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Strong Black Woman Schema:
Reconceptualizing Mental Health in African American Women

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Abstract

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The Covid-19 pandemic, social and political dissension, and racial discord have contributed to America's greatest mental health crisis. This mental health challenge is even more significant in African American women, where the Strong Black Woman schema (SBWS) and stigma of mental health in the African American communities create even more barriers for prevention and treatment of mental health conditions. The current literature defines the impact of the Strong Black Woman schema on mental health in African American women, and it acknowledges the evidence-based practice of religious cognitive behavioral therapy in general populations. A gap exists for interventions combining these concepts to address mental health in African American women. The purpose of this research was to develop, implement, and evaluate a mental health intervention that combined mental health and religion to address the mental health of African American women. The project also examined the relationship between the SBWS and mental health seeking behaviors in African American women, guided by the research question: "Does an educational intervention addressing Strong Black Woman schema combining religion and mental health improve mental health seeking attitudes and behaviors in African American women?" The researcher expected to find an inverse relationship between SBWS and mental health seeking behaviors in African American women, and expected a reversal or modification of that relationship with the implementation of the mental health intervention. The researcher invited 117 African American women to participate in a 2 hour educational mental health intervention/session with pre and post-surveys to be completed by the participants. The *t* test of Dependent Means was used to assess the statistical significance of the mental health intervention based on the mean score differences of the pre and post-survey results. The mean score difference of the results were statistically significant, revealing the mental health intervention helped to effectively reverse and/or mediate the inverse relationship between the SBWS and mental health seeking behaviors in African American women. The implications of this study are clinically significant for the mental health and religious sectors as they address the mental health challenges of African American women during this unprecedented mental health crisis.

Strong Black Woman Schema:
Reconceptualizing Mental Health in African American Women

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A Final Project submitted to the Faculty of the
Candler School of Theology
in partial fulfillment of the requirements for the degree of
Doctor of Ministry
2024

Introduction

The Covid-19 pandemic, social and political dissension, and racial discord have contributed to America's greatest mental health crisis.[1] This mental health challenge is even more significant in African American women, where the Strong Black Woman schema (SBWS) and stigma of mental health in the African American community create even more barriers for prevention and treatment of mental health.[2] In African American communities, a mistrust of the medical profession, cultural and social barriers between the individual and the provider, and dependence on family and religious communities contribute to the stigma of mental health.[3] The Strong Black Woman schema is a racially gendered, cultural expectation placed on African American women to exemplify signs of emotional strength, determination, and caretaking qualities while continuously facing adversity.[4] The combination of the SBWS and the stigma of mental health in the African American community inhibit mental health seeking behaviors in African American women. Self-silence, self-reliance, and self-sacrifice typical of SBWS potentially leads to feelings of isolation, depression, and anxiety as precursors to hypertension, diabetes, obesity, and cardiac disease.[5]

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[1] Rasheeta Chandler, Dominique Guillaume, Andrea G. Parker, Amber Mack, Jill Hamilton, Jemea Dorsey, and Natalie D. Hernandez. "The Impact of COVID-19 Among Black Women: Evaluating Perspectives and Sources of Information." *Ethnicity & Health* 26, no. 1 (2021): 82, accessed January 20, 2024, https://doi:10.1080/13557858.2020.1841120.

[2] Ibid.

[3] Earlise Ward, Jacqueline C. Wiltshire, Michelle A. Detry, and Roger L. Brown. African American Men and Women's Attitude Toward Mental Illness, Perceptions of Stigma, and Preferred Coping Behaviors. *Nursing Research 62,* no. 3 (2018): 188, accessed January 20, 2024, https://doi.org/10.1097/NNR.0b013e31827bf533

[4] Kelly Liao, Meifen Wei, and Mengxi Yin, "The Misunderstood Schema of the Strong Black Woman: Exploring Its Mental Health Consequences and Coping Responses Among African American Women." *Psychology of Women Quarterly 44*, no.1 (2020): 84, accessed January 20, 2024. https://doi.org/10.1177/0361684319883198

[5] Martinque K. Jones, and Brandi Pritchett-Johnson, "Invincible Black Women:" Group Therapy for Black College Women." *Journal for Specialists in Group Work 43,* no. 4 (2018): 355, accessed on January 20, 2024. https://doi.org/10.1080/01933922.2018.1484536

Self-Reliance

Self-reliance is a Black woman's belief that she should exemplify strength and control in every situation, or at least some semblance of control. [6] The SBW manages a myriad of conflicts independently (i.e., raising kids, grandkids, caring for elderly parents and extended family-financially, mentally, and physically). The Black woman is externally overloaded with overwhelming responsibilities while internally feeling overwhelmed, anxious, and depressed. Instead of expressing authentic emotions or seeking help, the SBW attempts to maintain the facade of self-reliance and competence by promoting a strong sense of self, which leads to the second characteristic of *self-silence*.

Self-Silence

Self-silencing behavior involves inhibition of feelings, thoughts, and desires in order to maintain relationships, appear strong, prevent loss, evade harm, and avoid conflict.[7] This behavior erodes into loss of one's authentic self from fear of rejection, loss, or isolation. Self-silencing is a trademark sign of SBWS with four distinct presentations: 1) silenced-self (i.e., not expressing wants, needs, feelings, or desires), 2) divided-self (i.e., presentation of submission and humility despite feelings of anger and hostility), 3) self-sacrifice (i.e., putting needs and feelings of others ahead of one's own needs), and 4) self-perceptions (i.e., critiquing oneself based on cultural standards and externalized perceptions).[8] Self-silencing allows Black women to

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[6] Martinque K. Jones, Koeshia J. Harris, and Akilah A. Reynolds, "In Their Own Words: The Meaning of the Strong Black Woman Schema Among Black U.S. College Women." *Sex Roles: A Journal of Research 84*, no. 5-6 (2021): 347–359, accessed on January 20, 2024. https://doi.org/10.1007/s11199-020-01170-w

[7] Jasmine A. Abrams, Ashley Hill, and Morgan Maxwell. "Underneath the Mask of the Strong Black Woman Schema: Disentangling Influences of Strength and Self-Silencing on Depressive Symptoms Among U.S. Black Women." *Sex Roles: A Journal of Research 80,* no. 9 (2019): 522, accessed January 20, 2024, https://doi.org/10.1007/s11199-018-0956-y.

[8] Ibid., 524.

project a "loss of self" as a "strong self" which promotes self-sacrifice and discourages mental health seeking behavior.

Self-Sacrifice

Self-sacrifice occurs when Black women place the needs of others before their own extending to the point of neglect.[9] The SBW attempts to anticipate and meet the needs of others, usually at the sacrifice of her own health and well-being. Although the SBW feels overwhelmed and wants or needs assistance, she does not seek or receive help from others. Her self-silencing is viewed as a "strong self" causing her needs and feelings to not be seen by others, which promotes increased self-reliance.[10] Thus, this paradox results in a vicious cycle, where the SBW begins the cycle again.

Background and Significance

The SBWS has its' roots in black feminism, and a history that dates back to slavery.[11] The enslaved African American woman was portrayed as physically stronger than a European American White woman leading to justification of enslavement and inhumane treatment. This socialized and systemic oppression instilled and promoted the behaviors and features of the SBWS as African American women performed arduous labor under heart-wrenching conditions with no control over her own children, family, or person.[12] This brutal and violent life was perpetuated and passed on to African American girls in preparation for the destined hardships they would also endure. Joy DeGruy, in *Post Traumatic Slave Syndrome,* describes this

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[9] Martinique et al., 351.

[10] Abrams et al., 523.

[11] Liao, Wei, and Yin, "The Misunderstood Schema," 85.

[12] Ibid.

phenomenon as "passing down the effects of trauma," as she compares the brutal trauma and effects of slavery to a form of post-traumatic stress syndrome (PTSD) that she called *Post Traumatic Slave Syndrome* (PTSS).[13] DeGruy's depiction of PTSS easily encompasses the SBWS as a by-product or co-morbidity inherent of traumatized Black women.

