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Adjustment Profiles of Low-Income Caregivers from the United States and South Africa: Contrasts and Commonalities

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Abstract

Although low-income parents living in under-resourced communities in the United States and around the world face challenges, many do well while others struggle in one or more areas of functioning. The present study examined patterns of adjustment among maternal caregivers living in the United States (US) ($N = 320$) and South Africa (SA) ($N = 324$). Cluster analyses across four domains of functioning representing both positive and negative adjustment and conducted within country revealed similar patterns of adjustment, with a majority of caregivers (37.8% in the US; 47.5% in SA) landing in a “holding steady” pattern, exhibiting good but not exceptional adjustment. Other patterns of adjustment (three additional in the US sample; two additional in the SA sample) showed elevated impairment in somatic complaints, problems with alcohol, or life satisfaction. In both the US and SA, support from family, friends, and neighbors differentiated the adjustment profiles. Further, both current stressors within and outside of the family and previous stressors including direct and indirect exposure to violence discriminated caregivers who were “holding steady” from those who were struggling in one or more domains. Additionally, across

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Ethical approval: All procedures performed in these studies were in accordance with the ethical standards of the institutional research committees of Virginia Commonwealth University and the University of KwaZulu-Natal, who approved the studies, and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent:

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Author Contributions

WK: designed and executed the study, conducted the data analyses, and wrote portions of the paper. JSY and AWW: collaborated with the design of the study and wrote portions of the paper. BJP: contributed to the design of the study and collaborated in editing the final manuscript.

both countries, caregivers who were “holding steady” evidenced less avoidant coping. Implications of this work for fostering resilience among caregivers and their children are discussed.

Introduction

Low-income caregivers are exposed to numerous challenges which could negatively affect their well-being and the children in their care. In the United States, the majority of low-income maternal caregivers are ethnic minorities (Hispanics and African Americans) (Simms, Fortuny, & Henderson, 2009). Many of these caregivers have low levels of education, limiting the skills needed for decent wage jobs (Povich, Roberts, & Mather, 2013), which often results in fewer job opportunities and opportunities for advancement. These problems are further compounded by employment in jobs that do not provide benefits such as health insurance, paid sick leave, and other wage benefits. Similarly, in other contexts such as South Africa, low-income maternal caregivers are more likely to have low levels of education, low employment rates, and high rates of illness (Wright, Noble, Ntshongwana, Barnes, & Neves, 2013). Other studies with low-income caregivers have highlighted individual characteristics such as low self-efficacy regarding their ability to care for their children and to manage emotional stressors, and low satisfaction with respect to the quality of their supportive resources (Olson, Ceballo, & Park, 2002). In addition, low-income mothers are more likely to be single, unemployed, and have a large number of children, including children under age five (Kemp, Bradshaw, Dornan, Finch, & Mayhew, 2004; Loprest & Nichols, 2011–12; Sword, Merriman, & O’Donnell, 2012) than more advantaged mothers.

In addition to stressors associated with low education and low levels of employment, in both the United States (US) and South Africa (SA) caregivers with low incomes, particularly in under-resourced urban environments, face environmental stressors including exposure to community violence, elevated noise levels, homelessness or poor housing quality, and frequent change in residence and employment, in addition to family stressors such as family discord and children with behavior problems (Bassuk et al., 1997; Conger, Ge, Elder, Lorenz, & Simons, 1994; Kliewer, 2013; Kliewer, Goodman, & Reid-Quinones, 2013; McLoyd, 1990; Olson et al., 2002). Further, caregivers who identify with historically disadvantaged groups may face discrimination due to their race or ethnicity (Collins et al., 2000; Miller & Major, 2000). These chronic stressors may take a toll on the health and well-being of caregivers, resulting in lower life satisfaction (Mammen, Bauer, & Lass, 2009), elevated internalizing symptoms (Lennon, Blome, & English, 2001; Lloyd & Rosman, 2005; Mistry, Vandewater, Huston, & McLoyd, 2002), problems with substance abuse (Bassuk, Buckner, Perloff, & Bassuk, 1998), physical health problems (Weinreb, Goldberg, & Perloff, 1998), or disruptions in social relationships (Hall, Williams, & Greenberg, 1985). Besides the likely impact on caregivers’ well-being, there is the potential for ripple effects on children through the channel of parenting. For example, low-income caregivers are more likely to use punitive and harsh measures to discipline children (McLoyd, Jayratne, Ceballo, & Borquez, 1994; Olson et al., 2002) and less likely to be emotionally supportive to their children (McLeod & Shanahan, 1993) than caregivers who are more economically

advantaged. These methods of parenting could adversely impact children's physical, psychological, and cognitive development.

Despite the toll exacted by exposure to chronic stressors, caregiver response to environmental demands is not uniform. Some caregivers cope well, managing their day to day activities without difficulty. Other caregivers struggle in one or more areas of adjustment. Prior studies have identified factors that differentiate low-income caregivers who function optimally despite the diverse stressors they experience. For example, available and supportive social support ties buffer against the adverse effects of stressors on the well-being of caregivers experiencing economic challenges (Green & Rodger, 2001; Olson et al., 2002; Olson, Kieschnick, Banyard, & Ceballo, 1994; Pillay, 1996). However, it is not only the presence of support that matters, but the caregiver's perception of this support. Satisfaction with the quality of support was positively associated with mental health among low-income mothers (McLoyd et al., 1994; Olson et al., 1994; Simons et al., 1993).

Risk factors also differentiate low-income caregivers who fare better versus poorly. For example, Hall and et al. (1985) found that chronic stressors including being unmarried or unemployed predicted higher levels of depression in low-income mothers of young children. Additionally, Swords et al. (2012) found that parent-child conflict and relationship problems with their partner were risks factors for poor well-being in low-income parents.

