POSTPARTAL SOCIAL SUPPORT:

A COMPARISON OF HISPANIC AND ANGLO MOTHERS

by

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CHAPTER I

INTRODUCTION

One of the major premises of this study is that the transition to parenthood represents a time of major change and potential crisis in the parents' lives. For the woman, this transition period involves major changes in roles and self-concept. Initially the adjustment period is influenced by physical factors such as fatigue, physical discomfort and lack of sleep. Many factors may affect the degree of ease or difficulty with which the new mother adapts to motherhood. One such factor may be the quality and/or quantity of social support the mother receives.

There is very little research describing the Hispanic woman in the postpartum period, including her support system during this period. The researcher, in her work with Hispanic women intrapartally, has often wondered to what sort of environment these patients return following the short hospitalization for the birth of a child. The characteristic of familism is generally attributed to the Hispanic family. Are the Hispanics in Oregon separated by distance from important family members? If so, this situation could increase the amount of stress or difficulty experienced during the postpartum period. In addition to the possibility of being separated from family, the Hispanic may be separated, or alienated, from the support offered by the existing health care system due to language, economic and cultural barriers.

The postpartum period is considered to be an important period

during which the foundation is laid for the future mental health of the mother and her family. Postpartum depression and child abuse are two examples of conditions that may be avoided by facilitating healthy adaptations to parenthood. Hispanics represent the second largest minority group in the United States. The population of Hispanics in Oregon is one that continues to grow. In view of their numbers and the fact that Hispanic women have higher fertility rates than any other ethnic group in the United States (Canino, 1982), it seems important to investigate the unique conditions and needs of this minority group in regard to their social support in the postpartum period.

It is hoped that the information produced by this study will be of value to nurses in the planning and giving of nursing care to the Hispanic parturient. This knowledge may help nurses to evaluate the Hispanic woman's need for social support and to assist the Hispanic to find the support she may desire and need.

Review of the Literature

The review of the literature begins with a summary of the research addressing the subject of transition to parenthood. Next there will be a discussion of the literature pertaining to the concept of social support as a factor facilitating adaptation to motherhood. A section concerning the conceptualization and measurement of support will follow. Finally, the available literature addressing the Hispanic family relevant to the research topic will be discussed.

Transition to Parenthood

The changes occurring during the transition to parenthood may

be viewed in terms of the conceptualization of the family as a small social system. From this viewpoint, the addition of a new member (i.e., the birth of a child) necessitates reorganization of that system, including major role changes. The existing research attempting to document and quantify the degree of crisis or change that comes with parenthood, varies in its findings. The sample populations that have been studied have generally been white and middle-class. The earlier studies (LeMasters, 1965; Dyer, 1965) found a higher degree of crisis than later studies. The investigators who have studied this subject have used various means of data collection and tools of measurement. LeMasters (1965) gathered his data by interview whereas the later researchers (Hobbs, 1976; Russell, 1974) used a questionnaire with approximately a 50% return rate. Russell (1974) found that nonrespondents tended to be younger and less educated. It is certainly possible that the nonrespondents may have experienced more difficulty with parenthood than the respondents.

Rossi (1968) argued against the use of the word "crisis" in describing initial parenthood and suggested that, instead, parenthood should be considered as a time of transition. Hobbs's (1976) and Russell's (1974) retrospective studies evaluated parents at approximately six to seven months postpartum. A British study (Paykel, Emms & Fletcher, 1980) found a 20% prevalence of mild clinical depression in women at six weeks postpartum. At six to seven months Hobbs (1976) and Russell (1974) found that only moderate to slight difficulty was experienced by new parents adjusting to their first child. Per-

haps different results would be found if parents were evaluated during the first month or two of parenthood. Based on the results of his study, Hobbs concluded, in agreement with Rossi's position, that "beginning parenthood is a transition rather than a crisis" (Hobbs, p. 723).

While the degree of difficulty in adjusting to parenthood has been debated, there is general agreement that parenthood represents a time of change and transition. As already mentioned, this time of change includes major role changes. For the woman this means entering into the maternal role and consequent adjustment in the other roles (such as the marital role) which comprise her feminine identity. Rubin (1967) has stated that the maternal role, far from being an intuitive feminine function, is a complex social and cognitive process that is learned. Sheehan (1981) has described the first six weeks after delivery as a "potential crisis" in a woman's life in view of these changes in roles and identity. In addition to the psychological changes cited above, there are other types of changes the new mother must adapt to in the initial postpartum period. These changes include a new time structure centered around the needs and demands of the infant. The mother may have to adapt to a different economic situation also, if she was previously working and is no longer employed. Simultaneously this period is influenced by the fatigue and healing processes following the birth of a child.

Support Systems; Their Effect on Transition to Parenthood

Several variables have been examined which may facilitate or

hinder this transition to parenthood and suggest why some parents have a more difficult time than others. Hobbs (1976) however, concluded that more research is needed to further identify and describe these variables. Russell (1974) claimed that maternal health, level of education, marital adjustment and salience of the maternal role were significant factors in determining the degree of crisis experienced in the transition to parenthood. Dyer (1965) also found significant relationships between marital adjustment, as well as number of years married, and the degree of crisis. Marital adjustment may be thought of as a partial indicator of adequacy of social support. If one considers the postpartum period as a time of change, representing various degrees of stress and crisis, social support may well be one of the more important factors influencing adaptation to motherhood. Kahn and Antonucci (1980) state that "the need for social support may be heightened when any of a person's major life roles undergoes change" (p. 265).

Various researchers have studied the relationship of social support to adaptation to life stressors, including the impact of this relationship on health. "Evidence indicates that a positive response to stressful life events is facilitated by socially supportive environments" (Brandt, 1981, p. 277). Social support has been viewed as a buffer which protects people in crisis, moderating the impact of the major transitions in life (Cobb, 1976). In a study of over 6,000 adults (randomly selected from an urban county in California), Berkman and Syme (1979) found that people who lacked social and commun-

ity ties were more likely to die in the follow-up period (9 years) than those with more extensive contacts.

Nuckolls, Cassel and Kaplan (1972) studied the relationships between psychosocial assets, social stresses and the prognosis of pregnancy. Their sample consisted of 170 white primiparas married to enlisted men. A measurement of current social stresses was made using Holmes's cumulative life change score. Documentation is lacking that the various ratings given to each life change event on this tool represent accurate ratings of stress for all socioeconomic classes. The measurement of psychosocial assets was not purely a measure of social support but included psychological measures such as self-esteem, ego-strength and the meaning of pregnancy to the individual. The prognosis of each pregnancy was evaluated from the medical record. Medical records were reviewed following delivery to classify the total course and outcome of each pregnancy as either "normal" or "complicated." An important finding of this study was that, of the women who had high life change scores, those women with strong psychosocial assets had only one third the complication rate of women with weak psychosocial assets. This finding lends credence to the idea that social support can have a protective or immunological effect on general physical and psychosocial well-being (Pilisuk & Froland, 1978). Carveth and Gottlieb (1979) studied 99 mothers at eight weeks postpartum and found weak to moderate associations between social support and level of stress. Three measures of social support were used and the analysis suggested that unique types of support are

provided by different network members. The concept of the "doula," as discussed below, is an example of a unique type of support valuable to women in the postpartum period.

In the postpartum period, the concept of a "doula" affirms the idea that women have definite needs for social support during this time. The term "doula" comes from an ancient Greek word for female assistant. A doula is a woman who supplies traditional information and gives physical help and emotional support to the parturient; she "mothers" the mother. For example in India, during the later stages of pregnancy, the young woman will move home to her parents' house where she will give birth and then be cared for by her mother and the tranditional midwife in the ways described above (Jelliffe & Jelliffe, 1974). In this way, the mother gains reassurance that she is capable of caring for her infant. Mercer (1981a) identifies reassurance as a basic need and priority concern of new mothers at one month postpartum. MacElveen-Hoehn and Eyres (1982) suggest that the transition to parenthood will be facilitated when new parents "are in a network where they have contact with others sharing the same experience" (p. 8). Such a network provides assurance for new parents that their new feelings, experiences, etc., as new parents are normal.

