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The Impact of the “Strong Black Woman” Schema, Stigma, and Discrimination on
Professional Mental Health Help-Seeking Intentions Among Modern-Day Black Women

by

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ABSTRACT

Title of Dissertation: The Impact of the “Strong Black Woman” Schema, Stigma, and Discrimination on Professional Mental Health Help-Seeking Intentions Among Modern-Day Black Women

Katrina D. Powell, M.A., M.S., 2020

Thesis directed by: Tracy Sbrocco, Ph.D., Professor, Department of Medical and Clinical Psychology

The purpose of this study was threefold: 1) examine the type and level of distress experienced by Black women; 2) investigate the impact of socio-cultural factors, such as the Strong Black Woman (SBW) Schema, stigma, and discrimination on help-seeking intentions among Black women of higher SES (Modern-Day Black Women [MDBW]) using an extended Theory of Planned Behavior (TPB) model; and 3) explore MDBW’s attitudes, beliefs, and potential barriers to help-seeking. The study included a sample of 111 Black women and utilized a mixed method approach to investigate these culturally related variables toward help-seeking intentions. Linear regressions revealed that higher income was associated with lower levels of psychological distress ($p = .01$). An independent samples T-test also showed that there was a significant difference in type of distress between low- and high-income Black women ($p = .01$). Help-seeking intentions were assessed by applying and extending the TPB, a well-established model that has been adapted to predict a range of physical and mental health help-seeking behaviors.

Regression analyses revealed the TPB model was associated with intentions to seek mental health care ($p < .001$). Findings partially supported the hypotheses that socio-cultural factors (SBW schema, stigma, discrimination) and SES were associated with less help-seeking intentions. Specifically, stigma was the only factor to yield a significant negative association with help-seeking ($p < .001$), such that as stigma increased, help-seeking intention decreased. Qualitative analyses revealed that overall, MDBW viewed those who sought mental health care positively, believed Blacks with higher education were more likely to seek mental health care, and reported that experiences with racial and sexist discrimination in academic and work environments have impacted their psychological well-being. Further, MDBW expressed the need for cultural competence (education, research, resources, more Black female psychologists) to improve Black women's mental health. Differences among income, social status and identified barriers to help-seeking intentions highlight the need for further research, education, training, and targeted psychological care within and for this understudied population.

TABLE OF CONTENTS

LIST OF TABLES	x
LIST OF FIGURES	xi
CHAPTER 1: Introduction	1
OVERVIEW	1
Mental Health Disparities and Service Utilization Among Black Women	2
Prevalence	2
Help-Seeking Intentions and Service Utilization	2
Modern-Day Black Women	5
Factors Impacting Help-Seeking Intentions in MDBW	6
Psychological Consequences of SBW Schema, Stigma, and Discrimination	7
Summary	8
Applying Theory Of Planned Behavior To Mental Health Help-Seeking and Service Utilization among Modern Day Black Women	8
The Theory Of Planned Behavior	8
Attitudes	10
Attitudes Toward Mental Health Help-Seeking	11
The Strong Black Woman Schema	12
Strong Black Woman Schema among MDBW	13
Subjective Norms	14
Subjective Norms Regarding Help-Seeking	15
Mental Health Stigma	16
Perceived Behavioral Control	18
Perceived Behavioral Control and Help-Seeking	18
Discrimination	19
Discrimination among MDBW	20
Locations of Discrimination: Workplace and Academic Institutions	21
Current Study And Model	22
Specific Aims and Hypotheses	23
CHAPTER 2: Methods	26
Study Design	26
Recruitment	26
Inclusion and Exclusion Criteria	27
Measures	28
Qualitative Data	35
Data Analytic Plan	36
Quantitative Analyses	36
Qualitative Analyses	37
Power Analysis	38
CHAPTER 3: Results	39
Demographics and Self-Report Measures	39
Social Status: <i>The MacArthur Scale of Subjective Social Status</i>	41
Distress Measurement: <i>Hassles and Uplifts Scale (HUS)</i>	43
The Strong Black Woman Schema: <i>Strong Black Woman Cultural Construct Scale (SBWCCS)</i>	43
Public Stigma: <i>Stigma Scale for Receiving Psychological Help (SSRPH)</i>	44
Self-Stigma: <i>Self-Stigma of Seeking Help Scale (SSOSH)</i>	44
Racist Discrimination: <i>Schedule of Racist Events (SRE)</i>	44

Sexist Discrimination: <i>Schedule of Sexist Events (SSE)</i>	45
Help-Seeking Intentions: <i>Predicting Mental Health Service Utilization Scale (PMHSUS)</i>	46
Results for Primary Analyses	47
Hypothesis 1a: The Association of Income, Education, and Social Status on Psychological Distress	47
Hypothesis 1b. Types of stressors by income.	49
Aim 2: Extended Theory of Planned Behavior	50
Hypothesis 2a: SBW Schema as a measure of Attitudes and help-seeking intentions.....	51
Hypothesis 2b: Stigma as a measure of Subjective Norms and help-seeking intentions.....	51
Hypothesis 2c: Discrimination as a Measure of Perceived Behavioral Control and Help- seeking.....	52
Hypothesis 2d: TPB expanded model	53
Aim 3: Help-seeking Themes	53
CHAPTER 4:	59
Overview and Summary of Study Findings	59
Understanding Help-Seeking Intentions	62
Implications	68
APPENDICES	73
Appendix A. Recruitment and Informed Consent	73
Recruitment Flyer	73
Email Example	74
Consent Form	75
Appendix B. Self-Report Measures	77
MacArthur Scale of Subjective Social Status (3; 43)	81
Hassles and Uplifts Scale (36).....	83
Strong Black Woman Cultural Construct Scale (SBWCCS) (49).....	86
Stigma Scale for Receiving Psychological Help (63)	89
Self-Stigma of Seeking Help Scale (113)	90
Schedule of Racist Events (64)	92
Schedule of Sexist Events (62).....	97
Predicting Mental Health Service Utilization Scale (PMHSUS)	101
Appendix C. Qualitative Questions	103
Appendix D. Additional Study Results	104
REFERENCES	105

LIST OF TABLES

Table 1. Demographic Information..... 40

Table 2. Self-Report Measures 42

Table 3. Mean Hassles and Uplifts by Group 49

Table 4. Matrix of Correlation Coefficients for Demographics 104

Table 5. Matrix of Correlation Coefficients for Measures 104

LIST OF FIGURES

Figure 1. Theory of Planned Behavior (4; 5).....	9
Figure 2. Theory of Planned Behavior Extended Model. Socio-cultural Factors in Mental Health Help-Seeking Among MDBW.....	10
Figure 3. Help-Seeking Intentions Measures.....	29

CHAPTER 1: Introduction

OVERVIEW

The gaps in mental health treatment disparities among racial/ethnic minority groups are well documented and have been identified as a high priority by the Institutes of Medicine and National Institutes of Health (33; 96; 99). There have been several initiatives designed to increase national attention to this issue (25; 53; 95). Research assessing psychological distress, help-seeking, and mental healthcare for women of African descent (e.g., African American (AA)/Black, African, Caribbean, Interracial) have been at the center of these mental health disparity initiatives(37; 81; 106). The majority of research has examined women of lower socioeconomic status (SES) by exploring external factors, including insufficient access to psychological care (e.g., geographical location, transportation) and financial barriers (e.g., insurance coverage) (7; 20). Barriers to help-seeking among Black women of higher SES whose financial resources and access to care, referenced as modern-day Black women (MDBW), have been less examined.

Although modern-day Black women represent a subgroup of Black females who have financial resources and access to care, differences in help-seeking behaviors may remain. Internal barriers and culture specific challenges, such as pressure to exude strength, known as the Strong Black Woman [SBW] schema, stigma associated with care seeking, and discrimination may contribute to dampening formal help-seeking (23; 99; 124). Expanding on an existing model of help-seeking behaviors, the Theory of Planned Behavior, may assist in understanding how culture-specific factors may prevent help-seeking behaviors among Modern-Day Black Women (11; 18; 27; 47; 51; 65; 71; 72; 74;

75; 93; 123). A review of mental health disparities among Black women and an expansion of the Theory of Planned Behavior, which includes culturally specific elements for to understand help-seeking behaviors among Modern-Day Black Women, are included below.

MENTAL HEALTH DISPARITIES AND SERVICE UTILIZATION AMONG BLACK WOMEN

Prevalence

Approximately 20% of Black/AA adults are diagnosed with a mental illness (30; 77). Prevalence of psychopathology, including depression, anxiety, and psychological distress may be particularly high among Black women (55; 78; 115). Hudson and colleagues (55) found that, compared to Black men, Black women reported a significantly higher 12-month and lifetime prevalence of depression. Williams and colleagues (126) used data from the National Survey of American Life and found that Black women had almost two times the rate of lifetime prevalence of depression compared to Black men (13.1% versus 7%). Black women also have higher levels of depression and are more likely to endorse sadness, hopelessness, and worthlessness, compared to White women (31). These data suggest that Black women may be more susceptible to psychological distress and mental health disorders than their White and male counterparts.

Help-Seeking Intentions and Service Utilization

Seeking and utilizing professional services, including psychotherapy or psychopharmacology, are important in addressing major mental health concerns among Black women. Help-seeking intentions refers to an individual's willingness to pursue

professional treatment when distressed and include one's perception of usability and worth of services. For purposes of this study, the term "professional" is used to identify treatment or services from the following: psychiatrist, mental health nurse, social worker, psychologist, therapist. Nonprofessional or informal help refers to seeking the assistance of a friend, family member, acquaintance (hairstylist, coworker) or clergy (with no formal training in a medical profession). 'Professional' and 'formal' are used interchangeably throughout the document.

Research assessing help-seeking intentions discrepancies between Black and White women has suggested that differences between these two groups may be related to historical, social, and ecological factors (85; 115-117). In Okeke's discussion, the author describes (85) a history of medical mistreatment, such as the Tuskegee Syphilis Study and other medical experimentations, and lack of cultural sensitivity from healthcare professionals, inaccessibility to healthcare (i.e., insurance) as contributing factors to treatment seeking disparities among Black women. There have been similar findings in other qualitative studies (115-117). For example, in their study among 15 Black women, Ward and colleagues (115) found that women identified more individual-level barriers (e.g., lack of awareness about mental illness, knowledge of services, and cultural perception such as "Strong woman syndrome") than systemic-level barriers (e.g., poor quality of care, culturally incompetent clinicians, facilities not located within Black communities) when seeking mental health services. Moreover, Black women's overlapping experiences of racial and gender discrimination, commonly referred to as intersectionality, may influence behaviors, beliefs, and attitudes that could potentially

create and exacerbate mental health disparities (38; 95), further preventing treatment seeking.

Mental health service utilization refers to using services within the healthcare system to address one's mental healthcare needs. Rates of mental health service utilization among Black women relative to other groups are mixed. At least one report suggests that rates of service utilization are not significantly different compared to White women (94) while most others show lower rates of service utilization compared to their White counterparts (77). Black women have been found to have higher rates of mental health service utilization compared to Black males (33; 79), but lower rates compared to White women (19; 77; 87). One study found that while more White women utilized medical providers for mental health services (mood, 40.9% vs 13.4%; anxiety, 24.4% vs 8.2%; psychiatric comorbidity, 35.5% vs 13.3%), rates of outpatient mental health service utilization did not differ significantly (94). By contrast, in a report from the National Institute of Mental Health (NIMH) from 2008- 2012, the number of adult Black women who utilized professional psychological services was less than half (10.3%) the percentage of White women who utilized these services (21.5%)(77).

Taken together, evidence suggests that disparities in mental health conditions, help-seeking intentions, and service utilizations exist among Black women relative to their counterparts. However, no data exists on the prevalence of mental health conditions, help-seeking intentions, or service utilization among Modern-Day Black Women, a subset of Black women who may be particularly vulnerable to mental health challenges and limited help-seeking intentions and service utilization despite their higher education and economic status. For purposes of this study, service utilization is discussed, but only

to provide context and background about the disparate rates of pursuing psychological care within this community.

Modern-Day Black Women

Although research exploring mental health among Black women has steadily increased over the past ten years, most studies have focused on Black women in general, Black women of lower SES, or college aged Black women (26; 48; 89; 115). There are no studies examining the role, experiences, and challenges specific to Black women of higher SES. For the purposes of this project, these women are defined as Modern-Day Black Women (MDBW) and include women of African descent who: (1) have obtained at least one advanced degree (Bachelor's or higher) from an institution of higher education; and (2) have a household income equal to or exceeding the U.S. median household income of \$56,516 (91). Thus, MDBW may often financially support family members and friends due to higher income, are likely to manage academic and career demands due to attaining more advanced education, and are likely to be immersed in predominantly white environments, which often provide more access to higher living standards and social positions(15; 122). These factors may serve as chronic stressors that are unique to MDBW compared to Black women in other subgroups. Although the majority of the literature related to help-seeking intentions focuses on financial capability, the unique demands MDBW experience highlight the importance of going beyond financial access to identify unique stressors and experiences within this population. As previously noted, there are no studies examining mental conditions, help-seeking intentions, or service utilization among MDBW. Given the paucity of data in this

area, the following review attempts to examine factors impacting help-seeking intention that may be applied to an understanding of MDBW specifically.

Factors Impacting Help-Seeking Intentions in MDBW

There are several internal and cultural factors that may further impact MDBW's help-seeking intentions: (1) endorsing the Strong Black Woman Schema; (2) stigma; and (3) racial and sexist discrimination. MDBW may endorse the Strong Black Woman (SBW) schema. For consistency, the Strong Black Woman (SBW) Schema is used to denote other commonly used terms such as the Sojourner Syndrome, Strong Black Womanhood, Strong Black Woman Stereotype, and the Strong Black Woman Archetype, which are all used in research assessing strength among Black women. A SBW is defined as a female of African descent who embodies characteristics such as “strength, self-reliance, and self-silence,” as well as faithfulness, generosity, hard work, selflessness, and a caring spirit(15; 16; 37; 39; 119). The SBW schema is one manifestation of a phenomenon known as “Black tax,” which refers to the additional pressures and expectations placed on Black individuals to accomplish daily activities in White environments (16), as well as within Black communities (53). Based upon the literature, women who hold SBW schemas are expected by others and themselves to be mentally, emotionally, and physically resilient (15; 37; 128), which may diminish intentions to seek mental health care. There are several mental and physical consequences of endorsing the SBW schema (16). The following section reviews the psychological consequences of the SBW schema and may provide insight into cultural norms that could negatively impact treatment seeking that have been largely neglected in the scientific literature.

Psychological Consequences of SBW Schema, Stigma, and Discrimination

The SBW Schema, stigma, and discrimination may all contribute to decreased help-seeking. The SBW schema has received increased attention in the literature due to the mental and physical health disparities experienced by Black women (16).

Endorsement of the SBW schema has been associated with psychological distress, anxiety, and depression, as well as several physical health outcomes, including cardiovascular disease, hypertension, and obesity (2; 118; 120; 122). The SBW schema has been linked to women endorsing self-sacrifice (“please the masses”), emotional suppression (“game face”), and postponement of self-care (“last on the list”), which has been shown to evoke internal distress and lead to negative health consequences (16). The association of endorsement of the SBW Schema on these negative health outcomes should be further assessed among Black women from different economic groups, specifically those of higher SES.

Additionally, stigma has been found to be a significant deterrent to help-seeking within the Black community (67). Both public and self-stigma have negative impacts on Blacks seeking and pursuing professional mental health services (14; 21; 38), as well as discontinuing services (7; 83). The resulting psychological consequences include lowered self-esteem, untreated depression, and anxiety (7; 83). Endorsement of public and self-stigma may deter Black women from disclosing mental illnesses, for fear of being deemed “crazy” or “weak”.

Lastly, discrimination against Black women may impact mental health help-seeking. Specifically, Black women’s “double minority” status places them at increased risk of potentially developing psychological stress or disorders (48). Psychological

impacts, such as higher levels of anxiety, hypervigilance, and heightened emotional distress have been found to be associated with discriminatory experiences among this population (28; 101; 127; 130). Further exploration should be given to Black women of higher SES who are immersed in work and social environments, who may face immense pressure and be expected to “defy the odds”, “be in control” and “prove their worth” among non-minority peers.

Summary

To date, there are no studies examining help-seeking intentions among MDBW. MDBW may be particularly vulnerable to difficulties in help-seeking due to their higher SES. Prior research assessing help-seeking intentions and service utilization among Black women has been limited to exploring access to care (i.e., financial and logistical) among Black women of lower SES. Thus, this understudied group’s help-seeking intentions are in need of further exploration.

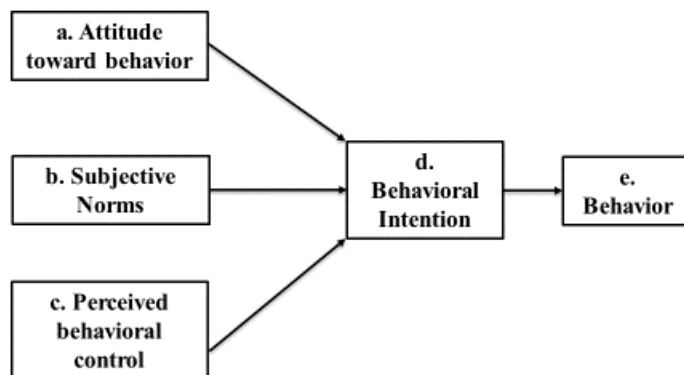
The Theory of Planned Behavior, a model that has been used to predict help-seeking behaviors for a variety of health issues, can be expanded to assess the impact of cultural factors on intention to engage in professional mental health help-seeking. Below, the TPB constructs used for this study are described, with an emphasis on using the TPB framework to examine help-seeking among MDBW. Next, the culturally specific variables (SBW schema, stigma, and discrimination) that may be associated with help-seeking among Black women will be reviewed and incorporated into the existing TPB.

