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### Interpretative Repertoires That Shape Low-Income African American Women's Reproductive Health Care Seeking: "Don't Want to Know" and "Taking Charge of Your Health"

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# Interpretative Repertoires That Shape Low-Income African American Women's Reproductive Health Care Seeking: "Don't Want to Know" and "Taking Charge of Your Health"

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In the context of reproductive and sexual health, African American women have higher incidence of disease and poorer outcomes on key indicators when compared with White women. In this study, we used discourse analysis to identify and examine the workings of two clusters of interpretive resources ("interpretative repertoires") associated with reproductive/sexual health care seeking among low-income African American women who participated in semistructured interviews as part of a health promotion initiative. Interpretative repertoires are ways of accounting for engaging in or refraining from engaging in actions, which are shared by people in a community. We labeled the two interpretative repertoires "Don't Want to Know," and "Take Charge of Your Health." Within the "Don't Want to Know" repertoire, that testing would lead to threatening findings was assumed, a chain of devastating consequences was imagined, and a preference for uncertainty over certain knowledge was expressed. Conversely, the "Take Charge of Your Health" repertoire valued certainty over uncertainty, though in both interpretive frameworks, knowledge-based and emotion-based decision-making were intertwined. We conclude that health promotion initiatives—if they are to succeed in encouraging women to obtain valuable preventive health care services—must respond, in their choices of language and outreach strategies, to the expressed dilemma of wishing for reassurance but fearing bad news, to the intertwining of emotional reasoning and technorationality in health decision making, and to the particular relational experiences of African American women. Failure to do so will contribute to the continuation of reproductive and sexual health disparities.

In the context of reproductive and sexual health, African American women have higher incidence of disease and poorer outcomes on key indicators when compared with White women. African American women are both more likely to contract cervical cancer and more likely to die of it than non-Hispanic White women.<sup>1</sup> Although less likely to get breast cancer than European American women, African American women are more likely to die from it.<sup>2</sup> In New York State, the site of the study reported on

here, African Americans represent only 15% of the state's total female population but 56% of all women living with HIV/AIDS, and 64% of women newly diagnosed with HIV, with sexual intercourse the dominant mode of transmission (New York State AIDS Advisory Council, 2005). In addition, in the 2003–2004 National Health and Nutrition Examination Survey conducted by the Centers for Disease Control and Prevention (CDC), which found that about 25% of teenage girls in the United States have one or more sexually transmitted diseases, the rate of infection for African American teens was approximately twice the overall average (Altman, 2008).

It is widely acknowledged that the causes of health disparities are both distal and proximate, and rooted in systematic inequities of education, income, conditions associated with the physical environment, and political influence (Airhihenbuwa & Liburd, 2006). Moreover, in smaller

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<sup>1</sup>At 5.3 versus 2.4 deaths per 100,000 (National Institutes of Health, 2006).

<sup>2</sup>With 119.4 versus 149.4 incidence per 100,000, but 34.7 versus 26.2 deaths per 100,000 (National Institutes of Health, 2006).

towns and cities (like the site for the research reported on here), women can encounter environment-specific barriers in obtaining health care, such as limited providers and lack of public transportation (Golden, 2014). Eliminating inequalities in disease incidence and outcomes therefore requires intervention at multiple levels and dimensions of individuals' environments. We need, for example, public policy changes to expand access to health care, education to influence individuals' lifestyle choices, and community-level interventions that are fitted to the local context.

Research focusing specifically on African American women and breast cancer finds that most of the disparity in outcomes is explained by the fact that their cancers are diagnosed at more advanced stages, as a result of not receiving recommended screenings (Silber et al., 2013). Moreover, this finding is part of a larger picture in which African American women were less likely to report having a primary care visit in the year preceding the study and were in poorer overall health. Many reasons for underutilization of preventive health care by African American women have been proposed, including informational and logistical barriers (such as lack of knowledge regarding screening guidelines, cost, transportation, and navigating the health care system) (Farmer, Reddick, D'Agostino & Jackson, 2007); fatalistic attitudes toward health (Powe & Finnie, 2003); the tendency to place the care of others before care of the self (Woods-Giscombe, 2010); and a desire to avoid health matters that call attention to their sexuality, given the negative sexual stereotypes African American women have been subjected to (Warren-Jeapierre, 2006).

We report here on an analysis of data gathered as part of a project whose purpose is to identify effective community-based strategies for encouraging low-income African American women in a smaller urban setting to seek regular reproductive/sexual health care services, with a particular focus on annual "well woman" exams (often referred to as "annual G-Y-N exams"). These annual exams are crucially important, especially among underserved women. Even though guidelines for cervical cancer screening ("pap smears") have reduced the recommended frequency from annually to every 2 to 3 years, an annual well-woman exam at a reproductive health care provider encompasses many other health screenings (e.g., checking for elevated blood pressure, glucose and protein in urine, enlarged thyroid). Moreover, for many low-income women, this is their only annual checkup for such basic health indicators (Frost, Gold, Frohwirth, & Blades, 2012). These exams are also where women typically get scripts for mammograms and a context for being offered sexually transmitted infection (STI) and HIV screening.

The project was a collaboration among a university research team, a local publicly funded reproductive health care provider, and other local health and human service organizations, and was informed by principles of community based participatory research (Minkler & Wallerstein,

2008), and social ecological approaches to health promotion (Stokols, 1996). We conducted and evaluated community-based interventions designed to overcome barriers associated with lack of (a) health knowledge regarding screening guidelines and risk factors, (b) ability to pay for services, and (c) transportation. We organized community health education events, where residents could meet representatives of local health and human service organizations, and we offered taxi vouchers to women who made appointments for services. These interventions were successful in moving some women in the community to obtain reproductive health care services. However, the project's results demonstrate that even when interventions remove knowledge, financial, and logistical barriers, underserved women still may not seek reproductive health care services. Thus, resources and knowledge, while necessary requirements for women to seek health care services, may not be sufficient because of additional barriers left unaddressed, which is the focus of this article.

