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The Moderating Influence of Strength on Depression and Suicide in African American Women

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THE MODERATING INFLUENCE OF STRENGTH ON DEPRESSION AND SUICIDE IN
AFRICAN AMERICAN WOMEN:

EXAMINING A CULTURAL AND GENDER-RELEVANT CONSTRUCT

by

BRANDEIS GREEN-GOODE

Under the direction of Dr. Leslie C. Jackson

ABSTRACT

Strength for African American women and its psychological ramifications are being newly conceptualized and explored empirically in psychological research. The Strong Black Woman Attitudes Scale, (Thompson, 2003) was created to empirically test a three factor theoretical model: self reliance, affect regulation, and caretaking as a reliable culturally relevant coping mechanism for African American women. The primary aim of this study is to explore if cultural coping (SBW) moderates the relationship between depression and suicide in African American women. Other aims include, replicating the factor structure of the SBWAS with a community sample, and examining relationships between the SBW, racial identity, traditional coping, and depression. The Strong Black Woman Attitude Scale (SBWAS) was used to measure cultural coping, and the Ways of Coping Questionnaire (WOCQ) was used to measure traditional coping. Racial regard and centrality subscales from the Multidimensional Inventory of Black Identity (MIBI) measured racial identity and the Beck Depression Inventory (BDI) and Beck Suicide Scale (BSS) measured depression and suicide respectively. Results showed significant moderations for the total SBW score and the affect regulation subscale. Additionally, racial

identity was positively associated with cultural coping, and cultural coping was negatively associated with traditional coping. Depression was positively related to the SBW and suicide. The three factor model was also upheld. The results of this study support the notion that strength for African American women can have detrimental psychological effects on women utilizing this coping style.

INDEX WORDS: Depression, Suicide, African American, Women, Strength, Strong Black Woman, Culture

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BRANDEIS GREEN-GOODE

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

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Georgia State University

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Introduction

A myriad of factors may impact depression and suicide in contemporary African American women. While some of these influences may be related to social or political factors, i.e. low SES, poor housing and inadequate access to necessary resources, such as healthcare and public education, cultural and historical factors can also influence psychological distress. Social scientists and social critics have examined the construct of the strong Black woman (SBW), as a historical, social and cultural idea that informs the well being and identity development of African American women (hooks, 1993). More recently, a strong Black woman construct, which refers to a culturally imposed notion of emotional resilience (Romero, 2000), has been explored in the psychological literature as a possible coping mechanism for African American women (Hamin, 2008; Thompson, 2003 & Romero, 2000).

Romero (2000) originally conceptualized a two factor model of this construct through observations gleaned from clinical case studies in her work with African American women. She identified self reliance and caretaking as important components of this concept. The Strong Black Woman Attitudes Scale, as developed by Thompson (2003) was created to empirically test the two factor model proposed by Romero and resulted in a three factor model of this construct, including the factors of self reliance, caretaking and affect regulation. Thompson's results confirmed the construct. Hamin's (2008), follow up work revised Thompson's scale in order to explore the cultural components of the construct and its relationship to psychological well being in African American women. The results of her empirical study strengthened the psychometric properties of the scale, by confirming the existence of a three factor model and suggested that the

strong Black woman construct could be seen as a coping mechanism in relationship to stress and ethnic identity in African American women.

The scale attempts to capture the understanding of “strength” in an African American context as a cultural and gendered ideal. Although strength has generally been seen as a positive attribute of African American women, the strong Black woman refers to an iconic identity which encourages women to be self sacrificing, detached from their own emotions and reluctant to seek help for their own needs (Romero, 2000). Although this identity has historical roots that predate chattel slavery in the United States, the U.S. context of post-slavery into the present day exacerbated and altered aspects of this construct. One version of contemporary understandings of this identity has been encapsulated or expressed through stereotyped versions of African American womanhood as exemplified in the Mammy, Sapphire, and Jezebel caricatures (West, 1995). Exploring this construct specifically, as identified by Romero, relative to the psychological experiences, and mental health of African American women may help explain current health disparities and risk factors for depression and suicide in African American women. Additionally, investigating the relationship between this iconic identity and psychological health can help inform relevant research and interventions with African American women. Hamin (2008) investigated the relationship between the strong Black woman and stress, but researchers have yet to explore the SBW and more severe psychopathology e.g., depression and suicide.

Although estimates vary, current research shows that African American women are vulnerable to depression and suicide. Waite & Killian (2008), in a qualitative study of depression and African American women, reported that 56.5% of African American women suffer from depression as compared to 38.6% of White women, and found that as few as 7% receive treatment. Other studies have found African American women and White women to have

comparable rates of depression (Adebimpe, 1981, 1994; Kessler, 1995). Despite these inconsistencies, a general consensus exists regarding the paucity of research on African American women and depression. Researchers may have difficulty determining prevalence rates for these women, particularly: if they are not presenting as depressed, if they do not experience themselves as depressed and/or if they are not seeking mental health treatment.

Carrington (2006) has found that the etiology of depression is based on a complex interplay of social, psychological, genetic and environmental factors. African American women in particular face many risk factors across these categories that increase their vulnerability to depression and suicide. For example, African American women are disproportionately represented in the lower socioeconomic classes, which has been associated with poor health. De Groot, Auslander, Williams, Shernaden & Haire-Joshu, (2003) found that single mothers head approximately 50% of African American households and that 45% of those households exist in poverty. Low SES is related to less access to resources, greater exposure to stressful life events, overcrowding, high crime rates and high unemployment (Reed, Mcleod, Randall, & Walker, 1996). All of which, relate to poorer mental and physical health outcomes.

Compounding the environmental contributors to depression, social and cultural factors may also impact depression and health disparities among African Americans in general and African American women in particular. Across racial groups, women have a 1.5 - 3 times greater incidence of depression in the United States than men (Kessler, et al., 2003, & Kessler, 2000). African American women in particular, carry the dual identities of two historically marginalized groups and face the compounded negative effects of sexism and racism (Thomas, Witherspoon & Speight, 2008). Recent studies have shown a negative relationship between racial identity, (specifically regard for one's race) and depression in African American women (Settles,

Navarrete, Pagano, Abdou & Sidanius, 2010) supporting the existence of a link between a woman's racial experience in the world and her mental health.

Experiencing discrimination has shown deleterious effects on mental health outcomes for this population. When African Americans seek treatment for psychological problems, they are less likely to see mental health professionals and less likely to receive a depression diagnosis. This may be related in part to the somatization of depressive symptoms, which is often seen in African American populations. Additional considerations may include: a) African American women's reluctance to discussing symptoms with their physicians (Jackson, 2006); b) their use of unique coping styles regarding depressive symptoms that could impact help seeking and receipt of treatment; c) demand characteristics of the context, and d) cultural norms (Reed, et. al., 1996). Unpacking the strong Black woman construct in relationship to depression could help shed light on some of these factors.

Although historically, African Americans have trailed White Americans in rates of suicidality, risk factors for suicide in African Americans remain not well understood. Abe, Mertz, Powell & Hanzlick (2004) (as cited in Walker, Wingate, Obasi & Joiner, 2008) have found that African American suicides had a lowered likelihood of depression, less likelihood of having financial problems, fewer previous attempts or gestures, and less chronic disease or substance abuse than their White counterparts. As such, investigating correlates or influences on suicide as well as depression for African Americans in general, and African American women in particular fills an important gap in the psychological literature. Doing this through a cultural lens could provide further information on the unique influences of a cultural construct on suicide in African American populations.

The strong Black woman construct provides an example of a cultural norm that could affect the mental health of African American women, and perhaps help to explain some of the gaps in the mental health treatment of African American women, specifically in regards to depression and suicide. This study aims to explore the relationship of the three factors associated with strength, as outlined by Thompson (2003) to specific psychological constructs in this sample of African American women, including depression and suicide.

Literature Review

Given their sociohistorical context of capture, enslavement, emancipation and subsequent civil rights struggles, African American women have unique influences and considerations with regards to gender and racial identity development from their White counterparts. Consequently, when investigating the psychological health of African American women and the influences thereon, taking these influences into account becomes vital. African American women experience early exposure to the characteristics associated with a strong Black woman (SBW) ideal as generations transmit these socially and culturally based norms of African American womanhood found in the African American and larger American contexts. The strong Black woman (SBW) paradigm may influence the existent relationship between depression and suicide in African American women. The present study suggests that this paradigm may act as a moderator for this relationship, and that such a gendered and culturally specific ideal, can serve as a coping mechanism and a moderating influence on the mental health of African American women.

This study discusses the ideal of strength in two ways: as it has been explored and discussed in the psychological literature and within other disciplines, and as operationalized in a particular paradigm. The “strong Black woman (SBW)” references this general construct of

strength, which includes an exploration of stereotypes, whereas the Strong Black Woman refers to the specific paradigm that will be utilized in this research. The following section will discuss the origins of some of the aspects of the SBW ideal and the messages that African American women have learned about being African American and being a woman.

Historical context of strength in African American women

The “strength” of the SBW construct, which has become a motif in the African American cultural milieu, has roots in the cultural traditions of the West African countries from which the original enslaved Africans were taken. The model of strength in this study mirrors the primary factors of caretaking, self reliance, and affect regulation as identified by Romero (2000) and validated in a scale by Thompson (2003) and Hamin (2008). The concept of strength, although generally acknowledged and accepted within the African American cultural context as positive, can also be associated with detrimental psychological outcomes for those attempting to embody this ideal. These particular factors have historical roots from African origins to post chattel slavery contexts in the New World.

With an eye towards the history of women of African descent, prior to their arrival in the New World, Thompson (2003) provides extensive detailing of the primary role of the African woman as nurturer. In the polygamous West African context, her role as nurturer often superseded her role as wife. Although she had wifely duties to attend to, because she was often one of many wives, her role as mother of both biological and non-biological children was emphasized most strongly. She had designated time set aside to care for the children of her family and of her community and also collaborated with other women in the community to assist in their caretaking duties. West African women also contributed their labor to the larger society, crafting and selling their own textiles in the marketplace as well as participating in agricultural

work. The expectation that the West African woman would work and her ability to do so provided her with a certain level of economic independence and livelihood separate from that of her husband's (Thompson, 2003). Robinson, (1983), who takes a feminist perspective in her review of historical literature as it relates to the psychological development of African American women, asserts that African women also shared in the political and social affairs of the tribe alongside men and enjoyed more of an egalitarian role than the traditional patriarchy of Western societies. As such, not only were African women equipped with capacities for nurturing, but they also retained a certain amount of independence transmitted through the expectations placed on them in their cultural contexts. Those realities could have provided a foundation for the characteristics that have been identified as caretaking and self reliance in African American women (Romero, 2000, Thompson, 2003, & Hamin, 2008).

Although the capture and subsequent enslavement of Africans in the New World thrust them into a wholly unfamiliar context with unknown cultures, many Africans were able to retain their cultural norms and values as Rodgers-Rose (1980) points out in her overview of the history of African American women. As a result, many of the social norms of African womanhood were passed down within the new African American cultural context of slavery and servitude. Although, as stated by Robinson (1983), African American women had descended from foremothers who maintained their own work ethics, which included independence, the context of slavery exacerbated this trait. Given the reality that slave families were subject to disruption and dismantling, African American women had little opportunity to create strong ties with those other than her children. African American men also had little opportunity to effectively protect their women or their families. Both of these factors necessitated the African American woman's need to rely on herself.

In the context of slavery, other aspects of life also changed for the African American woman. In addition to her existent familiarity with nurturing and independence in a community context, contact with Europeans within slavery introduced a novel situation to which African American women had to adjust. The women found themselves not only in the caring role for their own children and other children in their community, but many also acquired the additional and primary responsibilities of caring for the enslaver's household (Rodgers-Rose, 1980). Performing household and childcare duties within the enslaver's household, meant frequent contact with the enslaver and his family. This frequent contact may have contributed to the development of a third component of the "strength" of the SBW: a need to control the expression of negative feelings. During slavery, the African American woman may have developed a façade to mask her true feelings associated with her position as an enslaved person. Robinson (1983) details the ways the enslaved African woman suffered abuse, exploitation and oppression at the hands of her enslavers. Not only was she expected to perform the same back breaking work as a man, for as long as a man, but she was also subject to sexual abuse, physical violence and the constant threat of the disintegration of her family at the behest of her enslavers. African American women in captivity did not have the luxury of expressing all of the pain, anger and negative emotions that resulted from their societal position. Concealing their feelings therefore, may have developed as a coping mechanism in response to the double bind of experiencing abuse and oppression while simultaneously having to mask emotional vulnerability.

Strength and contemporary stereotypes

Following the period of enslavement, characteristics and traits of African American women were exaggerated, imaged and stereotyped in the popular American imagination. West (1995), in her article detailing the intersections of historical stereotypes and implications for

therapeutic practice with African American women, links these images of African American women with current problems faced by these women. West (1995) recognizes that stereotypes abound in society and that these stereotypes influence the encoding and interpreting of information about members of a certain group, as well as the behavior of the members of the target group. Thomas, et al., (2004), conducted a survey of 186 African American women, to verify the development of the “Stereotypic Roles for Black Women” scale. These researchers found that women recognized the four main stereotypical archetypes of African American women, Mammy, Jezebel, Sapphire and Superwoman. All four of the stereotypes correlated negatively with self-esteem in the women. Additionally, they also found that although women’s racial identities predicted self-esteem in their sample, introducing the gendered stereotypes added its own independent contribution. West (1995) details the deleterious effects that these images may have on the well-being of African American women noting that these images pervade mainstream and African American cultural discourses. As such, notions of womanhood, tied to these images have often been passed down and reinforced within family and community circles. Consequently, African American women learn to mimic their mothers, grandmothers and aunts early on in their development, growing up with these stereotypical notions, which eventually shape their own constructions of womanhood.

Role strain and the strong Black woman

The intersection of these stereotypical notions and contemporary functioning in African American women occurs when African American women incorporate aspects of these notions into their lives. The ideal of independence as germane to African American women has been reflected in both past and present social contexts and reflects cultural expectations of independence as well as social and economic realities. As DeFrancisco & Chatham-Carpenter,

(2000) point out in their qualitative study of 21 African American women of various socioeconomic statuses; many African American women find themselves carrying the bulk of responsibility within the home in addition to work duties outside of the home, as they often are the primary breadwinners in the household. Multiple responsibilities can potentially have adverse health effects. West (1995), who defines “role strain” as the “difficulty in fulfilling role obligations,” discusses this concept as an important barrier to health for African American women. West (1995) explores role strain in the context of many African American women carrying the sole responsibility for maintaining their households and on average having fewer finances to work with as they earn less money than their White counterparts. The 2000 U.S. Census found that African American women headed slightly over one half (55%) of African American households and although in the past decade, the overall amount of U.S. households headed by women has increased across races, African American female headed households have grown far faster than other races. As such, the likelihood of African American women as the primary caretakers of themselves and others seems increasing more likely.

Societal factors such as the historical employment discrimination against African American men, has left the burden of supporting the African American family on the woman, thus contributing to this need for her autonomy, (Collins, 2005). Collins reviewed the sociohistorical context of African American women in her exposition on the politics of gender and sex within the African American community and described how factors such as high incarceration rates of African American men have subsequently affected gender roles for African American women. Wyatt (2008) further described how the African American woman’s multiple roles as primary breadwinner in the household coupled with her already existent childcare responsibilities have compounded her responsibilities as head of household. Here, again is a

social and economic reality which necessitates the over-functioning of African American women. Therefore, viewing African American women solely through the stereotypical lens of “strength” obscures these social pressures and inappropriately locates her tendency to over function in an inherent character trait rather than as a mechanism for survival. Additionally, viewing African American women unidimensionally, as self reliant also obscures the detrimental effects of such over functioning on the well being of these women.

As stated above, multiple roles and multiple expectations can contribute to role strain. Role strain exemplifies only one possible manifestation of the relationship between historical notions of African American womanhood and mental health. Contemporary researchers have begun to explore psychological functioning in African American women in relationship to having various roles. Although findings have been mixed, such as Parnell’s (2008) study of busy African American mothers, who found that busy women who handled financial stress effectively, had some improvement in health, other studies have found more negative outcomes. Douhit (2002), in his mixed method study of the stress and coping resources of African American women with multiple roles, found that role stress (which is similar to role strain) correlates negatively with coping resources and that multiple role stress related positively to wife and mother role stress. Essentially, these women, who had multiple roles, also experienced high levels of stress related to those roles and diminished abilities to cope.

Beliefs about the centrality of nurturing, and the controlled expression of emotions as other aspects of the stereotypical notions of African American womanhood have also shown negative effects on African American women’s well-being, particularly perceptions of stress and depression (Rozario & Derienzis, 2008). Given societal expectations to smoothly handle multiple responsibilities and support others, African American women may learn to internalize their

emotions which, when coupled with other factors such as stress or exposure to discrimination, can lead to various psychological problems, including depression and low self-esteem and prevent them from seeking much needed care, (Hamin, 2008; Romero, 2000; Thomas, Witherspoon & Speight, 2004; Thompson, 2000; West, 1995). This restriction of emotional expression therefore, limits the African American woman's ability to express her need for support or access social support for effective coping.

Internalization of gender and cultural stereotypes

Wyatt (2008) in her review of *Black Sexual Politics* (Collins, 2005), continues the discussion of African American womanhood beyond the aforementioned stereotypical archetypes. She locates the notion of "strength," as a central trait generally imposed upon and identified with the African American woman. Within her review, she utilizes a definition of the SBW crafted by Morgan (1999), "A strong Black woman does not show weakness or neediness but remains always stoic and competent, the 'dependable rock for every soul that need[s] [her],'" (p. 90). According to Wyatt (2008), this ideology permeates the African American cultural context and gender expectations for women are constructed with this "strength" component as central. As such, stepping outside of this cultural norm could result in exclusion from their communities, thus reinforcing acceptance and perpetuation of this cultural notion. DeFrancisco & Chatham-Carpenter (2000) in their qualitative study of the relationship between community and self-esteem for African American women found that for the women in their sample, community formed an essential piece for the development of positive self-esteem. These researchers concluded that for these women, their concept of self was related to the community; it was "community based." Therefore, without community support, the development of coherent and affirmative self-perceptions could prove difficult for African American women. It could be

surmised that when families and communities encourage the notion of “strength” in the African American woman, this encouragement results in the dual consequences of ensuring that she continues to feel predisposed to over functioning and that she continues shielding herself and the community from her own needs.

