THE STRONG BLACK WOMAN ARCHETYPE AND INTENTIONS TO SEEK THERAPY FOR DEPRESSION: A CULTURAL APPLICATION OF THE THEORY OF PLANNED BEHAVIOR

By

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ABSTRACT

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Black women are less likely to seek mental health services than their White counterparts (Wise, Adams-Campbell, Palmer, & Rosenberg, 2006). Cultural beliefs and norms may contribute to this disparity in psychological help-seeking. The Strong Black Woman archetype, a salient cultural gender norm which mandates that Black women uphold a mask of emotional and physical strength, appear fiercely self-reliant, and serve as caretaker for their family, church, and community, is one cultural factor that has been associated with depressive symptoms and the low rates of help-seeking among Black women (Beaubouef-Lafontant, 2007). The theory of planned behavior is a well-established psychological theory used to predict a multitude of behavioral intentions, including intentions to seek mental health services (Armitage & Connor, 2001). The theory states that intentions to perform specific behaviors can be predicted by attitudes toward the behavior, subjective norms, and perceived behavioral control (Ajzen, 1991). Because attitudes, norms, and control beliefs about behaviors can be greatly influenced by cultural norms, the Strong Black Woman archetype is important to consider when predicting psychological help-seeking among Black women. The current study examined the relationship between the Strong Black Woman ideal, depressive symptoms, the theory of planned behavior, and intentions to seek therapy for depression. First, a new measure of the Strong Black Woman ideal was created, evaluated, and validated using a sample of
234 Black and White female undergraduates. Three factors were identified (Mask of Strength, Care-Taking, and Self-Reliance). Black women scored significantly higher than White Women on the Strong Black Woman Scale total score and the Mask of Strength and Self-Reliance subscales. Analyses conducted with a second sample of 240 Black adult females examined the relationship between the Strong Black Woman ideal, the theory of planned behavior, and intentions to seek therapy. Analyses revealed that higher scores on the Mask of Strength and Care-Taking domains of the Strong Black Woman ideal were associated with more severe depressive symptoms. The theory of planned behavior significantly predicted intentions to seek therapy, with the addition of the Strong Black Woman ideal and past use of mental health services explaining significant additional variance. Specifically, women who had internalized the Strong Black Woman ideal and had never used mental health services were less likely to seek therapy services in the future. Additionally, the theory of planned behavior mediated the relationship between the Strong Black Woman ideal and intentions to seek therapy for depression. In light of these findings, psychological help-seeking promotion efforts designed for Black women should be informed of the Strong Black Woman archetype as a potential barrier to seeking services. Therapy for depression with Black women should address the potential positive and negative consequences of trying to live up to the Strong Black Woman ideal.
To those whose experiences have thus far been silenced.
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INTRODUCTION

African Americans are less likely to receive mental health services than other racial groups, according to the 2001 U.S. Surgeon General report, (Chow, Jaffee, & Snowden, 2003; U.S. Department of Health and Human Services [USDHHS], 2001). Black women specifically are less likely to receive psychological services than White women, even though they are not psychologically healthier (Wise, Adams-Campbell, Palmer, & Rosenberg, 2006). Research has shown that Black women who do receive specialty mental health services from psychiatrists and therapists use it as a last resort, thereby exacerbating their psychological symptoms over time and presenting more severe symptom pictures upon initial clinical interview (Heurtin-Roberts, Snowden, & Miller, 2001; Williams & Gonzalez et al., 2007).

Treatment barriers such as lack of health insurance and access to care have been cited as possible explanations of this racial disparity in service utilization rates (Revicki et al., 2005). However, this disparity still exists even after controlling for socioeconomic and health insurance status (Padgett, Patrick, Burns, & Schlesinger, 1994; Swartz et al., 1998), leaving the source of this disparity undetermined. The National Comorbidity study found that only 16% of African Americans with a diagnosable mood disorder visited a mental health professional, and less than one third discussed these concerns with a health care provider of any kind (Kessler et al., 1994). Examining additional factors shared by African Americans, such as beliefs about help-seeking and cultural norms, may help to predict intentions to seek mental health treatment and ultimately provide avenues to reduce these disparities.

Womanist theory asserts that the intersection of gender and racial identity for African American women gives rise to a unique constellation of cultural beliefs and standards unshared by both their White female and Black male counterparts (Jones & Shorter-Gooden, 2003). The
Strong Black Woman archetype is a cultural gender norm that describes Black women as strong, invulnerable, and able to withstand pressure without showing discomfort (Wallace, 1978). Those who seek mental health services, however, are often stigmatized as being weak and unable to carry their own burdens (Thomas, Witherspoon, & Speight, 2004). The incongruence between these two views of self may inhibit mental health help-seeking among Black women. Discrepancies between the Strong Black Woman ideal and the true self may also lead to a sense of failure, disappointment, and ultimate depression (self-discrepancy theory; Higgins, 1987). Some scholars have theorized that Black women especially would be at greater risk for depression than White women (Barbee, 1992; Carrington, 2006). However, prevalence studies have again returned mixed results after rates between Black and White women were examined (e.g. higher rates: Wise, Adams-Campbell, Palmer, & Rosenberg, 2006; equal rates: Van Hook, 1999; lower rates: Jonas et al., 2003; Skaer et al., 2000). If cultural beliefs and values affect the initiation of depressive symptoms, they should also be used to inform depression treatment. Therefore, the Strong Black Woman ideal should be examined as a potential risk factor for depression and included in models predicting intentions to seek psychological services.

A well-established social psychological theory of intentions, the theory of planned behavior (Ajzen, 1991) has been successfully used to predict a wide range of behaviors (see Ajzen, 2001 for a review), including psychological help-seeking (Mo & Mak, 2009; Skogstad, Dean, & Spicer, 2006). However, cultural gender norms had never been tested alongside this model, and the relationship between the Strong Black Woman ideal and depressive symptoms had never been examined quantitatively. The current study sought to fill this gap in the literature by creating and validating a measure of the Strong Black Woman ideal and examining its
relationship with depressive symptoms, the theory of planned behavior, and intentions to seek therapy for depression.

Study 1 described the creation and validation of the Strong Black Woman Archetype scale, compared the new scale’s internal consistency and factor structure to previous measures of the Strong Black Woman ideal, and contrasted Black and White female participants’ endorsement of the ideal. Study 2 used the new scale to examine the relationship between the Strong Black Woman ideal, depressive symptoms, the theory of planned behavior, and intentions to seek therapy for depression. Specifically, the study tested: the correlation between the Strong Black Woman and severity of depressive symptoms, the ability of the Strong Black Woman ideal, theory of planned behavior, current depressive symptoms, and past use of mental health services to predict intentions to seek therapy for depression in the future, and the mediating effect of the theory of planned behavior on the relationship between the Strong Black Woman image and therapy-seeking intentions. Finally, limitations, future directions, and implications of study results for help-seeking promotion and therapy with depressed Black women is discussed.
STUDY 1: DEVELOPMENT AND VALIDATION OF THE STRONG BLACK WOMAN ARCHETYPE SCALE

Purpose

The goal of the first study was to develop and validate a measure of the Strong Black Woman ideal. First, the archetype of the Strong Black Woman was defined and distinguished between the Superwoman Ideal common among Caucasian women. Then, previous efforts to measure the Strong Black Woman archetype are reviewed. A new measure of the archetype was proposed, and construct validity, internal consistency, and cultural specificity of the new measure was evaluated. The analysis of the utility of Strong Black Woman Scale items used an emic approach by including only Black female participants. In psychological and anthropological research, a distinction is made between emic and etic approaches to research. Emic approaches focus on constructs indigenous to a particular culture, and etic approaches import constructs developed in one culture to assess those in another culture (Ægisdóttir, Gerstein, Leung, Kwan, & Lonner, 2009). The emic approach used in this study sought to develop a consensus of native informants (Kottak, 2006), namely the Black women in this sample, to determine whether the Strong Black Woman construct proposed in this study matches the perceptions of women in the culture. This emic perspective allowed for a focused look at a cultural gender norm that is meaningful to members of the Black community.

The Strong Black Woman Archetype

The image of the Strong Black Woman is a salient cultural gender norm within the Black community (Harris-Lacewell, 2001; Randolph, 1997, 1999). Examples of the image can be found in literary, film, and popular culture depictions of Black women (Harris, 1995; Thomas, Speight, & Witherspoon, 2005). Literature on the Strong Black Woman archetype has sought to define
this cultural image, juxtapose it with the myth of the superwoman in White culture, and relate it to the initiation of depressive symptoms and reticence to engage in help-seeking in Black women when discrepancies between this ideal and real self arise.

**Defining the Strong Black Woman Archetype**

The Strong Black Woman is defined by her physical strength, emotional invulnerability, struggle, perseverance, self-reliance, care-taking, and self-sacrifice. The Strong Black Woman archetype mandates that Black women appear physically and emotionally strong in front of others. Physical strength has been discussed by lauding Black women’s large size, physical endurance, and ability to do any work a man can do (Harris, 1995; Wallace, 1978). Black women are also expected to appear emotionally strong and not allow the fears and insecurities that afflict other women to show through their mask of strength (Wallace, 1978). Black women are often expected to be unshakable and invulnerable to fatigue or sorrow (Wallace, 1978) and to maintain an appearance of strength in front of others (Beaubouef-Lafontant, 2007).

The life of the Strong Black Woman is defined by struggle and management of life’s obstacles without acknowledging distress (Comas-Diaz & Greene, 1994; Snorton, 1996). Black women are idealized to be capable of tolerating more obstacles and misery than others (Wallace, 1978), including poverty, discrimination, raising children as single parents, illness, and the death of loved ones (Etowa, Keddy, Egbeayemi, & Eghan, 2007; Shambley-Ebron & Boyle, 2006). Black women often view themselves as invincible survivors (Jones & Shorter-Gooden, 2003). In qualitative interviews, participants reported that obstacles and suffering were an expected part of a Black woman’s life and that strength was imperative in order to survive (Beaubouef-Lafontant, 2007). As stated by one participant in a study of Black women living with HIV/AIDS, “I know that I’m a Black woman and I’m strong too. No matter what I go through, I always overcome it,
just being strong and wanting to fight” (Shambley-Ebron & Boyle, 2006, p. 200). This resilience through constant struggle is an essential part of their racialized gender identity (Beaubouef-Lafontant, 2007; Harrington, 2007). Not only are obstacles expected, but Black women are thought to be further strengthened by enduring these difficulties (Etowa et al., 2007; Young, 1989).

The Strong Black Woman archetype also urges Black women to be self-reliant and self-sufficient (Wallace, 1978). Specifically, Black women are expected to be financially independent (Littlefield, 2003) and forego support from others, even as they go through the innumerable obstacles described above (Greene, 1994; Jones & Shorter-Gooden, 2003; McNair, 1992; Morgan, 1999). In qualitative interviews, Black women have reported that even with the confidence afforded by this strong and independent image, the expectation to exhibit superhuman abilities can be a burden (Settles, 2006). Many Black women felt limited by the restrictions present in this racialized gender norm for seeking emotional, physical, or financial support from others (McNair, 1992). Due to the mandate of self-reliance, women may remain silent about their needs even among those that rely on them for support and guidance.

The Strong Black Woman also has the responsibility of caring for children, husbands/lovers, extended family, elders, and community members (Etowa et al., 2007; Heath, 2006; Shambley-Ebron & Boyle, 2006; Young, 1989). Black women have been described as the “mules of the world” (Hurston, 1937) who are able to endure more than others and pull others’ weight. The Black woman often must fulfill multiple roles in her family (Talleyrand, 2006), including those of the financial provider and emotional nurturer (Wallace, 1978; Young, 1989), even to the detriment of her own self-care (Beaubouef-Lafontant, 2007).
Another key component of the Strong Black Woman archetype is self-sacrifice (Harris, 1995). The Black woman is expected to suppress her own physical and emotional needs in order to care for others (Young, 1989) and women who pay attention to their own needs are admonished for appearing weak (Beaubouef-Lafontant, 2007). As one woman described, “[To be a Strong Black Woman] you have to die to yourself. And let everybody else live. And help them live. That’s what our community tells us” (Beaubouef-Lafontant, 2007, p. 42). The Black woman is encouraged to believe that she cannot simultaneously serve her community and attend to her own needs, thereby making self-sacrifice the only responsible option.

Theoretical and qualitative literature on the Strong Black Woman archetype has also described Black women as hardworking (Etowa et al., 2007), good housekeepers (Wallace, 1978), religious (Harris, 1995; Wallace, 1978), good mothers (Davis, 1998; Wallace, 1978), not particularly attractive (Wallace, 1978), too masculine (Harris, 1995; Wallace, 1978), rigid and inflexible (Wallace, 1978), and asserting unquestionable authority over her children (Harris, 1995). Newer Black feminist writers have also discussed the Strong Black Woman archetype (e.g., Springer, 2002). Joan Morgan, the author of *When Chickenheads Come Home to Roost: My Life as a Hip-Hop Feminist* (1999), wrote the idealized image, strongblackwoman, as one word to declare the three terms as inseparable identities. The author herself became burdened with the pressures to always appear strong and controlled. She found herself trapped in the mantra “No matter how bad shit gets, handle it alone, quietly, and with dignity” (Morgan, 1999, p. 72). Both Morgan (1999) and Springer (2002) in her summary of third wave Black feminist writings suggest that there is power in recognizing the pull of this unrealistic standard and displaying vulnerability.

*Defining the Strong Black Woman in Contrast to White Women*
In addition to describing what the Strong Black Woman is, theorists have also focused on what she is not. Specifically, the Strong Black Woman has been contrasted against the normative female gender norms stereotypically embodied by White, middle-class women (Beaubouef-Lafontant, 2003, 2007; Cleaver, 1970; Wallace, 1978). Descriptions of Black women as strong, independent, and aggressive are in stark contrast to descriptions of the mainstream female gender role as sensitive, emotional, dependent, submissive, and passive (Romer, 1980; Stockard & Johnson, 1980; Thomas, 1986). Some have argued that Black women would have to be stronger than other women, because of the history of slavery and the current presence of discrimination, single-parent households, and poverty among Black women (Carey, 1979; Kuppersmith, 1987; Mahmoud, 1998; Wallace, 1978). Harris (1995) theorizes that this contrast between Black and White women arose during slavery as Black women were seen working in the fields alongside men and entering White women’s homes only to take care of their children, cooking, and house cleaning. The life of a Black female during this time was defined by struggle and survival, whereas the life of a wealthy White woman was stereotypically defined as one of privilege and ease (Harris-Lacewell, 2001).

Qualitative work has also captured Black women’s thoughts and feelings about their identity in relation to their White counterparts. In a study of Black Caribbean women from the United Kingdom, participants asserted that the struggle and survival history of Black women has endowed them with strength and resilience unavailable to White women from relatively less strife-marked histories (Edge & Rogers, 2005). A participant in a study of Black West-Indian women from Ontario, Canada echoed a similar sentiment, “I think Black women are stronger [than Whites]. They’ve been, I mean, I’m talking about going back with generations so you were raised to be, you know, the strength of the home, the mother” (Schreiber, Stern, & Wilson, 2000,
p. 41). This participant owed the greater strength of Black women to managing life as the head of the household. Interviews with African American women have uncovered similar comparisons. In one study, Black women described other Black females whose lives were not marked with struggle as “weak,” “not Black,” and “White” (Beaubouef-Lafontant, 2007, p. 38). A 29-year-old divorced mother described her cousin as “livin’ the White life” because she was a successful business owner: “being a Black woman means, you know: You’re at home, you struggle, you get out once in a while, and that’s supposed to be meaningful to you” (p. 38). A life without struggle prevents one from being authentically Black and female.

Distinguishing Between the Strong Black Woman and Superwoman Ideals

Some would argue that a similar gender norm, the Superwoman, exists among White American women. These women are described as striving to fulfill multiple roles, such as wife, mother, homemaker, and business woman (McBride, 1997; Shaevitz, 1984), all while maintaining good looks and physically fit bodies (Poirer-Solomon, 2002). The goal for these women is to perform all of their roles to perfection (Amatea & Cross, 1981; Baker, 1985). The Superwoman syndrome (Shaevitz, 1984) drives women to “have it all”, the perfect husband, high achieving children, an exciting social life, the perfect home, great looks, and the perfect job (Mensinger, Zotter-Bonifazi, & LaRosa, 2007; Poirer-Solomon, 2002; Smolak & Levine, 1996). These Superwomen often attempt to do everything on their own (Poirer-Solomon, 2002) and take care of those around them (Baker, 1985), while holding unrealistic expectations of their abilities (McBride, 1997).

There are several similarities between the Superwoman and the Strong Black Woman. Women who ascribe to these identities spread themselves across multiple roles, feel compelled to take care of others, and refuse to seek support from others. Because of their unrealistic
expectations, trying to live up to these stereotypes can be harmful as women become overwhelmed by their many responsibilities. Negative psychological consequences, such as increased stress and disordered eating, have also been associated with the Superwoman syndrome (e.g., Mensinger et al., 2007; Porter, 2006).

However, there are also important distinctions between the two images (Harris-Lacewell, 2001). The Superwoman’s focus on achieving perfection in all areas is in contrast to the Strong Black Woman’s focus on struggling and surviving when faced with enumerable obstacles. It is expected that the Superwoman will reach high levels of achievement in all of her endeavors. The Superwoman’s goal is not to merely finish a task; the goal is to complete it perfectly. The Strong Black Woman, on the other hand, is praised for just “keeping her head above water” amidst a sea of extenuating circumstances. It is expected that the Strong Black Woman will encounter numerous obstacles, living a life defined by struggle and survival. Although the Superwoman experiences a similar struggle to meet her responsibilities, her life is defined by achievement.

As part of the cultural mandate, the Superwoman is required to find the perfect husband that shares her achievement goals and works to provide equal, if not more, financial support for the family. The Strong Black Woman is expected to remain completely self-reliant, raising her family alone, many times without ever finding an equally contributing male partner. Some have also suggested that the multiple roles of the Strong Black Woman extend to community and church activities, whereas those of the Superwoman do not (West, 1995). The Black woman is often the hands, if not the face, of the Black church and expected to defer attempts at gender parity until racial equality is achieved within the Black community.

*Measuring the Strong Black Woman Archetype*
Three measures were previously developed to assess endorsement of the Strong Black Woman ideal. The first was a dissertation by Thompson (2003) describing preliminary validation of an 18-item “Strong Black Woman Attitudes scale.” Factor analysis suggested a three-factor structure: Self-Reliance, Affect Regulation, and Care-Raking. Although the factor structure is in line with previous descriptions of the Strong Black Woman ideal (e.g., Romero, 2000), the internal consistency of the total and subscales was fairly low (total score: alpha = .74; Self-Reliance: alpha = .69; Affect Regulation: alpha = .72; Care-Taking: alpha = .66). Additionally, Self-Reliance was negatively correlated with Affect Regulation even though theoretical and qualitative literature would predict positive correlations between the three factors. Due to these counter-intuitive results, Thompson (2003) considered whether the construct of self-reliance was adequately measured by the scale items. Also, the validation study included both Black and White women, but did not directly compare groups to determine whether the construct was specific to Black women. The Strong Black Woman Attitudes scale development study has yet to be published and has not been used in any published studies.

The second measure developed to assess the Strong Black Woman ideal was the Superwoman subscale of the Stereotypic Roles for Black Women Scale (Thomas, Witherspoon, & Speight, 2004). In addition to the Strong Black Woman subscale, the 34-item scale included subscales for three other stereotypes of Black women: the Jezebel, Sapphire, and Mammy. As the only published quantitative measure of the Strong Black Woman ideal, it is unfortunate that the reported internal consistency of the Superwoman subscale was fairly low (alpha = .67). Also, with only 11-items in the subscale (see Table 1.1 for scale items), it did not adequately cover the breadth and depth of characteristics outlined by previous literature on the Strong Black Woman ideal. The subscale did not include items that referred to a life defined by struggle and only
included one item related to self-reliance, which would help to distinguish the Strong Black Woman from the Superwoman ideal. Also, the five items that would likely represent the mask of strength/emotional invulnerability domain were almost solely represented by items discussing the ease/difficulty of sharing problems with others (e.g., “I do not want others to know if I experience a problem,” “It is difficult for me to share problems with others,” and “It is easy for me to tell other people my problems (reverse coded)”).

