ARTICLE

African American Mothers in South Central Los Angeles

Their Fears for Their Newborn's Future

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Objective: To determine what African American mothers in a low-income community fear for their newborn's future.

Design: An interview survey was conducted with mothers of recently born infants randomly sampled from birth certificate records in the spring of 1994 in 10 postal codes in the Compton Health District in south central Los Angeles, Calif, with high concentrations of low-income African American children. Among 522 eligible mothers, 419 (80%) were interviewed. Children were an average of 17.7 days old at the time of the interview.

Main Outcome Measure: The open-ended survey item, "What is your biggest fear for [child's name] growing up?" Mothers were prompted to give more than 1 answer. Responses were classified into 16 categories.

Results: Thirty-nine percent of the mothers reported a fear of gangs, violence, or both. The largest other response categories included disease, illness, and health problems (17%); drugs and alcohol (15%); growing up in the local environment (10%); and society and the world in general (6%). Fifty percent of the mothers of boys reported a fear of gangs, violence, or both compared with 28% of the mothers of girls ($P<.001$).

Conclusions: More than half the fears are in the medical and public health domains. Some involve traditional health concerns (eg, disease), while others are problems that the health professions have been addressing more recently (eg, violence). The American Academy of Pediatrics has recommended counseling families about violence prevention and the prevention of firearm injuries. While this study shows that many mothers are concerned about these subjects, we need a greater understanding of what role physicians can play in helping their patients (and their patients' families) address violence in their lives.

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ALMOST HALF of African American children in the United States live in poverty.[1] While national poverty rates have remained fairly stable during the past 2 decades,[1] there has been a growing concentration of poverty in urban centers.[2] Some have argued that geographic concentration tends to intensify the effects of poverty, and social critics have written extensively about the effect of poverty on children and their future.[3,4] Persistent poverty has been associated with a higher likelihood of infant mortality, low birth weight, childhood disease, longer hospitalizations, mental health problems, delayed intellectual development, behavioral problems, missed school days due to health problems, poorer school achievement, not completing high school, unemployment, crime and delinquency, and adolescent pregnancy.[5]

While population-based statistics provide some understanding of the risk profile for the future of African American children born in poor urban centers, little is known about how people who live in these communities perceive their children's future. Therefore, we asked a random sample of African American mothers from south central Los Angeles, Calif, about their biggest fear for their newborns as they grow up.

There has been an increasing emphasis in pediatric practice on understanding the family and community context in which children grow and develop so that physicians can more appropriately address parents' concerns and tailor their advice to the child's needs.[6] The information provided by this study may help clinicians who work in urban centers anticipate patients' and families' needs and address their concerns in the proper context.

RESULTS

DEMOGRAPHIC AND OTHER CHARACTERISTICS

Table 2 provides the demographic variables and other characteristics of our sample. The mean age of the mothers in our sample was 24.8 years. Eighteen percent were married, and 31% were cohab-

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PARTICIPANTS AND METHODS

SAMPLE

The sample was recruited as part of a study to improve access to immunizations and well-child care. The sample was drawn from birth certificates of African American infants born between February and May 1994 with addresses in 10 postal codes in the Compton Health District in south central Los Angeles, where there are high concentrations of low-income African American children. Twice a week, the Los Angeles County Vital Statistics Branch provided us with the names and addresses of all African American women living in the study area who had given birth. With the use of a reverse telephone directory, we recruited mothers by telephone or in person if they did not have a telephone. Of 606 African American children born during the study period, 84 were ineligible (ie, deceased, adopted, or moved without a forwarding address). Among the 522 mothers of eligible children, 419 (80%) agreed to participate in the study and completed the baseline survey.

SURVEY ADMINISTRATION

An interview survey was administered to the mothers in their homes shortly after the child's birth. Trained survey administrators from RAND, Santa Monica, Calif, conducted the interviews, which took about 45 minutes. The average age of the infant at the time of the interview was 17.7 days (SD, 8.3 days; range, 5-42 days).

Mothers provided informed written consent. The survey and consent procedures were approved by the Human Subjects Protection Committee of RAND.

OUTCOME VARIABLE

The main outcome variable for this study was the open-ended interview survey item, "What is your biggest fear for [child's name] growing up?" The interviewer wrote down verbatim responses. After mothers gave an initial response, interviewers probed for additional responses as well.

The fear item appeared close to the beginning of the survey, following a few basic demographic questions. Therefore, later survey questions covering immunization and well-child care knowledge, attitudes, and behaviors were unlikely to influence the response to the fear item.

