Externalizing Problems in Children: Examining the Role of Caregiver and Child Adversities and Parental Involvement

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ABSTRACT
Previous research has shown that exposure to adverse childhood experiences (ACEs) is associated with increased behavior problems in children. Few studies, however, have taken a multi-informant approach to examine how different factors involving both the child and caregiver affect children's externalizing problems. Guided by Bowen's Family Systems Theory, the current study examined how child age and gender, caregiver age, household income, child and caregiver adversity, and child and caregiver report of caregiver involvement were associated with children's externalizing problems. The sample included 65 caregiver-child dyads recruited from community organizations in the Midsouth, United States. Youth were aged 6-12 years and primarily identified as Black or African American (95.45%) and as boys (54.55%). Two linear regression models were run with caregiver-report of child externalizing problems as the dependent variable in both models. One model focused on child variables, including child age, child gender, child adversity, and child-report of parental involvement, while the other centered caregiver variables, including caregiver age, income, caregiver ACEs, and caregiver report of their own parental involvement. Only the caregiver model was significant, with more caregiver ACEs related to higher child externalizing problems. None of the other independent variables were related to child externalizing problems. These results demonstrate the impact of caregiver's history of adversity on child functioning. Interventions that target children's externalizing problems may benefit from incorporating an assessment of parent adversity history. Future research should explore underlying mechanisms that may explain this association to identify modifiable factors that could be included in treatments for youth experiencing externalizing problems.

KEYWORDS
Intergenerational; Behavior Problems; Adverse Childhood Experiences; ACEs; Caregiver-child Dyads; Youth Functioning; Family Systems; Multi-informant

INTRODUCTION

Felitti and colleagues pioneered the study of adverse childhood experiences (ACEs), which include different types of abuse, neglect, and household dysfunction.[1] Over the past 25 years, ACEs have been widely researched across different populations and developmental epochs.[2, 3] ACEs have been linked to short- and long-term mental health difficulties, such as behavior problems, depression, and anxiety,[4] as well as physical health problems in youth.[5] It is rare that ACEs only affect the person who experienced the adversity as there is ample evidence of intergenerational transmission of risk, which involves the transmission of the impacts of traumatic events from caregiver to child.[6, 7] For example, caregiver ACEs have been associated with externalizing behaviors in their children.[8] Although past research has shown the potential consequences of both direct and intergenerational adversity, less is known about other factors beyond caregiver and child ACEs that may be related to child externalizing behaviors, such as parenting practices. The current study examined how parenting practices (i.e., parental involvement), caregiver's exposure to adversity during their childhood, and children's own adversity exposure were related to children's externalizing problems.

Externalizing problems in children

Externalizing problems involve outward behaviors that cause conflict between the individual and their environment; they typically develop in childhood and adolescence.[9, 10] In school-aged children, externalizing problems may manifest as defiance, hyperactivity, lying, and aggression.[11] Common behaviors of youth with externalizing problems are physical aggression and rule breaking.[10] Studies also suggest that relational and indirect aggression, such as hostility and social exclusion, should be included as part of the

spectrum of externalizing problems.[12] Youth who exhibit externalizing problems are at risk for developing oppositional defiant disorder (ODD) and increased involvement with the criminal legal system,[13] as well as substance misuse in adulthood.[14] Externalizing problems, particularly hyperactivity, in middle childhood have been associated with the development of attention-deficit/hyperactivity disorder (ADHD) in adolescence.[15] According to the Centers for Disease Control and Prevention,[16] approximately six million American children (9.8%) aged 3-17 have received an ADHD diagnosis. Additionally, approximately 5.8 million American children (8.9%) experience behavioral problems (*e.g.,* defiance, hyperactivity, impulsivity), demonstrating the need to further explore factors that may increase the expression of, as well as factors that may mitigate, externalizing problems.