The scale also tried to make distinctions between the Strong Black Woman and the Mammy role that may not accurately reflect the two constructs. Theoretically, there is substantial overlap between the Mammy and Strong Black Woman images. Like the Strong Black Woman ideal, the Mammy is described as a care-taker, nurturing and self-sacrificing. However, the Mammy role also encompasses unshared traits: non-threatening, passive, overly congenial, and deferential to others (Thomas et al., 2004). Although the authors ultimately confirmed a four-factor structure for their scale due to a significant chi-square difference, a three-factor structure which collapsed the Mammy and Strong Black Woman roles had similarly adequate goodness-of-fit index and root mean square error of approximation. This suggested a significant, yet relatively small improvement in fit from the 3- to 4-factor model and considerable overlap between the two stereotypes. The few distinguishing characteristics of the Mammy and Strong Black Woman image (e.g., deference, passivity, and congeniality in the Mammy ideal), surprisingly, were not included in the 5-item Mammy subscale; all of the Mammy subscale items referred to care-taking and self-sacrifice (see Table 1.1).

Additionally, the wording of the Stereotypic Roles for Black Women scale did not allow for racial comparisons of endorsement of the stereotypes. The items specifically referred to Black women, eliminating their relevancy for women of other races (e.g., “Black women have to
be strong to survive” vs. “Women of my race have to be strong to survive”). Although the Thomas et al. (2004) study has been frequently cited for its descriptions of Black female stereotypes, the Superwoman subscale has never been used outside of this preliminary validation study and unpublished dissertations (e.g., Harrington, 2007).
### Table 1.1 Stereotypic Roles for Black Women Scale Items with Suggested Strong Black Woman Domains

<table>
<thead>
<tr>
<th>Scale Items</th>
<th>Suggested Domain Placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>I find it difficult to ask others for help.</td>
<td>X</td>
</tr>
<tr>
<td>Black women have to be strong to survive.</td>
<td>X</td>
</tr>
<tr>
<td>I tell others that I am fine when I am depressed or down.</td>
<td>X</td>
</tr>
<tr>
<td>I do not want others to know if I experience a problem.</td>
<td>X</td>
</tr>
<tr>
<td>It is difficult for me to share problems with others.</td>
<td>X</td>
</tr>
<tr>
<td>It is easy for me to tell other people my problems. (reverse)</td>
<td>X</td>
</tr>
<tr>
<td>If I fall apart, I will be a failure.</td>
<td>X</td>
</tr>
<tr>
<td>I am often expected to take care of family members.</td>
<td>X</td>
</tr>
<tr>
<td>I am always helping someone else.</td>
<td>X</td>
</tr>
<tr>
<td>I will let people down if I take time out for myself.</td>
<td>X</td>
</tr>
<tr>
<td>I am overworked, overwhelmed, and/or underappreciated.</td>
<td>X</td>
</tr>
<tr>
<td>People often expect me to take care of them.</td>
<td>X</td>
</tr>
<tr>
<td>I feel guilty if I cannot help someone.</td>
<td>X</td>
</tr>
<tr>
<td>I feel guilty when I put my own needs before others.</td>
<td>X</td>
</tr>
<tr>
<td>I should not expect nurturing from others.</td>
<td>X</td>
</tr>
<tr>
<td>I often put aside my own needs to help others.</td>
<td>X</td>
</tr>
</tbody>
</table>

Note. SRBWS = Stereotypic Roles for Black Women Scale. SW = Superwoman. M = Mammy.
The most recent measure of the archetype, the Strong Black Woman Cultural Construct Scale, was created and validated in a dissertation by Hamin (2008). Hamin’s goal was to revise Thompson’s (2003) Strong Black Woman Attitudes scale to improve its reliability and confirm its factor structure. The scale was revised by removing one item which previously loaded on multiple factors, rewording six items with previous cross-loadings, adding two items to increase the number of Care-Taking and Self-Reliance scale items, and re-introducing/re-wording items previously discarded by Thompson through the scale validation process. The item evaluation process resulted in 22-items and three subscales with a range of somewhat low to adequate internal consistencies: total score: alpha = .76 (vs .74 on Thompson scale); Self-Reliance: alpha = .62 (vs .69); Affect Regulation: alpha = .69 (vs .72); Care-Taking: alpha = .75 (vs .66).

Although improvement of internal consistency was the goal, the revised scale actually had similar, if not less reliable, internal consistency.

The author also sought to improve Self-Reliance scale items to eliminate the negative correlation between Self-Reliance and Affect Regulation found in the Thompson (2003) study. However, instead of creating a positive relationship between the three subscales as suggested by Strong Black Woman theory, Self-Reliance was not statistically correlated with any of the other subscales after scale revision. The author also indicated surprise that some subscales lacked face validity. Items with theorized relationships with one subscale, loaded highly on another factor. For example, the items “People think I don’t have feelings” and “I do not let most people know the real me” were hypothesized to fall onto the Affect Regulation factor, but instead had higher factor loadings on the Care-Taking subscale. Further research is needed to determine whether these items are truly misplaced or should be considered as characteristics of Care-Taking.
In order to adequately examine the relationship between the Strong Black Woman archetype, depression, and therapy-seeking intentions, the current study sought to improve measurement of this cultural gender norm. Specifically, attempts were made to improve the internal consistency of the scales, create subscale correlations consistent with theory, re-word items for use with men and women of all races, cover the breadth of Strong Black Woman characteristics, and determine the cultural specificity of the gender norm through scale response comparisons with Black and White women. Items from previous measures of the construct and additional items created from descriptions of Black female participants in qualitative studies were used to represent the depth and breadth of the Strong Black Woman archetype and its hypothesized characteristics.

Summary

A Strong Black Woman has been defined as physically and emotionally strong. Her life is defined by struggle and survival. She is independent, self-sufficient, hardworking, self-sacrificing, and ever-ready to take on the responsibilities placed on her by family, community, and church. She is often defined in contrast to gender stereotypes for White women. Although there are some similarities between this image and the Superwoman, the Superwoman’s focus on perfectionism and the Strong Black Woman’s focus on ever-present struggle, set them apart. Consequences of the Strong Black Woman ideal have not been examined because reliable measurement of the cultural gender norm is lacking. However, theoretical and qualitative research has suggested that endorsement of the Strong Black Woman archetype may lead to depressive symptoms and inhibit Black women from seeking therapy for depression once their symptoms are recognized. The goal of the current study was to develop and validate a measure of the Strong Black Woman archetype.
Method

Participants

Participants were recruited from the psychology department subject pool of a large Midwestern University if they self-identified as either Black and female or White and female. A total of 234 female students (Black $n = 143$; White $n = 91$) participated in this study. Participants ranged in age from 18-60 years ($M = 19.96$, $SD = 3.33$) and were representative of all of the college years. Table 1.2 presents detailed information about the sample and results of chi-square difference tests between Black and White women on demographic factors. Black and White students were similar on all demographic variables except for income. White students were more likely to report parent annual incomes in the higher ranges ($$75,000 – 500,000$$) than Black students. Therefore, parents’ annual income was used as a covariate in all analyses.
Table 1.2. Description of Study 1 Participants

<table>
<thead>
<tr>
<th>Variable</th>
<th>Black women</th>
<th>White women</th>
<th>$\chi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$N$</td>
<td>$%$</td>
<td>$n$</td>
</tr>
<tr>
<td>Relationship Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>93</td>
<td>65</td>
<td>55</td>
</tr>
<tr>
<td>Committed relationship</td>
<td>48</td>
<td>33.6</td>
<td>31</td>
</tr>
<tr>
<td>Co-habitating</td>
<td>1</td>
<td>0.7</td>
<td>3</td>
</tr>
<tr>
<td>Married</td>
<td>1</td>
<td>0.7</td>
<td>2</td>
</tr>
<tr>
<td>Number of Children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>139</td>
<td>97.2</td>
<td>90</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>2.1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>0.7</td>
<td>0</td>
</tr>
<tr>
<td>Year in School</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st</td>
<td>47</td>
<td>32.9</td>
<td>34</td>
</tr>
<tr>
<td>2nd</td>
<td>36</td>
<td>25.2</td>
<td>21</td>
</tr>
<tr>
<td>3rd</td>
<td>25</td>
<td>17.5</td>
<td>15</td>
</tr>
<tr>
<td>4th</td>
<td>21</td>
<td>14.7</td>
<td>15</td>
</tr>
<tr>
<td>5th and above</td>
<td>14</td>
<td>9.8</td>
<td>6</td>
</tr>
<tr>
<td>Parents' Annual Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;19,000</td>
<td>19</td>
<td>13.3</td>
<td>1</td>
</tr>
<tr>
<td>19,001-30,000</td>
<td>22</td>
<td>15.4</td>
<td>3</td>
</tr>
<tr>
<td>30,001-50,000</td>
<td>28</td>
<td>19.6</td>
<td>7</td>
</tr>
<tr>
<td>50,001-75,000</td>
<td>29</td>
<td>20.3</td>
<td>10</td>
</tr>
<tr>
<td>75,001-100,000</td>
<td>18</td>
<td>12.6</td>
<td>21</td>
</tr>
<tr>
<td>100,001-200,000</td>
<td>14</td>
<td>9.8</td>
<td>30</td>
</tr>
<tr>
<td>200,201-500,000</td>
<td>4</td>
<td>2.8</td>
<td>14</td>
</tr>
<tr>
<td>500,001-750,000</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>750,001-1,000,000</td>
<td>1</td>
<td>0.7</td>
<td>2</td>
</tr>
<tr>
<td>1,000,001+</td>
<td>1</td>
<td>0.7</td>
<td>1</td>
</tr>
</tbody>
</table>

**p < .001

**Procedure**

Participants were invited to complete a 60-minute online survey of “Culture, Emotions, and Therapy Beliefs.” Informed consent was obtained from all participants before beginning the survey. Participants were compensated with research credit. Upon completion of the study, all
participants were provided with debriefing information outlining the purpose of the study and listing local mental health referral sources.

**Measures**

*Demographics.* Participants reported their age, gender, race, relationship status, number of children, parents’ annual income, and year in school. See table 1.2 for a full list of relationship status, number of children, income, and school year categories.

*Strong Black woman archetype.* The Strong Black Woman Archetype scale’s initial pool of 63 items was selected and modified from the Strong Black Woman Cultural Construct Scale (SBWCCS; Hamin, 2008; 14 items), the Mammy and Superwoman subscales of the Stereotypic Roles for Black Women Scale (SRBWS; Thomas, Witherspoon, & Speight, 2004; 15 items), selected items from a general measure of self-sacrifice (the Silencing the Self Scale (STSS); Jack & Dill, 1992; 3 items), and items created by the author (31 items) based on theoretical literature on the construct and the rational approach to scale development (Dawis, 2000; see Table 1.3). The initial pool of items was created to reflect the range of characteristics of the Strong Black Woman. Items were specifically created by the author to reflect statements of Black women about the mandate of strength cited in qualitative research (Beaubouef-Lafontant, 2007; Schreiber et al., 2000; Shambley-Ebron & Boyle, 2006), and to cover dimensions of the Strong Black Woman ideal that were untapped by previous measures of the construct (physical strength and life of struggle). Items from previous scales were reworded to improve clarity and to allow use with men and women of all races.

The scale was created to measure eight dimensions of the Strong Black Woman archetype: the mask of strength (15-items; e.g., “I try to always maintain my composure.”), perceived strength (4-items; e.g., “Women of my race have to be strong to survive.”), physical
strength (7-items; e.g., “I can endure more physically than other women.”), emotional
invulnerability (5-items; e.g., “I have too many responsibilities to spend time feeling sorry for
myself.”), struggle (8-items; e.g., “The women in my family are survivors.”), self-reliance (8-
items; e.g., “I believe that it is best not to rely on others.”), caretaking (11-items; e.g., “People
often expect me to take care of them.”), and self-sacrifice (5-items; e.g., “I will let people down
if I take time out for myself.”). Participants were asked to rate their agreement with each
statement on a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). Item
responses were summed to create subscale and total scores, with higher scores representing
stronger endorsement of the Strong Black Woman ideal.
Table 1.3. Initial Pool of Strong Black Woman Scale Items

<table>
<thead>
<tr>
<th>Scale Items</th>
<th>Scale</th>
<th>Subscale</th>
<th>Reworded</th>
<th>Retained</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am often expected to take care of family members.</td>
<td>SW</td>
<td>Care</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I am always helping someone else.</td>
<td>SW</td>
<td>Care</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I tell others that I am fine when I am depressed or down.</td>
<td>SW</td>
<td>Mask</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I do not want others to know if I experience a problem.</td>
<td>SW</td>
<td>Mask</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>It is difficult for me to share problems with others.</td>
<td>SW</td>
<td>Mask</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>It is easy for me to tell other people my problems.</td>
<td>SW</td>
<td>Mask</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>If I fall apart, I will be a failure.</td>
<td>SW</td>
<td>Mask</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>[Women of my race] have to be strong to survive.</td>
<td>SW</td>
<td>Perceived</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>I find it difficult to ask others for help.</td>
<td>SW</td>
<td>Reliance</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I will let people down if I take time out for myself.</td>
<td>SW</td>
<td>Sacrifice</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I am overworked, overwhelmed, and/or underappreciated.</td>
<td>SW</td>
<td>Sacrifice</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>People often expect me to take care of them.</td>
<td>M</td>
<td>Care</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I feel guilty if I cannot help someone.</td>
<td>M</td>
<td>Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel guilty when I put my own needs before others.</td>
<td>M</td>
<td>Sacrifice</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I often put aside my own needs to help others.</td>
<td>M</td>
<td>Sacrifice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take on more responsibilities than I can comfortably handle.</td>
<td>SBWCC</td>
<td>Care</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I [often] take on [other people's] problems.</td>
<td>SBWCC</td>
<td>Care</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>I do not let most people know the &quot;real&quot; me.</td>
<td>SBWCC</td>
<td>Mask</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I do [NOT] like to let others know when I am feeling vulnerable.</td>
<td>SBWCC</td>
<td>Mask</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scale Items</th>
<th>Scale</th>
<th>Subscale</th>
<th>Rewored</th>
<th>Retained</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have difficulty showing my emotions.</td>
<td>SBWCC</td>
<td>Mask</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I try to always maintain my composure.</td>
<td>SBWCC</td>
<td>Mask</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I need people to see me as always confident.</td>
<td>SBWCC</td>
<td>Mask</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>People think that I don't have feelings.</td>
<td>SBWCC</td>
<td>Mask</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I am strong.</td>
<td>SBWCC</td>
<td>Perceived</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I feel uncomfortable asking others for help.</td>
<td>SBWCC</td>
<td>Reliance</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I believe that it is best not to rely on others.</td>
<td>SBWCC</td>
<td>Reliance</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I cannot rely on others to meet my needs.</td>
<td>SBWCC</td>
<td>Reliance</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I am independent.</td>
<td>SBWCC</td>
<td>Reliance</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>At times I feel overwhelmed with problems.</td>
<td>SBWCC</td>
<td>Struggle</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Often I look happy enough on the outside, but inwardly I feel [overwhelmed and unhappy].</td>
<td>STSS</td>
<td>Mask</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>In order to feel good about myself, I need to feel independent and self-sufficient.</td>
<td>STSS</td>
<td>Reliance</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>[I tend] to put myself [and my needs] first, because no one else [will].</td>
<td>STSS</td>
<td>Sacrifice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel as though I have a duty to give back to my community.</td>
<td>Created</td>
<td>Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am expected to play an active role in my church.</td>
<td>Created</td>
<td>Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is very important that I have children and be a good mother/father.</td>
<td>Created</td>
<td>Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not have any responsibility toward my community.</td>
<td>Created</td>
<td>Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In my family, I give more than I receive.</td>
<td>Created</td>
<td>Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scale Items</th>
<th>Scale</th>
<th>Subscale</th>
<th>Reworded</th>
<th>Retained</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am not as bothered by things emotionally as others of my gender (e.g., for men: compared to other men, for women: compared to other women).</td>
<td>Created</td>
<td>Invulnerable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women of my race do not get clinical depression.</td>
<td>Created</td>
<td>Invulnerable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My friends would describe me as emotionally sensitive.</td>
<td>Created</td>
<td>Invulnerable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t let life stresses get me down.</td>
<td>Created</td>
<td>Invulnerable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have too many responsibilities to spend time feeling sorry for myself.</td>
<td>Created</td>
<td>Invulnerable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel pressured to appear strong, even when I’m feeling weak.</td>
<td>Created</td>
<td>Mask</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>If you have a problem, you should handle it quietly and with dignity.</td>
<td>Created</td>
<td>Mask</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I do not like others to think of me as helpless.</td>
<td>Created</td>
<td>Mask</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is important for me to feel strong.</td>
<td>Created</td>
<td>Perceived</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Women of my race are stronger than women of other races.</td>
<td>Created</td>
<td>Perceived</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I usually ask a male friend to help me carry heavy objects.</td>
<td>Created</td>
<td>Physical</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I can do any physical task that a man can do.</td>
<td>Created</td>
<td>Physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can endure more physically than other women/men can.</td>
<td>Created</td>
<td>Physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women of my race are expected to have larger bodies than women of other races.</td>
<td>Created</td>
<td>Physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I usually ask others to help me lift or carry heavy things.</td>
<td>Created</td>
<td>Physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is important that I appear small and petite.</td>
<td>Created</td>
<td>Physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am physically strong.</td>
<td>Created</td>
<td>Physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I enjoy being able to rely on my friends for emotional support.</td>
<td>Created</td>
<td>Reliance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>As I become an adult, it is important that I become financially independent and not expect a boy/girlfriend or husband/wife to support me financially.</td>
<td>Created</td>
<td>Reliance</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

Table 1.3. (cont’d)

<table>
<thead>
<tr>
<th>Scale Items</th>
<th>Scale</th>
<th>Subscale</th>
<th>Reworded</th>
<th>Retained</th>
</tr>
</thead>
<tbody>
<tr>
<td>The women in my family are survivors.</td>
<td>Created</td>
<td>Struggle</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I have not had to endure many obstacles in life.</td>
<td>Created</td>
<td>Struggle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I expect to experience many obstacles in life.</td>
<td>Created</td>
<td>Struggle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes, I feel like I’m invincible.</td>
<td>Created</td>
<td>Struggle</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>I think I can tolerate more stressful life events than others of my gender (e.g., for men: compared to other men, for women: compared to other women).</td>
<td>Created</td>
<td>Struggle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not know if I will be able to overcome all of the obstacles life hurls at me.</td>
<td>Created</td>
<td>Struggle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I should be able to handle all that life gives me.</td>
<td>Created</td>
<td>Struggle</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Superwoman ideal. The Superwoman Scale (Murnen, Smolak, & Levine, 1994), a 27-item self-report measure designed to assess respondent’s emphasis on perfection and achievement in multiple domains, was used to evaluate endorsement of the Superwoman ideal. Sample items include: “While it’s hard for most people to do, I think I can have a strong family life and a very successful career,” “I don’t leave the house until I look my best,” and “I will make sure that I ‘age gracefully’ by controlling eating and exercise habits.” Participants were asked to report the extent to which each item characterized them on a 6-point scale, ranging from (1) not at all to (6) extremely well. Item responses were summed to create a total score, where higher values reflect stronger identification with the Superwoman ideal (range = 27-162). Past research reported an internal consistency coefficient alpha of .83 for the scale (Murnen et al., 1994).

Descriptions of self, mother, and grandmother. In order to understand participants’ spontaneously generated views of themselves and important women in their life, three open-ended items directed participants to “Describe your self/mother/grandmother in one word.” Individual responses were examined and similar responses were counted and compared.

Data Analysis

Descriptive statistics, Pearson correlations, corrected item-total correlations, exploratory factor analysis, and Cronbach’s coefficient alpha in SPSS 18 were used to validate the Strong Black Woman Archetype scale and compare the Strong Black Woman and Superwoman ideals by race. Descriptive statistics were used to provide anecdotal racial comparisons of the most popular mother, grandmother, and self descriptors. Pearson correlations and corrected item-total correlations between Strong Black Woman Archetype scale items were evaluated to eliminate items with low correlations. Exploratory factor analysis with a promax rotation was used to
determine the factor structure of the new scale. Internal consistency of the new and previous scales were compared using Cronbach’s coefficient alpha. Pearson correlations were used to compare relationships between factors with the relationships posited by Strong Black Woman theory and factors found in previous measures of the Strong Black Woman ideal. Finally, analysis of covariance compared Black and White women on endorsement of the Strong Black Woman and Superwoman ideals, controlling for parents’ annual income.