APPLYING THEORY OF PLANNED BEHAVIOR TO MENTAL HEALTH HELP-SEEKING AND SERVICE UTILIZATION AMONG MODERN DAY BLACK WOMEN

The Theory Of Planned Behavior

The Theory of Planned Behavior (TPB), proposed by Ajzen as an extension of the Theory of Reasoned Action (41), is depicted in Figure 1. As shown in Figure 1, one's behavioral intention predicts their behavior (4; 6; 75). Intentions are conceptualized as influenced by three socio-cognitive components: attitudes toward a given behavior; social pressures or subjective norms surrounding the behavior; and perceived behavioral control (4; 18; 66; 92). The theory has been applied to understand and predict a wide range of behaviors including alcohol use, condom use, physical activity, and other health-related conditions (11; 27; 34; 47; 51; 69; 71; 93). Despite the large body of work that utilizes the TPB to explain help-seeking intentions and behaviors within physical health research, no studies have applied the theory to explain help-seeking intentions among MDBW. Further, to date, no study has extended the TPB and utilized culture-specific factors that may be inform help-seeking intentions among MDBW.

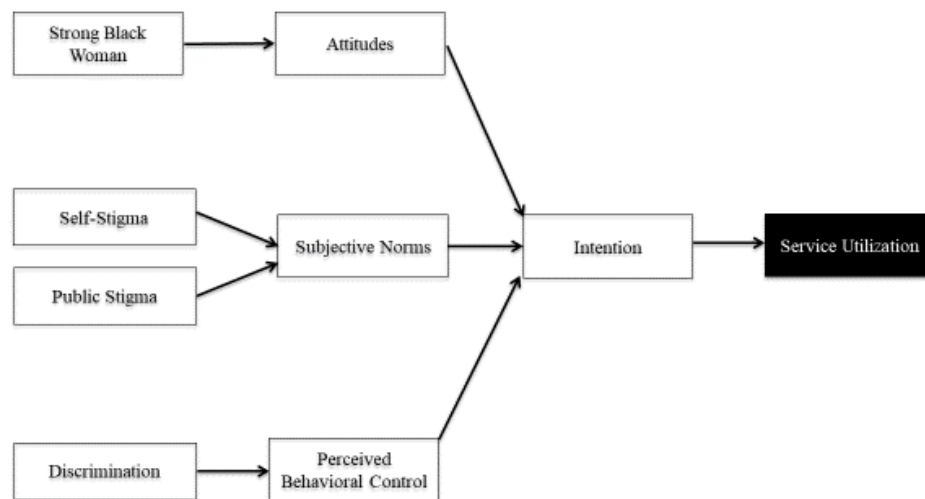
Figure 1. Theory of Planned Behavior (4; 5)



The present study sought to expand the TPB model to understand MDBW's mental health help-seeking intentions (intentions) and service utilization (behaviors) by

incorporating unique culture-specific stressors that may contribute to poor psychological well-being in this group. A culturally tailored TPB is presented in Figure 2. Three culturally tailored constructs; SBW Schema, stigma, and discrimination operationalize attitudes, subjective norms, and perceived behavioral control, respectively.

Figure 2. Theory of Planned Behavior Extended Model. Socio-cultural Factors in Mental Health Help-Seeking Among MDBW.



Attitudes

According to the TPB, attitudes about behaviors are associated with intentions to perform the specific behavior (4). Attitude refers to an individual's evaluation of the behavior (104). According to the theory, one's appraisal (e.g., favorable or unfavorable; positive or negative) of the behavioral outcome, as well as the value attached to the outcome contributes to the intent of the behavior (4; 5; 61; 72; 104). If one perceives the outcome to be positive, there will be a greater intention to engage in the behavior. In contrast, if the individual perceives the outcome to be negative, the intentions to engage in the behavior will decrease(104). Deeply engrained attitudes toward help-seeking

within the Black community, as well as common beliefs and stereotypes within predominately White communities may significantly influence one's intention to seek professional psychological care. The impact of attitudes on help-seeking within both Black and White communities will be discussed, followed by an explanation of the SBW Schema as a culture specific factor to further understand influences in help-seeking among MDBW.

Attitudes Toward Mental Health Help-Seeking

As a whole, Blacks generally report negative attitudes toward seeking and engaging in psychological care, with cultural mistrust labeled as one of the strongest contributors (84; 103; 115; 124). In her comprehensive review of literature assessing treatment seeking disparities between Blacks and Whites, Buser (23) identified several racial disparities that have been shown to contribute to negative attitudes toward psychological treatment. Negative attitudes include disparate mental health care practices, diagnostic differences, over diagnosis and under diagnosis of particular psychological disorders (e.g., schizophrenia) by primary care physicians, and discrepant prescription rates of psychotropic medications (e.g., Blacks being less likely to receive current medications compared to Whites). Research has also shown that Blacks hold negative attitudes toward mental illness and toward those with mental illnesses (116; 117). Within the Black community, mental illness is often perceived as a weakness and this attitude is frequently accompanied by feelings of embarrassment and shame (108). Masuda, Anderson, and Edmonds (67) assessed help-seeking attitudes, mental health stigma, and self-concealment (i.e., withholding distressing and potentially embarrassing personal information from others) among 163 Black college students. They found that

self-concealment and mental health stigma were both negatively associated with attitudes toward help-seeking. Thus, the more self-concealment and mental health stigma experienced by these students, the less favorable help-seeking attitudes (67). Although Black's beliefs toward mental illness and treatment are well known, MDBW's experiences and attitudes are less known. MDBW's attitudes may differ from Black men, especially if they endorse the SBW schema (2; 12; 15; 37; 39; 46; 49; 80; 107; 118; 119; 122).

The Strong Black Woman Schema

As previously noted, the SBW schema, a race-gender schema, is hypothesized to deter help-seeking among Black women. There is a wealth of research that has assessed the concept of the SBW schema in Black women (12; 15; 16; 37; 39; 49; 80; 119; 128). While some data suggests that this schema is beneficial to maintaining Black culture and provides a positive self-image among its members, research has primarily identified the negative impacts it has on Black women's overall well-being (15; 37; 39; 119; 128). Evidence demonstrates that negative implications associated with the SBW schema include depression, anxiety, relationship strain, higher levels of stress, overeating, obesity, excessive drinking, and suicide (15; 37; 128). For instance, Donovan and West (37) found, that endorsement of moderate and high levels of the SBW schema among AA/Black college women was associated with increased depressive symptoms and stress. Another study by West et al. (122) found that over half of the Black female participants who endorsed the image of the SBW experienced a negative impact on their mental health. For example, one participant indicated that "living up to the image" and "...cop[ing] with a lot of traumatizing things" (p.402) was often difficult and one of the

negative aspects of endorsing the SBW image. A recent quantitative study (118) examining the association between the SBW schema, perceived social support, and psychological distress in 158 Black women (ages 18-59) found that those who endorsed higher levels of the SBW schema, perceived less emotional support (from family and friends) and had greater psychological distress. These studies (118; 122) suggest a relationship between the SBW schema and poorer mental well-being among women of African descent. Additional research investigating the association between the SBW schema and mental health outcomes in MDBW is needed.

Strong Black Woman Schema among MDBW

Although the SBW schema is a phenomenon that can impact Black women from varying SES, MDBW may be particularly vulnerable to endorsing higher levels of the schema. Particularly, MDBW may perceive overcoming a number of obstacles throughout their lifetime (e.g., first generation college student), experience and help solve emotional problems daily, may not be able to emotionally rely on others, experience difficulty showing vulnerability or feel comfortable doing so. Further, MDBW may perceive distress as a part of “making it” and problems as “working itself out naturally”, thereby holding themselves to a higher standard and thus contributing to these women not wanting to seek professional care when emotionally distressed.

Preliminary research suggests that endorsement of the SBW schema may vary depending on Black women’s educational background, social status and environment (119). In earlier work, Watson and Hunter (119), qualitatively analyzed positive and negative experiences of internalizing the SBW schema among 13 Black women from both college and community populations. Black women enrolled in college (53% of the

sample) utilized the SBW schema in response to academic stressors whereas women not enrolled in college enacted the SBW schema in response to financial and caretaking stressors. While previous findings provide an initial understanding of positive and negative aspects of endorsing the SBW schema, there is a paucity of literature on the impact of these schemas on MDBW. Evaluating a group of women who are educated, are within the middle to upper socioeconomic class, and have obtained a higher level of social status could potentially garner different perspectives on the SBW schema and mental health help-seeking intentions. Therefore, one aim of this project was to assess the relationship between the SBW schema and psychological care seeking among MDBW, as well as the utility of the SBW schema on help-seeking intentions.

As previously noted, additional factors, including social pressures and one's beliefs about how others (e.g., friends, family members) perceive the behavior may also impact an individual's willingness to engage in a particular behavior. Therefore, though influential, the SBW schema, individually, may not explain mental health help-seeking intentions among MDBW. Investigating the construct of subjective norms is important in understanding behavioral intentions to pursue psychological care within this population.

Subjective Norms

Subjective Norms, which refers to the degree of perceived social pressure an individual feel to engage in a particular behavior (13; 72) is the second construct described in the TPB. Others' approval or disapproval of the behavior and one's motivation to engage in behaviors that are important to others may impact norms (5). Thus, societal and environmental influences significantly affect one's intentions to engage in a specific behavior (14; 21; 32). Implications of subjective norms on help-

seeking within the Black community are described, followed by a discussion of the construct, stigma, and its utility in helping to predict treatment seeking intentions in MDBW.

Subjective Norms Regarding Help-Seeking

Subjective norms, such as societal and environmental factors (i.e., stigma), may significantly influence intentions to seek help among Blacks. The strong sense of community, kinship bonds, and connectedness highly regarded in the Black community (50; 78) may influence help-seeking patterns. As such, Black's decision to pursue care may depend upon family and friend's attitudes and beliefs toward help-seeking. For instance, one study found that greater subjective closeness to family and friends were significantly associated with help-seeking among minority and non-Hispanic White women (130). These data suggest that informal resources (i.e., family, friends) play a significant role in intentions to seek help and may be used as an alternative for providing mental health care among Black women compared to professional services.

Woods (129) found that Black females who believed treatment seeking was acceptable to individuals who they perceived as important (e.g., family, friends), had more intentions of seeking therapy for depressive symptoms. While research has shown that Black women's decision to seek help are significantly associated with the beliefs and opinions of family, friends, and important community members, less is known about the degree of influence of subjective norms regarding help-seeking among MDBW. Due to differences in MDBW's social settings (i.e., predominantly white environments), the influence of subjective norms, such as stigma, may vary compared to women from lower SES.

Mental Health Stigma

Stigma is a type of subjective norm that influences attitudes toward help-seeking intentions (72; 115). Stigma is defined as a phenomenon in which an individual with a certain attribute is discredited by his/her society and is rejected as a result of the attribute (44). According to DeFreitas and colleagues (35), mental health stigma occurs when an individual possesses negative thoughts and beliefs about others with psychological illnesses or those pursuing psychological treatment. These negative thoughts and beliefs about mental illness may deter ethnic minorities from seeking care (32). Within the Black community, stigma has been identified as the most significant barrier in professional mental health care seeking (67). In a qualitative study using focus groups, Doornbos and colleagues (38), identified stigma as the first psychosocial barrier in accessing mental health services among Black, Hispanic, and White women. One participant stated that talking about mental health (i.e., depression and anxiety) would lead others to “[think]ing we are crazy” (p.282). Another participant voiced feeling ashamed and having others “make fun of them” (p.282) for seeking psychological services (38). Inconsistent with previous studies, Ward and Heidrich (116) found that 83% of women indicated feeling comfortable talking to a mental health professional and 60% reported not being embarrassed when communicating their help-seeking behaviors to friends. In other words, in this study, perceived stigma did not influence Black women’s willingness to seek professional care. However, only two questions were used to measure their perceived stigma toward treatment seeking. It is important to examine stigma and help-seeking intentions among Black women from differing backgrounds through more reliable and valid measurements.

Public stigma and Self-stigma

There are two types of stigma; public and self-stigma. Research indicates that public stigma and self-stigma may have a negative impact on the utilization of mental health treatment(14; 21; 38). Public stigma refers to attitudes, negative beliefs, and thoughts pertaining to mental disorders held by the general population (14; 21). Self-stigma refers to an individual's acceptance of prejudiced beliefs about oneself, consequently contributing to one's lowered self-esteem and self-efficacy (109). Brown et al. (21) found while public stigma was not significantly associated with mental health utilization attitudes among Blacks, internalized stigma was negatively correlated to help-seeking behaviors. Further, self-stigmatizing beliefs have been shown to hinder Black women's willingness to continue therapy. Several studies have supported these findings (7; 83). Oakley and colleagues (83) examined self-stigmatizing beliefs in low-income Black, White and Latina women. Consistent with findings from previous research, women from all three ethnic backgrounds reported higher stigma scores surrounding endorsing mental health concerns: nearly 40% of women would not disclose their depression with someone else; 55% indicated they would disclose this information to a best friend, parent (47%), or spouse/partner (43%); and over two thirds (80%) indicated they would not disclose this information to a healthcare professional (83). Although women of all ethnicities experience significant levels of stigma toward help-seeking, the study only assessed beliefs in low income, working women in three regions of Wisconsin. These results are not generalizable to MDBW. Expanding research to examine stigma using a more diverse population could foster further insight in barriers to help-seeking and lead to tailored suggestions for increasing access among MDBW. It is

unclear whether these findings would generalize to MDBW. Thus, this study examined how both self-stigma and public stigma may influence help-seeking intentions in MDBW.

Perceived Behavioral Control

Perceived behavioral control refers to an individual's capacity to engage in a particular behavior (72). According to the TPB, individuals who perceive that they have the ability, control, or access to resources will be more likely to pursue the behavior (5). Sense of control varies depending on the situation, level of difficulty, and if one perceives there will be a successful outcome (72). The impact of control on help-seeking within the Black community is described, followed by an exploration of daily stressors on control and help-seeking among MDBW. Perceived behavioral control is often used interchangeably with the construct "self-efficacy." For purposes of this dissertation and to follow terminology utilized within the TPB, perceived behavioral control will be used exclusively.

Perceived Behavioral Control and Help-Seeking

Evidence suggests that within the Black community, perceived behavioral control predicts health behaviors (82) and may be one of the strongest predictors of mental help-seeking intentions (72). Using the TPB model, Mesidor and Sly (72) examined help-seeking intentions among 111 international and AA college students. They found that perception of control was the strongest predictor of both international and Black college students' intentions to seek mental health care services. That is, when students perceived they had the necessary resources or abilities, they were more likely to seek psychological

services (72). These findings highlight the importance of perceived control in treatment seeking and may be applicable to other minority populations, including MDBW.

Cultural factors, such as discrimination, racism, sexism, and cultural mistrust can impact an individual's perceptions of control. Among Black women, influences such as race, gender, and social class may exacerbate feelings of powerlessness (100) and lower control, further reducing intentions to engage in help-seeking behaviors (22). Black women's experiences and responses to stressors and daily life are different from those of Black men and different from women from other racial and ethnic groups (22). Women of color, because of their gender and race, are considered "double minorities" and frequently encounter discrimination in the workplace and academic settings. This intersectionality may lead to a greater likelihood of stress and to the onset of mental health disorder (s). Moreover, frequent encounters of discrimination may contribute to feelings of lower perceived control. MDBW's experiences and how these daily encounters may contribute to psychological distress, mental illness, and impede help-seeking are discussed below.

Discrimination

The term "discrimination" refers to behavioral consequences and acts of prejudice and mistreatment of individuals of a different gender or racial background (97; 100; 109). Perceived discrimination is an important contributor to long-term stress related health disparities (125) among Black women (38). When merged with frequent experiences of racism and sexism, this can become a chronic stressor for Black women (48). Research on the effect of discrimination on help-seeking has been mixed (88; 130). In one study, using data from the National Survey of American Life, Woodward (130) investigated the

association between race, perceived discrimination, and use of professional and nonprofessional mental health services among a sample of over 1,350 AAs, black Caribbean, and non-Hispanic whites. Results yielded no significant differences between the three groups regarding experiences with discrimination and help-seeking (130). By contrast, Perry et al. (88) found that there was an indirect and direct association with experiences of racial and gender discrimination on the health and well-being in a sample of 204 low SES Black women. Women in the study reported experiencing a moderate degree of racial and gender discrimination. Women who reported higher levels of lifetime racial and gender discrimination were at increased risk for other negative life events, such as employment and financial issues. Further, several other studies have found that discriminatory experiences in minority populations were related to the following consequences: exacerbation of chronic stressors, induction of emotional distress, greater use of nonprofessional services, higher levels of anxiety, hypervigilance, and negative provider attitudes (28; 101; 127; 130). As evidenced by the literature, the intersection of race, ethnicity, and gender can result in multidimensional forms of discrimination and can increase physical and mental health vulnerabilities among minority populations. Understanding the adverse consequences of discrimination on help-seeking intentions and behaviors among MDBW are warranted in order to comprehend vulnerabilities within this understudied group.

