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African American caregivers' resources for support: Implications for children's perceived support from their caregiver

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1. Introduction

This cross-sectional, school-based study examines whether African American caregivers' stressful life events, affective symptoms, and perceived support from their social network are associated with children's perceptions of support from and conflict with their caregiver. In the United States, African American families are disproportionately exposed to adversities such as discrimination, joblessness, and poverty, which are directly linked to disparities in health and educational attainment for their children (e.g., Pascoe & Richman, 2009; McLoyd, 1990; Hurd, Sanchez, Zimmerman, & Caldwell, 2012). African American children who experience feelings of oppression are more likely to experience difficulty with emotions, concentration and behavior, be diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), and report their health as not excellent or very good when compared to non-Hispanic Whites (Flores & Tomany-Korman, 2008). A lower income level can exacerbate this situation by contributing to children's depressive symptoms and problem behaviors such as delinquency and aggression (Bogart et al., 2013). Additionally, African American children who experience a higher number of stressors (e.g., discrimination, poverty) experience achievement gaps in mathematics and reading when compared to non-Hispanic Whites, and attain significantly lower levels of earnings and assets during young

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adulthood (Fantuzzo, LeBoeuf, Rouse, & Chen, 2012; Wickrama, Simons, & Baltimore, 2012).

To ensure that African American youth achieve optimal mental health and realize their full educational potential, it is important to examine mechanisms by which their resilience can be fostered. One such mechanism is social support from primary caregivers, which has been positively linked to the well-being of children and adolescents (Borawski, Ievers-Landis, Lovegreen, & Trapl, 2003; Chu, Saucier, & Hafner, 2010; Li, Feigelman, & Stanton, 2000; Sroufe, Egeland, Carlson, & Collins, 2005). Two types of support from caregivers are especially protective for the child – emotional and instrumental support (McMahon, Felix, & Nagarajan, 2011; Brody & Flor, 1998; Wills & Cleary, 1996). Emotional support involves accepting and valuing another person through expressions of trustworthiness, empathy, and love, while instrumental support involves providing tangible aid, such as assistance with tasks (Cohen & Wills, 1985; Wills, Vaccaro, & McNamara, 1992).

2.0. Conceptual Framework

Heaney and Israel's (2008) model of social networks and social support can be applied to relationships between children and their caregivers, as well as relationships between caregivers and members of their extended social network. In this model, social support is both directly linked to mental health and physical health, and indirectly linked to health outcomes through the development of resources for resilience to stress, such as coping skills. The model suggests that an individual's ability to provide support to others is impacted by the community in which an individual is embedded, as well as the individual's own health status.

Consistent with Heaney and Israel's (2008) conceptual model, children who perceive greater support from their caregivers experience fewer mental health problems and exhibit fewer health risk behaviors (e.g., Rueger & Malecki, 2011; Resnick et al., 1997). Applying Heaney and Israel's model to caregiving, one can infer that caregivers' ability to provide support to their children is impacted by larger social-ecological factors, such as stressors. In the span of their child's development, caregivers may encounter a variety of stressful life events in different domains. Social ecological stressors may lead to affective symptoms, unhealthy forms of coping, and strained parenting among caregivers, which in turn can interfere with a caregivers' ability to provide adequate support to their children (Tein, Sandler, & Zautra, 2000). For example, work-related events ranging from racial discrimination to scheduling conflicts are associated with feelings of stress, anxiety, anger, and guilt among African American mothers, as well as perceived interference with family responsibilities (Gipson-Jones, 2009; Cole & Secret, 2012). Law-related events such as incarceration of a primary caregiver are associated with unstable childcare arrangements and strained parenting (Murray, Farrington, & Sekol, 2012). Health-related events can also impact caregivers' ability to support their children (e.g., Davey, Nino, Kissil & Ingram, 2012). In addition to stressors, experiencing high levels of affective symptoms such as depression, anxiety, stress, and anger can interfere with parenting behavior and various aspects of parent-child interaction (Compas & Williams, 1990). In turn, children may perceive less support from their caregivers (Deater-Deckard, 2004). For example, higher levels of parent depression,

anxiety, and anger among African American parents have been associated with parental report of less positive parent-adolescent interactions (Gutman, McLoyd, & Tokoyawa, 2005). In one study, African American fathers with moderate or severe depressive symptoms reported less contact with, lower closeness to, lower monitoring of, and greater conflict with their preteen sons (Davis, Caldwell, Clark, & Davis, 2009).

