FROM MOTHERS TO DAUGHTERS: A QUALITATIVE EXAMINATION OF THE REPRODUCTIVE HEALTH SEEKING BEHAVIOUR OF AFRICAN AMERICAN WOMEN

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African American women continue to underutilize standard medical services available to women such as prenatal care, mammography and pap smears. Embedded within the Black Feminist Thought paradigm, this qualitative study employs grounded theory techniques to present a critical approach to the health seeking behaviour of African American women for obstetric/gynecologic services. Through the context of mother/daughter communication this research examines how the negative construction of African American women's sexuality impacts upon the women's decisions to seek preventive health care. Semi-structured in-depth interviews were conducted with 17 mother/daughter dyads, to a total of 34 interviews. Results indicate that mothers have a significant effect on their daughters' decisions to seek obstetrical/gynecological health care and/or their knowledge about reproductive health care. This study identifies barriers to obstetric/gynecologic health care utilization for African American women and girls and describes policy changes that could increase utilization of care.

African American women experience a substantially higher rate of disease and disability than do their White female counterparts for a number of female specific conditions such as breast cancer and cervical cancer (Centers for Disease Control, 2006). They also experience higher infant mortality of their children in comparison to their White female counterparts (Kochanek & Smith, 2004). The health disparities experienced by African American women could be due in part to a lack of access to, or utilization of preventive standard women's health-screening procedures such as mammograms, prenatal care and pap smears. Research indicates that health-screening procedures have been historically underutilized by low income, minority and inner-city women.

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Moreover, LaVeist (2005) states that history plays an important role in understanding why health disparities exist and how they might be eliminated.

The underutilization of preventive health screenings such as pap smears by African American women is not fully understood (Selvin & Brett, 2003). Even after adjusting for socioeconomic status (SES) and insurance coverage, racial disparities in health still exist (Lillie-Blanton, et. al., 1999; Smedley, Stith, & Nelson, 2002; Williams & Collins, 1995) and according to the Institute of Medicine (IOM) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care (Smedley, Stith & Nelson, 2002), the quality of care received by racial and ethnic minorities is generally lower than that provided to the majority population.

Some reasons given for the lack of utilization of standard medical services experienced by African American women include distrust of the medical profession, inadequate health care insurance (Ford & Cooper, 1995), a shortage of African American and/or female physicians (LaVeist, Nuru-Jeter & Jones, 2003) and logistical barriers that include insufficient child care and transportation (Libbus & Sable, 2000). However, these reasons provide a limited explanation as to why the phenomenon exists. I argue that the reproductive health seeking behaviour of African American women cannot be adequately understood without considering how the negative portrayal of Black female sexuality in U.S. society impacts upon the women’s reproductive health seeking behaviour.

The negative portrayal of Black female sexuality comprises a portion of the ideological fabric of America. In U.S. culture, racist and sexist ideologies permeate the social structure so emphatically that they become the norm (Collins, 2000). The negative sexual stereotypes surrounding African American women are systemic of a racist, classist and sexist ideology. This ideology serves to define Black womanhood in U.S. society, which in turn plays a role in the societal and familial sexual socialization of Black women.

The purpose of this study is to explore the health seeking behaviour of African American women relative to sexual socialization. Through the context of mother/daughter communication, which is embedded in the larger structural context of U.S. society, this research examines how the negative construction of African American women’s sexuality impacts upon the women’s decisions to seek preventive health care. This study is largely grounded in a Black Feminist Thought conceptual framework which views race, gender and class as mutually constructing systems of power (Collins, 2000).

Benkert & Peters (2005) examine African American women’s perceptions of prejudice in health care and their strategies used to cope with the negative experiences. They conclude that the larger societal
forces of race relations affect African American women’s perceptions of the health care system and of health care providers. However, their analysis is limited in that it does not consider how race, class and gender converge to define the health care experiences of many African American women, especially with regard to reproductive health care. Racism, sexism and classism form an interlocking system of oppression that may well contribute to African American women receiving inadequate health care as well as seeking preventive care less often.

