



# African American Women

## Speak Out on Health Care

A Focus Group Report  
commissioned for  
**The Alliance for Innovations  
in Health Care**



**Maricopa County**  
Department of Public Health

# **A Summary of Five Focus Groups: African American Women's Views on Health Care Use, Satisfaction, and Community Strength in South Phoenix, Arizona**

*Brackette F. Williams, Ph.D  
Text Management Services, Tucson, Arizona  
Drexel G. Woodson, Ph.D  
Bureau for Applied Research in Anthropology  
University of Arizona, Tucson, Arizona*

*Prepared for the Alliance for Innovations in Health Care and the  
Maricopa County Department of Public Health*

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*For additional information on the Alliance, contact Alyce-Anne Meadows  
[alyce-annemeadows@mail.maricopa.gov](mailto:alyce-annemeadows@mail.maricopa.gov) 602-506-6347*

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## Executive Summary

### I. Method and Subjects

Between August and September 2006, the Alliance for Innovations in Health Care conducted five, 90-minute focus groups, using five scenarios to explore six topics—access, deliberation, community strength, coping, recall, and refusal.

- **Access**—when and how South Mountain residents learn about reproductive issues, health care needs, and how timing influences the use of prenatal health care and other social services.
- **Community Strength**—assets in South Mountain Village and South Phoenix neighborhoods that promote healthy outcomes for mothers and babies.
- **Coping**—strategies women devise to manage their own and their children’s health care.
- **Deliberation**—knowledge and planning that influence how mothers decide to when to reproduce and when to use prenatal and other health care services to have healthy babies and maintain their children’s health.
- **Refusal**—factors that keep women from using services for which they are eligible.
- **Recall**—experiences with health care workers that influence use of and satisfaction with health care services.

The 59 women, ages 18 to 43, had completed high school or the Graduate Equivalent Diploma. Fifty-four had completed two-year technical school, two or more years of college, or a Bachelor’s degree, and five held Masters’ degrees. Only four women reported personal income over \$30,000, with 15 exceeding this figure as combined household income. In Groups 4 and 5, accounting for 21 and 13 participants, respectively, only ten had personal or combined household incomes equal to or exceeding \$30,000. These two groups did not differ by education, and included two of the persons holding a Master’s degree, both of whom were employed in health care and social service.

Scenario discussions produced views that interrelated topics. Chapter 1 summarizes views that interrelated access and deliberation, Chapter 2 coping, refusal, and recall, and Chapter 3 community strength.

### II. Access and Deliberation

1. Resources for health care and other social services are scarce and poorly advertised. Single and two-parent-working households do not have time to locate hard-to-find resources. Girls (ages 11 to 17), who become parents, do not have the knowledge to locate and use scarce resources.

2. Parents are often physically or effectively absent during their children's early years. When fathers are present, they do not instruct and monitor children because gender-roles make females responsible for these tasks. Many mothers and female relatives are also physically absent because they are chronically ill, or addicted to drugs or alcohol. More important, healthy parents may be effectively absent because, based on their own childhood experiences, they consider it inappropriate to inform their children about sexuality. Therefore, they do not begin instructing children or monitoring their sexual activities until they are involved in practices that the parents find difficult to change. Schools and churches may offer instruction, which is either too late or ineffective, because parents do not permit young children to take part, thinking they do not need the service.

3. Differences in household income, education, and composition influence when and how children receive parental instruction, but these differences do not ensure that first-time mothers have the necessary reproductive knowledge or health care and parenting skills. Adults in higher income, two-parent households, may be too busy with work and other obligations to attend to these matters. The current generation of effectively present parents uses their own and others' negative experiences to devise reverse role modeling for parenting practices. They closely monitor their children and openly discuss matters on which their parents were silent.

4. Gender role traditions result in young males receiving less parental guidance, learning few parenting skills, and attending to their own health care only in a crisis. These role traditions also mean that women take responsibility for children's and adult males' health care needs. Young unwed mothers, trying not to alienate male affection and economic support, do not press men to become involved in seeking or using health care and other social services for their children.

### **III. Coping, Recall, and Refusal**

1. A young unwed mother, who does not care for her first child, does not learn parenting skills and acquire the knowledge for effective infant health care. She may continue having children, either because she still lacks knowledge about contraceptives or because certain, mainly aesthetic, side effects discourage their use. Successive pregnancies result in increased shame and decreased support from family and friends. When parents and grandparents take over, rather than assist a young mother, she may not learn to take responsibility and may continue having children that neither she nor the children's father or fathers support. If the pregnancies involve multiple fathers, this further increases shame and decreases approval and support. Shame encourages hiding a pregnancy, and some expectant mothers do not receive prenatal care before the fifth or six month, and others not until delivery. Although rare, the same factors encourage some expectant mothers to deliver without medical assistance.

2. Young girls raised in the church see anal and oral sex as meeting parental and church calls for abstinence. Despite the spread of alternative sexual practices, girls eventually engage in vaginal sex and become pregnant, but may have already contracted sexually transmitted diseases from the alternative sexual practices. They may not learn about infection until care for a pregnancy begins.

3. Low contraceptive use, community proscription of adoption, and doctors' refusing young women's requests to have their tubes tied, make abortion a taken-for-granted solution to unwanted pregnancy. Using abortion to reduce the number of children after having several adds to its prevalence. Focus group participants estimate that some mothers of six children may have had three or more abortions. Available insurance funds assure that most abortions are medically assisted. However, lack of insurance and hiding pregnancies from parents encourage some to self-abort. Unless health care workers check for signs of self-abortion, they may diagnose premature labor and miscarriage. Young girls who abort consecutive pregnancies do not process the emotions that may follow from abortions, and community proscription of mental health services means that they are unlikely to seek psychological counseling. Some mothers, mentally stressed by raising several very young and unwanted children, may abuse the children physically and mentally.

4. A mother who takes responsibility for raising her first child learns from this experience. Responding to fears from her first pregnancy, she may not use certain prenatal services for subsequent children. At the same time, as other obligations consume time, the mother depends on older children to care for younger ones. The lack of attention to all children may result in reproducing negative patterns that begin with children looking for attention and affection outside the home.

5. Over generalizing from a few badly behaved patients, especially the youngest and least informed mothers, health care workers develop negative stereotypes, which they extend to all African Americans. They also assimilate all African Americans to negative stereotypes about welfare recipients as freeloaders. To present themselves as exceptions to negative stereotypes, and, thus, as deserving health care workers' respect and professional care, the women attend to dress, speech, and other aspects of comportment that they associate with displaying self-respect. Using available sources, such as hot lines, triage nurses, the library, and the Internet, mothers get information to become medically knowledgeable before going to the doctor. They expect these efforts to improve the quality of care. Instead, they consistently interact with health care workers, who convert ignorance of medical knowledge, poor comportment, and difficulty communicating about symptoms into a stereotype of race-based low intelligence. Responding to their own presumptions, health care workers consider it a waste of to answering African American patients' questions, because they are incapable of understanding the

explanations. Persistent patients confront health care workers who see them as aggressive, hostile conduct that threatens the worker's safety.

6. Although mothers devise strategies to "educate" health care workers, faced with negative responses, they simply get through the interaction or immediately request another health care worker. When insurance and other factors permit, patients change doctors, facilities, or both, for future care. Such interactions mean that mothers bring a child to the doctor only after trying home remedies or they cease using health care. Confronting these problems during a child's medical crisis is more frustrating. Health care workers dismiss the child's complaint as insignificant, offer no treatment, provide little or no useful information, or continue prescribing ineffective treatments. These ineffective responses result in repeat visits, multiplying co-payment costs.

#### **IV. Community Strength**

1. Failing to find a satisfactory facility in the community, mothers expand community boundaries by using facilities in bordering municipalities. Some find that outside facilities offer better care, are cleaner facilities, and have shorter waiting times. The nearest facilities often have large patient populations and, therefore offer no greater opportunity to see a primary care physician or the same health care workers on successive visits. Involvement in a series of humiliating and unproductive interactions sharpens the mothers' understandings of systemic medical practices, which, in addition to the stereotyping of their community, produce negative health care outcomes. After trying facilities in one bordering community or in several, they return to South Mountain Village or South Phoenix, or cease using health care. Mothers who return use what they learn about systemic medical practices to select a facility where workers cooperate with the mothers' strategies to reduce co-payments for repeat ineffective visits. Community facilities are more likely than outside ones to recognize and accept their strategies.

2. Despite a shared view of creative strategies and individual resilience, focus group participants insist that there is no community. This means that patterns of interaction among residents of South Mountain and South Phoenix do not facilitate sharing and using poorly advertised scarce resources. Many factors, the participants explain, create obstacles to cooperation among African American residents, who confront increasing competition for scarce and diminishing resources from growing populations of other races and ethnic groups. Efforts by individuals to solve their own and their families' problems promote individualism, which encourage status envy, jealousy, and invidious distinctions, which, in turn, discourages cooperation. Persons who feel disadvantaged in status competition may not attend events that could promote community building. While recognizing that joint action is needed to solve community problems, the participants note that the African American population, contrasted with other populations, is not a voting block for race-based

government representation. There are few African American elected officials, and they make “backroom deals” undermining campaign promises that would benefit the community. There are many self-help organizations “working behind the scene,” participants say. However, working parents (sometimes holding several jobs), can only take advantage of the organizations’ resources during special or annual events. Consequently, they do not assist organizations to build community and increase resources.

3. For new arrivals—resident for a few months to decade or more—the sense that there is no community begins with ethnic or racial demographics. The small, scattered local African American population differs from concentrated populations and services to which the new arrivals are accustomed. They find few gathering places in the community to meet African Americans who might informally share resource information. This problem is exacerbated, both new arrivals and long-time residents note, when African Americans encountered in other social spaces and workplaces ignore or spurn greetings.

4. The lack of gathering places in the community is difficult to change. If the facility is in the community, residents might use it, but creating the option is possible only by overcoming a mind-set that judges the activity as beyond the boundary distinguishing Black and White “culture.” The range of culturally acceptable activities decreases, because once acceptable but long-absent ones become White and, therefore, difficult to reintroduce.

5. Comparing Phoenix and Arizona with other locations, especially those in “down South,” the focus groups contend that residents lack traditions for joint action, in part, because schools teach the young generation little about the history of African American civil rights struggles. Apathy (passively waiting for other races to provide resources) reflects individuals’ long-term adjustment to scarce resources and the lack of government representation. It is demoralizing, participants say, to realize that, despite self-help actions, they have little outside support. The government favors new immigrants, who communally share resources within their identity boundary. Class diversity increases problems as the private sector takes over space to provide middle- and upper-class housing for persons who, even if they are African Americans, keep to themselves.

6. Mothers must “deal with what comes.” Underemployed mothers quit work because they cannot afford help to care for preschool children or to monitor older children after school. Focus group members say these mothers trade work for welfare dependency and humiliation, because health care and social service do not design regulations to “uplift families.” To qualify for benefits, one must “work to system,” circumventing the regulations by denying other sources of support. Hence, a mother with adequate resources avoids the “welfare trap,” even if income and housing subsidies, health care insurance for her and her children, or fees for

education would improve her situation. Lacking adequate resources, mothers may present themselves as single and “broke,” and deny knowing their child’s father. This strategy lends support to health care workers’ negative stereotypes, thus making the mothers’ and other African Americans’ subsequent interactions more difficult.

Despite the sense that others act to undermine African American self-esteem and destroy their community, individuals must make choices. Even when choosing between bad and worse options, parents must try to break negative cycles and silences, because if they wait for good choices, African Americans in South Phoenix will “drop like flies.” Resenting health care workers’ “nasty attitudes,” focus group members contend that these workers should understand that they have jobs because South Mountain residents have babies, because many are in poor health, unemployed or underemployed, and because, facing life as “hustle and hassle,” some abuse drugs or alcohol, while others commit crimes and fill the jails and prisons.

## Introduction

### I. Method

The Alliance ran five focus groups to learn about factors that promote or impede South Mountain women using health care services before and during pregnancy to assure a healthy delivery and to keep themselves and their growing children healthy. The scenarios for six topics three sets of questions:

1. What do young women know about conception and prevention? At what ages do they learn these facts, and from whom? How does this knowledge influence their decisions about when to become pregnant, how to gain prenatal care, and how to maintain their own health and the health of infants?
2. How does recall of experiences with health-care facilities influence their decisions to use or refuse use of health care facilities, or other social support services for subsequent pregnancies, and to maintain their own and their young children's health?
3. What community strengths and forms of individual resilience do African American women reveal that shape and direct their coping strategies?

### II. Scenario Topics

To order discussion across the focus groups, a subcommittee composed of Thelma Brandon, Rose Howe, Wanda Thompson, Carole White, the moderator, and Andrea Sturzen, a co-moderator, devised six scenarios to probe the basic topics (see Appendix 1). The subcommittee defined the topics as follows:

- **Access**—when and how South Mountain residents learn about reproductive issues, health care needs, and how timing influences the use of prenatal health care and other social services.
- **Community Strength**—assets in South Mountain Village and South Phoenix neighborhoods that promote healthy outcomes for mothers and babies.
- **Coping**—strategies women devise to manage their own and their children's health care.
- **Deliberation**—knowledge and planning that influence how mothers decide when to reproduce and when to use prenatal and other health care services to have healthy babies and maintain their children's health.

- **Refusal**—factors that keep women from using services for which they are eligible.
- **Recall**—experiences with health care workers that influence use of and satisfaction with health care services.

To achieve a balanced discussion of the six topics across five groups, the moderator deliberately varied the time devoted to each topic within the 90-minute limit. For example, the first group addressed Scenario 1 (access) for 25 minutes and devoted approximately 15 minutes to each remaining scenario. The second group devoted 25 minutes to the deliberation scenario, and so on through the five groups. With six topics and five groups, the last topic—refusal—did not receive 25 minutes. However, the overlap between this topic and all the others did not pose a problem for obtaining substantive commentary on refusal. Differences for time notwithstanding, groups discussed some topics in greater detail and responded to probes in different ways. The summary reflects transcript coding for five groups responses to the six topics.<sup>1</sup>

Following each focus group, Rose Howe, Wanda Thompson, and the moderator held a conference call to review the discussion and add probes as needed for the different topics. Following the final group, the two co-moderators joined in the conference to discuss how to summarize the five discussions.<sup>2</sup> Chapter 1

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<sup>1</sup> An identifier number (e.g., G2) refers to a focus group, and fictive names to participants in that group. MV plus a number (e.g., MV2) indicates that several participants responded simultaneously. When the transcriber could not identify the speaker, but the comment was audible, UNK plus the group number identifies the quote.

Ideally, a focus group should not include more than 15 participants. When the group is larger, the note taker has difficulty keeping track of who is speaking, and the transcript includes more unidentified speakers. For example, Group 4, with 21 participants, has the largest number of unidentified speakers, despite the efforts of three note takers and the transcriber. While many comments were audible and the transcription captures them, tracking a particular speaker's comments proved more difficult for Group 4 than for the others. Tracking speakers builds up accounts of participants' statements about themselves and highlights the experiences on which they base their comments about all of the topics. Where participants disagree on a point, it is important to consider the experience that may influence their different points of view. The description of the population refers only to the information collected in a one-page questionnaire designed to assist the transcriber in using the notes to identify speakers and relate their comments during a group. It does not include information Rose Howe and Wanda Thompson used to select participants for the focus groups.

<sup>2</sup> Co-moderator Andrea Sturzen and Dr. Jarita Holbrook of the Bureau of Applied Research in Anthropology (BARA) at the University of Arizona, served as a volunteer co-moderator, and took notes during the focus groups. Andrea Sturzen assisted with transcription and with coding the transcript to set criteria for general coding. Dr. Holbrook, using Atlas ATI, helped sort the initial topics to compose code sets from the total transcript. Rose Howe and Wanda Thompson gathered information, such as selection criteria for age, residence in the research zones, and number and ages of children in each household, and assisted with taking notes during focus groups. After an initial

concerns the participants' views on access and deliberation, Chapter 2 their views on coping, refusal and recall, and Chapter 3 their views on community strength.

### **III. Population**

The focus group population totaled 58 African American women ages 18 to 43. A brief profile questionnaire for each group revealed that all but ten participants completed high school. The rest finished two to three years of college, or completed a bachelor's or masters' degree. Over half of the women earned personal or combined household incomes below the currently established poverty line. For most of the others, incomes ranged from \$20,000 to \$30,000. During discussion, however, some participants indicated that their personal or combined household incomes were \$10,000 or more above the profile questionnaire's \$30,000 cut off. Others indicated both on the questionnaire and in discussion that they earned no personal or household income.

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draft in February 2007, Dr. Brackette F. Williams of Text Management Service, Tucson, Arizona, and Dr. Drexel G. Woodson, authored the five-group and Executive summaries. All public documents based on these summaries are the responsibility of the Alliance for Innovations in Health Care, of Maricopa County, Arizona, and should include a byline consistent with the changed authorship.

## Chapter 1

### Access and Deliberation

- **Access**—when and how South Mountain residents learn about reproductive issues, health care needs, and how timing influences the use of prenatal health care and other social services.
- **Deliberation**—knowledge and planning that influence how mothers decide when to reproduce and when to use prenatal and other health care services to have healthy babies and maintain their children’s health.

#### I. “Just keep your legs closed”: Home, School, and Church Training

Learning about biological reproduction or childcare, the participants say, comes too late and sources of knowledge are too few. We begin with Frances (G2), a 39-year-old mother of a 15-year-old daughter and a preteen son.<sup>3</sup>

I mean I’m college educated and blah, blah, blah, blah, and haven’t seen the inside of a clinic and all that kind of stuff. Um, was married many years, five or six years before I had a baby, right, and blah, blah, blah, blah, did all the stuff you’re supposed to do. But, I just didn’t know, I didn’t have any children... little babies around me, I didn’t have, little... Bebe’s Kids... sisters, and the kids across the street. I didn’t have any of that. So, when I had my daughter I, I, I, I didn’t even know what... She was just like... I’m like, “What do I do with this?” You know? The doctor said, “Give her a half a jar of baby food,” and, so... gives her a half a jar of baby food.

Frances, like other participants, thinks that schools do not provide timely sex education and moral guidance, because general American cultural values set the timing of this instruction without reference to the realities of children’s exposure to factors that promote early progression from sexual awareness to sexual activity.

Questioned about when young girls first learn about reproduction and contraceptives from school-based instruction, the groups agree that it formally occurs between fourth and eighth grade—with sixth grade as the most prevalent answer. They disagree on whether all schools include sex education, basic human biology, or human reproduction classes. Catherine (G1) sums up the view, consistent across the groups, of instruction that schools offer.

I would say that she [a female grade-schooler] learns about getting pregnant, she would learn something about that in elementary school, fourth grade, fifth grade, at

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<sup>3</sup> Frances reports a household income higher than the profile cut off. She completed a bachelor’s degree, placing her among participants with the highest formal education; second only to four who had completed postgraduate degrees.

least... Ah, I know at school, they have sex education. They teach them about their bodies, and, ah, ah, what's developing. I have a 12-year old, and I know she is learning about that, you know, in elementary school, and [from] her peers, too.

Members of Catherine's group and others also agree with qualifications Carine (G3) introduces in noting the rudimentary content of instruction that they think schools offer children.

Okay. I think she would learn about [basic human biology] when she's... ah... within seventh and eighth grade. If they do health or sex education, as far as, like, the human reproductive system. But... other than that... [shrugs].

Other participants add that schools do not offer this instruction before the ages at which girls may already be sexually active or become pregnant. They think that schools might respond better to this reality by lowering the grade at which instruction begins.

As two further comments suggest, however, participants do not always agree on when schools first offer instruction. Dianna (G3) thinks sixth grade is later than schools teach basic reproductive biology. Beatrice (G3) agrees with Dianna. Based on her experience raising two teenage girls, she remarks, "I think they start prepping them around ten." When others look doubtful, she adds that she is referring to "Their parents... the moms," not the schools. Darlene (G2), who works for AHCCCS at a hospital, speaks from her work experience, from her first pregnancy at 17, and from her knowledge of friends and neighbors whose first pregnancies occurred even earlier.

She sums up critical aspects of the participants' view that sexual activity is happening earlier today and well before schools begin instruction. "I feel like, in this day and age, they [schools] should [provide earlier instruction], because there are kids that—I mean like ten, 11 years old—having kids, and they don't have no idea what's going on."

Yet, even if schools lower the grade of first instruction, participants agree with Elena's (G3) view that a girl's substantive learning begins "...when she gets pregnant, [then] she learns about [conception]." Considering the likely age of first pregnancy, multiple Group 5 speakers, agreeing with an unidentified speaker, remarked, "That period... It's the period... when that period starts." Their remark echoed comments by participants across the focus groups.

Probed to report the earliest age at which a first pregnancy occurred among siblings and friends, participants across the groups provide examples ranging from 11 to 13, but one replies that she knows of a girl who became pregnant at age ten. Overall, participants agree with Paula's (G5) conclusion: "[Age] 13, and after they have a baby. Yeah, I have a couple friends who had babies at 13."

Participants' accounts of their own and their siblings' ages for first pregnancies—12, 13, 14, and 15—support their general responses. The self-reported age range for first pregnancies among the 58 participants was 12 to 38, and their comments about siblings, other relatives, and friends suggest that 15 is the most prevalent age for first pregnancy. Still, Dana (G5) reports the extreme age that participants recount in their stories: "I know someone who had a baby at eleven," which suggests a progression to sexual activity as early as age ten. Participants across the groups also agree with Elena (G3) about the need to change the timing of sex education in school and at home: "[E]arlier. I know a lot of my friends learned... [when they got pregnant], you know."

When the moderator asks Group 5 why they think girls become pregnant at such early ages, UNK (a participant who, unfortunately, typically comments in side whispers) replies, "Cause they hot!" Others in Group 5 concur. Across the groups, participants discuss the factors underlying and motivating being "hot." Generally, they agree with Margaret (G3): "They [are] not listening to their parents." Evelyn (G4) elaborates on this view.

But you have to remember how many kids did what their parents said. Our parents told us all that [i.e., the dangers of sexual experimentation and early pregnancy], at least half of it, but we still chose to go out and do [what they advised against], on your own or with your friends.... I think back to some of the things I was doing as a little girl that I had no business doing, and thought it was okay, because it was taught to me, not by my parents, but by other places in society.

Where schools provide instruction on sex-related matters, the focus group participants note, parents must sign consent forms. Based on experience with family and close friends as parents, the participants insist that many parents are unwilling grant consent because they do not want their children to "have that conversation." When parents are physically or effectively absent, younger siblings, who become substitute parents, are too young to sign consent forms. For parents who are trying to be effective, participants also agree with Paula (G5), who counters:

Parents in poverty, they don't have time to teach their kids a lot that they would like to teach [them] in [a] way... in the manner they wanna teach 'um.... You have to work so much. And, by then, you think sex education in school is good, but that is not good lotta times.

Fern (G5), sums up another general view, explaining that what schools teach may be distorted by peers and, thus, have unintended negative consequences. "When I was growing up, I learned it from people who had already learned in high school, and they were telling middle-school kids, this is how to use condoms."

The problem, Fern and others note, is that these secondhand lessons on condom use are as likely wrong as right, and a girl's male peers suggest that there is no need for condoms. Young boys, says Dana (G5), tell their female grade peers

that condoms are unnecessary because they know how to prevent pregnancy: “[T]hey will pull it out”.

Helen (G1) links the impact of working parents to media influence and peer misinformation.

Yeah, it's gotta be because you go outside... If you don't get [information] because your parents are busy working three or four jobs, trying to make it, you have to get that information from somewhere. Nowadays, with this generation, they get it from TV. The kids, they sit in front of the TV or... the video game and they pick up all that stuff. And, it's not like when my Grandma.... [You] could go to her Grandma's house [noting another participant] and sit and, you know, get educated, just like it was my Grandma's house. It's totally different these days. And, when the parents are working, you get the kids out at the Y and stuff, and they are getting advice from people, like their coaches or just their friends. And, whatever they think the advice is, because their parents are not at home, when things are not in their household, they are going to get the information elsewhere.

When Group 5 participants agree on the increasingly lower age for sexual activity, and an unidentified speaker stage whispers, “Yeah, they are getting younger and younger by the year.” Lois (G5) adds, “That’s what I am saying, that [grade school] may be too late—by the time they learn about it.” Dianna (G3), a parent of two teens and foster home mother to grade school and younger children, expands on this view in her group.

I think things are *changing*, because, I know, the kids now get, ah... You know, the parents have to sign consent for them to learn about good touch, bad touch. My daughter has learned about puberty [and she is] in the fourth grade... Yeah, so, I think times are changing, but I think that the school is mostly responsible, versus... the parents.

Ula (G4) makes a similar point during her group’s discussion: “In society today... I think, I think ages [for sexual awareness] are getting earlier. It’s normal in today’s society.”

The focus groups see changes in school curriculum and in society moving in opposite directions. Participants 40 and older recall grade schools teaching “human development” in health education classes, which included basic biology, hygiene, and nutrition, and some schools offered sex education. Mary (G4) says:

Um, gosh, I am 41, so... [when] I went to Julian, Martin Luther King—some of you know these schools—they were teaching us about our period; about a lot of things. They taught us about sex.

Participants 30 and younger say this is no longer true, even when schools offer classes in the sixth, seventh, or eighth grades. They think that, currently, the earliest school instruction occurs in the sixth grade, but insist that today’s classes include less information. Hence, younger participants in Mary’s group quickly and

persistently counter the older women's experiences. "It's not that way anymore," they say, referring to their own school years and to schools that their children now attend.

Returning to Dianna's point about school versus parental responsibility, some Group 3 participants agree that parents are most responsible, while others disagree by considering constraints on parents. While seeing the school as having a critical role, Glenda (G3) places this role in a racial context, emphasizing society's generally negative view of African Americans. For this reason, parents should not count on schools, participants agree, especially in Arizona.

My parents... I know from my parents. My mother, you know, and my grandmother. My grandmother is from Mississippi and you had no choice, you had no choice but to stand strong. Those were hard times, back then... and it's still hard times this very day. Nothing has really changed. It has gotten better for us African American people generally, but, still, we are in hard times. And, it goes back to the home front. We can't expect society to raise our child.

Hearing this, Alexis (G3), in her mid 20s and the mother of three grade-school-age boys, and a younger girl, responds:

Not necessarily. I look at [it] not as society is raising our kids, but there are some people who feel they have that teaching ability. And, honestly, I know that I don't have no kind of teaching ability, because I don't have no patience. To teach somebody, you have to have patience. And I'm the type of person, if I say, "Two plus two is four," I don't want my child... if I tell him how to add it up to four, I don't want him not to understand how to do it the very first time.

Therefore, while the mothers agree that parents have primary responsibility and individuals some of their own problems, they see social influences as integral to community problems and individual responses. When children enter school, even the most diligent parent loses control of what the school environment exposes their children to and how peer pressure influences the children's responses to home training. Within and across groups, participants disagree on the relation among school assistance, parental supplements, and individual resistance to parents' advice. Only one participant, an unidentified speaker in Group 4, insists, "I did everything my parents said."<sup>4</sup> Overall, participants agree that basic knowledge is the key to understanding both reproductive dynamics in the community and their implications for when expectant mothers begin using prenatal care. However, many other factors affect whether mothers continue prenatal care during a first pregnancy, and whether they will use social services for subsequent pregnancies.

The focus group participants' experiences of negative attitudes toward African Americans and South Phoenix residents lead them to question how schools can help

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<sup>4</sup> Unfortunately, we cannot track how this might influence her other views, because the transcript does not identify her.

raise their children's self-esteem. Participants see low self-esteem among parents and children (especially among "children raising children") as a major cause of negative community dynamics. Along with peer pressure once children enter school, they note that the media promote negative messages. Working parents have access to few resources, participants say, to establish positive role models. Resources are both scarce and hard to find outside working hours. For African American children, participants add, American values do not offer messages to build self-esteem, but rather encourage the children to think of success as "living the exception."

The lack of options for building self-esteem, participants say, begins with a school curriculum that excludes positive African American role models or only highlights a few individuals who achieve high status and high incomes by "living the exception." As examples, they mention sports stars, musicians, and entertainers. Irene (G1) sums up this view and the participants' criticism of it.

[N]owadays, they want us to live by the exception. Kari [the young father in the scenarios] came straight out of high school and now he's a big star. And, "I'm gonna push you to go through high school 'cause, you know, I ain't got no money, so you need to git, to get that football scholarship or whatever it is." But, that's the exception... I tell my daughter this all the time, and she is only nine: "It's up to you to go out and seek the resources." And, I always inform her that no matter what choice you have, regardless of the lowest of your low, whatever it is, wherever you are at, you have a choice. It may be one choice, but you have a choice of that choice, whether you take it or not.

Across the groups, participants also suggest that differences in resources for schools in South Mountain and South Phoenix, as compared to other areas, make the parents' task still more difficult. Glenda (G3) addresses this point and its implications for inadequate school instruction.

[I]t is a problem because, I feel like, in different districts... South Phoenix, there is not enough education... sexual education, for our children. It should start as early as first grade. They start that in Tempe. They learn about their bodies. [Beatrice agrees, "Yeah."] They don't learn... about the sexual aspects of it. They learn about the body—how their bodies function, and so forth. That should be brought to South Phoenix itself.

Asked to account for the difference, Glenda responds, "It's because of the race," thereby pinpointing a factor reiterated across the groups as an influence on the quantity and quality of all services, including health care facilities, in South Mountain and South Phoenix.

To summarize: Seeing knowledge as the most important factor for access and deliberation, participants agree that some instruction occurs in school, but say times are changing, and schools offer too little information too late to address the realities their children face. Nonetheless, the participants see many parents making matters worse by denying their children's early sexual awareness and progression to sexual

activity. Regardless of what schools provide, they emphasize, the bigger problem is that many parents neither sign school consent forms nor actively instruct and monitor their children at home. Many participants base their views about the rate of refusal to grant consent on experiences with other parents, but some mention their own refusal until they confronted a crisis.<sup>5</sup> Too few African American parents, the focus groups conclude, are willing to talk to their children and monitor their maturation.

Parents resist, focus group participants agree, because they fear that providing accurate information, even basic biology, might encourage children to experiment with new and undesirable activities. Where parents take this position, participants say, it results in unconstructive denial. Often, the parents believing most insistently that their children are sexually unaware or active, learn too late the error of their assumptions.

Betina (G2), now in her late 30s and the mother of three college-enrolled children, was a teen mother. She had her first child at 16, following an abortion of the baby she conceived at age 12. For Betina, her early life experience is a “testimony of how far God has brought me.” Founder of “The Women’s Global Ministry,”<sup>6</sup> she offers sex education classes for teens that stress abstinence until marriage. Her classes are voluntary and require both parental consent and agreement to children’s confidentiality. Parents resist allowing her to talk to their children about general sexual matters, Betina insists, and think she is “crazy” when she uses her personal experiences to support her views. In Betina’s account of her early progression from sexual awareness to sexual activity, she hints at incest and admits to sexual relations with older men.

People... when I talk about things, people look at me like I’m *crazy*. But they don’t understand, this is *my testimony!* Why should I be ashamed of how far God has brought me? Why should I be *ashamed* of the things that I have been through? I should want to share it. You know, it helps someone not to go through the same thing. You know... it bothers me, it *bothers* me.

In a later exchange with Betina, Frances (G2) dubs Betina’s testimony the “dark, dirty stuff.” The exchange between these mothers of teens is instructive. Frances begins by explaining why parents resist Betina’s classes.

‘Cause we think—if you talk to [my daughter] about that dark, dirty stuff that you did when you were 15 or 16—that you might expose [too much]. Now, now, she might only be thinking about drinking Apple Bacardi. But if you tell her about the—I don’t even know what—dadadada that you did, now my daughter might say, “Hmm, so there’s marijuana, so I can get...” So, so, so, that’s why moms aren’t putting their daughters in front of you to say okay. I don’t know your name, but, lady in pink

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<sup>5</sup> How many parents refuse to sign, is a matter that needs documentation.

<sup>6</sup> I have altered the name of Betina’s ministry to protect her identity.

[referring to Betina], don't talk to my daughter because, hell, she might... you might... that's like putting... [shrugs].

The possibilities of Betina's "dark, dirty stuff" leave Frances speechless and she retains her view, despite having trouble with her daughter. Frances links her own lack of instruction from a mother "who raised her on silence" to being unprepared to note signs of her daughter's sexual activity and alcohol abuse. Only when officials called Frances to school after finding her daughter passed out in the bathroom did Frances awaken to her daughter's realities.<sup>7</sup>

When the moderator asks Betina about the ages of the parents most likely to resist her classes or the church's involvement in children's guidance, she suggests age 60 and above. This sparked immediate, negative head shaking around the table. Frances (G2), reflecting on her own parental conduct, voices the point of disagreement.

Yeah, I'm not [60, but]... I'll tell you, *I'm one of those people*. I did not realize... because, I didn't have that, that experience. I came—I think everybody in here probably came from some kind of dysfunction in their home—but, because I didn't, I didn't know that I was supposed to be talking to my daughter, or I just thought, if I made sure that her belt matched her shoes and that she had that... [it was enough]. I didn't [talk about other matters], because that's how my mom raised me.

## II. "Cause they hot": Raging Hormones and Media Influence

Across the groups, participants expand on why, by age 12, maturing girls and boys (the latter, perhaps, becoming sexually active earlier) are bundles of raging hormones. They experience feelings they do not understand and about which they cannot speak to their parents and other adults in the community. Instead, they discuss the feelings among themselves. Participants see "the media" as the prime source of misinformation that peers distribute. Most particularly, the media broadcast messages that transform sexual awareness into early experimentation. Peers combine distorted information from schools and parents with responses to media messages linking sexiness and self-worth to produce the misinformation on which they act. Participants say that peer competition to obtain or to become what, according to the media, creates self-worth, promotes a fast progression from understandable or "natural" curiosity and sexual awareness to sexual activity.

Well before first grade, participants insist, the media expose children to messages that equate sexiness with competitive self-worth. When speaking of negative media influences, participants do not refer to print products, such as

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<sup>7</sup> In every focus group, at least one participant insisted on "keeping it real." Betina took on this role Group 2. When any participant seemed to speak about ideal situations, others challenged the ideal with what they saw as hard realities. Insisting on keeping it real accounts, in part, for the participants' attention to the negative aspects of personal experiences and community conditions, even as they charge outsiders with seeing only the negative.

magazines, books, or newspapers. Instead, they focus on audiovisual media, emphasizing television shows, commercials, and music lyrics and videos. They also mention Internet websites as a source of problems in homes that have personal computers.

Raised on television, participants first recognize the power that the media had in their own lives. Frances (G2) explains:

I had to cut off cable because *I* was addicted to the videos. Not the kids. So, that helped them by me [not watching videos], because I love.... I'd sit up there, after work, just sit there and watch them myself all daylong.

Referring to rap music lyrics and videos, Frances also expresses shared contentions as she insists: "I think [it is] these nasty boys... I got a ten-year-old son, too. But I think... I think these, these, um, these *disrespectful, dirty boys*, and, I guess, girls because they [the boys] couldn't do it by themselves." Though once she was addicted to television, Frances goes on to say, now:

I can't even listen to my radio and I can't watch television.... I mean the commercials... I am just, I'm just sickened by the way these girls wear these little shirts, and, I just, I think that television has made it okay.... And, it was bad when we were growing up, you know; you don't be disrespectful, but now it is just...

Frances's comment fades into other Group 2 participants' statements about today as a time when "anything goes." She sees her daughter copying the media messages and using sexiness and, in her view, self-deprecating names to gain peer approval.

My daughter would say, I'm Mia—her name is Mia<sup>8</sup>... and her little moniker is Mia Bia. Well, somebody had to tell me *bia* means B-I-T-C-H. I didn't know that. But my daughter—my little cookie-cutter daughter—is Mia Bia... and rocks Mia Bia; wants to be Mia Bia; is proud to be Mia Bia.