The roots of the SBWS embedded in Black Feminism highlight the great female activists of history, such as Sojourner Truth, Anna J. Cooper, Ida B. Wells and Mary Church Terrell undergirding the civil rights platforms and movements of the 1960s and 1970s, where the systemic and social subordinating challenges of Black women rendered them double marginalized for race and gender in America.[14] Kimberle Crenshaw, in "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color," coined the term *intersectionality* in relation to the intersecting identities of being Black and female that serve as systems of discrimination, domination, and oppression for African American women.[15] The synergism of these intersecting identities independently provide reinforcement for inequality as this "double-minority" represents a multidimensional stress comprised of racial, gendered, economic, political, and social stressors that impact the mental health of African American women.[16]

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[13] Joy DeGruy, *Post Traumatic Slave Syndrome: America's Legacy of Enduring Injury and Healing* (Baltimore, MD: Uptone Press, 2017); 101.

[14] Michele Wallace, *Black macho and the myth of the Superwoman* (New York, NY: Verso, 2015), 78.

[15] Kimberle Crenshaw, "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color," *Stanford Law Review 43,* no. 6 (2010): 1244, https://doi.org/10.2307/1229039

[16] Stephanie Castelin and Grace White. "I'm a Strong Independent Black Woman:' The Strong Black Woman Schema and Mental Health in College-Aged Black Women." *Psychology of Women Quarterly 46*, no. 2 (2022): 199, accessed on January 20, 2024. https://doi.org/10.1177/03616843211067501

The rate of mental illness in African American women is approximately 50 percent higher than that of Caucasian women with only 7 percent of Black women receiving treatment for depression as compared with 20 percent of the general population.[17] This attenuation of treatment is related to the endorsement of the SBW ideology, as a mask of mental, emotional, and physical strength through a fierce self-reliance that serves family, church, and community.[18] The SBW ideology poses as both a coping strategy, and a barrier of mental health services for Black women.[19]

The weight of SBW ideology on Black women, is even more intensified by the stressors of the Black community. Black men are incarcerated at five times the rate of white men; and statistically account for 37 percent of drug arrests, but only 14 percent of drug users.[20] Black Americans are more likely to be diagnosed with schizophrenia, more likely to die of suicide, and more likely to be involved in a violent crime.[21] Only one in three Black Americans who need mental health care receive treatment, and the lack of insurance has only added to the problem.[22]

While the SBW ideology serves as a source of strength against the oppressive nature of American society, it also serves as a major source of psychological stress for African American

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[17] Center for Disease Control and Prevention, *Summary health statistics: National Health Interview Survey:* 2021. *Table A-7.* Accessed on January 20, 2024, https://www.cdc.gov/nchs/pressroom/calendar/2021_schedule.htm

[18] Louisa Codjoe, Sarah Barber, Shalini Ahuja, Graham Thornicroft, Claire Henderson, Heidi Lempp, and Joelyn N'Danga-Koroma, "Evidence for Interventions to Promote Mental Health and Reduce Stigma in Black Faith Communities: Systematic Review." *Social Psychiatry & Psychiatric Epidemiology* 56, no. 6 (June 2021): 902, accessed January 20, 2024, http://doi:10.1007/s00127-021-02068-y.

[19] Camilla J. Hall, Kyaien O. Conner, and Kimberly Jones. "The Strong Black Woman versus Mental Health Utilization: A Qualitative Study." *Health & Social Work 46*, no. 1, (2021): 35. https://doi.org/10.1093/hsw/hlaa036

[20] Christina Carrega, Black Americans are Incarcerated at Nearly Five Times the Rate of Whites, 2021. Accessed January 20, 2024. https://www.cnn.com/2021/10/13/politics/black-latinx-incarcerated-more/index.html

[21] Center for Disease Control, *Health Statistics.*

[22] Ibid.

women. Cohen et al. (1997) defines stress as the process in which environmental demands over exceed the adaptive capacity of an organism, resulting in psychological and biological changes that place an individual at risk for disease.[23] This complex stress places African American women at a greater risk for depression, anxiety, post-traumatic stress disorder (PTSD), and suicidal ideations with even more mental compromise posed by the stigma of mental health in the African American communities.[24]

African American women exposed to the pressures of SBW schema and the stigma of mental health in the African American community suffer under tremendous levels of stress and mental instabilities.[25] Chronic social stress plays a significant role in the occurrence and progression of psychological and physiological disease. Although short-term stress can potentially have protective benefits, long-term exposure can lead to unhealthy allostatic loading, or "severe wear and tear on the body."[26] This occurs as Black women place extreme demands on themselves, failing to share life's responsibilities with others. They are viewed as strong, resilient, and invincible.[27] These positive characteristics are stretched to the point of emotional exhaustion, and mental and physical decline. These circumstances are further complicated by the stigma of mental health in the African American community.[28]

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[23] Sheldon Cohen, Ronald C. Kessler, and Lynn Gordon, *Measuring Stress: A Guide for Health and Social Scientists* (New York, NY: Oxford University Press, 1997), 85.

[24] Abrams et al., "Underneath the Mask," 519.

[25] Codjoe et al., "Evidence for Interventions," 904.

[26] Cohen, Kessler, & Gordon, *Measuring Stress,* 63.

[27] Isabella E. Lopez, "What is Superwoman Syndrome." *Step To Health,* accessed January 20, 2024. https://steptohealth.com/what-is-superwoman-syndrome/.

[28] Earlise Ward, Jacqueline C. Wiltshire, Michelle A. Detry, and Roger L. Brown. African American Men and Women's Attitude Toward Mental Illness, Perceptions of Stigma, and Preferred Coping Behaviors. *Nursing Research 62,* no. 3 (2018): 186, accessed January 20, 2024, https://doi.org/10.1097/NNR.0b013e31827bf533

This mental health dilemma has challenged the healthcare sector to widen their scope of practice, to include the adaptation of evidence-based mental health treatment modalities addressing the vulnerable population of African American women.[29] Since one of the barriers to prevention and treatment of mental health in the African American community is a dependence on family and religious communities, that barrier will be utilized as an asset and tool to address the mental health of African American women. The purpose of this project is to combine mental health therapies and religion, in order to develop an educational intervention addressing the Strong Black Woman schema and the stigma of mental health in African American women.[30]

Review of Literature

A comprehensive literature search was conducted to acquire relevant articles on the Strong Black Woman schema (SBW) and the stigma of mental health in African American communities. The research databases included: Medline (EBSCO) with Full Text, CINAHL, Nursing & Allied Health Databases (ProQuest), and religious databases. The search terms included Strong Black Woman schema, Superwoman, Black women, African American women, Black women and strength, Black women mental health, Black women health seeking behaviors, mental health stigma, barriers to mental health in African Americans, mental health and religion, and cognitive behavioral therapy. The inclusion criteria for selected articles included articles published in the last 5 years (excluding seminal or landmark articles), peer reviewed, and written

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[29] Rasheeta Chandler, Dominique Guillaume, Andrea G. Parker, Amber Mack, Jill Hamilton, Jemea Dorsey, and Natalie D. Hernandez, "The Impact of COVID-19 Among Black Women: Evaluating Perspectives and Sources of Information," *Ethnicity & Health* 26, no. 1 (2021): 82, accessed January 20, 2024. https://doi:10.1080/13557858.2020.1841120.

[30] Codjoe et al., "Evidence for Interventions," 901.

in English. Three qualitative studies, one descriptive study, and one quantitative study were included in this review.

