Advances in Nursing Science
Vol. 29, No. 3, pp. 195–206

In Our Grandmother's Footsteps

Perceptions of Being Strong in African American Women With HIV/AIDS

Donna Z. Shambley-Ebron, PhD, RN; Joyceen S. Boyle, PhD, RN, FAAN

One of the most significant challenges facing the health of black women in the 21st century is the growing numbers of human immunodeficiency virus/acquired immunodeficiency disease (HIV/AIDS) infections. An ethnographic study of African American mothers living with HIV/AIDS revealed that they believed in a tradition and heritage of strength that fostered their survival during difficult life experiences such as living and mothering with HIV/AIDS. They enacted this strength in culturally significant ways. This article discusses the importance of recognizing and supporting cultural strengths of African American women to help manage illness, while remaining cognizant of the context of oppression, discrimination, and stigma that distort cultural traditions and instead penalize women when they are ill. **Key words:** *African American women*, *culture*, *ethnography*, *HIV/AIDS*

SINCE their arrival on the shores of America, women of African descent have faced challenges unlike any other group. Those women who survived the Middle Passage, that horrific journey from Africa to the Americas, became the forerunners of generations of women who would survive against incredible odds. Hine and Thompson[1] chronicled the history and struggle of African American women illustrating a consistent pattern of hard work, struggle, family preservation, resistance, and dignity. Although still labeled with colonizing and stereotypical images that carry over from slavery, and faced with race and gender discrimination, African American women have demonstrated remarkable courage and resilience. Heirs of rich cultural traditions, African American women have overcome obstacles related to race, class, and gender discrimination as well as negative life experiences, including significant health threats, all with varying degrees of success. Even though cultural strengths have survived, the stereotypical myth of the "strong black woman," large and imposing, still exists in the minds of many Americans. While the power of this symbol may be transformative, it may lead nurses and other healthcare providers to ignore or diminish African American women's need for help when they face issues of health and illness.

Most recently, one of the most significant health challenges facing African American women has been the growing numbers of human immunodeficiency virus/acquired immunodeficiency disease (HIV/AIDS) infections. In 2004, the Centers for Disease Control and Prevention (CDC) reported that 74% of heterosexually acquired HIV infections in women were in non-Hispanic blacks.[2] When added to the health-damaging effects of race and gender discrimination, this increasing presence of HIV/AIDS presents a serious threat to the survival of African American

From the College of Nursing, University of Cincinnati, Cincinnati, Ohio (Dr Shambley-Ebron); and the College of Nursing, University of Arizona, Tucson (Dr Boyle).

The primary author thanks the American Nurses Foundation for funding this research.

Corresponding author: Donna Z. Shambley-Ebron, PhD, RN, College of Nursing, University of Cincinnati, Procter Hall, Room 244, 3110 Vine Str, Cincinnati, OH 45221 (e-mail: donna.shambley-ebron@uc.edu).

women and their families. African American women who are mothers may face unique challenges related to childrearing because of low socioeconomic status, racism, gender oppression, and, in general, the lack of opportunities to make a better life for themselves and their children.[3] How these mothers who have HIV/AIDS as an additional burden manage to care for themselves and their children is important to formulating culturally appropriate nursing interventions.

The purpose of this article is to discuss the perceptions of being strong by African American mothers and the ways in which they enact this perceived strength while living and mothering with HIV/AIDS. This article will also explore the implications of this perceived strength. The data are drawn from an ethnographic study that explored how African American women mother their children and care for themselves when both are diagnosed with HIV infection.

BACKGROUND AND SIGNIFICANCE

In just 2 decades, HIV/AIDS has become a serious threat to the health of the black community, with the most rapidly growing group of affected persons being non-Hispanic black women. The CDC reported that in 2004, African American women were 23 times more likely to be infected with HIV/AIDS than white women and were infected at 5 times the rate of Hispanic women. It was also reported that about 80% of the African American women diagnosed with HIV/AIDS during this same time period were infected through heterosexual contact.[2]