Internalizing negative messages or stereotypes can also have other effects on the target group. Researchers have used a phenomenon termed “stereotype threat” to illustrate some of the harmful influences that stereotypes can indeed have. In a study investigating the effects of stereotype threat on performance of a cognitive task, Brown & Day (2006), defined stereotype threat as “[the] awareness of a stereotype of inferiority produc[ing] an evaluative threat of confirming that stereotype (or being judged by others to have done so), which then leads to the poorer performance predicted by the stereotype,” (p. 979). Thus, individuals who feel stigmatized in a particular domain may feel a heightened sense of performance pressure, and/or awareness of an inferiority stereotype can trigger a self-fulfilling prophecy of poor performance. Studies of stereotype threat and its relationship to gender or race, have consistently found evidence of this phenomenon. Brown & Josephs’ (1999) study of math performance in women showed that women performed worse in the condition in which they had been informed that the task was an indicator of the weakness of their mathematical aptitude (consistent with general stereotypes about women) versus a condition where the task was an indicator of their mathematical strength (inconsistent with general gender stereotypes). Researchers attributed these findings to the activation of negative stereotypes in the women about inferior math performance due to gender. Spencer, Steele & Quinn (1999) found similar results in their empirical study of comparative performance on math tasks between men and women in low and high stereotype threat conditions. As expected, women performed less well in the high stereotype

threat condition than in the condition of low threat. These results were replicated in several other studies of gender, math and stereotype threat (Oswald & Harvey, 2001; Keller, 2002).

In Nguyen & Ryan's (2008) meta-analysis of 151 studies of stereotype threat and race and gender, researchers found that studies testing race/ethnicity, minority status, and stereotype threat had larger effect sizes than those measuring gender and stereotype threat. Thus, although substantial evidence exists to suggest that people's behavior is influenced by other's ideas of them, in the form of stereotypes, stereotypes about race/ethnicity seem to have a greater effect than just gender alone. African American women have the unique situation of carrying at least two stigmatized identities.

Researchers investigating the effects of race and gender based stereotypes on African American women have used a similar rationale for their studies. Studies of stereotype threat can provide some insight into how internalizing negative or perhaps positive stereotypes can affect how a person copes with the world. DeFrancisco & Chatham-Carpenter (2000) reference the work of author, and social critic, bell hooks (1993), drawing from her experiences with African American women in a support group, who asserts that the Mammy and Jezebel stereotypes have influenced African American women's ability to love themselves and to develop self esteem. For African American women, a legacy of stereotyping various aspects of their lives may have affected not only their outward behaviors, but how they see themselves, how they see other African American women and how they construct their own sense of themselves in various domains of life.

Thomas, et al, (2004) have termed the process of internalizing these societal stereotypes about African Americans, internalized racism. They have also included idealizing Whites and

White culture and reacting to stereotype threat in their definition of internalized racism.

Although this is not the focus of this paper, it is important to point out that internalized racism refers to the mechanism by which racial stereotypes operate in people's lives. It is partially through internalized racism that members of a target group either act out the stereotype (i.e. self fulfilling prophecy) or react against the stereotype as a way of managing the negative affect associated with it. As this process is indeed internalized, the manifestation of internalized racism most likely occurs outside of the realm of immediate awareness. Consequently, people may act out of or in reaction to stereotypes about their group without realizing that they are doing so and without recognizing the consequences of their behaviors. They may also not recognize their actions or reactions as ways of coping. Because African American women carry (at least) two target identities, and thus, at least two sets of stereotypes, they risk internalizing and acting out stereotypes related to both their race and gender.

Race and gender effects in African American women

Investigating the effects of racial stereotypes combined with gender stereotypes has led researchers to coin the term gendered racism to describe this phenomenon (Thomas, Witherspoon & Speight, 2008; Falcon, 2008). Additionally, Thompson (2003) and Hamin (2008), in their studies of the SBW construct in relationship to various psychological factors in African American women discussed the importance of recognizing gender and race as important parts of social identity for African American women. They also recognized these identities as target identities, and therefore urged studying the effects of discrimination based on both of these identities and not just one. Hamin (2008) found in her study on the Strong Black Woman construct and its relationship to racial identity, stress and social support, that although the construct was related to racial centrality (i.e. the women's assessment of the importance of race

in their identity); it was not related to the women's perceptions of others' views of African Americans (i.e. stereotypes). However, the scale used to measure racial identity, only included items assessing racial regard, and did not consider gender. African American women may not experience themselves as racial individuals or gendered individuals separately. Nor might they differentiate between their race and gender with regards to the discrimination they receive. Therefore, this scale may have more effectively captured a relationship to regard if it tapped into perceptions related to African American women, as opposed to African Americans as a whole.

Beauboeuf-Lafontant (2005) in her qualitative study of African American women and "strength", discussed the inclusion of strength in the construction of African American womanhood. In her literature review, she concluded that historical depictions of African American womanhood have contained the themes of selflessness, abuse, and superhuman expectations while facing inequalities; essentially the overarching idea that strength means an African American woman will never break down. Although this can indeed induce pride and a sense of perspective, it can also minimize the potency of problems that contemporary African American women face. Beauboeuf-Lafontant (2005) explains that one consequence of this thinking encourages sick or troubled African American women to seek help primarily through religious means rather than in medical settings. As such, this "embodiment of strength," which has been tied to depression in African American women, while a source of pride, can also serve as a type of defensiveness, protecting herself and others from her negative feelings.

In Beauboeuf-Lafontant's (2005) study, she found contemporary African American women articulating similar notions of strength that have been tied to African American womanhood historically: self sacrifice, limitless endurance of adversity, and the hiding of and privately dealing with emotions. The women also expressed that acting strong did not necessarily

mean feeling or being strong. However, the African American women in the study held onto the notion of strength, even as they had awareness of its limitations. Consequently, this concept and its intimate tie to African American womanhood proves to be quite complex and does not easily lend itself to categorization as wholly positive or wholly negative. For African American women, it may serve as a source of pride amidst the few positive stereotypes of African American women in general but it can also be burdensome and a way of colluding with the notion that the needs/desires of African American women should remain part of their internal lives and do not deserve or warrant attention. African American women, having enjoyed recognition primarily for these traits of strength, endurance, and overcoming, as Beauboeuf-Lafontant (2005) points out, can find themselves on a pedestal, which further alienates them and continues to render their personal struggles invisible. This further perpetuates the idea that African American women must suffer in silence, rather than allowing them to truly express concern for themselves and to express their full range of emotional complexity.

Measurement of the strong Black woman construct

Beauboeuf-Lafontant's (2005) study is one of an emerging trend of researchers, and clinicians beginning to empirically investigate the construction of "strength" in African American womanhood within a sociohistorical frame. Although her study offers important insights into the intersections between historical and contemporary notions of strength and African American womanhood, her small sample size, offers only a snapshot of the experiences of contemporary African American women. Thomas, et al., (2004) have also offered their effort at operationalizing the construction of African American womanhood through their development of The Stereotypic Roles for Black Women Scale. These investigators developed this scale understanding that the construction of African American womanhood differs from that of White

womanhood within the social climate of the United States. They also asserted that certain characteristics have been primarily associated and emphasized most strongly with African American women and not White women. Specifically, racial and gender stigma and discrimination impact African American women's identities in ways that most White women do not experience.

Thomas et al. (2004) also noted that examinations of African American womanhood have often looked at issues of race or gender, without recognizing the interplay and impacts of both in tandem. However, in a mixed method study of self concept among African American female college students, researchers found that African American women identified with both their gender and their race and that those identities interacted (Jackson, 1997). Poindexter, Cameron & Robinson, (1997) also found positive correlations between racial identity and womanist identities, in their investigation of racial and womanist identities in African American women in college. These studies suggest an empirical relationship between racial and gender identity, which can be extended to include an existent relationship between gender and racial discrimination. In fact, Thomas et al. (2004) found that the above mentioned gendered stereotypes contributed to the variance in respondents' self esteem scores beyond racial identity attitudes. This supports the previously established link between racial and gender factors as themes in the African American female construction of womanhood.

Although this scale provides a very important attempt at empirically measuring the effects of internalizing stereotypical messages and has some important findings, it also presents some limitations. Mostly undergraduate students comprised the sample, which may not be representative of the majority of African American women in this country, therefore limiting

generalizability. The study also did not investigate the possible effects of these stereotypes on more serious psychological factors for African American women.

Another contemporary attempt at measuring the psychological characteristics of African American womanhood comes in the form of the Strong Black Woman Attitudes Scale, on which the current research is based. Slightly over a decade ago, Romero (2000) published observations from her clinical work with African American women. Throughout her time working with these women, she noticed two common themes among them: strength, and caretaking. In Romero's estimation, strength symbolized a kind of emotional resilience which referred either to the women's dedication to endure the adversities associated with being African American or that the women felt a very strong sense of self. She termed this sense of strength, self reliance. The second theme of caretaking spoke to a responsibility that the women felt to care for their partners, their children and their community, but not for themselves. They seemed to have received the message that what they did held more value to others than who they were. As such, Romero noted, these women often found themselves in relationships where they constantly strived to meet the needs of others but their own needs went unfulfilled. Romero termed this caretaking. Romero also thought of the use of these traits as a particular kind of psychological defense style. According to her, the African American woman's caretaking allows her to preserve her façade of competency, as though she is the only capable partner in a relationship, while also maintaining the appearance of the emotional control of relationships, shielding herself and others from her vulnerabilities, and ultimately, resulting in her not receiving the love and care she needs/desires.

The Strong Black Woman Attitudes Scale

Building on Romero's (2000) observations from her clinical work with African American women, Thompson developed The Strong Black Woman Attitudes Scale (SBWAS) in 2003, through the use of focus groups with African American women. This scale sought to operationalize the strong Black woman construct as a psychological coping mechanism. Adding to Romero's original conceptualization, Thompson utilized first a two, then a three factor model of self-reliance, caretaking and affect regulation to describe this construct. The affect regulation component spoke to an apparent tendency for African American women to wear a façade of strength to mask their negative emotions from others, especially sadness and therefore always appearing to be in control and invulnerable. Thompson's research upheld this three factor model. A confirmatory factor analysis revealed an adequate alpha for the entire scale ($\alpha = .74$), and the goodness of fit index for the three factor model, was also adequate (GFI = .871). Alphas for the three subscales were caretaking (.66), affect regulation (.72), and self reliance (.60).

Psychometric results of this scale were mixed given the low internal consistency for the subscales and low total score on the criterion variables. Thompson suggested that this initial version of the scale, therefore, may not have completely captured the SBW construct. In particular, the self reliance subscale seemed to tap into the attitudes associated with a 'self assessment' of strength versus a sense that others perceive strength, which is more consistent with the theory that states the SBW does not perceive herself as strong. Results indicated a negative relationship between self-reliance and affect regulation, ($r = -.20, p < .01$) which contradicted the theoretical model that these women were projecting an image of strength, which they may not have felt. Thompson attributed this surprising finding to two factors: problems with the scale (i.e. it may not have captured the intended construct), or a sampling issue, given the

relatively high SES and education level of the sample. Thompson suggested that the scale seemed to measure more of the woman's subjective view of herself as strong and not as much her understanding of how others perceived her, which was the crux of the proposed theory. A modified scale, with clearer distinctions between a woman's subjective view of herself versus her perception of how others see her, may have more accurately reflected the expected results.

In attempting to further validate this scale in regards to its theoretical foundations, as being uniquely rooted in African American culture, and as being a way that African American women react to a sociohistorical context of stereotyping, Thompson investigated the scale and its subscales in relationship to other psychological factors: the imposter syndrome, internalized stereotypes, and social desirability. Thompson found a relationship on the Clance Imposter Phenomenon (IP) scale (Clance, 1985) ($r = .37, p < .01$) that women with high SBW attitudes, also endorsed feeling like an imposter, which was consistent with the theory that women who hold these attitudes overall, may not feel as competent, in control or "strong" as they appear.

Thompson also found that SBW attitudes were related to internalized racism. Women who endorsed high SBWAS scores also endorsed more negative stereotypes about Blacks, ($r = -.20, p < .01$). The SBWAS total score was also negatively correlated with social desirability ($r = -.31, p < .01$) and positively related to internalized racism ($r = .20, p < .01$) measured by both the NAD/NAD-R (Taylor & Grundy, 1996). The first finding seemed to speak to highly identified women who utilized this ideal as being unlikely to indicate that they were concerned with appearing in a particular way. However, the second finding implies a relationship between this paradigm and negative views of their race. However, Thompson did find some surprising relationships such as the negative correlation between self-reliance and feeling like an imposter ($r = -.36, p < .01$), and the negative correlation between self-reliance and affect regulation ($r = -$

.20, $p < .01$), both of which contradict central tenets of the theory. Thompson noted that the scales used in her study measured stereotypes of African Americans in general and not African American women specifically. Perhaps scales that captured the internalization of both gender and racial stereotypes would have impacted these findings differently.

In investigating the unique socialization experiences of African American women, Thompson found that African American women were more likely to have androgynous traits (32%) than White women (17%), suggesting that African American women are socialized with both masculine (i.e. instrumental) and feminine traits. However, SBW attitudes did not predict this. She found that androgyny correlated positively ($r = .51$, $p < .01$) with self reliance and negatively ($r = -.34$, $p < .01$) with affect regulation. Drawing on the relationship between self reliance and androgyny, she suggested that endorsement of more, masculine or self reliant traits, could act as a buffer against psychological distress. This seemed to be an early indication that perhaps, one part of the SBW construct served a protective function for African American women.

Thompson also found apparent class and race differences that needed more investigation and reiterated the need for the use of a version of the SBW scale with a different sample. Thompson did not find the expected significant differences between the African American women in her sample and the White women on the SBW Attitudes scale, which could refute the idea of the SBW as a cultural construct. However, she also pointed out differences in her focus group samples in that the middle class and lower income African American women had differing definitions of the SBW. For example, the middle class women felt that SBWs were rare, whereas the lower income women felt that they encountered SBWs regularly. She also noted that the women in the middle income focus group tended to view the SBW more negatively than the

women of lower SES. This suggests that this construct may operate differently in different income and educational levels. Consequently, Thompson acknowledged the need for further exploration of this phenomenon with a more representative sample of African American women.

Hamin's (2008) research sought to address some of the mixed findings of Thompson's study and to expand it, using a modified version of the scale with a community sample of African American women. Hamin's version of the scale predicted a relationship between racial identity (i.e. public regard, private regard and centrality), social support, and stress in a representative sample of African American women. The internal consistency on the revised scale total score (.76) and subscales; caretaking, affect regulation, and self reliance were (.75, .64, and .62) respectively. These loadings reflect a change in both the modified affect regulation and self reliance subscales from those findings reported by Thompson that needed revision. Hamin's version of the scale did not replicate the negative significant relationship between the self-reliance and affect regulation subscales found in Thompson's research. This indicated an improvement upon the discriminant validity between the subscales. The revised measure supported the three factor model providing further evidence that the three subscales measured distinct components of the SBW construct. Hamin sought to frame the SBW Attitudes scale in a more cultural context, and to make it more reflective of cultural coping by investigating the relationship of the SBW scale and racial identity.

Following up on Thompson's work around racial identity and the SBW, Hamin found that SBW attitudes were related to racial centrality, but not racial regard. Using the revised SBW Attitudes scale, centrality related to the SBW Attitudes total score. African American women who felt a strong attachment to their racial identity also endorsed these attitudes, which suggested that maintaining SBW ideals held some importance for women for whom race held

importance. Racial public regard demonstrated a negative relationship to perceived stress, suggesting that women who felt others regarded African Americans favorably had lower stress scores and conversely, those who believed African Americans were seen less favorably, showed higher stress levels. Hamin's study therefore, demonstrated a relationship between SBW attitudes and racial centrality and between racial regard and stress.

The present study will also measure racial identity and its relationship to the SBW in this sample of African American women in an attempt to clarify Hamin's findings. Additionally, this exploration provides a response to the literature on stereotypes. Given findings detailing the importance of including racial and gender identity when exploring factors related to African American women (Beauboeuf-Lafontant, 2005; Eliason, 1999; Pascoe & Richman, 2009; Thomas, Witherspoon & Speight, 2004; West, 1995), this study seeks to continue exploring the gender and race interplay.

Hamin found several interesting relationships between the SBW total score, the subscales, and the psychological variables of stress and social support. Results indicated a relationship between the SBW total score, perceived stress and number of stressful life events in women's lives. Among the subscales, higher levels of caretaking were also associated with higher levels of perceived stress and number of stressful life events. Hamin suggested that a woman's tendency to attend to the needs of others, and not her own may increase her perception of stress in her world. Additionally, higher perceptions of stress are related to increased numbers of stressful life events, as women who are already stressed may be more likely to label situations as stressful. Affect regulation was also related to higher levels of perceived stress. Hamin suggested that the suppression or denial of internal emotion, lends itself to higher stress levels in African American women. Additionally, regulated affect may prevent potential support givers, or

caretakers from knowing that these women need help and thus make them less likely to offer support. As such, these women may not experience the decreased stress levels which could result from receiving helpful social support.

Self reliance demonstrated a negative relationship to perceived stress suggesting that those women who saw themselves as strong and independent may also feel more in control, and thus, less stressed. Hamin suggested that this subscale combined with affect regulation could heighten these women's stress levels but perhaps on its own, self reliance could serve as a protective factor for African American women. This echoes an earlier suggestion posed by Thompson (2003) of the possible protective potential of the self-reliance subscale.

Hamin included the factor of social support in her study to investigate its relationship to the SBW construct, as social support has often been seen as a protective factor in regards to stress (Schulz, Israel, Zenk, et. al. 2006; Bradley, Schwartz & Kaslow, 2005; Brown, Parker-Dominguez & Sorey, 2000). The caretaking and affect regulation subscales neither predicted receipt of social support nor did they predict satisfaction with social support received. However, caretaking did predict reciprocity of support, more specifically, higher levels of caretaking correlated with lower levels of reciprocity of support. This finding fits with the underlying theory of the construct that, those women who extend themselves to others often do not receive comparable levels of support from others, which could be due to factors within and outside of themselves, including affect regulation.

Summary. Both studies utilizing this scale provided evidence of the SBW construct as a coping style and affirmed that racial identity was related to gender in African American women in a complex interplay not often acknowledged in the literature. Although this construct seems to

be a culturally salient phenomenon, it has important gendered aspects. Findings also support what researchers, social scientists and social critics had previously observed, that this phenomenon indeed exists within the African American cultural realm, that it has a relationship to racial identity and that it has some psychological impact on the women endorsing this coping style. The Thompson and Hamlin studies focused primarily on scale development and strengthening the psychometric properties of the SBW scale. Although both of the aforementioned researchers discussed the importance of exploring the SBW construct in relationship to more serious psychological difficulties, those factors fell outside of the purview of those studies. As a next step, the current study proposes to continue to validate the measurement of the SBW construct as a coping mechanism with a clinical population, and to explore this construct with depression and suicide.