The transition from awareness to activity, Group 2 agrees, is both happening more quickly and drawing in progressively younger children. Frances comments on the different climate for her teen years and those her daughter faces today.

Yeah. I'm 39 and I learned it [facts about reproduction] at 25 when I had one [a baby].... But, I'll tell you what, I have a 15-year-old daughter that I talk to, I mean on a daily basis, because just in the twenty-year difference between her and I, the world—something just... *something has happened*, you know. And, so, now, my um cookie-cutter-Ivy League little girl that I think ought to be in the Angel Choir, and on the Junior Usher Board, and doing all the things that my parents *insisted* that I do (wasn't even an option) wants to be a hip-hop chick; wants to be a badabada; wants to ride or die! So, I have no *choice* but to say "Well, Mia, you know, but let's talk about condoms, let's talk about... um, your body, let's talk about sex, let's talk about oral sex, stuff like that. I mean, conversations that I never even had I'm having to

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<sup>8</sup> The daughter's name is fictive, included for the sake of the rhyme on which Frances comments.

have with my 14-year old because... I mean she's, she, ...it's her *life!* It's the stuff that's going on around her. So, 25 for me, 15 for my baby—something happened.

Others in Group 2, like participants across the groups, were quick to conclude, "Television happened" (MVG2). In Group 5, Paul says, "Television—they see it on TV," and an unidentified speaker add, "Yeah, all you have to do is push a button." Ester (G2) adds, "It's television and music!" Then, she goes on to explain the connection other participants also see between exposure to media messages and children's motivations to transform sexual awareness into sexual activity for competitive self-worth.

And, those videos and television shows have said, "If you're not sexy, if you don't put it out there, you won't be successful." So, [children] have correlated how successful you will be to how much you put out there. And, I think for young girls and young boys, they cannot differentiate between what that means. To them, that's the, that's the end all.

Lois (G5) qualifies and places the dynamic in community space.

I would say it's the community you are in. 'Cause, I know, me being in South Phoenix—I haven't lived here all my life—but, just being around, and knowing certain areas, you learn some areas do and some areas don't. So, if there are children out there—12 years old—out there kissing, shaking their butt, doing something they see on the videos, you like, "What she doing?" And, the dudes—don't get me wrong—[girls] like, "He's a cute dude," and [he] may not have nothing at all. And they, like, "He messing with that girl shaking her butt. I want him, so I'm gonna shake my butt, too." Well, he's already hitting that [having sex with the first girl], he's like, "I wanna hit that [have sex with the second girl, too]. I wanna see what she got." So, that's where that comes from [inaudible]. And, [if] you don't have a mother and father... [shrugs, indicating that the second girl becomes sexually active].

Responding to Group 2 participants' comments, Frances (G2) later qualifies her reference to those "disrespectful dirty boys." She and other participants make it clear that they do not see the problem as either limited to the community (as a spatial or as a generalized African American identity unit) or to African American male rappers or hip-hop musicians.

Because, if [Mia] is looking at, um, Brittany Spears and Paris Hilton, and I don't even know the Black folks, but, but all these people [Group 2 laughs]... who are whomever... —uh, Little Kim and, you know, whomever else. To... see somebody that, that's got clothes on, it's gotta be Clare Huckstable [wife and mother on *The Bill Cosby Show*], or you, or me. And, we're not cool; we're *so* not cool. So, who's cool *and* got clothes on? I don't know. Does anybody? You guys [referring to other participants] are young. Who? ...So what are the other options? If they're not looking at somebody's *butt* in the camera, then what channel can they turn to and see Maya Angelou or somebody talking about something that's of value?

Fern (G5) qualifies the family structure/community conjunction of which Lois speaks, when she notes that two-parent households are not proof against children's absorption in the sexy-as-self-worth dynamic.

I had both parents, and my dad was in the military, so they were always there; made you want to do it more. Like, well, I'm gonna sneak out and do it anyway. 'Cause [that's] what got... the guys. And, no matter what... how your parents talk to you, because you see everyone in the community... it looks hip, it looks hot, and you want to do it... Because I had both parents, I was like, "She doing it and she popular." So, if you don't have someone in your ear telling you, "It's just not right," even though your parents say [it], well, they ain't nobody.

Across the groups, other participants agree, basing their views on their teen behavior, on being members of two-parent households, and on raising children in both single- and two-parent households. To the conclusion by Frances and others that mom and dad are "so not cool," Fern (G5) adds that children, intent on being popular with peers, believe their parents speak "to be mean." She returns to Frances's questions: How can parents find alternative sources of knowledge, role models, and moral guidance? What do communities offer to aid parents and teens struggling with media-driven messages and resulting peer pressures?

You don't know there are, like, people in the community you can go to and talk about it. I didn't know you could go to the school counselor and talk about that kind of stuff. I thought the school counselor's only help was with school stuff, not "I'm feeling pressure to do this." I didn't know you could do that. It is not known because people don't spread that; they don't let you know, "Oh, you can talk to anybody about it." Most kids would be like, "Well, they school counselors [and] I'm not listening to my mom and dad [because] they just saying it to be mean." People know that sex can get you pregnant, but, like, they are not thinking about [that].

Beatrice (G3), raising three teens in a two-parent home, echoes Fern's views. She adds the home/community interface to the difficulties that parents manage as schools and peers expose children to activities parents once could control.

I can tell you this, my 16-year old—'cause I have a set of 17-year-old twins, they are a boy and a girl—... when my 16-year old started, ah, junior high, sixth grade, ah, we had this... I would buy whatever kinda music they listen to and play it in the car. We didn't do the radio. Well, she rides the bus to school. What they doing? [Laughs] They playing the radio.... I'm not living in a fantasy world. I know.

Beatrice insists that home training can overcome these influences.

[I]f you train up a child a certain way, there are certain things that they just *won't desire*. Because, I don't have to say, "Don't do that, don't do that, don't do that." If I don't make a big deal out of it and you know what it is. [It's] kinda like you know how you can take a little baby wandering around, you don't want him to go here, so you set him in that direction and they go that way. That is all it was. I did not have her pay attention to what was over here, so she just focused to what was over there. That's her focus. So now, she is a junior in high school.

Where parents are patient and work at guiding their children, they still face negative societal influences. Individual responses to different household mentalities

produce variations in outcomes that parents otherwise expect to see from reverse role modeling. Linda (G4) remarks,

I think it depends on both. You can have a child that grows up in a dysfunctional family, but [is a child] that's real stern and disciplined. And they just got something inside of them that's, like, that is just not me. You know what I mean.

She goes on to insist that a child's intellectual capacity should determine when parents begin instruction about sex and reproduction.

If a child is aware of everything, and can sing the song and memorize the lyrics, and do this and that, they should be able to know. I got a six-year-old daughter and she knows. She knows what sex is and she knows not to look at it on TV. When people are kissing, she turns her head. She knows it's just something she not suppose to do, and she will tell me like, "Mom, they not suppose to do that 'til they get out of college. Mom, they not suppose to be kissing until they get out of college." You know, you just... you instill it in her; this how it is suppose to be. Not, "Oh, this is how it's done; what you see." She [is] thinking, they doing something wrong. They are supposed to do that when they get out of college.

Other Group 4 participants disagree. Like Frances, they note the pervasiveness of negative influences with which parents must contend at earlier ages and from new sources. They also see sexual activity as "human" and note the many influences a child will face before finishing first grade. As Linda talks, other speakers express doubts in the background about the long-term effectiveness of her home training. An unnamed speaker sums up the basis for doubt: "Everybody bonks." Karen (G4) provides another reason why participants question Linda's view, seeing her as the kind of overconfident parent who notices a child's sexual activity too late.

I think it has to with do we are all human. When you think back to when you were young, and what children see on TV. It has nothing to do with society. It has to do with everybody is human and they are gonna do things. And, as long as your children are able to talk and can hold a conversation with you, they ought to be taught all of that, because anything can go on anywhere. So it should, it should have no basis in any of that.

Anita, Mary, and Evelyn agree, but, like participants in other groups, do not see inherent human sexuality as independent of social influences. Instead, they comment on why outsiders may see this human response more often or only among young girls and women in South Phoenix. Evelyn (G4) says,

But, it's true. It's just more out there. It's too obvious with women in South Phoenix, which is sad, because other women, they try to hide it... [E]veryone in the human world does what we do on the Southside.... But it's true. It's just more out there.

"It's just walking down the street in front of you with us," Anita (G4) remarks, and Mary (G4) elaborates:

We are always exposed in South Phoenix as being bad, but they never focus on the good things that Black women in South Phoenix does. They always talking about that negativity. You know, we don't do no badder than any other side [of Phoenix]; any other race. We may put our stuff out there... 'cause we may be proud. They don't know our situation. They never been in our situation. They don't even know us, to portray us to be like that [referring to the deliberation scenario].

Group 2 agrees about the influence of television, radio, and music videos, but adds "the Internet" to the mix. "They are on that..."—others, speaking simultaneously, finish Betina's thought—"MySpace! MySpace!" The problem of Internet influence begins, according to Group 2, with children as young as age ten. Other focus groups place less emphasis on the Internet because they think that few people have personal computers or make use of those in libraries. Nonetheless, participants agree that a personal computer at home becomes one more source of negative social influences on children, access to which parents must take primary responsibility for monitoring. Computer-based interaction makes it more complex and more difficult for parents to monitor children's exposure to negative influences and associated peer pressures.

Yet, while the focus groups see audiovisual media as motivations for children's behavior, they do not consider the media the only cause of negative reproduction patterns. The participants detail family and community dynamics that worsen media influences. Most important, they insist again, is parental denial—"Not my child!" Denial allows children to progress from sexual awareness to sexual activity before parents are willing to accept the reality and intervene. As Catherine (G1) puts it,

A lot of parents won't go there [face sex education issues]. They are like, "I don't want my child to know about that stuff at their age." But what you don't know was that your child watches TV. There is a lotta stuff on TV that your child shouldn't be seeing, but they see and they sit up there and they get curious. And, they like, "I wonder what that's like? Oh, I don't have that body." And, "I wonder why I don't look like that. Maybe if I do this, this boy will like me. If I have that, that boy will like me." Maybe they—kids—see stuff, and they repeat what they see.

Across the groups, participants agree that, once youths begin destructive conduct, it is very difficult for parents and social institutions to redirect them. Youths interested in being popular in peer competition willfully act against parents and other family members' efforts to redirect their conduct.

Parents, as previously noted, turn to religious institutions for assistance, thinking that raising a child "in the church" offers protection from peer pressure. Churches may be more open to discussions of sexuality than parents are, but parents must accept church intervention for children to benefit from it. Betina (G2), running her own ministry as "a testimonial to God's blessing," presents a view with which Group 2 and participants in other focus groups agree.

I'm a minister. And, uh, a lot of churches are lacking. They don't want to deal with the real issues.... I'm gonna be real with you. Um, I have a ministry that deals with the real issues.... [When] the church steps up to the plate and deals with the real issues, that's when we get something solved. We need to be [real]. Like this church—I was... amazed that it [the focus group] was being held at a church. I really agree, it's daunting [redirecting youths' destructive conduct].... [Invention by ministers is] a beginning.

Speaking about her own ministry and her experience with other ministers, Betina adds, "[Church] people are scared. Some of them be like, *"No! We don't want to talk about that; we not supposed to talk about that in church!"*

Still, some participants see churches stepping up to the plate, but fewer today than during their teen years. Irene (G2) describes a discussion group at her church:

It's called "Girl Talk." You know, letting teenage girls come together, and then [they] have a ministry for the boys. So, the girls get together with an adult, and share what they want to know about. Questions they don't *dare* ask their parents.

Beatrice (G3) offers her opinion:

[T]hey want to say this is the problem, but they don't wanna be part of that solution.... And, yes, it is church, but, you know, it's kinda like this is how you get the education out. You don't have to have [the church] explaining the reproductive process. You can have preventive. You could start with that self-esteem class for these women to know that they are important, and it's important to make your kids feel important.... Our churches are probably the only thing we have left, community wise, [where] we all come together and... communicate.... [B]ut you can't just, like I said, hide the problems.... You got that teen pregnant girl coming into the church, whatever. So, something happened, so you know.

If some churches start programs, the moderator asks Group 3, why are they not helping parents? Church programs, the participants suggest, do not last. They fail either because parents do not allow their children to participate or because parents want instructors to report to them what children say. Beatrice expresses a view with which other participants agree: Like schools, the church is responsible for helping parents deal with realities, not with ideals. Yet, Group 3 holds parents accountable, first, for facing up the realities and, then, for accepting assistance when others offer it. Churches might offer assistance, participants say, where parents and schools fail.

Nonetheless, participants in all of the focus groups emphasize that the effectiveness of church programs depends on parents' responses. Brenda (G1) makes this point:

When I was growing up in church, we had, a group called YWA. They called it young women, but it was Young Women's Association. But it was [for] any child under 18

and we actually had open discussions about sex, things we were curious about. Our parents weren't there.... I think one thing we can all agree: parents didn't show up there; they don't wanna talk about this, you know. I started my period, they didn't... [really talk]. My mom's like, "You need these [tampons] *right here*," and I'm like [looking puzzled]. You know?

Unwilling parents—those who would prefer that no one broach sexual topics—may be no more open to churches than schools teaching their children.

Yet, parental reluctance is neither the only obstacle nor the most critical one for this cooperation. Even when churches and parents work in concert, peer pressure affects youth "in the church." In fact, some participants note, they may play a leading role in teaching increasingly younger children about sexual practices, such as anal and oral sex.

An unidentified speaker opens Group 5's discussion of this sensitive issue by muttering, "Some shake [their butts] more" [meaning some young churchgoers are more sexually active than their peers]. Other participants elaborate on this point. Involvement in the church may encourage forms of sexuality that young people see as satisfying parents and church officials, while remaining popular with peers. Thus, church youth may engage in all sexual activities, participants across the focus groups contend, except sexual intercourse. As Betina (G2) explains, "That's how... a lot of, um, young girls that go to church... think, too.... They think if they do the other, the other sexual... um, enjoyments, that they're still a virgin."

Betina's use of "too" is important, because the focus groups see these alternatives to sexual intercourse spreading for reasons other than fooling parents in the church. They can make an already difficult parent-youth conversation more difficult. Even women who became mothers in their early teens may be of "another generation" in their response to these sexual alternatives. Participants say they find the sexual activities of today's youth "gross." Recall that Frances (G2), recounting how awakened to her daughter's sexual activity, was stunned by the "dark, dirty stuff" she was doing, not merely that she was sexually active. In other words, children today engage in sexual activities, the participants think, that African American females of their generation as well as their older siblings' and parents' generations did not, because they "respect[ed] themselves." Oral or anal sex and sexual intercourse during menstruation are acts that participants attribute to females of "other races," particularly Whites. These acts, they complain, are becoming acceptable—"bleeding into the community"—as young African American girls, who want to remain a virgin while being hot enough to compete with peers within and outside the race, expand their sexual activities.

Three women's statements illustrate general views about these changes across the focus groups. "They [boys mainly, but also girls] tell you," Lois (G5) observes about her high school days, "you can't get pregnant when you are on your cycle... and other gross things." Ester (G2) reports:

Anything from kissing to touching, to what they call, "dry humping," or, ah, oral sex [goes]. Anything but what they call, "vaginal sex," anything but that, they consider okay... I mention this group of girls that... [considers] things like—now I hate to be, I don't mean to be graphic about it—but they consider things like anal sex as not having sex [because] you can't get pregnant. They are still a virgin.

"In my generation," Edna (G5) notes, "they weren't doing it in the mouth."

The focus groups clearly associate changing patterns of sexual conduct with church youth, but they do not consider them the only young people promoting "gross" sex acts. Until recently, participants contend, African American women's self-respect limited non-vaginal sex and, therefore, limited sexually transmitted diseases whose symptoms appear in the mouth. For instance, Lois (G5) says, "I don't know about the older generation, but I didn't learn about doing it in the mouth and butt until I got older—21. I didn't hear about oral for Black girls." These acts were racially out of bounds, participants across the groups agree, because "White girls were doing [them]" and, as many Group 5 participants simultaneously explained, White girls behave that way because "they *nasty!*" An unidentified speaker exclaims her agreement, "Yeah!" Then, Edna (G5) adds, "They will do things that Black girls won't do." Lois (G5) continues:

*They do that!* So, I didn't hear about that until I got older. Black girls be like, "That's the wrong hole! [Group laughter.] She like, "What you doing?" We were *fast*, but not *that* fast. We were like... who could be best dressed, who had the best clothes on.

If self-respect once precluded non-vaginal sex for African American women, Group 5 participants claim, desegregated competition for male affection now undermines restraint among young African American women. "[White girls] throw it at [Black males, especially athletes]," according to Charlotte, behavior which others also see as setting the conditions for interracial competition. "[W]e [are] telling you they [African American males] like White," adds Margaret. "White is right." [Many voices echo agreement.] "Yeah," Charlotte concludes, "That's the bottom line, right there."

However, for Group 5, mere color preference is not the bottom line. "White girls, Edna insists, "have the money and the cars." African American self-respect restraints, if they existed, no longer hold. "[That's] because... we do... we respect ourselves, but then it just starts bleeding into the community, and everybody do it. Ménage-à-trois and...." [Group laughter]. Edna continues, "Well, [Black males] got the White girls over there, and they will do anything. And [Black males] come back to the Black girls, and [say], 'It's just you and me, 'I would never do anything [like that],' and, 'Why you bring it up?'" As Frances (G2) learned when she took her daughter Mia to see a pediatrician, Group 5 participants also think that parents become aware of their children's oral sex practices when a doctor diagnoses mouth sores as symptoms of a sexually transmitted disease.

Whether young African Americans engage in “gross” sex acts to achieve intra- or interracial peer popularity, their parents, as members of generations with different values, may confront the possibilities of their children’s behavior too late. These possibilities—previously unfathomable—came together as Frances (G2) talked with her daughter after the school emergency.

So, of course, I took her out the door, and she got in the car and said, “*Mama*, I’m drinking alcohol and I’m having oral sex, and I’m doing this and I’m doing... [spoken in the daughter’s crying voice].” I said, ‘What is going on with you?,’ expecting to get, like, [resuming the crying voice] “I don’t know, Mom.” But, she said, “Well, I was at the movie theater and so-and-so told me to go in the bathroom and blah, blah, blah.” And I just... just listened to her, and so I took her to the doctor, and I.... I know about diseases of the mouth and all that stuff because, of course, I didn’t know how much Mia was telling me was true. And, you know how we all tell something, but you never tell everything? [Several others finish the last phrase with her]. So, how much did you *not* tell me? So, it was at that time that the doctor sat with us—that was our pediatrician, because she’s a baby—and talked to us about this is what it looks like, this is what herpes is, this is.... [names other diseases].

As usual, Frances fades into speechlessness. Neither she nor most participants in other focus groups led sheltered childhoods. Yet, some parents simply cannot imagine what their children may be doing based on their own experiences.

Despite sexual creativity, participants across the focus groups say, young girls eventually “put out” to remain popular, and pregnancies follow. First-time mothers may only learn that they have contracted a sexually transmitted disease when they begin prenatal care, Charlotte (G5) notes, expressing a prevalent view across the groups. Participants in all five groups also agree with Lois’s (G5) conclusion that expectant mothers often delay health care until delivery, and only then learn of their infection and get treatment.

The focus group does not see this problem as class-restricted, but its economic aspect (“White girls have the money and cars”) suggests that the youngest African American girls with the lowest incomes are the least materially competitive. The girls’ interest in popularity shapes their willingness to “do everything.” Thus, they rapidly progress from petting to oral and anal sex, exposing themselves to sexually transmitted diseases. “Stepping up their game” in the peer popularity competition may also result in vaginal sex and pregnancy. Self-respect and shaming or disapproval from family and friends already dispose the girls to hide pregnancies. They also discourage the girls from seeking treatment for sexually transmitted diseases. According to the participants, this combination of factors helps to explain the prevalence of young girls, pregnant for the first time, who receive no prenatal care before hospital delivery. The moment when the girls must reveal one problem exposes their other problems.

Lois (G5) describes the situation that many young, African American women expecting their first children face with sexually transmitted diseases.

They probably don't know till they go to the hospital, pregnant. "Oh, also, I see you have Chlamydia. Oh, also I see you have gonorrhoea." They never know. That's probably why she was hot, and infected a lot of people around the 'hood. And, she got pregnant, they, "Oh, I hope you know you gotta get treated for this, and she probably, like "Dag! I've infected all these people. Now, I gotta go tell them." But, before, she don't know.

Paula (G5) comments on problems that follow from the expectant mother's lack of knowledge: "Well, hopefully, she gets some prenatal care and the doctors prescribe something. But most of the time, it don't work like that." Other fears discourage a young woman from seeking treatment for diseases, Paula notes, especially fear of censure or violent responses from... well, from everybody. She might not want her mother to know, you know.... [S]he scared of what the boyfriend gon' say. 'Cause, if you having babies and stuff, that's already bad, then, now you are diseased! That's the problem.... No one is going to take her to the doctor.... She probably wouldn't tell her parents. She would probably talk to her friends, and they know about it, and tell her, "Why don't you go here, and they won't tell your parents and you can get it taken care of."

When neither friends nor family prod the person experiencing symptoms to seek treatment, participants believe, the health authorities will eventually catch her. "[T]hey come get you," according to Charlotte (G5). Edna (G5) adds, "I see them come around. They like, 'You ain't registered.'" However, neither family and friends' prodding nor health department surveillance ensures that young expectant mothers—especially first-time mothers—will get treatment in time to decrease potentially adverse effects on fetal development.

When commenting on communication about sexually transmitted diseases between young, unmarried couples, focus group participants speak only of the expectant mothers' fears about revealing their infections. Some participants mention fear of violence, but their references to "being beaten up" mean unpleasant encounters that endanger continuing the relationship as readily as physical assault. Summing up this view, an unidentified Group 5 speaker emphasizes, "It ain't gon' be pretty!" Overall, participants see the emotional stress of being infected adding to the disdain and censure that a young, pregnant, unmarried girl expects from family, friends, and the community.

We turn next to the influence of shame and secrecy.

### **III. "They'd Be Lying": Shame and Secrecy**

The focus groups contradict statements suggesting that the African American community (local and national) and American society morally condemn unwed teen pregnancies less today than in the past. An unmarried teen mother, the groups insist, expects condemnation from family and friends, the condemnation creates shame, and shame promotes secrecy. Group 2 expounds most clearly on how shame and secrecy may delay an unmarried teen mother's effort to seek prenatal care or prevent her from getting it. Alice (G2) expresses her group's general view, as she agrees with calls for change to combat the influence of shame and ignorance.<sup>9</sup>

I feel like we need some more information. 'Cause, like I say, there's lots of kids having kids. But, if they don't have no information, they have no clue about maybe I should go to the doctor; maybe I should do this [or that]. Because it's, like, I [the expectant mother] feel ashamed. But, [it would be better] if there was more information out there available to young kids [telling them] where they could go to get information.

Darlene (G2), pregnant at 17, experienced her father's shame, but also his later support and pride in his grandchild. Her mother took her to doctors' appointments and, for Darlene, that support was a positive difference between her and her peers. Still, Darlene experienced the disdain of friends and kin, as well as health-care workers, for the "cheerleader who got herself knocked up." Working at a hospital now, Darlene sees patients much younger than 17, who lack family support as they face her co-workers' disdain.

Well, I work for AHCCCS at the hospital. And, we... I have a lot of clients that go up there, like little girls that's pregnant. I think the youngest I've seen are like 12, 12 or 13, and they don't have no prenatal care, no nothing the whole pregnancy.... [They] don't hear about nothing. [They don't] know nothing about any of that until they get to the hospital having a baby.

Betina (G2) adds, "Especially if it's a secret, and it's not told until after a certain amount of months, then, yes [they know nothing]. It's a lot, a lot of secrecy." Crystal (G2) emphasizes health-care workers' disdain for her as a very young

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<sup>9</sup> Some focus group participants' comments, though not directly concerned with shame and shaming, reveal their importance within and outside the African American community. Betina (G2) insists on sharing her testimony and challenges those who see her as "crazy" by asking why she should be ashamed to discuss wild youthful experiences that shaped her views as a mature woman. Karen (G4) rejects blame for exposing her children to drug addiction, drug dealing, and prostitution. She is not ashamed to speak truthfully, and she will allow anyone to look down on her for her past. Likewise, when Evelyn (G4) says, "We put our stuff out there because maybe we proud," she does not refer to high rates of illegitimacy, premature births, or infant deaths, but to the fact that it is morally more acceptable to own up to than to hide one's conduct and its consequences. These indirect responses help to understand participants' explanations of young mothers' behavior. Belligerent responses to shaming and disapproval, participants maintain, encourage competitive reproduction among a subset of young mothers. In addition, many young mothers reject both adoption and abortion as failures to honor values in the expression, "If they are woman enough to lie down and make a baby, they should be woman enough to stand up and raise it."

mother, recalling the courage her family's support gave her to return to the doctor after experiencing humiliation at her first appointment.

I think [it is] the attitude when you go to the doctor's office.... Because I was a very young mom and a lot of the nurses were very rude to me. And, thank goodness, I had the support of a family that encouraged me, you know, to keep on going. But, if I didn't have that support, maybe I wouldn't go back, because I would feel so ashamed, you know.

For focus group participants, doctors, nurses, and other health staff add to community and family censure. Their attitudes, insults, and humiliations make it difficult for the young mother to use prenatal care. Like Crystal and Darlene, other participants who experienced early first pregnancies, think that very young mothers who have no support from family or friends face the greatest difficulty. As Crystal (G2) puts it,

It's just a tremendous amount of shame. Especially for families, and that's what I hear a lot. You've shamed our family name. And, so, they spend so much time trying to push that person, you know, out, away from their family, so it doesn't reflect poorly on them. Instead of trying to help them, and figure out what's going on with that little [girl].

Therefore, Betina (G2) voices a view the focus groups accept when she contends that, if people say unwed teen pregnancy is no longer a source of shame, "They'd be lying." Nonetheless, she sees unwed teen pregnancy having "become a part of society. It's accepted now, you know. No one no longer talks about abstinence [until marriage], and stands up in front of children and says what is abstinence, and why is it important to practice abstinence."

Still, whatever Betina means by "accepted," neither she nor other participants think it implies an absence of shaming practices or shame for unwed teen mothers. Instead, they promote secrecy about a first pregnancy and attempts to hide subsequent ones. Alice (G2), who had her first child at 38, recalls how shame resulted in the tragic death of a friend's second baby when they were teens.

But, see, I can say I know from personal experience that there is [shame]. One of my friends, she was a teenager, and she hid her pregnancy through the whole time—went outside and delivered the baby herself and that baby died. And, the baby died because she was too ashamed to tell, because it was her second kid—to tell her parents that [she was pregnant again].

The combined effects of shaming and disapproval, Alexis (G3), notes may reduce support from family and friends as young girls continue having babies.

Maybe some people don't have family members. Maybe the family members that they have are not the best role models for them to be going to. So, if you feel like you are in something all alone, and the only person you can go to—let's say you were the older, the oldest sister... you were the oldest and best friend, or whatever.

And, that was the only person that your best friend can come to, and your best friend came to you and told you she was on her third baby. And, you automatically were like, "You haven't learned from the first two?" And, you gon' automatically send the thought, like, "Well, *dang!* If that's how people feel about me having a third baby, well I shouldn't have it."

With each pregnancy, Alexis continues, shame may increase and longer delay revealing the pregnancy and seeking health care.

I'm gonna have to take care of [another baby]. I have two that I'm already taking care of [and I'm] gonna need to do more to take care [of three]. And, then somebody—let's say, you don't even tell somebody—you get to the point where you say, "I'm not gonna tell you, because I already know how you are gonna react to it. Either you gon' be, "Oh, I'm so *happy* for you! [or, you will disapprove]."

Group 3's responses to Alexis's personal and hypothetical accounts demonstrate the reactions to which she refers. Glenda (G3) interrupts Alexis to ask, "But you had the first two. Why, if you [are] struggling with the first two kids, and you know all..." Alexis, cutting her off, interjects that birth control sometimes fails. Whatever the reason for having more babies, where the mother has transferred the care of her previous children to relatives, their shame combines with their resentment of her continuing poor choices and impractical economic decisions.

Across the focus groups, participants agree that a first child may result from efforts to give birth to a love object, a substitute for lack of love in the mother's natal household. Yet, producing a child to give and receive love, participants emphasize, does not mean knowing how to love. Young unmarried mothers often see children as dress-up dolls, participants say, and have skewed priorities. They expend scarce resources on status appearance and this increases family and community censure. As the mothers have more babies, family and community members see the mothers' concern with dressing up doll babies as a poor use of scarce funds. Onlookers judge harshly young mothers who cannot afford medicine for their well-dressed babies when health insurance does not cover it. Greta (G1) reports:

[T]hese are things I [would] see in the community all the time... especially when I worked at the pharmacy.... I had one mother once come in and say, "If my baby needs it, then I need to buy it." The medicine's not covered.... But, this was only one instance where the girl said something like that. I've seen other times when there's the best lotion, the best soap, and the best of everything in the cart. You got Mickey Mouse outfits, everything, and your child needs this antibiotic to get better, and you're not willing to pay for it. (G1)

As Crystal (G2) puts it, "[T]he little outfits—put a baseball cap on it, and [they have] someone to love them."

Frances, who had her first child after 20, asks younger Group 2 members who became mothers when they were younger than 20, about the love-object

motive for giving birth. Others agree when Betina (G2) replies, "Yeah, [you are] looking for someone to love [you]—especially if you come from a dysfunctional family, and you don't know... [T]he family is not practicing love, don't know the definition of love, [is] not walking in love. Oh, yeah, definitely, for me, I was seeking for love.

The baby, as love object, offers ways to attach the affections of family, friends, and a male. The structure of disaffection in a young mother's natal household influences how she may seek attachment and to whom. In large families, focus group participants report, younger children receive either the most attention or the least attention, depending on parents' reasons for varying attention by age.

Helen (G1) responds to the focus group scenario about the implications of birth-order position for three siblings: Kari, a boy, and two girls, Kesha and Karla. Her response presents a view that participants in other groups express.

So, I just think with that the older child, [Kari] may have been the leader. Then a lot of responsibilities was on him that maybe he didn't want. So, therefore, he wanted to be himself in his youthfulness, and go—I don't wanna say 'sow his oats'—but, you know, go do his thing. The middle child [Kesha] was trying to find her niche. And, then, the younger one [Karla] was like, "I have everybody telling me what to do." I mean, it could be a variety of things that are going on.

Brenda (G1), a middle child in a large family, was looking for attention, but she could not get it by having a baby. Her competitor for attention was an older sister, who already had a baby and had "stepped up her game," moving past her "slip up" to continue her self-development.

We [middle children] do feel left out... like nobody is paying attention to us, 'cause [parents] are always worried about what the older one is doing, and what the baby is doing. So, I have two older sisters and two younger siblings, a... brother and... sister. And, my older sister, she's the nurse—an RN. My second oldest, she was a really famous hairdresser in Detroit. She was known all over the city. And... there is me... I'm next in line. So, now, I feel like I have to prove myself. I have to step my game up. I have to do something, you know, because I have a child. My oldest sister... had a child when she was 15. And, even though she did slip up—not that she made a mistake, because none of her kids are mistakes—she slipped up. But, she... stepped her game up, and now she is a registered nurse... doing good for herself. [S]he owns her own house and everything. But... nobody wasn't paying attention to me. And, I'm like, "You need to step your game up." You need to [do] this because your sister is doing this, your other sister is doing that. And, it's like I'm invisible.

The implications of being the oldest or middle child also differ with the size and paternal/maternal reproduction composition of a household. Ellen (G1) describes why her youngest sister thought having a baby was a way to gain attention and distinction because Ellen had done everything else well.

I'm the oldest of 14 [children]. My mom and my dad had three—the first three—and the rest are my dad's.... [M]y sister said, "The only thing that I could have done that you did not do was have a baby." Because, I went through school, and all that. And, [my parents] like, "Be [Ellen], be like [Ellen]," [by my sister says] "I'm not [Ellen]. So, that's the only thing I could do that distinguished me from [Ellen]."

Yet babies do not guarantee mothers a place in others' lives. The price of trying to secure this place for a mother is greater emotional and financial dependence. Failure means greater insecurity and feeling more neglected or abandoned. The support and approval of family and friends dwindle as each child shows the mother's inability to learn from her mistakes. Alexis (G3) notes that, "[I]t's like, when people care enough to say, 'Okay, this is what you need to do', then that's when I do it." The moderator asks whether the lack of support from others might influence a mother to seek or use prenatal care for her second, third, and later babies. Alexis's response is consistent with other focus group participants' views.

Not as much. If you in pain, you will go to the emergency room. [With] my third baby, I ended up going to the emergency room. Yeah, because, by then, I have four different fathers—and... I'm with the last one, right now, so I guess that's a good thing. But, in the end, if that other person is not there for you—and, I mean, your family is like, "We know that this is your baby," you know, "so we gon' be there." But, you can't always count on the guy to be there. And, every child always, like—it might sound weird—but it takes something out of you. If there is not a whole lot of love around you and around the child, then that weighs on you, as well.

Elena (G3) agrees.

[B]y the third one—I think about someone I know right now who's in that [position]—she just don't even wanna tell nobody, because they [will] say, "Well, where is the first two babies' daddies? Are they helping? You need help some more? Well, you should have thought about that." I wanna say there's some depression; I don't even wanna know.

Babies thus become capital for making other kinds of love in families, among friends, and with males, as fathers or potential new relationships.

Nevertheless, participants describe mothers who are more interested in partying, alcohol, drugs, and sex than in their children. As Brenda (G1) says of her mother, and as Anna (G1) and Karen (G4) say of earlier periods in their lives, some mothers are strung out and trying to manage drug problems. Yet some neglectful mothers, participants insist, only appear callous and indifferent to their children's welfare because they are following models that their mothers and other female family members set.

Turning to young fathers, Lois (G5) expresses a view consistent across the groups: "He probably went [with the mother to health care or birthing class] the first time and thought it was a waste of time, and wouldn't go again." Most young

women concerned with holding onto male affection, participants contend, allow the males' reactions to direct their involvement with prenatal health care and social services.

The moderator asks, "So, she just follows him?" Katrina (G5), replies, "Yeah, because she probably thought she was in love." Lois (G5) agrees:

Pretty much. She thought she was in love, and she thought she might lose him, and that one thing and another thing—having kids as a teenager, and dealing with the dude—[are difficult]. That dude tell[s] you whatever you wanna hear. And like [the girl says], "I'm gonna do whatever he say, because I wanna keep him." But, really, that's not gonna keep him. But, she doesn't know that, because she doesn't have enough resources, and probably nobody talked to her when she was younger, [telling her], "You can't keep a man by just listening to what he say." You know what I mean? That was probably why she like, "He don't wanna go [to a health-care facility]. I don't wanna go either; whatever he said.

Paula (G5) adds:

I think they were probably scared to go by they self. She needed that back and support. She also need[s] somebody. She probably felt she needed someone there to go see how the [birthing or parenting] class would be. You know what I mean? She was like, "He's not going to go with me. I'm not going by myself. So, I'll just do it the best way I know how.

Closing the exchange, Dana (G5) remarks:

They feel that... their love is coming from... [the males in their lives]. That's where their attention is. That's who gon' keep them safe. That's who is going to protect them. So, that [is] who they gon listen to.