Child adversity, caregiver adversity & externalizing problems

Past research has identified potential risk factors for the onset and maintenance of externalizing problems, such as child abuse and neglect.[17] Research has also begun to uncover intergenerational impacts. For example, Yoon and colleagues found that when young mothers were exposed to adversity in their childhood, they were more likely to experience parenting stress and utilize physical discipline, which was then linked to aggression and rule-breaking behavior in their children.[18]

Research shows a link between experiencing abuse and neglect during childhood and the onset of externalizing problems, specifically higher aggression.[19] For example, physical abuse has been associated with higher aggressive and disruptive behaviors in preschool children.[19] Another factor related to higher externalizing problems in children is being exposed to a caregiver who misuses substances.[20] Manly and colleagues found that abuse, neglect, and being exposed to a family member with a substance use disorder were associated with a higher risk for developing externalizing problems.[20] Another adversity related to increased externalizing problems is experiencing community violence.[20] Further, stressors such as the death of a family member, family discord, and income loss were linked to an increased risk for externalizing problems.[21, 22] Research shows that most children will experience at least one adverse event,[23] and a significant number will endure multiple adversities.[24] Polyvictimization, as defined by Finkelhor and colleagues,[25] is the occurrence of multiple types of adverse experiences. Studies have repeatedly found that polyvictimization is associated with behavior problems and aggression,[26] and externalizing problems more broadly in youth.[27, 28]

Caregiver's own exposure to ACEs can also have a significant effect on youth's functioning.[29] This is known as intergenerational transmission of risk.[7] For example, maternal ACEs have been associated with children's externalizing problems.[30] Kang and colleagues explored the intergenerational transmission of risk in Korean mother-child dyads, with children ranging in age from 6 to18 years old, and their results indicated that the more ACEs experienced by the mother, the higher the risk of her offspring developing externalizing problems.[31] Like Kang and colleagues, Stepleton and colleagues found that for each additional ACE experienced by the caregiver, there was a moderate increase in externalizing behaviors in children.[29, 31] Although these studies provide valuable information regarding the association between types of adversity and externalizing problems in children, several gaps remain in the literature. First, most of these studies were conducted with primarily White samples, so they are limited in racial diversity. Loheide-Neismann and colleagues found in their meta-analysis that 35 out of 42 studies examining the impact of maternal ACEs on child externalizing behaviors were conducted with a majority White population.[32] Besides the overabundance of studies with a majority White sample, it is also important to assess a sample that is majority Black/African American because of differences in frequency of ACEs; Black/African American youth have an increased risk for exposure to ACEs due to systemic inequality and oppression.[33] Because of this systemic disparity, it is valuable to further understand the relation between exposure to adversity and psychosocial outcomes in diverse samples.[33] Second, many study samples represented a vast age range spanning from infancy to older adolescence despite evidence that externalizing problems manifest differently and change in frequency as children age.[34] Specifically, previous research has shown that externalizing problems often begin and increase in early childhood and then start to decline around early adolescence;[22] thus, it is beneficial to examine externalizing problems in specific developmental epochs that would take this trend into account.[22] The current study aimed to address these research gaps by evaluating a predominantly Black/African American sample of youth in the middle childhood years (*i.e.*, 6-12 years old). This age range has previously been shown to contain major transition points in childhood, including in the parent-child relationship.[34] Another missing component from past research concerning adversity is examining both caregiver and child adversity in the same study. Previous research typically evaluates one form of adversity despite evidence that they are associated with each other.[35]

Theoretical framework: Family Systems Theory

Bowen's Family Systems Theory provides a conceptual foundation to understand how caregivers' and children's exposure to adversity may influence children's functioning.[36] This theory posits that family members influence each other based on their interactions with one another.[37] For instance, a mother demonstrating aggressive tendencies towards her children influences her child to develop aggressive behaviors.[38] Additionally, one of the qualities of Family Systems Theory is that it is circular, meaning

that each member has an influence on one another; in other words, just as the caregiver influences the child, the child also influences the caregiver.[39] For example, a child who has experienced adversity may develop behavior problems (*e.g.,* misconduct, aggression) that can affect how their caregiver parents them; parenting challenges could then lead to further issues for the child.[40] Family functioning and parenting are key points of transmission for how caregivers affect their offspring's mental health. Johnson and colleagues found a relation between caregiver exposure to ACEs and poorer family functioning, and this poorer functioning was associated with increased risk for externalizing problems in children.[40] Given that effective family functioning is associated with fewer youth externalizing problems, it is critical to examine factors linked to effective family functioning, such as positive parenting.

