parental responsibilities.

Because these families are often fragile at the time of seeking therapy, and the bonds along biological lines are stronger than between the couple, working with the entire family can be damaging (Pasley et. al., 1996; Visher & Visher 1991). Until the couple relationship is a solid one, the family itself may be in jeopardy as it is often the glue that holds the family
together and maintains its stability (Visher & Visher, 1985). Thus, Visher and Visher (1991) suggest that a good couple bond be developed or already exist before other members of the system are involved in the therapeutic process. The professional can help the couple understand the importance of developing a healthy couple relationship by pointing out that this relationship means stability for the household and can serve as a model for their child's future relationships. Once the couple grasps how the couple bond can positively influence the children, it often allows the couple to focus on their relationship without feelings of guilt. In fact, Golish's (2003) study found that “strong” stepfamilies compared to stepfamilies experiencing more difficulties are more likely to protect the image of the other parent in front of the children. Results from Golish's study showed that 71 percent of the strong families practiced “image protecting” compared to only 19 percent of the families experiencing difficulties.

**Re-defining Expectations.** Often members of these family forms believe that this family is going to or should function like that of the biological family form. Pasley et. al., (1996) suggest that an awareness that the stepfamily is different than that of a biological family can aid family members in developing realistic expectations, allowing them to explore alternative ways of looking at roles, defining rules, and adopting new rituals. In fact, clinicians suggest that realistic, achievable, and meaningful expectations become therapeutic goals and lead the therapeutic process (Papernow, 1993; Visher, Visher, & Pasley, 1997). These clinical recommendations are strengthened by the research completed by Kelley (1992). This study consisted of 83 individuals in 20 stepfamilies. The study focused on healthy stepfamily functioning and was qualitative in nature. Findings showed that higher-functioning stepfamilies avoided forcing their families into the biological model.
The unrealistic expectations that members of these families often hold can lead to stress and frustration when these expectations are not fulfilled. In fact, Pasley et al. (1993) recommends that professionals encourage members of this family form to explore the expectations they have for themselves, their spouse, their children and stepchildren in order to increase role clarity. Visher, Visher, and Pasley (1997) also make the suggestion that helping these families re-define their expectations can be a source of relief. In fact, a participant in Visher, Visher, and Pasleys' 1997 study stated: "She (therapist) helped me re-define my definition of success in terms of being a good stepmother. I was trying to be Maria in the Sound of Music. This put so much pressure on me I was constantly stressed. I've changed my expectations of myself and them—and this has helped a lot." (p. 205). Thus, once again it is important for the professional to be knowledgeable of the typical dynamics, challenges, and structures of this type of family form. Without such knowledge the therapist would be unable to help these families re-define and recognize any unrealistic expectations that may be held.

**Grieving Loss.** The members of this family form have experienced significant losses. The losses may come in the form of actual relationships, time with significant others, resources, or dreams and expectations of what the past family could have been. Children often experience multiple losses such as the loss of an exclusive relationship with their residential parent, the loss of hope that their parents will reconcile, the loss of their place in the family system, loss of friends and perhaps the place in which they have lived their entire lives (Pasley et al., 1996; Visher & Visher, 1985). Based on their clinical experience, Visher and Visher (1991) state that children's grief and anger over their losses often show up in the
form of: withdrawal, a decrease in academic performance, acting out behavior, and poor social relationships. Thus, children are often brought into therapy as the identified patient.

While the adults losses may be cushioned by the euphoric feelings of a new marriage (Visher & Visher, 1985), adults must also identify and deal with loss. For example, adults in stepfamilies must deal with the loss of the first marriage, and the expectations of creating the ideal family (Pasley et al., 1996). Whatever the source and magnitude of the loss it causes grief and sorrow for all involved and must be dealt with so that the new family form can move through the developmental process successfully. Pasley et al. (1996) states that the stepfamily’s ability to develop successfully often depends on their ability to resolve unresolved issues from the past; otherwise, issues can reemerge in the new family.

The clinical literature does offer suggestions to the professional for helping members of this family form deal with their loss, and thus, sense of grief. Visher and Visher (1985) state that the professional can help the children deal with their losses by: helping them stay out of their biological parents disagreements, encouraging them to talk about their feelings rather than acting them out, helping them identify things they can control and letting go of things they cannot, and working with the couple so that they can aid the children in this process. Visher and Visher (1985) suggest that the couple can help the children by: gaining an understanding that the biological parent and stepparent will react to the child differently, being able to accept the child’s angry feelings, developing a parental team, and working with the other household so that the children can experience a smooth transition between the households.

Pasley et al. (1993) also suggests that the professional make time during the therapeutic process for family members to explore issues around any unresolved grief. Citing
that adults may have yet to complete the process of emotional divorce which can lead to lingering attachment to the ex-spouse, and additional stress for the newly married couple. In addition, she suggests that the professional reframe the divorce so that the adult can move toward a more positive perception of the divorce. Pasley et. al. (1993) also suggests that the professional be sensitive to the parent who may have lost a residential relationship with a child. This parent often experiences feelings of alienation from their biological child and may experience concern and guilt in regards to both their biological and stepchildren. Pasley et. al. (1993) suggests that if this pain is ignored, and thus, not identified the pain and grief experienced can lead to anger and aggression.

**Clarifying Roles and Boundaries.** The complex structure of this type of family form often leaves the members to face ambiguous roles and boundaries. Pasley et. al.(1996) reports that not only do clear boundaries need to exist between the new family and the previous family but that these same boundaries must be permeable enough to allow a relationship between the children and the non-residential parent. Thus, these boundaries must allow such activities as: co-parenting, movement of the children between households, and other needed resources such as money and decision making; all of which needs to take place without intruding on the newly formed family. Visher (1985) makes the clinical suggestion that the professional provide “sympathetic counseling” so that the family can understand the complex nature of their new family structure, work on changing issues in which they have control, and stop attempts to control the other household. Visher also suggests that the children’s adjustment to movement between households is more successful if the differences in rules and expectations between households are clearly stated and the children are given time to adjust during times of transition. In addition, Pasley et. al. (1996)
report that when boundaries are not clearly defined and prior relationship issues are not
resolved intrusion from the non-residential parent is more likely, and thus, increases loyalty
conflicts for the children.

The literature also discusses the lack of role clarity within the stepfamily form. In
fact, Pasley et. al. (1996) reported, as a result of empirical research, that one of the most
common concerns of these family forms, at the initiation of therapy, is that of role confusion,
particularly the role of stepparenting and parenting. These concerns involved such things as
the rights and responsibilities of the stepparent, limit setting, and discipline. While these
concerns were often reported in terms of children’s academic and behavior problems, and
behaviors of the former spouse, they were ultimately found to be issues of role confusion.

