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Maternal Trauma and Children’s Functioning: The Role of Kinship Social Support

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**ABSTRACT**

Although research has documented the detrimental effects of maternal trauma on child behavior (Lambert, Holzer, & Hasbun, 2014), the role of extended family support in potentially mitigating the effects of intergenerational transmission of trauma is not clearly understood. With a diverse community sample of 52 trauma-exposed mothers and their children between the ages of 7 and 12, we investigated relationships between kinship social support, maternal trauma exposure severity, maternal posttraumatic stress disorder (PTSD) symptom severity, and child behavioral problems. Results showed that kinship social support was negatively related to maternal trauma exposure severity, maternal PTSD symptom severity, child internalizing behaviors, and child externalizing behaviors. Additionally, kinship social support moderated the relationship between maternal trauma exposure severity and child internalizing behaviors. These results have implications in the implementation of interventions aimed at supporting diverse families facing trauma that incorporate extended family networks.

Research on child exposure to family and community violence has demonstrated that children are strongly affected by indirect trauma, especially when the victim is someone with whom they have a close relationship (Margolin & Gordis, 2000). Trauma exposure among individuals of low socioeconomic status in urban settings is high, with an estimated 87.8% of this population experiencing one traumatic event during the course of their lifetime (Gillespie et al., 2009). Based on the theory of the intergenerational transmission of trauma, the negative effects of parental trauma can be passed on to children through a complex set of factors, including both the trauma exposure itself and the parents’ negative mental health outcomes associated with trauma (Schwerdtfeger & Goff, 2007; Yehuda, Halligan, & Grossman, 2001). Such outcomes include intrusive memories, avoidance, emotional
numbing, or dissociation. Mental health sequelae associated with trauma exposure are widespread and include posttraumatic stress disorder (PTSD), depression, and anxiety (Laugharne, Lillee, & Janca, 2010), and again, are particularly prevalent for women of color and low socioeconomic status (El-Khoury et al., 2004).

Previous research indicates that both maternal trauma exposure and PTSD predict child behavioral problems (Chemtob & Carlson, 2004; Levendosky & Graham-Bermann, 2001; Lieberman, van Horn, & Ozer, 2005), which provides evidence of the transmission of trauma from mothers to their children. Specifically, maternal PTSD has been related to significant child difficulties, including emotion dysregulation (Samuelson & Cashman, 2008) and high rates of child behavioral problems (Chemtob et al., 2010; Lambert, Holzer, & Hasbun, 2014; Levendosky & Graham-Bermann, 2001; Levendosky, Huth-Bocks, Shapiro, & Semel, 2003; Samuelson & Cashman, 2008). These studies underline the crucial role of both maternal trauma exposure and mental health on child functioning in families exposed to trauma. Identifying sources of strength and resiliency that protect children against the intergenerational transmission of trauma will inform approaches to family treatment.

Ecological perspectives of trauma outline the important contributions of individual, community, and environmental contexts in recovery (Harvey, 1996). According to Harvey’s (1996) ecological model, individual responses and recovery from trauma vary based on complex interactions between individual (e.g., prior trauma, demographics), situational (e.g., frequency, severity, and duration of the traumatic event), and environmental factors (e.g., support systems, community). This model emphasizes the inclusion of natural supports and community factors in trauma recovery and providing interventions that address and include relevant environmental factors and systems (Harvey, 1996). Levendosky and Graham-Bermann (2000) expanded on the ecological model to address the influence of parental mental health following trauma on child outcomes. Based on this theoretical model, it is necessary to understand community and cultural factors in addition to individual and family characteristics in the treatment of trauma.