Caregivers' resources for social support may offset the negative impact of stressors and affective symptoms. A large body of literature demonstrates that support from family, friends, and community networks is related to less risk-taking, better physical health, and fewer psychological symptoms among adults (e.g., Bowleg et al., 2013; Warren-Findlow, Laditka, Thompson, Laditka, 2013; Lincoln, Chatters, & Taylor, 2003). Caregivers who experience higher levels of support from their social network may be better able to provide support to their children despite stressful life circumstances and affective symptoms (Shook, Jones, Forehand, Dorsey, & Brody, 2010). In a study of African American youth from single-mother homes, mothers' report of higher levels of support from a co-parent (e.g., biological father, grandmother) was associated with greater child cognitive competence (e.g., very good at schoolwork) (Shook et al., 2010). In another study of predominantly White children, higher levels of social support from caregivers moderated the relationship between children's stressful life events and their behavior problems, such that children's stressors were only linked to behavior problems when the availability of social support from caregivers was low (Dubow & Tisak, 1989). Parenting interventions also highlight the importance of providing support to parents in order to positively impact child outcomes. Stewart-Brown and Schrader-Mcmillan (2011) qualitatively synthesized 53 systematic reviews identifying effective interventions to support parents, parenting, and the parent-child relationship from the ante-natal period to adolescence. They found that programs yielding the most positive outcomes (e.g., decreases in children's externalizing behaviors) focused on the parent-child relationship, specifically, teaching emotion communication skills and ways of fostering more positive parent-child interaction. Surprisingly, the effectiveness of programs did not improve with the addition of components such as teaching parents problem-solving techniques, developing children's academic, cognitive, and social skills, or providing additional services. What did influence program success was whether the program facilitators offered non-judgmental, strengths-based support to validate parents' needs to be recognized and respected, and whether facilitators encouraged the development of support networks among participating parents (Stewart-Brown & Schrader-Mcmillan, 2011).

If caregivers are well-supported, children may perceive greater support from caregivers, which in turn may prevent or ameliorate children's mental health symptoms. Perceptions of received support are particularly important to assess because they are associated with an individual's wellbeing more strongly than are objective ratings of interactions between people (Wethington & Kessler, 1986; Chu et al., 2010). Previous studies have examined African American parents' perceived support from their social network (e.g., kin) in relation to different child outcomes, including parent/child communication and children's affective symptoms (e.g., Hoagwood et al., 2010; Taylor, Seaton, & Dominguez, 2008), as well as children's social and cognitive development (e.g., Burchinal, Follmer, & Bryant, 1996). Studies have also examined children's perceived support from primary caregivers in relation to perceived parental warmth and father involvement (e.g., McCabe & Clark, 1999), as well

as children's social behavior (e.g., Anan & Barnett, 1999). However, previous literature has not examined the association between caregivers' perceived support from their social network and children's perceived support from their primary caregiver. Children's perceived support from caregivers may be the mechanism by which programs to enhance caregivers' support have a positive impact on children's outcomes. A better understanding of the association between caregivers' perceived support from their social network and children's perceived support from their primary caregiver can have practical implications for strengthening children's mental health and educational outcomes (Hoagwood et al., 2010). To the extent that children's perceived support from caregivers is a function of caregivers' perceived support from their network, interventions should target the enhancement of caregivers' support networks. The present study therefore aims to examine whether African American caregivers' stressful life events, affective symptoms, and perceived support from their social network are associated with children's perceptions of support from and conflict with their caregiver. The following research questions are examined:

- Is caregivers' stressor exposure associated with their affective symptoms?
- Is caregivers' stressor exposure associated with their perceived social support?
- Is caregivers' perceived social support associated with their affective symptoms?
- Is caregivers' stressor exposure associated with children's perceived social support from caregivers?
- Is caregivers' perceived social support from others associated with children's perceived social support from caregivers?
- Are caregivers' affective symptoms associated with children's perceived social support from caregivers?

3.0. Methods

3.1. Research Site

This research is part of a community and academic collaboration involving the Minnesota Association of Black Psychologists, a non-profit organization focused on enhancing the well-being of African Americans through social change programs and positive approaches to research (Brady, Winston, & Gockley, 2014). The school from which caregivers and their children were recruited for this study serves a predominantly lower-income, ethnic minority community in the Midwestern United States. When data were collected, over 85% of enrolled students received free or reduced price lunch.

