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Perceptions of support by Mexican American women during their first pregnancy

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PERCEPTIONS OF SUPPORT BY MEXICAN AMERICAN WOMEN DURING THEIR FIRST PREGNANCY: A RURAL PERSPECTIVE

by

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THESIS

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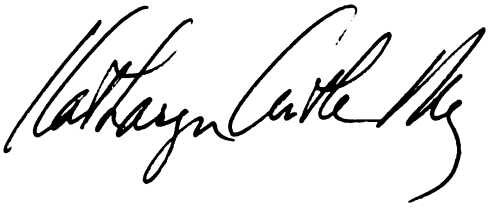
ABSTRACT

This pilot study explores the perceptions of support by rural Mexican American women during the course of their first pregnancy. A semi-structured interview has been given to a convenience sample of ten subjects drawn from the Fresno County area. This study is a descriptive exploratory study which aims to provide information on the social supports of this particular ethnic group. Suggestions are made for improving the health care of this ethnic group and for future studies.



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CHAPTER I

INTRODUCTION

Many nurses and other health professionals working with the Mexican American (M-A) population have little information regarding this group's identification and use of support systems as a means of coping with life transitions. A family's first pregnancy is a time of great change with potential for promoting health among all family members. Research is limited regarding the transition of pregnancy in the M-A culture. In particular, no study has systematically looked at who is identified as supportive in the M-A first-time pregnant woman.

Purpose and Significance

This exploratory study focuses on M-A women and whom they view as supportive during the course of their first pregnancy. This information can be used to expand the knowledge base of health professionals who provide care to first-time M-A mothers.

Pregnancy: A Transition in the Family Life Cycle

The family is defined as a system of inter-relationships among its members. The expectant parents* bring past childhood expericences with their respective parents into their present family system. During the

* Throughout this study 'expectant parents' refers to a first time pregnant woman and her partner experiencing their first pregnancy together.

transition to parenthood*, they may experience phases of disorganization, relearning and reorganization. This process is likely to produce stress.

Support As a Means of Adaptation and Growth

To promote successful adaptation and growth, the researcher recognizes the need for health professionals to help the family identify, develop, and maintain their emotional support systems. Briggs (1979) identifies three other areas in which caregivers can provide for the emotional needs of expectant parents besides mobilizing sources of support. These are:

1) ego strengthening and general supportive measures,
2) anticipatory guidance, and
3) help in specific crisis situations.

Pregnancy is a time when all three areas need recognition.

Support As Self-Care

The perceptions of support provide a basis for evaluating self care practices among M-A families and for determining the type and extent of emotional needs in first time pregnant M-A women. For instance, this information could be used in the design and implementation of programs for expectant parents.

* Transition to parenthood refers to the entire pregnancy period as the couple await the coming child.

Role of Health Care Providers

This study has further significance for health care providers and pregnant M-A women and their families for many reasons. It is important that health care providers and recipients share a common understanding of support. M-A women may have significantly different views than other women in the U.S. during their pregnancy.

If health care professionals are sensitive to cultural differences they can make appropriate changes in the care given to M-A women. For example, alternative sources of support could be identified for the M-A women found to be at high risk emotionally.

This knowledge can also be used to educate nurses and other health care providers to assume a facilitator role in helping M-A women and their families recognize and utilize their supports. This process may strengthen their abilities to cope, thus promoting a more positive pregnancy experience. Further knowledge can guide health professionals in the development of an assessment tool for pregnant M-A women to identify sources of support.

The findings of this study can direct caregivers in whom they include in the future care of the first-time pregnant M-A families. Ascertaining the type of support given provides further insight into how to include others in the pregnancy experience. The purpose is to decrease the stressfulness of this period and enhance adaptation to the new family member.

Assumptions

Awareness of certain notions from family theory can help nurses and other health professionals prevent a potential crisis during pregnancy. A few of these assumptions follow.

1) Relationships exist between the past and the present family systems.
2) The emotional growth of each expectant parent has an effect on the functioning of the expected infant.
3) Past experiences of each parent may not be resolved, producing conflicts. Resolution of these conflicts has significant impact on future parenting skills.
4) Specific emotional components characterize the pregnancy experience.
5) Women tend to be receptive to psychological intervention during pregnancy (Shereshefsky, 1973).
6) Psychological needs of expectant couples vary.
7) Resourceful social networks available to the family need recognition (Caplan, 1974, Briggs, 1979).

Research Questions

Questions to be investigated in this study are:

1) Who is identified as supportive? Would this be nuclear family, extended family, or others?
2) In what ways are the identified people supportive?
3) Why are the supportive people considered important?

4) In what ways might health care providers give more support?

Further questions raised are, do M-A women seek help during the transition to parenthood? If so, whom do they select and why? If not, might health care providers encourage the development of a support network based on cultural needs?

Preliminary Hunches

The researcher had hunches in mind as to what the findings would reveal. First, the pregnant woman's mother or another significant female in the family would be identified as the major source of support since women have traditionally relied on other women during pregnancy. "The practical, direct assistance usually comes from other women. In most cultures, daughters, sisters, mothers, mothers-in-law, co-wives, and other relatives and friends are regarded as the natural helpers of a woman during the childbearing process" (Mead, 1967, p. 192). In addition, the woman's husband might be identified as the major source of support due to the breakdown of the extended family.

CHAPTER II

REVIEW OF LITERATURE

Overview

This chapter reviews the recent literature regarding support as a significant factor in health care, including Mexican American (M-A) ethnic studies and, what is known about M-A support systems.

Support

A recent review of the literature revealed that individuals with a good support system adapt more successfully under stress than those who lack such systems (Cobb, 1976, Unger, 1980). Nucholls et al. (1972) reported one of few empirical studies that has attempted to investigate the relationship between stress and social support. This study found that women's adaptive potential during pregnancy was dependent upon not only the amount of stress involved, but also upon the nature and strength of the women's supportive networks. Hirsch (1980) also supported this contention. Since only a few studies had been done in this area, the need for further research was apparent.

A significant problem found throughout the literature was the wide variety of definitions used for social support. This study defined social support as "a set of presently significant others who are either members of one's family, friends, or affiliated professionals, e.g., nurse, physician, or clergy, who play an important part in

maintaining the psychological and physical integrity of the individual" (Hirsch, 1980, p. 160). Caplan (1974) also used this definition. Cobb (1976) measured support by classifying people's perceptions into the following three categories:

1) One feels cared for and loved.
2) One feels esteemed and valued.
3) One belongs to a network of mutual obligations.