Pasley et. al. (1993) suggest that early assessment of the stepparent-stepchild
relationship and the way in which the spouses support one another on this issue is critical in
the initial phase of therapy with this type of family form. In fact, they suggest that the
relationship between that of the stepparent and stepchild is an important determinant of
marital quality. In order to assess the nature of this relationship the professional can discuss
the expectations each member holds in regards to parenting behavior and also discuss how
this relationship is viewed by each member of the family (Pasley et. al., 1993).

The importance of the stepparent-stepchild relationship was demonstrated in a 1984
study by Crosbie-Burnett. This study compared the importance of the marital relationship
versus the step relationship in predicting family happiness. The self-reported cognitions,
emotions, and behaviors of each individual family member in 87 mother-stepfather
households with one or two adolescent children were assessed through questionnaires.
Multiple regression analysis indicated that satisfaction with the stepparent-stepchild
relationship is more central to family happiness than is satisfaction with the marital relationship. The importance of this relationship was also demonstrated by Orleans, Palisi, and Caddel (1989). This study consisted of 60 stepfather families in which the stepfather completed a mailed questionnaire. Dependent variables consisted of marital adjustment and marital happiness. Independent variables included negative feelings, negative acts, and participation with stepchild(ren). Correlation coefficients indicated that negative acts and negative feelings between the stepfather and the stepchildren had negative affects on marital adjustment, and participation between the stepfathers and stepchildren were positively correlated with both marital adjustment and marital happiness. However, this was a correlational study and thus cause and effect can not be determined.

The clinical literature also provides many suggestions in regards to how the stepparent and parent can successfully parent and discipline the children. Overwhelmingly the literature suggests that the stepparent move into the parenting role very slowly and that the biological parent be primarily responsible for parenting and discipline (Papernow 1993; Pasley et. al. 1993; Visher, & Visher 1991). In fact, Visher and Visher, (1991) state that the stepparent may never take on this role especially if the children are adolescents at the time of remarriage.

Specific suggestions have been identified in the literature for biological and stepparents to make the transition to parenting easier, and also to clarify the stepparent role. One suggestion for stepparents is to begin the process by simply entering the family as a sort of “monitor of behavior” (Papernow 1993; Pasley et. al. 1993; Visher, & Visher 1991). That is, the stepparent simply aids the biological parent by enforcing the rules and expectations they have set. Pasley et. al. (1993) suggests that the professional help stepparents embrace
monitoring behavior and help the biological parent take the more active role in disciplining the children. In addition, the professional should educate the parent and stepparent on the benefits of the stepparent taking a more indirect role in disciplining.

Pasley et. al. also suggest “therapeutic parental undermining” as a way to establish a quality stepparent stepchild relationship. This behavior is described as the stepparent first befriending the stepchild by offering encouragement, support, and understanding and suggest this can be successfully done even to the extent of stepparent stepchild coalitions. Pasley et. al. (1993) suggests that “therapeutic parental undermining” be done in a gradual manner and using the following process. At first the stepparent defers such things as monitoring and discipline to the biological parent, then they occasionally indicate to the child that they agree with them that the rule and/or consequence was too harsh. This can lead to a discussion with the biological parent where he or she decides to change the rule and/or consequence.

The purpose of this behavior, although paradoxical in nature, is to establish the stepparent as an ally to the steppchild. Pasley et. al. (1993) suggest that the stepparent use this behavior in conjunction with the monitoring behavior. Over time, the stepparent can also participate in befriending behavior in situations that are least likely to involve limit setting. In this way the stepparent can create positive regard with the steppchild and serve in the role of an adult friend, parental helper, and mentor rather than parental disciplinarian (Pasley et. al., 1993; Visher & Visher, 1991).

Often times stepparents feel powerless over the quality of the relationship with their steppchild. If the professional can offer appropriate suggestions on how to interact with their steppchild (monitoring behavior, befriending, and therapeutic parental undermining), conflict in the stepparent stepchild relationship can be reduced (Pasley et. al. 1993). Based on clinical
experience, Visher and Visher (1991) state that in order for the family to be successful, it is important that the stepparent-stepchild relationship be satisfactory to both the stepchild and stepparent.

Pasley et. al. (1993) advocates that subtle enactment, limit setting, and a gradual transition into a more active parental role can enhance the adjustment and experience of all family members. Pasley et. al. also suggests that in order for this transition to be successful the biological parent must aid the stepparent in becoming more familiar with the families past so that an understanding of what is typical and acceptable interaction between family members can be developed. The lack of such knowledge may lead the stepparent to misinterpret interactions and act inappropriately. The professional can aid the family in this process by encouraging them to share their past histories and experiences, which also increases middle ground for the family (Papernow, 1993; Pasley et. al., 1993; Visher & Visher, 1982).

The above clinical recommendations are supported by research completed by Erera-Weatherly (1996) and Kelley (1992). Erera-Weatherly’s (1996) study was qualitative and consisted of 32 remarried couples. The focus of the study was to assess factors related to the adoption of alternative stepparenting styles. Results showed that stepparents who adopted “the friendship style” compared to other parenting styles (i.e., the biological parent, the “super good” stepmother, the detached, and the uncertain) were more likely to have good relationships with their stepchild(ren). Kelley (1992) reported similar findings. Through her qualitative study, one of the common themes of healthy stepfamilies was the importance of the biological parent to be in charge of the rules and discipline for their biological children; particularly at the beginning of the relationship. Stepparents who successfully shared the
discipline had been married for a long time, the children were of a younger age, or special relationships had been established prior to the marriage.