Because of more effective treatment and increased length of survival, HIV/AIDS can now be considered a chronic illness. In the case of HIV/AIDS, chronicity denotes not only a long-term incurable disease but also the accumulation of demands that an individual must incorporate into daily living.[4] Managing HIV/AIDS requires considerable internal and external resources as well as life management skills. African American women who are infected with HIV/AIDS, and who have children similarly affected, experience multiple challenges related to the care of children and families, the physical and emotional demands of living with chronic illness, the distinctive stigma associated with HIV/AIDS, and in many instances, poverty as well.[5] HIV/AIDS may be a more life-threatening disease for African Americans. As with other chronic illnesses, the disparities between African Americans and their white counterparts are apparent in the increased morbidity and mortality experienced by African Americans.[6]

Camphina-Bacote has noted that the manner in which African American people respond to illness often corresponds with their beliefs, values, and established lifeways.[7] Those values that are inherent in an African American cultural framework have been identified as core cultural values by Baldwin and others.[8] When discussing core values, it is important to acknowledge that African Americans are not monolithic in values, beliefs, and practices. Important differences exist among and between peoples of African descent in relation to history, social class, geographical origin, and residence and economic status. These differences contribute to a myriad of experiences leading to diversity in ways of thinking, living, and being in the world.

In spite of this diversity, many black scholars agree that certain core values, readily identifiable in people of African descent, have survived, and continue to influence all aspects of their lives.[8] Common experiences such as historical oppression, systematic discrimination, and racism in America have preserved many of the values that have served to foster survival of African Americans in a less than supportive and sometimes hostile environment.

The experiences of African American women are unlike those of African American men because of differing experiences that are related to gender roles and expectations, and as a result, theories of black womanhood have emerged from the voices of black women that help explain their realities, lifeways, and values.[3,9,10] Black feminist thinkers, such as Collins,[3,11] hooks,[12] Hudson-Weems,[13] and Banks-Wallace,[10] have explicated how black

women's experiences, history, and heritage have shaped their worldviews. A tradition of physical, psychological, and spiritual strength has permeated these theories. It is this tradition of being strong, and how it is perceived and enacted in African American women's lives when they are mothers and have HIV-positive children, that is the topic of this article. We will examine the implications for healthcare providers as well as for African American women of unquestioningly accepting a reality of inherent strength or "being strong women" as a cultural attribute.

HISTORICAL SIGNIFICANCE

It has been well documented that African American people have had a history of hardship since coming to America.[14,15] African women and men, when transported to America during the active days of slave trade, were stripped of their languages, names, cultures, and identities and essentially reduced to nonhuman property.[16,17] Both men and women were exploited for their bodies; men were mostly relegated to manual labor, whereas women were sexually abused. Women were used to breed slaves, raped by their slave masters, used as prostitutes, and forced to bear undesired children.[1] Their oppression was, therefore, linked not only to their subhuman status but also to their status as women. African American women attempted in various ways to resist these assaults on their personhood. We do not argue that the inhumane treatment and oppression of African American women is unparalleled among any other group, but we do argue that slavery in America as well as the continuing oppression and racism African American women have experienced has had lasting and profound effects.

In spite of these harsh beginnings, African American women remained committed to their families and were fiercely protective of their children. Hine and Thompson[1] observed that even after emancipation, it was still difficult and challenging to maintain a family life. Families were often small groups or communities, a form of organization that was consistent with their African heritage and persisted because of the necessity of caring for one another. This model of family living continues today, in spite of the assimilation of the European model of nuclear families.[18] Often relegated to positions of servitude and child care in the homes of wealthy whites, African American women continued to raise the children in their immediate families, extended families, and communities. They traditionally assumed responsibility for other children in their communities and have also raised grandchildren or children of other relatives when necessary, even in the face of economic hardship.[3,11] These roles have given rise to the expressions "othermother" and "community othermother."[11(p132)]

The mothering role continues to hold great value and significance in African American culture,[3,18] and older women hold positions of honor because of their status as elder women who have raised children and weathered the storms of adversity. Mothers serve as models of strength and survival for the younger women and as surrogate mothers and grandmothers for both children and adults.[3,11] In summary, African American women have experienced a history of oppression in the United States as well as learned cultural traditions of strength, resistance, and resilience. In addition, they have mothered their children, nurtured their families, and preserved and transmitted culture. It is this history that provides the context and background for understanding the tradition of being "strong women" within African American culture, and specifically, how African American mothers perceive that this strength supports them when they are faced with adversity, in this case, living and mothering with HIV/AIDS.

