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Maternal Adaptation to Child Disability in a Hispanic Population*

Johanna Shapiro and Ken Tittle**

This study examines psychosocial adaptation of 38 Hispanic mothers to the presence of orthopedic disability in their child. Results indicate that maternal emotional and attitudinal adaptation is most closely correlated with the disabled child's psycho-behavioral adjustment. Maternal stress appears related to emotional (but not attitudinal) adaptation, while the inverse is true for family function. Maternal communication patterns which focused on problem solving and information seeking are correlated with more positive maternal attitudes toward disability, while emotion-focused communication styles are related to decreases in maternal depression. Implications for physicians and therapists working with Hispanic patients and families are discussed.

Research has shown that a chronic illness or disability in a child affects not only that child's psychological well-being, but that of the entire family as well (Campbell, 1984; Seligman, 1983; Shapiro, 1983). Other researchers have identified a family health and illness cycle (Doherty & McCubbin, 1985) which indicates how the family responds to illness, but also implies that each family member is simultaneously affected at some physical and/or emotional level by a given illness in the family. It has also been observed that some parents adapt better than others to the stressor of a handicapping condition in their children (Friedrich & Friedrich, 1981; Turk & Kerns, 1984).

Unfortunately, what clinical and research information exists pertinent to parental outcomes of childhood disability has been derived primarily from investigations of white, middle-class families (Arnold, 1983). Yet as growing numbers of families seen in medical facilities in the United States come from other countries, particularly south of the border (Mumford, 1985), it is important to understand the interaction of illness and cultural beliefs. These families are often attempting to function under the double stigma of ethnicity and disability (Asch, 1984). Thus, knowledge about family adaptation and coping (Cohen & Lazarus, 1979) in this population becomes increasingly important, particularly since a family-based response to illness which emphasizes the pivotal influence of family on the individual's worldview has been noted as characteristic of Mexican-American families (Schreiber & Hamiak, 1981). Zuniga (1988) also confirms the importance of family assessment in defining a patient's presenting problems in the Hispanic population. Adkins & Young (1976) studied factors interfering with the successful implementation of intervention programs aimed at physically disabled Mexican-American children and their families, and documented strong family pride resistant to the help of "outsiders" and family values encouraging child passivity, as well as pervasive negativism in the extended family.

The objective of the current study is to determine how factors such as psychosocial adjustment of the disabled child, externally perceived maternal stress and burden, maternal communication patterns, family function, and social support are associated with maternal adaptation in a group of Hispanic mothers who exhibited a range of responses to their child's physical disability.

Definition of Variables

Five sources of potential influences on maternal adaptation to child disability were selected for investigation: (a) Index child adjustment, including psychosocial and behavioral components such as child's moods, fears, acting out, relations with peers, measured by teacher report, both in terms of overall adjustment and of specific disability-related responses. (The term *index child* refers to the child with disabilities present in each family.) (b) Maternal stress and burden (problems between mother and index child; maternal expectations of a normal future for their child), specifically related to the disabled child, measured both by teacher report and by two different interviewer ratings. (c) Maternal communication patterns (emotion-focused or problem-focused) about child's disability, assessed by interviewers. (d) Family adjustment, both general and specifically related to the disabled child, evaluated variously by teacher report (family disruption attributed to child's disability), interviewer ratings (family problems), and maternal self-report (Family Environment Scale). (e) Availability and effectiveness of outside support for the mother determined by interviewer rating.

Using both affective and cognitive assessments of maternal adaptation, mothers were defined as having poorer adaptation to their child's disability if they evaluated themselves as more depressed and had a more negative attitude toward disabled persons in general. Depression has often been used as a measure of maternal adaptation to child disability (Burden, 1980). Similarly, negative cognitive attitudes toward disability have been shown to correlate with a range of maladaptive responses, including hostility and anxiety (Sellar, 1964; Sellar & Chapman, 1964).