3.2. Procedure

Letters of invitation to participate in research were sent to caregivers (parents or legal guardians) whose names appeared as primary caregivers of African American children who were enrolled in an urban elementary school. After letters of invitation were sent, school-based staff phoned caregivers to provide further information about the research opportunity, answer questions, and screen interested families for eligibility. Only one child and one caregiver could participate per eligible family. In families with more than one caregiver, any caregiver could participate. Inclusion criteria were (a) caregiver-reported African American

ethnicity of both child and caregiver, (b) age of child within 8–12 years, inclusive, and (c) residence within the United States since both the child and caregiver were 4 years old. Structured interviews were held at school after class or on Saturdays. After obtaining consent from caregivers and assent from children, trained members of the research team interviewed family members in separate rooms via a close-ended structured survey.

The survey assessed a variety of topics that may impact children's well-being, including (a) caregivers' exposure to stressful events, (b) caregivers' affective symptoms, and (c) caregivers' and children's resources for social support. Caregivers were given the option to self-administer surveys or to have questions be read to them by an interviewer and choose responses from Likert scales displayed on response cards. Most caregivers chose to have questions be read to them. All study procedures were approved by the Institutional Review Board (IRB) of the authors' university and the participating school district. Each family member was compensated with a \$20 Target gift card for participation.

3.3. Research Population

Among 151 potentially eligible African American families on the 2011/2012 school enrollment list, 40 (26.5%) consented to be interviewed. An additional six African American families with children who subsequently transferred from the school had been interviewed prior to the 2011/2012 academic year as part of piloting. These six families were included in the study sample because interview procedures did not vary between piloting and subsequent data collection. This yielded a total sample of 46 African American families; 43 of 46 caregivers (93.5%) and 21 of 46 children (45.7%) were female. The mean age of children was 10.3 years ($SD=1.4$).

Nearly two-fifths of households (39.1%) were headed by two parents. Forty of the 46 households (87%) included biological mothers, 9 (19.6%) included biological fathers, and 12 (26.1%) included a stepfather or man who was described as fulfilling a father role. In addition, 3 households (6.5%) included aunts, 4 (8.7%) included uncles, 8 (17.4%) included grandmothers, and 2 (4.3%) included grandfathers. Caregivers were not asked to identify whether each extended family member acted in a supplemental or surrogate caregiving role.

When asked to describe their relationship status, nearly a fifth (19.6%) of interviewed caregivers reported being married; an additional 23.9% reported being unmarried and in a relationship that was the same as being married. Slightly over 15% reported being single and in a relationship; 41.3% reported being single and not in a relationship. The majority of mothers (76.9%) had graduated from high school; 10.3% had also completed a 4-year degree.

3.4. Measures

Stressful life events among caregivers were assessed through the Peri Life Events Scale (Dohrenwend, Krasnoff, & Askenasy, 1978), which was developed with a racially and ethnically diverse sample. In addition to 46 items from this scale, the following four items were added to reflect potential incidents of institutionalized discrimination: (a) I was forced to move from my home; (b) I was harassed by bill collectors; (c) I was harassed or

discriminated against by the police; and (d) A close family member, significant other, or friend got in trouble with the law. Caregivers indicated whether each event occurred in the past year (0=no; 1=yes), yielding a total life events composite score ranging from 0 to 50. Selected life events were tallied to create specific domains of non-mutually exclusive stressor exposure. Domains were as follows: 10 economic events (e.g., I had my car, furniture, or other belongings repossessed); 10 work-related events (e.g., I took on a greatly increased work load); 6 law-related events (I was accused of something for which a person could be sent to jail); 4 health-related events (e.g., I was unable to get treatment for an illness or injury); and 4 relationship-related events (e.g., My relationship with my spouse/significant other changed for the worse). Consistent with other life events checklist measures, test-retest reliability for the Peri Life Events Scale is modest (correlations above .55 for event subgroups across a 10-month recall period) (Raphael, Cloitre, & Dohrenwend, 1991). The number of events reported is significantly lower when events are recalled over an extended period of time (e.g., 10 months) than when they are reported monthly (Raphael et al., 1991).

Community violence exposure among caregivers was assessed through a modified version of the Things I Have Seen and Heard Scale, which has been shown to be valid and modestly reliable among children over a 2-year period (Thompson et al., 2007). Caregivers indicated whether each of 10 community-based events (e.g., heard gun shots) occurred since the time they had been caring for the participating child (0=never), as well as the number of times each occurring event had taken place (1=once, 2=twice, 3=three times, 4=four or more times). These scores were summed to create a community violence exposure composite.