Strong Black Woman Schema (SBWS) and Mental Help Seeking Attitudes

Hall, O'Conner, and Jones (2021) conducted a qualitative study of the relationship of SBW schema on the mental help seeking attitudes of Black women.[31] The primary purpose of the study was to examine the effects of SBW schema on mental health seeking attitudes across various age groups. The study included a convenience sample of African American women from the southeast region of Tennessee. A total of 163 women aged 18 to 72 years participated in the study. The median age of participants was < 27 years old. Participants were divided into 8 focus groups with 20-21 women per group. The methodology included a semi-structured interview using the Attitude Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF), used in either a face to face or video conference format with one 3-hour session.

The results indicated that younger Black women were more flexible, and open to redefining maladaptive thought patterns and adopting positive coping skills associated with SBW schema; and older Black women were more resistant to redefining maladaptive thought patterns, but open to enhancing existing coping skills and adopting new positive coping skills.[32] Participants endorsed and embraced the SBW ideology with positive accolades, such as, "stay strong, even when you feel down," "pray until something happens," "storms do not last forever," and "just stay positive, and everything will work out."[33] Older participants displayed greater tension between the stigma of mental health, and mental health seeking behaviors.

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[31] Hall, O'Connor, & Jones, "A Qualitative Study," 38.

[32] Ibid., 34.

[33] Hall, O'Connor, & Jones, "A Qualitative Study," 38.

The demographic data revealed 41% were single/never married, 19% were married, 22% were divorced, 3% widowed, and 15 % cohabitating. The study revealed the participants in each focus group endorsed ongoing tension to maintain emotional stability, and 35% admitted to maladaptive coping skills to relieve stress. One of the participants, a 44 year old married mother of two, admitted the SBW schema was her protection against falling into despair, and being vulnerable to racism and sexism. She believed the SBW schema might exist as a "grandiose illusion," but she felt it helped her maintain her independence and self-sufficiency.[34] Participants emphasized the SBW ideology provided strength for a "Black woman's defense."[35] Single women admitted to increased stress and pressure to be both mother and father, with associated feelings of depression if it could not be accomplished. Overall, participants felt the normal pressures of life produced various levels of stress, either from exhaustion or feelings of failure; and 48% of participants believed that Black women struggled with periods of depression when experiencing excessive exhaustion and/or severe stress.

Participants believed Black women embrace SBW schema secondary to decreased support systems, and the stigma associated with having mental issues. Focus group discussions relating to SBW schema and seeking mental health treatment revealed a reliance on prayer and strong support from Pastors and religious leaders. Older participants expressed lessons from older Black matriarchs expressing increased anxiety and depression should equal increased prayer; and even if prayer brought no relief, they would still not seek mental help or therapy. Six out of the eight focus groups believed SBW relied on religion and spirituality to provide wisdom

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[34] Ibid.

[35] Ibid.

and strength. One of the participants reflected "we are fulfilled, but burdened," and 72% of the participants agreed with this statement.[36] Six percent of participants admitted they had spoken with a professional life coach when experiencing stress at work or feeling overwhelmed with family responsibilities. However, only one of these participants (a 48-year-old divorced college administrator) considered those sessions as "therapy."[37]

Anxiety, Depression, Self-Reliance and Self-Silencing

Watson and Hunter (2015), conducted a seminal quantitative study to examine whether African American women's attitudes toward SBWS increased anxiety, depression, and mental health seeking attitudes.[38] Participants included a convenience sample of 95 African American women, ages ranging from 18 to 65 years of age, at the University of Illinois. The research findings revealed a significant embrace of SBWS was associated with anxiety and depression. This phenomenon was intensified when seen in conjunction with self-reliance and self-silence. The greatest indifference to mental health seeking attitudes was seen in older African American women who viewed increased resistance to mental health seeking attitudes as resilience.[39]

In the sample population, anxiety was noted to be higher in participants who strongly embraced the SBW ideology. Interestingly, correlation analyses indicated age and gross annual income correlated with mental health-seeking attitudes. The younger participants and participants with higher incomes had an increased chance for mental health seeking attitudes, and

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[36] Hall, O'Connor, and Jones, "A Qualitative Study," 39.

[37] Ibid., 35.

[38] Natalie Watson, and Carla D. Hunter. Anxiety and Depression Among African American Women: The Costs of Strength and Negative Attitudes Toward Psychological Help-Seeking. *Cultural Diversity and Ethnic Minority Psychology 21*, no. 4 (2015): 606, accessed on January 20, 2024, https://doi.org/10.1037/cdp0000015

[39] Ibid., 608.

the older participants and participants with a lower income had a decreased chance of mental health seeking attitudes. The results revealed a strong resistance to mental health seeking attitudes with self-reliance and self-silence in older African American women. The limitations of the study were noted as a decreased ability to generalize findings secondary to the demographics of the sample population (single/never married, rural, Midwest, college age, African American women with no children and a median age of 20 years old). Researcher recommended future studies should utilize a larger sample size with various age groups, and more specific measuring instruments for more definitive findings, and greater potential for generalizing the study.[40]

Strong Black Women, Perceptions of Strength, and Willing to Seek Help

Ligon (2021) conducted a qualitative study investigating the role of SBW schema on Black women's perception of strength, mental help seeking attitudes, mental health stigma, and barriers of using the theory of planned behavior.[41] The purposes of the study was to (1) Examine the experiences of Black women with SBWS in relation to depression, binge-eating, self-silencing, and emotional distress, (2) Examine SBWS in relation to the role of strength, the stigma of mental health, and mental help seeking attitudes in Black women, and (3) Examine participants' opinions of stereotypes related to Black females, such as Sapphire, Mammy, Jezebel, welfare queen, and the Angry Black Woman.[42] The study was conducted at the University of Michigan with a randomized sample population of 439 Black females who completed an on-line survey. The study revealed SBW themes reflected by the participants were pride, strength, tension, and stress. Participants verbalized embracing and embodying SBWS was

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[40] Watson and Hunter, "Anxiety and Depression," 605.

[41] JaLeshea Ligon. "Being a Strong Black Woman and Willing to Seek Help," *University of Michigan Library* (2021): 17, accessed January 20, 2024. https://deepblue.lib.umich.edu/handle/2027.42/171099

[42] Ibid., 25.

crucial for survival, enhanced self-esteem, and a sense of pride. Participant's expressed the importance of strength for Black women to invoke social change.[43]

This study revealed the stigma of mental health racially and culturally acts as a major barrier to Black women seeking mental help. Older Black women were noted to be least likely to seek mental health treatment, as compared to younger Black women.[44] Researchers noted participants who were asked about mental illness and/or mental health treatment responded similar to being asked about mental stigma and barriers to mental health. The theoretical model guiding this study was the "Theory of Planned Behavior" which predicts the intentions for seeking medical services. Increased intention for treatment equals increased motivation for treatment. The study participants dismissed the need for mental health treatment by believing that mental compromise would resolve without treatment, making the need to seek treatment unnecessary. Barriers to seeking mental health treatment were stigma of mental health, SBWS, lack of access to health care (a crucial barrier), age, and religious convictions. The study revealed age was a significant factor in mental health seeking attitudes. Younger Black women had more favorable attitudes toward mental health seeking attitudes than older Black women. Black women over 50 years of age were shown to be least likely to seek mental health services.

Older Black women could identify with SBWS, but were not willing to seek mental health services, even in cases of severe mental stress or decline. The study detailed a 90% endorsement of the SBWS, with only 20% positive mental health seeking attitudes. No significant findings were noted in regards to religion on endorsement of the SBW schema. Researcher recommendations for future studies noted an increased need for diverse mental health

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[43] Ligon, "Seek Help," 40.

