Racial/Ethnic Differences in Caregiver Strain and Perceived Social Support Among Parents of Youth With Emotional and Behavioral Problems

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This study examined several hypotheses related to racial/ethnic variations in caregiver strain and perceived social support among parents caring for children with emotional/behavioral problems. A subsample of youth from the Patterns of Care (POC) study, which drew a stratified random sample of high-risk youth active to 1 of 5 public sectors of care, was used to test these hypotheses. When controlling for youth age, parental education, presence in an alcohol/drug or mental health (ADM) sector, and severity of child problems, African Americans reported significantly lower caregiver strain than did non-Hispanic Whites (NHWs), whereas Asian/Pacific Islanders (APIs) and Latinos did not differ significantly from NHWs. Contrary to prediction, both African Americans and APIs reported significantly lower perceived social support than NHWs, whereas Latinos did not differ significantly from NHWs. When perceived social support was controlled, the tendency of African American and API parents to report lower caregiver strain than NHWs became more pronounced. Thus, differences in perceived social support did not explain African Americans’ lower caregiver strain. Other cultural variables such as familism and tolerance should be examined to identify processes that result in reduced perception of caregiver strain among African American parents caring for children with emotional/behavioral problems.

KEY WORDS: caregiver strain; burden of care; race/ethnicity; Children and adolescents; emotional/behavior problems; parental burden; family impact.

Caregiver strain has attracted increased attention among researchers seeking to understand the experience of parents caring for a child with an emotional or behavior problem (Farmer, Burns, Angold, & Costello, 1997). Caregiver strain has been defined as “the demands, responsibilities, difficulties, and negative psychic consequences of caring for relatives with special needs” (Brannan, Hellinger, & Bickman, 1997, p. 212). Caregiver strain, often referred to as “burden of care,” or “family impact,” was first given attention in the study of family caregivers of dementia patients (e.g., Aranda & Knight, 1997; Janevic & Connell, 2001), but has also been found to be relevant to families caring for adult mentally ill family members (Guarnaccia & Parra, 1996; Horwitz & Reinhard, 1995), and more recently, children with emotional and behavioral problems (Angold et al., 1998; Brannan et al., 1997; Farmer et al., 1997; Messer, Angold, Castello, & Burns, 1996; Owens et al., 2002).
Angold et al. (1998) found that 10.7% of parents in a community sample that participated in the Great Smoky Mountains Study (GSMS) perceived burden associated with their children’s symptoms. In the GSMS sample, parents of youth with a psychiatric disorder or impairment who received mental health services in any setting reported more worries, depression, feelings of incompetence due to their children’s symptoms than did parents of non-service using youth (Farmer et al., 1997). Furthermore, data from the GSMS indicated that parental burden accounted for the relationship between disorder severity and mental health service use among youth with emotional and behavioral problems (Angold et al., 1998; Farmer et al., 1997). In addition, a recent study reported an association between parenting difficulties and additional stressors resulting from their children’s psychosocial problems and perceived barriers to mental health care among a primarily African American sample, suggesting that caregiver strain is likely to play a role in inhibiting service use among African American families (Owens et al., 2002). Thus, caregiver strain appears to be of significant importance in understanding the experience of parents of youth with emotional and behavioral problems. However, these studies have not included sufficient diversity to examine how the experience of caring for a youth with emotional and behavioral problems may differ across racial and ethnic groups.