One reason it is important to understand the variety of functioning within low-income caregivers is that despite the risks that poverty and low maternal education confer for developmental outcomes of their offspring, including poor psychological adjustment, emotion dysregulation, and high allostatic load (Brody et al., 2013; Shaffer, Suveg, Thomassin, & Bradbury, 2012), there are many ways in which parents can be positive influences on the development of their children. Support from parents is a protective influence against engagement in violence (Brookmeyer, Henrich, & Schwab-Stone, 2005), externalizing behaviors (Li, Nussbaum, & Richards, 2007), and anxiety (Hill & Madhere, 1996). Parental involvement in a child's education is associated with higher achievement of that child (Kliewer et al., 2013; Miliotis, Sesma, & Masten, 2010). Adolescent prosocial behavior results from caregivers who provide emotional support along with consistent and fair discipline (Reese et al., 2000). Similarly, high quality parenting, defined as a strong parent-child relationship with high structure in addition to high warmth, interacts with adversity level such that high parenting quality can protect against some of the negative effects of adversity, leading to resilient outcomes in disadvantaged youth (Masten et al., 1999). Recent work following youth from age 10 to 33 from the Seattle Social Development Project (Jones et al., 2016) illustrates how positive family environments in early adolescence set the stage for future social interactions and had positive influences on functioning both in the short- and long-term. A few scholars have documented the range of patterns of adjustment children and adolescents have in response to stressors, with some youth showing average or high functioning in one or more areas while struggling in others (Brody et al., 2013). Thus, it is reasonable to hypothesize that parents also will show dynamic patterns of adjustment when multiple areas of functioning are considered simultaneously.

As argued, maternal low socio-economic status and exposure to other stressors negatively impact maternal well-being with ripple effects on children. However, the present study focused on the caregivers themselves in order to understand the risk and protective factors that differentiate caregivers who adjust well from those who do not. As a first step in attempting to capture dynamic patterns of adjustment of low-income caregivers we evaluated patterns of adjustment across multiple domains of functioning. We believe this would position us to better understand the ways in which parental functioning influences child functioning in later analyses. We examine two samples of low-income caregivers living in under resourced communities – one from the southeastern United States and one from South Africa. Although the two samples were from two different contexts, both have close similarities with respect to socio-economic status, exposure to environmental stressors, and racial discrimination. Our intention was to explore whether or not their patterns of adjustment to similar stressors would be similar or different. For both the SA and US samples, risk and protective factors were examined to determine the extent to which they could differentiate adjustment profiles. Based on analyses with youth showing that high percentages facing adversity evidence favorable adjustment despite risk (Wright, 2016) we anticipated that a sizable percentage of caregivers in both countries would show favorable adjustment despite family economic and neighborhood risk. Further, based on work documenting the protective effects of support (Shor, Roelfs, & Yogeve, 2013) we anticipated that support from family and community would differentiate caregivers who demonstrated the best adjustment relative to other profiles, and that both current and previous stressors would discriminate caregiver adjustment groups (Helgeson, 2011). Lastly, we anticipated that caregivers who were better adjusted would engage in less avoidant coping relative to other groups, but not more active coping, based on evidence that active coping among low-income samples can be harmful (Chen, 2012; Chen & Miller, 2012).

Method

Participants

The SA sample consisted of 324 maternal caregivers ($M = 41.57$, $SD = 9.86$, Range = 21 – 75) participating in a study of risk and protective factors for child adjustment. Most of the sample identified as Black (55.6%), but Coloured (14.5%), Indian (23.1%) and White (6.8%) race/ethnicities were represented in the sample. Approximately half (55.7%) of the sample was married or cohabitating; 31.4% had never married; 7.5% were widowed; 3.8% were divorced; and 1.6% were separated. Educational attainment was low, although there was diversity in the sample. Two-fifths of the sample (42.3%) had graduated secondary school. A third (29.7%) had completed some secondary school or technical school. Smaller percentages completed primary school (13.2%), college or technical school (5.7%), or had completed 4 or more years of college (7.3%). A minority never attended school (1.9%). Given the nature of the study, household income was low, with more than half of all families reporting earning R 3501–4500 per month or less [equivalent to \$350–\$450].

The US sample consisted of 320 maternal caregivers ($M = 39.58$, $SD = 7.80$, Range = 24–71) who also were participating in a study of risk and protective factors for child adjustment. Most of the sample identified as African American/Black (91.9%), with White (5.0%),

Multiracial (2.2%), Asian (0.3%), Non-Hispanic White (0.3%), and American Indian (0.3%) rounding out the racial/ethnic composition of the sample. A third (33.2%) of the sample was married or cohabitating; 39.7% had never married; 14.7% were separated; 10.6% were divorced; and 1.9% were widowed. As with the SA sample, overall educational attainment was low, although there was diversity in the sample. A quarter (27.9%) of the sample had graduated from high school or completed a General Education Diploma (GED). A sizable percentage (23.2%) did not complete high school. Another quarter (24.8%) completed some college; 13.8% earned a vocational or Associate's degree; and 10.4% of the sample earned a Bachelor's degree or higher. Given the nature of the study, household income was low, with half of all families reporting receiving \$401–500/week, and a third of the sample reporting \$201–300/week or less.