Hypotheses

Several hypotheses were generated: (1) Poorer index child adjustment would be associated with in-

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creased maternal depression and maternal negative attitudes toward disabled persons. It has been observed that the demands of childhood disability often result in an enmeshed, overinvolved mother-child relationship (Jaffe-Ruiz, 1984). Thus a positive correlation was hypothesized between perceived child adjustment and maternal adjustment. (2) Maternal stress and burden would be positively associated with maternal depression and more negative attitudes toward persons with disabilities. Similar findings have been documented in populations of white, middle-class mothers of disabled children (Breslau, 1983). (3) Mothers who engaged in more open, frequent, and specific communication with others about their child's disability would be less depressed and have more positive cognitive attitudes toward disabled persons. Again, suggestive findings supporting this hypothesis exist for other populations and other medical conditions (Schilling, Gilchrist, & Schinke, 1984; Shapiro & Shumaker, 1987). (4) Family dysfunction and disruption would be associated with maternal depression and more negative maternal cognitive attitudes. Earlier studies suggest that high family cohesion is related to individual self-esteem (Levy, 1984) and to psychological well-being (Fuller & Carlson, 1981). Further, lack of family support has been associated in women with increased depression and psychosomatic symptoms (Holahan & Moos, 1981). Other research shows a clear relationship between maternal emotional well-being and overall family functioning (Trute & Hauch, 1988). (5) Maternal social support would be negatively related to depression and positively related to positive attitudes toward the disabled. The link between social support and adaptation has by now been clearly established (Cohen, 1988; Wallston, Algna, DeVellis, & DeVellis, 1983).

Method

Subjects

Subjects were 38 Hispanic mothers of a physically handicapped child and the 35 teachers from six local elementary schools who were the primary instructors of these children. A potential group of 100 handicapped children was identified through a private orthopedic clinic in a Southern California border town, which provided diagnostic and limited therapeutic services for the Mexican community on the other side of the border. Criteria for index children in the study were: (a) be between the ages of 5 and 12 years, (b) have a physically disabling condition of moderate severity which impeded mobility, as evaluated by the physician investigator, (c) have normal intelligence, determined by medical records and physician-investigator assessment; (d) have a congenital disorder or early onset paralytic polio (traumatic injuries were excluded); (e) have at least one sibling present in the home (because of the relative uniqueness of single-child families in the study population and the possibility that the dynamics of such families might differ from those of larger families, single-child families were excluded).

Of the 100 children identified through clinic records, the families of 50 eventually were contacted. This low percentage was related to several factors: (a) the somewhat transient nature of the population (i.e., frequent movement both across the border and to other areas of Mexico); (b) the virtual nonexistence of telephones, which meant families had to be contacted by going directly to their homes; and (c) the frequent changes of address within the community. Of the 50 families approached, 38 completed the study. Reasons cited by the 12 noncompleters included spousal opposition to the interview and embarrassment at discussing their personal situation with a stranger. With 5 of the noncompleting mothers, it proved impossible to schedule a mutually convenient interview. The difficulties in obtaining the sample introduced a significant potential for bias and prevented true randomization. Based on discussions with clinic staff, it appeared that families participating in the study could be characterized as somewhat better off financially, more stable, and higher functioning than the overall clinic population.

Families. The 38 families included in the study averaged 4.6 children per family. The mean age of the index child was 8.2 years. Of these 38 children, 16 had early onset paralytic polio, 9 had spina bifida, and the remainder had a variety of congenital lower extremity anomalies, such as club foot, requiring mechanical aid in ambulation. Almost 75% of the children had been hospitalized at some point because of their orthopedic problems.

In general, these were poor families with a median monthly income of less than $200.00 (in U.S. dollars). Subjects' educational level was fairly low, with 6 reporting they had never attended school, 22 having attended some elementary school, 6 having completed grade school, and 4 having some high school. About 90% of the mothers were full-time homemakers. Most of the fathers were employed in unskilled, low paying jobs. The age of the parents ranged from early 20s to late 50s, with a mean age for mothers of 36.5 years and a mean age for fathers of 40.3 years. The average length of marriage for the couples was 13.5 years, and 92.3% of the mothers described themselves as either moderately or very satisfied with these marriages. The majority of respondents stated their religious affiliation and that of their husband as Catholic, with the second largest denomination (15%) being Latter Day Saints. Their homes had an average of 3.5 rooms, usually with electricity and running water; however, several homes had neither indoor toilets nor refrigerators. About 20% of the sample shared their house with another family.

