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Relationship Between Self-Silencing and Self-Neglect Behaviors and Disordered Eating and Stigma Toward Seeking Behavioral Health Support Among Black Women Who Adopt the Superwoman Schema

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Self-silencing and self-neglect behaviors, key dimensions of the superwoman schema (SWS), function as protective coping mechanisms in response to psychosocial stressors. However, these behaviors often perpetuate self-sacrifice, leading to an increased risk of physical and mental health decline. The purpose of this quantitative correlational study was to examine the relationship between self-silencing and self-neglect behaviors (independent variables) and disordered eating and stigma toward seeking support from behavioral health services (dependent variables) among Black women who adopt the SWS. The theoretical and conceptual frameworks of silencing the self and intersectionality guided this study. The 78 participants who self-identified as Black and female and met the inclusion criteria of SWS endorsement were recruited through social media platforms and flyers. Data were collected using the Silencing the Self scale, the Mammy subscale of the Stereotypical Roles of Black Women scale, the Eating Behavior Pattern Questionnaire, and the short form of the Attitudes Toward Seeking Professional Psychological Help scale. The multiple linear regression analyses revealed that self-silencing and self-neglect behaviors as a product of SWS endorsement in Black women were significant predictors of disordered eating. However, self-silencing and self-neglect the behaviors as a product of SWS endorsement in Black women were not significant predictors of stigma toward seeking support from behavioral health services in Black women who endorse SWS. This study can be used for positive social change to train culturally competent behavioral health clinicians about the importance of promoting mental health wellness and addressing barriers to care among Black women.

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Dedication

This study is for my ancestors, especially my mother, Wanda Ellen Griffin Smith. You had a way of nurturing others while sacrificing yourself. May your sacrifices always be remembered by those individuals touched by your presence on a daily basis. And for my daughters, Meya and Kera, may you always remain strong but soft in your foundation even as cultural and societal expectations attempt to define your personhood.

Acknowledgments

I give God all the glory, for He has been my constant refuge.

I would be remiss not to acknowledge Dr. Patricia Loun, Dr. Amanda Rose, and Dr. Christopher Cale's dedication to promoting my growth and development while helping me complete this chapter of my professional journey. I cannot thank you enough for your time, commitment, and consistency during this process.

To my parents, thank you for fostering my love for obtaining knowledge. Since I was very young, you set the stage for me to pursue any dream that may have appeared impossible for others. Thank you for modeling consistency and tenacity despite the odds for success. I can never express enough gratitude for your love and dedication.

To my family, thank you for your sacrifices and support throughout this journey. I am overwhelmed with love for Michael, my constant companion and cheerleader. Thank you for always believing in me, pushing me through challenges, not allowing me to give up, and investing in my dreams. Meya and Kera, please know that you are my biggest inspiration because I always wanted to be a positive example for you, but to my surprise, you have been a consistent example for me. You have passed on a bounty of unconditional love, energy, and support. Christina, you have been a source of unwavering prayer and support from the beginning of this journey. Ebony, you have always brought me back to my foundation when anxiety appeared and pressed me to give up on my dreams. Finally, to all my Black sisters, thank you for your sacrifices in service to others, but it is time for you to feel and live.

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Chapter 1: Introduction to the Study

"I am so overwhelmed that I want to scream! Nevertheless, as a 'strong' person who cares for everyone, no one can see or hear my pain." This internal narrative for Black women who abide by the self-silencing and self-neglect characteristics of the superwoman schema (SWS) is a possible precursor to psychological distress. The origination of the Mammy stereotype began in slavery as the Black woman became the epitome of unbreakable strength in domestic and caretaking roles (Collins, 1990; West, 2008; as cited in Carter & Rossi, 2019). SWS demands that Black women who adopt it place others' needs above their own, exhibit strength despite personal hardship, and never verbalize emotions (Jerald et al., 2017). In turn, this strong superwoman (SW) appearance demands physical strength, emotional restraint, and silence as a means of survival (Woods-Giscombe, 2010). Moreover, Black women often use this image as a protective mechanism against intense stress from daily experiences with racial microaggressions and enduring stress due to experiences with gendered racism (A. Davis & Jones, 2021). (Essed 1991, as cited in Thomas et al., 2008) defined *gendered racism* as a form of subjugation that Black women experience that originated through a racist perception of their defined gender roles. Thomas et al. (2008) described gendered racism as a double jeopardy of racism and sexism that produces psychological distress in Black women. A 2006 study highlighted that Black women who experienced increased stress and coping levels were more susceptible to psychological distress (Brown, 2022).

I determined the need to study the survival mechanisms of self-silencing and self-neglect as instigators of disordered eating in Black women. The National Eating

Disorders Association (n.d.) acknowledged that eating disorders in Black women are a byproduct of external stressors as a result of intersectional experiences. Evidence-based research indicated that maternal communication in early childhood instigates the juxtaposition of emotional eating to binge-eating (BE) behavior and binge eating disorder (BED), which is becoming visible in Black women at the college level (Longmire-Avital & Finkelstein, 2020). Although Black women are clinically recognized as impacted by compound stress, clinicians are more than twice as likely to not refer Black women, in comparison to White women, to a higher level of treatment (National Eating Disorders Association, 2021). Statistically, 8% of Black women were active in treatment-seeking behavior for BED compared to 22% of White women (Conason, 2020). Although this is problematic, there is a deficiency in research regarding Black women and eating disorders (Conason, 2020). For example, the *International Journal of Eating Disorders* included only 38 studies with Black participants (Conason, 2020).

Although the adoption of the SWS serves as a practical means of coping with environmental stressors, it also encourages maladaptive coping mechanisms. SWS as a conceptual framework offers insight into psychological coping and the hindrance of seeking support from behavioral health services. Although prior psychological researchers used an intersectional approach, they combined the female social category as one demographic without acknowledging the effects of political systems and current protests (McCall, 2005; Nash, 2008; Warner & Shields, 2013; as cited in Warner et al., 2018). In the current study, intersectionality theory offered a framework to study the effects of stigma through an intersectional lens of race, gender, class, and sex on the

individuality of Black women. Because one characteristic of the SWS is self-silencing, the self-silencing theory was a crucial theoretical framework for understanding the link between depressive symptomology and self-silencing behavior. Jordan-Zachary (2017) found in the California Black Women's Health Project in 2003 that Black women were 60% likely to experience depressive symptomology. However, their use of mental health services was substantially lower than their White counterparts (Jordan-Zachary, 2017). I determined a need to examine self-silencing and self-neglect as behaviors of SWS adoption and the effects on disordered eating and stigma toward seeking support for those symptoms from behavioral health services in Black women.

Outcomes from the current study may promote social change by generating awareness among behavioral health specialists and empowering Black women to become more involved in their mental health. Behavioral health professionals may use the findings to advocate for culturally sensitive assessments that welcome more transparency regarding symptomology in Black women and aligned diagnostic criteria. Chapter 1 provides the background of the study and the problem statement. Also, it includes the purpose of the study, research questions and hypotheses, the theoretical and conceptual frameworks, the nature of the study, definitions, assumptions, scope and delimitations, limitations, the significance of the study, and a summary.

Background

Abrams et al. (2014) stated that Strong Black Woman (SBW) as a schema related all the cognitive and behavioral mandates in response to gender and cultural mandates. The researchers argued that the schema comprises the ability to formulate many strength

constructs, mask the effects of adverse intersectional oppression, display fulfillment as a Black woman, and exercise religious/spiritual beliefs. Superwoman Schema, Sisterella Complex, and Sojourner Truth constructs are modernized references that define the characteristics of a SBW, but there is a need for a single construct to measure and conceptualize gender and cultural role beliefs that have adverse cognitive and behavioral effects on the Black woman (Abrams et al., 2014). Furthermore, future research may emphasize the importance of isolating SBWS traits instead of incorporating the entire schema to understand the effects of the belief system that has adverse cognitive and behavioral implications (Abrams et al., 2014).

Allen et al. (2019) suggested that SBWS is a conscious or unconscious defeatist coping mechanism in response to the emotional strain from gendered racism experiences. Allen et al. contend that this expectation of self-sacrifice can lead to chronic stress, burnout, and an increased risk of adverse physical and mental health outcomes. And the pressure to always be strong may also discourage seeking support, including behavioral therapy, which is essential for maintaining mental health (Allen et al.). More importantly, it is vital to differentiate the impact of stressful experiences with oppressive social constructs (Allen et al.). Davis et al. (2018) agreed that intersectional stress lends to the internalization of psychological stress that propels the likelihood of poor physical health.

It was essential to focus on the experiences of Black women in their search for identity while negatively coping with internal and external distress. Green (2019) suggested that as a tangible coping mechanism, the SBW identity has the propensity to negatively impact Black women at the intersection of culture, gender, and race. Green

stated that Black women have the psychological propensity to mentally dissociate from copious amounts of discrimination that lends to the adoption of maladaptive eating as a coping mechanism. Green reiterated that depressive symptoms are a mediator between stress from racial discrimination and disordered eating. Talavera et al. (2019) affirmed that as Black women experience increased stress from racial discrimination, they become vulnerable to depression/anxiety. Salami et al. (2019) agreed as they found an association between race-related stress and eating pathology with depression as a mediator.

Harrington et al. (2010) noted that there has been extensive research on White women and the lack of affect regulation on BE. Goode et al. (2020) concurred that previous research focused on BEDs and treatment-seeking in White women, although Black women reported experiencing the same symptoms. Goode et al. addressed the gap in the literature with a systematic review of the effects of race and gender discrimination on BE and additional disordered eating symptoms in Black women. Goode et al. found that the onset of BEDs begins between 18 and 28.5 years of age, with the contributing factors of depression and stressors from discrimination experiences. In addition, Longmire-Avital and Finkelstein (2022) asserted that emotional eating is juxtaposed with BE and BED, especially in this age demographic, including Black women in college, because they experience racialized gender discrimination. According to Longmire-Avital and Finkelstein, BE is characterized by eating copious amounts of food as an avoidant coping style, while BED is the diagnosed mental condition resulting from BE. Maternal communication in early childhood is a primary instigator of the SW persona to endure

and protect against discrimination experiences and may be related to the basis for increased disordered eating occurrences (Longmire-Avital & Finkelstein, 2022).

Black women who adopt SWS as a coping mechanism are more critical of themselves, and their social networks either do not take their distress seriously or do not have the tools to assist them (Liao et al., 2019). Watson-Singleton (2017) suggested that the perception of the lack of emotional support influences SWS adoption and psychological distress. SWS impacts cognition and stress-coping behaviors that affect levels of depression, anxiety, and BE (Watson-Singleton, 2017).

Problem Statement

The specific research problem that was addressed in this study was the unknown extent of the relationship between self-silencing and self-neglect of Black women ages 18–75 who internalize SBWS and disordered eating and stigma toward seeking support from behavioral health services. It is comparable to the SBW role that requires independence, family and community care, hard work and high achievement, overcoming adversity, and emotional containment (Nelson et al., 2016). Regardless of SBWS consciousness levels, many Black women often question their performance's authenticity; this self-imposed pressure contributes to isolation, resentment, and psychological distress. As a result, Black women's need to manage powerful emotions as a means of counteracting racialized gender microaggressions may produce emotional suffering that lends to maladaptive coping such as self-silencing (Longmire-Avital & Finkelstein, 2022).

Recent research lacked information on the effects of self-silencing and self-neglect on disordered eating and stigma toward seeking behavioral health support in Black women who adopt SWS. There was no quantitative research on the effects of isolating self-silencing and self-neglect on disordered eating and stigma toward seeking help from behavioral health services in Black women aged 18–75 who adopt SWS. Watson and Hunter (2015) state that this population has the tendency to describe physical symptoms of headaches as opposed to symptoms of a mental health crisis that appear as uncontrollable crying and isolation.

According to the Centers for Disease Control and Prevention (2016, as cited in J. C. Hall et al., 2021), depression is the leading disability among individuals across the world. Moreover, the rate of depression among Black women is approximately 50% higher than among White women. However, only 7% of Black women seek treatment for depression compared to 20% of the population (Abrams et al., 2018, as cited in J. C. Hall et al., 2021). Additionally, Black women are often not represented in research at adequate levels because they are either not presenting with depressive symptomology or may not experience depression to the extent of seeking behavioral health services (Green, 2019). There are mixed perceptions of what constitutes strength in Black women and the importance of developing various mental health approaches to psychological distress.