Positive parenting practices

Knerr and colleagues found that parenting practices have a strong influence on children's mental health, including externalizing problems.[41] Shelton and colleagues illustrated how parenting practices fall into different categories; one of which is positive parenting practices, which includes parental involvement.[42] Parental involvement is defined as taking an active role in the child's life. This can be represented by attending the child's social activities (*e.g.,* clubs, sports), as well as supporting the child emotionally, for example, helping them process their feelings.[43] Anderson and colleagues found that among caregivers exposed to ACEs, those who exhibited more open and involved parenting had children with fewer externalizing problems.[8] Meanwhile, caregivers who did not display positive parenting practices had children with more externalizing problems. Anderson and colleagues proposed that a lack of open communication and support serves as an obstacle to the development of self-regulation and emotion regulation skills in children.[8] This link between higher levels of parental involvement and lower externalizing problems has been found in diverse samples of youth, including African American children.[44] Notably, there is inconsistency across studies, with some research not identifying a significant relation between involvement and externalizing problems.[45] Considering the variable findings in the literature, more work is needed to understand the relation between positive parenting practices and youth externalizing problems, especially among racially diverse samples. Previous research has explored how caregivers view the effects of their parental involvement, but much less work has been done on children's perceptions of parental involvement. Child-report of parenting practices is critically important because children provide a unique perspective that is generally lacking from past research.[46] Importantly, a small body of work has noted discrepancies in children's and caregiver's reports of parenting; typically, caregivers rate themselves higher on dimensions of parenting compared to children's ratings.[47] Such findings underscore the need to examine both child and parent reports of parenting practices.

Demographic factors

Previous research has identified demographic variables that may influence children's externalizing problems, such as gender, income, and age. Bem detailed how a child's sex-based preferences, skills, and behaviors are influenced by the gender roles placed on them by their guardians and authority figures.[48] In past work, there is a focus on boys' externalizing behaviors because of a perceived higher aggression rate among boys than girls.[49] Previous research has also shown that rule-breaking and aggressive behaviors are related to externalizing problems at a higher rate for boys than girls.[50] Notably, other studies are inconclusive about the role gender plays in child behavior. For instance, Flores and colleagues concluded that gender was not a significant factor in predicting externalizing problems in youth.[51] Thus, the current study sought to clarify the relation between child gender and externalizing behaviors.

Other demographic factors have been consistently related to externalizing problems in youth. For example, previous research has shown that the lower the family income, the higher the risk for externalizing problems in youth[52], and this has been evident in African American samples, as well.[53] Further, economic hardship can have a significant effect on the family system, parenting practices, and the effects of parenting on children's functioning.[54] Child age is another factor to account for when examining externalizing behaviors. Past research has found that as youth age, their externalizing problems lower.[56] Even within specific developmental epochs (i.e., middle childhood), there is evidence of a relation between age and externalizing behaviors[57]. Finally, there is also evidence that caregiver age can play a role in their report of youth's externalizing behaviors. Carneiro and colleagues conducted a review of the literature and found multiple studies in which maternal age was significantly associated with child behavioral problems in school.[58] More specifically, younger maternal age was linked to higher risk of behavioral problems in children.[58] Previous research seems to coalesce around the finding that family income, child age, and caregiver age can influence reports of youth externalizing behaviors; thus, the current study controlled for the effects of these variables when examining youth externalizing problems.

The current study

Previous research has shown a connection between children's direct and intergenerational exposure to adversity and their externalizing problems.[20, 31] Further, studies indicate that there is a significant inverse association between parental involvement and child externalizing problems.[8] It is necessary to take a multi-informant approach to this work by examining both caregiver and child report of their own adversity, as well as caregiver and child report of parental involvement, to develop a comprehensive understanding of how these factors are related to children's externalizing problems. It is also important to consider the role of known influential demographic factors, such as age, gender, and income. Although previous literature has explored factors that increase the risk for externalizing problems in children,[20, 30] there is a need to expand this research to non-White majority samples and to focus on a specific developmental period. It was hypothesized that 1) more caregiver exposure to adverse childhood experiences would be associated with more child externalizing problems, 2) more child exposure to adversities would be associated with more child externalizing problems, 3) less caregiver involvement, per child and caregiver report, would be associated with more child externalizing problems, and 4) identifying as a boy would be associated with more externalizing problems. Analyses controlled for household income, caregiver age, and child age.