Coping

This study will also specifically explore the relationship between the SBW construct as a coping mechanism for African American women with regards to the traditional ways of measuring coping. Davis (1998), detailed coping in African American women in her phenomenology exploring meaning in the lives of depressed African American women. In doing so, she found that several themes emerged: survival, identity, self-expression and empowerment. These themes spoke to the women's survival through self-nurturance, finding and defining themselves through art, relationships and other fulfilling activities, restricting emotional expression to specific areas of their lives and empowering themselves through limiting their obligations, as much as they could. Discussing coping through this cultural and gendered lens provides a contrasting take on the ways that coping for African American women has generally been discussed in the broader literature. Some studies explore religious involvement and

spirituality as coping mechanisms for African American women (Carrington, 2006), whereas others have characterized African American women's coping styles within a paradigm that quarters coping styles into active (approach), passive (avoidant), problem-focused (focus on resolving source of stress) or emotion focused (focus on emotions related to stressor), (Catz, Gore-Felton & McClure, 2002; Pascoe & Richman, 2009; Thomas, et al., 2008). The "strength" construction of African American womanhood suggests that African American women may "cope" in ways not traditionally explored in research. Exploring the SBW coping paradigm (i.e. self-reliance, affect regulation and caretaking) in relationship to the traditional way coping has been measured, utilizing Lazarus' transactional model of stress as described in Vitaliano, Russo, Carr, Maiuro & Becker's (1985) revision of the Ways of Coping Questionnaire (WCQ) can provide insight into the ways that coping for African American women may converge or differ from traditional notions. As such, this study utilizes the Strong Black Woman Attitudes Scale (Thompson, 2003) and the Ways of Coping Questionnaire (Folkman & Lazarus, 1986) as measures of coping.

Recently, researchers have questioned the reliability of the WCQ, suggesting that the factor structure of the scale is unstable, and is not replicable across samples (Parker, Endler & Bagby, 1993). Additionally, they have suggested that utilizing this scale forces researchers to focus on certain coping mechanisms, to the exclusion of others. In light of these psychometric concerns, measuring coping utilizing a racial and gendered framework, with a population of color could better capture coping in this group and inform general understandings of effective coping.

Health Disparities & African American Populations

Sociocultural context of disparities. According to an Institute of Medicine (IOM) (2003) report investigating racial and ethnic disparities in healthcare, African Americans in general suffer health disparities in various domains including, treatment for cardiovascular disease, cancer, HIV/AIDS and cerebrovascular disease. Evidence of these disparities take the form of African Americans having the highest mortality rates from these diseases than any other ethnic group in the U.S. Contextual factors such as African Americans having less access to appropriate health insurance coverage, less access to high quality care, the tendency for African Americans to seek medical care primarily in emergency rooms and low SES have been considered as some of the reasons for these disparities. However, according to this 2003 report, even when those factors are taken into account, African Americans still receive lower quality medical care than their White counterparts. A previous 1999 IOM report defined quality of care as "...the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (p. 21). They also defined health services as encompassing physical and mental health care. Although the report extensively reviews research related to racial and ethnic differences in medical care, it also cites disparities in mental health care, revealing that it is this area of healthcare that has evidenced the most inequalities.

The IOM report references a 2001 surgeon General's report which notes that populations of color in the U.S., including African Americans, have less access to quality psychological services; that mental illnesses prove more disabling for African Americans and that in some instances; African Americans receive higher quantities of medications than Whites for the same

conditions. In at least one study, researchers found that African Americans received more oral dosages and injections of antipsychotics than Whites (Segal, Bola & Watson, 1996). The findings of Alegria, Canino, & Rios, et al., (2002), in their analysis of the 1990-1992 Comorbidity Survey, which included over 900 African Americans, found that group to have less access to specialty mental health services than Whites and Latinos. This held true even when adjusting for insurance status and psychiatric morbidity. With regards to depression, Melfi, Croghan, & Hannah, et al., (2000) found differences between likelihood of treatment between Whites and African Americans where 44% of Whites received antidepressant treatment within 30 days of the first sign of depression as compared to 27% of African Americans.

These findings point to a failing of the healthcare system to adequately care for their African American and other minority group clients. Also of importance, is the reality of various cultural factors, mistrust, skepticism and misinformation that many African Americans have about mental health treatment, which in turn informs their decisions about how, when, where and why they seek and accept treatment. Additionally, sociohistorical influences may also contribute to the health inequalities these studies highlight (Gamble, 1997). A mix of historical accounts of medical mistreatment coupled with cultural attitudes about the medical establishment and cultural notions of health may provide some insight into the relationship between health seeking behaviors for African Americans in general and African American women in particular.

African American women and health disparities. Many factors hold importance when investigating health in relationship to African American women. According to the Center for Disease Control and Prevention (2006), health related quality of life (HRQL) is defined as, “an individual’s perception of physical and mental health.” Ware, Kosinski & Keller (1994) (as cited in Hu, 2007), from their summary of a scale measuring physical and mental health, added to the

above definition that HRQL is “a multidimensional construct that includes physical functioning, role limitations, mental health, social functioning and general health perceptions,” (p. 254). This definition has several implications for measuring health related outcomes of African American women. According to this definition, quality of life and its relationship to health incorporates a social context, which includes social roles, perceptions, and experiences in addition to actual physical and/or psychological symptomology.

Hu (2007) in conducting a cross-sectional study of quality of life and its relationship to health in low SES older African American women with chronic diseases found unique interactions between quality of life and health. Hu also found that 53% of her sample rated their overall quality of life as fair or poor which is lower than the national average of people over 60. The study also raises the possibility that on a whole, African American women experience a poorer quality of life than their White counterparts, which could have implications for their health.

In discussing quality of life, health and health disparities, defining health in terms of African American women’s perception serves a central purpose. Schulz & Lempert (2004) discussed the unique ways that African American women define health in their ethnography of urban women in Detroit. Through the use of focus groups, researchers gained an understanding of these women’s perceptions of health in relationship to their environment, social relationships, physical/mental well being and resources. Researchers found that women discussed the intersection between health and physical spaces. Women mentioned that although they understood the importance of physical activity and connecting with others for their health, ineffective policing of public spaces prevented them from interacting in these spaces as they wish they could have. Women in this sample also defined “staying active” for good health in

terms of being involved in relationships and community affairs. The women felt that not having many opportunities to engage with others in safe, public spaces and constantly confronting that lack negatively impacted their health. Additionally, they referred to other contextual areas of lack: lack of access to nutritious foods, lack of accessible transportation, unsafe neighborhoods, unemployment, dirty neighborhoods, and no social support from public institutions, i.e. law enforcement, less revenue and fewer locally based businesses, as also impacting their ability to have good health.

Schulz & Lempert (2004) also found that the women utilized various kinds of coping, including social support, and a kind of coping, similar to the SBW construct described above in order to manage the uncontrollable environmental aspects of their lives. Researchers likened this coping style to various terms that have been used to describe African American women's efforts to actively cope with the adverse structural conditions that support resource asymmetry in their communities. These terms include, "weathering," "John Henryism" and the "Sojourner Syndrome." Additionally, women claimed that these structural inequalities were due to racism, to which, the women responded that they "were not cared about because they lived in the African American community," (p. 447).

Perceived racism and sexism have been linked to negative health outcomes in African Americans in general, and to African American women specifically. Pascoe & Richman (2009) in their meta-analysis of studies (spanning 1987-2007) investigating relationships between perceived discrimination and health outcomes in African Americans, found that perceived discrimination had negative effects on global (physical & mental) health. The majority of the studies concentrated on racial or ethnic discrimination (66%), whereas only 17% of the studies measured gender discrimination. More specifically, researchers found that perceived

discrimination related to negative mental health outcomes across varying types of mental health categories. Researchers also found evidence to suggest that perceived discrimination could also be associated with clinical levels of mental illness, although they could not examine this relationship quantitatively due to the small number of studies that actually measured diagnoses of mental illness. Researchers who investigated the effects of experiencing racist events on the psychological health of African American women also found evidence of this relationship (Kwate, Valdimarsdottir, Guevarra & Bovbjerg, 2003). From this quantitative study, results indicated that most of the 71 female African American sample participants had experienced some racism in their lifetimes. Racist events correlated positively with overall psychological distress and women with more lifetime experiences of racism rated their overall health more poorly. The negative mental health effects of racism are replicated with the addition of sexism.

Thomas, et al, (2008), in their quantitative study of perceived discrimination, coping and gendered racism in African American women found similar results to the Pascoe & Richman (2009) study. Researchers conducted the study in response to a body of psychological literature which historically has ignored the racist and sexist context that African American women confront in their lives, usually focusing on one or the other. Results of the study indicated that most of the participants experienced gendered racism in interpersonal situations. Additionally, these experiences of gendered racism had a significant relationship to the women's experience of psychological distress such that those who endorsed more experiences of gendered racism also endorsed higher levels of distress. Woods- Giscombe & Lobel's (2008) quantitative study of race, gender and stress found similar results. Results indicated that an index comprised of the three factors of race related stress, gender related stress and generic stress predicted global stress

in African American women better than any of those factors alone. They also found that no single factor affected distress beyond the three factor model.

Unfortunately, racism and sexism have been and continue to be a part of African American women's experience of the healthcare system. Researchers have begun to attend to the ways that racism has impacted healthcare workers and access to healthcare for African American women. Eliason (1999), in her literature review of the nursing profession's treatment of racism and African American women outlined the ways that nurses (as a part of the overarching medical establishment), have learned to collude with racism. She includes factors such as: nursing's emphasis on empathy, which leads nurses to believe they should treat all patients "the same;" their individual focus, which denies socioeconomic, cultural or historical factors; having racially homogenous groups of nursing students and faculty, for more "efficient" teaching and the tendency of the profession to teach conflict avoidance. Other influences included "color-blindness," denial of racism and the simplification of issues of race into "cultural diversity."

Drawing on previous research conducted by Hummer (1996), who proposed a conceptual model for understanding Black-White differences in healthcare in a review of those differences, Eliason outlined his 3 pronged model which maps the influences of racism on health. Hummer proposed that racism manifests itself in health: 1) on an institutional level which can look like residential segregation and racial isolation, 2) on an economic level as evidenced by economic stratification in income, education, occupational status and stability and 3) individual level racism in majority group behaviors of discrimination. Noting that sexism most likely operates in a similar way, Eliason, (1999) discusses the importance of recognizing the dual effects of racism and sexism in the treatment of African American women who seek care. She urges the nursing profession to take a self-conscious look at their own proliferation of racism and sexism within

the healthcare industry as both of these forms of discrimination may affect African American women's ability to seek and access competent, comprehensive and effective healthcare. Murphy & Clark (1993) in their qualitative study of U.S. and British nurses have also noted that racism and lack of knowledge of racial and cultural differences can impact patients' receipt of adequate care.

Given the myriad of factors affecting African American women's health, i.e. the historical and contemporary context of unequal access to healthcare, unequal access to and receipt of medical and psychological treatment, environmental factors, economic hardship and the effects of gendered racism, it seems important to consider the interface of culture with these factors. As a cultural construct, the SBW has been conceptualized as a psychological defensive style and coping mechanism (Romero, 2000; Thompson, 2003; Hamin, 2008). While this construct may relate to protecting one's self against one's own vulnerabilities and social harms, it may also have some relationship to how African American women manifest and handle psychological distress.

Depression & African American Women

Depression is one of the most debilitating mental illnesses in the contemporary world, and its etiology, manifestation and treatments differ across racial and gender lines. Williams, Gonzalez, & Neighbors et al., (2007), in their review of the prevalence and incidence of depression among African Americans, reported that depression ranks as the fourth leading cause of disability worldwide. Despite this statistic, this disorder remains under-detected and thusly, underdiagnosed in African American women as Waite & Killian (2009) found in their qualitative work investigating explanatory models of depression in African American women. Within the social science and psychological literature, researchers have shown mixed findings with regards

to prevalence rates of the disorder among African American women with some reporting higher levels of depression among these women as opposed to White women. Carrington (2006), in her literature review of depression treatment and research with African American women, references a study conducted by Kessler (2003), who found depression prevalence rates among African American women to be twice that of White women. However, other studies, such as Kubiak & Seifert's (2008) comparative study of depression rates among White and African American women with felony drug convictions, found higher rates of depression for the White women in the sample. Jackson (2006), in her review of psychiatric medicines and the treatment of depression, cites a Baltimore, MD study of over 1,000 African American young adults that found an overall prevalence rate for lifetime MDD of 9.4% of the sample, with women being 1.6 times more likely to have the disorder than males (Ialongo, et al., 2004). This finding closely mirrors rates of depression in the general American population, suggesting equivalent rates of depression across races. These rates however, could be affected by structural barriers such as lack of access to resources, poverty, the prevalence of misdiagnosis, and socio cultural factors such as hiding negative affect (i.e. affect regulation), taking care of the needs of others and neglecting one's own (i.e. caretaking) and depending on one's self to handle all of one's life stressors (i.e. self reliance).

However, even with the discord over prevalence rates and incidence of depression in African American women, evidence exists to suggest that these women have a unique vulnerability to this disorder. Results from a large scale study conducted in California of over 9,000 women of African descent receiving services at county entitlement clinics, revealed African American women to have 2.94 greater odds of developing depression than Black women born outside of the U.S. (Miranda, Siddique, Belin, & Kohn-Wood, 2005). This suggests the

influence of particular sociocultural factors relevant to the African American woman's experience that predispose her to depression and psychological distress. Conflicts within the psychological literature about prevalence rates and a general dearth of knowledge regarding the etiology, manifestation, and treatment of depression among African American women, accentuate the need for more research on this disorder within this social group.

Ojeda & McGuire (2006), in their investigation of utilization of outpatient substance abuse and mental health treatment along racial and gender lines, found that African American women use less of these services than their White counterparts. According to their results, African American and Latina women are less than half as likely to seek treatment as White women. When researchers controlled for healthcare environmental factors, participation by African Americans declined even further. However, researchers found that those depressed patients who had a "gatekeeper" to services were more likely to use services than not. Researchers concluded that various barriers to care existed, including practical ones, such as: cost of care, inability to secure appointments soon enough, and cultural barriers, i.e. embarrassment with discussing problems and fearing stigma. Findings suggest a confluence of structural and cultural barriers that hinder treatment of depressed African American women and also impact studies on prevalence rates.

Several factors impact the treatment and development of depression for African American women. Carrington (2006) cites determinants such as having less access to services, receiving less relevant help, misdiagnosis and under diagnosis of depression, and co-morbid conditions as some of the factors complicating the picture of depression in African American women. She continues to point out that cultural factors such as the history of slavery, discrimination, gendered racism and caretaking tendencies attributed to the SBW paradigm, can

also affect African American women's ability to seek and receive treatment for depression. These women may have developed a sense of distrust of medical institutions, may have experienced or fear experiencing gender and racial discrimination and may have spent their time and resources caring for others rather than themselves. Without proper identification, diagnosis and treatment, African American women have a higher chance of experiencing more severe forms of depression for longer periods of time.

Although Kubiak & Seifert (2008) reported lower levels of depression for the African American women in their sample as compared to the White women, they found important increased risk factors for the African American women. Social support increased depression risk for the African American women but decreased risk for their White counterparts, suggesting that social support could have a harmful relationship to psychological distress in African American women. This suggests a difference in the nature of social support for African American women.

Perhaps, the presence of significant members of a woman's social network also implies responsibility and obligation, rather than the seeking or receiving of support. The SBW paradigm suggests that African American women tend to identify nurturing as part of their identities. As such, they may have a number of people in their lives to whom they provide care, but not necessarily from whom they receive support. These relationships rather than being reciprocal in nature may actually represent relationships in which the African American woman over functions (i.e. caretaking), which could contribute to psychological distress. Measures of social support that do not take this into account, such as the WCQ may conflate social networks with "social support," thus wrongly characterizing women's experience of social support. This could inaccurately depict risk or protective factors for depression for African American women.

Perhaps “social support” does not predispose African American women to depression, but “caretaking” and engaging in non-reciprocal relationships does.

Higher income African American women were also more at risk for depression than higher income White women, which researchers attributed to the possible assimilation and isolation that may occur for higher income African American women and to the possibility that higher income African American women have more “caretaking” responsibilities than higher income White women. These findings suggest the need for viewing this disorder through a more sociocultural lens in addition to the other ways that it has been conceptualized and support a possible relationship between the cultural and gendered norm of caretaking and psychological distress.

Although both of these studies speak to an apparent cultural or gender construct that may be affecting their results, i.e. “caretaking,” neither study investigated the relationship between this phenomenon and depression in African American women. Additionally, the findings that social support and higher income, factors often conceptualized as protective factors against depression show the opposite relationship for African American women suggests that social support and having a higher economic status may carry different meanings for African American women. Depression and coping have not been conceptualized in a way that appreciates and captures the experiences of African American women thoroughly. Perhaps findings related to depression and coping in African American women would address some of these questions if conceptualized through more of a sociocultural and gendered lens.

O’Malley, Forrest & Miranda (2003) in their study of the experiences of nearly 1,000 urban, low income African American women in primary care settings, highlight in their literature

review, the tendency for depressed African American women not to seek treatment, and when they do, to prefer primary care settings rather than mental health settings. The authors also report that primary care providers are more likely to diagnose depression in White women than in African American women. Researchers subsequently found that the level of involvement and interest in the patient's condition from the primary care provider impacted the client's ability to receive appropriate treatment for depression. Overall, findings indicated that rates of inquiry about depression were fairly low, even though 98% of the depressed women in the sample had attended at least one primary care visit within the past year. For women who received comprehensive care, they had a greater likelihood of being asked about depression, and receiving treatment. Additionally, women who had longer term relationships with their primary care providers and who perceived those providers as more respectful also had a higher likelihood of being asked about and treated for depression. These results suggest a cultural and interpersonal aspect to detecting and acquiring treatment for depression in African American women. It also suggests that many African American women, who may have depressive symptoms and seek care in a primary care setting, may not receive the help they need, which can also contribute to the mixed findings of depression prevalence rates in these women.

The study's findings highlight several important aspects of mental health treatment and conceptualization for African American women. The high prevalence rate of depressed African American women in medical settings as opposed to mental health settings could suggest that African American women may view depression primarily as a physical illness, if they even recognize depression in themselves at all. Concentrating solely on the psychological and not physical symptoms of depression, as they have been defined, can cause providers and the women themselves to miss this disorder or misdiagnose depression in African American women. This

has important ramifications for African American women as recent studies have shown the tendency for depressive symptoms to be associated with somatic symptoms in these women (Gary & Yarandi, 2004; Huprich, Porcerelli, Binienda, & Karana, 2005; Jackson, 2006). An epidemiological study of psychiatric disorders, which included a sample of 19,000, revealed African American women to have much higher rates of somatization than any other group (Swartz, Landerman, George, Blazer & Escobar, 1991). Perhaps a more culturally competent view of the manifestation of depression could aid in medical providers' detection of the disorder in African American women and in the ability of these women to detect the disorder in themselves. Additionally, the higher rates of depressed African American women seeking services in medical rather than mental health settings raises questions about their access to, knowledge of and notions about mental health treatment.

