Individual and Family Correlates Among Poor, Spanish-Speaking Women of Their Attitudes and Responses to Children and Adults With Disabilities

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Abstract

This study explored family attitudes and hypothetical responses of low socioeconomic, Spanish-speaking women toward people with disabilities and specifically toward children with disabling conditions. Results indicated a significant relationship between attitudes toward individuals with disabilities and both individual psychological and general family factors. Maternal attitudes were related to both family cohesion and independence. Perceived stress of a hypothetical disabled child was related to maternal depression. Specific coping strategies endorsed by subjects were related both to respondent psychological and emotional health, and to the family factors of cohesion and conflict.

Coping with a disabled child is a process that taxes the resources of parents, siblings, and the entire family unit (Bruhn, 1977; Burr, Good, & Del Vecchio-Good, 1978; Huth, 1978; Kew, 1975; Tavormina, Boll, Dunn, Luscomb, & Taylor, 1981). Darling (1979) provided evidence that families are either helped or hindered in this coping process by the quality and nature of the societal response they encounter with reference to their disabled child. Parents can receive strength and benefit from contact with support groups composed of families facing similar problems (Forstenzer & Curry, 1980); they can also feel their lives enriched through contact with empathetic health care providers and even strangers (Craig, 1979). Just as easily, parents can experience a sense of social ostracism by the rejection of their neighbors (McMichael, 1971). Some research now supports the hypothesis that the community at large tends to hold parents responsible for the serious health problems of their children (Shumaker, Shapiro, & Kellerman, 1981).

Despite the increasing representation of members of third-world, developing countries in various parts of the United States, there remains very little information about cultural variations which might influence the normative community attitudes toward disability. Yet, as health care providers encounter more examples of disability in this population, it is important to document how individuals of other cultural backgrounds, who are not white and middle-class, understand disability and respond to it.

The Southwestern border region (comprising parts of Arizona, New Mexico, California, Texas, and their geographically proximal Mexican territories) is of special concern to U.S. health care professionals, because of the continuing influx of both legal and illegal aliens back and forth across the border (Rosenthal, in press). Fear of deportation in many of these individuals limits contact with the medical community during crisis situations. They are also often limited by an inability to meet the financial costs of medical care (Cornelius, 1980). Thus, encounters with the health care system tend to be transitory and to occur in high-pressure situations which are not conducive to facilitating understanding and communication. Further, the U.S. medical system is often perceived by large parts of this transitional population as officious, expensive, and even derogatory (Clark, 1970). Under these conditions, attempting to anticipate how such a population will respond to the existence of a chronic condition such as the physical disability of a family member can be a frustrating and unproductive experience for physicians and other health care providers.

There is already documentation of negative attitudes toward illness among the Mexican-American population, including a "machismo" denial of symptoms, perceived loss of social acceptability, and sense of being punished by God (Clark, 1970). It is not clear whether such attitudes extend to perceptions of physical disability (Shapiro & Tittle, 1986). Further, such interpretations tend to be anthropological and sociological in nature, emphasizing the culture-specific determinants of such attitudes. There has been no attention given to the relationship of such attitudes to relevant psychological and familial factors. This latter dimension is of particular concern because of evidence suggesting that the Hispanic patient's approach to health care is less of a purely individual, and more of a family-based response (Schreiber & Hamiak, 1981).

Purpose of the Study

Overall, this study was intended to investigate whether negative attitudes and responses toward adults and children with disabilities among Mexican mothers who did not have previous significant contact with disabled people might be related to individual psychological health and /or family functioning. If such a relationship were established, interventions aimed at altering such "bias" against disabled people would have to take into consideration not only culture-specific factors (i.e., folk beliefs about illness), but also psychological and family function factors as well. For the purposes of this research, the following two aspects of individual psychological functioning were selected: (a) depression, because of evidence of widespread depression among Mexican women (Meadows & Stoker, 1965; Quesada, Spears, & Ramos, 1978); and (b) psychosomatic symptomatology, which is also a widespread expression of psychopathology among Mexican-Americans (Torrey, 1972). Family variables chosen for study were cohesion, independence, and conflict, all of which have been shown in U.S. populations to be correlated with overall healthy family functioning (Moos, Clayton, & Max, 1979).