When the moderator asks whether males (as legal spouses or unwed fathers) provide protection, Group 5 asserts that mothers cannot count on them. Instead, they say that males (particularly young ones) often convince young women not to use contraceptives, especially condoms. Summing up this view, Edna (G5) observes, "He kept her from protection she needed earlier on." Yet the opposite view also emerges—that a young woman undermines male efforts to prevent pregnancy if she want a child to secure male affection. According to Charlotte (G5), "She put[s] a hole in it [the condom]." Young girls or women do this, participants think, because having a baby is a means to more firmly attach that male's affection and, perhaps, to ward off female competitors.

#### **IV. "When reality sets in...": From Dress-up Doll to Baby's Body**

Resistance to parental advice or other constructive guidance produces lack of knowledge. This, in turn, encourages first-time mothers to think of babies as dress-up dolls for competitive show, focus group participants across income and education levels insist—until reality sets in.

Most young mothers are raised on silence and, thus, unprepared for the complex realities they face rearing children and managing health care for themselves. Participants maintain that neither income nor formal education ensure knowing the difference between the needs of adult and child bodies. As children mature, mothers will not automatically understand their children's realities or know how to manage them. Frances (G2) elaborates on this point:

I was best dressed in high school. I mean, we had all the accouterments of what you were supposed to look like. Right? But, maybe your heart wasn't right or your soul wasn't right. So, of course, I have a kid... [but] I don't know... you're not supposed to give them Coca-Cola.<sup>10</sup> I had this little girl, and so I start putting all this papier-mâché on her and dressing her up, but I didn't know that she was dealing with real stuff. So, I'm probably one of those people that are 60 in that elderly group, and... *I just didn't know what I didn't know...* until... I got a call from the school saying that Mia was passed out drunk in the bathroom, and didn't know what was wrong... [exclamations of surprise]. And so, mind you, I don't *know anything* that's happening with my kid, so I'm thinking that she's got low-blood pressure. She's anemic [self-mocking sarcasm]. So, I race across town to deal with some medical issue, because... I can't even *fathom* that [it is anything else].

Ester (G2) echoes and generalizes this point about lack of knowledge: "But, they don't [know]. They see baby, they see cute, dress it up. You know?"

Fatima (G3), reflecting on her sibling's experience, addresses what happens when a mother's interest in dressing the doll confronts the complexities of caring for an infant.

She would have her baby dressed up in all these fancy clothes and shoes and all this. But, then, once that wore off, reality set in. [She realizes], "Now I am mother and father, and I'm not cut out for all that right now. I wanna go out and show who I am, out in the community, and I do have a baby but, you know, my, my life is more important." ...I am hearing like, "It's your responsibility as a parent," but... [young mothers] are not getting it. So, you can preach, preach, preach all daylong that... it's your responsibility to take care of your children, get them to the hospital, or get them the care they need. But, they're not listening to that.

As very young mothers (or older, but also uninformed ones) confront the reality of childrearing, their lack of basic biology knowledge influences how they view a baby's body and how its needs differ from their own. Young or first-time mothers do not understand the details of parenting, participants insist, and thus play at mothering. They do not agree, however, that this means general ignorance or translates as indifference for all.

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<sup>10</sup> She refers to another Group 2 participant's account of observing a young mother feed her infant Pepsi in a baby bottle.

Yet, whether young mothers take on or transfer their children's care, the base problem remains. Raised on silence, they are not prepared for childcare and for negotiating health care. Their efforts to attach and maintain the affection of other people through responses to the child only complicate the lack of basic knowledge and role models for learning needed skills. Mothers, participants say, begin by seeing children merely as small versions of themselves and, so, think that what is good for them as adults or what did not harm them during childhood, will not harm their babies. When a mother's younger sibling assumes responsibility for childcare, this lack of knowledge about parenting—especially, when, how, and where to seek appropriate health care—becomes even more critical.

In Group 2, Ester provides an example that shocks the other women.

[In] the delivery part... a lot of those women—like a few that I know of—by the complete Grace of God, they have a healthy baby. And, it's nothing that they're doing to, you know, to get their bodies ready. ...[T]he most disturbing part is when you see the baby in the infancy, those first few months, when things like breast milk or formula are important, [the mother will] give them Pepsi in a bottle. Have you ever seen that? I kid you not. I was behind someone that did that yesterday—took her Pepsi, opened it up, poured it in the baby's bottle, turned the cap, and gave it to a two-month old! [Group moans] And I was like, "Oh, my God, [I] can't say nothin' 'cause we'll be fighting." [Group laughter] "It's not my business." Of course, it's not right. And, my husband's like, "Don't say nothing here." And I'm like... I'm just twitching.... [The mothers do not provide] the proper nutrition, because they just don't know. No one ever told them that you're not supposed to do that. No one ever told them.

Frances thinks that even a young first-time mother should know how her body responds to the drink, and generalize from that. "You know what Coca-Cola does to you, if you drink it, burns your throat, burns your mouth." Ester agrees, but, along with others, counters that mothers probably act on their own childhood experiences. As children, they survived many things that were not good for their growing bodies and, so, have no reason to think their actions might harm a developing fetus, newborn, or infant. Ester concludes:

Lack of information—I mean, but no one ever told them not to do it. Do you know what I mean? And, people only do what *they* know how to do. Their point of reference is, as far as they've been educated on things, "So no one ever told me that drinking Pepsi was bad for me, and I'm drinking it and it hasn't killed me yet. So, why's it gonna..." I mean that's the mentality.

Many first-time mothers (young or old), Group 2 generally agrees, do not sense that their babies are too frail for some things, which, as children, the mothers survived. The best nutrition and care, as they understand them, are those their parents gave them.

School instruction about childcare based on play-acting, Ester (G2) maintains, fails to give young mothers adequate practical experience, even as it encourages a sense of competence.

Something that you'd have to care for [like a fragile egg]... seemed kinda facetious. ...[You're] like, "Oh, I'm just going to buy another egg... I'm gonna go... whatever... (not that I ever did that!) [group laughter] ...[B]ut, what I'm saying [is] that right now there's no, there's no modeling. I think that's what it is.... [Girls will learn more if they]... have some of those dolls... an opportunity to spend some time in a crisis nursery, or something where they had practical experience about [babies].... Because, what they conceptualized as a child, you know, [is not one] that screams all hours of the day, that demands complete attention, that... could tear up... and could eat anything poisonous.... I think that, for [young mothers and younger siblings who raise older siblings' children], it's overwhelming, and no one would choose that.

Frances (G2) interjects, "So, I'm thinking that [a young mother's sister is] probably dealing with these nieces and nephews... and [thinking] I don't want no kids." Agreeing, Alice (G2) chimes in, "Heck, yeah! It was for me."

During a similar discussion in Group 1, Greta recounts her disinterest in having and rearing children after she cared for young siblings.

[W]hen you are a family of five—take my older siblings, every summer, they had to baby sit the younger ones. That irritated me. I just didn't wanna ever be... I couldn't *stand* kids at that age. That's why I didn't get pregnant... until I turned 30.... I saw that there was more to it than just having a baby.

Like other participants, Greta recognizes why her parents called on older siblings to care for young siblings. This does not reduce older siblings' resentment of their experiences, which often influence their feelings about becoming parents.

Because... [of]... my parents (because of their economic situation; not being able to afford day care, not having no alternatives), we were forced to raise our siblings. Which instilled envy in me for that, you know. I still resent [it].... They did the best that they could do. I don't resent my parents; I resent the situation. I don't resent my parents, because they did what they had to do. But that plays in with a lot of things with the middle child. They look at experiences that their older siblings are going through and learn from them. [A]t the same time, they are being annoyed; being affected by the other children that are in the household.

Perhaps more important, Greta combines the typical responsibility for childcare in low-income families with her response to intense involvement with her older sister's teen pregnancy and the premature baby's death.

My older sister, she got pregnant early and her first baby died.... Something about the sac broke—I still don't understand a whole bunch about babies—and, ah, the baby slipped out, and she had premature birth. And the baby died a week later, which tore her up. And I went through all those experiences with her and her having a baby. And what happens is that when you have a sister that has a baby, that sister

relies on you a *whole* lot. Especially when you are two years apart, they rely on you a whole lot to fix a bottle, to do this, to do that. And I just never wanted... and that's irritating.

Problems in small, high-income households, Frances (G2) points out, mirror those in low-income households. Mothers reared in both later face the consequences their childhood training and trying to compensate effectively for the absence of parents and other elders.

I have a small family. Everybody is, um, a jet-setter. My granny... my grandma... is "Mother dear," because she's too fine to be granny. And, my mother—the grandma, the grandmother of my children—is, um, "Nana." So, I have these high-profile, jet-setting, page-me-if you-need-me grand women in my family, you know. Women in our life... in my life are really independent. And, so, nobody is nurturing and suckling, and showing how to clip toenails. So, that's why I had to look to people in my community, [people] around me, to figure out, you know, what [to do].

For Betina (G2), the emotional and effective absence of elders in a three-generation household occurred long before divorce "broke" her family.

Well, I come from a very dysfunctional family. For me, at 12... I come from a, okay, a... three-parent family: my grandfather, my mother, and my father. I grew up in an abusive home where I watched my father beat my mom. He was an alcoholic. So, um, they were separated around—I was around six, when they got divorced—and, by that time, I experienced a lot of other things with the family; with boys, with boys that I was related to. So, by the time I got to 12 years old, I was messed up.... [S]o I was looking for love; not only from a mother, but from a man, as well. And, a lot of times, as a teenager, when you don't have it at home, you seek it. And, sometimes you seek it by having early relationships.... For me, a man—it wasn't a boy; It was a man.

Time for adults to show younger children affection and attention becomes scarce in households coping with substance abuse, long workdays, elders who continue to produce and rear younger full and half-siblings, and siblings who produce nieces and nephews. These conditions exist across African American households, focus group participants say, despite differences in income, formal education, and generational structure. Consequently, young women begin learning what they need to know after becoming pregnant. Mothers learn about parenting and, later, health care needs by trial and error. They diligently seek information and advice as necessary, while trying to find role models among neighbors or among persons in other spaces of social interaction.

Frances (G2) got help from women who volunteered it and from others she approached, because she saw them as caring and knowledgeable.

[O]ne of the ladies told me, "You don't let people touch your kids." My baby was little and everybody wanted to mess with him. But, one of the ladies said, "Don't let them; you don't know if people are clean." And then... [another one said], "I might hold tight and you might hold loose." So, here's this baby that's getting squeezed

and... maybe you hold the face, and, so maybe, she's sore at the end of the day. So, I just tried to put those things in motion when I dealt with both the kids. But it didn't come from Mother Dear or Nana, because they were in Europe, and doing their own things. So, it came from the lady in the church that would say, "Baby, I would wrap that so-and-so." So, ...like that, you know, [is how it was] for me.

However, Betina (G2) became aware of parenting problems when her mother ordered, "Either have this abortion or get out of my house." At 12, she had the abortion, but she was pregnant again at 16. Only then did she learn about positive parenting models. When Frances asks if Betina should have had the child conceived at 12, she says yes, because [the abortion] "*Messed me up.*"<sup>11</sup>

The focus groups disagree with simple cause-and-effect relations between different household types (by size, income, education, and generational structure) and ignorance resulting in teen pregnancies or negative parenting practices. Yet the participants also disagree with one another about whether typical views of the African American community as rife with drugs and dysfunctional families provide adequate explanations. This disagreement, as an exchange in Group 3 illustrates, reflects different understandings of class demographics in the community. Fatima remarks:

And, another thing, I would have to say about, you know, going right back to parents. As far as, you know, the young women getting pregnant, and the scrubs per se or whatever. I think that in this community, if you really look at a lot of parents, [they] are on drugs; a lot of parents. The mothers have their own issues to deal with... [and] they abandon the girls... [who] are really left with doing their own thing... I am blessed, because I have a lot of information. [But] I have friends who are getting pregnant, and they have six and seven babies. But, I have two [children]. I feel very blessed and fortunate to have stopped at, you know, that number. And, [to] just have more information on sex education and, you know; the different preventive ways not to get pregnant. But, again, going back to the parents: Yes, the parents are responsible, because they have [been] given... that right to have the child, and then educate that child. But then, at the same time, if we are talking about them in this community, you have to look at again that a lot of people are on drugs.

Beatrice replies:

I disagree. There is a lot of drug use, but there is a lot of positives—probably more than we know about. But, that's the problem. We don't know about it. There are a lot of affluent African American people in this community, who keep to themselves. And, ah, if I was at a forum with those same people [referring to the deliberation scenario], I would say you have what in their mind is a drug-infested community. What would be the next way? If you know that you won't get the parents to educate [their children], how would you do it? Well, in the first place, what used to be [true in] a predominantly African American community, would be [involving] the churches. So, you get these church leaders to come into a contemporary process of thinking.

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<sup>11</sup> This exchange sparked Group 2's discussion of abortion as a solution to problems created by young women's ignorance about sexuality, pregnancy, and childcare. Other focus groups added detail and complexity to the discussion of this issue (see Chapter 2).

And, say, you know, this *is* something that, ah, our young people are dealing with.

Not knowing is the key, the focus groups consistently maintain, for understanding individual and community dynamics. Beatrice (G3) points to class demographics about which the participants do not know and cannot use to their advantage, because the affluent “keep to themselves.” Yet participants in other focus groups see a larger problem: parents who are present and healthy, but who do not provide the information their children need. When the participants’ own parents, mainly mothers, were present and engaged, communication included little of substance. In Group 2, Ester observes:

My mom used to threaten me. She’d say, “I will kill you, if you come up [pregnant],” you know what I mean. It probably wasn’t the right way to [have that conversation], but, yeah, that’s kind of how that conversation went.

Alice succinctly reports, “My mama *didn’t* tell me *nuthin!*” Before Betina’s first pregnancy and abortion, she could not talk to her mother for fear that “[I]f I asked any questions, I might get beat down.”<sup>12</sup>

Francine sums up how Group 1 connects the consequences of home and school silences.

I would say the same thing, because I was 16 when I became pregnant with my son, and everything was hush-hush. I was real sheltered. In church, they don’t talk about that, you know, having [sex or babies]. The only thing I was told by them was “Just keep your legs closed.” So, when I got in high school, everything was new to me, and it was just like, ah, you know, I just kinda went wild [laughs].

Denise reports similar experiences with a lack of home training and school instruction that comes too late.

For me, I learned it on my own. I was a teenage mother. I got pregnant at the age of 13 and had my child when I was 14... [S]ex was not... talked about in our household. Everything was kept quiet. So... I pretty much learnt about it [on my own] when it happened to me. ‘Cause, I was six-months pregnant when my mom found out... [T]hen, even after having my baby... it was like a little baby doll to me, you know. ...[So] I had to become a mother, and didn’t know how [to be a parent].

All focus groups emphasize that children in South Mountain need earlier instruction about sex and its consequences, instruction *before* the typical age of first pregnancy. Girls in particular, the participants underscore, need instruction not merely about reproduction, but also about parenting skills as well as when, where, and how to seek health care.

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<sup>12</sup> “Beat down” may, but need not, include physical assault. We understand it better as verbal castigation, humiliation, withdrawing approval and support, and other responses that depress a person.

## V. "I think it's our generation": Breaking Silence and Cycles

For focus groups, *generations* are eras of acceptable attitudes, values, and practices regarding sexuality in American culture and in their community. Rooted in experience, these eras involve different patterns of individual sexual conduct and different styles of parenting communication—mainly between mothers and daughters. "Older generation" parents might only be in their late 20s to mid 30s when their oldest children mature. However, they do not talk about sexuality and parenting in their households, and this silence distinguishes them from parents of the "younger generation." At most, parents of the older generation hint, joke, threaten, and, when faced with failure, punishes. When emotions cool, these parents may offer whatever emotional or financial support they can muster, depending on an expectant child-mother's attitude and behavior.

Ranging in age from 18 to 43, the focus group participants see themselves as a generation that contrasts with two other generations in different ways. Regarding style of communication, their generation contrasts with the previous one that "does not talk" about sexuality. Their generation also contrasts with the following generation, the children they are raising, based on attitudes and values about acceptable sexual conduct. "[M]ost of us came from another generation than these kids now[a]days," says Patricia (G4) summing up this view, "because they are from another *brand!*"

Negative experiences that shape childhood, the focus groups maintain, provide examples for reverse modeling. Raised by the generation that refuses to speak about sexual matters, the participants, now parents themselves, see breaking the silence and cycle of negative outcomes as learning how, with scarce resources, to turn bad examples into good practices. According to Brenda (G1),

[I]n South Phoenix, there is a lack of resources... or... a lack of resources available to young African American women. [They] should be taught. They get a brief discussion about [sex] in grade school, but, in grade school—in my eighth grade class, seventh and eighth grade class—there were girls who were pregnant. So... obviously, the information was not brought into the homes. We also need to educate the parents. It's okay to be open, but I feel it's a fine line to walk. Because sometime, if you are a little too open... your daughters, your sons can consider you a peer.

Beginning to parent at a young age combines with what Helen (G1), like many other participants, sees as the drawbacks of personal responses to poor childhood training.

[A]s parents, we have drawbacks to our history—what we did as a child. We have to take some of the blame, because, your kids are eventually gonna ask, "You did, why can't I? Why was it all right for you and not me?"... And, while you know what you struggled through, and how hard it was, they may not see that. They may just see, "I want brand-new tenny shoes, and Mom can afford to get 'um now." They don't

know what mom had to do—how much overtime mom had to punch in—to do it. All they know is, they have the things that other kids may not have.

A young mother's problems with becoming an open and engaging parent do not result from trying to be "cool," but rather from her oldest child becoming sexually aware and perhaps active when the mother is less than twice his or her age. In addition, although a boy's female peers have little information, gender-role differences promoting the view that "boys will be boys" encourage parents to ignore a young male's information needs. Therefore, participants think, young males are unprepared to contend with earlier male sexual awareness, experimentation, and peer pressure to become sexually active. They are also less capable of being good parents, even though they may become parents as early if not earlier than girls do. Glenda (G3) puts it this way:

I feel like from that stage...—boys... around eight to 10... [and] girls... around 11, 12—the hormones are kicking in. ...[T]hey're experiencing unknown body, you know, pleasure. And, then, they gaze out toward, toward the other sex. But, like I say, it goes back to the home front. The parents are supposed to be monitoring their child's life. Whether female or male, it is [irrelevant]: sometimes... [children] are naive, very naive, at that stage. That is why the parents have to step in and participate more in [children's] activities, to prevent... [negative outcomes from sexual experimentation].

Parents may be unaware that, or unwilling to consider how, their different responses to boys' and girls' sexual conduct produce "scrubs."<sup>13</sup> Influenced by gender-role practices, some young males target female age peers who, they think, receive no home training about sex or do not listen to their parents. Nonetheless, when the moderator asks Group 3 who raises the scrubs, Beatrice's response captures the general view.

The same women, who have let another scrub... [get them pregnant]. My first child is not by my husband. No, not my first child; my first child died. But... my oldest now is not by my husband. But, when... her father—he was going to school in Texas or whatever (he's an engineer now)—could have been potentially something positive in her life, he chose not to be there. I made up my mind right then and there that the next man that fathered my child was going to be my husband... [even if] that meant... I did not have... another boyfriend. I told the Lord, "You her daddy." ...But it took me, within myself, to say how much more I was going to take... [and] "I don't like this." ...[N]ow, my husband, who I have been married to for 11 years, is the only father my child has ever known. And, when she met her real father, she said, "I

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<sup>13</sup> "Scrubs" are young males pursuing sex without parenting responsibilities, but interested in producing babies to compete with male peers. While scrubs have no resources, some focus group participants say, this does not mean that all scrubs are products of low-income households. As Beatrice's comments suggest, scrubs adopt a negative attitude toward parental responsibility and, thus, may include well-educated men and those with adequate incomes to support their children. In Chapter 3, we will hear participants' views about factors that specifically influence parenting among males from low-income households. The focus group methodology centered on women's responses to pregnancy and use of prenatal or general health care. Thus, it did not capture sufficient information to understand men's views about or involvement in reproduction and parenting.

already have a father." You know, "I have a daddy." ...And, so I think there are cycles to be broken. ...[W]ithin our individual self, we have to say, "No." We have to say, "Is it important to have a warm body next to me or is it important for me to just love myself?" And, then, make someone else know how to love me.

Still, the focus groups agree that parents give boys too little information about sex and parental responsibility. Group 5, responding to the young male parent scenarios, illustrates comments from the other groups. Fern concludes, "He had to learn a lot of things on his own." Edna adds, "I think he didn't receive any encouragement, so he just started... he said, "I'll just go for it. They don't think anything of me, so I'm not gonna make anything of myself." For Charlotte, one popular young male was under extra pressure, "'Cause he was into sports and the White girls [were] just hitting on him" [group laughter]. An unidentified speaker mutters in the background, "That why he got those babies," referring to the scenario describing the male's two children's mothers as Hispanic and White. Although Margaret does not dismiss the importance of these factors, she concludes, "Naw, he [is] just too hot in his pants."

As noted above, Beatrice (G3) believes that girls and young women must achieve self-realization to gain control over their reproduction. Group 3 agrees, but insists that, before self-realization occurs, parents and young girls may be unaware that a naïve girl's male peers target her. Girls remain naïve, participants explain, because parental denial and inadequate school instruction leave girls without the necessary knowledge.

Alexis reports a version of this experience that Group 3 finds shocking but credible, while doubting that male practices are usually so blatant and flagrant. Alexis begins:

I believe that boys *definitely* know [more about sex than girls]! I'm sorry, because I know... I got pregnant when I was about 16. *But before* I got pregnant *by* the person I got pregnant by, he sat at a table and told my mom that he gits little girls pregnant so they can go back home cryin' to they mamas. And, he said he git 'um pregnant to teach what they mama should'a taught 'um, and basically had been trying to tell 'um.

As Alexis continues, the women's facial expressions change from surprise to astonishment.

[My mother]... was sitting there in awe. Like maybe thinking, "*You didn't say that at my table!*" [Others mutter assent in the background.] So, by the time I did git pregnant and he was gone, it was more that I was in a state of confusion. Because, I'm like, "Hey, now I don't have no baby for my dad" [intends the reverse]. And, if I *do* mention this dude, you know, they gon' be like "*Did you not hear him say he git y'all pregnant for this purpose, right here?*"

At 16, Alexis was too old, Glenda thinks, to be as naïve as she presents herself. Fatima thinks Beatrice, at 20, was too old to expect that younger mothers can achieve the self-realization necessary to “break the cycle” of succumbing to scrubs. She also sees Beatrice’s first experience (a stillbirth) influencing her later decision. That experience and her older age made Beatrice’s decision-making ability greater, Fatima concludes, than younger mothers in her family and those she encounters at the Birthing Project.

Well, [Beatrice] said she was 20. All I heard was 20. And, I think a 16-year old versus a 20-year old is a little bit different in the mindset because of what they’ve [older persons] experienced and what they’ve gone through. That’s not necessarily all true, but I just think a 16-year old versus a 20-year old.... Because, I know I am different. When I was 16, I thought a certain way. Now that I am 20, I have more information... [Now] I say, “No.”

Glenda also disagrees that parents must respond to gender differences when monitoring children’s early sexual awareness.

Untrue. Untrue. A child is a child. Whether male or female, a child has a whole different way of thinking. They are scared. They are lost. Um, in fact, they don’t know who they are at that point. They’re experiencing changes through their body.

In addition, supporting Fatima’s view that age-based experiences are important for maturation and self-realization, Glenda contradicts her earlier comment about how mature Alexis should have been at age 16.

[S]o far as pregnancy wise... a 16-year-old woman is still a child in my eyes, because either they are coming from a broken home [or] lack of supervision [or] lack of love, and they figure if [they] git, got pregnant, they will find love with this particular person [the baby’s father]... [U]nfortunately, they find more issues that they have to deal with: the abuse from that individual, having to move out of their parents’ home, and so forth.

As Glenda continues, we get the sense that the male’s blatant and planned actions motivate her challenge to 16-year-old Alexis’s naïveté.

A 16-year old would be more frightened at that age being pregnant than anything else. I had my sister—she was 16 when she had got pregnant and she moved out of the house. I mean she had to grow up fast. But, the fact was, she never grew up mentally because she was still at that age frame. Luckily, she had adults—his adult family helping her raise her child—because she was still considered a child. I mean, a child doesn’t know how to raise a child, *honestly*.

Young single mothers raising children who become sexually aware or active at an early age face especially difficult parenting problems. While still maturing, the mothers must deal with the consequences of patterns of conduct that their parents inadvertently established. At the same time, the young mothers must manage their children’s involvement in matters about which they are only beginning to gain the

necessary knowledge to devise coping strategies. Aside from having their first children as teenagers, women may continue to give birth throughout their childbearing years and, thus, raise children of very different ages. By age 30 or 40, some women are “running on empty” and looking for ways to “refill” enough to manage basic responsibilities.

Offering glimpses of these parenting difficulties, Elena (G3) reflects on the importance of self-esteem.

I think a lot of the parents are empty. They have low self-esteem. They're working hard. I have two sets of kids. I have... a 20-year old, [and] I have 21-month-old twins. So, I have the whole gamut. And, I know, that there've been times when I was just wiped.... I am not making excuses for anybody; I'm just saying I was wiped. My self-esteem was very, very low. And, I was doing the very best I could, but with low self-esteem, with me being empty, giving to everybody else but me being empty *emotionally*, it's hard to connect. ...[M]y son, my older son, had some problems in school at the time. And, I'm sure the teachers make judgments of me. It's like a fight... it's like a fight when you have no energy. And, I think, if we could put self-esteem back in the women or in the families... [O]ne of the things I started doing after I had my twins was going to the Women's Center. I didn't even know it existed. But, there is a women's center in downtown Phoenix, across the street from Good Sam.

Considering her emotional state before attending Women's Center classes, and thinking of stages in her struggle, Elena reflects on why Alexis's mother may not have responded to the young man's blatant comment.

[The Women's Center has] all kind of classes on self-esteem and boundary setting, and all that kind of stuff. And, it's making me feel stronger, because I can sit here now and say, “What did your mother say?” But... six months ago... I may have just like [takes a deep breath indicating resignation]. You know, just one more thing, you know what I mean? Not totally empty; just one more thing. Now, I would probably say, “You got to get out my house. You got to stay away from my daughter.” But, you have to have the esteem to start with.

Dianna (G3) is a foster mother caring for young children and two teens. She sums up other participants' views on finding the energy for parenting despite “running on empty.”

I have a 12-year old daughter and a 13-year-old son. ...[L]ike you say [referring to Beatrice], there is no parental controls, but... I am a stay-at-home mom. So, I don't drop them off at the skating rink; I take them. We go bowling, we do things... and we go to Denny's and get free bowling tickets, you know. I hustle for the kids. If they are giving up something free, an activity for the kids, I'm there. My 12-year old, I started her off at nine. I started training her up, building up her self-esteem. You're a beautiful child. You don't just take that. Okie-dokie? Then, I don't give them that leeway to even experience anything like that [referring to negative TV or peer influences]. I'm up in her face, because I want her to have better than what I had. And she started her period over the summer, so we're like... and my 13-year-old son;

we sit there and watch *Maury*. You know, here's a brother, been on there 12 times... [referring to Povich's paternity-testing shows].

## VI. "We weren't talked to": Role Modeling in Reverse

Having begun parenting from ages 13 to about 30, some of the focus group participants see themselves as the *generation* that learns and builds parenting practices by reverse role modeling. They undertake practices directly opposed to their own parents' practices regarding communication with children, involvement in children's lives, and monitoring their physical and social maturation.

In Group 1, both Francine (first child at 16) and Greta (first child at 21), now raising teenage daughters, count themselves as members of the generation that parents by reverse role modeling. Greta observes,

I think that's our generation. We weren't talked to, but I know I am very open and candid with my daughter, because I don't want her to find out [about sex and its consequences] from some boy or whatever. You know, I would rather be the one to tell her. ...I mean, I learned from my mom... from her experience, as far as not having children [too young]. I did wind up pregnant.... I was... 21, but my mom's experience, she had me... got pregnant with me when she was 15. ...From her experience, she was typical... of the community, in her house, [about] communication with her mother, as far as pregnancy, STDs and stuff like that [inaudible], as far as what went on in her home. Now, I have a younger sister who is 12... and, at certain ages, things like, for instance, having breasts, just the development of the young woman... [happen, but my mother does not talk about them]. [I]n my [mother's] household, sex education is not open at this time.... But, I [talk]. I [also] think [young girls] learn a lot of stuff from their friends.

Francine picks up the theme, saying, "So, from my experience, having two girls, I don't shelter them. I let them know what's out there. I let them have their space, but...." Francine fades out when the moderator asks two questions that Group 1 finds difficult, given that they define their generation by the lack of information they received from their parents' silent or near-silent generation. How much does a parent say and when? How can they know if they have no positive childhood role models to guide them?

Across the focus groups, participants disagree on whether mothers who did talk about sex provided information about contraceptives. Darlene (G2) had her first and, so far, only child at 17. Her mother talked about contraceptives, warning her to use them *if* she became sexually active. On learning that she was pregnant, Darlene's parents were emotionally and materially supportive. Darlene did not use pregnancy as a reason not to attend college. Instead, she attended a local college, worked, took responsibility for her child's care, and used contraceptives to prevent another pregnancy.

Effectively present parents, the focus groups agree, respond to the expectant mother's response to her pregnancy. Yet participants maintain that parental support after the first pregnancy does not always provide a positive model for the young

mother to learn childrearing skills and to take responsibility. In Group 2, Darlene describes differences between her conduct and her cousin's during their first pregnancies. She then explains complex cause-and-effect links between the two mothers' conduct and their parents' responses.

A lot of [young mothers] I know don't learn any lessons. Like, I remember when I got pregnant I was 17. It was like, you seen me you seen my cousin.<sup>14</sup>...She was 19 [and] she had two kids. Well, so, she got pregnant... [in] May and mine was in July, so we were both pregnant. And, you know, they're cracking jokes that we really do do everything together, because we were both pregnant at the same time. And, I remember her excuse was like, "Well, at least I graduated. I waited until I was 19." And, well... I had my son a month before my 18<sup>th</sup> birthday. My parents... of course they got used to it that I'm going to have a baby. But, it's like, when it came to wanting to go out,... it was like they were not going to just [snaps fingers] [allow me to] throw them off, throw them off [leave children with them]. But like my cousin that's 19, it's like you call her, "Where your kids?" Nowhere in sight.... [Her parents] didn't teach her her lesson. Not teaching her, but, you know, let her take her own responsibility [for her kids].... Like, "I can't just go drop them off, drop them off, drop them off.... I basically learned my lesson, you know? Now... I'll be 22... and... she turned 24, and now she has three kids, and I still have my one.

When grandparents take over childcare for their grandchildren, young mothers may learn negative lessons about parenting responsibilities. For the focus groups' older participants, first-time mothers in their 20s and 30s, the children's *great-grandmothers* may be just over 50. By contrast, for the youngest mothers, a first child's *grandmother* may only be in her late 20s. Yet, even in considering grandmothers' and great-grandmothers' age as factors, we should keep in mind Frances's earlier account of her children's grandmother and great-grandmother—jet-setting, independent, beep-me-if-you-need-me professional women. Participants in both single- and two-parent households, whose parents and grandparents were effectively present, see getting help from them as a burden the elders can ill afford.

Ester illustrates Group 2's discussion of this issue.

[Y]ou talk about the whole thing—family issues, and that whole idea of self-esteem and self-worth, and things like that. It is so generational that, I think, more often than not, I've seen more grandparents with young babies at doctors' appointments than I've *ever* seen before. And, it's... looking like, that can't be your [child], you know?

Grandparents often engage in a form of reverse role modeling, Group 2 admits, attempting to fix mistakes they made with children by raising grandchildren. Yet this

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<sup>14</sup> Although Darlene and her cousin were very close friends, their different responses to childcare have altered the closeness that might have served them as parents. It is important to keep this in mind later when we consider how female friendship circles influence reproduction choices and decisions as well as decisions about taking responsibility for childcare when a woman's choices result in several pregnancies or babies before age 20.

strategy does not produce constructive results if it prevents a young mother from learning to be a responsible parent. Ester concisely makes the point:

You're in your 50s or 60s, and you have a six-month old, or three of them, or whatever. And, I think, for [the grandparent in that position], they're still trying to fill a gap or a hole or whatever exists in their heart or their mind or their soul. And, whatever they felt they couldn't do for their children, they're now feeling, "Well I'll just do it for the grand babies." But, what you're doing is a huge disservice to the *child* [who is the parent], because you've basically said, "Go ahead, you give me the kids, baby, you go do whatever."

Elders who assume parenting and childcare responsibilities may be in poor health. Some may have substance abuse problems, and others may suffer the long-term effects of poor nutrition or genetic family diseases. Pointing to these possibilities, Carine (G3) simply states, "Not all grandparents are stable." Charlotte (G5) says, "They already tired and used up... from trying to help they self. And, if they still living... sometimes you have relatives that's in the house with them and need help." Other participants agree that many young mothers face this situation when they turn to parents and grandparents for support.

Alexis (G3) had her first child at 16, and her stories suggest that her mother had a first child at 14 or 15. Thus, when Alexis's eldest sister had her first baby, at 15, the child's grandmother would have been about 30. "They 50, almost 60," Alexis, now in her mid 20s, says of her parents and her children's paternal grandparents. She seldom sees her mother and, still more rarely, her children's paternal grandparents who live in Arkansas.

With my second child, I was out in Arkansas, and even though I was around his dad and his grandma—I mean, he's 6 now—they don't call for birthdays, and, if they do, they tell him they sending him something, and, ah, it's so far and few in between that I would rather not have to deal with that. So, when it's only one person that feel like... they are there for their child, by the time the third one comes around, it's just like, *whatever*. I don't feel like I have to tell y'all 'cause y'all gon' look down on me anyway. Y'all look down on me for the first one. I mean, you may go get that first set of vitamins and, you know, the first check up and everything, and it's like, "Well, it's all good now, it will be all good later." With the first one... I stayed with my sister, because, um, ah, I don't think I told my mom until I was probably like four or five months pregnant. 'Cause that's how much I seen my mom.

Then, reflecting further on her pattern of reproduction and its implications for a sibling's role modeling with regard to prenatal health care, Alexis says:

I moved out. It seemed like every time I moved away from home, I got pregnant. That's also a thing. But, seriously, um, with the first one, my sister was there. She made sure I went to my appointments. She was like, "No, [Alexis] you need to go," because she had already had kids. You know? So, she stressed the importance of me needing to go with the first one. With the second one, I was engaged to be married, so she was, like, "You'll be out there in Arkansas, just remember to go to the appointments."

Responding to Alexis's views, Glenda (G3) speaks to the frustration of family members who, caring deeply about children, try to help their relatives. Like other participants, she sees family members become overwhelmed as young mothers transfer responsibility, continue producing babies, and need persistent prodding to get pre- and postnatal health care.

It's just ridiculous. I mean, okay, we're suppose to be adults, adult women. After your first child, you should know better. Second, third—I... have a sister just like that [referring to Alexis's self-account]. You know... because I am the oldest, I took care of the siblings, the younger one's, and it's amazing, that pattern, it's like, "Don't you get it? You are a mother, now. It's your responsibility to step in and raise these kids, and if you don't want any more kids, take prevention. Get on birth control. That's what birth control [is for]." It's just so *frustrating!* I am hearing from you [Alexis]; that's how my sister speaks. She has *no* clue.

Alexis closes the exchange with a typical retort: "When you get too frustrated, it don't help the person who is pregnant, trying to make it. They know they have another baby on the way [and] that don't make it easier."

Speaking of grandmothers and great-grandmothers, some focus group participants express views that we might more readily associate with the ideal model of elders—wise and strong people, ever ready with sound advice for family and community. While describing this ideal, Glenda (G3) expresses a view that many focus group participants hold: Arizona is less conducive than the South to producing strong elders. Her stability of her parents and grandparents, she thinks, is a result of growing up in Mississippi. This made them strong and wise because, they have told her, strength was the only option for African Americans in the South.