Procedure

This cross-country comparison study focused on low-income communities characterized by violence and poverty. The South African sample was recruited from low-income neighborhoods in the greater Durban, SA area. The US participants were recruited from neighborhoods within Richmond, VA and the neighboring counties with high levels of violence and/or poverty according to police statistics and 2000 census data. The Institutional Review Boards at Virginia Commonwealth University in the United States and the University of KwaZulu-Natal in South Africa approved all study procedures. Written informed consent was obtained from all individual participants included in the study. The SA sample was recruited via local primary and secondary schools. Once enrolled, home interviews were scheduled and trained research assistants conducted interviews in the home. Bilingual (English/isiZulu) staff was available to ensure that isiZulu-speaking participants were properly informed about the study; all participants had the choice of completing the interview in English or isiZulu. Each item of the interview was translated into isiZulu and then back-translated to English. In addition, all measures were reviewed for appropriateness by a team of South African clinical psychologists familiar with the target population; approximately 44% of the caregivers completed the interview in isiZulu. The SA interviews were completed between April, 2012 and October, 2014. US participants were recruited from neighborhoods within Richmond, VA, and the neighboring counties with high levels of violence and/or poverty according to police statistics and 2000 census data. The study was advertised through community agencies and events and by canvassing qualifying neighborhoods via flyers posted door-to-door. In all, 63% of eligible participants agreed to be in the study, which is consistent with studies using similar designs and populations. Once enrolled, trained research assistants conducted interviews in the home. The US participants were enrolled in a longitudinal study. Data for the present paper comes from Wave 2, which was selected because it contained important risk and protective factor variables. Wave 2 was completed between January, 2006 and May, 2007. Ideally, recruitment for the SA and US samples would be identical. However, permission to recruit through the schools in the United States was not obtained, so a community recruitment approach in the United States was used. More critically, both in SA and in the US, the samples were recruited from low-income neighborhoods, and data were collected via face-to-face home interviews with caregivers in both studies. This is likely a greater source of variation than the sample recruitment method per se, and it was consistent across the US and SA. Interviews lasted

approximately 2.5 h in each country. Families were paid a R50 shopping card voucher in SA, and a \$50 gift card in the US for their participation.

Measures

Indicators of Adjustment—Measures representing both positive and negative aspects of functioning and indicating distinct areas of adjustment (e.g., health, interpersonal relationships, life satisfaction) were utilized in both the US and SA samples. Satisfaction with Life was assessed with the 5-item *Satisfaction with Life Scale* (SWLS; Diener, Emmons, Larsen, & Griffin, 1985), designed to assess subjective life satisfaction. In contrast to measures that apply some external standards, the SWLS captures the individual's own judgment of his or her quality of life. This instrument is short and unidimensional. A sample item is "In most ways my life is close to my ideal." Responses are measured on 7-point Likert-type scale ranging from 1 (*Strongly disagree*) to 7 (*Strongly agree*). Item scores are summed for a total score, which ranges from 5 to 35, with higher scores reflecting more satisfaction with life. The internal consistency of the SWLS is very good, with an alpha of .87. The instrument appears to have excellent test-retest reliability, with a correlation of .82 for a two-month period, suggesting it is very stable. In the current study, Cronbach alpha was .85 for the SA sample and .86 for the US sample. Difficulty identifying and describing emotions, or Alexithymia, which has implications for social relationships, was measured with the 20-item Toronto Alexithymia Scale-20 (TAS-20; Bagby, Parker, Taylor, 1994). Respondents rate their agreement with a series of statements on a 5-point Likert scale ranging from 1 (*Strongly disagree*) to 5 (*Strongly agree*). Items are summed to create 3 subscales: *Difficulty Identifying Feelings*, *Difficulty Describing Feelings*, and *Externally Oriented Thinking*. The present study combined the 7-item difficulty identifying feelings and the 5-item difficulty describing feelings subscales as these are the most reliable. In prior work, test-rest reliability has been acceptable ($r = .77$; Bagby et al., 1994) and convergent validity good (Cusack, Deane, Wilson, & Ciarrochi, 2006). Cronbach alpha was .87 for the SA sample and .87 for the US sample. Problems with Alcohol were quantified with the 10-item Alcohol Use Disorders Identification Test (AUDIT; World Health Organization, 2001), designed to identify individuals with unhealthy patterns of alcohol consumption. The AUDIT items cover the three domains of hazardous alcohol use (frequency and quantity of drinking), dependence symptoms (impaired control over drinking, increased salience of drinking, morning drinking), and harmful alcohol use (guilt, blackouts, injuries, others concerned). The AUDIT has demonstrated good reliability and validity in numerous studies, including various international samples, versions in various languages, and various administration settings. Reinert and Allen's (2007) examination of studies published since 2002 yielded a median reliability coefficient of 0.83, with a range of 0.75 to 0.97. Cronbach alpha was .90 for the SA sample and .81 for the US sample. Somatic Complaints were indexed by the 7-item somatization subscale of the Brief Symptoms Inventory (BSI; Derogatis, 1983), developed to evaluate current psychological symptom distress. Examination of internal consistency of the BSI subscales resulted in alpha coefficients ranging from .71 to .85, while test-rest reliabilities ranged from .68 to .91 (Morlan & Tan, 1998). Cronbach alpha was .91 for the SA sample and .78 for the US sample. All four indicators were standardized (i.e., scaled such that $M = 0$, $SD = 1$) for use in the cluster analysis.

Protective Factors—The Multidimensional Scale Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988) was used to assess perceived availability of support from family (4 items) and friends (4 items). Sample items include, “My family really tries to help me,” and “I can count on my friends when things go wrong.” Responses on this measure range from 1 (*Very strongly disagree*) to 7 (*Very strongly agree*), with higher scores indicating greater perceived support availability. In the present study, separate scores for family and friend support were used. Zimet et al. report good internal consistency (Cronbach’s alpha = .88). The scale is negatively correlated with depression ($r = -.25$), positively correlated with self-concept ($r = .42$), and unrelated to social desirability (Kazarian & McCabe, 1991). Cronbach alpha was .93 (family) and .92 (friends) for the SA sample and .94 (family) and .93 (friends) for the US sample. Support from neighbors was indexed by a 10-item measure of collective efficacy developed by Sampson, Raudenbush, and Earls (1997). Caregivers were asked questions about the degree to which they could rely on neighbors to intervene in five situations (e.g., child skips school) and about the degree of social cohesion in five items (e.g., people around here are willing to help their neighbors). Items were rated on 5-point scales ranging from 1 (*Very likely* or *Strongly agree*) to 5 (*Very unlikely* or *Strongly disagree*) and were coded so that higher scores reflected higher degrees of collective efficacy. This measure has demonstrated adequate reliability and validity (Sampson & Raudenbush, 1999). Cronbach alpha was .78 for the SA sample and .92 for the US sample.