After reviewing responses to the outcome variable, members of the research team developed 16 categories for use in classifying the responses (**Table 1**). Two public health professionals working at the offices of the Special Supplemental Nutrition Program for Women, Infants, and Children in the community where the study was performed independently assigned each (blinded) response to 1 of the 16 categories. Staff members from these offices were selected because the study had been based there, and they were familiar with the population that had participated in the study. Their initial categorizations were the same for 548 (94%) of 583 items (κ=0.93, $P<.001$), so they jointly selected final categories for the 35 items on which they had initially disagreed.

So many mothers specifically mentioned gangs when talking about violence that we made separate categories for violence (gangs not mentioned) and gangs (gang violence) when classifying mothers' fears. However, separate analyses of the 2 categories did not provide a greater understanding of the data than analyses with the categories combined. Furthermore, many of the responses coded in the violence (gangs not mentioned) category suggested gangs (eg, "drive-by shootings" and "getting shot in cross fire"). Therefore, for the results provided in this article, we combined these 2 categories into a single category, gangs, violence, or both.

INDEPENDENT VARIABLES

Maternal characteristics include age at birth of the index child, being a high school graduate, employment during the year prior to the child's birth, marital status at the time of the baseline survey, cohabitation status (living with a spouse or partner) at the time of the baseline survey, and whether the child was the respondent's firstborn.

We do not have a measure of income for each respondent. However, the sample was drawn from a county service planning area in which 48% of the children were living below the poverty level in 1994.[7] As a proxy for income status, we report insurance coverage for prenatal care: Medicaid coverage, other government-sponsored coverage, no coverage, and private coverage. For bivariate and logistic regression analyses, we combine the large percentage of mothers with Medicaid coverage (84%) with the small percentage who had other government-sponsored coverage or no coverage (5%).

We define children as having a low birth weight if they weighed 5.5 lb (≈2.48 kg) or less. We included low birth weight in our analyses as a marker for children who are more likely to have had health problems that could influence mothers' fears for the future.

Additional items asked whether the respondent had been robbed or assaulted face-to-face, had been burglarized, or had witnessed a violent crime during the past year.

ANALYSIS METHODS

For cross tabulations between dichotomous variables and fear of gangs, violence, or both, we report significance tests based on Pearson χ^2 statistics. For the correlation between maternal age (which is a continuous variable) and fear of gangs, violence, or both, we use a 2-sample t test. We use logistic regression to predict whether (1) or not (0) a mother reported fear of gangs, violence, or both.

iting with a partner (including a husband). Eighty-four percent had had Medicaid coverage for prenatal care.

FEARS

Twenty-two percent of the mothers reported no fears, 50% gave 1 answer, 20% gave 2 answers, and 9% gave 3 or more (up to 6) answers. The total number of responses (including none) was 583.

When all fears were counted, 39% of the mothers reported a fear of gangs, violence, or both (Table 1). Other large response categories included disease, illness, and health problems (17%); drugs and alcohol (15%); growing up in the local environment (10%); and society and the world in general (6%). The remaining categories were all reported by lower percentages of mothers (Table 1).

Because a mother's initial response to the survey item may have differed from her additional responses when

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Table 1. Types of Fears Reported by Mothers

Types of Fears*	Percentage of Mothers Who Reported the Fear, by Sex of the Child†		
	Total (N=419)	Boys (n=213)	Girls (n=206)
Gangs, violence, or both	39	50	28‡
Disease, illness, or health problems	17	13	21§
Drugs and alcohol	15	15	15
Growing up in the local environment	10	8	12
Society and the world in general	6	7	5
The child having behavioral, social, moral, or professional problems	5	6	4
Inadequate education	4	4	5
General problems with safety, injury, or accident	4	3	4
Early pregnancy	3	0	6‡
Difficulty being a parent and providing for the child's needs	3	2	4
That the child will be taken away by authorities or kidnapped	2	2	2
Rape or molestation	2	1	2
Racism	1	1	0
Pollution	‖	‖	‖
None, do not know	22	20	23

*Answers reported in response to the question, "What is your biggest fear for [child's name] growing up?"
†Columns add to more than 100% because mothers could report more than 1 fear.
‡Mothers of boys and mothers of girls reported responses that differed significantly by the Pearson χ^2 test, $P<.001$.
§Mothers of boys and mothers of girls reported responses that differed significantly by the Pearson χ^2 test, $.01 \leq P < .05$.
‖The percentage is a nonzero value less than 0.5.

prompted for additional fears, we assessed the distribution of categories for the first reported fear in addition to the distribution for all reported fears. The distribution for the first fear was similar in order of categories to the distribution of any fear. Thirty-one percent of the mothers reported a fear of gangs, violence, or both. The next largest response was disease, illness, and health problems (14%), followed by growing up in the local environment (7%), society and the world in general (6%), and drugs and alcohol (5%).