Teachers. Teachers of the index children were contacted with permission of parents and the school administration. A total of 36 teachers were contacted (at two schools, two of the index children were in the same classroom). All teachers agreed to participate; however, data from 1 teacher could not be obtained due to scheduling conflicts. All teachers were women with a mean age of 24.7 years. Their length of time in teaching ranged from 2 to 12 years, with an average of 5.5 years. Fourteen reported exposure to children with disabilities prior to the presence of the index child in their class. None of the teachers had ever had formal training in working with handicapped youngsters. The source of their information about the index child and his/her home life was direct classroom observation, parent-teacher conferences, occasional home visits, and comments from other teachers or school personnel familiar with the family.

Measures

A combination of open-ended interviewing and standardized psychological assessment instruments was used in this study. The three respondent domains measured by standardized instruments were maternal depression, maternal attitudes toward the disabled, and maternal perceptions of family function.

Respondent depression was measured by the Center for Epidemiological Studies *Depression (CES-D)* Scale, a 20-item symptom checklist used to assess situational depression (Radloff, 1977; Roberts, 1980). This instrument was selected because of its high internal consistency and a similar factor structure and pattern of construct validity among whites, blacks, and Mexicans. A typical item from this scale reads, "During the past week, I felt sad (*rarely . . . most of the time*)."

Maternal attitudes toward disabled people in general, selected as a measure of cognitive beliefs about disability, were measured through a standardized instrument, Attitudes toward Disabled Persons (ATDP) (Yuker, Black, & Campbell, 1966). A representative statement from this measure reads, "Disabled persons usually do not make much of a contribution to society," rated on a 6-point scale.

Family functioning was measured by the Family Environment Scale (Moos, 1976), which also has been used previously with Spanish-speaking populations. The Family Environment Scale (FES) is a true-false instrument with 90 items yielding 10 subscales: cohesion, expressiveness, conflict, independence, achievement-orientation, intellectual-cultural orientation, active-recreational orientation, moral-religious emphasis, organization, and control.

While these three instruments were standardized, small modifications both in their content and administration based on pilot testing proved necessary. On both the ATDP and FES, certain changes in wording were made to facilitate greater subject comprehension. All three instruments were administered orally, a violation of standard procedure, because of the low literacy level of subjects. These changes may have impacted the reliability and validity of the instruments. However, with the exception of the CES-D Scale, no reliability and validity data exist for these instruments for a female, Mexican population; unfortunately, this sample was too small to permit such analyses. Internal reliability checks performed using Cronbach's alpha yielded coefficients of .93 for the CES-D Scale, .71 for the ATDP, and from .64 to .79 for the 10 subscales of the FES.

In addition, several other scales were constructed post hoc, based on structured interview data from the index children's teachers, in order to access information on the constructs mentioned earlier. These scales were as follows:

Maternal burden and stress. This measure was an 11-item scale which achieved a reliability coefficient (Cronbach's alpha) of .94. The scale was related to mother's sense of burden and stress regarding her disabled child. It consisted of statements such as "Mother seems stressed by worries about index child's emotional health"; "Mother appears to have most of the responsibility for index child's daily care"; "Mother feels unsupported by the rest of the family."

Child adjustment. This 23-item scale was used to solicit teacher evaluation of the index child's overall mood, behavior, anxieties, and interpersonal relationships based on classroom observation. This scale had a reliability coefficient of .83.

Child specific response to disability. This measure consisted of 10 items such as "Index child seems angry at disability"; "Index child uses disability to get special treatment"; "Index child feels disability is a punishment from God." It was intended to measure teacher perception of how the index child's disability seemed to affect him/her. The scale had a reliability coefficient of .78.

Family disruption. This scale was used to assess the degree of family disruption attributable to the disabled child. It contained 10 items such as "Child's disability seems to interfere with family activities"; "Siblings appear overly protective of index child." This scale had a reliability rating of .98.