Risk Factors—Current life stressors were measured with the 20-item Life Stress Scale (Miller-Johnson et al., 2004), which taps a variety of life stressors that adults may have experienced in the past year. Respondents rated each item on a 3-point scale (“0 = *Did not occur*”, “1 = *Caused minor stress*”, or “2 = *Caused major stress*”). Item scores were averaged to obtain a mean severity rating, with high scores reflecting higher levels of stress. Cronbach alpha was .79 for the SA sample and .71 for the US sample. Current negative emotional climate in the family (US sample only), capturing criticism, contempt, and anger, was assessed with the 10-item negative-dominant subscale of the Family Expressiveness Questionnaire (FEQ; Halberstadt, 1986). Items were rated on a 9-point scale ranging from 1 (*Not at all frequently in my family*) to 9 (*Very frequently in my family*). Respondents are instructed to think about how often each emotional scenario occurs in their family compared to other families. Halberstadt (1986) has reported alphas up to .88 for negative dominance. Retest reliabilities over a 10-day period were .89 to .92. Cronbach alpha was .83 for the US sample. Lifetime victimization (10 items for the US study, 11 items for the SA study; an item about carjacking was added to the SA study) and witnessing violence (16 items for the US study, 17 items for the SA study; an item about carjacking was added to the SA study) was assessed with Richters and Saltzman’s (1990) *Survey of Exposure to Community Violence*. Caregivers reported on their lifetime exposure using a scale from 0 (*Never*) to 4 (*Every day*). Richters and Saltzman’s (1990) measure has been widely used and validated. Cronbach alpha was .89 (victimization) and .90 (witnessing) for the SA sample and .77 (victimization) and .92 (witnessing) for the US sample. The Childhood Trauma Questionnaire (CTQ; Bernstein et al., 1994) was utilized to assess caregivers’ experiences of physical neglect, physical abuse, emotional abuse, emotional neglect, sexual abuse, and minimization while growing up (SA sample only). Questions were answered with a 5-point

scale ranging from 1 (*Never true*) to 5 (*Very often true*), with higher scores indicating more self-reported abuse during childhood (Bernstein et al., 2014). Bernstein et al. (1994) report good reliability and validity. Cronbach alphas for SA were: .85 (emotional abuse), .90 (emotional neglect), .87 (physical abuse), .95 (sexual abuse), and .72 (minimization). The alpha for physical neglect was not acceptable so that subscale was not analyzed.

Coping—Active and avoidant coping was assessed with the higher order factors from the COPE (Carver, Scheier, & Weintraub, 1989), which assesses ways in which people cope with stress. Items were rated on a 4-point scale ranging from 1 (*I don't do this at all*) to 4 (*I do this a lot*). The active coping factor includes 12 items capturing planning, active coping, and positive reinterpretation and growth. The avoidant coping factor includes 12 items assessing denial, mental disengagement, and behavioral disengagement. Carver et al. (1989) report acceptable reliability and good validity. Cronbach alpha was .91 (active coping) and .88 (avoidant coping) for the SA sample and was .89 (active coping) and .79 (avoidant coping) for the US sample.

Data Analyses

Using the four adjustment variables, cluster analyses within each country were used to capture dynamic patterns of adjustment of low-income caregivers across multiple domains of functioning. The extent to which adjustment groups differed on demographic, protective, and risk factors was evaluated by comparing groups within country using chi-square analyses and Analyses of Variance. For the cluster analyses, a hierarchical cluster analysis approach was conducted using Ward's method with squared Euclidean distance as the distance variable. Cluster analysis was selected as the analytic technique because we had no *a priori* hypotheses or knowledge about the structure or number of profiles that would emerge. All indicators were standardized prior to including them in the cluster analysis. Squared Euclidian Distance magnifies the importance of large distances and diminishes the importance of small distances. Ward's method maximizes the significance of differences between clusters, making it a statistically powerful method. Analyses were run with the possibility of 2–6 clusters, to determine the model that best fit the data. The dendrogram, icicle plot, and significance of between-cluster differences were used to determine the most optimal cluster solution.

Results

Table 1 presents correlations among adjustment indicators by country, with correlations for South Africa above the diagonal and correlations for the United States below the diagonal. Table 2 presents descriptive information on the risk and protective factors across country.

Cluster Analyses Identifying Adjustment Groups

For the SA sample, a three-group solution seemed optimal. Solutions with four or more groups had only one case in one of the groups. Table 3 presents descriptive information on and differences between the three clusters for the SA sample. Group 1, the largest group ($N = 154$, 47.5% of the sample) might best be described as *holding steady*. This group was in the positive column on all measures, but not over 1 *SD* on any measure, so the group

exhibited good but not exceptional adjustment. Group 2 ($N = 102$, 31.5% of the sample) might best be described as *dissatisfied*. With just under a third of the sample represented, this group is characterized by the highest level of life dissatisfaction and alcohol problems in the sample. Group 3 ($N = 68$, 21.0% of the sample) might best be described as *caregivers with elevated somatic complaints*. With just over one-fifth of the sample represented, this group was characterized by a high level of somatic complaints and elevated alexithymia scores.