Studies of caregivers of adult family members indicate important differences in the caregiving experience across racial/ethnic groups. For example, several studies have found that African American caregivers suffer from less depression and report less burden than do non-Hispanic Whites (NHWs), even given similar or more demanding caregiving roles for a relative with dementia (e.g., Connell & Gibson, 1997; Fredman, Daly, & Lazur, 1995; Haley et al., 1996), an adult with mental retardation (Valentine, McDermott, & Anderson, 1998; Hatchett & Jackson, 1993; Uba, 1994). Strong social networks may relieve caregiver strain by distributing responsibility for caregiving tasks across a wider number of individuals, and by reducing the feelings of isolation and loneliness that can be associated with caregiving. Thus, racial/ethnic differences in perceived social support may explain the relationship between race/ethnicity and caregiver strain. However, despite suggestions that ethnic minority families have stronger social support networks than do NHWs, a recent review of the literature has called this into question (U.S. Department of Health and Human Services [USDHHS], 2001). Several studies have found that although a cultural emphasis may be placed on familialism among ethnic minorities, they may be no more likely to have strong social support networks than are NHWs (Haley et al., 1996; Roschelle, 1997). Questions remain as to whether ethnic minority families experience or perceive greater social support, and whether this support helps to reduce perceptions of strain when caring for an ill family member. Studies have also yet to examine the relationship between perceived social support and caregiver strain among caregivers of youth with emotional/behavioral problems.

This study utilizes cross-sectional data from the Patterns of Youth Mental Health Care in Public Service Systems Study (POC), which drew a multiethnic, stratified random sample of high-risk youth active to one of five public sectors of care, to examine racial/ethnic variations in caregiver strain among parents caring for children with emotional/behavioral problems and to test the hypothesis that racial/ethnic differences in perceived social support explain race/ethnic differences in caregiver strain in this population. The study was guided by the hypotheses that, among parents caring for youth with
emotional/behavioral problems with a history of public service use

1. African American, API, and Latino parents will perceive lower levels of caregiver strain than will NHW parents, controlling for potential confounds;
2. higher perceived social support will be associated with lower caregiver strain;
3. African Americans, APIs, and Latinos will report higher perceived social support than will NHW parents, controlling for potential confounds; and
4. racial/ethnic differences in perceived social support will account for racial/ethnic differences in caregiver strain.

METHOD

Participants

Participants were a subsample composed of 999 youth aged 11–18 and their parents, drawn from the larger POC sample. Youth were included if they met our criteria (described below) for having emotional/behavioral problems; were identified by self or parent as either African American, API, NHW, or Latino; were being cared for by a parent or other close relative; and had complete data on all study variables.

The POC study surveyed a representative sample \( (N = 1,715) \) of youth aged 6–17 who were active to one or more public sectors of care in San Diego County (alcohol/drug treatment, child welfare, juvenile justice, mental health, and youths designated as having Serious Emotional Disturbance (SED) in the public schools) during fiscal year 1996–97. On average, participants completed an interview 1 year after their presence in a service sector was recorded (range 4–24 months). In juvenile justice, only adjudicated delinquents were included, and in child welfare, only court-ordered dependents were included. These restrictions excluded individuals in both child welfare and juvenile justice whose cases were still under investigation or review. From the sampling frame of 12,662, a total of 3,417 were randomly selected for recruitment. Of these 3,417 cases, 845 (24.7%) refused to participate, 791 (23.2%) could not be located, and 66 (2%) could not be recruited for other reasons (e.g., unable to obtain ex parte order for permission to participate). At least one member of the parent–child dyad was interviewed in 1,715 cases. Participants did not differ significantly from nonparticipants on age, gender, sector affiliation, or race/ethnic distribution except that slightly fewer Asians participated relative to the eligible sample. The sample was stratified by service-sector affiliation, race/ethnicity (as determined by administrative data), and level of restrictiveness of treatment setting (i.e., home vs. aggregate care setting). Because particular groups were purposely oversampled to ensure adequate sample size for subgroup analysis (e.g., APIs and youth in alcohol/drug treatment), a poststratification weighting procedure was used to ensure that the data reflect the proportions of these groups in the total population of service users (Henry, 1990). All analyses were conducted using the STATA 7.0 statistical package.

Of those youth included in this study, 13.4% had received services from alcohol/drug treatment, 11.0% from child welfare, 37.1% from juvenile justice, 55.4% from mental health, and 27.8% from school services for youth with SED during the second half of fiscal year 1996–97. Some 36.6% received services from more than one sector of care. The racial/ethnic distribution was 43.2% NHW, 29.9% Latino, 18.4% African American, and 8.4% APIs. The average age at the time of the interview was 15.26 years \( (SD = 2.09) \) and the sample was 29.9% girls \( (n = 299) \). Median household income fell between $18,000 and 18,999 per year. Parents/primary caregivers with a high school diploma or lower level of education made up 60.7% of the sample.