METHODS

The findings presented here are from a larger ethnographic study conducted in the southeastern United States with African American women diagnosed with HIV/AIDS

and who had one child who was also HIV positive.[5] The study was informed by the concept of culture and based on the assumption that culture is learned and shared among members of a group, and as such can be observed, described, and understood. The study was an attempt to allow African American mothers with HIV/AIDS to tell us about their life experiences, their concerns, their tribulations, and their joys. Understanding these issues from the viewpoint of African American women will enable nurses and other healthcare providers to anticipate and understand client behavior as well as to plan care that builds upon and reaffirms strengths and already established lifestyles and values. The study received full approval from the university's institutional review board and from each agency that facilitated participant recruitment. The study's purposes were broad; this article reports one aspect of the findings.

Sample

The purposive sample consisted of 10 African American women who were living with HIV/AIDS and who had 1 or more children who had been diagnosed with HIV/AIDS. The age range of the participants was 18–45 years; mean age was 30.4 years. One of the participants was currently married, 2 had been widowed (from HIV/AIDS), and the remaining 7 women were heads of households, essentially living alone and caring for their children. Six of the mothers had graduated from high school or earned their general equivalency diploma, and 2 had college or technical school credits. Personal income varied considerably with working status. Employment status varied; many of the participants worked in minimum wage earning jobs when their health and the health of their ill children permitted them to work outside of the home.

The number of children in the families ranged from 1 to 7. The age range of the children with HIV/AIDS ranged from 9 months to 11 years, with the mean age being 6.8 years. Three mothers had been diagnosed with AIDS. The others had not progressed to AIDS, but struggled with changing viral loads. During the course of the study, one participant died from the complications of AIDS and another died shortly after the study was completed. Several of the participants were quite ill during the course of the study and some of the children with HIV/AIDS had episodic health crises also.

We examined the data for concepts related to the cultural theme of "strong black women" and sought to understand how this cultural tradition influenced our participant's lives. The data from this purposive sample of 10 African American women described here were derived from what Hammersley and Atkinson described as sampling *within* cases.[19(p45)] Careful attention was paid to time, people, and context, and sampling occurred within the study until both adequacy and appropriateness were assured. Morse defined appropriateness as "the degree to which the choice of informants and method of selection 'fits' the purpose of the study as determined by the research question and the stage of research. Adequacy. . . refers to the sufficiency and quality of the data."[20(p134)]

Data collection

The 10 participants were recruited from rural HIV public health clinics and private physicians' offices. Flyers were posted advertising the study, and potential participants contacted the researcher. An appointment was made to determine eligibility and to obtain informed consent. To be eligible for participation in the study, women had to identify themselves as African American, be between the ages of 18 and 44 years, have a diagnosis of HIV or AIDS, and be the mother of a child who was also HIV positive and who lived with them. Procedures to ensure confidentiality were maintained throughout the study.

All participants were interviewed at least 3 times over a course of 1 year. Semistructured broad questions were designed to elicit data at each interview with appropriate time for probing and exploration of hunches and related topics and issues. Questions were

structured over the 3 interviews to elicit experiences and behavior, opinions and values, feelings, and knowledge. The dimension of time was important as attitudes and activities of the mothers revealed different patterns of mothering and concern for children over the length of the study, and as the health of many of the mothers worsened. The ethnographic dimension on people (the participants) included a focus on self-identified or member-identified categories. For example, "strong black women" was a typification that was employed by the participants themselves; that is, strong black women was a "folk category" situated in the vocabularies of the participants themselves and inextricably linked with the development of analytical ideas and the collection of data. Context of the participants influenced the collection and analysis of data as within any setting the participants could distinguish between a number of different contexts that required different behaviors.

Data in the form of field notes were collected across settings, at home when children were both present and absent and when mothers and children were ill or well. Field notes were made in social settings, such as church services, and during visits to healthcare providers. All interviews were tape-recorded and transcribed verbatim immediately after each interview. Tapes were compared with transcripts by the principal investigator to make certain that transcriptions were accurate.

Data analysis

All interviews were transcribed directly into *The Ethnograph 5.0*,[21] a qualitative software program that facilitates data management. Each interview was read, and sections of data were coded with a word or phrase that explained how participants coped with HIV and how they described strong black women. A codebook was developed to ensure consistency in coding and to provide an audit trail. Codes were abstracted into larger, more conceptual patterns of meaning that were labeled challenges of living with HIV and categories related to strong black women. As these patterns emerged, they were examined for linkages or relationships to other conceptual abstractions, a process that is consistent with the tradition of ethnographic research.[20] Field notes were compared to the interview texts to expand, clarify, and place the interview data within the contextual setting. The field notes directed additional observations and questions as well as theoretical hunches and methodological possibilities as the study was unfolding.

