Predicting the Influence of Social Resources on African American Wife and Daughter Caregivers' Depressive Symptoms
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This study—on 100 African American wife and 258 daughter primary caregivers — uses a contextual approach in its examination of the relationship between social resources and caregiver depressive symptoms. At the bivariate level, significant differences in certain key characteristics of primary caregivers and care receivers underscore the generational differences between the caregiver samples. Using separate ordinary least squares regression models, the authors found that satisfaction with family functioning was a significant predictor for lower depressive symptoms for both wives’ and daughters’ depressive symptoms. However, social participation and availability of secondary help were negatively associated with depressive symptoms for daughters. Receipt of instrumental support was predictive of higher levels of depressive symptoms among daughters. The findings indicate the importance of accounting for the contextual differences in our understanding of depressive symptoms, specifically the differences in the relationship between social resources and depressive symptoms for wives and daughters. Practice and theoretical implications are also discussed.

Keywords: African Americans; caregiving context; depressive symptoms; social resources

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Researchers have established the importance of contextual factors in understanding the psychological outcomes of primary caregivers of older adults (Dilworth-Anderson, Williams, & Cooper, 1999; Seltzer & Greenberg, 1999; I. Williams, 2005), particularly the negative association between their social resources and primary caregivers’ psychological distress (e.g., Li, Seltzer, & Greenberg, 1997; Miller et al., 2001). The availability and use of social resources from the caregiver’s network is believed to be associated with lower caregiver psychological distress (Pearlin, Mullan, Semple, & Skaff, 1990). Other contextual factors that are associated with psychological distress include the caregiver’s race or ethnicity, gender, social class, health, and kinship relationship and the care receiver’s functional and physical health status (Cattanach & Tebes, 1991; Dilworth-Anderson et al., 1999; Knight, Silverstein, McCallum, & Fox, 2000; Neal, Ingersoll-Dayton, & Starrels, 1997; Seltzer & Greenberg, 1999; I. Williams, 2005).

Building on prior research, our study highlights the role of social resources and kinship relationship between primary caregivers and their care recipients as important contextual factors to examine in relation to African American wife and daughter caregiver depressive symptomatology. Specifically, we examine the association between social resources and depressive symptoms among African American wife and daughter caregivers when controlling for other identified contextual factors known to be associated with the psychological distress of White wife and daughter caregivers in prior studies (see Seltzer & Greenberg, 1999). We focus on African American wife and daughter caregivers because evidence indicates that these caregivers are more predisposed to the risk of psychological distress in their role as primary caregiver than husband and son caregivers are (Pinquart & Sorensen, 2003). The choice of depressive symptoms as a measure of psychological distress for the current study is informed by prior literature suggesting that women are at greater risk of affective disorder when faced with stressful life events (Aneshensel, Rutter, & Lachenbruch, 1991; Brown, Brody, & Stoneman, 2000). Furthermore, our study is guided by Brown et al.’s (2000) argument that the contextual complexity of Black women’s lives may influence their risk of depression. Hence, in this study, we address the following research question: Are social resources similarly predictive of the depressive symptoms for African American female caregivers along kinship lines?