Various authors have lamented the absence of the doula in contemporary American society. Margaret Mead is among those who have "criticized the lack of support for new mothers in American society, their alienation from the mainstream of life, the lack of helpful kinsfolk,

and the threat of mobility" (Edwards, 1973, p. 19). Voicing similar thoughts, Rossi (1968) has stated:

> Family systems that provide numerous adults to care for the young child can make up for this discrepancy in need between mother and child (child's need for mothering and woman's need to mother) which may be why ethnographic accounts give little evidence of postpartum depression following childbirth in simpler societies. Yet our family system of isolated households, increasingly distant from kinswomen to assist in mothering, requires that new mothers shoulder total responsibility for the infant precisely for that stage of the child's life when his need for mothering is far in excess of the mother's need for the child (p. 27).

Again Pilisuk and Froland (1978) have claimed that urbanization and mobility have greatly decreased the ability of the extended family to provide reliable support. A somewhat identical observation by Brown and Hurlock (1977) was that the parturients participating in their study on breast-feeding needed a "doula." This was the strongest clinical impression they derived from home visits to the parturients. Pillitteri (1976, p. 188) has emphasized the special needs of the new mother:

> Before a mother can begin to concentrate on her child, she needs adequate rest and sleep and concerned attention to the relief of her physical discomfort. The more she is ministered to during this period, the easier it seems for her to minister to her

new child. The more she is touched and nourished, the more readily she seems to reach out and touch and nourish her infant.

The need for social support in the postpartum period seems clear. The available sources will vary for new mothers. The above discussion of the "doula" refers to the specific support that another woman may offer the parturient. Mercer has reported that a "friend who has had a baby is often cited as the most helpful person by new mothers" (Mercer, 1981a, p. 344). For new parents, a social network which includes other new parents may be particularly important in American society where the extended family is often not able to provide support.

Husbands, or partners, are another important source of social support and vary in their ability to contribute support to the new mother. Shereshefsky, Liebenberg and Lockman (1973) found a strong correlation between the husband's supportive role and the mother's maternal functioning. Westbrook (1978) found that positive marital relationships were linked with calmer reactions to the initial maternal experience. Negative relationships were associated with a longer period of crisis and maternal anxiety which seemed to hinder the establishment of warm mother-child relationships.

Measurement of Social Support

Thus far the review of the literature has been directed at the needs of the new mother and at the extent to which social support facilitates her adaptation to motherhood. What exactly is social support and how might it be measured? In general there has been "a

lack of conceptual agreement on what is social support and how it functions to protect health or buffer the effects of stressors (Norbeck, et al., 1981, p. 264). The question of definition of social support is crucial to the development of its conceptualization and measurement. Cobb (1976) defines social support as information which causes a person to believe that he is cared for, loved, esteemed and that he belongs to a network of communication and mutual obligation. Cobb does not include tangible services or material aid in his conception of social support. In contrast Kahn (1979) defines social support as "interpersonal transactions that include one or more of the following: the expression of positive affect of one person toward another; the affirmation or endorsement of another person's behaviors, perceptions or expressed views; the giving of symbolic or material aid to another" (p. 85). Kahn used the term "convoy" to signify the set of persons on whom the individual relies for support and those who in turn receive support from the individual. MacElveen-Hoehn, et al. (1982) states that "social support is a very complex construct which, for all its intuitive appeal, we are only beginning to understand" (p. 27).

However one defines social support, its effect on individual well-being may be attributed to its direct contribution (economic aid, physical assistance) as well as its ability to moderate the effects of stress (Kahn & Antonucci, 1980). Cobb (1976) suggests that social support may buffer the effects of stress through facilitation of coping and adaptation. For instance, esteem support may

encourage a person to cope with and master a problem. "Likewise, emotional support and a sense of belonging might provide the climate in which self-identity changes can most readily take place" (Cobb, 1976, p. 311).

Social support has been measured in a variety of ways. Barrera (1981) has stated that "...few of these measures have been systematically developed and repeatedly used with different populations" (Barrera, p. 76). The diversity of approaches various researchers have taken towards the assessment of social support illustrates the multifaceted nature of support. Some researchers in their attempts to measure support have focused on the providers of support, others on the individual's subjective appraisal of support, and still others on the activities involved in the provision of support (Barrera, 1981). In addition it has been observed that the perception of social support may not be congruent with the help that is actually received. However, most researchers to date have used subjective measures of social support (MacElveen-Hoehn, et al., 1982).

Norbeck (1981) has designed a multidimensional tool to measure social support, which is based on Kahn's definition of social support described above. The NSSQ (Norbeck Social Support Questionnaire) measures several dimensions of social support: the number of persons in the convoy; the quality of each individual relationship (duration of relationship, frequency of contact); and the amount of functional support provided (affect, affirmation and material aid).

Characteristics of the Hispanic Family

The literature review has up to this point been primarily focused on theoretical concerns and research based on the general American population. There appears to be a lack of research directed at the Hispanic woman and her support system during the postpartum period. Thus some characteristics of the Hispanic family will be described.

It is generally agreed that the Hispanic family is familistic (Keefe, Padilla, & Carlos, 1979). Family ties are usually strong and highly valued by the Hispanic. For most individuals the family remains the single most important reference group throughout life. Mirande (1977) states that familism is probably the most significant characteristic of the Hispanic family. Extended family relationships are important. Murillo writes: "Among family members there is often much communication, visiting, sharing and closeness of relationship. Such family members are expected to call upon one another and help one another whenever there is a need" (p. 21). In a large study of Hispanics residing in several towns in southern California, it was found that the Hispanics consistently relied on relatives most often for emotional support regardless of their geographic accessibility (Keefe, et al., 1979).

In describing the Hispanic family of Tucson, Arizona, Kay (1978) found that family ties are strong especially among the women and that most social relationships are still determined by kinship. If child-bearing women do not actually live with their mothers or mothers-in-law, they maintain these relationships through daily phone calls

or visits. "Thus the classical extended family is not always visible in the same house but stretches down the street or across the ditch" (Kay, p. 93). Kay also found that following delivery, the parturient will either go to her mother's home or her mother will come to hers.

For Hispanics who are mobile or newly located away from their extended family, it is unknown if the old, familiar support system is gone. According to Keefe et al., (1979) "Mexican-Americans who do not have a local kin network are not very likely to have substitute sources of help at hand in times of stress" (p. 151). If the health care system can contribute to social support of the Hispanic in the postpartum period, it is important to keep this in mind. It is also relevant to consider that Hispanics in general receive poorer medical care than do Anglo Americans. Quesada and Heller (1977) found that nearly one-third of Hispanic mothers have received inadequate prenatal care as opposed to 5% of Anglo mothers. Medina (1980) found that Hispanic women in California tend to receive later prenatal care than women in most other ethnic groups and that some Hispanic women receive no pre- or postnatal care at all.

Summary of the Review of the Literature

Following the delivery of her newborn child, a new mother faces a period of change and transition in her life. The degree of difficulty she has in adapting to the changes varies and is influenced by many factors. One variable affecting the ease of transition may be the strength of her social support system. Social support has been described as having a buffering effect for those experiencing crisis

or stress; socially supportive environments may facilitate a positive response to stressful life events.

Conceptual Framework

The literature describes specific needs the new mother has for social support during the postpartum period. These needs include physical help, reassurance and assistance in mothering skills. For American women many of these needs may go unmet; new mothers may find themselves isolated or alienated from the mainstream of life. Also urbanization and mobility have decreased the ability of the extended family to provide reliable support. For the Hispanic woman, who has traditionally experienced strong extended family ties especially among the women of the family, mobility may upset the traditional family structure and therefore the social support system.

Social support has been defined and measured in a variety of ways. However, there is a lack of conceptual agreement about what constitutes social support. Several researchers have come to the conclusion that it is a multidimensional concept (Barrera, 1981; Carveth & Gottlieb, 1970; Norbeck, Lindsey & Carrieri, 1981). Social support can be considered as having functional and network properties, both of which should be considered in the measurement of perceived social support. Functional properties include the giving/receiving of emotional and physical support. Network properties of a social support system include the size, stability and availability of the "convoy." Kahn (1979) defines the convoy as the set of persons on whom the person relies for support and those who rely on him or her for support.

Considering the characteristic of familism attributed to the Hispanic family, Hispanic and Anglo women may exhibit important differences in their perception of social support. Hispanics tend to receive poorer medical care than do Anglo Americans as cultural, language and economic barriers hinder the Hispanic's use of the health care system. Thus, social support during the postpartum period may presently be inadequate for many Hispanic women and there may be important differences in the function and makeup of social support for these two groups.