METHODS AND PROCEDURES

Participants

Participants included 65 caregiver-youth dyads. Youth ranged in age from 6 to 12 years (M = 9.11, SD = 2.25) and caregivers ranged in age from 23 to 67 years (M = 36.67, SD = 9.32). Caregivers predominantly identified as Black or African American (93.93%), 3.03% identified as White or European American, 1.52% identified as biracial or multiracial, and 1.52% identified as another race. Among youth, 95.45% identified as African American or Black, 3.03% identified as White or European American, and 1.52% identified as American Indian or Alaskan Native. The relationship between caregivers and offspring was largely biological mother-child dyads (83.33%). Most of the youth identified as boys (54.55%) and the rest identified as girls (45.45%). The caregiver sample predominantly identified as female (98.48%). Caregiver's annual income ranged from less than $5,000 to greater than $50,001; 27.27% reported receiving less than $5,000 a year, 24.24% made $5,001 - $10,000, 15.15% made $10,001 - $15,000, 6.06% made $15,001 - $20,000, 10.61% made $20,001 - $30,000, 6.06% made $30,001 - $40,000, 6.06% made $40,001- $50,000, and 4.55% made above $50,001.

Procedure

Following institutional review board approval, participants were recruited from community programs in a mid-sized city in the Midsouth, United States. Data for this study were drawn from a larger project. Inclusion criteria for the larger project were that families spoke English fluently and received services from local community organizations. Further, caregivers had to be at least 18 years old and the primary caregiver of a child three months to 17 years old. For the current study, children had to be between the ages of 6-12 years and not have cognitive or sensory impairments that would impede their ability to participate in an interview. This age range was selected to align with study measures that were validated for youth aged 6-12 years. Caregivers who were interested and eligible provided informed consent and permission for their child to participate; child participants provided assent. Caregivers and youth completed separate interviews with a trained study staff member. Specifically, study staff read each item aloud to the participant and recorded their responses on a paper copy or directly into a computer software program (i.e., Qualtrics). Reading each item aloud helped account for differences in literacy across participants, and provided an opportunity for the staff member to clarify items if a participant did not understand the prompt. Interviews lasted approximately 90 minutes. Caregivers and youth each received a $30 gift card for their participation in the study. Caregivers also received a list of resources for local and national mental health services.

Measures

Demographics

A demographics questionnaire was completed by both child and caregiver participants. Both the caregiver and child were asked to report on the race and gender with which they identify, as well as their age. The options for both caregiver and child for gender included male, female, or other. Children also reported on their relationship to their caregivers (*e.g.,* biological mother, biological father, stepmother, adoptive father). The caregiver was asked about the family's annual household income with the question phrased as, "What is your total household income per year from all sources (including child support)?"

Behavior Assessment System for Children- Third Edition (BASC-3 PRS)

The BASC-3 PRS measures caregiver's perspective on the behavior of their children ranging from 2 to 21 years old in the domains of externalizing, internalizing, and adaptive behaviors.[59] There are three versions of the measure based on child age; two

were used in this study: the Child form for ages 6-11 and the Adolescent form for ages 12-21. On the Child form, there are 175 items with four answer choices ranging from "Never" to "Always". On the Adolescent form, there are 173 items with the same four response options of "Never" to "Always." Q-global, an online scoring software program, was used to generate a norm-referenced t-score (mean of 50 and standard deviation of 10) for externalizing problems across all respondents, with higher scores reflecting greater symptomology. Scores from the BASC-3 PRS were aggregated using a composite scale. Previous examination of psychometric properties of the BASC-3 has shown that it has adequate internal consistency and test-retest reliability.[59] The BASC-3 has also shown adequate validity for African American/Black samples.[60] In the current study, Cronbach's alpha was .96 for the caregiver-reported externalizing problems scale.

BRFSS Adverse Childhood Experiences (ACEs) Module

The BRFSS ACEs Module is an 11-item measure assessing different types of abuse, neglect, and household dysfunction.[61] Caregivers were asked if they had experienced sexual, physical, or emotional abuse, witnessed intimate partner violence, observed substance use or mental illness in the household, experienced parental divorce, had an incarcerated family member, or experienced physical or emotional neglect before the age of 18. The measure is scored by summing all the items to create a total score that ranges from 0-11. Internal reliability for this measure was not calculated because participants could experience one ACE without necessarily experiencing another. The BRFSS ACEs module has demonstrated adequate validity for African American/Black samples.[62]

Coddington Life Events Scale (CLES)

The CLES is a 45-item measure completed by children that is used to identify how positive and adverse life events may have affected their growth and adjustment.[63] A total adverse life events score is created by summing 17 items related to children's experiences with death/illness of a loved one, divorce/separation of parents, parental loss of job/income, problems at school, substance abuse, experiencing/witnessing physical abuse, community violence, and parental incarceration. Responses are measured dichotomously with 0 = "No, this did not happen to me" and 1 = "Yes, this did happen to me." Example items are "Did this ever happen to you: Death of a grandparent" and "Did this ever happen to you: Failing a grade in school." The CLES has been identified as a valid measure for examining children's adverse life events, including among African American/Black youth.[64] Internal reliability for this measure was not calculated because children could experience one of the adversities without necessarily experiencing another.