The presentation of data in this article is aimed at examining the following research questions:

1. Are the general attitudes toward disabled persons held by members of a Mexican border community related to either

individual or family measures of adjustment? Existing research relates attitudes toward physical disability both to psychological correlates (English, 1977) and to overall family functioning. Thus, the researchers hypothesized that, in the current study population, more negative attitudes toward disabled persons would be related to increased respondent depression and poorer respondent health, and to decreased family cohesion and independence and increased family conflict.

2. Are specific maternal responses to a hypothetical disabled child related to either individual or family measures of adjustment? In this study, it was hypothesized that lower levels of individual and family functioning would be associated with more negative maternal reactions to a hypothetical disabled child, and to the maternal perception that this child places a greater stress and burden on the family unit.

3. Are the hypothetical coping strategies that mothers think they would use to deal with a disabled child in their family related to levels of individual and family functioning? Again, it was hypothesized that higher individual and family functioning would be associated with positive coping strategies, whereas lower individual and family functioning would be associated with more negative coping strategies. Despite evidence which shows that coping is situation-specific and cannot easily be labeled positive or negative (Cohen & Lazarus, 1979), the researchers considered problem-focused, emotion-focused (Lazarus, 1980), and normalizing (Salk, Hilgartner, & Granich, 1972) strategies to be positive, since they have a positive mediating effect on various patient and family outcomes. On the other hand, avoidance and self-blame were considered more negative coping strategies, because of numerous observations in the anecdotal literature to this effect (Green, 1968; Morgan, 1979).

Methods and Procedures

Subjects

Twenty-two mothers of nondisabled children recruited from two local churches in a Mexican border community served as subjects for this study. Contact by members of the research team with this community indicated that the Catholic church played a significant role in community life, and that a large majority of citizens were involved in church activities. Criteria for subject inclusion in the study were as follows: (a) a father as well as a mother had to be currently involved in the family, (b) at least one child between the ages of 2 and 12 had to be present in the family, (c) at least one other sibling had to be part of the family, and (d) a disabled individual could not be part of the immediate family. Thirty women met these criteria, and agreed to participate in the study. Of these, 22 or 73.3%, completed the interview process. Of the remaining eight, three had family emergencies which precluded their participation, two moved to other parts of Mexico, two could not be contacted subsequently, and one reported that she did not wish to talk about the topic of the study.

A detailed description of these women is provided in the report of another study (Shapiro & Tittle, 1986). In general, these subjects came from relatively poor families, with a median monthly income of less than $600.00. The majority of women (80.0%) and their husbands (75.0%) had not completed elementary school. Forty-six percent of the husbands, although employed, worked in unskilled, low-paying jobs; 31.0% were employed as skilled laborers; and 23.0% were unemployed. The majority of women (76.2%) were full-time homemakers. Their homes, which averaged four rooms and a mean of 5.36 people per household, all had electricity and running water. In the majority of the families (54.5%), mother and father were either currently married or living together. The average length of marriage was 21.9 years, and mothers reported on the average being moderately satisfied in these relationships. The mean age of mothers was 41.4 years, and they had a mean of 2.3 children currently living at home. Almost all of the respondents (77.3%) and their spouses (100.0%) were practicing Catholics.

Measures

Several standardized measures, as well as a semi-structured interview, were employed in this study. Measures of respondent individual adjustment included: (a) a modification of the Center for Epidemiological Studies (CES) Depression Scale, a 20-item symptom checklist used to assess situational depression (Roberts, 1980), and (b) a measure of respondent perceived physical health, based on health incidents and frequency of psychosomatic symptoms (Langner, 1962; Marx, Garrity, & Bowers, 1975). The modified version of these two measures each had reliability coefficients of .86. Attitudes toward disabled people were measured through use of a standardized instrument, the ATDP (Attitudes Toward Disabled Persons), used to assess general, rather than disability-specific attitudes (Yuker, Block, & Young, 1966). The measure of family function employed was the Moos FES-Family Environment Scale (Moos & Moos, 1976). Of its 10 subscales, three (i.e., cohesion, conflict, and independence) were used in the data analysis. These three scales were selected because of their face validity (Minuchin, Baker, Rosman, Liebman, Milman, & Todd, 1972; Minuchin, 1974, 1978) as dimensions associated with positive family function. Both the Depression-CES and the FES scales exist in Spanish language versions. The remaining instruments were translated into Spanish by two bilingual graduate students. In addition to these instruments, one other scale was developed from the interview data. This 11-item scale, measuring the perceived stress of having a disabled child in the family, had a reliability coefficient of .92.