Statement of the Problem

The objective of this study is to describe the social support of Oregon Hispanic women and compare the extent and type of their support to that of Anglo women in the postpartum period.

The specific research questions to be posed are:

1. Do Hispanic and Anglo women in the postpartum period have different perceptions of functional support?
2. Do Hispanic and Anglo women in the postpartum period have different perceptions of total network support?
3. Do Hispanic and Anglo women in the postpartum period experience differences in the number of recent (past year) losses in their social support system?

CHAPTER II

METHODS

This chapter begins with a description of the design of the study, the sample population and the setting for the data collection. The instrument used for data collection will then be introduced and defined, followed by a discussion of its reliability and validity.

Design

A descriptive design was used to compare the type and amount of social support reported by Hispanic women with that of Anglo women during the postpartum period. All data were collected by interviewing these women during the postpartum hospitalization. The interviews were conducted in English or Spanish as appropriate.

Sample and Setting

Two samples were drawn from women delivering at a university teaching hospital. One group consisted of Hispanic women; a second sample was comprised of Anglo women. There were 25 subjects in each group. The Hispanic women were sampled from those women currently living in Oregon who have a Spanish surname, and whose birthplace or that of their parents was Latin America. The Anglo women were selected from a population of white women whose yearly income was less than $7,000. Both groups were restricted to women between the ages of 18 and 40. For each Hispanic participant, an Anglo woman was matched according to age, parity and marital status. Age was matched according to the following age groups: 18-20, 20-30, 30-40. Matching for parity was done according to primiparity or multiparity.

Marital status was matched according to whether the woman was living with a partner or living alone. Further description of the two samples is included in the Results section.

Both groups of subjects were drawn from the population of obstetrical patients who deliver at the chosen hospital. At the time this study was originally designed there were about 225 deliveries per month at this location. At the time data collection occurred certain financial policies had changed at this hospital which made it more difficult for low-income patients to gain access to this health care facility. As a result, the number of deliveries per month dropped to 150. This meant that fewer Hispanics were delivering at this hospital; consequently only 7 to 10 percent of the patient population on the maternity ward was Hispanic at the time of data collection. Many of those Hispanics who were not able to make a down payment for hospital care were delivering at home or at the clinics where they received prenatal care. As a result, the investigator believes that the Hispanic population sampled was wealthier than the population that had been anticipated.

Ordinarily parturients remain in the postpartum unit anywhere from 24 to 48 hours following the birth of a child. It was during this time period that the subjects were interviewed. The sample for this study was a convenience sample; those women who delivered and were on the postpartum unit on the days the interviewer visited the unit and who met the criteria stated above were eligible for participation in the study.

A cover letter, approved by the institution's committee on Human Research, was read aloud to each potential interviewee. This letter briefly described the study and invited the woman to participate (see Appendix A). The response rate for those subjects the interviewer approached was 100%.

Data Collection

Data collection began in October of 1982 and was completed in January of 1983. The data were collected at the aforementioned hospital floor by means of an interview. The interview was based on the Norbeck Social Support Questionnaire (Norbeck, et al., 1981). (See Appendix B). The decision to interview was made in view of the fact that some of the subjects might have been illiterate or unable to understand the questionnaire sufficiently. The interview closely followed the format of the questionnaire; the interviewer clarified as needed. All interviews were administered by the investigator who is bilingual.

Measurement of Social Support

The Norbeck Social Support Questionnaire (NSSQ) was chosen as the instrument to measure social support because it assesses multiple dimensions of social support yet is relatively simple to administer. Simplicity of the instrument was important as some of the respondents interviewed had limited formal education.

The NSSQ is a new instrument based on Kahn's definition of social support and definitions from network theory (Norbeck, et al., 1981). The instrument measures three main dimensions: total functional support, total network support and total loss. Total functional sup-

port refers to the functional properties of social support: affect, affirmation and aid. Total network refers to the size, stability and availability of the "convoy," by which is meant the set of significant others with whom the person gives and receives social support. Total loss is a measure of recent losses of important relationships. These dimensions, which address the research questions, will be discussed individually.

The interview began with the request to the respondent to "name each significant person in your life. Consider all the persons who provide personal support for you or who are important to you now." First names or initials were used. The respondent was also asked to specify the relationship of each person named to the interviewer. A list of examples for the respondent to choose from was recited by the interviewer as follows: spouse or partner; family or relatives; friends; work or school associates; neighbors; health care providers; counselor or therapist; minister, priest or rabbi; and others. The respondent could name as many as 24 network members.

Total Functional Support

There are six questions on the NSSQ to measure total functional support. According to Kahn's definition, there are three functional properties of social support: affect, affirmation and aid. Two questions measure each of these properties. Each subject was asked to rate each network member for each question on a five point Likert scale. The questions for affect were: "How much does this person

make you feel liked or loved? and "How much does this person make you feel respected or admired?" The questions for affirmation were: "How much can you confide in this person?" and "How much does this person agree with or support your actions or thoughts?" The questions for aid were: "If you needed to borrow ten dollars, a ride to the doctor, or some other immediate help, how much could this person usually help?" and "If you were confined to bed for several weeks, how much could this person help you?" Affect, affirmation and aid were each measured through a summation of the ratings made in response to the two questions given for each. The three scores for affect, affirmation and aid were added together to give a single score for the variable Total Functional Support. Scores for this variable could range from 0 to 720. An example of scoring for the variable Total Functional is given in Appendix E.

Total Network Support

An overall single score for the variable Total Network was composed by summing the number of network members listed, and the ratings given for two questions which measured duration and frequency of relationships. These questions were: "How long have you known this person?" and "How frequently do you usually have contact with this person (phone calls, visits, or letters)?" Scores for this variable may then range from 0 to 264. An analysis of the source of the network members was made by assigning a category code number to each network member according to the type of relationship (spouse, friend, neighbor, etc.).

Total Loss

Total loss is a measure of recent losses of important relationships (questions 9, 9a and 9b). A single score for the variable Total Loss was composed of the responses given for three questions. Question 9 asks: "During the past year, have you lost any important relationships due to moving, a job change, divorce or separation, death, or some other reason?" The answer for this question was coded for a yes/no response. Question 9a states: "Please check the category(ies) of persons who are no longer available to you." The total number of categories checked in 9a constitutes a score of "number lost." Question 9b asks: "Overall, how much of your support was provided by these people who are no longer available to you?" The number on the Likert scale checked by the subject for question 9b was a score for "amount of support lost." A single score for the variable Total Loss was then made by summing the scores for loss, number of losses, and amount of loss. The scores for this variable may range from 1 to 16.

As the interview method was used for this study, the interviewer scored the responses directly onto a 1-page scoring sheet (see Appendix D).

Validity and Reliability

The NSSQ was initially tested (Norbeck, et al., 1981) on two groups of nursing students; one group of undergraduate students and one group of graduate students. Reliability was determined using the test-retest method with an interval of one week. High levels

of test-retest reliability were found; reliability for the questions pertaining to affect, affirmation, aid and network property ranged from .85 to .92. The total loss measure had a test-retest reliability score of .83.

High levels of internal consistency were also found. This was tested through intercorrelations among all items and use of Pearson Correlation Coefficients. The social desirability response bias was ruled out, using the Marlowe-Crowne Test of Social Desirability. Moderate levels of concurrent validity (range .31-.56 for the subscales) were found, when NSSQ subscales were correlated with the Social Support Questionnaire developed by Schaefer, Coyne and Lazarus (in Press).

Additional Data

In addition to the matching variables of age, parity and marital status, demographic data were also collected on educational level, duration of residence in Oregon, number of persons in household, employment status and language (see Appendix C). This information was obtained to further describe the sample population of both groups and to identify any confounding variables. A description of these demographic criteria follows in the Results section.

Data Analysis

Analysis of the data was aimed at describing and comparing the social support of the two study groups. Ethnicity was the independent variable and social support the dependent variable. Descriptive statistics were used to describe the samples' demographic characteristics, and where appropriate, statistical analysis was done to deter-

mine if significant differences existed between the two groups on any of the demographic data.

The research questions were analyzed by calculating mean scores for both groups of subjects for the Total Functional support scale, the Total Network scale and the Total Loss scale. The t test was then applied to these mean scores.