Multiple meta-analyses investigating the predictors of PTSD have demonstrated that social support is a significant protective factor against the development of PTSD (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003). Lack of social support emerged as the strongest risk factor for PTSD symptoms in a review of 77 studies of PTSD (Brewin et al., 2000). Additional research studying the direct and indirect effects of intimate partner violence (IPV) found that ecological factors, such as social support, were better predictors of parenting and child adjustment outcomes than the mothers’ trauma itself (Levendosky & Graham-Bermann, 2001). Specifically, lack of social support predicted maternal psychological functioning, which in turn predicted child adjustment. Additionally, research
indicates that social support serves as a protective factor against negative mental health outcomes, particularly for low levels of trauma severity (Beeble, Bybee, Sullivan, & Adams, 2009; Folger & Wright, 2013). In a study investigating social support as a protective factor following childhood trauma, family social support moderated the effect of childhood trauma exposure on adult mental health and behavior (Folger & Wright, 2013). Specifically, researchers found that perceived social support from family members buffered against negative outcomes in adulthood only in instances of low childhood trauma; when there were high levels of childhood trauma, family support no longer served a protective function. In a study investigating the effects of social support on well-being, social support had the strongest buffering effects when there was lower trauma severity in individuals who experienced IPV (Beeble et al., 2009). These results underscore the importance of further research to examine the relationship between social support and trauma severity. Therefore, including measures of trauma exposure severity in addition to maternal mental health functioning is necessary to accurately identify the factors that contribute to, and buffer against, negative outcomes associated with trauma in families.

Although trauma research has become more focused on the impact of maternal trauma on families, there is still a need for more culturally relevant constructs when considering the impact of trauma on diverse families. Families of color are at a higher risk for trauma due in part to the greater likelihood of facing extreme poverty and discrimination (Coll et al., 1996; El-Khoury et al., 2004; Gillespie et al., 2009). Although social support has been consistently documented as a protective factor against the development of PTSD (Ozer et al., 2003), the majority of this research is either generally focused on all means of social support or narrowly on support within the nuclear family. This existing literature has not yet considered extended networks of support. The extended family plays an important role in many cultures, and has been identified as a prominent aspect of family functioning in African American and Latino families (Coll et al., 1996; Hall, 2008). Interconnectedness and kinship are valued elements in African American culture that can help facilitate resilience and coping with stress (Jones, 2007). In African American families, the extended family network can provide additional support for single-parent families and during times of crisis (Hall, 2008). Similarly, familism, which outlines a strong identification, attachment, and loyalty to extended family, has been documented as an important source of emotional support for Latino families (Altarriba & Bauer, 1998; Keefe & Casas, 1980; Sabogal, Marín, Otero-Sabogal, Marín, & Perez-Stable, 1987). To tailor treatment to meet the needs of diverse families, it is important to better understand multiculturally relevant factors that might mitigate the effects of trauma within the family.

The construct of kinship social support can provide valuable insight into how diverse families who use extended family networks cope with
trauma. Kinship social support emphasizes the role of extended family in providing emotional, financial, and practical support in families (Taylor, Casten, & Flickinger, 1993). Past research has found that kinship social support is related to lower psychological distress in low-income African American adolescents (Taylor et al., 1993). In a sample of primarily single-parent, low-income African American families, kinship social support played a moderating role in the relationship between both maternal psychological control and adolescent internalizing problems, as well as mother-adolescent communication problems and externalizing problems (Taylor, 2010). In families where there were higher levels of kinship social support, there was a weaker relationship between parenting difficulties and adolescent behavioral problems. Additionally, kinship social support moderated the relationship between child exposure to chronic community violence and complex PTSD in African American children (Jones, 2007). To our knowledge, kinship social support has not yet been researched in the context of maternal PTSD and family functioning.

The goals of this study were to examine the relationships among kinship social support, maternal trauma exposure severity, PTSD symptom severity, and children’s behavior in a diverse community sample of mothers who experienced trauma. We hypothesized that kinship social support would be negatively related to maternal trauma exposure severity and PTSD symptoms, and that higher levels of kinship social support would predict lower levels of child internalizing and externalizing behaviors. Due to previous research on the protective role of family support (Andresen & Telleen, 1992; Campos et al., 2008; Jones, 2007; Ozer et al., 2003; Taylor, 2010; Taylor et al., 1993), it was hypothesized that kinship social support would moderate the relationship between maternal trauma and child behavior problems, potentially serving as a buffer against the intergenerational transmission of trauma.