[44] Ibid., 32.

care providers that look like the participants in order to decrease patient-provider barriers for mental health treatment. SBWS was not viewed as completely negative, but was also viewed as a potentially beneficial tool in the enhancement of mental health services by increasing open dialogue, assisting in transitional views of strength, and decreasing behaviors of self-silencing and self-sacrificing.[45]

SBWS and Female Black College Students

Jones, Harris, and Reynolds (2020) conducted a qualitative study to examine Black female college students' perceptions of strength in relation to SBW schema.[46] Participants included a sample population of 220 African American female college students from two large urban cities in the eastern region of the U. S. The participant's ages were 18 to 48 years of age, with a median age of 21 years old. The results revealed college aged Black women recognize the strong Black women persona may be perceived negatively (e.g., angry) by others, but continued to perceive strength as a relevant aspect of Black womanhood. The research findings also noted a continued relevance of strength among the majority of Black college women; however, participants felt their definitions of strength were different compared to prior generations. Younger participants expressed an appreciation for a new way of embracing the SBWS, and showcased how Black women have evolved to understand the image of Black womanhood differently compared to previous generations of Black women.

Research results revealed Black women are personally and creatively distancing themselves from traditional ideals of strength that no longer serve them by redefining strength in

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[45] Ligon, "Seeking Help," 37.

[46] Martinque K. Jones, Koeshia J. Harris, and Akilah A. Reynolds, "In Their Own Words: The Meaning of the Strong Black Woman Schema Among Black U.S. College Women," *Sex Roles: A Journal of Research 84*, no. 5-6 (2021): 347. Accessed January 20, 2024. https://doi.org/10.1007/s11199-020-01170-w

ways that enhance and facilitate mental wellness. Therefore, strength is not discarded, but redefined in a way that links strength with mental wholeness and stability. Participants attributed meaning to the SBWS using seven themes: resilience, independence, hardworking, nurturing, gendered-racial pride, new wave, and emotional wellness. Resilience, hardworking, and gendered-racial-pride were the three most common themes participants attributed to strength. Participants felt SBWS was a sustainable and necessary esteem in spite of attacks to their identity as Black women.

Strong Black Woman Schema and Successful Aging Among Black Women

Baker, Buchanan, Mingo, Roker, and Brown (2015) conducted a seminal descriptive study examining the relationship of SBWS and successful aging.[47] The study revealed multiple pathways to successful aging have been explored in Black Women, but expressed limited interventions have been implemented secondary to this research on successful aging among black women.[48] The existing literature suggests Black women experience various social challenges, such as sexism and racism, that represent barriers to successfully aging. The SBWS was described as embodying the image of the older Black woman with self-reliance, selflessness, and psychological, emotional, and physical strength. However, the marginalized social positioning of Black women exposes aging Black women to increased risk of feelings of powerlessness. The study suggested enhanced buffering through adaptive coping behaviors and support systems, can create an environment where older Black women can thrive.

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[47] Tamara Baker, Nicole T. Buchanan, Chivon A. Mingo, Rosalyn Roker, and Candace S. Brown, "Reconceptualizing Successful Aging Among Black Women and the Relevance of the strong Black Woman Archetype," *The Gerontologist 55*, no. 5 (2015): 52, accessed January 20, 2024, https://doi.org/10.1093/geront/gnu105

[48] Ibid., 53.

Successful aging was described as requiring three criteria: (1) Avoidance of disease and disability, (2) High psychosocial and physiological functioning, and (3) Remaining productive and active.[49] Successful aging was noted to be grounded in an older Black woman's identity, and if not maintained or accomplished could potentiate anxiety and depression.[50] Researchers recommended future research apply the SBW ideology to successful aging through theoretical strategies that maintain a strong sense of identity both as a woman and as a person of color. The study expressed that older Black women, as matriarchal figures, exude perseverance, strength, and optimism. Therefore, an age-gendered and race-focused theory with a gerontological approach for older Black women would respect their experiences as Black women while promoting the confidence and ability to age successfully among current and future generations of African American women.[51]

Discussion and Summary

The Strong Black Woman schema is beneficial for the psychological stability of African American women as an internal defense in a discriminatory society; but it can also be potentially detrimental to the psychological stability of a Black woman as a barrier against mental health seeking attitudes, secondary to the ideology of SBWS and the stigma of mental health in the African American communities.[52] [53] [54] First, the literature revealed an educational intervention

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[49] Baker et al., "Successful Aging," 54.

[50] Tamara Beauboeuf-Lafontant, *Behind the Mask of the Strong Black Woman: Voice and the Embodiment of a Costly Performance* (Philadelphia, PA: Temple University Press, 2009): 72.

[51] Baker et al., "Successful Aging," 55.

[52] Hall, O'Connor, and Jones, "A Qualitative Study," 38.

[53] Watson and Hunter, "Anxiety and Depression," 605.

[54] Ligon, "Seeking Help,", 37.

must address SBWS as an internal barrier and the stigma of mental health as an external barrier in order to promote mental wellness in African American women. The factors contributing to the stigma of mental health in the African American communities are: 1) A mistrust of the medical profession secondary to historical experiences, 2) Cultural and social barriers between the patient and provider, and 3) Dependence on family and religious communities.[55] Since one of the barriers to prevention and treatment of mental health in the African American community is a dependence on family and religious communities, that barrier will be utilized as an asset and tool to address the mental health of African American women. Therefore, the educational intervention must be **multi-focused** and combine mental health therapies and religion to address the *internal* barrier of the Strong Black Woman schema and the *external* barrier of the stigma of mental health in African American women.[56]

Second, the literature revealed younger Black women were more flexible, and open to redefining maladaptive thought patterns and adopting positive coping skills; and the older Black women were resistant to redefining maladaptive thought patterns, but open to enhancing existing coping skills and adopting new positive coping skills.[57] [58] Therefore, the educational intervention must be **multi-purposed**, facilitating young Black women in redefining strength, and assisting older Black women in enhancing existing coping skills, and adopting new positive coping skills.[59] [60]

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[55] Ward et al., "Perceptions of Stigma," 187.

[56] Ibid., 189.

[57] Hall, O'Connor, and Jones, "A Qualitative Study," 39.

[58] Jones, Harris, and Reynolds, "In Their Own Words," 355.

[59] Hall, O'Connor, and Jones, "A Qualitative Study," 39.

[60] Jones, Harris, and Reynolds, "In Their Own Words," 355.

Third, the literature revealed the educational intervention must be **multi-generational,** addressing SBWS in Black women of all ages with an age and race specific theory that understands the cognitive approach for Black women of all generations.[61] [62]An age specific educational mental health intervention must consider that although the brain stops growing in size by early adolescence, it is still being fine-tuned during the young adult years resulting in flexibility. The brain finishes developing and maturing in the mid-to-late 20s, and the last part of the brain to mature is the prefrontal cortex. The prefrontal cortex is responsible for planning, prioritizing, and making good decisions; which is the reason younger Black women are more flexible and open to redefining definitions of strength, changing maladaptive thought patterns, and adopting positive coping skills.[63] [64]

Older Black women were resistant to redefining maladaptive thought patterns, but open to enhancing existing coping skills and adopting new positive coping skills because their learning capabilities center around their hippocampus, and are based on adult neurogenesis. Adult neurogenesis is the concept that the brain continually makes new neurons.[65] Phipps (2022) conducted a study at the University of London on the brains of older taxi drivers who were

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[61] Baker et al., "Successful Aging," 54.

[62] Jones, Harris, and Reynolds, "In Their Own Words," 353.

[63] National Institute of Mental Health (NIMH). The teen brain: 7 things to know, 2023. https://www.nimh.nih.gov/sites/default/files/documents/health/publications/the-teen-brain-7-things-to-know/teen-brain-7-things-to-know.pdf

[64] Hall, O'Connor, and Jones, "A Qualitative Study," 38.