At this point, the literature was reviewed again for clues about themes or abstractions that are reflected in studies and theories of African American women.[10,22–24] We specifically examined the nursing literature to build upon and expand nursing science. In writing up the results for publication, an emic perspective (participant's interviews as well as our observations) was given precedence to emphasize the stories and voices of the participants. It was of great importance to us that we select a research and writing approach that was relevant to the social location of black women, both historically and in the context of the current HIV/AIDS epidemic. Data collection and analysis were concurrent, a process that is consistent with qualitative and ethnographic traditions. Results presented here focus on the participants' perceptions of "being strong" while living and mothering with HIV/AIDS, particularly the meanings associated with being a strong black woman.

RESULTS

The purpose of this article is to discuss the cultural meanings and ways of being strong in African American women with HIV/AIDS who were mothers of a child who also was HIV positive. Patterns were constructed in such a manner that they reflected the women's challenges of caring for themselves and their families, which demonstrated strength, and their beliefs about being a strong black woman. We will present data to illustrate what the women believed about

being strong, examine the patterns of challenges that the women faced which exemplified this strength, and explicate cultural lifeways that served as reservoirs of strength for the women.

BEING STRONG BLACK WOMEN

In the interviews, the women spoke of how they were the recipients of a tradition and heritage of being strong that had been transmitted from the black women who had come and gone before them. Being strong was described by the mothers as possessing an extraordinary courage as well as the ability to withstand trials of life that were common to black women. These trials often included poverty, discrimination, and raising children with meager resources as well as frequent encounters with illness and death.

One of women confidently spoke:

> Grandmothers, you know, the generations that have passed and I've seen, you know, they were *very* strong. And I know that I'm a black woman and I'm strong too. No matter what I go through, I always overcome it, just being strong and wanting to fight. . .

Another woman who had experienced the illness and death of her spouse and her brother from AIDS, as well as the HIV diagnosis of herself and then her daughter, said,

> A lot of stuff I went through! I should have had a total mental breakdown, but you know, it's something inside of me. I'm strong whether I know it or not, because as a black woman, I tell myself all of the time, "you can do it, you can go through all of it."

The women experienced unique and complex challenges that required an extraordinary ability to persevere, cope, and survive. These challenges were Illness and Physical Disability, Economic Hardship, Societal Oppression and Discrimination, and Mothering a Child with HIV/AIDS. Each of these challenges, alone and combined, required substantial inner strength to manage and never completely went away. In reality, it is difficult to isolate each challenge as they were all present at any one time and took, time, energy, and effort to deal with them on a daily basis.

Illness and physical disability

The women in this study had varying degrees of physical limitation and disability related to their HIV/AIDS infections. Their conditions ranged from extreme fatigue and headaches to neurologic symptoms and major organ failure. They were frequently ill.

One woman said,

> Once I get down, even with something like a cold, I have to have them (the children) help me, I mean, I can't even get off of the sofa. . . that's how hard it is.

Another woman who was afraid that her HIV infection was progressing to AIDS said,

> I feel weak at times and then I notice a change in my speech. . . I have a hard time remembering things. Sometimes I can't even remember my own birthday or my debit card pin number. . . I have to ask my oldest daughter to remember it for me.

This woman had a brother who had died from AIDS and remembered his neurologic symptoms, and now was afraid that she was developing a similar condition. The women described how, in spite of their poor health and feeling ill most of the time, they still were responsible for managing their households, including caring for their children, and going to their jobs every day whether they felt well or not.

Economic hardship

The women described the tremendous difficulties of making a sufficient income to support their families; most of them barely made the minimum wage. Women worked at fast food restaurants, in janitorial services, factories, and convenience stores. They continued to work when they felt ill, and when their children had medical appointments or were hospitalized, they had to miss work, which always meant a day or several days without pay as they worked jobs with no benefits.

One woman said,

With her being in the hospital, I have to be there mostly with her. . . I have to take time off from work and that lowers my income and then there's a lot of worrying about how my bills are going to be paid.

