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“un Abrazo A La Distancia”: Exploring Challenges Of Social Isolation In Pregnant Latina Women

Talia Robledo-Gil

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“Un abrazo a la distancia”: Exploring Challenges of Social Isolation in Pregnant Latina Women

A Thesis Submitted to the
Yale University School of Medicine
in Partial Fulfillment of the Requirements for the
Degree of Doctor of Medicine

by
Talía Robledo-Gil

2018
ABSTRACT:

“UN ABRAZO A LA DISTANCIA”: EXPLORING CHALLENGES OF SOCIAL ISOLATION IN PREGNANT LATINA WOMEN

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Social support during pregnancy is an important indicator for improved maternal and neonatal birth outcomes. We sought to understand Spanish-speaking Latina women’s perspectives about social support and social isolation during pregnancy. We recruited Spanish-speaking women ages 15-44 at less than 24 weeks estimated gestational age from urban walk-in pregnancy care sites in New Haven, CT, during the period from June 2014 to June 2015. We collected quantitative and qualitative data via self-administered, in-person surveys and semi-structured interviews, respectively. Interviews were conducted to explore women’s pregnancy intentions, initial reactions to new pregnancy, and feelings about the impact of this pregnancy on their lives. Content analysis was used to examine the transcripts text with the aid of Atlas.ti software. The sample included 31 Latina/Hispanic women who chose to be interviewed in Spanish. Participants averaged 28 years, with mean gestational age of 7(±2) weeks. Most were mothers already (87%), unmarried but living with a partner (51%), and reported this pregnancy as intended (68%). We identified social isolation as a central theme that was characterized by four interwoven and overlapping subthemes: (1) Sola - being alone; (2) Familismo cercano- experiencing challenges in relationships with children and partner(s); (3) Familismo lejano- maintaining relationship with other supports; and (4) Mi patria- preserving homeland cultural connectedness. Our findings suggest that social isolation among Spanish-speaking pregnant women may reflect loss of social support. Language preference may serve as a marker for Limited English Proficiency and the acculturation process, and may suggest the need for greater provider awareness and community support following confirmation of a new pregnancy diagnosis.
ACKNOWLEDGEMENTS:

I would first like to thank Dr. Aileen Gariepy for her tremendous support and guidance throughout this project. I did not have very much prior formal experience with qualitative research, but I knew I had a passion for using research to better inform the medical community of social determinants of health, particularly amongst the Latino/Hispanic community. Dr. Gariepy helped me further foster this interest and steered me through the process of learning and conducting qualitative analysis. I would also like to thank Shakkaura Kemet for the multiple discussions about what social isolation meant and the ultimate creation of the codebook. Furthermore, a big thanks to the members of the EXPRESS team, including Dr. Meredith Pensak, Dr. Abigail Cutler, Blair McNamara, Holly Kennedy, and Lisbet Lundsberg, for their tremendous contributions throughout the process of this project. Dr. Lundsberg was instrumental in helping me navigate explanation of methods and brainstorming ways to visually depict the findings.

Furthermore, I would like to thank Kayleigh Herrick-Reynolds for her tremendous support and discussion throughout the analytical phase of this process, which helped me better understand the patterns in my data. Additionally, I greatly thank my parents, particularly my mother, who felt very identified upon reading my thesis drafts, since she shares this experience of being sola as a newly immigrated pregnant Latina woman. Finally, a special thank you to the participants in our study and the many women who share in the struggles of being in a new place with unfamiliar surroundings. My work is meant to help be a better advocate for you and to elevate your voice in this discussion.
**Funding:** Ms. Robledo-Gil’s research funding was supported by the National Institute of Diabetes and Digestive and Kidney Diseases of the National Institutes of Health under Award Number T35DK104689, with additional funding from Yale University Medical Student Research Fellowship. Dr. Lundsberg and Dr. Gariepy were supported by grants received by Dr. Gariepy (NIH CTSA ULI TR000142 and the Albert McKern Scholar Awards for Perinatal Research). Funding sources had no involvement in the study or manuscript. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.
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FOREWORD:

I clearly remember that the objective of one of my first patient encounters as a medical student was to obtain a social history. As a newly minted health professions’ trainee in my starched, pristine, short white coat, I felt comfortable asking this litany of what can often feel like invasive and uncomfortably probing questions. Unlike some of my classmates, I felt that getting at the crux of what a person’s life was like, from the number of bedrooms in their home to the details of their drug use history, was vital to getting a sense of who I was taking care of. One of my primary motivations for entering medical school and what I focused my medical school personal statement on was my interest in understanding a patient’s personal context to best provide care tailored to their circumstance. Thus, finding that this aspect of the patient history was on the priority list made me feel comforted in choosing to pursue my professional development at Yale School of Medicine.

As I have progressed through my four years of training, my appreciation for the primary importance of the social history has expanded. If a patient is homeless, I realized that increasing their dose of Lasix was likely not going to be feasible since having frequent access to a bathroom was off the table. I found time and time again that asking about who a person turned to for support was also fundamental. For the 85-year-old formerly independent woman with a new hip fracture, it was important for me to understand that despite her closest son living in Ohio, she still wanted our team to talk to him daily. For the pregnant 16 year old patient, I needed to understand who was the trusted adult that she wished to share this news with, since we needed this person to be involved in future visits.

As a Latina myself, I have witnessed the importance and centrality of family relationships. In some cases, social support is synonymous with family, which
embodies the importance of these relationships for one’s well being. For one of my good friends who grew up in a boisterous Cuban family, it was necessary to have her parents, her uncle, her two cousins, and her grandparents present for the big college move from Miami to Boston. For my parents, who left behind their closest family and friends in their native country of Peru, I witnessed how challenging it was and continues to be for them to truly feel at home in this *new* country, even almost 30 years after their arrival. I found that in Spanish conversations with my Latino patients they often disclosed similar concerns, stating that they did not have the persons they truly relied on nearby.