My parents, I know from my parents. My mother, you know, and my grandmother. My grandmother is from Mississippi, and you had no choice... choice but to stand strong. Those were hard times, back then.

Nonetheless, Glenda strongly disapproves of transferring parenting responsibilities to the older generation.

My grandmother [her child's great-grandmother] is 86 years old and she is fully stable. Why are we counting on other adults... [to take] our responsibilities? Why... can't we put that on ourselves?

In addition, as both Darlene's and Glenda's views stress, grandparents' support for their children and grandchildren depends on how the children manage parental responsibility.

Some young mothers may have been substance abusers or effectively absent for other reasons when a child had a baby. In the household dynamics that follow effective absence, they may lack parental authority or have fewer childrearing skills than their eldest children and, sometimes, their middle or youngest children, have.

The child who took on the parent role learned hard lessons. Distrust weighs against the parent-substitute easily surrendering control to the returning parent.

Anna (G1) addresses this issue, speaking about her past addiction and its importance for understanding current dynamics in her single-parent household.

I was... an absent parent; I was strung out on drugs for a while.... I have three girls and one boy... [and] my oldest daughter kept my youngest kids. ... . I have a middle child that's a 17-year old, and then my baby is 15... My middle child and my 17-year old, I have to be careful with them, how I treat them, because they're like night and day. One is like... real rebellious and stuff, and she is real quiet. She is not use to being around people. And, coming back into their lives, I have to... you know... let them see that they can trust me. That I'm not going nowhere. I am responsible now. I pay bills.<sup>15</sup>

Anna reenters her household as a single parent and a grandmother to the child of her eldest daughter, a single parent. Household dynamics during Anna's absence now offer her assurance that her 15-year-old daughter is less likely to become a teen mother.<sup>16</sup>

I am a single parent. And, my oldest daughter had a baby, which my 15-year old helped her with. So, [eldest daughter's name] was, like, [youngest daughter's] mom, because my [17-year old] was the daughter [who] worked all the time.... [M]y youngest daughter, I don't have to worry about her getting pregnant because she has a resentment. She like, "I'm not taking care of no kids! Nuh-uh."

Yet Anna admits that she has few skills to offer her eldest daughter, who developed her own skills in Anna's physical and effective absence. Therefore, Anna finds it difficult to relieve her daughter of responsibilities for parenting younger siblings, Anna's children.

So, now my [oldest] daughter... she's real strict... real firm in what she says. And, she's like the mother figure, and there was times when I could not interject to what she wanted my youngest child to do, because she was taking care of her. So, it's like... she preaches to my 17-year old, because she do not want her 17-year old [sister] to go through things.... [S]he's a dental assistant right now, so she's doing good with her life. And she has a child, and she's real informative to her younger girls about where their life should go.... [S]he's like the overseer, and sometimes I have to look at her like, "Nigger, you like a warden. Hold up!" Because, she's real firm about stuff.

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<sup>15</sup> Although Anna mentions her son, she does not describe him, his reactions to her absence, whether he is a parent, or whether, during Anna's drug episode, her eldest daughter was his substitute parent. Once again, the focus group methodology concentrated on women. This accounts, in part, for the participants' limited discussions of their male children as parents, married or unmarried.

<sup>16</sup> Across the focus groups, participants stress the influence of household dynamics on younger daughters. Having helped older sisters with childcare, these young women show little interest in having children and may decide not to become mothers.

The view of the older generation shifts when Anna places her household in her kin group. We see a social history of inter-household skill exchange, and her daughter produces reverse role modeling from information she gains in this exchange. Anna describes her sister's role in their natal household.

I come from a family of ten, so my sisters raised [my eldest daughter]. She got her resources from my sister, 'cause my sister was a good mom, and she took care of her kids. Because she had all those resources [from her aunt], now she is able to help her little sisters out with these resources [by] directing them which way to go and... tell[ing] them about the little diamond, and you know.... When I sit and look at her... I say, "Man, where you get all these mothering skills from?" And all this information. [B]ut she's real... she has a voice on her, you know.

Unlike Anna, Karen (G4) had no family support during her drug addiction. She had her children during her struggle, and kept them with her. Karen's story reveals how her children experienced her previous behavior, and why it was more difficult for her to parent by reverse role modeling.

I showed my kids a lot negative things through [my experience], my ignorance.

When did you start showing them these negative things? (Moderator)

Ah, man... before they were even birthed into my ignorance. What I mean by ignorance is my experience, and I don't have no shame saying nothing, 'cause folks<sup>17</sup> gave my kids education in a lot of different areas. But I exposed my children, at an early age to street life, as far as watching they Mama do drugs. Watching me have to suffer and struggle on the street in making money, selling drugs, prostitution—you name it, I been there, I have done that.... I didn't have a family life where my family was there to help me out, so my children were with me during my struggle.

Karen is in her late 20s and the mother of three children, and her seven-year-old son is sexually active.

My child—my oldest one—is just turned 14. My middle one will be ten in December. And, my son will be eight. And, what I'm speaking on is, like I told you, he's seven and in second grade, and already caught behind the bleachers with a child that is in the fourth grade. And, that's my fault and I won't let nobody look down on me for it. But, by the same token, I put the fear of God in them.

Her son's partner was probably ten, lending support to the point made by all focus groups about the early age for the beginning of female sexual activity. Here that issue passes without comment. Group 4 focuses instead on Karen's son. When a participant asks if she tells her son that having sex at age seven is not good, Karen replies:

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<sup>17</sup> Karen's reference to the folks who educated her children is unclear. She may refer to social service workers, but it appears more likely that she means persons who, though also involved in street life, were better able than she to attend to her children's needs.

Yes, but like this lady [another participant] said, that's going to be so hypocritical of me to say "No, no, no," when [my children] say, "Mommy, guess what we seen you do?" So, what I try to do is put the fear of God in them, and love them at the same time, and give them a freedom of choice. Because, when my mom said, "Don't you go to that dance, tonight," I went to that dance. I give them a choice, and express it through love, [saying], "This is what's gon' happen if you choose to do what Mommy did."

Karen blames her own conduct for her family's lack of child-raising support. However, she sees a motive for her conduct in the "mentality" of her community and her natal household.

I was raised in a nice area... [an area which society considers high-class]... *but chose* to go out there in an area we call the street, right. Because, if it wasn't [for my low class household in the high-class area], I would have never went... where they consider the Southside low class, [but] where the mentality is very high class. And, ah, so, I think [young people's negative behavior] has to deal with, with the mentality of the household, before they even hit the streets.

Karen's use of "high-class" and "low-class" is a confusing mixture of economic and moral criteria. Nonetheless, it captures what she mean by "mentality" or "mind-set," a controlling factor for the individual, household, and community. Mentality is not a fixed or inherent property of these units, comments by Karen and participants in the other focus groups suggest. Instead, their comments point to social dynamics as explanations of how mentalities continuously develop from and reproduce new causes for behavior and new consequences of it. Responding to Karen's story, Rita (G4) provides an example of cause-and-effect feedback between mentalities and sexual behavior.

I think it has a lot to do with when the parents became [sexually] active, or what age they were at when they first learned, and... like [Karen] said, mentality. And, whether or not they feel it's okay for me to talk to my child about sex... I know these children at this age are already involved, and I want to make sure that my kids are knowledgeable about what's going on out there. So, I agree one hundred percent agree with her: it has to do with the mentality of the parents.

Thus, individual mentality also refers to variations in what parents have to work with—the differing fields of experience that Helen (G1) mentioned. Likewise, for cause and effect, focus group participants suggest that one cannot predict household mentality from household structure. Differences among comments by Carine (G3), Anna (G1), Darlene (G2), Fern (G5), and Karen (G4) about their household structures and dynamics underscore the participants' caution about these variations. They explicitly discourage hasty generalizations about causes and effects based on household type and composition. All household types—single-parent, female-headed, two-parent, or three-generation households—potentially expose youth to poor or unsatisfactory role models for parenting (including instruction about sexuality) and use of health-care services. When focus group participants describe

positive outcomes in two-parent households, they qualify and explain causes and effects that might account for them.

Group 4's discussion of this point is an example.

I think it's determined [by how soon children become sexually aware, or parents should be or are willing to begin sex education].... I think it is based off your living environment. So, it can be as early as six or it can be as late as your menstrual cycle. (G4 Fredricka)

What kind of living conditions would make the difference? (Moderator)

Depending on what your, ah... If you are a single parent, or if it's two parents, and one of the parents is in the medical field. It just really depends. (G4 Fredricka)

Uh-huh. [Does] everyone agree with Fredricka? (Moderator)

To a degree. (One unidentified speaker)

To a certain degree. (A second unidentified speaker)

I think it all has something to do with, ah, the mentality, period. (G4 Karen)

Neither "beating children with love" (that is, putting the fear of God in them) nor reverse role modeling have deterred Karen's seven-year-old son from initiating sexual activity with an "older woman" (age ten). Still, participants see many younger and older siblings taking responsibility for morally guiding one another. In Anna's story and accounts by others, younger siblings become effective role models, even though this situation is not ideal and may cause problems for using health care services. The reasons for parent-substitutes differ, but the consequences—a need to role model in reverse—do not.

The focus groups' accounts of household and family support clearly suggest two conclusions. First, the amount of reverse work everyone must do depends on intergenerational and inter-household skills. Those skills develop, largely, from individuals' negative experiences in the past. Second, the success of reverse role model work by this generation of parents or their substitutes depends on positive patterns of conduct in the present.

It is already too easy for youth to progress from sexual awareness to sexual activity, the focus groups agree, and family support may only make it easier for them to continue reproducing without a clue about the responsibilities that this involves. Therefore, participants insist, effective reverse role modeling requires that parents become their children's first positive role models. Discussion in Group 4 illustrates general agreement on this point. Mary asks, "But, what if you are teaching your children everything, but you are not living the example? So, you also have to be the example for your children, as well as teaching them. Patricia adds,

"You can say, 'Don't do this, don't this,' but [if] mommy got every man—Tom, Dick, whoever—running in and out the house, then she's got a conflict of interest. You say, 'Don't do this,' but you doing it."

#### **IV. "Unless something is broken off": Papa's Baby, Mama's Labor**

The physical or effective absence of fathers influences how youth mature. Mothers or other female relatives must compensate for a lack of male role models while learning to control their own reproduction, basic childcare skills, how morally to guide children. Boys receive less parental instruction and guidance than girls do, and the focus groups did not report older brothers as substitute father figures.

Only one participant speaks in detail about her brother offering guidance, although some mention male siblings when speaking about other topics. Even participants who discuss sibling competition in large families attend only to how their older female siblings influence their conduct. When participants comment on males, they emphasize the view in the community and in households that "boys will be boys." Comments across the focus groups suggest that boys must "make it on their own." Others expect little of them, or look to them to "live the exception" by achieving success in sports or entertainment.

Asked about the role of fathers and grandfathers in sex education for children, some participants answer that these men were present, but not involved. Most say they did not know their fathers. Others knew their fathers' families, although the fathers were not part of the natal households. Brenda (G1) expresses the most prevalent response.

A lot of people who have a lot of siblings have an absent father. With me, I have no idea who my father was—no clue whatsoever; never had a father figure, really. I've been from home to home, you know, with family members [but] never felt wanted. My mom, she was strung out somewhere. So, I was just a statistic. You know, just a statistic like everybody else, because of how my life played out. ... . [I]t's, like... most of the time you don't really know your other siblings, because y'all all spread out everywhere; you're everywhere. We were everywhere. And, my sister was 15, with a baby; doing it on her own. She couldn't go to nobody else, because nobody cared. My mom didn't care because she was strung out.

Although gender roles make females responsible for childrearing, participants see both mothers and female relatives failing to fulfill the responsibility. Alexis's comments on her child's paternal kin in Arkansas are suggestive. However, the high number of absent fathers among the participants means that too few comment on paternal relatives to gauge their roles in young mothers' lives. Participants speak of maternal relatives, although they were not always positive sources of support. For example, in Brenda's mother's absence, a maternal aunt cared for Brenda and her siblings as their state-appointed foster mother. Brenda (G1) notes the role that

gender prejudice played in worsening their aunt's generally unsympathetic childrearing.

My aunt, she was just in it for the money. To take care of us, she got paid. She treated us like *dirt*. We were just her little slaves. My brother—I'm not gonna say that [it was the same for him]. Me—my older sister and I—were treated like dirt. It was like she hated us. My brother was a prince. He got treated with the best of the best; with everything. I don't understand that, but that's how it was.

Brenda now works toward her own self-realization. She practices reverse role modeling to raise her daughter.

I became another statistic. I got pregnant at 17. I have a daughter, but I'm changing now, and I am not going to be a statistic for long. I'm gonna finish school, I'm gonna go to college, and I'm gonna show my daughter that there is more that [she] can do with herself. I'm not gonna shelter her, too much. I'm gonna let her know what's out there and let her go from there. Because, you can only do so much.

The beginning of self-realization, participants maintain, depends on the foundation for reverse role modeling that past experiences provides. Brenda continues:

[Y]ou had your mom and dad [pointing to several preceding speakers]. My mom, she was there for bits and pieces. She missed a lot of my life. She wasn't there for my first period, she wasn't there for graduation, she wasn't there for the first boyfriend. ... . [W]hen my mom came home, I couldn't go to her and say, "Mom, can I talk to you about this?" I'm the sort of child, I wanted to have that mother-daughter relationship, so I could communicate with you about anything. I told her that, and she was, like, "I don't wanna hear that." You know, she was real, real closed off, just 'cause that's how she was raised.

Group 1 participants "adopted" Brenda and, throughout the session, offered her advice. Their actions demonstrate their general premise that how others respond to a young, unmarried mother depend on signals that she is working to continue her self-development and taking responsibility for the present care and future possibilities of her child.<sup>18</sup>

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<sup>18</sup> We will later hear from focus group participants about the difficulties of "coming together" to form networks for sharing resources and building community. However, Group 1's action demonstrates that the difficulties result, in part, from a lack of opportunities to do so. As the session progressed, the women began passing a sheet to exchange contact information. On behalf of the Alliance, Wanda Thompson asked if they wanted to remain in contact, with the idea of forming a network among focus group participants. We added this option to the focus group process. With two exceptions across the five groups, participants consented to have Wanda draw up a contact list. Each focus group stressed the lack of gathering places for informal interactions that would allow them to get to know community residents and to share resource information. After each session, many participants told the moderator and Wanda Thompson that the focus group provided them with a rare, and much appreciated, opportunity to speak with other women about matters that they had never openly discussed.

Anna (G1) notes how an effectively absent father made it necessary for her mother to take on both parenting roles.

My dad was there, but he was very much an alcoholic, and my mom carried *the weight*. So, sometimes you[r] parent can be in the home but absent ... He's gone for two weeks; you don't see your dad. You get where you don't even worry about it.

In marriage or outside it, participants point out, gender-role differences mean that a father was, as Darlene (G2) puts it, "in the picture, but... wouldn't talk about [sexuality or other moral issues]. He would most likely prefer my mama to [do that]." When the moderator asks Groups 1, 3, and 5 for a roundtable response about the physical absence or ineffective presence of fathers, Betina (G2) sums up the most prevalent answer: "Mine wasn't in the picture." Earlier, Betina described her three-parent household, and her parents' divorce. Here, she does not mean that her father was physically absent before the divorce, but rather present and negatively involved in parenting. Other participants stress gender-role difference to explain the ineffective presence of fathers. Fathers talk to their sons, participants think, but the conversations are no more instructive than those between girls and mothers who talk.

Only one participant, Alma (G5), who is over 40, speaks of older brothers who offered her guidance. They taught her by their negative behavior and by pointing out other males, whom they saw acting on the same predatory response toward young girls.

I grew up with five brothers, so, I knew about sex, at probably, eight, because they were talking about the girls they were [pursuing for sex]. So, they were talking about the girls that were hanging out, that they really didn't like, but they were gon' get a piece from. But, they would say, "You stay away from him, because all he wants is this." So, I learned very young.

Heeding their advice accounts for why Alma did not have children until she was older. Still, she, like participants across the groups, does not reduce the problem to differences between single- and two-parent households. Instead, she expresses the participants' view of factors that shape interactions in households to which the community's children respond.

I think the bigger issue—I do think it is true that when you have one parent, it is difficult. I also think (and I'm older) that you can have two parents, but if they're not talking about sex, if... sex is bad, and that's how they talk about it, but... you have all these hormones going all over the place, you like, "How can I *not* do that when it can feel *so* good?" Also, I think even if we have parents around, we don't put the loving on our kids that we really should. Because, I think, even though you have those feelings when you are young, a lot of it is out of "I wanna attach to someone." You know, "I want somebody to make me feel special."

Alma pauses, clearly frustrated by the search for words to convey her point, before continuing.

[A]nd lot of times our mothers are getting on us, 'cause they're tired; they're working, you know—no dad to help with kids. And, fathers are very distant; business and whatever. So, I don't know. I think that part of the problem is that it is not about the baby and all that, or sex. It's, like, empowering kids and giving them other choices. [Saying], "Yeah, you have these feelings, but you don't have to do *this*, you don't have to do *that*. [Y]ou know, run [meaning exercise]. [Y]ou can talk to boys [but] demand respect." And, so, I don't know. I just wanted to give that view to it.

Consequently, comments that show mothers taking total parental responsibility may encourage us to think that the outcome is the "strong African American mother" ideal. Yet participants strongly discourage viewing this as an inevitable outcome or the most frequent one. Mothers and fathers are busy making a living. Equally important, mothers are products of their parents' training and their own experiences before having children. Many tasks continue to consume women's time and shape their interactions with their children and grandchildren. Real mothers, participants emphasize, are a complex mix of strengths, weaknesses, and vulnerabilities.

Recall Anna, a teen mother strung out on drugs, who is now trying, with great difficulty, to resume her parenting role, after her eldest daughter has become a strong woman—one with a "voice" or authority. Mothers who develop such strengths may manage well the dual parenting role. Do mothers provide instruction, the moderator asks Group 2, when fathers delegate the responsibility? Darlene, pregnant at 17, but who eventually had support from both her mother and father, answers from her experience with her mother: "A little. Not like... specifically. ... She would like... joke around with me to see if... [I was sexually active, but]... we never like sat [and] had... an actual talk." Across the groups, participants report that their mothers did not want to "have that conversation."

While the participants say they try to be open and instructive, and to monitor carefully their children's conduct, they admit that the negative impact of gender-role differences continues in their generation's practices. In discussions of various issues, their examples emphasize daughters. Like Anna, when recounting their parenting practices, many participants mention, but do not expand on experiences with male children, unless the moderator probes.

Thus, in Group 1's discussion of recommended interventions, Catherine makes a typical comment focused on girls.

[T]here needs to be some place where these girls can meet and talk openly about [sex and reproductive health], you know, however they want to talk about it. That was... was helpful for us. We had *questions*, and we just asked off-the-wall stuff, and it was stuff we knew we could not go to our parents and ask. And, they told you up

front they would not tell your mother or your father. Now, whatever goes on in here (they were careful back then) goes no further.

The moderator asks Group 4 how schools and other social institutions help parents. Demetria, recalling a program in her area, also passes over males.

Well, I know there was an African American education director at the Boys and Girls Club in this area, and she taught the girls, from six- years old on up. She used to have girls' day. And, what she would do, she would explain everything about hygiene—comb, brush, pads, tampons—and explain to the girls what they was. She did not go as far as talking about sex. She would explain things about their body, menstruation.

Although other Group 4 participants knew about this program, none could say whether it offered a boys' day. Asked about the earliest grade in which schools provide instruction, the group settled on sixth grade for boys and girls. Yet, when the moderator asks what boys learn in school classes, few could describe any of the topics.

Far from indicating that the focus groups do not recognize gender as an important factor in sexuality, reproduction, parenting, and health care, the participants' comments show that they had to pause, or even push themselves, to consider the implications of gender-role traditions for their reverse role modeling practices as mothers. They are aware of the need to include their sons in ways that disrupt gender-role expectations. Dianna's account of interacting with her 13-year-old son, reported earlier in this chapter, illustrates the point. In Group 2, Ester presents a typical view.

You know, and before I lose my train of thought, there's one thing that—when you [the moderator] were reading that last scenario—that I find disturbing, because I have a young boy. I think the conversations that we have with young girls are different than the ones we have with young boys. And I think [that]... has to change. You know, with young boys, it's like, "Boy, don't do that again!" Even though they have two babies out there, you know. And, so I think, as we have these conversations, they have to be translated to young boys the same way.

When participants stop to think about gender-role differentiation, they quickly recognize that it has a negative influence on male involvement in health care for themselves and their children. In Group 2, Frances joins Ester in an exchange that reveals how participants view this influence.

I think... that men don't really seek medical care. My experience has been... they don't really pursue medical care... unless something is broken off of them. ... . So, I imagine... if [at] 37... you not going to get your prostate checked out, you not going to care about your baby's stuff at 17.

Ester responds by recounting how she has to "trick" her husband into going to his doctor and accompanying her to their son's appointments.

Right. "That's your [the mother's] responsibility. That's your job. What you need me there for? I can't do nothing." And, they certainly won't be proactive about it, you know... things like dental. I ask like, "When [are] we taking [our son] to the dentist? My husband's like, "I don't know." Yeah, I mean, and this is an educated man. To him, he's never had to think about it. He's never had... to. He doesn't plan for himself, so *you know* he's not gonna go [to a child's appointment]. ... I have to *trick* him. Tell him were going to church, then stop off. [Laughs] And, it starts off early, and he has a late appointment in the afternoon, and [I] say, "Let's stop by this place a minute." And we go in, and it's a doctor's office. Because his mentality is, unless something is not broken, it's a waste of time, waste of money. And, you know, it's very sad, just all things, like prostate cancer, that are just more prevalent in the African American community. I literally have to threaten him, have to trick him. I have to use other things.

By "his mentality," Ester does not refer to individual personality. Instead, "mentality," like "mind-set," is shorthand for the cause and effect of gender-role training. Thus, following Ester's comment about using feminine wiles on her husband, Frances quickly links such practices to the difficulties a young mother faces getting a father involved in his baby's health care. For Frances, a young mother's greater difficulties result from trying to gain the assistance of a child's father assistance without alienating his affection for her.

*And, if you're the young girl, are you trying to keep that guy? You said that the babies are by the same father. So, maybe you are still dealing with that dude... [and] you don't really wanna piss him off or mess with him too much, because then he might not buy the package of diapers. I don't know, I'm guessing. You guys—I don't mean that condescending—but I am just guessing that you are not messing with a 17-year-old boy about taking the baby to get shots, because you might still be trying to have him in your life. So, you probably aren't asking him for that, right?*

During Group 3's discussion, Fatima, adds male imprisonment to the list of reasons why women must assume parental responsibility for childcare and reproductive health.

*My sister... has three children by the same man. When he is out of jail, he takes care of them, but when he's in jail, I'm taking care of them. And, you know, she's partying and doing whatever to go out and have more kids.... But, as far as the birth control, a lot of African American women look at it like it's harmful to their bodies, so they're not gonna do it. But, they would rather have [speaking over group laughter] the, the, you know, sexual encounter than protect their self.*

The focus groups agree that very young, unmarried first-time mothers have the most serious problems. Male disinterest and lack of involvement, the participants maintain, strongly influences whether or how actively these mothers seek health care. Eventually, young mothers learn that doing what men desire does not keep men in their lives. Women's efforts to do so may increase disapproval from family and friends, who become frustrated with the mother and less willing to help her with childcare.

We turn next to the interrelations of coping, recall, and refusal. Chapter 2 explores how community “realities” shape mothers’ decisions about whether, when, and how to use health care and other social services.

## Chapter 2

### Coping, Refusal, and Recall

- **Coping**—Strategies women devise to manage their own and their children’s health care.
- **Refusal**—Factors that keep women from using services for which they are eligible.
- **Recall**—Experiences with health care workers that influence use of and satisfaction with health care services.

#### I. “I’m on my sixth one”: Sexuality and Reproduction as Status Competition

Seeking affection outside the home, young girls turn to males, usually peers, but sometimes older men. They first produce babies as “mistakes,” “slip ups,” or “love objects,” and may continue having babies as they try to retain male affection. This pattern may begin with the “fast girl” in a friendship circle. Participants say the fast girl, as the first to become pregnant, sets the tone for her friendship circle. Her friends may see becoming sexually active or having a baby as part of female peer status competition. Expecting all girls in the friendship circle to “put out,” other girls’ boyfriends press them to become sexually active. Fast girls, who do not learn from a first mistake, then look for status approval among young mothers experiencing similar shame, disapproval, and inadequate family support.

Very young girls (ages 11 to 15), with little reproductive knowledge, do not expect to become pregnant. Initially, they are confused. Faced with censure, feeling isolated and overwhelmed, some become belligerent. As a consequence, they continue reproducing and may have several babies by age 20. The pattern, deliberate or inadvertent, creates a reproductive competition—bragging about the number of children they have had. Confronted with such behavior, health care workers develop and extend negative stereotyping to other African American patients. The extensions assimilate negative stereotypes of African Americans as welfare recipients and AHCCCS patients, whom health care workers see as freeloaders. These “non-paying customers” do not deserve the professional service they accord “paying customers.”

To her friends’ mothers, Alexis (G2) was the fast girl in her circle of friends. She describes how the pattern begins, saying, “Yeah, ‘cause, like, my friend’s mom told me that basically, before [my pregnancy], I was the fast one. And I did not see myself as the fast one. It was just that I was the one that got pregnant first, but I

was hanging out; before, all I was doing was going to school." Alexis speaks of her initial confusion.

I remember when I was 16—before I was 16, so probably around 14 or 15—when I entered into high school. And, I grew a whole new group of friends, because that's kind [of] what you have to do when you go into high school. You like, "Hey, hey, I know her, I know you, we all cool," you know. And at that point, I was going to parties and everything else. So, everything was *introduced* to me that I was not naturally accustomed to, but [the activities], had become a part of me, so to speak. So, that's why, when I ended up pregnant, I was seriously confused. That's why I agree with you [referring to Fatima or Glenda], because I was confused completely—through the whole pregnancy. I mean, after I had my first son was where I agree with you [referring to Beatrice]. When you tell someone not to do something, they do it.

Asked if they mean patterns following this confusion produce a literal competition, Fatima replies, "Yes, sometimes," and Glenda, Dianna, and Alexis agree. Alexis adds that some of her friends have had more babies than she has had, and contends several would have had more, were it not for abortions.

Consequently, the first baby in a circle of friends is a warning signal to other girls' mothers. Whether a mother responds quickly and openly to this warning depends on whether she accepts or denies the possibility of her daughter's sexual awareness. Those who accept this possibility devise "reality checks." For Group 1, Francine explains her response when she thought her daughter might follow fast friends.

[M]y daughter was among a group of girls, and some of 'um already had kids, and... some were pregnant. And so, it was kind [of] getting into her mind that it was okay, like, "Oh, it's a little thing to do." Well, I took her to the store. I went down the baby aisle, and I explained to her everything you actually need. And she's like, "Wow, that's very expensive." I said, "Well, on top of that, you don't have a job." And when I broke it down for her, that's when there came the realization that this is not a good thing.

The daughter may still become sexually active, however, because the reality check includes no reproductive knowledge or because she believes she will "beat the odds" and not get pregnant. Once pregnant, girls respond to a community prescription, which takes as failures African American women who do not have and raise their babies, and a proscription of adoption. Alexis recounts how, for her first baby, her mother encouraged both the prescription and proscription.

I think [it depends on]... people's outlook on, like, unexpected pregnancy. ... . [O]ne thing is, like a person did not expect to become pregnant, but I know, my mom told me, if I was "woman enough to lay down and make a baby, then I need to be woman enough to stand up and take care of it." So, not every person's mom or person that's taking care of them, would see it that way.

Parents may expect that standing up to assume responsibility also means taking contraceptives to prevent another “unexpected” pregnancy. Some, like Alexis, may have three babies before they begin thinking about managing reproduction. With two or more babies, the girl may then look to her circle of friends to decide whether she should continue having babies. Alexis also stresses the importance of a family’s and friends’ disapproval in directing this decision, declaring, “But when you have other people sitting around saying, ‘Girl, I can’t believe you pregnant, again,’ and, you know, it puts in your head, maybe I shouldn’t be having another baby. If my friend only have two, maybe I shouldn’t be having more than two, especially if you on your third one.”

Referring to their own or siblings and friends’ behavior, across the groups participants agree with Alexis’s conclusion: “The competition is—I have had friends to say, ‘Hey you on your fifth one.’ ‘Hey girl, I just had (I’m pregnant right now), I’m on my sixth one,’ you know. So, they are competing to say how many, and they have these different fathers.” None of the participants hazard an estimate for young girls that become involved in reproductive competition, but they acknowledge that the competition produces a subset of young unmarried mothers, whose conduct, and what participants take as their belligerent attitudes, make them highly visible, and promote health care workers’ negative stereotypes of all African American mothers. Bragging about reproduction does not mean that taking part in the competition begins as a deliberate decision. Instead, as noted, the underlying belligerence is more likely an inadvertent consequence of responding to censure by others, combined with community proscription and prescription.

However, once involved in this competition, even grave risk to the mother’s health may not encourage her to use contraceptives or to resist the prescription and proscription. Instead, she may continue thinking she can “beat the odds,” even if losing the wager may mean her death. During her first pregnancy, startled by a buzzing bee, Alexis stumbled on some stairs. The accident, she explains, resulted in her baby “hitting the bottom of the cervix or something.” Her second pregnancy damaged her spinal cord, she was in pain throughout the pregnancy, and doctors warned her that she might die if she had another child. Alexis recounts her belligerent response to this advice.

And knowing you should have no more babies, if you have any more babies you could die (and I probably should have listened), but I’m one of the beat-odds type of person. So, when my second child came around, and it sort [of] messed up my spinal cord—‘cause it kind [of] like hit a nerve, so I was having, like, back problems. And, they [health care workers] were like, “Your blood pressure is above and beyond what it should [be], and you shouldn’t have no more kids.” I’m like, “Yeah, okay.” [She speaks with disinterested, lackadaisical tone.] “Yeah, I heard that the first time around.” You know. Then, it was with the third child [laughs self-derisively], that I was like, “Okay, maybe I shouldn’t be having no more kids.” Because, at that point, they had went into my spinal fluid, and by the time they let me out [of] the hospital, I had spinal fluid leaking out [of] my back. So, my whole body was shutting down,

and when I went back, I was being treated like I was some kind [of an] alien, with a contagious disease. ... They put me in a room, and I'm like, "Okay, I just left last night, and came back because I can't hold down in any water, any food, I can't see, I can't talk," you know.

A confused young mother, even if belligerent, counts on others to encourage her to use health care as evidence of their affection. Nevertheless, when castigation accompanies encouragement, she may ignore the prodding and, as others' disapproval increases and their support decreases, take her cues for conduct from a circle of censured friends.

Moreover, general responses depend on whether others, who assist the mother with the first child, insist that she assume primary responsibility for childcare, develop self-help skills, and use health care and other social services. If the mother's have children by many fathers (a likely outcome of reproductive competition), participant reports that this is not desirable. Instead, having children by multiple fathers provides evidence that the mother is not learning from her mistakes, and increases censure. In turn, lack of support makes her more dependent on acceptance among similarly disdained mothers.

Operating in the least informed circles and with little adult support, the mother expects or confronts humiliating experiences from health care workers. The humiliations further discourage her use of prenatal and subsequent health care for herself and her babies. Negative experiences, participants say, have the greater influence on the youngest mothers, in particular those who are not accustomed to public humiliation. When physically or effectively absent parents do not accompany these mothers to appointments, often they do not continue health care.

Girls who become pregnant at the youngest ages (e.g., 11 to 13) do so before they learn about contraceptives. Older girls (e.g., 14 to 17), may know about contraceptives, but either do not use them or stop when they experience negative side effects, such as weight gain or secondary hair growth. In Group 3, Alexis also recounts how others' responses to these side effects discourage using contraceptives.

[T]he patch [did not work]. Then, I went to the shot in my arm, and [it] seemed like every since... I was just fat. And so, people would always be like, "Girl, you pregnant *again!* And I'm like, "No, I'm not pregnant. I got the darn shot in my arm. I'm just *fat!* ... . [W]hen people continue to call you fat, because you taking steps *not* to have no more babies, then you like, "Well, dang! I don't wanna be all *big and fat*, and, then, people always questioning am I pregnant. So, I need to get off this shot, so I can lose weight, so people won't always look at me like I *am* pregnant.

Darlene, whose mother accompanied her to doctor's appointments when she became pregnant at 17, agrees with the side-effect response, but notes that a girl's

reaction depends on parental support, and her life plans before the first pregnancy. Darlene contrasts her response to her closest friend's, a cousin, saying,

And another thing I know that contributes to [reproductive competition] is a lot of girls, they don't want to get on birth control because (well, the birth control I was on), it makes you gain weight—the Depo. And they say it makes you look... manly [facial hair growth]. Something, I don't know. I just know it tended to make me gain weight. Yeah, so, a lot of them, they don't want to get on birth control, because they say it makes you gain weight. And, the way I look at it, I've never weighed over 120 in my life, which I definitely weigh over that now. But, I have one child I can support fully. And my cousin, she still weighs 115, but now she has three kids [and] she can't support the first one.

These factors influence the role of contraceptives in managing reproduction, but other participants question why doctors limit their reproductive choices to contraception and abortion. They ask why they can easily get abortions if contraceptives fail, but doctors refuse their requests to have their tubes tied. For example, Carine did not experience negative side effects from birth control, but it failed. Pregnant with her second child, she asked for a different contraceptive and to have her tubes tied. The doctor told her she was too young for the procedure. Perhaps, as her comment suggests, the doctor thought she would later want to have another child. Nonetheless, the doctor's response angered Carine, who offered to pay for the procedure, even if her insurance did not cover it.

I had my first daughter—I was 19, twentyish—and I went in (I wasn't ready for another kid). I was like, "Hey, I gotta step up. I been doing good, so far. When I was gonna have a second baby, the first visit, I went in, I told them, "I wanna be put on birth control and I also want my tubes tied, and they told me that they couldn't tie my tubes, because I was too young. Why can't they (if I feel that right now I'm like, "I can't keep my legs closed")... just tie my tubes? I was willing to come out of pocket or whatever it took for them to tie my tubes, because I was taking birth control and [it] wasn't working.

They find it tragic that they can risk successive pregnancies or have consecutive abortions, but they cannot risk wanting another child later, even if they are unlikely to be able to afford it, and cannot support those they already have.

## **II. "She decided": Coping with Unwanted Pregnancies**

Faced with these choices, abortion becomes a taken-for-granted and consecutively exercised option for girls. Participants question whether girls who have consecutive abortions "process" the emotional and physical consequences. In Group 2, Betina, who, at her mother's demand, aborted her first pregnancy at age 12, agrees with other participants that abortion is "not on the table" as an issue in parental and community responses to sex and reproduction.

When neither a girl nor her family has a position on abortion, it becomes an option for managing unwanted pregnancies. Personal or family opposition does not discourage a girl from considering abortion, but it may result in her rejecting the option. Refusing the option, she begins thinking about how to manage childcare responsibilities. Darlene's remark on this point in the same group captures the general experience.

[A]fter... my first appointment—when I confirmed I was pregnant—I was like, "I'm not going to have an abortion. I've always been against abortion. I've been against it my whole life." So, it wasn't an option, basically. But, at first, it crossed my mind, because I was scared, you know.

Darlene also recalls, "I was like supposed to be on my way to U of A. And, *oh, my gosh!* I'm a [high school] senior and da-da-da. And, at first, I was scared. And I was like, 'How am I going to have this baby?' I don't got a job, you know, [but because] for my parents and, you know, my sisters, it [abortion] wasn't an option."