Procedure

Parents/primary caregivers (hereafter referred to as parents) were interviewed in person about the child's demographic characteristics, psychological symptomatology, service-use history, and exposure to risk and protective factors. Youth also reported in person on their own psychological symptomatology and service-use history. Parent and youth interviews were conducted an average of 7.78 days apart \( (SD = 47.1 days) \). Ninety-two percent of the parent and child interviews were conducted within 1 month of each other. Parents were paid $40.00 and youth were paid between $10.00 and 40.00, depending on age, for their participation.

Measures

Demographic Factors

Parents reported their yearly household income and the highest grade they had completed. Income
was measured using an incremental scale developed by the UNOCCAP (Use, Needs, Outcomes, and Costs in Child and Adolescent Populations) Work Group (1996) that allowed participants to select a numerical value of 1–32 that corresponded to distinct levels of income ranging from <$1,000 to $200,000. Parents also reported the age, gender, and race/ethnicity of the child.

**Diagnostic Interview Schedule for Children (DISC-IV; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000)**

Interviewers trained by a member of the DISC advisory board administered selected modules of the computer-assisted version of the DISC-IV to parents and youth. The DISC-IV is a widely used, structured diagnostic interview that generates categorical DSM-IV diagnoses for youth along with age of onset of each disorder. The DISC-IV has demonstrated adequate reliability for most diagnoses with Latino samples, and both reliability and validity with NHW samples (Bravo et al., 2001; Shaffer et al., 2000). A youth was considered positive for a categorical diagnosis if the parent or child report met full diagnostic criteria and had at least one moderate level of diagnostic specific functional impairment endorsed during the past year.

**Child Behavior Checklist (CBCL; Achenbach, 1991a) and Youth Self-Report (YSR; Achenbach, 1991b)**

CBCL and YSR were administered to parents and youth, respectively. The CBCL and YSR are parallel scales of child psychological symptomatology with established reliability and validity for both English- and Spanish-speaking samples (Achenbach, 1991a, 1991b). The CBCL provides age-normed comparisons for children aged 2–18, and YSR provides age-normed comparisons for children aged 11–18. The CBCL and YSR both produce overall Total Problem Behaviors Scores and broadband indices of Internalizing Problems and Externalizing Problems occurring during the previous 6 months. Scores on these scales were used as categorical variables for the purpose of sample selection, but were entered as continuous scores into multiple regression models.

**Child Global Assessment Scale (CGAS; Shaffer et al., 1983, 1996; Bird, Canino, Rubio-Stipec, & Ribera, 1987)**

CGAS scores were assigned by lay interviewers of both the youth and parent. The CGAS provides a global rating of the child’s functioning on a continuous scale from 0 to 100, with higher scores reflecting better functioning over the past year. The CGAS has demonstrated acceptable reliability and validity (Shaffer et al., 1983).

**Columbia Impairment Scale (CIS; Bird et al., 1993)**

CIS is a 13-item continuous scale with both parent and youth versions that reliably assess the extent to which a child experiences functional impairment over the previous 6 months among both Latino and NHW samples. Higher scores on the CIS reflect greater impairment. Children aged 9–18 completed the CIS for youth. Cronbach’s alpha values for the POC sample were .88 for the parent version and .82 for the youth version.

**Caregiver Strain Questionnaire (Brannan et al., 1997)**

The Caregiver Strain Questionnaire is a 21-item continuous scale designed to measure the impact of caring for a child with emotional and behavioral problems in six areas: economic burden, impact on family relations, disruption of family activities, impact on psychological adjustment of family members, stigma, anger, and worry/guilt. Parents were asked to report on a 5-point scale how much of a problem each item was during the past 6 months as a result of his or her child’s emotional and behavioral difficulties (sample item: “During the last six month, how much of a problem was interruption of personal time resulting from [child’s] emotional and behavioral difficulties?”). Scores were the sum of all responses divided by the number of items, and had a potential range of 1–5. Cronbach’s alpha for the POC sample was .94.