The interview focused on information in the following areas: (a) maternal perceptions of their own child's behavior; (b) specific attitudes, cognitions, and beliefs about disabled children; (c) speculation by respondents as to how they would deal with a disabled child in their own family (in terms of how stressful they would perceive such a child to be, what their emotional reaction to such a child would be, and what kinds of coping strategies they would employ in an effort to adjust to the presence of such a child); and (d) how their family would respond to the presence of a disabled child.

To facilitate the completion of the hypothetical and attributional parts of the questionnaire, the researchers constructed a composite profile of a disabled child, sex unspecified, approximately eight years old, having normal intelligence, but a significant mobility impairment due to early onset paralytic polio. The interview was pretested on five mothers who failed to meet the inclusionary criteria, but who were judged comparable to the desired sample. Based on these pretest experiences, the interview format was revised twice to tighten structure and improve translation problems.

Method

All standardized instruments, as well as the interview, were administered orally, because of the widespread illiteracy of the population studied. The overall administration took 2½ to 3 hours per subject. The interviewers consisted of a social work instructor and two social work graduate students from the Mexicali School of Social Work. In addition to being Spanish-speaking, these female interviewers had the added advantage of being quite familiar with the local community. They proved to be excellent interviewers. Approximately four hours were spent in interview training time, which stressed potential problems of response bias (Welch, Comer, & Steinman, 1973).

Data Analysis

Because of the large number of variables generated by the exploratory methodology employed, the researchers decided to collapse as many single variables as possible into scales. This was done, using Cronbach's alpha (Cronbach, 1951), which provides a post-hoc internal reliability coefficient. In addition, certain individual variables were selected for separate analysis. These included two items relating to family response to a disabled child: (a) "There would be a lack of acceptance of a disabled child on the part of some family members" (this statement was responded to with Yes/No, and analyzed with a t-test), and (b) "Other family members besides yourself would be involved in the care of a disabled child" (this statement was also responded to using Yes/No).

Finally, five items representing different types of coping strategies were selected from a lengthy coping checklist generated by the oral interview and analyzed separately. Problem-focused coping was represented by the item, "seeking solutions;" emotion-focused coping was represented by the item, "avoid thinking about my child's problem." Self-blame was represented by the statement, "a disabled child is a punishment from God for the sins of the parents." A normalizing coping strategy was represented by endorsement of the statement, "a disabled child can lead a full, happy life." These five items were all analyzed using a mean comparison test (either t-test or chi square) based on endorsement or nonendorsement of the item (Cohen, 1977).

Results

General Attitudes Toward Disabled People

It was hypothesized that attitudes toward disabled persons would be positively related to family dimensions of cohesion and independence; and negatively related to the family dimension of conflict. When maternal attitudes toward disabled people, as measured by the ATDP, were correlated with family function measures, using the Spearman rho correlation coefficient, the following findings emerged: More positive maternal attitudes were correlated with increased family cohesion ($r = .63$, $p < .01$) and independence ($r = .39$, $p < .05$). T-tests on two individual variables measuring aspects of family response to the presence of a disabled child indicated that mothers in families with a member who might reject such a child ($N = 3$) had more negative attitudes toward disabled people ($p = .01$), than mothers who felt their families would be accepting ($N = 19$). Mothers who thought another family member beside herself might be involved in the care of such a child ($N = 4$) had more positive attitudes toward people with disabilities ($p < .05$) than mothers who thought they would have to care for such a child by themselves ($N = 17$).

It was hypothesized that positive attitudes toward disabled persons would be negatively related to both subject levels of depression and physical symptomatology. This hypothesis was not confirmed statistically. However, there was a clear trend in this direction.

Specific Attitudes Toward a Disabled Child

Attitudes toward a disabled child were measured by a scale assessing maternal perception of how personally stressful it would be to have such a child present in the family. It was hypothesized that maternal stress would be related both to variables of family function and individual adjustment. Perceived maternal stress did not appear to be significantly related to the 3 dimensions of family function under investigation (cohesion, independence, conflict). However, the degree of mother's perceived personal stress resulting from such a child was related to maternal depression (Pearson correlation coefficient $= -.38$, $p < .05$). As positive mood increased in respondents, perceived stress decreased.

