Outcomes for children in new stepfamilies

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Introduction

Changing patterns in relationship formation and dissolution have meant that stepfamilies are currently the fastest growing family form in the UK (Ferri and Smith, 2003). Although the number of stepfamilies at any one time may not have changed greatly, the probability of a child or parent spending some time in a stepfamily has increased markedly: Ermisch and Francesconi (1996) estimated that about 30% of mothers would spend some time in a stepfamily before they were 45.

Most studies of health and behavioural outcomes for children in stepfamilies have adopted the 'deficit model' comparing stepfamilies with two parent families. The results of these studies are suggestive of a higher rate of problems in children from stepfamilies (Ferri, 1984; Zill, 1988; Amato and Keith, 1991; Hetherington, 1993; Hanson, McLanahan and Thomson, 1996; Dunn et al., 1998). More recent research has concluded that some of the apparently poor psychosocial outcomes for children in stepfamilies are actually due to factors that predate the existence of the stepfamily (Nicholson, Fergusson and Horwood, 1999). The increased risks for children in stepfamilies may be statistically significant, but by no means all children in stepfamilies experience difficulties, or problems. More recent studies, such as the one reported here, have begun to investigate the factors within stepfamilies that are associated with better or worse outcomes for children.

The stepfamilies study

This paper describes some of the findings from a study of a community sample of nearly 200 new stepfamilies, investigating variables within the stepfamily associated with child health and well being.

The sample

The stepfamilies, who had been together for between one and four years, were identified by means of a large scale screening exercise conducted via schools in three different geographical areas in the UK. In each of the stepfamilies there was at least one child aged between seven and eleven years, whose primary residence it was. The large majority (96%) were stepfather families.

Methodology

Mothers, stepfathers and up to two children aged between seven and eleven years, were interviewed. Interviews were conducted in the family home, separately, and by different interviewers. The interviews, which were interviewer-led and designed to obtain a mixture of qualitative and quantitative information, covered a wide range of topics, including the history of the stepfamily, family functioning and the quality of relationships within the household.

Child health and well-being

The main outcome measure was the Symptom Score: a 31 item standardized interview based assessment of child health, behaviour and well being. Items in the scale included anxiety, fears and phobias, sadness, irritable moods, temper tantrums, aggressive behaviour, sleep problems, hyperactivity, eating disorders, poor concentration, headaches, stomach aches and nausea. Each item was rated from 0 to 3 according to the frequency and

severity of the problem in the past year, and reflecting the degree of handicap resulting from the problem. The symptom score is the summed total of scores from the 31 items.

Comparative data

Data obtained previously (Smith and Jenkins,1991) from a community population sample of parents and children of comparable ages, using the same measures of relationship quality and the Symptom Score, were used for comparative purposes.

The results

Generally few variables relating to the structure of the stepfamily or its current status were associated with child outcome scores, although children in stepfamilies with a new half-sibling in the household did exhibit somewhat more problems. Similarly, few variables relating to the history of the stepfamily were associated with child outcomes. An exception was teenage motherhood, which was associated with more problems in children. Maternal mental health variables were associated with outcomes for children, but only in the parents' accounts.

There were, however, strong and robust associations between the quality of relationships in the household and the health, behaviour and well being of the child. This applied independently to the quality of the marital relationship, the parent/child relationship and the step-parent/child relationship.

When children in the new stepfamilies were compared with children of comparable ages from a community sample of two parent families, the associations between outcome scores and relationship quality were very similar in both groups, although it was notable that marital or partner relationships were generally better in the new stepfamilies. Comparative multivariate analyses showed no independent effect of stepfamily status on child health and well being.

Conclusions

The evidence from this study suggests that what is important for child well-being are factors in the 'here and now'. Past family history, structural variables relating to the stepfamily, potential mental health vulnerabilities in their parent, and even the relationship with the non-resident parent, were all insignificant, compared with the dominant influence on child well-being of relationship variables in the current stepfamily household.

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