**Conceptual Framework**

Conceptually, the term contexts refers to the “broader environment” that can directly affect caregiving outcomes such as psychological distress.
(Dilworth-Anderson et al., 1999, p. 391). Contexts provide caregivers the resources and support in carrying out their caregiving responsibilities (I. Williams, 2005). Furthermore, the stress-and-coping model highlights the importance of social resources—as measured by social networks and social support—in shaping the experience of stressful life events (Antonucci, 2001; Pearlin, 1989).Pearlin (1989) argues “that the effect of support is constrained or enhanced by the context in which the relationships exist” (p. 251). Drawing on the stress process model of caregiving by Pearlin et al. (1990), Dilworth-Anderson and colleagues (1999) conceptualized and examined empirically five contextual domains of the caregiving experience. The contextual framework assumes that caregiving occurs in multiple contexts. A sociocultural context focuses on the specific social and demographic characteristics of the caregiver; a situational context focuses on the care needs of care recipients; an interpersonal context focuses on relationships between caregivers and other people, including social resources and social networks; a temporal context focuses on the timing and duration of caregiving and other roles; and a personal context focusing on caregivers’ physical health status that may be associated with psychological outcomes (Dilworth-Anderson et al., 1999). The examination of contextual factors underscores Pearlin’s assertion that “incumbency in a major institutionalized role [in our study, wife and daughter] necessarily entails persistent encounters with a host of conditions and expectations that exert a structuring force on experience” (p. 242). Furthermore, prior studies support the utility of using this framework to examine psychological distress among African American caregivers (Dilworth-Anderson et al., 1999; I. Williams, 2005), but they do not distinguish wife and daughter caregivers from other informal helpers of African American elders.

Literature Review

Kinship relationships and psychological distress. Regarding wife and daughter caregivers, studies suggest that they may have different caregiving experiences and psychological outcomes because of the differences in their interpersonal and temporal contexts. Prior studies show that wife caregivers may be more vulnerable than daughter caregivers to psychological distress because wives are more likely to be solo caregivers, have less available social support in caregiving, share similar health problems to those of the care receiver due to similar age, and endure more caregiving hardships due to poor health and residential proximity (Pinquart & Sorensen, 2003). In their study of White caregivers, Seltzer and Greenberg (1999) documented that social participation reduced depressive symptoms for daughter caregivers but
not for wife caregivers. They speculated that the differences in kinship relationships might be a result of these caregivers’ different stages of life as well as a result of wife caregivers’ older age, lower education, poorer health status, and prior social expectations associated with the kinship relationship. Further studies suggest that daughters may be more vulnerable than wives to psychological distress due to conflicting demands between their caregiving and employment roles (Reid & Hardy, 1999; Stephens, Franks, & Townsend, 1994). However, both wives and daughters are more likely to assume the caregiver role because of cultural norms that support gender role socialization (Stoller & Cutler, 1992), and this suggests that wives and daughters may have similar as well as different psychological outcomes in caregiving.

Prior studies of depressive symptomatology among wives and daughters have focused mostly on samples of White caregivers (e.g., Bookwala & Schulz, 2000; Franks & Stephens, 1996; Lawton, Moss, Hoffman, & Perkinson, 2000; Li, Seltzer, & Greenberg, 1997, 1999; Pruchno, Kleban, Michaels, & Dempsey, 1990; Reid & Hardy, 1999; Stephens et al., 1994; Stephens, Townsend, Martire, & Druley, 2001). We located only one study that focused on African American and White caregiver daughters and daughters-in-law (White, Townsend, & Stephens, 2000), but it conflicted with prior studies relating that African American caregivers report lower levels of depressive symptoms than White caregivers do, although the former caregiver group may provide more care (Pinquart & Sörensen, 2005).

Although these studies on predominantly White samples provide useful information about the influence of contextual factors, their generalizability might be limited because of distinct racial and cultural experiences between African American and White caregivers. For instance, relative to White caregivers, African American adult child caregivers, commonly daughters, are more likely than wife caregivers to provide care to older African Americans (Pinquart & Sörensen, 2005; I. Williams, 2005), which may be due to greater marital dissolution and higher fertility rates in the Black population than in the general population (Pinquart & Sörensen, 2003). As such, more research is warranted to help clarify the influence of social resources on the depressive symptomatology among African American wife and daughter caregivers.