Results

Descriptive Statistics

The most popular responses for descriptors of participants self, mother, and grandmother (generated by at least four participants in one racial group) are listed in Table 1.4. The most popular response among Black women for descriptions of their mother and grandmother was the word “strong.” The most popular responses among White women were caring and loving for their mothers and caring for their grandmothers. As evidence of the salience of the Strong Black Woman ideal, even when asked to spontaneously generate descriptions of important women in their life, Black women used the descriptor “strong” more than any other adjective.
Table 1.4 Qualitative Responses of Mother, Grandmother, and Self Descriptors

<table>
<thead>
<tr>
<th>Popular Descriptors</th>
<th>All Participants</th>
<th>Black women</th>
<th>White women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Strong</td>
<td>31</td>
<td>13.8</td>
<td>24</td>
</tr>
<tr>
<td>*Caring</td>
<td>23</td>
<td>10.3</td>
<td>9</td>
</tr>
<tr>
<td>Loving</td>
<td>23</td>
<td>10.3</td>
<td>8</td>
</tr>
<tr>
<td>Amazing</td>
<td>17</td>
<td>7.6</td>
<td>9</td>
</tr>
<tr>
<td>Awesome</td>
<td>8</td>
<td>3.6</td>
<td>6</td>
</tr>
<tr>
<td>Determined</td>
<td>5</td>
<td>2.2</td>
<td>5</td>
</tr>
<tr>
<td>Hard working</td>
<td>5</td>
<td>2.2</td>
<td>5</td>
</tr>
<tr>
<td>Phenomenal</td>
<td>5</td>
<td>2.2</td>
<td>5</td>
</tr>
<tr>
<td>Grandmother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Strong</td>
<td>23</td>
<td>10.4</td>
<td>19</td>
</tr>
<tr>
<td>*Caring</td>
<td>22</td>
<td>9.9</td>
<td>13</td>
</tr>
<tr>
<td>Loving</td>
<td>14</td>
<td>6.3</td>
<td>9</td>
</tr>
<tr>
<td>Kind</td>
<td>7</td>
<td>3.2</td>
<td>3</td>
</tr>
<tr>
<td>Self</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determined</td>
<td>24</td>
<td>10.8</td>
<td>17</td>
</tr>
<tr>
<td>*Caring</td>
<td>17</td>
<td>7.7</td>
<td>11</td>
</tr>
<tr>
<td>*Strong</td>
<td>10</td>
<td>4.5</td>
<td>6</td>
</tr>
<tr>
<td>Out-going</td>
<td>9</td>
<td>4.1</td>
<td>2</td>
</tr>
<tr>
<td>*Independent</td>
<td>7</td>
<td>3.2</td>
<td>4</td>
</tr>
<tr>
<td>Sensitive</td>
<td>7</td>
<td>3.2</td>
<td>4</td>
</tr>
<tr>
<td>Helpful</td>
<td>6</td>
<td>2.7</td>
<td>5</td>
</tr>
<tr>
<td>Hard working</td>
<td>5</td>
<td>2.3</td>
<td>1</td>
</tr>
<tr>
<td>Intelligent</td>
<td>5</td>
<td>2.3</td>
<td>5</td>
</tr>
<tr>
<td>Unique</td>
<td>5</td>
<td>2.3</td>
<td>4</td>
</tr>
<tr>
<td>Loving</td>
<td>4</td>
<td>1.8</td>
<td>4</td>
</tr>
</tbody>
</table>

*Descriptors associated with the Strong Black Woman and Superwoman ideals.

Preliminary Analyses

Preliminary analyses screened for outliers and excessive missing cases. Item evaluation and factor analysis of the Strong Black Woman Archetype scale used data from the Black female participants only. Items were evaluated by examining Pearson correlations between items, corrected item-total correlations, and item variance as suggested by scale development theory (DeVellis, 2003). Items that were negatively correlated were reverse scored. The 33 items with
low correlations with other items, low corrected item-total correlations, and restricted variance were eliminated. Analyses proceeded using the remaining 39 items.

**Construct Validity**

Exploratory factor analysis with a promax rotation was used to identify the subscales in the Strong Black Woman Archetype scale. A promax rotation was most appropriate, because the factors were hypothesized to correlate with one another. A cutoff of .30 was used as a criterion for factor membership. Items that loaded onto multiple factors were placed by examining factor loading and face validity. The screeplot of eigenvalues showed a clear shift after the fourth factor, suggesting a four-factor solution. However, after factors with multiple loadings were redistributed, the fourth factor only contained three items and lacked face validity. Therefore, the fourth factor and its items were eliminated. The three remaining factors were then identified and labeled: (1) Mask of Strength/Emotional Invulnerability, (2) Care-Taking/Self-Sacrifice, (3) Self-Reliance and Strength. Factor labels were similar to the structure reported by the Thompson (2003) and Hamin (2008) validation studies. Thirty-six of the original 69 items were included in the final solution. Subscale items and factor loadings are presented in Table 1.5.

Adequate reliability was established using Cronbach’s alpha (range = .77-.92) that greatly improved upon internal consistency estimates reported using the Strong Black Woman Attitudes Scale (alpha range = .66-.74; Thompson, 2003), Superwoman subscale of the Stereotypic Roles for Black Women (alpha = .67; Thomas et al., 2004), and the Strong Black Woman Cultural Construct Scale (alpha range = .62-.76; Hamin, 2008 ). A summary of these results for Black women, White women, and the combined group is shown in Table 1.6. Factors were positively correlated with one another as predicted by theoretical literature on the Strong Black Woman ideal (see Table 1.7).
<table>
<thead>
<tr>
<th>Items</th>
<th>Factor Loadings</th>
<th>% of Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1: Mask of Strength/Emotional Invulnerability (14 items)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. I feel pressured to appear strong, even when I’m feeling weak.</td>
<td>.67</td>
<td></td>
</tr>
<tr>
<td>2. I do not let most people know the real me.</td>
<td>.57</td>
<td></td>
</tr>
<tr>
<td>4. I do NOT like to let others know when I am feeling vulnerable.</td>
<td>.74</td>
<td></td>
</tr>
<tr>
<td>8. I have difficulty showing my emotions.</td>
<td>.74</td>
<td></td>
</tr>
<tr>
<td>9. I try to always maintain my composure.</td>
<td>.34</td>
<td></td>
</tr>
<tr>
<td>11. It is difficult for me to share problems with others.</td>
<td>.77</td>
<td></td>
</tr>
<tr>
<td>12. I feel uncomfortable asking others for help.</td>
<td>.54</td>
<td></td>
</tr>
<tr>
<td>13. If you have a problem, you should handle it quietly and with dignity.</td>
<td>.38</td>
<td></td>
</tr>
<tr>
<td>14. I do not want others to know if I experience a problem.</td>
<td>.60</td>
<td></td>
</tr>
<tr>
<td>15. I find it difficult to ask others for help.</td>
<td>.66</td>
<td></td>
</tr>
<tr>
<td>17. I tell others that I am fine, even when I am depressed or down.</td>
<td>.57</td>
<td></td>
</tr>
<tr>
<td>21. It is easy for me to tell other people my problems. (reverse coded)</td>
<td>.57</td>
<td></td>
</tr>
<tr>
<td>22. People think that I don’t have feelings.</td>
<td>.50</td>
<td></td>
</tr>
<tr>
<td>23. The women in my family are survivors.</td>
<td></td>
<td>7.92</td>
</tr>
<tr>
<td>24. Often I look happy enough on the outside, but inwardly I feel overwhelmed and unhappy.</td>
<td>.48</td>
<td></td>
</tr>
<tr>
<td>Factor 2: Self-Reliance &amp; Strength (11 items)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Women of my race have to be strong to survive.</td>
<td>.52</td>
<td></td>
</tr>
<tr>
<td>18. As I become an adult, it is important that I become financially independent and not expect a boy/girlfriend or husband/wife to support me financially.</td>
<td>.66</td>
<td></td>
</tr>
<tr>
<td>20. In order to feel good about myself, I need to feel independent and self-sufficient.</td>
<td>.31</td>
<td></td>
</tr>
<tr>
<td>23. The women in my family are survivors.</td>
<td>.37</td>
<td></td>
</tr>
<tr>
<td>27. I believe that it is best not to rely on others.</td>
<td>.63</td>
<td></td>
</tr>
<tr>
<td>29. I am strong.</td>
<td>.46</td>
<td></td>
</tr>
<tr>
<td>Items</td>
<td>Factor Loadings</td>
<td>% of Variance</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----------------</td>
<td>---------------</td>
</tr>
<tr>
<td>30. I cannot rely on others to meet my needs.</td>
<td>.70</td>
<td></td>
</tr>
<tr>
<td>31. I need people to see me as always confident.</td>
<td>.39</td>
<td></td>
</tr>
<tr>
<td>32. I am independent.</td>
<td>.42</td>
<td></td>
</tr>
<tr>
<td>33. It is important for me to feel strong.</td>
<td>.67</td>
<td></td>
</tr>
<tr>
<td>35. Women of my race are stronger than women of other races.</td>
<td>.30</td>
<td></td>
</tr>
<tr>
<td><strong>Factor 3: Care-Taking/Self-Sacrifice (11 items)</strong></td>
<td></td>
<td>6.10</td>
</tr>
<tr>
<td>5. I will let people down if I take time out for myself.</td>
<td>.37</td>
<td></td>
</tr>
<tr>
<td>6. I am often expected to take care of family members.</td>
<td>.61</td>
<td></td>
</tr>
<tr>
<td>7. I am always helping someone else.</td>
<td>.39</td>
<td></td>
</tr>
<tr>
<td>10. I am overworked, overwhelmed, and-or under-appreciated.</td>
<td>.49</td>
<td></td>
</tr>
<tr>
<td>16. If I fall apart, I will be a failure.</td>
<td>.31</td>
<td></td>
</tr>
<tr>
<td>19. At times I feel overwhelmed with problems.</td>
<td>.37</td>
<td></td>
</tr>
<tr>
<td>25. I take on more responsibilities for others than I can comfortably handle.</td>
<td>.54</td>
<td></td>
</tr>
<tr>
<td>26. I feel guilty when I put my own needs before the needs of others.</td>
<td>.32</td>
<td></td>
</tr>
<tr>
<td>28. I often take on other people’s problems.</td>
<td>.38</td>
<td></td>
</tr>
<tr>
<td>34. I expect to experience many obstacles in life.</td>
<td>.37</td>
<td></td>
</tr>
<tr>
<td>36. People often expect me to take care of them.</td>
<td>.66</td>
<td></td>
</tr>
</tbody>
</table>
Table 1.6 Reliability Estimates of Cultural Gender Norm Scales

<table>
<thead>
<tr>
<th>Factors</th>
<th>All Participants</th>
<th>Black women</th>
<th>White women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>α</td>
<td>N</td>
<td>α</td>
</tr>
<tr>
<td>Strong Black Woman Scale Total</td>
<td>.91</td>
<td>195</td>
<td>.90</td>
</tr>
<tr>
<td>Mask of Strength</td>
<td>.88</td>
<td>210</td>
<td>.86</td>
</tr>
<tr>
<td>Care-Taking</td>
<td>.79</td>
<td>214</td>
<td>.80</td>
</tr>
<tr>
<td>Self-Reliance</td>
<td>.80</td>
<td>217</td>
<td>.79</td>
</tr>
<tr>
<td>Superwoman Scale</td>
<td>.78</td>
<td>185</td>
<td>.75</td>
</tr>
</tbody>
</table>

α = Cronbach’s alpha coefficient

Table 1.7. Correlations between Cultural Gender Norm Scale Totals and Subscales

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strong Black Woman</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale Total</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2. Mask of Strength/</td>
<td>.88**</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Emotional Invulnerability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Care-Taking &amp; Struggle</td>
<td>.82**</td>
<td>.62**</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4. Self-Reliance &amp; Strength</td>
<td>.71**</td>
<td>.41**</td>
<td>.34**</td>
<td>-</td>
</tr>
<tr>
<td>5. Superwoman Scale Total</td>
<td>.44**</td>
<td>.23**</td>
<td>.52**</td>
<td>.25**</td>
</tr>
</tbody>
</table>

** p < .001.

Cultural Gender Norm Differences Between Black and White Women

Analysis of covariance was used to compare Black (coded as 1) and White (coded as 0) female participants on the two cultural gender norm measures: the Strong Black Woman Archetype scale and the Superwoman Scale. Parents’ annual income served as the covariate. A summary of these results is presented in Table 1.8. Black women had higher endorsement than White women of the Strong Black Woman ideal and the Mask of Strength and Self-Reliance ideals. White women endorsed more of the Superwoman construct than Black women.

Responses to the Care-Taking subscale of the Strong Black Woman Archetype scale were
similar among White and Black participants. This is likely because the themes of responsibility towards others and self-sacrifice are found in both the Strong Black Woman and the Superwoman ideal.

Table 1.8. Comparisons of Black and White Participants on Cultural Gender Norm Measures

<table>
<thead>
<tr>
<th>Factors</th>
<th>Black women</th>
<th>White women</th>
<th>F-values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>n</td>
</tr>
<tr>
<td>Strong Black Woman Total</td>
<td>83.40</td>
<td>18.55</td>
<td>138</td>
</tr>
<tr>
<td>Mask of Strength</td>
<td>30.12</td>
<td>9.51</td>
<td>138</td>
</tr>
<tr>
<td>Self-Reliance</td>
<td>31.94</td>
<td>6.38</td>
<td>138</td>
</tr>
<tr>
<td>Care-taking</td>
<td>21.32</td>
<td>6.49</td>
<td>137</td>
</tr>
<tr>
<td>Superwoman Scale Total</td>
<td>71.75</td>
<td>14.54</td>
<td>130</td>
</tr>
</tbody>
</table>

*p < .01, **p < .05.

Summary

The goal of Study 1 was twofold: (1) create and provide preliminary validation of a measure of the Strong Black Woman archetype that improves upon previous measures of the construct and (2) determine the cultural specificity of the gender norm and scale. Items from previous measures were reworded for scale generalizability and clarity and items were added by the author to increase the breadth of Strong Black Woman ideal characteristics covered. Factor analysis determined a three-factor structure for the new 36-item scale: Mask of Strength/Emotional Invulnerability, Care-Taking/Self-Sacrifice, and Self-Reliance & Strength. Internal consistency for the new Strong Black Woman Archetype scale improved upon past reports and factors were positively correlated as suggested by theoretical literature on the construct. Preliminary evidence for cultural specificity and distinction from the Superwoman ideal was also established. Black women reported higher endorsement of the Mask of Strength and Self-Reliance subscales than White women. White women reported more endorsement of the Superwoman ideal. Responses to the Care-Taking subscale of the Strong Black Woman
Archetype scale were similar between races, likely because this characteristic is common to both the Superwoman and Strong Black Woman ideals.

Discussion

A Strong Black Woman Archetype Scale was successfully created and preliminary tests of validation were conducted. An emic approach was used to conduct item and factor analysis on the initial item pool in order to determine whether the cultural gender norm scale matches the views and beliefs of women within the culture. Factor analysis suggested the use of three meaningful factors, similar to those theorized (Romero, 2000) and found in previous scales (Hamin, 2008; Thompson, 2003): Mask of Strength/Emotional Invulnerability, Care-Taking/Self-Sacrifice, and Self-Reliance/Strength. The Mask of Strength domain includes the belief that any insecurities or vulnerabilities must be shielded from others and negative emotions should not be discussed or displayed. The Care-Taking domain includes the belief that the needs of others should be put before personal needs and others expect you to take care of them. The Self-Reliance domain includes the belief that independence and self-sufficiency is tied to positive self-esteem.

The new scale improved upon the less than desirable internal consistencies reported by previous scales (new scale alpha range = .77-.92 vs. previous scale alpha range = .66-.76; Hamin, 2008; Thomas et al., 2004; Thompson, 2003) and reported positive factor correlations consistent with theory on the Strong Black Woman ideal (Wallace, 1978), unlike previous measures that had negative factor correlations which contradicted theoretical and qualitative literature about the archetype (Hamin, 2008; Thompson, 2003). There was also preliminary evidence for the cultural specificity of the gender ideal, which validation studies of previous measures were either unable to test due to the race-specific wording of the scale items (e.g., Stereotypic Roles for Black
Women Scale by Thomas et al., 2004) or failed to test (e.g., Strong Black Woman Attitudes Scale by Thompson, 2003).

Black women endorsed more of the characteristics of the Mask of Strength and Self-Reliance than their White counterparts. Black women were more likely than White women to agree that it is difficult to share problems, emotions, and insecurities with others. Black women were also more likely than White women to agree that other women of their same ethnicity were survivors and prize self-sufficiency. Black and White women responded similarly to the Care-Taking subscale, likely because this trait is common to both the Strong Black Woman and Superwoman gender norms. Women who endorse these identities similarly spread themselves thin across multiple roles and feel compelled to take care of others. However, there are important distinctions between the two gender norms. An ideal Superwoman achieves perfection in all areas of her life, and an ideal Strong Black Woman lives a life defined by struggle and survival. For this reason, White women in the current study had a higher endorsement of these perfectionistic tendencies measured by the Superwoman scale than Black women.

Limitations & Future Directions

The current study took a focused look at the gender norms of Black women. It improved measurement of the Strong Black Woman archetype and found preliminary evidence for cultural specificity of the norm. However, some study limitations should be addressed. The current study only provided preliminary validation of the Strong Black Woman Archetype scale. Future studies should seek to examine the convergent and discriminant validity of the scale by testing its correlation with racial centrality.

It is also unclear how the age of the participants influenced the results. Women in this sample ranged in age from 18-60, but the average age of participants was approximately 20 years
old. Older women may have responded differently to the cultural gender norm scale items. The varied and potentially stressful life experiences of a middle-aged or elderly woman may have led her to respond differently than an 18-24 year old woman to scale items related to struggle (e.g., “I have not had to endure many obstacles in life” reverse scored). Similarly, a woman who has endured the physical pain of childbirth or debilitating illness may be more likely than young women without these experiences to endorse items related to physical strength (e.g., “I can do any physical task that a man can do” and “I can endure more physically than other women/men can”). A middle-aged woman who has to balance caring for her children and her own aging parents may also be more likely to endorse different items than younger women related to caretaking (e.g., “In my family, I give more than I receive”). In the same vein, age cohort effects may also affect responses to the Strong Black Woman Archetype Scale items. Black women who grew up in the era of segregation may be more likely to endorse the cultural gender norm than Black women from a younger generation that may have grown up in more racially diverse neighborhoods, grade schools, and colleges. Future research should use a sample of middle- to older-aged women to test the validity of the initial pool of 63 items suggested for the Strong Black Woman Archetype Scale by conducting item and factor analysis.

Our results also may not generalize to Black female adolescents. The literature-to-date has not addressed the socialization process for the Strong Black Woman ideal. Likely socialization agents include depictions of Black women in literature and film, examples set by female family members, prohibitions given to Black girls against displaying emotion, and knowledge of the history of Black women in America. One of the most recent examples of the Strong Black Woman can be found in the film *Princess and the Frog*. Before Tiana becomes Disney’s first Black princess, she works two jobs to save money to start a business. Throughout
the movie, Tiana repeats the mantra that hard work and self-reliance is the only way to attain her goals. Even though she rarely has time to sleep in between balancing day and night shifts as a waitress at two different restaurants, she masks her fatigue and greets customers and co-workers with a smile.

She is juxta­posed against her White best friend, Charlotte LaBouff, who seeks financial stability by wishing on the Northern Star for a prince. The animated film geared towards adolescent females illustrates the different expectations for Strong Black Women and Superwomen. The White female spends the movie seeking for an ideal mate of similar social class. The Black female is fiercely self-reliant and spends the entire movie seeking financial independence through sole ownership of a restaurant. She only finds her prince after a magic spell transforms her into a frog and forces her to spend time away from work and close to him.

In addition to Black female images in film, Black girls grow up surrounded by mothers, grandmothers, and aunts who serve as main contributors to, if not sole providers for, the family. These women are leaders of their church and community and often juggle multiple responsibilities and plow through enumerable obstacles all while maintaining the appearance of strength. Black girls may begin to idealize the older women in their life, by attending to their silent struggle without any knowledge of the frustration these women feel when facing challenges. Through example and sometimes even direct instruction, Black girls learn not to display emotional distress.

