2023

The Costly Performance of Strength: An Exploration of Mental Health Treatment Utilization Among Black Women in the Deep South

Amber N. Martin
University Of Alabama At Birmingham

THE COSTLY PERFORMANCE OF STRENGTH: AN EXPLORATION OF MENTAL HEALTH TREATMENT UTILIZATION AMONG BLACK WOMEN IN THE DEEP SOUTH

by

AMBER N. MARTIN

TENEASHA WASHINGTON, COMMITTEE CO-CHAIR
LARRELL L. WILKINSON, COMMITTEE CO-CHAIR
JESSICA T. CHAMBLISS
SARA N. LAPPAN
C. NICOLE SWINER

A DISSERTATION

Submitted to the graduate faculty of The University of Alabama at Birmingham,
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy

BIRMINGHAM, ALABAMA

2023

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AMBER N. MARTIN

PUBLIC HEALTH

ABSTRACT

Introduction: Strength is indoctrinated into the cultural tapestry of Black women, dating back to slavery, and passed down through intergenerational socialization. The incessant need for Black women to be strong diminishes their psychological health leading to poorer quality of life. Further, historical injustices and unethical practices in mental healthcare continue to perpetuate the need for Black women to perform in strength. The performance of strength is one explanation for the grave mental health disparities among Black women offering an opportunity to better understand their mental health needs. This project aims to center Black women within the cultural contextualization of the Strong Black Woman/Superwoman (SBW/SW) schema employing established public health models to frame our understanding about mental health treatment utilization in a region highly impacted by poverty and inequality which are primary risk factors for mental health disorders.

Methods: Qualitative in-depth interviews were conducted with Black women living in the Deep South to explore their lived experiences as it relates to mental health, help-seeking, and treatment utilization. Topics included defining the SBW/SW schema, awareness of mental healthcare and treatment utilization, experiences related to endorsement of the SBW/SW and mental health, barriers to mental health treatment utilization, and suggestions for improvement. Interviews were conducted virtually, and

audio recorded. Audio-recordings were transcribed, and transcripts were analyzed using thematic analysis.

Results: Interviews were completed with 13 Black women living in the Deep South exploring mental health treatment utilization and the unique factors that impact help-seeking and decision making. The first manuscript provides a theoretical conceptualization of the literature about the mental health needs of Black women and factors that may impact treatment utilization. The second manuscript describes the qualitative approach taken and the protocol developed to conduct the current study. The third manuscript reports findings related to the mental health needs of Black women and factors impacting mental health treatment utilization.

Conclusions: Results from this study helped established an understanding of how to support the mental health needs of Black women providing implications for the development of targeted interventions that address barriers to treatment utilization, provider training, and educational and promotion strategies to dismantle stigma. For example, we found that positive experiences such as compassionate person-centered care in the therapeutic setting increased desire to utilize mental health treatment services. Therefore, culturally responsive provider training may improve mental health treatment utilization among Black women over time.

Keywords: Black women, mental health, treatment utilization, superwoman, strength

DEDICATION

To God be all glory. Thank you for sustaining me through this process, remaining faithful throughout my entire life, and gracing me to overcome the hard things while using the hard things to build a character necessary for my purpose and destiny. Thank you for your heart of unconditional love. Thank you for the gifts you placed on the inside of me. Thank you for crafting me in secrecy and knowing the depths of my heart. Thank you for seeing me at my lowest and still calling me your daughter. Thank you for the vision you gave at 13 years old and continuing to guide me along the path. Thank you for teaching me I never had to prove myself to you to have value and be worthy. Thank you for making room at your table for me. Thank you for holding me close and never leaving my side. Truly your love never fells.

To Lennon and Margarette Martin Sr., Daddy and Mama I will never be able to put in words the magnitude of the sacrifice you both made for our family to make sure your children had opportunities that you never had. Daddy you are an incredible man of God, husband, father, friend, confidant, and leader. My admiration and awe for your ability to see something in your mind, put it on paper, and then execute it in excellence helped me to see that I could get through this process if I kept my head down, kept moving out, and kept trusting God. You didn't have the educational opportunities that you afforded us, but I want you to know getting across this finish line is just as much your victory as it is mine because without you it would not be possible. Having you as my earthly father is something I praise my heavenly Father for all the time and from the time I was born until now I remain daddy's little girl. I love you. Mama down through

yours we've developed a friendship deepening our mother-daughter bond that has sustained me in ways that brings me to tears. You are fearless, tenacious, and graced with the gift of a sustaining love that has been home to fears, frustrations, and hurt. Thank you for your counsel as a woman that teaches me my value and worth is not in what I do but in who I choose to be every day. Thank you for being a praying mama, stretching out for all your children and giving us back to God as the ultimate sacrifice knowing that he knows what is best. I've watch you walked through tough times holding everybody up remaining steadfast, and when I look for an example to follow, I don't look far because I have you and I remain in complete awe of who you are. I love you.

To my family, we've been through some tough times, but we've also shared incredible memories that have continued to sustain us. I love you all and share this milestone with all of you. To the oldest living patriarch, Henry Murray Gardner Sr. (Uncle Murray; 95 years old) and matriarch Clytee Nichols (Aunt Pot; 104 yrs old) in my life, you both have suffered and overcome for me to have this right. I honor your sacrifice and thank you for your rearing. To my family members who couldn't be here to see this accomplishment, I'm listing your names as an act of remembrance for your contributions to molding and shaping me into the woman I am today. In remembrance of Elzona Shumpert Martin (Big Mama), Emma Gardner Benjamin (Grandmama), Lee Benjamin (PawPaw), Ernest Benjamin (Uncle Bunny), David Benjamin, Michael Benjamin, James Benjamin, Lamar Martin, and Charles Martin. To the many other family members and friends, I have lost through the years this fight is to make a difference for us all in our community, and I'll take the memories of your lives with me every step of the way.

Finally, to all the strong Black women that will read this dedication including my family and friends, may you rest in the fullness of your humanness and give yourself permission to heal from the traumas the world has overlooked for centuries. May we find ourselves inviting vulnerability into our everyday lives, may we begin redefining the meaning of strength in a way that centers our humanity and gives us permission to rest and find meaning in who we are, not just what we do. Queens this one is for you. Black women I love you.

ACKNOWLEDGMENTS

Thank you to the following people who have assisted with the completion of this process:

1. To my friends and family thank you for giving me grace as I went through this isolating process. It was your prayers, words of encouragement, and acts of kindness that helped sustain the 20hr days and sleepless nights. This one is for all of us. We are going up!
2. To my therapy clients who are mostly Black women, your lived experiences have inspired this work so much and I hope you feel seen, heard, and valued. Thank you for choosing me as your therapist and inviting me into your journey toward mental and emotional wellness.
3. This work was made possible due to the financial contribution of the Boris Lawrence Henson Foundation. Thank you for your support as we continue to fight against mental health disparities and reduce mental health stigma within the Black community.
4. To Dr. Sara Lappan, thank you for seeing the importance and need for this work. You stepped into this process at a critical moment, and you've remained a trusted mentor. You were a part of my development as a therapist and now as a researcher. Thank you for being a true ally and for encouraging me along.
5. To my entire committee – Dr. Teneasha Washington, Dr. Larrell Wilkinson, Dr. Jessica Chambliss, Dr. C. Nicole Swiner, and Dr. Lappan your feedback and time spent reviewing papers undoubtedly meant time away from other obligations. Thank you for your efforts and helping me get here.

TABLE OF CONTENTS

Page

LIST OF TABLES

Tables *Page*

PAPER 2: EXPLORING MENTAL HEALTH TREATMENT UTILIZATION AMONG BLACK WOMEN IN THE DEEP SOUTH: A QUALITATIVE APPROACH

PAPER 3: THE COSTLY PERFORMANCE OF STRENGTH: EXPLORING MENTAL HEALTH TREATMENT UTILIZATION AMONG BLACK WOMEN IN THE DEEP SOUTH

LIST OF FIGURES

Figures *Page*

INTRODUCTION

In 2021, the America Psychological Association developed a continuing education model for *Effective therapy with Black women*[1] identifying the unique cultural and historical factors impacting the mental health and emotional wellbeing of Black women. This was one of the first call to actions within the mental healthcare field centering the mental health needs of Black women who have been underserved and understudied throughout research and in practice. The need for Black women to be "strong" encourages the relinquishing of their vulnerability to maintain their survival[2,3]. The most common misconception about strength and Black women within society is to automatically equate this strength with resilience without the deeper understanding of the deleterious effects the performance of strength has on the physical and psychological wellbeing of Black women[2,3,4]. Despite decades of research focused on improving health disparities among underserved populations, significant gaps still exist providing an opportunity for exploration to continue efforts to reduce burden and improve quality of life among Black women.

Indicators for Mental Health Disparities Among Black Women

While national estimates and most recent research still show that Black individuals have a lower prevalence of mental health reporting than their White counterparts[5] there is mounting evidence that Black individuals encounter greater amounts of psychological distress leading to more persistent mental health problems[6]. Persistent mental health problems largely increase when linked with systems of oppression and discrimination,

and for individuals living in poverty[7]. Black women living in the Deep South have a median income of $31,652 which is the second lowest wage earning for Black women in the US[8]. Additionally, Black women are often heads of household and responsible for the caretaking of immediate and extended family. The systems of oppression that continue to impact the economic stability of Black women also show up in the mental healthcare system. The Deep South has the lowest rates of access to mental health care than any other region in the US[9-11]. These stark disparities undoubtedly influence the way Black women navigate care for their mental and emotional wellbeing. The endorsement of the Strong Black Woman/Superwoman schema is a modality by which Black women are socialized to survive in the face of adversity and insurmountable odds. Sociohistorical factors including economic discrimination, and poor accessibility influence the ways in which Black women operate in the systems they inhabit.

Understanding the SBW/SW Schema

The Strong Black Woman/Superwoman (SBW/SW) schema is steeped in the relentless attainment of independence through strength and guides cognitions, meaning making, and health behaviors within Black womanhood[12]. It is important to note that the SBW/SW schema is strongly endorsed and internalized as a preferred perception of Black womanhood causing the schema to have both benefits and liabilities[3]. The complexities of this race and gender schema are imperative in the contextualization of Black women's mental and emotional wellbeing and provide unique qualifiers for how to navigate the exploration of mental health treatment utilization among this population. Black women who highly endorse the SBW/SW schema are more likely to experience higher mental

health issues (i.e., depression[4,13], PTSD[4,14], self-silencing[3], overeating[15], loneliness[14], isolation[16]) and are less likely to seek professional help[17].

Implications for Current Research

Both qualitative and quantitative research, provide evidence for the schema's detrimental effect on mental health outcomes, yet less is known about the perpetuation of this schema within systems that Black women navigate including professional mental health treatment services. Exploration of the SBW/SW schema in the past has primarily been about explaining the unique constructs at an individual level to inform Black women about its detrimental effects on their overall health, but what about the systems and environment that reinforce this need for Black women to be strong? Exploring specific constructs of the SBW/SW schema has led to identifying that the onus of change is on Black women, but the perpetuation of the incessant need to be strong may also be a driver within individual, community, and societal contexts influencing decision-making around mental health help-seeking and treatment utilization. To better understand factors that impact mental health help-seeking and treatment utilization among Black women it is critical to navigate the systems in which they inhabit and the intersections they navigate that influence mental health behaviors and overall wellbeing. The socioecological model theoretically explores the interdependence of multilevel systems on individual development and health related behaviors to better assess points of intervention that go beyond an individual[18] making it an important model to frame our understanding of mental health treatment utilization among Black women. Further, intersectionality posits that persons are not always affiliated with one social category but multiple[19]. For

example, Black women experience dual minority (gender and race) and exploring these intersections may provide better understanding about the nuances influencing mental health treatment utilization. This study explored integrating these two models to inform our understanding on how Black women navigate care for their mental health and factors that impact treatment utilization. We also incorporate the contextualization of Black women through the SBW/SW schema to better assess points of perpetuation.

Dissertation Purpose

This dissertation is comprised of three aims, which are described below:

Aim 1: Conduct a review of the literature to identify factors that may be determinants of psychological distress, and influence attitudes towards mental healthcare treatment utilization among Black women and explore socio historical factors that impact mental healthcare and perpetuate factors associated with mental health outcomes and treatment utilization contextualized by the SBW/SW schema to uncover connections that may lead to the underutilization of services among Black women.

Approach: Researcher explored the history of the SBW/SW schema, and ways in which the SBW/SW schema impacts Black women's mental health. This included discerning factors that impact Black women's mental health, exploring the SBW/SW schema's influence on attitudes and beliefs about mental health treatment, service utilization, and stigma as well as its influence on mental health outcomes. Secondly, researcher explored general and socio-historical information about the mental healthcare system as well as systemic barriers and group schema belief systems as it relates to Black women. After

conducting the literature review a conceptual review of this literature was compiled and reported in Paper 1.

Aim 2: Explore the bidirectional association of the SBW/SW schema's influence on help-seeking and mental health treatment utilization.

Approach: In-depth interviews were conducted with 13 Black women over the age of 18 and living in the Deep South for 10 years or greater to explore phenomena based on their lived experiences to better understand better how Black women access mental health care services, what challenges or obstacles they face when seeking or using these services, and overall navigation of care for their mental health as black women. Interview guides were developed using the socioecological and intersectionality models to better frame the information we wanted to collect. Participants were recruited by providing both electronic and hard copies of the study flyer to individuals, organizations, shops, churches, and community centers within Birmingham, AL. Interviews were approximately 60- minutes and conducted on a video-conferencing platform. The development of the entire study protocol is reported in Paper 2 and results, implications, and discussion are reported in Paper 3.

Aim 3: In tandem with Aim 1 explore the systemic perpetuation of the SBW/SW schema within mental health care treatment services and other societal structures.

Approach: The same approach listed above was used for this aim as well.

Research Contributions

These findings will increase our understanding of current knowledge gaps about mental health treatment utilization among Black women, systemic factors influencing the perpetuation of the SBW/SW schema among Black women and provide clear points of

intervention for improving mental health treatment utilization among Black women that can be further incorporated in research and practice. Conducting this research was a deeply personal and significant endeavor. My positionality as a researcher is shaped by my own lived experiences, cultural background, and social identities, which inevitably influence the way I approach and understand this research topic. As a Black woman, I bring a unique perspective to this study both professionally and personally. I have personally experienced the individual burden of performing in strength to the detriment of my mental and emotional wellbeing. Additionally, the societal expectations and pressures placed upon Black women to embody strength and resilience is often at the expense of our own wellbeing. This understanding allows me to approach this research with empathy and a nuanced understanding of the cultural context. My positionality also encompasses my professional attributes as a public health researcher, and a licensed clinical mental health therapist who sees predominantly Black women in the therapeutic space. I am keenly aware of the interconnectedness of racism, sexism, and mental health disparities. The compounding effects of these forms of oppression contribute to the complexities of mental health treatment utilization among Black women in the Deep South. This awareness drives my commitment to amplifying the voices of Black women and addressing the unique challenges they face in accessing mental health support.

EXPLORING MENTAL HEALTH TREATMENT UTILIZATION AMONG BLACK WOMEN: A THEORETICAL CONCEPTULIZATION

by

AMBER N. MARTIN, TENEASHA WASHINGTON, LARRELL L. WILKINSON, SARA N. LAPPAN, JESSICA T. CHAMBLISS, C. NICOLE SWINER,

In preparation to *Journal of Racial and Ethnic Health Disparities*

Format adapted for dissertation

ABSTRACT

This paper explores factors impacting mental health treatment utilization among Black women who endorse the Strong Black Woman/Superwoman (SBW/SW) schema. An integrated socioecological and intersectionality approach was employed to better understand barriers that hinder access to appropriate care, including financial constraints, limited resources, disparities in healthcare, cultural stereotypes, historical mistrust, and navigating the intersectionality of race and gender as well as systemic inequities. It also identifies what is known about the unique risks associated with the SBW/SW schema that may be determinants of psychological distress, and influence attitudes towards mental healthcare treatment utilization. The primary goal of this paper is to leverage any gaps in previous literature to better inform mental health care for Black women. At the individual level, understanding the influence of the internalization of SBW/SW schema and stigma is crucial. Strategies such as awareness, education, and stigma reduction can encourage Black women to prioritize their mental health. Building supportive networks and empowering individuals to seek care are important for addressing individual-level barriers. Community and societal level factors compound the challenges faced by Black women when navigating their mental health and emotional wellbeing. Lack of culturally responsive care, socio-historical factors, scientific racism, and limited representation in mental health professions contribute to healthcare disparities. Cultural stereotypes and biased treatment approaches exacerbate disparities when considering mental health treatment utilization, and intersectionality adds complexity to accessing mental health services. To address these issues, strategies must be implemented at multiple levels. Promoting culturally responsive care requires understanding and incorporating cultural

beliefs and practices into treatment approaches. Increasing representation in mental health professions is critical for providing relatable care. Advocating for policies that address disparities and discrimination is essential for a more inclusive mental health system. By understanding the factors that impact mental health treatment utilization in tandem with conceptualization through the SBW/SW schema, we can promote well-being, resilience, and potentially influence greater mental health treatment utilization among Black women. Collaboration among mental health providers, researchers, policymakers, community leaders, and advocates is necessary to dismantle systemic barriers and ensure equitable access to mental health services for Black women.

Keywords: strong black woman, superwoman, schema, mental health, treatment utilization, intersectionality, socioecological model

INTRODUCTION

Being "strong" has forced Black women to relinquish vulnerability and replace it with rigidity[1]. A common misconception is to equate this strength with resilience, ignoring the performance of strength among Black women is one of the greatest factors contributing to the grave mental health disparities seen in this population[2-5]. Despite the surge in treatment for mental health care, and the copious amounts of funding for mental health treatment advancement since the COVID-19 pandemic[6], the mental health needs of Black women both nationally[7-11] and internationally[12,13] continue to be underserved and understudied. Scholars consistently find that Black women are more likely to experience chronic, severe, and immobilizing symptoms of depression, anxiety, and posttraumatic stress compared to their White counterparts[2,7,14-15]; yet, awareness of this problem has not translated to treatment utilization[8,16,17].

Mental health treatment utilization among Black women is influenced by various factors, including individual, community, and societal level dynamics[18,19]. Additionally, previous literature posits that one of the greatest factors contributing to the negative mental health outcomes among black women is the endorsement of the Strong Black Woman/Superwoman (SBW/SW) schema. Given these complexities, it is crucial to explore how these factors contextualized with the SBW/SW schema impact mental health treatment utilization among Black women while identifying unique places of intersection furthering the lack of treatment utilization. By understanding the interplay among these factors, we can develop strategies and interventions that address barriers and promote equitable mental health care for Black women. The purpose of this conceptual literature

review is to identify what is known about the unique factors associated with the lack of treatment utilization among Black women within the context of the SBW/SW schema framed by the theoretical lens of the socioecological model and intersectionality. The goal of this conceptual literature review is to identify factors associated with mental health and treatment utilization while leveraging any gaps in previous literature to better inform mental health care for Black women.

UNDERSTANDING THE SBW/SW SCHEMA

Origins of the SBW/SW Schema

Strength is indoctrinated into the cultural tapestry of Black women dating back to slavery and evolving through the intergenerational socialization of Black women to combat an oppressive system created to diminish their humanity[18,20]. The Strong Black Woman (SBW) schema was born out of the enslavement of Black women and the grim reality of intersectional oppression, and is defined as an amalgamation of beliefs and cultural expectations of incessant resilience, independence, and strength that guides meaning making, cognition, and behavior related to Black womanhood[15]. The idea that Black female slaves were strong enough to endure any pain was a stereotype derived from White supremacist society and internalized by Black women as a means of survival in the struggle for equality[20]. In the book *Behind the Mask of the Strong Black Woman: Voice and Embodiment of a Costly Performance*, Beauboeuf-Lafontant describes the Strong Black Woman as tireless, deeply caring, and seemingly invulnerable[2]. They move from a definition of strong Black womanhood to describing the prescriptive nature of strength by stating the performance of strength is used as a measure of validation for the

worthiness of Black women to exist in the world, face unrelenting hardship, and remain unbothered mandating silence in the ongoing struggle[2]. Strength as described in this text reflects a supernatural ability for Black women to persevere through what seems humanly impossible; however, this half-told story of Black womanhood is incomplete and deceives society and Black women themselves into believing that they are incapable of human vulnerability[2,20]. It is important to note that the SBW/SW schema is strongly accepted and internalized by Black women as a preferred perception of Black womanhood rather than the negative colonial caricaturizations such as Mammy[21], Jezebel[14], Sapphire[2,21], and Welfare Queen[22].

The performance of strength that comes by virtue of internalizing the SBW/SW schema places a premium on strength, resilience, and self-sufficiency in the face of adversity. Black women are expected to be pillars of support for their families, communities, and even society at large, often at the expense of their own wellbeing. This narrative continues to exist and conditions society to believe that Black women are better at enduring distress and can immediately heal from trauma when reality proves a different story through stark mental health disparities[2-5,18]. While extant literature critiques the SBW schema calling it a stereotype used to control the image of Black women[23], further research has conceptually established this schema within a framework providing substantial understanding of its impact on Black women individually and within their ecological systems.