**Social Provisions Scale (Cutrona & Russell, 1987)**

Social Provisions Scale is a 12-item self-report continuous scale designed to measure global perceived social support, defined as the general impression that support would be available if needed (Sarason, Sarason, & Pierce, 1990). The questions ask...
about respondents’ perception of available social support in their lives in general and are not tied to a specific time period (sample item: “There are people I can depend on to help me if I really need it.”). Respondents rate the extent to which they agree with each statement on a 5-point Likert scale. Scores were the sum of all responses divided by the number of items, and had a potential range of 1–5. Cronbach’s alpha for the POC sample was .83.

Criteria for Presence of Emotional/Behavioral Problem

Presence of an emotional/behavioral problem was defined as meeting at least one of the following criteria: (1) a DISC-IV diagnosis; (2) CBCL or YSR Total Problems, Internalizing, or Externalizing criteria; (3) a CGAS score of 70 or below; or (4) a CIS score of 15 or above.

Analyses

First, a bivariate ANOVA comparing the four racial/ethnic groups on caregiver strain was conducted, followed by a series of post hoc t-tests comparing each group to NHWs. A Bonferroni correction was applied to control for the number of tests conducted. A multiple regression was also conducted to examine the relationship between race/ethnicity and caregiver strain controlling for demographics (youth age, gender, household income, and parental education) and problem severity (YSR and CIS youth report scores). A dichotomous variable reflecting whether the youth was sampled from an ADM sector of care (alcohol/drug services, mental health, and SED) was also entered to control for variance in caregiver strain that may be due to racial/ethnic differences in entry to public services through ADM sectors versus non-ADM sectors (e.g., juvenile justice and child welfare). Youth report on both youth functioning and symptomatology was used to reduce potential shared informant variance that would have resulted from parents reporting on both youth functioning and caregiver strain. Control variables (gender and household income) that did not change the size of the unstandardized beta weight reflecting the relationship between race/ethnicity and caregiver strain by 10% or more were eliminated from all models (Kleinbaum, Kupper, Muller, & Nizam, 1998). The remaining set of demographic variables (youth age and parent education) was retained for all analyses. All independent variables were entered simultaneously in the regression models, such that all effects reported represent the effect of that variable controlling for all other variables in the model. Second, a multiple regression examining the relationship between perceived social support and caregiver strain was conducted controlling for remaining demographics, presence in an ADM sector, and symptom severity. Third, the relationship between race/ethnicity and perceived social support was examined using both a bivariate ANOVA examining racial/ethnic differences in perceived social support and a multiple regression examining the relationship between race/ethnicity and perceived social support when controlling for potential confounds. Finally, the first multiple regression examining the relationship between race/ethnicity and caregiver strain was rerun with perceived social support as an additional independent variable, to examine whether the relationship between race/ethnicity and caregiver strain was reduced when perceived social support was taken into account. Reduction in the relationship between race/ethnicity and caregiver strain was operationally defined as a 10% or greater change in the unstandardized beta weight (Kleinbaum et al., 1998).

RESULTS

Hypothesis 1: Ethnic Differences in Caregiver Strain

An ANOVA tested the first hypotheses that African Americans, Latinos, and APIs would report lower caregiver strain than would NHWs. For caregiver strain, the overall ANOVA was significant (Adjusted F = 3.86, p < .01). t-Tests were then performed to determine which groups differed significantly from NHWs (M = 2.50, SD = 1.03). A Bonferroni correction for the number of test performed yielded a corrected alpha of .016. African Americans, (M = 2.28, SD = 1.08; t(1603) = 2.46, p < .016), and Latinos, (M = 2.30, SD = 1.03; t(1603) = 2.74, p < .01), reported significantly less strain than did NHWs. After correction, APIs did not differ significantly from NHWs on strain, M = 2.25, SD = 0.99; t(1603) = 2.05, p < .05. Results are summarized in Table 1.