There is a pervasiveness of BED over the lifetime of Black Americans at a rate of .62 - 1.48%, but with higher rate of 30% in Black women with obesity (Goode et al., 2022). Moreover, the National Alliance on Mental Illness (n.d.) claimed that although eating disorders have links to food and weight, research indicated that eating disorders

are an individual's attempt to cope with engulfing emotions and feelings by using food. Although evidence showed that Black women are more vulnerable to disordered eating as a maladaptive coping mechanism, this subject has not received sufficient attention in recent literature (Salami et al., 2019). Compared to White women, Black women have a 50% higher prevalence of BED. Nevertheless, recent research indicated that Black women report disordered eating symptoms as low as 1.5% and as high as 36% (Longmire-Avital & Finkelstein, 2021). Additionally, overeating as a form of BE is a maladaptive coping response to stress that is prevalent in overweight and obese Black women (Woods-Giscombe et al., 2021). However, the Black woman's experience with gendered racism is missing in empirical research (Thomas et al., 2008).

The perception of need before or during psychological distress is vital in seeking help from behavioral health services. According to the behavioral model of health service use, help-seeking behaviors have three influences: influencing characteristics, a prescribed narrative, and the need perception (Villatoro et al., 2017). Furthermore, recent research did not account for the effect of the intersections of race/ethnicity on stigma and the perception of the need for support from behavioral health support, presenting a gap in the literature. Villatoro et al. (2017) addressed this gap through an intersectional lens of race/identity with gender and socioeconomic status, in addition to opinions and views regarding mental health services. Villatoro et al. determined that White women traditionally understand their needs for mental health support compared to their male counterparts. However, the nontraditional roles of Black women hinder their needs perception, and they are less expressive about seeking behavioral health support. Nelson

et al. (2021) confirmed this assertion that the SWS cultural mandate may be the determinant of little research that links the SW role and the help-seeking process. However, there is some concern that adopting SWS may contribute to the necessity of strength, and seeking health-related support is in some ways the perception of being weak. Although Black women will admit to undergoing anxious and depressive symptoms, they are often biased about seeking behavioral health support (Watson & Hunter, 2015).

Purpose of the Study

The purpose of this quantitative study was to examine the extent of the relationship between self-silencing and self-neglect (independent variables) and disordered eating and stigma toward seeking support from behavioral health services (dependent variables) among Black women who adopt SWS. The focus of the study included two components of SBWS: self-silencing and self-neglect of Black women who adopt SWS and how it impacts disordered eating and stigma toward seeking behavioral health services. I was unaware of older or recent research on this topic.

Research Questions and Hypotheses

RQ1: To what extent does self-silencing as measured by the Silencing the Self Scale (STSS) and self-neglect as measured by the Mammy subscale of Stereotypical Roles of Black Women Scale (SRBWS) affect disordered eating as measured by the Eating Behavior Patterns Questionnaire (EBPQ) in Black women who adopt SWS as measured by the Giscombe-Superwoman Schema Questionnaire (G-SWS-Q)?

H_o1: Self-silencing and self-neglect behaviors are not statistically significant predictors of disordered eating in Black women who adopt SWS.

H_a1: Self-silencing and self-neglect behaviors are statistically significant predictors of disordered eating in Black women who adopt SWS.

RQ2: To what extent does self-silencing as measured by the STSS and self-neglect as measured by the Mammy subscale of the SRBWS affect stigma toward seeking help from behavioral health services as measured by Attitudes Towards Seeking Professional Psychological Help Scale (ATPPHS-SF) in Black women who adopt SWS as measured by G-SWS-Q?

H_o2: Self-silencing and self-neglect behaviors are not statistically significant predictors of stigma toward seeking help from behavioral health services in Black women who adopt SWS.

H_a2: Self-silencing and self-neglect behaviors are statistically significant predictors of stigma toward seeking help from behavioral health services in Black women who adopt SWS.

Theoretical and Conceptual Framework

Crenshaw's (1989) intersectionality theory and Jack's (1991) theory of silencing the self grounded this study. Intersectionality theory emphasizes the effects of stigma through an intersectional lens of race, gender, class, and sex as possibly instigating psychological distress in Black women. Also, this theory offered a structure for recognizing the interwoven effects of various social constructs on physical and psychological health (Fehrenbacher & Patel, 2020). The subsequent negative coping

behaviors that include self-silencing and self-neglect may influence disordered eating and stigma toward seeking help from behavioral health services.

Additionally, the theory of silencing the self suggests that women often experience depressive symptoms due to conformity in relationships with societal standards of feminine roles. The theory of self-silencing applies to Black women because internal narratives mandate strength presentation and the discretion of psychological pain (Abrams et al., 2018). There was a gap in research regarding the effects of the intersection of gender and race on specific characteristics of the SBW role adoption on psychological distress. Abrams et al. (2018) submitted that therapists become open to Black women's experiences and symptoms while creating healthy coping strategies. This theory was applicable to the current study because it provided a framework to investigate the personal experiences and outcomes of self-silencing in Black women and the effect on disordered eating and stigma toward seeking support from behavioral health services.

SWS was the conceptual framework that guided this research. The SW archetype employs restraint of emotions, autonomy, and caretaking at the expense of self (Abrams et al., 2014; Beauboeuf-Lafontant, 2009; Harris-Perry, 2011; Nelson et al., 2016; West et al., 2016; Woods-Giscombe, 2010, as cited in M. K. Jones et al., 2021). However, it was vital to understand the differing perceptions of strength and the impact cultural socialization has on disordered eating as a product of gendered and racialized stress and the impact on stigma toward seeking support from behavioral health services.

Nature of the Study

To answer the research questions in this study, I used a survey method with a correlational, nonexperimental design to examine the extent to which the independent variables, self-silencing and self-neglect, were related to the dependent variables, disordered eating and stigma toward seeking support from behavioral health services by Black women who adopt SWS. The participants were Black/African American women between the ages of 18 and 75 years who acknowledged a minimal level of SWS adoption. The following surveys were a part of the data collection for this research: G-SWS-Q, STSS, theMammy subscale of the SRBWS, the EBPQ, and the ATPPHS-SF. The correlational design was appropriate because the overarching goal was to measure the degree of the relationship between two or more variables (see Creswell, 2012, as cited in Creswell & Creswell, 2018).

Definitions

Binge-eating disorder (BED): A category of disordered eating that involves the criteria of eating more food than usual in a small amount of time (American Psychiatric Association, 2013).

Disordered eating: A mental disorder that involves life-threatening behaviors that include abstaining from food, self-provoked vomiting, or dissociated eating (Beccia et al., 2019).

Emotional eating: The proclivity to use food as a coping mechanism for negative emotions as a product of stressors (Longmire-Avital & Finkelstein, 2021).

Gendered racial identity: The term Black women use to describe their intersectional membership within Black and women social identity groups (M. K. Jones & Day, 2018).

Gendered racism: A term for the intersection of race and gender of Black women that explains the impact of socialized stress (M. K. Jones et al., 2021).

Intersectionality: A concept used to identify an individual who maintains membership in multiple subordinate groups while experiencing interlacing oppressions (Warner et al., 2018).

Microaggressions: Verbal and nonverbal messages that can be overt or covert and lend to the devaluing messages to individuals of minority status (Corbin et al., 2018).

Schema: A psychological process of coding based on experience that affects an individual's perception and response to external stimuli (Merriam-Webster Dictionary, 2022).

Self-silencing: A term used to reference the removal of crucial aspects of the self for the sake of a relationship (Jack, 1999).

Self-neglect: A personal lack of personal, physical, or mental care as a sacrifice of taking on multiple social roles (Abrams et al., 2014).

Stereotype: Generalizations about a group or social category that produce negative judgments or perceptions regardless of the incongruent nature (American Psychological Association, 2018).

Strong Black Woman (SBW) or Superwoman (SW) schema: A combination of principles and cultural expectancies that demand strength, autonomy, and flexibility that

guide thoughts and actions to counteract negative stereotypes deemed by Black womanhood (Abrams et al., 2018; Abrams et al., 2014; Leath et. al., 2022; Woods-Giscombe, 2010).

Assumptions

A few assumptions were made in this study. The initial assumption was that the easy access and anonymity of the survey method would make it unproblematic to recruit participants. Another assumption was that the instruments used to quantify variables captured correct data for internal and external validity. Although it was impractical to remove all levels of bias, the assumptions were necessary for the internal and external validity of the study. Intrinsically, selecting participants with specific characteristics may occur as internal and external threats to validity (Creswell & Creswell, 2018). However, I used purposeful sampling, limited the study to Black women between 18 and 75 years old who had a minimal level of SWS adoption.

Scope and Delimitations

The study was conducted to address the gap in research concerning the mental health outcomes of disordered eating and stigma toward seeking support from behavioral health services among Black women. Delimitations are features of the research in the researcher's control that impact the study's scope (Roberts & Hyatt, 2010). In the current study, participants were chosen based on their identification as Black or African American females and were accepted by their scores on the G-SWS-Q. According to Harrington et al. (2010), the scores necessary for SWS qualification are 15 to 51. I excluded other populations and individuals who did not minimally score on the G-SWS-

Q. The inclusion criteria deemed the study findings nontransferable to women of other races, Black women who do not adopt SWS, and Black men.

Limitations

This study had a few limitations. Initially, recruitment of the participants took place through social media platforms (Facebook and Instagram), churches, barbershops, and hair salons that service Black women. Participant selection was an internal threat to validity because participants might have answered according to perceived socially desirable responses. After all, cultural parameters stipulated privacy or politeness. Creswell and Creswell (2018) stated that potential external threats to validity in quantitative research are present in the participants' characteristics, location, and scheduling. A second limitation was the scope of the study, which limited the participants by gender and race. There was no comparison between males and women of other races. Creswell and Creswell (2018) identified this as a possible threat to external validity because of the limited attributes of the participants and the fact that the researcher can not generalize about individuals who lacked those features. A final limitation related to some measures' validity and cultural relevance because they were developed and normed for White samples.

Significance

This study was significant because it filled a gap in quantitative research in its examination of the effects of self-silencing and self-neglect on disordered eating and the stigma toward seeking support from behavioral health services by Black women who adopted SWS. This study has significant implications for growing research and social

change. Although past qualitative research acknowledged the adverse psychological effects of SBWS/SWS on Black women and the stigma they experienced toward seeking behavioral health services, there was a lack of quantitative research. The current study added to the research and offered an opportunity for improved diagnostic interventions for disordered eating in Black women and reduced the stigma toward seeking behavioral health. The results of this study may lead to positive social change by providing quantitative results from Black women to other Black women about disordered eating and the need to seek behavioral services as a counterargument to silent suffering and self-neglect as mandated by SWS. The results may contribute to a decrease in mental and physical health disparities in Black women as an argument for culturally sensitive prevention and intervention methods.

Summary

In Chapter 1 I offered an overview of the effects of SWS adoption of self-silencing and self-neglect in Black women as they attempted to maladaptively cope with stressors through disordered eating and the effect on the stigma of seeking support from behavioral health services. I understood the need to be aware of the schema as a deterrent and the necessity to improve Black women's vulnerability to disordered eating while informing mental health diagnosis and treatment protocols. Also, this chapter provided the background, problem statement, purpose statement, research questions and hypotheses, theoretical and conceptual framework, nature of the study, scope and delimitations, definitions, assumptions, and the significance for advancement in current research and social change. Chapter 2 includes the literature search strategy, an

explanation of the theoretical and conceptual frameworks used in the study, and a comprehensive review of the literature related to the relationship between self-silencing and self-neglect (independent variables) and disordered eating and stigma toward seeking behavioral health support (dependent variables) among Black women who adopted SWS.