Giscombe's Superwoman (SW) Schema Conceptual Framework (see Figure 1) deepens our understanding of the strong Black woman by providing a comprehensive understanding of the SBW/SW schema and its role in physical and psychological health

among Black women[24]. Specific constructs of this racial and gender schema are (a) an obligation to manifest an image of strength; (b) an obligation to suppress emotions; (c) resistance to being vulnerable or dependent; (d) determination to succeed, even in the face of limited resources; and (e) an obligation to help others[24]. To further operationalize this framework Giscombe created the Giscombe Superwoman Schema Questionnaire (G-SWS-Q). This measure is used to quantify psychological processes associated with Black womanhood. The 35-item questionnaire includes five subscales indicative of the constructs previously discussed (i.e., an obligation to manifest strength, an obligation to suppress emotions, etc.) with a positive association between endorsement of items and endorsement of the SBW/SW schema. The SBW/SW schema creates both benefits and liabilities among Black women making it complex in nature and difficult to navigate in society[24]. On one hand, the schema is embraced as a badge of honor fostering a positive self-image by increasing cultural pride, and feelings of self-efficacy promoting resilience[7,23,24]. Alternatively, the SBW/SW schema is associated with stress related health behaviors including overeating, smoking, poor sleep patterns, limited help-seeking, and maladaptive coping[25]. It has also been linked as an indicator for several mental health disorders including depression[11,13,14], generalized anxiety disorder[17], posttraumatic stress disorder[26], and binge eating[26,27].

Impact of the SBW/SW Schema on Mental Health

Depression, a common mental health illness is a leading cause of disability in the US and worldwide[28], and research has established that women experience depression at two times the rate of men[29]; however, research consistently indicates that Black women

are less likely to seek or accept mental health care[8,11,30]. Black women diagnosed with postpartum depression are less likely to be accepting of medication or therapy referrals than any other racial group[30], and scholars posit that Black women are more likely to suppress depressive symptomology[11,14,17]. Several studies report positive associations between the SBW/SW schema and depression. Donovan and West[14] examined whether endorsement of the SBW/SW schema provoked a deleterious relationship between stress and mental health among 92 Black women between the ages of 18 to 47[14]. This study employed a quantitative survey data collection utilizing the Depression Anxiety Stress Scale, Stereotypic Roles for Black Women Scale and found that the SBW/SW schema moderated the relationship between stress and depressive symptoms such that the association was stronger among those with higher SBW endorsement[14].

In another study[15], researchers examined the relationship between characteristics of the SBW/SW schema and depressive symptomology among 194 Black female college students and community members between the ages 18 to 82. Quantitative data collection occurred using The Center for Epidemiological Studies Depression Scale, The Silencing the Self-Scale and subscale, subscales from the Stereotypic Roles for Black Women Scale. Findings from this study identified that self-silencing and externalized self-perceptions better explained the link between the SBW/SW schema and an obligation to manifest strength and depression[15]. Finally, Green[31] explored the relationship between the SBW/SW schema and depression and suicide among 191 African American women utilizing the Beck Depression Scale, Beck Scale of Suicide Ideation, and a modified version of the SBW/SW scale[31]. Green found that Black women's higher endorsement of the SBW/SW schema strengthened the relationship between depression and risk for

suicidality, reinforcing the schema's characteristic of an obligation to suppress emotions[31]. Importantly, a recent study reported a 59% increase in the suicide rates among black females between 2013 and 2019[48]. Previously suicide rates among Black women were historically the lowest of all racial groups, and while this currently remains true what is noteworthy is the 200% increase in suicide rates among young Black women compared to older Black women[48,49]. All of these findings continue to highlight the negative mental health outcomes associated with the internalization and endorsement of the SBW/SW schema and provides direction for future research exploring the unique factors associated with the SBW/SW schema that may be determinants of psychological distress, emotional well-being, and influence attitudes toward mental health treatment utilization among Black women.

Anxiety disorders are reported to be common and more debilitating among Black individuals with posttraumatic stress disorder being more prevalent among Black women than their White counterparts[23]. Black women who highly endorse constructs in the SBW/SW schema are more likely to experience higher negative mental health outcomes like self-silencing[15], overeating[26,33], loneliness[34], isolation[35], and are less likely to seek professional help[36]. Both qualitative and quantitative research provide evidence for the internalized schema's detrimental effect on mental health outcomes and professional treatment utilization[11,16,17]. One study examining the potential mediating effect of the SBW/SW schema in the relationship between trauma exposure, distress, and binge eating tested a culturally specific model of binge eating among 179 African American female trauma survivors[26]. Harrington and colleagues[26] found that emotional dysregulation and eating behaviors to fulfill psychological needs were important mechanisms influenced by

SBW/SW schema, and that Black women used binge eating to manage negative affect associated with traumatic experiences. This maladaptive coping mechanism highlights the clinical significance of the SBW/SW schema in relationship to anxiety and eating disorders providing future directions for eating disorder research among Black women to address the obesity epidemic in the US. Because eating disorders are considered a mental health issue these findings also continue to highlight the detrimental mental health outcomes associated with SBW/SW schema.

Some studies have taken a qualitative approach to understanding more about how Black women navigate mental health including exploring beliefs, behaviors, and coping mechanisms to explain contextually the factors influencing positive and negative mental health outcomes. For example, Ward and colleagues[18] used the Common Sense Model to explore beliefs about mental illness, barriers to treatment seeking and coping behaviors among 15 African American community members. Findings from the study include a belief that cultural factors such as discrimination and oppression lead to depression, using prayer and informal networks (friends and family) as coping mechanisms, and accessibility as a barrier to treatment seeking[18]. Importantly researchers indicated spirituality and religion may have adverse consequences on delayed treatment seeking offering an opportunity for further exploration about how factors in context with the SBW/SW schema impact mental health treatment utilization.

The aforementioned quantitative and qualitative findings help better explain the role of SBW/SW schema among Black women and negative mental health outcomes helping us understand that while the SBW/SW schema may have initially emerged as a source of empowerment; it can have detrimental effects on Black women's mental

health[33]. The pressure to constantly appear strong and resilient can lead to the suppression of emotions and a reluctance to seek help. Black women may fear being perceived as weak or vulnerable if they admit to struggling with their mental health, perpetuating a cycle of silence and isolation, and the lack of treatment utilization among this population. To better understand these phenomena throughout literature we will start with a socio-ecological approach to understand the influence the SBW schema has on treatment utilization at varying ecological levels.

A SOCIO-ECOLOGICAL APPROACH TO MENTAL HEALTH TREATMENT UTILIZATION CONTEXTUALIZED BY THE SBW/SW SCHEMA

Urie Bronfenbrenner's socioecological model[37] posits that understanding individuals and problems is best done within ecological contexts (i.e., relationships, communities and environments, organizations, society, and institutions). The socio-ecological model depicts the importance of the interdependence of multilevel systems on individual development to better assess points of intervention that go beyond the individual[37]. For this reason, it is favored in the field of public health and continues to be adopted to better understand emerging public health issues[38]. Based on previous literature, a socioecological model (see Figure 2) of mental health treatment utilization has been created that may conceptualize Black women within the context of the SBW/SW schema based on the experiences, attitudes, culture, environments, and other factors that have been identified to impact the mental health and wellbeing in this population. It is also imperative to understand the tensions that arise at the intersections of race and gender for Black women and how they are informed by the SBW/SW

schema. Although intersectionality is discussed in greater detail later in this article, it is critical to point out how the impact of navigating multiple social identities such as race and gender interact at the individual level and are reinforced by systemic issues at the societal level[39]. Specifically in this model we use the SBW/SW schema to better define and understand the intersectional attributes that impact Black women and influence decision-making around mental health treatment utilization.

While the socioecological model details specific factors that might influence health behaviors, the intersections Black women face within these levels is worthy of deeper exploration given this is not often discussed. For this reason, embedded in Figure 2 is a schematic example of intersectionality within the socioecological model inviting the integration of both theoretical models to better address the mental health needs of Black women. For this article, we applied the socioecological model to mental health treatment utilization among Black women using the SBW/SW schema to contextualize nuances and provide more detail about factors at the individual, interpersonal, community, and societal levels. The focus of this paper will be on the individual, community, and societal levels of this model, in that order.

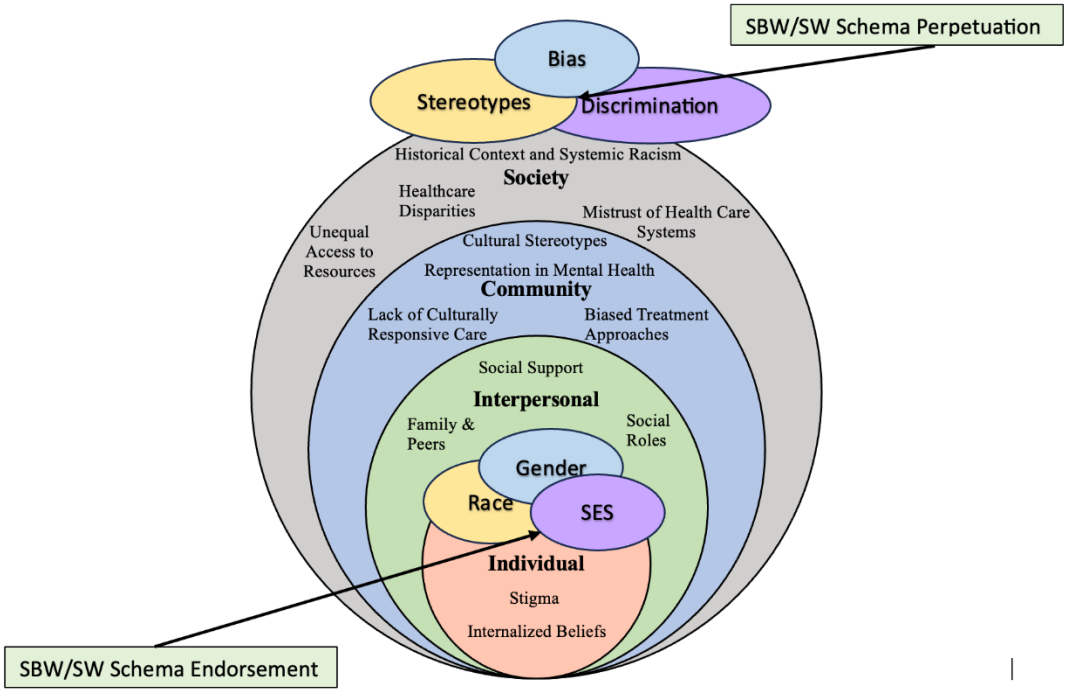

Figure 1. Integrated Socioecological and Intersectionality Model of Mental Health Treatment Utilization Among Black

Individual Level Impact on Mental Health Treatment Utilization

At the individual level, the internalization of the SBW/SW schema influences attitudes, cognitions, and behaviors of Black women that may lead to negative mental health outcomes, impact help seeking, and influence professional mental health treatment utilization[11,37]. One key impact of the SBW/SW schema is the reluctance to seek help[16-18]. Black women may feel pressure to handle their emotional struggles on their own, fearing that reaching out for support would be perceived as a sign of weakness or failure[16]. This can result in delayed or inadequate treatment, as individuals may attempt to cope with their mental health concerns independently, without accessing the appropriate professional help. Moreover, internalization of the SBW/SW schema can lead to the normalization of suffering[34]. Black women may believe that experiencing mental health

challenges is simply a part of their daily lives and that seeking help is unnecessary or undeserved. This normalization can prevent individuals from recognizing the severity of their symptoms and the impact on their well-being, further hindering their utilization of mental health treatment[40]. To further understand intervention at the individual level it is imperative to explore internalized beliefs and stigma associated with the SBW/SW schema and how they impact mental health treatment utilization.

Internalized Beliefs

Internalized beliefs associated with mental health contextualized by the internalization and endorsement of the SBW/SW schema hinder Black women's willingness to seek help and engage in treatment[40]. Internalized beliefs can influence how Black women interpret and respond to their own mental health symptoms. Black women may downplay or dismiss their experiences, attributing them to external factors rather than recognizing them as legitimate mental health concerns[18]. Lao and colleagues[34] examined the relationship between the SBW schema and depression, anxiety, and loneliness and found that the internalization beliefs of the SBW schema at the individual level were positively associated with maladaptive perfectionism. Maladaptive perfectionism refers to having unrealistically high standards, perceived pressure from others to be perfect, and being overly concerned with mistakes[34]. Negative mental health outcomes are associated with maladaptive perfectionism due to equating perfect performance with individual self-worth. Maladaptive perfectionism has been correlated with depression and anxiety in previous literature[41,42] and in this study, there was a positive association between maladaptive perfectionism, low self-compassion, and low use of collective coping leading to poorer psychological outcomes[34]. Though this

quantitative study identified several individual-level points of intervention the authors determined there was a need to focus on the perpetuation of the need to be strong from a societal perspective to better understand the need to maintain the SBW schema. The internalization and endorsement of the SBW/SW schema itself occurs when individuals adopt and incorporate societal expectations of strength, resilience, and self-sufficiency into their own self-perception, self-worth, and identity. Internalizing the belief that seeking help for mental health concerns is a sign of weakness or failure, perpetuates stigma and creates barriers to treatment utilization.

Stigma. Internalized beliefs related to the SBW/SW schema can contribute to the stigma surrounding mental health in several ways. The perpetuation of the SBW/SW schema often promotes a narrative that seeking help for mental health challenges is a sign of weakness or failure[15]. Black women may feel pressure to maintain an image of strength and resilience, fearing that admitting to struggling emotionally may undermine their perceived ability to handle life's challenges. Internalized stigma can also affect help-seeking behaviors by creating fear of judgment, discrimination, or negative social consequences[15,24]. Black women may hesitate to acknowledge their own mental health needs or may deny themselves the support and care they deserve[15,24,43]. Additionally, the stigma surrounding mental health within the Black community can further deter Black women from seeking treatment[8,15,24]. In a secondary analysis of a qualitative study conducted by Giscombe[44] 48 Black women from the southeast US were involved in focus groups using the SW schema to identify barriers to mental health service use among Black women[44]. Results from this study identified perceived stigma as a barrier to treatment utilization, and researchers found that there was stigma associated with seeking

therapy, stigma related to mental health diagnosis, and stigma around medication for mental health treatment[44], identifying that mental health concerns among Black women may be viewed as personal matters that should be kept within the family or community, making it difficult for individuals to openly discuss their struggles or reach out for professional help[43]. This stigma can be deeply entrenched and perpetuated by cultural norms[17], religious beliefs[44], and fear of judgment or rejection[43].

The intersection of mental health stigma in the Black community and socioeconomic issues creates unique challenges in accessing and utilizing mental health treatment services[45]. Stigma surrounding mental health within the Black community may be grounded in historical, cultural, and systemic factors[46]. This stigma, combined with socioeconomic issues, further compounds the barriers to seeking and receiving mental health care[46]. A discussion concerning socioeconomic status and access issues is the focus later in this article; however, it is important to note the importance of understanding systemic intersections that impact mental health treatment utilization among Black women as being paramount to addressing disparities.

Only exploring the SBW/SW schema at the individual level when discussing its impact on mental health treatment utilization puts the onus of change on Black woman and can distract from the opportunity to investigate how the perpetuation of this schema at the community and societal levels reinforce the need for Black women to subscribe to the performance of strength. This examination of the literature seeks to guide researchers and practitioners on a journey to furthering our discovery into how systematic structures may influence the perpetuation of this racial and gender schema it is critical that we explore impact at other levels. Previous literature positions the internalization of the

SBW/SW schema as being central to the lack of mental health treatment utilization and help-seeking, yet there is a need for more discussion around the social structures within our society that support the maintenance of the SBW/SW schema.

Community Level Impact on Mental Health Treatment Utilization

At the community level within the socioecological model, the SBW/SW schema has a significant impact on mental health treatment utilization among Black women. Communities play a critical role in shaping beliefs, attitudes, and access to resources related to mental health[37]. Understanding and addressing the influence of the SBW/SW schema at this level is essential in promoting help-seeking behaviors and reducing barriers to mental health care. One aspect of the community-level impact is the availability and accessibility of mental health resources[37]. Communities that lack sufficient mental health services, particularly those that are culturally responsive to the unique needs of Black women, can contribute to underutilization of treatment[44].

Additionally, limited access to affordable care, long wait times, and geographical barriers may prevent individuals from seeking and receiving the support they need. Community norms and beliefs surrounding mental health and the SBW/SW schema can influence help-seeking behaviors[44]. If community members reinforce the expectation that Black women must be strong and self-reliant, Black women may feel stigmatized or judged for seeking help. The presence of community-based organizations and support networks is crucial in addressing the impact of the internalization and perpetuation of the SBW/SW schema[34]. These organizations can provide culturally specific interventions, outreach programs, and educational resources to promote mental health and well-being.

Community organizations play a vital role in destigmatizing mental health concerns and providing safe spaces for Black women to seek support, share experiences, and access resources; however, the lack of culturally responsive care at the community level creates a barrier to mental health treatment utilization among Black women[47]. Moreover, socioeconomic status and treatment accessibility play a large role in the underutilization of mental health treatment at the community level.

Lack of Culturally Responsive Care

Culturally responsive care refers to the unique ability to see and value individuals for all aspects of their identity, background, and experience[48]. This type of care deliberately and consistently acknowledges the intersectional existence of every person as the foundation for determining goals, treatments, and interventions rather than the ideology that singular focus care models work for everyone[49]. At the helm of culturally responsive care is understanding and navigating cultural sensitivity, cultural awareness, cultural humility, and cultural competence and actively engaging in anti-oppressive practices that consider power imbalances[48]. A key challenge is the limited understanding of the unique experiences and cultural nuances of Black women within the mental health field. Without culturally responsive care, mental health providers may not be aware of the specific stressors, discrimination, and systemic challenges that Black women face that often contributes to misdiagnosis, inappropriate treatment, and a failure to address the root causes of mental health concerns.

Cultural responsiveness also involves acknowledging and respecting the intersectionality of race, gender, and other social identities. Black women often face multiple forms of discrimination and oppression, and their mental health concerns are

shaped by these intersecting factors. However, without an understanding of intersectionality, mental health providers may overlook the complex and unique challenges faced by Black women, leading to ineffective or incomplete treatment. The lack of understanding of how the SBW/SW schema impacts mental health can significantly limit the appropriate responsive care Black women receive. It is essential to create an environment in which Black women feel heard, understood, and supported in their mental health journeys, encouraging them to seek and engage in treatment.

Cultural Stereotypes and Biased Treatment Approaches

Cultural stereotypes and biased treatment approaches are significant challenges that impact mental health treatment utilization among Black women[18,24,50]. These biases can shape the ways in which mental health conditions are perceived, diagnosed, and treated, leading to disparities and inequities in care. In the case of the SBW/SW schema, mental health concerns may be dismissed or minimized due to the expectation that Black women should handle challenges without external support[15]. One of the common misconceptions about the SBW/SW schema is to equate strength with resilience often leading to overlooking vulnerabilities and mental health needs[2,3,24]. This stereotype can discourage Black women from seeking help, as they may fear being perceived as weak or unable to fulfill societal expectations[8,11,16].

Biased treatment approaches stem from cultural misunderstandings and the lack of culturally responsive care among mental health professionals[51]. The cultural norms, values, and experiences of Black women may be overlooked or misunderstood, leading to misdiagnosis or ineffective treatment[52,53]. Mental health professionals who are not knowledgeable about the diverse cultural backgrounds of their clients may

unintentionally perpetuate stereotypes or apply treatment strategies that do not align with the unique needs and perspectives of Black women[19,47,49].

Lack of Representation in Mental Health Professions

According to the American Psychiatric Association only two percent of psychiatrists, four percent of psychologists, and four percent of therapists and social workers are Black[77,78]. The lack of representation of Black professionals in mental health professions is a significant barrier to mental health treatment utilization among Black women[18,52,54]. Representation matters because having mental health professionals who share racial or cultural backgrounds with their clients can foster a sense of trust, understanding, and cultural competence[51]. However, Black women often face a scarcity of mental health providers who reflect their identities and experiences[18]. The limited representation of Black professionals in mental health fields has several implications for Black women seeking mental health treatment.

Firstly, the absence of racially and culturally diverse providers may contribute to a lack of understanding of the unique experiences, cultural norms, and social contexts that shape the mental health of Black women[51]. This can result in misdiagnosis, inadequate treatment, and a lack of appreciation for the sociocultural factors that contribute to mental health disparities. Additionally, the lack of representation can contribute to a sense of mistrust and discomfort when seeking mental health care. Black women may feel hesitant to disclose personal experiences and emotions to professionals who may not fully grasp the nuances of their racial and cultural identities[50]. The absence of relatable role models in mental health professions can perpetuate the notion that mental health care is not designed to meet the specific needs of Black women.

Societal Level Impact on Mental Health Treatment Utilization

The societal-level impact on mental health treatment utilization among Black women is influenced by various factors that shape access to, availability of, and utilization of services[37]. These factors arise from social structures, cultural norms, systemic inequalities, and historical contexts that shape the experiences and opportunities available to Black women[52]. Socio-historical factors that have impacted the field of mental healthcare continue to influence the care Black women receive today by sending the same messaging of being strong in the face of adversity and deeming this performance of strength an admirable quality to placate without addressing the physical and mental needs among this population[18,19,46,52]. Understanding and addressing these societal level factors is crucial for promoting equitable access to mental health care.