Ideally, expectant parents will be able to utilize this emotional support during the pregnancy period. Some possible functions that supportive persons can provide include:

1) offering validation of expectant parents feelings and reinforcing the universality of their reactions,
2) relieving individuals of some of the intense home responsibilities,
3) functioning as emotional sounding boards by listening,
4) giving factual information, and
5) sharing in day-to-day physical and emotional experiences with the expectant parents (Briggs, 1979, p.78).

In order to apply these concepts to M-A families, researchers have to begin with an exploratory study of this population.

Ethnic Studies

Several researchers also identified the need for more studies to explore characterstics of ethnic families in health and health care (Litman, 1979, Martinez Jr., 1977, Cromwell, 1975). Staples (1980) indicated that studies of M-As prior to the 1960s were based on meager or non-existent data, producing an overgeneralized, negative image of the family. A further limitation was that many populations studied were drawn from only a few geographic areas in the U.S., characterized by a low socio-economic status. Thus, it was unclear whether the findings identified cultural or socio-economic factors.

With the minority movement of the early 1960s, M-A scholars, who had an insiders view, began questioning the validity of past minority studies. During the 1970s, research tended to depict the M-A family as a more positive, nurturing social unit. However, these positive findings about the family were often resisted and described by other researchers as resulting from acculturation* or assimilation.

Mexican American Support Systems

Further literature review revealed controversy about the effects of acculturation on the extended family kinship

* Acculturation (vs. assimilation) is a process whereby there are two groups, one in a dominant relationship over the other. The interaction between them results in the mutual adoption, as well as rejection of each other's values, beliefs, and behavioral patterns (Manzanedo et al., 1980, p. 1971).

network. Grebler et al. (1970) posed a theory of familial breakdown, stating that "relationships within the extended kinship group among Mexican Americans have declined in importance with increasing urbanization, acculturation, and contact with the dominant system." On the other hand, Keefe et al. (1978) found that the "extended family established in the U.S. by the immigrants increases in size and the extent of integration in the second generation and maintains its strength in the third generation" (p. 19). The researchers concluded that "both relatives and friends are relied on mainly as an informal day-to-day kind of emotional support system" (Keefe et al., 1978, p. 32).

Studies focusing on the organization of the M-A kinship network had found that:

> Females are more involved in kin affairs than are males. They bear the major burden of the general obligation to keep in touch with kin, and mother-daughter and sister-sister relationships are ordinarily found to be subjectively or attitudinally closer than are other sibling and parent-child relationships (Zinn, 1978, p.70).

The question arose as to whether acculturation had affected this process. Since M-As are a growing segment of the U.S. population, further research is needed to investigate their present day family support systems within various stages of the life cycle.

Furthermore, study designs should consider variation in kinship networks related to urban and rural residences of M-As. The 1970 census data revealed that "the Mexican American community is more highly concentrated in cities

. . . nearly half live in central areas of all large cities, 32% in the suburbs, and only 15% in rural areas " (Weaver, 1976, p.66). Unger (1980) suggested that the cultural values of the person's environment may influence the type of networks utilized.

In conclusion, the paucity of research about M-A women as well as their identified supports during pregnancy lends itself to the significance of this study.

CHAPTER III

METHODOLOGY

Since a review of the literature revealed a paucity of information about support during pregnancy within the Mexican American (M-A) culture, this small pilot study was done to explore this concept. This chapter presents in detail, the selected sample and techniques used for data collection.

Sample

Ten rural M-A women participated in this study. These women met the following critieria to be included in the study sample. They were:

1) volunteers for this study,
2) between 17-30 years of age,
3) second generation M-A (This means one or both parents were born in Mexico but the subjects were born in the U.S. If only one parent is of Mexican descent, it is preferable that this be the mother due to the passing on of culture which occurs more frequently among the women of the family),
4) in the third trimester of their first pregnancy,
5) experiencing no medical complications* during the course of their pregnancy, since this would bring additional stresses to the women and their families,

* Medical complications will refer to any problem in pregnancy which is not considered short term or self-limiting in nature, i.e., hypertension or heart disease.

6) able to understand and communicate in English, and

8) living in a rural area (defined by a distance of eight or more miles from the Fresno City Limits) in Fresno County, California.

Due to intergenerational differences among M-As the investigator used the following rationale for determining her criteria.

1) A predictable language barrier in the first generation posed a feasibility problem since the researcher is not fluent in Spanish.

2) A greater number of second generation M-As had the ability to speak and understand English.

3) There was less likelihood that the second generation M-A would be assimilated into the dominant Anglo-American culture, as compared with third generation M-As.

Specific Procedures

In order to obtain subjects, the investigator first approached this group through the Catholic Church in Selma, then contacted the medical director at the Parlier Family Health Center, and finally contacted the medical director at the Selma Family Health Center. All three approaches were necessary to obtain subjects. Most subjects were found through the Selma Health Center. Rationale for selecting these sites were:

1) the high percentage of M-A women who may attend Catholic Church or receive health care through

either of these health sites;

2) the rural location of these sites (defined by a distance of eight or more miles from the Fresno City Limits) was in Fresno County, California; and

3) the time and convenience offered to the researcher.

After describing the purpose and significance of this study to the church pastor and the medical staff they decided to accept the researcher's request to help in obtaining subjects. The following steps were taken until the sample size was obtained.

1) A copy of the proposal remained at the church and clinic sites for reference.

2) The name and phone number of the researcher was available for the staff and subjects should any questions/concerns have arisen.

3) The names, addresses, and phone numbers were taken from all volunteers at the church. At the clinics, lists were compiled by the researcher identifying first-time pregnant women with a Spanish surname who received prenatal care there.

4) The researcher then contacted these women by phone. The study was described and the criteria for subjects reviewed. Those interested in participating as volunteers had an interview arranged.

5) Names of those planning to be interviewed at the clinic sites were given to the respective receptionists for prompt referral to the researcher

in case of inquiries.

6) Before each interview began, the researcher first reviewed the consent form for complete understanding by the subject and obtained the volunteer's signature. A copy of the consent form was given to each interested volunteer.

Risks - Benefits for Subjects

It was emphasized to all volunteers that the results of this study may not benefit them directly, but may improve the health care of other first-time pregnant women and their families. Husbands and other family members were welcomed to hear about the study even though they were not interviewed. (See appendices A and B.)

Interviewing other family members could have provided other perspectives around the study questions and thus verified or refuted information gathered from the women. The investigator chose, however, not to interview other family members due to possible language problems with those who could not speak English, and the time commitment for the families and researcher alike. In addition, analyzing data gathered just from the women was more manageable within the time frame of the investigator.