Few research studies concerned with the health seeking behaviour of African American women address how sexual socialization impacts upon the women’s actions. Consequently, there is a gap in the literature regarding the role of sexual socialization on women’s decisions to seek care related to reproductive health issues.

**Sexual Socialization & African American Women**

According to Collins (2004) Black sexual politics consists of a set of ideas and social practices shaped by gender, race and sexuality that frame Black men and women’s treatment of one another. It also addresses how African Americans are perceived and treated by others in society. Analogous to Black sexual politics, sexual socialization refers to the ways in which sexual norms, practices and preferences are shaped by race, gender and class. Sexual socialization also encompasses how African Americans, particularly women, respond to the negative treatment and perceptions that emanate from dominant groups. Negative images of Black womanhood are central to Black female socialization. As a result, African American women may often experience a contradiction in being. They may internalize as well as reject the negative images. The images include those of the Jezebel/Sapphire, welfare queen and the hoochie mama (Jewell, 1993). Because of these negative stereotypes African American women are often concretely portrayed in U.S. popular culture as being hypersexual, sexually permissive, sexually irresponsible, immoral and illicit. Black women are also defined as lacking maternal instinct based upon the mammy/matriarch images (Collins, 2000). The mammy and the matriarch images both serve to portray Black women as ‘bad’ mothers (Collins, 2000). For instance, the mammy image defines Black women as being loving and nurturing to White children at the expense of their own children. The image of the matriarch portrays Black women as being neglectful and uncaring mothers.

Sexual socialization occurs at both the societal level as well as the familial level. One contradictory manner in which many African American mothers sexually socialize their daughters is to overtly as well as covertly convey to them not to talk about any health issues that would call attention to their sexuality. In fact, a kind of shaming takes place among African Americans in reference to sex and sexual health.
(2003) writes that shaming is one way to intimidate and break the human spirit. Historically, dominant groups have shamed African Americans. The shaming process, which originated on slave auction blocks, was reinforced by religious doctrines that espoused dark skinned people to be the sinners of the world (hooks, 2003). The sexual silence that is perpetuated through mother/daughter generations is a form of the internalization of shame that has historically plagued African Americans.

Another contradiction that many Black mothers may face is teaching their daughters to conform to, as well as to resist their low social standing. A key part of Black girls’ socialization involves incorporating the critical posture that allows Black women to cope with contradictions (Collins, 2001, p. 44). Collins (2000) recounts an example of one Black mother’s attempt to sexually socialize her daughter as a matter of survival. As a young girl the renowned Black activist Ann Moody questioned why she was paid so little for domestic work that she began at age nine. Moody also insisted upon asking her mother why White male employers constantly sexually harassed Black women. Moody’s mother refused to respond to her inquiries and even reprimanded her daughter for stepping out of her ‘place’. The response that Moody was given by her mother may initially seem very cold and harsh. In fact, Moody’s mother acted in a manner that would curtail any chances of her daughter challenging the system and becoming an even greater target for victimization by the dominant society.

Collins notes that many Black mothers respond just as Moody’s mother did in a number of situations in order to protect their daughters from danger—danger of being singled out for sexual harassment, as well as physical and sexual abuse. Collins (2000, p. 183) states, “Mothers may have ensured their daughters’ physical survival but at the high cost of their emotional destruction.” I elaborate on Collins’ finding. Black mothers may be unconsciously contributing to their daughters’ physical demise by perpetuating sexual silence and shame regarding the Black female body. Consequently, many Black women may not seek preventive health care due to feelings of shame and secrecy that they learned from their mothers during adolescence. The shame that many women feel may be exacerbated by negative health care encounters. These negative encounters may be their own or others’. For instance, research indicates (Libbus & Sable, 2000) that many Black women feel that physicians have preconceived notions about Black women that influence the type of diagnoses and care they receive.
Sexual Socialization & Mother/Daughter Communication

This study utilizes mother/daughter dyads to assess the reproductive health seeking behaviour of African American women. The mother/daughter relationship is central to exploring how intergenerational sexual socialization impacts on Black women's health. The sexual socialization process occurs across all groups of women regardless of race (Dreifus, 1977). However, African American women warrant special attention when addressing sexual socialization because a paucity of research exists that speaks to mother-daughter communication and health seeking behaviour. As stated by Wade-Gayles (1984, p.8), sociological investigations of Black motherhood give a faint discussion about the relationship Black mothers have with their daughters who, unlike sons, are heir apparent to the halo of motherhood. Furthermore, the interlocking system of racism, classism and sexism create health care situations that are unique to African American women.