Young girls who have babies between ages 11 and 15, participants say, are either too young to have a stance on abortion or cannot talk to parents about it. Fearing the physical experience and expecting censure, they abort if they can get funds to do so. While the youngest, first-time mothers are most susceptible to these fears, the lack of reproductive knowledge and information on contraceptives means that college students may also take abortion for granted. Speaking of an African American self-help group at the college she attended, Darlene describes how this group of 18 to 20-year-old students included abortion as the solution to an unwanted pregnancy.

[W]e had done a class on abstinence and stuff like that. And, what most teens think (if they think) is [that] if they do everything but [sexual intercourse], you know, they won't get pregnant, or we can just get an abortion. ... . And, we do [have classes], like, usually about every year... but they [persons teaching the class and the students] don't know too much. They don't know too much of nothing.

Thus, participants see young girls, as they face pressures to become sexually active, assuming that they will get an abortion if they become pregnant.

Seeing very young girls as incapable of assuming parenting responsibilities, in Group 2, Frances insists the mother who forces her daughter to abort makes the right choice. Frances, the mother of a 15-year-old sexually active daughter, explains her view.

If Mia got pregnant, I don't think I would let her have the baby. I know that (I mean, we don't need to get into the whole abortion debate, and all of that), but... when you guys were 17 and 16, and when you guys were little, when you all were having these babies, did... you guys talk that through? Was that just not an option? Did you love the little boy? You going to have his baby. ... . Because, it seems like I would just be like, "Okay we're... that's over."

Several participants object to her view, suggesting that her solution only encourages reproductive irresponsibility. In effect, it promotes subsequent abortions and, no less important, can encourage the girl's younger sisters to give into boyfriends who pressure girls to become sexual active at increasingly earlier ages. Darlene recounts this outcome for her pre-teenage neighbors after their mother ordered their older sister to have an abortion.

*Oh, no!* I know somebody who... made [her daughter] do that. The beginning of her freshman year, she ended up pregnant. This girl lived across the street and... it was only her and her sister. [They] were like, 12 and 13 or 13 and 14, and... they were always fast. ... . She [the younger sister] was in eighth grade, like saying, "Well he kept bothering me to do it, so I done it."

Consequently, the participants' objection to abortion stems as much from their views of complex pragmatic consequences as from religious or other moral grounds. Ester, married, in her late 30s, and the mother of a five-year-old son, has a Master's degree, and a personal income above \$40,000. She explains views among girls with whom she works, the oldest of whom have already had one or more abortions.

[I]t's scary what's happening here, you know. You talked about the issue of abortion, and abortion is becoming like part of the solution. I mean, it's like you hear them, girls, talk about two or three abortions, and I'm thinking... I would be mortified after the *first!* I can't imagine that [multiple abortions] would be, like an *option*. And, their only concern is, I may not have the money. How am I going to pay for it without the money to pay?

After having several children, other young mothers abort to limit the number. In Group 3, Alexis recounts how she learned that her friends abort for this purpose: "[O]ne of my other friends, she ended up having—I think she would have had more [babies] than me—but, I know she has had two abortions. That was her choice, because she did not want to have so many children. *She decided.*" Insurance, including AHCCCS, participants conclude, make funds for abort readily available. Thus, responding to Ester's view, Darlene, who works at a hospital and sees expectant mothers as young as 11, insists, "AHCCCS *will* pay for that one," implying that while the insurance does cover other needed services, it covers abortion. Ester, again referring to the 13-year-olds among the girls with whom she works, reinforces this contention.

Oh, yeah! Absolutely! Absolutely! ... . I was telling you about the group of young girls that I had, and, at 13, one had already had an abortion, and [she] said, "Well, if I get pregnant again, at least I know that that was an easy process"—not even processing the emotional piece; because when those things hit you [one might expect emotional or physical difficulties].

Despite the participants' claim that insurance covers abortion, self-induced abortions add to the total. Some expectant mothers self-abort, participants contend, because they are too young to have insurance, or to know how to get a medically

assisted abortion without adult approval. Others do not seek parental help, because they are hiding the pregnancy to avoid shaming. These possibilities mean that some young girls delay revealing the pregnancy until a medically assisted abortion is impossible. Others prefer self-induced abortion to avoid revealing a pregnancy. An exchange that follows Alexis's explanation of self-induced abortion as "premature labor" captures the participants' general agreement that self-induced abortion supplements medically assisted abortions.

Whether they went to the clinic and had the baby taken out, I mean, a lot of times people go through steps to make themselves have an abortion. (Alexis)

How is that? (Moderator)

I know, for instance, they tell you, you should drink castor oil, and... that will send you into labor. (Alexis)

Yeah. Yeah. (Fatima)

All I'm saying is, once you go to the hospital, they look at you and like, "Okay, you are having a baby early." They don't necessarily check [for signs of self-induced abortion]. (Alexis)

So, it counts as miscarriage? (Moderator)

Yeah. (Alexis and other voices)

Probed for knowledge of other ways to abort, participants did not provide other methods.

In Group 5, Margaret provides a different reason for self-abortion. "They get pregnant faster than they have abortion money," she declares, implying that frequency of consecutive abortions may mean that insurance coverage for additional ones is not available. No one in any group knew the regulations for either public or private insurance. In any event, they understand Margaret's comment as also applying to persons who try to find funds because they are not old enough to have insurance and do not inform parents. Thus, they do not have access to their parents' insurance. Those who use parents' insurance to abort a first pregnancy may not seek parental help with a second or third pregnancy, because they expect censure. Although rare, participants report knowing friends who delivered their own babies, with tragic consequences.

From programs in the community, the young sexually active girl seeking contraceptives also receives advice on abortion, if she is pregnant. This, participants contend, encourages frightened young girls to abort. Asked for services in the community that provide contraceptives, all of the groups mention Planned Parenthood. In Group 3, when Fatima mentions Planned Parenthood as a source of contraceptives, other participants respond that it also advises the pregnant girl

about abortion or offers information. Comments in Groups 3 and 5 capture participants' views on Planned Parenthood and abortion.

They offer, like, birth control and methods to prevent pregnancy. (G3 Fatima)

Don't they [Planned Parenthood] also terminate? Abortions? (G3 Beatrice)

Yes, yes they do. (G3 Alexis)

They ask, "Do you want it?" (G5 unidentified speaker)

It—the baby? (Moderator)

Uh-huh. (G5 another unidentified speaker)

Nonetheless, participants do not see Planned Parenthood having a major influence on young girls' decisions to abort, because most do not know about Planned Parenthood. For Group 5, Edna explains why this is so, noting, "You can go by Keyes [Community Center] and get referrals, but, you know, there is no advertisement for these things. They are out there, but you never know, until you get referred personally."

Young girls who learn about Planned Parenthood also learn that it offers parenting-skill classes, sex education, and information on sexually transmitted diseases. However, seeing Planned Parenthood as primarily a profit-making service, participants say its fees are too high for most young mothers. Some disagree, saying that Planned Parenthood accepts volunteer work in exchange for services, and bases its fees on an income scale. Overall, inappropriate timing and poor advertisement reduce any service's value for young girls.

Still, participants recall getting their first contraceptive—condoms—from "the bowl" at Planned Parenthood. Anyone can take free condoms in strict confidence. Discouraged by boyfriends, participants say few young girls use the free service. Already pregnant during sixth, seventh, or eighth-grade health classes, having become sexually active as early as third or fourth grade, girls lack timely knowledge of contraceptives and turn to abortion. Thus, when the moderator asks Group 3 to consider how many abortions a mother in her early 20s, with six children, may have had, four members provide the following responses.

Three. (Dianna)

About three. (Fatima)

Yeah, about three. (Alexis)

You are saying they probably got pregnant nine times? (Moderator)

Yeah. Right. (Multiple voices)

I would say so. (Elena)

The Group 3 estimate is consistent with unsolicited estimates in other groups derived from members' comments on friends' and siblings' reproductive histories. Even so, participants also stress the consequences for mothers and children, when girls have unwanted babies.

### **III. "I never wanted you in the first place": Parenting, Discipline, and the "Village"**

Like adoption, counseling or psychotherapy is a proscribed behavior for "real" African Americans or "Black folks." An exchange in Group 3 explains the consequences for mothers who accept these proscriptions. First, Alexis, already raising two young children, recounts her mental distress as she faced censure for having a third child, which motivated her to try self-abortion.

I had actually got to a point where I was mentally stressed. I was borderline suicide, where I did not wanna kill myself, per se. I just didn't wanna have the baby. But, because my mom told me I had to stand up and be a mom (I did not want to be a mom to this baby), and [laughing] I ended up getting strapped to some kind [of] chair and stuff in the hospital, and they were like, "You weren't gon' kill yourself, were you?" I'm like, "Naw, just the baby," you know. And they were like, "You can't do that" [laughs]. And it was at that point, where they were like, "[You] probably need to talk to a psychiatrist."

Second, and despite Alexis's reference to community proscriptions, other participants ask why she did not get a medical abortion.

Just the baby! (Multiple voices, repeating Alexis's words)

Why didn't you get an abortion? (Simultaneous multiple voices, some using different wording)

'Cause my mom told me I had to stand up and be a baby... a mom. And, so, I was like... not quite sure that [was] what I wanted to do. But, [I did] because of that initial thought that if I was woman enough to lay down and make a baby, I had to take care of it. I'm already taking care of two, and ya'll coming down on me with the third. I think, if they would'a been more open to the third one, I would'na been through that. (Alexis)

No less important, as Alexis's account suggests, only when African Americans engage in extreme behavior that motivates health care workers to insist on counseling are mothers likely to act against the community proscription.

Self-respecting African American women are also unlikely to use adoption, because, participants insist, doing so is "taboo." As Group 2 discusses abortion, Crystal asks, "How about adoption? I know, in my family, two of my cousins are

adopted—their birth moms... [were] 12 and 11.” An unidentified speaker responds with a rhetorical question, “But do *we* put our kids up for adoption? Do *we* do that?” Adoption, multiple voices insist, is “taboo,” because, as one concludes, “[If] you can’t take care of [the baby], you’re a failure.” Ignoring the possibility of medical or self-induced abortion and miscarriage, another unidentified speaker adds, “You know, someone got pregnant [and] then the baby never came—I’ve never seen that.” Crystal explains that girls accept the adoption taboo “because people think about themselves, or like, ‘What will I be like if I give my baby up?’ instead of thinking [about the baby].” Participants across the groups agree the taboo discourages adoptions, and the lack of community discussion encourages abortion as a solution that hides failure.

As the Group 2 discussion continues, an unidentified speaker expresses shared views of consequences that may follow when a mother tries to raise children she does not want: “Right. So, you know, personally, like I said, they have their child and then they don’t want it. Then, they start raising their child, but they start being abusive to their child, because [they say], ‘I never wanted you in the first place.’” In short, the combined community proscriptions and prescription produce conditions for intense mental stress and physical exhaustion. Distressed, censured, and lacking friend and family support, some mothers mentally and physically abuse unwanted children. Participants distinguish this abuse from their support for disciplining children with corporal punishment, which, they contend, “Whites” see only as child abuse.

Mothers who do not abuse their children nonetheless may have little time and patience for the interactive ideal that participants refer to as “the village raising or minding the child.” The ideal should help stressed mothers. Instead, stressed mothers conserve their energy and try to secure their homes against negative community influence. Mothers who, in their own homes, witness other people’s children misbehaving, expel them rather than discipline or report the misconduct to their parents. Allowing a flow of children in and out of the home, participants say, undermines control over children and exposes them to negative community influences. Hence, busy mothers weigh help from this ideal against introducing negative behaviors, and the possibility of conflicts with other mothers over discipline or reporting their children’s misconduct.

Alexis, speaking of her three young boys and a younger girl, summarizes strategies that stressed mothers use to protect their energy and homes from others’ misbehaving children.

I think it all depends on the parent, really, and most parents don’t care who comes in and out of they house. That may sound crazy, but I’ve seen where it is just a steady flow of people coming in and out. But, that’s a natural thing for that particular household. But for *me*, I have adopted this attitude that, although I *love* my kid, it’s times when I just really don’t *like* kids. So, if I have times when I really don’t like

kids, I don't want somebody else's kids over there. 'Cause, see, I can discipline my kids. I can't discipline somebody else's kids. So, I don't *want* somebody else's kids... (it all depends on how that child is raised), if I hear a little kid in there saying "B" and "F you," I be done went in there and like, "*Whoa!* Who is it in here cussing?" You know? And it's not my child, then my anger level goes up just another whole notch, and I'm like, "You need to go home." And, so, I rather *choose* not have nobody else's kids in my home, except my own kids.

Not allowing one's children to play with a foul-mouthed, misbehaving child who visits one's home may provide a positive influence on the visitor, but the action does little to advance the ideal of "the village raising or minding the child," where it implies disciplining or reporting misconduct.

Less stressed mothers may also reject this ideal. The participants themselves avoid interacting with close kin, whose parenting practices expose their children to badly behaved relatives. For example, in Group 2, Crystal notes that she limits her children's interaction with her brother's family, because her sister-in-law does not discipline the children, and her brother is not involved in rearing them.

Well, my niece and nephew, they're half Mexican. My sister-in-law's Mexican and I love her to death, but we do things differently—our discipline. I mean, I discipline my children, you know, [but] she don't do that much with hers—acting nutty on the kids.

Although Crystal notes ethnic diversity among her kin, she emphasizes the importance of a father's involvement. Beginning with Kari, the young father in the scenarios, she explains,

I just think it depends on the individual father. Like with [Kari], it depends on age. If they have not been taught to be more, um, involved in their child's life—if the seniors, if the parents, are not in the home—how can they see... what's important? That it's important to go to the doctor with your child's [mother].

Other participants do not dismiss the importance of parental involvement, but insist that ethnic and racial diversity also account for different disciplinary practices. For these participants, an interracial or multiethnic "village" is a liability for effective parenting. Addressing this issue in Group 3, Dianna explains how ethnically or racially different disciplinary practices become a liability.

I have an older daughter and younger daughter. [Y]ou try... [to] make life better for or the same for them. I sent [my older daughter] to (we lived in a White neighborhood), I sent her to the better schools, you know. Then the, the Caucasian people taught her how to disrespect your mama, her mother—kick your ass, and ah, ah run away from you. She'd run away, and I'm dragging her out of other people's houses.

In the same group, Beatrice, who moved to Tempe to find better schools for her children, interjects, "Oh, Yeah... because that's what they [White parents] do. They have a different culture." Dianna concludes that White children "don't respect their

parents, because that's the way they are [what parents' allow]. They don't whip their ass, for one thing, you know. And, White, White families, the kids are whipping the parents' asses."

White parents, participants contend, accept their children's abuse, but censure other parents' use of corporal punishment as child abuse. Arguing that this means Whites ignore the failures their practices produce, Dianna adds, "They don't talk about it [how children abuse parents]. Children have to have their say—"Oh, Mom, shut the fuck up!"—you know, because, they have to have their say." Beatrice adds, "They got *rights!*" Interested in promoting open discussion as part of reverse role modeling, participants do not intend that children should be physically beaten or mentally cowed. Instead, as Dianna states, "I let them have voice, [but] not that kind [of] a voice." Again, Beatrice expands the point, saying, "[T]hey need to have an educated voice." Agreeing with these views, Alexis includes corporal disciplinary practices in parental efforts to help children overcome negative community "realities" that can derail their development.

They can't cuss me! I mean, my kids, my children, I let them go only so far. If they start to get to a point where they getting out of hand, I'm like, "Who do you think you talking to?" You know, I have to get that mom up in me. Like, "I'm not your friend, right now, I'm your mama. You need to understand that. And, if you sit up there and decide that you want to say something *else*, you gonna git hit." They go, "No, no mama, I was just playing." "No, you don't play with me like that." I draw a line, and I think you have to draw a line when it comes to kids getting outta hand. And, if you sit up there, and let your kids run around and cuss, like I seen some of my little kids' friends (I got three boys, and my youngest is a girl), and I seen little five-year-old boys running around saying "B" this and "H" that. And I'm like, "Oh, no, you will *not* be playing with him!"

Focus group participants look to their childhood experiences, rather than current "White" standards to judge the value of corporal punishment in parenting. Alexis, attributing her derailed development to a first pregnancy by a boy who deliberately took advantage of naive and rebellious young girls, uses her ignorance as a foundation for steering her older son to take a different view of his self-development and responsibility to girlfriends.

And honestly, I have taught my kids right now that as they get older there is only certain things I want—I expect of them. Now, I know the kids gon' do their own thing, but like I say, "[names oldest son], when can you have a girlfriend?" He like, "When I got a job and I can take care of her, just in case something happen." I'm like, "Are you going to be in school?" And he like, "Yeah, I got to finish school. If nothing else, I definitely have to finish high school and, then, I'm gonna go to college." I say, "I'm glad you got your plan set out ahead of you." Because, I think because of what happened when I was young, I honestly felt like, I was not (although I felt like I was being naive), I felt like *he* [the father of her first child] was more intelligent than I was. So, if I would'a had more education—like, "[Alexis], if they come at you with this, don't say this, you know; If they come at you [with] this, don't do that"—I would not have gone down the road I went.

Consequently, the “village” (as racially or ethnically diverse disciplinary practices), the “street,” schools, and even the church are liabilities against which parents must protect their homes. Home training becomes the primary, if not sole, means for effective parenting practices to keep a child on track. Otherwise, “the village raising or minding the child,” engulfs African American children in negative media messages and stereotypes that damage self-esteem and promote sexiness as a criterion for self-worth in peer status competition.

The racially or ethnically diverse “village” poses still more obstacles to effective parenting by reverse role modeling, when it entails a lack tolerance for variations in disciplinary practices to suit community realities. “White” or “better” neighborhoods represent conditions, participants across the groups agree, that undermine or undo the results of home training, because those conditions encourage behavior that increases the risk that their daughters will become single mothers. The same conditions also encourage early parenthood for males, but, more important, they inspire males to “live the exception,” meaning to ignore less glamorous employment in favor of occupations, such as sports, that promise “get rich quick” and the associated status.

Conserving their energy to protect home and children, does not mean older mothers are untroubled when they see young mothers engaging in behaviors that threaten to harm babies and young children. Even when older mothers do not intervene, they feel guilty and worry about the consequences of their silence. Some decide that, as mothers, they must speak, even if doing so embroils them in conflicts. In Group 2, Ester describes the emotional turmoil her inaction produced when she observed two young mothers’ poor parenting—one involving potential long-term nutritional damage, and the other a possibility of immediate death or serious injury.

You know, my thing about it is I have gotten to the point where (although it’s not my business), because I am a mother, and because I see it, I kind of feel like, I’ll take whatever you will give me [for interfering], but I won’t ever disrespect you. I’ll just say, “You know, can I just share something with you?” And you can say, “Hell no.” Or, you can say, “What?” Or, I mean, you can respond however you want to. But, like yesterday, I felt bad for the rest of the evening. I went through all this like, “I wonder how old that child was? I wonder what else—have you given a pacifier [before giving Pepsi]? *I went through this turmoil, and it’s not even my child!* I don’t even *know* this person. ... . Or, just like, like last week, I saw a woman put three children in her front seat with no seat belt, and peel out of the parking lot. A six-month old laying on the car seat, another child on the floor, [when she pulled out] in *front* of a car! And, I thought, “*Oh, Lord, have mercy!*”

Although Ester’s husband, present during the Pepsi incident, discouraged her interference, she vows to interfere in the future. Other participants agree that sometimes, for a child’s sake, one simply has to risk conflict with the mother.

None of the focus groups express a strong positive view of “the village raising or minding the child.” However, some participants agree with Rita, in Group 4, who says aspects of the ideal still operate in certain neighborhoods. “And I come from the, ‘it takes a community, it-takes-a-village-to-raise-a-child’ era,” Rita states. “In our family, in our home, our neighborhood—our whole community is involved in things like that [aiding young mothers with parenting skills and children with sex education].”

Whether mothers intervene, participants express great sympathy and empathy for very young mothers. Young mothers do not know any better, participants agree, because they model their behavior on their childhood experiences, and their friends’ behaviors. In Group 1, Helen calls childhood a “field of experiences,” which, other participants agree, establishes “foundations” for young mothers’ parenting. To become effective parents means devising reverse role modeling practices, which must begin with understanding past experiences as they face problems. However weak the foundation, young mothers must cope by building on it to change negatives to positives. Judging how positive these practices are, participants emphasize, depends on how young mothers understand and manage community liabilities. These result from scarce resources, racial and ethnic diversity, and, recently, new middle-class and upper-middle-class housing developments that increases competition for scarce and diminishing resources. Residents of the new housing developments bring infrastructural resources, but they keep to themselves, and the space they occupy further segregates and isolates poorest African American residents.

Helen captures the participants’ sense of how unemployed and underemployed African Americans work to develop positives out of negatives.

When they experience, ah, kind [of] what you had and what you didn’t have. Because, ah, this is my first time as a mom and I love it, I think my baby is the best baby, but, [I] take from what I did git and what I didn’t get, and then just as... a person trying to put your own... mix, mixture with people, you know. What is it they say, ‘the tribe minds the children’—that who they become [is] through their field of experiences.

Household types (by composition and single-parent or two-parent heads) are important, but do not determine individual outcomes, because sibling order and experience within households varies to make the field of experiences. Helen goes on to express the participants’ general view of sibling order as a factor that shapes the field of experiences within and across household types.

So, I just think with that older child, [Kari in the scenarios] may have been the leader, then a lot of responsibilities was on him that, maybe, he didn’t want. So, therefore, he wanted to be himself in his youthfulness, and go (I don’t wanna say sow his oats), but you know, go do his thing. The middle child [Kesha in the scenarios] was trying to find her niche, and then the younger [Karla in the scenarios]

was like, "I have everybody telling me what to do." I mean, it could be a variety of things that are going on.

Likewise, while sibling order may influence male conduct, other factors also vary the experiences that males bring to parenting.

Focus group participants see gender-role traditions resulting in males gaining from all household types a weaker childhood foundation than their female siblings and girlfriends. Young boys are less prepared for parenting and, as older brothers, they offer younger sisters little guidance as they grow up together. Alma, with five older brothers, was the only participant to say that she learned useful lessons from older brothers about how to interact with males.

In Group 1, Francine provides an example typical of how participants gloss over brothers' childhood experiences, when she says, "I'm a middle child, and my [older] brother didn't do anything much with himself." Addressing the same issue in Group 5, Fern explains Kari's behavior (in the scenarios) as the result of a lack of parental guidance, saying, "He had to learn a lot of things on his own." In the same group, Becky adds, "[H]e didn't receive any encouragement, so he... said, 'I'll just go for it. They don't think anything of me, so I'm not gonna make anything of myself.'" Also, in contrast to the many reasons for girls' early sexual activity, participants reduce male reproductive irresponsibility to interracial interactions. As an unidentified speaker puts it, "White girls throwing it [sex] at him, if he is in sports." Nevertheless, participants agree with Ester, who paraphrases views of parents' excusing their sons' reproductive irresponsibility: "Boy don't do that again."

Young mothers, who do not transfer childcare responsibilities, learn by caring for their first child. Experience eases fears and anxiety. Successful labor and a healthy baby also discourage using some prenatal health care and other social services for subsequent children. In Group 1, Helen, raising her first child, explains what she has learned from this experience.

I don't have two, but I have learned from watching the one. If I have a child again, she will be eating this [something she was told was for older babies] at six months, rather than ten. You know, you learn different things like that. Because you so nervous (well I was)—picky; wash your hand before you touch her, but then after that [you relax].

Group 1 laughs as they agree with an unidentified speaker, who says, "You saw she didn't die." In addition, the mothers' need to use time wisely makes some prenatal social services excessive. Irene captures a prevalent comment.

To be perfectly honest, you realized that some of all that stuff that you did to prepare for the first child wasn't necessary. ... . I went to classes, the birthing classes. We [as a couple] sat up there, did all this stuff together, then it was a breeze! And then, some of the things—you kind [of] know the game. You hope that you got the foundation right. You hope that you know, like, prenatal is important;

nutrition is important. You hope that you got all of that you needed from the first pregnancy. You just don't need as much coaching with the second pregnancy.

Yet Helen also questions whether relaxing might reproduce conditions that undermine reverse role model parenting. She asks other participants, "Do you think that has an influence on you raising that second child? Like the excitement is not there, maybe, because you did not go through all of that?" Responding, Francine considers her second daughter and wonders not about prenatal services but about attention to later children: "I say one thing, I did a lot of pictures, with my first one. I zoomed through a picture album. Then, I said, 'You know what, my daughter—my second—[when she] gets older, she'll ask, 'Where [are] my pictures?'" An unidentified speaker echoes this concern, as she recalls her mother's practice, saying, "Same thing for me. My mother took pictures of my sister, and mine are nowhere to be seen." Irene also speaks to this issue, declaring, "Right, because you already have one and you like, 'I'm gon' cut back on your pictures, so I get them tenny shoes now.'" Nonetheless, mothers benefit from experience only if they take responsibility for a first child. They know small things make a big difference for whether a child feels the need to seek attention and affection outside the home, and they guard against the search's consequences.

The youngest first time and single mothers who do not take responsibility do not refuse health care and social services. They simply are not primary caregivers. Across the groups, participants agree that, except when resources permit avoiding the "welfare trap," primary caregivers use services for which an infant qualifies. Some caregivers are younger than the birth parent and, without physically or effectively present adults, cannot sign for the infant benefit. When the caregiver can do so, participants insist, she uses benefits and extends these to the next child. She faces less paperwork and knows more about the relevant agencies.

In Group 1, Greta presents the rationale for using services and avoiding the welfare trap if other resources permit.

I'm saying, maybe things will change because you have more information. So like, she—the lady [Karla in the refusal scenario] was on WIC or AHCCCS, or whatever—[thinks], "Now, I can make an appointment to get my second child on." So, you are using those same resources, the same services, but the work involved is not as hard, because you have the information. And, maybe, she don't need that; the WIC, the milk, whatever. Maybe, she don't wanna do that this time. Maybe she wanna do something else, or something. She has it there, but then she wants to try something else.

Another exception is the young married or single mother who does not seek services because the father considers doing so a waste of time, or objects for other reasons. If using services does not conflict with male views, as Irene puts it, "She doing all the work, and he's just sitting back and relaxing. That's the way a lot of women

tend to do.” Even when a conflict exists, by the second child, if a mother lacks other sources of support, she may ignore male views and use available services.

Seeing the risk of reproducing negative cycles increase, working mothers may quit their job and sign up for services to have time to supervise their children. The time parents spend with children is the critical factor for reproducing negative cycles. Therefore, participants say, small, high-income families, with mothers, fathers, and elders busy with their professions and social life, also create conditions that reproduce negative cycles. In addition, growing up in high-income households may not prepare the young for parenthood, because parents there, as in low-income households, begin instruction too late. Like Frances, these mothers may expect that as long as they meet infant health care needs and growing children’s material needs, they can forego other services.

Many households, regardless of the parents’ income and education, are composed of the father’s and mother’s progeny. Participants contend that favoritism influences parental attention in these households. Favoritism is not a unique problem for these households, but participants suggest it is more prevalent and has greater negative consequences the larger the family. Some households include 14 or more children, variously composed of maternal and paternal full and half-siblings. In such cases, participants see favoritism as another problem to address by reverse role modeling. In Group 1, Francine describes the situation in her natal household, focusing on what it implies for parenting by reverse role modeling.

When it’s bigger families, there’s favoritism. That is something I learned. On my mother’s side, on my father’s side, we have like 15 children on each [side]. And, a mother and father always has favorites. I said, “When I have kids, I’m not doing that. If I get one something, I’m getting everyone something. If I praise one, I will praise the other.” And I think that makes a difference.

Asked if this favoritism negatively influences attention to children’s health care, participants were uncertain, beyond the general neglect of the least favored child or children.

#### **IV. “It’s just ingrained in who we are, visually”: Race, Age, and Color**

During health care interactions, when African American patients challenge workers’ insults, focus group members say, the workers concentrate on their own emotional distress. Patients who “come unglued” in response to workers’ insults escalate the workers’ defensive response. Hence, in Group 2, when Ester recounts being offended by a nurse’s response and asking for another nurse, the worker defended her actions, then complained that Ester was causing her emotional distress. Participants agree with Frances when she declares, “But, at the end of the day, you [Ester] were just a nigger woman that rolled in there. You could have been 12 years old.” Ester agrees, “*Absolutely!* Absolutely. Absolutely right. She was like, “I’ve done

thousands of deliveries, and been working here for 20 years,” and I said, ‘That’s a damn shame.’” The nurse may have thought the reference to her years experience with delivery would reassure Ester of her competence and good intentions. Instead, from the Group 2’s perspective, the nurse’s reaction continued the affront. In labor, Ester had neither time nor the patience to search the workers’ language for good intentions.

Ester and Frances’ reference to age invokes the participants’ understanding of how age becomes part of workers’ view of lower-class disreputability and racial infantilism, both of which encourage workers to talk down to African American patients or ignore their questions. However, age prejudice alone, participants contend, produces the same negative interactions. Darlene, who observes her co-workers interacting with expectant mothers in their pre- and early teens, and also recalls her teen pregnancy, states, “Yeah, they do that a lot, especially, like how I was 17, they do that [treat young mothers] real bad. Like, ‘Do you even know who the father is?’ Or like, ‘Do you know how to fill out the papers?’”

Without considering the experiences of older mothers, such as Ester, the workers’ language might seem to be straightforward information gathering. Darlene’s second question might only appear to be the health care worker’s attempt to help a very young patient with typical paperwork. Although focus group participants accept that some negative interactions may result from honest error, they attend to assumptions in the language workers use to ask questions. To wording, they add tone and attitude, and these reveal a complex interplay of age, race, and class as worker prejudices in adverse interactions. This interplay participants term “candy-coated racism.” Workers’ candy-coated racism does not rely on previous patterns of racist conduct. Nevertheless, the resulting practices, participants insist, deliver consistent insults. Ester sums up the focus groups’ view of this racism.

[I]t goes back to the whole thing of racism and the way it’s demonstrated. It’s very subtle and underlying, and it happens at all levels. You know, it’s not like they’re riding through town with hoods and, you know, burning crosses, any more. But, it’s *absolutely* there, and it will continue to be there. It’s just ingrained in who we are, visually.

As previously noted, however, when speaking of racism, the focus groups do not restrict its practice to “Caucasians.” Instead, in Group 2, Betina expresses the participants’ general conclusion on this point, saying, “Racism comes in (it just not only comes from, you know, Caucasians). Racism, it comes from every walk of race. So, I mean, Black people are racist against one another.” Thus, for Ester, “all levels” means institutional structures, and invidious distinctions within and across ethnic, racial, and socioeconomic strata that encourage individuals to erect status and moral hierarchies in interactions.

Interracial and intraracial assumptions about skin color differences produce distinctions that erect such hierarchies. Participants contend that assumptions from both sources result in dark-skinned African Americans experiencing the worst consequences of the complex interplay of age, race, and class. Intraracially, assumptions about color differences result in questioning whether light-skinned and biracial African Americans are “Black enough” to experience the “real” interracial consequences of being African American. Across the groups, participants’ comments about this issue draw on both intraracial and interracial responses to what they see as the long history of favoritism for light-skinned African Americans or biracial persons.

Each focus group included persons whose phenotypes encouraged other members to question their participation in an African American focus group. Others who revealed biracial backgrounds inspired the same questioning. In discussions, when these participants disagree with race as a causal factor for an adverse experience, others question their ability to assess subtle, candy-coated racism. Taking color bias as one source of status and moral distinction, these participants introduce a credibility gap, into which fair-skinned and biracial participants fall as “not Black enough.”

In Group 5, Rena very fair, with long brown hair, confronts this credibility gap. Some participants reject her suggestion that health care workers may see African American and AHCCCS patients after later arriving patients, noting that there are waiting lines for patients seeking different services. A few participants quickly agree, but others challenge Rena’s ability to know the difference. Although Rena is not speaking of her own experience as a patient, an unidentified speaker responds, “I just want to say, to them [Whites] she looks like she’s not Black.” Ola adds, “So, of course, she’s not gon’ git the same treatment that we [of darker hue] do.” These participants attend only to the color-based credibility gap, ignoring that Rena was speaking from her observation of systemic practices, and questioning causality for AHCCCS as well as African American patients.

In this group, Charlotte is the most insistent on workers’ biases against AHCCCS patients. She says, “I think it’s AHCCCS.” Other participants still emphasize the interracial implications of color bias. Speaking over one another, they insist that color matters for how White health care workers (and some African American co-workers) treat African American patients “past University.” They mean that color favoritism operates outside the predominantly African American community as a fixed spatial area. Edna declares, “It has to be [a factor in treatment] south of University,” with Paula completing the spatial boundary with, “But north of Baseline.” Multiple voices agree with Paula’s contention: “It’s just that treatment changes [for color, beyond this boundary].”

The change does not imply favorable treatment. The role of color bias in determining the quality of interactions depends on who interprets color and what it implies to them about patient worth. Interpreting light skin may lead to ethnic misidentification for equally bad or worse interactions. Thus, Rena counters the challenges: "To a lot of people, I look like I'm Mexican," with Charlotte remarking, "I was just about to say that." The challengers concede the point about misidentification. Rena goes on to note that "according to a lot of people here, they think Mexicans should not be here, so I don't... really think that makes a [positive] difference." Unwilling to concede the general point, unidentified speakers switch from color to hair texture. One declares, "I was just gonna say, when she came in, 'What is she doing here?' Then, [I] looked at her hair." Multiple voices agree that her hair is a giveaway, but another unidentified speaker adds, "But they [Whites] don't look at that first," implying that the momentary confusion provides leeway for more favorable treatment than a dark-skinned, nappy-headed African American receives.

Group 2 focuses on intraracial bias for light skin and straight or wavy hair. Responding to these biases deliberately included in two scenarios, participants explain Kari's pride in his children, insisting that his pride is a negative response to blackness. Thus, Betina states, "He ain't studying [does not care about] none of them [his two children and their Mexican and White mothers]. He just don't wanna deal with—he don't want none of Black women." Frances combines hair and color preference to explain Kari's pride, declaring, "Sure he is [proud], 'cause [his babies] got light skin and wavy hair." Consequently, participants agree with Darlene, "That's why he ain't got no Black woman as his baby's mama." In Group 5, participants joke that African American girls put holes in light-skinned African American males' condoms in efforts to have light-skinned, wavy-haired children. On a serious note, participants contend that color prejudice in families becomes another source of favoritism that may adversely influence parents' attention to children.

More generally, color bias adds another factor that participants see encouraging some African Americans to judge others as flaunting their good fortune over the less fortunate. Speaking to the point, Crystal (G2) reveals that her mother is White. Responding, Frances discloses thinking, "She kind [of] look White." Earlier Crystal notes that her brother's wife is Mexican, making her niece and nephew "half Mexican." In response to others' challenges, she reveals her frustration with African Americans who think light-skinned African Americans see themselves as "all that."

I know one thing, my brother has a baby, and so do I. And, as far as like, "Oh, they're so light, they're so this, they're so that," and I get tired of hearing it. ... I'm like, "So?" And you know, we can't help who we're born to. I mean the reason I'm light is 'cause my mom's White, you know. And people think, oh, I think I'm all that, and I'm like, "I really don't."

Supporting Crystal's view, Ester reveals that she is biracial and her husband is of Crystal's complexion. She recounts his efforts to signal that their son is "Black enough" to claim a share in African Americans' adverse experiences.

I agree with you [Crystal]. I can understand that, because my husband is, maybe, about your complexion, and I'm biracial, also—my mom is White. [I]t drives you insane. People will see him with our son, and they'll go, "Oh, his mama must be White," you know. And they immediately assume that, "Oh, he's [her husband] *one of them kind of brothers.*" [Group laughter] [H]e spends all day trying to justify, you know, that, "No, no, no, she's, she's [husband's mother] half Black, and she's born in Africa." And he go through this big diatribe, and I go like, "*Why do you care? Do you know the person that was standing [there questioning you]? I mean, why do you care?*" But to him... there has to be some justification that this child is Black *enough* for, you know.