The investigator acknowledged the potential benefit of studying both urban and rural groups of M-A women and their families due to differences and similarities that could have existed in their use of support. Factors which could have influenced the respective settings included population size,

cohesiveness of the family unit, family roles, friendship networks, occupation, life-style, self-care practices, and resources available.

Before a study of this magnitude could be attempted, independent, small-scale studies in both urban and rural areas were needed to begin exploring what was happening in the respective locales. The researcher concentrated her work in the rural Fresno area and looked closely at the support given a small number of first-time pregnant women, without making inferences to this total rural population. The goal of this study was to gain some understanding of what was occuring in a small portion of this community. This may guide a larger, more generalizable study in the County of Fresno.

Techniques of Data Collection

Through a search of the literature and contact with experts in the fields of social support, pregnancy, and M-A culture, the investigator did not find an appropriate tool for measuring support in the M-A population. Consequently, the semi-structured interview tool used in this study was designed by the researcher with suggestions from these experts. Once the questionnaire was complete it was reviewed by experts to assess its validity as a tool. They looked at the content, methodological format, and wording of the questions for comprehension. Appropriate revisions were made.

Interview Guide

The researcher used a semi-structured interview to obtain the woman's perceptions and feelings regarding who was supportive. This interview was conducted in the participants' home or their clinic site. Observing the interaction between the participants and others provided the researcher with verbal and non-verbal cues alluding to the type of relationships and communication patterns that existed, as well as how support was offered and received.

A pilot interview was carried out with two volunteer M-A pregnant women, although not all criteria for subjects were met. They seemed comfortable with the questions asked as seen in their expressions and heard in their responses.

All the subjects were willing to have the interview taped. The researcher found this tool invaluable as it provided a method of checking the accuracy and completeness of notes. It also was used as a reminder of those comments given particular emphasis by each subject.

CHAPTER IV

Findings and Analysis

This chapter first presents the demographic characteristics of the population interviewed, and then discusses subjects' responses to questions about support received during pregnancy.

Demographic Characteristics

Demographic characteristics of the sample are listed in Appendix IV. The following is a summary of those data giving an overview of the 10 women at the time they were interviewed.

1. GESTATIONAL AGE: All were in the third trimester (the last three months) of their first pregnancy.
2. AGES: Ages ranged from 17-28 with a mean age of 20.
3. CULTURAL GENERATION: All were second generation Mexican American (M-A), i.e., at least one parent was born and raised in Mexico, arriving in the U.S. prior to the subject's birth.
4. PLACE OF BIRTH: Seven were born in California while others were born in Arizona, Texas, and Nebraska.
5. MARITAL STATUS: Half were married, while the others maintained a close relationship with the father of the baby (FOB).
   A. All husbands were born in Mexico.
   B. All those married became pregnant after their marriage.
   C. Single mothers had known the FOB between 6

months and 3 years prior to pregnancy.

6. LANGUAGE:

   A. While growing up,

      6 spoke Spanish as the primary language

      2 spoke both English and Spanish; and

      2 spoke English as the primary language.

   B. Presently,

      5 speak Spanish as the primary language;

      3 speak both Spanish and English, dependent on with whom they are speaking; and

      2 speak only English.

7. EDUCATION: All 10 women were educated through the 11th grade. Three had 1-4 years of college. 7 had 2-8 more years of schooling than did their respective partners.

8. EMPLOYMENT: 8 women were presently unemployed. 2 were working as receptionists at a health clinic. All subjects' partners were working.

9. FINANCIAL STATUS:

   A. 5 Women stated their income was barely adequate to meet their financial obligations. Of these,

      3 received governmental financial aid;

      1 received money from her boyfriend; and

      1 was employed without health insurance.

   B. Of the 5 women who felt their income was adequate,

4 received governmental financial aid; and,

1 was employed with health insurance.

10. HEALTH CARE: All the women were receiving health care from a health professional;

8 from a community health center, and

2 from a private physicians' office.

11. PROXIMITY OF KEY SUPPORTIVE PEOPLE TO THE SUBJECT:

Mother:

2 lived with her;

5 lived within 5 miles from her;

2 lived within 15 miles from her; and

1 lived greater than 100 miles from her.

Partner:

All 5 married women lived with their husbands.

All 5 unmarried women lived within 5 miles of their boyfriends.

Siblings:

All but 1 subject had at least 1 sibling living within 15 miles of them.

Friends:

5 women stated that their close friends lived within 15 miles. In many cases the women had known these friends since grammar school.

Women's Perceptions of Support Given During Pregnancy

The data in Appendix E shows who was identified as the 1st, 2nd, or 3rd person offering the most help, how these persons were helpful, and why they were seen as supportive. It is important to know that the person perceived by these pregnant women as the one they could consult about anything was usually the same person perceived as most helpful during the pregnancy.

Persons Who Gave Support

Those viewed as most supportive by the women interviewed can be seen in Table I. Clearly a female relative was viewed as the most helpful person. Note that even when combining all three choices, 53% were female and 81% of these women were relatives. The gender of health care providers is not known.

Type of Support Given

Several women perceived more than one person as helpful for different reasons. For example, subject A-6 perceived her husband as supportive because he talks and shares things. Her mother was a source of good advice. The health professional provided a physical exam giving a sense of reassurance that the pregnancy was going well. Table II shows who gave what type of support and how often each type of support was mentioned as an important source of help.

Both mother and health professional were seen as giving advice, the source of support mentioned most often.

TABLE I

Identified Support Persons During First Pregnancy

A: 1st Identified Supportive Person

Number	%	Support Person Selected
4	40	Mother
2	20	Sister
1	10	Female Friend
2	20	Partner
1	10	Health Professional
Total 10	100	

B: 2nd Identified Supportive Person

Number	%	Support Person Selected
2	20	M-I-L
1	10	Mother
2	20	Sister
2	20	Female Friend
2	20	Partner
1	10	Health Professional
Total 10	100	

C: 3rd Identified Supportive Person*

Number	%	Support Person Selected
3	75	Health Professional
1	25	Female Friend
Total 4	100	

* Only 4 women mentioned a third supportive person.

TABLE II

Type of Support Given, By Whom, & How Often

	Types of Support Given					
	Gives Advice	Talks	Shares Similar Experience	Shows Concern	Gives P.E.	Gives Resources
By Whom						
Mother	5*	3	3			
Sister	1	1	1	2		2
M-I-L	2	1	1			
Husb/BF		2	3	1		
Friend	1	3	3	1		
H.P.	5		1	2	5	1

Key: P.E.=Physical Exam; H.P.=Health Professional (Doctor, Nurse); BF=Boyfriend; M-I-L=Mother-In-Law

* Numbers represent how often the women mentioned receiving help from these supportive persons. There are multiple responses for each subject, thus totals do not add up to ten.