When demographics, presence in an ADM sector, and problem severity were controlled, African Americans remained significantly lower on caregiver strain (B = −0.28, p < .01), however, Latino and API groups were no longer significantly different
from NHWs on reported caregiver strain ($B = -0.12$, $ns; B = -0.23, ns$). These results are summarized under “Model 1” in Table 2.

**Hypothesis 2: Relation Between Perceived Social Support and Caregiver Strain**

The second multiple regression, summarized in Table 3, indicated that perceived social support was significantly inversely related to caregiver strain ($B = -0.22, p < .001$), controlling for demographics, presence in an ADM sector, and severity of emotional/behavioral problems.

**Hypothesis 3: Ethnic Differences in Perceived Social Support**

An ANOVA comparing the four racial/ethnic groups on perceived social support was significant (Adjusted $F = 12.53, p < .001$; see Table 1). Contrary to prediction, however, African Americans, $M = 3.84, SD = 0.68; t(1630) = 3.97, p < .001$, and APIs, $M = 3.61, SD = 0.72; t(1630) = 5.23, p < .001$, reported significantly less perceived social support than did NHWs ($M = 4.07, SD = 0.62$). After Bonferroni correction, Latinos did not differ significantly from NHWs on perceived social support, $M = 3.94, SD = 0.86; t(1630) = 2.17, p < .05$.

A multiple regression was run to determine if the relationship between race/ethnicity and perceived social support persisted when controlling for potential confounds. The results, summarized in Table 4, indicated that African Americans ($B = -0.19, p < .01$) and APIs ($B = -0.39, p < .001$) reported lower perceived social support than did NHWs controlling for demographics, presence in an ADM sector, and problem severity. However, controlling for potential confounds, Latinos no longer reported lower perceived social support than NHWs ($B = -0.04, ns$).

**Hypothesis 4: Can Differences in Perceived Social Support Explain the Relation Between Race/ethnicity and Caregiver Strain?**

Next, the first regression examining the relationship between race/ethnicity and caregiver strain

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### Table 1. Bivariate Analyses of Racial/Ethnic Differences in Study Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>NHW</th>
<th>African American</th>
<th>API</th>
<th>Latino</th>
<th>Omnibus ($F$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIS youth report</td>
<td>13.35 (10.14)</td>
<td>13.51 (11.12)</td>
<td>12.43 (9.96)</td>
<td>13.47 (10.96)</td>
<td>0.88</td>
</tr>
<tr>
<td>YSR total problem</td>
<td>53.51 (12.37)</td>
<td>53.37 (14.26)</td>
<td>55.28 (12.84)</td>
<td>52.34 (16.83)</td>
<td>0.48</td>
</tr>
<tr>
<td>Caregiver strain</td>
<td>2.50 (1.03)</td>
<td>2.28 (1.08)</td>
<td>2.25 (0.99)</td>
<td>2.30 (1.03)</td>
<td>3.86**</td>
</tr>
<tr>
<td>Social support</td>
<td>4.07 (0.62)</td>
<td>3.84 (0.68)</td>
<td>3.61 (0.72)</td>
<td>3.94 (0.86)</td>
<td>12.53***</td>
</tr>
</tbody>
</table>

Note. A Bonferroni correction for the number of t tests was applied, yielding a corrected alpha of .016. Values represent mean (standard deviation).

- $p < .016$.
- $p < .01$.  
- $p < .001$.  