For the US sample, a four-group solution emerged as optimal. Table 4 presents descriptive information on and differences between the four clusters for the US sample. Group 1, also the largest group, ($N = 121$, 37.8% of the sample) also might best be described as *holding steady* for reasons similar to that of the SA sample – they exhibited good but not exceptional adjustment. Group 2 ($N = 113$, 35.3% of the sample) might best be described as *slightly dissatisfied*. Group 3 ($N = 54$, 16.9% of the sample) might best be described as *caregivers with elevated somatic complaints*. Group 4 ($N = 32$, 10.0% of the sample) might best be described as *caregivers with elevated alcohol use*, as they had alcohol problem scores more than 2 *SD* above the mean. See Figure 1 for a depiction of the adjustment groups across countries.

Differences in Adjustment Groups on Demographic, Protective, and Risk Factors

In terms of demographic differences, for SA, a number of significant or marginally significant differences in demographic indicators emerged. For comparison purposes, marital status was coded to compare caregivers who were married or cohabitating with caregivers who were not. There was a marginally significant chi-square difference on marital status across adjustment group, $\chi^2(2) = 4.93$, $p = .085$. The *holding steady* group was more likely to be married or cohabitating (61.0%) than the *dissatisfied* (48.0%) or *somatic complaints* (50.0%) groups. There was a significant difference in race/ethnicity distribution across adjustment clusters, $\chi^2(6) = 28.30$, $p < .001$. The *holding steady* group had more Indian (33.1%) and white (14.0%) members as a percentage of their total relative to the *dissatisfied* (13.5% Indian; 4.2% white) or *somatic complaints* groups (23.0% Indian; 1.6% white). There also were fewer black caregivers in the *holding steady* group (41.2%) relative to the *dissatisfied* (68.8%) or *somatic complaints* (62.3%) groups. In terms of caregiver age, there was a main effect of adjustment group on age, $F(2, 319) = 6.31$, $p = .002$. The *holding steady* and *somatic complaints* groups were older than the *dissatisfied* group. There also was a main effect of adjustment group on caregiver educational attainment, $F(2, 314) = 5.01$, $p = .007$. The *holding steady* group had higher educational attainment than the *somatic complaints* group. Household income also differed across adjustment clusters, $F(2, 307) = 15.71$, $p < .001$. The *holding steady* adjustment cluster had higher household incomes than both the *dissatisfied* and *somatic complaints* groups. There were fewer significant demographic differences in the US sample. The adjustment clusters did not differ by race/ethnicity $\chi^2(3) = 3.21$, $p > .10$, marital status $\chi^2(3) = 3.49$, $p > .10$, or age, $F(3, 308) = .60$, $p > .10$. Differences in educational attainment were marginal, $F(3, 315) = 2.47$, $p = .062$, with the *holding steady* group reporting higher educational attainment than the *elevated alcohol use* group. There were significant differences on household income, $F(3, 315) = 4.41$, $p = .005$.

The *holding steady* group reported higher household income than all other groups, who did not differ from one another.

Results of the protective and risk factor analyses are presented in Table 5. Regarding protective factors, as seen in the table, the *holding steady* groups in both countries reported more support from family, friends, and neighbors than other adjustment groups. In terms of concurrent risk factors, the *holding steady* groups in both countries reported fewer life stressors than other groups. Additionally, the *holding steady* group in the US sample reported less negative affect in the home relative to other groups. In terms of previous stressors, the *holding steady* and *dissatisfied* groups had lower lifetime victimization and witnessing levels than other groups (*somatic complaints* in SA; *elevated alcohol use* in the US). Finally, for the SA sample, childhood abuse and neglect was lowest among the *holding steady* group relative to other groups, with the exception of sexual abuse, where the *holding steady* group only differed from the *somatic complaints* group.

Differences in Adjustment Groups on Coping

For the final set of analyses, adjustment groups were compared on active and avoidant coping using ANOVAs (see Table 6). As seen in the table, for both SA and the US, avoidant coping, but not active coping, differentiated the adjustment groups. Caregivers who were *holding steady* reported using less avoidant coping than other groups.

Discussion

As a first step in attempting to capture dynamic patterns of adjustment in low-income caregivers we evaluated patterns of adjustment across multiple domains of functioning among caregivers from the United States and South Africa. The most significant finding from our study was that the majority of caregivers from both samples were holding steady – that is, exhibiting good but not exceptional adjustment. However, a substantial subset were struggling in one or more areas of functioning. The overall patterns of these two samples of caregivers were remarkably similar despite the fact that they were located in different cultural milieus on different continents. Perhaps the shared experience of struggle in the context of low resources against a backdrop of institutionalized racism and discrimination account for this similarity.

Consistent with expectation and consistent across both the US and SA samples, caregivers who were *holding steady* reported significantly more support from family, friends, and neighbors than caregivers in other adjustment groups. This finding confirms a wealth of literature highlighting the beneficial effects of social support – even among the most disadvantaged populations (Shor et al., 2013). Results also revealed that both current and past stressors differentiated caregivers who were *holding steady* from other adjustment groups. Specifically, caregivers in both the US and SA in the *holding steady* groups reported fewer life stressors than caregivers in other groups. In terms of past stressors, caregivers in the *holding steady* group experienced less community violence victimization and witnessed less community violence, both in the US and SA. Childhood abuse experiences were assessed in the SA sample and the *holding steady* group reported less abuse during childhood relative to other caregiver adjustment groups. Consistent with our expectations,

across both countries caregivers in the *holding steady* group used less avoidant coping relative to caregivers in other adjustment groups. This finding suggests that these caregivers have the psychological resources to acknowledge the reality of the stressors they face, rather than denying that the stressors exist or wishing them away, and is consistent with research on developing resilience (Park, Currier, Harris, & Slattery, 2017).