SEX OF THE INFANT

There were large differences based on the sex of the infant, with 50% of the mothers of boys reporting a fear of gangs, violence, or both compared with 28% of the mothers of girls ($P<.001$) (Table 1).

The mothers of girls were more likely than the mothers of boys to report a fear of health problems (21% vs 13%, $P=.04$) (Table 1). Reports of fear of drugs and alcohol were similar for the mothers of girls and boys (15% for both, $P=.89$) (Table 1).

OTHER DEMOGRAPHIC CHARACTERISTICS AND FEAR OF GANGS, VIOLENCE, OR BOTH

There were no significant differences in reports of fear of gangs, violence, or both by mothers' age ($P=.18$), completion of high school ($P=.86$), marital status ($P=.19$), cohabitation ($P=.38$), employment status ($P=.88$), or having private health insurance ($P=.52$). There was also no significant association with whether the child had a low birth weight ($P=.73$) or was the firstborn ($P=.63$).

Table 2. Characteristics of the Sample (N=419)

Characteristics	Percentage of the Sample*
Mother	
Age, y	
Mean (SD)	24.8 (6.2)
Range	14-43
Married	18
Cohabiting†	31
Employed in past year	41
High school graduate	64
Insurance for prenatal care	
Medicaid	85
Other government-sponsored insurance	2
No insurance	3
Private insurance	10
Child	
Male	51
Low birth weight	13
Firstborn	27

*Data are given as the percentage of the sample, except for age.
†Cohabiting refers to living with a partner, including a husband.

MATERNAL EXPERIENCE WITH VIOLENCE AND CRIME

A total of 14% of the mothers had been robbed or assaulted face-to-face (6%), had been burglarized (4%), or had witnessed a violent crime (6%) in the past year. (Individual percentages add to more than 14% because some mothers reported more than 1 type of experience.)

When mothers who reported at least 1 of these experiences were compared with mothers who did not report any, there was no significant difference in the percentage who reported fear of gangs, violence, or both (40% vs 37%, $P=.66$).

MULTIVARIATE PREDICTORS OF FEAR OF GANGS, VIOLENCE, OR BOTH

We specified a logistic regression model predicting whether (1) or not (0) mothers reported a fear of gangs, violence, or both (**Table 3**). The mothers of boys were more likely than the mothers of girls to report a fear of gangs, violence, or both ($P<.001$). Other predictor variables were not significant ($P \geq .05$).

COMMENT

More than half of the fears reported by African American mothers in this south central Los Angeles–based study are in the medical and public health domains. Some involve traditional health concerns, such as disease and unintentional injury. Others come under the domain of problems that the health professions have been addressing more recently, such as violence.[8]

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Table 3. Logistic Regression Analysis Predicting Mothers' Reports of Fear of Gangs, Violence, or Both (N=419)*

Characteristics	OR (CI)
Mother's age	0.97 (0.93-1.01)
Cohabitation	0.84 (0.52-1.34)
Employed in past year	1.12 (0.71-1.78)
High school degree	1.12 (0.71-1.77)
Private insurance for prenatal care	0.82 (0.38-1.78)
Robbed or assaulted face-to-face, burglarized, or witnessed a violent crime in the past year	0.82 (0.44-1.50)
Male child	2.55 (1.69-3.85)†
Firstborn	0.75 (0.44-1.27)
Low birth weight	1.21 (0.66-2.19)

**For the dependent variable, a report of a fear of gangs, violence, or both was designated 1; no report of a fear of gangs, violence, or both, 0. OR indicates odds ratio; CI, confidence interval.*

†*Significant at* $P<.001$ *by the* t *test.*

The dominant finding of our study is that 39% of the mothers reported that their biggest fear (or 1 of their biggest fears) for the future of their newborns was gangs, violence, or both. Such uniformity is striking given that the interview question was open ended and did not prompt the respondent with a list of possible answers. Furthermore, the mothers knew that the survey was part of an intervention to increase immunization rates and well-child care visits, so we had expected more answers related to vaccine-preventable diseases.