Data Collection Techniques

Maternal interview. The interview packet for mothers consisted of both the three standardized measures previously described (depression, attitudes toward disabled persons, and family function) and a series of open-ended questions which assessed the impact of having a disabled child on the mother and other family members, the nature of the mother's interactions with the medical system, her use of informal social supports, and patterns of communication within and outside the family relative to the child's disability. This packet was pretested on five mothers from the orthopedic clinic who failed to meet the inclusionary criteria, but were judged comparable to the desired sample. Based on this administration, the original interview was revised to improve comprehensibility.

All parts of the interview, including the standardized instruments, were administered orally in the subjects' homes by a social work instructor and a social work graduate student from the Mexicali School of Social Work who were native Spanish-speakers and familiar with the local community. Overall interview time lasted approximately 3-4 hours and was generally accomplished in two sessions. Total interview training time was approximately 8 hours, and emphasized potential sources of response bias (Welch, Comer, & Steinman, 1973).

Parent interviews included mothers only. Although initially efforts were made to interview fathers as well, some difficulties were encountered in this endeavor, which may have been attributable to: (a) The fact that both interviewers were women; (b) the interviews were about a subject (the child and the family) traditionally regarded as the province of women; (c) the focus of discussion was a child with disabilities, perhaps a source of embarrassment to the father; (d) the large majority of fathers were employed in jobs averaging 10 hours a day, so that it was difficult to contact them.

All interviews with mothers were audiotaped. An English transcript was also provided. Two additional social work students listened to each audiotaped interview and rated it as either "high" or "low" on each of the following dimensions: (a) parenting problems between mother and index child; (b) maternal expectations that index child would be able to lead a normal life, despite disability; (c) family problems and conflict attributed by the mother to the index child's disability; (d) mother's tendency to interact with informal social supports (family, extended family, friends, and neighbors) to meet her emotional needs related to the index child and her ability to share openly about her disabled child within these circles of support; (e) mother's tendency to focus on more technical, cognitive, and problem-solving aspects of her child's disability and to rely primarily on interaction with professionals (physicians, nurses); (f) the overall availability of social support to the mother. Interrater reliability for audiotape scoring was .91.

Teacher interview. The interview for teachers consisted of a series of forced choice questions on topics of child adjustment, maternal-child interactions, and family response to the index child's disability. Items were subsequently used to develop the post hoc scales discussed previously (maternal stress and burden, child adjustment, child response to disability, family disruption). This interview was pretested using two teachers from one of the local elementary schools and revised accordingly. All questions were administered orally, and time for administration was approximately 1 hour. These interviews were not audiotaped because of their structured nature.

Mothers were paid $10.00 (in U.S. dollars) for participation in the study. Teachers were not remunerated for the interview. Instead, they participated in a 2-hour group discussion about developing awareness of the needs of children with disabilities in an educational setting conducted at the end of the study.

Data Analysis

After scale construction (Cronbach, 1951), data between those scales designated as predictor variables and those scales designated as outcome variables were analyzed through correlational methods, using both Pearson and Spearman correlation coefficients depending on the nature of the scale (Cohen & Cohen, 1975). The interviews grouped into rater categories of *high* or *low* across the five dimensions specified above were analyzed in relation to individual respondent outcome scales of depression and attitudes toward disabled persons. T tests were used because the standardized measures employed interval scales.

Results

Comparison of sample and normative means on the CES-D Scale, the ATDPS, and the FES. When results from the three standardized instruments employed in the study were compared to normative data, significant differences were found. For the ATDPS, the sample mean was significantly higher than the normative mean (t = 2.44; $p < .05$). The CES-D Scale also indicated that the sample mothers were significantly more depressed than the normative sample (t = 3.70; $p < .01$). Data from the FES indicated that there were significant differences at the .01 level between the sample mean and the normative mean on 7 of the 10 subscales (higher on expressiveness and achievement orientation; lower on conflict, active-recreational orientation, moral-religious emphasis, independence, and intellectual-cultural emphasis). The sample did not differ significantly from normative data in terms of family cohesion, family organization, and family control.