**Loyalty Conflicts.** Loyalty conflicts are common among stepfamily members but can be particularly intense for the children. While parents may struggle with meeting the needs of both their children and their new partner, children are dealing with loyalty issues in regards to both of their biological parents and their stepparent. Pasley, Dollahite, and Inhinger-Tallman (1993) suggest that the change in structure upon divorce provides ample opportunity for loyalty conflicts and triangulation of the children. Even if the biological parents are able to get along there may be a covert competition of “who can be the better parent.” Thus, even if the parents are able to act civil towards one another the child may still feel caught in the middle as if they have to choose between two parents or a parent and a stepparent (Pasley, Dollahite, & Inhinger-Tallman, 1993). Visher and Visher (1985) report that the adults must send the message that it is okay for the child to have a relationship with all the adults involved and that loving one does not mean that they love the other any less. Pasley and colleagues (1993) also suggest that taking the children out of the middle of any possible conflict and triangulation is important in reducing loyalty conflicts for the children. They offer the following suggestions for the professional: educate the parents on the effects of putting children in the middle, discuss alternative ways in dealing with one another, and evaluate and adapt new behaviors as they are attempted. They also state that the professional may elect to conduct a few sessions to work on developing an appropriate and healthy co-parenting team in which the parent, non-residential parent, and stepparent are present. This recommendation is made so that all the adults involved become aware of the consequences of triangulating the child.
Identifying and Clarifying Problems. Stepfamily members often feel overwhelmed and helpless when trying to deal with the unique challenges and dynamics this family form can bring. In fact, a study done by Pasley et. al (1996) found that 73% of their sample sought therapy within the first three years of marriage a time that has been noted in the clinical literature (Papenow, 1993) to be chaotic. Pasley et. al. reported that 19.6% of clients stated that clarification of issues was most beneficial to them during the therapy process, and 75% reported that therapy was unsuccessful because it was too simplistic, not practical, goals were not set, problems were not identified, and issues were not resolved. Browning (1994) suggests that helping stepfamilies prioritize concerns and let go of those that are not under their control often restores feelings of control over an overwhelming and chaotic experience. The literature also suggests that helping family members learn appropriate problem solving, and communication skills can help the family cope with and identify the problems they are experiencing (Crosbie-Burnett, & Ahrons, 1985). Pasley et. al. (1996) suggests that helping the family view themselves from a systems perspective can be very helpful in solving conflict. When families begin to view themselves in this manner they are able to see that the needs and behaviors of one individual affect the whole system and then begin to see the perspective of the other members of the family. This understanding of other members experiences and points of view can then assist the family in communication, negotiation, and identification of problem areas (Visher, Visher, & Pasley, 1997).

Flexibility versus Cohesion. Pasley, Dollahite, and Ihinger-Tallman (1993) report that families often present in therapy because of lack of closeness, and thus, ask for help in creating emotional closeness or bonding. However, (Pasley et al., 1993) provide a warning to the professional stating that research has shown that successful stepfamilies are often more
flexible and less cohesive. Thus, to judge the appropriate amount of closeness by the biological model, which is a mistake often made by the naive professional, is a mistake that can have disastrous consequences. As such, they suggest that the professional work on more appropriate goals such as: working on the clarification of roles, defining rules, identifying decision making patterns, problem solving skills, and training in communications and conflict management. In fact, Pasley, Dollahite, and Ihinger-Tallman (1993) state that working towards the goal of cohesion rather than flexibility in the early phases may do a disservice to these families. The above clinical recommendations are strengthened by Kelley’s (1992) qualitative research. In fact, one of the themes Kelley found was the need for flexibility. Stepfamilies stated that “rigidity” that existed in their biological families does not work in this type of family form.

Conclusion

It should now be clear that the therapists knowledge of stepfamily structure, unique challenges, developmental process, and appropriate interventions are said to be crucial to the successful treatment of stepfamilies. However, there has been no clear recommendations on how the mental health professional obtain this knowledge, or how much knowledge professionals should possess in order to successfully treat this family form. It is also suggested that mental health professionals take a systemic stance when working with this complex family form. However, there has been no empirical evidence to support these recommendations. Thus, it is the purpose of this study to test the following hypotheses. 1) Stepfamily Association of America Affiliate Members and Licensed Marriage and Family Therapists will have more knowledge of stepfamily culture (i.e., the unique challenges, structures, and developmental processes that stepfamilies experience) than Licensed Mental
Health Counselors. Since Stepfamily Association of America Affiliate Members have specialized training in working with stepfamilies it is expected that they will have more knowledge because of this training. Since Licensed Marriage and Family Therapists have training in systems theory it is expected that this training will lead to a greater understanding of stepfamily culture. 2) Stepfamily Association of America Affiliate Members and Licensed Marriage and Family Therapists will have a greater knowledge of appropriate interventions than Licensed Mental Health Counselors. Since Stepfamily Association of America Affiliate Members have specialized training in working with stepfamilies it is expected that they will have more knowledge because of this training. Since Licensed Marriage and Family Therapists have training in systems theory it is expected that this training will lead to a greater understanding of appropriate interventions. In addition, this study will: 3) Examine the qualities of the mental health professionals in this study that may be the best predictors of knowledge of stepfamily culture. The predictors include: specialized training in working with stepfamilies, systems training, percentage of stepfamilies as clients in clinical practice, and years of clinical experience. 4) Examine the qualities of the mental health professionals in this study that may be the best predictors of knowledge of appropriate interventions. The predictors include: specialized training in working with stepfamilies, systems training, percentage of stepfamilies seen in the professionals clinical practice, and years of clinical experience.
METHOD

Participants

The participants in this study were 118 licensed mental health professionals. A total of 126 surveys were returned, however, eight were excluded because they were either left blank or had too few answers to be included in the survey. Participants consisted of Iowa Licensed Mental Health Counselors (n = 44), Iowa Licensed Marriage and Family Therapists (n = 42), and Stepfamily Association of America Affiliate Members (n = 32) located throughout the United States. The sample was 97.5% Caucasian (n = 115), .8% Asian/Pacific Islander (n = 1), and 1.7% of the participants indicated “other” as a answer choice (n = 2). The two participants who chose “other” specified English and French Canadian as their race/ethnic background. Of the 118 participants, 62.7% were married (n = 74), 18.6% were re-married (n = 22), 8.5% were divorced (n = 10), .8% were separated (n = 1), 3.4% were single (n = 4), 2.5% were widowed (n = 3), and 3.4% (n = 4) indicated “other” as their answer choice. The four participants who answered “other” indicated a committed relationship (n = 1), cohabitation (n = 1), or a partnership (n = 2). In regards to religion, 50.8% (n = 60) were Christian, 14.4% (n = 17) indicated “none” as their answer choice, 11.9% (n = 14) indicated “other” as their answer choice, 11.0% (n = 13) were Catholic, 8.5% (n = 10) were Jewish, and 2.5% (n = 3) were Mormon/LDS. Of the 118 participants, 55.1% (n = 65) indicated that they have been, or are currently, a member of a stepfamily, while 44.1% (n = 52) indicated that they have never been a member of a stepfamily. One participant (.8%) did not answer.

The average participant was 57.28 years old, (SD=10.01). The youngest participant was 27 years old and the oldest was 72 years old; a range of 45 years. Twenty-seven percent of the participants had a doctoral level degree, while the remainder (76.3%) had a masters
level degree. On average, the participants in this study have been practicing for 16.78 years, 
(SD = 9.13). Most of the participants practice in solo/private practice 44.1%(n = 52), with 
16.1% (n = 19) practicing in community mental health agencies, 11% in group practice (n = 
13), 4.2% practicing in more than one setting (n = 5), and 24.6% (n = 29) indicating that their 
current practice setting was something other than the answer choices provided. Of the 118 
participants, 72% (n = 85) were female and 28% (n = 33) were male.