Related to the findings of O'Malley, Forrest & Miranda (2003), Jackson (2006) found that higher depression scores in African American women related to a lowered likelihood of discussing symptoms with doctors, such that the most depressed women were the least likely to seek help. Longer term relationships with health care providers however, were related to accurate detection and diagnosis of depression in African American women, which reiterates the importance of the quality of this interpersonal interaction. The SBW paradigm suggests that African American women regulate or mask their negative affect in response to stress (i.e. affect regulation). Utilization of this coping strategy could lessen the likelihood of African American women disclosing their distress to their healthcare providers. However, within the context of a trusting relationship, they may feel more comfortable doing so.

Jackson (2006) also highlighted African American women's generally aversive attitudes towards treatment with antidepressants which can have implications for their ability to receive

treatment. Unpacking this aversion to treatment with antidepressants may shed some light on how African American women view mental health treatment and mental disorders. The focus on service utilization does not paint a comprehensive picture of the ramifications of mental illness for African American women. This reluctance to engage in antidepressant treatment may represent a rejection of the stigma associated with mental illness existent in their own cultural context. Earlier authors investigating the SBW construct and African American women, have articulated the idea that the SBW does not “break down,” (Beauboeuf-Lafontant, 2005). Depression, therefore, stands outside of the accepted realm of experience for African American women who may be utilizing this coping style. This raises questions of whether or not the SBW construct or particular aspects of it, serve to protect African American women from developing depression by acting as a coping mechanism or if it worsens the disorder by delaying detection and contributing to a negative view of treatment.

Risk factors. Several stressors have associations with depression and may even increase vulnerability to depression in African American women. Risk factors include environmental/contextual, material, interpersonal, and sociocultural influences. Neighborhood stress acts as a risk factor for depression in African American women. In their investigation of neighborhood context, personality characteristics, and stressful life events as predictors of depression in African American women, researchers highlighted the various ways neighborhood context can affect individual’s lives (Cutrona, Darnell, Brown, Clark, Hessling, & Gardner, 2005). These include daily stress levels, personal safety and access to resources. Results indicated that the women’s social support networks, including family members, friends and other members of women’s networks influenced the probability, severity and length of depression in the women. Additionally, high poverty and social disorder was also associated with higher

incidences of Major Depressive Disorder, even when controlling for individual characteristics. These findings corroborate the notion that mental illness can be linked not only to individual factors, like personality characteristics, but can also be influenced by environmental factors. African American women in highly stressful and disadvantaged environments have more of a vulnerability to mental illness than those who do not live in such contexts. Although this study utilizes a diverse sample of African American women, from varying educational and income levels, across rural, urban and small town settings, the design of the study does not allow for causal conclusions. Thus, while researchers can discuss associations, it is not possible to infer contributing factors to depression from this study.

Bromberger, Harlow, Avis, Kravitz & Cordal (2004) also found results emphasizing the importance of environmental or social factors on the development of depression in African American women. From their investigation of the prevalence of depressive symptoms among middle aged women of various races, researchers found that high levels of stress and low levels of social support predicted depressive symptoms across races. They also found racial differences between the women in their sample, such that African American and Latina women had higher levels of depressive symptoms as compared to the White and Asian women in the sample. In this study, financial strain, and unemployment were related to elevated depressive symptoms. Although the sample included African American women, they comprised slightly over one fourth of the entire sample. Investigating depression within an entirely African American female sample might allow for exploration of more psychological factors and their relationship to depression and depressive symptoms in African American women. Additionally, the entire sample included mainly women above 44yrs old. Depression may manifest itself differently in a younger sample of African American women.

Unemployment has also shown a relationship to depression in low income African American women. In their study of depressive symptoms and unemployment in a low SES population of African American women with a history of Intimate Partner Violence (IPV) and suicide, researchers found a significant relationship between depressive symptoms and unemployment (Mascaro, Arnette, Santana & Kaslow, 2007). Higher levels of depression were associated with having more difficulty acquiring and maintaining work. Researchers also found that changes in employment status over a 10 week intervention period, predicted employment patterns at 6 month and 1 year follow ups. Although the study found significant results, the small sample size (N=46) speaks to the need of further exploration of risk factors for depression in African American women with more representative and larger samples. Also, the high risk nature of the sample (i.e. interpersonal violence and history of suicide attempts), also limits the generalizability of its findings.

In addition to contextual and material factors, social and interpersonal variables have also been shown to impact depression in African American women. De Groot, et al., (2003) investigated the role of economic and social resources in predicting depressive symptoms in African American women at risk for type 2 diabetes. Results indicated that depression status in the women had associations with material as well as with emotional/psychological resources. Depressed women were less likely to work outside of the home, less likely to have assets, less likely to own a home, more likely to live in poverty, and generally had trouble meeting their needs. At an emotional/psychological level, these women had lower self esteem, more stressful life events and more intra-familial strain (i.e. family death, divorce). Although researchers used a contextual model (Conservation of Resources Theory, COR) to frame this study, important questions remain unanswered. Given the amount of risk factors in these women's environments,

it would be important to know whether or not the women saw themselves as depressed or at risk for depression. Noting the lack of material resources, investigating how women found ways to cope with their harsh environments may have also contributed to the development of depression in the sample. Additionally, having insight into the nature of social support for these women and their ability to access support or not, may have shed some light on the relationship between depressive symptoms and their association with stressful life events and intra-familial strain.

Jones, Beach, Forehand & Foster (2003) investigated the relationship between family stress and depressive symptoms in an urban sample of HIV positive African American women. In their literature review, researchers discussed the tendency for African Americans to utilize extended family networks and the greater fluidity in African American families as compared to Caucasian households. Additionally, they discussed the established link between family stress and depressive symptoms and women's particular vulnerability to depressive symptoms in the context of family stress (Kasper, et. al, 2008; Hammack, Robinson, Crawford, & Li, 2004). Findings indicated that stressful life events were associated with depressive symptoms and self-reported health. Stressful family events such as having a family member in jail, having an abortion or miscarriage, and witnessing family violence, comprised some of the stressful family events associated with depressive symptoms. These family stressors predicted a decline in women's health and heightened depression levels. Many of the women experienced stressful family events that would meet DSM-IV criteria for a trauma. Additionally, researchers found that depressive symptoms partially mediated the link between stressful life events and declining health in the women, suggesting that these symptoms, combined with family stress negatively impact health.

In the literature review of their study on depression and health related quality of life for low income African American women, Frank, Matzo, Revicki & Chung (2005) point out particular risk factors for African American women. These risk factors include poverty, minority racial status and womanhood. According to their literature review, African American women have a higher risk of living in poverty (54% as compared to 25% of White women), which may increase their vulnerability to depression. In two separate studies of low income, ethnically diverse women, researchers found higher levels of depression than in the general population; in one study of women who were uninsured or who received public healthcare benefits, 22% of the sample met criteria for Major Depressive Disorder, whereas in the second study of women recruited from public sector family planning clinics, 25% met criteria for MDD as compared to 6% of women in the general population (Spitzer, Williams, Kroenke et al.1994; Miranda, Azocar, & Komaromy, et al. 1998; Blazer, Kessler, McGonagle et al., 1994). Findings from the study of depressive symptoms and health related quality of life, revealed that depressed African American women in the sample rated their subjective well being (measuring energy and fatigue) lower than the general population of depressed Americans (Frank, et al., 2005). Consequently, for African American women, the relationship between depression and quality of life may interact differently than in the larger population, suggesting a more negative and impactful relationship between the two, for this population.

Overall, important dimensions of depression in African American women seem absent from the aforementioned studies. Many of the samples represent women who have multiple risk factors for psychological distress, such as low SES, interpersonal violence, HIV status, and living in highly stressful environments. Few of the studies address psychological health or disorder in samples of African American women that include women who are employed, live in

fairly safe neighborhoods, have access to resources and who do not necessarily have a history of violence or serious pathology, i.e. suicide. Most of the studies also neglect to explore depression, psychological distress, coping or social support while also accounting for the cultural and gendered perspectives of African American women. The possible influences on their psychological states do not include examination of their own cultural and gendered scripts which can impact functioning. Although the studies have discussed African American women's tendency to utilize medical rather than mental health services, they do not explore possible cultural and gendered norms that may influence their willingness to do so. Similarly, few studies explore coping in the context of African American cultural and gendered norms.

Cultural, Social & Historical Contributions

Waite & Killian (2008) explored depression in African American women using a model informed by African American women themselves, in their qualitative study. Researchers found that women had their own notions of the disorder and of its treatment. For these women, depression represented a holistic rather than a singular experience. Respondents recognized varying causes of depression, including traumatic events, stressful life circumstances, poor health and styles of coping. Similar to the SBW paradigm described earlier on in this literature review, some women felt they were not able to "break down," until they actually became sick because of the extent to which others relied on them. Women also reported depressive symptoms as "walking around in a fog," or "being weary," and further explained that they were not really aware that symptoms they were experiencing were related to depression. However, women did have awareness of the severity of the illness and mentioned enduring feelings of sadness, shutting down, being frightened of their own behavior, feeling as though depression attacked the soul and spirit and the possibility of hurting themselves or others. The women mentioned looking

towards their own faith and to the church for support and help with managing depression. They also advocated exercise, prayer, yoga, and meditation as preferable modes of treatment, listing antidepressants last. Antidepressants were reserved for more severe depression and women indicated stopping their use as soon as they felt better due to fears of dependency, side effects and addiction (Sleath, West, Tudor, Perreira, King & Morrissey, 2005; Waite & Killian, 2008).

This research exemplifies the idea that African American women have a unique perspective on and experience of depression. The above researchers pulled from the work of Beaubouef-Lafontant (2007) and her work describing the SBW and how depressed African American women often use this image to mask their feelings of frustration, tiredness and depression. From her qualitative study, she pointed out consistent themes of self-sacrifice and limitless endurance of adversity among the respondents. Although outwardly, they exemplified the picture of strength, inside they held their emotions bottled, and they seemed to use this façade to negotiate a world, that in their eyes, did not allow them the same allowances for emotional expression as it does for White women. Beaubouef-Lafontant (2007) discusses a process similar to the strong Black woman, as a coping mechanism for African American women, which helps them survive a context full of obstacles. However, she continues to point out that while this façade may contribute to her survival, it also can contribute to depression in African American women.

The “sisterella complex” explores this paradigm as a coping mechanism and its possible relationship to depression in African American women (Jones & Shorter- Gooden, 2003). Researchers utilized clinical case studies to illustrate “the sisterella complex,” which identifies the presentation of depression in some African American women. This complex is defined by caretaking and lauding others at the expense of self-care, which can appear as selflessness. The

women practicing such over-functioning which includes caring for others as well as juggling exorbitant responsibilities may be overachieving in an effort to combat society's messages that paint them as incapable, and inferior. The effects of this paradigm can manifest in occasional "blue moods," in a collection of symptoms, i.e., chronic sadness, hopelessness, sleep problems, anhedonia, and diminished energy, or in full-blown depression. However, African American women exemplifying the "sisterella complex" tend to hide their emotions and turn them inward, instead of sharing them; they continue to support others without receiving or seeking support themselves.

Uniquely, these women may not appear to be suffering- instead they overwork, and are detached from their feelings and needs, behaviors which can increase vulnerability to depression or deepen already existent depression. They may appear outwardly together, confident, and strong- a façade that has been termed affect regulation (Hamin 2008; Thompson, 2003) within the Strong Black Woman paradigm that guides this current research study. Thompson (2000) also refers to this façade and consistent self sacrificing, as "moral masochism." Having been socialized under this ideal of excessive personal sacrifice, partially captured in the caretaking piece of the SBW construct, these women continually give of themselves without viewing themselves as needing support. Coupled with this socialization of extreme caretaking is also the theme that African American women are strong and invulnerable, thusly appearing or acting depressed, researchers state, is incongruent with the cultural and gender norms associated with African American women. Depression for African American women, therefore, may not be precipitated by an external event, as is the classic conceptualization of the disorder, but may have more to do with the women's minimizing themselves, their identities, including their needs, wants and goals. As is the danger of severe depression in general, the depressed African

American woman may turn to suicide, when she remains exposed to stress but continues to operate as someone who does not seek support and who is functioning well.

Suicide & African American Women

On the more lethal side of psychological distress, lies suicide. Historically, African Americans overall have consistently shown lower rates of suicide than their White counterparts (Kaslow, et al., 2004). According to a 2000 CDC report, suicide rates in the population for African American adults are 5.8 per 100,000 (Klein & Proctor, 2000). Although men are more likely to complete suicides, women have more attempts (Kaslow, et al, 2004). Poussaint & Alexander (2000), who published a comprehensive study of suicide in the African American community, assert the importance of viewing suicide for this group through a sociohistorical and cultural lens. According to the authors, without identifying the unique circumstances of African Americans, important “warning signs,” may be missed. Specifically, Poussaint & Alexander (2000) reference the history of oppression under which African Americans have endured and point out that this history has influenced African Americans’ tendency to downplay depressive symptoms and suicidal thinking.

The authors assert early socialization experiences of African Americans prepare them to confront various challenges and injustices within society due to the racialized history of this country. Similar to the SBW paradigm, “strength” is invoked as a way of coping with these challenges. Suicide, therefore, lies in opposition to the underlying idea captured by this notion of “strength,” which refers to a limitless endurance of hardship. Specifically, suicide as the ultimate expression of human vulnerability, stands in stark contrast to the notion that an African American woman can depend on herself to meet her own needs (i.e. self reliance). A suicide attempt or completion also disrupts the façade of composure and emotional control that African

American women have learned to portray (affect regulation) by insinuating that life has become unbearable and thus, unlivable for her. Finally, the characterization of African American women primarily as nurturers implies that their needs are nonexistent or fall secondary to other's needs (caretaking). Suicide confronts this notion by bringing to the fore the reality of deeply unmet needs.

This viewpoint may discourage outward admittance of suicidal thinking; however the question remains if it actually decreases suicidal thinking. Poussaint & Alexander (2000) discuss the current trends in suicide among African Americans as a kind of "erosion...of three centuries' worth of communal strength and individual self preservation," (p. 17). Perhaps for those African American women utilizing the SBW paradigm, which emphasizes caretaking, feigning control and invulnerability (i.e. affect regulation), and reliance on the individual (i.e. self-reliance), suicide may be a desperate cry for help or an attempt at finding rest. Suicide for African American women has yet to be explored within this context.

Although the current body of psychological literature examining suicide and African Americans in general is scant, and is even smaller for African American women, some studies have attempted to explore risk and protective factors for suicide in African American women. Klein, Elifson & Sterk, (2006), exploring suicidal ideation in African American female cocaine users, described several factors in their literature review which may contribute to suicidal ideation, attempts and completions. Risk factors include: substance use, poor psychological well-being, depression, low self esteem and hopelessness. Researchers found that women with suicidal ideation were more likely to have a mental health disorder, low self esteem, lower levels of perceived family and social support and a history of physical, sexual or emotional abuse. Other studies have consistently shown similar results around risk factors for suicide in low

income African American women, specifically, hopelessness, high levels of psychological distress or a mental health diagnosis (i.e. depression), and low levels of perceived social support from family and friend networks (Compton, Thompson & Kaslow, 2005; Kaslow, Jacobs, Young and Cook, 2006; Kaslow, et al., 2000; Thompson, Short, Kaslow & Wyckoff, 2002).

In an attempt to explain reasons for the lower levels of suicide among African American women as compared to their White counterparts, some researchers have begun to investigate protective factors against suicide for this population. Marion & Range, (2003) in their literature review of a correlational study investigating protective factors and suicide, authors identified effective coping as a possible buffer against suicide in African American women. Specifically, researchers cite reliance on extended family networks and support, religiosity, and unacceptability of suicide as variables influencing lowered levels of suicidality in African American women. From their sample of undergraduates in southeastern university settings, researchers found negative correlations between ideation and family social support, and collaborative religious problem solving (i.e., working with God to solve a problem), and a positive correlation between ideation and attitude toward suicide acceptability. As such, those women with greater family support and more of a sense of religious connection were less likely to contemplate suicide. However, women who viewed suicide as a viable option for them, showed a greater tendency towards ideation. Consistent with these and the above mentioned studies of risk factors, Kaslow, et al. (2004), in their comparative study of African American male and female suicide attempters and non attempters, found attempters to have less religiosity, more psychological distress, and maladaptive coping.

Continuing to explore protective factors against suicide in African American women, Thompson, Short, Kaslow & Wyckoff (2002), investigated the effects of self efficacy on suicide

attempts in women survivors of Intimate Partner Violence (IPV). Researchers defined self efficacy as the degree to which women felt capable of planful action to access needed resources, including various kinds of social supports. Results indicated that self-efficacy was negatively related to suicide attempts and positively related to friend and family support. Meadows, Kaslow, Thompson & Jurkovic, (2005), found similar results to the above studies, finding that hope, spirituality, self-efficacy, coping, family and friend social support can act as buffers against suicide.

Although these studies have investigated suicide risk and protective factors in African American women and have consistently demonstrated links between mental illness, (i.e. depression) and suicide, they do not take into account unique factors, as Poussaint and Alexander (2000), have suggested, which may impact this relationship for African American women. The SBW paradigm provides an example of a culturally relevant, culturally informed, and familiar coping style for African American women (Beauboeuf-Lafontant, 2005; Morgan, 1999, Wyatt, 2008), which has demonstrated some relationship to their mental health (Hamin, 2008; Thompson, 2003). Although this relationship has yet to be investigated with more serious psychopathology, the quantitative and qualitative explorations of this paradigm suggest a relationship to psychological functioning and management of psychological symptoms, i.e. coping (Hamin, 2008; Jones & Shorter-Gooden, 2003; Romero, 2000; Thompson, 2003).