Moreover, learning about the history of Black women in America teaches Black girls that the ability to face many difficulties and still persevere is their birthright. Black girls also are taught that no challenge they might face could be as difficult as challenges faced by women before them. Therefore, Black girls are urged to live up to the tradition set by their female
ancestors. Future research could use the Strong Black Woman Archetype scale to compare the characteristics of the ideal, levels of endorsement, and potential the positive/negative consequences by factors like age and country of origin.
STUDY 2: THE RELATIONSHIP BETWEEN
THE STRONG BLACK WOMAN ARCHETYPE, DEPRESSIVE SYMPTOMS,
AND INTENTIONS TO SEEK THERAPY FOR DEPRESSION

Purpose

Study 2 utilizes the measure of the Strong Black Woman archetype developed in Study 1 to examine the archetype’s impact on depression and help-seeking. The goal of the second study was to examine the relationship between the archetype and depressive symptoms, and use the archetype alongside the theory of planned behavior to predict intentions to seek therapy in the future. (1) determine whether internalization of the Strong Black Woman archetype was associated with depressive symptoms, (2) determine whether the Strong Black Woman ideal, theory of planned behavior, current depressive symptoms, and past use of mental health services predicted intentions to seek therapy for depression, and (3) determine whether the theory of planned behavior mediated the relationship between endorsement of the Strong Black Woman ideal and therapy seeking intentions. First, research on depression in Black women is presented. Then, relevant literature on the relationship between the Strong Black Woman ideal, mental health, and psychological help-seeking are described. Then, the theory of planned behavior is defined, past studies of the theory predicting psychological help-seeking are reviewed, and cultural factors that were previously examined alongside the theory of planned behavior are discussed.

Depression

Depression affects 19 million adult Americans each year (National Mental Health Association [NMHA], 2005). Women are twice as likely to suffer from major depression (Kessler, 2000). Because of this disorder’s effect on home, work, and interpersonal relationships,
depression is the second leading cause of medical disability among women (Kramer, 2004). Although the effect of gender on depression has been well documented (Nolen-Hoeksema, 2001), researchers have just begun to examine the effect of race, ethnicity, and culture on depressive symptom expression (Carrington, 2006). Womanist theory asserts that the intersection of gender and racial identity for African American women gives rise to a unique constellation of cultural beliefs and standards unshared by both their White female and Black male counterparts (Jones & Shorter-Gooden, 2003). If these beliefs and values affect the way depression is expressed, they should also be used to inform depression treatment.

Major depressive disorder, as defined by the DSM-IV-TR (American Psychiatric Association, 1994), is characterized by the presence of at least one major depressive episode. A diagnosis of major depressive episode requires that five out of the following nine symptoms be present: depressed mood, anhedonia, significant appetite/weight changes, sleep disturbances, psychomotor agitation/retardation, fatigue, feelings of worthlessness or inappropriate guilt, concentration difficulties, and recurring thoughts of death (American Psychiatric Association, 1994). Several biological and cognitive risk factors have been linked to the development of depressive symptoms. Twin studies using clinical samples have found a heritability rate range between 48-75% for major depressive disorder (McGuffin, Katz, Watkins, & Rutherford, 1996). Low levels of the neurotransmitters norepinephrine and serotonin have also been linked to major depression (Delgado & Moreno, 2000). Rumination, the tendency to focus on negative affect and its consequences (Nolen-Hoeksema, 2002), is a cognitive factor frequently implicated in depression. The fact that women are more likely to engage in rumination has been used to explain the gender differences in depression prevalence (Nolen-Hoeksema, 2002).
In an attempt to understand experiences of depression among Black women, researchers have compared depression prevalence rates and symptom expression between Blacks and Whites, qualitatively examined the experiences of depressed Black women, and suggested specific risk factors and coping methods for this population.

*Depression Prevalence Rates Comparing Blacks and Whites*

Prevalence studies have found mixed results on the comparative rates of depression in Black and White Americans. Different studies have found higher rates of depression among Black Americans (Kaslow, Toomey, Brooks, Thompson, & Reynolds, 2001; Riolo, Nguyen, Greden, & King, 2005), similar rates between Blacks and Whites (Kessler, Berglund, Demler, et al., 2003), and even lower rates among their Black participants (Dunlop, Song, Lyons, Manheim, & Chang, 2003). Because of double jeopardy (racism and sexism), some scholars have theorized that Black women especially would be at greater risk for depression than White women (Barbee, 1992; Carrington, 2006). However, prevalence studies have again returned mixed results after rates between Black and White women were examined (e.g. higher rates: Wise, Adams-Campbell, Palmer, & Rosenberg, 2006; equal rates: Van Hook, 1999; lower rates: Jonas et al., 2003; Skaer et al., 2000). These varied results may be due to factors related to race, such as socioeconomic and marital status. In many of the studies, significant differences between Blacks and Whites disappeared after controlling for socioeconomic status, education, employment, income, or marital status (Jackson-Triche et al., 2000; Myers et al., 2002; Bromberger, Harlow, Avis, Karvitz, & Cordal, 2004). Many of these control variables are considered risk factors for depression that disproportionately affect Black women in this country (Myers et al., 2002).

*Racial Differences in Symptom Expression*
A closer look into the depression experiences of Black women reveals differences in the presentation of symptoms between Blacks and Whites. Theory has long posited that women from different cultures may display different behaviors and actions when suffering from depression (Lazarus & Folkman, 1984). Current empirical studies have specifically noted higher rates of paranoia (Myers et al., 2002), irritability (Kohn, Oden, Munoz, Robinson, & Leavitt, 2002), and somatization (Brown et al., 1999) among Black women as compared to White women. For example, a study of depressed women seeking treatment at an outpatient clinic found that Black women \((n = 46)\) reported more symptoms of paranoia than White women \((n = 36)\), even after controlling for socioeconomic status (Myers et al., 2002). Studies have also suggested that depressed Black women often displayed irritability instead of sadness (Fabrega, Mezich, & Ulrich, 1988; Raskin, Crook, & Herman, 1975). However, some of these results are difficult to interpret, because Raskin et al. participants were severely depressed hospitalized patients and Fabrega et al. participants also included men. Results from studies using severe mental health patients may not generalize to less impaired outpatient or community samples. Additionally, studies that generalize across men and women (e.g., Fabrega et al., 1988) may mask the presence of different relationships when comparing Black vs. White women. Although Myers et al. (2002) did not find ethnic differences in hostility among their depressed women, a study of cognitive-behavioral group therapy with Black women found that the predominant affective expression during videotaped therapy sessions was irritability rather than sadness (Kohn et al., 2002).

For African Americans, mental illness presentation is likely to include somatic complaints (Sherer, 2002; USDHHS, 2004; Myers et al., 2002). Studies have shown that a focus on somatic symptoms is commonly cited by depressed African Americans (Adebimpe, 1981;
Brown, Schulberg, & Madonia, 1996). Some have even suggested that depression manifests itself as medical symptoms, like hypertension, in African Americans (Pickering, 2000). Specifically a study of 68 African American and 92 Whites recruited from medical centers found more severe somatic symptoms among their Black subjects (Brown et al. 1999). Using the Hamilton Rating Scale for depression, psychiatrists rated the Black patients’ symptoms of sleep disturbance, decreased libido, and weight loss as more severe. Some suggest that these differences in somatization rates may be better explained by factors other than race (Myers et al., 2002). In another depression study, differences in somatic complaints between African Americans and Whites disappeared once comorbid disorders and sociodemographic factors were controlled (Wohl, Lesser, & Smith, 1997).

Studies of somatization and depression that specifically compared Black and White women have also returned mixed results. One of the first U.S. epidemiological studies found that more Black women than White women reported significant somatic symptoms (6.08% vs. 3.88%; Robins & Reiger, 1991). Another study of 125 depressed women seeking treatment at an outpatient clinic found that Black women reported more somatic symptoms on the Brief Symptom Inventory than White women. Differences in somatization rates still remained after controlling for sociodemographic factors like, education, employment, and marital status.

**Qualitative Experiences of Depressed Black Women**

Qualitative studies have allowed for an in-depth look into the ways Black women describe their own depression. Researchers have posited that Black and White women may have different experiences of depression (Barbee, 1994; Schreiber, 1996). One qualitative study of 36 Black women ranging in age from 18-64 years interviewed women that had received a diagnosis of depression in the past year (Waite & Killian, 2007). When asked to share what comes to mind...
when they think of depression, the women described feeling “crazy, down in the dumps, hopeless, being in a black hole, the devil, grief, rejection, sad, upset, fatigued, tired, irritable, losing control, pain, lonely, anger, exhaustion, stressed, out of balance, drowning, and sick”.

Focus groups with 113 middle-aged (40-65 years) depressed African Canadian women revealed that many of the women were surprised by how upset they became about things that would not have bothered them before (Etowa, Keddy, Egbeyemi, & Eghan, 2007). These women’s descriptions echo some of the findings from studies discussed previously that found irritability to be a significant component of depression among Black women (Kohn, Oden, Munoz, Robinson, & Leavitt, 2002). Women in the Etowa et al. study also described feeling so overwhelmed by their life circumstances and the physical and emotional changes of menopause that depression often seemed hard to identify and appeared as the “invisible grey fog” in the lives of Black women like themselves. From the limited sociodemographic information reported in the article, it seems as though the life circumstances mentioned by the women were not limited to poverty. Most of the women were married (55%) and 30% held a college degree. [insert some closing/explanatory statement]. These women also described wanting to isolate themselves from others in an effort to regain their strength privately. This may belie some fears among these women of others seeing them in their time of need and appearing weak or out of control.

Another study analyzed interviews with twelve, middle-class African-American women after their last episode of post-partum depression and found three stages in the course of their depression that lead many to seek help: Stressing Out, Feeling Down, Losing It (Amankwaa, 2003a). The initial stressors described by the women were physical (e.g., delivery complications and pain), emotional (e.g., loneliness and unmet expectations), and external (e.g., sick newborns and financial/partner concerns). Depressive symptoms, such as irritability, fatigue, and
sleeplessness, seemed to follow these stressors and make the women question their ability to care for their newborn child. These doubts about role fulfillment led to feeling down, uncontrollable crying, and deep sadness. Depressive symptoms reached their peak during the two intervals where women felt as though they had lost all control: two weeks and approximately six weeks after the birth of their child. During these periods, women reportedly felt as though they had lost almost all ability to care for their child and themselves. Some women experienced suicidal and homicidal ideation and two of the twelve women reported suicide attempts. Because many of their symptoms were visible to others at this point, family members urged several of the women to seek help, and nine mothers sought out mental health services.

Risk Factors for Depression

Studies have shown that low socioeconomic status, financial strain, physical inactivity, a lack of social support, stress, and poor physical health are associated with depressive symptoms in middle aged women (Bosworth, Bastian, Kuchibhatla et al., 2001; Bromberger & Matthews, 1996; Freeman, Grisso, Berlin, Sammel, Garcia-Espana, Hollander, 2001; Kaufert, Gilbert, Tate, 1992; McKinlay, McKinlay, Brambilla, 1987; Woods & Mitchell, 1997). However, only one of these studies included a significant number of ethnic minority women (Freeman, et al., 2001). In the last five years, more studies have begun to examine the risk factors associated with depression among African American women, including young age, poor physical health, low socioeconomic status, lack of social support, stressful life events, and discrimination.

Younger age. Studies of African Americans have found that being 20-29 years of age is associated with higher rates of major depressive disorder (Brown, Ahmed, Gary, & Milburn, 1995). In a national survey of 3,015 middle-aged women, younger age was a significant predictor of potential clinical depression (defined as a score of 16 or higher on the Center for
Epidemiologic Studies Depression (CES-D) Scale) among Black women ($n = 831$; Bromberger et al., 2004). The vast majority of Black women in this sample were employed (79%), had some college education (41%), and reported that they did not find it “very hard” to pay for their basic necessities (54%), representing a predominantly middle class sample.

**Poor physical health.** Poor physical health has been associated with depression for people from many different ethnic backgrounds. For example, a study of 7,690 older adults (aged 54-65) found that rates of major depression were significantly related to potentially life-threatening diseases, functional limitations, lack of health insurance coverage, smoking, and exercise across all ethnic groups (Dunlop et al., 2003). Depression research focusing on Black women has found similar links between poor health and depression (Taylor, Henderson, and Jackson, 1991). After analyzing responses from fifty in-depth interviews, a qualitative study of depressed, predominantly middle-class, mid-life (aged 40-65) African Canadian women found that women often cited health-related stress as the trigger for their depression (Etowa et al., 2007). Some participants that had long-endured their physical pain, began to lose hope that their pain would ever end, and depression ensued. Similarly, Link and Dohrenwend (1980) theorized a link between health problems and hopelessness.

Among their sample of 228 middle-aged Black women, Bromberger et al. (2004) found that perceived health rating was significantly related to depression, but actual physical health symptoms (vasomotor, irregular menstrual cycles, anemia, arthritis/osteoarthritis) were not. There are several explanations for this finding. This discrepancy between perceived and actual health may mean that the high negative affect associated with depression influenced these women’s single question self-rating of perceived health (excellent to poor). Alternatively, the health problems most relevant to Black women not explicitly solicited in this study’s measures.
Asking the same women about the actual physical health problems of obesity, hypertension, and diabetes may have revealed a significant relationship with depression.

**Low socioeconomic status.** Low socioeconomic status has also been associated with emotional distress for people of many different races (George & Lynch, 2003), and with depressed Black women specifically (Brown, Brody, & Stoneman, 2000; Worthington, 1992). In a nationally representative sample ($N = 8,449$) with Blacks and Mexican Americans oversampled, lack of education was related to the presence of dysthymic disorder among Black women (Riolo et al., 2005). Dysthymic disorder is a chronic depressive condition, unlike major depressive disorder which has more severe symptoms occurring within discrete episodes. Socioeconomic status risk, measured by income, hourly wage, parents’ occupational status and education level, and the family’s physical environment was also significantly associated with depression in a sample of 104 Black, married mothers from the rural South (Brown et al., 2000).

One study of 824 Black mothers with a household income below 250% of the federal poverty level living in one of the 39 poorest census tracts in Detroit, highlighted specific poverty-related factors that were associated with depression (Siefert, Finalyson, Williams, Delva, & Ismail, 2007). Risk factors included household food insufficiency and poorly maintained housing (e.g., cracked walls, peeling paint), which increased the odds of probable depression by 2.5 and 1.5 times, respectively, even after controlling for income and education. A cross-sectional study of 679 low-income Black mothers living on Detroit’s east side found that the relationship between household income and depressive symptoms was partially mediated by financial stress (5-items assessing worry about financing daily necessities) and social support (instrument and emotional; Schulz et al., 2006b). Similarly, a sample of twelve Black Caribbean
women from the United Kingdom, reported that they would not be depressed if they were financially independent (Edge & Rogers, 2005).

Lack of social support. Theoretical (Warren, 1997) and empirical work (Schulz et al., 2006) have suggested that a lack of social support may be a risk factor for depression among Black women. Bromberger et al. (2004) found a significant relationship between low social support and depressive symptoms across all ethnic groups \((N = 727)\) and among Black women specifically \((n = 228)\). In a sample of 104 Black, married mothers from the rural South, women who reported low spousal support also reported more depressive symptoms, but only when socioeconomic risk was high (Brown et al., 2000). Spousal support and maternal depression were unrelated at low risk. Also in this study, conflicts with co-caregivers (members of the extended family that aid in child-rearing) were significantly related to maternal depression. However, in a study of 125 Black, Latina, and White low-income and working-class women, level of social support did not predict depression severity or moderate the amount of stress the women reported. The authors speculated that because the women were clinically depressed, significant relationships would not be found between social support and depression because their social support networks had already proved unable to protect them from depression. An alternative explanation is that study’s measure of social support, the Social Support Questionnaire (Sarason, Levine, Basham, & Sarason, 1983), does not capture the full range of social resources used by Black women.

Stressful life events. High stress is predictive of depressive symptoms in all ethnic groups, and for Black women when analyzed separately (Bromberger et al., 2004). Stress and worry about the safety and future of children and family (Etowa et al., 2007) as well as stress due to managing a child with a behavior disorder (Brown et al., 2000) has been associated with
depression in Black women. Stress may be especially pertinent among Black samples, because they are more likely to experience stressful life events (Brown et al., 1999). Exposure to community and domestic violence puts Black women at high risk for depression and other comorbid disorders (Hill, Hawkins, & Raposo, 1995). One study of – found that concerns about neighborhood violence and safety had effects on depressive symptoms that were independent of income (Schulz et al., 2006b). Experiencing the death of a loved one has also been associated with depression among Black women (Etowa et al., 2007).

**Discrimination.** Studies have shown that experiences of everyday discrimination are related to poor mental and physical health (Belle & Doucet, 2003; Brown, Williams, Jackson et al., 2000; Ennis, Hobfoll, & Schröder, 2000; Gee, 2002; Karlsen & Nazroo, 2002; Landrine & Klonoff, 1996; Landrine, Klonoff, Corral, Fernandez, & Roesch, 2006; Noh & Kaspar, 2003; Schulz, Israel, Williams, Parker, James, 2000; Schulz, Williams, et al., 2000; Williams & Collins, 2001; Williams, Neighbors, & Jackson, 2003; Williams, Yu, Jackson, & Anderson, 1997). Discrimination is theorized to negatively affect mental health by eliciting feelings of frustration and powerlessness (Artinian et al. 2006; Harrell, 2000; Schulz et al. 2006b). The association between racial discrimination, depressive symptoms, and health are especially pronounced among African Americans (Jackson et al., 1996; Klonoff, Landrine, & Ullman, 1999). Using data from the National Survey of Black Americans, Brown et al. (2000) found that perceived discrimination was associated with poor mental health. Some have argued that self reports of discrimination may be influenced by high levels of negative affect associated with poor mental health. However, after analyzing two waves of data, the authors did not find a relationship between baseline mental health status and perceived racial discrimination at time 2.
This suggests that their results were not simply an artifact of participants with poor mental health reporting more experiences of unjust treatment.

Schulz et al. (2006a) also conducted a longitudinal study of 343 African American mothers living on Detroit’s east side. The authors surveyed their cohort of women in 1996 and 2001 and found that an increase in reports of everyday discrimination (e.g., “How often have other people acted as if they were better than you?”) from time 1 to time 2 was associated with a change over time in depressive symptoms and self-reported general health. Their longitudinal study design allowed for causal statements about discrimination leading to poor mental health to be made. These relationships were significant even after controlling for age, income, education, and baseline perceived discrimination and health status. In their study of 824 Black mothers, Siefert et al. (2007) also found that discrimination was a strong predictor of depression, increasing the odds of probable depression by 2.7 times.

Qualitative examinations of depression experiences among Black women have also highlighted discrimination as a risk factor. In their interviews with twelve middle-class Black West Indian women from Ontario, Canada, some of Schreiber, Stern, & Wilson’s (1998) participants explicitly identified racism as a trigger for their depression. African Canadian women in Etowa et al.’s (2007) study also discussed the ways prejudice had influenced their depression.

Depression is a widespread and debilitating psychological disorder. Whereas epidemiological surveys have returned results that suggest Black women may be at higher, lower, or equal risk for major depression as compared to their White counterparts, rates of paranoia, irritability, and somatization are more often seen among Black women suffering from depression than White women suffering from depression. Qualitative studies have provided
insight into the actual experiences of depressed Black women and empirical studies have concluded that Black women who are younger, in poor physical health, of low socioeconomic status, lacking social support, recovering from stressful life events, and experiencing discrimination are at higher risk for developing depression. Researchers have also begun to posit whether a gender norm specific to Black women, the strong Black woman archetype, influences the manifestation of depressive symptoms in this population.

The Effect of the Strong Black Woman Archetype on Depression in Black Women

There is great potential for harm in assuming that one is invincible to all obstacles, needs little or no self-care, and is relegated to a life of struggle, while simultaneously maintaining an outward appearance of strength (Wallace, 1978). For these reasons, the Strong Black Woman image has frequently been discussed as an integral part of Black women’s depression (Boyd, 1998; Amankwaa, 2003b; Danquah, 1998; Greene 1996; Jones & Shorter-Gooden 2003; Martin, 2002; Mitchell & Herring 1998). These discussions have led to theories on the role of this idealized image in ideal-self discrepancies and the initiation of depressive symptoms (Beaubouef-Lafontant, 2007) and suicide (Harris-Lacewell, 2001).

Black women who have internalized the Strong Black Woman ideal may find themselves struggling between who they really are (real self) and who they expect themselves to be (the ideal self; Amankwaa, 2003a). E. Tory Higgins’ (1987) self-discrepancy theory posited that differences between the actual and ideal self led to dejection-related emotions, such as sadness and disappointment. When a person failed to live up to the idealized expectations constructed by others, feelings of shame, embarrassment, and depression would ensue (Higgins, 1987). Similarly, falling short of the Strong Black Woman archetype may lead to a sense of failure,
frustration, and guilt which can evolve into depressive symptoms (Chisholm, 1996; Harris-Lacewell, 2001; Warren, 1994).