Although HIV medications were provided free of charge through the state health departments, the women were responsible for paying for medications for other conditions, even if these conditions were related to their HIV diagnosis. One woman described her difficulty in paying for medication:

I have an ulcer and the doctor told me I need to be on this medicine all the time. My mother was helping me pay for it as long as she could, but she just couldn't help me anymore because it just costs too much . . . so we're trying to find a way to pay for it.

Another woman said the following:

When I can't get to the doctor or to the emergency room at night, I have to try and get somebody to take me. I can't get around to get my bills paid or go to the store. It's just a real problem.

Women in the study provided for their children, often single-handedly by working physically demanding minimum wage jobs, even when they were too ill to work. One woman described her tenuous night job as a convenience store clerk:

I work as many hours as they let me, and you know, I'm a good employee, but you know, if I get sick, my job is gone.

Another woman talked about her quest to find a higher paying job at another fast-food restaurant. She said,

I really wanted that other job; they would pay me a little bit more, but it just couldn't work out, 'cause it's too far out, and I don't have any transportation.

The women and their families frequently lived in rented trailers in rural areas and low-rent apartment homes in more densely populated small towns. The women all had telephones in their homes, but when finances were low; this was the first luxury to be eliminated. Only 3 of the women had reliable means of transportation.

Facing oppression and discrimination

Oppression and discrimination were manifested most often through the display of powerlessness on behalf of women. Providing for their families required the women to seek monetary benefits from government programs. The most difficult benefit to obtain was Supplemental Security Income (SSI). This benefit would recognize the women as being disabled and provide them with an appropriate living subsistence. Even though the women at times were very ill and thus seemingly eligible for SSI benefits, they described the application process as embarrassing, humiliating, and difficult for them.

One woman described her experience:

I tried to go through the process of getting SSI twice. The second time, I got all the way through to the very end and I thought everything was going okay. Then they gave me these tests to do like I was in kindergarten or something. I said, "I'm not stupid, I'm just sick!"

Another woman said,

I've tried three times to get SSI and they keep turning me down. I really don't understand how it works. I hate to keep going to ask people for something. I need to get the papers and try again. I think they just want you to beg. I don't know how sick they want you to be.

When the women had to depend on strangers to provide basic needs for their families, they felt ashamed and powerless over what was happening to them and their children. One woman said,

I feel bad when I have to ask for extra food when my food gets low or either my case gets closed or something, and I try to bail myself out by getting extra hours (at work) so I can get more money, where I don't have to go and always ask for assistance.

Even though the women recognized this lack of power and spoke openly about it, they realized their inability to effect change in either the system that controlled them or their positions in it.

Interaction with healthcare providers was observed during healthcare visits. The

majority of healthcare providers were white males and females whose status was evident by their impeccable dress and white laboratory coats. The women responded obediently to these providers often without initiating eye contact or engaging the provider in discussion about their or their children's conditions. While none of the women identified these experiences as being indicative of oppression or discrimination, their actions reflected their status as African American women with a diagnosis of HIV/AIDS with all of the associated stigma and negativity.

Mothering a child who is HIV positive

Being a mother to a child who is HIV positive was a daunting task for the mothers. In addition to the usual tasks of mothering, mothers had to ensure that their child took the appropriate medications and was present at all appointments for healthcare. In addition, they cared for their child through health crises, and attempted to prepare their child for the future. These responsibilities were arduous, demanding, and stressful.

A difficult aspect of caring for their ill children was giving daily medications. One woman talked about the struggle of getting her child to take her medication:

> She takes three different kinds of pills. . . but she's so stubborn that I have to fight with her everyday about her meds. Sometimes I want to give up, but I've got to do it.

Many of the children had been hospitalized on numerous occasions. This required their mothers to take time off of work to stay with their hospitalized child and to enlist help to care for the other children in while they were absent with the sick child. One woman said,

> My baby was sick real bad with asthma. I had to take her to the hospital in the middle of the night and I had to find a way to get the others to my mom's house. The baby was in the hospital for a week. It was real hard.

Women also demonstrated extraordinary strength in their responsibility to prepare their children for future possibilities and realities. This preparation included informing and educating their children about how to live with HIV/AIDS, as well as preparing them for their own (the mother's) sickness and death. One woman said,

> My biggest challenge in mothering my little girl is explaining to her what this disease is and why she has it. She has to be able to understand how to take care of herself as she gets older, and I have to explain it to her, you know.