Chapter 2: Literature Review

For Black women, the adoption of the SBWS is a means of coping with the expectations of others while using their bodies as a sponge to soak up external biases as they stifle outward responses (Beauboeuf-Lafontant, 2009). Additionally, the SBW/SWS dictates that a projected persona outside of strength is a personal flaw and lessens the individual's ability to blame societal demands, increasing self-silencing and self-neglect behaviors. This psychological coping becomes a defense mechanism for Black women to normalize chaos to survive daily gendered racial microaggressions (Ricks, 2018). The significant psychological distress is an outcome of maladaptive coping, self-silencing, and self-neglect while experiencing a multiplicity of stressors and has negative physical and mental health consequences (Hopkins, 2021). According to the National Eating Disorders Association (n.d.), Black women are more susceptible to eating disorders because of multiple environmental stressors that include but are not limited to racism and socioeconomic status. Beginning in adolescence, Black females demonstrate bulimic behavior at a 50% higher rate than White peers. Health professionals are less likely to diagnose Black women with an eating disorder. However, they present with symptoms at a rate 24% higher than their White counterparts because of racialized gender stereotypes. Moreover, Black women who encompass strength as protection often stigmatize seeking mental health services (Curtis-Boles, 2019). Black Americans are more likely to report feelings of sadness, worthlessness, and hopelessness than Hispanic and White Americans (Harris et al., 2022). Black women who adopt SWS are more likely to experience unfavorable mental health incidents because of the stigma, fear, lack of education, and

access regarding mental well-being in the Black community (Avent Harris & Wong, 2018; Ward et al., 2009; as cited in Avent Harris et al., 2019;). The socialization of Black women at an early age to become silent sufferers of physical and mental pain serves as an obstacle to seeking behavioral health support (Harris et al., 2022). Therefore, there was a need for a deeper understanding of the link between psychological coping of SWS adoption and disordered eating. The current study provided insight into the stigma toward seeking behavioral health support. The internal narrative of SBWS dictates that Black women consistently strive to take care of the family/community and professional and social obligations while suffering in silence because exhibiting an outward display is delineated as a weakness (Abrams et al., 2014). Chapter 2 includes discussions of previous research that examined the association between the coping mechanisms of self-silencing and self-neglect according to SWS adopted by Black women, disordered eating, and stigma toward seeking behavioral health support.

Literature Search Strategy

The literature review encompassed a search through psychology and social work databases that included relevant literature from PsycINFO, PsycArticles, PsycBooks, PsycCritiques, PsycEXTRA, SOCIndex, CINAHL Plus, Project Muse, SAGE, and ProQuest Central. Limited research was found on the conceptual framework included self-silencing, self-neglect, or Mammy stereotype as separate entities of the SWS and disordered eating and help-seeking attitudes. The topic limitation warranted expanding the literature search from 1996 to 2021 to obtain a larger volume of pertinent literature. The following keywords were used: *Strong Black Woman Schema*, *SBWS*, *superwoman*

schema, *SWS, self-silencing*, *self-neglect*, *disengagement*, *self-sacrifice*, *emotional restraint*, *adopt*, *help-seeking*, *care-seeking*, *social support*, *mental health-seeking*, *behavioral health support*, *disordered eating*, *eating disorder*, *anorexia*, *bulimia*, *binge eating disorder*, and *emotional eating* in *Black or African American women*. I used databases in the Walden University and other university databases of behavioral and social sciences with a possible expansion into Google and Google Scholar. Additional research resources included other disciplines including nursing, counseling, and social work to attain saturation of the topic.

Theoretical Foundation

The theories grounding this study included Crenshaw's (1989) intersectionality theory and Jack's (1992) theory of silencing the self. Intersectionality theory offers a framework to study the effects of stigma through an intersectional lens of race, gender, class, and sex. The theory is applicable to the current study because it allows for the examination of the interconnection of race, gender, class, and sexuality as part of a Black woman's lived experiences. Previous research has shown that the subsequent negative coping behaviors of self-silencing and self-neglect coping mechanism influence disordered eating and stigma toward seeking support from behavioral health services. Additionally, the theory of silencing the self proposes that woman often experience depressive symptoms due to conformity in relationships that have expectations of societal standards of feminine roles. This theory is applicable to the current study because it provides a foundation to study psychological states and interpersonal complications as a product of self-silencing and self-neglect in Black women as a product of the adoption of

SWS and the effect on disordered eating and stigma toward seeking support from behavioral health services.

The theory of self-silencing offeres the opportunity to examine the psychological impact of socially prescribed gender roles on Black women in important relationships. Jack (1991) noted that the theory of self-silencing provides a framework that highlights a link between women's depressive symptomology and their roles in romantic relationships. As a social construct, girls often observe and mimic behaviors of self-sacrifice, self-silencing, and caretaking roles found in relationships around them (Jack, 1991). For example, Jack found in a longitudinal study of 12 clinically depressed women that their depression was not a symptom of the environment but a negative self-evaluation in social contexts. Also, Jack determined that gender socialization in childhood taught women to measure their value by various social classes, cultures, and past relationship models. Therefore, depressed women's self-evaluation became contingent on others' perspectives, causing a conflict between the authentic and projected self.

The link between depression and negative self-concept has existed since the work of Freud who asserted that the moral segment of the ego housed the depressive state (Jack, 1991). Jack recognized that a depression diagnosis was genderless and was present on the superego's realm in women. And the increase in depressive symptomology resulted from an inner moral language that dictated and assigned negative connotations to individual evaluation. As further research separated depression by gender, Freud, Piaget, and Kohlberg concluded that women's emotionality made them more susceptible to

following a moral judgment in contrast to men. Jack (1991) experienced a curiosity about women's ethical inner directive in response to the dependence level of relationships. Jack found that this internal narrative deemed it essential to immolate the self to avoid hurting others.

Additionally, Jack (1999) identified that women automatically rejected their most authentic foundation and become subordinate for the sake of a relationship. She stated that as the voice turned inward, the inner world becomes divided and alienated from the self. And this adoption created an incongruent dichotomy between the search for independence and the subordinate position in relationships that advanced depressive symptomology.

Patriarchal ideas were an overarching executor of morality for cultural and gender norms (Jack, 1991). As an example, Abrams et al. (2018) performed a quantitative study on the relationship between depressive symptoms and SBWS among 194 participants aged 18 to 82. Abrams et al. noted that, corresponding with the theory of self-silencing, Black women had the propensity to suffer from a mental health crisis and to maintain a strength façade. The current study was vital to the current research because it brings attention to the gap in the literature related not only to the effects of gendered racism through an intersectional lens of gender and race but also to the damaging psychological impact on Black women who adopt SWS.

For this study, intersectionality theory is an important framework for the exploration of the psychological impact of stress from racism at the intersections of gender and race and the resulting stigma toward help-seeking behavior for mental health

support in Black women who adopt SWS. Previous research examined the effects of psychological distress by separating gender and race into separate variables (Oexle & Corrigan, 2018). Crenshaw (1989) noted that intersectionality encompassed integrating Black feminist concepts and critical race theory. She added that this framework allowed for analysis of Black women's experiences through the intersection of gender, race, and social class systems that empower and disempower them. Historically, researchers were able to acknowledge and identify the effects of the coping mechanisms to counteract the impacts of intra- and outer-gender and race stressors in Black women through this framework. The struggles of Black women were not the product of a solitary issue. Their struggles must be considered with a Black feminist approach, advocating for their visibility in legal and political statutes (Crenshaw, 1989). Although Black women often experience twice the discrimination across racial and gender categories, they remain invisible in legal and political statutes. For example, judicial verdicts often referred to the gendered experiences of White women who held racial privilege or racist experiences of Black men who held gender privilege (Crenshaw, 1989).

Intersectionality has been an excellent antithesis to traditional health policies constructed from gender stereotypes and biological sex identities (Pederson et al., 2015, as cited in Fehrenbacher & Patel, 2020). This theoretical framework can be used as a health psychology instrument to analyze privilege and discrimination to decrease health care discrimination and improve access to health care (Warner et al., 2018). The intersectionality framework has the propensity to offer insight into external and internal weight stigma that has been underdiagnosed in marginalized populations that have an

augmented risk of disease across multiple risk categories for eating disorders (Burke et al., 2020).

Fehrenbacher and Patel (2020) asserted that intersectionality theory has been vital to qualitative research in constructing gender and health intervention research because it provided a trifold investigative lens in the exploration of the impacts of race, cultural narratives, and social class. Fehrenbacher and Patel offered several analysis methods for quantitative research, including hierarchal linear models, or multilevel models, that allowed for the dissection of characteristics within a group and readings between the examinations. The subsequent cross-level interactions of the clustered data revealed the processes for which social circumstances dictated and defined identity. The researchers found that heterogeneous treatment effects demonstrated variations in experiences, interventions, and treatment outcomes among individuals consistent with social and behavioral phenomena. Fehrenbacher and Patel concluded that intersectionality was a framework essential to gender health research, especially in the attempt to eliminate disparities across many identity and social categories.

Comparatively, Bauer and Scheim (2019) argued for analytical intersectionality instead of descriptive intersectionality because it was more beneficial for investigating the root causes of inequities at the intersections of race, gender, and social class. In their quantitative study of 2,542 participants ages 18–88 across six ethnoracial categories cross-stratified by two sexual or gender minority categories, Bauer and Scheim discovered that psychological distress was a product of yearly and daily discrimination at intersecting identities and varying levels. In the current study, this research is vital

because it stresses the importance of exploring the layers of factors that lead to psychological distress instead of proving its existence.

A solid gender racial identity is a powerful tool against oppressive experiences. M. K. Jones and Day (2018) argued that as Black women acknowledged this identity, it became a resource of strength against oppressive experiences. In a mixed-methods study of 240 Black women, M. K. Jones and Day hypothesized that the participants assigned different values to their intersectional identity. As part of a cluster analysis, M. K. Jones and Day found four significant profiles: "intersectional engaged, race progressive, intersectional aware, and gender expressive" (p. 1). Although the participants in all four categories embraced strength, resilience, nurturance, and awareness of oppressive experiences, members of the intersectional awareness category were more apt to voice against social injustices. At the same time, those in the gender-expressive group demonstrated an ability to become empowered by their identity as Black women and disregarded societal evaluations. Additionally, M. K. Jones and Day stressed the importance of using the cluster analysis method as part of the quantitative approach to bring attention to similar experiences across individuals instead of focusing on variables. This study permeates the significance of intersectionality, gendered racial identity, and the influence on SWS adoption and mental and behavioral outcomes.

Conceptual Framework

SWS is a concept for understanding the foundation, attributes, and connotations concurring with the SBW stereotype. This schema, closely related to the SWS, proposed that an SBW must remain independent and strong despite internal struggles because of

multiple oppressive experiences (Beauboeuf-Lafontant, 2009; Woods-Giscombe, 2010, as cited in Abrams et al., 2014). Moreover, the SWS conceptual framework not only a response to stereotypes but also contains five separate obligations: (a) strength appearance, (b) emotional suppression, (c) vulnerability concealment/restrained support-seeking, (d) the innate drive to succeed despite obstacles, and (e) placing others' needs at the forefront (Woods-Giscombe et al., 2019). Additionally, the framework outlines benefits that include self, family, and the community, in addition to the liabilities that encompass the adoption of stress, the procrastination toward seeking health support, and products of stress that may cause an upsurge in illness and tension within relationships (Woods-Giscombe et al., 2019).