Historical Context and Systemic Racism

Historical context and systemic racism have had profound and lasting impacts on mental health treatment utilization among Black women. Historically, Black women have faced significant challenges in accessing quality healthcare, including mental health care[55]. The legacy of slavery, racial segregation, and discrimination has shaped the social, economic, and health outcomes of Black communities. These historical injustices have contributed to mistrust of healthcare systems and institutions[49,55]. The exploitation and mistreatment of Black bodies in medical experiments and unethical practices, such as the Tuskegee Syphilis Study[56], and the Henrietta Lacks[57] story have deepened the sense of suspicion and skepticism towards research, healthcare providers, and healthcare

systems[46,49,55]. Systemic racism, both overt and subtle, continues to perpetuate inequalities in mental health treatment utilization.

Dating back to the 1800s and beyond, Black individuals have been grappling with systems of oppression and discrimination, and those same systems were responsible for creating the healthcare system infrastructure and protocols informing how we care for and treat individuals today[55]. In the United States scientific racism was used to justify slavery, and Black individuals were described as having primitive psychological organization make them "fit" for bondage[46]. Scientific racism is indicative of systemic control and containment for profitability, and leading health professionals propagated the idea that blacks were "less than" to justify exploitation and experimentation[46]. When we dive deeper into the foundations of mental healthcare (i.e., psychiatry and psychology) we find that the "father of American psychiatry", Benjamin Rush, was responsible for coining the term *Negritude,* which described Black individuals as suffering from a mild form of leprosy that could only be cured by becoming White[46,49,52,55]. Additionally, Samuel Cartwright, a mentee of Benjamin Rush, published a report inventing the psychiatric disorder *Draeptomania* to explain tendencies of enslaved people to run away or resist hard work as a mental illness[46]. Cartwright was also known for using the bible to support his findings leading to Black slaves being kept in a submissive state and treated like a child to cure them of this mental illness[46]. Prior to the civil rights movement the mental disorder schizophrenia was described as a white, docile, and harmless condition; however, during the height of the civil rights era the scientific community began describing schizophrenia as a violent social condition that afflicted *Negro men* and manifested as rage, volatility, and aggression[46,58]. The Black psyche was increasingly

portrayed as unwell, immoral and inherently criminal, which is one example of how scientific racism functions and the societal and reinforces internalized beliefs and stigma at the individual level[46].

At the foundation of the mental healthcare system there was a clear lack of concern for the mental and emotional well-being of Black individuals, and the mental health care needs of Black people were not factored into many of the frameworks and interventions used within mental healthcare treatment services today[45,46,52]. The unethical treatment of Black individuals exacerbates the suspicion and skepticism toward mental health providers and reinforces the need to be strong among Black women[56]. Throughout history, Black women have been subjected to various forms of oppression, including racism, sexism, and economic disparities[73]. In response to these challenges, Black women have developed coping mechanisms that emphasize strength and perseverance as a means of survival[74]. Subsequently, Black women often encounter racial bias and discrimination within healthcare systems, which can manifest as unequal treatment, dismissive attitudes, and a lack of cultural responsiveness[53,55,57].

One example of this phenomenon is the reproductive oppression Black women have faced including the reproduction of Black women being governed in relation to the slave economy[59], exploitative medical interventions that led to the sterilization of Black women[60], and ignoring Black women's pain during and after pregnancy[60] which may be influenced by the perpetuation of the SBW/SW schema at the societal level. Implicit biases may contribute to underdiagnosis or misdiagnosis of physical and mental health conditions, resulting in inadequate or inappropriate treatment[61]. These experiences of

racism and discrimination contribute to a hostile healthcare environment and erode trust, leading to decreased utilization of mental health services.

Mistrust of Healthcare Systems

While historical mistreatment and ongoing healthcare disparities have fostered a deep-seated mistrust of healthcare systems among Black women, it is the personal experiences of racism, bias, and discrimination within mental health settings that continue to guide skepticism and fear of mistreatment among Black women[19,24,62]. This mistrust can deter individuals from seeking mental health treatment, as they may be apprehensive about receiving appropriate and unbiased care. In one study examining mental health outcomes in relationship to moderate and severe endorsement of the SBW/SW schema, authors found there was greater chronic stress, emotional exhaustion, and feelings of isolation which were exacerbated when introducing past mental health treatment experiences into the equation[16]. This finding is significant in helping us understand the importance of evaluating the intersections of internalizing the SBW/SW schema and mistrust of healthcare systems which create additional barriers to accessing mental health treatment and retention in treatment services[36].

The combination of the SBW/SW schema and mistrust of healthcare systems can lead to delayed or avoided mental health treatment among Black women. These individuals may downplay their own needs and prioritize the well-being of others, viewing their mental health concerns as secondary[2,24]. They may also feel a lack of trust in the healthcare system's ability to provide culturally sensitive and effective care, which can result in a hesitancy to seek professional help. As previously stated, suppressing emotions, and neglecting self-care to conform to the SBW/SW schema can lead to

increased stress, burnout, and the development of mental health disorders such as depression and anxiety[3,14,35]. The reluctance to seek help due to mistrust of healthcare systems can result in untreated or undiagnosed mental health conditions, exacerbating symptoms and impairing daily functioning which may also influence the increase in suicidality among Black women[5,31].

Healthcare Disparities and Unequal Access to Resources

Studies have shown that Black individuals are less likely to receive evidence-based mental health treatments compared to their White counterparts, even when controlling for factors such as insurance coverage and clinical need[53,63]. The systemic inequalities embedded in society, including the mental healthcare system, can limit access to quality mental health care for Black women. Persistent mental health problems largely increase when linked with systems of oppression and discrimination, and for individuals living in poverty[55]. Black women experience higher rates of poverty, unemployment, and limited health insurance coverage compared to other demographic groups and are more likely to live in areas with limited access to quality healthcare facilities, including mental health clinics and providers[19]. This can result in longer travel distances, difficulties in scheduling appointments, and increased wait times, making it challenging for Black women to access timely and appropriate mental health care.

Healthcare disparities and unequal access to resources are significant factors that impact mental health treatment utilization among Black women. These disparities result from the complex interplay of systemic factors we've been discussing that limit equitable access to healthcare services, including mental health care[52]. When we consider the sociohistorical factors of racism and oppression in the field of mental health at the

intersection of health disparities and unequal access to resources the care for the mental health of Black women seems to disappear. This highlights the role of navigating intersections within systems which we will refer to as systemic intersectionality.

INTERSECTIONALITY AND MENTAL HEALTH TREATMENT UTILIZATION

Intersectionality, a concept coined by scholar Kimberlé Crenshaw, highlights the interconnected nature of various social identities and systems of oppression, such as race, gender, class, sexuality, and ability[64]. The term intersectionality was birthed due to the theoretical erasure of Black women because gender was viewed singularly as a White woman's issue and race a Black man's issue[64,65]. Crenshaw posited that examining marginalized populations within a single-axis framework contributes to their marginalization by excluding the unique experiences that occur at the intersections of multiple social identities[64]. Intersectionality recognizes that individuals experience multiple forms of discrimination and privilege simultaneously, which can significantly impact their mental health and help-seeking behaviors[19,65,70]. For Black women, the intersection of race and gender creates a distinct set of challenges that influence their access to and utilization of mental health treatment[19]. Understanding intersectionality is crucial for examining the complexities of mental health treatment utilization among Black women and the unique challenges they face. Additionally, intersectionality across systems of inequity like socioeconomic status and access issues introduces even greater complexity to mental health treatment utilization among Black women. Due to the paucity of research about intersectionality as it relates to systems of inequity this investigation presents an opportunity to add to the body of literature regarding the mental

health needs of Black women and factors that may influence the use of mental health treatment utilization among this population.

Understanding the Intersectionality of Race, Gender, and Mental Health

Race and gender intersect to create distinct experiences of mental health for individuals[66]. For example, Black women may face a range of stressors and challenges, including racial discrimination, gender-based discrimination, and stereotypes specific to their racial and gender identities (i.e., the SBW/SW schema)[55]. These intersecting forms of oppression can contribute to heightened levels of stress, anxiety, and depression[2,24]. The intersectionality of race and gender also shapes the social expectations and stereotypes placed upon individuals[3,20]. Black women may encounter societal pressures to be strong, resilient, and self-sufficient, while simultaneously experiencing the effects of racism and sexism[2,7,65]. These conflicting expectations can influence how Black women perceive and express their mental health concerns, as well as impact their help-seeking behaviors[24].

For this reason, the SBW/SW schema is used to help guide our conceptualization of Black women at the intersection of race and gender. It is important to not only navigate the multiple identities of Black women to understand their lived experiences at an individual level, but to also examine the messages that Black women have received about their gender and race (societal level) to better understand the internalization of constructs like “obligation to manifest an image of strength” and “obligation to suppress emotions” that have proven to be detrimental to Black women’s mental health[24]. In 1962, just 60

years ago, in one of the most memorable speeches from civil rights leader Malcolm X, he stated:

The most disrespected person in the world is the Black woman. The most unprotected person in the world is the Black woman. The most neglected person in the world is the Black woman[67].

This message may continue to resonate among Black women today, especially those who endorse the SBW/SW schema. Messages on what it means to be Black, and a woman intersect at the societal level teaching and reinforcing a narrative that impedes the mental health needs of Black women.

Understanding the Intersectionality of Inequitable Systems and Mental Health

Systemic inequality refers to the pervasive and interconnected social, economic, and political structures that perpetuate unequal outcomes and opportunities for marginalized groups within society[68]. These systemic inequities are deeply rooted in historical and ongoing patterns of discrimination, bias, and privilege[69]. Intersectionality emphasizes the need to consider the interconnectedness of race, gender, class, sexuality, ability, and other social categories when analyzing and addressing systemic inequality[64]. Applying intersectionality at the societal level helps us navigate oppressive, discriminatory, and bias systems that impact mental health treatment utilization among Black women.

The Intersection of Socioeconomic Status and Accessibility

Economic disparities often play a role in limiting mental health treatment utilization among Black women. According to the Center for American Progress (2018) the median wealth of Black families was $17,600 in 2016 compared to a median wealth

of $171,000 among White families for the same year[44]. This wealth gap is represented in the number of Black women living at or below the poverty line. There is a strong connection between mental health and financial well-being[45], and unfortunately economic instability maintained through discriminatory and oppressive systems intersects with unaffordable or inaccessible mental health treatment services which may lead to the perpetuation of the SBW/SW schema among Black women. Moreover, the intersection of the SBW/SW schema and financial constraints may create a belief that seeking mental health treatment is a luxury or a nonessential expense. The financial burden of seeking treatment, including therapy sessions, medication, and other necessary resources, may discourage Black women from pursuing the care they need, particularly when faced with competing financial priorities.

Limited availability of mental health services in certain areas, especially those offering culturally competent care, can create additional barriers to seeking help[69], and creates another systemic intersection that must be navigated. Inadequate insurance coverage or the absence of mental health services in low-income communities can reduce the availability and accessibility of culturally responsive care for Black women. Notably, even with insurance coverage, mental health services may have high copayments or limited coverage for therapy sessions and medication. This accessibility and financial burden can discourage individuals from seeking ongoing treatment or result in inconsistent care[69]. The SBW/SW schema constructs – determination to succeed even in the face of limited resources, and an obligation to help others – often may influence beliefs about the need to seek mental health treatment and ultimately be viewed as unaffordable within the context of other financial obligations.

Intersectionality calls for an inclusive approach to mental health research, policy, and advocacy. It requires centering the experiences and voices of individuals who hold multiple marginalized identities to inform the development of interventions, programs, and policies that are responsive to their needs[65]. Intersectional approaches highlight the importance of collaborative decision-making processes that involve diverse perspectives and experiences, ensuring that mental health initiatives are truly inclusive and address the intersecting dimensions of identity[66].

DISCUSSION

Strategies to Address the Impact of SBW/SW Schema on Mental Health Treatment Utilization

Addressing the impact of the SBW/SW schema on mental health treatment utilization among Black women requires targeted strategies that challenge the schema without dismissing or erasing its cultural significance, promote help-seeking behaviors, and provide culturally responsive care. By integrating a systems-level perspective with an intersectional lens, we discover that addressing the challenges Black women face concerning mental health is paramount and should be prioritized in both research and practice. It is critical to implement strategies that promote mental health awareness and destigmatization within the Black community as well as strategies to challenge, educate, and train our providers toward compassionate and holistic care.

Enhancing Awareness and Education

To address the individual-level impact of the SBW/SW schema on mental health treatment utilization, it is crucial to enhance awareness and education surrounding mental

health within the Black community. By providing accurate information and challenging the stigma associated with mental health, individuals can feel more empowered to prioritize their well-being and seek the support they need. Additionally, destigmatizing mental health through open dialogue, community support, and representation can foster an environment that encourages Black women to prioritize their mental health without fear of judgment or repercussions. Utilizing tools like the Giscombe Superwoman Schema Questionnaire[71] may encourage awareness at the individual level and serve as a tool for conceptualization and awareness at the community level.

Further, education campaigns can take various forms, such as community workshops, online resources, and public service announcements. These initiatives should aim to inform and challenge the SBW/SW schema by providing accurate information and debunking misconceptions. By increasing awareness about the harms associated with the schema, individuals can start to recognize its impact on mental and emotional well-being and feel empowered to seek help. Mental health literacy is needed at varying levels to combat mental health stigma. By promoting knowledge about mental health conditions, symptoms, and available treatment options, individuals can become more informed and better equipped to recognize when they may need professional support.

Promoting Culturally Responsive Care

Promoting culturally responsive mental health care is a crucial strategy to address the impact of the SBW/SW schema on mental health treatment utilization among Black women. Culturally responsive care involves understanding and incorporating cultural beliefs, values, practices, and experiences into the provision of mental health services. It is necessary for mental health providers and researchers to develop cultural awareness

and knowledge about the experiences and challenges faced by Black women. This includes understanding the historical context of systemic racism, gender discrimination, and the SBW/SW schema. Providers should educate themselves about cultural norms, beliefs, and values within the Black community to gain insight into the unique experiences and mental health needs of Black women.

It is also critical for mental health providers and researchers to acknowledge and confront their own biases and stereotypes as well as those biases and stereotypes that are maintained within society to prioritize rendering unbiased care. This involves examining personal assumptions and challenging stereotypes related to race, gender, and mental health. By actively working to dismantle bias, providers can create a safe and non-judgmental environment where Black women feel understood and validated. Moreover, challenging and working to dismantle biases will also influence the dismantling of the negative connotations of the SBW/SW schema that are consistently perpetuated within society, communities, and individually.

Recognizing the intersectionality of race, gender, and other identities is critical in providing culturally responsive care. Mental health providers and researchers should understand the ways in which various forms of discrimination and oppression intersect to shape Black women's experiences. This understanding helps tailor treatment approaches that address the unique challenges and needs arising from these intersecting identities and prioritizes the mental and emotional well-being of Black women. Additionally, culturally responsive care involves collaboration with Black women as partners, especially in the therapeutic process. Mental health providers should actively seek input, listen to their perspectives, and respect their autonomy and self-determination. By involving Black

women in decision-making and treatment planning, providers can ensure that the care aligns with their cultural values, preferences, and goals.

Finally, ongoing professional development and training are essential for mental health providers to enhance their cultural competence and equip them to be culturally responsive. This includes reviewing and updating academic courses that are outdated and underdeveloped, learning from experts, attending workshops and conferences, and engaging in discussions and reflective practices that deepen their understanding of cultural diversity and its implications for mental health care. This will support the adaptation of mental health theories to be culturally relevant and responsive to the needs of Black women.

Increasing Representation in Mental Health Professions

Representation refers to the presence and active participation of individuals from diverse racial and ethnic backgrounds, including Black professionals, within the mental health workforce[72]. Increasing representation in mental health professions is paramount to addressing the impact of the SBW/SW schema on mental health treatment utilization among Black women. The presence of Black mental health professionals serves as powerful role models for Black women seeking mental health treatment. Seeing individuals who share the same racial and cultural background in positions of authority and expertise can provide a sense of validation, familiarity, and trust. Black professionals can serve as relatable figures who understand the unique experiences, challenges, and cultural contexts faced by Black women as well as deepen the understanding of the cultural nuances, beliefs, and values within the Black community.

Increasing the representation of Black mental health professionals can help break down systemic barriers that limit access to care for Black women. By having professionals who are familiar with the challenges faced by their community, it becomes easier to navigate cultural, socioeconomic, and institutional barriers. Black mental health professionals can advocate for policy changes, increase awareness about available resources, and address healthcare disparities that disproportionately affect Black women.

Advocacy for Policies Addressing Healthcare Disparities

Advocacy for policies addressing healthcare disparities is essential to dismantle systemic barriers and create a mental healthcare system that is equitable, accessible, and responsive to the mental health needs of Black women. Advocacy efforts should focus on promoting equity in healthcare access by addressing disparities in insurance coverage, affordability, and availability of mental health services. This includes advocating for policies that expand Medicaid and increase funding for mental health programs in underserved communities. It also involves supporting initiatives that eliminate insurance coverage gaps for mental health treatment and ensure parity between mental health and physical health services.

To support training and education around culturally responsive care, policies should prioritize the development and implementation of standards for culturally responsive mental health care. This includes advocating for policies that require culturally responsive training for mental health providers, encouraging the recruitment and retention of diverse professionals, and promoting the use of evidence-based interventions that are culturally appropriate for Black women. Advocacy efforts should also support the integration of culturally responsive care into quality assurance and

accreditation processes. Moreover, advocacy should prioritize policies that enhance data collection and research on mental health disparities among Black women. This includes advocating for the inclusion of racial and ethnic identifiers in health records and research studies to accurately capture and address disparities. Policies should also support the allocation of resources for research on effective interventions, strategies to reduce disparities, and the evaluation of mental health programs specifically tailored for Black women.

CONCLUSION

The impact of the Strong Black Woman/Superwoman (SBW/SW) schema on mental health treatment utilization among Black women is influenced by various factors. Financial constraints, access issues, cultural stereotypes, and historical mistrust of mental healthcare contribute to underutilization of services. These barriers create challenges in seeking appropriate care, worsening mental health disparities. Strategies to address the impact of the SBW/SW schema involve awareness, education, and stigma reduction at the individual level. Empowering Black women to prioritize mental health and fostering supportive relationships also encourage help-seeking behaviors.

Community-based organizations play a crucial role by providing culturally specific interventions, outreach programs, and resources. They destigmatize mental health concerns and create safe spaces for support. Advocacy efforts at the community level can address systemic barriers, promote funding for services, improve access, and advocate for culturally responsive training. By raising awareness, influencing public

opinion, and mobilizing resources, communities support mental health treatment utilization among Black women.

At a societal level, addressing the impact of the SBW/SW schema requires a comprehensive approach. This involves promoting culturally responsive mental health care, increasing representation, advocating for policies to eliminate disparities, and supporting community-based interventions. Collaboration between mental health providers, researchers, policymakers, community leaders, and advocates is crucial to dismantle barriers. By prioritizing culturally responsive care, advocating for policy changes, and increasing representation, we can create a more inclusive and equitable mental health system. Ultimately, addressing the impact of the SBW/SW schema is essential for promoting the well-being and mental health of Black women.

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EXPLORING MENTAL HEALTH TREATMENT UTILIZATION AMONG BLACK WOMEN IN THE DEEP SOUTH: A QUALITATIVE APPROACH

by

AMBER N. MARTIN, TENEASHA WASHINGTON, LARRELL L. WILKINSON, SARA N. LAPPAN, JESSICA T. CHAMBLISS, C. NICOLE SWINER

In preparation to *Journal of Health and Social Behavior*
Format adapted for dissertation

ABSTRACT

BACKGROUD: The SBW/SW schema recognizes the cultural expectations placed on Black women to exhibit strength, resilience, and self-sufficiency, often leading to barriers in seeking mental health treatment. The socioecological model offers a holistic perspective by considering multiple levels of influence, including individual, community, and societal factors, in understanding help-seeking behaviors. Intersectionality further adds a critical lens, acknowledging the intersecting identities and social categories that influence mental health experiences and treatment utilization. The lack of mental health treatment utilization among Black women has been understudied throughout literature leaving a gap for this methodological paper to fill. This article discusses a study protocol created to better understand barriers to mental health treatment utilization among Black women living in the Deep South.

METHODS: The study employed a phenomenological qualitative approach, capturing the lived experiences and perspectives of thirteen Black women living in the Deep South using in-depth interviews lasting up to 60 minutes. Participants were purposefully selected to represent diverse intersections of identities, including age, socioeconomic status, and education. The researcher details how the interview questions for the in-depth interviews were developed and reports on the study aims, study setting, recruitment, and eligibility criteria, as well as the procedures conducted. The paper does not include results from study as that will be included in a subsequent paper; however, an explanation on how analysis is being conducted is included.

DISCUSION: This study is one of very few that have explored the mental health needs within a population and region that continues to be understudied and under-resourced.