While asking why her husband cares, Ester explains that she too must care, because color bias affects their son.

It bothers him and me, 'cause... I do see some (it's not necessarily in health care), but I do see, you know, people will say stuff about my son. Like, "He's cute for a Black, cute for a Black boy." I've had that happen twice! [Multiple groans and indications that this experience is both dismaying and typical.]

Although Ester's experience was not with health care workers, other focus group participants note that when similar events occur in a health care interaction and the mother challenges the worker, the worker reacts by accusing the mother of being oversensitive or having misunderstood. The moderator asks whether the participants return to a facility after such an experience. Ester provides the prevalent reply: "Oh, no! No, no, you don't go there. You find... you transfer." Neither transferring facilities nor getting another health care worker is always an immediate or long-term option. Time, insurance coverage, and other factors require that some mothers continue using the facility or service. Even if one eventually transfers, participants suggest, it is necessary to confront the workers. The child's care comes first, but, when the mother has taken care of that, as Betina notes, "You go back and deal with the issue, because, if it's happening to you, it is probably happening to others."

Confronting the worker will escalate the altercation, because African American patients are never right. Responding to Ester being told her son is "cute for Black boy," the following Group 2 exchange captures the participants' view of a typical escalating altercation.

Because they can tell you anything. They can tell you it's your perception. They can say you overreacted. They can say a myriad of things. "I didn't say that. I said he is as cute as can be. I didn't say that [he is cute for a Black boy]." (Ester)

Right... I've had that [happen]. (Betina)

That will make me wanna fight. (Ester)

[Y]ou need self-control. (Betina)

"Now [Ester], not only did it I not say that [your son is cute for a Black boy], now, I think you're being harassing to me," right? "Now, I don't feel safe. *Security!* [worker calls for intervention] [You] gotta go." And, you will be [ejected or arrested]. (Frances)

Right. Right. (Alice)

Security! [Multiple voices, agreeing that workers call security to remove a "hostile" Black patient.]

That's why I am saying I am not going back, I'm knocking you out now. [Group laughter] (Ester)

Ester jokes about physically confronting the workers, but focus group participants are serious when concluding that workers take any challenge as hostility, aggression, and a personal physical threat. If workers do not call security, participants say, they act to gain their co-workers' sympathy against the patient. Ester captures this view: "But, let me tell you, you pick out the White woman in the clinic—the nurse or whoever—that made that comment, and you come on too strong, you know, they going to start crying. 'Cause, you know, that's what they do." Paraphrasing a worker's response, Frances adds the finale: "'Now, you are aggressive. You are getting me upset. Now, you assume... you and your ugly baby.'" Thus, while holding themselves accountable for challenging bias, the participants also agree with Frances, who goes on to declare, "Trust me, I know what you saying. I leave them alone. I leave them alone." Faced with these outcomes, in Group 3, Dianna summarizes the consistent quality of health care interaction: "They think we are ignorant, you know."

## **V. "It *is* the same": Stereotyping in Child Health Care Interactions**

In Group 3, Glenda expresses the focus group participants' general view of how these factors influence child health care interactions.

*It is* the same. It is the *same*. It is very frustrating as a parent, because you are very worried about your child's health. And you are sitting there and they are asking you questions and you don't know anything [to tell the doctor].

In the same group, Beatrice describes a mother's frustration as she tries to get information about her child's illness, "You [are] trying to get [information] out of them [doctors]. ... . [Y]ou have to calm yourself down, 'cause the doctor would take [your behavior] as you being hostile towards them." Consequently, participants agree with Glenda's conclusion.

And every now and then... it's like something crazy [comes over you], but, in reality, all you asking for is help, you know, to get your child well. [But] 'cause you're hysterical (sometimes you are frantic... you can't see that [you are frantic or hysterical]), other people express that for you... then... [assume that patient hostility has become part of the interaction].

Unable to communicate calmly, Glenda tries to learn "What kind [of] medicine are you giving and what are the side effects?" The interaction degenerates, because, as Dianna says, "You know, they don't want you to ask questions like that." For Beatrice, "It's traumatic," as she already wonders whether her failure to insist that the doctor follow up may have contributed to the death of the baby she lost at age 18. Hence, expressing the participants' view of typical child health care interactions, Dianna states, "When you question them about what they are doing, I had one doctor tell me, 'Well, I am the doctor, I know what's best. ... . But, you need to explain to me, as the parent, what you are doing.'"

Focus group participants' experiences with many facilities, especially outside South Mountain and South Phoenix, allow them to recognize systemic practice that make interactions difficult for all mothers. Nonetheless, as African American mothers of sick children, getting useful information is more difficult, because health workers see the African American parents' hysterical behavior as typical for an ignorant, hostile Black person. Thus, in Group 3, Elena explains that an absence of good will results, because "it's their [health care workers'] view of Black folks." Even the mothers' positive conduct, participants say, health workers take as accidental or exceptional, and continue seeing negative conduct as typical for all African Americans. Accepting that the mothers' failure to remain calm reinforces health care workers' negative views of African Americans, this adds guilt to these patients' already frayed nerves.

Yet, while participants recognize the combined force of interracial and intraracial negative stereotypes, they try to turn "coming unglued" into a controlled burn. Given that workers will see any persistence as aggression, patients who get a "brush off" respond by continuing to ask questions, even as workers become irritated and try to move on to the next patient. In Group 1, Greta describes using irritation to get information.

I have a lot of theories about how I should be with people. If I feel like you are doing this to me—just giving me the brush off—I'll start asking more questions to irritate you. "Here, so let me be clear on this, so you are saying this, this, and this." Okay, if I still feel like they are rushing me, then... I'll just keep you there. That's what you are here for and I mean... I am not saying I just do it to irritate them, but I keep asking more questions to get them involved. If you don't wanna be involved in this interaction, in my best interest, I will take care of my best interest—and that is my child. You better know that I am gonna keep asking those questions, and I don't care if you are walking out the door; walking in with the next patient. I might be in that room with you, if I have [to], still asking my questions.

If workers associate this strategy only with the patients that engage in it, this would limit consequences for other African American patients. Instead, participants say it becomes additional proof of African American aggression and hostility, which justifies workers' extending negative stereotypes to all African American patients.

Expecting this response, other frustrated mothers try subtle ways of “educating” medical workers. Also, they do not hold themselves accountable for wasting energy on self-presentation when a child faces a medical crisis. They expect and confront the difficulties their lapses produce. Following Greta’s comment, Irene describes this alternative approach.

I go when I am sick, so I am not dressed up. I mean, my hair is a mess. I have on some raggedy clothes that I have on Saturday. And my head [is] dripping, because when I go to the doctor, I have to drag myself because that’s, that’s just me. [W]hen I went in there, it’s like, “I am not doing good, something is wrong,” and they [say], “Okay, we gon’ take care of you, just sit on the table, lean back, and we will figure out what it is.” And, I like... (excuse my tone), I get my old form, I have to draw my energy from wherever and, you know, like you say, speak their lingo, so they can hear me. He listens, but he is not hearing me. I’m like, “I’m... not comfortable with you right now, give me someone else.” And then, they can hear you. Well, they’re like, “What, what aren’t you comfortable with?” “*You!*”

When, as was the case with Irene’s visit, her child is also sick, a mother does not use subtle strategies. They “gather themselves up,” drawing energy from “wherever,” to ask questions.

In Group 3, Dianna reports on her child’s chronic respiratory problems. He has had acute problems many times, for which she has not received an explanation for what triggers them. Dianna has learned to administer breathing treatment at home and, when this fails, has made many trips to the emergency room. She thinks she knows when her child needs something more than the already prescribed treatment. Dianna describes health care interaction when her child experiences respiratory distress.

“[H]e’s in distress... why are you giving him this medicine?” “Is this a steroid?” I’m asking questions. And I’ve given him breathing treatments at home. Well, the doctor looks at me like, “You pretty much know what you are doing. You got this under control.” And he [my child] is still wheezing and, so, we need to do something else.

Mothers like Dianna hold themselves accountable for learning about their children’s illnesses, and for learning and acting on patient rights. Nonetheless, interactions with medical professionals mean continually acting to counter presumed ignorance as race-based lack of capacity to understand. They see workers who consider their questions a waste of time, “shutting them down,” and continuing the same treatment that produces no results. This results in costly and ineffective return visits.

In the same group, Elena, the mother of 21-month-old twins who were born prematurely, works to understand their illness. She pays attention to how it changes as they mature and encounter different environments, and knows when to use their breathing machine. Like Dianna, she has faced many crises that required trips to emergency rooms, hospitals, and clinics. Elena describes a typically ineffective

doctor's visit when one twin was experiencing severe problems breathing, vomiting, and was unable to walk without stumbling and falling.

They were born really early, so they were on RSV protocol. They have to get all these shots. They like can't be around sick folks. They can't be in day care because they catch illness. ... . So, one of my kids ended up having to go into the hospital to get an IV to be rehydrated, because he was dehydrated. And, he was just 21-months old, and he was stumbling and falling, and really, really weak. It was scaring me, and I hadn't slept at night—my baby throwing up, and diarrhea, and then with two of them. ... . So, finally, there was one doctor, then another doctor, then another doctor, and they would all start off, "This is what..." They would all cut me off, shut me down. They would say, "I want you to start with Pedialyte." Well, we done been through emergency room IVs; don't take me back to Pedialyte!

Health care workers who do not "shut them down" before they can explain previous treatments, mothers say, offer empty platitudes, such as those Dianna recounts. Focus group members see these as empty platitudes because treatments they report to have failed do not affect the next treatment the worker prescribes. More often, they contend, it means that workers send them home to "wait out" the problem.

Beatrice, whose child has asthma, like Elena and Dianna, has learned to research her child's illness. She uses information her private insurer supplies to learn what she can do at home to prevent recurring crises. She recounts the difficulties with getting doctors to provide additional information and referrals for treatments she thinks patient rights afford her.

I think that's when [we] have to really question, and know our rights as patients. 'Cause you're suppose to leave with an understanding. They have to tell you, they can't act like they don't wanna tell you. We learned about my son's asthma when he had an asthma attack. And then, he was three, they sent me home, with the breathing machine; a nebulizer. He starts kindergarten, and that's when all his other breathing problems [began]. I learned that he should have had maintenance medicines. ... . Here we were, watching the asthma tape or whatever, but, you know, you listen to the doctors and you trust what they say, and, then, a year later he's in the hospital. ... [W]e had to learn that certain times of the year was his trigger. So, it was like a learning process. And I get upset, because I am like, you know, "We took the resources that you gave us, but they weren't very good." ... [H]e ended up in the hospital when I had painted and he inhaled it. He was down to 76 percent of his lung capacity. We didn't know [the affect of paint]. It's trial and error. I hate that we have to learn the hard way. But now, he has to get different things. If he needs to do that, I need to send something to that school. ... . The doctor signs off on that.

To gather more information, participants say, proactive parents use hot lines and triage nurses. Few report having computers. Those who do, get information from the Internet and those lacking home computers may use Internet access at libraries. With more information against which to judge previous health care interactions, some, like Beatrice, look back and wonder whether a child's medical crises or death might have been prevented had the medical professional explained the ailment and referred the mother for proper follow up.

Consequently, participants say recalling past poor quality service makes current interactions, as Beatrice puts it, “traumatic.” Considering her own struggle and Elena’s to keep their twins healthy, Beatrice wonders whether greater knowledge and persistent questioning might have saved her first child.

I think [about] what happened to me with my first baby girl (I was 18). And, I was exactly 24 weeks when I went into labor with her. And, the only thing I can think was that, at my first doctor’s appointment, the doctor was like, “Hmmm.” I guess my cervix was a little more enlarged than it should have been. And I went along with that. ... . I went through premature labor just about the *whole* day, because I did not know I was in labor. This [baby] I lost. ... . [T]hey said her chances were under 50 percent. And then, it was 95 with my twins. [We were] in the same hospital, we [were] in the same situation. And there was a baby that had died in the same bed my baby had died in. And it was *way* too much. [I] just kind [of] wondered, when [the doctor] said, “Your cervix is enlarged” (because what had happened is that my bag had ballooned, and triggered the labor). So, I kind [of] just think about that. Why would [the doctor] just tell me that and not address it?

When other members of this group insist that an explanation and follow up might prevent premature labor and infant death, Beatrice agrees, “Exactly.” Asked how often they receive diagnoses with no explanations, advice, or referral for follow up, Alexis voices the prevalent response: “All the time. All the time.”

Participants who had been AHCCCS patients report receiving more information when they obtained private insurance. These focus group members join those who are current AHCCCS patients in insisting that health care professionals provide AHCCCS patients little information on their own or their children’s illnesses. Consequently, these patients more than privately insured ones must “learn the hard way”—by trial and error—but have little with which to work. Private insurance can make a positive difference. However, overall participants agree with Fern’s conclusion that this is less likely for single, young mothers. Fern insists, “It’s the same thing, before [doctors] can even talk to you, they look at you as a single mom. They still treat you wrong. They still look at you for having that child, and you [are] just wrong.” Regardless of the type of insurance, young, single African American mothers experience greater difficulties with problems that all African American patients confront—doctors who provide little information, rush interactions, and make the simplest, if any, diagnosis—all of which contribute to ineffective repeat visits.

While some doctors may be callous and uncaring, participants also agree that AHCCCS regulations set conditions that justify and reinforce all health care workers’ responses to these patients’ needs. Paula expresses the typical view: “[I]t’s like they say, you always have to get referrals or approval from AHCCCS before they do anything. My son, something’ll be wrong with his tooth, and they’re not going to pull or fix it, or whatever, until they get approval.” Many voices echo, “get approval,”

and generally agree with Paula's conclusion that "he needs it done *now*—not later." Therefore, in Group 5, Fern attributes health care workers' indifference to their knowing or believing that AHCCCS will not pay for referrals.

[T]he first time I was pregnant, and I got sent to Mountain Park on AHCCCS, I was like telling them about these pains, and they were like telling me, "We don't see anything wrong, but, if, in the middle of the night, you have [a problem] go to the County," or whatever. And I would go to the County, and they would have me waiting forever. And then, they would tell me nothing is wrong. It turned out my baby was developing too fast, and I had a miscarriage. And then, a lady at St. Joseph said, "I don't know why somebody didn't tell you. They should have been able to detect it sooner." ... . [T]hey didn't even wanna waste time running that many tests. They like, "Everything sound fine, just go on, and if you keep having pains, just go to the emergency room."

In this group, Lois compares prenatal care referrals for her two pregnancies.

I have two kids—the first [a girl] I had on AHCCCS, the other [a boy] I had on private insurance. And the first one (when I was on AHCCCS), they do you wrong, they don't care. Like [I] came in there with my stomach hurting, [and they say], "We have to wait and see. We have to get approval from AHCCCS to see if they can approve you for this procedure, or whatever needs to be done. But, when I had my private insurance, when I went there 'cause I said I had a little bit of blood, they [said], "Come in, let us take a look at you. Let's do this test." They look all in you. I had, like 18 ultrasounds. I had problems [when on AHCCCS], but they were just, "Oh well." I had one [ultrasound] with my daughter, [although] I had more complications with my daughter than I did with my son, and my son was practically fine.

Group 4's participants also see problems stemming from how AHCCCS regulations differ for adults and children. They contend adult medical needs go unmet, while the insurance covers the same ailment for children. Mary, who works for AHCCCS, summarizes the problem, but also notes that not all health care workers are indifferent to the regulatory constraints.

[F]or adults, it is hard to get a regular doctor, because they don't provide vision care and dental care for adults. Which I think is crazy. ... . [Adults] need to get their teeth done, too. I work for AHCCCS, and people come in there, they want this, they want that. [We say], "We can't give you that," and they [say], "Why can't you?" I [agree], why can't you? You give [it] to the kids, why can't you give it to the adults? It doesn't make sense. People need glasses; they can't go buy a \$40, \$50 pair of glasses.

Focus group members are particularly concerned about dental and vision care for adults. The government seeing adult care as "luxuries," they suggest, accounts for the restrictive provisions. In Group 2, Ula explains that restrictions occur "not so much [because adult care is] a luxury, [as because] whoever did these guidelines stayed in the box, forgetting that life goes outside the box."

Group 5 attributes both ineffective repeat visits and misdiagnoses to restrictive AHCCCS regulations, which make it difficult to get referrals for tests to ensure the best diagnosis. Paula contrasts diagnoses for her child's respiratory ailment after she changed to a private insurer.

[T]hey gon' take their time [to diagnose the problem]. "Oh, she has bronchitis. She has bronchitis." I have private insurance, [then] my baby has asthma. [The group laughs over multiple affirming voices.] And that's why she can't breathe! ... . On AHCCCS, she had bronchitis. She has breathing treatments [now that I have private insurance]. ... . They were like, "Well, kids grow out of it." And, "Some babies are born with respiratory problems, and it develops inflammation, and it develops into bronchitis." I'm, "Okay. Explain more to me. Does it go away, you know?" And I couldn't understand how can you keep having bronchitis month-to-month—chest caving in when you breathing, when you run, you can't breath. That's not bronchitis. Something else is wrong.

Asked if she thinks the insurance was the only difference, Paula replies, "Pretty much, 'cause every time I would take my daughter, they wouldn't touch her. ... . A few emergency visits, a few private insurance changes, and [a few] specialists [later], my baby has asthma. As long as I had AHCCCS, it was bronchitis." In the same group, Theresa, expresses the prevalent conclusion about AHCCCS: "They make it seem like they don't want to touch your baby, like she's infected, or something. They don't really check them."

Consequently, participants attribute the greater accuracy of diagnoses under private insurance to doctors' care in examining patients, referring for testing, and explaining cause and effect when patients ask questions. Thus, whether the proper diagnosis was chronic bronchitis or asthma, Paula's conclusion reflects participants' greater trust in diagnoses they receive as privately insured patients than as AHCCCS patients. AHCCCS diagnoses, focus group members insist, are overly influenced by workers' stereotypical responses to patients, and adherence to the program's restrictive regulations concerning referrals. Therefore, participants agree with Paula: "It's like they don't care." In Group 1, Helen expresses an equally prevalent conclusion: "A problem is a problem, no matter what [the workers] think it is, and how serious [they think it is]. And it just seems that there is a lack of genuine concern—a lack of trying to really help with your problem, [instead of] just pushing you through to [get on to] the next person."

Nevertheless, regardless of insurance type, participants contend, co-payment costs are the most important determinants of health care workers' attitudes about the quality of care a patient deserves. The AHCCCS co-payment (\$1), focus group members maintain, accounts for why these patients more often experience adverse health care interactions. In Group 5, Paula declares, "Oh, yeah, 'cause [if you have private insurance, doctors] can charge you!" Focus group participants do not mention differences in how AHCCCS and private insurance companies pay doctors for different services, but, rather, insist that the co-payment signals a difference

between paying and non-paying customers. The higher the co-payment the better the chance of receiving useful information and having a positive health care interaction.

Still, a high co-payment means neither excellent health care nor a lack of adverse interactions. Private insurance plus high co-payment only signal to health workers the relative worth of patients. For health care workers, focus groups members contend, only paying customers are worth the effort required to deliver quality care within systemic constraints. Moreover, health care workers look most favorably on the privately insured patients who pay the highest co-payment, because their jobs depend on these customers. On this equation, participants conclude, interaction quality decreases and negative attitudes increase the lower the co-payment. Consequently, across the focus groups, the women conclude that the AHCCCS co-payment does not buy the respect health care workers grant any privately insured customer.

In Group 2, Irene summarizes the participants' conclusion about co-payments and the complex interplay of factors that adversely influence health care interactions for South Mountain Village and South Phoenix mothers and their children.

Number one, [health care workers presume] that I am ignorant, that [my] child is not ill when [I] bring him there. [Y]ou know, you don't bring him in when he first have a fever; you wait and do whatever to be able to ride it out. ... . I'm giving them the background of what I have done to help my own child. So, by the time I get there, [the doctor is] listening to all of that, and he [is] saying, "There's really nothing ill with your child, so let me talk down to you, get you out here, because I got all these other people in this waiting room, and your problem is less severe." Which I can understand that to the point, but at the same time, I have paid my co-pay to come in here, so don't just throw me, "It's just a virus." At least explain to me what type of virus; give the virus a name. But [do not say], "Just a virus; it's going around. I see it all the time." I am not all those people. I am here now, and paid my co-pay just like everybody else, so treat me as an individual, not as a status quo community person. I didn't come in with a community. I came in here by myself.

## Chapter 3

### Community Strength

➤ **Community Strength**—assets in South Mountain and South Phoenix neighborhoods that promote healthy outcomes for mothers and babies.

#### I. **“I didn’t come in here with a community”: Refusing to Be the Forest of Stereotypes**

On the emotional condition that African American patients bring to health care interactions, focus group participants agree with Elena, who declares, “Life is a hustle and a hassle,” with residents making decisions when they are emotionally “empty.” Participants also agree with Irene, who says, “[N]o matter what choice you have, regardless of the lowest of your low, whatever it is, wherever you are at [financially and emotionally], you have a choice. It may be one choice, but you have a choice of that choice, [and] whether you take it or not.” Trying to make the best of the available choices for health care, mothers insist that health care workers, as Francine puts it, “[should not] think what [they] think about all of us. Yes, some of us don’t want to see others get ahead. Why? I don’t know.” She goes on to say, “We have to come together, [and] say we wanna help each other, and this is what we need to do to help each other.” Consequently, to improve health care interactions mothers insist health care workers address the problem that brings them to the doctor, rather than treat an example of a forest of negative stereotypes.

Race-group medical demography and family medical histories are additional sources of negative stereotypes that encourage health professionals to see the “status-quo community person,” instead of a patient with a problem. In Group 1, Helen expresses the participants’ shared view of how these profiles adversely influence doctor-patient interactions. “By calling us all one big group—like all African American women are alike—it is judging us all, and it’s creating an image for us that puts up a barrier for [the] physician to give us quality care in the community, really.”

Yet, focus group members disagree on the value of social statistics as indicators of medical and social problems. Generalizing from either statistics to individuals, they agree, encourages unproductive stereotypes. Even so, many of them think that some statistics might provide useful information on the community’s strengths and weaknesses. For example, Helen suggests that gathering statistics on residents’ health care behavior might combat the deliberation scenario’s negative stereotypes suggesting that mothers in the community are generally indifferent to their own and their children’s health care needs. Across the groups, other participants suggest that some social statistics reveal problems the community needs to address.

Thus, in Group 2, Frances responds to the deliberation scenario by suggesting that social and medical statistics reveal community weaknesses.

I would say that statistics would show that we do have the highest rates. And I know this, 'cause [of what] I just went through with my daughter. I'm keenly aware now of what's happening in the high schools. We do have (across the country) one of the highest rates of teen pregnancy, dropouts, blah, blah, blah. So, I know that your heart is telling you [to ask], "How could [the scenario panelists] say that about these people." ... . [T]he statistics show that we're higher than like, New York; we're higher than Los Angeles. We are off the chart, which is exactly what [the deliberation] scenario said. I think that the way that it was read, you know, that people, that women in South Mountain, don't care, da-da-da, that was harsh language.

Hence, focus group participants also agree with Evelyn (G4): "It's [the scenario panelists' view] not, it's not [false]. I can name at least ten of my friends who have been pregnant—seven kids, with seven men—and [they] have sex with different men, without condoms, while they are pregnant. And [they] get high, and do what they choose to do (and drink)." Still, the focus groups attend to how an individual becomes "a statistic." As Brenda (G1) puts it, "The way my life played out, makes me a statistic." Participants do not see their interactions improved by health care workers treating patients as caricatures of social statistics. Therefore, they conclude that while accurately portraying some factors that weaken the community, statistics on African Americans undermine quality care for community patients, because health workers over generalize these and interact with stereotypes.

Mothers enter interactions knowing they must "educate" physicians on how to see *individual* patients, focus group participants say, but they differ on whether physicians are the best workers to educate. Some participants suggest that other health care workers are more open to learning. For example, Irene (G1) explains the need to educate, and why some mothers prefer educating medical and physician assistants.

I educate them. I start telling them, "Yes, I come from a family that has glaucoma. Yes, I come from a family of high blood pressure, but this is what my need is now. Don't tie me into my back history. Yeah, it might have something to do with it. Yes, you can't rule it out, but don't label me just because of what I look like, and what you may think. Don't jump to conclusions." So, I tend to educate [them]. And, another thing I found out in the doctor's office is I see the PAs [physician assistants] and the MAs [medical assistants], because they wanna learn. They wanna get all the information. ... . They are ready to learn, as opposed to doctors; they have already been through school, they know everything. At least they *think* they know everything, so they tend not to *hear* you. Whereas the MAs and PAs take a little more time, a little more effort, to really get to the nature of your problems.

Before mothers try to educate any health care worker, they work at learning to speak health care workers' "lingo."

However, before mothers begin those processes, they counter what they insist are health care workers' presumption of ignorance. That is to say, the stereotypes according to which health care workers conclude it wastes their time to explain what ails African American patients and their children, because as a race they lack the intellectual capacity to understand explanations. Countering this presumption begins with dress, comportment, and speech—petty details, focus group members say, that ought not to be, but are very important determinants of the quality of care they receive.

Thus, in Group 2, Crystal says, “[W]e can all look rundown, when you gotta go [to the doctor ill], but *some of us* [drawn out in a tragic voice making others laugh]. She means that African American patients, who arrive dressed outrageously, speaking in loud voice, and failing to attend to other aspects of “proper” comportment, make matters worse for themselves and, more important, all African American patients. Participants draw on their experiences to support a conclusion that following such displays, health care workers extend adverse attitudes to the next African American patient. Confronted with a few such patients, workers generalize the behavior to stereotype all African American patients. Among health care workers, participants consistently single out front office personnel as the worst offenders. These workers’ “nasty” attitudes set the tone for the facility. Faced, for instance with a receptionist’s entrenched nasty attitudes, mothers say, their best efforts to signal self-respect seldom alter positively the health care interaction when finally they see a health care professional.

In Group 2, Greta voices the prevalent contention that despite the lack of positive influence, African American patients must attend to comportment if they not do want to encourage worse interactions for themselves and future African American patients.

[Y]ou should not be judged, regardless of [how you present yourself], but if you *want* respect, you [must] carry yourself with respect. ... . You carry yourself with the right poise. You walk in there talking loud and [you get no respect]. I have been to the doctor’s office in South Phoenix, and, in all honesty, I am just saying, us, as a community, not putting color in or anything, but they are *loud*. And, you know, you come in with blue hair, and it shouldn’t matter, but sometimes we have to hold ourselves accountable. ... . I mean, as a community, we do have to face it; [given such displays] whose gon’ take [us] seriously?

Ellen agrees with this contention, but reveals participants’ view that given workers’ obdurate stereotyping, patients’ respectability presentations do not control the outcome. However, Greta goes on to note, African Americans holding themselves accountable means not being at fault when workers continue producing and acting on negative stereotypes based on a few cases of bad behavior. The times when a patient is too ill to bother with self-presentation poses a problem for accountability.

It shouldn't go into what you look like to get service. But, as a person, you should always have esteem about the way you look—[and for] whoever is with you, how they look. So, I wouldn't even say that [it's] a cultural issue. I would say it's a personal thing. You should come into the office, no matter what you look like... I'm just saying... so what if I look busted, I'm coming here to get help, so I don't have to look busted no more. But these things happen.

Therefore, it is unrealistic to hold sick mothers and those worried about children's illnesses accountable for self-presentation. Instead, workers are accountable for using poor self-presentation to justify stereotypes, while ignoring lack of proper self-presentation as an effect of a patient's medical distress. In Group 1, Helen expresses this view.

[My daughter's] sick and I'm sick, and I have been up with her all night, and I don't feel like [dressing for respect]. So, I snatch her out the bed, and no, I didn't comb her hair today, 'cause I said, "I'm tired." And, we ran down there, and this is what we look like. We look like a mess, 'cause I feel like a mess. She feels like a mess.

Still, participants agree, complaining about the injustices when one fails to attend to these details does not increase the probability that workers will take one seriously. Instead, they must be ready to manage hurtful words, longer waits, and getting no pertinent information from doctors or health care workers.

Participants insist that being an AHCCCS patient consistently triggers adverse health care interactions that self-presentation does little to moderate. In Group 5, Paula voices the prevalent comment on this issue.

I have to be honest, because sometimes if you are on AHCCCS insurance, a lot of people already have a stereotype of you. [Workers think], "You don't really care about your kids." You just basically trying to get a check." And it's not always like that, you know. There's a lot of hardworking women out there, and basically that's where I come from. If they put a stereotype on you, you don't get as good health care as somebody who might have a higher insurance. I would go in there and I'm pregnant, and I would find out things about my baby later. I'm like, "Why didn't you tell me about this earlier?" Or, I'd be sitting in the office for hours, while people... I was there before... get seen before me. So, in some ways it's kind [of] disrespectful.

Educating and properly comporting themselves does not predict what triggers particular adverse worker responses. Instead, focus group participants say, trial and error is the enduring strategy to ameliorate health care workers' offensive responses. Helen (G1) describes the complex interplay of factors influencing poor quality health care interactions.

[W]hen you come in there, they look at [African Americans] a certain way, like, "Well, they don't know nothing." If you come in there wearing a certain thing or talking a certain way, well that means that you are not educated enough to know what you are talking about. That you don't know enough to say, "Hey, there is something wrong." They're like, "No, there's not. You don't know what you're talking about. I'm the doctor." You don't know what you are talking about, because of the

way you are carrying yourself, and such. And that is *so aggravating!* It so irritating, because, you know, now you feel like you have *got* to speak their language in order for them to *hear you, even a little bit.*

Seeing patients at their worst (or from the patients' perspective, most vulnerable—looking a busted mess), front office personnel offer the most consistent disrespect, with AHCCCS patients as their prime targets. Across the focus groups, participant say the front office undermines quality care by assimilating African American patients to workers' stereotypes of welfare recipients. According to these stereotypes, all welfare recipients are disreputable "freeloaders." Independent comments in Group 1 summarize this conclusion.

The first thing you see when you walk through the door—the office assistant—[this tells] you every time. It tells me every time, if they have a nasty attitude, [because they think], "Serving you is not my job." (Ellen)

[Paraphrasing an office assistant's thought] "I'm gonna be nice, because I am in a good mood today." But, the first person that you are presented to, she usually has the nastiest attitude. (Greta)

[T]hat is such a valid point, because when you are sick, and you're going to the doctor, the last thing you want is somebody with a snotty attitude looking down at you soon as you walk in the door. (Brenda)

While focus group participants usually imply "Caucasian" or "White" office personnel when speaking of snotty, nasty attitudes, they carefully note that such attitudes are not restricted by race. As with other aspects of "candy-coated racism," complex interplays of age, class, and race stereotypes assure that the presence of African American workers does not reduce adverse interactions. Instead, African American office personnel, who try to position themselves as exceptions to negative stereotypes of African Americans, sometimes have nastier attitudes than their co-workers of other races or ethnic identities. Thus, for all health care workers, participants agree with Ester's conclusion, in Group 2: "They need sensitivity training! Go ahead and say it! I mean, seriously [group laughter]." Darlene, speaking of her African American health care co-workers, declares, "They're pompous," and explains that African American workers who were once welfare recipients have the nastiest attitudes.<sup>19</sup> Participants think that these workers' identity and welfare experiences should make them sensitive to difficulties faced by African Americans and low-income patients of other races. However, they agree with Ester's conclusion about the workers' offensive conduct: "[M]akes it even worse! That *actually* makes it even worse!"

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<sup>19</sup> At least one participant in each focus group had worked or currently works for a hospital, clinic, or pharmacy. Several, such as Darlene (G2) works in programs that serve AHCCCS patients. While they often agree with other participants' views, based on their work experiences they sometimes disagree with or qualify these views.

Returning to the co-payment equation, participants attribute poor quality service to how health care workers combine attitudes toward co-payments with stereotypes of welfare recipients as disreputable freeloaders. AHCCCS-insured patients are most adversely affected. In the workers' view, participants contend, such patients (especially young, single mothers) do not deserve professional service, they deserve mistreatment. Group 5's comments reveal how participants explain this combination of adverse influences.

I wouldn't necessarily say [it's] the people on the panel [referring to deliberation scenario]. Probably, it's the people that feel AHCCCS is not paying them. Because, it's the people that [are] working—the nurses that's working in that South Mountain hospital, or wherever—they are like, "Oh, AHCCCS, we ain't getting paid." It's kind [of] how you feel that you are getting pushed aside. (Lois)

'Cause with AHCCCS (I don't know how others do it, but when I had AHCCCS), you don't pay no co-pay. With regular insurance, you pay a co-pay. (Charlotte)

You pay a dollar [with AHCCCS]. What's a dollar? (Multiple overlapping voices)

Okay, a dollar co-pay. But, with my insurance you pay... whatever it is. But with AHCCCS you don't pay co-pay, so I feel they don't care [because] you're not paying them. ... . [I]f you working in customer service, you like, "I gotta be nice to the people who are paying their bill, because that's where I get my paycheck." But, they feel, you got AHCCCS, you just government. (Paula)

Despite attributing some community resource problems to ethnic competition, participants also note that low-income or monolingual Spanish-speaking Mexican American patients experience similar adverse interactions. Darlene recounts secondhand her co-workers' behaviors.

I work at the county hospital. [B]ecause it's [the] County, they already think that these [are] low-class people that can't afford insurance and stuff. Well, this other lady that works with me (I didn't witness [it]) was going to E.R. to get some applications and stuff. She said there was a Mexican guy there (I know they got it like real bad, right now)... and she was saying that he had went (he didn't speak English) to get services [for] a sore throat or something. And the lady was literally cussing him out, without cusswords, saying that he needs to learn English before he come up there. And this is a worker at the hospital telling him this stuff! And then, he's like, you know, telling some other lady in Spanish how bad [the hospital worker] treated him, and this and that. I've seen it a lot where they get on [Mexican Americans]. [B]asically, she was disrespecting him real bad.

In the community, many AHCCCS and other low co-payment patients are African American. Thus, African Americans' visits to pharmacies present the same problems. Greta (G1) had worked at a South Phoenix pharmacy for many years. Although she disagrees when participants generalize biases about co-payment, AHCCCS, and African Americans to all workers, she qualifies her disagreement by noting that it would have been accurate for the pharmacy at which worked had she not confronted her co-workers when she noticed them "blue binning" these patients.

I often had to check the people in the pharmacy. I don't care where, what kind of doctor, I don't care if they are on AHCCCS, we are not gonna put this person in a blue bin because they are all AHCCCS patients. They deserve a certain amount of... [another participant interrupts to reject her view, before Greta continues]. No, no, it's, it's equal. You know, one lady use to come in all the time, and she use to yell at us, "I'm not your paycheck! I'm your patient."

Looking at co-payment, participants say, blinds health care workers to age and class differences among African American female patients; they all become single, low-income, unwed mothers. In Group 2, Ester recounts the kind of experience on which participants' base this conclusion.

[Racism] exists, because, here I am, I'm 30 [and] I went into Scottsdale Medical to have my son. My husband had to [work]... you know, so he's on the way. I get there, the nurse registers me. By that time, my fingers are fat, so the rings are off. I'm like, "*Look, I am just ready!*" And she says to me, "Are you married?"