The Black woman who endorses the SBW stereotype strives for resilience in the face of adversity. The historical foundation of this stereotype was the response to the mental toll of slavery (Abrams et al., 2018). Black women were socialized as a means of survival through communal narratives that signified strength despite the circumstances (Evans et al., 2017). Female elders passed down this narrative that emphasized a persona of courage regardless of adversity which has since become a paradoxical situation (Davis, 2015). Moreover, Geyton et al. (2022) argued that the SBW identity has the propensity to shift as a form of self-protection resulting from experiences with discrimination. For example, Williams and Lewis (2021) examined the effects of intersectional oppression and social identities during gendered racial identity development in Black women. In their qualitative study that included 19 Black women, they found that the participants' identity development was the effect of stereotypes, socialization, and oppressive

occurrences. Their results underscored four stages of identity development: alertness, intentionality, refutation, and preparation. Additionally, the results addressed that gendered racial identity differed by context. Consequently, despite generational narratives, Black women continue to consider the meaning and modify their gendered racial identity (Williams & Lewis, 2021). Comparatively, Jones et al. (2021) asserted that as a part of identity development, Black women adopted the SBW ideal and their self-concept in response to external perceptions. The researchers conducted a qualitative study at a local university that included 220 Black female participants aged 18 to 48. In this study, the researchers concluded that despite the participants' adverse responses to the angry stereotype related to SBW, they gave credence to strength as a positive cultural trait. Additionally, the researchers found that as the participants increased their shifting of identities, there was a substantial effect on depressive symptomology. This research supports the current study by emphasizing how self-identity and experiences with gendered racism can differ across age groups. The implication is that factors such as generational influences, societal changes, and life stage may shape how Black women perceive and navigate gendered racism. Moreover, Corbin et al. (2018) asserted mass media was liable for the amplification of the negative SBW stereotype. For example, Coleman et al. (2019) conducted a quantitative study of 115 Black women and investigated the effect of the heavy consumption of "Black-oriented reality television" (BORT) would increase alignment with the stereotypes of Sapphire, Jezebel, and SBW. And they found that higher consumption of BORT aligned with the participants' belief in the projected stereotypes. Conversely, Coleman et al. found that the Black female

audience who did not regularly watch television, possessed higher incomes, and had experience with other racial traditions demonstrated agreement with the projected stereotypes.

In contrast, Stanton et al. (2017) conducted a quantitative study with 412 Black women and found that as SBW endorsement increased, psychological distress increased despite the projections of constructive gendered racial identity through Black media platforms. Consequently, it is vital to the current study to understand the effects of media portrayals on Black women stereotypes in developing Black adolescents. However, Jerald et al. (2017) disagreed with this finding as their research highlighted the need to study the effects of Black media on the identity development of Black female adolescents. They performed a quantitative study using 404 Black adolescents as participants. The researchers concluded that despite the media format, the male adolescents were more vulnerable to the projected traditional feminine social constructs and SBW ideals and stereotypes. Consequently, in terms of the current study, this example deepens the understanding of how Black women experience gender racial identity oppression within their relationships with significant male figures.

SWS as a strength-based schema has associations with anxiety and depression, sleep deprivation, lack of self-care, decrease in health-seeking behaviors, and disordered eating in Black women (Abrams et al., 2018; Black & Woods-Giscombe, 2012; Harrington et al., 2010; Watson & Hunter, 2015; Woods-Giscombe et al., 2019; as cited in Harris et al., 2022). However, quantitative research is lacking because it is a new discussion topic (Allen et al., 2019; Glenn, 2020; Knighton et al., 2020; Woods-

Giscombe et al., 2019; as cited, in Perez et al., 2023). In response, Perez et al. examined associations between stressors from the social environment and mental and physical health among 208 African American women. As a result of their study findings, the researchers concluded that the SWS dimensions of self-silencing and self-neglect were protective properties and harmed health. For the current study, these results illuminate the absence of current research on SWS and psychological distress and the importance of finding correlations between the schema and adverse health conditions.

Moreover, Pickett (2020) defined *psychosocial stress* as an individual's inability to respond to the pressures of the environment. This stress weakens an individual's mental and biological pathways, making them vulnerable to disease risk. Harris et al. (2022) performed a study to seek the connection between SWS adoption and the perception of biological, psychological, and sociological barriers to attaining and sustaining healthy weight management in response to the absence of research on this topic. In a sample of 169 adult Black women, they found that psychological ailments and body mass index (BMI) were predictors of biological barriers. Furthermore, Harris et al. asserted that mental barriers are the product of psychological disorders, BMI, and SWS. At the same time, sociological barriers resulted from illness of the physical body, BMI, and SWS.

In contrast, Lewis et al. (2023) proposed that activating the Superwoman phenomenon in response to life stressors had the propensity to increase the risk for a cardiovascular event. In their research, they examined the relationship between systemic versus personal stressors and elevated blood pressure in 392 African American women.

In their research, Lewis et al. found that systemic stressors are associated with hypertension levels. Nevertheless, there was no association with personal stressors or the adoption of SWS.

Literature Review Related to Key Variables and/or Concepts

Psychosocial Factors and Coping

Gendered racism causes a psychological response via SBWS as a coping mechanism that helps protect Black women from their exposure to gendered racial microaggressions (Thomas et al., 2008; Lewis et al., 2017; as cited, in Liao et al., 2020). Moreover, Green (2019) hypothesized that through the intersectional lens of culture, gender, and race, there was a link between detrimental mental health and the combination of SBW as a coping style, depressive symptoms, and suicidality.

As an example, Liao et al. (2020) built on the earlier quantitative studies (Donovan & West, 2015; Harrington et al., 2010) to explore the relationships between SBWS, depression, anxiety, and loneliness by testing four potential mediators: "maladaptive perfectionism (MP), self-compassion, and collective and spiritual coping" (p. 85). Their quantitative investigation of a sample of 222 Black college women through an online survey recruitment process examined serial mediation effects. They conducted structural equation modeling while controlling age, family income, and education level while testing for the direct association between SBWS and depression, anxiety, and loneliness. They defined MP as impractical high-performance standards based on the perception of others and self-compassion as the individual's aptitude to see oneself with compassion and nonjudgment in problematic situations and encompass three components

that include self-soothing during difficult experiences, the expectation of suffering as a part of living, and cognitive awareness of the physiological effects of pain and suffering. Initially, Liao et al. found that SBWS generated significant positive relations with depression, anxiety, and loneliness, including all mediators. Secondly, the researchers found statistical significance between the different indirect effects from SBWS, MP, depression, and anxiety symptoms, which shows MP mediated between SBWS and depressive and anxious symptomology, but not loneliness. Next, they tested the different indirect effects of SBWS, self-compassion, depression and anxiety symptoms, and loneliness. They found them all significant, signifying that self-compassion mediated with medium effects between the variables. Furthermore, their test of separate indirect effects from SBWS, collective coping, depression and anxiety symptoms, and loneliness demonstrated a small effect between SBWS, collective coping, and loneliness, implying that collective coping mediated SBWS and loneliness. In the sixth test, the three indirect effects of SBWS, MP, self-compassion, depression and anxiety symptoms, and loneliness were significant with medium effects. Moreover, in the final test for the indirect effects between SBWS, MP, collective coping, depression and anxiety symptoms, and loneliness, there was only a small significant indirect effect on the loneliness outcome.

Additionally, Liao et al. supplemented their findings with the research of (Abrams et al., 2019; Harrington et al., 2012) and found a positive association between self-silencing and emotional inhibition as positive correlates between SBWS and may serve as a mediator between SBWS and loneliness. As for self-neglect, the researchers suggested that individuals who adopted SBWS were more apt to engage in self-neglect and not be

cognitively or emotionally aware of personal pain, which led to lessened self-compassion and poor mental health. Although Liao et al located earlier studies that highlighted the coping strategies did not lessen race-related stressors or mental health distress, there was a significant positive correlation between collective and spiritual coping and SBWS adoption in stress management. In other words, individuals who endorsed SBWS may take part in collective coping and continue to feel unsupported and isolated. Liao et al pointed out that younger participants or millennials were less dependent on religious behaviors in comparison to their elders. However, young individuals used their religious/spiritual belief systems like those of their elders to cope with demanding situations. Therefore, future studies may want to examine age as a mediator in collective coping and SBWS. Additionally, the study highlights the need to understand how an increase in MP leads to less collective coping and greater self-silencing and self-neglect resulting from SBWS adoption and adverse psychological effects outcomes in Black women. Finally, the researchers noted the necessity of including a demographic question that inquires whether the participant is a mother because motherhood may enhance the adoption of SBWS.

Leath et al. (2021) provided another example as they added to existing literature by considering the sociocultural obligation to project strength as a factor in increasing psychological distress in Black women by examining the relationship between Black women's adoption of SBWS as a gendered racial stereotype and increased exposure to adverse childhood experiences questionnaire (ACES), and mental health. According to a report from the Public Health Management Corporation (2013, as cited in Leath et al.),

Black adults had a higher rate of ACEs than White adults. Therefore, they addressed the gap in the literature regarding the impact of the intersection of gender and race on increasing psychological symptomology in Black women. They performed a quantitative, correlational study on 447 Black women from 20 to 35 who completed the Adverse Childhood Experiences Survey (ACES), Superwoman Schema endorsement, and mental health measures. The researchers concluded that a higher score on the ACES correlates with an increased determination for success, leading to amplified stress and anxious symptomology, as 70% of the sample report at least one adverse childhood experience. Effectively, this complemented the study mentioned above demonstrating a link between MP and the determination for success in this population. Therefore, this research is vital to my study because it examines the relationship between SWS adoption as a coping response acquired through adverse childhood trauma that often magnifies externalized stressors and implicates behavioral health-seeking in adulthood.

Self-Silencing and Self-Neglect

Consequently, Black women have the susceptibility to disconnect from mental and emotional burnout mentally and physically for extended periods and, in turn, lack awareness of the dire effects of this state (Green, 2019). Furthermore, the trepidation of being perceived as the stereotypical angry Black woman often contributed to anger suppression or aggressiveness in Black women (Jack, 1999). Thus, Jones et al. (2021) acknowledged that even if the SBWS stereotype is a foundation of a solid gendered racial identity, the resulting disconnected coping style of self-silencing and self-neglect leads to adverse psychological outcomes. Consequently, it served as a protective mechanism

against microaggressions. (Curtis-Boles, 2019). Moreover, Hambrook et al. (2011) found a link between the core psychopathology of disordered eating and the propensity towards self-silencing behaviors. Subsequently, minority women engaged in the coping mechanism of self-silencing when they become stressed by a cultural mismatch in a larger group. Emotional suppression (self-silencing) was a means of maintaining harmony in the group but produces personal struggles with anxiety and depression (Talavera et al., 2019).

As an example of racism as a stressor, Allen et al. (2019) addressed the gap in the literature regarding the link between stress responses, psychological processes, and biological pathways to health in Black women who adopted SWS. This framework included strength obligation, emotional suppression through self-silencing, opposition to show vulnerability, and the obligation to help others via self-neglect. Additionally, Allen et al. used allostasis as a term to describe the body's biological regulatory response to environmental changes. However, they posited that too much adaptation leads to chronic stress and increased allostatic load. The researchers asserted that coping styles fall into two categories: (a) innate ability to use both cognitive and affective mechanisms that are usually stable reactions to surroundings and (b) a conscious choice to regulate emotional, cognitive, and physiological responses to a stressful environment. Allen et al. initially hypothesized that SBWS offered protective and harmful coping mechanisms in occurrences of racial and gendered racism, and the women will undergo wide-ranging health consequences. Additionally, the researchers hypothesized that emotion suppression through self-silencing would equate to an instrument of health protection. Finally, they

hypothesized that the dimensions of SBWS of not asking for help, working hard to succeed, and self-neglect in care for others will negatively impact health because of increased experiences with racial discrimination means and a varied association between racial discrimination and "allostatic load" and will harm health. To test the hypothesis of their quantitative research, they used purposive sampling in their study that included 208 Black women between the ages 30-50 in the San Francisco Bay area.

Next, Allen et al. used path analysis to test interactions among SWS characteristics using linear and quadratic models. Conclusively, they found the following: (1) the relationship between racial discrimination and "allostatic load"; (2) varying levels of SWS adoption affect the relationship between racial discrimination and "allostatic load"; and (3) the SWS adoption levels vary according to strength association level because it has the potential for harm or protection. Most importantly, the researchers found that in an exploratory association between study variables, there is an increase in levels of not asking for help (strength) and self-neglect correlated with increased food/substance consumption in response to stress. Therefore, this study is essential to my current research because it revealed the influence of racial discrimination and gendered racism on self-silencing as a protective/coping mechanism and the impact of self-neglect on behavioral health-seeking behavior.