While these findings throw into question whether the three instruments can be considered "standardized" for the population of this study, the explanation for these differences is fairly straightforward. In terms of the ATDPS instrument, normative data exist only for disabled and nondisabled individuals; none is available for *parents* of disabled children. In fact, when comparisons were made between these two sets of norms and the present study population, the latter fell almost exactly midway between the two (i.e., less biased against persons with disabilities than nondisabled persons, but more biased than disabled persons).

While the CES-D Scale was normed to include data from a Mexican sample, obviously the normative data did not address the issue of disability within a family. Therefore, it was to be expected that these sample mothers were more depressed than a normative sample which did not have to deal with the stressor of child disability.

Similarly, although the normative data for the FES were based on a black and Mexican-American sample, there is no reason to believe that group was representative of the present particular study population. It is impossible to know whether the differences which emerged and were often quite large were related to cultural and socioeconomic factors, the presence of a disabled child in the family, or a combination of all of these.

Relation of child adjustment, maternal burden, family disruption to maternal depression and attitudes. The two outcome measures identified in this study, depression and attitudes toward disabled persons, were shown to be independent by correlational analysis (r = –.11, p = .26). Based on additional correlational analyses, teacher measures of child adjustment were negatively correlated with maternal depression. As child adjustment increased, maternal depression decreased (r = –.42, p = .01). This appeared true both in terms of the child's general, overall adjustment and also in terms of the index child's specific response to his/her disability (r = –.41, p = .01). Teachers' perceptions of the mother's sense of burden and stress regarding the index child (r = .41, p = .01), and degree of family disruption in connection with the index child also were positively related to maternal depression (r = .39, p = .01).

Teacher perceptions of child adjustment were also strongly associated with maternal attitudes toward disabled persons in general (r = .51, r = .54, p = .001). There was no relationship between teacher perception of maternal stress or family disruption and maternal attitudes.

Relation of family environment to maternal depression and attitudes. In terms of family function data, a strikingly different picture emerges. Family function had no relationship to maternal depression. However, with a few exceptions (moral-religious orientation and control), the subscales of the FES consistently showed moderate correlations with maternal attitudes toward disabled persons. Cohesion (r = .52), Independence (r = .48), Organization (r = .41), and Expressiveness (r = .34) had highest correlations with maternal attitudes.

Interviewer assessment of mother-child problems, family problems, maternal communication styles, and social support in relation to maternal depression and attitudes. (See Table 1.) Mothers rated as reporting more problems between themselves and the index child were more depressed (t = 2.6, p = .01). Mothers rated as relying heavily on informal, emotion-focused communication were less depressed than mothers who did not tend to use this form of communication (t = –3.2, p = .01). Expectations of child normalcy, family problems, or problem-focused communication were not associated with maternal depression. However, these three areas all were significantly related to maternal attitudes toward disabled persons in general. Mothers who were rated as expecting that their own disabled child would be able to lead a normal life (t = 3.9, p = .001) and who emphasized more cognitive, problem-focused, and technical interactions with physicians, according to rater evaluations (t = 3.0, p = .01) also reported more positive attitudes toward disabled persons. Mothers who were judged as exhibiting more family problems associated with the index child's disability also reported more negative attitudes (t = –2.5, p = .01). Finally, high social support outside the immediate family was characteristic of mothers with both lower depression scores (t = 2.5, p = .01) and more positive attitudes toward the disabled (t = 2.4, p = .01).

Discussion

The index child's overall adjustment and the presence of strong social support were the most significant factors associated with positive maternal adjustment. Child adjustment and support outside the family had positive relations both to mothers' levels of depression and to the beliefs which they formed about the abilities and

Table 1.
Relation of Maternal Depression and Attitudes to Interviewer Ratings of Maternal Response to Child Disability