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### Table 2. The Effect of Perceived Social Support on the Relationship Between Race/Ethnicity and Caregiver Strain

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1 B</th>
<th>SE</th>
<th>Model 2 B</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American*</td>
<td>-0.28**</td>
<td>.09</td>
<td>-0.32***</td>
<td>.08</td>
</tr>
<tr>
<td>Asian/Pacific Islander*</td>
<td>-0.23</td>
<td>.13</td>
<td>-0.33*</td>
<td>.13</td>
</tr>
<tr>
<td>Latino*</td>
<td>-0.12</td>
<td>.09</td>
<td>-0.12</td>
<td>.08</td>
</tr>
<tr>
<td>Youth age</td>
<td>0.02</td>
<td>.01</td>
<td>0.03</td>
<td>.02</td>
</tr>
<tr>
<td>ADM sector: yes</td>
<td>0.25**</td>
<td>.07</td>
<td>0.22**</td>
<td>.07</td>
</tr>
<tr>
<td>Parental education</td>
<td>0.12**</td>
<td>.04</td>
<td>0.14***</td>
<td>.04</td>
</tr>
<tr>
<td>CIS youth report</td>
<td>0.01*</td>
<td>.00</td>
<td>0.01*</td>
<td>.00</td>
</tr>
<tr>
<td>YSR total problem score</td>
<td>0.01*</td>
<td>.00</td>
<td>0.01*</td>
<td>.00</td>
</tr>
<tr>
<td>Perceived social support</td>
<td>-0.25**</td>
<td>.05</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Model 1: $R^2 = .09, p < .001$; Model 2: $R^2 = .13, p < .001$.

- $p < .05$.
- $p < .01$.
- $p < .001$.  

*Reference group is NHW.
controlling for demographics and severity of emotional/behavioral problem was repeated, with the addition of perceived social support as an independent variable (see Model 2, in Table 2). The relationship between race/ethnicity and caregiver strain was significantly altered by the entry of perceived social support, but not in the predicted direction. Rather, the entry of perceived social support into the regression resulted in an even stronger negative relationship between race/ethnicity and caregiver strain was significant related to lower caregiver strain similar to that of NHWs after a Bonferroni correction was applied. It is more difficult to compare this result with past studies, which have found both equivalent (Youn et al., 1999) and reduced (Shaw et al., 1997) levels of caregiver burden among different API subgroups compared with NHWs. The API sample in this study contains substantial heterogeneity (i.e., ethnicity of the family members’ illness (Connell & Gibson, 1996; Shaw et al., 1997). Analyses indicated that Latinos did report lower caregiver strain than NHWs, but this effect was explained by differences in demographics, presence in an ADM sector, and problem severity. Thus, our findings are consistent with Aranda and Knight’s assertion (Aranda & Knight, 1997) that Latinos caring for a family member with dementia experience similar or higher burden of care when compared to NHWs. APIs, on the other hand, reported levels of caregiver strain similar to that of NHWs after a Bonferroni correction was applied. It is more difficult to compare this result with past studies, which have found both equivalent (Youn et al., 1999) and reduced (Shaw et al., 1997) levels of caregiver burden among different API subgroups compared with NHWs. The API sample in this study contains substantial heterogeneity (i.e., ethnicity and acculturation levels), and this aggregation may mask important subgroup differences.

The second hypothesis predicted that parents who reported higher perceived social support would report lower caregiver strain. This hypothesis was supported, even after controlling for potential

### Table 3. Regression of Caregiver Strain on Perceived Social Support

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADM sector: yes</td>
<td>0.23*</td>
<td>.07</td>
</tr>
<tr>
<td>Youth age</td>
<td>0.03</td>
<td>.02</td>
</tr>
<tr>
<td>Parental education</td>
<td>0.16***</td>
<td>.03</td>
</tr>
<tr>
<td>CIS youth report</td>
<td>0.01*</td>
<td>.01</td>
</tr>
<tr>
<td>YSR total problem score</td>
<td>0.01*</td>
<td>.00</td>
</tr>
<tr>
<td>Perceived social support</td>
<td>-0.25***</td>
<td>.05</td>
</tr>
</tbody>
</table>

Note: R² = .10, p < .001. *p < .05, **p < .01, ***p < .001.