[65] Matt Puderbaugh and Prabhu D. Emmady, "Neuroplasticity." *National Library of Medicine*, 2023, Accessed January 20, 2024, https://www.ncbi.nlm.nih.gov/books/NBK557811/

shown to have enlarged hippocampi, twice as large as people in their same age group.[66] This area of the brain shrinks with age, and is damaged with dementia and Alzheimer's; but it was found to be completely opposite in the older taxi drivers in London. In London, a taxi driver must obtain a taxi license, which requires an extensive test. The test is a blank map of the entire city of London; and in order to pass the test, a driver must name and label every street in the city of London, from memory in one seating. The rote memorization in preparation for the test causes increased adult neurogenesis, forming new neurons and creating new neural pathways, which enlarges their brains from the influx of new data. The neurogenesis occurs in the hippocampus, the center of emotions, memory, and learning. Older Black women learning and adopting new coping skills and strengthening existing coping skills would also utilize the hippocampus stimulating adult neurogenesis.[67] [68] [69] These are both evidence based-patterns of learning in cognitive behavioral therapy; however, in every learning environment there will be outliers (i.e., young Black women that prefer utilizing coping skills over redefining strength, and older Black women that prefer redefining strength over utilizing coping skills).

Theoretical Framework

The Fenn and Byrne's Cognitive Behavioral Theory (CBT) and the Albert Ellis' ABC model were selected as the theoretical models to guide this clinical project.[70] [71] These models

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[66] Laura Phipps, London Taxi Drivers' Brains Being Scanned for Alzheimer's Research," *University College of London*, 2022: accessed January 20, 2024, https://www.ucl.ac.uk/news/2022/feb/london-taxi-drivers-brains-being-scanned-alzheimers-research

[67] Phipps, "London Taxi Drivers."

[68] Hall, O'Connor, and Jones, "A Qualitative Study," 38.

[69] Jones, Harris, and Reynolds, "In Their Own Words," 353.

[70] Kristina Fenn and Majella Byrne, "The Key Principles of Cognitive Behavioral Therapy," *InnovAiT 6*, no. 2 (2013): 580.

[71] Joaquin Selva, "Positive CBT in 'What is Albert Ellis' Model in CBT Theory?"

function as middle-range theories that integrate theoretical and evidence-based research to address nursing and healthcare problems among vulnerable populations, such as African American women. The Fenn & Byrne's Cognitive Behavioral Theory (FBCBT) examines the associations between thoughts, emotions, and behaviors.[72] This structured approach correlates a person's feelings related to his/her perception of their daily lives as a person's behavioral patterns are positively or negatively affected by their thought patterns. FBCBT has a strong evidence-based approach that aims to alleviate stressors by helping patients develop more adaptive cognitions and behaviors that enhance and generate positive outcomes.[73]

The Albert Ellis' ABC model is patterned after a form of therapy called Rational-Emotive Behavior Therapy (REBT), which is a subset of CBT. REBT emphasizes external events or adversity (A) does not cause emotional consequences (C), but is really secondary to poor thought processes and cognitive distortions (B).[74] The ABC model focuses on changeable processes in which events lead to beliefs that result in consequences. The goal when using the ABC model is to help individuals transform irrational beliefs into rational beliefs that lead to positive outcomes.[75]

Postivepsychology.com. Accessed January 20, 2024. https://positivepsychology.com/albert-ellis-abc-model-rebt-cbt/

[72] Fenn and Byrne, "Cognitive Behavioral Therapy," 581.

[73] Ibid.

[74] Selva, "Positive CBT."

[75] Harold G. Koenig, Michelle J. Pearce, Bruce Nelson, and Alaattin Erkanli. "Effects on Daily Spiritual Experiences of Religious versus Conventional Cognitive Behavioral Therapy for Depression. *Journal of Religion & Health 55,* no. 5 (2016): 1765, accessed January 20, 2024, https://doi.org/10.1007/s10943-016-0270-3

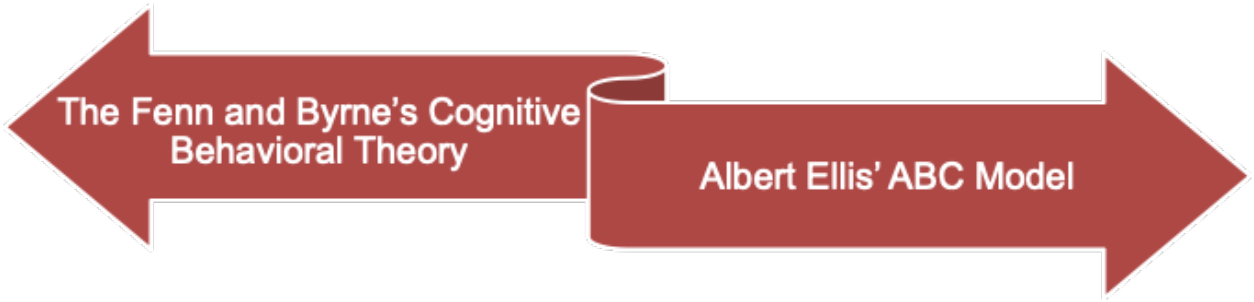

Figure 1: The Religiously Integrated Cognitive Behavioral Therapy (RCBT)

The Religiously Integrated Cognitive Behavioral Therapy (RCBT) model was formatted from a combination of the Fenn & Byrne's Cognitive Behavioral Theory (FBCBT) and the Albert Ellis' ABC model (ABC). The combination of these two models will help African American women enhance positive coping skills, redefine the maladaptive thoughts patterns of the SBW ideology, and improve their mental health seeking behaviors. The FBCBT aims to alleviate stress by helping patients to develop more adaptive and positive thoughts and behaviors, and the Albert Ellis' ABC model reveals how the redefining of strength in African American women as external events or adversity (A) does not cause emotional consequences (C), but is really secondary to poor thought processes and cognitive distortions (B).[76] The ABC model focuses on the changeable process in which events lead to beliefs that result in consequences. The goal when using the ABC model is to help the client transform irrational beliefs into rational beliefs that lead to positive outcomes.[77]

In *Measures of Religiosity*, Koenig et al. (2016) explained the significance of spirituality and religion as key components in the mental and physical wellbeing of every individual. It can therefore be theorized that cognitive behavioral therapy combined with religion will help to

[76] Selva, "Positive CBT."

[77] Koenig et al., "Effects on Daily Spiritual," 1763.

correct cognitive distortions (B), secondary to adversity (A), that lead to negative reactions (C); thereby, decreasing maladaptive thought processes, facilitating positive coping skills, increasing mental health seeking attitudes, and promoting positive consequences that will lead to positive outcomes in African American women.[78]

The current literature acknowledges the benefit of religion and cognitive behavior therapy; and acknowledges the need for interventions to address the mental healthcare needs of African American women. However, there is a gap in the development and provision of evidence-based interventions designed to address the mental health needs of African American women.

Methodology

Purpose

The purpose of this Doctor of Ministry research is to: (1) Combine mental health therapies and religion to develop and implement a multi-focused, multi-purposed, and multi-generational educational intervention addressing Strong Black Woman schema and the stigma of mental health in African American women and, (2) Evaluate the effect of the intervention to determine the impact on knowledge levels and mental health seeking attitudes and behaviors. The following question will be used to guide this research project: Does an educational intervention addressing Strong Black Woman Schema (SBWS) with combined mental health and religion improve mental health seeking attitudes and behaviors in African American women?

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[78] Ibid., 1764.

Expected Outcome

The expected outcomes following implementation of the mental health educational intervention were: (1) increased knowledge of Strong Black Woman Schema in African American Women, and (2) improved mental health seeking attitudes and behaviors in African American women.

Design

A pretest and posttest design was used to measure knowledge of Strong Black Woman Schema and mental health seeking attitudes and behaviors in African American women. De-identified data was collected from the participant sample prior to and after the educational intervention, and analyzed using various statistical tests in a Statistical Package for the Social Sciences (SPSS) system.

Participants

A convenience sample of 117 African American women attending the General Missionary Baptist Church Convention Deaconesses, Deacons' Wives, & Deacon's Widows Conference in Kingsland, Georgia in August of 2023 were invited via on-line flyers to participate in the project. The inclusion criteria for participants were African American women, at least 18 years of age and older.