Social resources and social support. The term social support refers to the “social resources one actually uses for dealing with life problems” (Pearlin, 1989, p. 251); it also describes the content and quality of interpersonal transactions, which comprise three elements: aid, affect, and affirmation (Antonucci, 2001). Researchers note that African American families
have strong filial bonds and value reciprocity (Dilworth-Anderson & Burton, 1994), and family members are a critical source of instrumental support to older relatives (Dilworth-Anderson & Anderson, 1994). Krause (2001) offers three categories of social support measures: social embeddedness, receipt of tangible support, and subjective evaluations of support. Although it is commonly believed that African Americans have higher levels of social support than Whites do, findings on the rates of social support among African American caregivers have been inconclusive (Martin, 2000). Some researchers have argued that social support reflects the quality of caregiving relationships and is important in explaining caregiver well-being (Dilworth-Anderson et al., 1999). Others propose that positive social support, which includes instrumental assistance and emotional sustenance, has clear implications for promoting well-being (Wethington, Moen, Glasgow, & Pillemer, 2000). In addition, Chang, Brecht, and Carter (2001) report that difficulty in arranging help from confidants and friends was significantly associated with depression among caregivers of people with Alzheimer’s disease. Furthermore, I. Williams (2005) documented that a larger social network and greater satisfaction with the level of social activities were associated with fewer depressive symptoms among caregivers.

Focus of the Study

Despite prior evidence indicating that contextual variables such as social resources (e.g., social support) may be associated with psychological distress among wife and daughter caregivers, the applicability of this evidence to African American wife and daughter caregivers has not been established due to inadequate research on these caregiver groups. Even though we recognize the merits of cross-cultural comparisons, we also believe that the sole focus on African American caregivers may uncover the diversity that exists within this group. We use a within-race gender approach to examine the influence of social resources on the depressive symptomatology among two groups of African American caregivers: wives and daughters. This approach avoids confounding race and ethnic differences with social structural inequities (Fox, Hinton, & Levkoff, 1999).

Drawing on the caregiving stress process model and a contextual framework, we hypothesize that social resources, as measured by limited social participation, satisfaction with family functioning, perceived instrumental support, and availability of secondary informal help, will be significantly associated with depressive symptoms among African American wife and daughter caregivers. More importantly we extend the work of Seltzer and Greenberg (1999) in that we examine how social resources may have
different influences on the depressive symptoms of African American wife and daughter primary caregivers because of the differences in their interpersonal and temporal contexts.

**Design and Method**

**Research Design, Sample, and Data Collection**

Data for this study came from a larger cross-sectional study of 521 urban and rural midwestern African American female caregivers of older African Americans (age 65 and older). The larger study was conducted between July 1999 and August 2002 in the state of Missouri, with the approval of the Institutional Review Board of Washington University in St. Louis.

The sampling method is further described in published works (Chadiha et al., 2004; Chadiha, Rafferty, & Pickard, 2003). Researchers acquired a list of Medicare enrollees from the former Health Care Financing Administration. To screen elders and recruit caregivers, study staff adapted and employed the reverse screening method of Picot, Samonte, Tierney, and Connor (2001) to generate a sample of African American female caregivers by screening older Medicare enrollees to determine if elders and caregivers were eligible for study inclusion.

An elder was eligible for study participation in the larger study when he or she self-identified as African American, Black, Negro, or Colored; reported being 65 years or older; reported getting unpaid help from an African American woman with at least one activity of daily living (ADL; e.g., bathing, grooming, dressing) or instrumental activity of daily living (IADL; e.g., shopping, housekeeping, managing money) or in decision making; and lived within the targeted area. Eligible elders or their proxies (i.e., an adult living with an elder) were asked for contact information for up to two unpaid African American females who provided help—one who helped the most and another who also helped; 95% of caregivers in the final sample identified themselves as helping the most. Identified caregivers were contacted to verify their study eligibility (self-identifying as an African American female and as 18 years or older and currently providing unpaid ADL, IADL, or decision-making help to the elder) and solicit their consent to a personal interview.