Affective symptoms among caregivers were assessed with the Depression, Anxiety, Stress Scales (DASS) Short Form, shown to be both valid and reliable over time (Antony, Bieling, Cox, Enns, & Swinson, 1998; Henry & Crawford, 2005). Caregivers indicated whether each item 'did not apply to me at all' during the past week (coded 0), or applied 'some of the time' (coded 1), 'a good part of the time' (coded 2), or 'most of the time' (coded 3). Items were summed within each scale. Cronbach's alpha indices of internal consistency for the present study are as follows: *Depression* (e.g., I couldn't seem to experience any positive feeling at all; 7 items; $\alpha=.92$); *Anxiety* (e.g., I felt that I was close to panic; 7 items; $\alpha=.83$); *Stress* (e.g., I tended to overreact to situations; 7 items; $\alpha=.87$). Caregivers also completed the *Angry Afterthoughts* subscale of the Anger Rumination Scale, a valid and reliable measure (test-retest reliability coefficient = .77 over a 1-month period) (Sukhodolsky, Golub, & Cromwell, 2001). Participants rated each item using a 4-point scale ranging from 1=almost never to 4=almost always. The six items were averaged to form a composite (e.g., When something makes me angry, I turn this matter over and over again in my mind; $\alpha=.83$).

Different domains of perceived support among caregivers were assessed through the Social Provisions Checklist, a valid measure (Davis, Morris, & Kraus, 1998). Prior to reading items, the interviewer explained, 'In this next section, I'll be asking how much you get different kinds of benefits from your relationships with other people. Relationships with some people may provide different benefits than relationships with other people. That's okay. Just tell me how much you get each benefit.' Caregivers who chose to self-administer

surveys read a similar set of instructions before completing the checklist. Caregivers rated each item on a 5-point scale ranging from 1=not at all to 5=very much. Six perceived support subscales, each comprised of five items, were computed by averaging across items. Support subscales and Cronbach's alpha indices of internal consistency for the present study are as follows: (a) *Attachment* (e.g., emotional closeness; $\alpha=.82$); (b) *Reassurance of worth* (e.g., appreciation of your abilities; $\alpha=.82$); (c) *Guidance* (e.g., trustworthy advice; $\alpha=.86$); (d) *Reliable alliance* (e.g., reliable help; $\alpha=.87$); (e) *Social integration* (e.g., a feeling of being included; $\alpha=.84$); (f) *Opportunity for nurturing others* (e.g., a feeling of being needed; $\alpha=.85$).

Two domains of children's perceived support from caregivers, as well as perceived conflict with caregivers, were assessed through the Family Support and Conflict Scales (Wills & Cleary, 1996; Wills & Shinar, 2000). Using a modified 3-point scale (1=not at all; 2=a little; 3=very much), children rated the extent to which different items were true for their caregiver. Items were averaged within subscales. Perceived support subscales and Cronbach's alpha indices of internal consistency for the present study are as follows: (a) *Emotional support* (e.g., I can share my feelings with my (caregiver); 5 items; $\alpha=.79$); (b) *Instrumental support* (e.g., If I'm having a problem with a friend, my (caregiver) would have advice about what to do; 6 items; $\alpha=.63$); (c) *Conflict* (e.g., I have a lot of arguments with my (caregiver); 3 items; $\alpha=.64$).

3.5. Analyses

Distributions of and correlations between study variables are reported. Correlations between children's perceived support and other variables are adjusted for child's age and gender. Correlations utilized transformed variables for caregivers' perceived social support (squared); caregivers' depression and anxiety scales and children's perceived conflict with caregiver (natural log); and children's perceived emotional and instrumental support from caregiver (cubed). Transformations were conducted to reduce the influence of extreme values that were low in frequency. Correlations are effect sizes, or in other words, indices of strength of association between two variables. Correlation coefficients of .10 are considered 'small,' whereas correlations of .30 are considered 'moderate' and those of .50 are considered 'large' in terms of magnitude of effect sizes (Cohen, 1988).

Multiple linear regression analyses of children's variables (perceived support and conflict) on caregiver variables were planned only in the event that different domains of caregiver variables (stressors, perceived support, affective symptoms) were associated with children's variables. Multiple linear regression analyses of caregivers' affective symptoms (depression, anxiety, stress, anger) on caregivers' stressors and perceived support were planned only if both stressors and perceived support were associated with affective symptoms. Multiple linear regression analyses inform the question of whether different domains of caregivers' life experiences appear to independently influence their affective symptoms and children's perceptions of support and conflict.