Interventions to encourage health care seeking that focus on resources (i.e., means to pay for services, transportation to services) and knowledge (i.e., guidelines regarding screenings, the benefits of early detection for reproductive cancers and HIV, and the impossibility of knowing one's disease state without medical screening) emphasize a traditionally rational biomedical approach to health. Within this framework, more knowledge about one's health is always preferable to less knowledge. This assumption, however, may be quite problematic, as demonstrated by previous interpretive research on breast cancer screening practices among African American women (Lende & Lachionde, 2009).

Babrow and Kline's (2000) analysis of breast self-exam campaigns identifies a mechanistic biomedical paradigm of uncertainty reduction, within which the reduction of uncertainties about one's disease state is assumed to be unequivocally advantageous. They challenge this paradigm by pointing out both the difficulties that may ensue when uncertainty is reduced and the potential advantages attached to preserving uncertainty. Similarly, Johnson (2012) has argued that an HIV testing campaign claiming that "Knowing is Beautiful" presumes negative results and ignores the potential consequences of finding out that one's HIV status is positive.

In this article, we likewise challenge the "ideology of uncertainty reduction" (Babrow & Kline, 2000), and the expectation that the provision of material resources and knowledge will necessarily lead to greater reproductive health care seeking. The results of a detailed discourse analysis of women's accounts for not seeking preventive reproductive/sexual health care services point to the conclusion that providing resources and health knowledge about the value of screenings, while potentially helpful, does not address the full complexities entailed in moving women from a position of uncertainty to one of certainty—of not knowing to knowing their disease status. Through close analysis of the accounts that women offer for their own and other

community members' health care seeking behaviors, a fuller understanding of the complex positions these women take up with respect to health care seeking emerges. Within these positions, "rationality" and "emotionality" are inextricably intertwined, and many women grapple with ambivalence over their desire for certainty and their fears of threats to their well-being. Working from a sociocultural perspective, our approach is discursive, presenting the interpretive resources women in this community draw on in constructing explanations of their own and other community members' health care seeking behaviors, which have important implications for interventions to encourage health care seeking.

## METHODS

### Participants and Data Collection

We conducted semistructured interviews with women to discuss their reactions following 16 community health education events (over a period of 28 months) where information about reproductive and sexual health and an opportunity to sign up to receive services were provided. The participants included 118 women who self-identified as Black, Black and Hispanic, Black and White, or Black and American Indian. The interviews were aimed at eliciting the respondents' reactions to the events as well as their accounts for engaging in reproductive health care seeking behavior or not engaging in this behavior, both for themselves and for other women in their community. More specifically (after obtaining participants' informed consent to be interviewed, as approved by the institutional review board of the researchers' university), we asked participants whether they were up-to-date with their recommended reproductive health screenings (i.e., had a "well-woman" or "annual G-Y-N exam" within the past 12 months, or had a mammogram within the past 1 to 2 years, if aged 40 years or over), and, if they were not up-to-date, what obstacles they felt prevented them from getting screened. If they reported that they were up-to-date, we asked what they felt were the most common obstacles that prevented women who weren't up-to-date from obtaining recommended screenings. All interviews were audio-recorded and transcribed in their entirety. For readability purposes, in this article we have somewhat simplified the interview excerpts we include by eliding interviewer interjections such as "yeah" and "mmm hmm."

Our rationale for eliciting the participants' reports of their own reasons as well as other women's reasons for seeking and not seeking health care services was twofold. First interpretative repertoires are resources that are shared in a community for interpreting actions and events as reasonable/unreasonable or legitimate/illegitimate. Asking interviewees about other women's reasoning as well as their own reasoning is a way of tapping into the shared (rather than individual idiosyncratic) reasoning in the community.

Second, we suspected that women might feel that claiming to be up-to-date with their screenings was a particularly socially desirable response in this context, that is, speaking with a researcher who was also an organizer of the health education events. Asking about "other women" gave respondents a chance to report accounts that they might be reluctant to ascribe to themselves in this context.

To elaborate on the second point just described, we did not assume a straightforward isomorphic relationship between what women reported as their screening status in the interview context and their health care seeking behavior outside of the interview situation. We took an agnostic position with respect to the "truth" of women's reports about being up-to-date with their screenings and did not treat the interviews as a potential means of gathering "facts" about participants' health care seeking practices (Silverman, 2004). Rather, we consider the interviews an occasion for participants to display their interpretive resources in accounting for this behavior, resources that we assume to be communally held. To those who might infer that women who attended the events (and participated in interviews) would be more likely to actually be up-to-date on their screenings, we respond that (a) women offered reasons for attending the events other than an actual intrinsic interest in women's health (which might indicate that they were actively taking care of their health)—for example, being invited by a friend and coming in order to fulfill a relationship expectation, coming for the incentives, or even just being bored and looking for something to do; and (b) women are not necessarily in a state of either wholly embracing reproductive health screenings or firmly rejecting them because they don't want to know the results—rather, they may be somewhere in between, reflecting a state of ambivalence between wanting the reassurance that screenings can provide and fearing a positive finding and the ensuing consequences.