Interviewer Ratings		Maternal Self-Report of Depression				Maternal Self-Report of Attitudes Toward Disabled Persons			
		$\bar{X}$	*SD*	*t*	*df*	$\bar{X}$	*SD*	*t*	*df*
Mother/child problems	High	28.4	8.2	2.6*	28	116.0	13.9	-.64	28
	Low	13.6	8.3			119.9	15.1		
Maternal expectations of child normalcy	High	17.3	2.4	-.57	34	124.5	11.9	3.9**	34
	Low	20.7	7.1			104.9	11.8		
Family problems because of handicap	High	23.0	6.1	1.5	33	109.2	12.0	-2.5*	33
	Low	15.5	2.0			123.0	14.3		
Problem-focused communication	High	11.8	2.9	-1.2	34	134.8	11.1	3.0*	34
	Low	19.6	2.7			117.6	13.3		
Emotion-focused communication	High	13.9	2.1	-3.2*	36	120.3	15.7	.31	36
	Low	28.4	4.8			118.7	9.9		
Outside support	High	10.8	5.1	2.5*	35	124.9	13.7	2.4*	35
	Low	20.6	3.0			114.4	11.6		

*$p < .01$.
**$p < .001$.

rights of disabled people in general. Children who had few behavior problems, were socially well integrated, and doing well in school, had mothers who were less depressed and who had positive views of disabled persons. Similarly, mothers who were rated as having high support also reported lower depression and more positive attitudes.

The ways in which mothers communicated with their support systems also were significant. Mothers who were able to share feelings and who talked easily and openly with family and friends about their child's disability were less depressed, but they did not exhibit significantly more positive attitudes and beliefs about disabled persons in general. Conversely, mothers who coped by learning as much as they could factually about their child's medical condition, and who spent more of their time talking with physicians, had more positive attitudes and beliefs about persons with disabilities, but did not appear to be less depressed. Thus, reliance on the emotional support from informal networks significantly affected respondents' self-perceptions of loneliness, isolation, and sadness. However, this contact in itself did not positively influence their beliefs about the abilities and rights of physically handicapped individuals. What appeared to affect these latter perceptions were interactions with professionals, in particular American physicians, who exchanged much-needed knowledge about their child's medical condition with these Mexican mothers and exposed them to the U.S. perspective of equality for disabled persons. Anecdotal evidence suggested that mothers who had heard about such possibilities as disabled athletics or public transportation to accommodate wheelchairs also tended to think about the opportunities for their child and all disabled people in more optimistic and positive ways.

Family function factors also were related to maternal adaptation. According to teacher perception of family function, family disruption was associated with increased maternal depression. However, according to maternal self-report and rater evaluation of maternal interviews, family function was *not* related to maternal depression, but rather to maternal negative cognitive attitudes. This discrepancy may have been due to the fact that teachers evaluated the home situation primarily through their interactions with the mother and actually may have been evaluating not so much familial, as maternal, disruptions. On the other hand, teacher report might have been more objective and therefore a more accurate reflection of home realities.

Mothers reported that when their families were cohesive, expressive, encouraging of independence in their children, spending significant time together in recreational activities, and highly organized, they also tended to have more positive cognitions regarding disabled persons. Rater-identified family disruption was significantly related to more biased maternal attitudes. While the findings regarding family function and maternal attitudes toward disability partially confirm hypothesis #4, the findings on the relationship between family function and maternal depression contradict the original hypothesis and are counterintuitive. One would certainly expect mothers from high-functioning families to be less depressed than those from low-functioning families. Perhaps families in which the index child was well integrated, which stressed both warmth and independence for family members served in the mother's eyes as a microcosm for society, and thus influenced her views regarding the potential kind of normalcy of disabled persons. This positive family environment, however, apparently did not extend a beneficial influence on maternal affect, at least according to maternal self-report. One might speculate that perhaps the high functioning of certain families was at times achieved at the expense of mother's well-being. Conforming to the demands of their culture, these mothers might well be attending to the needs of their child and family, but not to their own needs for relief from caretaking and family responsibilities. It is also possible, as other findings in this study suggest, that mothers' most important source of nurturance and support came not from the nuclear family, but the extended informal network of other women (relatives and friends), with whom they were able to share their most intimate feelings and whose encouragement significantly affected their feelings of depression.