Hearing this collection of experiences and stories made me curious about what was particular to this culture and community. Moreover, how can we take this understanding and apply it to concrete interventions? This curiosity is what drew me to Dr. Aileen Gariepy and her group’s work on the EXPRESS study, which stands for Experiencing Pregnancy Sharing Stories. For me the importance of harnessing stories and women’s experiences during the vulnerable period of pregnancy seemed essential to identifying how to best be an advocate for this community. By focusing on the stories that Spanish-speaking women shared with our research team, I hope to help inform the medical and academic community about cultural differences that can have large impacts on health care and health outcomes, in an effort to improve health inequities in this population. The only way to achieve this is by amplifying the voices of those who are often not heard, allowing space for these women to showcase their stories.
INTRODUCTION:

The idea of social support and its importance moved to the forefront of scientific research in the 1970s, particularly with respect to its relationship to mental health. The emergence of the importance of social support within the field of medicine is evident in 1976, when Dr. Sidney Cobb made a pivotal statement as part of his Presidential Address to the American Psychosomatic Society’s annual meeting:

“Social support is defined as information leading the subject to believe that he is cared for and loved, esteemed, and a member of a network of mutual obligations...It appears that social support can protect people in crisis from a wide variety of pathological states: from low birth weight to death, from arthritis through tuberculosis to depression, alcoholism, and the social breakdown syndrome.”

Social support can come from relationships with partners, relatives, friends, co-workers, and broader community ties, in the form of verbal communication, actions, and other behaviors. It has been further categorized into three main categories: “instrumental (e.g., help with tasks), informational (e.g., advice), and emotional (e.g., a sense that one is loved, cared for, and listened to) support”. These forms of support can impact a variety of factors, from allowing a patient to keep medical appointments and ensuring medications are taken on a daily basis, to helping individuals cope with the news of an unexpected diagnosis. In support of these anecdotal examples, studies have shown that positive social support plays a role in recovery after major illness, such as improved recovery after stroke and better quality of life in women with a breast cancer diagnosis.
In defense of the critical need to address and understand social support, House et al amassed data from several prospective studies and in their 1988 publication explained their findings of how low quantity and low quality social relationships increased mortality. In addition to examining these studies in humans, they also found animal studies that echoed this same association between social isolation and mortality. In their late 1980s publication in *Science*, House et al concluded that:

“These developments suggest that social relationships, or the relative lack thereof, constitute a major risk factor for health—rivaling the effects of well-established health risk factors such as cigarette smoking, blood pressure, blood lipids, obesity, and physical activity.”

This controversial yet groundbreaking statement had major implications for how medicine was practiced and what factors came to be considered important for health, namely the lack of social relationships.

Since then, numerous studies have tried to better understand the link between social isolation and its deleterious effect on health. One such investigation conducted several decades after these initial statements identified a strong link between social isolation and poor survival in patients with significant coronary artery disease, resulting in an increased mortality rate in more isolated individuals. Thus, more current investigative efforts have continued to support House’s statement: “without social ties, distress emerges and health fails.”

Another important consideration is how social relationships are impacted by geography and proximity to social networks. In a recent study from the Wisconsin Medical Journal, researchers explored the relationship between women’s geographic isolation and social support on their health, including both self-perceived and actual
ailments. This was particularly interesting since many of these women lived in remote, rural areas, limiting their opportunities for social contact. This study also distinguished between two different types of support: belonging and tangible support. Belonging support was defined as perceptions of access to people who one can engage in activities with, while tangible support was defined as perceptions of how available material supports were. The researchers identified that geographic isolation served as a negative predictive factor for access to both types of support. As expected, there was a positive correlation between higher levels of social support and better self-perceived health status.

This body of literature importantly demonstrates the inextricable link between social networks, geography, and health outcomes. It requires us to think critically and assess how these factors are at play in our own environment. As summarized by Umberson and Montez’s 2010 publication, “given the ability of social ties to have both positive and negative effects on health, existing research has likely underestimated the true impact of social ties on health. Future research should consider how the positive and negative facts of social ties work together to influence health outcomes, as well as consider how this balance may vary over the life course and across social groups.”

One such life stage to consider is pregnancy. One pivotal study from 1972 conducted by Nuckolls et al used a scoring system to assess a woman’s ability to adapt to a pregnancy, through a questionnaire to identify a woman’s psychosocial assets. These psychosocial assets include the primary components of social support as previously described, including marriage, relationships with extended family, and community relationships. The main conclusion from this study was that women who had higher levels of psychosocial assets, or social support, had dramatically
lower levels of pregnancy complications, as compared to their comparison group with low psychosocial assets, which is hypothesize to be due to a protective aspect of social support.  

Additional studies have built upon this foundation by identifying how social support contributes to healthy behaviors, which leads to better maternal and child health outcomes. These studies report that social support is associated with better maternal health before and during pregnancy, including improved adherence to recommended antenatal vitamin intake, improved glycemic control for women with gestational diabetes, higher birth weights, and better mental health outcomes. In addition to positively impacting these health behaviors, positive social support is important for buffering the effects of overall stress during pregnancy. Conversely, lack of social support, especially from family, and stress are associated with poor maternal and pregnancy outcomes, including depression, low birth weight and preterm birth.

As has been documented in other aspects of health outcomes, the protective effect of social support in pregnancy varies by maternal race, ethnicity, and cultural values, and appears especially important for pregnant Latina/Hispanic women, with differences even noted between those born in the U.S. versus abroad. In a study of U.S.-born Latinas, foreign-born Latinas, and non-Latina U.S. born European American women, social support during pregnancy was associated with higher infant birth weight among foreign-born Latinas only. Benefits of social support may be due

* The U.S. Office of Management and Budget “defines "Hispanic or Latino" as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race” (23. Hispanic Origin. at https://www.census.gov/topics/population/hispanic-origin/about.html.). In our analysis, we will use the term “Latina/Hispanic” to include all women identifying within this ethnic community. In text where only one or the other is used, we are using the language used in the primary data.
to the high value Latin American cultures place on *familism*, also called familialism.\textsuperscript{24-26} Cultural psychologists have previously described Latino culture “as a collectivist culture that prioritizes warm, emotionally positive social interaction and places special importance on close family relationships”.\textsuperscript{24} When considering Latino *familism*, the primary distinction is the extent to which it focuses on emotionally positive, supportive family and community relationships as the center of social life and primary source of social support.\textsuperscript{24,27} However, data exploring social support and *familism* experienced by Spanish-speaking Latina women during pregnancy is sparse.\textsuperscript{27}