Discrimination among MDBW

Despite their educational status, social status, and income level, MDBW may encounter experiences of discrimination, which may further hinder intentions to seek professional mental health care. Research has shown that level of success does not protect

Blacks from discrimination (97). Sellers and colleagues (97) found a negative relationship between racial discrimination and mental health among well-educated, middle-class, Black men such that as discrimination increased, treatment seeking decreased. Thus, despite education level and higher SES, these AA men still experienced racial discrimination and a decreased likelihood of seeking treatment. These findings could be related to participants not feeling comfortable seeking care due to cultural mistrust, to perceived judgment by providers, family and friends, or to previous experiences of discrimination in health care settings (38). Notably, over half of this sample held advanced degrees and a mean annual income over \$87,000 (97). Although there may be a perception that individuals of higher income are protected against discrimination, data suggests that well educated, middle-class Blacks are also vulnerable, and may not seek psychological care. While researchers did not assess discriminatory effects on help-seeking in MDBW, they may encounter similar experiences. Exploring MDBW's daily encounters of discrimination in the environments they most likely function within, the workplace and academic environment, will be critical in understanding the impact of these stressors on psychological well-being and help-seeking.

Locations of Discrimination: Workplace and Academic Institutions

Work and academic environments are areas where MDBW are most likely to encounter discrimination (98). MDBW are often the only female or persons of color within their workplace (40) or academic setting. A lack of diversity, as well as perceived discriminatory practices, such as unfair promotion and hiring processes, not being recognized for their abilities, lack of mentorship, exclusions from work groups, and

coworkers assuming they are incompetent may impact MDBW's level of stress and psychological well-being(40; 48). Experiences of prejudice can lead to several behavioral consequences (109). Durr and Wingfield (40) utilized direct observations and semi-structured interviews to explore 45 professional Black women's experiences in a predominately white work environment. Participants were employed in various capacities, including public and private organization administrators, lower level executives, middle managers, roles in state and city government, and at universities. Data showed that behavioral expectations and performance differed for Black women in the workplace (40). In one part of their study, the researchers conducted direct observations with 20 Black women, all of whom possessed an advanced academic degree, held managerial or professional positions, and were employed by predominately white organizations (40). Black women reported needing to alter their self-presentation and communication style in order to avoid being scrutinized or perceived as incompetent to effectively carry out their position (40). Black women also reported coping with feelings of alienation by engaging in etiquette and emotional labor (e.g., impression management) (40). Although the authors (40) suggest that professional Black women may conceal their true feelings and experiences to avoid scrutiny and judgment by peers, these findings may indirectly shed light on a larger issue. Specifically, that professional Black women might engage in similar behaviors to avoid seeking professional psychological care when needed. Studies investigating these differences should be given further attention.

CURRENT STUDY AND MODEL

There is currently a paucity of research examining the experiences related to mental health, help-seeking intentions, and service utilization by MDBW. Their

endorsement of the SBW schema, stigma, and perceived discrimination are internal and cultural factors that may influence help-seeking intentions and service utilization. To mitigate this important gap in the literature, the SBW schema (as a proxy for attitude), stigma (as a proxy for subjective norm), and discrimination (as a proxy for control) were used to extend the TBP model in order to understand help-seeking intentions and service utilization in MDBW.

Specific Aims and Hypotheses

The extended TBP was used to accomplish three specific aims designed to characterize the stress experienced by MDBW and understand their intentions to seek help.

Specific Aim 1. Sources of Psychological Distress and Uplifts among Black women by level of achievement. The first aim was to understand the level and types of psychological distress experienced by Black women and to examine distress and uplifts in relation to indices of achievement. Achievement was indexed by the socioeconomic indicators: income (household), education level, and subjective ratings from the MacArthur Scale of Subjective Social Status (Society, Community).

Hypothesis 1a: The amount of distress differs by level of achievement such that education and stress, income level and stress, and social status and stress are all associated.

Hypothesis 1b: Relative rankings of stressors differ based on income group (Low vs. High). Higher income Black women endorse more job-related stressors and family-related stressors, while lower income Black women endorse more financial stressors.

Specific Aim 2. Intent to Seek Mental Health Care: The Theory of Planned Behavior (TPB). The three components of the TPB (attitudes, subjective norm, and perceived behavioral control) were used to examine the relationship between cultural constructs and intentions to seek mental health care among 96 women.

Hypothesis 2a: The SBW schema (attitudes) are associated with help-seeking intentions, such that stronger endorsement of the SBW schema is negatively associated with intention to seek professional mental health care.

Hypothesis 2b: Stigma (subjective norm) is significantly associated with help-seeking intentions, such that greater stigmatization is negatively associated with intentions to seek professional mental health care.

Hypothesis 2c: Discrimination (perceived behavioral control) is significantly associated with help-seeking intentions, such that more discriminatory experiences are negatively associated with intentions to seek professional mental health care.

Hypothesis 2d: Together, the three components of the extended TPB (SBW schema, stigma, and discrimination) provide the best model for predicting intentions to seek professional mental health care.

Specific Aim 3. Help-seeking themes. Qualitative data were used to identify and explore themes pertaining to help-seeking beliefs, attitudes, and intentions among 96 MDBW. Eight open-ended questions were developed for this study and interspersed throughout the survey to gain a better understanding of MDBW's perspectives to seek and utilize mental health services. Questions focused on gathering qualitative detail

pertaining to the following cultural concepts: attitudes (SBW Schema), subjective norm (stigma), and perceived behavioral control (discrimination) with the goal to:

- 1) Identify and explore themes pertaining to help-seeking beliefs, attitudes, and intentions among MDBW
- 2) Analyze and highlight potential barriers to treatment seeking
- 3) Determine strategies and techniques to improve mental health services within this community

CHAPTER 2: Methods

STUDY DESIGN

The study used a cross-sectional mixed methods approach to examine help-seeking intentions in Black women of higher and lower achievement. The primary aims of the study were; (1) to examine the level and type of distress among higher and lower achievement Black women and (2) to apply an extended model of the TPB to predict help-seeking intentions among MDBW. These aims consisted of seven predictor variables (the SBW schema, stigma (self and public), discrimination (racist, sexist), SES, age) and two primary outcome variables (psychological distress and professional mental health help-seeking intentions). The third aim consisted of a qualitative assessment of MDBW's attitudes, beliefs, and potential barriers to help-seeking. Overall, results from all three aims were expected to identify the factors associated with help-seeking intentions for mental health concerns for MDBW.

RECRUITMENT

Data were collected through an Institutional Review Board (IRB) approved study conducted by American University. Data were obtained through a formal data use agreement between American University and the Uniformed Services University. Due to prior IRB approval from American University, the Uniformed Services University did not require an IRB review. Participants were part of a convenience sample of 171 Black women, between ages 22 and 66 years recruited online and face to face to participate in a study examining barriers to mental health help-seeking at American University through a snowball sampling technique. The snowball sampling strategy has been utilized to assess

and recruit hard to reach populations (91). Electronic announcements were posted on websites and emailed to listservs of professional organizations detailing the purpose of the study, as well as providing a website link to Survey Monkey questionnaires. In-person recruiting strategies (flyers/in professional meetings) were also used to recruit potential participants. Professional emails were sent requesting permission for flyers to be posted at community churches, within professional organization buildings, and other local facilities (e.g., fitness clubs). See **Appendix A** for email example and for flyer verbiage used at American University to collect data.

Inclusion and Exclusion Criteria

Each survey response was electronically screened to determine if potential participants met the following inclusion criteria:

- 1) Female
- 2) Self-identified as Black or African American, Black Caribbean, Biracial (one parent of African descent), African, Black Hispanic
- 3) 22 to 66 years of age at beginning of study
- 4) Internet access
- 5) Fluent in English language.

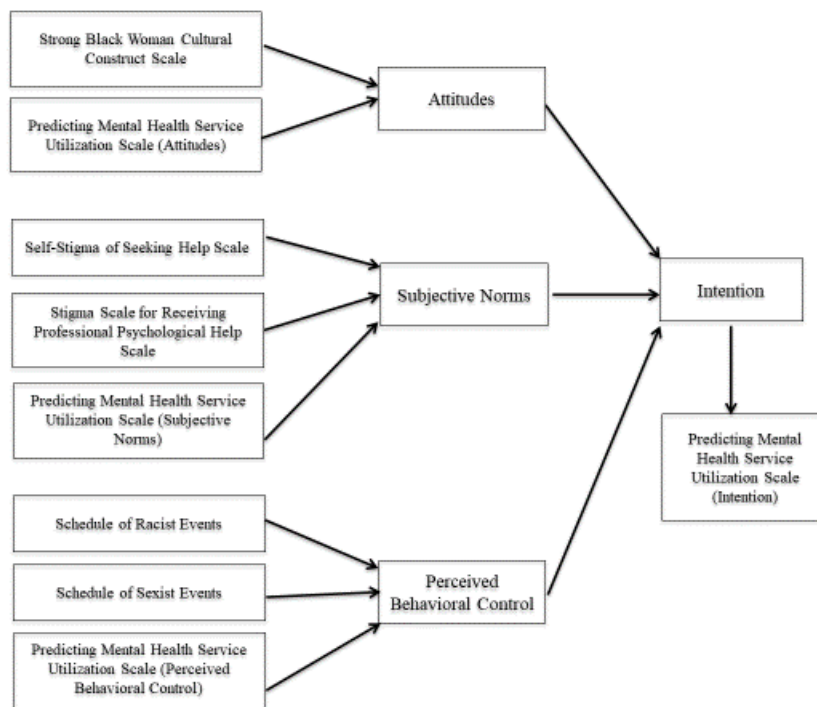
Upon completion of all study questionnaires, participants were redirected to an information page containing a link providing contact information of licensed mental health services in the participants' residential area (i.e., business phone and email address, specialty area). They were also given an option to provide their contact information (i.e., email address) to receive study findings. Lastly,

participants were given the opportunity to enter a drawing to win one of two \$100 Target gift cards. To enter the drawing, participants were asked to provide their email addresses, which were not connected to the participants' questionnaire. Ninety-seven (72%) participants selected to enter the drawing. Participants were not be penalized in any way for choosing not to enter the drawing.

MEASURES

Six measures were presented in a standard order using the Survey Monkey online platform. All measures are provided in **Appendix B. Figure 3** below depicts a summary of the measures utilized to examine the key constructs in the TBP. Attitudes were measured using the Strong Black Woman Cultural Construct Scale (SBWCCS) (49) and two questions from the Predicting Mental Health Service Utilization Scale (PMHSUS), created for this study. Subjective norms were measured using the Self-Stigma of Seeking Help Scale (SSOSH) (113), Stigma Scale for Receiving Professional Psychological Help (SSRPH) (63), and two questions from the PMHSUS. Perceived Behavioral Control was measured using the Schedule of Racist Events (SRE) (64), Schedule of Sexist Events (SSE)(62), and two questions from the PMHSUS. Intentions to seek care was assessed using two questions from the PMHSUS.

Figure 3. Help-Seeking Intentions Measures



1. **Demographic information.** Demographic information, including participant's age, gender, race/ethnicity, SES, employment status, and educational level were collected from a 15-item self-report questionnaire.

2. **SES/Cultural Status: *The MacArthur Scale of Subjective Social Status.*** The MacArthur Scale of Subjective Social Status was used to measure subjective social status as it relates to an individual's relative position in their cultural group (3; 43). Using a numbered stepladder image, participants identified where they believe they stood on two separate 10-step ladders. The first ladder assessed societal SES, an individual's social standing compared to other members of society. The second ladder assessed community SES, an individual's standing within her community (3; 43). Scores located higher on the

ladder indicate higher living standards and social position, while numbers located on the lower end of the ladder indicate poorer living standards and lower social position (3; 43; 86). The MacArthur Scale of Subjective Social Status has been shown to have good test-retest reliability (43; 86). In the current study, the two ladders yielded a Spearman's correlation of .53.

3. Distress measurement: *Hassles and Uplifts Scale (HUS)*. Psychological distress was measured using the 53- item Hassles and Uplifts Scale (HUS), a revised version of the Daily Hassles Scale (59) and Uplifts Scale (36; 59). Hassles were defined as negative events that evoke daily irritation or frustration (54). Uplifts were described as positive events, ones that evoke happiness, joy, and satisfaction (36). The HUS examined daily exposure to hassles and uplifts (36) within various life domains, including work, family, health, environment, and finances (110). Participants were asked to rate the undesirability (hassles) and desirability (uplift) for each item on a 4-point Likert scale ranging from 0 (None or not applicable) to 3 (A great deal) (36).

Responses from the Hassles scale were summed. Possible scores could range from 0 to 159 and higher scores indicated higher perceived intensity of hassles (45). Responses from the Uplifts scale were also summed with possible scores ranging from 0 to 159 and higher scores indicating higher perceived intensity of uplifts. Intensity scores for each hassle and each uplift was also scored.

The HUS has been found to be a valid predictor of several adverse mental and physical health outcomes (58; 111; 121). The scale has been adapted and revised for use across various racial/ethnic, age, and occupational samples (45; 56; 110; 111). Previous studies have been able to identify differences in the top 10 hassles and uplifts in middle-

aged and undergraduate samples (36). In this sample, the 53 items on the Hassles scale yielded a Cronbach's alpha of .93. The 53 items on the Uplifts scale yielded a Cronbach's alpha of .95. In this sample, the HUS had low internal consistency (Cronbach's $\alpha = 0.57$).

4. Strong Black Woman Schema: *Strong Black Woman Cultural Construct Scale*

(SBWCCS). The Strong Black Woman Schema was measured using the Cultural Construct Scale (SBWCCS) (49). The 22-item inventory assessed cultural attitudes on a 5-point Likert scale ranging from 1 (Never) to 5 (Almost Always) (46; 49), with scores ranging from 22 to 110. There were three subscales: Caretaking, Affect Regulation, and Self-Reliance (49). Caretaking referenced actions of shouldering other's problems. Affect Regulation referred to having control over her emotions. Self-Reliance referred to being reliant on one's self and having control over one's own matters (46; 49). Higher total scores indicate endorsement of the Strong Black Woman construct.

The SBWCCS has demonstrated good internal consistency and adequate to good internal consistency has been shown on each subscale (46; 49). In this sample, the SBWCCS had good internal consistency (Cronbach's $\alpha = 0.88$) and the subscales had adequate internal consistency (Self-Reliance, Cronbach's $\alpha = 0.60$; Affect Regulation, Cronbach's $\alpha = 0.71$; Caretaking, Cronbach's $\alpha = 0.79$).

5. Public Stigma: *Stigma Scale for Receiving Professional Psychological Help*

(SSRPH). Stigma toward mental health care seeking was measured using the Stigma Scale for Receiving Professional Psychological Help (SSRPH) (63). The SSRPH is a 5-item questionnaire used to assess public stigma, rated on a 4-point Likert scale ranging from 0 (Strongly Disagree) to 3 (Strongly Agree). Total scores range from 0 to 15. Higher scores indicate higher perceived public stigma toward psychological care (63).

The scale has been used to measure public stigma in adolescents (90) and young adults (63) and has been found to be internally consistent (63; 90). In this sample, the SSRPH had low internal consistency (Cronbach's $\alpha = 0.61$).

6. Self-Stigma: *Self-Stigma of Seeking Help (SSOSH)*. Self-stigma toward mental health care seeking was measured using the Self-Stigma of Seeking Help (SSOSH) (113). The SSOSH is a 10-item questionnaire, rated on a 4-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). Total scores range from 10 to 50, with higher scores indicating more stigma (113). The scale has been used to measure self-stigma across samples from several different countries, among college students, and veterans and active duty military and has been found to have high internal consistency (17; 52; 112; 113). In this sample, the SSOSH had good internal consistency (Cronbach's $\alpha = 0.79$).

7. Racist Discrimination: *Schedule of Racist Events (SRE)*. Racist discrimination was measured using the Schedule of Racist Events (SRE) (64). The SRE assessed the frequency of racial discrimination within the past year (recent) and within a lifetime (lifetime), and the perceived level of stress associated with the event (appraisal) (64). The SRE was comprised of 18 items on a 6-point Likert scale with scores ranging from 1 (the event never happened) to 6 (the event happened almost all of the time) (64). Scores of the stressfulness of the event (appraisal) ranged from 1 (Not at All) to 6 (Extremely) {Landrine, 1996 #401}. Seventeen items measured Appraisal. Two scores were calculated for the SRE: Lifetime (score ranges from 18-108) and Appraisal (score ranges from 17-102) (64). The SRE has been found to be a reliable measure of recent and lifetime racist discrimination and stress among Blacks (64). In this sample, the 18 items on the SRE

scales had high internal consistency (Cronbach's $\alpha = .90$ (Lifetime); Cronbach's $\alpha = .93$ (Appraisal).