Overall there were few differences in the profiles across the US and SA samples; most of the differences concerned the pattern of demographic differences across adjustment profiles which appeared in the SA sample but not in the US sample. The racial differences in the SA sample could be to a considerable degree attributed to the past political system in South Africa which impact on the well-being of Black South Africans. The apartheid system not only legalized racial segregation, job reservation, and restricted mobility, it also provided inferior education and health care services, and deprived Black South Africans of the most basic human rights leaving a legacy of pervasive poverty and lack of opportunities (Moultrie, 2001; Pillay, 2000). Apartheid led to lower mental health and higher psychological distress among Black South African women (Hocoy, 1997) as well as more psychological disorders and maladjustment in children (Hickson & Kriegler, 1991). Even after years of the abolishment of apartheid, it is believed that Black South Africans remain disadvantaged and the impact of apartheid remains (Gallie, Sayed, & Williams, 1997). The lack of racial differences in the US sample could be associated to the high composition of African Americans/Blacks forming about 92% of the present sample compared to the SA sample which had representations from different ethnic groups. Similar to South African Blacks, American Blacks are exposed to stressors related to racial segregation, lack of employment opportunities and access to poor educational systems (Wilson, 2011). The impact of the racial segregation among American Blacks are high levels of poverty and limited access to employment (Son, Dyk, Bauer, & Kotras, 2011; Wilson, 2011) and high rate of mental illnesses (Budhwani, Hearld, & Chavez-Yenter, 2015; Copeland & Snyder, 2011).

Implications for Future Research

Future studies should attempt to replicate this model of parent adjustment profiles and determine which areas of adjustment have the strongest influence on child developmental outcomes. Looking at the adjustment of child and parent together, through this dynamic approach, will provide insight as to which areas of negative parent functioning have the biggest impact on child outcomes, and therefore deserve the most attention from intervention and prevention programming. Exploration of parent and child profiles together also could reveal areas of adequate or positive parent functioning which counterbalance areas in which they are struggling. For example, perhaps the feeling of above-average life satisfaction in the *holding steady* groups counterbalances the potential negative effect on children of their slight elevation in alexithymia. Identifying whether certain profiles balance out their areas of negative influence through positive areas would reduce the burden on interventionists to provide assistance to all parents with alexithymia, for example. Hypothetically, one could determine whether a parent struggles with alexithymia *and* has high or low life satisfaction before raising concern for child outcomes.

Another area for future research might be to examine parents who have experienced a similar history of abuse, neglect, or victimization then determine what factors predict landing in a *holding steady* or similar pattern versus in a pattern with elevations in one or more areas of dysfunction. This would provide insight into the kind of interventions needed to help people overcome the long-term effects of abuse and neglect.

Although social support discriminated the *holding steady* group from other adjustment groups, it was unclear from this analysis how effective (or not) support was at reducing the impact of current and previous life stressors on adjustment stressors. A third area for future research might be to explore the limits of social support or other protective factors.

The potential for adverse effects of racial discrimination on well-being, although not specifically explored in the present study, emerged in the pattern of demographic differences among the various profiles, especially in the SA group. A fourth area for future research might be to measure institutionalized racism and discrimination and their impact of well-being of low-income mothers and their children. This would provide insight into the specific impact of such experiences on well-being and interventions to mitigate their effects.

Strengths and Limitations

Strengths of the study include comparison of two low-income samples spanning two countries, and a unique focus on caregiver adjustment, and factors that discriminate adjustment profiles. Well-validated measures were used to quantify the adjustment groups and to test the risk and protective factors that could potentially differentiate distinct groups of caregivers. Despite these strengths, a number of limitations to the study can be noted. First, due to resource and access issues, the study only focused on maternal caregivers. Thus, the adjustment profiles of paternal caregivers were not considered, and may differ from that of maternal caregivers. Second, the study focused on risk and protective factors that were common across the two data sets including support from numerous sources, current life stressors, past violence exposure, and coping behavior. However, there likely are other viable risk or protective factors that are equally important to examine that could discriminate between the caregiver adjustment groups. Third, we assessed caregiver adjustment and risk and protective factors at the same point in time, which did not allow us to examine how risk and protective factors predict adjustment profiles. Although beyond the scope of the current study, future work that examines the stability of adjustment profiles and factors associated with adjustment and change in adjustment could inform prevention and intervention efforts.

Conclusion

The present study contributes to our understanding of patterns of adjustment among low-income maternal caregivers across two diverse cultural contexts. The study demonstrated robust similarity in patterns of adjustment as well as factors that discriminated between different groups of caregivers. This study found that a *holding steady* pattern – exhibiting good but not exceptional adjustment – was the most common adjustment pattern in both countries. Further, the study showed that relative to other adjustment groups, which had elevated impairment in at least one domain of functioning, the *holding steady* groups reported more social support and less avoidant coping, less current life stress, and less past

exposure to violence. Overall these data suggest that it is important to assess caregivers in multiple areas of functioning. Further, for caregivers with past or current exposure to life stressors or traumas, these data suggest that social support is not sufficient to ensure good functioning; additional intervention to address help caregivers process the trauma or manage the life stressors may be warranted.