In the following example, Jones et al. (2021) addressed the gap in the literature concerning the association between coping styles of SBWS and depression in Black women. The quantitative research sample includes 240 Black women from 18–48 years of age with varying educational levels. They examined the coping styles of social

support, disengagement through self-silencing, spirituality, and "problem-oriented/engagement" as mediators in the relationship between SBWS adoption and depressive symptomology through a quantitative study. Initially, Jones et al. hypothesized that an increased sanction of SBWS would produce an increase depressive symptomology. As a second hypothesis, they suggested that coping styles, especially social support, would positively mediate SBWS adoption and depressive symptoms. First, they conducted a series of bivariate correlations to investigate the associations between the variables. Then, the researchers performed a "parallel multiple mediation" analysis using PROCESS Model 4 to assess the coping styles as mediators in the association of SBWS endorsement and depressive symptomology. As a result, the participants acknowledged a moderate endorsement of SBWS and all four coping styles. Additionally, the researchers found a positive correlation between SBWS endorsement and depressive symptomology. However, the mediation between SBWS endorsement and depression was as follows: no substantial mediation for social support coping; disengagement coping or self-silencing was a significant mediator; and no significant mediation for spirituality. Thus, the researchers determined and agreed with previous research findings (Abrams et al., 2018; Harrington et al., 2010; Liao et al., 2020; Watson-Singleton, 2017) that the previously mentioned coping styles did influence depressive symptomology. Therefore, they concluded that Black women with substantial SBWS endorsement would renounce or underestimate the psychological impact of stressors. Therefore, this study is conducive to the current study because it linked the effects of

self-silencing as a form of emotional suppression to the stigma towards behavioral health-seeking support in Black women.

Next, Pintea and Gatea (2021) conducted a quantitative study to add to the literature concerning the correlation between self-silencing and depression. They explored potential relationship mediators through a meta-analysis of 31 published and 11 unpublished studies with 10,108 participants and 131 effect sizes. The researchers found that only a few studies assigned ethnicity as a potential moderator in self-silencing and depression; however, gender as a moderator in AA women had a high correlation to self-silencing and depression. Additionally, they found from recent studies that participants' mean age of 14.5 to 55.7 years was essential because self-silencing behavior tended to decrease in aging. Next, they found that sexual orientation was a potential moderator because lesbians demonstrated higher levels of self-silencing behavior in correlation to depression. Lastly, they found that education level was a potential moderator of self-silencing and depression. However, they found no support in their analysis that gender and ethnicity were not moderators due to variations in gender roles, values in relationships, and schemas. This study is salient to the current study because it linked the self-silencing dimension of SBWS as a determinant for depression. Additionally, it aligned with the theoretical framework that identified adverse psychological outcomes as products of externalized perceptions and self-silencing.

Moreover, Knighton et al. (2022) attended to the gap in literature with a consideration of the impact of Superwoman Schema on the mental health outcomes of African American women who experience chronic racial microaggressions. They

hypothesized that AA women who held the minority position in White-dominant work and social spaces endured an increase in racial microaggressions and employed the strength persona with emotional suppression as a protective measure that contributed to more significant psychological distress. Knighton et al conducted research using a sample of 243 AA women between the ages of 19 and 72, and through factor analysis, they evaluated the obligation to show strength/suppress emotions subscale. Their research model included descriptive statistics, multiple linear regression, and mediation analyses to examine the associations between the variables. Subsequently, they gleaned that AA women felt obligated themselves to show strength and suppress emotions when they perceived racial microaggressions increased psychological distress. Therefore, this study is vital to the current research because it associated the relationship between increased SBWS endorsement and self-silencing as a coping mechanism in response to racial microaggressions.

Furthermore, Adkins-Jackson et al. (2019) stated that Black women represent 14.4% of the female population in the United States and 52% of the African American population. However, their mortality rates surpass all races, and the more they experienced discrimination, the less likely they were to engage in self-care. Therefore, they addressed the gap in the literature regarding the association between stress and "self-reported health" (SRH) and the effect on Black women's active choice of engaging in self-care engagement. Their correlational study included 223 Black female participants in the United States and sought to examine the relationships among mindfulness exercises, flexibility, self-care, stress, and SRH. The researchers found that as the participants had

increased encounters with family and community, there was a decline in self-care efforts. Additionally, they found that experiences with discrimination correlated with weight and SRH. This study has valuable information to the current research on Black women's adverse coping in response to stress from experiencing acts of and the sacrifice of self for the care of others. In turn, as Black women adopted SBWS, their levels of self-criticism increase, and there was a decreased propensity to ask others for help or support due to mistrust (Liao et al., 2019). Consequently, SBWS adoption leads to isolation, depression, and dysfunctional coping behaviors that ensue relationship strain (Liao et al., 2019).

Disordered Eating

The American Psychiatric Association (2013) categorizes eating disorders as rumination, avoiding/restricting food, bulimia, binge or emotional eating, and anorexia nervosa. BE is an amalgamation of loss of control with eating habits by simultaneously eating large amounts of food. In contrast, anorexia nervosa (AN) encompasses two categories: "restrictor type" and the most recognizable, "binge-eating/purging" type. The latter type has been the producer of long-term illnesses in adolescent girls that affect physical appearance, social lives, and mental health (Halse et al., 2007). Moreover, Conason (2020) asserted that although Black women have a higher rate of BED than White women, they are not likely to initiate treatment. Statistically, Black women participate in BE treatment at an 8% rate compared to the 22 percent participation rate of White women. As a stress response to experiences with gendered racism, Black women with low SES are more likely to engage in disordered eating behaviors. Accordingly, Gray (2020) described her experience as a Black woman who sought help for AN as a

very lonely experience because the staff and other patients did not have a means of connection with her.

The SBW or Superwoman ideal adoption has been in response to the trauma from discriminatory experiences yields disordered eating patterns (Beauboeuf-Lafontant, 2005; Harrington et al., 2010, as cited in Davis & Jones, 2021). Women are most vulnerable to eating disorders as social constructs increase voice suppression (Maji & Dixit, 2019). In one example, Goode et al. (2020) performed a systematic review of 38 studies to understand racial disparities among Black women who sought treatment for binge-eating disorder (BED). The researchers found that White females were the primary topic of research in most of the literature on the effects of disordered eating, although Black women had higher disorder rates. And they added, for the Black female population, the symptoms of BED would present between the ages of 18 and 25 as they began to experience depressive symptoms and stress from gendered racism. This study was important to highlight the detrimental effects of stress from integrated gender and race microaggressions that lend to disordered eating symptoms in Black women. Additionally, this research may be conducive to creating education programs about preventative care for Black women.

However, an additional activation for unfavorable eating behaviors may have roots in messages that Black mothers pass along to their daughters. For example, Longmire-Avital and Finkelstein (2021) built on the systematic review of Goode et al. (2020) with qualitative research of 143 Black college women participants to understand maternal communication concerning eating socialization. They found through a

framework analysis that the mothers often inadvertently perpetrated their daughters' disordered eating behaviors by their negative evaluations through a racial and societal lens. The research of Longmire-Avital and Finkelstein highlighted the importance of educating the Black community about eating disorders through preventive methods instead of interventions. Also, it emphasized the gap in information on culturally appropriate assessments for eating disorders in the population and the link between emotional suppression and eating disorders.

Additionally, Salami et al. (2019) indicated that studies have begun to understand the relationship between experiences of racial discrimination, depression, anxiety, and anger/hostility because of negative coping behaviors. Therefore, they conducted a quantitative study with 119 Black women ages 18–60 to understand the association between race-related stress and eating pathology with depression as a mediator. The research procedure included a moderated mediator analysis to examine race-related stress, self-reported depressive symptoms, eating pathology, and demographic variables. Subsequently, the descriptive statistics demonstrated a positive correlation between race-related stress and depression and a positive association between eating pathology and race-related stress. They used the moderated mediation model and determined that depressive symptomology increased eating pathology. Therefore, their research is valuable to the study because it offered insight into eating pathology as a product of the experiences of Black women with race-related stress.

Next, Raheb-Rauckis and Jarosz (2018) determined that statistically, AA women often experience an increase in obesity rates that advanced adverse health outcomes.

However, they conceded there is a lack of information about this population and the link between obesity and BE because they do not report symptoms or seek treatment. Effectively, Raheb-Rauckis and Jarosz indicated that current literature lacks information because of differentiation in definitions and assessments and a lack of consideration for cultural experiences. Therefore, they used Walker and Avant's concept analysis to research articles from 2008 to 2017 about AA or Black women and binge-eating behavior as keywords. Although the "loss of control" (LOC) was one determinant for a diagnosis of BED, they cited Napolitano and Himes (2011) in their findings that African American women were less likely to disclose feeling any distress from LOC in binge eating, and this made it difficult to diagnose and treat. Their research included the following instruments: the BE Scale (BES), the Eating Disorder Examination Questionnaire (EDE-Q), and the Questionnaire on Eating and Weight Patterns Revised (QEWP-R) for BE behavior assessments. They surmised that the latter two were more considerate of cultural differences. Therefore, this study is vital for my research because it demonstrated that there may be a different way to diagnose Black women with BE. The researchers found that in Black women, LOC was not a determinant for the behavior, and distress levels should be a part of the assessment.

Moreover, Beccia et al. (2019) conducted a descriptive correlational study of 11,514 high school students participating in the 2012 National Youth Risk Behavior Surveillance System. The purpose of their study was to understand the risk of eating disorder factors among various social identities. As they used White male participants as a point of reference, their study results highlighted that one-fifth of the AA adolescent

female participants were vulnerable to the following characteristics of adverse eating behaviors: fasting, purging, and other eating disorder diagnoses, except for diet pills. This study is significant for understanding discrimination as a product of social processes, stigma, and disparities that hindered help-seeking behaviors. Additionally, it underscored the importance of intersectionality theory as a lens to understand the impact of several factors at the macro level that influence health disparities. Furthermore, this study accentuated the importance of including varying development stages in the current research to gain insight into SWS levels across adulthood lifespan in Black women.

Stigma Toward Seeking Behavioral Help Support

In the Black community, the subject of mental health and seeking support for it connotates weakness (Curtis-Boles, 2019). As a result, Black women often present with a strong identity and resist seeking support from behavioral health services to avoid being perceived as weak. Furthermore, Curtis-Boles (2019) offered that Black woman, who are minorities across sexual, gender, and religious identities face isolation and traumatic stress within and outside of their communities. Moreover, in turn, they stigmatize seeking behavioral health support.

Villatoro et al. (2018) addressed the gap in the literature regarding the perception of mental health among the minority population. The researchers used self-identification theory as a framework in a study of 14,906 adult participants that were at least 18 years-old from the Collaborative Psychiatric Epidemiology Surveys. They sought to analyze the intersections of race/ethnicity, gender, and SES and correlated them with the perception of needing support. Their research method included a multivariable analysis using

logistics regressions to understand the impact of traditional gender roles and cultural norms on the perception of needing help or support. This research of Villatoro et al. is important to the current study because it highlighted the androgynous aspects of adopted SBWS and the means it may inhibit the perception of healthcare needs in Black women. Comparatively, Nelson et al. (2020) addressed the gap in the literature about SBW adoption among depressed Black women and the stigma of seeking support from behavioral services while using intersectionality as a theoretical framework. The results of their qualitative analysis of 30 Black females showed that even as participants advocate for mental health care to others, they often delayed or dismissed personal treatment for themselves. Additionally, they declared that help-seeking behavior in Black women who adopted the SBW role of self-neglect are dependent on their levels of depressive symptoms.

Additionally, Hall et al. (2021) found that despite the focus of past research on the SBW ideal as a hindrance to Black women's negative attitudes towards seeking support from behavioral health treatment, there had never a discussion about the positive influences of the schema on help-seeking attitudes. They argued that although most Black Americans had positive regard for mental health utilization, and they generally do not seek help. Therefore, to address this congruence, they conducted a qualitative study with 62 participants separated into eight focus groups, 18 to 72 from the local community and college. There were two distinct themes because of the convenience sampling: (a) tension and stigma and (b) privilege that affected treatment-seeking compliance for psychological distress. Accordingly, in the tension and stigma category, the participants stated that they

felt a steady tension to remain strong despite psychological distress from stigmatization by their community and peers for seeking out mental health support and despite feeling that prayer did not ease their psychological suffering, they did not seek mental health treatment. Secondly, the participants compared their work status as better than that of their grandparents and parents in a response to not seeking support. Hall et al stated that their present access to certain privileges protected them from seeking mental health services because time off from their job allowed them to decompress from emotional overload. More importantly, the participants emphasized the importance of encompassing the SBW identity as a source of pride because it integrated the intersectional identity of being Black and a woman. Hall et al concluded that the participants conceived the SBW identity as an operational coping strategy and a barrier to this population seeking mental health services. Consequently, this study is fundamental to the examination of the assets and liabilities of SBW adoption as it concerns seeking mental health support.