8. Sexist Discrimination: Sexist Discrimination: *Schedule of Sexist Events (SSE)*. The Schedule of Sexist Events (SSE) was used to measure lifetime and recent (past year) sexist discrimination (62). The SSE was comprised of 20 items on a 6-point Likert scale with scores ranging from 1 (the event never happened) to 6 (the event happened almost all of the time [more than 70% of the time] (62; 76). Each item assessed the lifetime (SSE Lifetime) and recent (SSE Recent) frequency of the perceived sexist event with scores ranging from 0 (no perceived sexist events) to 120 (frequent perceived sexist events). Higher scores indicated greater perceived sexist events (62; 76). The measure has four factors: Sexist Degradation and Its Consequences, Sexism in Distant Relationships, Sexism in Close Relationships, and Sexist Discrimination in the Workplace (62). For this study, one score was calculated for SSE Lifetime. The measure has been used to examine sexist discrimination in college, middle, and older women of color and White women in various settings (i.e., the workplace, academic environment) (62; 76). The SSE has been found to be a reliable and valid measure of sexist discrimination, yielding high internal consistency of lifetime and recent scores (62; 76). In this sample, SSE Lifetime had high internal consistency (Cronbach's $\alpha = 0.91$).

Theory of Planned Behavioral Variables

No standard questionnaire for the TPB currently exists (5; 42; 129). Instead, questions assessing the TPB constructs have been adapted for this study to reflect individual behaviors (i.e., help-seeking) and populations (i.e., MDBW) of interest (42; 74). Attitudes, subjective norms, perceived behavioral control, and intentions

questionnaire items were modeled after guidelines and previous research utilizing the TPB model (5; 42; 65; 72; 129). A total of eight items were used to assess mental health help-seeking attitudes, subjective norm, control, and intentions to seek professional care. The eight-item questionnaire comprised the Predicting Mental Health Service Utilization Scale (PMHSUS), a measurement developed specifically for this study. Four subscales were included: Attitudes (2 items); Subjective norm (2 items); Perceived Behavioral Control (2 items); and Intentions (2 items). In this sample, the PMHSUS had high internal consistency (Cronbach's $\alpha = 0.89$). A description of each component of the PMHSUS can be found in **Appendix B**.

9. ***PMHSUS Help-Seeking Attitudes***. Two items (Questions 1 and 2) were used to measure participants' attitudes toward mental health help-seeking. Responses were on an 8-point Likert scale ranging from 0 (Very Useless; Very Worthless) to 8 (Very Useful; Very Worthwhile). Statements consisted of the following: "Seeking mental health services is..." and "Seeking mental health services will be..." Higher scores indicated more positive attitudes toward help-seeking. In this sample, Attitudes had high internal consistency (Cronbach's $\alpha = 0.97$).

10. ***PMHSUS Subjective Norms About Mental Health Help-Seeking***. Two items (Questions 3 and 4) were used to measure participants' perceptions of others' approval/disapproval of mental health help-seeking. Responses were on an 8-point Likert scale ranging from 0 (Definitely False) to 8 (Definitely True). Statements consisted of the following: "Most people like me seek professional psychological help (i.e., from a psychiatrist; mental health nurse; social worker; psychologist) when needed." Higher

scores indicated higher levels of subjective norm. In this sample, Subjective Norms had adequate internal consistency (Cronbach's $\alpha = 0.58$).

11. *PMHSUS Perceived Behavioral Control Concerning Mental Health Help-Seeking.*

Two items (Questions 5 and 6) were used to assess participants' overall feelings of control in seeking professional psychological care when needed. Responses were on an 8-point Likert scale ranging from 0 (Definitely False/Definitely Disagree) to 8 (Definitely True/Definitely Agree). Statements consisted of the following: "I am confident that I will seek professional mental health services if I want to" and "Seeking and utilizing mental health services is completely up to me." Higher scores indicated higher levels of control. In this sample, Perceived Behavioral Control had adequate internal consistency (Cronbach's $\alpha = 0.73$).

12. *PMHSUS Intentions to Seek Mental Health Services.* Two items (Questions 7 and 8) were used to measure participants' mental health help-seeking and utilization intentions. Responses were on an 8-point Likert scale ranging from 0 (Definitely False) to 8 (Definitely True). Statements consisted of the following: "I intend to seek professional mental health services if I experience distress and/or other emotional problems." Higher scores indicated higher levels of help-seeking intentions. In this sample, Intentions had high internal consistency (Cronbach's $\alpha = 0.99$).

Qualitative Data

Eight open-ended questions were developed for this study and interspersed throughout the survey and correspond to quantitative measures to better understand Black women's perspectives on beliefs, attitudes, and level of control, and help-seeking and utilizing mental health services. Questions focused on gathering qualitative detail

pertaining to the following cultural concepts: attitudes (SBW Schema), subjective norms (stigma), and perceived behavioral control (discrimination). In addition, questions sought to identify potential barriers not previously highlighted in the literature, as well as gain insight into potential coping mechanisms and future clinical considerations. Examples of questions used to explore cultural concepts were: “What factors do you believe impact your mental health the most and why?”, “What factors do you believe impact Black women’s intentions of seeking mental health services?”, “How do you feel when speaking to family and friends about your mental health?,” and “What do you believe should be done in order to improve mental health utilization in Black women?” A complete list of questions can be found in **Appendix C**.

DATA ANALYTIC PLAN

Quantitative Analyses

Specific Aim 1: Psychological Distress, Income, Education and Social Status

Linear regressions were used to examine the association of SES (income, education, social status) on psychological distress (measured by Hassles total score) and uplifts (measured by the Uplifts total score) among 111 Black women.

An independent samples T-test was used to examine differences in level of distress and uplifts among two groups: high income and low-income Black women. In addition, Kendall’s Tau analysis was used to investigate the relative rankings of stressors between low (below \$50,000) and higher income (above \$50,000) women.

Specific Aim 2: Expanded TPB Model

Multiple linear regressions were used to examine associations between the SBW schema, stigma, and discrimination (predictor variables) on professional mental health

help-seeking intentions (outcome variable) among 111 Black women. The SBW schema (hypothesis 2a), public and self-stigma (hypothesis 2b), and discrimination (hypothesis 2c) were used to examine associations with help-seeking intentions, the outcome variable. Lastly, all three predictor variables were examined in investigating barriers to help-seeking intentions (hypothesis 2d).

Data were examined for outliers and screened for normality. All analyses were conducted using SPSS, Version 22.0 and SAS, Version 9.4. Two-tailed tests were conducted, and differences were considered significant at $p \leq .05$.

Qualitative Analyses

Specific Aim 3: Help-seeking themes

Open ended questions were used to further assess Black women's attitudes on mental health help-seeking, beliefs about Black women with higher education and help-seeking intentions, and potential barriers including the SBW Schema, stigma, and discrimination to help-seeking. Responses were imported into a Microsoft Excel file and then analyzed using an open coding technique (selecting sections from sample's text and coding with key terms generated from data) (68). Due to the small sample size ($N=96$), a single coder was used to initially code and identify themes from the study's responses. A codebook describing each theme was developed, using quoted examples from this study's sample. To mitigate interpretative bias by the primary researcher, two graduate students were assigned 20% of participants' responses (per question) and asked to identify the preselected themes from the codebook. The primary researcher provided codebook training to all research assistants prior to identifying the themes in the selected data. An

inter-rater reliability (IRR) of 80% between raters per selected responses was used to ensure consistency. No specialized qualitative coding software was used.

Power Analysis

For Aim 1, a sample size of 77 is required to detect a medium effect size ($f^2=0.15$) based on a linear regression model testing three independent variables of interest (income, education, social status) after adjusting for a single covariate (age), with 80% power and 5% significance level.

For Aim 2, a sample size of 98 is required to detect a medium effect size ($f^2=0.15$) based on a linear regression model testing six predictor variables of interest (SBW Schema, self-stigma, public stigma, racist discrimination (Lifetime), sexist discrimination (Appraisal, Lifetime) after adjusting for a single covariate (age), with 80% power and 5% significance level. Therefore, based on the larger sample size required for Aim 2, the sample size was sufficient for Aim 1. To allow for potential incomplete responses, attrition was assumed at 20%, and a larger sample size of 110 total was used.

CHAPTER 3: Results

A total of 171 Black women completed at least part of the survey and 60 of these participants were excluded for the following reasons: one individual did not provide consent, nine participants did not meet/indicate age or race inclusion criteria, twenty-three participants were excluded because they did not identify as Black/AA, and twenty-seven participants did not complete at least 50% of the survey measures. Therefore, 111 participants were used to analyze data.

DEMOGRAPHICS AND SELF-REPORT MEASURES

Demographics for the 111 participants examined in Aim 1 are presented in **Table 1**. All participants described their race as Black, with the majority identifying as African American and non-Hispanic or Latina ($n = 94.6\%$). The typical participant was in her mid-thirties with slightly more single/never married. The educational attainment and income are depicted in **Table 1**.

Table 1. Demographic Information			Range
Age in years, <i>M</i> (SD)	36.5 (11.1)		22-66
Race, <i>n</i> (%)			
Black/AA	111 (100%)		
Ethnicity, <i>n</i> (%)			
Hispanic	3 (2.7%)		
Non-Hispanic	105 (94.6%)		
Children, <i>n</i> (%)			1-4
Yes	57 (51.8%)		
No	53 (47.7%)		
Education Level, <i>n</i> (%)			
HS degree or Equivalent	4 (3.6%)		
Some college, no degree	7 (6.3%)		
Technical/Trade/Vocational	1 (.9%)		
Associates	3 (2.7%)		
Bachelor's	38 (34.2%)		
Master's	51 (45.9%)		
Doctorate/Professional	7 (6.3%)		
Individual Income, <i>n</i> (%)			
Less than \$20,000	21 (18.9%)		
\$20,000-\$34,999	16 (14.4%)		
\$35,000-\$49,999	18 (16.2%)		
\$50,000-\$74,999	15 (13.5%)		

\$75,000-\$99,99	17 (15.3%)
\$100,000-\$150,000	19 (17.1%)
Over \$150,000	5 (4.5%)
Household Income, <i>n</i> (%)	
Less than \$20,000	16 (14.4%)
\$20,000-\$34,999	10 (9.0%)
\$35,000-\$49,999	13 (11.7%)
\$50,000-\$74,999	17 (15.3%)
\$75,000-\$99,999	21 (18.9%)
\$100,000-\$150,000	16 (14.4%)
Over \$150,000	18 (16.2%)

Social Status: *The MacArthur Scale of Subjective Social Status*

Scores from the MacArthur Scale of Subjective Social Status (5; 40) were used as predictor variables to assess psychological distress (Aim 1). Participants reported having a higher sense of place within their community ($M = 6.4$, $SD = 1.6$; range = 2-9) than within society ($M = 5.9$, $SD = 1.4$; range = 1-9). In the present study, there was a moderate positive correlation between the society and community ladder, $r(131) = .51$, $p < .001$. Data from this study were consistent with partial findings from Cené and colleagues' Cené et al (29) examination of 306 Black men and women's self-reported social standing within their community ($M=6.8$) and US (distal) ($M=5.6$) scores. Descriptive data for

Society and Community social status are shown in **Table 2**.

Table 2. Self-Report Measures

Measure	M	SD	Range
McArthur Scale of SSS			
Society	5.9	1.4	1-9
Community	6.4	1.6	2-9
Hassles and Uplifts Scale			
Hassles	32.9	21.3	1-116
Uplifts	37.0	26.7	0-133
SBWCCS	77.1	11.8	54-107
SSRPH (Public Stigma)	5.6	2.2	0-11
SSOSH (Self-Stigma)	21.4	5.8	10-38
SRE Lifetime	46.8	15.2	20-108
SRE Appraisal	55.2	20.7	17-102
SSE Lifetime	48.1	15.5	20-97
Sexist Degradation	22.3	7.8	7-44
Sexism in Distant			
Relationships	12.3	4.4	6-25
Sexism in Close			
Relationships	7.3	2.9	3-16
Sexism Discrimination			
in the Workplace	6.1	2.8	3-18

PMHSUS			
Attitudes	13.8	3.2	0-16
Subjective Norms	10.7	3.6	2-16
Perceived Behavioral			
Control	13.8	2.8	6-16
Intentions	12.2	4.0	0-16

Distress Measurement: *Hassles and Uplifts Scale (HUS)*

The HUS (36) was used to measure psychological distress assessed in Aim 1. On average, participants reported a low frequency of hassles ($M = 32.9$, $SD = 21.3$); range 1-116) across life domains. Participants also reported that they experienced few uplifts ($M = 37.0$, $SD = 26.7$; range 0-133). Compared to Jain and colleagues Jain et al (57) study of 118 AA and Caucasian men and women, frequency of hassles ($M = 29.9$, $SD = 10.3$) and uplifts ($M = 34.0$, $SD = 9.4$) were slightly higher in the present study.

Descriptive data for HUS measurements are shown in **Table 2**.

The Strong Black Woman Schema: *Strong Black Woman Cultural Construct Scale (SBWCCS)*

The SBWCCS (49) was used to measure the SBW Schema and used as a predictor of help-seeking intentions in Aim 2. On average, participants endorsed a moderate level of the SBW Schema ($M = 77.1$, $SD = 11.8$; range = 54-107). Level of endorsement of the SBW concept was slightly higher in the present study compared to Hamin's (49) findings on 152 Black women from community based organizations (49), specifically among

those who were single ($n= 91$, $M= 75.3$, $SD= 10.1$) and those who were married ($n= 34$, $M= 73.6$, $SD= 9.9$).

Public Stigma: *Stigma Scale for Receiving Psychological Help (SSRPH)*

The SSRPH (63) was used to assess public stigma toward receiving mental health treatment among AA women and used as a predictor of help-seeking intentions in Aim 2. On average, participants endorsed low to high levels of public stigma ($M = 5.6$, $SD = 2.2$; range = 0- 11). Wallace and Constantine (114) found a similar stigma mean score ($M=5.7$, $SD= 2.4$) among Black women ($n= 147$) in their study of 251 male and female African American college students at a predominately white institution (PWI).

Self-Stigma: *Self-Stigma of Seeking Help Scale (SSOSH)*

The SSOSH (113) was used to measure self-stigma and used as a predictor of help-seeking intentions in Aim 2. Participants endorsed a moderate level of stigma on the SSOSH ($M= 21.4$, $SD= 5.8$; range = 10-38). This study's self-stigma scores were slightly lower than the mean scores ($M= 25.9$, $SD= 8.0$; range = 10-44) from Held and Owens (52) sample of 126 military service members' (active and retired) stigma toward mental health treatment seeking.

Racist Discrimination: *Schedule of Racist Events (SRE)*

The SRE (64) was used to assess racial discrimination examined in Aim 2. On average, participants reported experiencing some type of racist event during their lifetime ($M = 46.8$, $SD = 15.2$; range= 20-108) and indicated finding these experiences stressful (Appraisal; $M = 55.2$, $SD= 20.7$; range= 17-102). Norms from Landrine and Klonoff's

(64) study examining the association between racist events, psychiatric symptoms and cigarette smoking among 153 AA men and women differed, yielding lower reports of Lifetime racist events ($M = 53.9$) but slightly higher Appraisal ($M = 51.5$) of racist events. Further, findings from this study were three times higher than mean Lifetime scores from Stevens-Watkins and colleagues (102) study which assessed racism in 204 AA women ($M = 15.0$, $SD = 12.3$, range = 0- 67). Of note, the aforementioned study only assessed 17 out of the 18 SRE questions.

Sexist Discrimination: *Schedule of Sexist Events (SSE)*

The SSE (62) was used to assess sexist discrimination examined in Aim 2. On average, the total score indicated participants reported experiencing some type of sexist discrimination during their lifetime ($M = 48.1$, $SD = 15.5$; range = 20-97). Participants also reported discrimination on the four factors for the SSE. In Klonoff and Landrine (62), women of color endorsed slightly higher Lifetime sexist events ($M = 50.8$, $SD = 19.2$) than found in the present study.

Sexist Degradation. Participants reported experiencing some degradation (e.g., name calling, hearing degrading jokes, sexual harassment) throughout their lifetime ($M = 22.3$, $SD = 7.8$; range = 7- 44). Scores for this study were lower than those found in Klonoff and Landrine (62) ($M = 25.6$, $SD = 10.6$).

Sexism in Distant Relationships. Participants reported experiencing sexism in a distant relationship (i.e., being treated unfairly by individuals in service or helping jobs, strangers, teachers or professors, or colleagues) at some point throughout their lifetime ($M = 12.3$, $SD = 4.4$; range = 6-25). Scores for this study were

slightly higher than those found in Klonoff and Landrine (62) ($M = 11.6$, $SD = 5.2$).

Sexism in Close Relationships. Participants reported experiencing sexism in a close relationship (i.e., fairness of treatment by family members or boyfriend, husband, or other important men in life) throughout their lifetime ($M = 7.3$, $SD = 2.9$; range= 3-16). Scores for this study were lower than those found in Klonoff and Landrine (62) ($M = 9.9$, $SD = 4.4$).

Sexist Discrimination in the Workplace. Participants reported experiencing discrimination in the workplace (e.g., promotability, raise, filing a grievance, mistreatment by employers and supervisors) throughout their lifetime ($M = 6.1$, $SD = 2.8$; range= 3-18). Scores for this study were higher than those found in Klonoff and Landrine (62) ($M = 4.9$, $SD = 2.6$).