Another woman talked about preparing her children for the possibility of her own death. This mother died shortly after her last interview as a participant in this study. During that last interview, she said,

> I want to make sure that I don't leave my children with a burden. . . but my oldest knows and understands that the baby's dad and his family have promised to take care of them when something happens to me.

Drawing strength through cultural traditions

Cultural tools from which the participants drew strength were spiritual and religious traditions and female kinship connections. These learned traditions enabled the women to deal with life's adversities in the patterns of their ancestral mothers. For the women in this study, spirituality referred to a personal belief and faith and/or a relationship with the Divine, identified as God by the women. Religious practices were the ways in which spirituality was actualized in the women's lives. Women described a faith that provided the strength to get through difficult times, and to help deal with the pressures of living and mothering with HIV/AIDS. One woman directly attributed her strength to God. She said,

> God done made me stronger. I had to be strong for me to be able to handle me being sick. I had to be strong before I could take care of my children. I have to be strong enough to take care of myself.

The women talked about how spirituality and religious activities had been passed down to them and their importance stressed by

their mothers and grandmothers. One woman said,

> My mother and grandmother always made sure that we were at church every week. We always prayed at home, and my mother always told me to trust God for everything. I still pray now and read the verses my mother taught me.

Some mothers sought comfort, consolation, and fellowship in the church after their HIV diagnosis. Another woman said,

> I like going to the church, and being with the women in Sunday School. I feel safer there, like maybe sometime I might be able to share my secret. I think maybe they might understand.

Spirituality and religious practices produced hope and strength for future trials. Attending church together with some of the women revealed spirited services with musical texts that spoke to the women's personal realities. Spiritual practices, including worship, singing, reading sacred texts, praying, and listening to spiritual music, were the ways in which the women found strength to live and to care for themselves and for their children. Prayer functioned as a healing force that enabled the women to find a way of coping with depression, with illness, with stigma, and with oppression.

African American mothers with HIV/AIDS also drew strength and support through their interactions with other women, primarily women kin. Female relatives, mothers, sisters, grandmothers, aunts, and "othermothers" (those older women who acted as mothers in the women's lives) provided a supportive and helpful network for the mothers in this study. One of them talked about her interactive supportive relationship with her mother:

> So, I'm kind of like her backbone . . . and she's mine. I have a brother, the one that is younger than me . . . she's been raising his little boy since he was three months old. So I take him off her hands for awhile and help her with stuff and she helps me take care of my children too.

These African American women believed in a cultural tradition of being strong in the face of physical disability, economic hardship, facing oppression and discrimination, and caring for a child who was HIV positive. They utilized cultural survival skills, particularly spiritual traditions and women kin-centered networks, to manage difficult and challenging life experiences.

DISCUSSION

African American women with HIV/AIDS, particularly those caring for a child who is also HIV positive, live complex lives and face a multiplicity of challenges with which they must grapple on a daily basis.[5,25] These challenges are related to being black, female, and living in poverty, and they are compounded by living with HIV/AIDS, a chronic, life-threatening, stigmatizing disease. Although HIV/AIDS is one of the most recent health conditions that have unequally assailed African American women, the women in this study believed that because of their strength and cultural history, their circumstances were just another hurdle to rise above in the tradition of their foremothers.

African American women perceived themselves to be the possessors of an indwelling character of strength that consisted of certain survival skills. These survival skills, embedded within cultural traditions and practices, have enabled black women to resist oppression, negative stereotypes, and colonizing images.[11] In this study, these learned skills included reliance on a spiritual tradition and a tradition of family support and women-centered networks, all consistent with an African ethos.[26]

Nursing and social science literature contains examples of the importance and tradition of spirituality and religious practices in the lives of African Americans in both health and illness.[22,27–29] According to black historians and philosophers, this spirituality is an integral part of the African worldview and presents itself in almost every aspect of black life. Nobles[30] identifies this spirituality as part of the black psyche, seeing the self, nature,

and the world as spiritual in nature, with a life force that is all-encompassing.