Qualitative research with Black women has also supported Higgins’ (1987) theory that discrepancy between the socially expected and the real self leads to guilt, shame, and depression (Boyd, 1993). In one qualitative study, a woman recently diagnosed with depression made a direct connection between her symptoms and socially constructed expectations of strength and care-taking (Beaubouef-Lafontant, 2007). After both of her parents became terminally ill, the woman was single-handedly responsible for taking care of them, even though she had male siblings that lived in the area. To make matters worse, she was chastised by other women in the community for not living up to their expectations of emotional invulnerability and self-sacrifice. Failing to live up to the image of strength in front of others made her feel weak and small, the opposite of the Strong Black Woman her community called her to be. This discrepancy between the socially expected and the real self led to a sense of public failure and depression.

Previously, the relationship between the Strong Black Woman archetype and depression had only been examined qualitatively. The current study was the first to test this relationship empirically. Specifically, the current study determined whether endorsement of the ideal and its specific traits (emotional invulnerability, care-taking, and self-reliance) were associated with more severe depressive symptoms. Because at its extreme, the Strong Black Woman archetype is unrealistic and impossible to attain, women who demonstrate high endorsement of this ideal will experience a discrepancy between the ideal and their actual self. The shame and guilt associated with this discrepancy may manifest itself as depressive symptoms.

The Effect of the Strong Black Woman Archetype on Help-seeking
Belief in the Strong Black Woman ideal may limit self-care activities like seeking psychological services due to the mandate of self-reliance and self-sacrifice (Beaubouef-Lafontant, 2007). The time and additional resources needed to engage in psychotherapy may be seen as detracting from resources needed to serve the family, church, and community. Because the Strong Black Woman is expected to handle her problems independently, receiving mental health services may be seen as an admission of weakness or failure (Harris, 1995; Littlefield, 2003; Thomas et al., 2004). Due to the negative attributions associated with seeking help, women who strive to attain this archetypal image often suffer in silence, feeling frustrated and isolated because they cannot ask for the support they need (Atkins & Rollings, 1996; Harrington, 2007; McNair, 1996; Shambley-Ebron & Boyle, 2006). Qualitative research has also suggested that depressed Black women may choose to uphold the mask of strength rather than seek therapy (Amankwaa, 2003a). For these reasons, the current study will include a quantitative examination of the relationship between the Strong Black Woman archetype and mental health help-seeking beliefs. Specifically, this study will examine whether endorsement of the Strong Black Woman ideal is related to women’s attitudes, perceived social norms, and perceived obstacles to seeking mental health services using the theory of planned behavior and whether these beliefs are associated with women’s intentions to seek therapy.

Theory of Planned Behavior

*Defining the Theory of Planned Behavior*

The theory of planned behavior is a useful framework for predicting intentions to seek therapy. The theory has been described as the most integrated explanation of social behavior (Conner & Norman, 1994; Weinstein, 1993) and has received empirical support in predicting intentions to engage in a multitude of behaviors (see Armitage & Conner, 2001 for a meta-
The theory states that intentions to perform specific behaviors can be predicted by three beliefs: attitudes toward the behavior, subjective norms, and perceived behavior control (Ajzen, 1991; see Figure 1). Attitudes are an evaluation of the acceptability, desirableness, and usefulness associated with the behavior. Subjective norms refer to the perceived social pressure to perform the behavior, and perceived behavior control is the amount of control each participant believes they have over performing the behavior. Attitudes, norms, and control predict intentions to engage in the behavior, while intentions directly predict performance of the actual behavior. Individuals are more likely to engage in a behavior if they have positive attitudes toward the behavior, believe that the behavior is acceptable to important others, and feel that they have control over performance of the behavior.
The theory of planned behavior has been used to successfully predict a variety of behaviors including bus use among college students (Bamberg, Ajzen, & Schmidt, 2003), hunting behavior (Hrubes, Ajzen, & Daigle, 2001), high school completion among African Americans (Davis, Ajzen, Saunders, & Williams, 2002), and vitamin use in African American college women (Pawlak, Connell, Brown, Meyer, & Yadrick, 2005) too name a few. A meta-analysis reviewing 185 studies conducted using the theory of planned behavior calculated a large effect size ($r = .63$), concluding that the theory as a whole is well-equipped to predict behavioral intentions (Armitage & Conner, 2001).

**Theory of Planned Behavior and Help-seeking**

Previous attempts to predict psychological help-seeking often lacked theoretical models and would benefit from the use of a well-established behavioral theory. To date, six studies have used the theory of planned behavior to predict mental health service use. Results from these
studies have suggested that the theory of planned behavior, as well as, past use of psychological services and current psychological well-being are important predictors of therapy seeking intentions.

The theory of planned behavior has predicted psychological service use in studies across the globe. Past research using Fishbein and Ajzen’s (1975) earlier theory of reasoned action, which only used attitudes and subjective norms to predict intention (perceived behavior control was added later), has successfully predicted intentions to seek general mental health services in an Australian adult sample (Bayer & Peay, 1997) and psychological services for alcohol abuse in an American college sample (Codd & Cohen, 2003). More recently, the latest version of the theory of planned behavior (Ajzen, 1991) was used to predict length of psychiatric treatment delay among African American relatives of first-episode psychosis patients (Compton & Esterberg, 2005) and intentions to seek help for emotional problems and suicidality among New Zealand prison inmates (Skogstad et al., 2006). The New Zealand study also assessed participants’ history of mental health service use due to past research demonstrating that those with prior experiences with psychologists were more likely to seek psychological help (Deane, Skogstad, & Williams, 1999; Pescosolido & Boyer, 1999). Past behavior, often described as the best predictor of future behavior, has been discussed as a potential addition to the theory of planned behavior (see Ajzen, 2001 for a review). In line with this hypothesis, those who had previous experiences with prison psychologists had lower help-seeking intentions, but those who had seen psychologists out of prison had higher intentions to seek help.

Attitudes toward the behavior, subjective norms, and perceived behavioral control were also related to intentions to seek mental health services among Chinese in Hong Kong (Mo & Mak, 2009). The study also assessed participants’ psychological well-being, but it was unrelated
to help-seeking intentions after considering variance explained by the theory of planned behavior. However, studies that do not include the theory have shown that current psychological distress is associated with increased likelihood of seeking mental health services (Jorm, Griffiths, Christensen, Parslow, & Rogers, 2004; Thompson, Hunt, & Issakidis, 2004; Vogel & Wei, 2005). Mo & Mak (2009) suggested that the powerful stigma against psychological help-seeking in Chinese society, may make an individual weigh the negative beliefs and subjective norms about therapy more heavily than actual need when determining whether to enter therapy. Therefore, the inclusion of variance due to attitudes toward the behavior, subjective norms, and perceived behavior control explained all the related variance in help-seeking intentions.

In sum, the theory of planned behavior uses evaluations of attitudes, subjective norms, and perceived behavioral control to successfully predict intentions to engage in a behavior. Although the theory has successfully predicted a multitude of behaviors, including mental health help-seeking, some research suggests that prediction may be enhanced by including past use of mental health services and current psychological symptoms in the model. The current study seeks to build upon past research by adding to the paucity of theory-based research on help-seeking, testing the predictive power of the theory of planned behavior, past behavior, and current symptoms, while considering the influence of culture and gender.

**Inclusion of Cultural Factors in the Theory of Planned Behavior**

Past research has provided evidence for the cross-cultural generalizability of the model (Hagger et al., 2007; Jemmott, Jemmott, Hines, & Fong, 2001; van Hooft, Born, Taris, & van der Flier, 2006; Nehl et al., 2009) and measurement equivalence among different ethnic groups in the theory of planned behavior questionnaire (Nigg, Lippke, Maddock, 2009), but only three have added culture-specific variables to the model. Culturally linked self-concepts of
independence versus interdependence were found to predict subjective norms and perceived behavioral control, respectively, in the prediction of intentions to quit smoking in a mainly Asian, Pacific Islander, and White sample (Lee, Hubbard, O’Riordan, & Kim, 2006). Subjective norms were more important to those high in interdependence, and perceived behavior control was more important for those high in independence. The addition of independence and interdependence provided a significant increase in the amount of variation explained, compared to the initial model of planned behavior.

Another study examined the role of homosexual and ethnic identification in the theory of planned behavior when predicting intentions to engage in safer-sex behavior among gay Asian Australians (Boldero, Sanitioso, & Brain, 1999). The relationship between subjective norms and behavioral intentions was only significant for individuals strongly identified with the gay community. Identification with the Asian community did not influence this relationship. The authors used social identity theory (Hogg & Abrams, 1988; Tajfel & Turner, 1979; Turner, 1982) to explain these findings. Gay identity, and not Asian identity, served as a moderator because it is a more salient social identity than ethnic identity when discussing sexual behaviors. Those who were highly identified with the Asian community were more likely to report that important others had unfavorable views of safer-sex behaviors. Past research has shown that Asian Australians have less positive views than White of safer-sex behaviors (Rigby & Dietz, 1991). Individuals who are highly identified with the Asian community likely have important others that are part of that community and therefore hold unfavorable views of safer-sex behaviors. In this study, gay and ethnic identity influenced the relationship between subjective norms and intentions to engage in the behavior.
The next study used the theory of planned behavior and additional cultural factors to predict intention to obtain a mammogram among African American women (Bowie, Curbow, Laveist, Fitzgerald, & Zabora, 2004). Behavioral beliefs, perceived behavioral control, and socioeconomic factors were related to intentions, but subjective norm was unrelated. However, none of the culturally-influenced factors (religiosity, trust in health providers, and trust in the health system) significantly predicted intentions. The null findings among these factors is surprising, considering that past research has shown that mistrust negatively affects health-related help-seeking, especially among African Americans (see Whaley, 2001 for review). The cultural factors may have an indirect effect on help-seeking intentions through their influence on attitudes toward the behavior, subjective norms, and perceived control. Mistrust in the health system and its providers may negatively influence attitudes towards help-seeking. These negative attitudes are then associated with decreased likelihood of seeking psychological services.

The one study to use gender norms and the theory of planned behavior to predict psychological help-seeking (Smith, Tran, & Thompson, 2008) found that endorsement of traditional masculine ideology mediated the relationship between psychological help-seeking attitudes and intentions to engage in mental health services in a male, predominantly White sample. Men with more traditional ideology had more negative attitudes toward psychological help-seeking and were less likely to report intentions to seek psychological help. However, this study only used the theory of planned behavior as a framework for testing the relationship between attitudes and intentions. The authors did not specifically measure subjective norms and perceived behavioral control as defined by Ajzen (1991). Additionally, the authors did not control for participants’ psychological well-being. Men who were currently experiencing psychological problems may have endorsed a less masculine ideology and been more willing to
seek therapy because of their symptoms. Failure to consider participants’ psychological well-being makes it extremely difficult to determine effects within a cross-sectional design, a limitation that current research has not yet addressed.

The previous study is the closest approximation to a quantitative examination of gender normative beliefs, not just participant’s gender, in the context of the theory of planned behavior. The current study is the first application of this theory to use gender-specific cultural norms to predict mental health help-seeking behavior. It examined which factors, including the theory of planned behavior, the Strong Black Woman ideal, past history of mental health service use, and current depressive symptoms, distinguish between Black women who intend to seek therapy for depression in the future and those that do not. The study also tested the mediating effect of the theory of planned behavior on the relationship between the Strong Black Woman ideal and therapy-seeking intentions.

The Current Study

Previous qualitative research has shown that endorsement of the Strong Black Woman archetype was related to depressive symptoms and negative attitudes about mental health help-seeking (Beaubouef-Lafontant, 2007), but this relationship has not been examined quantitatively. The theory of planned behavior has been used to predict intentions to engage in various behaviors, including mental health help-seeking, but has not considered the influence of cultural gender norms. Failure to examine these associations is likely due to the fact that the current study is the first to develop a reliable and valid measure of identification with the Strong Black Woman archetype. The goal of Study 1 was to develop and validate a quantitative measure of the Strong Black Woman ideal so that Study 2 could examine the relationship between the Strong Black Woman archetype, depressive symptoms, and intentions to seek therapy for depression among
Black women using the theory of planned behavior. Study 2 used an emic approach, rather than an etic cross-cultural comparison, by including only Black female participants. The study’s goal was to understand the relationship between the cultural gender norm, depression, and help seeking within a particular culture, and not to contrast responses across different races.

Hypotheses

The following hypotheses were examined:

_Hypothesis #1a: Endorsement of the Strong Black Woman ideal will be associated with more severe depressive symptoms._ Based on E. Tory Higgins’ (1987) self-discrepancy theory, women who hold themselves to the unrealistic expectations of the gender norm likely suffer from disappointment, sadness, and guilt when their actual self does not match the Strong Black Woman ideal.

_Hypothesis #1b: The mask of strength domain of the Strong Black Woman ideal will have the strongest positive relationship with depressive symptoms, compared to the care-taking and self-reliance domains._ The mask of strength domain, which encompasses desires to hide emotions and problems from others and appear strong even when feeling weak, has the most direct correspondence with self-discrepancy theory. Women who endorse this belief already recognize that their actual self falls short of the ideal; therefore, they consciously engage in behaviors (e.g., refusing to ask for help, putting on a happy face) used to hide this discrepancy from others.

_Hypothesis #2: The theory of planned behavior will predict intentions to seek therapy for depression, whereby positive attitudes toward the behavior, acceptable subjective norms, and high perceived control will be positively related to intentions._ The theory of planned behavior has successfully predicted a wide range of behaviors among populations across the globe, and is
a well-established theory of conscious behavior. Therefore, it is highly likely that the theory will also be able to predict intentions to seek therapy in adult Black women.

*Hypothesis #3: The Strong Black Woman ideal will predict additional variance in therapy-seeking intentions, whereby endorsement of the gender ideal is negatively related to intentions.* The theory of planned behavior suggests that beliefs and perceived norms about a specific behavior affect intentions to engage in that behavior. Because the Strong Black Woman gender norm is a belief set that mandates against appearing emotionally vulnerable, engaging in self-care, and relying on others, it is likely relevant for Black women considering psychotherapy. Specifically, women who ascribe to this gender norm are predicted to be less likely to engage in therapy because the norm is at odds with admitting psychological “weakness” and asking for help.

*Hypothesis #4: Women who have used mental health services in the past will be more likely to consider seeking therapy in the future.* Past positive experiences with psychological services may make women more likely to engage in therapy in the future. Past behavior has been previously discussed as possible addition to the theory of planned behavior (Ajzen, 2001) and previous studies of psychological help-seeking have found a relationship between past use of services and current intentions (Deane et al., 1999; Pescosolido & Boyer, 1999).

*Hypothesis #5: More severe depressive symptoms will be associated with increased intentions to seek therapy.* Although past research using the theory of planned behavior has not found a relationship between current symptoms and therapy-seeking intentions (Mo & Mak, 2009), studies unrelated to the theory have found a positive correlation between symptoms and likelihood of seeking services. More severely depressed women may be more likely to seek therapy because they are in need and see therapy as a path to symptom relief.
Hypothesis #6: The theory of planned behavior will mediate the relationship between the Strong Black Woman archetype and intentions to seek therapy for depression. Culture is defined as a set of shared beliefs, values, and customs (Fouad & Arredondo, 2007). Therefore, by definition, beliefs about therapy would be heavily influenced by one’s culture. Similar to the relationships between male gender norms, the theory of planned behavior, and help-seeking intentions found in an earlier study (Smith et al., 2008), the relationship between the Strong Black Woman ideal and therapy seeking intentions is likely explained by the cultural gender norm’s influence on attitudes toward therapy, perceived control over engaging in therapy, and subjective norms regarding therapy (see Figure 2).

Figure 2. Theory of planned behavior mediating the relationship between the Strong Black Woman archetype and therapy-seeking intentions

Method

Participants

62
Participants were drawn from respondents to online advertisements and undergraduate students at a large Midwestern university. Participants were recruited online through a snowball sampling strategy. Initial emails with a link to the online survey were sent to Black female sororities, community service groups, and social groups. Participants were asked to forward emails about the study to other Black females between the ages of 18-65. Participants were also recruited through the university’s psychology department subject pool. Participation was restricted to those who identified as female, Black, and at least 18 years of age. Using the most stringent criteria, a projected sample size was computed using the G*Power 3 analysis (Faul, Erdfelder, Lang, & Buchner, 2007). Analyses predicted that with a sample of 191 women and an alpha of .05, there would be adequate power (β = .8; Field, 2005) to detect medium to large effects (d = .3 or greater; z = 1.96).

To determine if participants from the two recruitment strategies could be merged, the two groups were compared on several demographic variables and all of the study variables. Analyses revealed that on average, women recruited online were older (online \( M = 28.81, SD = 6.08 \); college \( M = 20.05, SD = 4.10 \); \( t(230) = -13.10, p < .001 \)), more likely to be married (online = 20.6%; college = 0.7%; \( \chi^2 (4, N = 240) = 42.10, p < .001 \)) and have children (online = 22.7%; college = 2.8%; \( \chi^2 (1, N = 240) = 23.65, p < .001 \)) than were the college recruitment participants. However, chi-square and \( t \) tests comparing the two samples on the study variables revealed no significant differences between the two groups (all \( ps > .05 \)). Therefore, the two samples were combined to provide sufficient power for the study analyses, resulting in an \( N = 240 \) (college \( n = 143 \); online \( n = 97 \)). As an additional precaution, all analyses included recruitment (college = 0; online = 1) as a control variable. Participants’ ages ranged from 18-60 years (\( M = 23.60, SD = 6.59 \)). A Bachelor’s degree was the highest level of education for 43% of participants; 33% had
attained a Master’s degree. Additional demographic information for Study 2 participants is presented in Table 2.1.
Table 2.1. Description of Study 2 Participants

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**Procedure**

Participants were invited to complete the 60-minute Culture, Emotions, and Therapy beliefs survey online. Informed consent was obtained from participants immediately prior to participation in the study, and participants were compensated with either research class credit or
a $25 gift card. Upon completion of the survey, all participants were provided with debriefing information regarding the aims of the study and mental health referral sources.

**Measures**

*Demographics.* Participants self-reported their age, gender, race, marital status, number of children, household annual income, year in school, and the degree toward which they were currently working. See Table 2.1 for a full listing of all demographic categories.

*Strong Black woman archetype.* The Strong Black Woman Archetype scale created in Study 1 was used to measure endorsement of the cultural gender norm. The scale measured three clusters of Strong Black Woman ideal characteristics: the Mask of Strength and Emotional Invulnerability (14-items; e.g., “I try to always maintain my composure.”), Care-Taking and Self-Sacrifice (11-items; e.g., “I will let people down if I take time out for myself.”), and Self-Reliance/Strength (11-items; e.g., “In order to feel good about myself, I need to feel independent and self-sufficient.”). Participants were asked to rate their agreement with each statement on a 5-point scale ranging from 0 (*never*) to 4 (*almost always*). Item responses were summed to create subscale and total scores, with higher scores representing stronger endorsement of the Strong Black Woman ideal.

*Depressive symptoms.* Participants completed the 20-item Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) to assess their experience of depressive symptomology during the past week. Items included: “I felt that I could not shake off the blues even with help from my family or friends” and “I felt that everything I did was an effort.” Participants indicated how often they have felt each symptom on a 4-point scale ranging from 0 (*rarely or none of the time [less than 1 day]*) to 3 (*most or all of the time [5-7 days]*) Item scores were summed to create a total depression score ranging from 0-60. The CES-D has demonstrated
adequate reliability (Cronbach’s alpha = .89), specificity, and predictive validity (Shean & Baldwin, 2008).

Theory of planned behavior variables. Because questions must be adapted to reflect the specific behavior being predicted, there is no official theory of planned behavior questionnaire. Researchers are encouraged to use descriptions of theory variables (Ajzen, 1991), guidelines for constructing a theory of planned behavior questionnaire (Ajzen, 2002), and quantitative studies using this theory (e.g., Davis, Ajzen, Saunders, & Williams, 2002; Hrubes, Ajzen, & Daigle, 2001) as a scale creation guide. Therefore, items, scoring, and survey order for the theory variables were modeled after these resources.

Attitude toward the behavior. Attitudes toward therapy for depression were assessed using nine evaluative semantic scales with two opposite words at each end of the 7-point scale. Participants were asked to respond to each item using the stem “Entering into therapy for depression would be . . .” The nine anchors of these scales included: rewarding-punishing, useful-useless, bad-good, harmful-beneficial, wise-foolish, unpleasant-pleasant, desirable-undesirable, boring-exciting, acceptable-unacceptable. The mean of this scale was used as a composite score ranging from 1 to 7. In past research predicting different behaviors, this scale has demonstrated adequate reliability (Cronbach’s alpha = .82) and test-retest reliability (Davis et al., 2002).