Alabama Parenting Questionnaire (APQ)

The APQ is a 42-item measure that assesses five dimensions of parenting including involvement, positive parenting, poor monitoring/supervision, inconsistent discipline, and corporal punishment.[42] Each item is scored on a five-point Likert scale (never = 1, almost never = 2, sometimes = 3, often = 4, always = 5). The current study utilized the parental involvement subscale, which consists of 10 items. Both caregiver and child reports of parental involvement were included. Items on the two versions are identical, except that they are phrased to be from the child's or caregiver's perspective. An example item on the involvement subscale of the child version is "You play games or do other fun things with your parent." For the caregiver version, this same item reads as "You play games or do other fun things with your child." Reliability and validity of the APQ has previously been shown to be adequate for majority Black/African American samples.[65,42] In the present study, Cronbach's alpha was .84 for the caregiver involvement subscale and .80 for the child report of caregiver involvement.

Data analytic plan

Analyses were completed in SPSS v.29. Prior to running the primary analyses, the sample was screened for normality, outliers, missingness, and multicollinearity. There was no evidence of skewness or kurtosis (values under |2|). There was one outlier in the caregiver reported involvement subscale; it was removed prior to analysis. There was no evidence of multicollinearity (VIF < 2). Missing data was low, with 1.16% missingness across study measures. Given the low amount of missing data, mean imputation at the item level was used to address missingness. Two linear regression models were conducted, one child model and one caregiver model. The child model assessed the relations between the independent variables of child gender, child age, child adversity, and child report of caregiver involvement and the dependent variable of caregiver report of child's externalizing problems. The caregiver model examined the relations between caregiver age, household income, caregiver ACEs, and caregiver report of caregiver involvement and the dependent variable of caregiver report of child's externalizing problems.

RESULTS

Correlations and descriptive statistics for the continuous study variables are displayed in **Table 1**. For caregiver-reported child externalizing problems, the mean score was 55.06 (*SD* = 12.73; Range = 37-91), which falls in the average range of externalizing problems. Regarding caregiver ACEs, most caregivers reported experiencing at least one ACE (80.00%; *M* = 3.23, *SD* = 2.94; Range = 0-10). The most frequently reported types of caregiver ACEs were parental divorce/separation (55.38%), verbal abuse (46.15%), and household substance use (46.15%). All youth reported at least 2 adversities (*M* = 8.02, *SD* = 3.82; Range = 2-17). The most frequent types of child-reported adversities were death of a grandparent (56.92%), hospitalization of a parent (50.77%), and being hospitalized for an illness or injury (40.00%). For caregiver-reported involvement, the average score was 42.02 (*SD* = 5.47; Range = 28-50), while the average score for youth-reported caregiver involvement was 38.91 (*SD* = 8.24; Range =17-50).

	1	2	3	4	5	6	7	8
1. Child Externalizing Problems	-							
2. Child Age	-.05	-						
3. Caregiver Age	.06	.23	-					
4. Household Income	-.10	.11	.09	-				
5. Caregiver ACEs	.36*	.08	-.004	.06	-			
6. Child Adversity	-.03	.18	.13	.05	.21	-		
7. Involvement (Caregiver report)	-.24	.17	.03	.003	-.09	.04	-	
8. Involvement (Child report)	-.19	.09	-.01	-.08	.06	-.01	.41**	-
M	55.06	9.15	36.20	3.06	3.23	8.02	42.02	38.91
SD	12.73	2.23	8.58	2.05	2.94	3.82	5.47	8.24

Table 1. Means, Standard Deviations, and Correlations Among Continuous Study Variables. *p < .01, **p < .001; ACEs = Adverse Childhood Experiences

Results of the linear regression that included child-focused variables are detailed in **Table 2**. This model was not significant (F(4, 58) = .93, p = .46, R^2 = .06). Results of the linear regression that included caregiver-focused variables are provided in **Table 3** and show that the overall model was significant (F(4, 58) = 3.31, p = .016, R^2 = .19). In this model, caregiver ACEs were significantly related to child externalizing problems (β = .34, sr = .34 p = .006), such that more caregiver ACEs were associated with more child externalizing problems as reported by the caregiver. This finding supported hypothesis 1. None of the other independent variables were significantly related to externalizing problems in this sample (p's > .05); thus, hypotheses 2-4 were not supported.