Wetherell (2003) argues, in answer to her question, "What can interviews tell us? I think they can tell us crucial things about a segment of a society's conversations with itself, about the ways in which the world is typically legitimated, organized, and justified. . . . Interviews tell us about the cultural resources people have available for telling their patch of the world" (p. 13). Focusing more specifically on the production of meaning through the interaction of interviewer and interviewee, Wetherell (1998) notes that the "interviewer's questions key into two very pervasive and inter-related discursive activities—describing events (formulating their nature) and accounting for and evaluating those events" (p. 390). She goes on to explain that "interpretative repertoires comprise members' methods for making sense in this context—they are the common sense which organizes accountability and serves as a back-cloth for the realization of locally managed positions in actual interaction" (pp. 400–401). Interpretative repertoires are "culturally familiar and habitual line[s] of argument comprised of recognizable themes, common places and tropes" (p. 400). Our

analysis of the interview accounts was therefore informed by the form of discourse analysis described by Wetherell and Potter (1988) that focuses on the identification of “interpretative repertoires”: “In dealing with lay explanations the analyst often wishes to describe the explanatory resources to which speakers have access and to make interpretations about patterns in the content of the material. The interpretative repertoire is a summary unit at this level” (p. 171).

## Data Analysis

The starting point for the analysis reported here was selecting segments of interview transcripts that contained interview questions and responses related to reasons why women might choose or not choose to seek reproductive health care services, and the development of coding categories for these segments. Starting with a review of a small number of interviews, we developed an initial set of coding categories, which were then refined by reviewing additional interviews until no new categories emerged. Research assistants coded the entire collection of interviews using the coding categories we developed, using the NVivo qualitative data analysis software program. The research assistants were instructed to keep note of instances in which they had questions about the fit of a code to the instance, and we discussed and reconciled those instances.

Using NVivo, we examined the interviews for categories of accounts given by respondents for other women’s not seeking health care services and the respondents’ not seeking health care services themselves. After eliminating accounts that referenced structural barriers such as lack of insurance and lack of transportation, the most frequent, and often initially mentioned, explanations that emerged were “They don’t want to know” and “I don’t/didn’t want to know.” Further examination of the two groups of explanations revealed frequent ambiguity as to whether respondents who offered explanations for other women were also talking about their own reasons. Additionally, in some interviews, respondents went seamlessly back and forth between talking about self and others. Because of the ambiguity, we combined both “They don’t want to know” and “I don’t/ didn’t want to know” as the focus of our analytic attention.

We then closely examined each instance and surrounding talk where participants offered “they/I don’t want to know” as an explanation for not seeking health care services, making analytic notes on our observations and insights. As we examined the instances and the surrounding talk, we paid attention to the particular words the participants used, the ways explanations were structured, and how the explanations functioned in the ongoing talk. We wrote memos on recurring aspects and features of this set of interview excerpts. Over the course of our analysis, it became apparent that the “don’t want to know” repertoire was frequently intertwined with a complementary, contrasting repertoire that we labeled

“taking charge of your health,” and we expanded our analysis to look specifically at this repertoire as well. We describe the features of the two repertoires in the Findings section; we explain the relationship between them in the Discussion section.

## FINDINGS AND INTERPRETATION

As noted already, interpretative repertoires represent resources that speakers have access to in providing lay explanations, or their “practical reasoning” (Wetherell & Potter, 1988, p. 173) regarding activities that are part of their lifeworld. An analysis that focuses on identifying these interpretive resources “depends on the study of variation, working from the way discourse is constructed to some conclusions about the functions discourse might be serving” (p. 172), such as “accusations and justifications” (Wetherell, p. 401, 1998). The rhetorical power of an interpretative repertoire derives from its commonsensical quality: “The whole argument does not need to be spelt out in detail. Rather, one fragment or phrase . . . evokes for listeners the relevant context of argumentation—premises, claims and counter-claims” (Wetherell, p. 401, 1998). We focus here on two repertoires that emerged from participants’ accounts of their own and other women’s reasons for choosing to seek or not to seek reproductive health care services. Drawing directly on participants’ own discourse, we labeled the first repertoire “Don’t Want to Know” (DWTK), which encompasses the interpretive resources respondents drew on in explaining why women (predominantly others, but sometimes also themselves) did not seek recommended services. We labeled the second repertoire, which contains the interpretive resources for explaining why women either do seek or should seek services, “Taking Charge of Your Health” (TCYH).

### “Don’t Want to Know” (DWTK)

The basic argument this repertoire asserts is that women in the community who do not seek reproductive/sexual health screenings choose not to because they do not wish to know the results of the screenings.

Interviewer (I): What do you think, for woman who don’t do that [get regular reproductive health screenings], is like, the biggest thing that gets in the way?

Participant (P): They don’t want to know. “If there is something wrong, I don’t want to know what it is wrong” until it is almost too late.

The readiness with which participants offered this account point to its status as a “culturally familiar and habitual line of argument” (Wetherell, 1998, p. 400), which serves

as shorthand for a set of premises shared among the community. Participants did not always stop at the shorthand, though; they also elaborated this basic “don’t want to know” argument using a distinctive set of discursive features and rhetorical moves, as described in the following. It becomes apparent that while these elements have been separated for analytic purposes, they can be very closely interwoven.

**Fearful anticipation of likely bad news.** The reasoning that participants described women engaging in for not seeking reproductive health screenings rested in part on arguments regarding the likelihood of obtaining unfavorable findings, as well as the fear associated with receiving those findings. In some cases women cited specific risk factors that might point to an increased probability that testing would disclose a health problem, including behaviors that put women at risk for sexually transmitted infections, family histories of cancer, or troublesome symptoms. In other cases, though, the women cited no specific grounds for concern but rather a bias toward the likelihood that testing would reveal a previously undetected problem. In addition, it was assumed that the problem would be life-threatening, such as breast or cervical cancer or HIV.