**Instruments**

Because there is no research on therapist characteristics in regards to the treatment of 
stepfamilies, a survey was developed to assess therapists' characteristics and their knowledge 
of stepfamily culture and appropriate interventions (see Appendix A). The 65 item survey 
was developed based on the clinical and empirical literature. The survey consists of 3 
informational vignettes, each followed by 2 to 4 multiple choice questions. Of the eight 
multiple choice questions six were designed to assess knowledge of appropriate interventions 
(questions 1-6), and two were designed to assess knowledge of stepfamily culture (questions 
7 & 8). Thirty-three likert-scale questions were also included in the survey which were 
designed to assess knowledge of stepfamily culture (questions 15-41), and appropriate 
interventions (questions 9-14). The four point likert scale questions range from 1 strongly 
agree to 4 strongly disagree. Questions 9, 11-15, 18, 20, 22, 25, 27, 28, 31, 34-37, 39, and 40 
were reverse coded so that a higher score reflected more knowledge.

Four scales were created from the survey. Questions 1-6 and 9-14 were summed to 
create a total score for knowledge of appropriate interventions with a possible score of 48. 
Questions 7-8 and 15-41 were summed to create a total score for knowledge of stepfamily 
culture with a possible score of 106. Questions were summed so that a higher score reflected
more knowledge. In addition, stepfamily training scores and systems training scores were developed in order to assess the amount of training each participant had received in these areas. Five dichotomous questions (yes, no) were asked about specific training received in systems theory producing a possible score ranging from 0 to 5. Six dichotomous questions (yes, no) were also asked about specific training received on stepfamilies producing a possible score of 0 to 6. Higher training scores reflect more training. Twenty-four demographic questions were also included. Participants were asked demographic questions relating to age, gender, religious preference, race/ethnic background, marital status, level of education, years as a practicing clinician, licensure and/or certification, clientele, and specialized training.

Procedure

Participants were selected from membership lists provided by The Iowa Association for Marriage and Family Therapy (IAMFT), The Iowa Department of Information Management, and The Stepfamily Association of America (SAA). The listing provided by IAMFT consisted of 179 Licensed Marriage and Family Therapists in the state of Iowa. This group was selected because of the extensive training received in systems theory. The listing provided by the Iowa Department of Information Management consisted of 533 Licensed Mental Health Counselors in the State of Iowa. This group was selected because the training received is largely individually orientated. The listing provided by the SAA was taken directly from their website and consisted of 75 Stepfamily Association of America Affiliate Members located in the United States. This group was selected because they are identified as experts in stepfamily therapy and have received additional training to be considered as such.
The three lists were compared for duplicate names. Any name that appeared on more than one list was removed from all lists in which the name appeared. A total of 9 names were removed from both the Mental Health Counselor (MHC) list and the Marriage and Family Therapy (MFT) list. No names were removed from the Stepfamily Association of America Affiliate Member list. After removing the 9 duplicate names from the MHC and MFT lists, 524 remained on the MHC list and 170 remained on the MFT list. A total of 125 names were then randomly selected from each of the MHC and MFT lists. All members from the SAA list were selected because of the small sample size.

Each mental health professional was mailed a survey along with a self addressed stamped envelope. In the cover letter (see Appendix B), professionals were asked to return blank surveys even if they chose not to participate. The cover letter also explained that a return of either a blank or completed survey would qualify them to be entered into a drawing for an e-coupon worth $40 to Barnes and Nobles Book Store, if postmarked by June 28, 2003.

Analysis

A one-way analysis of variance was utilized to identify whether there were any significant differences between Licensed Marriage and Family Therapists, Licensed Mental Health Counselors, and SAA professionals in regards to their general knowledge of stepfamily culture. An additional one-way analysis of variance was utilized to determine if there are any significant differences between these three groups on their knowledge of appropriate interventions. A post-hoc comparison utilizing the Tukey test was applied to determine which pairs of means were significantly different from the others. Stepwise multiple regression analyses were implemented to determine if years of clinical experience,
specialized training, training in systems theory, and percentage of stepfamilies seen in the professionals clinical practice are predictive of both knowledge of stepfamily culture and knowledge of appropriate interventions.
RESULTS

Partial support was found for the first hypothesis that Stepfamily Association Affiliate Members and Licensed Marriage and Family Therapists would be more knowledgeable about stepfamily culture than Licensed Mental Health Counselors. One-way analysis of variance (ANOVA) showed that there was a significant difference between the three groups of mental health professionals in regards to their general knowledge of stepfamily culture. A post-hoc Tukey test revealed that Stepfamily Association Affiliate Members \((M = 91.72, SD = 7.95)\), scored higher than both the Licensed Mental Health Counselor group \((M = 81.80, SD = 6.04)\), and the Licensed Marriage and Family Therapy group \((M = 84.05, SD = 6.33)\) which was statistically significant \(F(2,115) = 21.40, p < .000\). In addition, (using a 95% confidence interval) it was determined that all Stepfamily Association Affiliate Members scored between 6.22 to 13.62 points higher than all Licensed Mental Health Counselors, and 3.93 to 11.41 points higher than all Licensed Marriage and Family Therapists on the stepfamily culture component of the survey.

Partial support was also found for the second hypothesis that Stepfamily Association Affiliate Members and Licensed Marriage and Family Therapists would be more knowledgeable about appropriate interventions than Licensed Mental Health Counselors. One-way analysis of variance (ANOVA) showed that the three groups differed on the intervention component of the survey. A post-hoc Tukey test revealed that the Stepfamily Association Affiliate Members \((M = 41.53, SD = 4.58)\), scored higher than both the Licensed Mental Health Counselor group \((M = 36.93, SD = 4.58)\), and the Licensed Marriage and Family Therapy group \((M = 36.81, SD = 4.01)\) which was statistically significant, \(F(2,115) = 13.22, p < .000\). In addition, (using a 95% confidence interval) it was determined that all
Stepfamily Association Affiliate Members scored between 2.18 to 7.01 points higher than all Licensed Mental Health Counselors, and 2.28 to 7.16 points higher than all Licensed Marriage and Family Therapists.

Two multiple regression analyses, utilizing stepwise comparisons, were conducted to determine the predictive value of the following variables: years of clinical experience, specialized training, training in systems theory, and percentage of stepfamilies seen in the professionals’ clinical practice. The only variable that was predictive of both knowledge of stepfamily culture and appropriate interventions was the stepfamily training score. All other variables were excluded as predictor variables from both models. Stepfamily training accounted for 7.8% of the variance in the knowledge of stepfamily culture score with a significant beta of .279 ($p < .01$). In regards to the appropriate interventions score, stepfamily training accounted for 3.9% of the variance with a significant beta of .198 ($p < .05$).