4. Results

4.1. Caregivers' Stressors and Affective Symptoms

The left portion of Table 1 shows that the mean number of total life events experienced by caregivers within the last year was 8.2. On average, caregivers reported 1.8 of 10 possible economic-related events, 1.9 of 10 possible work-related events, 1.2 of 6 possible law-related events, 0.3 of 4 possible health-related events, and 1.0 of 4 possible relationship-related events. Since the time their child was born, caregivers experienced an estimated 16 violent events, on average. When compared to the normed values of the short-form version of the Depression, Anxiety, Stress Scales (DASS-21), mean levels within the present sample were higher for depression ($M=5.1$ vs. $M=2.8$), anxiety ($M=3.6$ vs. $M=1.9$), and stress ($M=7.5$ vs. $M=4.7$) (Henry & Crawford, 2005). When compared to normed values of the Anger Rumination Scale for women, the present sample reported similar levels of angry afterthoughts ($M=2.1$ vs. $M=1.9$) (Sukhodolsky, Golub & Cromwell, 2001).

4.2. Caregivers' and Children's Perceived Support

The top left portion of Table 2 shows that caregivers' mean levels for each type of support were relatively high (between 3.9 and 4.2) compared to the scale midpoint of 3. Correlations across caregivers' perceptions of support in different domains were significant (see top right portion of Table 2; r 's ranged between .65 and .87).

The bottom left portion of Table 2 shows that children reported high levels of emotional and instrumental support from caregivers ($M=2.6$ and $M=2.7$, respectively) compared to the scale midpoint of 2, while report of conflict was relatively low ($M=1.4$). Children's perceptions of emotional and instrumental support from their caregivers were correlated but not redundant with one another ($r = .44$, $p < .01$, not shown in table). Children's perception of conflict with their caregiver was associated with lower levels of perceived emotional support ($r = -.43$, $p < .01$) and instrumental support ($r = -.35$, $p < .05$).

4.3. Inter-Correlations between Study Variables

Table 3 shows correlations between caregivers' exposure to stressors in the past year and their recent affective symptoms. Angry afterthoughts were not associated with any of the measured caregiver stressors. Caregivers who experienced a greater number of total life events and work-related, law-related, or relationship-related events reported more symptoms of depression and stress. In addition, caregivers who experienced a greater number of law-related events reported more symptoms of anxiety. In this sample, experience of economic-related and health-related stressors was not associated with affective symptoms. Caregiver report of community violence since the time their child was born was also not associated with recent affective symptoms.

The top right portion of Table 1 shows that there were no significant correlations between caregivers' exposure to stressors and caregivers' perceived support in different domains. The bottom portion of Table 1 shows correlations between caregivers' perceived support in different domains and caregivers' affective symptoms. Lower levels of attachment and social integration were correlated with more symptoms of depression, anxiety, stress, and

anger. Lower level of reassurance of worth was correlated with symptoms of depression, stress, and anger. Lower level of guidance was associated with depression and stress. Lastly, lower level of perceived opportunity for nurturance was correlated with anxiety. There were no significant associations between caregivers' reliable alliance with others and affective symptoms.

The right portion of Table 2 shows correlations between caregivers' and children's perceived support (see bottom three rows). Children who perceived high instrumental support from their caregiver tended to have caregivers who reported greater attachment, reassurance of worth, guidance, reliable alliance, social integration, and opportunity for nurturance of others. When children reported greater emotional support from their caregiver, caregivers tended to report greater attachment to members of their social network. Children's report of conflict with their caregiver was not significantly associated with caregivers' report of support in any domain. Of note, caregiver-reported stressors and affective symptoms were not associated with children's perceptions of support from and conflict with their caregiver (data not shown in table).

4.4. Multiple Linear Regression Analyses

Caregivers' perceived support from their network, but not their reported stressors and affective symptoms, were associated with children's perceived support from their caregivers. Thus, multiple linear regressions of children's perceived support on different caregiver variables was not conducted. Both caregivers' stressful life events and perceived support from their network were associated with caregivers' affective symptoms. Table 4 shows results from a series of multiple linear regression analyses in which a single index of caregivers' self-reported affective symptoms (depression, anxiety, stress, and anger) was regressed on caregivers' total social support composite and total number of stressful life events. Total social support was significantly associated with fewer symptoms of depression ($\beta = -.06$; $SE = .02$), anxiety ($\beta = -.05$; $SE = .02$), and stress ($\beta = -.32$; $SE = .11$), independent of total life events. Total life events were significantly associated with more symptoms of depression ($\beta = .05$; $SE = .02$) and stress ($\beta = .35$; $SE = .12$), independent of total social support.