Factors Affecting Selection of Support Persons

Women stated they selected supportive persons because of their 1) availability, 2) ability to exchange one form of help for another , 3) ability to share similar experiences (i.e., pregnancy, schooling), and 4) role expectations of particular family members in how they would relate to a pregnant women, i.e., "He's my husband" or "She's my mother."

Persons Not Identified as Supportive

Never was a subject's father or other male family member (i.e., brother, uncle, grandfather, or godparent) mentioned as supportive.

Professional persons and institutions were viewed as minimally supportive. In fact, only one subject reported the clinician to be the most helpful person during pregnancy, while others identified him as second or third most helpful. It is significant to note that despite these findings, every subject was receiving health care from a health professional. No one claimed to be receiving care from a cuarandero.

No question was asked to directly ascertain why a particular individual was not perceived as helpful during this transition. However, some women volunteered this information through discussion. The following are a few examples:

1) One subject said she would ask the clinic staff questions but often received advice which directly

conflicted with advice given by her mother. Her mother was perceived as most helpful.

2) Four subjects stated that they were close to their husbands but did not consider them helpful during pregnancy because it was also the husband's first experience with this transition. These women received little information or reassurance from their husbands.

3) One subject stated that although her mother was her confidant, it was the clinic personnel who told her what community resources would help her during her pregnancy. She found this most helpful.

Support from Non-Relatives

Lay Groups

To understand what other social or out-of-the-family type supports were utilized and how, the following questions were asked:

1) Have you participated in any church groups or organizations? (PTA, La Raza) How frequently?

2) Has this group been a source of friendship, help, recreation, or obligation?

Five women stated they had gone to church in the past for reasons of consolation or meeting with friends. "It gives a way to share experiences and to know what's right and wrong," stated one woman. However, none of the subjects presently belonged to any group or club.

Perhaps more significant is the fact that three of

these women were churchgoers and none of them identified the clergy as one of the most supportive persons throughout their pregnancy.

Health Professionals

Interview questions were asked to determine 1) where and from whom health care was received for this pregnancy, 2) who was most helpful in that setting (receptionist, nurse, clinician), and 3) in what ways those persons were helpful (providing materials, classes, talking/listening, or counseling). Findings are listed in Table III. Subjects' responses to questions 7 through 10 are charted in Appendix F.

Women's Suggestions for Improving Health Care

A final interview question addressed how health professionals might better support M-A women during their first pregnancy. Eight of the women could identify ways to improve support provided by health professionals. These women made the following suggestions:

1) Four women recommended that the waiting period prior to an office visit be shortened. However, if there is a wait, consider some type of educational media with significance to pregnant women, i.e., cassette tapes, reading materials, or even video cassettes, could be offered. Specific areas mentioned included labor and delivery, nutrition in pregnancy, and common problems in pregnancy.

TABLE III

Source of Care, Type of Help, and Professional Viewed Most Helpful

A: Source of Health Care	Number	%
Doctor's Office	3	30
Clinic (Community Health Center)	7	70
Total	10	100

B: Health Professional Most Helpful*	Number	%
Doctor(MD)	4	40
Nurse Practitioner(NP)	3	30
Physician Assistant(PA)	2	20
Nurse(RN)	1	10
Total	10	100

C: Type of Help Given by Health Professionals**

	Health Professionals			
Type of Help Given	MD	NP	RN	Clinician***
Gives Physical Exam	2	2		2
Gives Reassurance	1	2		1
Gives Advice	3	2	1	1
Instills confidence and Trust	3	2		1
Is informative	2	1	1	
Gives Pamphlets		1	1	1
Listens	1	1		1

* It is unknown how many women may have referred to the NP or PA as their doctor.

** There are multiple responses for each subject, thus numbers do not add up to ten.

*** Clinician refers to whomever provided care (MD, NP, or PA).

2) Several women suggested that more written information be given within the first few office visits. They felt it would be helpful to receive pamphlets and instruction sheets describing common features of pregnancy.
3) One subject requested more information regarding how she could obtain financial aid and/or baby furniture and clothing which she could not afford to purchase.
4) One subject requested that health professionals be more responsive. She commented that, "It makes me feel like my question is OK and not stupid when my doctor returns my call."
5) Four perceived it could be more helpful to them if the health professional would initiate discussion during the office visit of topics and common concerns of pregnancy. 60% of these women stated that it is sometimes hard to remember their questions at the time of the visit, or they are embarrassed to ask questions for fear of appearing stupid or uninformed.

Summary

In summary, about half the women selected either their mother or a sister as the most helpful person during their first pregnancy. They gave many reasons for their reliance on this person. Most women mentioned that they selected particular people as supportive person because the person

was available, could give advice, and/or was able to share in daily or weekly thoughts or events.

The health professionals were viewed as helpful because they provided advice and reassurance that all was well via the physical exam. Women requested more initiation of discussion to questions and common problems in pregnancy. They also suggested the use of more audio-visual aids during the waiting period associated with the office or clinic visits. The significance of these requests is presented in Chapter V.

CHAPTER V

DISCUSSION of FINDINGS

This final chapter discusses the findings in relation to the research questions and assumptions posed in chapters I and II. Gaps and limitations in this study are stated, as well as potential areas for further research. Given the small number of subjects in this study, findings have limited generalizability and only tentative suggestions can be made about how to improve nursing services to Mexican American (M-A) pregnant women.

Limitations

Two major limitations of this study are 1) the small sample size , and 2) the case-study, descriptive approach used for data collection and analysis.

The case study approach lends itself to description of subject characteristics and perceptions, but does not allow an analysis of causal relationships because of the lack of control over the variables. Familial processes, and the effects of assimilation/acculturation on the supportive networks of the M-A woman are too complex to be adequately understood through data obtained by a purely descriptive study.

Little data was gathered in this study regarding some potentially important factors. For example, the number of persons at home during the interview may have influenced pregnant womens' responses about their supportive network. Only subjective observation could give any information as to

whether this was so. In addition, it is difficult to determine whether these pregnant women gave complete and accurate information in response to the interview questions. The assumption is that they did. However, the researcher is aware that these women may not be as frank with female researchers of another culture as they may be with a female researcher from their own culture.

Summary of Findings

Demographic Characteristics

The ten subjects interviewed were second generation M-A women in the third trimester of their first pregnancy. Their mean age was 20. Although only half were married, all were in close contact with the father of the baby. Nine women lived within five miles of their parents and/or in-laws.