An additional post hoc analysis was conducted to determine if Stepfamily Association Affiliate Members did, in fact, possess more training on stepfamilies than Licensed Mental Health Counselors and Licensed Marriage and Family Therapists. This was done for three reasons. First, Stepfamily Association Affiliate Members were hypothesized to do well on the survey because of their stepfamily training. Second, Stepfamily Association Affiliate Members scored significantly higher than the Licensed Mental Health Counselors and the Licensed Marriage and Family Therapists on both the general stepfamily culture component and the appropriate interventions component. Third, stepfamily training was the only predictive variable of both the stepfamily culture component and the appropriate interventions component. Therefore a one-way analysis of variance (ANOVA) was conducted. This analysis revealed a significant difference between the three groups of mental
health professionals in regards to their stepfamily training score. A Tukey test showed that Stepfamily Association Affiliate Members ($M = 3.42, SD = 1.20$) possess more stepfamily training than both the Licensed Mental Health Counselor group ($M = 1.68, SD = 1.41$), and the Licensed Marriage and Family Therapy group ($M = 2.26, SD = 1.48$), which was statistically significant, $F(2,115) = 14.41, p < .000$.

Since the stepfamily training score was the only variable that was predictive of both knowledge of appropriate interventions and knowledge of stepfamily culture two additional stepwise multiple regressions were conducted to determine which type of stepfamily training was most predictive. The first stepwise multiple regression was computed using the knowledge of appropriate interventions score as the dependent measure; the independent variables were training received through the Stepfamily Association of America, training received through workshops, training received through course-work, training received through CEU’s, and training received from another source not provided as an answer choice. The only variable that was predictive of the knowledge of appropriate interventions was training received through the Stepfamily Association of America. Training received through the Stepfamily Association of America accounted for 10.7% of the variance with a significant beta of .327 ($p < .01$).

The second stepwise multiple regression was computed using the knowledge of stepfamily culture score as the dependent measure. The independent variables were training received through the Stepfamily Association of America, training received through workshops, training received through course-work, training received through CEU’s, and training received from another source not provided as an answer choice. Training received through the Stepfamily Association of America accounted for 21.4% of the variance with a
significant beta of .428 ($p < .01$), while training received through workshops accounted for an additional 2.8% of the variance with a significant beta of .223 ($p < .01$), and training through course-work accounted for another 3.0% of the variance with a significant beta of -.182 ($p < .05$). This negative beta weight shows that this variable is functioning as a suppressor variable. That is, it reflects the part of the Stepfamily Association of America training and the part of the workshop training that are unrelated to the knowledge of stepfamily culture and is related to training received through course-work.
DISCUSSION

The clinical and empirical literature suggests that mental health professionals be aware of the literature and its recommendations when working with stepfamilies in clinical practice. More specifically, the literature suggests that mental health professionals must possess knowledge of both appropriate interventions and stepfamily culture (Pasley, Dollahite, & Ihinnger-Tallman, 1993), as well as view these families systemically (Berger, 1998; Preston, 1984; Visher & Visher, 1988) in order to be successful with this family form. The literature suggests that a lack of such knowledge can lead to mistaken assumptions and, as a result, have detrimental effects on these families. Visher, Visher, and Pasley (1997) believe that professionals lacking this knowledge may be unaware that they are not familiar with "stepfamily culture." Thus, their picture of a "family" may lead them to use the nuclear model when working with stepfamilies. Visher and Visher (1982) state that viewing stepfamilies as biological or nuclear families leads to unrealistic and unattainable expectations, goals, and interventions that result in more pain and stress for those involved. In fact, both the clinical and empirical literature overwhelmingly suggest that the therapist's knowledge of stepfamily culture and appropriate interventions is a major key to successful stepfamily therapy.

In addition, it is suggested that the therapists knowledge of the stepfamily form and the therapists ability to view this family form from a systems perspective is important to the success of treatment. Visher and Visher (1991) believe, because of the complexity of structure, that the therapist must be required to think in terms of the supra-family system in order to successfully treat this family form. Bray (1995) also suggests that a systems orientation in treating stepfamilies is useful. Bray states that this approach allows the
therapist to understand the multiple family systems and subsystems involved and the interactional processes that produce both positive and negative experiences. In addition, a systems view allows for a better understanding of the interaction between the developmental changes and the unique challenges of this family form which can produce a complex set of relationships. However, as O' Connor, Hetherington, and Clingempeel (1997) point out, that while systems theory is extensively cited in the clinical and developmental research for understanding family relationship influences, there has been no research to affirm these suggestions.

Based on the above recommendations, this study set out to examine mental health professionals' understanding of interventions and stepfamily culture, and if systems training, training specific to stepfamilies, years of clinical experience, and percentage of stepfamilies seen in the professionals' clinical practice influenced their understanding. The findings from this study did support suggestions that mental health professionals with specialized training are more knowledgeable in regards to recommended interventions and stepfamily culture. In fact, Stepfamily Association Affiliate Members scored significantly higher on both stepfamily culture and recommended interventions and were the group with the greatest amount of training geared specifically to stepfamilies.

Findings from this study did not suggest that mental health professionals with training in systems theory were any more knowledgeable in regards to recommended interventions and stepfamily culture. However, the present study was limited to self report of systems theory training and did not test whether there was an actual understanding of systems theory. In addition, this study did not ask how much systems training was acquired through each of the possibilities provided. For example, this study inquired about whether systems training
was gained through such venues as course work, but it did not inquire about how many credits and/or courses were taken on systems theory. As such, someone who had taken one course in systems theory would have been given the same score as someone who had taken ten courses in systems theory. Thus, mental health professionals who in fact do hold substantially more training in systems theory would have been overlooked due to the design limitations of the survey. Because of the above mentioned limitations, future research would benefit from not only inquiring about how systems training was garnered, but also the amount of systems training earned through each possible venue. Future research would also benefit from gathering information about the mental health professionals’ understanding of systems theory rather than relying on the amount of training to make this assumption.

In this study, an assumption was made that clinicians with more years of clinical experience would be more knowledgeable in the areas of interventions and clinical issues than clinicians with less experience. It was also assumed that clinicians who see a greater percentage of stepfamilies in their clinical practice would be more knowledgeable than clinicians who do not treat a high percentage of stepfamilies. However, years of clinical practice, and amount of experience in working with this family form did not significantly contribute to a knowledge of recommended interventions or knowledge of stepfamily culture in this sample.