METHODS

Design

Two questions guide this research: (1) Is there a connection between mother/daughter communication and health seeking behaviour? (2) Does the sexual socialization of African American women impact their gynecologic health seeking behaviour?

In order to answer the questions posed by this research, semi-structured in-depth interviews were conducted in person with seventeen mother/daughter pairs for a total of thirty-four women. To ensure confidentiality, the interviews were conducted separately. The interviews all took place at the most convenient location for the respondents. Thirty-two interviews were conducted in the women's homes. The remaining two interviews occurred at local coffee shops. Interviews ranged 1-4 hours in length.

Sample

The women in this study are residents of an urban, Midwestern city. Nationally, this city has a high rate of certain communicable diseases such as chlamydia and syphilis. The reported cases of chlamydia in the city are nearly four times the national rate. Additionally, in the city, the infant mortality rate remains consistently higher than those of the state and the nation. Thus, based upon its high rate of selected communicable diseases and high infant mortality rate, the city is an ideal locale for conducting reproductive health research.

The women in this study had to meet four screening guidelines. I recruited women who were African American, 18 years of age or older,
had experienced at least one obstetrical/gynecological exam and had a mother or daughter in the area willing to participate in the study. The mean age of the mothers is 60 years old, with the oldest mother age 82 and the youngest mother age 46. The mean age of the daughters is 31, with the oldest daughter age 55 and the youngest daughter age 20. Table I sums up salient sample characteristics.

Recruitment

I recruited women for this study using a snowball sampling technique via my social network. I asked various women within my social network to refer me to other women whom I did not know personally. In addition to asking women within my social network to refer me to potential participants, each participant was given two recruitment flyers about the study, one to keep and one to pass along to her mother/daughter.

My insider status as an African American woman gives me a unique advantage for entrée into the lives of other African American women. One important advantage of my insider status is that the lens through which I experience social reality may be similar to that of the

<table>
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<th>Pair</th>
<th>Age</th>
<th>Marital Status</th>
<th>Education</th>
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<th>Pregnancies</th>
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study participants. Moreover, my insider status may have contributed to the women feeling at ease and willing to openly share their experiences with me.

**Data Processing**

With consent from the participant, each interview session was tape-recorded and responses were transcribed verbatim using a word processing program. To ensure confidentiality, all respondents were assigned fictitious names. To compensate the women for their time and any inconvenience, each participant was awarded a $20 gift certificate to a retailer of bath and body products or to a grocery store.

Before I developed the interview guide I systematically reviewed newspaper and magazine articles and medical, social, historical and public health literature regarding African American women and sexuality and African American women and health seeking behaviour. I then created a list of themes pertaining to mother/daughter communication, African American women and their health seeking behaviour and African American women and sexuality. I subsequently merged the themes from the categories in order to create an interview guide of approximately 5 open-ended, broad grand tour questions and 52 probes.

**Data Analysis**

After all of the interviews were conducted, I transcribed the tapes verbatim using a word processing program. I then exported the files into Ethnograph, a qualitative data analysis software program (Seidel, 2005).

I utilized a grounded theory approach to examine the data. Grounded theory is defined as theory that is derived from data, systematically gathered and analyzed through the research process (Strauss & Corbin, 1998, p.12). By utilizing this approach I was able to construct a substantive theory that was based upon the lived experiences of the women. An integral component of grounded theory consists of identifying the relationship between macro and micro social conditions. Strauss and Corbin (1998) further define macro conditions as those that are broad in scope and possible impact. They define micro conditions as those that are narrow in scope and possible impact. The conditions/consequences represent the structural context in which action/interaction occurs (Strauss & Corbin, 1998, p.192). For instance, the acquisition of standard women’s health services by African American women (action) may result in part by the level and type of mother/daughter communication about sexual health (interaction). The negative sexual stereotypes of African American women function as the macro condition by which the women’s actions and interactions are facilitated.