Subjective norm. Five items were used to provide a direct measure of subjective norms of therapy for depression. Using the stem, “If I was feeling depressed, most people who are important to me . . .,” three of the items were followed by: “would think I should enter into therapy for depression,” “would be disappointed in me if I entered into therapy for depression,” “would expect me to enter into therapy for depression.” The last two items included: “Many
people like me would seek therapy if they were feeling depressed” and “Most people who are important to me would seek therapy if they were feeling depressed.” Participants were asked to respond on a 7-point scale ranging from (1) false to (7) true. The mean of the five items was used as a composite score. A similar scale has demonstrated adequate internal consistency (Cronbach’s alpha = .85; Mo & Mak, 2009).

*Perceived behavior control.* Six items were used to measure the amount of control each participant believes they have over receiving therapy for depression. Responses to items were given on a 7-point scale and included: “I can overcome any obstacles or problems that could prevent me from receiving therapy for depression if I wanted it” (*strongly disagree* – *strongly agree*), “For me to begin therapy for depression would be . . .” (*very easy* – *very difficult*), and “How much control do you believe you have over entering into therapy for depression?” (*no control* – *complete control*). The mean of the six items was used as a composite score. Adequate internal consistency has been reported for similarly created scales (e.g., Cronbach’s alpha = .77; Mo & Mak, 2009).

*Intentions to seek therapy for depression.* Using the stem “If I were ever depressed,” five items were used to assess intentions to seek therapy for depression on a 7-point scale ranging from (1) *strongly agree* to (7) *strongly disagree*. Sample items included: “I would try to seek therapy for depression,” “I would be determined to seek therapy for depression,” and “I might not seek therapy for my depression” (reverse scored). The mean of the five items was used as a composite score. A similar scale used in past research obtained an adequate internal consistency (Cronbach’s alpha = .77) and test-retest reliability (Davis et al., 2002). Participants were also asked to respond “yes” or “no” for their agreement to the statement: “If I were ever depressed, I
would definitely seek therapy for depression.” Responses to this single item were used to create a dichotomous measure of intentions to seek therapy for depression.

**History of mental health service use.** Participants were asked to respond “yes” or “no” for their agreement to the statement: “Have you ever seen a mental health professional for problems with your emotions, nerves, alcohol/drug use, life stress, or any other psychological problems?”

**Negative affectivity.** The 10 item negative affect subscale of the Positive and Negative Affectivity Schedule (Watson, Clark, & Tellegen, 1988) was used to measure current negative feelings. Because negative affectivity has been shown to influence responses to emotion-laden material (Sheldon & Elliot, 1999), it was used as a control variable in all analyses. Participants were asked to indicate the extent to which they currently felt “ashamed,” “guilty,” “upset,” etc. on a 5-point scale ranging from 0 (very slightly or not at all) to 4 (extremely). The negative affect subscale has demonstrated good internal consistency (Cronbach’s alpha = .86; Downey & Chang, 2007). Item responses were summed such that higher scores corresponded to greater negative affect.

**Data Analysis**

Partial correlation, sequential logistic regression, and multiple mediation in SPSS were the analytic strategies used to test the six hypotheses in the study. To facilitate analysis, missing data was imputed through LISREL 8.80 using the hot-deck imputation method (Joreskog & Sorbom, 2001). This method imputes data based on the responses of participants that most closely match the participants with incomplete data on a set of specified matching variables. In total, 703 data points were imputed out of the total possible of 4,800 (14.6%). This resulted in 240 participants with complete data for all variables. To verify the integrity of the imputed data, means before and after imputation were compared on each variable. None of the comparisons
yielded significant differences. A dichotomous variable was also created to compare subjects with complete data to subjects with incomplete data. Correlations between missingness and all original independent and dependent variables were either non-significant or small in size ($r < .25$).

*Predicting Depressive Symptoms (Hypotheses #1a-b)*

A second-order partial correlation assessed the relationship between the Strong Black Woman Archetype scale total, domain scores (Mask of Strength/Emotional Invulnerability, Self-Reliance/Strength, and Care-Taking/Self-Sacrifice), and depressive symptoms, controlling for negative affect and recruitment. Before conducting any analyses, the data was examined for normality and outliers. A two-tailed test was conducted because as the first quantitative examination of this relationship, the direction of the relationship between each of the Strong Black Woman archetype domains and depression was uncertain. The correlation coefficients were then compared. Because the correlations are from the same sample and are therefore dependent, the $t$-statistic was computed to determine the significance of potential differences.

*Predicting Intentions to Seek Therapy (Hypotheses #2-5)*

Sequential logistic regression was used to determine which variables predicted the dichotomous outcome, intentions to seek therapy for depression in the future. Before conducting any analyses, the adequacy of expected frequencies was evaluated for recruitment type and past use of mental health services to assure that each of the cells formed by the categorical predictors included an adequate number of participants. The continuous predictors were assessed for any violations of linearity in the logit using the Box-Tidwell approach to assure that there was a linear relationship between the continuous predictors and the logit transform of the dependent variable (Tabachnick & Fidell, 2001).
To directly test each hypothesis, model fit at each step was compared to determine whether the predictors, as a set, reliably distinguished between women who do and do not intend to seek therapy. The amount of variance in intentions to seek therapy predicted by the independent variables was evaluated and the ability of the model to correctly classify participants who do and do not intend to seek therapy was assessed. The ability of individual predictors to reliably enhance prediction was assessed by comparing models with and without each predictor. Lastly, the size and direction of odds ratios for significant predictors was interpreted and the means of these significant predictors for women in each category (those who do and do not intend to seek therapy) were compared.

When conducting the logistic regression, negative affect and recruitment type were entered into the model first as control variables. The theory of planned behavior was entered into the second step to test Hypothesis #2 (the theory of planned behavior will predict intentions to seek therapy for depression, whereby positive attitudes toward the behavior, acceptable subjective norms, and high perceived control will be positively related to intentions). The Strong Black Woman Archetype scale was entered into the third step to determine incremental and overall model fit according to Hypothesis #3 (the Strong Black Woman ideal will predict additional variance in therapy-seeking intentions, whereby endorsement of the gender ideal is negatively related to intentions). Lastly, past use of mental health services and severity of depressive symptoms were entered into the final step to test Hypothesis #4 (women who have used mental health services in the past will be more likely to consider seeking therapy in the future) and Hypothesis #5 (more severe depressive symptoms will be related to increased intentions to seek therapy).

The Mediating Effect of the Theory of Planned Behavior (Hypothesis #6)
A series of multiple mediation models were conducted using SPSS macros provided by Preacher and Hayes (2008). Four models tested the indirect effect of the Strong Black Woman Archetype scale total and three subscales on the continuous measure of intentions to seek therapy for depression through the three theory of planned behavior variables: attitude toward the behavior, subjective norm, and perceived behavior control. Negative affect, recruitment strategy, and past use of mental health services were entered as covariates.

Two methods of testing mediation were conducted: the Baron and Kenny (1986) method and nonparametric bootstrapping (Preacher & Hayes, 2008; Shrout & Bolger, 2002). In the Baron and Kenny model, a mediational model is supported if the following criteria are met: (1) the independent variable significantly predicts the dependent variable, (2) the independent variable significantly predicts the mediator, and (3) the mediator significantly predicts the dependent variable while controlling for the independent variable. The bootstrapping technique is a formal test of the mediation effect, whereby a 95% confidence interval is created for the size of the indirect effect. If the confidence interval does not contain zero, an indirect effect exists between the independent variable and the dependent variable by way of the mediating variable.

Results

Descriptive Statistics

Table 2.2 presents correlations, coefficient alphas, means, standard deviations, and ranges for all of the variables used in the current study.
Table 2.2. Correlations, Means, Standard Deviations, and Ranges

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<td>.47**</td>
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<td>0-1</td>
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Note: Recruitment is categorized as follows: college = 0 and online = 1. Past use of mental health services is categorized as follows: no = 0 and yes = 1. Intentions (yes/no) is categorized as follows: no = 0 and yes = 1. All values are Pearson correlations unless otherwise specified. Internal consistency (Cronbach’s alpha coefficient) is presented for each multi-item scale on the diagonal. 

a Point-biserial Correlations.  b Cramer’s V 
** p < .01, * p < .05.
The Strong Black Woman Ideal and Depressive Symptoms (Hypotheses #1a-b)

Consistent with Hypothesis #1a, the Strong Black Woman scale total \( (r = .25) \) and the Mask of Strength \( (r = .33) \) and Care-Taking \( (r = .27) \) subscales were significantly correlated with depression symptoms \( (p < .001) \). However, the Self-Reliance subscale was unrelated to depression symptoms \( (r = -.026, p = .69) \). The \( t \)-statistic was used to determine whether the dependent correlations were significantly different from one another. As hypothesized (Hypothesis #1b), the correlation between depressive symptoms and Mask of Strength was significantly larger than the correlation between depression and Care-Taking \( (t = 3.69, p < .01) \); moreover, the correlation between depressive symptoms and Care-Taking was significantly larger than the correlation between depression and the Strong Black Woman Archetype scale total \( (t = 10.73, p < .01) \).

In sum, endorsement of the Strong Black Woman archetype was significantly related to symptoms of depression. The Mask of Strength had the strongest relationship with depressive symptoms, followed by Care-Taking and overall endorsement of the Strong Black Woman ideal. However, the Self-Reliance domain of the Strong Black Woman archetype was unrelated to depressive symptoms.

Predicting Intentions to Seek Therapy (Hypotheses #2-5)

Sequential logistic regression was used to distinguish between participants who do and do not intend to seek therapy for depression in the future. Evaluation of the adequacy of expected frequencies for the two categorical predictors (recruitment and past use of mental health services) revealed that each of the cells had an adequate number of participants. Therefore, there was no need to restrict model goodness-of-fit tests. Additionally, the Box-Tidwell approach confirmed that there was no violation of linearity in the logit for the six continuous predictors.
There was poor model fit on the basis of the control variables alone, negative affect and recruitment \((\chi^2 (2, N = 240) = 1.66, p = .44)\). Consistent with Hypothesis #2, after addition of the theory of planned behavior direct measures, there was reliable improvement in model fit (Step \(\chi^2 (2, N = 240) = 98.08, p < .001\)). The predictors accounted for a moderate amount of variance in intentions to seek therapy, with Nagelkerke’s pseudo \(R^2 = .46\). Prediction success was good, with 72% of those unlikely therapy-seeking cases and 83% of likely therapy-seeking cases correctly predicted (overall successful prediction rate = 78%). Table 2.3 shows odds ratios, 95% confidence intervals, and \(\chi^2\) values for all of the predictors and steps in each model.

### Table 2.3 Logistic Regression Odds-Ratios, Confidence Intervals, and Step \(\chi2\) for Predictors of Intentions to Seek Therapy

<table>
<thead>
<tr>
<th>Variables</th>
<th>OR</th>
<th>95% CI</th>
<th>(\beta)</th>
<th>df</th>
<th>Step (\chi2)</th>
<th>Model (\chi2)</th>
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76
Table 2.3 (cont’d)

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<th>Variables</th>
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<td>0.95 – 0.99</td>
<td>-0.03</td>
<td>6</td>
<td>5.47*</td>
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<td>0.97 - 1.06</td>
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Note. OR = odds ratio; CI = confidence interval. MH = Mental Health. The reference category is: Yes, I would seek therapy for depression. **p < .01. *p < .05.
Attitudes toward therapy and subjective norms regarding therapy were both significant predictors of intentions to seek therapy for depression. However, perceived behavioral control was unrelated to therapy intentions. Women who reported they would seek therapy if depressed had more positive attitudes toward therapy \((M = 5.68, SD = 0.89)\) than women who indicated they would not seek therapy \((M = 4.55, SD = 1.15)\). Women who intended to seek therapy also believed that important others would promote potential decisions to enter into therapy \((M = 4.88, SD = 1.09)\) more than women who would not seek therapy \((M = 3.50, SD = 1.19)\).

When the Strong Black Woman ideal was entered in the third step, model fit was significantly improved \((\text{Step } \chi^2(1, N = 240) = 5.47, p < .05)\) (see Table 2.5). Endorsement of the Strong Black Woman ideal decreased the odds of seeking intentions to seek therapy. Women who reported they would seek therapy if depressed had lower endorsement of the Strong Black Woman \((M = 80.88, SD = 18.58, n = 137)\) than women who indicated they would not seek therapy \((M = 87.19, SD = 17.18, n = 103)\).

The addition of depressive symptoms and past use of mental health services in the fourth step did not increase model fit \((\text{Step } \chi^2(2, N = 240) = 5.92, p < .05)\) (see Table 2.6). However, past use of mental health services was a significant predictor in the final model including all eight variables. For women who had never seen a mental health professional, their intentions to seek therapy were fairly split \((\text{do not intend to seek therapy} = 48.2\% \text{ vs. intend to seek therapy} = 51.8\%)\). Conversely, women who had previously seen a mental health professional were more likely to consider seeking therapy for depression in the future \((\text{intend to seek therapy} = 80.0\% \text{ vs. do not intend to seek therapy} = 20.0\%\).

\textit{Theory of Planned Behavior as a Mediator between the Strong Black Woman Ideal and Therapy Seeking Intentions}
Analyses were first conducted to determine the ability of the theory of planned behavior to mediate the relationship between the Strong Black Woman ideal and intentions to seek therapy (see Figure 3). Following the Baron and Kenny (1986) method, the relationship between the Strong Black Woman ideal and therapy seeking intentions was not significant \((\beta = -0.04), t(240) = -1.47, p = .14\). The relationship with the Strong Black Woman ideal was significant for one of the proposed mediators, subjective norm \((\beta = -0.01), t(240) = -2.29, p < .05\), and approached significance for behavior control \((\beta = -0.01), t(240) = -1.72, p = .09\), but was non-significant for attitude toward the behavior \((\beta = 0.002), t(240) = 0.59, p = .55\). Women who were high in endorsement of the Strong Black Woman ideal had more negative perceptions of subjective norms against therapy for depression and there was a trend towards less perceived control over engaging in therapy.

All three of the theory of planned behavior variables were significantly and positively correlated with intentions: attitude toward the behavior \((\beta = 2.79), t(240) = 7.04, p < .001\), subjective norm \((\beta = 2.55), t(240) = 2.51, p < .001\), and behavior control \((\beta = 0.98), t(240) = 2.51, p < .05\). Finally, the direct effect of the Strong Black Woman ideal remained non-significant when controlling for the three mediators \((\beta = -0.02), t(240) = -0.80, p = .42\). Due to the non-significant relationship between the independent variable (the Strong Black Woman ideal) and the dependent variable (intentions to seek therapy), this model does not meet the criteria for mediation set forth by Baron and Kenny (1986).
Figure 3. Theory of planned behavior as a mediator for the relationship between Strong Black Woman ideal and therapy seeking intentions.

Note: Strong Black Woman Ideal ranges from 0 to 144. Attitude toward the behavior, subjective norm, and behavior control range from 1 to 7. Intention ranges from 1 to 35.

However, some have argued that a significant direct relationship between the independent and dependent variable is not necessary for determining whether the independent variable indirectly effects the dependent variable through a third mediating factor (Shrout & Bolger, 2002). To properly determine whether a mediating relationship exists, it is best to test for the mediation effect specifically using the bootstrapping technique (Preacher & Hayes, 2008). The bootstrapping procedure suggested that subjective norms significantly mediated the relationship between the Strong Black Woman ideal and intentions, whereby zero fell outside of the 95% confidence interval around the indirect effect (range = -0.06 to -0.01). Attitude toward the
behavior and behavior control were not significant mediators. The overall model accounted for 60% of the variance in therapy seeking intentions.

The indirect effect of Self-Reliance/Strength on therapy seeking intentions was also tested through multiple mediation (see Figure 4). The direct effect of Self-Reliance on intentions was non-significant \((\beta = 0.06), t(232) = 0.78, p = .44\). The correlation with Self-Reliance was only significant for attitude toward the behavior \((\beta = 0.02), t(232) = -2.09, p < .05\).

Surprisingly, internalization of the Self-Reliance ideal was associated with more positive attitudes toward therapy. The theory of planned behavior significantly predicted intentions: attitude toward the behavior \((\beta = 2.70), t(232) = 6.78, p < .001\), subjective norm \((\beta = 2.62), t(232) = 8.18, p < .001\), and behavior control \((\beta = 1.01), t(232) = 2.61, p < .05\).

The direct effect of Self-Reliance and intentions maintained non-significance after controlling for the three mediators \((\beta = 0.03), t(232) = 0.50, p = .61\). Due to the non-significant direct relationship between Self-Reliance and intentions, the model does not meet the Baron and Kenny (1986) criteria for mediation. However, the nonparametric bootstrapping procedure yielded a significant mediating effect of attitude toward the behavior (range = 0.01 to 0.12).

Women who believe in the Self-Reliance ideal have more positive attitudes towards therapy; these positive attitudes are associated with increased intentions to seek therapy for depression in the future.
Figure 4. Theory of planned behavior as a mediator for the relationship between Self-Reliance/Strength and therapy seeking intentions.

\*p < .10. *p < .05. **p < .001. \(^a\)Significant 95% confidence interval for the indirect effect.

**Note:** Self-Reliance/Strength subscale ranges from 0 to 44. Attitude toward the behavior, subjective norm, and behavior control range from 1 to 7. Intention ranges from 1 to 35.

Multiple mediation was then used to test the theory of planned behavior as a mediator for the relationship between the Mask of Strength/Emotional Invulnerability and therapy seeking intentions (see Figure 5). The effect of Mask of Strength on therapy seeking intentions was significant [(β = -0.16), \(t(232) = -2.61, p < .05\)]. Women who felt pressured to hide emotional distress were less likely to consider seeking therapy for depression in the future. The relationship with Mask of Strength was also significant for two of the mediators, subjective norm [(β = -0.02), \(t(232) = -2.05, p < .05\)] and behavior control [(β = -0.02), \(t(232) = -2.29, p < .05\)], but non-significant for attitude toward the behavior [(β = -0.01), \(t(232) = -0.63, p = .53\)]. Women who
endorsed the Mask of Strength reported more negative subjective norms and less perceived behavior control over entering into therapy.

Again, the theory of planned behavior was significantly related to intentions: attitude toward the behavior \( (β = 2.79), t(232) = 7.16, p < .001 \), subjective norm \( (β = 2.54), t(232) = 8.03, p < .001 \), and behavior control \( (β = 0.93), t(232) = 2.39, p < .05 \). The direct effect of the Mask of Strength became non-significant after considering variance from the three mediators \( (β = -0.07), t(232) = -1.88, p = .06 \). The Mask of Strength model meets the Baron and Kenny (1986) mediation criteria. Using the bootstrapping technique, both subjective norm (range = -0.11 to -0.002) and behavior control (range = -0.05 to -0.002) were significant mediators of the indirect effect. The model, where subjective norm and behavior control mediated the relationship between the Mask of Strength and therapy seeking intentions predicted 61% of the variance.
Figure 5. Theory of planned behavior as a mediator for the relationship between Mask of Strength and therapy seeking intentions.

Note: Mask of Strength subscale ranges from 0 to 56. Attitude toward the behavior, subjective norm, and behavior control range from 1 to 7. Intention ranges from 1 to 35.

The last model tested was the indirect effect of Care-Taking/Self-Sacrifice on intentions to seek therapy for depression (see Figure 6). The direct relationship between Care-Taking and intentions was non-significant [(β = -0.11), t(232) = -1.35, p = .18]. There was a significant relationship between Care-Taking and two of the proposed mediators, subjective norm [(β = -0.03), t(232) = -2.53, p < .05] and behavior control [(β = -0.02), t(232) = -2.11, p < .05], but the relationship was non-significant for attitude toward the behavior [(β = 0.003), t(232) = 0.22, p = .82]. Women who felt pressure to take care of others and sacrifice personal needs believed that others had more negative views of therapy and perceived more barriers to engaging in therapy.
The theory of planned behavior was significantly related to intentions: attitude toward the behavior \([\beta = 2.75], t(232) = 6.93, p < .001\], subjective norm \([\beta = 2.58], t(232) = 8.05, p < .001\], and behavior control \([\beta = 1.00], t(232) = 2.56, p < .05\]. The relationship between Care-Taking and intentions remained non-significant after considering variance from the three mediators \([\beta = -0.001], t(232) = -0.16, p = .87\].