Help-Seeking Intentions: *Predicting Mental Health Service Utilization Scale (PMHSUS)*

Mental health help-seeking attitudes, subjective norms, perceived behavioral control, and intentions to seek professional care were assessed using a measure developed for this study (Aim 2). Participants reported high levels of help-seeking attitudes ($M = 13.8$, $SD = 3.2$; range= 0-16); control ($M = 13.8$, $SD = 2.8$; range= 6-16) and intentions ($M = 12.2$, $SD = 4.0$; range= 0-16). Participants also indicated moderate levels of subjective norms, that is perceived social pressure to engage in a behavior ($M = 10.7$, $SD = 3.6$, range= 2-16).

Descriptive data for cultural variables and help-seeking intentions are shown in **Table 2**.

RESULTS FOR PRIMARY ANALYSES

Hypothesis 1a: The Association of Income, Education, and Social Status on Psychological Distress

Four linear regressions were conducted to examine the association between achievement (household income, education, social status [society, community]) and psychological distress among 111 respondents. It was hypothesized that the amount of distress would differ based on achievement level.

Distress was examined using the Hassles total score from the HUS. Three sets of analyses were conducted to examine whether achievement was associated with distress corresponding to the association of distress with reported income, education, and perceived social status: (1ai.) The association of income and distress; (1aii.) The association of education and distress; and (1aiii.) The association of perceived social status and distress.

Uplifts scores were also analyzed and will be briefly discussed below.

1ai. The Association of Reported Income and Reported Distress and Uplifts

A linear regression was conducted to examine the association between household income and distress. After adjusting for age, a significant negative association between household income and level of distress was found, $b = -2.66$, $SE(b) = 1.03$, $\beta = -.249$, $p = .011$, such that Black women with higher incomes have lower levels of psychological distress. A linear regression was conducted to examine the association between household income and uplifts. After adjusting for age, no significant association between household income and uplifts was found, $b = .520$, $SE(b) = 1.37$, $\beta = .039$, $p = .82$.

1aii. The Association of Education and Reported Distress

A linear regression was conducted to examine the association between education and distress. After adjusting for age, no significant association between education level and distress was found, $p = .08$. A linear regression was conducted to examine the association between education level and uplifts. After adjusting for age, no significant association between education level and uplifts was found, $p = .47$.

1aiii. The Association of Perceived Social Status and Reported Distress and Uplifts

Two linear regressions were conducted to examine the association between Society social status and distress and uplifts.

Society social status and Distress and Uplifts.

After adjusting for age, a significant negative relationship between society social status and distress was found, $b = -4.91$, $SE(b) = 1.44$, $\beta = -.33$, $p = .001$, such that Black women who perceived themselves as having higher social status in society reported lower levels of psychological distress. A linear regression was conducted to assess the association between Society social status and uplifts. After adjusting for age, no significant relationship between society social status and uplifts was found, $b = 2.32$, $SE(b) = 1.94$, $\beta = .12$, $p = .43$.

Community social status and Distress and Uplifts.

Two linear regressions were conducted to examine the association between Community social status and distress and uplifts. After adjusting for age, no significant relationship between community social status and distress was found, $b = -2.45$, $SE(b) = 1.28$, $\beta = -.18$, $p = .06$. After adjusting for age, no significant relationship between community social status and uplifts was found, $b = -1.14$, $SE(b) = 1.68$, $\beta = -.07$, $p = .50$.

Hypothesis 1b. Types of stressors by income.

An independent samples T-test was conducted to compare both level of distress and relative distress categories (hassles) between two groups: low- and high-income Black women. It was hypothesized that relative distress categories would differ based on individual income group (Low vs. High). Higher income Black women were expected to report greater distress related to work and family stress while lower income Black women were expected to report greater distress related to economic/financial stressors. There was a significant difference between groups in the mean distress across hassles with low income group reporting higher mean distress (n= 55, M= 38.0, SD= 24.3) compared to the high income group (n= 56, M= 27.8, SD= 16.6); $t(109) = 2.57, p = .01$. There was not a significant difference in the mean uplifts between low (M= 37.5, SD= 28.2) and high (M= 36.4, SD= 25.3) income Black women; $t(109) = .223, p = .82$. The top 5 hassles and uplifts for lower and higher income Black women are presented in **Table 3**.

Table 3. Mean Hassles and Uplifts by Group

Top 5 Hassles			
Low Income	M	SD	Range
Money for necessities	1.51	1.20	0-3
Money for extras	1.49	1.10	0-3
Money for emergencies	1.42	1.12	0-3
Political/Social Issues	1.33	1.15	0-3
Workload	1.18	1.02	0-3
High Income			
Workload	1.09	.99	0-3
Nature of Work	1.07	.94	0-3
Political/Social Issues	1.00	.95	0-3
Exercise	1.00	.90	0-3
Job Deadlines	.98	1.09	0-3

Top 5 Uplifts

Low Income	M	SD	Range
Friends	1.42	.94	0-3
Eating at Home	1.24	1.10	0-3
Being Organized	1.20	1.19	0-3
Nature of Work	1.18	1.09	0-3
Free Time	1.17	.87	0-3
High Income			
Children	1.39	1.30	0-3
Time Spent w/Family	1.32	1.18	0-3
Friends	1.29	1.01	0-3
Money for Necessities	1.18	1.08	0-3
Money for Entertainment (Home)	1.16	1.01	0-3

Kendall Tau's test was conducted to further assess the differences in the rankings of the major hassles between low- and high-income groups. There was a significant, negative correlation between low- and high-income groups and time spent with family, $r = -.30$, $p = .02$, such that low income Black women ranked spending time with family as more of a hassle compared to high income Black women. A significant, negative correlation between low- and high-income groups and parents, $r = -.32$, $p = .01$ was also found suggesting that low income Black women ranked their parents as more of a hassle compared to high income Black women. No other significant findings between the two groups and hassles were found.

Aim 2: Extended Theory of Planned Behavior

Four linear regressions were conducted to examine the relationship between cultural variables (the Strong Black Woman schema to assess Attitudes, Stigma to assess

Subjective Norms, and Discrimination to assess Perceived Behavioral Control) from the extended TPB and help-seeking intentions. The SBW Schema, stigma, and discrimination were predictor variables and intentions were measured by the Predicting Mental Health Services Utilization Scale [PMHSUS]), the dependent variable.

Hypothesis 2a: SBW Schema as a measure of Attitudes and help-seeking intentions

It was hypothesized that the SBW schema (attitudes) would be significantly associated with help-seeking intentions, such that stronger endorsement of the SBW schema would be negatively associated with help-seeking intentions. After adjusting for age, the SBW Schema was not significantly associated with mental health help-seeking intentions, $b = .005$, $SE(b) = .040$, $\beta = .02$, $p = .89$. Due to these non-significant findings, the three subscales of the SBWCCS were not analyzed.

Hypothesis 2b: Stigma as a measure of Subjective Norms and help-seeking intentions

It was hypothesized that stigma would be significantly associated with help-seeking intentions, such that higher levels of stigma were expected to be negatively associated with less intentions to seek professional mental health care. To assess the relationship between stigma and intentions to seek care, a multiple linear regression was conducted. The results indicated that the model with stigma (public and self) was negatively associated with help-seeking intentions, $F(3, 80) = 14.11$, $p < .001$. Public stigma (measured by the Stigma Scale for Receiving Professional Psychological Help [SSRPH]) was negatively associated with help-seeking intentions, $b = -.520$, $SE(b) = .197$, $\beta = -.27$, $p = .01$, after adjusting for self-stigma and age, such that as the public stigma score increased, Black women's intentions to seek care decreased. Self-stigma

(measured by the Self-Stigma of Seeking Help scale [SSOSH]) was also significantly negatively associated with help-seeking intentions, $b = -.297$, $SE(b) = .071$, $\beta = -.43$, $p < .001$, after adjusting for age and public stigma, such that as the self-stigma score increased, Black women's intentions to seek care decreased.

Hypothesis 2c: Discrimination as a Measure of Perceived Behavioral Control and Help-seeking

It was hypothesized that discrimination perceived behavioral control would be significantly associated with help-seeking intentions, such that more discriminatory experiences would be negatively associated professional mental health seeking. To assess the relationship between discrimination and help-seeking intentions, three linear regressions were conducted. A multiple linear regression was used to assess the association between all discrimination (racist, sexist) and help-seeking intentions. The results indicated that the model was not significantly associated with help-seeking intentions, $F(4, 77) = .669$, $p = .62$.

A linear regression assessing the association between racial discrimination (measured by the Lifetime and Appraisal subscales of the Schedule of Racist Events [SRE]) and help-seeking intentions was also not significant, $F(3, 78) = .692$, $p = .56$. Lifetime racist events (Lifetime) was not significantly associated with help-seeking intentions, $b = -.019$, $SE(b) = .050$, $\beta = -.07$, $p = .70$, after adjusting for stressfulness (Appraisal) and age. Stressfulness (Appraisal) of racist events was also not associated with help-seeking intentions, $b = .034$, $SE(b) = .037$, $\beta = .17$, $p = .36$, after adjusting for lifetime racist events and age.

A linear regression assessing sexist discrimination (measured by the Schedule of

Sexist Events [SSE]) and help-seeking intentions was conducted. Lifetime sexist events (Lifetime) was not significantly associated with help-seeking intentions, $b = .001$, $SE(b) = .029$, $\beta = .01$, $p = .97$, after adjusting for age. Due to non-significant findings, the four factors subscales of the SSE were not analyzed.

Hypothesis 2d: TPB expanded model

It was hypothesized that together, the three components of the extended TPB (SBW schema, stigma, and discrimination) would provide the best model for predicting intentions to seek professional mental health care. To examine the relationship between the cultural variables (SBW schema, stigma, and discrimination) and help-seeking intentions, a multiple linear regression was conducted. The results indicated that the model was a significant predictor of help-seeking intentions, $F(7, 74) = 6.87$, $p < .001$. The stigma variables, public stigma ($b = -.689$, $SE(b) = .221$, $\beta = -.35$, $p = .003$) and self-stigma ($b = -.273$, $SE(b) = .075$, $\beta = -.39$, $p < .001$), were the only variables to be significantly associated with help-seeking intentions. The other key variables of interest, SBW schema and discrimination, were not significantly associated with help-seeking intentions.

Aim 3: Help-seeking Themes

Eight open-ended questions were used to identify and explore Black women's attitudes, stigma, and obstacles to help-seeking. Additionally, these data were used to determine strategies and techniques to improve access and utilization of professional mental health services within this community.

Attitudes. In order to understand help-seeking attitudes, participants were asked the following questions: “How do you view people who seek mental health services?”, “How do you view Black women who seek mental health services?” and “Which factors do you believe impact your mental health the most and why?” Overall, participants described people, as well as Black women who sought mental health care positively. Terms used to define people and Black women seeking care were: “strong,” “human,” “brave,” and “reclaiming themselves.” In reference to attitudes toward Black women seeking mental health care, one woman stated that “they are turning to methods not traditionally used by the Af Am (sic) community...doing what white people do.” Another indicated that these women are “Strong. Society believes that Black women can do everything; a lot of the time, we have to. Knowing when to seek help and getting the right help is the strongest thing we can do.”

Five major themes emerged when assessing perceptions of help-seeking: strength, intellect, normalcy (i.e., “being Human”), empowering/encouraging and weakness. The majority of respondents indicated that they perceived Black women who sought psychological care favorably. One respondent described those seeking help as “Strong. Brave. Vulnerable. Rare.” Another woman expressed “...they have probably broken the usual mode of Black families that tend to only seek help in a religious way and taken their matters into their own hands... sought assistance in a more empirical manner.” One woman stated that she was “glad they aren’t bowing to the superwoman status.” Another stated that she was “appreciative of them daring to break generational and cultural curses.” In contrast, two respondents described Black women who sought mental health care negatively. Respondents labeled these women as “crazy” and “unstable.”

Nearly three quarters (71%) of respondents disagreed with the statement that those with higher education would be less likely to seek treatment. When assessing the explanations for this statement, six themes emerged for those who agreed more highly educated would be less likely to seek treatment: negative stigma; denial/rationalization; knowledge/education/normalization; and systematic/environmental barriers. Two themes emerged for those who disagreed that education would be associated with less seeking: knowledge/awareness of resources and access to care/affordability.

Women who disagreed that Blacks with higher education were less likely to seek professional mental health treatment expressed this was due to "...knowledge of the benefits of treatment," "...insurance," "...access to mental health care..," have access to "additional resources," and they are "...exposed to majority peers in which seeking treatment has become the norm." One respondent reported that she disagreed with the statement because she believed Blacks with higher education "...tend to be more aware of societal influences and how they can affect their perspective on mental health awareness. [They] most likely have been exposed to mental health discussions or opportunities on a college campus." Another respondent reiterated these claims, "Blacks with higher education are exposed to other people who can tear down stereotypes associated with mental health problems."

Participants who agreed that Blacks with higher education would be less likely to seek mental health care indicated that these individuals may not seek care because "...they feel embarrassed," "...are too proud and think we can handle things on our own," and "...time in a busy schedule, fear of looking weak or unable to handle stress load." Strength was also referenced as a barrier by over 15% of the respondents. Women

described “having to be strong becomes a mask you can’t take off,” and that these individuals “...can’t allow mental disability or weakness to be associated with them.”

Further, another woman reported, “Though mental health treatment among blacks is becoming more aware, I think there is still a lot of negative perception around it. For me, I struggle with letting people know that things are not always great with me. I feel an immense pressure to be okay and seem perfect.”

Stigma. Public and self-stigma was frequently voiced as a barrier to help-seeking among Blacks with higher education. Half of the respondents who agreed that Blacks with higher education were less likely to seek treatment endorsed the negative stigma theme. One woman stated, “There is a stigma. While I think that stigma is diminishing among Blacks in higher education, we are in the minority and those around us who are not in higher education (sic) believe we should be stronger, smarter, able to deal with issues which creates a barrier for us seeking or talking about seeking formal health treatment.” Another participant’s response provided further insight: “People already think we are crazy when we express ourselves. Higher education only makes it harder because the perception almost always becomes that the person is weak.”

Women in the sample also endorsed some stigma when discussing their feelings toward speaking with family and friends about mental health concerns. Some women described sharing psychological concerns as “burdensome,” “vulnerable,” “judged,” or “misunderstood” while others declared that they felt “free” and “very comfortable.” One woman reported that discussing mental health concerns with family and friends “...sometimes it’s hard for them to comprehend, especially when they are grounded in spiritual healing...” Another indicated “sometimes I feel really good about it, however,

sometimes I feel like my problems are so small- and they make them feel small, which in turn makes me feel crappier.”

Several women stated that they preferred speaking with friends rather than family members. One woman reported that speaking to relatives “...feels new and sometimes weird.” Another responded that “...I can only speak to certain relatives because some say ignorant things about mental health. I either feel supported or completely angry depending on what they say (positive & understanding vs. ignorant and blaming me for health.)” Another indicated that she does not feel “...understood, that I am being judge (sic) which is why I prefer to talk to my three best friends...”

Discrimination. To understand the potential impact of discrimination (racist and sexist) on help-seeking, participants were asked: “What factors do you believe impact your mental health the most and why?” Participants reported that environmental/societal stressors, such as race and sex issues within academic environments and workplace settings, as well as the current political climate were factors most impacting their mental well-being. Participants reported frequently experiencing “racism in academia” and “school microaggressions.” One woman expressed “...being a Black woman, I feel I’m always in position to ‘prove my worth’ whereas most others are given the benefit of the doubt.” Another reported that “...being the only Black person in my department forces me to do the diversity work that needs to be done which adds to my stress & anxiety.” Another indicated that “life experiences because of race & or gender in the military, school, community and marriage” was stressful, while another indicated that “daily triggers in the news and on social media” caused her the most distress.

Recommendations for Improving Psychological Care. Participants were asked “What do you believe should be done in order to improve mental health utilization in Black women?” Two major themes emerged: the need for cultural competency (education and knowledge) and barrier reduction. A significant portion of participants reported that they desired more recruitment, training, and service of more Black women in mental health occupations, as well as culturally competent providers. Participants also advocated for more education, research, and services (e.g., resources) for Black women with mental health concerns. Several Black women recommended that a discussion on psychological concerns should be a part of annual physical screenings and immersed within the Black community. One woman stated, “I think mental health services need to be offered simultaneously with physical health check-ups. I think the language needs to shift so that it’s almost hand and hand, see your PCP, check in with these mental health resources.” Another indicated “...service should be offered frequently and advertised as it is a normal thing and not taboo...and talked about more in our community and households with ease and understanding so no one feels ashamed or not normal.”

CHAPTER 4:

OVERVIEW AND SUMMARY OF STUDY FINDINGS

The first aim of this study was to better understand the level and type of distress among Black women. This understanding can be used to provide insight into areas of interest to specifically develop culturally tailored psychological services for Black women, particularly MDBW. The second aim of this study was to use an extended version of the TPB framework to predict help-seeking intentions. The framework was adapted by adding culturally relevant concepts to provide insight in help-seeking behaviors among MDBW to include the SBW schema (attitudes), public and self-stigma (subjective norms), and racist and sexist discrimination (perceived behavioral control). Examining help-seeking from the perspective of the TPB, a well-known framework, highlighted key barriers to help-seeking. The third aim was to explore MDBW's attitudes, beliefs, stigma, level of control, barriers, and intentions to mental health help-seeking. Recommendations for improving psychological care were also assessed. Both quantitative and qualitative data were used to capture personal, daily experiences of MDBW.