Boyle et al[31] and Sowell et al[32] found that spirituality served as a mechanism of resistance for African American women. For each of the women in this study, a religious tradition had been a part of their lives since childhood and was a culturally learned way of dealing with hardship and adversity, as well as helping them develop into "strong women." Each woman told her own story of a faith that transcended their present living experiences. Abrums[22] observed that religious beliefs or spiritual traditions offer insights that are based on black women's personal experiences. The tradition of the black worship experience allows for verbal expression in the form of testimony that is conducive to the edification of those who are present and are the hearers and witnesses to the testimony.[33,34]

Supportive relationships with women-kin are another cultural source from which women are able to draw strength. This collective support system of African American women is consistent with the communality that was the social essence of traditional African societies.[35,36] The strong system of reciprocal family support among women in the study was empowering for them and affirmed the strength of women caring for one another. Collins[3] posits that these women-centered traditions operate to help women in times of need. Davis[26] argues further that these interconnected support systems are life affirming and enable women to deal more effectively with stressful situations.

Women enacted "being strong women" by economically providing for their children, yet coping with economic hardship because there was never sufficient money to cover basic expenses. In African American culture, women working outside of the home has been necessary to provide for their families and is a valued dimension of black motherhood.[37] Women demonstrate strength by constantly giving to their family members, including their children, and often do so while neglecting their own needs.[38]

However, the implications of being expected to always demonstrate strength may actually inhibit black women from receiving the support that they need when they and their children are ill.

Stereotypes of black women that have been created and perpetuated by white patriarchal society have often portrayed black women as "super-strong." It is clear that these stereotypes are a threat to the health of black women. For example, requiring women who are ill with HIV/AIDS to work physically demanding jobs for low pay while caring for their sick children is not only unjust but also unjustly punitive for women. When black women internalize stereotypical myths, believing that they possess a greater degree of emotional strength than other women, they are more likely to set high expectations of their own abilities to manage life's difficulties.[39] Both women and children suffer when the so-called social safety nets are not there for them.

Caring for ill children may require the self-sacrifice that is characteristic of a strong mother. Living with HIV/AIDS and providing for one's family alone, while facing the possibility of death, requires an inordinate amount of strength. Black women, believing that they must be strong at all costs, may hesitate to ask for the support that they need from healthcare providers. In addition, when healthcare providers assume that black women can manage the challenges of caring for children when resources are scarce and the women themselves are ill may not be sensitive to the needs of those who live in such adverse circumstances.

African American women demonstrate a history and legacy of physical, emotional, and psychological strength. This strength has enabled them to survive in less than optimal conditions. African American women with HIV/AIDS believe that they are heirs to this strength, and they enact it in ways that help them live and mother with a life-threatening and chronic condition. It is important that nurses understand the context in which oppression, discrimination, and

stigma have been allowed and sometimes encouraged to stifle and distort cultural traditions in ways that penalize African American women, especially when they have HIV/AIDS and are caring for HIV-positive children.