**Method**

**Participants**

This study drew data from a larger research project examining relationships among maternal trauma exposure, PTSD, parenting, attachment, and children’s outcomes. Participants were recruited through therapist referrals and flyers posted at a community mental health agency located in a low-income, predominantly African American community, from online postings, and flyers at aftercare programs, domestic violence shelters and agencies, community support groups, and churches. The sample included both clinical and nonclinical community participants. Participants included 54 mothers and their children, ages 7 to 12 years old, from the San Francisco Bay Area. To
participate in the study, mothers had to be older than 18 years old, be fluent
in English, and have at least one child between 7 and 12 years old. The
mothers also had to have experienced at least one traumatic event as defined
by Criterion A1 of the PTSD diagnosis in the *Diagnostic and Statistical
Psychiatric Association, 2000). By this definition, the individual experienced
or was confronted with an event including actual or threatened injury or
death, or a threat to one’s physical integrity, or witnessed these events
occurring to another person. Traumatic events included child abuse, IPV,
sexual assault, community violence, accidents, or natural disasters. All
mothers in the study met the criteria for trauma exposure. Demographic
characteristics of the mothers and children who participated in our study are
presented in Table 1.

### Table 1. Descriptive Statistics for Demographics, Independent, and Dependent Variables.

<table>
<thead>
<tr>
<th>Variables</th>
<th>M</th>
<th>SD</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother’s marital status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>27</td>
<td>51.9%</td>
<td>27</td>
<td>51.9%</td>
</tr>
<tr>
<td>Married</td>
<td>10</td>
<td>19.2%</td>
<td>10</td>
<td>19.2%</td>
</tr>
<tr>
<td>Divorced</td>
<td>11</td>
<td>21.2%</td>
<td>11</td>
<td>21.2%</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>3.8%</td>
<td>2</td>
<td>3.8%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>3.8%</td>
<td>2</td>
<td>3.8%</td>
</tr>
<tr>
<td><strong>Mother’s racial background</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>31</td>
<td>59.6%</td>
<td>31</td>
<td>59.6%</td>
</tr>
<tr>
<td>Latino</td>
<td>6</td>
<td>11.5%</td>
<td>6</td>
<td>11.5%</td>
</tr>
<tr>
<td>Caucasian or White</td>
<td>4</td>
<td>7.7%</td>
<td>4</td>
<td>7.7%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>11</td>
<td>21.2%</td>
<td>11</td>
<td>21.2%</td>
</tr>
<tr>
<td><strong>Child’s racial background</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>30</td>
<td>57.7%</td>
<td>30</td>
<td>57.7%</td>
</tr>
<tr>
<td>Latino</td>
<td>4</td>
<td>7.7%</td>
<td>4</td>
<td>7.7%</td>
</tr>
<tr>
<td>Caucasian or White</td>
<td>1</td>
<td>1.9%</td>
<td>1</td>
<td>1.9%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>17</td>
<td>32.7%</td>
<td>17</td>
<td>32.7%</td>
</tr>
<tr>
<td><strong>Child’s gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>30</td>
<td>57.7%</td>
<td>30</td>
<td>57.7%</td>
</tr>
<tr>
<td>Female</td>
<td>22</td>
<td>42.3%</td>
<td>22</td>
<td>42.3%</td>
</tr>
<tr>
<td><strong>Mother’s age</strong></td>
<td>34.77</td>
<td>6.19</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child’s age</strong></td>
<td>9.29</td>
<td>1.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mother’s income estimate (N = 50)</strong></td>
<td>$25,568</td>
<td>$18,794</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternal PTSD symptom severity</strong></td>
<td>51.25</td>
<td>19.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternal trauma exposure</strong></td>
<td>18.96</td>
<td>21.24</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Kinship social support</strong></td>
<td>37.37</td>
<td>8.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child internalizing behaviors</strong></td>
<td>7.84</td>
<td>7.48</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child externalizing behaviors</strong></td>
<td>10.24</td>
<td>9.26</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: N = 52. PTSD = Posttraumatic stress disorder; Maternal PTSD symptom severity = PTSD Checklist total score; Maternal trauma exposure = Trauma History Questionnaire severity score; Kinship social support = Kinship Social Support Questionnaire total score; Child externalizing behaviors = Child Behavior Checklist Externalizing scale; Child internalizing behaviors = Child Behavior Checklist Internalizing scale.*
Measures

Trauma History Questionnaire
The Trauma History Questionnaire (THQ; Green, 1996) is a 24-item measure that assesses trauma exposure in three areas: crime, disaster and general trauma, and unwanted physical and sexual experiences. Participants indicated whether or not they experienced a particular traumatic incident and the number of times and age of occurrence for each incident experienced. Maternal trauma exposure severity was calculated by summing all traumatic experiences endorsed by participants, which is one method for calculating trauma severity described by the measure’s authors (Hooper, Stockton, Krupnick, & Green, 2011).