	β	sr	t	R^2	F
				.060	.926
Child Gender	-.15	-.15	-1.15		
Child Age	-.07	-.06	-.50		
Child Adversity	.03	.03	.20		
Involvement (Child)	-.14	-.14	-.1.09		

Table 2. Linear Regression Model Examining Child Variables Associated with Children's Externalizing Problems.

	β	*sr*	*t*	R^2	*F*
				.19	3.31*
Caregiver Age	.07	.07	.60		
Caregiver Income	-.13	-.13	-1.07		
Caregiver ACEs	.34	.34	2.86*		
Involvement (Caregiver)	-.21	-.21	-1.73		

Table 3. Linear Regression Model Examining Caregiver Variables Associated with Children's Externalizing Problems. *$p < .05$; ACEs = Adverse Childhood Experiences

DISCUSSION

Previous research has examined how caregiver and child adversity are related to child externalizing problems; however, few studies have assessed parental involvement alongside adversities, and even fewer have included both child and caregiver report.[26, 29] The current study, guided by Bowen's Family Systems Theory, advanced the literature by examining polyvictimization and parental involvement concurrently, and included both caregivers' and children's experiences and perspectives. Such work provides unique insight into children's functioning within the context of direct and intergenerational adversity while accounting for both youth and caregiver perspective on relevant parenting practices.

In line with the first hypothesis, more caregiver ACEs were significantly associated with more child externalizing problems, which is consistent with previous research.[7, 8] Notably, this study adds to the literature as the sample consisted of majority Black or African American youth who have been historically understudied. This finding supports the concept of intergenerational transmission of risk; that is, caregiver ACEs have downward effects on the next generation's functioning.[7] Contrary to what was hypothesized, children's own adversity was not significantly related to their externalizing problems, as assessed by their caregiver. This contrasts with what has been shown in past research.[20, 21] Of note, the most common adversities experienced by youth in the current sample were hospitalization of themselves or a parent and death of a grandparent. It may be that these types of adversity are not as strongly related to externalizing problems as compared to adversities such as abuse and neglect, which were the focus of previous studies.[19] Additionally, since the current study sample was help-seeking, it may be that youth and their families had more access to resources that promoted adaptive functioning following adversity.

Contrary to what was hypothesized, boys did not exhibit significantly more externalizing problems than girls, as reported by their caregivers. This finding is in line with some previous work that found no significant association between gender and externalizing problems, but does not align with a larger body of past research that has found a significant relation between these variables.[50,51] It may be that past work showing boys to exhibit more externalizing problems represents a perceived higher aggression in boys driven by bias concerning gender stereotypes, rather than an actual heightened manifestation of symptoms.[49] Also in contrast to the study's hypotheses, both parent and child report of caregiver involvement were not significantly associated with child externalizing problems. Previous research has been inconclusive as to whether there is a significant association between caregiver involvement and decreased risk of children's externalizing problems, with some studies identifying a negative relation between the two variables and others finding no association or an association only in one gender.[40, 44] It may be that there is a stronger association between negative parenting practices (*e.g.,* corporal punishment, inconsistent supervision) and externalizing problems, consistent with some past research.[65] Pearl and colleagues noted that the relationship between harsh parenting and externalizing problems is circular; for instance, conduct problems in the child at school may lead to harsher punishment from the caregiver.[66, 67] That harsher punishment may, in turn, elicit more behavioral problems in the child. Additionally, Burlaka found no significant association between involvement and externalizing problems in children; however, this researcher did find a significant link between other forms of positive parenting and reduced externalizing behaviors.[65] Thus, it may be that involvement is not as strongly tied to externalizing problems in children as compared to other parenting practices, such as parental support or effective caregiver-youth communication.[68]

Strengths

The current study has several strengths. First, participants primarily identified as Black or African American. Black families have received minimal attention in past research, particularly regarding identifying family strengths, so focusing on the experiences of

Black children and caregivers expands the literature on mutable factors impacting child behavior. Another strength is that the age range of youth was constrained to middle childhood (6-12 years), which allowed for the examination of youth during a unique developmental period. Previous research has shown that externalizing problems manifest differently based on developmental epoch,[22] so focusing on one stage offers novel information. Next, the study included the perspective of both the caregiver and child, which is an advancement over previous work that examined only one individual's views. Finally, the study was theoretically grounded, which helped to guide our selection of variables and informed our hypothesized relations among those variables.