P: That’s the main reason why women don’t want to go. Nobody wants to hear bad news. And with this subject, it is kind of like a fifty-fifty chance. So, nobody wants to walk in the door feeling good and then walk out the door saying, “Oh, my God.”

P: I think it’s more of a fear of what the results is going to be. When you go for your G-Y-N and then, you know-and then find out that you have something or something’s wrong with you- it- some people just don’t want to hear that. And that’s- that’s a fear. A fear of going to that appointment and seeing- or going- or going for the mammogram and then find out that you might have a lump or . . .

The argument that the speakers were making was that women do not obtain recommended screenings because of the threat represented by findings. “Nobody wants to hear bad news” is indeed difficult to argue against in an absolute sense. However, the important rhetorical move here was the embedded assumption of the probability of testing resulting in bad news. It’s a “fifty-fifty chance” or “when you go and then you find out you have something”—rather than “if you find out you have something.” As noted earlier, the “objective reality,” according to public health statistics, is that African American women are actually somewhat less likely than White women to be diagnosed with breast cancer; unfortunately, they are more likely to die of it because of presenting at a more advanced stage, due to underscreening (Silber et al., 2013). Some research has linked the exposure of women in African American communities to such negative cases to the practical reasoning displayed here, which then leads to refusal of services (Farmer et al., 2007;

Jernigan, Trauth, Neal-Ferguson, & Cartier-Ulrich, 2001). We discuss this further in the following.

The fear associated with receiving the predicted “bad news” was a powerful and pervasive aspect of this interpretative repertoire that found expression in multiple discursive forms, aside from the form identified above. Additional distinctive ways in which participants discursively instantiated the experience of fear are identified next.

*“Thinking” versus “knowing”—valuing uncertainty.*

Another powerful move within the DWTK repertoire involved a contrast between two knowledge states with respect to the screening results. The current knowledge state, or epistemic status, of the women was cast as “thinking,” “guessing,” or “fearing,” while the contrasted knowledge state was cast as “knowing,” or “knowing for sure.” Within the DWTK repertoire, “thinking”—that is to say, uncertainty—was framed as the more valued or preferred state, whereas the “knowing” epistemic state was framed as potentially tremendously problematic because of the subsequent consequences (which are identified more specifically in the following). Being screened, going for an annual G-Y-N exam, going for a mammogram were actions intrinsically bound up with changing the epistemic status of thinking and guessing into knowing.

P: And you should go get G-Y-Ns. And you should go get mammograms. And you should check your health, because a lot of people are scared of the results. But you won’t know the results unless you go. And you can’t sit around for so long, because as you can see, people die every day from AIDS. All types of STDs. Like you have to be like certain and sure. And you can only be sure if you go get checked. If you don’t get checked, you can think all you want. But it’s not going to help you. You need to go find out the facts on paper.

In framing their current state as fearfully anticipating or projecting the results, the knowledge status at that point was less certain regarding one’s own state of health. If or when the results became known, the epistemic status of the woman’s state of health in that area would be sure, factual knowledge. In the following quote, the shift represented by “knowing” is underscored by the use of “really” (in contrast to merely thought or speculated about), and the problematic nature of that knowledge indicated by “afraid.”

I: What do you think is the biggest thing that gets in the way of women getting an exam?

P: Afraid to know if anything’s really wrong.

Many of the participant accounts highlighted this change in epistemic status through the use of the verb “find out” or “found out.” This choice of language—*finding*—particularly emphasized the idea of the presence of something (in this case knowledge about one’s health) that was absent prior to the act of *finding* or *finding out*.

I: What do you think is the biggest thing that gets in the way of women getting mammograms every year?

P: The fear of finding out if you have cancer- I think that's what it is. A lot of people are probably scared of- cuz I know I would be scared.

P: You know, a lot of people like my cousin, her sister had, um, two breasts removed, so she had to go take the test. She didn't want to take the test because she was scared with what it was going to find.

The presence—almost materiality—of this knowledge filled in what might be envisioned as a kind of negative space, or nothingness, where uncertainty resided, which then became a *something* that the individual had to reckon with.

*Scenarios of changes in knowledge state—“Hearing bad news.”* The importance of the change in epistemic status and the threat that was involved in that change were highlighted by a discursive move in which respondents referenced the interactional occasions in which women were informed of the bad test results, and focused in on “hearing” the news that the provider says.

I: Do you think that's [no insurance, no car] why a lot of women just don't go to the doctor?

P: A lot of women don't go because they don't want to really hear bad news if something really is wrong, you know.

P: And like I said, a lot of people, some people just scared to find out what the doctor going to say.

Sometimes this discursive move was elaborated into an imagined scenario (with direct reported speech) of an occasion in which a health care professional delivered test results.

I: I know at the beginning when I asked you that question, you said, yeah, you were going for your annual G-Y-N exams, but you hadn't had a mammogram.

P: I didn't. I missed my mammogram. I did. And- and it's just that fear of going and get that phone call and say, “Oh, you- something's wrong.” That's what scares me the most.

I: What do you think is the biggest thing that gets in the way of women getting an annual exam?

P: I think it's the fear of finding out something- something's wrong with them. And scared that they're going tell you, “Oh, you gonna have AIDS,” “Oh, you might have this,” or something so a lot of people are scared to go for that annual exam and I be glad- I'm glad that- I used to be one of them- one of them women that's like that. That didn't want to go and do the annual G-Y-Ns—none of that.