5. Discussion and Implications

5.1. Caregivers' Perceived Support from Others in Relation to Children's Perceived Support from their Caregiver

The present findings, when viewed alongside the larger literature, suggest that African American caregivers' resources for support are linked to the well-being of their children. Previous research has demonstrated that caregivers' perceived support from their social network is associated with children's social and cognitive competence (Burchinal et al., 1996; Shook et al., 2010) and affective symptoms (Taylor, Seaton, & Dominguez, 2008), as well as parent/child communication (Hoagwood et al., 2010). The present study's novel contribution is to demonstrate that caregivers' perceived support from their social network is associated with children's perceived support from their primary caregiver. When African American caregivers perceived they were well supported by their social network, children

perceived greater instrumental support from caregivers. Instrumental support represents caregivers' ability to assist their children across a variety of tasks (Wills, Vaccaro, & McNamara, 1992). Support from others may allow caregivers to provide instrumental support to their children, which may in turn help children develop tangible skills to navigate stressful situations throughout life (Alliman-Brissett, Turner, & Skovholt, 2004). This may be true regardless of the form that supportive interactions take within caregivers' social networks. In the present study, caregivers' perceptions of greater attachment, reassurance of worth, guidance, reliable alliance, and social integration were all associated with children's perceptions of greater instrumental support from their caregiver. In contrast, only caregivers' perceived attachment to their social network (e.g., emotional closeness) was significantly associated with children's perceptions of emotional support from their caregiver. Caregivers' close emotional relationships may assist them in forming a similar bond with their children. No associations between caregivers' perceived support from their social network and children's perceptions of conflict with their caregiver were found. It may be that caregivers differ in the degree to which they draw upon support from their network to prevent and handle conflict with their child, leading to no overall association between caregivers' perceived social support and children's perception of conflict with their caregiver.

5.2. Caregivers' Stressor Exposure and Affective Symptoms

In the present study, African American caregivers' stressors and affective symptoms were not associated with children's perceived support from or conflict with their caregiver. These findings suggest that many caregivers can experience stressors and affective symptoms and still be able to provide support to their children. However, caregivers' well-being does appear to be impacted by their stressors and resources for support from their network. Caregivers experienced an average of eight potentially disruptive life events per year. However, some families experienced as many as 24 events per year. Higher numbers of work-related, law-related, and relationship-related events were associated with greater depression and stress; in addition, higher numbers of law-related events were associated with greater anxiety. Caregivers' stressful life events were not associated with caregivers' perceived support from their social network, suggesting that some caregivers had adequate resources for support when they experienced adversity while others did not. Caregivers' perceived support from their network was associated with fewer affective symptoms. Social integration and attachment to one's social network, in particular, were associated with fewer reported symptoms of depression, anxiety, stress, and anger. Furthermore, regression analyses demonstrated that low levels of social support and higher numbers of stressful life events were independently associated with symptoms of depression and stress among caregivers. One advantage of having a supportive social network is that network members can assist in coping with stressors and avoiding potentially controllable stressors in the future. Collectively, findings highlight the importance of having a supportive social network with respect to caregivers' own well-being, as well as their ability to provide support to their children.

5.3. Implications for Practice

The present study's findings have several implications for community-based practices to promote mental health of both caregivers and children. First, organizations that provide mental health services for children should consider whether they may have a greater impact if they include caregivers by offering family-based services. Schools often provide programming to support the positive development of youth, which in turn may prevent early mental health problems (Weare & Nind, 2011). Teachers and other staff observe and interact with students on a regular basis, and have the potential to interact with students' caregivers as well. Based on the literature, several researchers have concluded that school-based mental health interventions should engage and support families to be most effective in promoting positive youth development and children's mental health (e.g., Greenberg, Domitrovich, & Bumbarger, 2001; Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2002; Browne, Gafni, Roberts, Byrne, Majumdar, 2004; Diekstra, 2008).

However, simply involving caregivers in programs designed for youth may not be enough. The present results suggest that caregivers must be well-supported in order to be perceived as a reliable source of emotional and instrumental support by children. Specifically, interventions should attempt to enhance caregivers' social networks such that caregivers perceive greater attachment to others, reassurance of their worth, guidance from others, reliable alliance, social integration, and opportunities to provide nurturance to others. In the present study, these categories of caregivers' perceived social support were associated with children perceiving greater instrumental support from their caregivers. Enhancing caregivers' attachment to others in their social network is particularly important, as this category of perceived social support was associated with children perceiving greater emotional support from their caregivers as well.