I analyzed the interviews line by line in order to code the data.
After the initial coding of the data, I selected core categories from the mass of codes for further analysis. Priority was given to topics that reflect recurrent or underlying patterns of activities among the women.

RESULTS

The major themes that emerged from this qualitative study are: (1) “Mama said, it’s time to get your snatch checked out”; and (2) “I wish we could have been more open.”

In order to get a sense of how the women communicated about reproductive health concerns they were asked to describe the relationship they had or have with their mother/daughter when it comes to discussing issues like menstruation, menopause, pregnancy and birth control.

“Mama Said, It’s Time to Get Your Snatch Checked Out”

‘Snatch’ is a code word used by the women to name the vagina and this theme is based upon a direct quote made by one of the participants. The majority of the women (N=26) reported that they refer to the vagina by a code name such as ‘snatch’, ‘pocketbook’ or ‘coochie’. The code names were passed from mothers to daughters and were commonly used when referring to reproductive health care issues.

Over half (N=18) of the respondents indicated that their mothers prompted their initial gynecological visit. Thirty-five percent (N=6) of the women in the mother generation decided to seek their first gynecological exams based upon their mother’s recommendations whereas seventy percent (N=12) of the women in the daughter generation decided to have their first gynecological exam based upon their mother’s guidance. Gloria (mother #4) indicated that she talked with her daughter about the importance of taking care of herself despite what other people may think about Black women. She stated:

I tell my daughter to make sure she takes care of herself because that is a part of loving yourself. If you see people as unworthy, you treat them that way. People have been trained that Black people don’t want much. We have overcome a lot, but there is still a lot we have to do. When you paint a people as the problem that is when it becomes a problem.

Several participants indicated that going to the gynecologist was just something they knew they had to do because mama said so. Tracy (daughter #15), said, “I guess my mom just told me it was time to start going. She did not tell me why.” Natasha (daughter #2) indicated that she was very embarrassed and uncomfortable during her first gynecological exam because she did not know what to expect. She stated:
I was so embarrassed. I went with my mother and sister and my mother went in the exam room with me. And I didn’t know about the tool that they use (the speculum). So I was just embarrassed and that is how I can describe it… During the visit, I said as least as possible.

Several of the women commented that their mother’s could only tell them what they knew in relation to women’s health. Sophia (mother #1) stated: “I was gonna ask her more questions, but she didn’t really have the information. There was not that much talking when it came to sex and your menstrual period, pregnancy and all that.”

Sophia also commented that her mother and grandmother did not talk to each other about women’s health and sex. Therefore, Sophia’s mother passed down to her what she learned from her mother.

Communication between mothers and daughters about reproductive health care was not always direct. For instance, Sabina (daughter #12) indicated that she was suspicious of health care providers based upon hearing how her mother had been treated during her reproductive years. Sabina also indicated that her mother’s low socio-economic status played a role in the type of care she received. Her mother had to go to a clinic for health care. Sabina commented that this clinic was a place that low-income Black families went for care. She stated:

I guess as an African American female I am just a little more suspicious of the medical field, that there would be different views because I am African American. And part of that I think comes from my mom too. Just in terms of when my mother was growing up, they would go to the doctor. They would go to the clinic. And a lot of times there was drug testing on the Black people at that clinic. Blacks would get the drugs that everybody else wasn’t using. They were the object of the drug tests. So my mom was always talking you know. And then you hear stuff like the Tuskegee experiment. Just things like that. Because I have that knowledge, for me as an African American and a minority I think I would still have the idea that I would be weary and careful because of my race.