Setting

The project was conducted at the Evergreen Missionary Baptist Church in Kingsland, Georgia during a session at the Deaconesses, Deacons' Wives, & Deacon's Widows Conference in August 2023. The conference was sponsored by the General Missionary Baptist Church Convention of Georgia.

Implementation and Data Collection

In June 2023, a meeting was held via phone conference with the Women's Auxiliary President of the General Missionary Baptist Church Convention to discuss the presentation of the mental health intervention at an upcoming conference in Kingsland, Georgia. The results of the meeting established the "Sisters in the Pews: A Pilot Study Addressing Mental Health in African American Women" would be presented during a session at the Deaconesses, Deacons' Wives, & Deacon's Widows Conference in August 2023, sponsored by the General Missionary Baptist Church Convention.

An educational intervention combining mental health and religion was developed based on literature review and mental health/religious best practices. The educational intervention addressed: (1) Mental health in African American women, (2) Stigma of mental health in the African American community, (3) Strong Black Woman schema (SBWS), (4) Impact of SBW schema on physical and mental health of African American women, (5) Positive and negative mental health coping skills, (6) Mental and physical warning signs and when to seek help, and (7) Mental health resources for African American women. The educational intervention was presented during a session at the General Missionary Baptist Convention Conference in Kingsland, Georgia in August 2023.

The interventional session was a single two-hour educational lecture concluding with an interactive discussion. All individuals in attendance were informed of the purpose and procedures of the study through verbal instructions and consent forms at the beginning of the session. Implied consent was obtained from each woman who completed and returned the surveys in order to protect participant confidentiality. The surveys administered were a demographic questionnaire, Superwoman Schema Instrument, Africultural Coping Systems

Inventory (ACSI), and an Attitude Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH). The demographic questionnaire, Superwoman Schema Instrument, and Attitude Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH) were given as pre-surveys at baseline prior to the educational intervention.

After baseline pre-surveys were administered, the educational session was conducted with the participants. At the completion of the session, the Attitude Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH) and Africultural Coping Systems Inventory (ACSI) were administered as post-surveys for post-intervention measurements. Information packets containing mental health resources and crisis information were also supplied to each participant at the conclusion of the session.

Measurement Instruments

The measurement instruments were the Superwoman Schema Instrument, Africultural Coping Systems Inventory (ACSI), Attitude Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH), and a demographic questionnaire. The Superwoman Schema Instrument was developed by Giscombe et al. (2019), and was administered in the original version at baseline. The instrument consists of 35-items, on a four-point Likert scale assessing cognitive and behavioral characteristics of Superwoman schema in African American women via the subscales: strength, emotions, vulnerability, motivation to succeed, and obligation to others. The responses range from 0 = this is not true of me to 3 = this is true of me all of the time. Content validity was established in African American women using the Cronbach's alpha for reliability with internal consistency described as good (a = .85).[79]

[79] Cheryl L. Giscombe, Amani M. Allen, Angela R. Black, Teneka C. Steed, T., Yin Li, and Charity Lackey. "The Giscombe Superwoman Schema Questionnaire: Psychometric Properties and Associations with Mental Health and Health Behaviors in African American women. *Issues in Mental Health Nursing 40*, no. 8 (2019): 674, accessed on January 202024, https://doi:10.1080/01612840.2019.1584654.

The Attitude Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF) was developed by Fisher and Farina (1995), and was administered in the modified short-form at baseline and at the conclusion of the session.[80] The instrument is a condensed scale adapted from the original 29-item ATSPPH scale created by Fischer and Turner (1970). The short Form is a 10-item, four-point Likert scale questionnaire modified to improve its psychometric properties; and is used to assess openness to seeking professional help for emotional problems, and the value and need in seeking professional help. The responses range from 1 = strongly disagree to 4 = strongly agree. Content validity was established using the Cronbach's alpha for reliability with internal consistency described as good (a = .87).[81]

The Africultural Coping Systems Inventory (ACSI) scale was developed by Utsey (1999), and was administered in the original version at the conclusion of the educational session.[82] The instrument is a 30-item, four-point Likert scale questionnaire assessing culturally specific coping strategies of African Americans in stressful situations and arenas (e.g., family, friends, school, job, romantic relationships, and various other arenas). The responses range from 0 = does not apply or did not use to 3 = used a great deal. Content validity was established In African Americans using the Cronbach's alpha for reliability with internal consistency described as acceptable to good (a = .70 - .82).[83]

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[80] Edward H. Fischer and Amerigo Farina. "Attitudes Toward Seeking Professional Psychological Help: A Shortened Form and Considerations for Research." *Journal of College Student Development 36*, no. 4 (1995): 368.

[81] Fischer and Farina, "Attitudes Toward Seeking," 369.

[82] Sean Utsey, Eve P. Adams, and Mark Bolden, "Developmental and Initial Validation of the Africultural Coping Systems Inventory," *Journal of Black Psychology* 26, no. 2 (2000):195.

[83] Ibid., 197

A demographic questionnaire consisting of 20 items was administered at baseline in a de-identified, multiple choice format to assess the diversity and demographics of the participants in the research project.

Ethical Considerations

An expedited application for this data collection was approved by the Georgia Southern University International Review Board (IRB). Written permission to conduct the study at the General Missionary Baptist Convention Conference in Kingsland, Georgia was obtained from the Women's Auxiliary President. Implied consent was obtained from participants who completed and returned the surveys, and the information obtained was collected in a de-identified format. The researcher mitigated risks, but in the event the intervention or survey questions invoked any physical, mental, or social discomfort; assistance was offered (24 hours/7 days a week) by calling 911, going to the nearest emergency room, or contacting their local healthcare provider. Also, a list of mental health resources was made available for each participant during the session.

Data Analysis

The purpose of the study was to evaluate the efficacy of a religious cognitive behavioral therapy intervention in facilitating an improvement in the mental health seeking attitudes and behaviors in African American women. A quantitative, quasi-experimental research design featuring a within-subjects, repeated measures approach was used to address the study's purpose. A non-probability, purposive sampling approach was used to achieve the study's sample of participants. A standardized research instrument, the Attitudes Toward Seeking Professional Psychological Help Scale was administered to study participants at two time points in a pre-

test/post-test fashion. Descriptive and inferential statistical techniques were used to analyze study data.

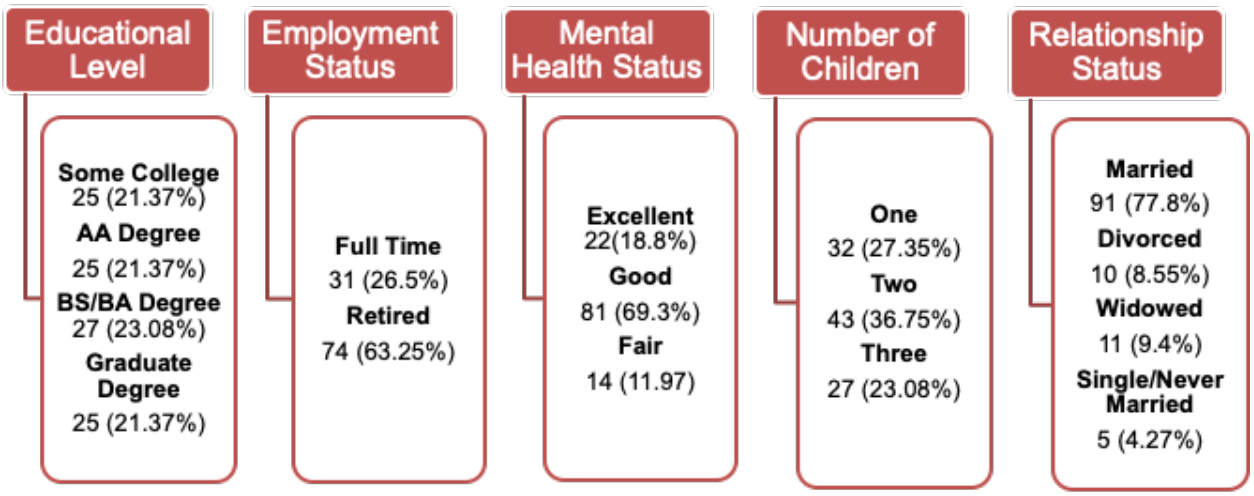

Figure 2: Demographics Data (n = 117)

Descriptive Statistics

The study's five central demographic variables were evaluated using the descriptive statistical techniques of frequencies (*n*) and percentages (*%*). The five demographic variables identified for study purposes were: participant relationship status, employment status, educational level, number of children, and participant perceived mental health status.