There is some evidence that these fears persist as children grow up. A 1990 national telephone survey conducted by the National Commission on Children found that 46% of low-income urban parents worried "a lot" that their children (aged 0-17 years) would be beaten up, attacked, or molested; 40% worried a lot that their child would get shot.[9]

The prevalence of violence and the toll that it has been taking on children and youth have been well documented in Los Angeles[10-12] and across the country.[13-25] Homicide is the only major cause of death that has increased for children aged 1 to 4 years in the United States from 1968 to 1992[26]; it is 1 of 2 major causes of death (the other is suicide) that has increased for children aged 5 through 14 years from 1968 to 1992[26] and for 15- to 24-year-olds from 1979 to 1991.[27] Gang-related homicide for African American boys aged 15 to 19 years in Los Angeles County more than tripled during the decade ending in 1989 to 1991; by 1994, 43% of all homicides in Los Angeles County were gang related.[28] A 1995 to 1996 study of a sample of Los Angeles high school students found that 49% reported that they had seen a weapon at school, 14% had themselves brought a weapon to school, 48% would find it "easy" to get a gun, 35% had seen a teenager shot in their neighborhood, and 41% had witnessed a drive-by shooting.[29]

Violence does not just affect those who are physically harmed. Children and adolescents who witness violence and live in violent environments show signs of posttraumatic stress disorder, other psychological trauma, and other negative effects on their development.[30,31]

Clinicians should be attuned to parental fears, even if they are unrealistic. Sometimes a parent is quite worried about an unlikely event because, for example, it occurred to a friend or family member. The physician can often place the fear in context and provide reassurance. However, given the social context of the community we studied, the high percentage of fear of gangs, violence, or both reported in this study seems to be realistic.

The American Academy of Pediatrics has recommended that physicians provide routine counseling to families about violence prevention and the prevention of firearm injuries.[32-34] A 1994 conference sponsored by the Johnson & Johnson Pediatric Institute on "The Role of the Pediatrician in Violence Prevention" produced a detailed list of recommendations for pediatricians,[35] and several researchers have developed clinical strategies for addressing violence.[36-42] For example, physicians can obtain a history of exposure to violence as a perpetrator, victim, or witness; teach parents and children about nonviolent problem-solving techniques; review firearm risks and safety; and provide ongoing support and reinforcement for violence reduction efforts.[35,40] There is limited information available on what effect physicians have when counseling about violence. However, the research literature on smoking cessation counseling suggests that counseling by physicians (as well as other health care professionals) can be effective.[43]

For physicians who want to address these issues beyond the individual physician-patient level, there are many articles that describe how physicians can participate in violence reduction efforts nationally and in their communities.[35,38,40-46] For example, physicians can work with local schools to implement violence prevention programs (eg, a conflict resolution program or a peer mediation program) and they can work with the media to increase awareness of the problem of violence.[35]

The child's sex was the principal predictor of fear of gangs, violence, or both. This is consistent with the large sex difference in the risk of being a victim of violence.[18] The sex differential raises questions about the effect these fears might have on how parents treat sons compared with daughters. Research on parent-infant attachment has suggested that prior to a child's birth, prospective mothers develop a script in their minds for their child's life.[47] This script guides parents' expectations and their parenting behaviors. We do not know how fear of being affected by gangs and violence influences parental behavior, but further research might shed light on its relationship with topics such as emotional attachment, family resource allocation, and discipline techniques.

If 14% of the respondents were victims of a crime or witnesses to a violent crime in just the prior year, a much higher percentage probably had such an experience during the past several years and certainly during their lifetimes. Many respondents probably also have relatives, friends, or neighbors who have had violent experiences. This may explain why having had a violent experience during the past year was not associated with a fear of gangs or violence.

Few mothers reported fears directly related to their own parenting abilities or the child's innate abilities. Instead, most of the fears were related to social conditions over which many mothers might believe they have little control. Many also related to problems that would not occur until the child was older. Also, fears did not vary for the firstborn child compared with other children, sug-

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gesting that they were not related to inexperience with parenting.

Our interview question about fear measured primarily what first came to mind for these mothers. With time for greater reflection, mothers might have reported somewhat different fears. A study that explored in greater detail the strength of fears and the reasons for fears would be informative. Mothers, fathers, and children may all have different fears, and fears may vary across communities and across demographic groups. Our sample includes African American mothers from a single community; further research on broader and more diverse samples would show how they compare with others. It would also be useful to study parents' hopes and dreams for their children's future.

From a clinical perspective, we need a greater understanding of how physicians can be most effective in helping their patients protect themselves from violence and its consequences and in helping prevent violence from occurring. Evaluations of physician-based interventions would be a valuable addition to the growing literature calling for physicians to address violence in their patients' lives. Of course, physicians need not limit their efforts to their office-based encounters. They may have their greatest effect by testifying in the public arena to the physical and psychological toll that violence takes on the lives of their patients and their patients' families.

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