Moreover, Erving et al. (2021) conducted quantitative research using an intersectionality framework and stress theory to help identify the stressors and psychosocial resources that contributed to AA women's mental and physical health or self-reported health (SRH) as they hold oppressive social positions. Their participant pool comprised of 2,077 AA women from the National Survey of American Life. Consequently, they integrated peer-reviewed literature on mental health and intersectionality that emphasized the interrelatedness between stress, resources, and health as operators in Black women's health according to the following hypotheses: mediation, suppressor, stress-buffering, and stress-exacerbating. Next, they conducted

statistical relations between stress exposure and psychological resources to test the stress-buffering and stress-exacerbating hypotheses and found four statistically significant interactions. The first significant interaction between discrimination and church attendance demonstrated an exacerbation effect, a predictor of fair to poor health. Secondly, the interaction between increased discrimination experience and practice of religious/spiritual faith for strength as a coping mechanism found that those individuals reported poor SRH. The following interaction between daily discrimination experiences and low religiosity demonstrated that individuals with a lack of psychological resources reported the worst physical health and was not consistent with the stress-exacerbation hypothesis. However, Erving et al found confirmation of stress-buffering in the last interaction between financial stress and social support. For example, those individuals who experienced an increase in financial stress and high social support had lower reporting rates of fair or poor health. The researchers surmised that participants with psychological resources recognized significant discrimination, and therefore, experienced the impact of SRH. There was a suggestion that despite Black women's proclivity to use psychological resources of social support, strength, and self-esteem, they did not protect them from the adverse effects of chronic stress from gendered racism. This study is vital to the current study because of the conclusion that the adoption of SWS as a means of coping in Black women negatively impacted their help-seeking for behavioral services.

Summary and Conclusions

Current research did not address the SBWS/SWS domains of self-silencing and self-neglect as coping mechanisms to intersectional stressors, the effects on disordered

eating, and the stigma towards seeking support from behavioral health services in Black women. As a theoretical approach, there was a lack of intersectional application that explored the relationship between gendered racism and mental health outcomes (Williams & Lewis, 2021). Therefore, the intersectionality framework for research is essential to understanding the vulnerability to eating disorders of individuals who cross multiple identities (Burke et al., 2020).

Davis (2015) asserted that SBWS as a coping style is protective and hurtful as a means of collective communication to process protection or experience of challenging times, but not emotional expression. She added that this defense mechanism against the intersection of race, gender, and class, although psychologically harmful, serves as protection and is often revered and enabled by the community. The adopted schema beckons the Black woman to be strong in the face of external adversity while sacrificing one's needs for others and suppressing emotions (Romero, 2000, cited in Green, 2019). This adoption is associated with adverse mental health outcomes (Abrams et al., 2014; Jones & Shorter-Gooden, 2003; Woods-Giscombe & Black, 2010, cited in Green, 2019). Culturally, Black women are socialized to lean on the community for support including family, friends, and the church. However, it also represents a double-speak that rejecting and isolating if they display weakness.

Black women have a pervasiveness for BED at a rate of 50% more than their non-Hispanic, White counterparts (Goode et al., 2020). However, recent research shows that treatment for Black women has been at rates as low as 1.5 % and as high as 36%, a significant sign that they are missing from research (Longmire-Avital & Finkelstein,

2022). Socialization of self-silencing and self-neglect is a legacy passed on by Black mothers to their daughters, as well as emotional eating to cope with stressors (Longmire-Avital & Finkelstein, 2022). Black women are more apt to normalize overeating behaviors as coping mechanisms for stress that lend to being overweight and obese (Wood-Giscombe et al., 2021). However, there is a lack of empirical research on the relationship between stress and obesity in Black women as a product of gendered racism (Woods-Giscombe et al., 2021).

Statistically, Black women experience more psychological distress than their White counterparts but are less apt to seek mental health support (CDC, 2016, as cited in Hall et al., 2021). Therefore, seeking mental health support is often stigmatized and designated for the weak (Green, 2019; Nelson et al., 2020). Hall et al. (2021) found in their research that Black women are culturally socialized to rely on prayer and support from religious leaders in times of psychological distress. However, even when they realized that their symptoms did not subside, they did not seek behavioral health support for fear of being viewed or assessed as weak.

This chapter provided an overview and discussion of SBWS's adoption of self-silencing and self-neglect as a conceptual framework, the theoretical basis for research, and a literature review of relevant research for the study. Chapter 3 outlines the research method, design, methodology, and data analysis plan for the study's variables.

Chapter 3: Research Method

The purpose of this study was to examine the extent of the relationship between self-silencing, self-neglect, disordered eating, and stigma toward seeking behavioral health support among Black women aged 18–75 years who adopt SWS. This chapter outlines the research design and provides an explanation for the alignment of the study's objectives. Additionally, there is a description of the sampling and sampling procedures and procedures for participant recruitment, participation, and data collection that I used for the implementation of the study. Moreover, I describe the instrumentation and operational constructs, ethical concerns, and threats to validity and reliability.

Research Design and Rationale

The nature of this study was quantitative with a correlational design. The primary reason for the design selection was that it allowed me to make predictions of a variable based on the value of two or more variables. The purpose of this study was to examine the extent of the relationship between self-silencing and self-neglect (independent variables) and disordered eating and stigma toward seeking behavioral health support (dependent variables) among Black women aged 18–75 who reported SWS adoption. The quantitative study incorporated a survey and correlational design to construct knowledge about the relationship between self-silencing and self-neglect behaviors in response to psychological distress outcomes of disordered eating and stigma toward seeking behavioral health support. Regarding the nature of the design, there were no concerns regarding resource constraints because I used Survey Monkey. This online data collection tool is available for public use. At the time of this study, no known research had covered

this topic to this extent. Two multiple regression analyses were used to evaluate the extent of the relationship between the variables. Multiple regression analysis expanded the simple linear regression analysis and allowed me to examine the combined and unique contributions of two or more independent variables in predicting a dependent variable.

Methodology

Population

The target population was Black women living in the United States. The American Community Survey of the United States Census of 2020 established that there were approximately 21.7 million Black women in the United States (BlackDemographics, n.d.). Black women make up 52% of the Black population. The current study included the human development of young to late adulthood (18–75 years old) in this demographic.

Sampling and Sampling Procedures

Black women between the ages of 18 and 75 were recruited through social media platforms and flyers placed in local Black churches and barber and beauty shops with a purposive sampling approach. The nonprobability sampling approach allows the researcher to choose participants from a specific population based on the needs of the study (Creswell & Creswell, 2018). One advantage of this sampling approach is that it has the propensity to save time and is cost-effective compared to other sampling approaches. Moreover, this sampling is used for identifying a subset of a population that is easily distinguishable (Babbie, 2017). This sampling strategy made it possible to

recruit Black women who met the inclusion parameters: 18–75 years of age and had an SWS adoption score of at least 15 on the G-SWS-Q.

To determine the minimum sample size for this nonexperimental quantitative study, I used the G*Power calculator, Version 3.1 (see Faul et al., 2009). I calculated the study's sample size using the *F*-tests family in G*Power and the linear multiple regression fixed model, R^2 deviation from zero with the following parameters: (a) effect size set to 0.15 medium, (b) a value set to 0.05, and (c) power set to .80 with two as the number of predictors. The statistical power analysis yielded 68. Although 68 was the minimum sample size required to calculate the essential power to answer the two research questions and determine whether to accept or reject the null hypotheses, I added 10% to the projected minimum sample size to account for any missing or incorrect data.

The inclusion criteria included Black women aged 18–75 with an SWS adoption score of at least 15 on the G-SWS-Q. Giscombe-Woods et al. (2019) developed the G-SWS-Q to understand the relationship between the SWS, illnesses, and psychological distress contributing to the risk of illnesses. The scores for SWS are computed by adding the responses and dividing them by 35, the total number of assessment items. In this study, adoption level referred to the extent to which a Black woman chose to use a SWS as a form of protection. I used the G-SWS-Q to assess each participant's level of SWS. The cutoff minimum score of 15 followed the research of Harrington et al. (2010) who found this to be a suitable minimum score for assessing SWS levels. Furthermore, the participants were required to have the ability to read, write, and understand English. In addition, the participants demonstrated the ability to comprehend and provide consent to

participate in the study. Furthermore, participants demonstrated knowledge about internet use and responded in English. The exclusion criteria included (a) women who identify with a gender identity other than female, (b) Black or African American women under the age of 18 and over the age of 75, and (c) individuals who scored less than 15 on the G-SWS-Q.

Procedures for Recruitment, Participation, and Data Collection

Black women age 18–75 from all regions of the United States were recruited for the present study. After approval from the Walden University Institutional Review Board (IRB # 02-05-24-0752235), I began recruiting participants through IRB-approved platforms such as LinkedIn, Instagram, the Walden University research pool, Facebook, and recruitment flyers (see Appendix A). Anonymous participants found the survey links on social media platforms and recruitment flyers in churches, barbers, and beauty shops frequented by the target population. The recruitment flyers contained a link for potential participants to access the survey. All modes of invitation requests contained the same information about the study.

Recruitment for potential participants began after IRB approval to collect data, and I planned to pursue Black/African American women between the ages of 18 and 75. The exclusion criteria included (a) identification other than Black/African American and female, (b) under the age of 18 and over 75, (c) individuals with a score less than 15 on the G-SWS-Q, and (d) participants who did not complete the entire survey. For example, if a participant selected any race other than Black/African American, the platform took the individual to the end of the survey and concluded participation. To ensure that

participants met the inclusion requirements, they had to affirm consent before moving on to the survey. Subsequently, they proceeded to the following instruments for data collection: STSS, Mammy subscale of SRBWS, EBPQ, and ATSPPH-SF.

I performed data collection procedures through a SurveyMonkey weblink and created a personal password and username for uploading surveys and checking the research progress. After creating the website link, the platform offered the opportunity to create, copy, or upload an existing survey. I took advantage of all options because the questionnaires for the study fit into all the categories. SurveyMonkey offered the opportunity to add closed-end and multiple-choice questions, a consent form, and a statement about privacy practices before the participants took the survey. An additional bonus to the platform is Skip Logic, and for this study "Question" Skip Logic was the best option. It allowed me to screen participants by the inclusion and exclusion criteria. For example, if the participant did not provide consent or chose a race or age outside the inclusion criteria, they were taken to the end of the survey and acknowledged for participation. In addition, the participant had to provide consent by clicking the "yes" or "no" box. If they clicked the "no" response, they were taken to the end of the survey with a thank you note from me. As the participant moved on to the survey, she completed the demographic form by clicking on an answer or choosing from the drop box options that pertained to her. As the participant moved on to the questionnaires and scale, she could answer the Likert-scale questions by clicking on the relevant box. SurveyMonkey tracked and added scores after each survey completion.

I uploaded the consent form, demographic form, G-SWS-Q, demographic form, STSS, Mammy subscale of the SRBWS, EBPQ, and ATPPHS-SF to the SurveyMonkey website. Also, I ensured that objectives were defined, checked for language bias, and performed a test for the flow and ease of the survey. After the participant provided consent, the platform prompted her to move on to the demographic questionnaire for inclusion criteria that included demographic information about gender, race, and age. Next, the platform induced her to complete the G-SW-Q to determine levels of SWS adoption. If the participant met all inclusion criteria, she could complete the rest of the survey. I ended access to the survey after reaching the required number of participants. Finally, I entered the data into a Microsoft Excel spreadsheet and Statistical Package for the Social Sciences (SPSS) and checked for missing data/outliers.