Coping Responses

It was hypothesized that problem-focused, emotion-focused, and normalization coping strategies would be positively related to family cohesion and independence; and negatively related to family conflict, individual depression, and health symptoms.

The problem-focused item, "seeking solutions," was not statistically related to any individual or family variables. Mothers who endorsed the emotion-focused coping strategy "seeking reassurance" ($N = 15$), tended to perceive themselves as having less physical symptoms ($t = -3.05$, $df = 19$, $p < .01$) than mothers who did not endorse this strategy ($N = 7$). Mothers who endorsed the normalization cognitive coping strategy (i.e., "a disabled child can lead a full, happy life") ($N = 13$) rated themselves as having significantly fewer physical symptoms ($t = -2.24$, $df = 20$, $p < .05$) and less depressed ($t = -2.16$, $df = 20$, $p < .05$) than mothers who failed to endorse this item ($N = 9$).

It was also hypothesized that negative coping strategies would be inversely related to family cohesion and independence; and positively related to family conflict; as well as to increased subject depression and physical symptomalogy. In terms of avoidance coping, mothers who reported they would try to avoid thinking about their child's problem ($N = 12$) perceived their family environments to be significantly less cohesive ($X^2 = 13.40$, $df = 6$, $p < .05$) and containing more conflict ($X^2 = 13.75$, $df = 6$, $p < .05$) than mothers who felt that they would not use this strategy ($N = 8$). Mothers who used self-blame (i.e., disability is a punishment from God) as a cognitive coping process ($N = 5$) also saw themselves as being more depressed ($t = 2.59$, $df = 20$, $p < .05$) than mothers who rejected this strategy ($N = 17$).

In summary, hypotheses regarding respondent attitudes toward disabled persons were accepted for family variables of cohesion and independence, but were rejected for the variables of family conflict, respondent depression, and respondent health. Hypotheses regarding perceived respondent stress were not confirmed for any family variables, or for respondent health, but the hypothesis regarding perceived stress and respondent depression was upheld. In terms of respondent coping, hypotheses regarding family function variables were rejected for problem-focused coping, emotion-focused coping, normalization, and blame; but were supported for the coping strategy of avoidance. Hypotheses regarding the relationship between respondent depression and coping were supported only in the case of respondent self-blame; while hypotheses regarding the relationship between respondent coping and health were upheld in the cases of emotion-focused coping and normalization coping.

Discussion

The small size of the sample makes consideration of the data purely exploratory. This is partly because sampling techniques did not allow for a complete randomization, thus limiting generalizeability. In addition, while only statistically significant findings are reported, it appeared that, had the sample size been larger, many of the nonsignificant results might have achieved significance, thus strengthening confirmation of the hypotheses tested. Nevertheless, it is possible to conclude that the findings reported point to important relationships which deserve to be investigated on a larger scale.

Overall, in terms of the research questions posed at the start of this article, there was some indication from this study that individual and family functioning are related to (a) respondent attitudes toward disabled people, (b) perceived stress associated with having a disabled child, and (c) the types of coping strategies the individual would employ in an attempt to adapt to the presence of such a child in the family. More positive attitudes toward disabled people were correlated with families that were warm and supportive, and that also encouraged independence. How stressful the mother felt such a child would be was highly related to maternal depression. Type of coping strategies employed also appeared to be related to individual and family function. "Positive" strategies were associated with a more positive mood, better physical health, and healthier family constellations (more cohesion, more independence, and less conflict).

This study sheds some light on those factors that are related to the attitudes toward disabled persons or children held by women from a low socioeconomic, Hispanic background. Individuals with higher levels of individual and/or family functioning had more positive attitudes; felt they would be less stressed by such a child; and speculated that they would tend to utilize positive, rather than negative, coping strategies. This research lends support to the importance of considering family environment and functioning in understanding the attitudes and responses to disability by individuals from another culture.

Further research is needed to determine whether a similar relationship exists between attitudes, coping, and individual and family functioning in populations from other cultural and ethnic backgrounds. Studies employing a larger number of subjects are also necessary to allow for the more sophisticated statistical analyses needed to understand more precisely the interactions among these variables.

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