Understanding Spanish-speaking Latina women’s experience with pregnancy, social support, and social isolation is important given the changing demographics of the U.S. In 2015, the Latino population accounted for 17.6\% of the total U.S. population, amounting to 56.6 million people.\textsuperscript{28} The U.S. Latino population is projected to grow to 119 million, 29\% of the total population, by 2060.\textsuperscript{29} Forty million residents aged 5 and older spoke Spanish in the home, and 42.6\% of Spanish-speaking Latinos identified as Limited English Proficient (LEP), meaning that they reported speaking English less than “very well”.\textsuperscript{28} A large majority of LEP persons are immigrants, and those who are not have immigrant parents.\textsuperscript{30} One systematic review found that being Hispanic and LEP were risk factors for worse self-rated health—reporting health as fair or poor—compared to non-Hispanic Whites and Asians.\textsuperscript{31} Reproductive health outcomes are also important in this population. In 2010 Hispanic women had the highest birth rate at 80.2 per 1,000 women, as compared to 66.6 per 1,000 in non-Hispanic black women and 58.7 per 1,000 in non-Hispanic white women.\textsuperscript{32} Although a recent report from the CDC cited declines in overall teen birth rate, Hispanics still have the highest teen birth rates at 38 per 1,000 births among 15-
19 year olds, compared to non-Hispanic black and non-Hispanic white women of the same age (34.9 and 17.3 per 1,000, respectively), demonstrating ethnic/racial differences.

Considering the growing Latino population, proportion of LEP Latinos, and high birth rates in this population, it is increasingly important to understand Spanish-speaking Latina women’s experiences with pregnancy in the U.S. To do so, we conducted in-depth interviews with Spanish-speaking Latina/Hispanic women with a new pregnancy diagnosis and evaluated their perspectives on social support during pregnancy. Since most study participants expressed aspects of social isolation, we explored the components and intersectionality of this isolation.
STATEMENT OF PURPOSE:

The EXPRESS study, from which our data derives, was designed to identify relationships between a woman’s pregnancy intention and several reproductive health outcomes, including possible symptoms of depression, anxiety, stress, and lack of social support. In this thesis, we are conducting analysis on the subset of women who chose to conduct their interview or focus group in Spanish. The purpose of focusing on this subset is to explore the particular experiences of pregnancy in Spanish-speaking women with a new pregnancy diagnosis in an urban U.S. setting. We believe that this subset will allow us to better explore particular concerns of this community. By using a systematic approach to qualitative data analysis, we will be able to identify common themes throughout the analyzed conversations. Additionally, we hope that this analysis will help to better inform screening tools and interventions to best address the needs of these women.
MATERIALS AND METHODS:

Contributions:

I, Talia Robledo-Gil, was responsible for the creation of this project within the larger EXPRESS study. My project focused on the Spanish-speaking interviews and focus groups. I was responsible for the literature review, transcript re-editing, codebook development, and analysis. With feedback from other team members, I developed the figure for this paper, which visually represents overall conclusions from my qualitative analysis.

Methods:

We conducted individual interviews and focus groups with pregnant women enrolled in a prospective cohort study to assess how a new pregnancy impacts the lives of women. Women who presented for pregnancy testing and abortion care were recruited from two sites in New Haven, CT from June 2014 to June 2015. Eligibility criteria for the whole study included: Spanish- or English-speaking, gestational age less than 24 weeks, ages 15-44 years old, and completion of study enrollment within one week of positive pregnancy test or their pre-op appointment. All eligible women were offered participation in this study. Detailed study methods have been published previously. From the overall cohort (n=161), a total of 42 women completed the study in Spanish. Of the 42 Spanish-speaking women, we excluded 4 women recruited from abortion care sites, to focus on the experience of women with a new pregnancy diagnosis, often a particularly vulnerable time before they had made a decision about whether to end or continue the pregnancy. Among those 38, four did not complete qualitative interviews and three interviews were not recorded. Our final sample for analysis consisted of qualitative interviews from 31 Spanish-speaking participants. Participants were offered the choice to participate in one-on-one
interviews or focus groups. Twenty-seven women chose to participate in one-on-one interviews and four elected to participate in two-person focus groups. Yale University’s Human Research Protection Program reviewed and approved the study protocol and all study participants gave written informed consent.

At study enrollment, participants completed a self-administered paper questionnaire that collected demographic data and reproductive history. We evaluated multiple pregnancy “contexts” including assessments of pregnancy intention, wantedness, planning, timing, desirability, and happiness. Study interviews were audio recorded and facilitated by two Spanish-speaking moderators who followed a semi-structured interview guide to explore women’s pregnancy intentions, their initial reactions to learning about this new pregnancy, their feelings about the impact of this pregnancy on their lives, how they thought the person they got pregnant with would feel once learning of pregnancy and how his reaction might influence them, the importance of the relationship with the person they got pregnant with, how the pregnancy might impact daily life (finances, work, or school), and how relationships with family and friends may be impacted by the pregnancy (Appendix). Both moderators were Latina/Hispanic and bilingual in English and Spanish.

Bilingual research assistants fluent in Spanish transcribed the audio files. A native Spanish speaker then verified all of the Spanish transcriptions using the original audio files, and then translated the transcriptions into English. A second native Spanish speaker (Robledo-Gil) verified the English translation by cross checking all English transcripts against the original Spanish audio files and made any necessary edits. Transcripts were initially examined without coding to identify major themes. Constant comparison was utilized in an iterative fashion until no new themes emerged. We organized codes into themes that reflected the content across all of the
data. The identified codes were organized into a codebook, and all transcripts were analyzed using this codebook (Robledo-Gil). To assess interrater reliability, two team members (Robledo-Gil, Kemet) coded the same five transcripts using the codebook, met to reconcile any coding discrepancies, and reached consensus (>85% agreement). Atlas.ti software was used to organize documents, code transcripts, and assign themes.