Trained African American female interviewers used a computerized structured questionnaire to conduct in-home interviews with caregivers that lasted about 2½ hours. Interviewers gained oral consent for caregiver participation at screening and then obtained written consent at the time of the interview. Of the 592 eligible caregivers who had given oral consent, 521
caregivers completed interviews, thus yielding an overall 88% response rate among contacted eligible caregivers, who were compensated $15 for participation in the study. As we were interested in comparing wife and daughter primary caregivers, the analyses of this study were done on a subsample of 100 wife caregivers and 258 daughter caregivers.

Measures

**Dependent variable.** Depressive symptoms were measured by the Center for Epidemiological Studies–Depression Scale (CES-D). The 20-item CES-D was designed to measure a person’s current level of depressive symptoms, with an emphasis on affect (Radloff, 1977). Responses ranged from 0 (*rarely or none of the time*) to 3 (*most or all of the time*). Some items were reversed scored, and a summary score was obtained for each respondent. The Cronbach’s alpha was .86. Higher scores are reflective of higher levels of caregivers’ depressive symptoms.

**Social resources.** Following the lead of Seltzer and Greenberg (1999), we measured social resources in three different ways: social participation, satisfaction with family functioning, and perceived instrumental support. We measured caregivers’ limitation in social participation with a single item: “Compared to others your age, are your social activities more or less limited because of your physical health or emotional problems?” (Sherbourne & Kamberg, 1992). The responses ranged from 1 (*much more limited*) to 5 (*much less limited*). A higher score reflects a higher level of perceived social participation relative to others.

We measured satisfaction with family functioning using the four-item family functioning scale (Sherbourne & Kamberg, 1992). The scale was designed to measure respondents’ satisfaction with their family relationships in four areas: closeness with their families, support they give each other, how much they talk things over, and their happiness with their family life. Responses were added up to obtain a summary score. A higher score indicates greater satisfaction with family relationships. The Cronbach’s alpha was .87.

Received instrumental family support was measured using the Duke Social Support Index for use in chronically ill elderly individuals (Koenig et al., 1993). The 13-item index measured ways in which caregivers received help from their family members, for example, “shop or run errands,” “help out with money,” and “provide companionship.” Responses (1 = *yes*, 0 = *no*) were summed to calculate a summary score, with higher scores indicating greater instrumental support. The Cronbach’s alpha was .59.
In addition, we included a measure of the informal caregiving network size, defined as primary caregiver/care receiver having any secondary caregiver (1 = yes). We derived this measure from two items: “Are there any people who provide care to (elder) but are not paid?” and “How many other people like this provide care to (elder)?”

**Control variables.** We identified the following control variables: caregiver’s age, education, duration of caregiving, self-rated health, geographical location, and employment status and the physical functioning of the care receivers. Caregiver’s age, education, and the duration of caregiving were measured in years. Knight et al. (2000) reported that caregivers’ poor self-rated health was positively associated with their emotional distress. We measured self-rated health using a single item: “In general, would you say your health today is . . .” The five-level responses on self-rated health ranged from 1 (poor) to 5 (excellent). Wood and Wan (1993) identified rurality as a predictor for increased objective needs and decreased availability of formal services. Hence, we controlled for geographical location, which we dichotomously coded as 1 (rural). Scharlach (1994) identified employment as a potential positive resource or a competing demand for caregivers. Employment status was a dichotomous variable that was based on questions about primary caregivers’ current employment status, with 1 referring to caregivers who were working full- or part-time.

The level of the care receiver’s functional impairment has been linked to caregivers’ distress (Pearlin et al., 1990; Pinquart & Sörensen, 2003). Consequently, we controlled for care receivers’ physical functioning, which was measured with the Older American Resources and Services instrument developed by Duke University (Duke University Center for the Study of Aging and Human Development, 1978). Caregivers were asked to rate (0 = no help needed to 2 = unable to do the task) their elders’ functioning in seven ADLs and seven IADLs. The higher summed scores represented greater functional dependency. The Cronbach’s alpha was .92.