Bootstrapping yielded significant results for subjective norms (range = -0.18 to -0.02) and behavior control (range = -0.07 to -0.001) as significant mediators of the indirect effect between Care-Taking and therapy seeking intentions. Belief in the Care-Taking ideal was associated with negative subjective norms for therapy and less perceived control in the decision to enter therapy. These negative subjective norms and increased barriers to therapy engagement were associated with lower therapy seeking intentions. The model predicted 60% of the variance in intentions to seek therapy.
Figure 6. Theory of planned behavior as a mediator for the relationship between Care-Taking/Self-Sacrifice and therapy seeking intentions.

\[
\begin{align*}
\text{Intention} & \quad 6.93^{**} \\
\text{Subjective norm}^a & \quad 8.05^{**} \\
\text{Attitude toward the behavior} & \quad 0.22^{ns} \\
\text{Care-Taking} & \quad -2.53^* \\
\text{Perceived behavioral control}^a & \quad -1.35^{ns} \\
& \quad -2.11^* \\
& \quad -0.16^{ns}
\end{align*}
\]

†p < .10. *p < .05. **p < .001. aSignificant 95% confidence interval for the indirect effect.

Note: Care-Taking subscale ranges from 0 to 44. Attitude toward the behavior, subjective norm, and behavior control range from 1 to 7. Intention ranges from 1 to 35.

Summary

The Strong Black Woman ideal, the theory of planned behavior, and past use of mental health services predicted Black women’s intentions to seek therapy for depression. Women with positive attitudes and subjective norms about therapy and past experiences with mental health professionals were more likely to consider entering into therapy. Conversely, women who believed strongly in the Strong Black Woman ideal were less likely to consider engaging in therapy. Attitudes toward therapy mediated the relationship between Self-Reliance and therapy seeking intentions. Subjective norms about therapy mediated the relationship between intentions...
and the Strong Black Woman ideal, Mask of Strength, and Care-Taking. Perceived control over engaging in therapy mediated the relationship between intentions and the Mask of Strength and Care-Taking ideals.

Discussion

Study 2 took an emic look at the relationship between cultural gender norms and intentions to seek mental health services among Black women. The study found that characteristics of the Strong Black Woman ideal were related to depressive symptoms and therapy-seeking intentions, even after considering variance explained by the well-supported theory of planned behavior. The theory of planned behavior also mediated the relationship between the Strong Black Woman ideal characteristics and intentions to seek therapy for depression.

Consistent with earlier theory, qualitative work, and Hypothesis #1a, endorsement of the Strong Black Woman ideal was associated with more severe depressive symptoms. Women who reported feeling pressure to keep up the appearance of physical and emotional strength also reported more severe symptoms of depression. The three domains of the Strong Black Woman image (Mask of Strength, Self-Reliance, and Care-Taking) had different relationships with depression. Consistent with Hypothesis #1b, the Mask of Strength ideal had the strongest relationship with depression, followed by Care-Taking. Women’s attempts to appear emotionally invulnerable during times of stress were strongly related to depressed mood. The Mask of Strength domain likely has the strongest relationship with depression because it is most closely related to E. Tory Higgins (1987) self-discrepancy theory. Women endorsing the Mask of Strength mandate are acknowledging that there is a discrepancy between the strong woman they
are called to be, and the weakness they feel at times. This discrepancy between the ideal and real self are what leads to sadness, disappointment, and depression.

Feeling pressured to assume responsibility for family and community was also related to depression. Serving as the financial and emotional provider across several domains leaves little time for self-care (Beaubouef-Lafontant, 2007), opening the door to unaddressed emotional stress and depressed mood. The urge to be independent and self-sufficient, however, was unrelated to depressive symptoms. The lack of a significant relationship between self-reliance and depression may be due to the fact that women who view their self-reliance as a strength may be less likely to develop depression, but those who view the mandate of self-sufficiency as a burden, are more likely to develop depression thereby splitting the results. Qualitative work has echoed this sentiment, finding that some women report that this self-reliant image gives them confidence (Settles, 2006) and others report that it prevents them from seeking help and support (McNair, 1992).

The theory of planned behavior significantly predicted intentions to seek therapy for depression (Hypothesis #2). Other studies using the theory to predict psychological help-seeking have found similar results (Bayer & Peay, 1997; Codd & Cohen, 2003; Mo & Mak, 2009; Skogstad et al., 2006). Women’s attitudes and subjective norms regarding therapy significantly predicted therapy-seeking intentions. Women who evaluated therapy for depression as more acceptable, useful, and desirable were more likely to intend to seek therapy if depressed. Similarly, women who believed those closest to them would offer encouragement to seek therapy if depressed reported higher therapy-seeking intentions. Perceived behavior control (reports of how easy it would be to overcome potential obstacles to seeking therapy), however, was unrelated to intentions to seek therapy. Perceived behavior control was correlated with therapy
intent in correlation analyses (see Table 2.2). The common variance between behavior control and the other two theory of planned behavior variables in the regression analyses may have caused the non-significant relationship between behavior control and intent.

Also as hypothesized, the Strong Black Woman ideal explained intentions to seek therapy for depression even after considering variance explained by the theory of planned behavior (Hypothesis #3). Because the Strong Black Woman gender norm is a belief set that mandates against appearing emotionally vulnerable, engaging in self-care, and relying on others, it was significantly relevant for Black women considering psychotherapy, over and above their general views about therapy assessed using the theory of planned behavior. Specifically, endorsement of the Strong Black Woman image decreased the odds of seeking therapy. The pressure to maintain the appearance of strength and appear emotionally invulnerable may cause women who believe in this cultural gender norm to shun mental health services (Thomas et al., 2004). A previous study of gender norms, the theory of planned behavior, and help-seeking also found that traditional masculine ideology, which mandates that men appear tough, independent, and aggressive, was negatively correlated with intentions to seek psychological help through its influence on attitudes toward therapy (Smith et al., 2008).

Women who had used mental health services in the past were more likely to consider seeking therapy in the future (80%) than those who had never seen a mental health professional (52%; Hypothesis #4). Past behavior, often cited as the best predictor of future behavior, served as a significant predictor of therapy seeking intentions as it has in previous studies (Deane et al., 1999; Pescosolido & Boyer, 1999). However, contrary to Hypothesis #5, severity of depression was not a significant predictor of intentions to seek therapy. A previous study predicting psychological help-seeking with the theory of planned behavior and current symptoms also did
not find a significant relationship between intentions and psychological well-being in their Chinese sample (Mo & Mak, 2009). Mo & Mak (2009) suggested that the negative societal views of mental health treatment may be so salient in Chinese society that individuals consider these negative subjective norms and attitudes toward the behavior when considering therapy more than actual need for services. Therefore, models that contain the attitudes and norms suggested by the theory of planned behavior will eliminate the potential variance in intentions related to psychological well-being in cultures with therapy stigma. The Strong Black Woman ideal proposes that Black women would hold similar stigmatized views, suggesting that views of psychotherapy are stronger predictors of help-seeking than current symptoms.

The theory of planned behavior mediated the relationship between the Strong Black Woman ideal and intentions to seek therapy for depression (Hypothesis #6). Attitudes toward therapy mediated the relationship between Self-Reliance and therapy seeking intentions. Surprisingly, women who internalized the belief that they must appear independent and strong also believed that therapy for depression could be rewarding, pleasant, and useful. These women may have believed in the utility of therapy, even though they did not think it would be an acceptable option for them. Only one item in the attitudes toward the behavior scale specifically addresses acceptability. The other eight items refer to the usefulness, reward, benefit, and desirableness of therapy for depression. The negative correlation between Self-Reliance and the forced yes or no response to intentions to seek therapy (see Table 2.2) suggests that when given the explicit option to engage in therapy, self-reliant women may be more likely to decline even if they do understand the potential utility of psychotherapy.

Subjective norms about therapy mediated the relationship between intentions and the Strong Black Woman, Mask of Strength, and Care-Taking ideals. Women who internalized the
overall mandate of strength, the pressure to appear confident and invulnerable, and the pull to take responsibility for others believed that those important to them would find therapy for depression unacceptable. When acknowledging emotional distress and devoting time and financial resources to self-care instead of others is dictated by one’s community as a mandate of strength, Black women are sent a clear message that those important to them would not approve of therapy (Beaubouef-Lafontant, 2007; Littlefield, 2003). As suggested by the theory of planned behavior, negative beliefs about therapy norms were associated with decreased likelihood of seeking therapy for depression. Perceived control over engaging in therapy mediated the relationship between intentions and the Mask of Strength and Care-Taking ideals. Women who felt pressure to appear strong and take care of others perceived more barriers to psychological treatment. It is not surprising that the notion of therapy as an admission of weakness (Mask of Strength) and an act of selfishness (Care-Taking) would act as barriers to mental health treatment. A lack of perceived control over engaging in therapy was correlated with lower therapy seeking intentions as predicted by the theory of planned behavior.

In sum, women who endorsed the Strong Black Woman ideal reported more depressive symptoms. Internalization of the Mask of Strength/Emotional Invulnerability domain was most strongly tied to depressive symptoms, followed by belief in Care-Taking/Self-Sacrifice. The theory of planned behavior successfully predicted intentions to seek therapy, and internalization of the Strong Black Woman ideal added significant additional predictive power. Women who would not consider seeking therapy for depression in the future were more likely to believe in the mandate of strength, struggle and self-sacrifice, and were less likely to have used mental health services in the past. Moreover, the theory of planned behavior successfully mediated the relationship between the Strong Black Woman ideal and therapy seeking intentions.
Endorsement of the Strong Black Woman ideal was associated with negative attitudes about therapy, and these negative attitudes were associated with lower intentions to seek therapy.

Limitations & Future Directions

The current study took a focused look at the gender norms and therapy beliefs of Black women. It is the first quantitative examination of the relationship between the Strong Black Woman ideal, depression, and psychological help-seeking and the first study to examine cultural gender norms alongside the theory of planned behavior. However, some study limitations should be addressed. Due to the cross-sectional nature of the study, cause-effect relationships between the Strong Black Woman ideal, depressive symptoms, theory of planned behavior, and therapy-seeking intentions cannot be established. This cross-sectional data does not prove that endorsement of the Strong Black Woman ideal causes depressive symptoms or leads to the avoidance of mental health services. Future studies should use longitudinal methods to prove whether belief in this cultural gender norm causes depressive symptoms and negative therapy beliefs. It is possible that a third variable exists that explains both factors, or conversely, that a reverse relationship exists (e.g., that depressed Black women more readily adopt negative aspects of the Strong Black Woman ideal).

The subjective norm scale used in this study asked participants about the expectations of “most people who are important to [them].” Subjective norms are sometimes assessed by first asking participants to rate how important certain people are to them (e.g., mother, father, best friend, sister, etc.), and then weighting responses to statements like, “My mother would expect me to enter into therapy” based upon the significance rating given earlier. However, the subjective norm scale in this study was worded to elicit ratings of people that are important to the participant, without listing specific people. Future studies may seek to determine whether similar
results would be found if ratings for individual persons and weighting was used to assess the relationship between the Strong Black Woman ideal, theory of planned behavior, and intentions to seek therapy.

The results of this study may not be generalizable to other groups of Black women. Because the studies were conducted online, there may have been a tendency for our participants to be younger in age and of a higher social class than Black women in general. Additionally, the online sample was older and more likely to be married with children, but there were no significant differences between the two samples on any of the study variables. Also, women outside of the Midwestern university participant pool were recruited online from fraternal and community service organizations for college-educated women. In light of their educational background, these women may be of an even higher socioeconomic status than the Midwestern university women and Black women in general. Black women belonging to a high social class may have a more racially diverse social circle and may have adopted more diverse gender norms. Exposure to different ideals of womanhood may make these women less likely to endorse the Strong Black Woman ideal and more accepting of mental health treatment. Therefore, the relationship between the archetype, therapy beliefs, and intentions to seek therapy may be even stronger for low income women than for the women in the current study’s sample. Additional research is needed to conclusively determine whether the relationship between the Strong Black Woman archetype, therapy beliefs, and intentions to seek therapy is similar for Black women across the range of age and socioeconomic status. Future studies could recruit samples stratified by age and socioeconomic status to complete the study either online or through paper-and-pencil questionnaires.
Additionally, our participants included adult women living in the U.S. that self-identified as “Black.” It is unclear whether the same relationships would hold among self-identified Black women in other countries. However, a similar body of theoretical and qualitative research on the Strong Black Woman ideal’s association with depression has been described by researchers in Canada (Etowa et al., 2007; Schreiber, Stern, & Wilson, 1998, 2000) and the United Kingdom (Edge & Rogers, 2005). Therefore, quantitative studies in these countries may also uncover similar findings.

Future studies could also examine the impact of “John Henryism”, a coping strategy associated with prolonged exposure to stress, which may serve as a cultural gender ideal among Black men and those of lower socioeconomic status (James et al., 1992). John Henryism refers to using physical strength to plow through life’s obstacles (often leading to over-exertion), similar to how the fabled John Henry died using his physical strength to outdrill a steam-powered machine (Keats, 1965). Sherman James developed the term after interviewing a participant for a racial health disparities study named John Henry Martin (James, 1993). Mr. Martin liberated himself from the early 20th century sharecropper system and personally owned 75 acres only to develop hypertension, arthritis, and peptic ulcer disease by age 50. Previous research has already connected this cultural stereotype to cardiovascular disease (James et al., 1992), but future studies could determine whether there is an association between endorsement of this coping strategy and mental health. The hyper-vigilant approach to coping may prove maladaptive, especially when faced insurmountable, prolonged stressors.

**Implications**

Due to its association with depressive symptoms and therapy-seeking intentions, knowledge of the Strong Black Woman ideal should be used to inform help-seeking promotion
efforts and therapy for depression for Black women. Black women are less likely than their White counterparts to seek psychological services (Wise et al., 2006). Therefore, mental health service providers should engage in outreach programs that collaborate with agencies frequented by Black women, such as churches and social groups. Psychoeducative workshops could help reduce the stigma associated with mental illness and treatment and directly address internalization of the Strong Black Woman ideal as a potential obstacle to service use. In order to work towards dispelling the myth that Black women are too “strong” to admit they are depressed, Black female participants may be encouraged to see images of people of color, and other Black women especially, in psychoeducative pamphlets. Outreach programs should also encourage community members to discuss their views about mental illness, as well as those of their family, friends, and the broader community. Concerns about stigma associated with receiving mental health services can then be addressed directly by a counselor sensitive to the community’s beliefs and values.

In the past ten years, there has been a push to develop mental health interventions that include cultural contexts and values (Griner & Smith, 2006). The literature suggests that culturally tailored interventions would help overcome some of the barriers Black women face when seeking mental health services (e.g., mistrust (Thomas et al., 2004), religion (Jones & Shorter-Gooden, 2003), etc. Cooper et al., 2003), and a meta-analysis has demonstrated the positive effect of culturally adapted therapy (Griner & Smith, 2006). Therapy with depressed Black women that have internalized the Strong Black Woman ideal should incorporate the cultural gender norm in goal-setting, case formulation, therapeutic interpretation, evaluation of automatic negative thoughts, and discussions of the therapeutic process. In determining whether their client has internalized the ideals of this gender norm, therapists can administer the Strong...
Black Woman Archetype scale and/or attend to allusions to the Strong Black Woman archetype. Therapists should be prepared to identify characteristics of this image: “keeping up appearances,” unreasonable self-sacrifice, and taking responsibility for others. If these emerge as common themes, therapy goals may need to include increasing the client’s capacity to seek help from others, prioritizing and eliminating some family and community responsibilities, and considering some of the positive effects and negative consequences of adherence to the Strong Black Woman ideal. Black female clients may need help in understanding how aspects of the ideal may be protective (e.g., the belief that one can overcome obstacles, the desire to appear confident, striving towards financial independence), but other aspects may cause problems when taken to the extreme (e.g., the belief that one’s life should be defined by struggle, the desire to maintain the mask of strength at all costs, and refusing support from others when in need).

The Strong Black Woman archetype may become central to the case formulation as an unrealistic ego ideal. Psychodynamic theorists assert that early experiences of helplessness may lead an individual to compensate through idealized visions of power and invulnerability in themselves and significant others (Busch, et al., 2004). Similarly, the Strong Black Woman image may offer Black women a way to feel powerful in a society where they are often powerless. Negative stereotypes of Black women as overly sexualized and welfare queens are widely available. Amidst this background of overwhelmingly negative stereotypical images, an idealized image of strength applied to oneself and the women on whom one depends may have developed and may be protective in some aspects.

Because the client may not be able to recognize the potential negative consequences of the adherence to the Strong Black Woman ideal, interpreting this material to the client should be done with sensitivity. The therapist can ask the client to generate on her own advantages and
disadvantages of this image and how she thinks it may have played a role in her current situation. The client may be better adept to accept this case formulation if she feels that it was in part self-generated. The therapist should also encourage the client to explore her feelings about appearing vulnerable in the therapy session, an aspect uncharacteristic of the Strong Black Woman archetype. Such an exploration would be most beneficial once a secure therapeutic alliance had been formed. At this time, the client will be most able to examine the fears associated with entering a very exposed, other-reliant relationship with the therapist.

In depression, episodes of depressed mood are often triggered by negative thinking (Friedman & Thase, 2005). In depressed clients, many negative automatic thoughts are untrue, and by weighing the evidence for and against the statement a more rational response can be generated. Other times, the negative thoughts are true, but the conclusion the client draws from them is distorted. This second type of automatic thought is most likely to plague women who have internalized the Strong Black Woman image. Their negative mood shifts are often preceded by thoughts like, “Because I cannot manage all of these responsibilities, I am a weak person.” This represents the imagined consequences of not living up to the ideal and these thoughts should be identified and evaluated in therapy.

In evaluating negative automatic thoughts, the therapist tries to determine if the client consistently engages in certain types of distorted thinking. The cognitive distortions characteristic of the Strong Black Woman ideal are all-or-nothing thinking and imperatives (Beck, 1995). Women engage in all-or-nothing thinking when they conclude that if they do not appear strong in all contexts, they are weak. Strength and weakness are not viewed on a continuum, but as dichotomous categories. When women think in imperatives, they may conclude, “It is horrible to appear vulnerable. I should always be in control.” These women have
a fixed idea of how they *should* behave as dictated by the Strong Black Woman archetype. This type of thinking often leads to overestimations of the negative consequences of not living up to this ideal. Identifying these common distortions allows for the client to quickly recognize their role in future occurrences, even after treatment has terminated.

Clinicians should also be educated about the Strong Black Woman ideal and its potential implications for therapy. Clinicians from other gender and racial backgrounds may be completely unfamiliar with this cultural gender norm. Workshops at local and national conferences and continuing education seminars could be used to disseminate information about the positive and negative aspects of the internalization of the Strong Black Woman ideal. Before they can use knowledge of the strong Black Woman archetype in therapy, clinicians may need to examine their own stereotypes and beliefs about Black women. Clinicians, especially those of African descent, should be encouraged to examine counter-transference associated with their own internationalization of the Strong Black Woman ideal. Black female clinicians may need to determine whether they are judging fellow Black female clients against the ideal and silently communicating disappointment with the client’s inability to live up to the ideal.

The Strong Black Woman ideal, or any idealized and inherently unrealistic image, can be harmful. However, belief in the Strong Black Woman ideal may play an adaptive role when not taken to the extreme. For example, a nuanced view of the Strong Black Woman archetype can serve as a positive, adaptive image among a mass of otherwise negative images and stereotypes of Black women. Some research has demonstrated the positive effects of the Strong Black Woman ideal, suggesting that Black women experience less role conflict, because their multiple roles as nurturer and economic provider are integrated, instead of disparate (Littlefield, 2003). Others have theorized that endorsement of this cultural image may promote resiliency by
increasing the sense of control and confidence women feel when facing obstacles and by providing inspiration and encouragement (Harrington, 2007; Littlefield, 2003). An image of Black women overcoming seemingly insurmountable obstacles can also serve as a source of pride to others (Harris-Lacewell, 2001). The strong Black woman archetype provides a positive stereotype of Black women in a society where negative images of Black women are rampant (Beaubouef-Lafontant, 2007; Harris-Lacewell, 2001). This cultural image encourages financial independence among Black women (Littlefield, 2003) and helps women to cope with the racism and sexism associated with the double jeopardy of being both Black and female (Etowa et al., 2007). For these reasons, clinicians should not immediately pathologize endorsement of the Strong Black Woman ideal. As with any cultural norm, clinicians should determine how the belief works in the woman’s world. Is it helping or hurting her? Does it give her a sense of power as she buffets the trials of life? Or is it the root of a fervent, maladaptive push to live up to an unrealistic ideal? This ideal has at times filled a need for Black women and future research should continue to examine how the Strong Black Woman archetype may serve as a positive and adaptive coping method.
CONCLUSION

Black women are less likely to seek psychotherapy than White women, even though they are not psychologically healthier (Wise et al., 2006). The internalization of unrealistic cultural gender ideals, like the Strong Black Woman archetype, which mandates that Black women appear strong, self-reliant, and care for others, may lead to depressive symptoms and help to explain this disparity in psychological help-seeking.