Posttraumatic Stress Disorder Checklist–Civilian Version
The Posttraumatic Stress Disorder Checklist–Civilian Version (PCL–C; Weathers, Huska, & Keane, 1991) is a self-report measure of PTSD symptoms in civilians completed by the mother based on the PTSD diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders (4th ed. [DSM–IV]; American Psychiatric Association, 1994). It includes 17 items assessing PTSD symptoms in the past month using a 5-point Likert scale ranging from 1 (not at all) to 5 (extremely). The PCL–C provides a continuous measure of severity of PTSD symptoms based on a total score. This measure has high internal consistency (α = .94; Ruggiero, Del Ben, Scotti, & Rabalais, 2003), and good convergent validity with the Mississippi Scale for PTSD (Vreven, Gudanowski, King, & King, 1995). This study demonstrated very good internal consistency (α = .94).

Child Behavior Checklist
Mothers completed the parent-report version of the Child Behavior Checklist (CBCL) to assess for children’s internalizing symptoms (e.g., anxiety, depression) and externalizing symptoms (e.g., aggression, hyperactivity, and non-compliance). This measure has high test–retest reliability (α = .95 for 118 specific problem items) and internal consistency (alphas ranged from .78–.97 for the problem scales; Achenbach, 1991). Strong construct validity has been established (Achenbach, 1991). Internal consistency was .89 for the Internalizing scale and .92 for the Externalizing scale in this study.

Kinship Social Support Questionnaire
The Kinship Social Support Questionnaire (Taylor et al., 1993) is a 13-item self-report questionnaire completed by the mother that assesses quality and degree of social and emotional support from relatives and kin. This measure has been found to be positively related to perceived availability of social support in previous research (Kenny, Blustein,
Chaves, Grossman, & Gallagher, 2003), which demonstrates convergent validity. In this study, internal consistency was very good ($\alpha = .92$), and similar to prior studies that have demonstrated alpha levels between .72 and .86 (Kenny et al., 2003; Stevenson, Reed, & Bodison, 1996; Taylor et al., 1993).

**Procedure**

All protocols and procedures were approved by, and in compliance with, the sponsoring university’s institutional review board. After obtaining informed consent, mothers participated in the parent study’s procedures, including completion of self-report measures used in this study. As part of the larger research study, which involved a 3-hour time commitment, participants were compensated $50 for their time and travel.

**Data analyses**

SPSS version 22 was used to perform all statistical analyses. Descriptive analyses of demographic and study variables were conducted. Assumptions required for Pearson’s $r$ correlations and multiple regressions were analyzed before running the primary statistical analyses. Nonparametric analyses were run when assumptions for parametric tests were not met. Zero-order Pearson’s correlations and hierarchical multiple regressions were run to determine the bivariate and moderator relationships among kinship social support, maternal PTSD symptom severity, trauma exposure severity, and child internalizing and externalizing behaviors. In the moderator analyses, maternal PTSD symptoms or maternal trauma exposure (the predictors), and kinship social support (the moderator), were centered to reduce problems associated with multicollinearity. Moderator analyses were conducted using the PROCESS Macro (Hayes, 2013). Four multiple regression analyses were conducted, with maternal trauma exposure severity or maternal PTSD symptom severity as the independent variable, kinship social support as the moderator variable, and internalizing or externalizing behavior scores as the dependent variables.

**Results**

**Preliminary analyses**

Means and standard deviations of study measures are presented in Table 1. Correlational analyses between demographic variables and independent and dependent variables were analyzed, and none were significant. Analyses of variance were conducted to determine if categorical demographic variables
were related to predictor and criterion variables. There were no significant differences in any of the independent or dependent variables based on mother’s race, child’s race, or child’s gender, except in the case of maternal PTSD symptom severity, which was higher for mothers with female children than male children, $t(50) = -3.03, p = .004$. As none of the demographic variables were related to both the predictor and criterion variables, they were not included as covariates in subsequent analyses.