Instrumentation and Operationalization of Constructs

The nonexperimental quantitative study included instruments designed by Dr. Cheryl Giscombe, Dr. Anita Thomas, and Drs. Dana Jack and Diana Dill, Dr. David Schlundt, and Drs. Edward Fischer and Amerigo Farina. The instruments were essential to answering the two research questions. The demographic questionnaire determined inclusion/exclusion criteria and control variables. I used the G-SWS-Q, STSS, Mammy subscale of SRBWS, and EBPQ to answer Research Question 1 regarding self-neglect and self-silencing behaviors and the relationship with disordered eating. I used the G-SWS-Q, STSS, Mammy subscale of SRBWS, and ATPPHS-SF to answer Research Question 2 regarding the relationship with self-neglect and self-silencing behaviors with stigma toward seeking support from mental health services.

Demographic Questionnaire

The survey included a demographic questionnaire (see Appendix B). The questionnaire addressed the participant's age, race/ethnicity, marital status, sexual orientation, highest level of completed education, household income, state of residence, and number of children. The demographic questionnaire provided the control variables for the study.

Giscombe Superwoman Schema Questionnaire

The G-SWS-Q is a 35-item questionnaire (see Appendix D; Woods-Giscombe et al., 2019) addressing Black women's endorsement of certain behaviors associated with the SWS. Woods-Giscombe et al. (2019) created the questionnaire to facilitate knowledge about the relationship between the SW construct and African American women's physical and emotional health. I obtained permission (see Appendix C) to use the questionnaire to establish the adoption of SWS. Woods-Giscombe et al. included three studies conducted with 739 African American women in the initial study. The purpose was to develop an empirically and theoretically grounded instrument congruent with the SWS conceptual framework to examine the association between SWS and African American women's health using 48 African American women who participated in eight focus groups to obtain qualitative data. In the second study, Woods-Giscombe et al performed a psychometric evaluation of the G-SWS-Q that involved a confirmatory factor analysis of 561 African American female participants. The confirmatory factor analysis was used to test the instrument's structure and examination of score distributions, item-total correlations, and internal consistency. Moreover, the final study

included a convenience sample of 130 women to examine the internal consistency, inter-item and item-total correlations, test-retest reliability, and construct validity by assessing associations of G-SWS-Q with other theoretically related variables.

The Likert-scale survey had five subscales that represented the domains of SWS endorsement. These domains included (a) the Obligation to Present an image of Strength subscale, e.g., "I try to present an image of strength"; $\alpha = 0.70$; (b) Obligation to Suppress Emotions subscale, e.g., "I display my emotions in privacy"; $\alpha = 0.85$; (c) Resistance to Vulnerability subscale, e.g., "Asking for help is difficult for me"; $\alpha = 0.86$; (d) Intense Motivation to Succeed subscale, e.g., "No matter how hard I work, I feel like I should do more"; $\alpha = 0.72$; and (e) the Obligation to Help Others subscale, e.g., "I put everyone else's needs before mine"; $\alpha = .87$. Scoring was based on the response options of this is true for me: *never* = 0; *rarely* =1; *sometimes* = 2; and *all the time* = 3. Items were added per subscale and then added to obtain an overall score. Woods-Giscombe et al. (2019) used the following scores for the schema adoption range: low (0–35), moderate (36–70), and high (7–105). The cutoff score for schema adoption in the present study was a score of no less than 15.

Platt and Fanning (2020) performed a study to understand the within-group differences in Black women using the demographic variables as predictors of SWS endorsement. The quantitative study consisted of 185 Black women aged 20–64 (M = 33.07, SD = 9.62) and used the G-SWS-Q to predict the association between SWS adoption, stress, and health outcomes. Platt and Fanning totaled the entire scale and used it as a primary predictor variable to find the relationship between (a) SWS endorsement

and the perception of stress and (b) demographic variables as a predictor of SWS endorsement levels. Platt and Fanning found good internal consistency of the full scale with α = .92. The Cronbach's alpha (α), standard deviations (*SD*), and sample means (*m*) for each subscale were as follows: Obligation to Present an image of Strength (α - .71, *m* = 72.49, *SD* = 2.93); Obligation to Suppress Emotions (α = .83, *m* = 13.03, *SD* = 4.41); Resistance to Vulnerability (α = .79, *m* = 14.22, *SD* = 3.78,); Intense Motivation to Succeed (α = .74, *m* = 14.05, *SD* = 2.94,); and Obligation to Help Others (α = .87, *m* = 16.43, *SD* = 5.61).

Silencing the Self Scale

The STSS (see Appendix E; Jack & Dill, 1992) is a 31-item assessment that has four subscales: (a) Externalized Perception, (b) Care as Self-Sacrifice, (c) Silencing the Self, and (d) the Divided Self. I was not required to obtain permission for use of the scale because it was publicly available. This assessment included a five-point Likert response scale with a range of *strongly disagree* (1), *somewhat disagree* (2), *neither agree nor disagree* (3), *somewhat agree* (4), and *strongly agree* (5), to indicate the degree of agreement with each statement. The total score was a product of the added item scores. The scores ranged from 31 to 155, and higher scores indicated increased endorsement of self-silencing to preserve a relationship. The initial purpose of the scale was to study the association between schemas related to women and depression (APA, 2023). The original research tested three samples of undergraduate women, a drug-dependent pregnancy group, a health study group, and a group from the battered women's shelter:

predominantly White (83.5%), Native American (7.2%), African American (5%), Hispanic (2.2%), and Asian (.7%; Jack & Dill, 1992).

Internal consistency for each group was in the alpha range of .86 to .94. Test-retest reliability coefficients ranged from .88 to .91. In turn, this assessment demonstrated high test-retest reliability, good internal consistency, and construct validity (Jack & Dill, 1992). Additionally, Carr et al. (1996) conducted a study of 80 participants (40 African American and 40 Caucasian women), the average age of the participants was 20.59 (*SD* = 4.43). The reliability analysis resulted in $\alpha = .87$ (.89 and >85 for White and Black female participants who agreed to remain silent to preserve a close relationship (Jack & Dill, 1992).

For this study, I used the 31-item scale to measure the independent variable, self-silencing. The 6-item, "Externalized Self-Perception," subscale includes statements, "I often feel responsible for other people's feelings." The 9-item "Care as Self-Sacrifice' subscale includes statements such as, "Doing things just for myself is selfish" and "In a close relationship, I don't usually care what we do, as long as the other person is happy". Moreover, the 9-item "Silencing the Self" subscale includes statements, "I think it's better to keep my feelings to myself when they conflict with my partner's", and "I rarely express my anger at those close to me". The last subscale, "Divided Self," has seven items including the following statement: "I feel that my partner does not know my real self". Therefore, the scoring for this study ranged from 31–155, the total score across the subscales. Higher scores indicated significant endorsement of self-silencing for a relationship.

Abrams et al. (2019) conducted a quantitative analysis of 194 Black women who ranged in age from 18 -82 years old (M = 37.53, SD = 19.88) to examine the relationship between SBW characteristics and depressive symptoms with self-silencing as a mediator. In order to test the hypothesis, they used bootstrapping at a 95% confidence interval (CI) with 5,000 samples. The results revealed that the indirect effect was significant (*ab* = .09, 95% CI [.03, -.18] because CI did not include zero. Their use of the "Silencing the Self" subscale demonstrated good internal consistency (α = .80). The "Externalized Self-Perception" subscale demonstrated a moderately strong internal consistency (α = .82). However, the researchers decided to exclude the "Care as Sacrifice" subscale due to low internal consistency (α = .48).

Stereotypical Roles of Black Women Scale

The SRBWS is a 34-item scale (see Appendix G; Thomas et al., 2004) used to examine perceptions of stereotypes of Black women. The scale has four subscales corresponding to Mammy, Jezebel, Sapphire, and Superwoman stereotypes. The instrument was not publicly available, so I obtained permission (see Appendix F). However, I used only the "Mammy" subscale to assess self-neglect, an independent variable for the present study. Thomas created a 34-item based on recent literature regarding the rational approach to scale development (Dawis, 2000). The original research included a sample of 10 undergraduate and graduate college women who ranged in age from 18–36 years of age to determine the readability and appropriateness of the items. Consequently, the second authors added the remaining items in response to the initial reactions and construct definitions (Dawis, 2000).

The ratings for the items were on a 5-point Likert scale: 1 =*strongly disagree*; 2 = *disagree*; 3 = *undecided*; 4 = *agree*; and 5 = *strongly agree*. Higher scores were indicative of more endorsement of the stereotypes. The Mammy subscale used statements such as, "I feel guilty when I put my own needs before others," "People often expect me to take care of them," and "I am always helping someone else." Thereby, the scale had a moderate internal consistency reliability coefficient of the Mammy subscales (.52). Current research supported the validity and internal consistency through significant positive associations with symptoms of depression and anxiety associated with the SBW stereotype (Watson & Hunter, 2015; Watson-Singleton et al., 2017), and the internal consistency demonstrated a range of .64 to .85 (Donovan & West, 2014; Watson-Singleton et al., 2017).

A study performed by Knighton et al. (2022) modified the SRBWS to a 10-item scale to assess the Superwoman's characteristics of obligation to display strength/suppress emotions despite multiple stressors. A factor analysis of 242 Black women from 19-72 years of age (M = 39.49 years) to assess the reliability of the obligation to show strength/suppress emotions subscale. Some items included: "I find it difficult to ask others for help," "I feel that I need to push my emotions down," and "I cannot let others see me cry." A 4-point Likert scale rated the participant's responses ranging from 1 = *strongly agree*, 2 = *agree,* 3 = *disagree to* 4 = *strongly disagree*, a different range from the original scale. The reason for the researchers' change of the parameters of the Likert scale is unknown.

The researchers assessed internal consistency using reliability analysis. The Cronbach's alpha was 0.88, and the summed item responses ranged from 20.00 to 40.00 (M = 26.67, SD = 5.74). A reverse score was applied to negatively worded responses were reverse scored. Moreover, higher scores indicated a more significant endorsement of the Superwoman stereotype that demands the display of strength and silence despite significant stressors. The researcher used only the Mammy subscale for this study—the five-item Mammy subscale - as a measure of self-neglect, which has a score range of five to 25. Furthermore, for this study, a minimum score of five on the Mammy subscale underlined low levels of the independent variable, self-neglect. However, scores above 16 were indicative of elevated levels of self-neglect behaviors.

Eating Behavior Patterns Questionnaire

The EBPQ (see Appendix H; Schlundt et al., 2003) measures six eating dimensions: low-fat eating, emotional eating, snacking on sweets, cultural/ethnic, haphazard planning, and meal planning. Each item, rated on a 5-point Likert scale, 1 = *strongly disagree,* 2 = *disagree,* 3 = *neutral or not applicable,* 4 = *agree,* and 5 = *strongly agree*. This instrument is not for public use; therefore, the researcher obtained permission (see Appendix J). For this study, the researcher used EBPQ to measure the dependent variable, disordered eating. Schlundt et al. (2003) created the questionnaire from a study that included 40 African American/Black women in focus groups, 80 African American/Black women to test the initial questionnaire, and 310 African American/Black women with different SES backgrounds to validate the questionnaire. The researchers used a statistical analysis through focus groups to create 113 behavioral items with a food

frequency questionnaire that reduced it to 51. Then, they used factor analysis to create the subscales and correlation (*r*) and multiple regression analysis (R) to check construct validity.

The questionnaire included six subscales. The "low-fat eating" is a 14-item subscale (score range of 14 - 70) that includes statements, "Instead of planning meals, I choose what is available and what I feel like eating" (α =.84, M = 38.3, SD = 9.6). "emotional eating" is a 10-item subscale (score range of 10 – 50) that included the following statement, "My emotions affect what and how I eat" (α = .77, M =30.8, SD = 6.5). The "snacking on sweets" is a 6-item subscale (score range of 6 – 30) that included the following statement such as, "I eat cookies, candy bars, or ice cream in place of dinner" (α = .74, M = 17.1, SD = 4.5). The "cultural/lifestyle behaviors" is a 7-item (score range of 7 – 35) subscale that contained the statement, "I have a serving of meat at every meal" (α = .59, M = 27.8, SD = 4.7). The "haphazard planning" is a 9-item subscale (score range of 9 – 45) that includes statements, e.g., "I would rather buy take-out food and bring it home rather than cook" (α = .50, M = 21.8, SD = 4.0). Moreover, the "meal skipping" is a 5-item subscale (score range 5 – 25) that included statements, "If I am busy, I will eat a snack instead of lunch" (α = .59, M = 15.9, SD = 3.4). Thus, the inventory demonstrated a reliability of α = .50 to .84. As for validity, the subscales were significant predictors of micronutrient (*R* values from .22 to .47 and macronutrient intakes (*R* values from .33 to .58) and demonstrated construct validity in relationship to other measures of eating behavior (*R* values from .22 to .65). For the present study, I used the entire scale and added the subscales to gain a total score that ranged from 51 -255 to

measure the dependent variable, disordered eating. Higher scores are indicative of adverse eating patterns.