Country of origin, immigration status, and specific questions about social support or social isolation were not included in the interview guide. Women independently described issues related to social isolation over the course of the interview, which is the focus of this analysis.
RESULTS:

All eligible women who chose to conduct their interview in Spanish (n=31) self-identified as Latina/Hispanic. Participants were 28 years old on average with a mean gestational age of 7±2 weeks (Table 1). Most study participants had at least a

Table 1. Participant characteristics and sociodemographics, n=31

<table>
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<tr>
<th>Characteristic</th>
<th>n (%)</th>
</tr>
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<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Mean age in yrs (SD)</td>
<td>28.4 (6.5)</td>
</tr>
<tr>
<td>Gestational age at Enrollment</td>
<td></td>
</tr>
<tr>
<td>Mean gestational in weeks (SD)</td>
<td>7.6 (2.4)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>&lt;12 years</td>
<td>5 (16.1)</td>
</tr>
<tr>
<td>HS diploma/GED</td>
<td>15 (48.4)</td>
</tr>
<tr>
<td>Some college, college degree</td>
<td>11 (35.5)</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td>Unemployed/homemaker</td>
<td>20 (64.5)</td>
</tr>
<tr>
<td>Full time/part time</td>
<td>11 (35.5)</td>
</tr>
<tr>
<td>Relationship status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>5 (16.1)</td>
</tr>
<tr>
<td>Married</td>
<td>9 (29.0)</td>
</tr>
<tr>
<td>Living with partner, not married</td>
<td>16 (51.2)</td>
</tr>
<tr>
<td>Separated, divorced, widowed</td>
<td>1 (3.2)</td>
</tr>
<tr>
<td>Parity</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>4 (12.9)</td>
</tr>
<tr>
<td>1</td>
<td>14 (45.2)</td>
</tr>
<tr>
<td>2+</td>
<td>13 (41.9)</td>
</tr>
<tr>
<td>Previous miscarriage</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11 (39.3)</td>
</tr>
<tr>
<td>No</td>
<td>17 (60.7)</td>
</tr>
<tr>
<td>Previous abortion</td>
<td></td>
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<tr>
<td>Yes</td>
<td>8 (30.8)</td>
</tr>
<tr>
<td>No</td>
<td>18 (69.2)</td>
</tr>
<tr>
<td>Ever diagnosed with depression</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3 (9.7)</td>
</tr>
<tr>
<td>No</td>
<td>28 (90.2)</td>
</tr>
<tr>
<td>Ever diagnosed with anxiety</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2 (6.5)</td>
</tr>
<tr>
<td>No</td>
<td>29 (93.5)</td>
</tr>
<tr>
<td>Intentions regarding pregnancy</td>
<td></td>
</tr>
<tr>
<td>I intended to get pregnant</td>
<td>21 (67.7)</td>
</tr>
<tr>
<td>My intentions kept changing</td>
<td>5 (16.1)</td>
</tr>
<tr>
<td>I did not intend to get pregnant</td>
<td>5 (16.1)</td>
</tr>
<tr>
<td>Wantedness</td>
<td></td>
</tr>
<tr>
<td>Wanted to have a baby</td>
<td>21 (67.7)</td>
</tr>
<tr>
<td>Had mixed feelings about having a baby</td>
<td>7 (22.6)</td>
</tr>
<tr>
<td>Did not want to have a baby</td>
<td>3 (9.7)</td>
</tr>
<tr>
<td>London Measure of Unplanned Pregnancy</td>
<td></td>
</tr>
<tr>
<td>Planned</td>
<td>17 (54.8)</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>13 (41.9)</td>
</tr>
<tr>
<td>Unplanned</td>
<td>1 (3.2)</td>
</tr>
<tr>
<td>Timing</td>
<td></td>
</tr>
<tr>
<td>Right time</td>
<td>23 (74.2)</td>
</tr>
<tr>
<td>Okay but not quite right time</td>
<td>8 (25.8)</td>
</tr>
<tr>
<td>Wrong time</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Desired pregnancy</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>29 (93.6)</td>
</tr>
<tr>
<td>Not sure</td>
<td>1 (3.2)</td>
</tr>
<tr>
<td>No</td>
<td>1 (3.2)</td>
</tr>
<tr>
<td>Happiness with pregnancy news</td>
<td></td>
</tr>
<tr>
<td>Very or somewhat happy</td>
<td>28 (90.3)</td>
</tr>
<tr>
<td>Neither happy/unhappy: don't know</td>
<td>3 (9.7)</td>
</tr>
<tr>
<td>Very or somewhat unhappy</td>
<td>0 (0.0)</td>
</tr>
</tbody>
</table>

Totals may not add to n=31 due to missing observations
high school diploma/GED or some college/college degree (83.9%), reported a prior birth (87%), and were unemployed or homemakers (65%). Approximately half (51%) were living with a partner but not married, while 29% were married. Few women reported a history of depression (10%) or anxiety (7%). In response to questions about their pre-pregnancy perceptions, 68% of women reported that they had intended to get pregnant and the same proportion (68%) had wanted a baby, while 54% reported answers to the London Measure of Unplanned Pregnancy scale indicating that they had planned to get pregnant. In response to questions about their post-pregnancy perceptions, 74% reported that it was the right time to be pregnant, 94% stated the pregnancy was desired, and 90% felt very or somewhat happy with the pregnancy news.

In addition to all participants being Latina/Hispanic and Spanish-speaking women, some participants (29%) implied being distant from their native country, through statements such as “my country” when not referring to the U.S., referencing connection to another “country”, or explicitly mentioning that their support networks were in Ecuador, Guatemala, or Mexico. These comments suggest geographic isolation. However, we did not quantitatively assess participants’ country of birth, immigration status, whether they lived with or near family, or other measures of geographic isolation.
During their interviews, 19 women (61%) described one or more aspects of social isolation. Pregnancy-related social isolation was associated with four subthemes that were interwoven and linked: (1) *sola*- being alone; (2) *familismo cercano*- experiencing challenges in relationships with children and partner(s); (3) *familismo lejano*- maintaining relationship with other supports; and (4) *mi patria*- preserving homeland cultural connectedness.