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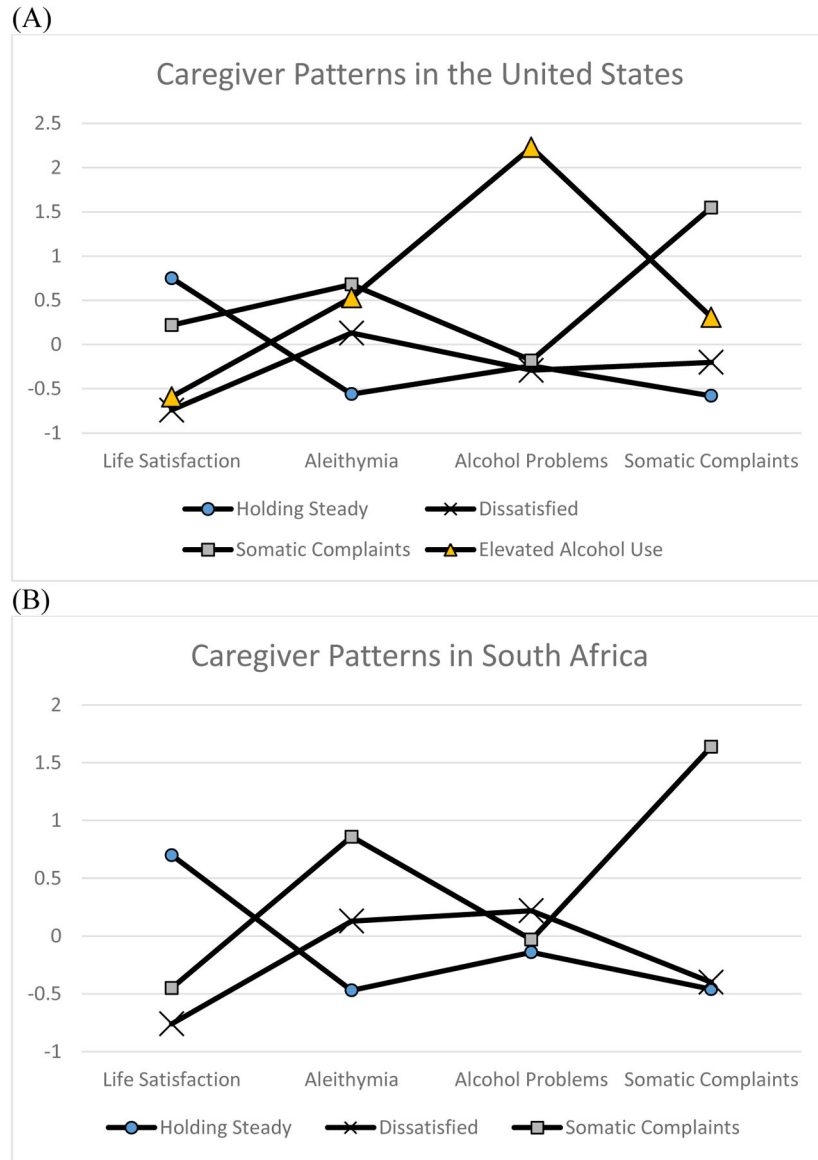


Figure 1. Caregiver patterns of adjustment in the United States and South African samples.

Table 1

Correlations Among Adjustment Indicators by Country (South Africa above the Diagonal; United States below the Diagonal)

	1	2	3	4
1 Life Satisfaction	--	-.21***	-.14*	-.21***
2 Alexithymia	-.18***	--	.06	.39***
3 Alcohol Problems	-.22***	.17**	--	.07
4 Somatic Complaints	-.20**	.38***	.16**	--

Note. Correlations for the SA sample ($N = 324$) are above the diagonal; correlations for the US sample ($N = 320$) are below the diagonal.

*
 $p < .05$;

**
 $p < .01$;

 $p < .001$.

Table 2

Descriptive Information on the Risk and Protective Factors in the Study

Variables	United States		South Africa	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Support from family	21.13	16.82	22.08	6.06
Support from friends	21.65	5.19	19.48	7.43
Collective efficacy	34.81	9.43	31.41	8.37
Past year life stressors	8.23	5.29	7.58	5.99
Negative emotional family climate	44.05	15.31	--	--
Lifetime victimization	3.96	3.78	4.18	6.39
Lifetime witnessing violence	16.82	11.31	15.63	13.49
Childhood emotional abuse	--	--	8.44	4.57
Childhood emotional neglect	--	--	11.41	6.30
Childhood physical abuse	--	--	8.35	4.71
Childhood sexual abuse	--	--	7.84	5.09
Childhood abuse – minimization	--	--	8.53	3.78

Descriptive information on and differences between the three clusters on adjustment indicators for the South African sample

Table 3

Indicator	1 (<i>n</i> = 154)		2 (<i>n</i> = 102)		3 (<i>n</i> = 68)		<i>F</i> (2, 321)	Group differences
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)		
Life Satisfaction	.70 (.57)	-.76 (.72)	-.45 (1.00)	141.67	****	All groups differ from each other		
Alexithymia	-.47 (.66)	.13 (.78)	.86 (1.17)	62.75	****	All groups differ from each other		
Alcohol Problems	-.14 (.22)	.22 (1.28)	-.03 (.34)	6.97	****	1 < 2; 2 > 3		
Somatic Complaints	-.46 (.41)	-.40 (.38)	1.64 (.87)	412.06	****	1, 2 < 3		

p < .001.

Descriptive information on and differences between the four clusters on adjustment indicators for the United States sample

Table 4

Indicator	1 (n = 121)		2 (n = 113)		3 (n = 54)		4 (n = 32)		F(3, 316)	Group Differences
	M (SD)		M (SD)		M (SD)		M (SD)			
Life Satisfaction	.75 (.58)		-.74 (.70)		.22 (1.00)		-.59 (.95)		85.44 ^{***}	1 > 2,3,4; 3 > 2,4
Alexithymia	-.56 (.52)		.13 (.82)		.68 (1.54)		.53 (.61)		31.86 ^{***}	1 < 2,3,4; 2 < 3,4
Alcohol Problems	-.24 (.50)		-.29 (.40)		-.18 (.49)		2.23 (1.60)		132.51 ^{***}	1,2,3 < 4
Somatic Complaints	-.58 (.39)		-.20 (.63)		1.55 (.99)		.31 (.89)		135.54 ^{***}	All groups differ from each other

^{***} p < .001.