Analyses from a series of linear regressions confirmed that there were significant relationships between psychological distress and household income and social status (Society) when assessing Black women (Hypothesis 1a). Contrary to hypotheses, education and Community social status were not significantly associated with psychological distress. Findings from an independent samples T-test showed that there was a significant difference in hassle categories between high- and low-income Black

women (Hypothesis 1b). Data from regression analyses suggested, overall, that the extended TPB model was associated with help-seeking intentions among MDBW. Relationships between self and public stigma and help-seeking intentions (Hypothesis 2b) were also found. However, counter to expectations, the SBW Schema (Hypothesis 2a) and discrimination (Hypothesis 2c) were not significantly associated with help-seeking intentions.

Characterizing Distress among Modern-Day Black Women

In comparison to the US Census data, MDBW in this sample were representative in age (36.5 vs. 34.5 years) yet had higher household incomes (\$50k and above vs. \$42k) and were highly educated (86.4% vs. 23.8%) with at least a Bachelor's degree (1). Thus, this study's sample is indicative of MDBW, the population of interest.

Findings from Aim 1 revealed a significant relationship between household income and psychological distress, such that higher income Black women were found to have lower levels of psychological distress. Higher income could provide financial stability as well as contribute to access to better mental health resources. This study differs from findings from a recent study conducted by Assari (10) which examined the association between depression and household income among Black and White men and women. Assari (10) found that higher income was associated with lower risk of depression among Whites but not Blacks. Differences in findings could be attributed to this study's comparison group (lower vs. higher income Black women) and not encompassing race or gender as a factor. Further research to examine the intersectionality of income, gender, and race on psychological distress between Black and White women would be pertinent in adding to this growing body of research.

Overall, women in the low-income group reported significantly higher mean distress than women in the high-income group. As hypothesized, low income Black women reported higher levels of distress in financial categories (money for necessities, money for extras, money for emergencies) compared to high income Black women. Although job related stressors (workload, nature of work, job deadlines) were indicated as top stressors among high income Black women, contrary to the hypothesis, high income Black women did not rank family as a top stressor compared to the low-income group. Instead, children and time spent with family were ranked as top uplifts among this population. This data suggests that family was viewed positively, and potentially seen as a means of comfort and support to Black women and did not contribute to heightened levels of distress.

Additionally, both groups highlighted political/societal concerns as a significant stressor. Data from the current study align closely with a recent report from the 2018 APA Stress in America survey, showing nearly two-thirds of adults reported that money, work, and the current political climate were significant sources of stress (8). The current political climate and uncertainty about the nation's future were specifically identified as contributing factors to political climate concerns (8), which were also voiced as issues for MDBW in qualitative analyses. Closer attention to stressful triggers should be analyzed further.

Contrary to hypothesis 1a, education level was not associated with psychological distress. Qualitative findings from the present study could be used to explain the discrepancy between distress in higher educated Black women. Many MDBW reported that higher education led to enhanced knowledge for need to engage in psychological

treatment, greater exposure to resources and access to care, as well as more financial means for mental health treatment. Moreover, several MDBW highlighted having Black educated friends or colleagues who significantly influenced their decision to seek mental health care when needed. Quantitative and qualitative data suggest that MDBW's education level lends more exposure and openness to formal care and is not as much of a stressor as it is a psychological benefit. These findings lend support to prior studies (9) which found that educational attainment among Black women serve as protective factors against distress and depressive symptoms. Specifically, higher education was shown to reduce psychological distress and depressive symptoms.

Lastly, findings from Aim 1 suggest that Black women's subjective position in society was also associated with distress, such that women who reported having a higher social standing reported less distress. Quantitative and qualitative findings from the present study support the abovementioned. These data emphasize that greater access, resources, and knowledge will increase the likelihood of improved psychological well-being among Black women.

Overall, based on Aim 1 findings, SES does not appear to fully explain psychological distress among Black women, but seem to be a significant contributor, particularly when examining the effects of income and social status. Research to explore other factors, outside of SES, which may impact psychological well-being within this population is warranted. For example, future research could assess relationship satisfaction and psychological distress, as well as the relationship between academic setting (Black women enrolled at a PWI vs. HBCU) and distress.

Understanding Help-Seeking Intentions

The second aim of this study was to investigate help-seeking intentions among MDBW using the TBP and then to follow up with qualitative analyses. The TBP was adapted for this study, utilizing three culturally relevant predictor variables: the SBW Schema, stigma (self and public), and discrimination (racist, sexist). Attitudes toward help-seeking were operationalized using the SBW Schema within the TPB. The SBW Schema was not associated with help-seeking intentions. However, the qualitative data on attitudes suggest there may be an evolution in this SBW syndrome whereby some are incorporating self-care and vulnerability into concepts of strength. There was recognition by some participants that seeking care is actually a sign of strength. At the same time, there were participants that saw help-seeking as weak and to be avoided. Additionally, there was recognition by some that help-seeking would not be supported by some of their family, for example. Future studies should take into consideration the transition that may be underway for some Black women and how it may impact the SBW schema.

Stigma measures were used to operationalize subjective norms for help-seeking. As predicted, both higher public stigma and self-stigma were associated with lower intention to seek help. Consistent with findings from previous studies (114) on public stigma, MDBW endorsed moderate levels of public stigma. Wallace and Constantine (114) found similar stigma mean scores among his population of college-aged Black males and females. Intersectionality of race/ethnicity, sex, class, and achievement may contribute to the exacerbation of distress and mental health illness, while also contributing to a decline in mental health service help-seeking and utilization due to negative perceptions of help-seeking among society, family and friends.

Attitudes and beliefs held by the general population (public stigma) were recognized as a determining factor in hindering help-seeking among this population. Fear of being judged or misunderstood by others, denial about mental illness, as well as the common misconception of Black women being immune from mental illness were voiced by MDBW as essential ideas they deemed important for society to know about Black women and mental health. Data from this study were similar to stigma related themes found in Alvidrez and colleagues' (7) and Ward et al. (115). Moreover, norms from Komiya and colleagues (63) revealed that college-aged women scored lower on the public stigma scale than MDBW in this study, indicating that the population of interest has greater perception of stigma associated with help-seeking.

MDBW's increased perception of stigma toward help-seeking can possibly be explained from a cultural lens. MDBW are exposed to several different cultures within their daily interactions. Each of these cultures carry their own norms and standards and MDBW must learn to navigate these individual environments. MDBW's perception of mental health self is complicated: within the Black community, mental health stigma is rampant. Contrastingly, society's views of psychological help-seeking are more accepted but appear to be less understood and perceived as not being as needed among MDBW. Due to the complex nature of stigmatization and MDBW's emergence into each culture, MDBW may encounter lower sense of belonging (being accepted by members of your group) within both communities, further impacting help-seeking intentions. For example, a MDBW who considers pursuing professional psychological care may become conflicted with her decision to seek treatment because she worries about being "disowned", considered "a sellout" or being seen as "an oreo" by adapting to White

norms from other members of the Black community. At the same time, the MDBW can also experience dissonance by believing that her White and male coworkers' stereotypes of Black women will be confirmed if she seeks help. For example, perceptions of the MDBW as "weak" or "vulnerable" may occur among coworkers, which may cause the MDBW to reconsider her decision to seek care. This latter behavior may be largely because she wants her coworkers to view her as strong, capable, and able to manage her mental well-being while also wrestling with work and family stressors.

Endorsing higher public stigma has been found to be associated with negative factors such as lower self-esteem and less sense of belonging, as well as mixed emotions and behaviors, to include anger and isolation. Internalization of these beliefs about self (self-stigma) are developed based on societal standards and persist due to endorsement and internalization of stereotypes and social learning (131). Shame and embarrassment of mental illness or potential need for a higher level of care could consequentially result in denial or decline in help-seeking.

Further insights into the relationship between public and self-stigma and help-seeking were seen in the qualitative data where women described the existence of stigma to prevent treatment seeking though some noted it was changing and also noted that seeking friends was sometimes preferred because there is less stigma and judgment versus family. These data highlight that despite education level, income, social status, stigma is still the primary barrier of help-seeking among Blacks. Although MDBW's perceptions of mental health treatment are starting to shift in a positive direction, these discrepancies remain relevant and consequential to this population's well-being and should be further explored to fully understand the needs of MDBW.

Sexist and racist discrimination were not associated with help-seeking intentions. Reports of discrimination experiences were low compared to other samples (26; 64). There are several possible explanations to be considered moving forward when examining this relationship in future research. One such explanation is that these assessments were not tied to health care or care seeking. They are measures of general experiences of discrimination. Future research may want to examine experiences of discrimination tied to help-seeking. Another possible explanation is the fact that most of this sample experienced some level of discrimination. The commonality of this experience may make it less likely to be of meaning in predicting help-seeking behavior. There is no doubt that discrimination is a stressor for Black women and, in fact, a recent report (8) suggests that nearly half of Black adults indicated that discrimination was a significant stressor in their daily lives.

It is also possible that the source of discrimination varies. Reported experiences found in this study differed slightly from earlier research (64). Landrine and Klonoff (64) found Blacks reported higher levels of discrimination by strangers, people in service jobs, and by institutions and policies while MDBW in the present study indicated experiencing higher levels of racial discrimination by institutions and its policies throughout their lifetime. For example, as indicated by qualitative responses, MDBW identified difficulties having to prove worth, frequent microaggressions, and experiences of racism in academic and work settings. Future studies should explore racial and sexist discrimination in academic and occupational settings.

The present study has several strengths and weaknesses. The strengths of this study included targeting and successfully recruiting an often-understudied group.

Additionally, the TPB was culturally tailored and extended. Aspects of this framework appear promising, but perhaps most importantly, this study serves as a model for the need to adjust such models and takes the next steps in how to adjust such models so they may be used to predict the intentions and behavior of understudied groups and populations suffering from health disparities.

Several limitations from the current study should be noted. One limitation of the study was reliance on the Predicting Mental Health Service Utilization Scale (PMHSUS) to assess intention to seek mental health care. This scale was developed for the purposes of this study. Though this measure has face validity, conclusions regarding its validity (does it measure help-seeking intention) require further study. The measure is correlated with the stigma measures, but not associated with the SBW schema measure or measures of discrimination. Again, before conclusions can be drawn, the validity of this measure must be examined.

Another limitation of this study was the recruitment strategy. This study used a convenience sampling method. Black women who chose to participate in the study could have been more willing to discuss their mental health concerns and psychological help-seeking than those who did not select to participate in the study. Further, the study was heavily advertised using social media platforms, targeting Black women who were highly educated (i.e., Master's degree or higher) in helping professions and consistently shared with women from similar backgrounds. Women who work in helping professions could have responded in a manner indicative of how they believed their clients or patients should behave versus their own beliefs. The study was also based on self-report measures. Although anonymous, participants could have decided not to disclose personal

information due to stigma and lack of trust in hierarchal systems. Women could have provided socially desirable responses to questions. Future replication studies should involve different recruitment strategies and include a social desirability scale.

Additionally, respondents were not asked if they had been diagnosed with a psychological disorder or current and prior treatment status. Respondents' views could have been biased based on previous diagnoses or treatment. Respondents who endorsed prior or current mental health diagnoses could have differed compared to those who did not endorse prior or current psychological diagnoses. Responses from both groups could have been compared to further explore differences in psychological distress, as well as socio-cultural variables assessed within this study. Future studies should include questions to assess psychiatric treatment history.

Implications

Collectively, findings from this study have several implications for best practices, psychoeducation, and research. MDBW expressed discomfort and distrust with sharing mental health status and concerns with clinicians who are not culturally competent or not from the same sex/race. Overall, while the racial/ethnic matching literature suggests matching clients with same race therapists does not have a significant impact on mental health treatment outcomes (24; 60), provider's cultural competency and ability to discuss key aspects of a client's experience related to topics such as discrimination may be important in treatment engagement and retention and client satisfaction (24; 60; 73; 105). As noted by others, there is a need for refining and defining the key concepts related to ethnic matching and cultural competency and an examination on the impact of these

variables on treatment seeking, engagement, and outcomes.

Further, as noted elsewhere, implementing culturally relevant practices and training culturally competent providers are needed in order to advance Black women's psychological well-being. Ensuring Black women (and men) are in the educational pipeline and ready to function as providers is also key as they may be seen as more accessible to this population and may "arrive" culturally competent. Moreover, educational initiatives for not only providers, but the Black community should be put into place. Raising awareness, educating minorities about mental health diagnoses, and debunking myths about mental health is warranted in order to assist in building trust and decreasing stigma toward mental health care. One approach to building trust within this population is to raise awareness through media outlets, such as television and radio. More recent celebrity endorsements of the mental health crisis within the Black community has sparked interest and some acceptance into seeking and engaging in professional mental health care. Popular television shows portraying Black women acknowledging psychological concerns and seeking assistance in a professional capacity will assist in establishing a new norm within the Black community. Recent episodes of shows such as 'Insecure' and 'She's Gotta Have It' have not only portrayed Black women seeking mental health care but has also provided a more realistic interpretation of session structure, a far cry from depictions of Freudian-type psychology sessions from previous TV shows. More so, the depiction of Black women in Psychologist roles within these shows further displays the impact of culturally aware and sensitive providers on Black women's well-being.

Additionally, new findings of the current political/social climate contributing to

ongoing distress and psychological concerns among Black women should be further investigated. Culturally relevant resources and programs to assist these women in processing and coping with current environmental stressors plaguing women (e.g., sexual harassment, sexual assault, abortion laws) and within the Black community (e.g., police shootings, KKK revitalization) should be implemented in clinical settings and readily accessible for Black women. Current environmental stressors have been largely ignored, particularly among Black women. As such, targeting current suppression/oppression when designing and adapting mental health services for Black women would be pertinent.

Closely related with efforts to improve political/social climate (a noted stressor among this population), implementation of several policies should be considered. One such policy is a potential for 100% annual mental health screenings, for all minorities, regardless of income level. Additionally, due to frequent misdiagnoses and under diagnoses of particular MH disorders (e.g., Schizophrenia, mood disorders) in Blacks (70), policies promoting more recurrent and effective screening strategies should be implemented. More targeted screenings will assist in prevention of mental health disorders, as well as inform intervention strategies for more efficacious treatment among this population.

Policies to train incoming and current health professionals on the importance of intersectionality within treatment interventions and outcomes is also needed. Culture, as well as stigma and other factors (ethnic background, race), have been shown to impact Blacks' self-report and symptom expression of mental illness (70). Undertrained and culturally incompetent clinicians with a lack of awareness about self-report and symptom

expression among this population could affect diagnostic clarification and consequentially, result in ineffective treatment plans and referrals.

Policies should promote improved quality of mental health care. For example, this study highlighted that Black women experienced some type of discrimination by institutions and its policies throughout their lifetime. Annual in-person courses (during graduate or professional programs) and trainings (for early to late career clinicians) to address discriminatory practices and process improvement in mental health should be mandatory for all professionals in the field. Implementing some, if not all of these policies, could reduce feelings of discrimination, stigma about mental health help-seeking and treatment, and increase sense of belonging and trust within the medical community.

Conclusion and Recommendations

Causes and levels of psychological distress among Black women vary, depending on income, education level, and social status. To date, there has been a scarcity of research exploring the mental health needs among Black women who are highly educated and have obtained a mid to high income level. Stigma (self and public) has been identified as the primary factor in shaping Black women's use of coping and mental health resources (formal vs. informal) and is associated with distress type and level and overall help-seeking intentions. As Black women continue to advance academically and develop more earning potential, contributing factors, such as stigma and other environmental stressors (e.g., workload, academic, family) stressors may intensify. Developing strategies to target these concerns and coping mechanisms to help this population will be critical.

Cultural variables, such as stigma, remain a significant barrier to professional mental health help-seeking within the Black community. More quantitative studies assessing cultural variables' impact on help-seeking intentions should be conducted. Although qualitative findings have provided a wealth of information about Black women, the SBW schema, and help-seeking intentions, there has been limited data that quantitatively explores these women's attitudes and beliefs. Therefore, additional qualitative and quantitative research exploring help-seeking intentions among minorities should be implemented to gain a deeper understanding of contributing factors to psychological stress, as well as barriers to psychological care.

Further, using well-established frameworks that have been shown to predict help-seeking intentions and behaviors among different populations, such as the TPB model, is critical. Models such as the TPB can be extended, integrating culturally specific concepts unique to minority populations to assist in predicting help-seeking intentions or behaviors. Extending these models can yield further insight into the attitudes, beliefs, and significant barriers that continue to increase the mental health disparities gap.

APPENDICES

APPENDIX A. RECRUITMENT AND INFORMED CONSENT

Recruitment Flyer

A recruitment flyer for a mental health survey. The flyer features a profile of a Black woman on the right side, looking towards the left. The background is white with large, colorful diagonal stripes in blue, red, and yellow. The text is arranged in a clear, readable format. The main title is in a large, blue, serif font. Below it, the subtitle is in a smaller, purple, serif font. The body text is in a black, serif font, with some lines underlined. The contact information is in a purple, serif font. The final line is in a black, serif font.