A visual representation modeling this understanding of social isolation is shown in Figure 1. In this figure, each circle represents a different sphere of influence. The spheres are overlapping and linked by social isolation to depict the complex intersectionality between all of these considerations for the individual woman, and when considered together represent the women’s sense of social isolation.

**Figure 1. Social Isolation.** Visual representation of women’s perspectives on social isolation and its components.

In this figure, each circle represents a different sphere of influence: (1) *Sola* - being alone; (2) *Familismo Cercano* - experiencing challenges in relationships with children and partner(s); (3) *Familismo Lejano* - maintaining relationship with other supports; and (4) *Mi patria* - preserving homeland cultural connectedness. The spheres are overlapping and linked by social isolation to depict the complex intersectionality among these components for each individual woman and, when considered together, represent a woman’s sense of social isolation.
1. Sola—Being alone

In response to questions about how women felt after finding out they were pregnant, many women described feeling alone, or “sola.” They were either alone without any family, or with just a husband or a child but nobody else.

“I have many friends. I don’t have family here. I’m all alone, with my son. He’s my family.”

Several women mentioned having family “far away”, or no family “here”, and distinguished between their own family of origin compared to their partner’s family. One woman from Ecuador described:

“I don’t have much family here. Most of my family lives in my country, Ecuador. And the only family that I have is my husband’s, which truthfully I have not seen in the last few days.”

Geographic isolation often contributed to women’s feelings of loneliness. Being alone and away from their sources of support created a social isolation that seemed overwhelming. One woman who moved to New Haven three years ago and identified herself as being “far” from her family shared this when asked how she was feeling now:

“Happy. Eh, happy, but a little exhausted. And let’s see, a bit worried because well I’m the only one out here…Mm, well who knows, since I’m going to be alone here. No, no I
can’t explain it. I can’t explain how everything is going to be around here.”

For this participant, being alone and being socially and geographically isolated contributed to uncertainty and concern about the future. While many other women shared their concerns about distance from family, friends, and other support systems, these examples show women who deliberately articulated being sola.

Some women described receiving visitors from abroad who had come to help relieve the burden of doing everything on one’s own. A woman from Ecuador with a young child at home and a new pregnancy described the assistance provided by her temporary visitor:

“…I have someone who is just visiting and if it were not for her, I wouldn’t do anything in the house because she helps me with everything, watches my baby, changes him…because I can’t tolerate much and I’m barely cooking due to the smell of food. So then, my daily activities have decreased by 90%.”

She received relief and respite by having a visitor come to help her with daily tasks, a type of support that she had limited access to otherwise.

Another woman from Mexico, in recounting whom she shared her pregnancy news with, discussed that her mother was visiting, planning to stay for another month, and return to the U.S. the following year to help. Her detailed description of her mother’s current visit and anticipation for future visits reflects the significance of
these stays. These women described consolation in having their support systems come
to them *here*, and even briefly relieve them of the burdens of being *sola*.
2. Familismo Cercano—Experiencing Challenges in Relationships with their Children and Partners

The theme of social isolation was also reflected in how women spoke about their relationships with their children and partners. As previously discussed, *familismo* as it pertains to the Latino community places family relationships at the epicenter of one’s social networks and primary social support. The importance of *familismo* to our participants is emphasized by their high regard for immediate family members—particularly partners and children, regardless of where they are. These reflections often revealed that loved ones were not in the U.S., but in another country.

When reflecting on their new pregnancy diagnosis, some women also described feeling conflicted about prior partners. One woman recounted leaving behind an abusive partner, the father of her daughter, in Ecuador when she moved to the U.S. Now newly pregnant with a different partner, she expressed feeling conflicted between returning to her former partner of many years or staying with her new partner in the U.S., and having mixed feelings about the pregnancy itself.

“Now I am living in a bit of a complicated situation, one would say, because I lived 12 years with the father of my daughter, and I have always loved him, and I continue to love him, the father of my daughter- not the father of the baby I’m expecting. So then he [daughter’s father] wants me to return to Ecuador so I can be with him there; therefore for that reason I also don’t want this baby, because the father of my daughter says no, to abort so I can go to be with him. So that is what has me like this. I was with him for 12 years, and with the partner I now have I
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have been with him 6 months, so I am unsure about my
feelings, and I don’t know what to do."

Despite being the victim of abuse and mistreatment by her former partner in Ecuador, she continues to feel a commitment to him. It is apparent the respondent is struggling with multiple, opposing emotions, including obligation and ambivalence. We don’t know what contribution, if any, comes from feelings of social isolation. Perhaps her ambivalence about going back to him is indicative of her obligation and desire to return to her familiar networks and community. Conversely, abusive relationships are also marked by power struggles and efforts by abusers to try to reclaim relationships if and when a victim establishes a new relationship.

One participant originally not from the U.S. delved into the hardship of having her four-year old daughter live apart from her. The daughter lived with the participant’s mother (child’s maternal grandmother) in another country for the last 2 years. Her daughter’s visits to the U.S. are very limited, for one week once a year. When asked how she felt about her daughter, she responded:

“Well, I am a bit sad because I would like for her to be here [in the U.S.], with us. Because, it's not, it’s not the same that she is over there and we are here. No truthfully, I don’t even know what she likes, don’t know what she thinks.”

The participant’s mother had become the primary caregiver of the daughter. While the daughter can come to the U.S. to live, the participant’s mother did not want that, further complicating the situation by limiting the parental/child bond. This may
further feelings of social isolation.

“…she [the daughter] can stay here. But the problem we have is with my mother. My mother is too accustomed to her [being there]. And every time she [the daughter] comes [here] she [my mother] gets very sick and sad. That’s why we have to let her return [to my mother]…it makes it difficult…No, no she [my mother] cannot come.”