The findings of this study are expected to provide valuable insights into the experiences, beliefs, and behaviors of Black women regarding mental health treatment utilization. The researchers expect that the integration of the SBW/SW schema, socioecological model, and intersectionality will illuminate the complex interplay of cultural, social, and structural factors that influence help-seeking behaviors. This knowledge can inform the development of culturally responsive interventions, policies, and support systems to enhance mental health treatment access and utilization for Black women in the Deep South.

IMPLICATIONS: The implications of this research extend beyond academia, with the potential to inform mental health practice, policy, and interventions. By recognizing and addressing the unique challenges faced by Black women in accessing and utilizing mental health services, this study contributes to the advancement of equitable and culturally responsive mental healthcare in the Deep South and beyond.

BACKGROUND

According to the World Health Organization (WHO), approximately one in eight people worldwide live with a mental disorder[1], and in the US one in five adults experienced a mental illness in 2021[2]. Access to mental health treatment services is a current public health crisis as it is estimated that 55% of adults in the US with mental health concerns received no treatment in 2022[3]. An even greater mental health crisis emerges when considering the mental health disparities among diverse populations. Despite decades of research focused on creating more efficacious and effective interventions and prevention programs, Black people in the United States still face vast racial health disparities[4].

Depression, a common mental health illness treated using mental health treatment services, is a leading cause of disability in the US and worldwide[5], and research has established that women experience depression at two times the rate of men[6]; however, research consistently indicates that Black women are less likely to seek or accept treatment for their mental health care[7-9]. Black women diagnosed with postpartum depression are less likely to be accepting of medication or therapy referrals than any other racial group[9], and previous literature posits that Black women are more likely to suppress depressive symptomology[9-11]. One explanation for the lack of mental health treatment utilization among Black women is the endorsement and internalization of the Strong Black Woman/Superwoman (SBW/SW) schema. The terms “Black” and “African American” are sometimes used interchangeably in the US, and for the purposes of this article we will use “Black”[12].

The SBW/SW schema is defined as a set of beliefs and cultural expectations of incessant resilience, independence, and strength that guides meaning making, cognition, and behavior related to Black womanhood[13]. The pressure to constantly appear strong and resilient can lead to the suppression of emotions and a reluctance to seek help. Previous studies have linked the SBW/SW schema to greater negative mental health outcomes and higher psychological distress[10,13-16]. Donovan and West[10] examined the relationships between endorsement of the SBW/SW schema and stress, anxious symptoms, and depressive symptoms among 92 Black female college students. This study revealed that both moderate and high levels of SBW/SW endorsement increased the relationship between stress and depressive symptoms whereas low levels of SBW/SW endorsement did not[10].

Another study tested a culturally specific model of binge eating among Black female trauma survivors to investigate possible explanations between trauma exposure and distress in relationship to binge eating symptomology[14]. Researchers enrolled 179 Black female trauma survivors who completed questionnaires focused on trauma, SBW/SW schema, emotion regulation, and binge eating. Results indicated that trauma exposure and distress predicted greater internalization of the SBW/SW schema which is associated with emotional inhibition and binge eating among Black female trauma survivors[14]. Similar to the findings from the aforementioned studies, scholars consistently find that Black women are more likely to experience chronic, severe, and immobilizing symptoms of depression, anxiety, and posttraumatic stress compared to their White counterparts[10,13,17-18]; yet, awareness of this problem has not translated to treatment utilization[7,11,19].

Black adults are more likely to have feelings of sadness, hopelessness, and worthlessness than their White counterparts and are twenty percent more likely to report serious psychological distress than White adults[20]; yet are less likely than most other racial demographics to seek mental health treatment. Importantly, mental health treatment utilization is impacted by several factors including access to care, service providers, insurance, costs, etc. According to Mental Health America,[3] approximately 28% of all adults with a mental illness reported not being able to receive treatment, and in the US, it is estimated that there are 350 individuals for every one mental health provider[3]. While the previous statistics reflect the US as a whole, it is important to recognize how these numbers vastly increase when centering Black individuals living in the Deep South.

Several studies have spent time defining the SBW/SW schema and its impact on physical and psychological health[13,17,28]. Beauboeuf-Lafontant[16] describes the Strong Black Woman as tireless, deeply caring, and seemingly invulnerable often leaning into the performance of strength[16]. The author asserts that the performance of strength is used as a measure of validation for the worthiness of Black women to exist in the world, face unrelenting hardship, and remain unbothered mandating silence in the ongoing struggle leading to diminished physical and psychological health[10]. Other studies have examined Black women's endorsement of the SBW/SW schema in relationship to patient reports of stress, depression, and anxiety [10,11,13]. Abrams, Hill, and Maxwell[13] examined how the characteristics of the SBW/SW schema relates to depressive symptomology among 194 African American women[13]. Findings from this study indicated that depressive symptoms are related to endorsement of the SBW/SW schema through the mechanism of self-silencing[13]. Additionally, Watson and Hunter[11] investigated whether endorsement of the

SBW/SW schema predicted increased symptoms of depression and anxiety among 95 Black women between the ages of 18 and 65 yrs[11]. In this quantitative study researchers found a significant relationship between the SBW/SW schema and greater depression and anxiety[11]. Further the authors established their study as one that provides empirical support for the role of SBW/SW schema plays in psychological distress and potential underutilization of mental health services[11].

The Deep South

The Deep South is recognized as the lower subregion of Southern US identified throughout history to be economically dependent on plantations and slavery[21]. The Deep South includes the following states: Louisiana, Mississippi, Alabama, Georgia, and South Carolina[21]. According to the American Psychological Association when states located in the South embraced harsh systems for racial control during the Jim Crow era (a time in US history when laws legalized racial segregation), the psychological health and safety of poor Black individuals in this region was neglected[22]. Additionally, the unsupported pathologizing of mental health among Black individuals during the Jim Crow era[22] has not been studied thoroughly throughout literature. Injustices within the healthcare system in the US have deep historical ties in the Deep South[23] and require a multi-layered investigational approach when understanding and discussing historical and current public health problems[23]. For these reasons the Deep South will serve as the setting for the current research study and potentially provide more understanding on how these social, cultural, and systemic factors impact mental health treatment utilization among Black women in the Deep South.

Moreover, poverty and inequality are risk factors for many mental health disorders[24], and the Deep South is known for being the region with the highest poverty rates in the US including Alabama, Mississippi, Louisiana, and South Carolina being identified in the top 10 poorest states as indicated by the US Census Bureau[25]. Additionally, according to a recent census report, over 58% of the Black population in the US live in the South[26]. Considering this information, the researcher felt it was imperative to conduct this study in the Deep South so that mental health treatment utilization of a marginalized population could be prioritized to fill gaps in the literature.

Four of the five states that make up the Deep South have the poorest mental health access ranking in the nation[27], which is indicative of less access to insurance, less access to treatment, poorer quality of mental health services, and an insufficient mental health workforce[3].

Very little attention has been given to exploring mental health treatment utilization among Black women living in the Deep South who endorse the SBW/SW schema. Even less is known about the bidirectional association of the SBW/SW schema's influence on individual mental health treatment utilization and the possible systemic perpetuation of the SBW/SW schema within the mental healthcare system that may impact Black women living in the Deep South.

Overall Study Purpose

There remains a significant gap in understanding how the SBW/SW schema impacts help-seeking and treatment utilization among Black women. Specifically, in the Deep South little to no research has been done to explore the lived experiences of Black

women who endorse the SBW/SW schema and what is necessary for developing public education, awareness, and intervention strategies to reduce internalized stigma related to the SBW/SW schema as well as the perpetuation of the SBW/SW schema within community and societal structures that ultimately impact mental health treatment utilization.

The purpose of this article is to begin addressing gaps in the literature. Specifically, this article discusses a phenomenological qualitative study protocol created to better understand barriers to mental health treatment utilization among Black women living in the Deep South. This article will describe methods used to develop the interview guide used during data collection as well as study recruitment and procedures to better inform points of intervention.

FRAMEWORKS AND THEIR USE IN THE STUDY

Strong Black Woman/Superwoman Schema

The Strong Black Woman (SBW) schema was born out of the enslavement of Black women and the grim reality of intersectional oppression[13]. The SBW/SW schema refers to the cultural expectations and pressures imposed upon Black women to always be strong and self-sufficient despite facing various challenges and stressors[13,17,28]. Many Black women endorse this schema with the belief that they must always portray an image of strength by resisting vulnerability and suppressing emotion[28]. This racial and gender schema provides an intersectional identity of Black womanhood to help conceptualize both the benefits and liabilities that evolve from placing a premium on strength in the face of insurmountable adversity. Black women are expected to be pillars of support for

their families, communities, and even society at large, often at the expense of their own well-being[11,17, 28].

Prior literature estimates that 70 to 80% of Black women sampled in previous studies either moderately or severely endorsed the SBW/SW schema as an internalized set of beliefs that guides cognitions, meaning making, and health behaviors[10,13,29]. The SBW/SW schema has been conceptually established within Giscombe's Superwoman Schema Conceptual framework[28] providing substantial understanding of its impact on Black women individually and within their ecological systems[28]. The intergenerational socialization of the SBW/SW schema describes this set of internalized beliefs being passed down from grandmothers to mothers and from mothers to daughters making it complex in nature and difficult to navigate in society[28]. On one hand, the schema is embraced as a badge of honor fostering a positive self-image by increasing cultural pride, and feelings of self-efficacy that promote resilience[18,28,30]. Alternatively, the SBW/SW schema is associated with stress health behaviors including overeating, smoking, poor sleep patterns, limited help-seeking, maladaptive coping[31], and has been linked as an indicator for several mental health disorders including depression[8,10,32] generalized anxiety disorder[11], posttraumatic stress disorder[14], and binge eating[14,33].

By employing this conceptual framework (as referenced in paper 1 of this dissertation) within the current study, the researcher explored through an intersectional lens how the SBW/SW schema may influence Black women's attitudes, beliefs, and behaviors regarding mental health treatment utilization. The aforementioned is indicative of the clinical significance of the SBW/SW schema in relation to mental health and invites researchers and practitioners into further exploration of Black women's lived

experiences, thereby enabling the exploration of how the SBW/SW schema shapes their perceptions of mental health, help-seeking, self-care, and treatment utilization. The insights derived from the current study can inform the development of interventions and policies that effectively address the mental health needs of Black women in the Deep South, considering the complexities of their cultural identities and the impact of the SBW/SW schema on their experiences.

Socio-Ecological Model

The Socio-Ecological Model (SEM) provides a comprehensive framework for understanding the complex interplay of individual, interpersonal, community, and societal factors that influence mental health treatment utilization among Black women in the Deep South[34]. By applying this model to guide the current research study, researchers explored the various levels of influence and their interactions, leading to a more nuanced understanding of the phenomenon under investigation. SEM provides a valuable framework for understanding the multiple levels of influence on individuals' health behaviors and outcomes[34]. In the current study the primary researcher applies this model to explore the interrelated factors operating at different levels and their impact on help-seeking behaviors and treatment utilization through the lens of the SBW/SW schema[28] and intersectionality[35].

At the individual level, factors such as personal beliefs, attitudes, and experiences shape mental health treatment utilization[34]. Phenomenological qualitative research[36] allows for an in-depth exploration of the lived experiences of Black women and how their individual characteristics influence their engagement with mental health services.

Through in-depth interviews the primary researcher uncovers the unique perspectives, perceptions, and attitudes towards identifying with the SBW/SW schema, mental health help-seeking, and other factors that impact treatment utilization.

At the community level, factors such as community norms, resources, and access to services play a significant role in mental health treatment utilization[34]. The Deep South region, characterized by unique cultural, historical, and social contexts[37], may present distinct community-level factors that shape Black women's access to and engagement with mental health services. Through phenomenological research, researchers can explore how community factors, including cultural beliefs, stigma, and availability of resources, influence treatment utilization patterns among Strong Black women.

Lastly, SEM recognizes the impact of broader societal and structural factors on health behaviors[22,37]. In the context of mental health treatment utilization among Black women in the Deep South, the primary researcher examines systemic barriers, such as healthcare disparities, perpetuation of the SBW/SW schema, financial constraints, transportation limitations, and the availability of culturally responsive mental health services. Additionally, intersectionality across systems of inequity that perpetuate the need for Black women to always be strong are interconnected at the societal level and include discrimination, bias, and stereotypes introducing an even greater complexity to mental health treatment utilization among Black women. The current study provides rich narratives that highlight the experiences of Black women navigating these structural challenges, shedding light on the ways in which societal factors shape their help-seeking behaviors and treatment utilization.

Intersectionality

Coined by scholar Kimberlé Crenshaw, intersectionality[35] highlights the interconnected nature of various social identities and systems of oppression, such as race, gender, class, sexuality, and ability[35]. The application of intersectionality to guide the current research study exploring mental health treatment utilization among Black women in the Deep South offers a nuanced understanding of how multiple social identities intersect and influence their experiences and help-seeking behaviors. As discussed earlier the Deep South is rooted in historical systems of injustice resulting in greater poverty rates among Black populations and greater physical and psychological burden and disease[22].

Navigating the multiple identities of being a Black woman living in the Deep South at the intersection of systemic bias, discrimination, and stereotyping may potentially influence mental health help-seeking and treatment utilization. Socio-historical factors that have impacted the field of mental healthcare continue to influence the care Black women receive by sending the same messaging of "being strong" in the face of adversity and deeming this performance of strength an admirable quality without addressing the mental and emotional needs among this population[22,37]. Because there is not much literature about intersectionality as it relates to systems of inequity, this is an opportunity for the researcher to employ this framework and begin uncovering the complex interplay of these intersecting identities and their impact on mental health treatment utilization among Black women in the Deep South.

Importantly, in the current study, intersectionality was used to guide participant recruitment and data analysis. The primary researcher purposively selected participants

who represent diverse intersections of identities, including Black women of different socioeconomic backgrounds, age, and educational levels. This ensured that the narratives captured in the study reflect a range of experiences within the population being investigated. When analyzing the data, the primary researcher paid close attention to the ways in which intersecting identities shape participants' experiences of mental health treatment utilization. By examining the narratives through an intersectional lens, the primary researcher identified the unique challenges and barriers faced by Black women at the intersections of race, gender, and other social identities. For example, the experiences of a Black woman who is also a low-income single mother may differ significantly from those of a Black woman who is a college-educated professional. By acknowledging and analyzing these nuances, the study provides a more comprehensive understanding of the complexities involved in mental health treatment utilization.

METHODS

Study Aims

The primary aims of this study were to (1) explore the bidirectional association of the SBW/SW schema's influence on help-seeking and mental health treatment utilization (2) in tandem with the systemic perpetuation of the SBW/SW schema within mental healthcare treatment services and other societal structures. In addition, this study explored suggestions and recommendations to improve the mental health treatment and care from Black women living in the Deep South. These aims were achieved through (1) exploring the lived experiences of Black women navigating the SBW/SW schema and their mental health care in the Deep South, and (2) using socio-ecological and

intersectionality frameworks to examine factors that influence mental health help-seeking and decision-making behaviors among Black women living in the Deep South. Exploring how systemic structures may reinforce the need for Black women to "be strong" while dismissing the struggles of Black women, may help us better understand the lack of professional treatment utilization as well as the growing mental health disparities in this population.

Study Design

Phenomenological Qualitative Approach

Exploring various aspects of the human experience to better understand the complex phenomena impacting their health and overall wellbeing is best situated within the context of a phenomenological qualitative approach[36]. Scholars within phenomenology posit that human beings extract meaning from the world from their personal experiences and these experiences are encapsulated in ambiguity and nuances[38] that cannot often be captured using a singular quantitative approach. This single site phenomenological qualitative study was employed to gather information that explains how Black women living in the Deep South tend to their mental and emotional well-being, and what informs their decisions to use or refrain from using professional mental health treatment services. This approach recognizes that there is not a single objective reality and that everyone experiences things differently[36,39]. Employing a phenomenological qualitative design was imperative and invites the opportunity for the researcher to learn more contextual factors that elucidate the mental healthcare needs of

Black women who are generally under-resourced and underrecognized in mental health treatment service offerings as well as understudied throughout literature.

Study Setting

The Deep South, which is made up of Alabama, Mississippi, Georgia, Louisiana, and South Carolina is home to the Civil Rights Movement and known for its history steeped in inequality within the context of the Jim Crow era establishing deep roots of injustice that continue to be seen through the poverty rates among the population within this region[21-24]. Additionally, four of the five states that make up the deep south have the poorest mental health access ranking in the nation (AL ranked 50th, GA ranked 48th, MS ranked 47th, and SC ranked 43rd)[27]. Moreover, this region is home to a diverse population with almost three quarters of the population identifying as Black or African American. According to the US Census Bureau the South makes up 58% of the nation's Black population with most of these individuals living in one of the five states that constitute the Deep South making this region an ideal setting for recruitment[25]. As previously mentioned, the rich historical and systemic complexities that impact this region along with the poor ranking for access to mental care made it imperative to conduct this pilot study in a setting that could provide more robust insights on the unique factors impacting mental health treatment utilization among Black women living in this region potentially leading to more explanation about the grave mental health disparities. This study was one of the first to explore the mental health needs within a population and region that continues to be understudied and under-resourced.

Recruitment and Eligibility Criteria

Black women living in the Deep South is a demographic not often researched, and given the unique cultural, social, and historical contexts that may impact the way they navigate care for their mental health including treatment utilization, the researcher prioritized selecting participants within this demographic to fill gaps in knowledge related to their mental health needs. The researcher investigated the live experiences of thirteen Black women living in the Deep South to gain deeper insights about how they understand the SBW/SW schema, mental health, and treatment utilization. Using a purposive sampling approach[36], the researcher recruited participants that (1) self-identified as Black/African American, (2) were at least 18 years and older, and (3) self-identified as living in the Deep South for at least 10 years. Inclusion criteria were established to target individuals that were best positioned to provide information in alignment with the study aims discussed previously. The exclusion criteria for the current study included (1) individuals who were unable to provide informed consent (2) individuals residing in South but not the Deep South. Prior to conducting any research procedure, permission to conduct this research study was granted by the University of Alabama at Birmingham Institutional Review Board (IRB) (#300009412).

The recruitment approach for this study was largely community-based. The researcher provided electronic and hardcopies of the study flier to individuals, organizations, shops, churches, and community centers within Birmingham, AL. Specific attention and consideration was given for recruitment from community settings as opposed to academic settings (i.e., colleges and universities) to gather a more representative sample of Black women living in the Deep South that may not otherwise

get the opportunity to participate in research such as this if recruitment was confined to an academic setting. The researcher also circulated emails among popular community Listservs that included members of Black community advisory boards to recruit community members especially those living in the Black Belt and lower resourced areas.

The researcher also joined ResearchMatch, an online recruitment tool used to connect interested participants with research studies[40], to improve recruitment outcomes and account for the assumed difficulties of recruiting a marginalized population for research. Finally, to support recruitment within a marginalized population, the researcher asked participants who enrolled and completed the study if they were willing to provide recommendations for subsequent participants. If participants indicated they were willing, the researcher provided the flyer and contact information to the participant so they could circulate it within their individual communities.

The recruitment flyer included a call to action (i.e., *Your Experiences Will Make The Difference)* and invited Black women who met criteria to participate in one 60-minute interview. When an interested participant reached out to inquire about the research study, the researcher completed a 15-minute or less screening call with potential participants to provide an overview of the study purpose and goal(s), review inclusion and exclusion criteria, and initiate the consent process. Consent was acquired verbally as we gained IRB approval for a waiver of signed informed consent. Consented participants were immediately emailed a copy of the informed consent document for their keeping, provided a QR code and direct link to complete an online demographic survey, and provided a link to schedule their study interview at a time that was most convenient. Per community-based research guidelines and recommendations, participants received one

$50 Clincard, which is a debit/credit card that could be used anywhere debit/credit cards are accepted, after completing the study to thank them for the time and effort given to completing study procedures.

Table 1

Online Survey Data Collection Measures

Black Women and Mental Health Online Survey Measure *developed in and collected through Qualtrics*			
Type of information collected			**Rationale**
Survey Data Collection	**Demographic Information**	• Birth Year, Race/Ethnicity, Gender, Sexual Orientation, Income, Education, Locality, Relationship Status, Dependents, Employment, Spirituality/Religion	• Help understand the unique characteristics of participants in the study • Provide some descriptive information that contextualizes the study participant and may inform their lived experiences
		• Assess prior mental health treatment service utilization. • Assess type of services used	• Help the interviewer know how to probe questions related to mental health access and treatment utilization

	Giscombe Superwoman Schema Questionnaire	• 35-item questionnaire includes five subscales:
		  ○ obligation to manifest an image of strength
		  ○ obligation to suppress emotions
		  ○ resistance to being vulnerable or dependent
		  ○ determination to succeed, even in the face of limited resources
		  ○ obligation to help others
		• Severity Level Assessment
		  ○ "This bothers me…"
			• Explore SBW/SW endorsement levels among study participants.
			• Used as a descriptor/qualifier when contextualizing study participants within their lived experience

Procedures

Development of the Semi-Structured Interview Guide

Development of the semi-structured interview guide (see Appendix A) began with a thorough review of the literature to identify the unique characteristics of the SBW/SW schema that impact mental and emotional wellbeing while assessing its influence on help-seeking and treatment utilization. This was followed by gaining better understanding of how this schema is internalized individually and perpetuated within the larger context of community and society. It is important to note that little to no peer-reviewed literature exists to explain how the SBW/SW schema is perpetuated within community and societal contexts revealing a gap that this study began to address. Next, the researcher reviewed the literature to better understand theoretical positioning for addressing help-seeking and service utilization within marginalized populations to help choose a framework to guide interview question development. The researcher used SEM and intersectionality as grounding frameworks to develop the interview guide and these same frameworks guided the thematic interpretation of the results. The researcher searched for previous literature that provided an overview of how the interview questions are generated using the literature review and chosen theoretical frameworks. There were little to no publicly available protocol papers that provided an example of question building to address the primary research aim, so it is the researchers hope that the example displayed in Figure 1 will provide an overview for how to build questions based on the theoretical

framework(s) that guided the research study.