Reasons for Selecting Support Persons

Seven women reported their mother, sister, or female friend as most helpful for reasons of availability, closeness, past experience with pregnancy and child rearing, and, sharing in daily or weekly events.

More than one person was perceived as supportive during the transition through pregnancy. A variety of reasons were given for this. One woman stated that the clinician gave her a sense of reassurance via the physical exam, yet, her mother was available and ready to give advice. It was important to many of these women that the support person be someone who had already experienced childbearing and child rearing.

Types of help given

Getting advice was mentioned most often as the type of support received, especially by the subjects' mother or health care provider. Other types of support mentioned were talking, sharing similar experiences, feeling cared for, receiving a physical exam, and being referred to appropriate resources. It is interesting to note that all the women found their partner of no help when it came to getting advice about pregnancy because, as one woman put it, "It's their first experience too!".

Help from Health Professionals

The clinician was most helpful in the office setting, although mentioned as most supportive only once, overall. Suggestions for increased help from the clinicians were given. Women asked that the wait be shortened prior to the clinicians' visits, and that more information be given during the wait. Perhaps most significant was the women's suggestion that during each visit the clinicians initiate discussion of topics related to pregnancy and childrearing.

Discussion

Previous Research Extended

Some responses to the research questions posed in this study extend previous findings. The perceived support of a female relative or friend during the first pregnancy lends support to Zinn (1978) who found that Chicano females are more involved in kin affairs and that "mother-daughter, sister-sister relatonships are ordinarily found to be

subjectively or attitudinally closer..."(p.70). This may suggest that M-A women are quite different than women in general as to whom they select as supportive during pregnancy.

The findings of this study are also consistent with Mead's research (1967) which found it common in most cultures for a woman to regard all other women as natural helpers during the childbearing process.

Findings from this study are consistent with Briggs' (1979) analysis of the possible functions that supportive people can provide. For instance, women in this study identified strongly with reassurance, a sense of trust in the clinician, and advice from their mother. These general supportive measures provided not only anticipatory guidance but also ego strenthening.

Emerging Themes

This study contributes new information on women's perceptions of how health care could be improved. No studies have systematically addressed this issue. Findings from this study suggest that audio-visual materials be available in the waiting room. This includes items such as video cassettes about 1) danger signs of pregnancy, 2) nutrition, 3) the process of labor and delivery (L&D), or, 4) care of your newborn. Also, pamphlets might be given to expectant mothers at their first prenatal visit to the doctor. This would give the women a chance to read interesting material and have questions ready for the

clinician. The clinician could then follow this up with the initiation of such topics as 1) sex during pregnancy, 2) the process of natural childbirth, 3) cesarean section, and 4) the father's role in labor and delivery.

Previous Research Not Supported

Data from this study did not support one finding of previous research. Keefe et al. (1979) viewed clergymen as a source of support. No women interviewed in the current study selected a clergyman as 1st, 2nd, or 3rd supportive person during pregnancy. A few women mentioned clergy as giving helpful advice, but he was not viewed as an important source of support. Few subjects were churchgoers. This finding may be related to the particular characteristics of these subjects and not to all M-A pregnant women.

Implications for Future Research

Validation of this study through replication with a larger sample of M-A women is necessary before findings can be generalized to other M-A first time pregnant mothers. A larger sample size and selection of women from other cultural or ethnic backgrounds is needed to systematically study the extent to which M-A women differ from other women with respect to extent, type, and use of a support network.

A key question is whether there is increased stress and isolation in pregnancy for the MA woman who lacks these supportive family members. Data obtained in this study are not adequate to determine the extent to which absence of support is related to any specific problems or the degree to

which lack of a support network may enhance the pregnant woman's susceptibility to stresses or disease. Further studies are needed to determine the relationship between support and physical or mental health during pregnancy (Nucholls et al., 1972, p.440).

Nursing Implications

Should there be a relationship between social support during pregnancy and a family's adaptation to stress, it would be important to address several potential implications for the design and delivery of services to M-A families during important life transitions such as pregnancy. We might anticipate this relationship and begin by identifying supportive people for M-A women in their first pregnancies.

At a general level, a tentative suggestion would be for health care providers to consider the social contacts with whom M-A women function. To do this, it would be important for health care providers to consider the following:

1) Take an accurate social history to identify who and how support is provided;
2) Be sensitive to the 'total' person, i.e., cultural as well as social, psychological and biological aspects;
3) Help the client identify potential supports and then maintain these supportive networks;
4) Encourage incorporation of the identified supportive people into the health care system (i.e., encourage mother, sister or another female

friend to attend prenatal classes, along with the couple);

5) Encourage discussion of advice given by the woman's mother and how this may or may not relate to the health providers' advice, thus reducing potential conflicts for the M-A woman. Encourage the mother's participation in office visits also;

6) Initiate further discussion of prenatal topics rather that simply asking if there are any questions. For example, identify constipation as a common problem during pregnancy. Identify what laxatives are acceptable to the M-A culture and suggest alternative ways that women have dealt with this problem.

Implications for Health Policy

Pregnancy history forms usually do not allow the clinician to systematically include the extent or adequacy of a pregnant woman's supportive network. Even the widely-used holister forms do not include this particular aspect of care. The lack of such a history form may be due to several reasons.

First, support is more a sociological rather than a medical aspect of health; thus, it may have been overlooked. Second, the importance of support in the M-A pregnancy has not been established due to the paucity of research on this topic.

The researcher recommends getting this social

information in anticipation that it may be very useful in prevention of problems during pregnancy for M-A women.

Conclusions

This study found that many M-A pregnant women heavily rely on female family members for support during pregnancy. The findings support previous research done on M-A families and their important role in providing support to their members. More studies are needed to validate this study's findings and describe differences between cultural groups.

This study suggests that female relatives are seen as the most supportive persons throughout the M-A women's first pregnancy. Findings suggest that health care providers evaluate the woman's support system at the onset of pregnancy, since lay supportive networks appear to make an important contribution to women's well being during pregnancy.

There remain many unknowns surrounding the impact of support systems on the transition to first time motherhood. Further research in this area is necessary. Hirsch (1978) states, "Understanding and promoting the health-enhancing capacibilities of such informal social structures is an important task of all health care providers" (p. 172).

Further research will provide the information necessary to add to our current knowledge and provide health professionals with the empirical base necessary to improve or enhance support provided to M-A women during their first pregnancy.