Waneta (mother #12), Sabina’s mother also indicated that she learned a lot about reproductive health from hearing her female family members talk about their experiences. Much of what she learned from her female family members about seeking health care was negative. Two maternal aunts raised Waneta. She recounted that both of her aunts were involuntarily sterilized, partially due to the fact that they were poor Black women living in the South.
Waneta stated:

One of my guardians had had a terrible experience with the doctor, with her female organs. She was in the south and they just butchered her. As a matter of fact they just butchered both sisters. Neither one of them ever had any children. One of them went because of her menstrual periods. The bleeding she went through was just horrible. She went to the doctors and she told me that they packed her. They packed her with cotton or whatever. The doctors packed her back in those days to stop the bleeding. It was terrible. They went in for help and they took out everything...I grew up in a home where there was a lot of mistrust of doctors. A lot of Black families went back in those years, to the doctor when they absolutely, positively had to. My mom would say, 'Oh I hate going to this doctor because he hurts.' And things like that. They don't know what's wrong with you. It was just negativism when they had to go to the doctor. Otherwise they were putting hot water bottles on their stomachs when they had cramps. She would talk to me about the doctor in passing a lot of times. It was not like she would sit down and say, let me tell you about the doctor. So that's the way you encountered it. It was a negative encounter from the very beginning. And it was not because of people teaching you negativism but it was because of the little things you would hear from your mom and her girlfriends sitting down talking about an encounter at the doctor or something. This stuff was just passed down. You know children sitting down listening to the unpleasantries [sic] that the mothers went through. It was like that for me growing up.

“I wish we could have been more open”: Mother/Daughter Communication

During the interview process the women were also asked if they would change anything about the way they communicated with their mothers about sex and women’s health. This theme is also based upon a direct quote from one of the participants. Over half of the mothers (N=9) responded that they would change something about what they taught their daughters about sex and women’s health. Similar to the moms, almost half of the daughters (N=8) responded that they would change how they communicated with their mothers about sex and women’s health. Waneta, (mother #12) succinctly stated: “I think I would be more liberal because of the way society is now. Because of the diseases that are so prevalent in the world now.”

There was agreement among many of the mother/daughter pairs
(N=9) about changing communication. The remainder of the responses from the matched pairs (N=8), indicate a discordance regarding mother/daughter communication. For instance, the mother of pair 11 responded that she would not change anything about how she communicated with her daughter. She firmly believed that she was very open with her daughter when it came to women’s health concerns. However, daughter of pair 11 gave a very different response. She did not feel that her mother had been very open with her about sensitive issues. In fact, daughter 11 believed that her mother lectured to her and that there was no opportunity for open discussion about sex or women’s health.

The following excerpt from Mavis (mother #3) demonstrates how her parents, in particular her mother talked very little to her about menstruation, sex and other women’s health issues. As a result of the way Mavis was socialized regarding her body and sexual health she in turn was very obscure about the way she communicated with her daughter, Nicole about sensitive issues.

Author: Did you ever talk to your mother about getting women’s health care?
Mavis: NOOO! My mother was very strict and we couldn’t even show our knees at home. Oh no never!! It was very hush, hush as far as women’s whatever. You know they used to say if a girl is menstruating she got the curse! When I started my period, my mother helped me prepare the napkins that we had to wear. But I don’t remember her saying anything but keep your dress down. Somehow I knew what could happen if I did not keep my dress down. It was never really discussed so I don’t know how I knew. I knew that the purpose of it was to protect myself from being molested or from somebody making overtures that I wasn’t ready for.

Author: When you were growing up did you have anyone to talk to if you had questions about sex?
M: No I don’t recall because I know my mother never talked about it. Most of the stuff I learned was from going away and talking to my friends in college.

When I asked Mavis what she taught her daughter about women’s health, her body and sex she basically indicated that she passed down to her daughter what she learned from her mother. Mavis learned very little from her mother about women’s health and sex. In turn, Mavis told her daughter that if she were to do “things” too early she would be stigmatized and shunned from the community. Mavis stated: “I talked a little bit to my daughter when she was in elementary school. The girl across the street was having a baby. She was a teenager. I told her (my
daughter) that some girls go out and do things that they shouldn’t do. You see what happens when girls do things early.”