Table 1

Descriptive Statistics Summary Table: Demographic Variables (Relationship Status; Employment Status; Educational Level; Number of Children; and Mental Health Status)

Demographic Variable	*n*	*%*	Cumulative *%*
Relationship Status			
Married	91	77.78	77.78
Divorced	10	8.55	86.32
Widowed	11	9.40	95.73
Single/Never Married	5	4.27	100.00
Missing	0	0.00	100.00
Employment Status			
Full Time	31	26.50	26.50
Part Time	4	3.42	29.91
Retired	74	63.25	93.16
Disabled	4	3.42	96.58
Unemployed	4	3.42	100.00
Missing	0	0.00	100.00

Education Level			
HS Diploma	14	11.97	11.97
GED	1	0.85	12.82
Some College	25	21.37	34.19
AA Degree	25	21.37	55.56
BS/BA Degree	27	23.08	78.63
Graduate Degree	25	21.37	100.00
Missing	0	0.00	100.00
Number of Children			
1	32	27.35	27.35
2	43	36.75	64.10
3	27	23.08	87.18
4	9	7.69	94.87
5 or More	6	5.13	100.00
Missing	0	0.00	100.00
Mental Health Status			
Excellent	22	18.80	18.80
Good	81	69.23	88.03
Fair	14	11.97	100.00
Missing	0	0.00	100.00

Descriptive Statistics: Attitudes Toward Seeking Professional Psychological Help Scale

Descriptive statistical techniques were used to assess the study's response set data for the Attitudes Toward Seeking Professional Psychological Help Scale at the pre-test and post-test phases of the study. The study's response data for survey items represented on the Attitudes Toward Seeking Professional Psychological Help Scale were specifically addressed using the descriptive statistical techniques of frequencies (*n*), measures of central tendency (mean scores), variability (minimum/maximum; standard deviations), standard errors of the mean (SE_M), and data normality (skew; kurtosis).

Table 2

Descriptive Statistics Summary Table: Attitudes Toward Seeking Professional Psychological Help Scale (Pre-Test; Post-Test; and Difference Score)

Study Phase	*M*	*SD*	*n*	SE_M	Min	Max	Skew	Kurtosis
Pre-Test	2.03	0.49	117	0.05	1.00	3.30	0.24	-0.34
Post-Test	2.81	0.24	117	0.02	1.70	3.20	-0.96	2.89
Difference	**0.78**	**0.48**	**117**	**0.04**	**-0.60**	**2.00**	**-0.25**	**-0.08**

Table 3

Descriptive Statistics Summary Table: Attitudes Toward Seeking Professional Psychological Help Scale (Pre-Test; Post-Test; and Difference Score) by Relationship Status

Relationship Status/Phase	*M*	*SD*	*n*	SE_M	Min	Max	Skew	Kurtosis
Married								
Pre-Test	2.01	0.45	91	0.05	1.00	3.30	0.16	-0.05
Post-Test	2.80	0.24	91	0.02	1.70	3.20	-1.18	3.74
Difference	**0.79**	**0.47**	**91**	**0.05**	**-0.60**	**2.00**	**-0.17**	**0.25**
Divorced								
Pre-Test	2.41	0.70	10	0.22	1.40	3.00	-0.54	-1.51
Post-Test	2.99	0.24	10	0.08	2.50	3.20	-0.96	-0.42
Difference	**0.58**	**0.56**	**10**	**0.18**	**-0.20**	**1.30**	**0.20**	**-1.54**
Widowed								
Pre-Test	1.83	0.49	11	0.15	1.10	2.90	0.64	0.29
Post-Test	2.82	0.17	11	0.05	2.50	3.10	0.20	-0.08
Difference	**0.99**	**0.45**	**11**	**0.14**	**-0.10**	**1.60**	**-1.22**	**1.33**
Single/Never Married								
Pre-Test	2.16	0.26	5	0.12	1.80	2.50	-0.08	-0.93
Post-Test	2.78	0.29	5	0.13	2.40	3.10	-0.21	-1.39
Difference	**0.62**	**0.45**	**5**	**0.20**	**-0.10**	**1.00**	**-0.79**	**-0.73**

Table 4

Descriptive Statistics Summary Table: Attitudes Toward Seeking Professional Psychological Help Scale (Pre-Test; Post-Test; and Difference Score) by Employment Status

Employment Status/Phase	*M*	*SD*	*n*	SE_M	Min	Max	Skew	Kurtosis
Full Time								
Pre-Test	2.15	0.50	31	0.09	1.10	3.30	0.32	0.00
Post-Test	2.90	0.22	31	0.04	2.30	3.20	-0.62	-0.06
Difference	**0.75**	**0.43**	**31**	**0.08**	**-0.60**	**1.30**	**-1.11**	**1.10**
Part Time								
Pre-Test	1.93	0.48	4	0.24	1.40	2.50	0.14	-1.40
Post-Test	2.70	0.22	4	0.11	2.50	3.00	0.69	-1.00
Difference	**0.78**	**0.51**	**4**	**0.26**	**0.20**	**1.30**	**-0.09**	**-1.70**
Retired								
Pre-Test	1.97	0.47	74	0.06	1.00	3.00	0.17	-0.46
Post-Test	2.80	0.24	74	0.03	1.70	3.20	-1.32	4.50
Difference	**0.83**	**0.48**	**74**	**0.06**	**-0.20**	**2.00**	**0.04**	**-0.33**
Disabled								
Pre-Test	2.20	0.67	4	0.33	1.60	3.00	0.26	-1.64
Post-Test	2.70	0.26	4	0.13	2.40	3.00	0.00	-1.36
Difference	**0.50**	**0.78**	**4**	**0.39**	**-0.20**	**1.40**	**0.19**	**-1.73**
Unemployed								
Pre-Test	2.17	0.54	4	0.27	1.50	2.80	-0.15	-1.08
Post-Test	2.65	0.17	4	0.09	2.50	2.90	0.89	-0.81
Difference	**0.47**	**0.54**	**4**	**0.27**	**-0.20**	**1.00**	**-0.33**	**-1.43**

Table 5

Descriptive Statistics Summary Table: Attitudes Toward Seeking Professional Psychological Help Scale (Pre-Test; Post-Test; and Difference Score) by Educational Level

Education Level/Phase	*M*	*SD*	*n*	SE_M	Min	Max	Skew	Kurtosis
HS Diploma								
Pre-Test	2.21	0.42	14	0.11	1.20	2.80	-0.92	0.59
Post-Test	2.81	0.38	14	0.10	1.70	3.20	-1.91	3.51
Difference	**0.59**	**0.51**	**14**	**0.14**	**-0.20**	**1.70**	**0.50**	**-0.22**
Some College								
Pre-Test	2.04	0.49	25	0.10	1.40	3.00	0.65	-0.72
Post-Test	2.77	0.19	25	0.04	2.40	3.10	-0.38	-0.50
Difference	**0.74**	**0.50**	**25**	**0.10**	**-0.20**	**1.40**	**-0.68**	**-0.77**
AA/AS Degree								
Pre-Test	1.83	0.37	25	0.07	1.10	2.30	-0.54	-0.70
Post-Test	2.78	0.21	25	0.04	2.30	3.10	0.08	-0.53
Difference	**0.95**	**0.38**	**25**	**0.08**	**0.30**	**1.80**	**0.19**	**-0.24**
BS/BA Degree								
Pre-Test	1.99	0.54	27	0.10	1.10	3.00	0.40	-0.68
Post-Test	2.87	0.24	27	0.05	2.20	3.20	-0.75	0.48
Difference	**0.89**	**0.47**	**27**	**0.09**	**0.10**	**2.00**	**-0.06**	**-0.22**
Graduate Degree								
Pre-Test	2.17	0.54	25	0.11	1.00	3.30	0.04	-0.18
Post-Test	2.84	0.21	25	0.04	2.40	3.20	0.007	-1.02
Difference	**0.66**	**0.51**	**25**	**0.10**	**-0.60**	**1.70**	**-0.18**	**0.32**