Romero (2000) has discussed her observations of strong Black women, as those who may be shut down to their own internal experience (affect regulating) and/or who neither ask for support nor receive the social support that they need (overly self-reliant). Being divorced from or denying one's needs, can delay treatment, or help, which may exacerbate symptoms. Women may not recognize warning signs within themselves, such as hopelessness, which one study

found to be the most significant predictor of suicide attempts in African American women, above and beyond other variables, such as unemployment, psychological distress, interpersonal stress (i.e., verbal & physical abuse) and social support (Kaslow, et al., 2000). Additionally, lacking social support has already demonstrated a relationship to suicidality in African American women. African American women may have been socialized to give, rather than receive social support (caretaking) and to hide their needs from others (affect regulation), which could increase isolation (self reliance), thereby increasing the likelihood of suicide attempts. As such, perhaps this paradigm can inform researchers about ways that African American women manage depression and suicidality. All women who have depression do not attempt suicide; neither do all depressed women express suicidal thoughts. As such, some variables may exist that influence the strength of the relationship between depression and suicide.

Summary. African American women exist in a sociohistorical context which has included a past of enslavement, racial discrimination and oppression and a legacy of discrimination that has resulted in the uneven allocation of resources evident today. In a contemporary context, these women have interfaced with stereotypical notions of themselves in conjunction with social and economic realities that have impacted their psychological and overall well being. The strong Black woman paradigm has been introduced as a way to explain one way that African American women have learned to cope with these various realities. Although many themes related to this construct exist, the present study will utilize a particular version of the construct that has theoretical and empirical underpinnings. This construct is comprised of the three factors of caretaking, self reliance and affect regulation, and have been shown to relate to the psychological health of African American women. Although researchers have begun to investigate this construct and have demonstrated its relationship to stress and social support in

African American women, this construct has not been examined in relationship to more serious psychopathology, i.e. depression and suicide.

Depression has been found to be one of the most debilitating mental illnesses of the contemporary age and some studies show that African Americans are disproportionately affected by this disorder. African American women have suffered from underdiagnosis, misdiagnosis and improper treatment for this disorder. Currently, the literature evidences many gaps in this field. The majority of the existent research on depression in African American women does not account for gender and culturally relevant coping styles or influences for these women. Similarly, suicide, as an extreme form of psychopathology in African American women, evidences the same gaps. The present study, therefore seeks to add to the literature, a culturally relevant investigation of coping for African American women in regards to depression and suicide. The SBW paradigm is proposed as a coping mechanism in this context and as a possible moderating variable in the existent relationship between depression and suicide in African American women.

Statement of the Problem and Hypothesis

This study sought to investigate the relationship between the Strong Black Woman coping style and depression and suicide in African American women. The psychological literature has suggested that this construct is a culturally relevant paradigm that African American women utilize and relate to their identities as women and as members of their racial group. Researchers have also suggested that this paradigm utilized as a coping mechanism may have detrimental effects on the psychological well being of African American women, but have yet to explore this in relationship to the psychopathology of depression and suicide. Both depression and suicide represent under-researched concepts in relationship to African American

women. Of the few studies that examine these issues with this population, an even smaller number consider cultural influences. In this study, depression is operationalized using an empirically validated self-report measure that assesses presence and severity of depressive symptoms. Suicide is measured using an empirically validated self-report measure that assesses the existence, severity and intensity of suicidal ideation and intent. The strong Black woman construct is measured using a modified version of the original *Strong Black Woman Attitudes Scale* as developed and validated by Thompson (2003).

The present study had six overall aims. The first aim was to explore whether or not the three factor model of the SBW was upheld in this sample. The second aim of the study was to replicate findings from the Hamin (2008) study that found an association between the SBW construct and racial identity. The third aim of the study was to explore how coping, as traditionally measured in the literature, correlated with the SBW coping style. The fourth aim was to explore whether or not the present sample replicated the findings in the literature of an existent relationship between depression and suicidality. The fifth aim was to investigate the relationship between the SBW and depression in these women. The sixth aim was to explore the relationship between the overall SBW construct in relationship to depression and suicide. The following hypotheses have been proposed:

H₁: Racial identity will be positively associated with the SBW in this sample of urban African American women.

H₂: Coping, as measured traditionally, will be negatively associated with the SBW in this sample of urban African American women.

H₃: Depression will be positively related to suicidality in this sample of urban African American women.

H₄: The SBW total score will show a positive relationship to depression in this sample of urban African American women.

H₅: The SBW total score will moderate the relationship between depression and suicidality such that this relationship is strengthened when women are more identified with this construct in this sample.

Methods

Data was collected from a total of 191 African American women in order to ensure meeting the target sample size of 150, (N= 150). This final number was comprised of previously collected data (N= 89) and newly collected data (N= 102). Using BWPower (Bakeman, R., & McArthur, D., 1999) a power analysis determined that for an alpha level of .05, and a moderate effect of .15, a sample size of 150 would be sufficient for an effect size of .99. The total sample is comprised of data collected at two different sites in Atlanta, GA.

Archival Data

A portion of the sample (N=89) was drawn from a larger study on domestic violence and suicidal behavior (The Grady Nia Project), which is housed in a large urban public hospital. The Principal Investigator (PI) of The Grady Nia Project, Dr. Nadine Kaslow, granted permission for the use of this data in the current study.

This subset of data, from the larger Nia Project database, explored suicide in African American women who presented at a large urban southeastern hospital for medical or mental health treatment. For inclusion in the study, participants had to be: female, self identify as African American, between 18 and 65 years old, and have made a suicide attempt within the last twelve months. Recruitment of women for the study occurred in various areas of the hospital, including the waiting rooms for the following services: hospital Emergency room, medical and psychiatric Emergency rooms, Ob/Gyn, and some respondents were direct referrals. Graduate and undergraduate students conducted the initial screens for the participants. Recruiters first read questions from an initial screening form to the women in order to see if they qualified for the study (i.e., a suicide attempt within the past 12 months, prior to being recruited) and to obtain

their agreement to participate in the longer interview. Following the screening, the women who met the study's criteria were then given more information, provided their contact information to researchers and were scheduled to come in for a longer interview and consenting process, or in some cases, the interview was conducted right then. This data collection occurred at four different time periods (baseline, 10 weeks, 6 months and 12 months). The present study only utilizes the baseline data. Participants received a myriad of questionnaires assessing various life domains including, overall mental health, family and social support, quality of life, racial identity, suicidality, coping, depression, SBW attitudes, use of and access to medical care. The present study utilizes results from the measures relevant to the variables, i.e. racial identity, SBW attitudes, coping, depressive symptoms, suicidality and hopelessness as described in the measures section below. This first portion of data collection occurred from October 2002 thru October 2006.

Participants

Demographic Information. Participants were asked to report their race/ethnicity (e.g. Black Hispanic, African American, Caribbean American or Biracial), place and date of birth, age, income level, education level, whether or not they were heads of their households, number of children, relationship status and employment status.

The researcher recruited the remainder of the participants (N = 102) from a smaller community organization which offers various health services to women and their families. For inclusion in the study, participants had to be: female, self identify as Black or African American, and between the ages of 18 and 65. The Center for Black Women's Wellness (CBWW) has a mission of empowering Black women through various health and skill based initiatives. The Center provides a variety of services geared specifically towards women of African descent,

including mental health screenings and referrals, preventative health services, maternal and child health services and training for self employment. Although the income levels varied, this site resides in a low income community.

The combined sample was primarily African American (92%) and single (52.9%). The mean age was 40.84 and the majority of respondents reported a household income of \$10,000 or below in the previous year (51.1%). Some demographic differences existed between the two samples. Overall, the CBWW sample was more educated, earned higher incomes and had fewer children than the Nia sample. Additionally, the majority of participants from the CBWW were employed (66.3%) versus the Nia women (12.4%) (See Table 1).

Table 1

Percentages and demographics for the Nia and CBWW samples

Variable	Percentage of Nia Sample (N = 89)	Percentage of CBWW Sample (N= 102)
Self Identify as African American or Black		
African American	95.5	98.0
Other	4.5	2.0
Marital Status		
Single/never married	38.2	66.0
Partner/not cohabitating	9.0	0
Partner/cohabitating	12.4	3.0
Married	4.5	21.0
Divorced	16.9	2.0
Separated	12.4	5.0
Widowed	5.6	3.0
Children		
Yes	78.7	73.0
No	19.1	27.0
Number of Children		
0-2	45.9	72.0
3-5	51.4	26.0
6-8	2.8	2.0
Yearly Household Income last year		
\$10,000 or below	52.7	38.8
\$10,000-19,999	16.3	25.5
\$20,000 – 29,999	11.2	13.3
\$30,000 – 39,999	0.0	7.1
\$40,000- 49,999	0.0	6.1
\$50,000 – 59,999	0.0	3.1
\$60,000+	0.0	6.1
Not reported	21.3	0.0
Education Level		
<12 th grade	40.4	13.4
12 th /High School graduate	27.0	28.9
GED	5.6	0.0
Some college/technical school	19.1	14.4
Technical school graduate	2.2	28.9
Bachelor's degree/college graduate	5.6	8.2
Graduate school	0.0	6.2
Employed		
Yes	12.4	66.3
No	87.6	33.7

Procedure

Site Collaboration. The Principal Investigator (PI) met and collaborated with members from the Center for Black Women's Wellness (CBWW) to explain the purpose and scope of the research and to solicit their assistance in referring potential participants to the study. The researcher also provided regular updates to members at the site in order to inform them of the study's progress. Additionally, the researcher, in collaboration with the director of CBWW developed a plan for dissemination of study findings and implications, in which the researcher will return to the agency to present these findings to staff and community members.

Training. Once the measures were finalized, a graduate research assistant from the psychology department, who possessed a current CITI certification for ethical research with human subjects, met with the PI to familiarize herself with the scope and purpose of the study, the instruments, and scoring procedures. The training included reviewing guidelines for recruiting study participants as well as administration procedures. The PI also provided her with a sample of the instruments with which to familiarize herself as well as written guidelines for data collection.

Additionally, the research assistant received training on data storage. As such, specific procedures were outlined for the handling of confidential information, including ensuring that surveys were transported and kept securely. The research assistant also accompanied the PI on a site visit to familiarize herself with the site and to meet the staff at the community organization.

Recruitment. The researcher recruited participants from fliers posted in the waiting room that contained the PI's contact information and through referrals from onsite workers. The researcher and research assistant also approached women in the waiting room of the

organization. Prior to the consent process, the researcher or research assistant gave an overview of the purpose and scope of the study. Women who agreed to participate underwent a thorough consenting process in which they were given the consent form to read while the researcher verbally reviewed the consent. As recommended by Cone and Foster (2006), participants were also offered the opportunity to indicate whether or not they would like a summary of the study's findings. They were able to indicate this to the researcher, as well as provide a mailing address on a separate index card.

The consent process and survey occurred either in a private area of the waiting room or in a separate private meeting room within the Center. Once the women agreed to participate, they completed the questionnaires onsite. Women completed the questionnaires either alone or in small groups. The PI offered the women two options: reading and completing the questionnaires on their own or having the researcher read the questionnaires to them. The majority of the women completed the questionnaires on their own. Questionnaires were distributed in a counterbalanced way across participants, although demographic information was obtained first from all participants. Questionnaires took approximately 20 to 45 minutes to complete. Participants received compensation for their participation in the study with a gift card of equal value to either a grocery store or discount retailer (i.e. Target).

Women, who completed the questionnaires, also received information about therapeutic referrals, in case they had interest in pursuing psychological care. The researcher debriefed all of the women following the surveys to solicit their feedback on the process and to explain the referral list to them. In the case of a woman who may have expressed some suicidality or exhibited some distress, the PI spoke with her privately and conducted a thorough suicide assessment. A licensed clinical psychologist was also on call in the case of an emergency.

Researchers provided women who could not complete the questionnaires due to having to leave for their appointments, with an envelope labeled “confidential” in which to place their completed questionnaires. They were instructed to leave the sealed envelope at the front desk for later pickup by the PI. Women who declined to participate were informed that their declining would not affect their ability to receive services at the organization in any way and were also provided with a list of referrals, if they desired one.

Measures

Coping. The study utilizes a modified version of the Strong Black Woman Attitudes Scale (SBWAS) (Thompson, 2003) as a measure of a culturally relevant and gender specific coping style for African American women. The original SBWAS was a 30-item self-report scale that assessed the extent to which women endorse this particular coping style. However, the present study used Thompson’s modified scale pursuant to her exploratory and confirmatory factor analyses (Thompson, 2003), which includes two additional items on the Self Reliance subscale. Additionally, she found that 11 items did not have adequate factor loadings. As such, this version of the scale is comprised of those 19 items with adequate loadings. Responses are on a 4-point Likert scale, ranging from 1 (Never) to 5 (Almost always). Higher scores indicate greater identification with this coping style. Items include statements such as “It pleases me when others give me feedback that they see me as strong,” and “People think I am strong.” Factor analysis has revealed three subscales: affect regulation, caretaking and self reliance (Hamin, 2008 & Thompson, 2003). Total scores can be obtained for the entire scale or for the subscales. Thompson found adequate internal consistency for the scale, as measured by Cronbach’s alphas: $\alpha = .74$, for the total scale and the three subscales were caretaking (.66), affect regulation (.72), and self reliance (.60). The current study also found adequate internal

consistency: $\alpha = .80$ for the total scale, and the three subscales of caretaking (.64), affect regulation (.78) and self reliance (.82)

The Ways of Coping Questionnaire (WCQ) (Folkman & Lazarus, 1986) was utilized in this study as a traditional measure of coping styles. The original WCQ is a 66- item scale based on Lazarus' transactional model of stress, which defines a stressful event as one that is subjectively perceived as potentially harmful to one's psychological well-being (Vitaliano, Russo, Carr, Maiuro & Becker, 1985). Total scores can be obtained for the entire scale or for the subscales. The original scale has been found to have sufficient test-retest reliability and adequate internal consistency for an African American sample (Cronbach's alphas range from .65-.80 for the subscales) (Mitchell, et al., 2006).

Researchers, however, have found psychometric difficulties with this scale, including difficulty replicating the subscales with comparable samples to the original sample (Parker, Endler, & Bagby, 1993). The current study utilizes a modified version of the scale in accordance with the results of the factor analyses performed by Parker, Endler & Bagby (1993). Thus, the modified scale utilized in this study is comprised of 37 items and has four subscales (Distancing/Avoidance, Confrontive/Seeking social support, Problem –Focused and Denial). The internal consistency for the entire scale for the current sample is $\alpha = .91$ and the Cronbach's alphas for the subscales range from .62-.82.

Racial Identity. The Multidimensional Inventory of Black Identity (MIBI) (Sellers, Rowley, Chavous, Shelton & Smith, 1997) is utilized as a measure of racial identity. The MIBI is a 51- item scale based on Sellers' Multidimensional Model of Racial Identity (MMRI). Factor analysis resulted in eight subscales- Racial Salience, Centrality, Private Regard, Public Regard

and four ideology subscales. The present study utilizes the Regard (private and public), and the Racial Centrality subscales. The Private Regard subscale assesses one's affective evaluation of his/her own ethnoracial group membership, with items such as "I am proud to be Black." Public regard assesses one's perceptions of how others view his/her ethnoracial group with items such as "In general, others respect Black people" and "Overall, Blacks are considered good by others." The Racial Centrality subscale measures the extent to which an individual identifies his/her race as being an essential or important component of his/her self and includes items such as, "Overall, being Black has very little to do with how I feel about myself." All items utilize a 7-item Likert scale ranging from "strongly disagree to strongly agree." As a measure of internal consistency, the MIBI is adequate, carrying a coefficient alpha .71, for the combined sample. However, the alphas for the centrality, private regard and public regard subscales were quite low, at .51, .40, and .41, respectively.

Depression. This study utilized the Beck Depression Inventory Second Edition (BDI-II) (Beck, Steer & Brown, 1996) as a measure of depressive symptoms in this sample. This 21- item self-report measure is a revised version of the original Beck Depression Inventory and is used to assess the presence and severity of depressive symptoms in accordance to the diagnostic guidelines set forth in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV). The revised version was an attempt to improve upon the reliability of the original scale by having it more closely resemble the diagnostic criteria for depression. Respondents were asked to rate the severity of symptoms on a scale from 0 -3, with 0 indicating the absence of a symptom, and 3 indicating the presence of severe symptomatology (i.e. "0-I feel the same about myself as ever," "3- I dislike myself").

Respondents rated these symptoms based on the most recent two-week time period, including the day on which they filled out the questionnaire. Scores on the 21-item scale were summed for a cumulative score. Scores between 0-13 are in the minimal range of symptom severity, between 14-19 are mild in severity; 20-28 are moderate in severity and 29-63 are severe. Two items assessing appetite and sleep allowed respondents to indicate either increases or decreases in these domains. The BDI-II's internal consistency has been shown to have adequate coefficient alphas of .87-.93 for samples of African American women (Mascaro, Arnette, Santana, & Kaslow, 2007). The coefficient alpha for the current sample was $\alpha = .96$.

Hopelessness. The researcher planned to use the Beck Hopelessness Scale (BHS) (Beck & Steer, 1988) as a measure of suicidality in the current study. However, despite findings in previous studies in which the internal consistency alpha coefficient was found to be adequate for African American female samples, at $\alpha = .95$ (Kaslow, Price, Wyckoff, Grall, Sherry, Young, et.al, 2004), the internal consistency alpha for this sample was exceedingly low ($\alpha = .30$). As such, the researcher dropped this scale from the analysis.

Suicidality. The Beck Scale for Suicide Ideation (BSS) (Beck & Steer, 1991) was utilized as a measure of suicidality. The BSS is a 21 item self report measure which includes 5 screening items for respondents who may not be experiencing any ideation. Respondents, who did not endorse any ideation, were directed to the last two questions which ask about past suicide attempts and wish to die during those attempts. Respondents, who positively endorsed ideation, were directed to answer the remainder of the questionnaire. Of the 21 items, only 19 items are scored and questions are designed to assess extent and severity of suicidal ideation, which has been linked to suicidal behavior. More specifically, items address frequency and severity of thoughts, reasons to either live or die or ambivalence about suicide, plans and opportunity,

expectations for follow through and preparation for an attempt. Responses range from 0 to 2, with 0 indicating least wish to die and 2 indicating the greatest desire to die. This scale carried a coefficient alpha of $\alpha = .96$ with this sample.

Data Analysis

Preliminary data analyses were conducted using descriptive statistics in order to examine the distribution and variance of scores in the sample. Data were missing at random in the dataset and the researcher utilized the Expectation Maximization algorithm (EM) estimation in order to replace missing data. According to Graham, Hofer and Mackinnon (1996) mean substitution methods utilizing the EM algorithm have been found to be among the most efficient and least biased methods for estimating variances and covariances in normal and slightly skewed data when data are missing at random. Subsequent analysis found that this method did not significantly change the mean values for the sample. Specifically, when means were compared from the dataset with the EM substitutions to the dataset without, there were no significant differences in the mean values. The data were also examined for normality and homoscedasticity. Box plots, histograms and frequency tables were utilized to inspect the data for outliers. Outliers were inspected and those that were errors in data entry were removed. Although all of the scales showed slight skew, the suicide and depression scales exhibited significantly non-normal distributions. In order to normalize the data, the researcher utilized a square root transformation on the depression and suicide variables, which created more normal distributions and reduced the impact of outliers. As such, outliers were retained in the final analysis.