Assess level of awareness; perceived stigma; intersectionality

Explore the experiences, attitudes, culture, environments, and societal factors that influence mental health treatment utilization.

Identify points for intervention, inform providers, researchers, policymaker, etc.

Figure 1. Model for the Development of a Semi-Structured Interview Guide

Online Survey

To gather descriptive information unique to each participant, an online survey measure was constructed. Participants were asked to fill out this survey prior to participation in the interview. The online survey included 20 demographic questions (see Table 1) for data collection points. Participants were asked to provide demographic information, prior mental health treatment utilization information, and complete the Giscombe Superwoman Schema Questionnaire (G-SWS-Q)[41].

Giscombe Superwoman Schema Questionnaire[41] was used within the current study to explore endorsement levels within the target population to guide participant

recruitment and ensure that the sample includes Black women who identify with or have experiences related to this cultural identity. By purposefully selecting participants who resonate with the SBW/SW schema, the primary researcher can capture the unique perspectives and challenges faced by these individuals in relation to mental health treatment utilization. Willis et.al.[42], discusses the addition of questionnaires within the context of a qualitative design to add necessary qualifiers or descriptors that can elevate the lived experiences of the individuals participating in research.

In this methodological paper the authors propose that the use of an interpretive phenomenological design enhances the phenomenological findings by situating them within specific disciplinary perspectives[42]. The G-SWS-Q is a 35-item scale based on the Superwoman Conceptual Framework designed to assess the physical, psychological, and biopsychosocial factors that influence Black women's health[41]. For the purposes of the current study, the G-SWS-Q scale was used descriptively in the reporting of results to describe SBW/SW endorsement severity in conjunction with emerging themes.

During data analysis, the primary researcher and coding team identified and analyzed themes related to the SBW/SW schema that emerge from the participants' narratives. This may include themes such as the pressure to maintain a performance of strength, the reluctance to seek help due to fears of being perceived as weak, or the impact of cultural norms on help-seeking behaviors. The analysis explored the ways in which the SBW/SW schema intersects with other societal factors, such as discrimination, bias, and stereotypes maintaining Black women's need to be strong and influencing mental health treatment utilization among Black women in the Deep South.

In-depth Interviews

Participants were provided a link to choose a date and time for them to complete one in-depth interview at a time that was most convenient for them. Interview time blocks were set for 60 minutes and participants were told that the interview "may last up to 60 minutes". The researcher emphasized the desire to collect as much information about the participants lived experiences as possible. When the interview went over 60 minutes the researcher provided the participants with three options: (1) continue with the interview until completion, (2) schedule a follow-up interview time with participant based on participant availability, (3) end interview at the 60-minute mark with no additional follow up. This occurred on two occasions.

The interview explored Black women's attitudes about their mental health, what it means to be a strong Black woman, perceptions of a strong Black women in society, exploring whether strength – in the context of the SBW schema – is a benefit and/or liability in their life, ways they tend to their mental health care, knowledge about the mental health care system and treatment services, barriers to treatment utilization, knowledge about mental health resources and treatment options, access to mental health treatment, and suggestions and recommendations for improving the mental healthcare Black women receive. The interview guide included eleven foundational questions with multiple probes (i.e., follow-up questions) to gain robust insights. Due to the sensitive nature of the topics discussed in the interview, the researcher built emotional check-ins into the interview guide to foster psychological safety and ensure participant distress was kept at a minimum. An example of an emotional check-in used throughout the interview guide was: "We have made it to a point in this interview where I'd like to pause and

check-in with you. How are you feeling in this moment? Are you willing to continue moving forward with this interview?" One additional step was taken by the researcher to compile a mental health resource list to provide to every participant upon completion of study interview.

All participants were debriefed once the interview ended, and the recording stopped. Debriefing included thanking the participant for their participation, providing next steps, and asking for follow up permission, as well as reiteration of how the data will be used and steps used to protect privacy and confidentiality. Interviews were audio-recorded and transcribed verbatim. Transcripts were de-identified and checked for accuracy prior to the start of analysis. Recruitment and study interviews ended once theoretical saturation was reached. The researcher identified theoretical saturation when no new emerging insights were gathered after three consecutive interviews.

Trustworthiness

Phenomenological qualitative research aims to understand the essence and meaning of individuals' subjective experiences and maintaining trustworthiness is crucial to preserving the integrity of their narratives[36]. Assessing trustworthiness involves ensuring the accuracy, authenticity, and faithfulness to the participants' lived experiences[36,39,43]. Phenomenological research typically involves purposive sampling to identify individuals who have experienced the phenomenon of interest[36,43]. The researcher reviewed the demographic makeup of the study sample to ensure that the selected participants represented a diverse range of perspectives and lived experiences related to the investigation of mental health treatment utilization among Black women.

The researcher paid close attention to age, socioeconomic status, prior mental health treatment utilization, and education as factors to diversify within the study sample. By ensuring diversity in the sample, the researcher enhanced the credibility and transferability of the findings, capturing a broader range of lived experiences[36].

Another crucial aspect of assessing trustworthiness is the establishment of a trusting and authentic relationship between the researcher and the participants. The primary researcher for the current study spent time developing rapport, establishing a safe and non-judgmental environment, and actively listening to the participants' stories. This began during the screening call where participants were asked if they had any reservations/hesitancies about participating. This rapport building continued at the beginning of the interview where the researcher again inquired if participants had any questions or concerns about the interview. This was followed by a 10-15 minute “get to know you” period where participants were able to share unique and interesting things about themselves with the interviewer, who is also the primary researcher. Building this rapport allowed participants to feel comfortable sharing their experiences openly and honestly. The researcher was attentive to verbal and non-verbal cues, allowing for a deep exploration of participants' lived experiences to capture rich and nuanced data.

Finally, to ensure trustworthiness, the researcher also employed rigorous data collection techniques. This involved using appropriate methods, such as in-depth interviews to gather participants' narratives. The researcher adhered to ethical considerations, respecting participants' autonomy, and ensuring informed consent. Verbatim transcription of interviews was essential for accurate representation and interpretation of participant experiences. The primary researcher engaged in reflexive

practices by acknowledging and examining biases and assumptions that could influence data interpretation. To assist with the trustworthiness of the current study, the researcher employed summarization techniques throughout the interview to facilitate member checking and confirm that the researcher's understanding of participants' experiences. Including summarization throughout the interview allowed participants to provide additional insights or corrections and strengthen the study findings thereby contributing to the credibility and confirmability of study results.

ANALYSIS

Description of Analytical Methods

The primary researcher employed important qualitative analytical methods to ensure quality and rigor during the analysis phase. These methods began well before arriving at the analysis phase of the study. In the current study, the researcher, who is also a member of the target population, acknowledged pre-existing knowledge and personal experiences that could influence participant narratives. As previously discussed, employing summarization techniques as a form of member checking throughout the interview process allowed the participants' perspectives to emerge without undue influence.

Coding is a fundamental analytical technique used to identify and categorize meaningful units within the data[36,45]. In phenomenological qualitative research, coding focuses on capturing significant statements or text segments that reveal the essential themes and structures of participants' experiences[36,39,45]. The primary researcher and coding team employed a mixture of inductive and deductive coding. Inductive coding

derives codes directly from the data and deductive coding derives codes based on existing theoretical frameworks. This process involves constantly comparing and contrasting data to develop a comprehensive coding scheme. The use of the coding team strengthened the rigor and completeness of the coding phase.

Finally, phenomenological reduction is a philosophical approach used to explore the underlying meaning of participants' experiences[36,46]. It involves a process of reflection and interpretation, aiming to uncover the essence or fundamental structures of the phenomenon being studied[46]. In the current study the primary researcher and coding team engaged in a rigorous process of exploring, comparing, and contrasting the identified themes and structures to develop a comprehensive understanding of the lack of mental treatment utilization among Black women endorsing the SBW/SW schema.

Analysis Plan

Recorded interviews were transcribed and entered into DELVE and MAXQDA, which are both qualitative software systems for conducting qualitative analysis. Thematic analysis was used to organize, interpret, and report the findings from the interviews[36]. Concurrent data analysis occurred along with data collection to detect when saturation was reached. A thematic analysis approach was applied to develop codes and themes. Using a codebook all codes were developed iteratively and organized to identify similar codes, contradicting codes, and new emerging codes.

Coding occurred both inductively and deductively[36] guided by the generated codebook. A code diagram was also developed to show hierarchical connections among codes thus helping to connected themes from a socio-ecological lens. The code book included code definitions and the interview questions. The primary researcher and

coding team read and re-read three transcripts making notes within the margins about potential codes and emerging themes prior to coding independently. For the current study the coding team was made up of a community-based qualitative expert, mental health provider, and a public health researcher. Codes revealing emergent themes and patterns identifying information related to the research questions and study aims were generated by each coder. After the first three transcripts have been coded by the coding team, we came together to compare and discuss concerns that have come up to adjust codebook if needed. Using the final codebook, the primary researcher completed the coding of all transcripts individually. Once codes were generated individually the coding team came together to review codes and resolve discrepancies through discussion. During this process the final codes/themes were compiled. The compiled codes and themes were then be coded inductively to allow for broader themes and new emerging codes. A record and report on code matching among the coding team for the initial coding phase was kept determining inter-rater reliability. Interpretation of the final themes occurred independently and then discussed together as a team. This ensured that the primary coder was interpreting codes and themes based on the codebook and definitions used to guide this qualitative analysis.

Quality Assurance

Ensuring quality assurance and rigor in a phenomenological qualitative research study is crucial to maintaining the credibility, dependability, and trustworthiness of the findings. Quality assurance began during the development of a research study prior to the implementation of the study protocol[36]. To ensure quality assurance in the current study

the primary researcher clearly articulated the primary research aim and theoretical underpinnings that would guide the study protocol. The researcher used purposeful sampling and adequately considered the study sample throughout study recruitment to ensure diversity and richness of experiences within the sample. Detailed descriptions of participant selection criteria and the rationale behind the choices made will be provided in the article reporting study results. Peer debriefing and member checking were implemented in the current study. This quality assurance measure seeks input and feedback from peers and other experts in the field to enhance the credibility and trustworthiness of the findings. Engaging in member check techniques by summarizing preliminary findings with participants to validate and refine interpretations helps ensure the accuracy and resonance of the analysis. Finally, the primary researcher provided a comprehensive and transparent account of the research process and continued in the fashion when reporting the study findings by clearly documenting the limitations and challenges encountered during the study and offer explanations for any deviations from the original research plan. This allowed readers to evaluate the study's rigor and trustworthiness.

Statement of Ethics

The researcher adhered to ethical guidelines and obtained informed consent from participants prior to the start of any study procedures. To foster ethical study activity the primary researcher clearly communicated the purpose of the study, potential risks and benefits, confidentiality measures, and participants' rights. Ethical approval from the University of Alabama at Birmingham was obtained before study start.

DISCUSSION

We implemented a phenomenological qualitative research study to explore mental health treatment utilization among Black women living in the Deep South. Peer-reviewed literature has introduced the endorsement of the SBW/SW schema as an explanation for the lack of treatment utilization, but very few studies have explored this phenomenon to develop public education and awareness campaigns and training programs to reduce mental health disparities among this population. The lack of mental health treatment utilization and access to mental health care is widely recognized as a public health crisis[47] and a mental healthcare priority[48]. Our prior conceptual literature review has highlighted a key need to explore the integration of theoretical frameworks to comprehensively address the research problem and provide implications for future research. Findings from the implementation of this phenomenological qualitative research will shed light on the experiences and perspectives of Black women in the Deep South regarding mental health treatment utilization. The narratives shared by the participants are expected to highlight several key themes and patterns, providing insight into the barriers and facilitators that influence their engagement with mental health services. The findings align with some of the existing literature on mental health treatment utilization among marginalized populations while also uncovering emerging information that will further inform future research. Recognizing the unique experiences and needs of this population is crucial for developing effective interventions and support systems that are culturally responsive and accessible.

Funding Statement

Funds to conduct this pilot research study were provided by Primerica and the Boris Lawrence Henson Foundation in support of reducing mental health stigma within the African American community.

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THE COSTLY PERFORMANCE OF STRENGTH: EXPLORING MENTAL HEALTH TREATMENT UTILIZATION AMONG BLACK WOMEN IN THE DEEP SOUTH

by

AMBER N. MARTIN, TENEASHA WASHINGTON, LARRELL L. WILKINSON, SARA N. LAPPAN, JESSICA T. CHAMBLISS, C. NICOLE SWINER

In preparation for *Cultural Diversity & Ethnic Minority Psychology*

Format adapted for dissertation

ABSTRACT

BACKGROUD: An estimated 55% of adults in the US with mental health concerns received no treatment in 2022, making access to mental health services a public health crisis. Research has established that women experience depression at two times the rate of men; however, research consistently indicates that Black women are less likely to seek or accept treatment for their mental health. One explanation for the lack of mental health treatment utilization among Black women is the endorsement and internalization of the Strong Black Woman/Superwoman (SBW/SW) schema. Many Black women endorse this schema with the belief that they must always portray an image of strength by resisting vulnerability and suppressing emotion. The link between SBW/SW schema endorsement and poor mental health outcomes is clearly defined throughout the literature, but less is known about mental health treatment experiences among Black women who endorse the SBW/SW schema. To understand the interplay of complex factors impacting treatment utilization among the target population, the researcher framed the study using the socioecological model and intersectionality to better identify and inform points of intervention from a public health perspective.

METHODS: An interpretive phenomenological qualitative approach was employed to gather information that explains how Black women living in the Deep South tend to their mental and emotional well-being, and what informs their decisions to use or refrain from using professional mental health treatment services. A purposive sampling technique was used to recruit 13 participants who completed a 20-question demographic survey, the 35-item Giscombe Superwoman Schema Questionnaire (G-SWS-Q) for descriptive and

recruitment purposes only, and a 60-minute in-depth interview. Interviews were audio-recorded and transcribed verbatim.

RESULTS: Thematic analysis was employed using a mixture of inductive and deductive coding techniques to generate robust insights from participant narratives. To ensure trustworthiness throughout the study, a coding team was assembled to ensure inter-rater reliability and prioritized the establishment of rigorous data collection techniques. Thematic analysis of 13 participants' responses revealed 4 recurring themes and 15 sub-themes detailing factors that impact mental health treatment utilization from a SEM and intersectionality perspective contextualized by SBW/SW schema endorsement.

CONCLUSION: Based on the study's findings framed within a socioecological and intersectionality perspective the current study, we identified efforts that should be made to increase mental health literacy and reduce stigma among Black women living in the Deep South as well as the larger community, a need for improved cultural responsive training among mental health professionals and other service providers, and policy changes that improve accessibility of mental health treatment services. We theorized that the needs of Black women in this region would differ from the needs of Black women in other regions and established throughout the results deviations from what has previously stated throughout literature.

IMPLICATIONS: It is our hope that the implications of this research provide insight for the development of targeted interventions that address barriers to treatment utilization among Black women.

INTRODUCTION

Mental health disparities persist among racially diverse populations, necessitating a deeper understanding of mental health treatment utilization that may better explain nuances impacting care. Access to mental health treatment services is a current public health crisis as it is estimated that 55% of adults in the US with mental health concerns received no treatment in 2022[1]. Depression, a common mental health illness treated using mental health treatment services, is a leading cause of disability in the US and worldwide[2] and research has established that women experience depression at two times the rate of men[3]; however, research consistently indicates that Black women are less likely to seek or accept treatment for their mental health care[4-6]. Previous literature posits that Black women are more likely to suppress depressive symptomology[6-8], and one possible explanation for the lack of mental health treatment utilization among Black women is the endorsement and internalization of the Strong Black Woman/Superwoman (SBW/SW) schema.

SBW/SW Schema

The SBW/SW schema is a unique race and gender schema that refers to the cultural expectations and pressures imposed upon Black women to always be strong and self-sufficient despite facing various challenges and stressors[9-11]. Many Black women endorse this schema with the belief that they must always portray an image of strength by resisting vulnerability and suppressing emotion[11]. This racial and gender schema provides an intersectional identity of Black womanhood to help conceptualize both the benefits and liabilities that evolve from placing a premium on strength in the face of

insurmountable adversity. Prior literature estimates that at least 70% of Black women sampled in previous studies either moderately or severely endorsed the SBW/SW schema as an internalized set of beliefs that guides cognitions, meaning making, and health behaviors[7,9,12], and several studies have spent time defining the SBW/SW schema and its impact on physical and psychological health[9-11]detailing the negative mental and emotional outcomes for Black women who moderately or severely endorse this schema. Beauboeuf-Lafontant[10] describes the Strong Black Woman as tireless, deeply caring, and seemingly invulnerable often leaning into the performance of strength[10]. The author asserts that the performance of strength is used as a measure of validation for the worthiness of Black women to exist in the world while facing unrelenting hardship and remaining unbothered mandating silence in the ongoing struggle leading to diminished physical and psychological health[10]. Abrams, Hill, and Maxwell[7] examined how the characteristics of the SBW/SW schema relate to depressive symptomology among 194 African American women and their findings indicated that depressive symptoms are related to endorsement of the SBW/SW schema through the mechanism of self-silencing[7].

Purpose

The link between SBW/SW schema endorsement and poor mental health outcomes is clearly defined throughout the literature[7-8,11,12], but less is known about mental health treatment experiences among Black women who endorse the SBW/SW schema as well as how the need to be strong may be perpetuated systemically. A recent qualitative investigation was conducted to determine the influence of the SBW/SW

schema on treatment seeking behaviors of Black women in the US[4]. This study conducted focus groups with 62 Black women between 18-72 years to better understand the factors that influence positive and negative attitudes towards help seeking[4]. Findings from this study included the emerging theme tension and stigma which discussed the tension between needing to be strong or being perceived as strong when facing psychological distress. Another emerging theme was racial-cultural pride which situated the SBW/SW schema as a factor that helps Black women maintain a positive self-image. Overall, the study provided evidence and some clarification on the impact of the SBW/SW schema on Black women's mental health and treatment seeking behaviors. One study is not enough to understand the gaps in treatment utilization among Black women endorsing the SBW/SW schema. The current study continues to fill this identified gap through an interpretive phenomenological qualitative approach exploring the (1) bidirectional association of the SBW/SW schema's influence on help-seeking and mental health treatment utilization (2) in tandem with the systemic perpetuation of the SBW/SW schema within mental healthcare treatment services and other societal structures among Black women living in the Deep South. A detailed description of the study setting has been discussed previously (in dissertation Paper 2). To understand the interplay of complex factors impacting treatment utilization among the target population the researcher framed the study using the socioecological model (SEM) and intersectionality to better identify and inform points of intervention from a public health perspective. In addition, this study explored suggestions and recommendations to improve the mental health treatment and care from Black women living in the Deep South. The primary goal of this qualitative research was to explore the experiences, perspectives, and suggestions

for improving mental health treatment utilization among Black women in the Deep South.

FRAMEWORKS AND THEIR USE IN THE STUDY

Socioecological Model

The current study was framed using a socioecological perspective that guided the development of the semi-structured interview guide and later informed the results detailing specific points for intervention. The socioecological model[13] posits that understanding individuals and problems is best done within ecological contexts (i.e., relationships, communities and environments, organizations, society, and institutions). SEM depicts the importance of the interdependence of multilevel systems on individual development to better assess points of intervention that go beyond the individual[13]. For this reason, it is favored in the field of public health and continues to be adopted to better understand emerging public health issues[14]. In the current study, the primary researcher applied this model to explore the interrelated factors operating at different levels and their impact on help-seeking behaviors and treatment utilization when contextualizing participants through the lens of the SBW/SW schema[11]. Further, use of SEM was integrated with the use of intersectionality at the individual and societal levels of the SEM to better understand the tensions that arise at the intersections of race and gender and systemic discrimination and bias for Black women.

At the individual level, factors such as personal beliefs, attitudes, and experiences shape mental health treatment utilization[13]. The current research allowed for an in-depth exploration of the lived experiences of Black women and how their individual

characteristics influence their engagement with mental health services. At the community level, factors such as community norms, resources, and access to services play a significant role in mental health treatment utilization[13]. The Deep South region, characterized by unique cultural, historical, and social contexts[15,16], may present distinct community-level factors that shape Black women's access to and engagement with mental health services. Through phenomenological research, researchers can explore how community factors, including cultural beliefs, stigma, and availability of resources, influence treatment utilization patterns among Black women. Lastly, SEM recognizes the impact of broader societal and structural factors on health behaviors[15,16]. In the context of mental health treatment utilization among Black women in the Deep South, the primary researcher explored systemic barriers, such as healthcare disparities, perpetuation of the SBW/SW schema, financial constraints, transportation limitations, and the availability of culturally responsive mental health services.