While it pained this woman to live socially and geographically isolated from her daughter, bringing her daughter to the U.S. is not a solution. Instead, it would devastate her own mother, potentially creating further social and geographic isolation. This example portrays the overlapping tensions between the spheres of familismo cercano and familismo lejano (below). This woman was willing to sacrifice her own well-being in order to comfort her mother, suggesting a deep sense of familism.

Distance seems to largely underlie and highlight these women’s feelings of ambivalence and isolation, while also emphasizing the reverence they feel for family and friends, as portrayed in the prior and following cases.
3. Familismo Lejano—Maintaining relationships with other support

Despite the distance between these women and their countries, communities, and families, many described heavily relying on family, friends, and other sources of support far from here. Many women overcame this challenge via utilization of long-distance communication. Some mentioned speaking to family in Mexico over the phone or calling a best friend in Ecuador every day. For these women when it came to sharing news of a pregnancy, overcoming the potential barrier of distance was necessary for sustaining their relationships abroad.

Conversely, for other women, these modes of communication did not help address the challenges of geographic isolation. They were unable to communicate as frequently as they would have liked or had to rely on suboptimal means of communicating personal news.

“[Relationships] With my friends they are very good and with family also, but I really don’t have communication with them because they live in another country and well I’m far from my family. Basically [I communicate] by computer.”

One woman mentioned no longer having her father’s phone number, which prevented her from sharing her pregnancy news. Another woman from Mexico mentioned the challenge of relying on the telephone to talk to her father who, even in person, was difficult to communicate with.

“[not told]…Well, my father, well, it’s not that he’s very strict, he just speaks quickly. When I talk to him by telephone, he talks more. And I say, how are you father?
I’m fine, everything’s fine, he says. And he’s said what he has to say.”

These women made it clear that the people with whom they most wanted to share the news of pregnancy were often not here, but instead resided in these women’s homelands.

Whether for personal or cultural reasons, some women were particularly cautious about sharing pregnancy news with those far away. Similar to what is observed in women of other cultures, some participants verbalized apprehension about announcing their pregnancy news and stated that they wanted to be “100% sure” or certain that “everything [will] come out fine…don’t want to…get our families hopes up”. Other women described sharing news with people geographically close to them, but not with those living further away. One woman living far from her sister in another country showed great apprehension when considering how to best share news of her pregnancy across long distances. In contrast, she did not give a second thought when it came to sharing news with family and persons geographically close to her:

“I don’t know, I don’t know. I haven’t told her [my sister]. I don’t feel it’s the moment to tell her. I haven’t told anyone in particular in my family. Not even my sister, no one. The only one that knows is my mom, my husband, my closest friends here and my boss. My sister doesn’t live here.”

It is notable that there are people—those here, such as a neighbor—that were privy to the news of the pregnancy, suggesting a different taboo or at least a reluctance to
communicate news by phone or online, across geographic lines. Similarly, another woman felt it was “bad luck” to reveal the news prior to the first three months of pregnancy, even though her friends and family _here_ knew before then that she was pregnant, as a result of having witnessed her symptoms of pregnancy.

By contrast, for a woman from Ecuador, the lack of communication with her father served to confirm the good, “happy” news about her pregnancy. Her father expected that no news meant good news:

“[Their response to the news]…Good. I know my father is happy, because I told him more or less. He said “oh, if you don’t call me this Monday, it’s because you are going to say yes [I am pregnant].” And I haven’t called him, so I assume that he’s happy. Yes, he wanted another…he told me not to let too much time pass by.”

For this woman, there existed a tacit understanding with her father that no communication meant she was pregnant. Despite the minimal conversation, there exists a strong bond between this woman and her father, so much so that she has an understanding of his happiness even without directly communicating with him.

Sharing news and communicating with family members was central in the interviews, reflecting the high priority women place on these support systems, which withstand the stress presented by long distance communication. Most participants described strong emotional ties with these networks, which continued to keep them connected. Some were able to maintain contact, helping to decrease their social isolation, while other women struggled, likely amplifying their feelings of social isolation.
4. Mi patria: Preserving Homeland Cultural Connectedness

During our interviews, it became evident that specific cultural identities, with respect to a certain country or to Latino culture as a whole, played a role in perceptions of and solutions to social isolation. Despite being away from their home country or home culture, women encountered components of their native culture woven in their day-to-day experience. For instance, one woman from Mexico described how her cultural values with respect to child rearing differ vastly from those she observes in the U.S.:

“...in this country many people don’t dedicate more of their time to their children because of work and that. So then I try to, well with my daughter, with my first baby, I try to spend as much time with her as possible.”

This woman asserted that what she observes here is unlike what she is culturally expected to follow. In considering observations of childrearing in the U.S. versus in her own upbringing, she consciously decides to follow the type of parenting she was exposed to, choosing to follow her roots despite her surroundings.

Although differences between U.S. and Latino culture are often pitted against each other both in these women’s interview responses and in a broader context, it is important to realize that these tensions can arise even within Latino communities. Latino culture is not a single monolithic society, but rather is comprised of various ethnic and geographical identities and values. Women pointed out that even within Spanish language interactions there might be stark differences due to geographically linked customs and speech. One participant noted that the interviewer’s accent was Puerto Rican. The interviewer and study participant then briefly exchanged an
acknowledgement that members of different Latino cultures speak differently, whether in word choice or accent. This highlights an important regionalistic attitude as well as reality that not all Latinos are the same, which may exacerbate social isolation despite sharing a language. Women may not truly feel identified within their new Spanish-speaking community, and instead may feel more isolated.

Yet despite the differences, some women overcame geographic and cultural borders to find new communities. Some women felt a sense of unity in being a part of a larger U.S. Latino community. One woman quoted a common cultural idiom to show how despite strained financial circumstances, she will persevere in this pregnancy. When asked how her pregnancy was affecting her finances, one woman explained:

Participant: “Oh yes. It holds me back. It will have some effect. But as they say, the saying “where one eats, three can eat.”

Interviewer: That’s it, that’s the way Latinos are.”