In order to explore the reliability of SBW coping scale with this sample of African American women, an exploratory factor analysis was done using the combined sample. This

study utilizes the subscales from Thompson's (2003) factor analysis. This exploratory factor analysis supported the three-factor model used to test differences between traditional and cultural coping and as a moderator of depression and suicide.

Bivariate correlations using the Pearson product coefficient and regression analyses were used to explore relationships between study variables, and relationships of the variables with the separate and combined samples. Correlation tables were utilized to explore relationships and covariates between the demographic variables and the study variables. To examine the influence of depression on suicide and the influence of the SBW on depression, hierarchical regression was used and the source of the sample was entered as a covariate in the first step in order to control for differences between samples. Although some of the variables were not normally distributed, the sample size and robust nature of regression analysis allows for these deviations from normality. Additionally, the suicide and depression data were transformed using a square root transformation. In the same vein, all variables fell within acceptable limits for kurtosis and skewness. Multicollinearity diagnostics indicated that this assumption had been met as well.

This study utilized modern statistical methods (i.e. bootstrapping), which have been recommended for use with normal and non-normal distributions (Erceg-Hurn & Mirosevich, 2008). Erceg-Hurn & Mirosevich (2008) assert that classic parametric statistics often rely on assumptions of normality and homoscedasticity which are rarely met within social science research. Utilizing these methods with non-normal data can increase the risk of Type I error. The authors have also pointed out the limited amount of power often associated with such tests. Bootstrapping however, is a modern statistical method which has been utilized to get a better sense of the sampling distribution of a statistic by replicating the sampling distribution hundreds of times over. Modern statistical tests, which allow for hypothesis testing in an equivalent way to

classic parametric tests, can then be performed on the sample (Erceg-Hurn & Mirosevich, 2008, p. 591). The final hypothesis exploring the influence of the SBW construct on the relationship between depression and suicide was tested using moderation analyses with a bootstrapped sample.

Results

Preliminary data analysis

An exploratory factor analysis (EFA) was conducted in order to discover if a revised version of the original scale, developed by Thompson(2003), when used with a clinical sample, would result in the same three factor model as previously found (Thompson, 2003).

Exploratory Factor Analysis. Results from Principal Axis Factoring on the SBW scale suggested three factors. The screeplot of eigenvalues exhibited a break after the third factor. Varimax rotation with Kaiser Normalization ($KMO = .78, p < .001$) was appropriate because it was assumed that the factors were correlated with one another. The three factor solution explained a total of 47% of the variance. The three factors of affect regulation, self reliance and caretaking each explained 19.1%, 18%, and 10.2% of the variance respectively. Overall, interpretation of the factors is consistent with previous research done on the SBW construct (Thompson, 2003 and Hamin, 2008).

Descriptive Statistics for Variables of Interest

Descriptive statistics for the study variables: suicide, depression, strong black woman, racial identity and coping are provided in Table 2.

Table 2

Descriptive Statistics for depression, suicide, SBW construct, racial identity and coping

Variable	M	SD	α
BDI	3.91	2.06	.96
BSS	1.64	1.82	.96
SBW	68.22	11.49	.80
SBW Affect Regulation	27.81	7.04	.78
SBW Self Reliance	23.68	5.02	.82
SBW Caretaking	16.73	4.10	.64
MIBI	99.38	14.04	.71
MIBI Centrality	41.16	7.55	.51
MIBI Private Regard	32.79	4.30	.40
MIB Public Regard	25.43	5.52	.41
WOC	61.35	19.67	.91
WOC Distancing/Avoiding	20.51	7.19	.77
WOC Confrontive/Social Support	15.49	6.94	.82
WOC Problem Focused	17.71	6.96	.82
WOC Denial	7.65	3.38	.62

Note: N= 191 for the combined sample, however the suicide measure (BSS) only had N=186 respondents.

Hypothesis Testing

The relationships between study variables were investigated using the Pearson product-moment correlation coefficient and regression analyses. Bivariate correlation matrices were developed for each sample separately and for the combined sample.

Hypothesis one. The first hypothesis that there would be a positive association between racial identity and the SBW was partially supported. Bivariate correlations were run on the combined sample to explore the relationship between the SBW and racial identity. Racial private regard related positively to self reliance ($r = .20, p < .01$). The MIBI total score was significantly negatively related to affect regulation ($r = -.19, p < .01$) as was racial centrality, ($r = -.20, p < .01$).

Hypothesis two. The second hypothesis that traditional coping (WOC) would be negatively related to cultural coping (SBW) was not supported. The WOC total score demonstrated a positive association to the SBW total score ($r = .28, p < .01$) Additional correlations explored the relationship between traditional and cultural coping styles in the combined sample. Contradicting the hypothesis that these relationships would be negative, all of the significant relationships between the scales and subscales were positive. The WOC total score correlated positively to self reliance ($r = .36, p < .01$) and to caretaking ($r = .15, p < .05$). Among the WOC subscales, confrontive/social support seeking correlated positively with self reliance. Distance/avoidance coping styles correlated positively with the total SBW score, and all of its subscales (i.e. self reliance, affect regulation and caretaking). Problem focused coping also related positively with two aspects of cultural coping: the SBW total scale score and affect regulation. Denial correlated positively with all aspects of cultural coping with the exception of the caretaking subscale. Bivariate correlations for the combined sample are presented in Table 3.

Table 3

Correlations between depression, suicide, traditional coping styles, racial identity and SBW for the combined sample

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. BDI	1.00														
2. BSS	.71**	1.00													
3. WOC	.00	-.17*	1.00												
4. Cf/SS.	-.11	-.26**	.87**	1.00											
5. D/Av	.29**	.13	.77**	.51**	1.00										
6. P/Foc.	-.24**	-.38**	.84**	.73**	.41**	1.00									
7. Den.	.12	.06	.66**	.43**	.50**	.45**	1.00								
8. MIBI	-.40**	-.39**	.18*	.28**	-.04	.20**	.11	1.00							
9. Cent.	-.36**	-.37**	.15*	.23**	-.04	.19**	.07	.89**	1.00						
10. Pr/.R	-.36**	-.41**	.14	.23**	-.04	.18*	.06	.72**	.50**	1.00					
11. Pub/R	-.22**	-.16*	.14	.22**	-.01	.11	.13	.78**	.50**	.39**	1.00				
12. SBW	.30**	.04	.28**	.13	.39**	.16*	.22**	-.11	-.14	.00	-.10	1.00			
13. S/R	-.31**	-.48**	.36**	.32**	.16*	.46**	.19**	.10	.10	.20**	-.03	.49**	1.00		
14. A/R	.52**	.33**	.11	-.03	.34**	-.09	.19**	-.19**	-.25**	-.10	-.08	.82**	-.01	1.00	
15. C/T	.32**	.14	.15*	.03	.32**	.03	.07	-.12	-.09	-.08	-.12	.79**	.16*	.60**	1.00

Note. Intercorrelations for the combined sample of community participants and clinical participants (N= 191) are presented above. For all scales, higher scores indicate higher endorsement in the direction of the construct being assessed. BDI = Beck Depression Inventory; BSS = Beck Scale for Suicidal Ideation; WOC = Ways of Coping Checklist total score; Cf/SS = WOC Confrontation/Social Support subscale; D/Av = WOC Distancing/Avoidance subscale; P/Foc = WOC Problem focused subscale; .Den. = WOC Denial subscale MIBI = Multidimensional Inventory of Black Identity total score; Cent = Racial Centrality subscale; Pr/R= MIBI Private Regard subscale; Pub/R = MIBI Public Regard subscale; SBW= Strong Black Woman Scale total score; S/R= SBW Self Reliance subscale; A/R = SBW Affect Regulation subscale; C/T= SBW Caretaking subscale.

* $p < .05$. ** $p < .01$.

Table 4 reports study variable correlations for the Nia and CBWW samples. Within the Nia and CBWW samples, significant relationships between traditional and cultural coping were also found. In the Nia sample, the WOC total score correlated positively with the total SBW score ($r = .42, p < .01$) and all of its subscales. Confrontive/social support and problem focused coping was positively related to the SBW total score and the self reliance subscale. The denial and distancing/avoidance subscales were positively related to the total SBW score and all of the SBW subscales (self reliance, affect regulation and caretaking).

In the CBWW sample the WOC total score demonstrated a positive relationship to the SBW self reliance subscale ($r = .23, p < .01$). Additional significant relationships were found between the WOC subscales and the SBW scale. The confrontive/social support coping style related positively to self reliance. Distancing/avoidance positively related to the SBW total score, and caretaking. Problem focused coping showed a positive relationship to the self reliance aspect of cultural coping.

Table 4

Correlations between depression, suicide, traditional coping styles, racial identity and SBW for the CBWW and Nia samples

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. BDI	----	.66**	-.05	-.06	.02	-.11	.02	-.21*	-.22*	-.18	-.09	.00	-.13	.22*	-.14
2. BSS	.35**	----	-.17	-.19	-.06	-.27*	.07	-.20	-.21*	-.17	-.08	-.17	-.29**	.12	-.28**
3. WOC	.17	-.18	----	.87**	.80**	.88**	.60**	.29**	.26*	.15	.27*	.17	.23*	.04	.13
4. Cf/SS	.05	-.25*	.87**	----	.54**	.75**	.35**	.30**	.22*	.21*	.30**	.11	.21*	-.02	.06
5. D/Av	.35**	-.04	.83**	.60**	----	.52**	.44**	.18	.19	.09	.13	.26*	.16	.18	.25*
6. P/Foc.	-.06	-.29**	.83**	.70**	.50**	----	.44*	.21	.21	.06	.21	.12	.25*	-.06	.12
7. Den.	.24*	.04	.73**	.54**	.55**	.51**	----	.25*	.23*	.11	.24*	.01	.03	.07	-.12
8. MIBI	-.29**	-.25*	.03	.18	-.08	.02	.00	----	.85**	.75**	.77**	.03	-.04	-.02	.15
9. Cent	-.21*	-.19	.02	.16	-.09	.02	-.30	.89**	----	.46**	.46**	-.03	-.09	-.12	.22*
10. Pr/R	-.23*	-.35**	.08	.15	-.01	.11	.02	.63**	.41**	----	.40**	.09	.04	.05	.12
11. Pub/R	-.27**	-.14	.00	.12	-.06	-.05	.03	.80**	.50**	.41**	----	.02	-.01	.05	-.00
12. SBW	.37**	-.17	.42**	.24*	.43**	.33**	.39**	-.10	-.10	.10	-.15	----	.66**	.75**	.78**
13. S/R	-.08	-.36**	.50**	.35**	.36**	.55**	.39**	-.01	.01	.10	-.17	.64**	----	.10	.39**
14. A/R	.49**	-.01	.26**	.10	.35**	.12	.30**	-.08	-.13	.10	-.08	.87**	.27**	----	.45**
15. C/T	.34**	-.08	.25**	.15	.27**	.19	.20*	-.10	-.08	.01	-.13	.78**	.34**	.57**	----

Note. Intercorrelations for community participants, CBWW (N=102) are presented above the diagonal, and intercorrelations for the clinical participants, Nia (N= 89) are presented below the diagonal. For all scales, higher scores indicate higher endorsement in the direction of the construct being assessed. BDI = Beck Depression Inventory; BSS = Beck Scale for Suicidal Ideation; WOC = Ways of Coping Checklist total score; Cf/SS = WOC Confrontation/ Social Support subscale; D/Av = WOC Distancing/Avoidance subscale; P/Foc = WOC Problem focused subscale; Den. = WOC Denial subscale MIBI = Multidimensional Inventory of Black Identity total score; Cent = Racial Centrality subscale; Pr/R= MIBI Private Regard subscale; Pub/R = MIBI Public Regard subscale; SBW= Strong Black Woman Scale total score; S/R= SBW Self Reliance subscale; A/R = SBW Affect Regulation subscale; C/T= SBW Caretaking subscale.

* $p < .05$. ** $p < .01$.

Hypotheses three. The third hypothesis that depression was related to suicide in this sample was supported. When entered into the bivariate correlation analyses, depression and suicide demonstrated a significant positive relationship ($r = .71, p < .01$). As such, a hierarchical regression analysis was run using depression as the predictor variable and suicide as the dependent variable to explore the nature of the predictive relationship between depression and suicide in this sample. The combined sample variables, which were found to have significant relationships with study variables in the correlation analysis, were entered into the regression along with study variables. The source of the sample (i.e. Nia and CBWW) along with demographic variables including, number of children, education level and employment status were entered into the first step of the analyses. After controlling for demographic variables and source of the sample, depression was entered into the second step of the regression analyses. Depression significantly predicted suicide in the combined sample, ($F(1, 153) = 55.20, p < .001$), $\Delta R = .12$. Specifically, increased levels of depression predicted increased levels of suicide. Overall, the complete regression model accounted for 64% of the variance. (See Table 5)

Table 5

Hierarchical regression predicting suicide from depression for the combined sample

Predictor	Step 1			Step 2		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Source	-2.15	.26	-.59***	-1.40	.25	-.39***
Number of Children	-.03	.07	-.03	-.01	.06	-.01
Education	-.15	.06	-.15*	-.10	.05	-.10
Employment	-.46	.25	-.12	-.22	.22	-.06
BDI				.38	.05	.43***
R ²		.52			.64	
F for change in R ²		42.39***			51.19***	

Note. N = 191. Source refers to controlling for differences between the Nia and CBWW samples. Confidence interval was set at 95%.

* $p < .05$. *** $p < .001$.

Hypothesis four. The fourth hypothesis that the SBW cultural coping construct was related to depression in this sample was supported. When entered into the bivariate correlation analysis, depression and the SBW total score demonstrated a significant positive relationship ($r = .30, p < .01$). As such, hierarchical regression analysis was run with the SBW total score as the predictor variable and depression as the dependent variable to further explore the nature of the predictive relationship between cultural coping and depression in this sample. The combined sample variables, which were found to have significant relationships with study variables in the correlation analysis, were entered into the regression along with study variables. The source of

the sample (i.e. Nia and CBWW) along with demographic variables including, number of children, education level and employment status were entered into the first step of the analysis. Traditional coping was added into the second step of the regression analysis following the covariates in the first step. When the total SBW score was entered into the last step of the analysis, it significantly predicted depression in this sample, ($F(1, 146) = 12.30, p < .001$), $\Delta R^2 = .02$. Specifically, increased endorsement of the SBW cultural coping style, when controlling for traditional coping, predicted slightly increased levels of depression. The overall model accounted for 43% of the variance. (See Table 6).

Table 6

Hierarchical regression predicting depression from the Strong Black Woman measure

Predictor	Step 1			Step 2			Step 3		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Source	-	.34	-	-	.34	-	-	.34	-
	1.91		.46***	1.55		.38***	1.45		.35***
Number of Children	-.07	.09	-.05	-.04	.09	-.03	-.05	.09	-.03
Education	-.11	.08	-.10	-.08	.08	-.07	-.10	.08	-.09
Employment	-.65	.34	-.16	-.50	.33	-.12	-.50	.32	-.12
WOC Total				-.02	.03	-.18	-.01	.03	-.14
D/A				.08	.04	.31*	.07	.04	.24
P/F				-.03	.05	-.12	-.04	.05	-.14
Denial				.10	.06	.16	.09	.06	.14
SBW Total							.03	.01	.16*
R ²		.35			.41			.43	
F for change in R ²		20.01***			4.03**			5.21*	

Note. *N* = 191. WOC Total = Ways of Coping total score. D/A = Distance/Avoidance coping subscale on Ways of Coping Scale. P/F = Problem Focused coping subscale on Ways of Coping Scale. Denial = Denial coping subscale on Ways of Coping Scale. SBW Total = Strong Black Woman Scale total score. Confidence Interval = 95%

p* < .05. *p* < .01. *** *p* < .001.

Further analysis of the SBW subscales, demonstrated that affect regulation showed a significant relationship to depression in the sample. When entered into the last step of the regression, after the traditional coping variables in the second step, and covariates in the first

step, affect regulation significantly predicted depression ($F(1,146) = 15.36, p < .001$), $\Delta R = .08$. Specifically, increased levels of affect regulation predicted increased levels of depression. The overall model predicted 49% of the variance (See Table 7).

Table 7

Hierarchical regression predicting depression from the Affect Regulation subscale of the SBW measure

Predictor	Step 1			Step 2			Step 3		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Source	-		-	-		-	-		-
	1.91	.34	.46***	1.55	.34	.38***	1.27	.33	.31***
Number of Children	-.07	.09	-.05	-.04	.09	-.03	-.05	.09	-.04
Education	-.11	.08	-.10	-.08	.08	-.07	-.09	.08	-.08
Employment	-.65	.34	-.16	-.50	.33	-.12	-.34	.31	-.08
WOC Total				-.02	.03	-.18	-.01	.03	-.08
D/A				.08	.04	.31*	.05	.04	.19
P/F				-.03	.05	-.12	-.03	.05	-.11
Denial				.10	.06	.16	.06	.06	.09
Affect Reg.							.09	.02	.32***
R^2		.35			.41			.49	
F for change in R^2		20.01***			4.03**			21.46***	

Note. $N = 191$. WOC Total = Ways of Coping total score. D/A = Distance/Avoidance coping subscale on Ways of Coping Scale. P/F = Problem Focused coping subscale on Ways of Coping Scale. Denial = Denial coping subscale on Ways of Coping Scale. Affect Regulation = Affect Regulation subscale on Strong Black Woman Scale.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Hypothesis five. The hypothesis that the SBW scale moderates the relationship between depression and suicide by strengthening this relationship was supported.