CHAPTER III

RESULTS AND DISCUSSION

This chapter begins with a description of the two sample groups. The findings of the research question will then be analyzed and discussed. Nursing implications are interspersed throughout the discussion and the chapter concludes with a brief synposis of addutional descriptive and reliability data.

Sample

As previously described, the Anglo sample was matched to the Hispanic sample for income, parity, age and marital status. As seen in Table 1, both samples were similar except for education background. Anglos averaged 11.8 years of school while Hispanics averaged 7.1 years. When the Hispanic sample was separated into two groups (foreign-born and native-born) it was found that the foreign-born accounted for this difference in education; native-born Hispanics averaged 11 years of school while foreign-born averaged 5.6 years.

The mothers in both Anglo and Hispanic samples tended to be married or living with a partner (88%) had on the average 2.5 children, and did not work outside the home (92%). Subjects in both groups had, on the average, moved one time during the past year. Typically both Hispanics and Anglos had resided in Oregon for more than one year. The manner in which duration of residence was measured was

insensitive to potential differences in the two groups. The three categories for this scale were: less than six months; six to 12 months; and greater than a year. Perhaps if the scale had been lengthened to include the categories of one to two years; two to three years; three to four years; and greater than four years, a difference might have been found between the two groups.

Although reported incomes were roughly the same between the samples, many of the Anglos reported to the interviewer that they had recently experienced a significant drop in their income. Hispanics did not mention this; they appeared to be more accustomed to their reported income.

Other differences were found between the two sample groups. First, Hispanics tended to have one more person in their households than Anglos and that, although parity was similar, there was on the average, one more child in the Hispanic's household than the Anglo's. It was observed by the interviewer that Hispanics sometimes shared a dwelling with another family whereas Anglos did not. There may be some benefit to the Hispanic mother who is sharing her home with other parents; this situation may provide social contacts including peer support during the transition to parenthood. MacElveen-Hoehn and Eyres (1982) suggest that a network of new parents provides assurance for those parents that their new feelings, experiences, etc. as new parents are normal.

Among the Hispanic sample, 52% spoke Spanish only, 4% spoke English only and 44% were bilingual. Seven Hispanics were born in

Table 1

Comparison of Hispanic and Anglo Mothers

on Selected Demographic Characteristics

Characteristic	Ethnicity					
	Hispanic (N=25)	Anglo (N=25)	t	Hispanic A[a] (N=7)	Hispanic B (N=18)	t
Age (years)						
mean	25.04	23.24	1.54	23.57	25.6	-.96
S.D.	(4.8)	(3.4)		(3.4)	(5.2)	
Education (years)						
mean	7.12	11.76	-5.14**	11.00	5.61	3.44*
S.D.	(4.2)	(1.5)		(1.4)	(4.0)	
Parity[b]						
mean	2.64	2.36		1.85	2.94	-1.40
S.D.	(1.8)	(1.5)		(.9)	(1.9)	
No. of living children						
mean	2.52	2.32	.48	1.85	2.77	-1.32
S.D.	(1.5)	(1.3)		(.9)	(1.7)	
No. of children in house						
mean	3.36	2.28	2.30*	2.42	3.72	-1.54
S.D.	(1.9)	(1.3)		(1.9)	(1.9)	
No. of moves in last year						
mean	1.20	1.24	-.13	1.14	1.22	-.17
S.D.	(1.0)	(1.2)		(.7)	(1.2)	
No. of persons in house						
mean	5.64	4.52	2.06*	4.42	6.11	-1.76
S.D.	(2.2)	(1.5)		(2.5)	(1.8)	

* $p < .05$
** $p \leq .001$

[a]Hispanic A = native-born; Hispanic B = foreign-born
[b]Parity: number of children given birth to

the U.S.; 16 in Mexico; one in Cuba; and one in Argentina.

Research Questions

There were no significant differences in the social support scores between Hispanic and Anglo women for any of the major research questions (see Table 2). However, when the Hispanic sample was separated into foreign-born and native-born, significant differences were found in the perception of social support between these two subgroups. The foreign-born experienced less total functional support, reported smaller support networks but less network loss. Each of the three research questions and the differences among the Hispanics will be discussed individually.

Table 2

Comparison of Total Functional, Network and Loss Scales Between Hispanics and Anglos and Between Hispanic Subgroups

Scales	Hispanic	Anglo	t	Hispanic A[a]	Hispanic B	t
Total Functional						
mean	198.7	230.53	-1.04	315.71	153.16	3.89**
S.D.	(118.2)	(96.4)		(95.5)	(93.1)	
Total Network						
mean	93.6	101.08	-.60	144.0	74.0	4.29*
S.D.	(48.1)	(39.4)		(34.6)	(37.4)	
Total Loss						
mean	2.2	1.64	.75	4.0	1.5	2.17*
S.D.	(2.8)	(2.5)		(2.8)	(2.5)	

[a] Hispanic A = native-born; Hispanic B = foreign-born

*$p < .05$
**$p \leq .001$

It is important for nurses caring for Hispanic women to realize the diversity which exists among Hispanic peoples. This study particularly points out the differences between foreign-born and native-born Hispanics.

Perception of Functional Support

The first research question was; do Hispanic and Anglo women in the postpartum period have different perceptions of functional support? As seen in Table 3, the two samples did not differ significantly on any of the functional support subscales. Within the Hispanic sample however, significant differences were found between foreign-born and native-born Hispanics on all three subscales.

Table 3

Comparison of Affect, Affirmation and Aid Subscales Between Hispanics and Anglos and Between Hispanic Subgroups

Subscales	Hispanic (N=25)	Anglo (N=25)	t	Hispanic A[a] (N=7)	Hispanic B (N=18)	t
Affect						
mean	80.56	86.64	-.54	124.0	63.67	3.72**
S.D.	(45.1)	(34.4)		(34.3)	(37.2)	
Affirmation						
mean	63.36	72.0	-.83	96.0	50.67	2.84*
S.D.	(40.7)	(32.1)		(35.7)	(35.7)	
Aid						
mean	54.76	71.88	-1.76	95.7	38.83	4.77**
S.D.	(37.0)	(31.6)		(30.7)	(25.2)	

[a]Hispanic A = native-born; Hispanic B = foreign-born
*$p < .01$
**$p \leq .001$

It is interesting to note also that the native-born Hispanics scored higher than the Anglo sample. In general the researcher sensed that it was more difficult for the Hispanics to respond to the interview questions than for the Anglos. Those Hispanics with a minimum of formal education sometimes appeared to be quite apprehensive or suspicious about the whole interview process; the investigator's perception was that it was difficult for these women to understand what the investigator wanted and why. The investigator attempted to allay these suspicions by chatting informally before or during the interview.

One of the first questions measuring functional support in the interview was "How much does your husband (or other network member) make you feel liked or loved?," This question appeared to be an invasion of privacy for some Hispanics. One woman began to giggle when asked this particular question; it was later apparent that this woman did not perceive her husband to be very supportive. The investigator felt it was embarrassing for this woman to say that her husband was not very supportive.

Some of the Hispanic women had difficulty answering the questions according to the standardized responses. For example, in response to the question, "How much does your husband make you feel liked or loved?," one woman would reply, "Me quiere" (he loves me). It required several attempts to elicit one of the standardized responses (i.e., not at all, a little, quite a bit, etc.). It appeared that for this woman, as well as several others, it was difficult to concep-

tually quantify how much her husband loved her. During the interview process the investigator often questioned the validity and reliability of the NSSQ for the Hispanic sample.

Affect and affirmation support (support which tells the woman that she is loved, respected, affirmed) may facilitate coping and adaptation during the transition to parenthood. Cobb (1976) suggests that esteem support (equivalent to affect and affirmation support) may encourage a person to cope with and master a problem. New mothers who are receiving a great deal of affirmation may have more self-confidence to deal with the demands of their infants than mothers who receive little affect and affirmation support.

Differences in aid support between foreign-born and native-born Hispanics were highly significant ($p<.001$). This finding carries important nursing implications. The fact that a foreign-born Hispanic woman may have no phone and no network members who could drive her or her infant to a clinic or hospital in the event that an acute medical condition arose, forms an important part of the nurse's data base. For example, this type of information needs to be taken into account when deciding on the appropriate time for discharge from the postpartum floor. Every effort should be made to provide thorough postpartum teaching which is well understood by the Hispanic parturient. This teaching must include instruction on the signs and symptoms of illness in both the mother and baby such as hyperbilirubinemia, mastitis, endometritis, etc. Home visits can be planned to assure the well-being of those Hispanic women who have little aid

support and who may be relatively isolated. The nurse can also help the Hispanic woman to utilize available resources such as WIC (a federally funded food supplementation program for women and children).