### Table 4. Regression of Perceived Social Support on Race/Ethnicity

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American*</td>
<td>-0.19**</td>
<td>.06</td>
</tr>
<tr>
<td>Asian/Pacific Islander*</td>
<td>-0.30***</td>
<td>.10</td>
</tr>
<tr>
<td>Latino*</td>
<td>-0.04</td>
<td>.06</td>
</tr>
<tr>
<td>ADM sector: yes</td>
<td>-0.16**</td>
<td>.06</td>
</tr>
<tr>
<td>Youth age</td>
<td>-0.02</td>
<td>.01</td>
</tr>
<tr>
<td>Parental education</td>
<td>0.07*</td>
<td>.03</td>
</tr>
<tr>
<td>CIS youth report</td>
<td>-0.01</td>
<td>.00</td>
</tr>
<tr>
<td>YSR total problem score</td>
<td>0.00</td>
<td>.00</td>
</tr>
</tbody>
</table>

Note: R² = .06, p < .001. *Reference group is NHW. **p < .05. ***p < .01. ****p < .001.
confounds. Although this finding is consistent with theories suggesting that support provided to caregivers by members of their social networks may alleviate some of the stress associated with caregiving (e.g., Fredman, Daly, & Lazar, 1995; Horwitz & Reinhard, 1995), conclusions about the direction of this relationship cannot be drawn given the cross-sectional nature of the current study. It is also possible that families who experience less caregiver strain are more able to maintain their social networks and take advantage of the support offered by family and friends.

Contrary to the third hypothesis that ethnic minority groups would report higher levels of perceived social support than would NHWs, both African Americans and APIs reported significantly lower levels of perceived social support, whereas Latinos did not differ from NHWs. Although theorists have long argued that the strong value placed on extended family and fictive kin networks among African American, API, and Latino cultures should result in higher levels of social support than is found among NHWs (Dilworth-Anderson & Anderson, 1994; Guarnaccia & Parra, 1996; Uba, 1994), the findings from this study are consistent with other recent studies that have found similar levels of perceived social support across African American and NHW groups (Haley et al., 1996; Roschelle, 1997).

Studies also suggest that despite a value on familism, Latinos face significant challenges to maintaining strong support networks, including disruption of social networks resulting from immigration and a decrease in traditional values associated with acculturation (Aranda & Knight, 1997). Similar disruptions are also likely to be prevalent among our API sample that included a large number of recent immigrants. In addition, Youn et al. (1999) point out that familism does not necessarily translate into higher levels of social support or lower levels of caregiver strain. In their study of caregiving, they found that although Koreans and Korean Americans were higher on familism than were NHW Americans, this did not translate into lower perceptions of burden. They speculate that familism in Korean culture may be associated with feelings of obligation rather than mutual support. In support of this notion, Cox and Monk (1993) reported a significant positive relationship between adherence to the norm of filial support and depression among a sample of Latino caregivers of patients with Alzheimer’s disease.

The fourth hypothesis, that perceived social support would explain lower caregiver strain among ethnic minority families as compared with NHWs, was also not supported among youth with a history of public service use. The entry of perceived social support into the regression equation with caregiver strain as the dependent variable resulted in an even stronger negative relationship between African American and API race and caregiver strain. Although this model had not been previously tested among caregivers of youth with emotional/behavioral problems, lower perceptions of burden among African Americans were not explained by perceived social support among caregivers of adult relatives with mental illness (Stueve, Vine, & Struening, 1997) or Alzheimer’s disease (Haley et al., 1996). Thus, the explanation for reduced reported strain as compared with NHWs among these families must be sought elsewhere. Haley et al. (1996) propose several possible explanations for lower perception of burden among African American caregivers for a family member with dementia.