Mavis used the pregnant girl who lived across the street as an example of what happens when girls do ‘things’ that they shouldn’t do in order to discourage her daughter from doing those things. Although Mavis warned her daughter about doing things too early, she never told her daughter what those ‘things’ were. As a consequence, Mavis’ daughter grew up believing that sex was bad and dirty. Nicole (daughter #3), admits that what she learned from her mother regarding sexuality and women’s health has had a major impact upon her life. The following excerpts from Nicole, illustrate how she feels now about what her mother taught her about sex and women’s health during her childhood and adolescence.

Nicole: I wish we could have been more open. I wish we could have just talked you know because I think that my views towards sex even to this day have been dampened by my mother’s presentation of what sexuality is all about.

Author: What messages did you receive from your mother about seeking women’s health care?

N: It never really came up. There was no discussion about it. I can’t recall her being discouraging or encouraging. It just never came up. I think the only time it ever really came up was when I had really bad cramps and I was absent from school.

Nicole indicated that her mother never talked about menstruation with her until a crisis arrived. While growing up, Nicole suffered from severe menstrual cramps. Nicole’s cramps got to the point where she could no longer function normally. At that point, her mother was forced to talk with her about the cramps and to seek help from a physician. Ultimately, Nicole was taken to a gynecologist for help. During her adult life Nicole discovered that her severe menstrual pain was and still is caused by endometriosis.

Although Nicole stated that her mother talked very little to her about sex and women’s health, her mother believed that she did an adequate job in educating her daughter about such issues. The following excerpt demonstrates how Mavis thought she did well when it came to discussing sensitive topics like sex and menstruation. Mavis felt relieved that she did not have to discuss those topics in detail with her daughter because her daughter was learning about those things in school. Additionally, Mavis did not want to seem too open with her daughter about sex because she thought that the openness would pique her daughter’s curiosity about sex and inspire her daughter to experiment at an early age.
When I got to the place where I would talk to her about sex and stuff she had already been taught that in school. They spared me the job. If she had any questions I would answer it. It just very seldom came up because I was under the assumption that my girl was not going to do these things that you see these other girls doing. Now she could have done it ten times, but I don’t know, she didn’t tell me. I just told my daughter that if you go out and do those things you see what happens. I didn’t go into detail about things with my daughter because they start teaching that in the schools now at an early age. I said something to her and she said they discussed that in class. So I did not make it so important that it must be discussed because sometimes that makes them anxious to see what this [sex] is all about.

The approach that Mavis took with her daughter is very similar to the way her mother handled talking to Mavis about sex and her body. However, despite Mavis listening to her mother about what to do when it came to taking care of herself during certain times of the month, Mavis blatantly disregarded her mother’s orders. Mavis stated that the secrecy that shrouded her mother’s orders about sex and women’s health actually inspired her to “experiment” in order to find out if what her mother said was actually true: “I would sometimes test the things that my mother said don’t do by going and doing them. When I got to high school I did whatever. I was such a violator. I was doing a lot of things mama said don’t do. I would experiment.”

The experimenting that Mavis referred to had the potential to be very dangerous for her. Mavis questioned her mother’s orders because they did not make sense to her. If Mavis and her mother had been able to speak openly about some of her mother’s admonishments, Mavis may not have felt the need to go and experiment. Mavis also believed that her mother did not express much understanding for her need to know more about her body.

Keisha (daughter #16), explained that she and her mother did not communicate very much at all when it came to women’s health and sex. There was a lot of secrecy in her household when she was growing up. Keisha believes that if mothers and daughters communicated, a lot of health problems could be avoided: “If mothers and daughters really communicated at an early age it would cut down on a lot of the STD’s and pregnancy. If the mother is a role model, girls will follow her behaviour. If the mom takes care of herself, her daughters will too.”