Limitations

There are notable limitations to the current study. The data were cross-sectional, which limits the interpretation of directionality and temporality between the variables. Data were also self-reported, which introduced potential for reporting bias. Additionally, the sample size was small ($n = 65$) which impacted power and limited the complexity of analyses that could be conducted. Another limitation is that the only aspect of parenting measured was parental involvement; there are other forms of parenting that could be considered in future studies (*e.g.,* corporal punishment, positive parenting).[8] The way in which caregiver adversity was measured is another limitation of the study. Caregiver ACEs were measured dichotomously (i.e., whether an event happened), which does not allow for the evaluation of frequency or severity of the events. Additionally, caregiver adversity was examined only in childhood, so the current study did not account for adversity exposure across the caregiver's lifespan. Most notably, this study did not have access to a child report of the child's own externalizing problems, which is a significant limitation because there is a need to examine how youth view their own functioning and behavior.

Future directions

Future research should explore variables that may explain the intergenerational link identified in this study, such as other positive and negative parenting practices or parent-child relationship factors (*e.g.,* communication, attachment). Additionally, future research should examine caregiver and child adversity and parental involvement longitudinally to enhance understanding of the direction of relations between variables, including any mediating or moderating pathways. Further, future research should account for potential protective factors that may mitigate externalizing problems in youth exposed to adversity, such as resilience or close peer and familial relationships.[69] Evaluating protective factors in addition to adversity variables would enhance future research by providing opportunities to better understand how strengths within youth and families can promote positive functioning even in the context of adversity.[70] Future research should also include an examination of the frequency and severity of caregiver ACEs, as well as measuring caregiver adversities across the lifespan. The current study highlighted the utility of including multiple informants, so future research should continue to do so, and include other potential informants, such as teachers, coaches, or mentors. Future studies should assess youth's own perception of their functioning and specifically include child-report on their own externalizing behaviors. The inclusion of different types of measures other than self-report, such as lab-based observational tasks, could also provide a more comprehensive assessment of child functioning and parenting practices.

Clinical implications

Results from this study demonstrate the importance of considering multiple factors and perspectives when assessing and treating youth's psychological functioning. This is especially important in Black and African American families who often experience disparities in health care, including a relative lack of culturally responsive care and higher rates of stigma.[70] Study findings highlight the impact of parental adversity on youth functioning, indicating that more than just the child's own adversity needs to be considered when developing a comprehensive treatment plan. Thus, providers treating youth with externalizing problems should assess caregiver's history of adversity and how experiencing ACEs may affect their parenting as well as their child's functioning. Future intervention efforts should examine past familial adversities from multiple perspectives when treating externalizing problems in children. Study findings also partially support Bowen's Family Systems Theory and underscore the value of examining multiple perspectives and experiences within the family system, which shows the need to include multiple viewpoints and consider family therapy when developing treatment plans for youth experiencing externalizing problems.

CONCLUSIONS

The current study took an intergenerational, theoretically grounded, and multi-informant approach to examine how individual, familial, and adversity related factors were linked to child externalizing problems. Findings showed that caregiver's history of ACEs was associated with externalizing problems in children. This study makes valuable contributions to the child psychopathology literature by examining variables concurrently that have been previously studied separately, and by using both caregiver and child report. Knowledge gained from this study may be used to develop more effective interventions for youth displaying maladaptive functioning.

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PRESS SUMMARY

Previous studies have shown that exposure to adverse childhood experiences (ACEs) is associated with increased behavioral problems in children. Notably, past research has rarely explored both the child's and caregiver's ACEs exposure. The current study examined how individual, familial, and adversity related variables contribute to children's externalizing problems using information provided by both the child and their caregiver. Results showed the intergenerational impact of caregiver ACE history on child functioning, with more caregiver ACEs related to higher externalizing problems in children. Mental health professionals should consider incorporating an assessment of caregiver adversity history when developing treatment plans for youth experiencing externalizing problems.