**Analyses**

In addition to the descriptive statistics, we computed bivariate statistics. At the bivariate level, we examined whether or not wife caregivers differed from daughter caregivers along the variables of interest. Next, using ordinary least squares regression, regressing depressive symptoms on each social support variable separately, while controlling for the social and health characteristics of the caregiver (age, education, employment status, self-rated health), geographic location, the duration of caregiving, and elder’s physical functioning. Because of the comparative aim of this study,
we juxtaposed the multivariate models of wife and daughter caregivers, using the same set of control and independent variables. Regarding multicollinearity, our lowest tolerance values in the regression models were .60, which was well within the acceptable range. A statistically significant result for all analyses was defined as $p < .05$.

Findings

Sample Description

Table 1 provides the profile of the study sample of wife and daughter caregivers and bivariate comparisons of certain key characteristics. Wife caregivers were significantly older, had less education, were less likely to be employed, had poorer self-rated health, were less likely to have help available from others with their caregiving, and had spent a longer duration in providing care the daughter caregivers. Care receivers of daughter caregivers were significantly older than those of wife caregivers. However, the two groups of caregivers did not differ in other characteristics. On the average, their care recipients needed assistance in about 10 ADL and IADL areas. Using a cutoff of 16 points on the CES-D, a roughly equal proportion of daughter caregivers (15%) and wife caregivers (16%) met the threshold for clinical depression.

Table 2 presents two separate multivariate models for the two subsamples of wife and daughter caregivers. For wife caregivers, satisfaction with family functioning is the only social support variable that was significantly predictive of depressive symptoms ($b = -0.654, t = -2.35, p = .0209$). The relationship was negative. In addition, wife caregivers’ self-rated health was negatively predictive of their depressive symptoms ($b = -1.528, t = -1.97, p = .0515$).

A slightly different pattern of significance was observed for daughter caregivers versus wife caregivers. For daughter caregivers, having another person to help with elder care was negatively associated with depressive symptoms ($b = -2.439, t = -2.20, p = .0292$). Furthermore, greater social participation ($b = -1.639, t = -3.17, p = .0018$) was significantly associated with fewer depressive symptoms. In addition, daughter caregivers who reported higher satisfaction with their family functioning reported significantly lower levels of depressive symptoms ($b = -0.490, t = -3.12, p = .0021$). Perceived instrumental support was positively related with depressive symptoms ($b = .248, t = 2.02, p = .0455$). Furthermore, daughters who rated their health positively reported significantly fewer depressive symptoms ($b = -1.546, t = -3.04, p = .0026$).
Table 1
Comparison of Characteristics of African American Wife and Daughter Caregivers

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Wife Caregivers (n = 100)</th>
<th>Daughter Caregivers (n = 258)</th>
<th>Test Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (in years)</td>
<td>68.89 (9.73)</td>
<td>48.74 (11.09)</td>
<td>t = −15.94***</td>
</tr>
<tr>
<td>Education (in years)</td>
<td>10.91 (3.16)</td>
<td>12.89 (2.34)</td>
<td>t = 5.68***</td>
</tr>
<tr>
<td>Employment status (1 = employed)</td>
<td>30.0% (1.06)</td>
<td>63.6% (0.98)</td>
<td>χ² = 32.71***</td>
</tr>
<tr>
<td>Location (1 = rural)</td>
<td>51.0% (15.61)</td>
<td>51.6% (6.99)</td>
<td>t = −3.83***</td>
</tr>
<tr>
<td>Self-rated health</td>
<td>2.83 (1.06)</td>
<td>3.33 (0.98)</td>
<td>t = 3.94***</td>
</tr>
<tr>
<td>Duration of caregiving</td>
<td>14.32 (6.86)</td>
<td>8.12 (6.79)</td>
<td>t = 0.33</td>
</tr>
<tr>
<td>Elder’s physical dependency (ADL and IADL)</td>
<td>20.05 (1.05)</td>
<td>20.31 (1.00)</td>
<td>t = −0.23</td>
</tr>
<tr>
<td>Availability of secondary help</td>
<td>27.27% (4.71)</td>
<td>55.25% (4.50)</td>
<td>χ² = 22.44***</td>
</tr>
<tr>
<td>Limitation in participationa</td>
<td>3.06 (3.09)</td>
<td>3.03 (3.41)</td>
<td>t = 0.95</td>
</tr>
<tr>
<td>Instrumental family supportb</td>
<td>3.74 (4.09)</td>
<td>4.17 (4.50)</td>
<td>t = −0.80</td>
</tr>
<tr>
<td>Family functioningb</td>
<td>16.32 (3.09)</td>
<td>15.97 (3.41)</td>
<td>t = −0.90</td>
</tr>
<tr>
<td>Depressive symptoms (CES-D)c</td>
<td>8.93 (7.8)</td>
<td>8.99 (8.42)</td>
<td>t = 2.10*</td>
</tr>
<tr>
<td>Elder’s age</td>
<td>76.23 (7.89)</td>
<td>78.14 (7.27)</td>
<td>t = 2.10*</td>
</tr>
</tbody>
</table>