Perception of Network Support

The second major research question was; do Hispanic and Anglo women in the postpartum period have different perceptions of total network support? Again, no significant differences were found between the Anglo and Hispanic samples. And again, within the Hispanic sample, significant differences were found among native-born and foreign-born Hispanics. It was also again found that the native-born Hispanics scored higher on the total network score than the Anglos. Native-born Hispanics tended to list six more network members than Anglos. Foreign-born Hispanics listed on the average three less network members than Anglos. Scores for duration of relationship and frequency of relationship followed the same trend; native-born Hispanics score highest, followed by the Anglos and then the foreign-born Hispanics. Duration of relationship was a composite score of the length of time the mother had known each network member. Frequency of relationship measured the frequency of contact with each network member.

If the foreign-born Hispanic woman has both a smaller social network and receives less perceived support from this network, she may be at risk for developing problems during the transition to parenthood. Nursing intervention includes the assessment of the mother's support system. Beginning with prenatal care, efforts should be directed at including significant others in the care and teaching of Hispan-

Table 4

Comparison of Total Network Subscales Between Hispanics and Anglo and Between Hispanic Subgroups

Subscales	Hispanic (N=25)	Anglo (N=25)	t	Hispanic A[a] (N=7)	Hispanic B (N=18)	t
Number Listed in Network						
mean	10.04	11.16	-.77	16.0	7.72	4.47*
S.D.	(5.6)	(4.7)		(4.3)	(4.1)	
Duration						
mean	43.04	45.64	-.42	66.57	33.89	3.90*
S.D.	(23.7)	(19.5)		(12.5)	(20.6)	
Frequency						
mean	40.52	44.28	-.73	61.42	32.39	4.36*
S.D.	(19.8)	(16.5)		(18.7)	(13.3)	

*$p \leq .001$

[a]Hispanic A = native-born; Hispanic B = foreign-born

ic women. Fathers, and other family members, should be made to feel welcome in the health care facility. As appropriate, nurses can actively facilitate family relationships. Throughout the intrapartum experience fathers and others can be encouraged to participate in the mother's care and share in the event of childbirth. During the postpartum hospitalization, the nurse can temporarily play the part of the "doula;" offering information and encouragement to the new mother. Public health nurse visits can be planned to provide ongoing interaction including information and encouragement. Not to be forgotten is the need for adequate translation for those Hispanics who do not speak English.

In response to the initial request to name network members, it was interesting to observe that some mothers listed their newborn baby and that some did not. Some mothers said that their baby made them feel loved a great deal; others stated that their baby was too young to make them feel loved.

Perception of Loss

The third major research question was; do Hispanic and Anglo women in the postpartum period experience differences in the number of recent losses in their social support system? This study suggests that there are no significant differences in perceived loss among the Hispanic and Anglo samples. When the two Hispan-

Table 5

Comparison of Total Loss Subscales Between Hispanics and Anglos and Between Hispanic Subgroups

Subscales	Hispanic (N=25)	Anglo (N=25)	t	Hispanic A[a] (N=7)	Hispanic B (N=18)	t
Loss						
mean	.40	.32	.58	.71	.27	2.09*
S.D.	(.5)	(.5)		(.5)	(.5)	
Number lost						
mean	.44	.32	.80	.71	.33	1.50
S.d.	(.6)	(.5)		(.5)	(.6)	
Amount of loss						
mean	1.36	1.0	.76	2.57	.89	2.31*
S.D.	(1.8)	(1.6)		(1.9)	(1.5)	

*p<.05

[a]Hispanic A - native-born; Hispanic B = foreign-born

ic subgroups are compared, there are significant differences. Interestingly, foreign-born Hispanics had less perceived loss than native-born Hispanics. The researcher does not interpret this to signify that foreign-born Hispanics do not experience great losses in their social support network; in most cases highly significant others were left behind in Mexico, including offspring. Foreign-born Hispanics tended not to name relatives living in Mexico or other places as network members or as losses even though it was evident that there were strong emotional attachments to these people.

Information regarding family in Mexico is generally guarded by foreign-born Hispanics as this type of information is associated with immigration officials and deportation. Generally, there is a great deal of fear of confrontations with American officials even if the Hispanic is here in Oregon with the proper legal papers. As an Anglo stranger, presenting herself in a formal manner with pen and paper, the investigator may have posed a sufficient threat to the foreign-born Hispanics so that they would not be willing to speak of relatives in Mexico. It is the investigator's perception that many of the foreign-born Hispanic mothers interviewed in this study often suffer important losses in their social support network due to their immigration to Oregon. The investigator also perceives that familial ties in Mexico are maintained and it is to family in Mexico that these Hispanics would turn to if help was needed.

Additional Descriptive Data

First, in the composition of network members, no significant

differences were found in the source categories of network members among Hispanics and Anglos. The great majority of network members for both samples came from the first three categories; spouse (or partner), family/relatives, and friends. One Anglo named a minister, one Anglo named a health care giver and one Hispanic named a neighbor as a network member. These are similar results to those for the normative sample (N=136) Norbeck has described. One difference is that 50% of the normative sample listed work or school associates in their networks whereas none of the subjects in this study named network members from this source category. Most mothers in this study were neither working outside the home nor going to school. Norbeck's normative data was based on a sample of baccalaureate and graduate nursing students.

Again, when the Hispanic sample is separated into foreign-born and native-born subgroups, a significant difference emerges. Foreign-born Hispanics named fewer relatives as part of their network than native-born Hispanics; foreign-born Hispanics named an average of six relatives whereas native-born Hispanics named an average of 13 relatives.

This is an important finding in that it supports the investigator's perception that foreign-born Hispanics have experienced losses in their social support system due to their immigration to Oregon. In considering the significance of this finding it is important to recall the familistic characteristics of the Hispanic peoples and that "Mexican-Americans who do not have a local kin network are not

very likely to have substitute sources of help at hand in times of stress" (Keefe, et al., 1979, p. 151).

Support Source Categories

A second additional finding emerged from the evaluation of the perceived functional support from the various source categories. For purposes of comparison, the scores for the subscales of affect, affirmation and aid were broken down into the three source categories most commonly named by the subjects: spouses, family and friends. Table 6 shows the mean scores given by Hispanics and Anglos for these categories. A comparison of the two samples reveals a significant difference in the mean scores given to spouses for affect and affirmation support; Hispanics score their spouses significantly lower. This difference is also seen in the scoring for spouses on aid support.

The support of a spouse during the postpartum period can be an important variable influencing the degree of ease or difficulty with which a new mother makes the transition to parenthood. Dyer (1965) found significant relationships between marital adjustment and the degree of crisis new parents experienced. Shereshefsky, et al., (1973) found a strong correlation between the husband's supportive role and the mother's maternal functioning. These findings were based on white Anglo middle-class samples. Marital expectations during the postpartum period may be different for Hispanic couples than for Anglo couples. It is important for nurses to sensitively include spouses in the obstetrical care of Hispanic women so that spouse support is facilitated yet without alienating or offending the spouse.

Table 6

Comparison of Functional Support Scores for

Spouses, Family and Friends Between Hispanics and Anglos

Subscale	Hispanic N=25	Anglo N=25	t	p-value
Affect/spouse				
mean	8.64	9.63	-3.39	.002
S.D.	(1.2)	(.6)		
Affect/family				
mean	65.17	63.68	.15	.880
S.D.	(37.3)	(31.2)		
Affect/friends				
mean	21.27	20.87	.07	.944
S.D.	(15.1)	(13.7)		
Affirmation/spouse				
mean	8.05	9.18	-3.59	.001
S.D.	(1.2)	(.9		
Affirmation/Family				
mean	49.45	50.12	-.08	.938
S.D.	(30.4)	(28.7)	-.08	.938
Affirmation/friends				
mean	18.36	23.62	-.73	.472
S.D.	(15.4)	(20.1)		
Aid/spouse				
mean	8.32	9.18	-2.22	.032
S.D.	(1.5)	(1.0)		
Aid/family				
mean	39.46	50.68	-1.39	.172
S.D.	(27.0)	(29.5)		
Aid/friends				
mean	18.18	18.94	-.14	.888
S.D.	(14.4)	(13.0)		

In cases where the Hispanic spouse does not perceive his role to be strongly supportive to the new mother, the nurse should assist the woman to find alternative sources of help such as a sister or woman friend.