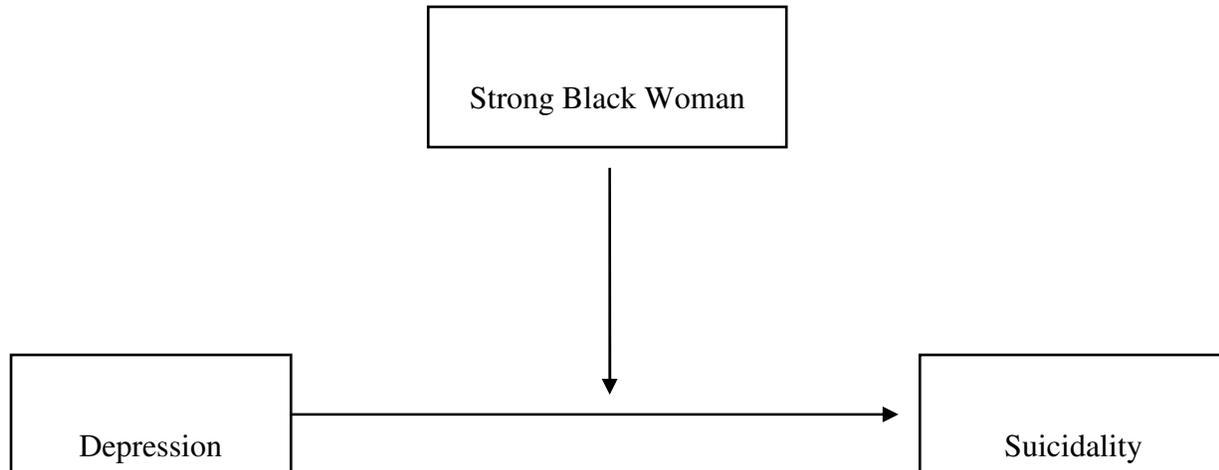


Figure 1. Moderation Model

Hierarchical regression analyses were used to test the moderation hypothesis. Moderation analyses were conducted using the SBW total score and its subscales (i.e. affect regulation, self reliance and caretaking) to explore the influence of cultural coping on the relationship between depression and suicide in this sample. Significant relationships were further probed to discover the exact values at which the interactions became significant, utilizing the *pick a point approach* as delineated by Hayes & Matthes (2009). This approach estimates the effect of the focal predictor at three different levels of the moderator (low, moderate and high). *Low* is defined as one SD below the mean, *moderate* is the sample mean and *high* is defined as one SD above the sample mean.

Results of the moderation analysis with the SBW total score demonstrated that women who endorsed higher levels of cultural coping and depression also reported higher suicidality (F

(7, 144) = 39.64, $p < .001$). The source of the sample (Nia and CBWW) was entered first into the regression along with the demographic variables including number of children, education level and employment status. Depression was entered into the second step of the analysis. The SBW total score was entered into the third step before the interaction term and significantly predicted suicide in this sample. Both depression and the SBW total score were entered into the last step of the analysis (See Table 8).

Table 8

Moderating influence of the SBW total score on depression and suicide

Variable	Coefficient (b)	SE	t	p
Constant	6.29	1.15	5.45	.00**
Source	-1.32	.25	-5.34	.00**
No. of children	.00	.06	-.01	.99
Education	-.08	.05	-1.41	.16
Employment	-.24	.23	1.06	.29
Depression (D)	-.02	.22	-.07	.94
SBWS total (S)	-.06	.02	-3.79	.00**
D x S	.01	.00	2.08	.04*

Note. $R^2 = .66$, $\Delta R^2 = .01$, $F(7, 144) = 39.64$ $p < .05$. Source refers to the Nia and CBWW samples.

Utilizing the pick a point approach, the significant interaction was probed to explore the strength of the relationship between depression and suicide at three levels (low, moderate, and high) of the moderator, the SBW total score (See Table 9).

Table 9

Conditional effect of Depression at Low, moderate and high Values of the SBW scale

SBWS Total	Coefficient (b)	SE	T	<i>p</i>	95% CI	
					LL	UL
56.61	.38	.06	6.29	.00	[0.26, 0.50]	
68.32	.46	.06	8.26	.00	[0.35, 0.57]	
80.03	.56	.08	7.20	.00	[0.40, .70]	

Note. CI = confidence interval: LL = Lower limit; UL = upper limit.

Of the SBW subscales, affect regulation demonstrated the sole significant moderation ($F(7, 144) = 38.69, p < .001$). Women who endorsed higher levels of affect regulation, and depression also reported higher suicidality. Depression was entered into the second step of the analysis following the covariates in the first step. The affect regulation subscale score was entered into the third step before the interaction term and significantly predicted suicidality. Both depression and affect regulation were entered into the last step (see Table 10).

Table 10

Moderating influence of the Affect Regulation subscale on depression and suicide

Variable	Coefficient (b)	SE	t	p
Constant	5.24	.86	6.10	.00**
Source	-1.27	.25	-5.08	.00**
No. of children	.00	.06	.02	.99
Education	-.10	.05	-1.81	.07
Employment	-.34	.23	-1.47	.14
Depression (D)	-.11	.17	-.64	.52
A/R	-.12	.03	-4.23	.00**
D X A/R	.02	.01	3.53	.00**

Note. A/R = Affect Regulation subscale from the SBWS measure. $R^2 = .65$, $\Delta R^2 = .03$, $F(7, 144) = 38.69$. Source refers to the Nia and CBWW samples.

Utilizing the pick a point approach, the significant interaction was probed to explore the strength of the relationship between depression and suicide at three levels (low, moderate, and high) of the moderator, affect regulation (See Table 11).

Table 11

Conditional effect of depression at low, moderate and high values of the Affect Regulation subscale

Affect Regulation	Coefficient (b)	SE	t	p	95% CI	
					LL	UL
21.06	.34	.07	5.14	.00	[0.21, 0.47]	
28.12	.48	.06	8.07	.00	[0.37, 0.60]	
35.18	.63	.08	7.87	.00	[0.47, .80]	

Note. CI = confidence interval; LL = Lower limit; UL = upper limit.

Discussion

The strong black woman paradigm carries with it particular connotations and consequences for African American women. Constructed within the context of historical and present day oppression, “strength” has come to exemplify not only a marker of Black womanhood, but also a mechanism by which Black women learn to navigate stressful life circumstances. Although this coping mechanism has beneficial aspects, including characterizing one of the few positive stereotypes of African American women, it also comes with serious implications for the women embodying this coping style.

This study sought to explore the moderating influence of the cultural notion of “strength” on the relationship between depression and suicide for African American women. Results indicated mixed support for the five hypotheses. The central hypothesis that “strength” would reinforce the relationship between depression and suicide was supported. Specifically, the total SBW score moderated this relationship in addition to affect regulation (the tendency to mask

negative emotions), such that women who endorsed utilizing the “strength” paradigm as it has been defined in this study (i.e. self reliance, affect regulation and caretaking) or who endorsed utilizing the affect regulation aspect of cultural coping, also endorsed high levels of depression and suicidality. Results partially supported the first hypothesis that racial identity and cultural coping were positively associated particularly through the private regard and centrality subscales. Women who endorsed high levels of private regard were more likely to believe that they could only rely on themselves, i.e. self reliance. However, women whose racial identity was central to their overall identities were less likely to mask negative emotions, yet within the community sample, these women were more likely to engage in caretaking behaviors.

Results did not support the second hypothesis that traditional and cultural coping would show a negative relationship to each other. All of the significant relationships between the traditional and cultural coping measures were positive including relationships between the total scale scores and scores on the subscales. Although the Ways of Coping Questionnaire has been utilized as a valid and reliable measure of coping, psychometric difficulties with the scale, particularly in replicating the subscales (Parker, Endler, & Bagby, 1993) call into question the reliability of this scale with various populations. Perhaps a culturally based coping measure such as the SBW scale could capture specific cultural and gender relevant coping styles of African American women more accurately than a scale that was not normed on this population. Results supported the third hypothesis that depression is positively associated with suicide in this sample. This finding replicates existent literature which has explored this relationship in samples of African American women (Compton, Thompson & Kaslow, 2005; Kaslow, Jacobs, Young and Cook, 2006; Kaslow, et al., 2000; Thompson, Short, Kaslow & Wyckoff, 2002).

Results also supported the fourth hypothesis that the SBW would be positively related to depression in this sample. Sample differences were of particular note. Within the community sample, women who endorsed utilizing affect regulation specifically were also more likely to endorse depressive symptoms. However, within the clinical sample, depression showed positive relationships to the overall scale score, affect regulation and caretaking. As such women within this sample who endorsed depressive symptoms were also more likely to utilize the overall strength paradigm, deny distressing emotions and over-function in their interpersonal relationships.

Important demographic differences may come into play here. In addition to having a recorded history of psychological distress, the clinical sample was also less educated, earned less money, had higher unemployment and had more children than the community sample. Perhaps these women, who may have less access to resources, and also more need for resources have to employ more of their coping mechanisms than those women who may have more external sources of support. Given these women also, on average have more children than their counterparts in the community sample, they may also have more caretaking responsibilities and thus more opportunities for those interpersonal relationships to become stressful. Greater caretaking responsibilities, less access to resources, a history of psychological distress and more stressful life circumstances could speak to the apparent differences between the samples with regards to depression and “strength” as a coping mechanism. Additionally, both the overall scale score and the affect regulation subscale predicted depression in the combined sample. These results support the notion that “strength” as a coping mechanism can have detrimental psychological effects on the women who use this paradigm, regardless of demographic

differences of income, employment status, education level, psychological history or family composition.

Traditional vs. Cultural Coping for African American women

Much of the literature that explores coping and psychological distress in African American women does not utilize a cultural and gendered lens. Specifically, these studies do not utilize culturally consistent measures of coping. This study has suggested that viewing coping and experiences of psychological distress through a cultural and gendered lens forms an essential piece of conceptualizing and approaching these phenomena for African American women. The positive associations found between the traditional coping and cultural coping measures and their subscales suggest that “strength” can be at least partially understood as one way that African American women handle life stressors as suggested by previous authors (Beauboeuf-Lafontant, 2009, Thompson, 2003, Romero, 2000). Additionally, the low to moderate strength of these relationships suggests that while both measures may tap into coping for African American women, they may be tapping into different aspects of coping. It appears that African American women in this sample utilize both traditional and cultural coping techniques.

An alternate explanation is that African American women utilize coping mechanisms that have been previously seen in a decontextualized way. However, through the use of cultural coping measures, more relevant understandings may be gleaned. For example, the caretaking aspect of cultural coping was positively associated with the confrontive/social support seeking subscale of traditional coping. African American women’s apparent efforts to garner social support in stressful times, if viewed through a cultural lens, could be seen as their engaging in caretaking behaviors, which implies relationships in which they function primarily as caregivers

rather than receivers. Thus, these relationships, previously seen as protective against psychological symptoms could be reframed as potential areas of distress. Consequently, the women's functioning in these relationships could also be seen as their attempt to maintain a façade of competency and emotional control by taking care of others, rather than taking care of themselves when they may need it the most, thus perpetuating self neglect. Additionally, denial was positively associated with affect regulation. Although traditional coping measures may be able to capture the reality that a woman may choose to ignore her distress, they may not tap into the performance of "strength," which includes, but does not solely consist of the denial of negative affect. Furthermore, the nuances of this uniquely culturally sanctioned type of "denial" remain obscured or misunderstood.

Racial Identity, cultural coping and psychological outcomes

This study explored the relationship between "strength" and racial identity as strength represents both a gendered and racial ideal in the African American community. Specifically, this study asserts that "strength" for African American women represents a culturally acceptable way of handling life stressors that has been a part of the racial socialization of these women. For black women, strength has been related to their gender and their race, such that Black women who do not embody the particular notions of strength, as they have been identified are deemed "not black" or "white" (Beauboeuf-Lafontant, 2009). Such an accusation reflects the interrelationship between race, gender and strength for these women. In other words, strong black women learn that women in general may or may not be strong, but if you are Black and you are a woman, you must be strong. Those Black women who do not fit this notion find themselves cast out of their race, not their gender category.

According to Beauboeuf-Lafontant (2009), the authenticity provided by the “strength” notion is further transformed into an essential identifying marker of Black womanhood. This marker reflects the apparent acceptance within and outside of the black community, that to be a Black woman, means to be a person who has endured and even embraced struggle. Those Black women, therefore who have not endured struggle, may not be seen as authentically Black, and it is the struggle and the endurance of struggle that becomes the distinguishing factor between Black women and women of other races.

Consistent with the findings of Hamin (2008) and with others’ theories about “strength” as a cultural and gendered embodiment of social norms in the African American community (Romero, 2000 & Beauboeuf-Lafontant, 2009), racial identity and the SBW measure were related in this study. Significant associations between the subscales of the SBW measure and the MIBI indicated both positive and negative relationships, particularly through the centrality and private regard subscales. Recent research has explored the relationship of racial private regard and racial centrality to psychological health for African American women. Settles, Navarrete, Pagano, Abdou, et al. (2010) in their quantitative study of racial identity and depression in African American women found that high private regard was associated with lower levels of depression through self-esteem. Although researchers found a significant interaction between private regard and centrality on depression, they did not find significant interactions between the regard subscales and depression. The current study could further illuminate the work this study has begun by adding a culturally relevant gender component. Perhaps, assessing the racial aspect of Black women’s lives, separate from the gendered aspect, leaves out important information about these women's experience of depression. This research however, establishes an important

link between racial identity and depression further supporting the necessity of viewing depression in black women at least partially, through a racial lens.

Strength, depression, and suicide

“Strength” has been constructed for black women as a blueprint for how they should behave and what they should concern themselves with rather than pertaining to how they actually feel or what they experience. Black women learn “strength,” from the women role models in their lives and they learn to appear “strong” even when they do not feel that way. In addition to learning to over function, (self-reliance), to prioritize the needs of others over their own (caretaking), they also learn to hide their negative or “weak” emotions from the world, and also themselves. Beauboeuf-Lafontant (2009), in her investigation of the strong black woman construct, references a story of the reframing of a difficult emotional experience for a young Black girl, in which she declares her fear of attending kindergarten for the first time and is told by her mother, that in fact she does not feel fear. Such minimization not only encourages the silencing of these kinds of emotions, but also the denial of and detachment from one’s internal emotional life. Thus, women find themselves restricted to expressing particular, “acceptable” emotions while simultaneously denying or minimizing their own distress. Results from this study suggest that this experience of restricted emotional expression and detachment from internal emotional life (affect regulation) actually increases the experience of emotional distress for these women, i.e. depression, even to the point of increasing their likelihood of suicidality.

Unlike prevailing notions of mental illness, Black women may not recognize depression as being pursuant to or rooted in genetic predisposition or chemical imbalance, rather they may see depression as linked to a variety of causes. Depression has been described as “taking a break,” implying that it is only in this state of distress or brokenness that Black women are allowed space

to care for themselves. Consistent with the hiding or disguising of negative or vulnerable emotions, Black women do not easily discuss depression nor admit to depressive feelings. Symptoms that may meet DSM criteria for clinical diagnoses may be considered “problems” or “issues” for Black women rather than signals necessitating external intervention. As there are few safe spaces for Black women to discuss these “problems” or “issues,” many suffer silently, thereby decreasing the likelihood that they will seek or receive help and increasing the likelihood that they will be in a severe state if/when they are able to acquire the help they need. Additionally, if depression or “breaking down” has become normalized for strong black women, and there is no alternative construction of Black womanhood, they may find themselves stuck in a cultural paradigm that takes their mental health for granted, normalizes serious emotional distress and does not provide the space for the adequate healing from or prevention of such distress. Romero (2000) and Beaubouef-Lafontant (2009) have termed this double bind, the “paradox of strength,” and have also noted its potential harmful consequences for Black women.

Conversely, according to Beaubouef-Lafontant (2009), some Black women see themselves as protected from depression because of the identifying marker of Black womanhood, struggle, which has been assumed to cultivate “strength.” Strong black women have become accustomed to struggle and therefore are more adept at coping with hardship. As such, they do not possess the same vulnerabilities to depression as their White counterparts, for example. According to this perspective then, Black women who admit to experiencing depression were not “strong enough” to “handle it.” Depression in this case, rather than being seen as an expected response to life difficulties, is seen as an exemplification of a Black woman’s essential weakness.

Additional reasons for masking negative emotions speak directly to the historical context of oppression of African American women. Shorter-Gooden (2004) found in her qualitative study

of Black women's responses to discrimination in various life areas, that Black women employ varying coping mechanisms for handling racial and gender oppression. She has coined the term "shifting" in order to broadly describe these mechanisms. The researcher highlighted a particular coping strategy which she termed "role flexing." Similar to affect regulation, this strategy involves African American women adapting their behaviors and appearance to fit in better with the dominant group. These women as such, often find themselves hiding their true feelings, particularly anger and appearing composed and controlled at all times. More than just wanting to appear professional and appropriate, this coping strategy is directly associated with a hyper vigilance about the dominant group's perceptions of these women. Two women's responses exemplify this, "I observe extra care in my approach in order to avoid negative responses [at work]," and "I am more cautious about my perception by others in the workplace." (Shorter-Gooden, 2004, p. 416).

All of the previous interpretations of the experiences of depression and negative emotions of Black women, although culturally consistent, perpetuate the use of the "masks" that many Black women have learned to wear and decrease their accessibility to treatment. They also offer little opportunity to handle emotional distress in alternative ways. Additionally, interpretations of black women's experiences of depression and suicidality that do not account for cultural messages, such as that of "strength," and affect regulation in particular are equally problematic. All serve to limit Black women's access to adequate care. If health care providers, doctors and mental health providers alike have little to no awareness of Black women's socialization to deny vulnerable feelings, to not properly identify and name them and to wear the "strength" façade in front of others, they may miss important opportunities for adequate assessment of Black women's distress. Without adequate assessment, prevalence rates remain inconsistent and the

lack of culturally relevant interventions persists. If Black women do not learn more holistic and healthier ways of approaching their emotional experiences, they may find themselves perpetuating their own psychological harm and socializing the female children around them to do the same.

Implications

The findings of this study have several implications for theory, research and application. In terms of theory, the notion of “strength” for African American women continues to evolve. Theory should take into account important demographics such as education and income levels when conceptualizing how and when African American women utilize “strength” as it has been defined. Researchers could also consider how Black women who are not native to the United States, but who live here, engage with “strength” and how this relates to their experiences of psychological distress. In terms of research, researchers have generated much of their notions about Black women and strength from qualitative studies; this study utilizes a quantitative instrument which attempts to capture this paradigm. Further revision of this scale is needed in order to refine and further validate the use of this measure with varying populations, particularly with regards to its specific subscales.

In terms of clinical or treatment implications, mental health providers may benefit from gaining an understanding of “strength” as a coping mechanism and find other ways to assess Black women’s experiences of depression and suicide. For example, rather than utilizing words like “depression,” they may ask women to describe changes in their functioning in their own words or use words like “broken down” or “tired.” Additionally, rather than looking for symptoms such as isolation and a decrease in functioning, they may look for over functioning in many areas of the women’s lives, including interpersonal relationships. Treatment implications

include helping women access the full range of their emotional lives in the context of safe and affirming spaces and allowing these women to explore their identities in relationship to their emotional experiences. As such, these women can begin to understand how “strength” has been married to their racial and gender identities and explore the ways this has served as well as harmed them. This will give them the opportunity to create a fuller, more realistic picture of themselves, their relationships and their emotional lives.