Thus, a second implication of the present study's findings is that organizations providing mental health services for children may have a greater impact if they offer individual services to caregivers. For example, caregivers may benefit from school programming that allows them to form relationships with one or more staff members and view staff as part of their network of support. A recent literature review by Hoagwood et al. (2010) revealed that less than one-third of family support programming includes emotional and affirmational support for caregivers (i.e., shared communication to promote caregiver's feelings of being appreciated) as a key component of programming. For families whose members face stressors related to socioeconomic status and race, support provided through school programming may be particularly likely to promote positive youth outcomes (Hoagwood et al., 2010; Stormshak et al., 2011). By focusing on the well-being and mental health of caregivers, school- and other community-based programming may be able to prevent and/or ameliorate children's mental health symptoms. Program staff can attempt to augment caregivers' existing support networks by periodically contacting caregivers and offering guidance or referral to a variety of resources. Program staff may also be in a position to provide individual counseling and/or referral to mental health services for caregivers who may not have a strong network of support to cope with stressors or who may be experiencing affective symptoms.

A third implication of the present study's findings is that many African American caregivers are capable of supporting their children despite experiencing stressful life circumstances and affective symptoms. In the present study, caregivers' stressors and affective symptoms were not associated with children's perceptions of support from caregivers. This type of resilience is not always part of the canon of human service professionals and thus, may not be acknowledged as a strength of African American caregivers.

In summary, caregivers' perceptions of support from their social network were associated with children's perceptions of emotional and instrumental support from caregivers. This not only highlights the importance of providing direct services for caregivers who may be in need of assistance, but also of encouraging caregivers to form and nurture social ties to individuals who may enhance their ability to provide support to their children.

5.4. Study Limitations

Findings should be considered in light of limitations, including the study's small sample size and cross-sectional design, which precluded more sophisticated analytic techniques.

Although it is plausible that caregivers' perceptions of support from their social network could impact their parenting, and in turn children's perceptions of support from the caregiver, strong inferences about causality cannot be drawn. Similarly, although findings are consistent with a model in which inadequate support from caregivers' social network may lead to caregivers' development of affective symptoms, causality cannot be inferred. It is possible that affective symptoms were off-putting to some social network members and resulted in less offered and perceived support. However, affective symptoms were not significantly associated with the reliable alliance measure in the present study, which would seem to contradict the possibility that affective symptoms led to lower levels of support. In one longitudinal study of adults, Cruwys et al. (2013) found that higher levels of social group membership reduced the risk of future depression among adults with a history of symptoms, and predicted lower likelihood of future depression among adults who were not initially depressed (Cruwys et al., 2013). Thus, it is plausible that supportive relationships impacted the mental health of African American caregivers in the present study.

Future longitudinal research should examine associations between study variables in a larger African American sample, as well as other communities that experience disproportionate numbers of stressors, have been historically disadvantaged, or are more likely to experience disparities in mental health and educational attainment. A larger study sample would allow for examination of potential differences in perceived support and associations between caregiver-child variables in households that vary with respect to kinship caregiving. Gibson (2014) has highlighted differences between primary caregivers and supplemental caregivers with respect to roles enacted; these differences may impact relationships between children and caregivers. Future research should also take possible confounding variables into account, including both child and caregiver characteristics (e.g., caregivers' parenting style; children's personality).

5.5. Conclusion

The support that African American caregivers receive from their social network may be a critical determinant of whether children perceive adequate emotional and instrumental support from caregivers. Caregivers may be in a better position to support their children emotionally if they are attached to others in their social network. Caregivers' provision of instrumental support to their children may be facilitated by caregivers' perceptions and receipt of support in a variety of domains, including being attached to and integrated with others, reassured of their worth, guided by others, and able to rely on others.

African Americans are disproportionately exposed to stressors that may constrain community members' ability to support one another (Cutrona, Russell, Hessling, Brown, & Murry, 2000). If future research is consistent with the present set of findings, this body of work may be used to aid in the justification of policies that expand school-based mental health programs and services to include caregivers as well as school-attending children. Community-based and school-based mental health practitioners should attempt to increase their visibility and accessibility among African American communities. Practitioners may need to be creative in their strategies to encourage caregivers to utilize resources for support, as many caregivers prioritize the needs of their children above their own, and thus delay seeking support (Pavuluri, Luk, & McGee, 1996). Additionally, African Americans often delay or forego seeking mental health services because of the stigma associated with it (Swick, 2004). School-based mental health practitioners are in an ideal position to assess the social support and mental health needs of caregivers and to provide appropriate referrals and/or services, as they are in an accessible community setting. School-based mental health practitioners can also facilitate links to less formal resources for support by offering information about surrounding neighborhood and community groups that meet regularly. Attending to the need for caregivers to receive social support may ultimately benefit the mental health of their children.

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Highlights

- Caregivers who experience a higher number of life stressors report more symptoms of depression, anxiety, and stress.
- Caregivers' perceived resources for support – but not their life stressors and affective symptoms – are associated with children's perceptions of support from caregivers.
- Caregivers' social networks may assist them in providing vital emotional and instrumental support to their children.