Table 6

Descriptive Statistics Summary Table: Attitudes Toward Seeking Professional Psychological Help Scale (Pre-Test; Post-Test; and Difference Score) by Income Level

Income Level/Phase	*M*	*SD*	*n*	SE_M	Min	Max	Skew	Kurtosis
$21,000 to $30,000								
Pre-Test	1.85	0.36	8	0.13	1.40	2.30	-0.28	-1.58
Post-Test	2.74	0.17	8	0.06	2.50	3.00	-0.25	-0.74
Difference	**0.89**	**0.27**	**8**	**0.10**	**0.50**	**1.30**	**0.01**	**-1.18**
$31,000 to $40,000								
Pre-Test	2.21	0.53	11	0.16	1.40	2.90	0.02	-1.36
Post-Test	2.83	0.24	11	0.07	2.40	3.20	-0.01	-0.67
Difference	**0.62**	**0.57**	**11**	**0.17**	**-0.20**	**1.30**	**-0.36**	**-1.47**
$41,000 to $50,000								
Pre-Test	2.10	0.50	13	0.14	1.10	2.80	-0.44	-0.50
Post-Test	2.80	0.22	13	0.06	2.40	3.10	-0.21	-0.78
Difference	**0.70**	**0.47**	**13**	**0.13**	**-0.20**	**1.60**	**0.10**	**-0.19**
$51,000 to $60,000								
Pre-Test	2.24	0.46	17	0.11	1.50	3.00	0.18	-1.12
Post-Test	2.85	0.37	17	0.09	1.70	3.20	-1.93	3.90
Difference	**0.61**	**0.46**	**17**	**0.11**	**-0.10**	**1.30**	**0.05**	**-1.28**
Over $60,000								
Pre-Test	1.95	0.49	66	0.06	1.00	3.30	0.47	0.16
Post-Test	2.82	0.21	66	0.03	2.20	3.20	-0.37	-0.20
Difference	**0.87**	**0.48**	**66**	**0.06**	**-0.60**	**2.00**	**-0.37**	**0.49**

Table 7

Descriptive Statistics Summary Table: Attitudes Toward Seeking Professional Psychological Help Scale (Pre-Test; Post-Test; and Difference Score) by Perceived Mental Health Status

Variable	*M*	*SD*	*n*	SE_M	Min	Max	Skew	Kurtosis
Excellent								
Pre-Test	2.06	0.42	22	0.09	1.30	3.00	0.50	-0.07
Post-Test	2.80	0.34	22	0.07	1.70	3.20	-1.72	3.06
Difference	**0.73**	**0.49**	**22**	**0.10**	**-0.10**	**1.80**	**0.10**	**-0.50**
Good								
Pre-Test	2.04	0.50	81	0.06	1.00	3.30	0.22	-0.31
Post-Test	2.83	0.21	81	0.02	2.30	3.20	-0.10	-0.61
Difference	**0.79**	**0.46**	**81**	**0.05**	**-0.60**	**1.70**	**-0.48**	**0.15**
Fair								
Pre-Test	1.94	0.55	14	0.15	1.10	3.00	0.31	-0.92
Post-Test	2.74	0.21	14	0.06	2.50	3.10	0.65	-0.90
Difference	**0.81**	**0.59**	**14**	**0.16**	**-0.20**	**2.00**	**0.14**	**-0.53**

Internal Reliability

The internal reliability of participants' responses to survey items represented on the study's research instrument, the Attitudes Toward Seeking Professional Psychological Help Scale, were evaluated using Cronbach's alpha. As a result, the internal reliability achieved through data produced using the study's research instrument was considered adequate.

Table 8

Internal Reliability Summary Table: Attitudes Toward Seeking Professional Psychological Help

Scale	# of Items	α	Lower Bound	Upper Bound
Attitudes	20	.74	.69	.80

Note. The lower and upper bounds of Cronbach's α were calculated using a 95.00% confidence interval.

Discussion

Research Question

Will an educational intervention combining religion and mental health (cognitive behavioral therapy) improve mental health seeking attitudes and behaviors in African American women?

One overarching research question was stated at the outset of the study to guide the study's purpose. Descriptive and inferential statistical techniques were used to analyze data associated with the study's overarching research question. The threshold level for findings in the overarching research question to be considered as statistically significant was established at $p < .05$.

The *t* test of Dependent Means was used to assess the statistical significance of mean score difference from the pre-test to post-test phases of the study in the wake of the implementation of the intervention variable of cognitive/behavioral therapy. The assumption of data normality associated with the use of the *t* test of Dependent Means was addressed through inspection of the skew and kurtosis of the mean difference score from the pre-test to post-test phases of the study. As a result, the skew value of -0.25 and kurtosis value of -0.08 were within the parameters for data normality using skew and kurtosis values and thereby satisfying of the assumption of data normality.

The mean score difference of 0.78 from the pre-test to post-test phases of the study was statistically significant ($t_{(116)} = 17.65$ $p < .001$). The magnitude of effect for the mean score difference from the pre-test to post-test phases of the study in the wake of the intervention variable was considered very large at $d = 1.63$.

Table 9

Summary Table: Evaluating the Statistical Significance and Magnitude of Effect of the Study's Intervention Variable of Religiously Cognitive Behavioral Therapy

Post-Test		Pre-Test				
M	*SD*	*M*	*SD*	*t*	*p*	*d*
2.81	0.24	2.03	0.49	17.65	< .001	1.63

Note. N = 117. Degrees of Freedom for the *t*-statistic = 116. *d* represents Cohen's *d*.

Limitations of the Study

This project was completed within a limited time frame of one 2 hour session with African American women within a religious setting in the Southeast region of the U. S. In order to gain a more extensive analysis of the intervention within a larger population of participants, it would be beneficial to have at least two or more sessions with African American women of various age groups from different regions of the U.S within various settings (religious, clinical, and/or community).

Recommendations for Future Research

Feedback from the educational mental health session and data analysis results will be used to make necessary revisions to the mental health intervention, and assist in the development of an SBW schema mental health resource toolkit for African American women. Future SBWS and mental health seeking behaviors research should focus on age specific criteria for mental health interventions that strategically target various age groups in African American women.

Conclusion

The overall outcome of the research study supports the efficacy of combining mental health and religion to address the mental health of African American women. The SBW ideology poses as a blessing in resiliency for Black women, and also serves as a burden for their mental stability. African American women have required religious and medical sectors to integrate a multidisciplinary approach when addressing mental health (Koenig et al., 2016). A religiously cognitive behavioral therapy intervention that is multi-focused, multi-purposed, and multi-generational addresses the unique and diverse mental health needs of African American women by enhancing the knowledge of the SBWS and facilitating mental health seeking attitudes and behaviors. Currently, ministry and medicine must holistically and therapeutically care for the

whole person- mind, body, spirit, and soul. This therapeutic approach refuses to compartmentalize African American women, but seeks to view and treat the whole person while bridging the gaps caused by racial and gendered disparities within America's current mental health crisis.

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