First, ethnic minority individuals have been described as having interdependent, as opposed to independent, self-construals (Markus & Kitayama, 1991). In this context, caring for a child with emotional/behavioral problems may be experienced as expected and normative, even if the experience of caregiving is not attended by greater availability of social support. Second, African American caregivers may be more tolerant of disturbance in family members. Weisz, McCarty, Eastman, Chaiyasit, and Suwanlert (1997) have proposed that adults view child behavior through a cultural lens that influences what behavior will be considered distressing. For example, cross-national evidence suggests that Jamaican adults rate child behavior problems as less troublesome than their American counterparts (Lambert et al., 1992). Consistent with this notion, African American parents are more likely to give lower ratings of their child’s behavior problems relative to ratings made by their child’s teacher than are NHW parents (Youngstrom, Loeb, & Stouthamer-Loeb, 2000; Zimmerman, Khoury, Vega, Gil, & Warheit, 1995). Finally, past experience with life stressors that may be associated with minority status in the United States may provide a better preparation for the demands of caring for an ill relative. Exposure to discrimination-related stressors may increase an individual’s ability to reframe and accept difficult life circumstances that cannot be changed (Wood & Parham, 1990).

Although these potential explanations must be viewed with some caution as many were based on studies of caregivers of adult dementia patients, they may be applicable to caregiving for children as well. On the other hand, the experience of caring for a
child with emotional/behavioral problems is significantly different than that of caring for an adult with dementia. Although parents are clearly prepared for the demanding task of caring for a child, the additional demands of caring for a child with an emotional/behavioral problem are unexpected. In addition, stigma is likely to be greater for mental illness, especially for ethnic minority individuals who may view mental illness as particularly shameful (USDHHS, 2001).

The current investigation has several limitations that should be noted. Because youth were selected into the study as a result of contact with a public service agency in a largely urban county, the sample is not typical of youth in the community. These results should only be generalized to urban youth who have already entered public service systems. In addition, the fact that youth in our sample already had contact with public service sectors limits our ability to answer questions about the relationship between caregiver strain and service entry for ethnic minority youth. Although participants did not differ from nonparticipants on a number of demographic variables, this study’s low response rate may have resulted in a biased sample and limits the generalizability of our findings. The study relied on cross-sectional data, which precludes inferences about causality. In addition, this study did not include measures of cultural constructs that might mediate between race/ethnicity and caregiver strain beyond perceived social support, such as familism, stigma associated with mental illness, fatalism, tolerance for child behavior problems, and religiosity. Future studies should examine these potential explanatory factors. Parents reported on both perceived social support and caregiver strain, which could artificially inflate the relationship between the two variables because of shared informant variance. In addition, we relied on parent report of perceptions of social support, which may differ substantially from the actual amount of support received (Dunkel-Schetter & Bennett, 1990). Finally, although the measures in the current study generally included youth from ethnic minority groups in their validation samples, most of the measures used in the current study were not specifically validated for the racial/ethnic groups included in this study. The possibility that observed racial/ethnic differences are attributable to differences in measurement reliability and validity across groups cannot be entirely ruled out. Further efforts to develop instruments that are reliable and valid across racial/ethnic groups are needed.

IMPLICATIONS

Despite these limitations, this study provides preliminary evidence that African American caregivers of children with emotional and behavior problem have lower perceptions of strain than do NHWs, in addition to lower perceptions of social support. Further investigation of this phenomena may help to elucidate the unique strengths and coping mechanisms that African American parents bring to the caregiving role. On the other hand, the profile of having low levels of caregiving distress coupled with insularity may prevent families from accessing appropriate mental health services. Difficulties engaging and retaining families in treatment may arise when parental motivation is low because of lower perceived distress and when social networks supporting treatment are lacking. In addition, service providers should be aware of the possibility that African American families caring for a child with an emotional/behavioral problem may appear to be less burdened by their role as caregivers, despite the severity of the child’s problems. This presentation may lead service providers to underestimate the seriousness of the child’s problems, or to underestimate the efforts being put forth by the parent on the child’s behalf. Although the fact that the current sample was drawn from public service systems prohibits conclusions regarding community samples, the fact that ethnic minorities in public service systems report lower caregiver strain suggest that caregiver strain may also be a potential explanatory factor for lower rates of mental health service utilization among ethnic minority children (McCabe et al., 1999). Future studies should examine the ability of racial/ethnic differences in caregiver strain to explain mental health service utilization patterns.

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