The current study improved measurement of the cultural gender norm and provided preliminary evidence for its cultural specificity. Using the new scale, endorsement of the Strong Black Woman ideal was related to depressive symptoms and intentions to seek therapy, even after considering variance explained by the well-established theory of planned behavior. The beliefs described in the theory of planned behavior mediated the relationship between the Strong Black Woman ideal and intentions to seek therapy for depression. Due to its association with psychological help-seeking and well-being, knowledge of the Strong Black Woman ideal should be incorporated into help-seeking promotion efforts and therapy for depression.
APPENDICES
Appendix A
Strong Black Woman Archetype Scale

Instructions: Please read the following items and either fill in the blank or rate how often you think that each of the following statements applies to you.

1. I feel pressured to appear strong, even when I’m feeling weak.
   _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

2. I do not let most people know the “real” me.
   _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

3. Women of my race have to be strong to survive.
   _____ 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 will let people down if I take time out for myself.
   _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

6. I am often expected to take care of family members.
   _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

7. I am always helping someone else.
   _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

8. I have difficulty showing my emotions.
   _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

9. I try to always maintain my composure.
   _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

10. I am overworked, overwhelmed, and/or underappreciated.
    _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

11. It is difficult for me to share problems with others.
    _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

12. I feel uncomfortable asking others for help.
    _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

13. If you have a problem, you should handle it quietly and with dignity.
    _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

14. I do not want others to know if I experience a problem.
15. I find it difficult to ask others for help.
16. If I fall apart, I will be a failure.
17. I tell others that I am fine, even when I am depressed or down.
18. As I become an adult, it is important that I become financially independent and not expect a boy/girlfriend or husband/wife to support me financially.
19. At times I feel overwhelmed with problems.
20. In order to feel good about myself, I need to feel independent and self-sufficient.
21. It is easy for me to tell other people my problems.
22. People think that I don’t have feelings.
23. The women in my family are survivors.
24. Often I look happy enough on the outside, but inwardly I feel overwhelmed and unhappy.
25. I take on more responsibilities for others than I can comfortably handle.
26. I feel guilty when I put my own needs before the needs of others.
27. I believe that it is best not to rely on others.
28. I often take on other people’s problems.
29. I am strong.
30. I cannot rely on others to meet my needs.
   _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

31. I need people to see me as always confident.
   _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

32. I am independent.
   _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

33. It is important for me to feel strong.
   _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

34. I expect to experience many obstacles in life.
   _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

35. Women of my race are stronger than women of other races.
   _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always

36. People often expect me to take care of them.
   _____ Never   _____ Rarely   _____ Sometimes   _____ Frequently   _____ Almost Always
Appendix B
Center for Epidemiological Studies – Depression Scale

Instructions: Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the PAST WEEK by choosing the appropriate time span.

1. I was bothered by things that usually don't bother me.
   0. Rarely or none of the time (Less than 1 day)
   1. Some or a Little of the Time (1-2 days)
   2. Occasionally or a Moderate Amount of the Time (3-4 days)
   3. Most or All of the Time (5-7 days)

2. I did not feel like eating. My appetite was poor.
   0. Rarely or none of the time (Less than 1 day)
   1. Some or a Little of the Time (1-2 days)
   2. Occasionally or a Moderate Amount of the Time (3-4 days)
   3. Most or All of the Time (5-7 days)

3. I felt that I could not shake off the blues even with help from my family or friends.
   0. Rarely or none of the time (Less than 1 day)
   1. Some or a Little of the Time (1-2 days)
   2. Occasionally or a Moderate Amount of the Time (3-4 days)
   3. Most or All of the Time (5-7 days)

4. I felt that I was just as good as other people.
   0. Rarely or none of the time (Less than 1 day)
   1. Some or a Little of the Time (1-2 days)
   2. Occasionally or a Moderate Amount of the Time (3-4 days)
   3. Most or All of the Time (5-7 days)

5. I had trouble keeping my mind on what I was doing.
   0. Rarely or none of the time (Less than 1 day)
   1. Some or a Little of the Time (1-2 days)
   2. Occasionally or a Moderate Amount of the Time (3-4 days)
   3. Most or All of the Time (5-7 days)

6. I felt depressed.
   0. Rarely or none of the time (Less than 1 day)
   1. Some or a Little of the Time (1-2 days)
   2. Occasionally or a Moderate Amount of the Time (3-4 days)
   3. Most or All of the Time (5-7 days)

7. I felt that everything I did was an effort.
   0. Rarely or none of the time (Less than 1 day)
   1. Some or a Little of the Time (1-2 days)
2. Occasionally or a Moderate Amount of the Time (3-4 days)
3. Most or All of the Time (5-7 days)

8. I felt hopeful about the future.
0. Rarely or none of the time (Less than 1 day)
1. Some or a Little of the Time (1-2 days)
2. Occasionally or a Moderate Amount of the Time (3-4 days)
3. Most or All of the Time (5-7 days)

9. I thought my life had been a failure.
0. Rarely or none of the time (Less than 1 day)
1. Some or a Little of the Time (1-2 days)
2. Occasionally or a Moderate Amount of the Time (3-4 days)
3. Most or All of the Time (5-7 days)

10. I felt fearful.
0. Rarely or none of the time (Less than 1 day)
1. Some or a Little of the Time (1-2 days)
2. Occasionally or a Moderate Amount of the Time (3-4 days)
3. Most or All of the Time (5-7 days)

11. My sleep was restless.
0. Rarely or none of the time (Less than 1 day)
1. Some or a Little of the Time (1-2 days)
2. Occasionally or a Moderate Amount of the Time (3-4 days)
3. Most or All of the Time (5-7 days)

12. I was happy.
0. Rarely or none of the time (Less than 1 day)
1. Some or a Little of the Time (1-2 days)
2. Occasionally or a Moderate Amount of the Time (3-4 days)
3. Most or All of the Time (5-7 days)

13. I talked less than usual.
0. Rarely or none of the time (Less than 1 day)
1. Some or a Little of the Time (1-2 days)
2. Occasionally or a Moderate Amount of the Time (3-4 days)
3. Most or All of the Time (5-7 days)

0. Rarely or none of the time (Less than 1 day)
1. Some or a Little of the Time (1-2 days)
2. Occasionally or a Moderate Amount of the Time (3-4 days)
3. Most or All of the Time (5-7 days)

15. People were unfriendly.
0. Rarely or none of the time (Less than 1 day)
  1. Some or a Little of the Time (1-2 days)
  2. Occasionally or a Moderate Amount of the Time (3-4 days)
  3. Most or All of the Time (5-7 days)

16. I enjoyed life.
  0. Rarely or none of the time (Less than 1 day)
  1. Some or a Little of the Time (1-2 days)
  2. Occasionally or a Moderate Amount of the Time (3-4 days)
  3. Most or All of the Time (5-7 days)

17. I had crying spells.
  0. Rarely or none of the time (Less than 1 day)
  1. Some or a Little of the Time (1-2 days)
  2. Occasionally or a Moderate Amount of the Time (3-4 days)
  3. Most or All of the Time (5-7 days)

18. I felt sad.
  0. Rarely or none of the time (Less than 1 day)
  1. Some or a Little of the Time (1-2 days)
  2. Occasionally or a Moderate Amount of the Time (3-4 days)
  3. Most or All of the Time (5-7 days)

19. I felt that people disliked me.
  0. Rarely or none of the time (Less than 1 day)
  1. Some or a Little of the Time (1-2 days)
  2. Occasionally or a Moderate Amount of the Time (3-4 days)
  3. Most or All of the Time (5-7 days)

20. I could not get "going."
  0. Rarely or none of the time (Less than 1 day)
  1. Some or a Little of the Time (1-2 days)
  2. Occasionally or a Moderate Amount of the Time (3-4 days)
  3. Most or All of the Time (5-7 days)
Appendix C
Theory of Planned Behavior Measures

Attitude Toward the Behavior
1. If I were feeling depressed, entering into therapy for depression would be . . .
BAD :___1__:___2__:___3__:___4__:___5__:___6__:___7__: GOOD

2. If I were feeling depressed, entering into therapy for depression would be . . .
BORING :___1__:___2__:___3__:___4__:___5__:___6__:___7__: EXCITING

3. If I were feeling depressed, entering into therapy for depression would be . . .
REWARDING :___1__:___2__:___3__:___4__:___5__:___6__:___7__: PUNISHING

4. If I were feeling depressed, entering into therapy for depression would be . . .
ACCEPTABLE:__1__:__2__:__3__:__4__:__5__:__6__:__7__:UNACCEPTABLE

5. If I were feeling depressed, entering into therapy for depression would be . . .
HARMFUL :___1__:___2__:___3__:___4__:___5__:___6__:___7__: BENEFICIAL

6. If I were feeling depressed, entering into therapy for depression would be . . .
UNPLEASANT :___1__:___2__:___3__:___4__:___5__:___6__:___7__: PLEASANT

7. If I were feeling depressed, entering into therapy for depression would be . . .
DESIRABLE :___1__:___2__:___3__:___4__:___5__:___6__:___7__: UNDESIRABLE

8. If I were feeling depressed, entering into therapy for depression would be . . .
WISE :___1__:___2__:___3__:___4__:___5__:___6__:___7__: FOOLISH

9. If I were feeling depressed, entering into therapy for depression would be . . .
USEFUL :___1__:___2__:___3__:___4__:___5__:___6__:___7__: USELESS

Subjective Norm
1. If I was feeling depressed, most people who are important to me would expect me to enter into therapy for depression
TRUE :___1__:___2__:___3__:___4__:___5__:___6__:___7__: FALSE

2. Most people who are important to me would seek therapy if they were feeling depressed.
TRUE :___1__:___2__:___3__:___4__:___5__:___6__:___7__: FALSE

3. Many people like me would seek therapy if they were feeling depressed.
TRUE :___1__:___2__:___3__:___4__:___5__:___6__:___7__: FALSE

4. If I was feeling depressed, most people who are important to me would be disappointed in me if I entered into therapy for depression.
TRUE :___1__:___2__:___3__:___4__:___5__:___6__:___7__: FALSE
5. If I was feeling depressed, most people who are important to me would think I should enter into therapy for depression.

TRUE :___1___:___2___:___3___:___4___:___5___:___6___:___7___: FALSE

**Perceived Behavior Control**

1. For me to begin therapy for depression would be . . .

   IMPOSSIBLE :___1___:___2___:___3___:___4___:___5___:___6___:___7___: POSSIBLE

2. If I wanted to, I could enter into therapy for depression

   TRUE :___1___:___2___:___3___:___4___:___5___:___6___:___7___: FALSE

3. For me to begin therapy for depression would be . . .

   EASY :___1___:___2___:___3___:___4___:___5___:___6___:___7___: DIFFICULT

4. I can overcome any obstacles or problems that could prevent me from receiving therapy for depression if I wanted it.

   DISAGREE :___1___:___2___:___3___:___4___:___5___:___6___:___7___: AGREE

5. How much control do you believe you have over entering into therapy for depression?

   NO CONTROL :___1___:___2___:___3___:___4___:___5___:___6___:___7___: COMPLETE CONTROL

6. It is mostly up to me whether or not I enter into therapy for depression.

   DISAGREE :___1___:___2___:___3___:___4___:___5___:___6___:___7___: AGREE

**Intentions to Seek Therapy for depression**

1. If I were ever depressed, I expect that I would seek therapy for depression.

   AGREE :___1___:___2___:___3___:___4___:___5___:___6___:___7___: DISAGREE

2. If I were ever depressed, I would try to seek therapy for depression.

   AGREE :___1___:___2___:___3___:___4___:___5___:___6___:___7___: DISAGREE

3. If I were ever depressed, I would NOT seek therapy for my depression.

   AGREE :___1___:___2___:___3___:___4___:___5___:___6___:___7___: DISAGREE

4. If I were ever depressed, I would be determined to seek therapy for my depression.

   AGREE :___1___:___2___:___3___:___4___:___5___:___6___:___7___: DISAGREE

5. If I were ever depressed, I MIGHT NOT seek therapy for my depression.

   AGREE :___1___:___2___:___3___:___4___:___5___:___6___:___7___: DISAGREE
Appendix D
Negative Affectivity Scale

Instructions: Read each item and then indicate to what extent you feel this way RIGHT NOW.

1. Irritable
   a. Very slightly or not at all
   b. A little
   c. Moderately
   d. Quite a bit
   e. Extremely

2. Distressed
   a. Very slightly or not at all
   b. A little
   c. Moderately
   d. Quite a bit
   e. Extremely

3. Ashamed
   a. Very slightly or not at all
   b. A little
   c. Moderately
   d. Quite a bit
   e. Extremely

4. Upset
   a. Very slightly or not at all
   b. A little
   c. Moderately
   d. Quite a bit
   e. Extremely

5. Nervous
   a. Very slightly or not at all
   b. A little
   c. Moderately
   d. Quite a bit
   e. Extremely

6. Guilty
   a. Very slightly or not at all
   b. A little
   c. Moderately
   d. Quite a bit
   e. Extremely

7. Scared
a. Very slightly or not at all
b. A little
c. Moderately
d. Quite a bit
e. Extremely

8. Hostile
a. Very slightly or not at all
b. A little
c. Moderately
d. Quite a bit
e. Extremely

9. Jittery
a. Very slightly or not at all
b. A little
c. Moderately
d. Quite a bit
e. Extremely

10. Afraid
a. Very slightly or not at all
b. A little
c. Moderately
d. Quite a bit
e. Extremely
Appendix E
Online Recruitment Study Advertisement

Would you like to participate in a study of culture, emotions, and therapy beliefs?
Are you a Black female between the ages of 30-60?

Then complete our online survey.

The goal of our study is to explore . . .
   Cultural and personality traits,
   Depression symptoms,
   And beliefs about therapy for depression.

The total time for the survey is approximately 60 minutes.

The Buchanan Research Group will email you a $25 Amazon.com® Gift Card\(^1\) as compensation for your participation.

Gift Cards will be emailed within two weeks of survey completion to the first 200 participants who respond before 05/01/2010. At the end of the study, you will also be given additional information on the study’s purpose and a list of mental health resources.

To participate, please email woodskry@msu.edu for a weblink to the online survey.

Questions? Please contact the study coordinator:

Krystle Woods, M.A.
woodskry@msu.edu
Michigan State University
26 Psychology Bldg.
East Lansing, MI 48824

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Appendix F
College Recruitment Consent Form

Culture, Emotions, and Therapy Beliefs

This is a research study to explore your cultural beliefs, emotional well-being, beliefs about psychotherapy, and experiences at work or school. Should you agree to participate, you will complete a survey that should take about 60-90 minutes to complete. Please complete each question as thoroughly and honestly as possible. There are no right or wrong answers. You will be given 90 minutes of research credit (3 credits) as compensation for your participation. If you need to re-access the survey site, the website is [https://psychology.msu.edu/BuchananResearch/Encrypt/AccessID.asp](https://psychology.msu.edu/BuchananResearch/Encrypt/AccessID.asp), and the access code is "beliefs".

You will not directly benefit from your participation in this study. However, your participation in may contribute to the understanding of disparities in mental health service use. Even though many participants find such surveys to be interesting and thought provoking, there is a risk that you may feel uncomfortable answering some questions. For example, some of the questions ask about your thoughts and feelings and about negative experiences you may or may not have had in your lifetime. You have the right to skip any questions or stop participating in this research at any time, without penalty. We strongly urge you to consult a professional in your community if these feelings are interfering with your well-being. Further, referral information will be provided to you when you are done with the survey. If you have any questions, you will also have the opportunity to contact a member of the research team to discuss the survey and referral information.

Participation in this study is voluntary. You may choose not to participate at all, decline to participate in certain portions of the study, or not answer certain questions. At any time during your participation, you have the right to discontinue your participation without penalty or loss of benefits to which you are entitled. At the conclusion of this study’s data collection phase, a brief document explaining the main findings of this study will be distributed to participants that request such material.

Every participant will be assigned a study ID number that will be used to protect the confidentiality of their answers. Only your ID number will be connected to survey data. A list linking ID's to names will be kept in a secure location (locked cabinet in the lab of the investigator). Identification information will be retained only for the purpose of assigning credit for the psychology subject pool. The study does not require that we link names with responses and there will be no need to retain a list linking ID’s to names. After participants are reimbursed, we will have no use for their identification information and it will be deleted from the files and paper copies will be shredded. Therefore, there will be nothing to identify a participant with his/her responses. Participants will not be identifiable in any report of research findings. Research reports on this study will report group (rather than individual) findings. Your confidentiality will be protected to the maximum extent allowable by law.
Data will be stored on computers in the lab and office of the investigator. One key is required to enter the building in which the room is located and a separate key to enter the room itself. These data computers require that a password be entered to open programs on the computer. Only members of the research team and the MSU Institutional Review Board have access to the lab or the computers on which data is stored. At the completion of the project, data will be transferred to disks, stored in a locked cabinet, and retained for a minimum of five years in this secure location.

If you have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report an injury, please contact the researcher, NiCole T. Buchanan, Ph.D. by email (buchanansurvey@gmail.com) for the quickest reply. For less urgent concerns, you may also contact her by phone ((517) 355-7677) or mail at 26 Psychology Building, East Lansing, MI 48864.

If you have any questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this research study, you may contact, anonymously if you wish, the Michigan State University Human Research Protection Program at 517-355-2180, FAX 517-432-4503, or e-mail irb@msu.edu, or regular mail at: 207 Olds Hall, MSU, East Lansing, MI 48824.

You indicate your voluntary agreement to participate and have your data included in the data set by completing the survey on the following pages.
Appendix G
Online Recruitment Consent Form

Culture, Emotions, and Therapy Beliefs

This is a research study to explore your cultural beliefs, emotional well-being, beliefs about psychotherapy, and experiences at work or school. Should you agree to participate, you will complete a survey that should take about 60-90 minutes to complete. Please complete each question as thoroughly and honestly as possible. There are no right or wrong answers. The Buchanan Research Group will send a $25 Amazon.com® Gift Card as compensation for your participation via e-mail within two weeks of survey completion. Gift Cards are provided to the first 200 participants who respond before 04/01/2010. If you need to re-access the survey site, the website is https://psychology.msu.edu/BuchananResearch/Encrypt/AccessID.asp, and the access code is "culture".

You will not directly benefit from your participation in this study. However, your participation may contribute to the understanding of disparities in mental health service use. Even though many participants find such surveys to be interesting and thought provoking, there is a risk that you may feel uncomfortable answering some questions. For example, some of the questions ask about your thoughts and feelings and about negative experiences you may or may not have had in your lifetime. You have the right to skip any questions or stop participating in this research at any time, without penalty. We strongly urge you to consult a professional in your community if these feelings are interfering with your well-being. Further, referral information will be provided to you when you are done with the survey. If you have any questions, you will also have the opportunity to contact a member of the research team to discuss the survey and referral information.

Participation in this study is voluntary. You may choose not to participate at all, decline to participate in certain portions of the study, or not answer certain questions. At any time during your participation, you have the right to discontinue your participation without penalty or loss of benefits to which you are entitled. At the conclusion of this study’s data collection phase, a brief document explaining the main findings of this study will be distributed to participants that request such material.

Every participant will be assigned a study ID number that will be used to protect the confidentiality of their answers. Only your ID number will be connected to survey data. A list linking ID's to names will be kept in a secure location (locked cabinet in the lab of the investigator). Identification information will be retained only for the purpose of providing participants with their participation reimbursement. The study does not require that we link names with responses and there will be no need to retain a list linking ID’s to names. After participants are reimbursed, we will have no use for their identification information and it will be deleted from the files and paper copies will be shredded. Therefore, there will be nothing to identify a participant with his/her responses. Participants will not be identifiable in any report of research findings. Research reports on this study will report group (rather than individual) findings. Your confidentiality will be protected to the maximum extent allowable by law.
Data will be stored on computers in the lab and office of the investigator. One key is required to enter the building in which the room is located and a separate key to enter the room itself. These data computers require that a password be entered to open programs on the computer. Only members of the research team and the MSU Institutional Review Board have access to the lab or the computers on which data is stored. At the completion of the project, data will be transferred to disks, stored in a locked cabinet, and retained for a minimum of five years in this secure location.

If you have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report an injury, please contact the researcher, NiCole T. Buchanan, Ph.D. by email (buchanansurvey@gmail.com) for the quickest reply. For less urgent concerns, you may also contact her by phone ((517) 355-7677) or mail at 26 Psychology Building, East Lansing, MI 48864.

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REFERENCES