Appendix A

CONSENTIMIENTO PARA PARTICIPAR EN ESTA INVESTIGACION

INVESTIGACION: MEXICO-AMERICAN WOMEN'S PERCEPTIONS OF SUPPORT DURING THEIR FIRST PREGNANCY: A RURAL PERSPECTIVE

INVESTIGATOR: Charlene Lund **TELEFONO:** 225-3164

Charlene Lund es una enfermera graduada y esta estudiando en la Universidad de California, San Francisco, Escuela de Enfermeria. El proposito de este estudio es el de ganar y obtener informacion de las madres que tienen su primer bebe, para saber que personal le dan ayuda o guia durante el embarazo.

SU PARTICIPACION ES COMPLETAMENTE VOLUNTARIA. Charlene Lund se comunico conmigo por medio de la clinica de Selma y yo estoy de acuerdo en que ella venga a mi casa para una entrevista, o en cualquier otro sitio que yo escoja. La senorita Lund hablara conque personas que me dan ayuda o guia por mis preocupaciones durante el embarazo.

La conversacion sera gravada, pero yo tengo el derecho de refusar a la gravacion si yo quiero. Yo tambien tengo el derecho de refusar a la participacion o retirarme de este estudio a qualquier momento que yo quiera sin ninguna consequencia.

La Senorita Lund me confirma que la informacion que yo lo de sera mantenida confidencialmente con todas las precauciones necesarias para proteger me nombre, pensamientos y mis sentimiento como participante.

Quizas los resultados de este estudio no me van a dar ningun beneficio directo, pero si ayudaran a mejorar el cuidado de salud de otras madres embarazadas por primera vez y sus familias Mexico-Americanas.

Si yo tengo alguna pregunta yo puedo llamar a Charlene Lund y tambien se me ha ofrecedo una copia de esta forma.

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FECHA FIRMA

Appendix B

CONSENT TO BE A RESEARCH SUBJECT

INVESTIGATION: MEXICAN AMERICAN WOMENS' PERCEPTIONS OF SUPPORT DURING THEIR FIRST PREGNANCY: A RURAL PERSPECTIVE

INVESTIGATOR: Charlene Lund **PHONE NUMBER:** 225-3164

Charlene Lund is a nurse and graduate student at the University of California, School of Nursing. The purpose of her study is to gain information from first-time pregnant women about who helps them and in what ways these people are helpful during the course of their pregnancy.

Charlene Lund first contacted me through the Selma Family Health Center and I agree to have her come interview me in my home or another location of my choice. Ms. Lund will talk with me for about 1 1/2 hours. She will ask me questions about who has helped me with concerns related to my pregnancy. The conversation will be tape-recorded, but I have the right to refuse the tape-recording if I want to. I also have the right to refuse to participate or to withdraw from the study at any time without harming myself.

Ms. Lund states that any of the information I share will be kept as confidential as possible and that every precaution will be taken to safeguard my name, thoughts, and feelings as a participant.

While the results of this study may not benefit me directly, they may improve the health care of other Mexican American women and their families who are pregnant for the first time.

If I have any questions or concerns I may call Charlene Lund.

_____ _____

DATE SIGNATURE

APPENDIX C

INTERVIEW GUIDE

DEMOGRAPHIC DATA

1.	M F H B		1. Where was your Mother (M) born? Father (F)? Husband (H)? Boyfriend (B)?
1. Mexico	_ _		
2. U.S.	_ _		
3. _____	_ _		
9. _____	_____		
2. a,b,c, & d	M F H B		2. When did your Mother come to the U.S.? Your Father? Your Husband or Boyfriend?
1. before 1920	_ _		
2. 1921 - 1930	_ _		
3. 1931 - 1940	_ _		
4. 1941 - 1950	_ _		
5. 1951 - 1960	_ _		
6. 1961 - 1970	_ _		
7. Do not know	_ _		
9. _ _	_ _		
3.			3. What state were you born in?
1. California			
2. Arizona			
3. New Mexico			
4. Texas			
5. _____ write in			
9. _____			
4. ____ ____ ____			4. What is your birthdate?
Mo. Day Year			
5. a, b, c, d, e, f	M F m f H B S G Gl C O		5. Where do the following people life in relation to you?
1. with you	_ _		a. Parents (M, F)
2. 1 to 5 miles	_ _		b. In - laws (m, f)
3. 6 - 15 miles	_ _		c. Husband/Boyfriend(H/B)
4. 16- 30 miles	_ _		d. Mother's parents(G)
5. 31 - 50 miles	_ _		e. Father's parents(Gl)
6. 50 - 100 miles	_ _		f. Siblings (S)
7. Greater than 100 miles away	_ _		g. Compadres-godparents(C)
9. _ _	_ _		h. Other (O)
6. 1. Spanish			6. What language was spoken h when you lived with your parents while growing up?
2. English			
3. _ _ (write in)			
9. _ _			

APPENDIX C (Cont.)

7. 1. Spanish
   2. English
   3. _ _ (write in)
   9. _ _

   7. What language do you speak most often at home now?

8.		V	H	B
1.	Grade 1 - 8	_		_
2.	Grade 9	_		_
3.	Grade 10	_		_
4.	Grade 11	_		_
5.	Grade 12	_		_
6.	Beyond H.S.	_		_
9.	_ _	_		_

   8. a. What grade did you complete in your education/schooling? (V=volunteer)
   b. Your husband?

   (H.S. = High School)

9. a.
   1. Yes
   2. No
   9. _ _ (write in)

   b._ _ (write in)

   9. a. Do you work?

   b. What do you do?

10. a.
   1. Yes
   2. No
   9. _ _

   b. _____(write in)

   10. a. Does your husband/boyfriend work?

   b. What does he do?

11. a.
   1. Yes
   2. No
   9. _ _

   b.1. Yes
   2. No
   9. _ _

   11. a. Are you receiving any financial support? (WIC, food stamps, unemployment, or $ from others).

   b. If no, would you say you have enough to live on?

12.		M	T
1.	1 year		
2.	2 years		
3.	3 - 5 years		
4.	6 - 10 years		
5.	Greater than 10 years		
9.	_	_	

   12. a. How long have you been married?(M)
   b. How long have you been together?(T)

13. 1. Clinician _ _(specify)
   2. Curandero _ _(specify)
   3. Family member_ _
   4. None
   5. _ _(write in)
   9. _ _

   13. Who do you receive most of your health care from?

APPENDIX C (Cont)

SUBSTANTIVE DATA
(Comments)

1. Was there anyone with whom you could talk about yourself, your husband/boyfriend, your pregnancy, plans for the baby, any concerns/problems, or anything else during the course of your pregnancy?