Limitations

This study has several limitations. Given that this study utilizes a newly developed measure, it may not have fully captured the construct of “strength” as researchers have defined it. For example, loadings on the caretaking subscale were somewhat low, which may speak to some difficulties with the wording of some of the statements pertaining to this aspect of strength. The researcher also used self-report measures and women, particularly in the community sample may have felt reluctant to disclose suicidality or depressive symptoms for fear of hospitalization or various other unknown consequences. As such, the researcher may not have gotten an accurate view of the community sample. Additionally, the researcher had to transform the independent variable, depression and the dependent variable, suicide. Some researchers have warned against using transformations on non-normally distributed data stating that doing so does not allow researchers to draw the most accurate conclusions about the sample, and thus limits generalizability (Erceg-Hurn & Mirosevich, 2008). As such, if this study was replicated, and analyses were run with non-transformed data, utilizing more modern statistical methods, researchers may find different and possibly more accurate results.

Future directions

The field of psychology continues to move in a more culturally competent direction. This has included the advent of research that has explored psychological implications of cultural phenomena. However, as the field pursues this course, it must broaden its definition of culture to encompass the various social identities of which human beings are comprised. In the case of historically oppressed groups such as Black women, race and gender are intimately related and influence various areas of psychological experience, including but not limited to: identity, coping, and distress. These areas all have very real consequences and implications for these women. In order to most effectively approach, assess and treat Black women, mental health providers must have an understanding of the interplay of these identities and be able to effectively educate and treat these women. They will be better equipped to do this, when psychological scholarship is better able to conceptualize, integrate and investigate gender and racial identity and their influence on the psychological life of Black women.

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Appendix A: Demographic Questionnaire

Please answer each of the following questions. If you cannot respond to one of the questions, please write N/A in the space provided.

A1. What is your birth date? _____

A2. Where were you born (city, state, country)? _____

A3. If you were not born in the U.S., how long have you lived here? _____

A4. Do you have any children (circle one) YES NO (go to A6)

A5. Please list the ages and sexes of your children: _____

A6. What is your marital/relationship status?

Single Married Divorced Separated Widowed

A7. If you are currently in college, what is your classification? (please circle, if not in college go to A8)

Freshman Sophomore Junior Senior Graduate student

A8. If you are **not** currently in college, what is the highest education degree that you have obtained?

A. None

B. High school diploma

C. Associate degree

D. Vocational degree (e .g. cosmetology school, etc.)

E. Bachelor's degree

F. Master's degree

G. Ph.D., J.D., M.D., etc.

A9. What race do you consider yourself to be? _____

A10. Think of which racial subgroup best describes you and circle the category which is closest.

- A. African American
- B. Caribbean American
- C. Biracial (with one parent of African Descent)
- D. Black Hispanic
- E. Other (specify:_____)

A11. Think of all of the income from persons who live in your home. Please circle the category (A, B, C, etc.) which is closest to your household income last year (to Jan. 1).

- A. \$10,000 or below
- B. \$10,000 to 19,999
- C. \$20,000 to 29,999
- D. \$30,000 to 39,999
- E. \$40,000 to 49,999
- F. \$50,000 to 59,999
- G. Over \$60,000

Appendix B: Ways of Coping Questionnaire

Page 1 of 2

Tell me about the most stressful situation that has happened to you in the past year. _____

Please read each item below and indicate by circling the appropriate category, to what extent you used it in the situation you have just described.

- 0 = Not Used
 1 = Used Somewhat
 2 = Used Quite a Bit
 3 = Used a Great Deal

- ___ 1. Just concentrated on what I had to do next—the next step.
 ___ 2. I tried to analyze the problem in order to understand it better.
 ___ 3. Turned to work or substitute activity to take my mind off things.
 ___ 4. I felt that time would make a difference—the only thing to do was to wait.
 ___ 5. Bargained or compromised to get something positive from the situation.
 ___ 6. I did something which I didn't think would work, but at least I was doing:
 ___ 7. Tried to get the person responsible to change his or her mind.
 ___ 8. Talked to someone to find out more about the situation.
 ___ 9. Criticized or lectured myself.
 ___ 10. Tried not to burn my bridges, but leave things open somewhat.
 ___ 11. Hoped a miracle would happen.
 ___ 12. Went along with fate; sometimes I just have bad luck.
 ___ 13. Went on as if nothing had happened.
 ___ 14. I tried to keep my feelings to myself.
 ___ 15. Looked for the silver lining, so to speak; tried to look on the bright side
 ___ 16. Slept more than usual.
 ___ 17. I expressed anger to the person(s) who caused the problem.
 ___ 18. Accepted sympathy and understanding from someone.
 ___ 19. I told myself things that helped me to feel better.
 ___ 20. I was inspired to do something creative.
 ___ 21. Tried to forget the whole thing.
 ___ 22. I got professional help.
 ___ 23. Changed or grew as a person in a good way.
 ___ 24. I waited to see what would happen before doing anything.
 ___ 25. I apologized or did something to make up.
 ___ 26. I made a plan of action and followed it.
 ___ 27. I accepted the next best thing to what I wanted.
 ___ 28. I let my feelings out somehow.
 ___ 29. Realized I brought the problem on myself.
 ___ 30. I came out of the experience better than when I went in.
 ___ 31. Talked to someone who could do something concrete about the problem.

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- ___ 32. Got away from it for a while; tried to rest or take a vacation.
- ___ 33. Tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.
- ___ 34. Took a big chance or did something very risky.
- ___ 35. I tried not to act too hastily or follow my first hunch.
- ___ 36. Found new faith.
- ___ 37. Maintained my pride and kept a stiff upper lip.
- ___ 38. Rediscovered what is important in life.
- ___ 39. Changed something so things would turn out all right.
- ___ 40. Avoided being with people in general.
- ___ 41. Didn't let it get to me; refused to think too much about it.
- ___ 42. I asked a relative or friend I respected for advice.
- ___ 43. Kept others from knowing how bad things were.
- ___ 44. Made light of the situation; refused to get too serious about it.
- ___ 45. Talked to someone about how I was feeling.
- ___ 46. Stood my ground and fought for what I wanted.
- ___ 47. Took it out on other people.
- ___ 48. Drew on my past experiences; I was in a similar situation before.
- ___ 49. I knew what had to be done, so I doubled my efforts to make things work.
- ___ 50. Refused to believe that it had happened.
- ___ 51. I made a promise to myself.
- ___ 52. Came up with a couple of different solutions to the problem.
- ___ 53. Accepted it, since nothing could be done.
- ___ 54. I tried to keep my feelings from interfering with others things too much.
- ___ 55. Wished that I could change what had happened or how I felt.
- ___ 56. I changed something about myself.
- ___ 57. I daydreamed or imagined a better time or place than the one I was in.
- ___ 58. Wished that the situation would go away or somehow be over with.
- ___ 60. I prayed.
- ___ 61. I prepared myself for the worst.
- ___ 62. I went over in my mind what I would say or do.
- ___ 63. I thought about how a person I admire would handle this situation and used that as a model.
- ___ 64. I tried to see things from the other person's point of view.
- ___ 65. I reminded myself how much worse things could be.
- ___ 66. I jogged or exercised.

Appendix C: Beck Depression Inventory

This questionnaire consists of 21 groups of statements. Please listen to each group of statements carefully, and then pick the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. If several statements in the group seem to apply equally well, choose the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 or 18.

Sadness

- 0 I do not feel sad.
- 1 I feel sad much of the time.
- 2 I am sad all of the time.
- 3 I am so sad or unhappy that I can't stand it.

Pessimism

- 0 I am not discouraged about my future.
- 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

Past Failure

- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- 2 As I look back, I see a lot of failure.
- 3 I feel I am a total failure as a person.

Loss of Pleasure

- 0 I get as much pleasure as I ever did from the things that I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- 3 I can't get any pleasure from the things I used to enjoy.

- 5. Guilty Feelings
 - 0 I don't feel particularly guilty.
 - 1 I feel guilty over many things that I have done or should have done.
 - 2 I feel quite guilty most of the time.
 - 3 I feel guilty all of the time.

6. Punishment Feelings

- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7. Self-Dislike

- 0 I feel the same about myself as ever.
- 1 I have lost confidence in myself.
- 2 I am disappointed (unhappy) with myself.
- 3 I dislike myself.

8. Self-Criticalness

- 0 I don't criticize or blame myself more than usual.
- 1 I am more critical of (find more fault with) myself than I used to be.
- 2 I criticize myself (blame) myself for all my faults.
- 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would like to kill myself if I had the chance.

10. Crying

- 0 I don't cry anymore than I used to.
- 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

11. Agitation

- 0 I am no more restless or wound up than usual.
- 1 I feel more restless or wound up than usual.
- 2 I am so restless or agitated it's hard to stay still.
- 3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

- 0 I have not lost interest in other people or activities.
- 1 I am less interested in other people or things than before.
- 2 I have lost most of my interest in other people or things.
- 3 It's hard to get interested in anything.

13. Indecisiveness

- 0 I make decisions about as well as ever.
- 1 I find it more difficult to make decisions than usual.
- 2 I have much greater difficulty in making decisions than I used to.
- 3 I have trouble making any decisions.

14. Worthlessness

- 0 I do not feel I am worthless (good-for-nothing).
- 1 I don't consider myself as worthwhile and useful as I used to.
- 2 I feel more worthless (good-for-nothing) as compared to other people.
- 3 I feel utterly worthless (totally good-for-nothing)

15. Loss of Energy

- 0 I have as much energy as ever.
- 1 I have less energy than I used to have.
- 2 I don't have enough energy to do `very much.
- 3 I don't have enough energy to do anything.

16. Changes in Sleeping Patterns

- 0 I have not experienced any change in my sleeping pattern.
- 1a I sleep somewhat more than usual.
- 1b I sleep somewhat less than usual.
- 2a I sleep a lot more than usual.
- 2b I sleep a lot less than usual.
- 3a I sleep most of the day.
- 3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

- 0 I am no more irritable (cranky) than usual.
- 1 I am more irritable (cranky) than usual.
- 2 I am much more irritable (cranky) than usual.
- 3 I am irritable (cranky) all the time.

18. Changes in Appetite

- 0 I have not experienced any change in my appetite.
- 1a My appetite is somewhat less than usual.
- 1b My appetite is somewhat greater than usual.
- 2a My appetite is much less than usual.
- 2b My appetite is much more than usual.
- 3a I have no appetite at all.
- 3b I crave (want) food all the time.

19. Concentration Difficulty

- 0 I can concentrate (pay attention) as well as ever.
- 1 I can't concentrate (pay attention) as well as usual.
- 2 It's hard to keep my mind on anything for very long.
- 3 I find I can't concentrate (pay attention) to anything.

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20. Tiredness or Fatigue

- 0 I am no more tired or fatigued than usual.
- 1 I get more tired or fatigued more easily than usual.
- 2 I am too tired or fatigued to do a lot of the things I used to do.
- 3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

- 0 I have not noticed any recent change in my interest in sex.
- 1 I am less interested in sex than I used to be.
- 2 I am much less interested in sex now.
- 3 I have lost interest in sex completely.

Appendix D: Strong Black Woman Attitudes Scale

Instructions - Using the following scale, please rate how often you think the following statements apply to you.

0 = Never
1 = Rarely
2 = Sometimes
3 = Frequently
4 = Almost always

1. ____ I believe that it is best not to rely on others.
2. ____ I feel uncomfortable asking others for help.
3. ____ I have difficulty showing my emotions.
4. ____ I do not like to let others know when I am feeling vulnerable.
5. ____ I believe that everything should be done to a high standard.
6. ____ I pride myself on my ability to take care of others.
7. ____ I am independent.
8. ____ I take on more responsibilities than I can comfortably handle.
9. ____ I feel like a failure when I do not live up to the expectations that I set for myself.
10. ____ I believe that I should be able to handle all that life gives me without any struggle.
11. ____ I am strong.
12. ____ I rely on my friends and family less than they rely on me.
13. ____ I am not as confident as I seem.
14. ____ Being in control is very important to me.
15. ____ I feel anxious when I am sad or angry.
16. ____ I have difficulty finding ways to have my needs met.
17. ____ I take on others' problems.
18. ____ I do not express myself in order to avoid making others feel uncomfortable.
19. ____ I feel that I owe a lot to my family.
20. ____ When I help others, I do not expect anything in return.
21. ____ I put others' needs first.
22. ____ People think that I don't have feelings.
23. ____ I maintain my composure.
24. ____ It pleases me when others give me feedback that they see me as strong.
25. ____ It is hard to say, "No," when people make requests of me.
26. ____ I become anxious if relationships become emotionally intimate.
27. ____ I do not like to be perceived as needy.
28. ____ I do not let most people know the "real" me.
29. ____ People think that I am strong.
30. ____ People think that I am independent.

Appendix E: Beck Scale for Suicide Ideation

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Directions: Please carefully read each group of statements below. Circle the one statement in each group that best describes how you have been feeling for the past week, including today. Be sure to read all of the statements in each group before making a choice.

Part 1

1. 0 I have a moderate (medium) to strong wish to live.
1 I have a weak wish to live.
2 I have no wish to live.
2. 0 I have no wish to die.
1 I have a weak wish to die.
2 I have a moderate (medium) to strong wish to die.
3. 0 My reasons for living outweigh my reasons for dying.
1 My reasons for living or dying are about equal.
2 My reasons for dying outweigh my reasons for living.
4. 0 I have no desire to kill myself
1 I have a weak desire to kill myself.
2 I have a moderate (medium) to strong desire to kill myself.
5. 0 I would try to save my life if I found myself in a life-threatening situation.
1 I would take a chance on life or death if I found myself in a life-threatening situation
2 I would not take the steps necessary to avoid death if I found myself in a life threatening situation.

Part 2

6. 0 I have brief periods of thinking about killing myself which pass quickly.
1 I have periods of thinking about killing myself which last for moderate (medium) amounts of time.
2 I have long periods of thinking about killing myself.
7. 0 I rarely or only occasionally think about killing myself.
1 I have frequent (often) thoughts about killing myself.
2 I continuously (all the time) think about killing myself.
8. 0 I do not accept the idea of killing myself.
1 I neither accept nor reject the idea of killing myself.
2 I accept the idea of killing myself.
9. 0 I can keep myself from committing suicide.
1 I am unsure that I can keep myself from committing suicide.
2 I cannot keep myself from committing suicide.

Subtotal Part 1 _____

If you have circled the zero statements in both Groups 4 and 5, then skip down to Group 20. If you have marked a 1 or 2 in either Group 4 or 5, then go to Group 6.

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10. 0 I would not kill myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc.
 1 I am somewhat concerned about killing myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc.
 2 I am not or only a little concerned about killing myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc.
11. 0 My reasons for wanting to commit suicide are primarily aimed at influencing other people, such as getting even with people, making people happier, making people pay attention to me, etc.
 1 My reasons for wanting to commit suicide are not only aimed at influencing other people, but also represent (are) a way of solving my problems.
 2 My reasons for wanting to commit suicide are primarily based upon escaping from my problems.
12. 0 I have no specific plan to kill myself.
 1 I have considered ways of killing myself, but have not worked out the details.
 2 I have a specific plan for killing myself.
13. 0 I do not have access to a method or an opportunity to kill myself.
 1 The method that I would use for committing suicide takes time, and I really do not have a good opportunity to use this method.
 2 I have access to/anticipate having access to the method that I would choose for killing myself and also have or shall have the opportunity to use it.
14. 0 I do not have the courage or the ability to commit suicide.
 1 I am unsure that I have the courage or the ability to commit suicide.
 2 I have the courage and the ability to commit suicide.
15. 0 I do not expect to make a suicide attempt.
 1 I am unsure that I shall make a suicide attempt.
 2 I am sure that I shall make a suicide attempt.
16. 0 I have made no preparations for committing suicide.
 1 I have made some preparations for committing suicide.
 2 I have almost finished or completed my preparations for committing suicide.
17. 0 I have not written a suicide note.
 1 I have thought about writing a suicide note or have started to write one, but have not completed it yet.
 2 I have completed a suicide note.

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18. 0 I have made no arrangements for what will happen after I have committed suicide.
 1 I have thought about making some arrangements for what will happen after I have committed suicide.
 2 I have made definite arrangements for what will happen after I have committed suicide.
19. 0 I have not hidden my desire to kill myself from people.
 1 I have held back telling people about wanting to kill myself.
 2 I have attempted to hide, conceal, or lie about wanting to commit suicide.
20. 0 I have never attempted suicide.
 1 I have attempted suicide once.
 2 I have attempted suicide two or more times.
21. 0 My wish to die during the last suicide attempt was low.
 1 My wish to die during the last suicide attempt was moderate (medium).
 2 My wish to die during the last suicide attempt was high.

Subtotal Part 1 _____**Subtotal Part 2** _____**=Total Score** _____

Appendix F: Multidimensional Inventory of Black Identity

Please rate how much you agree with the following items:

	Strongly Disagree			Neutral			Strongly Agree	
A1. Overall, being Black has very little to do with how I feel about myself.	1	2	3	4	5	6	7	
A2. I feel good about Black people.	1	2	3	4	5	6	7	
A3. Overall, Blacks are considered good by others.	1	2	3	4	5	6	7	
A4. In general, being Black is an important part of my self-image.	1	2	3	4	5	6	7	
A5. I am happy that I am Black.	1	2	3	4	5	6	7	
A6. I feel that Blacks have made major accomplishments and advances.	1	2	3	4	5	6	7	
A7. My destiny is tied to the destiny of other Black people.	1	2	3	4	5	6	7	
A8. Being Black is unimportant to my sense of what kind of person I am.	1	2	3	4	5	6	7	

A9. In general, others respect Black people.	1	2	3	4	5	6	7
A10. Most people consider Blacks, on the average, to be more ineffective than other racial groups.	1	2	3	4	5	6	7
A11. I have a strong sense of belonging to Black people.	1	2	3	4	5	6	7
A12. I often regret that I am Black.	1	2	3	4	5	6	7
A13. I have a strong attachment to other Black people.	1	2	3	4	5	6	7
A14. Being Black is an important reflection of who I am.	1	2	3	4	5	6	7
A15. Being Black is not a major factor in my social relationships.	1	2	3	4	5	6	7
A16. Blacks are not respected by the broader society.	1	2	3	4	5	6	7
A17. In general, other groups view Blacks in a positive manner.	1	2	3	4	5	6	7
A18. I am proud to be Black.	1	2	3	4	5	6	7

A19. I feel that the Black community
has made valuable contributions to
this society.

1	2	3	4	5	6	7
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A20. Society views Black people as an
asset.

1	2	3	4	5	6	7
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