Bivariate correlations were conducted to examine relationships among kinship social support, maternal posttraumatic stress symptom severity, maternal trauma exposure severity, and child behaviors (see Table 2). Spearman’s Rho was used in all analyses because parametric assumptions were not met. Results indicated negative relationships between kinship social support and maternal posttraumatic stress symptom severity, maternal trauma exposure severity, child externalizing behaviors, and child internalizing behaviors. There were significant positive relationships among maternal posttraumatic stress symptom severity, child internalizing behaviors, and child externalizing behaviors. Additionally, maternal trauma exposure severity was positively correlated with maternal PTSD symptom severity and child internalizing behaviors.

Four multiple regression analyses were conducted testing kinship social support as a potential moderator in relationships between the two maternal trauma variables (maternal trauma exposure severity and maternal PTSD symptom severity) and child internalizing behaviors and child externalizing behaviors. Maternal PTSD symptom severity and maternal trauma exposure severity were analyzed separately and variables were mean-centered to reduce issues with multicollinearity. In each analysis, the maternal trauma variable and kinship social support were entered in the first step, and the interaction of the two variables was tested in the second step. The results indicated kinship social support was a significant moderator in the relationship between maternal trauma exposure severity and child internalizing behaviors (see Table 3). The moderation effect accounted for 8.7% of the variance in

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**Table 2. Summary of Intercorrelations for Independent and Dependent Variables.**

<table>
<thead>
<tr>
<th>Measure</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maternal PTSD symptom severity</td>
<td>—</td>
<td>.302*</td>
<td>−.299*</td>
<td>.477***</td>
<td>.425**</td>
</tr>
<tr>
<td>2. Maternal trauma exposure</td>
<td>—</td>
<td>—</td>
<td>−.372**</td>
<td>.260</td>
<td>.314*</td>
</tr>
<tr>
<td>3. Kinship social support</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>−.428**</td>
<td>−.288*</td>
</tr>
<tr>
<td>4. Child externalizing behaviors</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.634***</td>
</tr>
<tr>
<td>5. Child internalizing behaviors</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

Note: $N = 52$. PTSD = Posttraumatic stress disorder; Maternal PTSD symptom severity = PTSD Checklist total score; Maternal trauma exposure = Trauma History Questionnaire severity score; Kinship social support = Kinship Social Support Questionnaire total score; Child externalizing behaviors = Child Behavior Checklist Externalizing scale; Child internalizing behaviors = Child Behavior Checklist Internalizing scale.

*p < .05. **p < .01. ***p < .001.
child internalizing behaviors over and above that accounted for by the other predictors. Specifically, results demonstrated that with high levels of kinship social support (defined as 1 SD above the mean), there was a significant positive relationship between maternal trauma exposure severity and child internalizing behaviors ($b = .429, p = .036$). With low levels of kinship social support (defined as 1 SD below the mean), there was no longer a relationship between maternal trauma exposure severity and child internalizing behaviors ($b = .046, p = .511$; see Figure 1). When predicting child externalizing behaviors, maternal trauma exposure severity did not uniquely predict child externalizing behaviors, and kinship social support was not a significant moderator in the relationship between maternal trauma exposure severity and child externalizing behaviors (see Table 3).

TABLE 3. Kinship Social Support as a Moderator of Relationship Between Maternal Trauma Exposure Severity and Children's Functioning.