Looking back retrospectively, Keisha’s mother, Donna (mother
#16) believes that she failed her daughters. One reason that she believes she failed her daughters is because at the time of the interview, two of her daughters were pregnant and not married. She stated:

> With my daughters there was no talk about birth control or pregnancy. I think I failed them. All I told them was that I don't believe in abortion. I wish I had been more in tune with taking more time to talk about abstinence. I would have told them more about preventive sex behaviours like birth control.

Another example of how secrecy between mothers and daughters has the potential to create dangerous health situations occurred between pair #2 Natasha and Valerie. Natasha (daughter #2) almost lost her life at age twelve due to excessive blood loss that stemmed from having a very long period. Natasha did not tell anyone that she had been bleeding heavily for over thirty days because she felt like she had no one to tell. Natasha stated:

> I came so close to dying, bleeding to death because I didn't want my mom to know. I was getting so weak that I couldn't move. If I would have felt a little more comfortable maybe I would have come to my mother before I had gotten to that point and let her know that there was something going on with my body, that I need to go to the doctor. But since I was too embarrassed—and not that I had done anything wrong, so I tried to let it go unnoticed. Author: Do you remember how you felt during that time?

> N: I felt like I was wrong for withholding information that was life threatening to me. But I felt like what else was I supposed to do. I felt like there was nobody here that I could really tell...If I had a daughter, I would definitely be open with her because my mother wasn't like that with me. I feel if she was, maybe I wouldn't have let her in because of the way I am, but if she had forced herself upon me, which she had the right to do, then maybe things would have been different in my life. I would have been more compelled to come to her when I had problems. I wouldn't have had the choice but to open up to her. I think that I would have been saved from a lot of things, from a lot of decisions that I made if we had an open relationship.

Natasha’s experience is symptomatic of the relationship shared by her mother and grandmother. Valerie (mother #2) stated that she wished that she and her mother had had more open communication regarding certain topics. Valerie passed down the secrecy and
embarrassment about sex and women’s health to her daughter that was passed down to her from her mother. The following quote from Valerie illustrates how open communication may have positively impacted her life.

*I think I would be bolder and ask more questions. I would force my mother to be more open with me about it and not feel like it was a secret. I think that – getting more knowledge about it would probably change some of the decisions I made during my growth and development as a teenager and into womanhood.*

According to Valerie, if she had experienced a more open relationship with her mother about women’s health and sex, she may have been more open with her daughter Natasha about such issues. Additionally if Valerie had shared with Natasha that when she was a young girl she suffered from similar menstrual symptoms, Natasha might have found it easier to approach her mother for help when she was suffering from extreme blood loss due to her menstrual period.

**DISCUSSION & CONCLUSIONS**

As confirmed by the women in this study, the type of communication between mothers and daughters, whether it was open or closed had an impact on the women’s comfort levels during gynecological exams, both physical and emotional. This finding is in agreement with Cooper’s (1985) viewpoint that open communication between mothers and daughters is important for health reasons. The women’s consciousness surrounding how racism, classism and sexism intersect to influence the quality of health care that Black women receive also had an impact on the type of communication (direct or indirect) mothers and daughters experienced.

Also, the first generation of women’s insistence on their daughter’s seeking gynecological care may have resulted in part to the disproportionate risk of HIV/AIDS experienced by African American adolescents. For instance one mother commented that if she had to do it over again she would definitely be more open and realistic with her daughter because the world is much different now in comparison to when she was a girl. This finding coincides with research (Dilorio et al., 2000, p. 1) that states parental involvement in educating adolescents about sex has taken on a new sense of purpose in the era of AIDS. Additionally, the results discussed in the ‘I wish we could have been more open’ category coincide with research (Dilorio, Kelley, & Hockenberry-Eaton, 1999) that reports children see their parents as more restrictive in sexual attitudes than parents see themselves, which reveals the possibility of a generation
gap in sexual attitude sharing. This generation gap in sexual attitude sharing may have contributed to the mother/daughter discordance regarding reproductive health communication.