Frances, who is acquainted with Ester apart from the focus group and knows her class status asks, "She doesn't know that you're blah, blah, blah [naming Ester's public persona]?" Ester replies, "No! No. No. She says, 'Are you married'—first question. And I said, 'Well, not that that's any of your business, but what's the point of the question?'" As the interaction continues, the nurse asks, "Well, is the baby's daddy going to be here when you deliver?" For Ester, and participants generally, the language of the question delivers a typical insult to an African American patient's morality. Outraged by how the nurse asks the question, Frances responds, "Oh, no she *didn't!* Did you say, '*Do you know who I am?*'"

Participants agree that age and racial identity override class status, unless health workers see the African American patient as a "Coleangelou," a term combining Keshia Cole and Maya Angelou to indicate an acclaimed African American woman. Noting this exception, Ester expresses the participants' conclusion about the conflation of African American and lower-class disreputability: "Right, if I was Coleangelou, you would not be treating me like this." Considering the importance that participants place on holding one another accountable for dress and comportment to display self-respect, the moderator asks what happens when they are wearing only a hospital smock. Ester's reply summarizes the typical experience.

I was in the same thing that everybody else [wears], right; the traditional smock that you wear. But, [the nurse] did a couple of things. She made a few assumptions. She looked at my... wedding finger and saw there was no ring on, so she immediately assumed, "Oh, she's not married." I came in by myself and, instead of asking, "Are you expecting your husband?", she immediately assumed, and went to *baby's daddy*. I can't imagine her saying to an Anglo patient, "Is the baby's daddy coming to the delivery?" And, I thought, I mean, I literally demanded another nurse.

When workers use *baby's daddy*, focus group participants agree, it signals a presumption that Black race equals lower-class disreputability. They take the

expression as a veiled or polite version of the offensive question, "Do you know the daddy?"

In Group 2, Ester explains that "[baby's daddy] refers to being unwed and just having another person that has donated sperm." Betina adds, "That dude. That dude," with Ester completing Betina's thought saying, "That dude that knocked you up, basically is what they're saying, without saying it. And I really, I, I came unglued." Frances further explains, "[The dude] means you got multiple partners. You know, them asking you, 'Do you know *who* the daddy is?' means that you are promiscuous." Although some participants use "baby's daddy," they all agree that, to avoid insult, health care worker should use father, spouse, husband, or partner when regulations require them to ask questions.

Ester expresses participants' contention that, if the patient challenges the insult, the worker defends her or his conduct and ignores the patient's medical distress.

Right. Right. Right. With the different situations that exist in the world right now, I could have a female partner. I mean, *you don't know!* So, to make the assumption that, you know, I'm unwed and having a child—and she was, "That's not what I meant." I said, "Oh, it's not [sarcastic disbelief]? But that's what you said. ... I don't have the time to try to figure out what you meant, so you need to go." And she said, "Well, I'm getting upset." I'm like, "Hell, you are. Oh, no, you got to go." And my mom's like, "Please leave the room before she smack you." I mean, I'm in *labor!* [Multiple voices echo, "In labor!"] I don't have time to decipher your prejudices. I don't have the time.

Participants understand that workers are under pressure, work long hours, and see many patients, and their questions may seek routine information. Mothers also know hospital regulations determine how workers ask questions, but hold workers accountable for the assumptions revealed in the language they use.

## **II. "I found out about Ahwatukee": Health Care and the Extended Community**

Trying to obtain better health care, participants extend "community" to include bordering municipalities. In this sense, they speak of South Mountain and South Phoenix as "the community" or "inside the community," and other areas of Phoenix and bordering municipalities as "outside the community." Yet greater travel and time expenditures decrease benefits from this extension. Confronting the same problems, mothers' experiences provide criteria for comparing the consequences of stereotypes in their community with systemic health care delivery practices that produce humiliating and discouraging interactions. Comparing the resources in other communities, they note specific resources that facilities in their community lack.

Mothers use the knowledge they gain to select the best facilities and doctors. Apart from less intense negative stereotyping and “nasty attitudes” among front office personnel, mothers seek in rough order of significance:

- health care workers who listen and answer questions
- opportunities to see a primary care physician or, at least, the same health care professional on successive visits
- short waiting time
- cleanliness
- separate waiting rooms for sick and well-visit patients
- practices designed to serve families
- helpful information on displays in waiting rooms

Where mothers judge an outside facility satisfactory by these criteria, they continue using it. Confronted with unsatisfactory service at an outside facility, they ask for another health care worker. When this request does not improve service, they transfer within the outside community, and if that fails, try another bordering community. If these efforts do not improve service, mothers return to an in-community facility and some cease going to the doctor for themselves or their children.

Focus group participants agree that inside and outside the community, the attitude of front office personnel is a decisive factor, in part, because it signals what to expect from health care workers at the facility. Participants report experiencing less hostility toward African Americans at some facilities in bordering communities. Where hostility prevails, participants contend that front office personnel remain the prime offenders, and they disproportionately target AHCCCS and very young patients. Regardless of co-payment, African American patients who are very young and unmarried, participants say, still face the worst experiences in health care interactions.

Some of the nearest and best facilities in bordering community offer shorter waits, are cleaner, and display more information in waiting rooms. However, even though the nearest facilities have reputations for high-quality expertise, this does not mean increased opportunities to see the same health care professional on successive visits. Patients see different associates, but note that this is not decisive for whether they continue using those facilities. Instead, they consider whether seeing different associates amounts to getting “lost in the system.” When associates

do not listen to patients' reports about previous treatments, they prescribe treatments that have already failed. Repeat visits for the same ailment increase expenditures for co-payments. Thus, focus group participants say that their unsatisfactory health care service, both inside and outside the community, results from having access to too few medical practices designed to care for families.

Speaking of very young children, focus group participants say that a sick child's siblings will soon become ill, requiring another doctor's visit and co-payment. Illness spreads among children in day care as well as during a doctor's visit to which mothers must bring all children, because they do not have baby-sitters. Exposure to illness also increases when facilities do not have separate waiting rooms for sick and well patients. Mothers devise strategies to resolve such problems, participants observe, and look for family-oriented practices that support those strategies inside or outside the community.

For "new arrivals" to South Mountain or South Phoenix, focus group participants report, extending the spatial community begins when they cannot find a community facility that meets their criteria for quality care.<sup>20</sup> Often accustomed to a large African American presence, the new arrivals look first for African American doctors or facilities. Failing to find any or any that meet their expectations, they select an outside facility based on insurer-provided information about facility reputations and specialties, or by trial and error. Catherine, a new arrival in Group 1, describes why and how she made this decision.

I moved out here to Phoenix 12 years ago. Didn't know... anybody and I went to Jesse Owens or that clinic over there... I walked in there, and felt like I have insurance and this is what I'm paying for? It was terrible. I went to the dentist; it was terrible over here. So, I found out about Ahwatukee real quick, and I haven't stopped going to that side of town since. Had I known, though, when I moved here... in South Phoenix there is this good doctor, or that Ahwatukee had this Black doctor, I would have used that resource. I didn't know, and didn't know where to go [to get that information].

Paula (G5) is new to the area. She recounts a variant of this experience at a facility in Phoenix. On the way to the appointment, Paula had a flat tire, and arrived tired, sweaty, and in pain after walking a long distance in over 100-degree heat.

I went to a doctor in Phoenix one time. And, the first time I was there, they looked, and they whispered, and they talked, and they whispered. And I'm like, "*What are they doing?*" I went back [to the front desk], and the lady's like, "They did not want to come in the room. ... . They were scary [afraid of her]. ... . I was tired. I have this headache. I was like, "Somebody help me," you know. [The doctor] finally came in there, and she was like, you know, "Here, you need this" and "I'll write you up a prescription." I was having fibroid problems at the time, and so... I needed a referral,

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<sup>20</sup> "New arrival" refers to time periods from a couple of years to a dozen or so, but generally means an African American who was not born in Arizona.

so I had to go see her. And she just asked me a couple of questions, and finally referred me. And she didn't even go into the details, she just, "Uh-huh, uh-huh, abnormal period. Bye." That was the first time I was at the doctor, and, you know, when you go to the doctor the first time, they ask you a long list of questions. They didn't do that. And they got me [waiting] inside of there, and I had that flat tire outside.

Paula finishes with, "Yeah, it's a 115 [degrees]. I am anemic, I got these fibroids, and they didn't tell me anything." Other participants, sympathetic and with knowing laughter, echo one another, saying, "They showed you the door."

New arrivals and long-term residents report going to bordering communities to shorten waiting time. Greta (G1) provides a typical account of this motive.

In my experience, I reach out of the community for my health care, because I feel like there is a lack of care for the people around here. I don't like long waits. My opinion [is that] I should not to be at the doctor's office for more than an hour. And, if I go to Ahwatukee, or Chandler, or go anywhere [other than a community facility], I am not in there more than an hour. There is no long wait. There is a well [waiting] room and a sick room. When I take my kids to the pediatrician, if they are well (just there to get an immunization or something), I don't want them sitting around a bunch of sick people, and I bring them back two days later, and [have to pay] another \$25 co-pay, because they've gotten sick in the doctor's office.

Yet, all mothers, who have the means and can make the time to travel, look outside the community. Knowing that if everyone tries to escape community problems nothing will change, focus group members report their diligent attempts to manage with local facilities. Combinations of health crises and wasted co-payments override their commitment to using community facilities. Looking outside, some mothers draw on knowledge of bordering communities that they first acquire when moving children or residences for better schools. Although speaking of schools, Glenda (G3) describes the frustration and resentment that participants across the groups report when they leave the community seeking better health care.

[M]y daughter is in Tempe, not because I want her to be. It is because she will gain more knowledge over there versus in South Phoenix. ... . I *drive* her to Tempe. Back and forth, you know. Yeah, unfortunately, I would like her to be in South Phoenix. I grew up in South Phoenix, you know.

None of the focus group participants expects that changing facilities (in or outside the community) will solve all problems. Thus, only if other factors weigh in favor of an outside facility do they continue using that facility or look for another facility in the same bordering community or in a different one. Otherwise, they look for a South Mountain or South Phoenix facility that offers the best service. Paula expresses a typical view about transferring facilities.

I go to Tempe, Mesa, I go far. But, I have private insurance. You go to the same locations. 'Cause I can't get AHCCCS (but I need AHCCCS), I pay all this money out

of my check every two weeks to get this health care. ... . Then, they don't even touch you. They ask you what your symptoms are [and say], "Okay," [and] write you a prescription. And then, I am paying \$30, \$40 for co-pay, then I have to go back, because they misdiagnosed me. I call my insurance carrier and get a new provider. But, I mean, how many [of these providers] are on the Southside?

Many of these factors diminish in importance, the focus groups maintain, if health care workers willingly answer questions to advance a patient's understanding of illnesses. Participants think that patients who are better informed about illnesses, alternative medical treatments, and the side or interactive effects of prescribed medicines, would manage their health care more effectively. They would weigh useful information against racist interactions and other criteria for poor quality service. In Group 3, Fatima's comments capture this view.

It's been said, they have a stereotype on how Black people are in general. And they can just tell you anything, and when you get to asking more questions, then like, you become a threat to them. Because I have been everywhere... to Scottsdale... to Chandler. I've been to different facilities, and they really just want to give you the quickest answers and get you out [of] there. So, that's all I felt. I really haven't been, per se, to any of the hospitals in this area, because I feel they are very poor anyway. When I go into a place, I look for cleanliness and, if that place is not that clean, I don't wanna be serviced there. So, I would... just find them not suitable for me to go in, because of my expectations of a facility. [The] cleanest one I've found around this area would be Good Samaritan, and that's not that up to par. But I go there and I'm given information, and I think Good Samaritan is a good facility to go to. Whenever I go, I get accurate information... I feel I need to get me to the next level.

Elena (G3), facing a crisis with her 21-month-old twins and unable to manage with community facilities, transferred to a facility in a bordering community, only to return to a community facility. She explains: "I... took my kids out of the community—my babies—to Mesa Pediatrics. ... . I think the doctors there are very good and very smart. But it's a big practice, and they have these policies that don't support families of sick children."

Other participants begin using bordering community facilities to get better adult health care, but learn about systemic factors that affect child health care. In Group 1, Ellen highlights these systemic practices.

I haven't been through it with my daughter, because my daughter is only 11 months. But, I been through it with myself, because I go to the doctor a lot, because there is always something wrong. I don't go as soon as something happens to me. I wait to ride it out; to see [if] maybe it will go away. Most of the time, I am just in pain. ... . I know something ain't right. And, I am going to my doctor, and I'm like, "Can you *please* check this out?" And they telling me, "Well, it's not anything, really, just take this, just take that, go home and lay down." [She responds], "I've laid down. I've tried that. Now, I need you to tell me what is wrong with me." So, I have to switch doctors, like, all the time. And, I finally get to a doctor who sits down and listens to me, [but] she's so far away. ... . [Y]ou have to go out [of] the, the urban community

and go somewhere else to get the attention you need. Because I'm going to my doctor, and most of the time he can't even see me. I'm seeing another doctor. I'm seeing a nurse or something, and I want to see *my doctor*.

Despite complaints about health care workers' presumption of "African American ignorance," participants in each focus group blame African American ignorance for the problems that Ellen describes. African Americans do not get to see primary care physicians, these participants argue, because they try to make last-minute appointments at their own convenience. African Americans go to the wrong kind of doctor, the same participants add, because they do not bother to learn about medical specialties, and do not schedule annual exams to monitor their health. Greta levels this charge in Group 1, claiming that South Mountain residents do not use information about hot lines and triage nurses that insurance providers supply.

Other participants challenge these charges. Agreeing that because the charges are accurate for some African Americans does not explain why other African Americans, who make timely appointments, rarely see primary care physicians or the same health workers on successive visits. These participants also counter the charge about annual examinations, noting that, even for this purpose, African American patients seldom see a primary care physician. Thus, the dissenting participants do not argue that patients should always expect to see primary care physicians, but should be able to make an appointment rather than *always* seeing another health care professional. Consequently, the underlying problem is seeing different health care professionals on successive visits, if it means starting over, because the next worker simply ignores information, and takes persistent questioning as patient hostility.

Elena (G3) voices the typical response for giving up on outside facilities: "I'm driving from 35<sup>th</sup> and Baseline all the way to Mesa for *that*. So, finally, I changed the doctor, and said, "I can't deal with this." Thus, Elena returned to a facility in the community, like Fatima, who tried facilities in Scottsdale and Chandler before Good Samaritan. Whether mothers return to community or continue with an outside facility, some may restrict visits to crisis treatment or cease using health care.

When mothers return to a community facility, they bring knowledge acquired from outside experiences. This knowledge, focus group participants report, helps in selecting the best facility or doctor the community offers. To choose the best, other criteria notwithstanding, mothers look for facilities that reduce co-payment costs resulting from ineffective repeat visits for an ailment. Whether for themselves or their children, mothers prefer family-oriented practices. Elena describes her choice after transferring from Mesa Pediatrics.

I'm back in the community. Although I have not seen Doctor [names primary care physician] yet, every time I go, I see the same woman. ... . In fact, week before last, we went twice in the week. She saw one of my kids; they'd had ear infections. The second time we went back, they had this awful cough that would keep them up at

night. But she remembered, she recalled them. We didn't get lost in the system. So that was nice. ... . The other thing is, for me, my co-pays. ... . To go to Emergency, it is a \$100 co-pay. ... . I spent \$300 last month in co-pays, and don't have it to spend. So, the last time we went to the doctor, I just took the sickest one.

Across the focus groups, to cut co-payment expenses, participants report making an appointment for the sickest child, but asking the doctor to see another child during that visit. In Group 1, Irene further describes the influence of co-payment expenses on facility selection.

The co-pay, I really don't understand. Mine's not \$25. It's \$10, but I have children that are younger, so there is a separate room in the doctor's office. So, I chose the higher premium, so I would have the lesser co-pay. But, if I go to see the doctor on Monday, and he says bring them back on Wednesday or Thursday, why I am I paying another co-pay? ... . That's so irritating... and grating, because you already know you have a sick child, and you go before the doctor, [who] says, "It's really not sick, really [it's] a virus and there is nothing you can do, but just make him feel comfortable." Well, I came to you, if I hadn't done all that at home, we wouldn't be here in the first place.

Mothers who wait out a crisis first exhaust knowledge and advice they get from family and friends. Faced with ineffective expensive visits, others do not take children to the doctor. Again, Irene states the typical rationale first for delaying visits until after a crisis, then stopping visits: "So, I think that is something that has shielded me away. Now, I tend to let their illnesses go. I don't go to see the doctor, to pay a co-pay, so I can be talked down to." Most mothers continue looking for a cooperative family-oriented facility where health care workers provide the information needed to "get to the next level."

Some community facilities readily cooperate with mothers' strategies whereas outside facilities do not. Elena, speaking of her current community facility, explains: "I had an appointment for the sickest one. And... [the doctor] said, 'While you are here, do you want me to look at your other one?' I don't think they would have ever done that at Mesa Pediatrics." Therefore, Elena concludes, "So, here is an example where I feel more supported [in the community], 'cause I was seeing money go out that I don't have, and I have to pay light bills and house note and, you know." In Group 3, Beatrice paraphrases the common view of health care workers who refuse to cooperate: "'We don't have his chart. You didn't check him in.'"

Nonetheless, overall, participants agree that, as a consequence of health care workers' negative stereotypes (not restricted by race or ethnic identity), the quality of health care experiences for African Americans varies little inside and outside the community. Hence, they agree with Fatima's summary statement, "[I]t all, like, depends on the expectation... you would have of the persons giving you the information and servicing you."

### III. “There is no community”: Networking to Share Health Care Information

Asked about community of South Mountain or South Phoenix, participants across the focus groups first respond that it has no strengths. Within the zone or collection of neighborhoods, they contend, patterns of interactions do not constitute a community. Participants, new to and natives of Arizona, Phoenix or South Mountain, find locating the “Black” community difficult. Based on their experiences in African American communities in other states, some new arrivals insist that there is no African American community. First, these participants see the problem as a lack of gathering places in the area. There are no facilities or open spaces where residents regularly gather to share information through casual conversations. Second, this absence hinders meetings among African American residents to share information about health care and social services.

Elena (G3) pinpoints a new-arrival’s perspective.

I think part of the problem here... that I see in South Mountain, Phoenix is that there is no community. There is no community area. Where I used to live (before we moved here), in Portland, [OR], there were bookstores, and places people gathered. ... . And people got to know each other. So, I’m at the bookstore, and someone else comes in and say, “Hey, how you doing?” I could talk to them. And it’s like, you know things, and [pointing to women around the table] *you* know things, *you* know things, but I don’t know these women. I don’t never see them.

Both natives and new-arrivals see the space and place problems as reflections of the ethnic and racial demographics of Phoenix, in particular, and Arizona, in general. When referring to this demography and its consequences, focus group participants contrast Arizona with locations in Southern states, or “down South” as a region. In Group 5, Margaret expresses the typical contrast, saying, “Black people here are very limited [few]. When you go back down South or something, they’re everywhere.” Multiple voices agree, “Yeah!”

Therefore, focus group participants emphasize three factors about community strength. First, the small demographic presence of African Americans explains the lack of voting-block strength needed to elect racially representative officials to “back up” individual efforts. Second, Arizona African Americans, scattered as well as having small numbers, do not develop a political “tradition” of coming together to solve community problems through joint action. Third, these conditions place Arizona’s African Americans at a disadvantage in competition for scarce and dwindling resources with a rapidly growing population of other race or ethnic groups that find housing in once predominantly African American space. Margaret (G5) gives an overview of how these factors influence finding, sharing, and using available resources: “Even though we get more food stamps than [African Americans in the South] do, we do get treated worse [here] because we don’t have

nobody to back us up. ... . [D]own there... they have government that's Black or Mexican or whatever, [but] we don't have that."

On the first issue, Fern (G5) contrasts Arizona and "down South" locations: "[M]y sister is in Atlanta, Georgia. And she thinks the difference with people down here [in South Mountain or South Phoenix is] we know a lot of stuff, and we could [do] this, and we could do that, [but] we don't come together, like down South." Fern continues: "[African American residents] don't understand it takes more than one person. They say [in general political rhetoric] you can voice this or that, but you need a group... to actually get it enforced. Come together and this, this, and that."

Nonetheless, across the groups, participants suggest there are many organizations working "behind the scenes" to improve community resources. Edna (G5) most clearly expresses this conclusion about the role of these organizations in sharing resources.

There is so many [organizations]. You can't belong to so many. There is all kinds of advocates out there, working behind the scenes. And, you don't know, 'til someone puts a flyer up that they exist. And you go for that one benefit, get it, and leave, and not know all the work it took for you to get it. ... . It's not sustained.

Hence, when the moderator asks if participants belong to organizations or regularly take part in any, most answer, "No." The participants stress the importance of networking. Yet, when asked how many were part of a network, the highest show of hands in any group was less than ten percent of the group. As Edna explains, working residents cannot spare time from childcare and other family obligations. Thus, Fern asks, "How many of them [organization activities] happen after seven? I have to go to work."

As Fern's comment suggests, participants see the problem as organizations sponsoring one-time or annual events. If residents receive information in time to attend an event, often the activities offer too little information on African American businesses and social services. Where there is an attendance fee, some low-income or unemployed residents cannot afford it. For other events, the same residents may not attend, expecting to be embarrassed because they cannot afford sale items.

In Group 3, Alexis speaks to the advertising problem.

They use to have like a big ole party-type thing. ... . They invite the whole community, but most of the time kids will go. ... . If you have people, who would walk throughout the community, who pass out flyers, there's gonna be people that attend.

Beatrice comments on the problems of a one-time (possibly annual) event, with high attendance fees and costly sale items. "[T]hese were things... for Black women.

[Y]ou can network, you can go find different [information or resources]. You can learn about Black-owned businesses.” However, she goes on to explain, “But, you know, number one, it was an expensive event to go to, but, once you got there, you wanted to buy some of the stuff [but some cannot afford it].” Participants across the groups agree that there are opportunities to gather if a Christmas Bazaar (once sponsored, they think, by the Black Women’s Task Force) or Martin Luther King, Jr. Day and Juneteenth celebrations actually take place.

South Mountain and South Phoenix residents, participants say, find these events divisive more often than not, because status cliques make the events unpleasant for some, thus discouraging future attendance. For Group 3, Glenda expresses this view, shared across the groups, and contrasts Arizona unfavorably with “Down South.”

I do attend those activities. I notice there are cliques... , [even though] we are suppose to get together... and communicate. ... . It’s not that [way] here in Arizona. My parents are from Tennessee. Down South, you had *no* choice but to be together. You know what I mean? Here, it’s *totally* different.

During gatherings, invidious status jockeying undermines sharing information. Glenda explains, “[A]s African American people, we need to actually get together and share information, but, unfortunately, we’re looking... at what we are driving, at what we are wearing, and how we are looking.” Alexis interjects, “And, how many children you got.” Glenda agrees, “And, how many children you got, and all that.” Elena once again adds a new-arrival’s perspective, saying, “We are not together. I felt so isolated, so isolated.”

In Group 1, Anna summarizes obstacles to joint action that participants see other racial and ethnic groups overcoming.

First, we have to come together, ah, make a plan, make a goal, and we go to the councilmen. It’s something we have to do. The Hispanic community, they have all kind [of] flyers, telling you about what’s going on. And sometimes, what I found out about, I learned through the Hispanic community.

New arrivals point out that the first obstacle to overcome is African Americans’ failure to acknowledge one another, even in passing, in South Mountain or South Phoenix. In social spaces outside the community and in workplaces, some African Americans also spurn one another’s greetings. Edna (G5) describes general views of this experience: “We don’t even speak to each other here. We have to start speaking to one another first. You make eye contact, the Black girl look away, but she will talk to the White girl!” Regarding the workplace experience, Paula notes: “People on my job do that! Put their head down when they see you, [you say,] “Hi,” and [they don’t answer, because] they don’t want nobody to know they speak to someone who is Black.” Agreeing, Lois, a new-arrival in the same group, says, “This

is truth. When I first came from California, I felt like a speck in a cotton boll. When I would see somebody Black, they would hurry and put their head down.”

Thus, the inability to meet and informally share information with other African American residents influences how both new and long-term residents search for health care and social service resources. As previously noted, Catherine (G1), also a new arrival, looked for a “good doctor” or a Black doctor in the community, but did not know how to get the information. Selecting a facility or doctor based on race, the focus groups recognize, is no less racist than facilities and doctors refusing or treating patients differently for that reason. Given contrary evidence, they do not assume that African American doctors will be more sensitive to African American patients. Instead, participants stress, the absence of doctors diminishes the total pool of resources available in a poor community.

Consequently, while chiding African Americans for their ignorance of medical specialties, Greta (G1) notes how pleased she was to have “stumbled across a sister,” who specialized in internal medicine. Greta explains the medical value of this encounter and the community’s loss when physicians, whatever their identity, go elsewhere to practice their specialties.

I stumbled across a sister, who was an internal medicine doctor, and she ended up being... a hospitalist. She said, “This is really *not where I wanna be*,” but we had her for about two years, and she educated me on *so many things* that other people couldn’t tell me. And she wasn’t in the, the South Phoenix community. She was right outside, in Ahwatukee, but she said, especially for us women... adult women, I should say, an internal medicine doctor is better, because they actually delve into your family history. They want to know more and more details. They wanna paint a bigger picture than, “Oh, she is just walking in with a cough today. She’s just here for a pap smear.” They wanna know if your mother had cancer, if your grandmother’s mother [did]. They wanna know—go into all of these things. And that stuff, I didn’t get from this community. ... . I had to reach out somewhere else and get [it].

Among long-time residents who know one another, sharing information is also difficult. Status competition among residents encourages hoarding rather than sharing information, because, participants say, those who share resources fear that doing so will allow others to advance and, once better off than them, flaunt the achieved status. Evidence of formal education, such as “educated” speech and “middle-class” styles of dress or comportment, signals flaunted achievements. The same mind-set that judges some facilities as White also labels evidence of these achievements as acting or trying to be White. Participants say that this mind-set limits options for self-development, discourages using some services, and undermines cooperation in joint action.

In Group 3, when Elena suggests introducing new gathering places, participants explain the expected mind-set response.

[I]t could be a few places, but just places people could just relax. You know what I mean. And you could go any time. Event, you go when the event is happening, but, if it's a bookstore, [you] say, "I think I will go up; I see they are having a poetry reading, or see they are having a little book reading, or some author [is visiting]."

Beatrice interjects: "But, you know what? The mind-set would [conclude that] you [are] trying to be White. They'd say, 'You [are] not Black.'" When Elena expresses disbelief that a bookstore could provoke this response, Beatrice continues, "I am not disagreeing with you [about the value of a bookstore], but I'm saying [that is what some will say]." In this and other focus groups, participants explain that activities of the type Elena describes once existed in South Mountain or South Phoenix. However, when the activities have been absent for a long time, residents of this mind-set judge them, if not solely culturally White, then not culturally Black. Therefore, participants contend, the mind-set also limits using some existing facilities because they are White or outside the community, and this also makes it difficult to introduce Black-operated facilities to the community.

Even if such facilities are Black-owned but not in the community, their use is questionable. The moderator asks, "How far outside of South Mountain do you think people would go to hang out in a bookstore like that?" Fatima (G3) provides the prevalent response for all focus groups: "Not far." The participants also agree with Elena's conclusion: "It would, I think it would need to be in the community." Fatima is more emphatic: "[I]t would have to be *in* the community." Thus, to make changes, participants say they face a double bind. If the gathering place is not in the community, residents will not use it, but introducing it in the community will meet resistance because it does not *belong* in a Black community. Ruling places and types of conduct out of African American cultural bounds, according to participants, combines with other factors that leave individuals to solve problems without joint action.

Where culturally proscribed services exist in the community, the same mind-set can discourage using them. During Group 3's discussion, Elena, deeply stressed by problems she had raising a family that "ran the gamut" (a 21-year-old son, and 21-month-old twins), reports that she found helpful mental care service at a women's center in downtown Phoenix. An unidentified speaker quickly tells her, "People see that as acting White." She meant seeking assistance from a White-sponsored mental care service and the African American cultural proscription of counseling or psychotherapy. In Group 2, an exchange between Ester and Betina explains the mental health service proscription.

What she's talking about is the one thing that I think really affects me as a young parent, because I'm big into like, mental health, and just putting it out on the table. And, there's such a huge stigma around [using psychotherapy]. Like, you know, [saying], "I don't *tell* nobody about my business; ain't gonna put it out in the *street*. My kid ain't *crazy*." I have a sister now, that has two children... that are 11 and soon

to be six. And they are having some *serious, serious* problems, you know. I'm always solution driven. Let's try and take them there and talk to somebody. "Oh no, *unh-unh, no, we* don't put our business out on the street like that!" (Ester)

Uh-huh. Yeah. Black folks don't receive counseling. (Betina)

You know! "We'll... we'll work it out." And, I always tell [my sister] that when this child turns 16 or 17, she's gon' hate you. (Ester)

Certain behaviors thus become indicators of persons acting or trying to "pass" culturally for White or another racial group.

Betina and Frances continue, revealing the combined influence of intraracial and interracial presumptions that set race-based boundaries for cultural conduct. Speaking from an intraracial perspective, Betina says, "By leaving California and moving here, and I mean, getting an education... I sound like a White woman, you know." Speaking from an interracial perspective, Frances responds, "You don't mean 'White woman,' you mean 'articulate.'" Betina stresses that she speaks not of the behavior, but of African Americans of an intraracial mind-set who interpret educated speech as White: "No, but, to them, they call it White." Referring to both interracial and intraracial mind-sets, multiple voices agree that Betina "sounds like a White woman." Frances, who remains focused on the interracial mind-set, concludes, "Just because I have command of the King's English, doesn't mean I'm talking like a White woman." Overall, the focus groups agree that to be called "articulate" is an interracial euphemism that signals an exception to the negative stereotype of Black linguistic competence. By either mind-set, Betina notes, "[They] say my son and my daughters [are] acting White or 'uppity,' you know. But, it's not that, you know. When we get [an] education, your vocabulary changes."

The mind-sets pose different problems for the meaning of community. However, participants stress the mind-set collusions that influence all aspects of community life, especially joint action. Adults and children who display certain self-development behaviors find themselves accused intraracially of flaunting their achievements, and interracially of being arrogant, aggressive, or, the old standby, "uppity." In general, these mind-set limits combine with scarce resources to set conditions that shape how residents make choices and judge choices that others make. The limits narrow options for racially acceptable status criteria, encouraging emphases on sexuality and reproductive competition.

Focus group participants also emphasize how the collusion of intraracial and interracial mind-sets limits mothers' ability to promote patterns of conduct that build children's self-esteem. Participants address this issue most consistently and intensely as a problem that hampers parents' efforts to reduce children's susceptibility to media-driven images of sexiness as the measure of self-worth in peer status competition. Media messages affect very young children most immediately and intensively. However, their negative impact is broader and long term, focus group

participants insist, because it extends into adulthood. Persons influenced by these messages see achieving status as “living the exception,” which means they prefer glamorous activities with “get rich quick” potential to other ways of making a living.

Mothers, focus group participants maintain, must continually expend energy challenging this collusion. Intraracially, challenges create difficulty for mothers in interactions with African American health care workers, who see speech, dress, and comportment as putting on airs. In interactions with White health care workers, mothers must defend against those who see challenges as uppity or arrogant, and assimilate them to stereotypes that make persistent questioning a threat to the workers’ safety. Challenging the collusions, mothers hold one another accountable for behavior that signals self-respect, but find that the behaviors do not signal for White health care workers that African American patients deserve respect and, with it, the best service given systemic constraints. Therefore, participants describe situations that show how the collusion of mind-sets adds to the complex interplay of age, race (as color), and lower class status as elements of a disreputable African American identity. The interplay of factors sets conditions, participants contend, that discourage mothers, especially very young mothers, from using health care and social services.

As focus group participants discuss these issues, one glimpses other behaviors that may signal invidious intraracial distinctions that discourage coming together for joint action. When describing negative patterns of conduct among residents that weaken the community, for example, the speaker most often uses language that excludes her from the negative stereotypes of African Americans. The speaker negatively characterizes other residents’ behaviors and their consequences for community dynamics. Invariably, other speakers challenge the claim of exceptionality. Focus group exchanges therefore qualify and explain the negative characterizations. Most qualifications address differences between attributions of African American cultural patterns, the complex interplay of biases, and the consequences of long-term resource scarcity.

In Group 1, Ellen’s comment typifies a frequently voiced negative characterization of African American cultural conduct.

A lot of time, I would say—the African American community—we don’t even go out to search for resources. We just want them to come to us, [want persons from other races to say], “Oh, let me tell you about this.” And that’s not the case, I mean, there is a lot of things [available, but no one is going to bring them to you]. For instance, I never knew about equity residence, and just like you rent an apartment and a certain portion of your rent goes toward a down payment on a house.

Based on this characterization, Ellen describes responses to the exceptional person.

[I]t’s so funny. When you regurgitate this information to other African Americans, sometimes they look at you like, “Why you giving me this information?” Well, okay,

I'm giving you this information, just to help you out. But this—our, our community—we don't wanna see one another succeed. Right? Like other communities, like other races, would, you know. [Instead, if we try to help someone to] get up, [they] always think we gonna belittle, you know, [thinking] I'm telling you this so I can sound good. That's not the case. So, we need to get out of that as a whole; help each other. If you got some information, get out and help each other, "Hey girl, such and such," or whatever you know to say. So, what Kesha [the know-it-all character in the refusal scenario] is saying is that Karla and [everyone] had the same resources available to them. ... . It's gotta be knowledge, and you always have to have somebody. I think everybody should have somebody that they should be able to come to, and be comfortable with. ... . Everybody needs that, and it may not be your parents, but you can reach out there and find somebody who can help.

Others hear in Ellen's language the presumption of exceptionality that implies that she is flaunting achievements. In Group 3, Glenda's language more pointedly reveals the put down that all focus group participants hear.

That, that hits home a lot. You know, because I have a lot of friends who lack information about what is going on the community. Because I decided to further my education, and I know what is out there, and I try to give them information they need to help themselves, and they look across—they do say those terms [flaunting and know-it-all]. Yes, yes, it's very hurtful. And they don't see past [that] thinking, they limit themselves, like for the information they really, truly need.

And, later on, they come and I say, "Are you going to listen? 'Cause I am saying it from the heart, you know. I don't think I know it all, and all this stuff, because I was right there where you were. I am not *too* far from that." So, yeah, you do get a lot of feedback. And you stop talking... unless they come to you. The people have to come to you, because when you go to them, they like, "I don't wanna hear it. You Miss High Ditty," whatever. So, "Yeah, fine bye!" You know. It's very hurtful. And... I notice, in South Mountain, we're not together. African American people... we're biases, we're envious, we're jealous. It's ridiculous!

Speaking to a person who is seeking help, as if that person were a recalcitrant child, focus group participants say, does little either to offset reactions that the speaker finds hurtful or to encourage others to come to her for information. Thus, Glenda's inclusion of "not *too* far from that" signals an invidious distinction and status comparison. Although a person may voice such comments to play down differences and indicate good intentions, "speaking from the heart," listeners hear the paternalistic tone as an adult chiding a recalcitrant child. Thus, in Group 5, Alma agrees that hurtful responses occur. Yet, she insists that the persons sharing information must always consider the low energy and fragile mental states of those who need help finding resources.

Resources are limited, and I think people have limited time. I think people have limited energy. Everybody is dealing with something. I mean, you have to *really* care about the other person to, to stick with 'um, and help out. I mean it takes, it takes a lot.

Consequently, in each focus group, when generalizations begin to verge on stereotyping, participants challenge one another. The challengers qualify negative characterizations by attending to complex causal factors in community dynamics. These exchanges sharpen participants' explanations of how scarce resources influence individual efforts to find and use health care and social service.

Alexis criticizes culturally inappropriate media advertisements with useless information to qualify statements about African American passivity—the most prevalent negative characterization of the community. She thus counters the charge that African Americans merely wait for members of other races to deliver resources.