Table 1

Distributions of caregivers' stressors and affective symptoms and correlations with perceived support. ^a

Variable	M (SD)	Observed Range	Atfch	Caregivers' Perceived Support (n=46)				
				RoW	Guid	Rel All	Soc Int	Opp Nurt
Caregivers' Stressors								
Life Events								
Total	8.2 (6.0)	0-24	.05	-.00	-.08	-.08	-.04	.10
Economic	1.8 (1.6)	0-5	.17	.19	.15	.08	.08	.13
Work	1.9 (2.0)	0-8	.08	.07	.10	.03	-.03	.13
Law	1.2 (1.5)	0-5	-.14	-.18	-.28	-.12	-.14	-.17
Health	0.3 (0.6)	0-3	-.02	-.05	-.14	-.13	-.05	-.12
Relationships	1.0 (1.1)	0-4	-.01	-.08	-.16	-.17	-.05	.07
Community Violence Exposure	16.0 (10.4)	0-39	.02	.08	.10	.18	.10	.12
Caregivers' Affective Symptoms								
Depression	5.1 (5.8)	0-21	-.34 *	-.40 **	-.34 *	-.27	-.53 ***	-.25
Anxiety	3.6 (4.4)	0-19	-.34 *	-.22	-.21	-.06	-.41 **	-.39 **
Stress	7.5 (5.4)	0-21	-.36 *	-.38 *	-.33 *	-.17	-.51 ***	-.26
Anger	2.1 (0.8)	1-4	-.33 *	-.32 *	-.20	-.15	-.31 *	-.23

^a Atch=Attachment; RoW=Reassurance of Worth; Guid=Guidance; Rel All=Reliable Alliance; Soc Int=Social Integration; Opp Nurt=Opportunity for Nurture.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Table 2

Distributions of and correlations between caregivers' and children's perceived support.

Variable	M (SD)	Observed Range	Caregivers' Perceived Support ^a (n=46)					
			Atch	RoW	Guid	Rel All	Soc Int	Opp Nurt
Caregivers' Perceptions								
Attachment	3.9 (1.0)	1.2–5	--					
Reassurance of Worth	4.2 (0.8)	2.2–5	.86***	--				
Guidance	4.0 (1.0)	1.4–5	.82***	.87***	--			
Reliable Alliance	3.9 (1.0)	1.4–5	.73***	.79***	.86***	--		
Social Integration	3.9 (1.0)	1–5	.84***	.84***	.80***	.74***	--	
Opportunity for Nurturance	4.1 (0.9)	1.6–5	.82***	.81***	.76***	.65***	.70***	--
Children's Perceptions ^b								
Emotional Support	2.6 (0.4)	1.2–3	.31*	.23	.21	.24	.22	.19
Instrumental Support	2.7 (0.3)	1.7–3	.34*	.40**	.32*	.53***	.33*	.33*
Conflict with Caregiver	1.4 (0.5)	1–3	-.10	-.22	-.11	-.27 +	-.10	-.05

^a Atch=Attachment; RoW=Reassurance of Worth; Guid=Guidance; Rel All=Reliable Alliance; Soc Int=Social Integration; Opp Nurt=Opportunity for Nurturance

^b Adjusted for children's age and gender.

+ $p < 0.10$.

* $p < 0.05$.

** $p < 0.01$.

*** $p < 0.001$.

Table 3

Correlations between caregivers' stressors and affective symptoms.

	Caregivers' Affective Symptoms (<i>n</i> =46)			
	Depression	Anxiety	Stress	Anger
Caregivers' Stressors				
Life Events				
Total	.35*	.12	.39*	-.13
Economic	.20	.04	.21	-.11
Work	.29*	.04	.35*	.01
Law	.35*	.32*	.31*	.02
Health	.07	.11	.20	.02
Relationships	.30*	.07	.34*	-.11
Community Violence Exposure Composite	-.03	.04	.04	.03

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

Table 4
 Caregivers' self-reported affective symptoms, regressed on the total social support composite and total number of stressful life events.

Independent Variables	Depression			Anxiety			Stress			Anger		
	β	SE	95% CI	β	SE	95% CI	β	SE	95% CI	β	SE	95% CI
Total social support	-.06 **	.02	-.10, -.02	-.05 *	.02	-.09, -.00	-.32 **	.11	-.55, -.09	-.04	.02	-.08, .00
Total life events	.05 *	.02	.01, .10	.02	.02	-.03, .06	.35 **	.12	.11, .58	-.02	.02	-.06, .02

* $p < .05$.

** $p < .01$.

*** $p < .001$.