Note: Standard deviations are in parentheses. ADL = activities of daily living; IADL = instrumental activities of daily living; CES-D = Center for Epidemiological Studies–Depression Scale.

a. Higher scores indicate lower levels of functioning or participation.
b. Higher scores indicate better support or functioning.
c. Higher score indicates greater depressive symptoms.

Discussion

Using data from a larger regional study that included a systematic sample of African American female primary caregivers generated from lists of African American Medicare enrollees, we used a within-race gender approach to address whether social resources (i.e., limitations in social participation, satisfaction with family functioning, perceived instrumental support, availability of secondary informal help) were similarly and significantly associated with the depressive symptoms for wife and daughter caregivers. Furthermore, we
addressed this question when controlling for other contextual factors known to be associated with the psychological distress of caregivers. We drew on the caregiving stress process model and contextual caregiving framework to understand and interpret findings about social resources that were significantly associated with the depressive symptoms of these caregivers. Overall, our findings on African American wife and daughter caregivers build on and expand prior works that addressed the differential influence of social resources on depressive symptoms in predominantly White samples of wife and daughter caregivers (Li et al., 1997; Seltzer & Greenberg, 1999). Study results indicate not only significant sample differences between African American wife and daughter caregivers on key sample characteristics but also sample differences on specific measures of social resources that were associated with depressive symptoms. The uniqueness of this study’s findings is that they are based on wives and daughters—two groups of African American primary caregivers that has not received adequate attention in prior research.

Although African American wife and daughter caregivers were similar on certain sample characteristics (residential location, care recipient’s physical functioning, and all four types of social resources), daughters as compared to wives were, on the average, significantly younger; more educated; and more likely to rate their overall health better, to have had shorter

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Wife Caregivers</th>
<th>Daughter Caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.106</td>
<td>-.056</td>
</tr>
<tr>
<td>Educational level</td>
<td>-.4160</td>
<td>-.417</td>
</tr>
<tr>
<td>Employment status (1 = employed)</td>
<td>-.533</td>
<td>-1.483</td>
</tr>
<tr>
<td>Geographic location (1 = rural)</td>
<td>-1.305</td>
<td>-.873</td>
</tr>
<tr>
<td>Caregiver self-rated health</td>
<td>-1.528*</td>
<td>-1.546**</td>
</tr>
<tr>
<td>Years in caregiving</td>
<td>-.032</td>
<td>-.133</td>
</tr>
<tr>
<td>Elder’s physical functioning</td>
<td>-.002</td>
<td>.084</td>
</tr>
<tr>
<td>Availability of help</td>
<td>-.851</td>
<td>-2.439*</td>
</tr>
<tr>
<td>Limitation in participation</td>
<td>-.358</td>
<td>-1.639**</td>
</tr>
<tr>
<td>Family functioning</td>
<td>-.654*</td>
<td>-.490**</td>
</tr>
<tr>
<td>Instrumental support</td>
<td>.071</td>
<td>.248*</td>
</tr>
<tr>
<td>Adjusted $R^2$</td>
<td>.104</td>
<td>.168</td>
</tr>
</tbody>
</table>

Note: Caregiver’s age, education, employment status, residential context, self-rated health, and duration of caregiving and elder’s physical functioning are control variables. Beta coefficients are unstandardized.