Make Your Voice Heard

Participate in a Mental Health Survey!

Why: *To discuss thoughts and feelings about seeking mental health care*

Who: *Black women between ages 22 - 66*

What: *30-35 minute online survey*

Where: *Access link here:*

<https://www.surveymonkey.com/r/HelpSeeking>

For questions about the survey, please call: 804-620-7451

Individuals will be entered into a raffle to win one of two \$100 gift cards

Email Example

Good (Time of Day) (Organization Name/POC),

I would like to tell you about an exciting research study that may be of interest to some of your organization's members. We are conducting a research study at American University on formal mental health help-seeking among African American women. We are primarily interested in race, sex, attitudes, thoughts, and feelings toward mental health care within this population. We are looking for African American females between the ages of 22 and 66 to participate in the study. The study will be conducted online and will take 30-35 minutes to complete. If they choose, participants will be entered into a raffle to win a \$100 Target gift card upon completion of the survey.

Interested individuals should click on the following link:

<https://www.surveymonkey.com/r/HelpSeeking>

Thank you for your time.

Jacquelin Darby, Psy.D

Counseling Center

American University

jdarby@american.edu

Consent Form

Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by Dr. Michele Carter from American University. The purpose of this study is to better understand formal mental health help-seeking intentions among Black women.

Research Procedures

Should you decide to participate in this research, you will be asked to electronically sign this consent form on SurveyMonkey. This study consists of surveys that will be administered to individual participants online. You will be asked to provide answers to a series of questions related to attitudes, thoughts, and feelings toward mental health care. Additionally, you will be asked to answer questions about racial and sexist discrimination.

Time Required

Participation in this study will require 30-35 minutes of your time.

Risks

The investigators do not perceive more than minimal risks from your involvement in this study. It is expected that experiences in mental health help-seeking intentions may differ among race/ethnicity, education level, and economic circumstances for women. Your responses may evoke feelings of embarrassment, discomfort, and distress. We ask that you respond to questions openly and honestly, as your responses will help us to better understand experiences in mental health help-seeking and tailor resources and interventions for diverse groups of women.

Benefits

There are no direct benefits of your participation in the study; however, the information collected from this study will help further the extant scientific literature.

Payment

Upon completion of the questionnaires, you will be asked if you would like to be entered into a raffle to receive a \$100 Target gift card. There will be two \$100 Target gift cards available. If you have selected to enter the raffle, you will be asked to provide an email address in order to be contacted following the survey.

Confidentiality

Your participation and responses will be anonymous and confidential. In the event of any publication or presentation resulting from the research, no personally identifiable information will be shared. The results of this project will be coded in such a way that the respondent's identity will not be attached to the final form of this study. The researcher retains the right to use and publish non-identifiable data. While individual responses are confidential, data will be presented representing averages or generalizations about the responses as a whole. Responses will be stored on a password-protected computer that

only the research team can access. Upon completion of the study, all information that matches up individual respondents with their answers will be destroyed.

Participation & Withdrawal

You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind. You may also refuse to answer any individual question without consequences.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the final aggregate results of this study, please contact:

Dr. Jacquelin Darby
Counseling Center
American University
jdarby@american.edu

Dr. Michele Carter
Psychology
American University
mcart@american.edu

Questions about Your Rights as a Research Subject

Matt Zembrzusi
IRB Coordinator
American University
(202)885-3447
irb@american.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. I certify that I am at least 22 years of age.

If you have read and understand the consent form and agree to participate, select the “I agree” box to continue to the study.

APPENDIX B. SELF-REPORT MEASURES

The following is a list of self-report measures (in order) included in Appendix B:

Demographic Questionnaire

MacArthur Scale of Subjective Social Status

Hassles and Uplifts Scale (HUS)

Strong Black Woman Cultural Construct Scale (SBWCCS)

Stigma Scale for Receiving Psychological Help (SSRPH)

Self-Stigma of Seeking Help Scale (SSOSH)

Schedule of Racist Events (SRE)

Schedule of Sexist Events (SSE)

Predicting Mental Health Service Utilization Scale (PMHSUS)

Demographics

1. Which best describes your race/ethnicity?
 - a. Black/African American
 - b. Black Caribbean
 - c. Biracial
 - d. African
 - e. Other (Black): _____
2. Which best describes your ethnicity?
 - a. Hispanic or Latina
 - b. Not Hispanic or Latina
3. What is your age? _____
4. What is the highest degree or level of education you have completed?
 - a. Less than high school diploma
 - b. High school degree or equivalent (e.g., GED)
 - c. Some college, no degree
 - d. Technical/Trade/Vocational training
 - e. Associates degree (e.g., AA, AS)
 - f. Bachelor's degree (e.g., BA, BS)
 - g. Master's degree (e.g., MA, MS, MEd)
 - h. Doctoral degree (e.g., PhD, PsyD, EdD)
 - i. Professional degree (e.g., MD, JD)
 - j. Other: (Please specify)
5. Are/Were you a first-generation college student (i.e., one of your parents does not have a college degree)?
 - a. Yes
 - b. No
6. Which best describes your current employment status?
 - a. Employed, full time (40+ hours weekly)
 - b. Employed, part time (Less than 40 hours weekly)
 - c. Unemployed and currently searching for work
 - d. Unemployed and not currently searching for work
 - e. Student, full time
 - f. Student, part time
 - g. Retired
 - h. Self-employed
 - i. Stay at home
 - j. Unable to work/Disabled
7. Which of the following categories best describes your primary area of employment?

- a. Farm laborer, day laborer
 - b. Unskilled worker, service worker
 - c. Machine operator, semi-skilled worker
 - d. Skilled manual worker, craftsman, police and fire services, enlisted military and non-commissioned officer (NCO)
 - e. Clerical/sales, small farm owner
 - f. Technician, semi-professional, supervisor, office manager
 - g. Small business owner, farm owner, teacher, low level manager, salaried worker
 - h. Mid-level manager or professional (e.g.: architect, engineer, accountant, attorney), mid-sized business owner, military officer
 - i. Senior manager or professional (e.g.: physician, college professor, minister), owner or CEO of large business
 - j. Other (Please specify)
8. Which best describes your role with your current employer?
- a. Management
 - b. Staff (Administrative, Support)
 - c. Student
 - d. Temporary employee
 - e. Other: (Please specify)
9. Please classify your **individual** income:
- a. Less than \$20,000
 - b. \$20,000 to \$34,999
 - c. \$35,000 to \$49,999
 - d. \$50,000 to \$74,999
 - e. \$75,000 to \$99,999
 - f. \$100,000 to \$150,000
 - g. Over \$150,000
10. Please classify your **household** income:
- a. Less than \$20,000
 - b. \$20,000 to \$34,999
 - c. \$35,000 to \$49,999
 - d. \$50,000 to \$74,999
 - e. \$75,000 to \$99,999
 - f. \$100,000 to \$150,000
 - g. Over \$150,000
11. What is your marital status?
- a. Single, never married
 - b. Married or in a domestic partnership
 - c. Divorced
 - d. Separated
 - e. Widowed

12. Do you have any children?

- a. Yes
- b. No

13. If you have children, please indicate the number of children: _____

14. Which state in the U.S. do you currently reside in? _____

15. Which best describes the area you live in?

- a. Rural (e.g., open, spread out, countryside, farm, etc.)
- b. Suburban (e.g., suburbs, residential district, surrounds larger cities, and metropolitan areas)
- c. Urban (e.g., city, metropolitan area, large population [i.e., 1,000 people per block])

MacArthur Scale of Subjective Social Status (3; 43)



Imagine that the ladder I am showing you represents the place that people occupy **in society**. At the top of this ladder are the people who have more money, more education and better jobs. At the bottom of the ladder are the people who have less money, less education and worse jobs or are unemployed.

The higher you consider yourself on this ladder, the closer you will be to the people who are at the top of the ladder, and the lower, closer you will be to people who find themselves at the bottom. Where would you place yourself on the ladder? Please indicate the number that best represents where you think you stand at this time in your life, compared to other people **in society**.

Imagine that the ladder I am showing you represents the place that people occupy in **your community**. At the top of this ladder are the people who have more money, more education and better jobs. At the bottom of the ladder are the people who have less money, less education and worse jobs or are unemployed.

The higher you consider yourself on this ladder, the closer you will be to the people who are at the top of the ladder, and the lower, closer you will be to people who find themselves at the bottom.

Where would you place yourself on the ladder? Please indicate the number that best represents where you think you stand at this time in your life, compared to other people in **your community**.



Hassles and Uplifts Scale (36)

HASSLES are irritants—things that annoy or bother you; they can make you upset or angry. UPLIFTS are events that make you feel good; they can make you joyful, glad, or satisfied. Some hassles and uplifts occur on a fairly regular basis and others are relatively rare. Some have only a slight effect, others have a strong effect.

This questionnaire lists things that can be hassles and uplifts in day-to-day life. You will find that during the course of a day some of these things will have been only a hassle for you and some will have been only an uplift. ***Others will have been both a hassle AND an uplift.***

DIRECTIONS: Please think about how much of a hassle and how much of an uplift each item was for you **today**. Please indicate on the left-hand side of the page (under “HASSLES”) how much of a hassle the item was by selecting the appropriate number. Then indicate on the right-hand side of the page (under “UPLIFTS”) how much of an uplift it was for you by selecting the appropriate number.

Remember, select one number on the left-hand (Hassles) side of the page and one number on the right-hand side (Uplifts) of the page for each item.

How much of a hassle was
this item for you today?
HASSLES

How much of an uplift was this
item for you today?
UPLIFTS

0 = None or not applicable
1 = Somewhat
2 = Quite a bit
3 = A great deal

0 = None or not applicable
1 = Somewhat
2 = Quite a bit
3 = A great deal

DIRECTIONS: Please circle one number on the left-hand side (Hassles) and one number on the right-hand side (Uplifts) for each item.

0 1 2 3	1. Your child(ren)	0 1 2 3
0 1 2 3	2. Your parents or parents-in-law	0 1 2 3
0 1 2 3	3. Other relative(s)	0 1 2 3
0 1 2 3	4. Your spouse	0 1 2 3
0 1 2 3	5. Time spent with family	0 1 2 3
0 1 2 3	6. Health or well-being of a family member	0 1 2 3
0 1 2 3	7. Sex	0 1 2 3
0 1 2 3	8. Intimacy	0 1 2 3
0 1 2 3	9. Family-related obligations	0 1 2 3
0 1 2 3	10. Your friend(s)	0 1 2 3
0 1 2 3	11. Fellow workers	0 1 2 3
0 1 2 3	12. Clients, customers, patients, etc.	0 1 2 3

0 1 2 3	13. Your supervisor or employer	0 1 2 3
0 1 2 3	14. The nature of your work	0 1 2 3
0 1 2 3	15. Your workload	0 1 2 3
0 1 2 3	16. Your job security	0 1 2 3
0 1 2 3	17. Meeting deadlines or goals on the job	0 1 2 3
0 1 2 3	18. Enough money for necessities (e.g., food, clothing, housing, health care, taxes, insurance)	0 1 2 3
0 1 2 3	19. Enough money for education	0 1 2 3
0 1 2 3	20. Enough money for emergencies	0 1 2 3
0 1 2 3	21. Enough money for extras (e.g., entertainment, recreation, vacations)	0 1 2 3
0 1 2 3	22. Financial care for someone who doesn't live with you	0 1 2 3
0 1 2 3	23. Investments	0 1 2 3
0 1 2 3	24. Your smoking	0 1 2 3
0 1 2 3	25. Your drinking	0 1 2 3
0 1 2 3	26. Mood-altering drugs	0 1 2 3
0 1 2 3	27. Your physical appearance	0 1 2 3
0 1 2 3	28. Contraception	0 1 2 3
0 1 2 3	29. Exercise(s)	0 1 2 3
0 1 2 3	30. Your medical care	0 1 2 3
0 1 2 3	31. Your health	0 1 2 3
0 1 2 3	32. Your physical abilities	0 1 2 3
0 1 2 3	33. The weather	0 1 2 3
0 1 2 3	34. News events	0 1 2 3
0 1 2 3	35. Your environment (e.g., quality of air, noise level, greenery)	0 1 2 3
0 1 2 3	36. Political or social issues	0 1 2 3
0 1 2 3	37. Your neighborhood (e.g., neighbors, setting)	0 1 2 3
0 1 2 3	38. Conserving (gas, electricity, water, gasoline, etc.)	0 1 2 3
0 1 2 3	39. Pets	0 1 2 3
0 1 2 3	40. Cooking	0 1 2 3
0 1 2 3	41. Housework	0 1 2 3
0 1 2 3	42. Home repairs	0 1 2 3
0 1 2 3	43. Yardwork	0 1 2 3
0 1 2 3	44. Car maintenance	0 1 2 3
0 1 2 3	45. Taking care of paperwork (e.g., paying bills, filling out forms)	0 1 2 3
0 1 2 3	46. Home entertainment (e.g., TV, music, reading)	0 1 2 3
0 1 2 3	47. Amount of free time	0 1 2 3

0 1 2 3	48. Recreation and entertainment outside the home (e.g., movies, sports, eating out, walking)	0 1 2 3
0 1 2 3	49. Eating (at home)	0 1 2 3
0 1 2 3	50. Church or community organizations	0 1 2 3
0 1 2 3	51. Legal matters	0 1 2 3
0 1 2 3	52. Being organized	0 1 2 3
0 1 2 3	53. Social commitments	0 1 2 3

Strong Black Woman Cultural Construct Scale (SBWCCS) (49)

Instructions – Please rate how often you think that each of the following statements apply to you.

1. I believe that it is best not to rely on others.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

2. I feel uncomfortable asking others for help.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

3. I have difficulty showing my emotions.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

4. I do not like to let others know when I am feeling vulnerable.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

5. I believe that everything should be done to a high standard.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

6. I am independent.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

7. I take on more responsibilities than I can comfortably handle.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

8. I believe I should always live up to other's expectations.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

9. I should be able to handle all that life gives me.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

10. I am strong.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

11. I need people to see me as always confident.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

12. I like being in control in relationships.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

13. I cannot rely on others to meet my needs.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

14. I take on others' problems.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

15. I feel that I owe a lot to my family.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

16. People think that I don't have feelings.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

17. I try to always maintain my composure.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

18. It is hard to say, “No,” when people make requests of me.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

19. I do not like others to think of me as helpless.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

20. I do not let most people know the “real” me.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

21. In my family I give more than I receive.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

22. At times I feel overwhelmed with problems.

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	------------------

Stigma Scale for Receiving Psychological Help (63)

Instructions: Please rate how often you think that each of the following statements apply to you.

0= Strongly Disagree 1 = Disagree 2 = Agree 3 = Strongly Agree

1. Seeing a psychologist for emotional or interpersonal problems carries social stigma.
2. It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems.
3. People will see a person in a less favorable way if they come to know that he/she has seen a psychologist.
4. It is advisable for a person to hide from people that he/she has seen a psychologist.
5. People tend to like those who are receiving professional psychological help.

Self-Stigma of Seeking Help Scale (113)

Instructions. People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1. I would feel inadequate if I went to a therapist for psychological help.

1	2	3	4	5
Strongly Disagree	Disagree	Agree and Disagree Equally	Agree	Strongly Agree

2. My self-confidence would NOT be threatened if I sought professional help.

1	2	3	4	5
Strongly Disagree	Disagree	Agree and Disagree Equally	Agree	Strongly Agree

3. Seeking psychological help would make me feel less intelligent.

1	2	3	4	5
Strongly Disagree	Disagree	Agree and Disagree Equally	Agree	Strongly Agree

4. My self-esteem would increase if I talked to a therapist.

1	2	3	4	5
Strongly Disagree	Disagree	Agree and Disagree Equally	Agree	Strongly Agree

5. My view of myself would not change just because I made the choice to seek professional help.

1	2	3	4	5
Strongly Disagree	Disagree	Agree and Disagree Equally	Agree	Strongly Agree

6. It would make me feel inferior to ask a therapist for help.

1	2	3	4	5
Strongly Disagree	Disagree	Agree and Disagree Equally	Agree	Strongly Agree

7. I would feel okay about myself if I made the choice to seek professional help.

1	2	3	4	5
Strongly Disagree	Disagree	Agree and Disagree Equally	Agree	Strongly Agree

8. If I went to a therapist, I would be less satisfied with myself.

1	2	3	4	5
Strongly Disagree	Disagree	Agree and Disagree Equally	Agree	Strongly Agree

9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.