2. Who is it that you talked with most? Shared secrets with, confided in) How frequently did you talk with this person?

3. Would you say this person has been the most helpful during your pregnancy? (most important?) If not, who has been?

4. How has this person been most helpful?

5. Why did you find this person helpful?

6. a. Have you participated in any church groups or organizations? (i.e.,PTA, La Raza) How frequently?

   b. Has this group been a source of friendship, help, recreation, or obligation?

7. Have you been receiving health care for your pregnancy?

8. If so, from whom?

9. Who has been most helpful in that setting? (Receptionist, Nurse, Clinician)

10. In what ways have they been helpful? (reading materials, classes, talking/ listening, counseling)

11. Are there any ways that you might have been helped more? (A-V materials, pamphlets, initiating discussions of common questions or concerns during pregnancy)

APPENDIX D

CHARACTERISTICS OF SUBJECTS

Subjects	A-1	A-2	A-3	A-4	A-5	A-6	A-7	A-8	A-9	A-10
Character-istics										
Place Born										
Mother	Mexico	Mexico	U.S.-TX	Mexico	U.S.-CA	Mexico	Mexico	Mexico	/U.S.-Tex	Mexico/
Father	U.S.-AZ	U.S.-CA	Mexico	Mexico	Mexico	U.S.-CA	U.S.-TX	Mexico	Mexico	U.S.-CA
Husb/Byfrd.	Mexico/	/U.S.-TX	Mexico/	/Mexico	/U.S.-CA	Mexico/	/U.S.-CA	Mexico/	/U.S.-CA	Mexico/
When came to U.S										
Mother	'58	'56	N/A	'54	N/A	'61	'58	'54	N/A	'54
Father	N/A	N/A	'54	'58	'51	N/A	N/A	'54	'63	N/A
Husb/Byfrd.	'58	N/A	N/A	'71	N/A	'79	N/A	'69	N/A	'70
Where Born	AZ	CA	CA	CA	CA	NE	CA	CA	CA	TX
Present Age	28	18	20	19	20	20	17	21	18	26
Weeks left in pregnancy	2	1	10	6	11	4	12	Overdue	10	11
Where live in Relation to Subject										
Mother	With	Next Door	With	With	With	>100 mi.	With	1 Block	1 - 5 mi.	15 mi.
Father	With	Next Door	With	> 100 mi.	Died	>100 mi.	With	1 Block	>100 mi.	15 mi.
M-I-L	>100 mi.	>100 mi.	Mexico	3 mi.	5 mi.	With	1 - 5 mi.	With	Mexico	Mexico
F-I-L	>100 mi.	1 Blk.	Mexico	3 miles	5 mi.	With	1 - 5 mi.	With	2 miles	Mexico
Husb/Byfrd.	With/	w/Father	With/	w/parents	w/parents	With	w/parents	With	w/father	With
Siblings	1 - With 1 - 5 mi. 1 -15 mi.	1 - With 3 w/Parents	6 -15mi. 1 - Tex. 1 ->100mi.	6 - 2 mi. 2 - > 100mi.	2 - With 8 - 5 mi. 1->100 mi.	8 are>100 miles	2 - N Calif 2 -(1-5)mi.	5 (15)mi. 1 - Tex. 1 - N. Ca.	2 >100mi 2 (15)mi.	2 w/parents 8 - 5 mi. 1->100mi.
Mat-Grdfolks	1-Died, 1 >100mi.	Both 1 Blk.	1 - Died 1 >100 mi.	Both >100mi. in Mexico	Both Died	>100 mi. in NE	Both Died	2 miles	Both>100mi in TX	Both Died
Pat-Grdfolks	Both-1blk	Both >100 mi.	1 - Died 1 >100 mi.	Both- Died	Both >100 mi. - Mex.	>100 mi. in CA	1 - 5 mi.	1 - Died 1-(2)Blks	Unknown	Both Died
Godparents	Had None	5 mi.	Unknown	Had None	Had None	Unknown	Unknown	Had None	Had None	Had None
Other	Friend 15 mi.	--	--	Best Friend Next Door	--	Friend 15 mi.	--	--	Friend Next Door	Friend miles
Language While Growing Up	Spanish	Eng/Span	Eng/Span	Spanish	Eng/Span	Spanish	Spanish	Spanish	English	Spanish
Language Now Spoken	Spanish	English	Spanish	Spanish	Eng/Span	Eng/Span	Spanish	Eng/Span	English	Spanish
Education-Yrs										
Subject	13	12	11	11	12	12	10	13	11	16
Husb/Byfrd.	8	10	8	11	(?)12	10	10	11	8	6 (in Mex.)
Working Now - Yes/No (Y/N)--Doing What										
Subject	N	N	N	N	N	Y/Receptnst	N	N	N	Y/Rcptnst
Husb/Byfrd	Y/Fields	Y/Mechanic	Y/Fields	Y/Busboy	Y/Fields	Y/Fields	Y/PackHse	Y/Driver	Y/-Pack Hse	/Y-PackHs
Financial Aid(Y/N)	Y	Y	Y	N	Y	Y	Y	Y	Y	N
Type	Med-i-cal	Med-i-cal	Med-i-cal	Byfrd Supts.	WIC,Fd.Stp	WIC	Fd.Stp,Welf	Insurance	Fd. Stp.	None
Making it OK	Y	Y	Barely	Barely	Barely	Barely	Y	Y	Y	Barely
How long known each other	2 1/4 yrs.	3 3/4 yrs.	2 3/4 yrs.	1 1/4 yrs.	3 1/4 yrs.	2 3/4 yrs.	2 1/4 yrs.	3 3/4 yrs.	1 1/4 yrs.	5 3/4 yrs.
married	9 mos.	N/A	5 mos.	N/A	N/A	1 year	N/A	1 1/2 yrs.	N/A	2 yrs.
Who provides Health Care	Doctor	Community Health Ctr	Community Health Ctr	Community Health Ctr	Community Health Ctr	Community Health Ctr	Community Health Ctr	Community Health Ctr	Community Health Ctr	Doctor