Reliability

As a measure of reliability, the scores for each pair of questions for the functional support subscales were correlated using the Pearson Correlation Coefficient (see Table 7). For example, the scores for the first two questions of the interview which measure affect support were correlated. Strong correlations were found for each pair of questions within the subscale. Correlations were significant ($p<.001$) for both the total sample (N=50) and for Hispanic sample alone (N=25).

Table 7

Pearson Correlation Coefficients for Subscale Items of Functional Support : Total Sample and Hispanic Sample

Functional Support Questions	Pearson r Total Sample N=50	Hispanic Sample N=25	p-value
Affect 1 and 2	.96	.96	.001
Affirmation 3 and 4	.94	.94	.001
Aid 5 and 6	.88	.86	.001

This provides support that both the Anglo and Hispanic subjects understood the questions pertaining to functional support and answered consistently.

CHAPTER IV

SUMMARY

This chapter begins with a summary of the study. Limitations of the study, implications for nursing practice and finally, recommendations for future research will then be discussed.

Summary

The purpose of this study was to compare and contrast the social support system of Hispanic and Anglo women in the postpartum period. The investigator also wished to determine if Hispanic women experience significant losses in their support system due to immigration to Oregon.

This study was based upon the conceptual framework that the transition to parenthood represents a time of challenge and/or crisis for new parents. The degree of difficulty a new mother experiences in adapting to the changes the birth of a child brings is influenced by many factors. One variable affecting the ease of transition may be the strength of the mother's social support system. Social support may have a buffering effect for those experiencing crisis or stress and socially supportive environments may facilitate a positive response to stressful life events.

For the Hispanic woman, who has traditionally experienced strong extended family ties, especially among the women of the family, mobility may upset the traditional family structure and therefore her social support system. This may render her more vulnerable to the stresses of the postpartum period.

Two samples consisting of 25 Anglo women and 25 Hispanic women

were selected by convenience on the postpartum floor of a metropolitan teaching hospital. The Anglo women were individually matched to the Hispanics on income, parity, age and marital status. The subjects were interviewed following delivery, during their stay on the postpartum floor. The Norbeck Social Support Questionnaire was used to measure the subjects' perception of social support. Additional demographic data were gathered to further describe the sample and rule out confounding variables.

The Anglo and Hispanic mothers in this study were of low economic status, tended to be married and have several children. An important difference between the two groups was that the Hispanics had significantly less education than the Anglos. There were no significant differences in the social support scores for Hispanic and Anglo women for any of the research questions. However, when the Hispanic sample was separated into foreign-born and native-born, significant differences were found in the perception of social support between these two subgroups. The foreign-born scored significantly lower on functional support, reported smaller social networks and less network loss than the native-born. The native-born Hispanics had larger networks than the Anglos and scored higher on functional support, perhaps reflecting the characteristic of familism generally attributed to the Hispanic family.

Foreign-born Hispanics tended not to name important family in Mexico as network members nor as network losses. However, the fact that foreign-born Hispanic women had significantly smaller networks

and named less than one-half the number of relatives that native-born Hispanics named in their networks, suggests that foreign-born Hispanics do suffer important losses in their social support systems.

Limitations

Several limitations must be borne in mind as one reviews the findings of this study and its practical applications. First of all, the sample sizes were small. This is particularly important in regard to the differences which emerged within the Hispanic sample, creating two very small subgroups.

Secondly, caution must be used in generalizing the findings pertaining to the Hispanic sample to other Hispanic populations. Oregon has a relatively small Hispanic population and Oregon Hispanics experience important differences in their social environment as compared for example, to a Hispanic living in a Los Angeles barrio. The present Hispanic sample may also not be representative of the universe of Hispanics in this state. Oregon Hispanics excluded from the sample were those who are sufficiently wealthy to obtain care from private hospitals and those who are too poor to obtain care at the chosen teaching hospital. The Hispanic sample was predominantly Mexican; as differences exist among Hispanic subgroups, care must be taken in generalizing findings to other Hispanic groups such as Cubans, Puerto Ricans, etc.

Thirdly, it is important to remember that the measure of social support used for this study was based on the subject's perception and may not accurately portray objective social support. However, this is a general problem in all current measures of social support.

Fourth, in regards to these findings, the investigator wishes to express serious doubts as to the reliability and validity of the instrument due to the language and cultural differences of the Hispanic sample. The instrument used for data collection may have certain ethnocentric biases and may be inadequate for accurate data collection from Hispanic subjects. Also, due to the apprehension evoked in the Hispanic subjects during the interview process, the setting and manner in which data were collected from this ethnic group was less than desirable.

Recommendations for Future Research

Due to the apprehension of the Hispanic subjects the investigator felt was evoked by the interview process, it is strongly recommended that future research inquiring into the social support systems of Hispanic peoples be carried out in a different manner than that described in this study. The investigator suggests that data collection be carried out in a more informal manner and over a series of interviews. For future studies of postpartal support, perhaps women could be first contacted in the prenatal setting. There the investigator could establish rapport and talk informally about their family and support systems. Home visits would be excellent in terms of the

comfort of the Hispanic woman and would afford objective appraisals of the woman's support system. Whenever possible, the use of pen and paper during the interview process should be avoided.

If the NSSQ is to be used for Hispanic peoples, certain adaptations should be made to ensure its usefulness for accurate data collection. The investigator's original translation of the NSSQ was done with the supervision of a hospital translator who was from Spain. Following data collection, the investigator reviewed her translation of the NSSQ with a professional translator from Mexico to determine if any flaws existed in the translation. This Mexican translator felt that the usage of the language was somewhat awkward and the questions themselves sometimes culturally offensive. For example, the Loss question includes asking the woman if she has experienced loss due to divorce. In Mexico, if a woman is labeled a divorcee, this is congruent with calling her a prostitute. Hence, asking a woman if she is divorced is like asking her if she is a prostitute.

Another cultural disparity is found in the use of the Likert scale; in regards to the question "How much does your husband make you feel liked or loved?" It makes no sense to a Hispanic to quantify her husband's love, he simply loves her.

Question five, which evaluates physical aid received from network members, is somewhat culturally irrelevant in that it starts by asking if the network member would be able to loan the subject money. The unit of exchange among Hispanic families is not generally money. If someone is hungry, he will be fed at someone's table; if they

have no place to sleep, they will be welcomed into a relative's home; etc.

Before using the NSSQ again for a Hispanic sample, the investigator should try to find person typical of the sample, who could help to correct and adapt the NSSQ for a Hispanic sample.

In regards to postpartal social support, it may be helpful to measure social support at six weeks postpartum, rather than the immediate postpartum period. At this time, the parturient may have changed her perceptions of who and what type of support was particularly helpful to her.

Implications for Nursing Practice

This study points out the differences which exist among Hispanic women due to being native-born or foreign-born. Nurses should take this into account when caring for the Hispanic woman in order to provide optimal care. This information can easily be obtained from the hospital registration sheet.

Because the foreign-born Hispanic woman typically has had a minimum of education, postpartum teaching may need to be adjusted so that the information presented is complete and well understood. Public health nurses and/or midwives can make home visits during the postpartum period to review teaching done in the hospital as well as to provide the new mother with continued assistance in the care of herself and her newborn. Due to the fact that many foreign-born Hispanic women do not speak English, translation services, if the

nurse is not Spanish-speaking, are essential to postpartum teaching.

Foreign-born Hispanic women reported smaller networks and scored significantly lower than the native-born on all the subscales of functional support. This may signify that the foreign-born Hispanic woman is at risk for developing problems in the postpartum period. Affect and affirmation support are important variables in that they may facilitate the new mother's ability to cope with the demands of her infant. Postpartum nursing care should emphasize the encouragement and affirmation of the Hispanic woman in her mother role. Again, home visits made by either the public health nurse or the midwife may provide some amount of continuing encouragement and affirmation.

Because foreign-born Hispanic women reportedly receive less aid support than the native-born, the public health nurse can help these women to be aware of and use available resources such as WIC. Before making the decision to discharge the foreign-born Hispanic woman from the postpartum floor, the nurse and/or nurse-midwife should assess the amount of help the woman will receive at home. She will probably have no phone and may have no one to drive her and her infant to medical assistance in the event that a postpartum or neonatal complication arose.