Both teacher- and rater-identified *maternal* stress and conflict attributed to the index child were significantly related to maternal depression. Mothers who appeared burdened by the responsibilities of their disabled child and who seemed to be confused as to how to parent such a child were characterized by increased depressive affect. Again, the directionality of such a relationship cannot be determined by the present study, so that it is equally likely that depression is the underlying phenomenon which "causes" conflict and sense of burden in the mother, as it is that stress and burdensome caretaking lead to maternal depression.

Implications for Practice

In considering maternal well-being in Hispanic families of children with disabilities, this study points to several important clinical implications: The first is in the area of family adjustment to child disability. For teachers, social workers, physicians, and psychotherapists having direct contact with a Hispanic child with disabilities, any sign of maladaptive functioning in this child should suggest the possibility of further levels of emotional disturbance in the home environment. Particularly fruitful clinical aspects to explore might focus on maternal sense of burden and conflict between mother and child.

In addition, because of the importance of family-based responses to issues of health and illness alluded to earlier, family assessment should clearly play an important role in the formulation of treatment plans (Zuniga, 1988). Of special importance may be ascertaining to what extent harmonious family functioning is being achieved at mother's emotional expense.

Encouraging the identification and utilization of support systems outside the nuclear family may also be an effective clinical focus. With the high levels of mobility identified in this sample, this may require systematic initiative on the part of school personnel, social service agencies, and health care professionals to stimulate such therapeutic linkages. Similarly, for Hispanics without strong community ties in this country, special attention to networking issues might be a critical component in addressing problematic maternal adaptation.

This study also suggests that Hispanic mothers who rely heavily on cognitive information and more technical interaction with physicians, nurses, and other professionals about their child's disability may develop more positive beliefs about disabled people in general, while remaining unaffected in terms of personal levels of depression. Conversely, Hispanic mothers who emphasize the meeting of their emotional needs through informal social networks may be able to positively impact their own levels of depression, but may continue to maintain negative biases toward disabled persons. Seeking information and seeking emotional support thus appear to be two important but independent coping strategies with different impacts on maternal outcome. Interestingly, Hymovich and Dillon-Baker (1985) reported that, in an Anglo population of parents of children with cystic fibrosis, talking with the physician (instrumental) and praying (more expressive, emotionally focused) were the two most frequent coping strategies used in response to stressful medical situations. These findings are particularly interesting in light of anecdotal evidence documenting Hispanic families' reluctance to communicate about emotional concerns and engage in active information-seeking behaviors (Keefe, 1982). Although open communication at both the factual and emotional level may violate some cultural norms, those mothers who are able to engage in such modes of communication appear to derive considerable adaptational benefit.

Several clinical approaches to address this problem deserve further empirical investigation. For example, through modeling and prompting, professionals might encourage Hispanic mothers of disabled children to engage in both factual and emotional communication. A second possibility might be the formation of self-help groups, where participants could receive training in both assertiveness and emotional expressiveness. A variation on this idea which might be culturally less threatening would be for health care and other professionals to facilitate one-to-one networking among Hispanic mothers. This would serve the triple purpose of promoting social support, facilitating the exchange of information, and providing for the possibility of emotional sharing in an intimate context. A family conference to address topics of maternal burden, clarification of information, and the importance of open communication could also help to locate the child's disability in its most culturally familiar context. A family-oriented approach (Kazak & Marvin, 1984) including family members such as grandmothers or grandfathers, might be more effective than working with mother alone, or even mother and father, because of the tendency among Hispanics to react to illness from an extended family perspective.

Finally, although most of these subjects had little formal education, receiving information about their children's condition was an important way of coping for them. Waitzkin (1984) has documented physician tendency to underestimate the desire for information and education among less well-educated, lower socioeconomic patients. The findings of this study suggest that education has an important role to play in the development of maternal attitudes and expectations toward disabled persons, even in a poorly educated population.

In conclusion, it is important to recognize that parental adaptation to physical disability in a child must be defined on a variety of dimensions, including the affective and the cognitive. The two dimensions identified in this study, depression and attitudes toward disabled persons, are shown to be unrelated to each other, but significantly related to different aspects of maternal coping and family functioning. This type of information, when replicated for other populations, has important implications for the clinical care of child patients and their families.

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