There appears to be an understanding between the participant and interviewer that this is a cultural phenomenon, and something experienced and acknowledged within a shared cultural community.

The women in our cohort reported feeling tensions between understanding and embracing their new pregnancy in the U.S., and preserving and embodying their cultural heritage, which may be different. For some, preserving traditions may be a mechanism to overcome social isolation they feel when observing practices in their new culture. In other cases, a new culture – the U.S. Latino culture – emerges, serving as a possible solution for dealing with social isolation.
DISCUSSION:

In this study, we explored the impact of social isolation on Spanish-speaking Latina/Hispanic women’s perceptions of pregnancy and self. Participants spoke about being alone, being far from their children and partners, far from their friends and family, and far from their heritage. Some women maintained connections by relying on technology and engaging in cultural practices, while others felt overwhelmed by the separation. These Spanish-speaking women embody a unique connection to their homes and cultural relationships. They represent an important subset of Latinas, reflecting important considerations for health care and support during pregnancy and the perinatal period.

We can speculate that the women in this study may not feel as integrated into their communities in the U.S. or may be early on in the acculturative process, which could impact their sense of social isolation. Their strong ties and longing for their original communities may suggest a particular variation of familism, one that is experienced when moving to a new community. Despite not seeing or being with their primary support networks, these women continued to rely on their cultural values, and on their family members and friends who live far away. The importance placed on these support networks and cultural values emerged in several ways through our analysis—experiencing loneliness despite having a partner or child nearby; relying heavily on computers and text to frequently communicate with family members abroad; feeling an obligation to return to former, in some cases abusive, partners in their homeland; and contemplating the right time to share pregnancy news to their loved ones miles away.

In previous work, researchers have discussed the importance of maintaining pride about one’s country of origin and of keeping cultural traditions alive, as vital
parts of the immigrant experience.\textsuperscript{39} We found components of this in our study, such as how women compared child-rearing traditions in a home country with those they observed in the U.S.; moreover, they often deemed the practices they grew up with as being better than what they saw in the U.S. This sense of pride in valuing one’s cultural traditions above others may also serve as an extension of familism that is experienced when one resettles in a new place. In addition to this, the preference for these cultural practices may be an indicator of how far along in the acculturative process these women are. For women in the beginning of this acculturation process, the longing for their culture may reflect their overall sense of social isolation.

In prior studies focused on the Hispanic community, several scholars have discussed the concept of the Hispanic paradox. This phenomenon, first described in 1986, refers to the improved health of Hispanic/Latinos compared to their non-Hispanic black and white counterparts, when examining various health outcomes such as infant mortality, life expectancy, mortality from cardiovascular diseases, mortality from cancer, and other measures of functional status.\textsuperscript{40}

\textquoteright\textit{Although Hispanics are the least likely group to be insured in the United States and are among the groups with the lowest average household income, they appear to have protective factors that may reduce both the morbidity and mortality of many diseases, compared to that found among similarly disadvantaged groups}\textsuperscript{41}

This research suggests that lifestyle or perspectives unique to Hispanic culture account for these differences, such as familism’s powerful and fundamental role in these communities.
However, perhaps protective effect that familism may have in pregnancy is contingent on Latina/Hispanic women having their strong social support proximal to them, such as here in the U.S. Thus, if a woman’s family and support networks remain in another country, then her access to these networks may be limited, which could prevent her from experiencing the benefits of the Hispanic Paradox. The issue of proximity becomes particularly important when considering a person’s U.S. vs foreign-born status, and should be incorporated into exploration of social support in Latinos/Hispanics.  

In our study, we found that familism is indeed related to social isolation. The Spanish-speaking pregnant women in our group demonstrated a complex relationship with ideals and expectations of familism, which helped women overcome social isolation and in other instances enhanced it. Factors that may contribute to the positive health outcomes of the Hispanic paradox, such as family providing primary support, may become jeopardized when distance separates families and communities. The women in our study relied on and were comforted by their familial connections, but the physical distances were a major stressor and highlighted their feelings of social isolation. Thus, when considering the importance of social support as it pertains to Latina/Hispanic women during pregnancy, isolation and absence of these women’s typical primary support systems could potentially increase their health risk.  

Our study has several strengths. Unlike former studies that required Latina/Hispanic participants to have proficiency in English, we examined concerns of Latina women who specifically chose to complete the interview in Spanish without requiring an English proficiency. Moreover, focusing on language preference as a central characteristic of our study participants allowed us to identify factors that are specific to this Latina subgroup. Given that all participants in this analysis chose to
conduct their interview in Spanish, we can assume both a familiarity and preference for their native language, and hypothesize that these women spoke English less than “very well”, which has important implications as it pertains to health and well-being. For example, in one study examining general health, participants with LEP reported poorer health, which led to increased stress levels particularly at the beginning of their settlement in the United States and acculturation process.\textsuperscript{42}

Furthermore, our study captured women’s perspectives soon after their pregnancies were diagnosed. This improves upon earlier retrospective studies that interviewed women after delivery and asked them to recall what they experienced during pregnancy\textsuperscript{43-45}, which introduces a recall bias into the data collection process. Additionally, receiving a diagnosis of pregnancy may represent a complicated time in which women are vulnerable. Because of this, they may be willing to more readily share their concerns and fears in the hopes of finding comfort in others. Thus, in our study we were able to capture these concerns in real time since the interviews were conducted shortly after learning of a new pregnancy diagnosis.

On the other hand, our study has its limitations. For instance, our study is limited by incompletely assessing language preference and proficiency (e.g. why they chose to participate in Spanish versus English, and what their proficiency in English was), immigration status, birthplace, length of time in the U.S., the possible impact of acculturation, or their feelings of geographic isolation. Additionally, our analysis only focused on the 61\% of women in our cohort who spoke about isolation. We are unable to comment on whether the other 39\% of Spanish-speaking women in the cohort also experienced isolation, since the interview questions did not specifically address this issue.
Explicitly including inquiries regarding distance or time away from family and self-reported degree of social and emotional support would improve our understanding of women’s overall experiences with social isolation during pregnancy. It would allow us to better characterize the women in our cohort and possibly identify specific relationships between these elements, social isolation, and health outcomes. Future studies with a larger sample size that collect information on the aforementioned factors and on experienced isolation are needed to identify how social, cultural and geographic isolation in LEP Latinas may affect quality of life measures and pregnancy outcomes. With this information it may be possible to define and identify patterns of social isolation in these communities.