Assessment of the foreign-born Hispanic woman's support system should begin with prenatal care. Effort should be taken to include significant others in the care and teaching of the Hispanic woman. Fathers, and other family members or friends, should be made to feel welcome in the health care facility. As culturally appropriate, nurses

can actively facilitate family relationships. Throughout the intrapartum experience, fathers and others can be encouraged to participate in the mother's care and share in the event of childbirth. During the postpartum hospitalization, the nurse can temporarily play the part of the "doula;" offering information and encouragement to the new mother. Public health nurse visits can be planned to provide ongoing interaction including information and encouragement.

The Hispanic subjects in this study rated their spouses lower than Anglos for the amount of functional support their spouses provided. This may reflect cultural differences in marital role expectations. Nurses can sensitively facilitate marital relationships and help the Hispanic woman to find alternative sources of help (such as that of a sister or friend) when appropriate. It is important to determine from the Hispanic woman's point of view, who is important to her and from whom does she expect or desire to receive functional support.

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APPENDIX A

My name is Sandra Inman and I am a graduate nursing student at the Oregon Health Sciences University, working under the supervision of Mary Ann Curry, RN, DnSc, Associate Professor, School of Nursing. I would like to invite you to join in a study about the social support that is available to and used by Hispanic and Caucasian women during the first few months following the birth of a child. The information obtained from this study may aid health providers such as nurses and doctors, to help new mothers deal with the changes and demands which follow the birth of an infant.

Participation in this study means that you will be interviewed by myself, at your convenience, during your stay in the hospital. The interview will take about fifteen to twenty minutes and will ask about the people in your life who are important to you and the help or support these people give you.

The information obtained will be kept confidential. Your name will not appear on the records and confidentiality will be assured by the use of code numbers.

You may ask me any questions you might have about your participation in this study. You do not have to join in this study and may say "no" at any time without hurting your relationship with the Oregon Health Sciences University.

Me llamo Sandra Inman y soy una enfermera y estudiante de parteria en la Universidad de Oregón. Le invito a participar en un estudio acerca de la ayuda de familia y amigos que tiene una mujer después de nacer un niño. La información que resultará de este estudio es importante para el cuidado prenatal, durante y después del nacimiento. La información obtenida por este estudio ayudará a los doctores y enfermeras a proveer ayuda después del parto. Hay muchos cambios en la vida diaria después de nacer un niño. La ayuda de un esposo o de otra mujer con experiencia con los niños es muy importante.

Su participación en este estudio conlleva una entrevista que durará de 15 a 20 minutos. Preguntaré acerca de las personas importantes en su vida y la ayuda que le ofrecen estas personas.

Guardaré las respuestas de cada persona en estricta confidencia. Su nombre no aparecerá en los papeles. En lugar de usar su nombre usaré un numero.

Puedo contestar cualquier pregunta que tenga acerca de este estudio. No tiene que participar y puede decirme "no" en cualquier momento sin afectar su relación con el hospital.

APPENDIX B

The Norbeck Social Support Questionnaire

SOCIAL SUPPORT QUESTIONNAIRE

PLEASE READ ALL DIRECTIONS ON THIS PAGE BEFORE STARTING.

Please list each significant person in your life on the right. Consider all the persons who provide personal support for you or who are important to you.

Use only first names or initials, and then indicate the relationship, as in the following example:

Example:

	First Name or Initials	Relationship
1.	MARY T.	FRIEND
2.	BOB	BROTHER
3.	M.T.	MOTHER
4.	SAM	FRIEND
5.	MRS. R.	NEIGHBOR

etc.

Use the following list to help you think of the people important to you, and list as many people as apply in your case.

- spouse or partner
- family members or relatives
- friends
- work or school associates
- neighbors
- health care providers
- counselor or therapist
- minister/priest/rabbi
- other

You do not have to use all 24 spaces. Use as many spaces as you have important persons in your life.

WHEN YOU HAVE FINISHED YOUR LIST, PLEASE TURN TO PAGE 2.

Number _____ [1-4]
Date _____

PERSONAL NETWORK

	First Name or Initials	Relationship	
1.			[32]
2.			[33]
3.			[34]
4.			[35]
5.			[36]
6.			[37]
7.			[38]
8.			[39]
9.			[40]
10.			[41]
11.			[42]
12.			[43]
13.			[44]
14.			[45]
15.			[46]
16.			[ ]
17.			[48]
18.			[49]
19.			[50]
20.			[51]
21.			[52]
22.			[53]
23.			[54]
24.			[55]

For each person you listed, please answer the following questions by writing in the number that applies.

1 = not at all
2 = a little
3 = moderately
4 = quite a bit
5 = a great deal

Question 1:

How much does this person make you feel liked or loved?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

Question 2:

How much does this person make you feel respected or admired?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

1 = not at all
2 = a little
3 = moderately
4 = quite a bit
5 = a great deal

Question 3:

How much can you confide in this person?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

Question 4:

How much does this person agree with or support your actions or thoughts?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

1 = not at all
2 = a little
3 = moderately
4 = quite a bit
5 = a great deal

Question 5:

If you needed to borrow $10, a ride to the doctor, or some other immediate help, how much could this person usually help?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

Question 6:

If you were confined to bed for several weeks, how much could this person help you?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

Question 7:

How long have you known this person?

1 = less than 6 months
2 = 6 to 12 months
3 = 1 to 2 years
4 = 2 to 5 years
5 = more than 5 years

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

Question 8:

How frequently do you usually have contact with this person? (Phone calls, visits, or letters)

5 = daily
4 = weekly
3 = monthly
2 = a few times a year
1 = once a year or less

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

PLEASE BE SURE YOU HAVE RATED EACH PERSON

9. During the past year, have you lost any important relationships due to moving, a job change, divorce or separation, death, or some other reason? [57]

_____ 0. No
_____ 1. Yes

IF YES:

9a. Please indicate the number of persons from each category who are *no longer available* to you.

_____ spouse or partner [58]
_____ family members or relatives [59-60]
_____ friends [61-62]
_____ work or school associates [63-64]
_____ neighbors [65-66]
_____ health care providers [67]
_____ counselor or therapist [68]
_____ minister/priest/rabbi [69]
_____ other (specify) _____ [70] [71-72]

9b. Overall, how much of your support was provided by these people who are no longer available to you? [73]

_____ 0. none at all
_____ 1. a little
_____ 2. a moderate amount
_____ 3. quite a bit
_____ 4. a great deal

Social Support Questionnaire

1. Por favor dígame cada persona que tenga importancia en su vida: cada persona que provee ayuda o le importa.

   Aquí tengo una lista de varias tipas de personas que posiblemente tengan importancia para Ud. Dígame cuales le importan. Use el nombre o iniciales. Después de nombrar cada persona diga el parentezco o relación, por ejemplo:

Nombre	Relacion
1. Juan	esposo
2. Maria	hermana
3. Sara	amiga
4. Luisa	vecina
5.	otro relaciones posibles: las personas de su trabajo, su médico o enfermera, el padre de su iglesia, o el ministro, etc.

   Voy a hacer unas preguntas con respecto a las personas de su lista. Para cada pregunta dígame la respuesta correcta para cada persona de su lista.

   1. nada
   2. muy poco
   3. moderadamente
   4. Bastante
   5. muchísimo

#1. ¿Cuánto sienta que esta persona la ama o gusta de Ud.?
#2. ¿Cuánto siente Ud. que esta persona le respeta o admira?
#3. ¿Cuánto puede Ud. confiar en esta persona?
#4. ¿Qué tanto está de acuerdo esta persona con sus pensamientos y acciones? o cuánto apoya sus pensamientos y acciones?
#5. ¿Si necesita un préstamo de $10.00 o transportación al hóspital u otra forma de ayuda immediata, cuánto pueda ayudarle esta persona?
#6. ¿Si se enferma y tiene que quedarse en cama por varias semanas cuánto puede ayudarle esta persona?
#7. ¿Cuánto tiempo hace desde que conoció a esta persona?
#8. ¿Con cuánta frecuencia tiene contacto con esta person? (por ejemplo llamadas por teléfono, cartas, visitas.)