REFERENCES

1. Hine DC, Thompson K. *A Shining Thread of Hope: The History of Black Women in America*. New York: Broadway Books; 1998.
2. Centers for Disease Control and Prevention. HIV/AIDS among African American women. Available at: http://www.cdc.gov/hiv/pubs/Facts/afam.htm. Accessed November 26, 2005.
3. Collins PH. *Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment*. 2nd ed. New York: Routledge; 2000.
4. Bennett J. Empowering persons affected by acquired immunodeficiency syndrome. In: Miller JM, ed. *Coping With Chronic Illness: Overcoming Powerlessnes*. 3rd ed. Philadelphia, Pa: FA Davis; 2000: 377–432.
5. Shambley Ebron DZ, Boyle JS. Self-care and mothering in African American women with HIV/AIDS. *West J Nurs Res.* 2006;28(1):42–60.
6. Centers for Disease Control and Prevention. HIV/AIDS among African Americans. Available at: http://www.cdc.gov/hiv/topics/aa/resources/factsheets/aa.htm. Accessed March 25, 2006.
7. Camphina-Bacote J. African Americans. In: Purnell LD, Paulanka BJ, eds. *Transcultural Healthcare: A Culturally Competent Approach*. Philadelphia, Pa: FA Davis; 1998:53–73.
8. Baldwin D, Johnson P, Contanch P, Williams J. *An Afrocentric Approach to Breast and Cervical Cancer Early Detection and Screening*. Washington, DC: American Nurses Association; 1996.
9. Shambley Ebron DZ, Boyle JS. New paradigms for studying African American women. *J Transcult Nurs*. 2004;15(1):11–17.
10. Banks-Wallace J. Womanist ways of knowing: theoretical considerations for research with African American women. *Adv Nurs Sci.* 2000;22(3):33–45.
11. Collins PH. *Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment*. New York: Routledge; 1991.
12. hooks b. *Sisters of the Yam: Black Women and Self-recovery*. Boston: South End Press; 1993.
13. Hudson-Weems C. *Africana Womanism: Reclaiming Ourselves*. Troy, Mich: Bedford Publishers; 1988.
14. Kain JF, ed. *Race and Poverty.* Englewood Cliffs, NJ: Prentice-Hall; 1969.
15. Gutman HG. *The Black Family in Slavery and Freedom*. New York: Pantheon; 1976.
16. Franklin JH, Moss AA. *From Slavery to Freedom: A History of African Americans.* 7th ed. New York: McGraw-Hill; 1994.
17. Carter CJ. *Africana Woman: Her Story Through Time*. Washington, DC: National Geographic Society; 2003.
18. Hale-Benson J. *Black Children: Their Roots, Culture and Learning Styles*. Baltimore, Md: The Johns Hopkins University Press; 1982.
19. Hammersly M, Atkinson P. *Ethnography: Principles in Practice*. 2nd ed. New York: Routledge; 1997.
20. Morse JM. Strategies for sampling. In Morse JM, ed. *Qualitative Nursing Research: A Contemporary Dialogue*. Newbury Park, Calif: Sage; 2001:127–145.
21. Seidel R. *Ethnograph: A Program for the Analysis of Text Based Data*. Denver: Qualis Research Associates; 1998.
22. Abrums M. Faith and feminism: how African American women from a storefront church resist oppression in healthcare. *Adv Nurs Sci.* 2004;27:187–201.
23. Taylor J. Womanism: A methodologic framework for African American women. *Adv Nurs Sci.* 1998;21(1):53–64.
24. Taylor J. Colonizing images and diagnostic labels: oppressive mechanisms for African American women's health. *Adv Nurs Sci.* 1999;21(3):32–45.
25. Gilbert J, Wright EM. *African American Women and HIV/AIDS: Critical Responses*. Westport, Conn: Praeger Publishers; 2003.
26. Davis RE. Discovering "Creative Essences" in African American women: the construction of meaning around inner resources. *Women's Stud Int Forum*. 1998;21(5):493–504.
27. Mattis JS. Religion and spirituality in the meaning-making and coping experiences of African American women: a qualitative analysis. *Psychol Women Q*. 2002;26:309–321.
28. Daly A, Jenkins J, Beckett JO, Leashore BR. Effective coping strategies of African Americans. *Soc Wk.* 1995;40(2):240–248.
29. Cervantes JM, Parham TA. Toward a meaningful spirituality for people of color: lessons for the counseling practitioner. *Cultur Diversity Ethnic Minority Psychol*. 2005;11(1):69–81.
30. Nobles WW. African philosophy: foundations for black psychology. In: Jones RL, ed. *Black Psychology*. New York: Harper & Row; 1972:18–32.
31. Boyle JS, Hodnicki DR, Ferrell JA. Patterns of resistance: African American mothers and caregiving for adult children with human immunodeficiency virus disease. *Holis Nurs Pract.* 1999;11:27–35.
32. Sowell R, Moneyham L, Hennessy M, Guillory J, Demi A, Seals B. Spiritual activities as a resistance resource for women with HIV. *Nurs Res.* 2000;49(2):73–82.

33. Hall J. Marginalization revisited: critical, postmodern, and liberation perspectives. *Adv Nur Sci.* 1999;22(2):88–102.
34. Ross R. *Witnessing and Testifying: Black Women, Religion, and Civil Rights*. Minneapolis, Minn: Augsburg Fortress; 2003.
35. King TC, Ferguson SA. "I am because we are": clinical interpretations of communal experience among African American women. *Women and Therapy. Proquest Document* [online]. 1998;18(1): 33–46. Available at: http://proquest.umi.com. Accessed April 19, 2005.
36. Nobles WW. Africanity: its role in black families. *Black Schol.* 1974;5:5–10.
37. Staples R. An overview of race and marital status. In: McAdoo HP, ed. *Black Families.* 3rd ed. Thousand Oaks, Calif: Sage;1997:269–272.
38. Jones C, Shorter-Gooden K. *Shifting: The Double Lives of Black Women in America*. New York: Harper Collins; 2003.
39. Thompkins T. *The Real Lives of Strong Black Women: Transcending Myths Reclaiming Joy*. Chicago: Agate; 2004.