Appendix E

Characteristics of Support Networks for Present Mexican American Women

Subj.	Support Person *	Reason for Selecting Support Person (Direct Quotes)	Type of Support Given (Key Words)
A-1	1-Physician	"He takes care of my baby"	Does Physical Exam
	2-Friend	"I see her everyday"	Talks, Gives Advice
A-2	1-Sister	"She helps with everything (clothes, $, advice)"	Gives Advice
	2-Physician	"Tells me to call with ?s"	Does Physical Exam
	3-FNP	"They see alot of pregnant women"	Gives Direction
A-3	1-Mother	"I talk with her every day"	Talks, Gives Advice
	2-Sister	"She has 4 kids"	Has Experience
	3-Clinic Staff	"They ask me ?s about about me and the baby"	Shows Concern, Gives Resources
A			
A-4	1-Mother	"I see her 3-4 X/ week"	Is Available, Gives
	2-Friend	"Because she's my Mother"	Advice, Talks
A-5	1-Boyfriend	"He asks about me & baby" "I'm closest to him"	Shows Concern, Is Close
	2-Mother		Gives Advice
A-6	1-Husband	"Because he's my husband"	Talks, Shares
	2-M-I-L		Gives Advice
	3-Physican		Does Physical Exam
A-7	1-Mother	"I'm closest to her" "She helps me work through my thoughts about the preg"	Comforts, Gives Advice Is Understanding, Shares, Is Trusting
	2-Boyfriend	"I talk with him sometimes"	Talks
A-8	1-Mother	"I talk w/ her every day"	Is Available, Gives
	2-Sister	"Because she's my Mother"	Advice, Talks, Buys clothes
A-9	1-Sister	"She's not embarrased" "I can exchange babysitting for information"	Is Trusting, Shows Concern, Exchanges Advice for babysitting
	2- M-I-L	"She talks to me about her son"	Gives Advice
	3- Friend	"I've known her since 4th grade"	Talks, Shares
A-10	1-Friend	"I've known her since grammar school"	Shares
	2-Husband	"He's more sensitive to my needs"	Is Close, Shares

* Support persons are listed in order of 1st, 2nd, and 3rd, as given.

Appendix F

Site, Source, & Type of Support Given by Health Professionals

Subjects	Site/Source of Health Care	Most helpful person at this site	How help was given
A-1	PMD Office	Doctor	Advises, Listens
A-2	CHC	Clinician	Does P.E., Gives Relief, Gives Reassurance
A-3	CHC	Doctor	Gives Instruction, Advises, Is Trusting
A-4	CHC	FNP	Does P.E., Advises, Gives Pamphlets, Builds Confidence
A-5	PMD Office	MD & RNs	Gives Information, Listens, Is Directive, Gives Pamphlets
A-6	CHC	FNP	Does P.E., Gives Reassurance, Shows Concern
A-7	CHC	Doctor	Advises, Counsels, Does P.E., Builds Confidence
A-8	CHC	Clinician	Does P.E., Gives Vitamins Gives Information about Self Care
A-9	CHC	FNP	Builds confidence, Is Directive, Listens, Counsels
A-10	PMD Office	Doctor	Does P.E., Gives Security, Builds Confidence, Gives methods of Relaxation and other information, Is Directive

P.E.= Physical Exam
PMD = Primary Medical Doctor
CHC = Community Health Center
Clinician = Physician or Family Nurse Practicioner (FNP) (whomever subject sees @ visit)

BIBLIOGRAPHY

Barry, H.R. & Adler, S.P. The Pregnant Father IN Psychological Aspects of Pregnancy, Birthing, and Bonding. Edited by Barbara L. Blum, New York: Human Sciences Press (Publication for National Institute for Psychotherapies) 1978.

Briggs, E. Transition to Parenthood. Maternal-Child Nursing Journals. Summer, 1979, 8 (2), pp. 69-83.

Caplan, G. Support Systems and Community Mental Health. New York: Behavioral Publications, 1974.

Cobb, S. Social Support as a Moderator of Lifestress. Psychosomatic Medicine, 1976, 38 (5), pp. 300-313.

Cromwell, R.E., Vaughn, C.E., & Mendel, C.H. Ethnic Minority Family Research on an Urban Setting: A Process of Exchange. The American Sociologist, 10 (3), August, 1975, pp. 141-150.

Fuller, S. & Larson, S. Life Events, Emotional Support, and Health of Older People. Research in Nursing and Health, 3, 1980,. pp, 81-89.

Grebler, L., Moore, J.W., & Guzman, R.C. The Mexican American People. New York, Free Press, 1970.

Hirsch, B. Natural Support Systems and Coping with Major Life Changes. American Journal of Community Psychology,8 (2), 1980, pp. 159 - 172.

Hobbs, D.F. & Cole, S.P. Transition to Parenthood: A Decade Replication. Journal of Marriage and the Family, 1976, pp. 723 -731.

Johnston, M. Cultural Variations in Professional and Parenting Behaviors. Journal of Gynecological Nursing, 1980,9 (1), pp. 9 - 13.

Keefe, S.E., Padilla, A.M, & Carlos, M.L. Emotional Support Systems in Two Cultures: A Comparison of Mexican Americans and Anglo Americans. Occasional Paper #7 for the Spanish Speaking Mental Health Research Center, Santa Barbara, University of California, 1978.

Litman, R.J. & Venters, M. Research on Health Care and the Family: A Methodological Overview. Social Science and Medicine, 13A,1979, pp. 379 - 385.

Manzanedo, H.G., Walters, E.G., & Lorig, K.R. Health and Illness Perceptions of the Chicana. IN Twice a Minority: Mexican American Women, Edited by Margarita Melville, St. Louis, C.V. Mosby Co., 1980.

Martinez, J. Jr. Chicano Psychology, San Francisco, Academic Press, 1977.

May, K. A Typology of Detachment and Involvement Styles Adopted During Pregnancy by First Time Expectant Fathers. Western Journal of Nursing Research, 2(2), 1980 pp. 445 - 453.

Mead, M. & Newton, N. Cultural Patterning of Perinatal Behavior. IN S. Richardson & A.F. Guttmacher (eds.), Childbearing: Its Social and Psychological Aspects, Williams and Wilkins, 1967.

Nucholls, K., Cassel, J. & Kaplan, B. Psychosocial Assets, Life Crisis and the Prognosis of Pregnancy. American Journal of Epidemiology, 95(5), 1972, pp. 431 - 441.

Staples, R. & Mirande, A. Racial and Cultural Variations Among American Families: A Decennial Review of the Literature on Minority Families. Journal of Marriage and the Family, 1980, pp. 887 - 903.

Shereshefsky, P.M. Psychological Aspects of a First Pregnancy and Early Postnatal Adaptation, Edited by Paulin M. Shereshefsky and Leon J. Yarrow, New York, Raven Press Publications, 1973.

Unger, D. & Powell, D. Supporting Families Under Stress: The Role of Social Networks, Family Relations, 29, 1980, pp. 566 - 574.

Weaver, J. National Health Policy and the Underserved, St. Louis, C.V. Mosby Company, 1976.

Zinn, M.B. Marital Roles, Marital Power and Ethnicity: A Study of Changing Chicano Families. (Doctoral Dissertation, Universtiy of Oregon), 1978.