Nevertheless, our qualitative approach is a first step to unveil and decipher the complex relationships between social isolation, culture, and language during a new pregnancy. Future work would benefit from a mixed methods approach, employing quantitative and qualitative exploration.

“Quantitative data are essential for identifying patterns between variables in the general population and, particularly, for revealing how social isolation…is associated with regularity in social experiences (e.g., relationships and health). However, population-level data are limited in their ability to reveal rich social contexts that allow us to analyze the meanings, dynamics, and processes that link social ties to health over time.”

Ideally by using both methodologies, we could better understand the complexities that are associated between individual perspectives and population level health trends.
Our findings contribute to a growing body of research on the experience of Spanish-speaking Latina/Hispanic women by focusing on the women who chose to participate in Spanish, which we used as a marker for LEP. However, in future research we recommend that specifics about language proficiency be collected at the outset of a study. Additionally, further research is needed to investigate how social, cultural, and geographic isolation in LEP Latinas may affect pregnancy outcomes and quality of life measures. With this information, it may be possible to define and identify patterns of social isolation in these communities, and find ways to create interventions, provide support, and mitigate adverse effects of social isolation during pregnancy and the immediate postpartum period.

Social isolation may present a distinct challenge for women, particularly at the time of a new pregnancy diagnosis, when many women may be vulnerable and rely heavily on their support systems. Given the benefits of social support during pregnancy for both mother and baby, it is critical to understand how social isolation may negatively affect this dyad. This understanding may be particularly important for Spanish-speaking Latina/Hispanic pregnant patients.

These concerns about social isolation and access to support systems have become even more important in our current political climate. Since the advent of the new administration in the White House, there is great fear amongst immigrants about deportation and denial of entry for their families. Such stressors will likely further threaten these support systems. Since our study was completed prior to the current political climate, we were unable to observe the impact of recent policy changes on social isolation and support. However, it is likely that these changes may further weaken social support and increase social isolation for Spanish-speaking Latina/Hispanic pregnant women.
The social isolation experienced by pregnant Spanish-speaking Latina/Hispanic women in our study highlights the need to understand this particular community. Healthcare providers and investigators must thoughtfully consider language barriers and not address them solely with an interpreter service, but instead must be aware and sensitive to the implications that language preference may have on crucial issues including access and proximity to support systems. These differences that are present within specific ethnic and racial communities are important factors to consider since social support is recognized as one of the social determinants of health, both globally by the World Health Organization and nationally through the Office of Disease Prevention and Health Promotion’s Healthy People 2020.\textsuperscript{46,47} We must use evidence from rigorous research to help inform policymakers of these key distinctions.

“Thus, we must develop a policy foundation that integrates scientific evidence on the linkages between social ties and health, and that foundation must do two things: (1) ensure that policies and programs benefit the populations that need them; and (2) maximize health-related benefits for recipients while minimizing costs for providers and recipients.”\textsuperscript{10}

To best serve our patients in the ideal capacity, we must see how inextricably social factors are tied to health care and health care outcomes. We must let the demographics around us guide our sensible exploration—with the ultimate goal of striving for a healthy community. In the face of growing Latino/Hispanic and LEP populations, it is imperative to understand perspectives from this community, to better provide comprehensive, patient-centered care, and to diminish health disparities by
finding ways to create interventions, provide support, and mitigate the adverse effects of social isolation for Spanish-speaking Latina/Hispanic patients during pregnancy and the perinatal period.
References


APPENDIX:

FOCUS GROUP/ INDIVIDUAL INTERVIEW GUIDE

As you know we are doing a study to learn about women’s experience of pregnancy, especially about how they felt about being pregnant and the impact of the pregnancy on their lives. Some of the questions we will ask will seem rather personal and it is completely up to you to share what you are comfortable with and will be kept confidential to those in this room. You will never be identified by your real name.

If you decide you do not want to share your feelings in the group that is fine, we can talk privately later if that is better for you.

1. When did you find out that you were pregnant?

2. Pregnancy can be intended, unintended or ambivalent. How would you describe your intention about this pregnancy?

3. Can you tell me your initial thoughts after receiving your positive pregnancy test?
   a. How would you describe your initial feelings?
   b. How would you describe your mood?

4. How are you feeling now?
   a. How would you describe your mood?
   b. Have your feelings changed at all since you received your pregnancy test?
   c. What do you think caused this to change?

5. How do these feelings influence your decision about whether you want to parent, adopt out, or terminate the pregnancy?

6. What does it mean to you to be a good mother?
   a. Do you think you’d be a good mother now? Why or why not?

7. Regarding the person you got pregnant with, how do you think he feels or would feel (if he doesn’t know yet) about your positive pregnancy test?
   a. How do those feelings influence you?
   b. How important is your relationship with him (whether in a relationship or not) to how you’re experiencing this pregnancy?

8. How has this pregnancy impacted your daily life?
   a. How are things at home?
b. With finances?
c. With work/school?
d. How do you think they will be impacted in the future? Positively or negatively?

9. How are your relationships with your friends and family lately?
   a. How do you think your relationships will be impacted by this pregnancy in the future?
   b. Will they change or stay the same? For the better or worse?

10. Who have you told about the pregnancy?
    a. Who have you not told?
    b. Why?
    c. How have they responded to the news?
    d. Were you pleased or displeased with their responses?
    e. Were you surprised with their responses?

11. Are there additional issues related to your feelings and your pregnancy that you'd like to discuss?

**PROBES**
- Would you give me an example?
- Can you elaborate on that idea?
- Would you explain that further?
- I'm not sure I understand what you're saying.
- Is there anything else?
- What do you think?
- Do others agree?