Intersectionality

Intersectionality, a concept coined by scholar Kimberlé Crenshaw[17], highlights the interconnected nature of various social identities and systems of oppression, such as race, gender, class, sexuality, and ability[17]. The term intersectionality was birthed due to the theoretical erasure of Black women because gender was viewed singularly as a White woman’s issue and race a Black man’s issue[17,18]. Crenshaw posited that examining marginalized populations within a single-axis framework contributes to their marginalization by excluding the unique experiences that occur at the intersections of multiple social identities[17]. The application of intersectionality to guide the current

research study exploring mental health treatment utilization among Black women in the Deep South offer a nuanced understanding of how multiple social identities intersect and influence their treatment experiences and help-seeking behaviors. A unique contribution of the current work is the navigation of the multiple identities of Black woman living in the Deep South at the intersection of systemic bias, discrimination, and stereotyping that may potentially influence mental health help-seeking and treatment utilization. Because there is not much literature about intersectionality as it relates to systems of inequity, this was an opportunity for the researcher to employ this framework and begin uncovering the complex interplay of these intersecting identities and their impact on mental health treatment utilization among Black women in the Deep South.

METHODS

Interpretive Phenomenological Qualitative Approach

Hermeneutical Phenomenology, also known as Interpretive Phenomenology, is a philosophical qualitative approach that seeks to understand the human experience through the description of recurring patterns and nuances as phenomena inclusive of the interpretive assumptions and biases of the primary researcher[19]. The rationale for use of a phenomenological qualitative approach is to explore various aspects of the human experience to better understand the complex phenomena impacting their health and overall wellbeing. For the current study the researcher felt the best methodological approach for studying the primary research issues was situated within the context of an interpretive phenomenological qualitative approach[20]. Scholars within phenomenology posit that human beings extract meaning from the world from their personal experiences

and these experiences are encapsulated in ambiguity and nuances[21] that cannot often be captured using a singular quantitative approach. The most important reason for choosing an interpretive phenomenological design for the current study was to allow the primary researcher, who is mental health practitioner, a public health researcher, and a member of the research study population, to engage in a self-reflective process that gives considerable thought to their own experiences which is essential to the interpretive process of this qualitative approach[20]. This specific approach asserts that interpretation of the results is inclusive of personal assumptions of the primary researcher by overt acknowledgement of these assumptions and influences as key contributors to the research process[20].

This single site phenomenological qualitative study was employed to gather information that explains how Black women living in the Deep South tend to their mental and emotional well-being, and what informs their decisions to use or refrain from using professional mental health treatment services. This approach recognizes that there is not a single objective reality and that everyone experiences things differently[20,22]. Employing an interpretive phenomenological qualitative design was imperative and invited the opportunity for the researcher to learn and draw on more contextual factors that elucidate the mental healthcare needs of Black women who are generally under-resourced and underrecognized in mental health treatment service offerings as well as understudied throughout literature.

Sampling and Recruitment

A purposive sampling technique was used to recruit participants who (1) self-identified as Black/African American, (2) were at least 18 years and older, and (3) self-identified as living in the Deep South for at least 10 years. The researcher provided electronic and hardcopies of the study flier to individuals, organizations, shops, churches, and community centers within Birmingham, Alabama. Specific attention and consideration were given to recruitment from community settings as opposed to academic settings (i.e., colleges and universities) to attempt to gather a more representative sample of Black women living in the Deep South that may not otherwise get the opportunity to participate in research such as this if recruitment was confined to an academic setting. The researcher also joined ResearchMatch, an online recruitment tool used to connect interested participants with research studies[40], to improve recruitment outcomes and account for the assumed difficulties of recruiting a marginalized population. Finally, to support recruitment within a marginalized population, the researcher asked participants who enrolled and completed the study if they were willing to provide recommendations for subsequent participants. If participants indicated they were willing, the researcher provided the flyer and contact information to the participant for distribution.

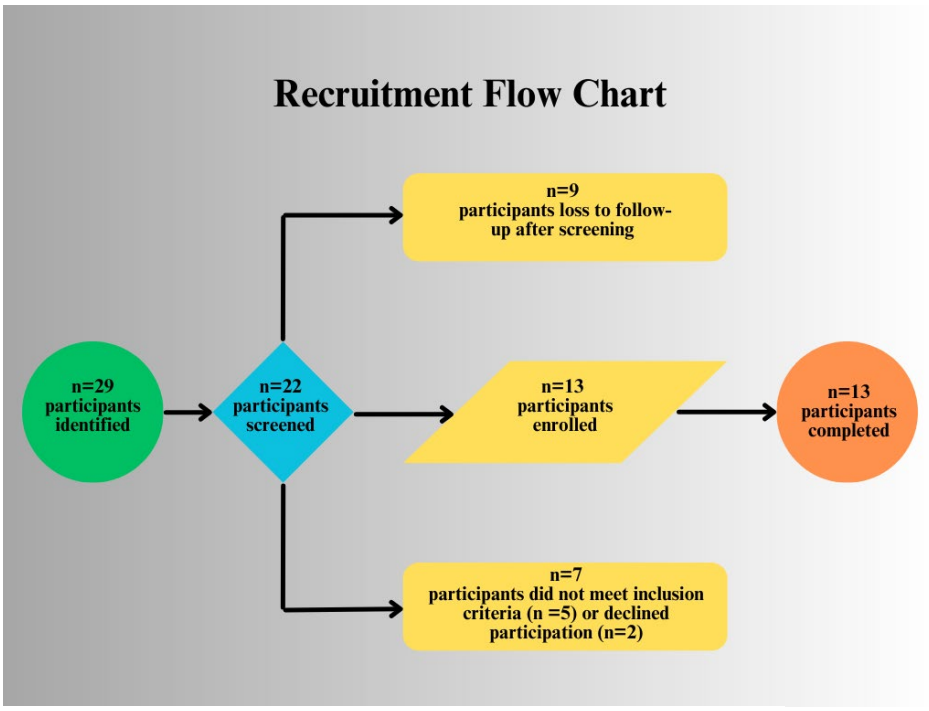

Figure 1. Study Recruitment Flow Chart

Twenty-nine participants were identified as potential participants and 13 of the 29 potential participants met criteria and went through informed consent prior to enrolling in the current study (see figure 1). Participants who were identified as potential participants went through a roughly 15-minute screening phone call that provided an overview of the study purpose and goal(s), review of inclusion and exclusion criteria, and initiated the consent process. Consent was acquired verbally as we gained IRB approval for a waiver of signed informed consent. Consented participants were immediately emailed a copy of the informed consent document for their keeping. The sixteen participants excluded from the study were due to the following reasons: lack of participant follow-up after screening (n=9), participants who had not lived in the Deep South for at least 10 years (n=5), and participants who declined participation during the screening due to the time commitment (n=2).

Table 1

Sociodemographic Characteristics of Participants

Demographic characteristic	n	%	M	(SD)
Age			34.8	(5.34)
18 – 28	2	15.4		
29 – 38	7	53.8		
39 – 48	4	30.8		
Marital status				
Never Married	8	61.5		
Married/partnered	2	15.4		
Divorced/widowed	3	23.1		
Socioeconomic Status			$58,462	
$30,000 – 39,000	3	23.1		
$40,000 – 49,000	1	7.7		
$50,000 – 59,000	2	15.4		
$60,000 – 69,000	3	23.1		
$70,000 – 79,000	1	7.7		
$80,000 – 89,000	1	7.7		
$90,000+	2	15.4		
Highest educational level				
HS/some college	1	7.7		
Associates (2yr.)	2	15.4		
Bachelors (4yr.)	4	30.8		
Masters	5	38.5		
Doctoral	1	7.7		
Employment				
Unemployed	0	0		
Student (full-time)	1	7.7		
Employed (full-time)	12	92.3		
Spirituality/Religion				
Yes	11	84.6		
No	2	15.4		
Years living in Deep South				
10 yrs or greater	1	7.7		
20 yrs or greater	4	30.8		
30 yrs or greater	8	61.5		
Previous mental health service use				
Yes	12	92.3		
No	1	7.7		
Types of mental health services				
Counseling/Therapy (i.e., Individual, Couples, Family, Group, etc.)	9	69.2		
Alternative Therapy Practice (i.e., Facilities/Programs that ONLY offer meditation, yoga, mindfulness, etc.)	2	15.4		
Outpatient Facility or Clinic (i.e., visits for medication prescriptions, mental health referrals, etc.)	3	23.1		
Support Group or Step Programs	3	23.1		
Spiritual Guidance/Church Clergy	4	30.8		
Endorsement of SBW/SW schema (G-SWS-Q scale; Range 0 – 105)			62.3	(18.45)
Low (scores 0 -35)	1	7.7		

Moderate (scores 36-70)	8	61.5
High (scores 71-105)	4	30.8

Study Setting

The Deep South, made up of Alabama, Mississippi, Georgia, Louisiana, and South Carolina, is home to the Civil Rights Movement and known for its history steeped in inequality within the context of the Jim Crow era establishing deep roots of injustice that continue to be seen through the poverty rates among the population within this region[16,24-26] (For more detailed information, see dissertation Paper 2). The rich historical and systemic complexities that impact this region along with the poor ranking for access to mental care made it imperative to conduct this pilot study in a setting that could provide more robust insights on the unique factors impacting mental health treatment utilization among Black women living in this region potentially leading to more explanation about the grave mental health disparities.

Data Collection and Procedures

Prior to conducting any research procedure, permission to conduct this research study was granted by the University of Alabama at Birmingham Institutional Review Board (IRB) (#300009412). In-depth interviews were employed virtually using the Zoom videoconferencing platform and interviews lasted up to 60 minutes. The interview guide was developed and tested prior to use in the current study. The researcher refined the interview guide based on pilot testing prior to sending for IRB approval. At the beginning of each interview, the researcher reviewed the consent information and set guidelines for

the interview to foster a safe and supportive environment for participants to share their lived experiences.

Prior to participation in the virtual interview, all participants completed a 20-question online demographic survey as well as the 35-item Giscombe Superwoman Schema Questionnaire (G-SWS-Q)[27]. This questionnaire was used to contextualize the participants by gaining an understanding of their level of SBW/SW schema endorsement. Collecting the G-SWS-Q helped the researcher to purposefully select participants who resonate with the SBW/SW schema allowing for the capture of the unique perspectives and challenges faced by these individuals in relation to mental health treatment utilization. Willis and colleagues[28], discuss the addition of questionnaires within the context of a qualitative design to add necessary qualifiers or descriptors that can elevate the lived experiences of the individuals participating in research. The primary researcher proposes that the use of an interpretive phenomenological design enhances the phenomenological findings by situating them within specific disciplinary perspectives[28].

Giscombe Superwoman Schema Questionnaire (G-SWS-Q)

The G-SWS-Q is a scale based on the Superwoman Conceptual Framework designed to assess the physical, psychological, and biopsychosocial factors that influence Black women's health[27]. For the purposes of the current study, the G-SWS-Q scale was used descriptively in the reporting of results to describe SBW/SW endorsement severity in conjunction with emerging themes. The total score range for this questionnaire is 0-105 with scores falling between that range indicating a low, moderate, or high endorsement (See Table 1). In the current study 61.5 % of participants and 30.8% of participants indicated a moderate and high SBW/SW schema endorsement respectively.

This provides evidence that most participants in this study endorsed the SBW/SW schema and were well positioned to explore the narratives of Black women and mental health treatment utilization in the Deep South.

Semi-structured In-depth Interviews

A semi-structured interview guide was used to explore the lived experiences of Black women navigating the SBW/SW schema and their mental health care in the Deep South. The interview guide was framed using the socioecological and intersectionality frameworks to explore factors that influence mental health help-seeking and decision-making behaviors among Black women living in the Deep South. Sample questions from the interview guide included (1) How has being a strong Black woman impacted your mental and emotional health? (1a.) How might it impact your decision to seek mental health care services? (2) Describe society's thoughts/beliefs about the Strong Black Woman/Superwoman. (3) Tell me about your mental health treatment service experience. (3a.) If you have never used mental health treatment services, can you tell me the reason(s) that have informed your decision? Interview time blocks were set for 60 minutes and participants were told that the interview "may last up to 60 minutes". When the interview went over 60 minutes the researcher provided the participants with three options: (1) continue with the interview until completion, (2) schedule a follow-up interview time with participant based on participant availability, (3) end interview at the 60-minute mark with no additional follow up. This occurred on two occasions. All interviews were audio-recorded, and recruitment stopped after reaching theme saturation as indicated by no new emerging insights after three consecutive interviews. Participants

received one $50 Clincard after completing the study to thank them for the time and effort given to completing study procedures.

DATA ANALYSIS

Audio-recorded interviews were transcribed verbatim and thematic analysis was conducted[29]. Prior to the start of analysis, the primary researcher checked each transcript against the audio recording to ensure accuracy of the transcription process. The primary researcher went on to begin the iterative process of thematic analysis which includes (1) familiarizing oneself with the data, (2) generating initial codes, (3) searching for themes and sub-themes, (4) reviewing themes and sub-themes, (5) defining and naming themes and sub-themes, finalized by (6) producing the final report which can be found under the result and theme discussion section of this article[29]. As part of the thematic analysis process, coding is a fundamental analytical technique used to identify and categorize meaningful units within the data[20,30]. In phenomenological qualitative research, coding focuses on capturing significant statements or text segments that reveal the essential themes and structures of participants' experiences[20,22,30]. The primary researcher and coding team employed a mixture of inductive and deductive coding. Inductive coding derives codes directly from the data and deductive coding derives codes based on existing theoretical frameworks. This process involves constantly comparing and contrasting data to develop a comprehensive coding scheme. The use of the coding team strengthened the rigor and completeness of the coding phase.

Transcribed interviews were entered into DELVE and MAXQDA, which are both qualitative software systems for conducting qualitative analysis. Thematic analysis was

used to organize, interpret, and report the findings from the interviews[20]. Concurrent data analysis occurred along with data collection to detect when saturation was reached. Using a codebook, all codes were developed iteratively and organized to identify similar codes, contradicting codes, and new emerging codes. Completing thematic analysis in the current study yielded four overarching themes encompassing fifteen sub-themes.

TRUSTWORTHINESS

To ensure trustworthiness of the data analysis process the primary researcher employed several methods central to qualitative research. To call out the assumptions of the primary researcher overtly and include them in the interpretive process, the primary researcher instituted summarization and clarifying techniques during the interview process to consistently engage if self-reflexivity, an ongoing conversation about experiences while simultaneously living in the moment and constructing interpretations of the experiences[19]. Another crucial aspect of assessing trustworthiness is the establishment of a trusting and authentic relationship between the researcher and the participants. The primary researcher for the current study spent time developing rapport, establishing a safe and non-judgmental environment, and actively listening to the participants' stories. This began during the screening call where participants were asked if they had any reservations/hesitancies about participating. The primary researcher continued with rapport building at the beginning of the interview process by including a *get to know you* segment before starting with the interview questions.

Additionally, to ensure trustworthiness, the researcher also employed rigorous data collection techniques. This involved using appropriate methods, such as in-depth

interviews to gather participants' narratives. The researcher adhered to ethical considerations, respecting participants' autonomy, and ensuring informed consent. Verbatim transcription of interviews was essential for accurate representation and interpretation of participant experiences. Finally, for the current study, a coding team of all Black women was assembled made up of a community-based qualitative expert, mental health provider, and a public health researcher. The primary researcher and coding team read and re-read three transcripts making notes within the margins about potential codes and emerging themes. The collective the coding team achieved a 97% inter-rater reliability and discussion occurred to address areas of disagreement until consensus was met.

RESULTS AND THEME DISCUSSION

The thematic analysis of 13 participants' responses revealed 4 recurring themes and 15 sub-themes, as represented in Table 2. Following the table are descriptions and discussion of these themes, providing illustrative quotes from our participants. Participant quotes begin with the participants pseudonym (i.e., made up name for deidentification), participant age, and participant SBW/SW endorsement score to help contextualized each participant throughout the theme and sub-theme discussion.

Table 2: Key Themes Identified

Theme	Sub-Themes
Negative Experiences Using Professional Mental Health Services	*Inadequate Treatment or Care*
	Lack of Empathy and Rapport Building
	Provider Bias and Discrimination
	Access and Availability Challenges
Positive Experiences Using Professional Mental Health Services	*Compassionate Person-Centered Care*
	Confidentiality and Trust
	Accessible and responsive services
Being Strong Impacts my Decision to Seek Mental Health Care	*SBW/SW Identity*
	Cultural stigmas and barriers
	History is Still in Front of Me
	Is it Because I'm Black, A Woman, or Both? – Navigating Intersectionality
	Cultural resilience and coping mechanisms
Suggestions for Improving Mental Health Treatment Utilization	*Enhancing Awareness and Education to Combat Stigma*
	Collective Healing
	Culturally Responsive Care

Narratives of Themes

Negative Experiences with Healthcare Professionals

Prior use of mental health treatment services appeared to have a big impact on current treatment utilization among this study population. Narratives within this theme highlighted unfavorable encounters or outcomes by participants while seeking or

receiving treatment from healthcare professionals or services. Participants described negative experiences with healthcare professionals, highlighting four sub-themes:

Inadequate Treatment or Care. Several participants mentioned instances where they felt that the treatment or care provided by mental health professionals was insufficient, ineffective, or poorly tailored to their specific needs. This included issues such as misdiagnosis, inappropriate medication, or a lack of personalized treatment plans. This sub-theme is reflective of factors that could impact Black women at the community level within SEM and influence the lack of treatment utilization.

Lack of Empathy and Rapport Building. Participants described experiences where they felt that mental health professionals did not demonstrate empathy, compassion, or a genuine understanding of their concerns, leading to feelings of being invalidated or misunderstood. Narratives falling within this sub-theme are reflective of the lack of safety participants felt when using mental health treatment services making it difficult for them to reach out for additional care. This sub-theme also seemed to be a factor impacting treatment utilization among Black women at the community level. There was also a pattern amongst most of the narratives in this sub-theme of providers reinforcing the need for Black women to be strong in a space that is supposed to be meant for them to be vulnerable.

Provider Bias and Discrimination. Several participants expressed dissatisfaction with healthcare professionals when participants encountered stigmatizing attitudes or discriminatory behavior from mental health professionals due to their mental health condition, leading to feelings of shame, embarrassment, or a reluctance to seek further help. This sub-theme seemed to encompass factors at the community and societal levels

withing the SEM that influence Black women's decision to seek and maintain professional mental health treatment services. There was also a unique pattern amongst many of the narratives in this sub-theme of Black women feeling they "must be strong" while navigating provider bias and discrimination. It appeared that the perpetuation of being strong is subconscious in nature for both the provider and the Black woman enduring the biases or discriminatory remarks. More research is needed to understand this phenomenon more concretely.

Access and Availability Challenges. Most participants described difficulties encountered in accessing mental health services due to long waiting times, limited availability of appointments, financial barriers, or a lack of options in terms of providers or treatments. Particularly in this sub-theme the researchers identified a need to navigate the intersections of inequitable systems and the impact that has on mental health treatment utilization among Black women living in the Deep South. Narratives within this sub-theme depicted issues at the societal level withing the SEM that influence Black women's decision to seek mental healthcare services. Further, when Black women are contextualized within the SBW/SW schema, the need to put others before themselves often becomes a barrier to seeking mental health especially when the cost seemingly outweighs the benefit from Black women's point of view. Finally, given the economic disparities between Black and White individuals in this region, navigating the intersection of financial lack and mental health treatment costs is too big of a gap for Black women to navigate on their own yet their consistent efforts to navigate this gap reinforces the need for them to be strong and "get through it" or "suppress the feelings and emotions and they will eventually go away".