The key factor contributing to both knowledge of stepfamily culture and recommended interventions appears to be training specifically geared towards the stepfamily form. As such, even clinicians with years of clinical experience and experience with this family form would presumably benefit from training specific to stepfamilies. However, even this key factor only accounted for a small percentage of the variance in both knowledge of
stepfamily culture and recommended interventions. Thus, factors that were not included in this study may be more influential to the knowledge of stepfamily culture and recommended interventions. Therefore, future research would benefit from investigating other variables that may also contribute to the knowledge of this family form and ways in which to intervene.

Limitations

While the findings from this study can inform us about the amount of knowledge these mental health professionals hold, and what contributes to this knowledge, it does not tell us how these professionals utilize this knowledge in their clinical practice. Thus, it is not known if mental health professionals who scored higher in the areas of stepfamily culture and interventions are any more effective when treating this family form than those mental health professionals that scored lower in these areas.

This study utilized surveys to obtain information about mental health professionals and their knowledge of interventions and stepfamily culture. While this gave us a look into the knowledge level of mental health professionals and what contributed to this knowledge, future research could include observations of therapy sessions, stepfamilies reactions to the therapy they received, and stepfamilies reports of effectiveness to answer questions about how these professionals utilize their knowledge and training, and if it is being used effectively. Thus, it would be beneficial for researchers to focus efforts not only on self-report of training and knowledge, but on how mental health professionals apply this training and knowledge when working with this unique family form in their clinical practice.

While training in systems theory was hypothesized to contribute to an understanding of stepfamily culture and recommended interventions, findings did not support this. However, as previously discussed, several factors may have contributed to the lack of
significance. For instance, this study was not able to determine if mental health professionals who had received training in systems theory possess an actual understanding of systems theory concepts. This study was also unable to determine the amount of training received through each of the venues. Thus, this study was not able to determine if the amount of training received through a specific venue would have contributed to the mental health professionals' knowledge or if an understanding of systems training would have contributed to the knowledge of stepfamily culture or recommended interventions.

In addition, caution should be taken when generalizing these findings to all mental health professionals for the following reasons. First, the sample of Licensed Mental Health Professionals and Licensed Marriage and Family Therapists were limited to those who hold licensure in the state of Iowa, while the Stepfamily Association Affiliate Members were mental health professionals located throughout the United States of America. Thus, geographical location may have influenced the findings of this study. Second, Stepfamily Association Affiliate Members responded at a higher rate (43%) than Licensed Marriage and Family Therapists (35%) and Licensed Mental Health Counselors (35%). Thus, characteristics of the mental health professionals who chose to respond may differ from the mental health professionals who chose not to respond. Third, the overall sample size was also limited to 118 participants which may have influenced the significance of the findings.

Implications

These findings indicate the importance of specialized training for mental health professionals who intend to work with this family form. While training specific to stepfamilies accounted for a small amount of variance, it was the only predictor variable for both the knowledge of recommended interventions and the knowledge of stepfamily culture.
Thus, mental health professionals should access, and become familiar with, both the clinical and empirical literature. Clinical training should include information about recommended interventions and stepfamily culture, as well as, supervision in practicing these techniques with this family form. Clinical training would also benefit from formatting their training curriculum to that of the training provided by the Stepfamily Association of America, as this was the training found to account for the greatest amount of variance in both knowledge of recommended interventions and stepfamily culture. Since neither amount of clinical experience with stepfamilies, or years of clinical experience contributed to knowledge of recommended interventions or knowledge of stepfamily culture, seasoned mental health professionals would presumably benefit from obtaining training to work with this family form.
APPENDIX A.

SURVEY ON STEPFAMILY CULTURE AND PRACTICE
Survey on Stepfamily Culture and Practice

QUESTIONS 1 AND 2 REFER TO THE FOLLOWING SCENARIO:
(Please circle the one best answer. Space is provided below each question if you have additional comments)

A. Mr. and Mrs. Davis have been married for two years, and together parent a fourteen year old daughter from Mrs. Davis' previous marriage. Mr. and Mrs. Davis have sought out therapy because they feel that there has been a distance in their family and would like their family to be closer.

1.) Which of the following initial statements do you feel would be most beneficial to this family?
   a.) “What you’re experiencing is perfectly normal. We can begin by exploring your expectations for your family and then focus on the closeness that you desire.”
   b.) “It’s normal for families to experience a sense of distance during the adolescent stage of the family life cycle.”
   c.) “In order to blend successfully the whole family must spend time together as a unit. Once you begin to do this, your family will gain a sense of closeness.”
   d.) “What you are experiencing is normal. Some stepfamilies never reach a feeling of closeness and that’s okay.”

   Additional Comments

2.) What issues do you feel would be most important to address when initially working with this family?
   a.) Working towards closeness in the family
   b.) The family’s expectations of what their family should be like
   c.) Adolescent development
   d.) Mr. and Mrs. Davis’ relationship

   Additional Comments

QUESTIONS 3 AND 4 REFER TO THE FOLLOWING SCENARIO:
(Please circle the one best answer. Space is provided below each question if you have additional comments)

B. Mrs. Klein and Mr. Davenhoop have presented in your office because they are concerned about Mrs. Kleins 10 year old daughter (Shelly). Mrs. Klein and Mr. Davenhoop report that they have a good relationship. They also report that Shelly and Mr. Davenhoop have a good relationship and usually have a lot of fun together, however, when Shelly returns from her fathers she is very remote and wants nothing
to do with Mr. Davenhoop. Mrs. Klein and Mr. Davenhoop also report that Shelly has recently been having problems at school.

3.) As a therapist you would encourage Mrs. Klein and Mr. Davenhoop to:
   a.) Consider having the father investigated for child abuse
   b.) Talk to Shelly and tell her that they both love her very much
   c.) Talk to Shelly's father and try to resolve all past disagreements
   d.) Talk to Shelly and reassure her it is okay to love all of the adults in her life

Additional Comments

4.) As a therapist your initial hypothesis is that Shelly's reaction to Mr. Davenhoop is most likely a result of:
   a.) Depression
   b.) Loyalty conflicts
   c.) Adolescence
   d.) A coalition between Shelly and her father

Additional Comments

QUESTIONS 5, 6, 7, AND 8 REFER TO THE FOLLOWING SCENARIO:
(Please circle the one best answer. Space is provided below each question if you have additional comments)

C. Mr. and Mrs. Stewart, who have been married for three years, requested therapy to address conflict between several of their stepfamily members. Both experienced single parenthood for some time after the death of their spouses. However, Mr. and Mrs. Stewart are concerned with the oldest child, as he has been acting out both at home and at school. Both report that the other children seem to be doing fairly well. Mr. and Mrs. Stewart reported that the tension in the household has been building over the last three years which has affected their relationship. As a result, Mr. and Mrs. Stewart have been spending less and less time together and arguing more frequently. Mrs. Stewart stated that she has been trying her best to be a nurturing and caring figure to Mr. Stewart's children only to receive disrespect and noncompliance from the children. Mr. Stewart also stated that he has been doing everything he can to insure that he treat all of the children fairly by providing rules, structure, and discipline to all of the children equally. He also explained that he has been trying to befriend his wife's children, but they seem unresponsive to his attempts. Both are unsure about their parenting ability at this time. Mr. and Mrs. Stewart stated that they have tried everything and are beginning to think that it may be best for everyone if they divorced.