Wood and Kroger (2000), drawing on the work of Edwards and Potter (1992, cited in Wood & Kroger, 2000), note that “vivid description” and “narrative” are two techniques of “fact construction.” That is, the details of a “vivid description” “support the factual quality of a report,” and in a narrative, “the factual status of events is enhanced by embedding them in a particular narrative sequence” (p. 196). In accounts produced by our participants, they were not referring to events that actually happened but to events that might happen

or were seen as likely to happen, so participants were rhetorically enhancing the plausibility or the reasonableness of the argument by using the same techniques that Edwards and Potter cite as techniques of “fact” construction. By focusing in so tightly and vividly on the moment of the change from not knowing to being forced to acknowledge a serious problem, the speaker made a more compelling case for fear as a deterrent to screenings. In the quote just provided, the speaker's acknowledgment that she “used to be one of them” (i.e., women who “don't want to know”) further underscored the “understandability” of women who personally embrace the DWTK repertoire.

*Chain of consequences.* Beyond the moment of change in epistemic status, and the imagined revelation of a significantly threatening finding as a result of undergoing screening, the DWTK repertoire also included narratives of chains of consequences that unfold from the diagnosis of the disease itself (whether breast cancer, cervical cancer, HIV, or another less serious sexually transmitted infection). One type of consequence beyond the bodily threat posed by disease that was cited by multiple respondents was emotional, including states of depression, feeling overwhelmed, and devastation.

I: There was a point about where we talked about things that get in the way of women going to annual G-Y-N exams? Or if they are 40 or over, getting mammograms?

P: I felt like the main reason that no one brought up, because everyone said, “oh time, transportation,” and you know, “(what if I have) a job,” and this and that and the third. The main reason that women do not want to get tested is because they don't to be sick and then deal with depression on top of that.

P: I was scared. I was like “I don't know if I want to do this [go through with the mammogram appointment]. I don't know if I'll be able to handle it.”

P: I don't know if I have something or whatever the case may be, but I'm scared to find out, because if it is what I think it is, then I'm gonna be torn apart.

Another potential consequence, when diagnosis of HIV or an STI was included as part of a “don't want to know” account, was relational.

P: The fear of having cancer or the fear that you have a STD or a STI, because of infidelity or ins- you know.

I: Yeah.

P: And then going to the doctor's and something's wrong with me- I'm not doing anything, what's wrong with me? And something's not right and my body. Then the fear.

If a woman had committed to sexual exclusivity with a partner and then found she had HIV or another STI, she would be obliged to confront, at least to herself, that her commitment was not reciprocated—and then to decide how to proceed interactionally and relationally with that partner. Thus, the fear of “knowing” and therefore the “protection” afforded by “not knowing” is more than just protection from

the certainty of the knowledge of disease itself, but also protection from emotional devastation, depression, and the knowledge of relational betrayal and consequent relationship conflict and/or dissolution.

### "Taking Charge of Your Health" (TCYH)

This repertoire constituted a cluster of interpretive resources that were frequently invoked in contrast to the arguments and positions contained in the DWTK repertoire. Overall, this repertoire supported seeking reproductive/sexual health screenings as an active (taking charge) strategy for a woman to protect her health.

***Screening to "be sure I'm all right."*** This discursive move stands in marked contrast to discourse in the DWTK repertoire that asserted the likelihood of bad findings as a result of screening. In this move, screenings were framed as a means of "be[ing] sure I'm all right." In this alternative account (for seeking health care services), screenings were a means of confirming good news—either banishing a worry about a symptom, or affirming a continuing assumption of good health.

P: I am telling you, I have anything little hurt me, I'm going. Because I'm going to be sure I'm all right.

The TCYH repertoire also contained moves in which the possibility of bad news was forthrightly acknowledged. However, the "screening to be sure I'm all right" move is consistent with the other moves insofar as it counseled active seeking of information about one's health status.

***"Knowing" versus "thinking"—Valuing certainty.*** Within the TCYH repertoire, the epistemic status of uncertainty—rendered as "thinking about" what a likely result of screening might be—also figures prominently. However, in the context of this repertoire, this epistemic status is positioned as a less valued or less favored status. The epistemic status that was contrasted with "[merely] thinking" was "knowing."

I: But, what do you think are the biggest things that get in the way of women getting, you know, a regular annual checkup? And getting a pap smear? And getting a mammogram? And all that stuff?

P: Well, a lot of people are afraid. I know a lot of people are afraid.

I: Afraid?

P: Yeah. Of going. Like I say, on me, I want to know what's going on with my body but a lot of folks are afraid, you know, don't know what the answer is going to be. Then they don't go.

Unlike the "screening to be sure I'm all right" move, in this move the emphasis was centrally on the value of knowledge, presumably so that she could take steps to deal with any problems that might come up. Although that move was not explicitly articulated by this speaker, it was articulated by many others, as demonstrated in the following.

***Moral imperative to know for sure.*** Although in their rendering of the DWTK repertoire women expressed understanding of how fear could deter others from seeking screening, in the context of the TCYH repertoire, knowledge seeking was frequently cast in moral terms: "You should check your health. . . . You need to go find out the facts on paper." By using "should" and "need," therefore, this move goes beyond merely valuing certainty to advocating taking charge as an ethical choice.

***Early detection is the best protection.*** In this move, respondents actively took up the argument that is so frequently offered by the medical establishment in support of many screenings: that detecting a disease in its earlier stages increases the chances for curing or successfully managing it. While the actual steps for medical intervention were not articulated in any detail, what was notably absent were the devastating consequences of diagnosis that are a feature of the DWTK repertoire.

P: There's a million others people in this town that need the word—to hear, like, what the person [who spoke at the event] is saying to help them, so that you don't just be sitting in your bed all day and you could have cancer and you don't know it. Or you could have this and you don't know it because you're scared to find out what you have. When you know, once you find out, it's a big relief, so if it's good or bad, you might as well just hear it before it gets ten times worse. . . . So you can live a little longer and not just conk out, like, at the drop of a dime.