Theme 1: **Negative Experiences using Professional Mental Health Services**

Sub-Themes	Participant Quotes
Inadequate Treatment or Care	***April – 36yrs.; SBW/SW Endorsement = 79 (high)*** "I didn't wanna try any medicines really, honestly, I didn't communicate about medications with her. It was more so they didn't really give me a chance to express my feelings about medications. I feel like they're just trying to just piece things together because I tried probably about five sleeping pills before I was just like, okay, I've had enough, and I just didn't schedule any more appointments and I just took myself off all those medicines." ***Ashley – 28yrs.; SBW/SW Endorsement = 45 (moderate)*** "I think the main thing that was off putting about her, she was very nice and everything, but we had just started talking and she had mentioned medication, which I have no opposition to taking medication, but she had mentioned a specific medication talking about she was trying to screen me for ADHD essentially. She said to me, oh, do have you ever had trouble focusing, et cetera, et cetera? And I'm like, no, no, not really. She's like, well are you sure you know, cuz a lot of times people think they're okay and they're actually not. I kind of responded to her stating I'm aware, I have a degree in ancient language, which that required me to sit for hours on end translating paragraphs of this language, so I knew I didn't have ADHD. But I felt like when I said no, maybe we can assess then that that should have been the end of it; however, I feel like she was trying to force me to do something that I didn't want to do rather than saying, okay, well this option is here, it's available we can always revisit it. She's like, well, are you sure. Like immediately questioning my own understanding of myself and my needs."
Lack of Empathy and Rapport Building	***Megan – 38 yrs.; SBW/SW Endorsement = 69 (moderate)*** "Actually, I had one therapist at the time, and I went through that with my former employer because they offered it through our healthcare plan. I didn't feel like she was the best fit for me. She was a white lady and I didn't feel like she was taking the time to get to know me at all nor did she seem to get the cultural things that bothered me… like when George Floyd and Ahmaud Arbrey happened and I was struggling really bad especially thinking about my own nephews there was a lot of blank stares and redirecting me to something else which made it seem that she didn't care how I was feeling…" ***Eden – 45 yrs.; SBW/SW Endorsement = 86 (high)*** "I leave with more questions the first go around because it's just like, you know everybody's demeanor is different going into counseling. My second counselor was still in

	school, and then in my mind I was probably a little hesitant cuz she seemed more by the book and "what should I refer to in my book to tell her next" That's how I felt. It took a minute for me and her to kind of get any type of rapport just because I don't know if she just didn't have the experience if that makes sense. Because I feel like that was like her first counseling session with this group. Not to say she couldn't do it, it just felt more robotic if that makes sense."
Provider Bias and Discrimination	***Nicole – 31 yrs.; SBW/SW Endorsement = 65 (moderate)*** "I feel like it's just in the healthcare, how they try to play down symptoms for African American women and African American people. I was telling my primary care doctor I was going through things and had a little bit of anxiety and things like that, and versus him trying to help, he was just like talk to a psychiatrist and I feel like you would've done a little bit more or tried to give a little bit more advice or something like that if I wasn't a black woman. But all you tell me, just talk to a psychiatrist. No referral, follow up, or anything. I found myself falling back into that strong black woman type of we going to make it by any means necessary. Just forget about it, whatever." ***Eden – 45 yrs.; SBW/SW Endorsement = 86 (high)*** "The first couple sessions I liked the counselor, he was a white guy, but then like we had one counseling session, all while I'm going through court so it's all like stressful stuff at that point, but he inserted his own personal experiences into my situation and then at that point he was just like, you're wrong for what you're doing. You shouldn't be doing this you're in the wrong because you're acting like my ex-wife now. He told me his whole situation. He was telling me what happened when he got divorced during my time. I left crying, but I didn't let tears fall, but my eyes were really watery, and I never went back to him cuz it was just a terrible experience, and that experience made me hesitate to go get additional help, if that makes sense."
Access and Availability Challenges	***Emma – 36 yrs.; SBW/SW Endorsement = 64 (moderate)*** "I wasn't poor enough to get these services and I couldn't afford insurance out of pocket or whatever, blah, blah blah. So, it's like when in that middle ground, I feel like I would almost rather be poor than to be in the middle. Cause at least I can get some help if I'm have a lower income." ***Brit – 33 yrs.; SBW/SW Endorsement = 77 (high)*** "For me, I just feel like there's so much pressure to not ask for help, and I have a hard time asking because for me,

	that shows that I'm weak, that I can't handle what I've been given. And then paying wise, thinking of how much it costs, and the cost comes into play and stuff like that because I have to take care of other things and make sure my kids and my house are ok as well as other responsibilities. These services aren't always accessible when the priority is feeding your family and making sure everyone is good."

Positive Experiences using Professional Mental Health Services

Prior use of mental health services was not always viewed as negative. Some participants discussed positive experiences with prior service utilization that has increased their consistency with use of mental health treatment services. Narratives found under this theme were indicative of favorable encounters, outcomes, and perceptions of individuals who have sought or received treatment from mental health professionals or services. This theme focused on the positive aspects of engaging with mental health services and explored the factors that contribute to a positive experience. Three sub-themes emerged within this theme:

Compassionate Person-Centered Care. Participants described experiences where mental health professionals tailored treatment plans to meet the unique needs and preferences of individuals. This approach acknowledges that each person's mental health journey is different and encourages collaboration in decision-making regarding treatment goals and interventions. Participants discussed how providers used a holistic approach to mental health treatment helping them feel safe, valued, and heard. This sub-theme could be identified as a protective community-level factor when considering the SEM of treatment utilization among Black women in the Deep South.

Confidentiality and Trust. Participants expressed a level of trust and confidence in their providers that facilitated greater empathy and rapport building ultimately helping participants feel safe. Narratives within this sub-theme involved mental health professionals who uphold strict confidentiality, respecting the participant's privacy and consistently fostering a sense of trust. Confidentiality is essential for individuals to feel safe and secure when discussing sensitive and personal issues and all the Black women who participated in these interviews expressed needing to feel safe when it comes to mental health treatment utilization. This is another theme that could be identified as a protective community-level factor when considering the SEM of treatment utilization among Black women.

Accessible and Responsive Services. Some participants shared specific experiences about accessing services in a way that was helpful in getting them connected to care. Participants described experiences where mental health services were readily available, had reasonable wait times, and offered flexibility in scheduling appointments. This ensured that participants could seek timely help when needed. Though there weren't many participants identified under this sub-theme, the narratives of the participants captured a powerful illustration of why intervention at the societal level would make a difference in treatment utilization among this population.

Theme 2: Positive Experiences using Professional Mental Health Services

Sub-Themes	**Participant Quotes**
Compassionate Person-Centered Care	***Megan – 38 yrs.; SBW/SW Endorsement = 69 (moderate)*** "With my therapist, I felt like she possessed a lot of the qualities that I wanted in a therapist, and so I think that also helped me, helped her understand me. I just feel like that our connection was just purposeful and it was a great connection, and she is great with her methods and how she handles me and the things that we discuss. I feel like that she can understand me, because I think we just have certain values that are similar, and I truly think she works

	to see and understand me throughout everything we do in counseling." ***Joy – 39yrs.; SBW/SW Endorsement = 54 (moderate)*** "First time I went to counseling at my institution, which wasn't even officially, I think it might have been a student intern, you know I don't even remember who the person was I saw. But after I got out of that session, I felt so much better just by this lady telling me it's fine to cry. I can remember her saying, oh no, oh my gosh, you aren't crazy. These are very normal, very real feelings that you're experiencing. And that for me, it was the very first time that anybody had ever told me it was okay to cry. Nobody could hold me from a counselor from then on."
Confidentiality and Trust	***April – 36 yrs.; SBW/SW Endorsement = 79 (high)*** "My thoughts have changed a lot. I was very close-minded. I just thought it was someone who sat there, kind of listened and wrote down what I said I didn't think it was effective, but my therapist has kept everything I've said to her in confidence, and I have grown to trust the relationship we have built. I get excited to go to therapy because I know it's a time, I can just focus on me and not all my other stuff."
Accessible and Responsive Services	***Vivian – 27 yrs.; SBW/SW Endorsement = 58 (moderate)*** "I couldn't imagine trying to do this, like, not within the system that I'm in. So, like the education system, they have developed these offices and tools specifically for students. So, I haven't had issues, I guess having a resource to reach out to. Reaching out and getting help from that critical moment and having pretty easy access is what kept me actively using counseling services." ***Brit – 36 yrs.; SBW/SW Endorsement = 77 (high)*** "the therapist I chose is, she said her name, where she was from, and her objective was to help. Her first three lines wasn't what school they went to, what degrees they have. Hers was, I'm here to help. I want to be someone that you can be comfortable with. There's nothing wrong with bragging on yourself, but I like someone who has that compassion in their biography where they whole objective is to be inclusive to not just one part of a big world or a big world that we live in."

Being Strong Impacts my Decision to Seek Mental Health Care

Participants highlighted the unique experiences, beliefs, and cultural factors identified through the lens of the SBW/SW schema that influence the decision-making

process of Black women regarding seeking mental health care services. This theme highlights the intersectionality of gender, race, and cultural identity and how these factors shape the experiences and perspectives of Black women in relation to their mental health and help-seeking behaviors. Five sub-themes emerged:

SBW/SW Identity. All participants express their personal identities in relationship to the phrase “strong Black woman” and how their experiences impact their mental and emotional wellbeing as well as their decision to seek mental health care treatment services. Additionally, participants discussed the societal and cultural expectations to be strong, resilient, and self-reliant, which can create barriers to seeking mental health care. This theme explores how the notion of being a "strong Black woman" impacts their willingness to admit vulnerability, ask for help, or acknowledge their mental health needs. Narratives expressed throughout this sub-theme are factors impacting mental health treatment utilization across several levels with the SEM potentially providing substantial evidence for the use of the SBW/SW schema when conceptualizing the mental health needs of Black women and when creating intervention strategies to support the mental and emotional wellbeing of Black women.

Cultural Stigmas and Barriers. Most participants described the generational passing of the SBW/SW schema from their grandmothers, mothers, and other family members that believed seeking mental health treatment is for the “weak”. Further, narratives expressed within this theme identify the cultural stigmas and barriers that exist within the Black community regarding mental health. These stigmas include beliefs that seeking therapy is a sign of weakness or “you’re crazy”, a lack of trust in mental health professionals, and concerns about confidentiality and privacy. Factors impacting

treatment utilization within this theme are often found at the individual, interpersonal, and community levels of the SEM. The internalized beliefs and stigmas that impact treatment utilization among Black women would fall within the individual level; however, lack of trust, and concerns of confidentiality and privacy are larger community and societal level factors impacting treatment utilization.

History is Still in Front of Me. Discussion around historical discriminatory practices and how these practices have instilled mistrust and skepticism of the larger healthcare system emerges from participant narratives. Some participants alluded to the historical and systemic factors such as the Tuskegee Syphilis study, the loss of Black mothers to maternal mortality due to lack of doctor's hearing and believing Black women and being perceived as the "angry Black woman" in society when standing up for themselves which have contributed to the mistrust of mental health care services among Black women. This narrative included a legacy of discrimination, racial trauma, disparities in access to quality care, and experiences of racism within healthcare systems. This theme was another place where navigating the intersections of inequitable systems emerge providing stronger evidence for this phenomenon to be explored more concretely.

Is it Because I'm Black, A Woman, or Both? – Navigating Intersectionality. Several participants described not knowing what part of their identity was problematic when experiencing challenges related to mental health help-seeking and treatment utilization. This sub-theme acknowledged the intersectionality of race, gender, and other identities in shaping the experiences of participants. It recognized that the decision to seek mental health care is influenced by multiple factors, including gender roles, socioeconomic status, sexual orientation, and age. This theme seemed to intersect the

SEM at the individual level and at the societal level. Participants explicitly discussed the ways society view strong Black women and how this impacts the participants view of traditional mental health treatment services.

Cultural Resilience and Coping Mechanisms. Several participants described resilience and coping mechanisms they employ to navigate their mental health challenges. This narrative highlighted the cultural strengths, support networks, spirituality, and community resources that participants draw upon to maintain their mental well-being whether using professional mental health services or not. Interestingly narratives from this theme seemed to deviate from prior literature of how women feel/think about spirituality/religion in the place of professional mental health services. More exploration is needed to determine the details of this deviation; however, it is important to consider when thinking about the mental health needs of Black women in the Deeps South. Factors impacting treatment use within this theme are situated at the individual and community levels of the SEM.

Theme 3: Being Strong Impacts my Decision to Seek Mental Health Care

Sub-Themes	Participant Quotes
SBW/SW Identity	***Pat – 40 yrs.; SBW/SW Endorsement = 88 (high)*** "I definitely have an S on my chest. I mean, I'm the one everybody depends on. I'm the mom and the dad for my son. I have a mother who's disabled needs a lot of help. I help my 83-year-old grandmother. I have a 31-year-old sister. Everybody depends on me. So, I got a lot. I just had this conversation with my grandmother being that everyone is so dependent, and I let a lot of things worry me. So, if I don't get it done, I don't meet that deadline. It's always in the back of my head, just stressing me to death." ***Trisha – 31 yrs.; SBW/SW Endorsement = 50 (moderate)*** "Being a strong black woman, it just becomes really stressful to the point where eventually like we break down, whether it's breakdown in tears breakdown and release the anger out on somebody or, you know, unfortunately sometimes breakdown in suicide."

	Whitney – 39yrs.; SBW/SW Endorsement = 54 (moderate) "I tell you being strong it's definitely straining. It's definitely a stressor. It's definitely most days overwhelming. I've had plenty of conversations with [NAME] on work related drama and why are we still doing this? And it is a never-ending circle for lack of better words I'll say BS... because it's show up, do everything, go handle everything, go to work, deal with microaggression. It impacts my ability to think that I'm good enough or that I'm worthy, that I have value." ***Jasmine – 30yrs.; SBW/SW Endorsement = 21 (low)*** "It can make you feel like you always got to put on a certain type of face. Can never show weakness and things like that. So, you always got to be a strong no matter what you're going through. It can be stressful too because everybody need the release and if you got to play that role for so long, it can overcome you and it can cause you to break down mentally."
Cultural Stigmas and Barriers	***Brit – 36 yrs.; SBW/SW Endorsement = 77 (high)*** "I was about probably like 16 or 17 and I was going through a lot mentally and I remember thinking I wanna talk to a therapist or counselor. I was always a little different from my family, but they were like, you don't need that, talk to the Lord. I was like I tried. I spent many days in fasting and prayer, but sometimes I felt like I needed to talk to somebody. They was like, see that's the devil, you shouldn't be needing to talk to a complete stranger, you got us. I'm like that don't count." ***Emma – 36 yrs.; SBW/SW Endorsement = 64 (moderate)*** "So, my grandma was really strong, and my family really promoted the ways that she was very strong and how my granddad left and how she had to pull her up by her bootstrap and take care of the kids by herself. But nobody ever talked about how doing that probably contributed to the fact that she was having thoughts of suicide later on. So, my grandma has been diagnosed with bipolar depression. She's had suicide attempts. I remember going to a behavioral health center to visit her, not knowing what she was there for. So, everything was lumped in emotions and mental health and being crazy and trying to kill yourself." ***Whitney – 39yrs.; SBW/SW Endorsement = 54 (moderate)*** "Growing up in the church background, if you have problems, you go to church. That's just what's instilled in a lot of African American women. I know with my child

	we talk about mental health but those are just things that weren't talked about growing up. You know, kind of just don't know how people really felt. Or what kind of emotions people really going through, especially with being taught not to cry. You taught to be strong and not show if you're weak. It's looked at as weakness. So yeah. I wish though this is some of the change I'm trying to do...know more and seek mental health."
History is Still in Front of Me	***Pat – 40 yrs.; SBW/SW Endorsement = 88 (high)*** "Nobody's going to look at your situation as their own. So, I may be down, but people don't care about that. When they want you to do something, they want you to do it regardless. Whatever you got to do, you know, just got to push through. It may be one of those days I'm like I'm kind of hurting a little bit. My pain is probably at a 10, but they're thinking, you're just over exaggerating. You probably not even hurting the doctor gave you pain pills. You're okay. But I just had a whole hysterectomy. They don't see your situation as serious, and Black women die every day because society doesn't take us seriously." ***Vivian – 27 yrs.; SBW/SW Endorsement = 58 (moderate)*** "After my first counselor seemed to always be judgmental in my counseling sessions, I knew I wanted to see a black female counselor because I feel like the issues that black females go through are not really, even though they might be intellectually understood by other groups of people, I don't think they are I guess emotionally understood."
Is it Because I'm Black, A Woman, or Both – Navigating Intersectionality	***Brit – 36 yrs.; SBW/SW Endorsement = 77 (high)*** "I always say I have three things going against me all the time. I'm black, I'm gay, and I have lots of tattoos, so I already look intimidating now as is. So, the main thing that I have found to be honest, is more or less finding somebody I will feel comfortable enough to meet with in person for therapy." ***Emma – 36 yrs.; SBW/SW Endorsement = 64 (moderate)*** "I feel like we, black women, get kind of ignored. I feel like the world says here, we're going to get black men this attention. Y'all take that and y'all be fine with that. So being a black man is so very different from black women. Cause I feel like black men have their own set of discrimination against us in itself. And so, we don't need what's built for them, we need what's built for us." ***Ashley – 28 yrs.; SBW/SW Endorsement = 45 (moderate)***

	"So, I think it's complex, right? Where it's again, oh my goodness, black women, you're amazing. You do it all yourself, and so there's this kind of praise element, but I think that society doesn't, understand that that arose out of black women kind of being a one among the least protected kind of at the intersection of gender and racial oppression, you know, and other marginalized identities as well. So, it's kind of a, a thing of, okay, well if I don't have my back, who will?"
Cultural Resilience and Coping Mechanisms	***Nicole – 31 yrs.; SBW/SW Endorsement = 65 (moderate)*** "I haven't been to church in a year, and other than that I just can't think of anywhere else as far as a place to go to care for my mental health. I listen to music a lot, but honestly when I feel like I'm just at my peak as far as being overwhelmed, things like that, I'll literally just stop and take some deep breaths." ***Joy – 39 yrs.; SBW/SW Endorsement = 54 (moderate)*** "I hike three times out the month. So, I hike with my hike group, and then I do, I work out. And another focus for me is just eating better, trying to be healthier, just so many different, let's see. Things that I'm also trying to do is just really just focusing on being better for myself, being a better version of myself for me, and just really dealing with things for me." ***Brit – 36 yrs.; SBW/SW Endorsement = 77 (high)*** "I ended up taking that step to find a therapist to try to figure out what was going on, and she's like, you just grew up with so much self-doubt, so much unknown that by the time you're 30 now you're just like overpowered with emotions. And I'm like, dang, you. Right. And then I was going through situations with my relationship, and I just felt like last year was a horrible year for me mentally, but I took the steps to get better cuz I didn't wanna be dependent on medicine. I didn't wanna be dependent on any type of pill to control my emotions. But talking about it turned into a whole 180 and I'm like so much better now. Growing up in the church and having parents who were both ministers I was taught to turn to the church, prayer, and my family, but those things didn't work for me, so I found something that did. And I didn't want nobody religious. Because then I feel like they will put their religious beliefs before my mental needs, so I didn't want no one like that."

Suggestions for Improving Mental Health Treatment Utilization

After discussing the unique experiences Black women have that impact their decision to seek or use professional mental health treatment services, some time was spent exploring what suggestions and recommendations they had for improving treatment utilization. This theme refers to the exploration of strategies, recommendations, and perspectives that can help enhance the accessibility, effectiveness, and relevance of mental health care services for Black women who identify as strong and resilient. This theme focused on the identification of potential solutions to increase the utilization of mental health treatment among this population. Three sub-themes emerged:

Enhancing Awareness and Education to Combat Stigma. Participants described strategies to challenge and dismantle stigmas surrounding mental health within the Black community. This theme explored suggestions for fostering open conversations, raising awareness, and promoting education about mental health to normalize help-seeking behaviors and reduce the associated stigma. This type of strategy can be implemented at several points within the SEM including individual, interpersonal, community, and societal.

Collective Healing. Participants expressed the importance of promoting empowerment and healing among Black women and within the larger Black community. Within this theme was the exploration of suggestions for integrating strategies that empower strong Black women to prioritize their mental well-being, including generational healing sessions, stress management techniques, and tools for building resilience outside of just portraying an image of strength. This strategy can be situated at

the interpersonal and community levels within the SEM of treatment utilization among Black women living in the Deep South.

Culturally Responsive Care. This theme highlighted the importance of mental health care that is sensitive to the cultural, racial, and gender identities of Black women. Participants shared suggestions for mental health professionals to develop cultural competency, understanding the unique experiences and needs of Black women, and incorporating culturally relevant approaches into treatment modalities. The need for better provider training in basic skills to enhance therapeutic alliances and more in-depth training for all providers including African American/Black providers in techniques that supports the identity of Black women without perpetuating the need for Black women to be strong when seeking and using professional mental health services was centered in the narratives of most participants. This strategy type is best situated at the community and societal levels of the SEM.

Theme 4: Suggestions for Improving Mental Health Treatment Utilization

Sub-Themes	Participant Quotes
Enhancing Awareness and Education to Combat Stigma	***Eden – 45 yrs.; SBW/SW Endorsement = 86 (high)*** "Community education about mental health, providers, and overall knowledge about what to expect will make the mental health space feel a little safer because there is maybe a little bit more knowledge of what I might be going through and how to navigate all of that." ***Megan – 38 yrs.; SBW/SW Endorsement = 69 (moderate)*** "I think that's the biggest piece for me is having these conversations about mental health and therapy at church, having them at schools or workplaces where, I mean, cause we're all dealing with life and since Covid things have changed drastically for a lot of people. So, I just think just being open and transparent."
Collective Healing	***Joy – 39yrs.; SBW/SW Endorsement = 54 (moderate)*** "Let's talk about why are we as a culture, why are we afraid of therapy? Why haven't we really start seeking ways to help with our mental health? I just think having these types of discussions, having events to promote it, just things like that to really start helping our culture, our

	black women with some of things they're dealing with their issues. The healing begins with us together, sharing, being vulnerable and leaning on one another especially in a world that would love to continue seeing us divided and killing each other" ***Trisha – 31 yrs.; SBW/SW Endorsement = 50 (moderate)*** "Like we might need community therapy groups, we may need things like that, that further support what the culture is or whatever is needed for a certain group of people that may differ a bit from the norm. Some of the greatest healing happens when we come together because we were never meant to do life alone."
Culturally Responsive Care	***Jasmine – 30yrs.; SBW/SW Endorsement = 21 (low)*** "The first thing that comes to mind for providers is to make sure you place your biases aside and take time to learn. Make sure that you're carefully listening to the information that is being provided. To many times often, I find that, given my diverse experience of dealing with different counselors, we listen on different levels, or we actively listen on different levels, meaning that the information that is being interpreted or provided and the person is expecting advice or, or some type of guidance through that situation. However, it is difficult to do this without knowing about trigger words or being unknowledgeable in certain things." ***Emma – 36 yrs.; SBW/SW Endorsement = 64 (moderate)*** "I think providers need much, much more training. I did some stuff like motivational interviewing that stuff. I think providers need that and not just to go and sit through a training, but I think they need to use it. Also, cultural competency when it comes to black women. I feel like black women got skipped over in all of this treatment stuff."