   5. diariamente
   4. cada semana
   3. cada mes
   2. unas veces por año
   1. una vez por año o menos.

#9. ¿Durante el año pasado ha perdido relaciones importantes por mudanza, por cambio el empleo, divorcio, fallecimiento, u otra razon?

1. sí
2. no

9a. Por favor indique las personas a las que ya no tiene acceso, en la categoría que corresponda.

9b. ¿En general cuánto apoyo le fue provisto por estas personas a las que ya no tiene acceso?

APPENDIX C

Demographic Interview

Demographic Data

1 2 3 Number _____

1. Date of Birth_____

4 5

2. Marital Status: ___ 1. single, not living with partner
___ 2. married or living with partner
6 ___ 3. divorced or separated
___ 4. widowed

3. Educational level: the highest grade of school that has been completed:

7 8

Grade School								High School				College				Graduate School					
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	29	20	21	22

4. Ethnic background: ___1.Hispanic; __2.Caucasian; __3.Other

9

5. Yearly income: __1. $1000-2999 __4. $7000-8999
__2. $3000-4999 __5. $9000-10999
10 __3. $5000-6999 __6. >$10999

6. Birthplace of interviewee:

11 __1. U.S.A.; __2. Central America; __3. South America

7. Birthplace of interviewee's mother:

12 __1. U.S.A.; __2. Central America; __3. South America

8. Birthplace of interviewee's father:

13 __1. U.S.A.; __2. Central America; __3. South America

9. Duration of residence in Oregon:

14 __1. <6 months; __2. 6 months-1 year; __3. >1 year

10. Number of moves in the last year. _____

15 16

11. Number of persons who regularly live in household. _____

17 18

12. Employed outside of home. Yes__; No__

19

13. Language: __1. English __2. Spanish
__3. English & Spanish __4. Other_____

20

14. Parity: Number of children given birth to. _____

21

15. Number of living children. _____

22

16. Number of children currently living in household. _____

23

APPENDIX D

Scoring Sheet

Subject No. _____ [1-4]
No. in Network _____ [5-6]

SOCIAL SUPPORT QUESTIONNAIRE
Supplemental Scoring Sheet

Demographic Data: Age _____, Sex _____
Ethnicity _____, Education (yrs) _____
Marital Status _____
Type of Group _____ (e.g. dialysis patients)
[CARD 2]

	Relationship	Ques. 1	Ques. 2	Ques. 3	Ques. 4	Ques. 5	Ques. 6	Person Totals (from Ques. 1-6)	Ques. 7	Ques. 8
1.	[32]							[5-6]		[54]
2.	[33]							[7-8]		[55]
3.	[34]							[9-10]		[56]
4.	[35]							[11-12]		[57]
5.	[36]							[13-14]		[58]
6.	[37]							[15-16]		[59]
7.	[38]							[17-18]		[60]
8.	[39]							[19-20]		[61]
9.	[40]							[21-22]		[62]
10.	[41]							[23-24]		[63]
11.	[42]							[25-26]		[64]
12.	[43]							[27-28]		[65]
13.	[44]							[29-30]		[66]
14.	[45]							[31-32]		[67]
15.	[46]							[33-34]		[68]
16.	[47]							[35-36]		[69]
17.	[48]							[37-38]		[70]
18.	[49]							[39-40]		[71]
19.	[50]							[41-42]		[72]
20.	[51]							[43-44]		[73]
21.	[52]							[45-46]		[74]
22.	[53]							[47-48]		[75]
23.	[54]							[49-50]		[76]
24.	[55]							[51-52]		[77]
Question Totals										
		[7-9]	[10-12]	[13-15]	[16-18]	[19-21]	[22-24]		[25-27]	[28-30]

[67] Question 9 _____ 0 = No, 1 = Yes
[71-72] Question 9a _____ Category codes: [58] _____ [59-60] _____ [61-62] _____ [63-64] _____ [65-66] _____ [67] _____ [68] _____ [69] _____ [70] _____
[73] Question 9b _____

FIGURE 1

APPENDIX E

Example of Scoring for the Variable Total Functional

Figure A below represents that portion of the scoring sheet for the variable Total Functional. All of the ratings for individual network members for Affect (questions 1 and 2) will be summed to give an Affect score. Likewise, all of the ratings for Affirmation and Aid subscales will be summed. For a Total Functional score, the scores for Affect Affirmation and Aid will be summed as shown in Figure A.

Relationship	Ques.1	Ques.2	Ques.3	Ques.4	Ques.5	Ques.6
1. 3	2	3	3	2	2	2
2. 3	3	2	3	2	2	2
3. 2	3	2	2	2	2	3
4. 2	2	2	2	2	2	2
5.						
6.						
7.						
Question Totals	10	9	10	8	8	10

Fig. A

Affect: 10 + 9 = 19
Affirmation: 10 + 8 = 18
Aid: 8 + 10 = 18

Total Functional = 55

AN ABSTRACT OF THE THESIS OF

SANDRA INMAN

For the MASTER OF NURSING

Date of Receiving this Degree: June 10, 1983

Title: POSTPARTAL SOCIAL SUPPORT: A COMPARISON OF HISPANIC AND ANGLO MOTHERS

APPROVED: [redacted]

Mary Ann Curry, R.N., DNSc., Thesis Advisor

The purpose of this study was to compare and contrast the social support systems of Hispanic and Anglo women in the postpartum period. The investigator also wished to determine if Hispanic women experience significant losses in their support system due to immigration to Oregon.

This study was based upon the conceptual framework that the transition to parenthood represents a time of challenge and/or crisis for new parents. The degree of difficulty a new mother experiences in adapting to the changes the birth of a child brings, is influenced by many factors. One variable affecting the ease of transition may be the strength of the mother's social support system. Social support may have a buffering effect for those experiencing crisis or stress; socially supportive environments may facilitate a positive response to stressful life events.

For the Hispanic woman, who has traditionally experienced strong extended family ties, especially among the women of the family, mo-

bility may upset the traditional family structure and therefore her social support system, rendering her more vulnerable to the stresses of the postpartum period.

Two samples consisting of 25 Anglo women and 25 Hispanic women were selected by convenience on the postpartum floor of a metropolitan teaching hospital. The Anglo women were individually matched to the Hispanics for income, parity, age and marital status. The subjects were interviewed following delivery, during their stay on the postpartum floor. the Norbeck Social Support Questionnaire was the instrument chosen to measure the subjects' perception of social support. Additional demographic data was gathered to further describe the sample and rule out confounding variables.

The Anglo and Hispanic mothers in this study were of low economic status, tended to be married and have several children. An important difference between the two groups was that the Hispanics had significantly less education than the Anglos. There were no significant differences in the social support scores for Hispanic and Anglo women for any of the research questions. However, when the Hispanic sample was separated into foreign-born and native-born, significant differences were found in the perception of social support between these two subgroups. The foreign-born scored significantly lower on functional support, reported smaller social networks and less network loss than the native-born. The native-born Hispanics had larger networks than the Anglos and scored higher on functional support, perhaps reflecting the characteristic of familism generally attributed to the Hispanic family.

Foreign-born Hispanics tended not to name important family members

as network members nor as network losses. However, the fact that foregin-born Hispanic women had significantly smaller networks and named less than one-half the number of relatives that native-born Hispanics named in their networks, suggests that foreign-born Hispanics do suffer important losses in their social support systems. The investigator believes that the interview setting was inappropriate for sensitive data collection from Hispanic subjects and that the instrument used has certain ethnocentric biases. The measure of network loss was believed to be particularly inaccurate.

Other limitations of this study include the smallness of the sample sizes. Also, caution must be used in generalizing the findings pertaining to the Hispanic sample to other Hispanic populations. Oregon has a relatively small Hispanic population and Oregon Hispanics experience important differences in their social environment as compared, for example, to Hispanics living in Los Angeles.

This study points out the differences which exist among Hispanic women due to being native-born or foreign-born. Nurses should take this into account when caring for the Hispanic woman in order to provide optimal care. Because the foreign-born Hispanic woman typically has had a minimum of education, postpartum teaching may need to be adjusted so that the information presented is complete and well understood. Foreign-born Hispanic women reported smaller networks and scored significantly lower than the native-born on all the subscales of functional support: affect, affirmation and aid. Postpartum nursing care should emphasize the encouragement and affirmation of the Hispanic woman in her mother role. Nurses can also help these women to be aware of and use available resources.