In this move, and in the other moves that this repertoire encompassed, there was a distinctly different emotional tenor compared with the DWTK repertoire. DWTK focused on fear, whereas TCYH focuses on the "relief" of knowing for sure, even if the results were bad, and the composure and confidence that would accompany actively dealing with a problem that had been detected.

## DISCUSSION

We chose discourse analysis as an approach to better understand reproductive and sexual health care seeking by capturing the lived interpretive experiences of the women in our study. Discourse analysis helps "to do justice to the subtlety and complexity of lay explanations as they are deployed in natural contexts" (Wetherell & Potter, 1988, p. 183). The preceding analysis points to four areas of complexity, which we discuss more explicitly here. We follow the discussion of complexities by outlining recommendations for practice based on our findings and the complexities discussed below.

### Complexities of Lay Explanations

***Intertwining of "DWTK" and "TCYH"—Self and other.*** For analytical purposes, we separated the repertoires and their constituent elements in reporting our findings. Here

we bring them back together to discuss how they relate to each other. Although the primary focus of our analysis has been the “Don’t Want to Know” repertoire because of our interest in identifying barriers to health care seeking, that repertoire was often co-present with the “Take Charge of Your Health” repertoire. In some instances this was because participants were positioning themselves as being adherent to screening guidelines and “taking charge of their health,” while explaining the behavior of women who did not follow screening guidelines or seek regular reproductive health care by recourse to the “Don’t Want to Know” repertoire. Rhetorically, speakers used a comparison–contrast strategy to bring their own positions into sharper focus (as in “me, I want to know what’s going on with my body but a lot of folks are afraid, you know, don’t know what the answer is going to be”). In some instances, the comparison–contrast also displayed movement from a formerly held position to the currently held one (as in “I used to be the type of person” who didn’t want to know).

Frequently, though, the distinction was between self and other was far less clear, and thus it was less clear whether the speaker was deploying the DWTK repertoire with respect to her own thinking and actions or whether it was being identified as an interpretive resource drawn upon by others, as, for example, in the following participant’s discourse. When she was asked, “Is there anything that you think that you would change about taking care of your health as a result of having been to this event?” she replied:

P: I don’t know. I really don’t like doctors. I can’t say every year I go [get an annual G-Y-N exam], because I don’t, I can’t say that, but I try to. You know what I’m saying? I try to go get it done. But there’s sometimes where I go three years without getting it done. I’m like, “Well, maybe I should go get it done.” But, see, I don’t go out. . . . And I have that trust in him, and then he has that trust in me. So sometimes I don’t go get it. But that’s still not preventing me from getting cervical cancer. That’s still not preventing me from getting anything else, you know? So it’s just you don’t want to hear that result, you know. I mean, I don’t know what I would do if I found out if I ever had cervical cancer. I would probably flip the heck—you know? So people just have that in their head, like what they don’t know sometimes don’t hurt, sometimes they say. But then in the long run, I mean, like syphilis, if you’re pregnant, that can hurt your baby. You know what I’m saying?

It is somewhat ambiguous here whether the “you” who “[doesn’t] want to hear that result” in this context is the speaker herself or some generalized other—or indeed both at once. The tension between what she acknowledged she “should go get . . . done” “every year” and her fears of the results shows the coexistence of the two repertoires both across the community and within the discourse of individuals. Van den Berg (2003) notes that contradictions within an individual’s discourse can sometimes be understood in terms

of face-saving or argument-building. It may also be the case, though, that contradictions reflect “a ‘real’ or substantive dilemma that can’t be solved by rhetorical means, because it is part and parcel of the interpretative repertoires used by the interviewee in talking about the topic in question. . . . [and] the dilemmatic nature of common sense” (p. 135). The contradictions between not wanting to know and acknowledging medical recommendations that one should know one’s health status are in part—though not wholly—reflective of tensions between emotion-based decision making and knowledge-based decision making, which were intertwined throughout the repertoires, and are discussed further in the following. These contradictions also reflect a fundamental ambivalence on the part of some women between the desire for certain knowledge that they are “all right” and the estimation of the probability of receiving bad news rather than good following a screening, and the fear of the consequences to follow.

*Emotionality and rationality in health-related decision-making.* Wood and Kroger (2000) observe that “emotion concepts and metaphors constitute an important set of discursive resources for deployment within narrative and rhetoric” (p. 198). In our analysis, we have demonstrated that the discursive representation of emotion was integral to the rhetorical force of the arguments these repertoires made. This predominantly took the form of fear of screening results in the DWTK repertoire, but also took the form of relief that might come from banishing a worry in the TCYH repertoire. Emotion was therefore a common thread in both accounts of avoiding and accounts of seeking knowledge about one’s health.

From another standpoint, though, not wanting to know one’s disease status might be positioned as an irrational response to a potential threat, whereas seeking knowledge about one’s disease status might be positioned as the rational response and necessary element of the early detection approach favored by the medical establishment. In the traditional biomedical model of health care seeking and delivery, emotion is a downgraded form of experience and decision making, something undesirable to be minimized and controlled (Morgan & Krone, 2001). As Lupton (1998) points out, emotions have traditionally been positioned as “irrelevant or disruptive” to post-Enlightenment “rationality”; rational thought is privileged over irrational emotionality; rationality is associated with the thinking mind, whereas emotionality is associated with the feeling body; and rationality is disciplined, whereas emotionality is unruly (p. 3).