<table>
<thead>
<tr>
<th></th>
<th>CBCL Internalizing</th>
<th></th>
<th>CBCL Externalizing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE</td>
<td>B</td>
<td>Part corr</td>
</tr>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kinship social support</td>
<td>−1.36</td>
<td>1.11</td>
<td>−.184</td>
<td>−.169</td>
</tr>
<tr>
<td>Maternal trauma exposure</td>
<td>2.44</td>
<td>1.69</td>
<td>.216</td>
<td>.198</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kinship social support</td>
<td>−.566</td>
<td>1.12</td>
<td>−.077</td>
<td>−.067</td>
</tr>
<tr>
<td>Maternal trauma exposure</td>
<td>4.97</td>
<td>1.98</td>
<td>.441*</td>
<td>.332</td>
</tr>
<tr>
<td>Kinship social support × Maternal trauma exposure</td>
<td>4.01</td>
<td>1.79</td>
<td>.360*</td>
<td>.295</td>
</tr>
</tbody>
</table>

Note: $N = 50$. CBCL Internalizing = Child Behavior Checklist Internalizing scale; CBCL Externalizing = Child Behavior Checklist Externalizing scale; Kinship social support = Kinship Social Support Questionnaire total score; Maternal trauma exposure = Trauma History Questionnaire severity score; Kinship social support × Maternal trauma exposure = product term. Two cases were excluded from analyses due to missing data on CBCL Internalizing and CBCL Externalizing.

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

FIGURE 1. Moderation analysis results demonstrating the interaction of maternal trauma exposure severity and kinship social support on the prediction of child internalizing behaviors at low (−1 SD) and high (+1 SD) levels of kinship social support.
When predicting child internalizing behaviors, PTSD symptom severity made a unique incremental contribution, and accounted for 16.24% of the variance in child internalizing behaviors over and above that accounted for by the other predictors ($\beta = .426$, $p = .003$). Kinship social support failed to make a significant unique contribution in the model ($\beta = -.157$, $p = .259$), and did not serve as a moderator in the relationships between maternal PTSD symptom severity and child internalizing behaviors ($\beta = .112$, $p = .398$). Additionally, both maternal PTSD ($\beta = .335$, $p = .016$) and kinship social support ($\beta = -.282$, $p = .043$) made unique incremental contributions to the variance in child externalizing behaviors. Maternal PTSD symptom severity accounted for 10.05% and kinship social support accounted for 7.02% of the variance in child externalizing behaviors. Kinship social support did not serve as a moderator in this relationship ($\beta = .217$, $p = .102$).

**Discussion**

This study contributes to the existing research on kinship social support and child behavior in families that have endured trauma. We examined the role of kinship social support as a potential protective factor against child behavior problems in a culturally diverse, low-income community sample of trauma-exposed mothers and their children. Although social support is a well-established protective factor in trauma research, there has been very little research on the role of kinship social support in diverse families exposed to trauma. Families of color face higher rates of trauma (Coll et al., 1996; Gillespie et al., 2009), which was reflected in our metropolitan community sample that consisted of almost entirely African American, multiracial, and Latina mothers with high rates of trauma exposure and PTSD symptoms. We used a culturally relevant measure of extended family support to address the previously established role of kinship social support in African American and Latina communities (Coll et al., 1996; Hall, 2008). Our results demonstrated that kinship social support was related to lower levels of trauma exposure and PTSD symptoms in mothers, as well as lower levels of internalizing and externalizing behaviors in their children. This finding is consistent with previous research outlining the protective role of social support against negative mental health outcomes following trauma exposure (Beeble et al., 2009; Folger & Wright, 2013; Ozer et al., 2003), and brings attention to the importance of examining extended family support, which is particularly relevant for families of color.

Our hypothesis that kinship social support would moderate the relationship between maternal trauma and child behavioral problems was partially confirmed. The results indicated that the relationship between maternal trauma exposure severity and child internalizing behaviors was influenced by the level of kinship social support. This finding is in line with previous
research that documented the moderating role of kinship social support in the relationship between parenting difficulties and adolescent behavioral problems (Taylor, 2010) and between child exposure to violence and complex PTSD (Jones, 2007). Our moderation analyses demonstrated that for families with high levels of kinship social support, there was a positive association between maternal trauma exposure and child internalizing behaviors. This finding indicates that strong kinship social support plays a protective role in families with lower levels of trauma exposure, with children experiencing fewer internalizing behaviors. However, for mothers with lower levels of kinship social support, there was no relationship between trauma severity and child internalizing behaviors; higher levels of internalizing behaviors were experienced by children of mothers with both low and high levels of trauma exposure. Therefore, strong kinship social support appears to serve as a protective factor against child internalizing behaviors when there is lower maternal trauma exposure. This finding is consistent with previous trauma research indicating that social support serves a protective function for lower levels of trauma, but is no longer protective for higher levels of trauma (Beeble et al., 2009; Folger & Wright, 2013). Folger and Wright (2013) found that social support buffered against negative outcomes for individuals with lower levels of cumulative trauma, but not for higher levels of cumulative trauma, and in fact appeared to become a vulnerability factor for negative outcomes. According to the authors, social support cannot adequately protect against negative mental health and behavioral outcomes in cases where there are high levels of cumulative trauma, which has important implications for interventions targeting trauma treatment. Similar to the findings of Folger and Wright (2013), our results suggest that when mothers have endured high levels of trauma exposure, children show higher levels of behavioral problems despite additional kinship social support. These findings are helpful in better understanding the pathways of intergenerational transmission of trauma, and can inform the appropriate utilization of extended family in buffering against the negative effects of maternal trauma on children.