*p < .05. **p < .01.

Table 2
Estimates of the Ordinary Least Squares Regression of Depressive Symptoms on Social Resources for Wife and Daughter Caregivers
lengths of caregiving experience, to have secondary informal help available, and to assist older caregiver recipients. Certain descriptive findings warrant attention on the basis of prior knowledge. For instance, more daughters than wives were employed in the labor market, a finding that pinpoints the greater likelihood of daughters’ multiple roles beyond their caregiving role that may intensify their susceptibility to psychological distress (Reid & Hardy, 1999; Stephens et al., 1994). An average low rating of their overall health by wives may suggest a risk factor for their poor psychological health (Brown & Palenchar, 2004). Still, an equal but relatively small proportion of wives and daughters met the threshold for clinical depression.

Multivariate findings support this study’s hypothesis that social resources would be significantly associated with the depressive symptoms of African American wife and daughter caregivers. However, the pattern of significant covariates is dissimilar for both samples of caregivers in that satisfaction with family functioning was the only social resource that was similarly significant for wife and daughter caregivers’ depressive symptoms. Lower satisfaction in family functioning is associated with increased levels of depressive symptoms for both wife and daughter caregivers, a finding that corresponds with a prior study indicating that emotionally distressed caregivers reported lower levels of satisfaction with their social support (Dilworth-Anderson et al., 1999).

In addition, three other measures of social resources (limitations in social participation, availability of help, and instrumental support) were significantly associated with daughters’ depressive symptoms. Our findings for different patterns of significant predictors of depressive symptoms of wife caregivers versus daughter caregivers are similar to Seltzer and Greenberg’s (1999). In the current study, the negative association between social participation and depressive symptoms for daughters might be attributed to differences in norms associated with age and social participation. Social participation of older people is “more ambiguous and individualistic” than that of their younger counterparts (Seltzer & Greenberg, 1999, p. 391). Traditionally speaking, a wife is expected to be the nurturer and care provider for her husband. Thus, unlike wife caregivers, daughter caregivers, who have different role expectations stemming from the differences in their interpersonal and temporal contexts, may draw support from their social participation, which serves as a resource for the maintenance of their well-being (Wethington et al., 2000).

That the availability of secondary informal help was significantly associated with lower depressive symptoms for daughter caregivers accords with a prior study indicating that larger caregiving networks are significantly more likely among younger primary caregivers (Stommel, Given, & Given, 1998). Our finding dovetails with the one indicating that greater social participation
was associated with lower levels of depressive symptoms among daughter caregivers. Intuitively, this finding may mean that daughters’ social participation, as interactions with other people, relative to wives’, who are more likely to be solo caregivers (Pinquart & Sörensen, 2003), may serve to enhance the mobilization of help to daughters from other people.

Contrary to what we had expected on the basis of prior evidence about the role of social resources as serving to protect people from distress (Krause, 2001), we found that the receipt of familial instrumental support was positively related to daughter caregivers’ depressive symptoms. Our finding might mean that the receipt of instrumental support reflects the higher non-caregiving-related demands faced by daughters. It might also mean that such support might increase the potential for interpersonal disagreements over how and when it should be given. Irrespective of the explanation, more research is needed to illuminate this study’s finding for daughter caregivers, particularly as new findings are emerging about the relationship of negative interactions to depressive symptoms among African Americans (see Lincoln, Chatters, & Taylor, 2005). It is important to note that on the average, wife and daughter caregivers reported low levels of instrumental informal support, underscoring a point of a prior study indicating that minority caregivers, including African Americans, may not receive more support from families and friends than do their White counterparts (Dilworth-Anderson, Williams, & Gibson, 2002).