DISCUSSION

This research aimed to gain a comprehensive understanding of the experiences, perspectives, and suggestions related to mental health service utilization among Black women in the Deep South. The study used the SBW/SW schema as a contextualizing framework to better understand Black women and their unique needs related to mental

health help seeking and professional treatment utilization. Through qualitative analysis using a SEM and intersectionality lens, several themes emerged, including negative experiences using professional mental health services, positive experiences using professional mental health services, the impact of being a strong Black woman on seeking mental health care services, and suggestions for improving mental health treatment utilization among strong Black women. This discussion synthesizes the key findings from these themes within the SEM and highlights their implications for mental health care provision.

Individual Level Factors

The *Being Strong Impacts my Decision to Seek Mental Health Care* theme revealed individual-level factors that shape mental health service experiences for Black women. The strong Black woman identity and cultural resilience emerged as important individual factors influencing help-seeking behaviors. The emphasis on strength and resilience, while commendable, may contribute to a reluctance to seek help or admit vulnerability. Understanding these individual-level factors is crucial in developing tailored interventions that validate the strength and resilience of strong Black women while also promoting the importance of self-care and seeking appropriate mental health care when needed.

Interpersonal Level Factors

Though the primary researcher started out with a primary focus of understanding individual, community, and societal factors influencing treatment utilization among the

target population it is critical to discuss the interpersonal level factors that emerged during the analysis process. The experiences of Black women in mental health services are influenced by interpersonal factors such as communication, empathy, and trust. Negative experiences highlighted communication issues, lack of empathy, and breaches of trust, underscoring the need for mental health professionals to develop culturally responsive communication skills and establish trusting relationships with their clients. Positive experiences, on the other hand, were characterized by supportive and empathetic professionals who fostered open communication and demonstrated cultural competence. Building culturally responsive therapeutic alliances can improve mental health service experiences for Black women and enhance treatment outcomes.

Community-level Factors

The socioecological perspective recognizes the impact of community-level factors on mental health care utilization. The theme addressing the impact of being a strong Black woman on seeking mental health care services highlighted cultural stigmas and historical/systemic factors. Community norms and stigmas surrounding mental health can inhibit help-seeking behaviors. Community-based interventions are essential to challenge these stigmas, raise awareness about mental health, and promote culturally appropriate resources and support networks. Engaging community leaders, organizations, and faith-based institutions can play a crucial role in addressing community-level barriers and fostering an environment that promotes mental health care utilization. Additionally, negative experiences using professional mental health services included the sub-theme

provider bias and discrimination which continues to highlight the need for culturally responsive training and implementation at the community level.

Societal-level Factors

Societal-level factors, including access to care, affordability, and disparities, were significant themes identified in the research. Black women face barriers such as limited access to mental health services, financial constraints, and disparities in the quality of care. These factors can be attributed to systemic racism, discrimination, and unequal distribution of resources. Addressing societal-level factors necessitates policy changes, advocacy efforts, and the provision of culturally responsive and affordable mental health care services. It is essential to recognize the intersectionality of race and gender as well as the intersectionality of inequitable systems and work towards equitable and accessible mental health care for Black women, especially those living in the Deep South.

Improving Mental Health Treatment Utilization Among Black Women

The current study provided valuable insights into the barriers and challenges faced by Black women in relationship to mental health treatment utilization. Building upon the findings of the study, it is crucial to explore potential behavioral interventions that can address identified factors leading to barriers of care and foster promotion of mental health treatment services. By using the SEM and intersectionality models to frame findings, it is critical to explore ways in which intervention can happen at varying levels to address lack of treatment utilization among Black women. This section on the discussion focuses on key behavioral interventions that may be effective in improving

access to and engagement with mental health services among Black women in the Deep South.

Behavioral Interventions

Culturally Responsive Education and Awareness. One essential aspect of behavioral interventions is increasing mental health education and awareness to combat internalized and externalized stigmas. Mental health literacy and stigma were identified a barrier to care in this study and previous studies, but what has been less discussed is the need for culturally responsive education models and awareness campaigns that are inclusive of the cultural contexts impacting care. Providing culturally responsive information about mental health, destigmatizing mental health concerns, and debunking myths can help challenge the performance of strength and foster an environment that encourages help-seeking behaviors. Education programs and community workshops should be tailored to address the specific needs, experiences, and cultural contexts of Black women in the Deep South, ensuring they are accessible, relevant, and delivered in a culturally responsive manner. Education programs could be implemented on a 1:1 basis within a therapeutic space or provided in a community context using group-based practices in community settings such as faith-based organizations, schools, self-care businesses, etc.

Training and Cultural Responsiveness for Healthcare Providers. Behavioral interventions must also focus on training healthcare providers to be culturally competent, responsive, and aware of the unique experiences and challenges faced by Black women in the Deep South. This training should address implicit biases, stereotypes, and discriminatory practices that may impact the quality of care provided.

Additionally, understanding how endorsement of the SBW/SW schema impacts overall health and more specifically the mental health of Black women is imperative, and providing strategies like the implementation of culturally specific assessment tools within practice should be prioritized. Healthcare providers should be educated on the intersectionality of race, gender, and mental health to ensure they offer culturally responsive and compassionate patient-centered care.

Enhancing healthcare providers' cultural responsiveness through training interventions offers opportunity to improve patient-provider communication by employing effective communication strategies that acknowledge the unique experiences and perspectives of Black women. This includes active listening, using culturally appropriate language and terminology, and adapting communication styles to meet the needs of diverse individuals. It also provides an opportunity to promote strategies that foster trust and build rapport. Establishing trust is critical for Black women to feel safe discussing their mental health concerns and seeking appropriate treatment. Culturally responsive providers who are sensitive to the historical context of mistrust can work to build rapport, demonstrate empathy, and create a safe space for open dialogue. To foster this safe space, it is paramount for providers to address implicit biases and stereotypes. Training interventions should prioritize the confrontation of these factors using modalities like self-reflection, self-awareness, and critical examination of personal and societal biases. This intervention strategy can help build trust and improve the overall experiences of Black women seeking mental health treatment.

Collaborative Care and Policy Reforms. As presented in the results, the onus of mental health care is not isolated to just mental health providers. Primary care, specialty

care, workplaces, and schools are examples of places that are also involved in the providing mental health support to Black women. Integrating mental health services within other care settings can help overcome the stigma associated with seeking mental health treatment and improve access to care. Collaborative care models, where primary and specialty care providers, human resources, and administrators work alongside mental health professionals, can facilitate early detection, assessment, and treatment of mental health issues. This integrated approach ensures a holistic and coordinated approach to healthcare, providing Black women with accessible and comprehensive mental health support.

Additionally, addressing the systemic barriers is critical for improving mental health treatment utilization among Black women in the Deep South. Behavioral interventions should advocate for policy reforms that increase access to affordable and quality mental health services. This may include conducting behavioral interventions that provide evidence for expanding insurance coverage, increasing funding for community mental health centers in underserved areas, and implementing anti-discrimination policies within healthcare systems. Collaboration between researchers, policymakers, and community leaders is essential to drive these systemic changes. Intervention within this realm involves advocating for changes at the structural and systemic levels to improve affordability, and quality within mental health services. Promoting telehealth solutions and fostering a diverse and culturally competent mental health workforce are also key in policy reform. Policy reforms should address the integration and expansion of telehealth and digital health solutions, particularly in rural areas with limited access to mental health

services as well as prioritize initiatives that promote diversity within the mental health workforce, including the recruitment and retention of Black mental health professionals.

LIMITATIONS

While the qualitative research conducted on mental health treatment utilization experiences among Black women living in the Deep South provides valuable insights, it is important to acknowledge certain limitations that may affect the interpretation and generalizability of the findings. The research focused on a specific population of Black women, and the findings may not fully represent the diversity of experiences within this group. The demographic characteristics education and socioeconomic status were above average for the study population and may not fully represent the target population. The study population represented a higher education level and had a higher median income than the median education level and income for the selected region and population.

Qualitative research involves interpretation and analysis by researchers, which introduces subjectivity into the process. Different researchers may interpret the data differently, potentially influencing the identification and categorization of themes. Measures were taken to enhance objectivity and reliability, such as employing a coding team with diverse experiences and backgrounds who utilized established qualitative analysis techniques, but subjectivity remains an inherent limitation of qualitative research. The qualitative research focused on specific themes related to mental health service utilization experiences among Black women. Other important factors, such as specific mental health diagnoses and intersectionality that explored more nuanced identities that Black women navigate were not explicitly explored. Future research should

consider a broader scope to capture a more comprehensive understanding of mental health experiences in diverse populations.

CONCLUSION AND IMPLICATIONS

Based on the study's findings framed within a socioecological and intersectionality perspective, we expected that several implications for mental health practice and policy would be drawn. We identified efforts that should be made to increase mental health literacy and reduce stigma among Black women living in the Deep South as well as the larger community. We expected that the needs of Black women in this region would differ from the needs of Black women in other regions and established throughout the results and discussion portion of the article specific deviations that seemed to differ from what was previously stated throughout literature. These deviations require additional research to better understand these phenomena more thoroughly. We hope to use study findings to inform public awareness campaigns and culturally responsive educational initiatives that will help challenge the negative perceptions associated with the SBW/SW schema and mental health to promote help-seeking behaviors and treatment utilization among this population. It is our hope that this phenomenological qualitative study offers valuable insights into the mental health treatment utilization experiences of Black women in the Deep South and that the implications of this research provide insight for the development of targeted interventions that address barriers to treatment utilization including training for mental health providers in culturally responsive mental healthcare, health education and promotion strategies to dismantle cultural stigma and facilitate collective healing community groups to bring awareness to the generational trauma that

impacts Black women and foster a supportive and safe environment for healing among Black women and the larger community.

Funding Statement

Funds to conduct this pilot research study were provided by Primerica and the Boris Lawrence Henson Foundation in support of reducing mental health stigma within the African American community.

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DISCUSSION

Mental health disparities continue to be a pressing issue in healthcare, particularly among marginalized populations. Among these populations, Black women in the Deep South face unique challenges when it comes to mental health treatment utilization. This discussion centers the work of this dissertation which was to explore the underutilization of mental health treatment among Black women in the Deep South and the potential consequences of the performance of strength, a cultural norm often imposed upon Black women dating back to slavery and continuing to be passed down intergenerationally. The Strong Black Woman/Superwoman schema is not inherently bad; however, research continues to point to the need to redefine this schema to include vulnerability and rest as acts of strength necessary for the betterment of mental health outcomes among Black women. Due to historical and cultural factors, Black women are often expected to embody strength and resilience, acting as the pillars of their families and communities. Consequently, they may suppress their own mental health needs to prioritize the well-being of others. The performance of strength can act as a barrier, preventing Black women from seeking the help they require, as it contradicts the societal expectations placed upon them.

The consequences of low mental health treatment utilization among Black women in the Deep South can be severe. Untreated mental health issues can lead to a range of negative outcomes, including diminished quality of life, impaired functioning, and increased risk of developing chronic physical health conditions. Additionally, untreated mental health issues may contribute to the perpetuation of intergenerational trauma, as

unaddressed mental health concerns are more likely to affect the wellbeing of future generations. Furthermore, the economic burden of untreated mental health issues is significant, as it leads to increased healthcare costs, reduced productivity, and a higher demand for social welfare services.

This dissertation aimed to explore the underutilization of mental health treatment among Black women in the Deep South while using the SBW/SW schema to contextualize participants and better understand their lived experiences as it relates to navigating mental health. Despite the increasing recognition of mental health disparities, particularly among racial and ethnic minority populations, there remains a paucity of research focusing on the experiences of Black women in the Deep South. This study investigated the factors that contribute to the low rates of mental health treatment utilization among this population and examined the potential cost associated with the performance of strength, a cultural norm often imposed upon Black women. By analyzing qualitative data collected through interviews and focus groups, this research provides insight into the complex interplay of sociocultural, historical, and systemic factors that shape mental health treatment-seeking behaviors among Black women in the Deep South.

The theoretical positioning of this research allows an opportunity to compare findings from the literature with findings from the current study. The literature often highlighted individual-level factors influencing mental health treatment utilization, such as internalized beliefs, attitudes, and experiences. It emphasized the impact of stigma, cultural norms, and the perception of mental health issues on help-seeking behaviors. The current study supported these findings, uncovering the influence of the performance of strength, cultural norms, and personal experiences on treatment utilization among Black

women. It also revealed how societal expectations of strength and resilience can discourage seeking help for mental health issues. Further, the literature mostly emphasized the role of interpersonal relationships, social support, and social networks in mental health treatment utilization. It recognized the significance of family, friends, and community members as sources of support or potential barriers to seeking help. For the current study, it was decided not to explore interpersonal level factors impacting mental health treatment utilization among Black women to focus on the significance of the community and societal level factors that have been mentioned through the literature previously, but often go unaddressed in previous literature. However, this decision did not hinder interpersonal level factors from showing up in the data. The current study provided evidence that family and friends may serve as barriers to mental health treatment utilization which has been less researched previously. This provides an opportunity for future research and more concrete exploration.

The literature recognizes the influence of community-level factors on mental health treatment utilization, such as access to healthcare resources, availability of culturally responsive services, and provider and community attitudes towards mental health. In comparison the current work echoed these findings by elucidating the community-level barriers faced by Black women in the Deep South. The study revealed challenges related to limited access to affordable and culturally responsive mental health services, as well as the historical context of racial discrimination that affects attitudes towards seeking help. Interestingly previous literature posits the protective factors of faith-based organizations to be a safe space for mental health support; however, findings from the current study introduces a deviation in that several individuals felt faith-based

organizations were harmful to their mental and emotional wellbeing. More research is needed to understand this deviation and its implications for mental health treatment utilization among Black women, but deviations such as this provide implications for future work to explore generational differences related to mental health treatment utilization among Black women. Finally, the literature often highlights systemic factors, including healthcare policies, funding disparities, and discrimination, as important determinants of mental health treatment utilization among Black women living in the Deep South. The current study supported literature findings by uncovering systemic barriers faced by Black women in the Deep South, such as limited insurance coverage, provider bias, and the historical context of racial discrimination. The current research also highlighted the need to explore how navigating the intersections of inequitable systems can impact care. Future work to continue expounding on this finding may provide evidence for needed policy reforms and systemic changes to address mental health disparities among Black women.

Contextualizing Black women through the lens of the SBW/SW schema was a critical part of the current study based on previous findings within the literature. Previous research posits that the SBW/SW schema is one explanation for the detrimental mental health outcomes of Black women. Previous knowledge about the schema provided an intersectional lens to explore how Black women navigate the world and unpacked the negative impact on health behaviors like help-seeking and treatment utilization. Findings from the current work showed alignment and differences from previous findings.

The current study aligned with previous literature by continuing to emphasize and highlight the socializing of Black women to be strong from a cultural context. The current

work also revealed societal expectations of strength and resilience emphasizing the pressure on Black women to display strength and invulnerability, which discouraged help-seeking behaviors and treatment utilization. The current work also confirmed self-sacrificing, and an obligation to always help others as critical barriers to help-seeking. Results from the current work acknowledged the tendency for Black women to prioritize the wellbeing of others over their own. Both previous and current findings recognize the multiple roles and responsibilities that Black women often undertake, which contribute to neglecting their own mental health needs.

Some differences about the SBW/SW schema in previous studies emerged in the current work. Current findings recognized the diverse experiences of Black women in the Deep South and how the performance of strength may vary within this context. It acknowledges that not all Black women conform to or internalize the SBW/SW schema. This nuanced understanding goes beyond the generalization of the SBW/SW schema often found in the literature and emphasizes the importance of individual experiences and agency. Additionally, the current study explored the influence of sociocultural, historical, and systemic factors specific to the Deep South on mental health treatment utilization among Black women. It highlighted the impact of historical racial discrimination and limited access to culturally responsive services. In contrast, the SBW/SW schema literature often focuses on the internalized aspects of the schema without explicitly addressing the broader contextual factors that shape mental health behaviors.

Highlighting areas of alignment and difference related to SBW/SW schema literature provided a more comprehensive understanding of the complexities surrounding mental health treatment utilization among Black women and offers more direction for

strategic intervention program within future research. The strength of the current study was establishing insight about the ways in which broader ecological systems impact treatment utilization. This exploration called out an explicit need to involve a multilayered interventional approach when addressing the lack of mental health treatment utilization among Black women. Further this study highlighted the benefit of public health practices within mental health care to collaboratively improve care.

The main goal in conducting this body of work was to shed light on the multifaceted challenges faced by this population especially when the need to be strong is perpetuated throughout the systems they live. The findings have implications for mental health policy and practice, as well as the development of culturally responsive training programs and interventions that address the unique needs and experiences of Black women. It is hoped that this research will contribute to the body of knowledge on mental health disparities and foster a better understanding of the complexities involved in mental health treatment utilization among Black women.

The underutilization of mental health treatment among Black women in the Deep South is a complex issue with significant consequences. By acknowledging the influence of sociocultural, historical, and systemic factors, as well as the impact of the performance of strength, we can develop targeted interventions to promote mental health treatment utilization. It is imperative that policymakers, healthcare providers, and community leaders collaborate to address these disparities and ensure that Black women have equitable access to the mental health services they need. Only through concerted efforts can we begin to dismantle the barriers that hinder mental health treatment utilization among this vulnerable population and improve their overall wellbeing.

SELF-REFLECTION

As a Black woman conducting this research, I find myself reflecting deeply on my personal experiences and the significance of this study. This research has been an opportunity for me to explore and amplify the voices and experiences of Black women who have long been marginalized in discussions surrounding mental health. Throughout this journey, I have felt a profound sense of connection to the participants and their stories. Their experiences resonated with my own, as I too have navigated the cultural expectations of strength and resilience that are often imposed upon Black women. It has been both validating and challenging to delve into the complexities of this performance of strength and its impact on mental health treatment-seeking behaviors.

This research has allowed me to recognize the multi-dimensional nature of the barriers that Black women face in accessing mental health support. It has highlighted the intricate interplay of sociocultural, historical, and systemic factors that contribute to the underutilization of mental health treatment in the Deep South. By unraveling these complexities, I have gained a deeper understanding of the unique challenges that Black women in this region encounter, and the urgent need for targeted interventions and training programs to address their mental health needs. Engaging in this research has also brought to light the importance of intersectionality in understanding mental health disparities. Being a Black woman myself, I have experienced firsthand the compounded effects of racism and sexism on mental health. This realization has reinforced the significance of recognizing the diversity within the Black community and acknowledging the unique experiences of Black women.

Conducting this research has also been emotionally demanding. Listening to the narratives of Black women who have struggled with untreated mental health issues has evoked a mix of empathy, frustration, and sadness within me. It has further fueled my passion for advocating for equitable mental health services and dismantling the barriers that hinder access to care. Moving forward, I am committed to using the knowledge and insights gained from this research to create meaningful change. I aim to be an advocate for the mental health needs of Black women in the Deep South, working towards promoting culturally responsive training programs and interventions, educating healthcare providers, and advocating for policy reforms that address the systemic barriers they face.

In conclusion, this research journey has been a deeply personal and transformative experience for me as a Black woman researcher and therapist. It has reaffirmed the significance of amplifying the voices of marginalized communities and addressing the unique challenges they face in accessing mental health treatment. I am grateful for the opportunity to contribute to the body of knowledge on this topic, and I am committed to continuing this important work in the pursuit of mental health equity for all.

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APPENDIX
IRB APPROVAL FORMS

THE UNIVERSITY OF ALABAMA AT BIRMINGHAM
Office of the Institutional Review Board for Human Use

470 Administration Building
701 20th Street South
Birmingham, AL 35294-0104
205.934.3789 | Fax 205.934.1301 |
irb@uab.edu

Martin, Amber

University of Alabama at Birmingham Institutional Review Board
Federalwide Assurance # FWA00005960
IORG Registration # IRB00000196 (IRB 01)
IORG Registration # IRB00000726 (IRB 02)
IORG Registration # IRB00012550 (IRB 03)

14-Sep-2022

IRB-300009412
IRB-300009412-003
The Costly Performance of STRENGTH: Examining Mental Health Treatment Utilization Among Black Women In the Deep South

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The IRB reviewed and approved the Initial Application submitted on 12-Sep-2022 for the above referenced project. The review was conducted in accordance with UAB's Assurance of Compliance approved by the Department of Health and Human Services.

	Exempt
	2
Determination:	Exempt
Approval Date:	14-Sep-2022
Approval Period:	No Continuing Review

Documents Included in Review:

- IRB EPORTFOLIO
- IRB PERSONNEL EFORM