5.) As a therapist, whom do you feel would be most beneficial to see during the initial phase of therapy?
   a.) Mr. and Mrs. Stewart
   b.) The family as a whole
c.) The oldest child
d.) The sibling group

Additional Comments

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6.) As a therapist which of the following interventions do you feel would be **most** beneficial to this family during this period of time in their family development?
   a.) Teaching problem solving and communication skills
   b.) Provide information in order to place fantasies in perspective and normalize feelings
   c.) Provide feedback on what the family is doing well
   d.) Work on behavior management with the oldest child

Additional Comments

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7.) As a therapist it is your opinion, from what Mr. and Mrs. Stewart have told you, that the **main** challenges they seem to be struggling with are which of the following?
   a.) Feelings of guilt & loss of previous relationships
   b.) Ambiguity of roles & unrealistic expectations
   c.) Boundary ambiguity
   d.) Lack of shared history & competing developmental needs

Additional Comments

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8.) The issue presented by this family would lead you to believe that they are experiencing a transition between which of the following developmental stages identified by Patricia Papernow.
   a.) Action Stage into Resolution Stage
   b.) Awareness Stage into Mobilization Stage
   c.) Fantasy Stage into Immersion Stage
   d.) I am not familiar with Patricia Papernow's stages

Additional Comments

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PLEASE CIRCLE THE ANSWER CHOICE THAT BEST DESCRIBES YOUR OPINION
SA=STRONGLY AGREE
A=AGREE
D=DISAGREE
SD=STRONGLY DIS AGREE

SA A D SD
9.) When treating stepfamilies, therapy is most successful when taking the systems perspective.

SA A D SD
10.) It is possible to successfully treat stepfamilies using the nuclear family form as a model.
11.) Validating stepfamilies unique challenges is a crucial component to therapy and its outcome.

12.) Parents and stepparents can help the children deal with loss by accepting the children's angry feelings.

13.) It's important for the therapist to make time for the stepfamily to explore issues of grief and loss.

14.) Education through reading material can be helpful to stepfamilies in understanding their unique experiences.

15.) In order for the professional to provide quality interventions to stepfamilies the professional must be knowledgeable of stepfamily experiences.

16.) It is a realistic expectation that the new partner will relieve the demands of being a single parent.

17.) It is necessary that the rules and expectations for the children in both households be very similar in order to insure healthy transitions for the children.

18.) Typically, when a blended family is formed, the bonds between the biological children and their parents are stronger than that of the new couple.

19.) The percentage of remarriages that end in divorce is lower than first time marriages because the partners draw upon their previous experiences.

20.) Roles and responsibilities are less defined in stepfamilies when compared to intact families.

21.) In most instances it's beneficial for a blended family to utilize the biological family form as a model for parenting.

22.) Obtaining stepsiblings through their parents remarriage can, in turn, change the child's status, and thus lead to role confusion for the child.

23.) The majority of blended families at some time experience problems that require professional treatment.
24.) Children are the only members of a stepfamily to experience loyalty conflicts.

25.) One of the reasons blended families are more fragile than intact first marriage families is because they lack social support and clear norms to follow.

26.) It is best for the stepmother to enter as a mother figure rather than as a friend so her role is clearly defined as the parental figure to the stepchildren.

27.) The relationship between the custodial and non-custodial parent is important to the development of the child.

28.) In regards to stepfamilies, the first four years seem to be the most crucial.

29.) It is a realistic expectation that day-to-day life will be similar to that of the previous intact family form.

30.) It is a realistic expectation that the children will grow to love their stepparent.

31.) The strong biological parent-child relationship often leads to insiders and outsiders within the blended family.

32.) The couple relationship is the most important relationship of the blended family and should be given top priority regardless of the wants and needs of the children.

33.) The process of developing a blended family is surprisingly similar to that of developing a biological family.

34.) When a family transforms from a single parent family to a blended family, loyalty conflicts and feelings of alienation may escalate for both the children and the adults.

35.) Undefined boundaries can lead to loyalty conflicts.

36.) Unresolved feelings from the first marriage can affect the current relationship and cause difficulties.

37.) The relationship problems people have in their first marriages are usually the same problems that they experience in their second marriage.
38.) It is a realistic expectation that a stepparent can learn to love stepchildren as his or her own.

39.) The developmental process of forming a new family takes the average stepfamily about seven years to complete.

40.) Boundaries between the newly formed family and the previous family need to be permeable in order to allow the exchange of resources.

41.) It is best for the stepfather to immediately establish his role as a disciplinarian to gain the respect of the children and ease the transition.

FINALLY, I WOULD LIKE TO ASK A COUPLE OF QUESTIONS ABOUT YOU!

1.) I am _____ years of age

2.) Gender
   □ Male    □ Female

3.) What is the highest level of education you have completed and the year you received it?
   □ B.A./B.S./B.S.W. (Year:____) □ M.A./M.S./M.S.W./M.Ed. (Year:____)
   □ Ph.D. (Year:____)

4.) What is the discipline of your highest degree? (Check all that apply)
   □ Marriage and Family Therapy   □ Psychology   □ Social Work
   □ Counseling   □ Other (please specify)__________

5.) I have been practicing as a clinician for ____ years

6.) Current practice setting:
   □ Community Mental Health Agency   □ Solo/Private Practice
   □ Group Practice   □ Other ______________________

7.) I am licensed/certified in the following. (Please check all that apply)
   □ Marriage and Family Therapist   □ Social Worker
   □ Professional Counselor/Mental Health Counselor
   □ Other (please specify)______________

8.) Currently the majority of my clients are:
   □ Children   □ Families   □ Adults
   □ Adolescents   □ Couples   □ Other (please specify)______________
9.) I tend to practice the following mode of treatment most often:
- Individual
- Group
- Other (please specify)
- Couple
- Family

10.) Please rank order (#1, #2, #3) the top 3 theoretical orientations that best describe your work as a clinician.
- Cognitive-Behavioral
- Strategic
- Rogerian
- Psychoanalytic
- Solution Focused
- Gestalt
- Narrative
- Experiential
- Other
- Structural
- Bowenian