1	2	3	4	5
Strongly Disagree	Disagree	Agree and Disagree Equally	Agree	Strongly Agree

10. I would feel worse about myself if I could not solve my own problems.

1	2	3	4	5
Strongly Disagree	Disagree	Agree and Disagree Equally	Agree	Strongly Agree

Schedule of Racist Events (64)

We are interested in your experiences with racism. As you answer the questions below, please think about your ENTIRE LIFE, from when you were a child to the present. For each question, please circle the number that best captures the things that have happened to you. Answer each question TWICE, once for what has happened to you IN THE PAST YEAR, and once for what YOUR ENTIRE LIFE HAS BEEN LIKE. Use these numbers:

Select 1 = If the event has NEVER happened to you

Select 2 = If the event happened ONCE IN A WHILE (less than 10% of the time)

Select 3 = If the event happened SOMETIMES (10-25% of the time)

Select 4 = If the event happened A LOT (26-49% of the time)

Select 5 = If the event happened MOST OF THE TIME (50-70% of the time)

Select 6 = If the event happened ALMOST ALL OF THE TIME (more than 70% of the time)

1. How many times have you been treated unfairly by teachers or professors because you are Black?

How many times in the past year? 1 2 3 4 5 6

How many times in your entire life? 1 2 3 4 5 6

How stressful was this for you? Not at All 1 2 3 4 5 6 Extremely

2. How many times have you been treated unfairly by your employers, bosses and supervisors because you are Black?

How many times in the past year? 1 2 3 4 5 6

How many times in your entire life? 1 2 3 4 5 6

How stressful was this for you? Not at All 1 2 3 4 5 6 Extremely

3. How many times have you been treated unfairly by your coworkers, fellow students or colleagues because you are Black?

How many times in the past year? 1 2 3 4 5 6

How many times in your entire life? 1 2 3 4 5 6

How stressful was this for you? Not at All 1 2 3 4 5 6 Extremely

4. How many times have you been treated unfairly by people in service jobs (by store clerks, waiters, bartenders, waitresses, bank tellers, and others) because you are Black?

How many times in the past year? 1 2 3 4 5 6
How many times in your entire life? 1 2 3 4 5 6

How stressful was this for you? Not at All 1 2 3 4 5 6 Extremely

5. How many times have you been treated unfairly by strangers because you are Black?

How many times in the past year? 1 2 3 4 5 6
How many times in your entire life? 1 2 3 4 5 6

How stressful was this for you? Not at All 1 2 3 4 5 6 Extremely

6. How many times have you been treated unfairly by people in helping jobs (doctors, nurses, psychiatrists, case workers, dentists, school counselors, therapists, social workers and others) because you are Black?

How many times in the past year? 1 2 3 4 5 6
How many times in your entire life? 1 2 3 4 5 6

How stressful was this for you? Not at All 1 2 3 4 5 6 Extremely

7. How many times have you been treated unfairly by neighbors because you are Black?

How many times in the past year? 1 2 3 4 5 6
How many times in your entire life? 1 2 3 4 5 6

How stressful was this for you? Not at All 1 2 3 4 5 6 Extremely

8. How many times have you been treated unfairly by *institutions* (schools, universities, law firms, the police, the courts, the Department of Social Services, the Unemployment Office and others) because you are Black?

How many times in the past year? 1 2 3 4 5 6
How many times in your entire life? 1 2 3 4 5 6

- | | | | | | | | |
|--|---------------------------------|------------|---|---|---|---|-----------|
| | | Not at All | | | | | Extremely |
| | How stressful was this for you? | 1 | 2 | 3 | 4 | 5 | 6 |
9. How many times have you been treated unfairly by *people that you thought were your friends* because you are Black?
- | | | | | | | |
|-------------------------------------|---|---|---|---|---|---|
| How many times in the past year? | 1 | 2 | 3 | 4 | 5 | 6 |
| How many times in your entire life? | 1 | 2 | 3 | 4 | 5 | 6 |
- | | | | | | | | |
|--|---------------------------------|------------|---|---|---|---|-----------|
| | | Not at All | | | | | Extremely |
| | How stressful was this for you? | 1 | 2 | 3 | 4 | 5 | 6 |
10. How many times have you been *accused or suspected of doing something wrong* (such as stealing, cheating, not doing your share of the work, or breaking the law) because you are Black?
- | | | | | | | |
|-------------------------------------|---|---|---|---|---|---|
| How many times in the past year? | 1 | 2 | 3 | 4 | 5 | 6 |
| How many times in your entire life? | 1 | 2 | 3 | 4 | 5 | 6 |
- | | | | | | | | |
|--|---------------------------------|------------|---|---|---|---|-----------|
| | | Not at All | | | | | Extremely |
| | How stressful was this for you? | 1 | 2 | 3 | 4 | 5 | 6 |
11. How many times have people *misunderstood your intentions and motives* because you are Black?
- | | | | | | | |
|-------------------------------------|---|---|---|---|---|---|
| How many times in the past year? | 1 | 2 | 3 | 4 | 5 | 6 |
| How many times in your entire life? | 1 | 2 | 3 | 4 | 5 | 6 |
- | | | | | | | | |
|--|---------------------------------|------------|---|---|---|---|-----------|
| | | Not at All | | | | | Extremely |
| | How stressful was this for you? | 1 | 2 | 3 | 4 | 5 | 6 |
12. How many times did you *want to tell someone off for being racist but didn't say anything*?
- | | | | | | | |
|-------------------------------------|---|---|---|---|---|---|
| How many times in the past year? | 1 | 2 | 3 | 4 | 5 | 6 |
| How many times in your entire life? | 1 | 2 | 3 | 4 | 5 | 6 |
- | | | | | | | | |
|--|---------------------------------|------------|---|---|---|---|-----------|
| | | Not at All | | | | | Extremely |
| | How stressful was this for you? | 1 | 2 | 3 | 4 | 5 | 6 |

13. How many times have you been *really angry about something racist that was done to you?*

How many times in the past year? 1 2 3 4 5 6

How many times in your entire life? 1 2 3 4 5 6

How stressful was this for you? Not at All 1 2 3 4 5 6 Extremely

14. How many times were you *forced to take drastic steps* (such as filing a grievance, filing a lawsuit, quitting your job, moving away, and other actions) to deal with some racist thing that was done to you?

How many times in the past year? 1 2 3 4 5 6

How many times in your entire life? 1 2 3 4 5 6

How stressful was this for you? Not at All 1 2 3 4 5 6 Extremely

15. How many times have you *been called a racist name like nigger, coon, jungle bunny or other names?*

How many times in the past year? 1 2 3 4 5 6

How many times in your entire life? 1 2 3 4 5 6

How stressful was this for you? Not at All 1 2 3 4 5 6 Extremely

16. How many times have you *gotten into an argument or a fight about something racist that was done or said to your or done to somebody else?*

How many times in the past year? 1 2 3 4 5 6

How many times in your entire life? 1 2 3 4 5 6

How stressful was this for you? Not at All 1 2 3 4 5 6 Extremely

17. How many times have you been *made fun of, picked on, pushed, shoved, hit, or threatened with harm* because you are Black?

How many times in the past year? 1 2 3 4 5 6

How many times in your entire life? 1 2 3 4 5 6

How stressful was this for you? Not at All 1 2 3 4 5 6 Extremely

18. How different would your life be now if you *HAD NOT BEEN* treated in a racist and unfair way?

In the past year?

Same as now	A little different	Different in a few ways	Different in a lot of ways	Different in most ways	Totally different
1	2	3	4	5	6

In your entire life?

Same as now	A little different	Different in a few ways	Different in a lot of ways	Different in most ways	Totally different
1	2	3	4	5	6

Schedule of Sexist Events (62)

DIRECTIONS: Please think carefully about your life as you answer the questions below. For each question, read the question and then answer it twice: answer once for what your ENTIRE LIFE (from when you were a child to now) has been like, and then once for what the PAST YEAR has been like. Select the number that best describes events in YOUR ENTIRE LIFE and in the PAST YEAR, using these rules:

Select 1 = If the event has NEVER happened to you

Select 2 = If the event happened ONCE IN A WHILE (less than 10% of the time)

Select 3 = If the event happened SOMETIMES (10-25% of the time)

Select 4 = If the event happened A LOT (26-49% of the time)

Select 5 = If the event happened MOST OF THE TIME (50-70% of the time)

Select 6 = If the event happened ALMOST ALL OF THE TIME (more than 70% of the time)

1. How many times have you been treated unfairly by *teachers or professors* because you are a woman?

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6

How many times IN THE PAST YEAR? 1 2 3 4 5 6

2. How many times have you been treated unfairly by your *employer, boss or supervisors* because you are a woman?

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6

How many times IN THE PAST YEAR? 1 2 3 4 5 6

3. How many times have you been treated unfairly by *your coworkers, fellow students or colleagues* because you are a woman?

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6

How many times IN THE PAST YEAR? 1 2 3 4 5 6

4. How many times have you been treated unfairly by *people in service jobs (by store clerks, waiters, bartenders, waitresses, bank tellers, mechanics, and others)* because you are a woman?

How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6

How many times IN THE PAST YEAR? 1 2 3 4 5 6

5. How many times have you been treated unfairly by *strangers* because you are a woman?

How many times IN YOUR ENTIRE LIFE?	1 2 3 4 5 6
How many times IN THE PAST YEAR?	1 2 3 4 5 6

6. How many times have you been treated unfairly by *people in helping jobs* (by *doctors, nurses, psychiatrists, case workers, dentists, school counselors, therapists, pediatricians, school principals, gynecologists, and others*) because you are a woman?

How many times IN YOUR ENTIRE LIFE?	1 2 3 4 5 6
How many times IN THE PAST YEAR?	1 2 3 4 5 6

7. How many times have you been treated unfairly by *neighbors* because you are a woman?

How many times IN YOUR ENTIRE LIFE?	1 2 3 4 5 6
How many times IN THE PAST YEAR?	1 2 3 4 5 6

8. How many times have you been treated unfairly by *your boyfriend, husband, or other important man in your life* because you are a woman?

How many times IN YOUR ENTIRE LIFE?	1 2 3 4 5 6
How many times IN THE PAST YEAR?	1 2 3 4 5 6

9. How many times have you been *denied a raise, a promotion, tenure, a good assignment, a job, or other such thing at work that you deserved* because you are a woman?

How many times IN YOUR ENTIRE LIFE?	1 2 3 4 5 6
How many times IN THE PAST YEAR?	1 2 3 4 5 6

10. How many times have you been *treated unfairly by your family* because you are a woman?

How many times IN YOUR ENTIRE LIFE?	1 2 3 4 5 6
How many times IN THE PAST YEAR?	1 2 3 4 5 6

11. How many times have people *made inappropriate or unwanted sexual advances to you* because you are a woman?
- How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6
12. How many times have people *failed to show you the respect that you deserve* because you are a woman?
- How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6
13. How many times have you *wanted to tell someone off for being sexist*?
- How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6
14. How many times have you been *really angry about something sexist that was done to you*?
- How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6
15. How many times were you *forced to take drastic steps (such as filing a grievance, filing a lawsuit, quitting your job, moving away, and other actions)* to deal with some sexist thing that was done to you?
- How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6
16. How many times have you been *called a sexist name like bitch, cunt, chick, or other names*?
- How many times IN YOUR ENTIRE LIFE? 1 2 3 4 5 6
How many times IN THE PAST YEAR? 1 2 3 4 5 6
17. How many times have you *gotten into an argument or a fight about something sexist that was done or said to you or done to somebody else*?

How many times IN YOUR ENTIRE LIFE?	1	2	3	4	5	6
How many times IN THE PAST YEAR?	1	2	3	4	5	6

18. How many times have you been *made fun of, picked on, pushed, shoved, hit, or threatened with harm* because you are a woman?

How many times IN YOUR ENTIRE LIFE?	1	2	3	4	5	6
How many times IN THE PAST YEAR?	1	2	3	4	5	6

19. How many times have you *heard people making sexist jokes, or degrading sexual jokes*?

How many times IN YOUR ENTIRE LIFE?	1	2	3	4	5	6
How many times IN THE PAST YEAR?	1	2	3	4	5	6

20. How *different* would your life be now if you HAD NOT BEEN treated in a sexist and unfair way?

How many times IN YOUR ENTIRE LIFE?	1	2	3	4	5	6
How many times IN THE PAST YEAR?	1	2	3	4	5	6

THROUGHOUT YOUR ENTIRE LIFE?

The Same	A little different	Different in a few ways	Different in a lot of ways	Different in most ways	Totally different
1	2	3	4	5	6

IN THE PAST YEAR?

The Same	A little different	Different in a few ways	Different in a lot of ways	Different in most ways	Totally different
1	2	3	4	5	6

Predicting Mental Health Service Utilization Scale (PMHSUS)

Instructions: Please indicate which response best describes your attitudes, beliefs, and intentions toward seeking **formal** mental health care (i.e., psychologists, mental health nurses, social workers, and psychiatrists) when distressed.

1. Seeking mental health services is:

Very: ____ 1__:____ 2__:____ 3__:____ 4__:____ 5__:____ 6__:____ 7__: Very
Useless Useful

2. Seeking mental health services will be:

Very: ____ 1__:____ 2__:____ 3__:____ 4__:____ 5__:____ 6__:____ 7__: Very
Worthless Worthwhile

3. Most people who are important to me approve of my seeking professional psychological help (i.e., from a psychiatrist; mental health nurse; social worker; psychologist) when needed.

Definitely: ____ 1__:____ 2__:____ 3__:____ 4__:____ 5__:____ 6__:____ 7__: Definitely
False True

4. Most people *like me* seek professional psychological help (i.e., from a psychiatrist; mental health nurse; social worker; psychologist) when needed.

Definitely: ____ 1__:____ 2__:____ 3__:____ 4__:____ 5__:____ 6__:____ 7__: Definitely
False True

5. I am confident that I will seek formal mental health services if I want to.

Definitely: ____ 1__:____ 2__:____ 3__:____ 4__:____ 5__:____ 6__:____ 7__: Definitely
False True

6. Seeking and utilizing mental health services is completely up to me.

Definitely: ____ 1__:____ 2__:____ 3__:____ 4__:____ 5__:____ 6__:____ 7__: Definitely
Disagree Agree

7. I intend to **seek** formal mental health services if I experience distress and/or other emotional problems.

Definitely: ___ 1___:___ 2___:___ 3___:___ 4___:___ 5___:___ 6___:___ 7___: Definitely
False True

8. I intend to **utilize** formal mental health services if I experience distress and/or other emotional problems.

Definitely: ___ 1___:___ 2___:___ 3___:___ 4___:___ 5___:___ 6___:___ 7___: Definitely
False True

APPENDIX C. QUALITATIVE QUESTIONS

1. Do you agree or disagree with the following statement: Blacks with higher education are less likely to seek formal mental health treatment. Why do you disagree/agree?
2. How do you view people **who seek mental health services**?
3. How do you view **Black women** who seek mental health services?
4. How do you feel when speaking to family and friends about your mental health?
5. What factors do you believe impact **your** mental health the most and why?
6. On what circumstances would you choose to utilize mental health services?
7. What ideas do you believe are essential for society to understand about **Black women** with mental health issues?
8. What do you believe should be done in order to improve mental health utilization in **Black women**?

APPENDIX D. ADDITIONAL STUDY RESULTS

Table 4. Matrix of Correlation Coefficients for Demographics

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
(1) Education Level		-.20*	.06	.44**	.36**	.07	.05	.14	.07
(2) Generational status	-.20*		-.03	-.10	-.04	-.08	.06	-.01	-.03
(3) Employment Status	.06	-.03		-.15	-.14	.01	-.11	.04	.06
(4) Income-Individual	.44**	-.10	-.15		.79**	.20*	-.22*	-.05	.34**
(5) Income-Household	.36**	-.04	-.14	.79**		.26**	-.31**	-.09	.35**
(6) Marital Status	.07	-.08	.10	.20*	.26**		-.50**	-.31**	.52**
(7) Parental Status	.05	.06	-.11	-.22*	-.31**	-.50**		.30**	-.41**
(8) Lived Area	.14	-.01	.04	-.05	-.09	-.31**	.30**		-.26**
(9) Age	.07	-.03	.06	.34**	.35**	.52**	-.41**	-.26**	

*p < .05

**p < .01

Table 5. Matrix of Correlation Coefficients for Measures

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
(1) SSS Society		.54**	-.37**	.13		-.13	-.01	.11	-.34	-.17	-.26	.38**
(2) SSS Community	.54**		-.22*	-.05	-.13	-.01	-.05	-.21*	-.16	-.28**	.02	.19
(3) Hassles	-.37**	-.22*		.41**	.23*	.07	-.02	.44**	.46**	.44**	.12	-.24*
(4) Uplifts	.13	-.05	.41**		.02	.09	.07	.25*	.22*	.21*	.14	.05
(5) SWCCS	-.13	-.13	.23*	.02		.22*	.06	.31**	.33**	.36**	-.01	-.21*
(6) SSRPH	-.01	-.01	.07	.09	.22*		.33*	.08	.19	.17	-.30**	-.13
(7) SSOSH	.11	-.05	-.02	.07	.06	.33**		-.14	-.15	-.20*	-.52**	-.09
(8) SRE Lifetime	-.34**	-.21*	.44**	.25*	.31**	.08	-.14		.83**	.79**	.10	-.15
(9) SRE Appraisal	-.17	-.16	.46**	.22*	.33**	.19	-.15	.83**		.72	.15	.52
(10) SSE Lifetime	-.26**	-.28**	.44**	.21*	.36**	.17	-.20*	.79**	.72**		.13	-.21*
(11) PMHSUS	.06	.02	.12	.14	-.01	-.30**	-.52**	.10	.15	.13		.02
(12) Age	.38**	.19	-.24	.05	-.21*	-.13	-.09	-.15	-.06	-.21*	.02	

*p < .05

**p < .01

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