Kinship social support did not moderate the relationships between maternal PTSD symptom severity and child behavior problems, or the relationship between maternal trauma exposure and child externalizing behaviors, as was expected. Kinship social support uniquely predicted child externalizing behaviors over and above maternal PTSD symptom severity, suggesting that there is a protective role of extended family support in preventing childhood difficulties, such as aggression, delinquency, and hyperactivity, even in the context of maternal PTSD. It is possible that extended family support alleviated externalizing behavior problems through increased provision of supervision, structure, and support from additional family caregivers. Due to the significant literature indicating that maternal PTSD predicts higher rates of child behavioral problems (Chemtob et al., 2010;
Lambert et al., 2014; Levendosky & Graham-Bermann, 2001; Levendosky et al., 2003; Samuelson & Cashman, 2008), our lack of significant moderator finding suggests that the high levels of PTSD symptom severity in our sample contribute to higher levels of child behavioral problems, even when kinship social support is present. Although kinship social support can play a protective role in families with trauma exposure, it might be that once mothers develop significant mental health problems associated with high trauma exposure, kinship social support is not sufficient in buffering against child behavior problems that result from the inter-generational transmission of trauma. Given the lack of prior research on kinship social support in the context of trauma, it is necessary to continue research on the potential protective role of kinship social support on coping and resilience in low-income families that use extended family networks.

Limitations, directions for future research, and clinical implications

There are a number of limitations of this research that should be noted. This study included a small sample from the community, so it is important to be cautious about overgeneralization of findings. Due to the diverse sample of primarily low-income families of color with high rates of trauma exposure utilized in this research, the findings should only be generalized to similar urban communities. Furthermore, the inclusion of children between the ages of 7 and 12 presents a possible limitation for interpreting findings as child internalizing and externalizing behaviors likely differ for children in the lower and upper age ranges. Additionally, we evaluated maternal PTSD and children’s functioning through mother’s self-report, which might be influenced by maternal bias or distortions, as the mothers might not be able to objectively report their symptoms and those of their children. Using multiple sources of data, such as structured clinical interviews and teacher reports, would likely contribute to more complete evaluations of maternal and child functioning. Finally, the cross-sectional nature of the research design also presents limitations in the ability to fully understand the causal relationships between trauma and child behavior. Including longitudinal analyses of the role of kinship social support on child functioning would be ideal in fully understanding these relationships.

Given that many trauma-exposed families incorporate extended family networks, it is crucial to further research the role that kinship social support plays in families who experience trauma. Our results indicate that kinship social support can provide a buffer against maternal and child dysfunction in families exposed to trauma, as it is related to decreased maternal trauma exposure, maternal PTSD symptom severity, and child behavioral problems. These findings demonstrate the importance of involving extended family networks to mitigate intergenerational transmission of trauma. In line with Harvey’s (1996) ecological model, the inclusion of extended family members
and the mobilization of kinship support systems can be instrumental in providing culturally relevant interventions to low-income families of color. A better understanding of the complex role of family support on maternal mental health and child functioning within the context of the intergenerational transmission of trauma is essential in providing effective treatment services. The utilization of kinship social support networks as a source of strength for families exposed to trauma can serve as a valuable resource in interventions aimed at supporting families facing trauma, especially for parents with lower levels of trauma exposure.

REFERENCES