Altogether, our findings support the propositions that specific social resources contribute to caregivers’ well-being along generational lines (Pearlin, 1989; Seltzer & Greenberg, 1999). Unlike previous studies (Reid & Hardy, 1999; Stephens et al., 1994), we did not find a significant relationship between employment (a control measure) and depressive symptoms among daughter caregivers. Self-rated health of the caregiver, the only significant control measure in regression models, had a significant negative relationship with depressive symptoms for both samples of caregivers. This significant health finding for African American wife and daughter caregivers parallels a prior study with caregivers of persons with Alzheimer’s disease (Knight et al., 2000).

The cross-sectional nature of this study limits our ability to ascertain whether depressive symptoms were a function of social resources or vice versa; a longitudinal design can better uncover the mechanisms by which social resources influence caregivers’ depressive symptoms (Wethington et al., 2000). Because of the relatively small size of the wife caregiver sample, we were unable to test for the interaction effects of the interpersonal context and the relationship of the caregiver and care receiver. Prior research documents issues of validity using the CES-D across diverse populations and with non-probability samples of older African Americans (Long-Foley, Reed, Mutran,
& DeVellis, 2002; Skarupski et al., 2005). Nonetheless, the CES-D is a useful instrument in measuring the presence of psychological distress. The use of a single-item measure for social participation, although not ideal, serves as a useful proxy for caregiver participation, and as such, we can rely on its “sign and significance” in the regression models (Moody & Marvell, 2003).

Despite limitations, our focus on African American caregivers recognizes the diversity that exists within one racial and gender group as well as the uniqueness that may occur among informal caregivers in terms of their position in life stages, caregiving careers, and kin relationship as they shape the caregiving outcomes. As regards kin relationship, the differential patterns of resources that were significantly associated with wife caregivers’ versus daughter caregivers’ depressive symptoms underscore the need for researchers to design more studies that will allow the carrying out of separate sample analyses. Our multivariate findings provide useful baseline information for future studies on African American wife and daughter primary caregivers.

Our findings suggest a number of implications for theory and practice. They support the theoretical considerations of context, especially for African American caregivers. The significant sample differences between wives and daughters point to the differences in the temporal context of the caregiving experiences (Dilworth-Anderson et al., 1999). In line with Brown et al. (2000), we believe that “there are multiple contextual levels at which Black women’s risk of depression might be attenuated” (p. 196). The focus on context recognizes the intersection between individual outcomes and social structural factors that might influence them (Ryff, Marshall, & Clarke, 1999). This is important, as others have noted (S. Williams, Dilworth-Anderson, & Goodwin, 2003), that although African American caregivers are likely to report better outcomes than their White counterparts, we need to recognize that “African American caregivers have differential life experiences as well as differential resources” (p. 109).

In terms of practice, findings suggest that practitioners may want to pay closer attention to family functioning for both wife and daughter caregivers when making assessments of their depressive symptoms. Furthermore, practitioners will need to be cognizant that the receipt of instrumental support might not necessarily be a positive experience for daughter caregivers. Without careful attention to the differential patterns in significant factors associated with the depressive symptoms of wives versus daughters, practitioners may run the risk of designing and delivering services that are ineffective in meeting the needs of these caregivers. In conclusion, this study’s examination of contextual effects provides a better understanding of how kinship relationships between caregivers
and care recipients yield similar and different outcomes for depression in a sample of African American wife and daughter caregivers. The exploratory nature of this study suggests that more research is needed to build and expand on findings, particularly longitudinal research that examines the dynamic process of the caregiving experience for wife and daughter caregivers.

**References**