Table 5
Means, Standard Deviations, and Analyses of Variance for Effects of Adjustment Clusters on Protective and Risk Factors by Country

Variable	South Africa				United States				ANOVA
	Group 1: Holding Steady	Group 2: Dissatisfied	Group 3: Somatic Complaints	ANOVA	Group 1: Holding Steady	Group 2: Dissatisfied	Group 3: Somatic Complaints	Group 4: Elevated Alcohol Use	
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>		<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	
Familial Support	23.84 (5.21)	20.42 (6.50)	20.57 (6.25)	$F(2, 311) = 12.90, p < .001$ $1 > 2, 3$	23.49 (4.99)	18.89 (6.58)	21.54 (6.22)	19.38 (5.55)	$F(3, 315) = 13.04, p < .001$ $1 > 2, 3, 4$; $3 > 2$
Friend Support	21.17 (6.85)	17.91 (7.72)	17.98 (7.52)	$F(2, 310) = 7.72, p = .001$ $1 > 2, 3$	23.19 (4.54)	20.85 (5.09)	20.93 (6.09)	19.88 (4.92)	$F(3, 315) = 6.37, p < .001$ $1 > 2, 3, 4$
Neighbor Support	32.93 (6.57)	31.16 (7.83)	28.38 (7.94)	$F(2, 314) = .044-7.18, p = .001$ $1, 2 > 3$	37.24 (9.60)	32.98 (9.17)	34.22 (9.53)	33.00 (7.75)	$F(3, 315) = 4.70, p = .003$ $1 > 2, 3, 4$
Life Stressors	5.41 (4.68)	8.96 (6.46)	10.43 (6.16)	$F(2, 318) = 23.14, p < .001$ $1 < 2, 3$	6.40 (4.57)	8.98 (5.15)	9.60 (6.00)	10.23 (5.24)	$F(3, 314) = 8.88, p < .001$ $1 < 2, 3, 4$
Negative Emotion Family Clin	--	--	--	--	39.40 (13.95)	45.00 (15.58)	49.04 (15.23)	49.78 (14.85)	$F(3, 314) = 7.69, p < .001$ $1 < 2, 3, 4$
Lifetime Victimization	2.79 (5.27)	3.93 (5.18)	7.68 (8.72)	$F(2, 316) = 7.01, p = .001$ $1, 2 < 3$	3.23 (3.67)	4.47 (3.62)	3.65 (3.01)	5.41 (5.17)	$F(3, 315) = 3.98, p = .008$ $1 < 2, 4; 3 < 4$
Lifetime Witnessing	13.38 (12.24)	15.65 (13.35)	20.66 (15.12)	$F(2, 316) = 14.89, p = .001$ $1, 2 < 3$	15.52 (11.71)	15.57 (10.62)	18.76 (10.04)	22.84 (12.19)	$F(3, 316) = 4.71, p = .003$ $1, 2 < 4$
CTQ Physical Abuse	6.99 (3.34)	9.00 (5.28)	10.76 (5.55)	$F(2, 300) = 16.13, p < .001$ $1 < 2 < 3$	--	--	--	--	--
CTQ Emotional Abuse	7.03 (3.47)	8.78 (4.81)	11.55 (5.06)	$F(2, 299) = 23.78, p < .001$ $1 < 2 < 3$	--	--	--	--	--
CTQ Emotional Neglect	9.87 (6.02)	12.08 (6.06)	14.29 (6.31)	$F(2, 299) = 11.71, p < .001$	--	--	--	--	--

Variable	South Africa			United States				ANOVA
	Group 1: Holding Steady <i>M (SD)</i>	Group 2: Dissatisfied <i>M (SD)</i>	Group 3: Somatic Complaints <i>M (SD)</i>	Group 1: Holding Steady <i>M (SD)</i>	Group 2: Dissatisfied <i>M (SD)</i>	Group 3: Somatic Complaints <i>M (SD)</i>	Group 4: Elevated Alcohol Use <i>M (SD)</i>	
CTQ Sexual Abuse	6.59 (4.05)	7.80 (4.79)	11.18 (6.44)	--	--	--	--	$F(2, 298) = 18.69, p < .001$ $1, 2 < 3$
CTQ Minimization	7.63 (3.74)	9.05 (3.73)	10.01 (3.37)	--	--	--	--	$F(2, 299) = 10.15, p < .001$ $1 < 2, 3$

Table 6
Means, Standard Deviations, and Analyses of Variance for Effects of Adjustment Clusters on Coping by Country

Variable	South Africa				United States				ANOVA
	Group 1: Holding Steady <i>M (SD)</i>	Group 2: Dissatisfied <i>M (SD)</i>	Group 3: Somatic Complaints <i>M (SD)</i>	Group 1: Holding Steady <i>M (SD)</i>	Group 2: Dissatisfied <i>M (SD)</i>	Group 3: Somatic Complaints <i>M (SD)</i>	Group 4: Elevated Alcohol Use <i>M (SD)</i>		
Active Coping	38.46 (8.02)	37.33 (8.42)	37.61 (7.08)	36.90 (7.80)	35.15 (7.44)	36.31 (8.25)	35.87 (7.25)	$F(3, 314) = 1.02, p > .10$	
Avoidant Coping	23.94 (8.04)	26.15 (8.67)	31.95 (7.52)	19.18 (5.04)	21.79 (6.00)	23.07 (6.61)	24.26 (4.40)	$F(3, 314) = 10.61, p < .001$ $1 < 2 < 3 < 4$	