In contrast to this position, Shuler and Sypher (2000), in their work on emotional labor, argue that bifurcating emotion and reason creates a false duality because “emotion and rationality are intertwined” (p. 84); there is even a “logic of emotion” (p. 85). Similarly, Mumby and Putnam (1992), in their critique of bounded rationality in decision making, make the case that emotion has a knowledge-producing dimension because “sentiments about what is good, right,

and possible" (p. 480) have their roots in emotion. Indeed, in the DWTK repertoire, a logic of fear was intertwined with the likelihood of bad findings. It is a "logic" in the sense that fear becomes the understandable, if not justifiable, cause for not seeking preventive services. Thus, we argue that the results of our discourse analysis point to the conclusion that "emotional reasoning" must be acknowledged and honored, rather than simply supplanted, in attempts to overcome barriers to health care seeking.

*Critical versus sympathetic stances toward women who "don't want to know."* Another complexity in participants' explanations for health care seeking choices relates to the issue of blameworthiness, or accountability. Women who positioned themselves as "taking charge" took complex positions on the extent to which women who were choosing not to seek services because they "don't want to know" were considered blameworthy. This issue is intimately bound up with the discussion of emotionality and rationality. As Wood and Kroger (2000) point out, "Issues of agency and of blame and responsibility are viewed as central features in many reports" (p. 197). The link between being held accountable for not getting recommended health screenings and emotion is the centrality of fear in the DWTK repertoire. Edwards (1997, p. 194, cited in Wood & Kroger, 2000) suggests that emotion may be treated as either an irrational or a rational reaction, and the possessors of the emotions may be treated as accountable for their actions or unaccountable by reason of overwhelming emotion. The language with which speakers formulated the various moves in the DWTK repertoire suggests a somewhat equivocal position vis-à-vis blameworthiness. Not seeking services was clearly the dispreferred state of affairs, as demonstrated earlier by the women's acknowledgments that one "should" get an annual G-Y-N exam. But fear was rendered so powerfully within the DWTK repertoire that choosing not to obtain services became apparently at least a tenuously rational response to the fear. This was evident in formulations using "just," as in "Some people don't probably want to hear about—you know, they get their exam, something might be wrong, they don't want to hear about that and they might *just be afraid and scared*." This suggested that the speaker felt compassion for the other, at the same time that she argued for the preferability of "taking charge" and seeking information about one's own health status. Moreover, as noted earlier, the woman choosing not to seek services may actually be the other, or have been the self at some earlier point in time.

*Intersectionalities and low-income African American women's health-related decision making.* The impetus for this study's focus on low-income African American women sprang from widely reported disparities in reproductive and sexual health, overrepresentation of African American women among the poor in this smaller urban community (as elsewhere in the United States), and reported underutilization of the services of the local publicly

funded provider of reproductive health care by women of color (Golden, 2014). It is beyond the scope of this study to provide an empirically based comparison of low-income African American women's discourse with that of White women and/or women of different socioeconomic groups. However, contextualizing our findings with previous research does suggest certain areas of intersectionality and exclusivity. For example, income, educational attainment, and presumed access to prenatal care have not been found to produce a protective effect on the birth outcomes of African American women (Jackson & Phillips, 2003). The "Black superwoman" phenomenon has been found to transcend class lines, leading women to put off caring for themselves, resist situations that make them feel vulnerable or dependent, and suppress their own emotions (Woods-Giscombe, 2010). However, a comparative study of African American and White women's adherence to mammography screening recommendations did find significant differences regarding their fear of the procedure (Vadaparampil, Champion, Miller, Menon, & Skinner, 2003). Researchers attribute this fear to the greater likelihood of African American women knowing someone had a poor breast cancer outcome (Farmer et al., 2007; Powe & Finnie, 2003; Vadaparampil et al., 2003). Since poorer outcomes have now been conclusively linked to late diagnosis (see Silber et al., 2013), avoiding screening becomes a self-reinforcing cycle for the validity of the emotional reasoning that undergirds the DWTK repertoire. Thus, while, as one our participants noted, "nobody wants to hear bad news" (regardless of race), African American women may have higher expectations of receiving bad news following a screening, interpret this bad news in a more negative way, and therefore be more fearful of having screenings. At the same time, though, we note that there was considerable discursive variability within and across our demographically homogenous sample. The techno-rational arguments of the TCYH repertoire (including arguments for the value of early detection and valuing certainty over uncertainty) were frequently intertwined in the same individual's discourse with the more emotionally grounded reasoning of the DWTK repertoire. This underscores the importance, for designers of health promotion initiatives, of balancing an appreciation of how race and class shape health care seeking with an avoidance of essentializing women along racial or socioeconomic lines.

### Recommendations for Community-Based Health Promotion Practice

As noted earlier, we have treated the interview accounts that we gathered for this study not as factual reports of health behaviors but rather as patterned collections of interpretive resources that participants used for making sense of health care seeking behaviors. The particular resources that community members commonly draw upon, which we have identified here, have important implications for communicative

interventions to encourage preventive health care seeking. Discourse analysts argue that if “we come to understand the various interpretative repertoires through which . . . explanations [for social behavior and positions] are constructed and warranted, [we also] can start to understand the techniques through which these explanations can be undermined and transformed” (Wetherell & Potter, 1988, p. 183). We identify four implications of our findings for health communication interventions to increase preventive reproductive health care seeking.

***Address the probability of screening results that are not catastrophic.*** As we noted in our Findings section, a key feature of the DWTK repertoire is the projected likelihood of obtaining unfavorable screening results. We therefore recommend that messages included in community outreach that are aimed at persuading women to obtain recommended screenings remind women that one possible (and prevalent) outcome of screening is “no findings”—although, as indicated earlier, we do not endorse arguments that consist solely of getting screened to “make sure [you’re all right].” We also recommend the argument that not all findings are life-threatening. As one participant noted, after attending a presentation on breast health:

P: I used to be the type of person that I didn’t want to go to the doctor, afraid of what he might find. You know? So, instead of doing like that. Like she [the presenter] said, it’s not always cancer. So I’m going to do it now.