Furthermore, a lack of knowledge surrounding the specific reasons for the initial gynecological visit has the potential to thwart communication between the physician and the patient. Several participants indicated that their experience of not knowing what to expect at the visit made them feel very embarrassed and uncomfortable. The element of surprise that several women experienced during their initial gynecological visits did not foster a comfortable environment for them to ask questions, or voice their concerns with the physician.

Overall, many of the mothers in this study had very good intentions with trying to make sure that their daughters received reproductive health care. However, the manner in which many of the mothers introduced gynecological care to their daughters created uncomfortable situations for the women. Instead of the daughters asking very detailed questions about their health and communicating openly with their care providers, many did not ask questions because they just wanted the exam to be over.

Results of this qualitative study indicate that mothers have a significant effect on their daughter’s decisions to seek obstetrical/gynecological health care and/or their knowledge about reproductive health care. The fact that many of the mothers in this study prompted their daughter’s initial gynecological visit is very positive. However, the manner in which the subject of reproductive health was approached is an example of a contradiction in being that many of the women experienced. For instance, the majority of the women in this study learned to call the vagina by a code name. Referring to the vagina by code serves to reify the shame and secrecy associated with the Black female body. The limited communication that several of the mother/daughter pairs experienced is due in part to the sexual socialization process.

Mother/daughter communication seemed to be influenced by the closeness of the mother/daughter relationship. This result coincides with research (Pluhar, 2004) that indicates that if a mother and daughter are connected and close, talking about sexual issues could have more of an impact, while a disconnection in the relationship could negate any amount of talking. Additionally, research (Aronowitz & Morrison-Beedy 2004) indicates that mother/daughter connectedness has the potential to decrease adolescent girls’ propensity to engage in risky sexual behaviours. Connectedness is defined as a daughter’s perception about being cared for by her mother and the mother’s involvement in the girl’s life (Aronowitz & Morrison-Beedy, 2004).

Consciousness surrounding issues such as the importance of preventive health care; racism, sexism and classism and the necessity to
speak openly with physicians about health care, appeared to be higher among women who reported having open mother/daughter communication. The increased consciousness could be due in part to what Rockquemore (1999) refers to as emerging voice. The woman as objectified subject begins to find her voice as a member of a meaningful group (Rockquemore, 1999, p.57). In this study, emerging voice occurred when women reported discussing and comparing their health care encounters with their mothers as well as other important women in their lives.

The findings presented in this research suggest that open mother/daughter communication about women’s health would encourage women, from adolescence to adulthood, to ask more questions of providers during health care encounters. Thus, improved mother/daughter communication could facilitate improved physician/patient communication. Consequently, further research that examines how negative sexual stereotypes impact upon mother-daughter communication and the women’s subsequent decisions to seek health care is necessary in order to adequately understand the multiple barriers that many women face when utilizing reproductive health services.

Limitations
A limitation of this study is that the data consists solely of self-reports. The recall period of the mother generation was longer than that of the daughter generation, especially in regard to initial gynecological experiences. Thus, the reports of the older women may not have been as exact as those of the younger women. Another limitation of this study is that little class diversity exists within the sample. Based upon the measures of SES used in this study, (education, occupation and insurance status), the majority of the sample is middle-class. This is important to note because research suggests that low-income African Americans report higher levels of dissatisfaction with health care in comparison to their middle-class counterparts (Becker & Newsome, 2003).

Implications for future Research
A study that includes a more socioeconomically diverse population could reveal potential patterns of specific mother-daughter communication across varying SES groups. Additionally, a study that integrates an intervention into its research design has the potential to increase African American women’s utilization of standard women’s health services as well as improving providers’ delivery of medical care. For instance, an intervention that facilitates mother/daughter communication about reproductive health care, as well as open communication with health care providers about sensitive issues could serve to change patient as well as provider behaviour regarding women’s
health issues. For example, research (Willems et. al., 2005) indicates that physician’s are positively influenced by patient’s communicative style, such as asking questions. Moreover, an intervention that targets health care providers’ awareness of the impact of negative sexual, racial and class stereotypes on the delivery of care could serve to heighten consciousness among health professionals, hence improving the quality of care provided to marginalized groups.
REFERENCES