11.) What is your Race/Ethnic background? (Please Check One)
- Caucasian
- Native American/Alaskan Native
- Black/African American
- Hispanic/Latino
- Asian/Pacific Islander
- Other (please specify)

12.) What is your present Marital Status? (Please Check One)
- Single
- Divorced
- Widowed
- Other (please specify)
- Remarried
- Married
- Separated

13.) I am currently, or have been in the past, a member of a stepfamily
- Yes
- No

14.) What is Your Religious Preference? (Please Check One)
- Jewish
- Mormon/LDS
- Other (Please Specify)
- Catholic
- Christian (Specify Denomination)
- None

15.) Have you received training in Family Systems Theory?
- Yes
- No (If your answer is No, skip to question #17)

16.) I received Training in Family Systems Theory through: (Please check all that apply)
- CEU's
- Coursework
- Workshop(s)
- Other (please specify)

17.) Do you predominately take a systems perspective in your clinical work?
- Yes
- No

18.) Do you work with Stepfamilies in your clinical work?
- Yes
- No (If your answer is No, skip to question #20)

19.) Stepfamilies make up ____% of my current clientele.
20.) Have you received training on Stepfamilies?
   □ Yes  □ No (If your answer is No, skip to question #22)

21.) I have received training on Stepfamilies through: (Please check all that apply)
   □ CEU's  □ Coursework  □ Workshop(s)
   □ SAA (Stepfamily Association of America)  □ Other (please specify) _______ 

22.) I currently work:
   □ Full time: which is _____ hours per week
   □ Part time: which is _____ hours per week

23.) I would consider myself an expert in Systems Theory.
   □ Yes  □ No

24.) I would consider myself an expert on Stepfamilies.
   □ Yes  □ No

THANK YOU for taking the time to complete this questionnaire. Your answers are very valuable and your assistance and insight is very much appreciated. If there is anything that you would like to tell me about this questionnaire or its subject matter, please do so in the space below.
APPENDIX B.

COVER LETTERS
Dear Licensed Mental Health Counselor,

My name is Angela Thiesen and I am a master's student in the marriage and family therapy program at Iowa State University conducting a research study for my Master's thesis under the guidance of Dr. Marcia Michaels. I am interested in identifying ways to improve mental health services for stepfamilies. That's where you come in. I need your expert help and professional insight in answering this probing question!

You have been selected because of your specialized training, and are one of a select few Licensed Mental Health Counselors who will participate in this study. In order for the results to truly represent the thinking of LMHC's, it is important that each survey be completed and returned. Therefore, I have limited the number of questions so that this survey will only take 10 to 15 minutes of your time!

Upon the return of the survey, your name will be entered for a chance to win a $40 e-coupon at Barnes and Noble's Book Store! If you choose not to participate, please return the blank survey in the enclosed postage paid envelope. Returning the survey either blank or completed will qualify you to be entered into the drawing for the $40 e-coupon. Due to time restrictions, however, the returned survey must be postmarked by June 28, 2003 in order to be entered into the drawing.

All responses are confidential. Your name will not be associated with the answers to the survey in any way. Your participation is voluntary and you are under no obligation to complete this survey. However, I hope you feel the same way I do and elect to devote your valuable time and expertise to this important topic. If you have any questions about this research please feel free to contact me or my major professor, Dr. Marcia Michaels.

I would like to thank you for your time and consideration in advance. It is only through the generous help of people like you that allows us to answer this important question. If you would like to receive a summary of the survey results, please e-mail me with your request.

Sincerely,

Angela M. Thiesen
Graduate Student
Iowa State University
Marriage and Family Therapy
HD FS Palmer Building
Ames, IA 50010
athiesen@iastate.edu

Marcia Michaels, Ph.D., LMFT
Iowa State University
4380 Palmer Building
Ames, IA 50011-4380
(515)294-8439
marciam@iastate.edu
Dear Licensed Marriage and Family Therapist,

My name is Angela Thiesen and I am a master's student in the marriage and family therapy program at Iowa State University conducting a research study for my Master's thesis under the guidance of Dr. Marcia Michaels. I am interested in identifying ways to improve mental health services for stepfamilies. That's where you come in. I need your expert help and professional insight in answering this probing question!

You have been selected because of your specialized training, and are one of a select few Licensed Marriage and Family Therapists who will participate in this study. In order for the results to truly represent the thinking of LMFT's, it is important that each survey be completed and returned. Therefore, I have limited the number of questions so that this survey will only take 10 to 15 minutes of your time!

Upon the return of the survey, your name will be entered for a chance to win a $40 e-coupon at Barnes and Nobles Book Store! If you choose not to participate, please return the blank survey in the enclosed postage paid envelope. Returning the survey either blank or completed will qualify you to be entered into the drawing for the $40 e-coupon. Due to time restrictions, however, the returned survey must be postmarked by June 28, 2003 in order to be entered into the drawing.

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athiesen@iastate.edu

Marcia Michaels, Ph.D., LMFT
Iowa State University
4380 Palmer Building
Ames, IA 50011-4380
(515)294-8439
marciam@iastate.edu
Dear SAA Affiliate Member,

My name is Angela Thiesen and I am a master's student in the marriage and family therapy program at Iowa State University conducting a research study for my Master's thesis under the guidance of Dr. Marcia Michaels. I am interested in identifying ways to improve mental health services for stepfamilies. That's where you come in. I need your expert help and professional insight in answering this probing question!

You have been selected because of your expertise on stepfamilies. As you know, there are few professionals that can make such a claim! In order for the results to truly represent the thinking of SAA Affiliate Members, it is important that each survey be completed and returned. Therefore, I have limited the number of questions so that this survey will only take 10 to 15 minutes of your time!

Upon the return of the survey, your name will be entered for a chance to win a $40 e-coupon at Barnes and Nobles Book Store! If you choose not to participate, please return the blank survey in the enclosed postage paid envelope. Returning the survey either blank or completed will qualify you to be entered into the drawing for the $40 e-coupon. Due to time restrictions, however, the returned survey must be postmarked by June 28, 2003 in order to be entered into the drawing.

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I would like to thank you for your time and consideration in advance. It is only through the generous help of people like you that allows us to answer this important question. If you would like to receive a summary of the survey results, please e-mail me with your request.

Sincerely,

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Iowa State University
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4380 Palmer Building
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athiesen@iastate.edu

Marcia Michaels, Ph.D., LMFT
Iowa State University
4380 Palmer Building
Ames, IA 50011-4380
(515)294-8439
marciam@iastate.edu
REFERENCES


Family Relations, 42, 315-322.