[I]f you do look for the information... they play all kinds of commercials about teen pregnancies—but, they're not... actually gittin' down to the root of the problem [as it exists in the community]. Now, they'll show a girl at a party and, then, she turn up pregnant. At the end of the commercial, all you see is her standing... with a big belly, and the dude's not there. They need to have some kind of classes; some kind of sexual education class. Have people who've had experience with early teen pregnancy... come up there and speak from their *own* experiences. And, *maybe, even give a visual* to the... young children, 'cause otherwise they would not know [any more than they did before the commercial].

Francine (G1) adds another factor—demoralization that results from comparing resources in South Mountain or South Phoenix with those in other communities.

I was helping my daughter out. My daughter was in the Roosevelt School District. And, they was always in a budget crunch. I mean was... always having to recycle paper, to make it last throughout the week. I was looking at Scottsdale and Gilbert, and I was looking at Mesa, at, you know, other areas, where their money was just flying high. And I was like, "What can we do?" First of all, I think we have to pull together... to try to come out with a plan to... help the mothers that are struggling from paycheck to paycheck. We ought [to help] others that are not at home with young kids. You know, some kids come from families where they don't have the resources that tells them to take a shower, take care of yourself. ... . [So] in the end, the panel [in the deliberation scenario is] looking [at the situation] like that is the whole, like it's everybody. But, there are kids in the Roosevelt School District, where they come home to nobody. They get knocked up, the mother's on drugs, so they don't have anybody. ... . [W]e were finding these kids clothes and things, and helping them any way we can.

Comparing community resources, Catherine insists that lack of adequate resources, not passivity, is the root cause of both low individual initiative and inadequate self-help programs.

I think it requires some kind of revenue to come in, from where, I don't know—maybe, the state, the government can give communities assistance via the church. I know a lot of people willing to do it, but, you know, you need funds to put flyers out there. You need money to, to do outreach to children, you know, with no support from the fathers... and so on. So first off, I think there needs to be some kind [of] funding available.

To summarize, while focus group participants see jealousy, envy, and other negative consequences of individualistic status competition, these are not root causes that operate independently of adverse factors stemming from long-term and current resource scarcity. Under these conditions, many individuals no longer see options for self-development. Ellen (G1) explains that the most demoralized, merely existing, do not see that changing options apply to them.

I think it also is, we get comfortable, and in a state where we are just existing. And when you are just existing, and [others are coming out]... with different things... some [demoralized] people, they are not trying to go here and on [to] there. It's like sometimes when you go the library... you're... the only person of color... in the library. And there's a lot of resources in the library—reading materials and, for instance, they have the Internet—where you can get information.

In simplest terms, apparent passivity actually reflects the lack of time that working parents have to search for resources that deliberately or unintentionally, are poorly advertised. Again, Ellen succinctly states both the negative characterization and the positive qualification.

We have to go out and get the resources, because the resources won't always be there for us to see, or people are not always gonna tell you 'cause some of them don't want you see, or whatever reasons. But one of the things that outside the Black community, what people say about us, is that the best way to keep information from a Black person is put it in a book, because they will never look for it.

The comment about African Americans and books notwithstanding, focus group participants say they find in libraries few resources to assist parents to counter negative media influences, and negative stereotypes of African Americans. Comparing past and present curricula, participants agree that schools have progressively provided less knowledge of African American role models in US history. Ignorance of history promotes passivity. Commenting on present-day children's ignorance of African American leaders, Alexis (G3) contends, "A lot of people are starting not to go to Martin Luther King [celebrations] because they don't know [about him or the Civil Rights Movement]." She contrasts what she learned to what her children learn about the Civil Rights Movement and King's role in it.

I mean... I use to, like, write reports on him. ... 'Cause, I know, I had my kids going to Cordova and, ah, I think they were just bringing home pamphlets of who people were. But I don't think they were getting the knowledge they needed. They probably got more knowledge on President Bush or any of the Presidents than they did on African American leaders.

Across the groups, when the moderator asked if parents teach children about the Movement and its leaders, multiple voices reply, "Definitely," and other words of affirmation. Few agree with Alexis who suggests that, like her, some parents lack skills and patience for teaching her children what schools neglect. Instead, participants insist that African American parents must take primary responsibility for

this task. Disdain in American society for African Americans, they conclude, makes it unacceptable for parents to expect schools or any American institution to build their children's self-esteem. Arizona than "Down South," participants say, offering fewer resources to help parents build children's self-esteem. For participants who have computers, the Internet opens a world of possibilities. Young mothers without personal computers, participants suggest, must use computers in the library. In both cases, mothers must monitor children's use of computers to guard against them becoming another source of "candy-coated racism."

For the youngest mothers, raising several young children, all these matters are more difficult. Participants consider this difficulty when speaking of these mothers' conduct, agreeing with Brenda (G1), who concludes, "[I]t goes back to education. I'm not blaming them, because they really don't know better." Therefore, when Greta states, "They haven't gotten an education... young mother[s]," participants understand her to mean both formal and "cultural" education. Speaking of the youngest mothers (ages 11 to 15), for instance, Helen (G1) expresses what this lack of education means for a young mother's plans about pregnancy, and subsequent decisions about using health care and other social services.

[The deliberation scenario panelists] may think there is no planning because you [as a young mother] don't know what to do next. And, you know, having a baby is not like writing your name. It's a little bit more complicated and, so, just because you don't see the planning, you don't see that they have resources. And [because] they don't know what to do, it's easy to assume [they do not plan]. But, some people do plan in spite of their culture; start early to plan. And that's when you should make presentations and discussions after talking to people, not just assume, here is a trend and this is what I am going to run with.

Understanding community dynamics informs the focus group participants' view of individual behavior, and of what residents must do to produce the vision, which, they say, the community lacks. In Group 3, Fatima sums up the participants' contention: "I think... our community does not have a vision. Black women do not... and Black men, too. They're hanging out on street corners. They don't really have a vision." Like Fredricka, participants say without a vision for the community, the individual lacks "a focus." Fatima's additional remark captures the outcome—a turn to sexuality as the measure of self-worth.

[There is no focus] for life and, so, we turn to our sexuality to say, you know, this is what validates me in the community. So, you can say, all daylong, "Well, you need to keep you legs closed, you need to this, need to that, but other peoples [races and ethnic groups] have sexual relationships, and their sexual thing, but it's like these people [in the South Mountain, South Phoenix areas] are turning to their sexuality to make them somebody in the community. You know, so it's really hard.

Negative behaviors made visible by this turn, as Elena puts it, encourage outsiders to have "very [low] expectations... of Black peoples." When the Moderator asks Group 3 to whom they refer (e.g., politicians, health care workers, etc.), Alexis

quickly answers, "By our own people." Across the groups, participants agree, African Americans (locally and generally) share outsiders' low expectations for any African American community. In Group 3, Fatima replying simultaneously with Alexis, says, "All of the above." On the interplay of cause and effect that brings together Alexis and Fatima's comments, Dianna explains that those who "hold the purse strings" expect "so little... so, little [is] put here [in South Mountain and South Phoenix]." Thus, the focus groups see a parallel between health care workers who consider it a waste of time to answer African American patients' questions, and government officials for whom low expectations mean wasting public funds giving more to a community whose residents are incapable of using them.

Comments on the community's lack of vision and focus were both absolute and comparative. In the absolute, a community needs a vision to help individuals focus on how to develop their lives. However, viewed comparatively "in reality," that vision must include strategies for effectively competing with other ethnic and racial groups. Dianna, referring to impact of competition concludes, "I think we woke up one day, and, ah, the community was Hispanic. So, when you go to different health care facilities, there are Hispanics or Spanish-speaking people at the front desk, at the WIC office. I have run into so much friction, as far as health care [goes] here in South Phoenix, to where [now] I have to pick and choose where I go." Karen (G4) bluntly attributes the competitive imbalance to government policies that promote interethnic competition for scarce resources, but favor community funding that addresses new immigrants' needs.

It's evident. It's those coming in across the border. I'm gonna tell it like it is. It is the government. It ain't got nothing to with us not putting issues on ourselves. Yes, we do it to ourselves. But, what about those [African Americans who are] raised right, who are doing right, according to what the government [requires]? They are doing the most, and they are of the minority race. It's not really about race no more; it's about the government not giving a damn about those of us who were here first.

In all focus groups, participants express versions of Karen's view. It is consistent with their contention that the growing population of new immigrants poses a special problem. Nonetheless, participants strongly agree that African Americans could compete better if their self-help organizations had more resources. Again, participants see a double bind—to get more resources one must raise outsiders' and African Americans' expectations for the community. To the extent that effective self-help organizations provide evidence of a group's expectations for its community, African American residents must do more to help the self-help organizations, because their staffs are overwhelmed and operating with too few resources. However, working parents have little time to attend events and still less for sustained involvement. Fatima and Alexis summarize the basic problem: "[W]hen we talk about [self-help organizations], I think about *Chicanos por La Causa*, all that, you know, [and] I am sure *we..* have something." Alexis counters, "Black family health service or something like that, but they don't do anything." Others

disagree that the many organizations working behind the scenes do nothing, arguing instead that they are ineffective because staffing and resources are inadequate for the large and complexly needy populations they serve. In addition, focus group members stress the negative consequences of poor and inappropriate advertisements for all services.

Moreover, seeing the spatial community as composed of many distinct race or ethnic communities, participants adopt a zero-sum view of resource distribution. Resources that residents of other groups share and use are not available to the African American community. For example, funds and personnel devoted to assisting non-English speakers are resources diverted from, not added to, “the community” pool. Hence, Carine (G3) begins with an implicit zero-sum assumption as she describes her unsatisfactory health care interactions.

[W]hen I had my first daughter, I had a private practice doctor. I was really happy with the doctor. I had [my daughter] successfully, and she is healthy now. I just moved over here [to South Phoenix] about a year and a half ago. I had to go to (well, I guess I didn't have to), but I chose to go to the county hospital. So, when I went to the county hospital, when I would go to the doctor, I would sit there for two, three hours, and then, when I finally got seen, they saw me... [interrupted by several persons].

A chorus of voices tells Carine the doctor saw her for “two minutes, one minute.” Carine agrees and continues.

[T]wo minutes, and [the doctor] says, “We will schedule you for another appointment. I was like, what about... how is my health? And, Mexicans—there were like so many fricking Mexicans in there. They, like, spent all their time serving the Mexicans, so when it was my turn, they like, “Oh, we tired, and the day is almost ended, and we have seen you, so go home. And, if you have any problems, call us.” Well, my [second] pregnancy was not like my first pregnancy, so I was trying to get an explanation, like, why. “Well, we can't help you.” Very, very nasty attitude.

Accepting Carine's report of the doctor's comments reinforces participants' conclusion that doctors must distribute their time, but use it all on Mexican residents. Nevertheless, neither the competition for resources nor racial and ethnic favoritism lead participants to think that Hispanics patients always receive good treatment. Instead, given that African Americans are one population in a racially and ethnically segmented spatial community, the zero-sum view of scarce resources requires a vision that effectively directs individual focus. An effective African American vision means, as Dianna puts it, accepting that African American residents woke up in a community that is demographically Hispanic.

#### **IV. “We broke!”: The Welfare System and Creative “Refusal”**

Welfare or “the system” is the elephant in the forest of stereotypes. As much as African Americans may compete with one another and with other groups for

resources, focus group participants see themselves competing most with welfare system regulations. Although all the groups comment on welfare or “the system,” Groups 4 and 5 most insistently refer to welfare regulations to explain individual and community dynamics. Members of these groups agree that the regulations produce conflicting and contradictory eligibility criteria. Programs also withdraw or refuse support that would allow the individual or family to become independent of the system.

In all of the focus groups, at least one participant assumes the role of “keeping it real,” but in Groups 4 and 5 participants compete with one another to act as “reality-checkers.” These participants insist that, although “the system” will help those who help themselves, self-help requires lying and other forms of disreputable self-presentation to avoid being trapped in the system. Those expressing the most stridently negative view agree that helping oneself means learning to “work the system.” Working the system reverses ways of signaling that one is outside the system.

Showing that one is outside the system requires distancing oneself from negative stereotypes of African Americans. In Groups 4 and 5, participants insist that, to health care workers, the African American patient is a welfare recipient until she proves otherwise. It is difficult for her to do this, because the co-payment equation is at the core of these negative stereotypes. Corroborating this view in Group 2, Darlene relates two key aspects of the situation.

I think... when you're dealing with welfare systems and you're going to different places... people who are assisting you feel like it's coming out their pocket at that time. And sometimes, you have people at the customer service desk, who are *not so friendly*. ... . They look at you... [and] they think because you're on AHCCCS or something that you can't take care of yourself, or something. Like you're not... (I have my own medical insurance, as opposed to someone who's on AHCCCS), [but] they think... you know what I mean, like they can't support themselves because they're on *the welfare system* [sarcastic tone of voice] or something.

Convincing health care workers that they should exclude a particular patient from their views of welfare recipients begins with having private health care insurance. Darlene's parenthetical comment signals this distinction. Still, low co-payments associated with high private insurance premiums often buy the same disrespect from workers that AHCCCS patients and other welfare recipients receive. Privately insured patients must insist, as Irene says, “I am here now, and paid my co-pay just like everybody else, so treat me as an individual, not as a status quo community person.” (See Chapter 2.)

Working the system requires reversing signals of status distinction and worth. Not all participants are willing to do this. None approves of the reversal, because it means taking advantage of existing stereotypes by engaging in behaviors that justify health care workers' negative views. Having helpful friends and relatives, having a

job, attending school, being married or involved in a stable and supportive relationship are good for signaling self-respect, but they become disadvantages for mothers who still need a "helping hand" from welfare. For these mothers, participants say, it is better not to claim no spousal and family support, and despite the shame and disapproval, to allow workers to think a child is the product of a one-night stand.

Paula (G5) summarizes the motive for and drawbacks of denying spousal support.

But with [the father or husband present], she probably don't even qualify. They don't do nothing to uplift the family as whole. So, say both parents are working, or [the wife's] pregnant and the husband is working, there is nothing to uplift the family as whole. You have to be single, broke, and dusty to get some help. And if you are, they [say], "Well, you know what... [you do not qualify]." Well it's just not working like that. There is nothing to uplift the Black family.

Considering current norms to be shaped by demographics and stereotypes, focus group participants say that as mothers devise strategies they produce another meaning for "generation." (See Chapter 1, Section V.) Today's generation is accustomed to the single female household head, and can take advantage of stereotypes that workers develop from this "norm." Helen (G1), like participants in other groups, defines generation as different experiences with the single-parent norm.

I know the norms have changed, where, ah, being in a two-parent household [was] the thing, you know, the ideal situation. And, now because [the single-parent household] is so common (that's not excusing it), but now that is so common, because a lot of people, you know, [are] single moms, including myself. ... . Although it is not ideal, it's accepted. So, you have two different generations, looking at thing different, based on what is in front of them at the time.

Taking advantage of the norm to work the system, mothers face shame and disapproval in interactions with other African Americans. Single mothers or those denying spousal support by "looking at things differently" try to protect their families from regulations that all participants say disrupt already fragile family cohesion and financial support. For instance, mothers act to protect males from state intervention and, at the same time, seek benefits from the system for themselves and their children.

Charlotte expresses one view of this perspective on generation by concluding, "[T]he welfare system makes your daddies run away." She refers to fathers across generations. Unlike most focus group discussions that only mention males in passing, this one centers on men as part of the intergenerational patterns, which, according to participants, result from long-term involvement with "the system." They note that for family and household histories, the males with whom they grow up are

in the system as were their fathers. Charlotte (G5) comments on this intergenerational view.

Well listen, okay, if I grew up on low income and... I know my kids' father grew up on low income, but the system is charging him for all his child support. Then, when he gets older... he can't deal [with the system's regulations]. So my kids aren't getting anything anyway. How can [the system] charge our kids' daddies with all this child support, when they were already on low income—probably in the system with their parents?

Therefore, male age peers, as fathers, should take reproductive responsibility, participants argue, but having grown up in the system they lack the skills to comply with state regulations.

Efforts to protect fathers from “the system” add to, rather than displace, the other reasons participants give for why mothers, especially very young mothers, do not press fathers to be involved in finding and using health care and other social services for their children. As mothers try to keep fathers in their own and their children's lives, they must also manage welfare regulations to keep support that fathers provide. Thus, an unidentified speaker in Group 5 explains that the goal is to keep it “all [from] going to the system.” Just as mothers develop childrearing practices by reverse role modeling to break cycles that make families insecure, they also devise strategies to prevent regulations from breaking already fragile families. An exchange in Group 5 illustrates their view.

Uh-huh. So, this is that cycle thing? (Moderator)

Oh, yeah! (Charlotte)

So, how do you break it? (Moderator)

Shoot, get in there with um! (Charlotte)

Deny the father. (Multiple voices)

Lois summarizes the basic strategy, saying, “You say, ‘We broke up. I was out there, sleeping with everybody,’ [and then] all kind [of] help comes to you. Because, if you say you know who the daddy is, that's gon' bring him down, [and] that's not gon' help you much.” An unidentified speaker adds, “And, he ain't gon' talk to you no more.”

Despite references to changing norms, participants say new mothers or newly single mothers do not immediately see the need for these protective strategies. More often, they learn from their own and their friends' initial efforts to gain child support through the court. Lois recounts a typical experience that encourages mothers to deny everything in order that the system not deny them benefits and not take their support from other sources.

For example, I had two jobs. I hardly got to see my kids, and was denied everything—Section 8 housing, all kind [of] benefits. They told me I was making too much, so I quit working. I got overflowed with benefits, and I got time to spend with my children. So when you out there trying to do something to make it, successful on your own, it's not gonna help. It's so cold. It's horrible.

Without a job or other sources of support, participants agree with Edna's conclusion, "Oh, [then] they give you everything! Everything is free." Still, participants agree the freedom is a "trap," because, as Paula adds, "[Y]ou need day care while you working." Charlotte declares, "Don't get a raise!" The extra income, participants explain, disqualifies the working mother or parents, leaving household income constant or decreasing it. When the moderator asks if getting welfare requires at least looking for job, Edna replies, "Well, if you pregnant, you get the year off [before having to seek employment]. Then, they pay for your education." Paula adds, "If you working, they don't help [a pregnant woman] do nothing." The participants seem to be saying, the moderator suggests, that the system pays African American mothers to have babies. Edna agrees: "Pretty much. You are [paid to have babies]!" Charlotte concurs: "That's right!"

Having a baby qualifies a mother for system benefits, but, across the groups, participants contend that she must also surrender control of her life to remain qualified. To avoid surrendering control, participants agree with Lois (G5), who contends, "You literally have to lie to the system to get any type of benefits. When I told them the truth—I told them I had a car, I had a job—they told me, "No, no, no." Margaret adds, "You can't tell them you have a bank account."

Group 4's views of "the system" differ from those expressed by other groups on particular but not general conclusions about restrictive regulations. "It just depends on who you are dealing with [in the system]," the dissenters insist. "What's going on at that present time determines the service you gonna get from someone." As with other strategies to improve health care interactions, the dissenters concur with general conclusions that present the key problem as a mother's inability to predict a positive outcome for any strategy. Group 4 dissenters therefore argue that "it depends" means that the "luck of the draw" determines the quality of service received during interactions.

Whereas negative stereotyping and complex restrictive regulations are constants, workers' attitudes vary by the day of the week and the time of day. Long hours, stress, and shifts further influence whether a mother encounters a typically nasty or nice worker at a facility. In general, participants across the focus groups agree, it helps to know someone who works at the facility, or someone who knows an employee. The need to know someone could promote networking to share these contacts. However, this sharing, participants note, poses the same problems as other forms of networking. Hoarding resources and hurt feelings occur when sharing information is read as flaunting achievements. The information seeker becomes vulnerable to the other person's self-promotion or self-aggrandizement.

The Moderator asks whether mothers can make unpredictable interactions predictable. Across the groups, participants agree with Evelyn (G5): "No, no you

can't. You can't, you can't." An unidentified speaker expresses what follows from unpredictability: "You deal with it as it comes." To deal with what comes, participants say, it is best to lie when possible. Thus, aside from denying knowledge of who fathered a child, mothers deny assistance from family and friends, thereby making it appear that residents of the community do not help one another. "They ask me if a friend gave me \$20," Lois contends, "[and] I have to say she only gave [it to] me one time." Her comment sparks a humorous though serious discussion as Group 5 compares and contrasts questions that social service workers ask to calculate to the penny an applicant's supplemental support. Charlotte wins the question contest. "I think the dumbest question [is] 'How much money do you have in your pocket?'" Accountable for their income down to pocket change, participants see it best to declare, in Charlotte's words, "We broke!"

For mothers, declaring themselves broke becomes a means by which to creatively refuse to allow "the system" to "break" them, their parents, and their children's fathers. Effective mothering means devising practices to break negative cycles to extent possible, while taking care of immediate needs. Margaret (G5) explains that it is better to work the system than to act in accord with its regulation.

[I]f you have a father that take care of his child (say, he pays a third of your bill, and say, you get laid off), and you go and apply for assistance, [then] you are getting nothing, because he is working and you have child support. Well, he is not the one who needs the help. I need some help until I get another job. Ah, but because he has a job and he's outside the household, you are not getting any money. And, if he's *inside* the household, you certainly ain't getting nothing! So, how do you win? Like when I had my child, her father had a really good job, [but] I still put him on child support and everything. [W]e had to go to court and everything, [and until the court issued its order] I was getting money [from the state]. And it was \$275 a month from August to January. So, by January, they said I owed them [repayment].

Group 5 laughs intermittently as Margaret tells her story. Over the laughter, Charlotte restates participants' general conclusion about the system's motives: "[T]hey wanted to charge the father." The other participants agree that "wanting to charge" the father means the state intends to qualify males for jail or prison when they cannot pay.

Margaret continues her story, revealing that court-ordered child support means no support for children until their mothers repay the state.

I owed them \$2,000 back, and I was only getting \$275 a month for, maybe, four months. So, I was to get \$900 child support, [but] for four months, I didn't get shit! So, I was broke. They were taking all the child support I was getting from my daughter's dad. And, they were taking it all back, before I got anything. So that's, like, why you don't do it.

Charlotte recounts a similar experience and concludes, "They get they're's first... [and that] weights us down even more, [because] they do take it back." Although

mothers awaiting child support must repay the state, participants contend, their children still may not qualify for AHCCCS, because the state expects the mother to pay for health insurance from child support. If she can pay for private insurance, as Margaret declares: "They say, 'Oh, we see you have medical.' And on the paper, it says they aren't supposed to take back more than they should. That's a damn lie." Charlotte, never deterred from her protective intergenerational strategy, adds, "That's why our fathers don't want to work. They owe so much Economic Security!" Edna provides the final piece. "Get any support from the government, and workers see all your support coming out their pockets."

My ex-husband was paying child support, and I could get that check directly to me, but it would be counted as income, and I would have to start paying out of that child support check rent or whatever. It would be deducted out of my food stamps, but, as soon as I turned that check over to the system, "Oh, that's okay, as long as you give us the check, [then] it's not counted as income." So, I turned [it over to the state]. He paid, like, \$390 in child support, but, if I let the state take that check, I could get about \$50 more.

Then the people at the store wanna tell you, "You can't buy this, you can't buy that." And I'm, "This is, ah, this is my money. I only get \$50 of state money." If I could have his check in my hand—it's weird how they want you be in the system to benefit—but if you get in the system, you're just another groat.

Once caught in the welfare trap, focus group participants say, a mother cannot afford a job, unless she lies about support until her income amounts to an escape route. It is wise, they maintain, to refuse entering the system whenever it is possible to get by without its benefits. An exchange in Group 5 captures these points and the general conclusion that all focus group participants draw from them.

[I]f you ain't in the system, then how they gon' have some jobs that's helping you get in the system? (Margaret)

They want you to be in the system, just like they want you to go to jail! (Lois)

Uh-huh. It's all the same, ain't no jails, ain't [no prison] workers. (Margaret)

That's for real! (Lois)

No pregnancies, no [health care] workers. No health clinic, you know what I mean. No babies, they ain't getting paid. (Margaret)

[Health care workers would be like Southside residents]. You can't find no job on credit. You can't get no health care on credit. You die. (Lois)

The whole Southside will be dropping like flies. (Margaret)

All the Black people will be dead. (Charlotte)

Participants see individual and community strength in strategies that mothers devise to reverse role model, and turn stereotypes to their advantage, because doing so

helps break silences and negative cycles. However, they must always weigh long-term community development against fulfilling immediate individual and family health care needs.

Resources in South Mountain or South Phoenix are generally scarce, the focus group participants emphasize. However, they also point out that access to them is restricted, because mind-sets about African American cultural boundaries, including proscriptions and prescriptions, discourage using some existing services (e.g., adoption and mental health), and encourage destructive overuse of others (e.g., abortion). Instruction about the basics of sexuality and reproduction—at school, at home, or in the community—is poor and it comes too late. Advertisements for health care and other social services are inadequate or inappropriate, providing residents with little information for effective reproductive planning. Meanwhile, other social factors promote conditions that encourage children to become parents at a very early age. Busy with work and other obligations, parents have little time for community building that would improve health care outcomes.

Yet neither the absence of community nor the absence of community strength means that residents are “dropping like flies.” Many effective mothers, despite sometimes “running on empty,” devise means to confront community “realities” that weigh against obtaining quality health care and against constructive use of social services. Most often, mothers manage problems individually, and without fathers’ assistance. However, focus group participants see individualism as one of many obstacles to community development. Residents must overcome these obstacles among themselves, and in competition with other races, ethnic groups, and crosscutting class strata. To promote the joint action they must come together. To solve community problems, they must confront the interracial and intra-racial mind-sets contributing to the bias complex (e.g., age, race, color, and class) that produces candy-coated racism. Mothers, as residents and patients, cannot ignore, avoid, or confront these biases without escalating altercations in health care interactions and during gatherings intended to promote joint action. By insisting on “keeping it real,” focus group participants disclose the “reality” they contend South Mountain or South Phoenix residents must address to build and strengthen community, as an African American segment of an interracial and interethnic population.

## Appendix 1

### Focus Group Script and Topic Scenarios

#### I. Introduction

Introduce self, co-facilitator, note taker, and members of focus group committee who are present.

Read the Alliance statement of goals.

**“The Alliance for Innovations in Health Care wants to improve how women most in need of health care receive it. The Alliance is researching how women get health care, whether the care received is satisfactory, whether, over time, women continue receiving health care for themselves and their children, and whether they have healthy results from their efforts.**

**Your participation in these focus groups will help the Alliance discover, through your experiences and knowledge of your community, what aspects of health care provision and delivery are most and least satisfactory. The Alliance is interested in learning from you how to increase satisfaction and healthy results by better understanding the strengths you reveal for your community and how health care service can make use of these strengths.”**

Read the Alliance Privacy Statement and get permission signatures.

Distribute and collect the completed Profile Questionnaire.

#### II. Begin 90-Minute Session

Read Instructions

Over the next 90 minutes, I will read six statements describing family and community situations that represent issues on which the Alliance seeks your opinion. Persons presented in these statements are fictional. We intend them only to spark discussion on the issues implied. After each statement, I will open discussion for views based on your experience.

Occasionally, to keep the discussion focused, I may ask follow-up questions. Otherwise, please feel free to join in the discussion. You do not need to raise your hand, but only to enter in a manner that allows others to finish their thoughts. There are no right and wrong answers. You may agree or disagree with what others

are saying. As the discussion progresses, you may revise or add to your thoughts. Other than being polite to one another, there are no politically correct restrictions on language or points of view. The Alliance wants to know what each of you think. It wants to gain views that may help it in providing better health care experiences for African American women and their children.

After 25 minutes for the first topic, I will read another statement, allowing roughly 15 minutes for consecutive topics. We will follow this procedure until we have addressed the six topics.

Read scenarios (The co-facilitator will signal time for topic changes consistent with the progressive timing of each as it varies by focus group.)

### **Topic 1: Access**

Consider Kesha—full-figured and dark-complexioned, girl—who was born and raised in the South Mountain area. Based on your own experience, at what age does she first gain knowledge about how a woman becomes pregnant? When does she learn means for preventing pregnancy, and gain prenatal and other health care service?

**Moderator Prompts:** Use only if the discussion does not address these issues.

1. Keeping in mind your own or the experience of women close to you in South Mountain, what might encourage or discourage using health care services?
2. What tasks may decrease her chances of happy healthy pregnancy, and make her sad and stressed about being pregnant, and about health care for her and her baby? What increases her chances of a happy healthy pregnancy?
3. What are the greatest obstacles she faces in the community, in her family or friendship network? What obstacles does she face during health care and other social service interactions?

### **Topic 2: Deliberation**

During a health fair, you overhear some health care professionals talking. They say women in South Mountain do not plan to have children; they just have them. They do not care about their health during their pregnancy. For their babies' health, they just take their chances, letting the babies grow and hoping for the best. They do not consider nutrition and disease-prevention health care. Later you are on a panel with these professionals. You take the opportunity to respond to the views you overheard. Again, thinking about Karla, your own health care concerns, and those of women you know well in South Mountain, tell me how you respond to what you overheard.

**Moderator Prompts:** Use only to probe generalizations in respondents' statements.

1. Are you saying this so for first as well as later pregnancies?
2. Are you saying this is so for most women you know or for only a rare few?
3. If the professionals' views are false, why do you think they have these opinions?
4. If opinions are true, why do you think some women do not plan pregnancies, and pay attention to their own and their babies' health care needs?

### **Topic 3: Coping:**

Kesha is a middle child. She has a brother Kari and a sister Karla. Kari is two years older than Kesha, and Karla is two years younger than Kesha. Her mother and father, Katherine and Kelvin, both work, but seldom have jobs that paid above the minimum wage. They do their best to provide for the three children. The community respects them as honest, hardworking, and God-fearing.

Karla, sharing her mother's light complexion, too often thought herself "cute." No one in the family knew she had received treatment for sexually transmitted diseases—first, Chlamydia, and more recently, gonorrhea. She often ditched school. By 16, she was an unwed mother of two. Kari, an extraordinary athlete, completed high school, but teachers always complained that he was an academic underachiever. By 20, he fathered two babies—one with Hispanic and the other with a White woman. He is proud of his babies, but has little income for their support and time for their care. By age 20, Kesha has no children. She finished high school and vocational school. She is a dental assistant. Tell me how you would explain the differences in Katherine and Kelvin's children's involvement with having babies.

**Moderator Prompts:** Use only if discussion does not provide specific explanations.

1. Do you think the children had to cope with different kinds of problems or took advantage of different opportunities?
2. How might their age, sex, and place in the family have influenced their opportunities for self-development, and having and raising children?
3. What difference in supports or obstacles might they face in their family? What community values might influence view of opportunities and obstacles?

4: Did the level of formal education influence how they saw and responded to family and community supports and obstacles to gaining health care and other social services?

If respondents concentrate on obstacles, probe for supports.

#### **Topic 4: Community Strength:**

Behind her back (and when angry, to her face), Kari and Karla call their sister, Kesha, "Miss Know-it-all." They tell her she is self-righteous. She has a habit—they think she picked up from their mother—of telling them, "There are none so blind as those who refuse to see." Assume Kesha's comments refer to the resources for health care and other social service in the South Mountain. Tell me what Kesha thinks Kari and Karla refuse to see that could help them with their lives; especially in getting health care and other supports for themselves and their children.

**Moderator Prompts:** Use only if discussion does not provide specific explanations.

1. What may keep them from seeing these resources?
2. What might make it harder for Karla and Kari to take advantage of resources that Kesha thinks they refuse to see?
4. What changes in the community or in how health care services operate might help them take better advantage of available resources?

#### **Topic 5: Recall**

When Kesha, Karla, and Kari complain about racism and discrimination in health service, Katherine and Kelvin shake their heads. They tell their children they just do not know how bad things used to be. When Karla complains about the bad treatment she receives when she goes to get food stamps, WIC, and health care for her baby, Katherine tells her that she should be grateful she is living in these enlightened times.

She reminds Karla of a time when, as an unwed mother, she would have been unable to hold her head up. When Kari complains about low-paying dead-end jobs, Kelvin tells him he ought to have thought about that before he lowered his zipper one time too many and now cannot support his babies. He reminds Kari that available jobs and wages were worse in his early years, but still he kept a roof over their heads and food on the table. Miss Know-it-all chimes in saying, "Life is just what you make. Racism is no excuse, because it has always existed, and will always exist in America." Besides, Kesha tells them, racist people are just a few bad apples. They should just ignore them. Based on your own and your close friends experience

with social and health services, tell me whether you think Karla and Kari are just complaining, and whether ignoring the problems will help them.

**Moderator Prompts:** Use only to clarify issues respondents' terms, expressions, and unexplained implications.

1. Do you recall any race-based events that influenced your using health care services?
2. Are these experiences best explained as acts of a bad apple or are they part of health care services' views of African Americans?
3. Do you consider these experiences when selecting health care providers and social service programs that might help you and your children?
4. What do you do, if you think there is no alternative facility to which you can transfer your own or your child's health care needs?

**Topic 6: Refusal** (if running over time, begin with description of conduct for second child)

For Karla's first baby, after all the shouting stopped in her own and the father's home, the parents were full of advice. They told Karla about programs to which she should apply. Karla made and kept doctor's appointment. Her baby's father went with her to birthing classes, and to get information on health care and social service programs. Together, they learned about how drug and alcohol consumption might harm their baby's development. Karla signed up for programs, such as food stamps and WIC. She went to offices for other programs she had learned would help her with parenting skills and provide information on child nutrition. For her second child, the parents shouted less and offered less advice. Karla went to the doctor only when she had pains and feared something might be wrong with the baby. The baby's father—the same for her first child—discouraged her attending birthing classes. He told her, if she went, he would not go with her. She did not attend these classes. She did not sign up for food stamps and WIC. She avoided social workers that offered advice and information. She cared for her baby the best she could with money she earned, and the small support the father gave periodically. Considering your knowledge of friends or family members whose behavior is similar to Karla's and her baby's father, tell me why you think they responded differently to health care and social service for their second baby.

**Moderator Prompts:** Use only to gain details about specific services, facilities, and practices respondents mention.

1. Did the couple think they knew the routine and did not need advice, information, and birthing classes?
2. Do any views or values in the community, generally, or among health care providers, particularly, account for refusing to take advantage of available service for the second baby, which they used for first?
3. Could their experiences using services for the first child discourage using the same facilities?

### **III. Close**

Thank respondents and turn group over to Alliance member to explain what the Alliance plans to do with the focus group findings. Distribute fees, collect receipt signatures, and offer respondents refreshments

## Appendix 2

### Informed Consent and Permission Form

Alliance for Innovations in Health Care and  
the Maricopa County Department of Public Health

By participating in this focus group, you understand that you are asked to express your views according to the instructions provided for the purpose of a 90-minute focus group on health care service and delivery issues, as these bear on your understanding of your community. By participating, you grant permission to audiotape the discussion, and take one group photograph to assist the transcriber in matching speaker to chair number. You grant the Alliance use of the data generated from these tapes. Your decision not to participate, or lack of willingness to be recorded and photographed, will have no affect other than dismissal without payment of the \$50 fee, which is contingent on participation. Participation incurs no cost or future liability of any kind on your part or that of the Alliance.

For all participants, the Alliance will make every effort to safeguard the privacy and confidentiality of personal-identity information. This includes restricting use of information to the research team involved in data collection and analysis. In all documents and public presentations resulting from data analysis, never will your name be linked to any portion of that data. Instead, all quotes, and other forms of attributions will employ assigned numbers and fictive names to material used.

It is highly unlikely that you will experience an injury by participating in this focus group. In the case of injury or illness resulting from your participation, emergency medical treatment is available, but will be provided at the usual charge. No funds have been set aside to compensate you. This does not waive your rights in the event of negligence.

For questions, contact Rose Howe, Maricopa County Department of Public Health, at 602-372-1441.

Your signature indicates that you have read the information provided above and have decided to participate in this focus group under the specified conditions.

Signature

**I agree to take part in this focus group.**

**Print Name** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **Time** \_\_\_\_\_