This contrasts with the “early detection” argument, which is commonly used in messages to promote reproductive/sexual health screenings. The premise of the early detection argument is when cancer is found in an early stage, it is more likely to be curable; that is, the argument assumes that there has been a finding of cancer but that it is manageable. For women who so vividly imagine the moment of diagnosis that they are overwhelmed with fear, relying solely on the early detection argument may not be as effective in persuading them to obtaining screenings as the idea that not all findings are actually cancer. It may be easier to dislodge the idea that the “something” that the screening results in will always be cancer than it is to convince women that a finding of cancer can result in a cure if it is detected earlier enough—especially in an environment where women may have seen community members die of breast cancer because it was not detected early enough (Farmer et al., 2007). However, we maintain that such messages should still be combined with information regarding the benefits of early detection in the unlikely (which should be underscored) event that a screening does reveal a problem.

***Provide social support for coping with fears about screenings.*** Previous research on cancer screening beliefs and practices among African American women has found an association between social support—both instrumental and emotional—and adherence to guidelines (Farmer et al.,

2007; Jernigan et al., 2001). The discourse of participants in this study explicitly positioned social support as an effective counterweight to fear when deciding whether to go through with recommended screenings. We therefore recommend incorporating the provision of social support when designing community-based interventions to encourage reproductive health care screenings.

- P: I was a little hesitant at first cuz I was like just going to walk by the [mammography] van and the lady was standing outside. . . . Then my sister walked in right behind me because she was supposed to have been there before me. So I felt a little bit alright with my sister there. I said “Well, I’ll go ahead and go.”
- P: Well, like the presentation, you know? Mainly [they should] say that if you don’t have support, where to get support from, you know, before taking the test, talk to someone. You know, a lot of people like my cousin, her sister had, um, two breasts removed, so she had to go take the test. She didn’t want to take the test because she was scared with what it was going to find. So, you know, I say, “Well, I can come and go with you and when you get the results, I’ll be with you.” You know, people need support like that.

In the instances described by these participants, the social support comes from a family member; however, the second participant acknowledges that not everyone has such support available. Our project, in keeping with its community-based research approach, drew on the support of a group of interested community residents that emerged in its third year to develop a peer health advocate program offering both instrumental and socioemotional support for obtaining health screenings. The peers received education on reproductive health topics and outreach training, and they recruited friends, neighbors, and family members to participate in group screening events. The peers also acted as escorts to the health care providers and frequently obtained screenings themselves (see Golden & Matsaganis [2013] for further detail on the results of the peer health advocate initiative).

***Use scenario-based messages that incorporate emotion.*** Scenarios that made reference to interactional occasions of hearing bad news were a powerful feature of the DWTK repertoire. This suggests that an effective strategy for promoting health screenings might be similarly vivid narratives of interactions in which participants hear good news. We imagine, for example, our local breast health expert describing, as part of a community health education event, a scenario in which the anxious patient’s point of view is represented, along the lines of, “I was so scared of getting a mammogram because I could feel a lump in my breast, and then they called me and told me that it was just a cyst. And I was so completely relieved.” A narrative such as this validates the fears expressed in the DWTK repertoire and provides a replacement for the original narrative. A testimonial from a woman who whose screening procedure did

return findings but the findings turned out *not* to be cancer could be a particularly effective communication strategy.

*Deliver health promotion messages through interpersonal interactions with community members.* As we noted earlier, women reported reasons for attending the events that were sometimes quite unconnected to their health care seeking behaviors (e.g., coming because of being invited by a friend, to receive an incentive, or to be entertained), as well as the more expected health information seeking reasons. We therefore assume that women who participated in the events likely included a range of positions with respect to seeking reproductive/sexual health screenings, from unequivocally embracing them to avoiding them. Conversely, we assume that women who stayed away would have many reasons as well, and represent a range of positions on health care seeking, including those who “don’t want to know,” and as a result avoid situations (such as health education events) where this position is challenged. An alternative, then, to advertised health education events for making the initial contact with these women and offering alternative interpretive resources to DWTK may be interpersonal interactions, for example, via a network of community members trained as peer health advocates, as described earlier.

## CONCLUSION

Many public communication campaign messages urging screenings for breast and cervical cancer, as well as STIs and HIV, are grounded in the benefits of early detection: Find cancer early, and it is more likely to be curable; discover HIV or an STI early, and it is more likely to be successfully managed. The logic is that more knowledge is always better than less knowledge; if a woman knows her disease status, then she can take efficacious action against any problems detected. Our analysis of the accounts provided by participants in this study reveals a different “logic” or form of “rationality” from this more mainstream modernist “technorationality” (Morgan & Krone, 2001). Emotionality and rationality are complexly and inextricably interwoven in this form of reasoning and knowing, and arguably “not knowing” has as important a function in keeping anxiety and imagined devastating consequences in abeyance as “knowing” in providing peace of mind. The discourse of some women thus displays profound ambivalence with regard to the potential trade-offs between certainty and uncertainty. We conclude that interventions must be context sensitive and respectful of the subjectivities of community members—and work with their ways of reasoning and knowing in encouraging them to obtain valuable preventive health care services, rather than labeling these forms of reasoning “faulty” and women’s choices not to seek services as “failures.” Moreover, further analysis of the discursive management of ambivalence in this discourse community has the potential to yield additional

strategies for communicative interventions, especially those led by fellow community members in the form of peer health advocates.

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