Attitude Towards Seeking Professional Psychological Help Scale, Short Form

The ATPPHS-SF (see Appendix J; Fisher and Farina, 1995) is a 10-item shortened and revised version of the 29-item ATPPHS to measure psychological openness, indifference to stigma, and help-seeking propensity and demonstrated adequate reliability ($\alpha = .70$) with Black college students. To update the original version, the researchers selected 14 items with the highest-item total scale correlation (rs > .45) and made minor revisions. The ATSPPH-SF is a 4-point Likert scale with 0 = *disagree,* 1 = *partly disagree,* 2 = *partly agree,* and 3 = *agree*). Five of the ten items were reverse scored, and higher scores reflected positive attitudes towards seeking help from behavioral health. The revised and shorter form of the assessment contained the following statements: "If I were experiencing a mental breakdown, my first inclination would be to get professional attention," and "If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy." The instrument was publicly available, and for this study, the researcher used the ATPPHS-SF to measure the dependent variable, stigma towards seeking support from behavioral health.

The total scores of the ATPPHS-SF ranged from 0 – 30, with higher scores indicative of positive attitudes toward seeking professional psychological help. Thus, the mean and standard deviation for the ATPPHS-SF in Fischer and Farina's (1995) study was $M = 57.13$, $SD = 11.56$ (women), and $M = 45.36$, $SD = 12.74$ (men). The shortened

version correlated with the more extended version (.87) as they measured the same construct (Fischer & Farina, 1995). The revised and shortened form has demonstrated good internal consistency, test-retest reliability of .80 over one month, and convergent validity is indicated by significant associations with psychological help-seeking behavior.

Watson et al. (2017) performed a study with 251 Black women with age ranges from 18 -88 (M = 30.96, SD = 13.70) from online organizations and a Midwestern university psychology subject pool to construct and validate a scale that captures the perceptions and experiences of seeking psychological help. They found adequate reliability with Black college students (α = .70). For the present study, the researcher used the entire scale of the shortened version and added the total of the subscales.

For this study, the researcher used the entire scale of the 10-item, shortened version of the ATSPPHS. High scores corresponded with a lower stigma towards seeking support from behavioral health services. In comparison, low scores will equate to a higher stigma towards seeking support from behavioral health services. Additionally, the researcher used the ATPPHS-SF to measure the dependent variable, stigma towards seeking support from behavioral health.

Data Analysis Plan

The analysis plan for the study included data from a sample of Black/African American women aged 18–75 years from the SurveyMonkey platform that offered unidentifiable coding methods to keep participants' identities anonymous. The data from the SurveyMonkey platform were exported to an Excel spreadsheet to observe and exclude inadequate data before importing the information into SPSS, Although the

participants accessed the survey link anonymously, it was vital to scrub the data and expunge any identifiable information linked to the participant. Moreover, the data was verified for data accuracy alignment with SPSS, version 29, available through Walden University.

It was essential for the analysis of two multiple linear regression (MLR), one for each research question and dependent variable, which aided in addressing the two research questions regarding the relationship between the independent variables (IVs) and dependent variables (DVs). Before the final analysis, it was necessary to check and mitigate the following MLR assumptions: (1) continuous dependent variable, (2) sufficient sample size, (3) no significant outliers, (4) no multicollinearity, (5) independence of residuals, (6) linearity, (7) normality, (8) multivariate normality, and (9) homoscedasticity. The multiple regression analyses tested the extent of the relationship between (a) self-silencing and self-neglect behaviors and disordered eating and (b) self-silencing and self-neglect behaviors and stigma towards seeking support from behavioral health services. The two predictor variables were self-silencing and self-neglect, and disordered eating and stigma towards seeking support from behavioral services functioned as outcome variables. The study was guided by two research questions.
RQ1: To what extent does self-silencing and self-neglect behaviors affect disordered eating in Black women who adopt SWS.

H_o1: Self-silencing and self-neglect behaviors are not statistically significant predictors of disordered eating in Black women who adopt SWS.

H_a1: Self-silencing and self-neglect behaviors are statistically significant predictors of disordered eating in Black women who adopt SWS.

RQ2: To what extent does self-silencing and self-neglect behaviors affect stigma towards seeking help from behavioral health services in Black women who adopt SWS?

H_o2: Self-silencing and self-neglect behaviors are not statistically significant predictors of stigma towards seeking help from behavioral health services in Black women who adopt SWS.

H_a2: Self-silencing and self-neglect behaviors are statistically significant predictors of stigma toward seeking help from behavioral health services in Black women who adopt SWS.

As part of the cleaning and screening process, I removed cases with missing values. Initially, I ensured that the two independent and dependent variables were continuous variables. Before performing the MLR, I had to check that there was linearity between the dependent and independent variables with a simple linear regression and a visualization of scatterplots. Next, the assumption of independence of observations was tested using the Durbin-Watson test. Then, the assumption of homoscedasticity was checked with a plot of studentized versus unstandardized predicted values. The Quantile-Quantile (Q-Q) plot was used to test the assumption of normality of residuals. As there should have been an absence in multicollinearity, the assumption was assessed by calculating Variance Inflation Factor (VIF). Multicollinearity is a product of highly correlated independent variables and can disrupt the ability to determine the variance of the independent variable on the dependent variable (Laerd, 2015). If there was any

multicollinearity in the data, the Variance Inflation Factor value (VIF) would have been greater than 10. Finally, I checked for outliers using Cook's Distance. The presence of outliers or influential points have the potential to negatively impact the values of the independent and dependent variables, thus, affecting the regression line (Laerd, 2015).

The interpretation of the study results began with an assessment of key components of the MLR. This evaluation of the Model Summary included the evaluation of the multiple correlation coefficient (R) and the coefficient of determination (R^2). The statistical significance of the overall model was represented in the ANOVA table as the F, $p < 0.05$. The contributions of each independent variable controlling for the other were examined using the *partial r*.

Threats to Validity

I was continuously mindful and investigated any threats to validity because the entire study could have been in jeopardy. Studies with a non-experimental and correlational design are subject to low internal validity because the independent variable(s) are not manipulated (Cutler, 2017). However, it was essential for the researcher to recognize and resolve potential threats to validity. Threats to validity in this design and population had the propensity towards selection bias and the instruments chosen to measure the variables of interest.

External Validity

Threats to external validity are the generalization of the research findings to the participants or other individuals, settings, and past and future situations (Creswell & Creswell, 2018). Therefore, one crucial threat to external validity was selection bias.

Selection bias happens when the researcher select participants who encompass certain characteristics that may result in certain outcomes (Creswell & Creswell, 2018). The small sample size of 78 participants cannot be generalized to all Black/African American females.

Internal Validity

Correlational research is often low in threats to validity because the researcher does not manipulate or control the variables (Cutler, 2017). Instrumentation can threaten internal validity, especially if it does not correctly measure the variables of interest. Therefore, the researcher minimized this threat using instruments tested for good test-retest reliability and construct and content validity.

Ethical Procedures

I obtained permission from Walden University's Institution Review Board (IRB) to perform the study. All research participants received IRB-approved invitations and links to SurveyMonkey through online social media platforms (Facebook, Instagram, Walden University participant pool, and LinkedIn). Additionally, the I posted invitation flyers (see Appendix A) in local churches and barber/beauty shops. All recruitment material included my contact information to address any questions or concerns related to the study.

The informed consent form was available via SurveyMonkey at the survey initiation. There was the highest intent of privacy and confidentiality during the study. I maintained the anonymity of participants by never asking for names, email addresses, phone numbers, or any identifiable information. Participants received the link to the

surveys on SurveyMonkey, the chosen data collection platform, through online recruitment and flyers. Thus, the demographic forms or platform did not prompt potential participants to identify information.

Participants had the right to decline or abstain from participation at any time (they could stop the survey by simply exiting the browser). The survey was not deceptive because all qualifying information, confidentiality concerns, and minimal information about the study's purpose were available on the informed consent form. Furthermore, I used the SurveyMonkey platform and a personal computer to store the participant data, survey information, and results will be stored for five years. Thus, the information will be destroyed after this time. Only committee members and I had access to the data.

Ethical Concerns

There were several ethical concerns during the implementation of this study. One concern was the use of social media platforms for participant recruitment and anonymity. Although recruitment marketing guaranteed anonymity, social media platforms are vulnerable to exposing personal identity. Another ethical concern was a participant's ability to comprehend the questions and my inability to clarify any concerns. And a final concern was participant withdrawal because of a possible trigger to internalized stress or existing mental conditions.

Summary

Chapter 3 included a detail of the research plan for this study. The data was collected from Black women between the ages of 18 and 75 who self-identified with SWS adoption. This data for this sample was obtained with the online data platform,

SurveyMonkey. the proposed data collection and analysis plan comprising of the research questions, hypotheses methods, research design, instruments, construct reliability and validity concerns, research rationale, threats to validity, and ethical procedures. Chapter 4 will provide a comprehensive overview of the data collection procedures, descriptive statistics, research questions, hypotheses, analyses, and interpretation of the findings.

Chapter 4: Results

This quantitative analysis examined the extent of the relationship between self-silencing self-neglect, disordered eating, and stigma toward seeking support from behavioral health services among Black women aged 18–75 who adopted the SBWS. I used the G-SWS-Q to measure the adoption of SBWS, STSS to measure levels of self-silencing, the Mammy subscale of the SRBWS to measure self-neglect, the EPBQ to measure disordered eating, and the ATSPPHS-SF to measure stigma toward seeking help from behavioral health services. Multiple regression analysis was appropriate to examine the extent of the relationship between two independent variables (self-silencing and self-neglect) and each dependent variable (disordered eating and stigma toward seeking help from behavioral health services) according to the level of adoption of SBWS in Black women age 18–75. Two research questions and their corresponding hypotheses guided this study:

RQ1: To what extent does self-silencing and self-neglect behaviors affect disordered eating in Black women who adopt SWS?

H_o1: Self-silencing and self-neglect behaviors are not statistically significant predictors of disordered eating in Black women who adopt SWS.

H_a1: Self-silencing and self-neglect behaviors are statistically significant predictors of disordered eating in Black women who adopt SWS.

RQ2: To what extent does self-silencing and self-neglect behaviors affect stigma toward seeking help from behavioral health services in Black women who adopt SWS?

H_o2: Self-silencing and self-neglect behaviors are not statistically significant predictors of stigma toward seeking help from behavioral health services in Black women who adopt SWS.

H_a2: Self-silencing and self-neglect behaviors are statistically significant predictors of stigma toward seeking help from behavioral health services in Black women who adopt SWS.

In Chapter 4, I present the data collection process, sample characteristics, descriptive statistics for study variables, reliability, assumption testing, and analyses and results. The chapter concludes with a summary of the findings.

Data Collection

Walden University's IRB approved the research to begin on February 5, 2023. The target population was Black/African American women aged 18–75. I used the Survey Monkey platform for data collection and recruited participants through social media platforms (e.g., Facebook) and via recruitment posters placed in churches and beauty shops. The length of time for each participant to complete the survey was approximately 20 minutes. To ensure attrition did not affect the results, only participants who met the inclusion criteria and completed surveys were counted as part of the data analysis. This action resulted in removing 10 surveys containing missing data or participants not meeting the inclusion criteria. After cleaning the data and removing the 10 surveys, I analyzed the remaining 78 in SPSS 29 and included all Black female participants between 22 and 68 years of age. I used G*Power software Version 3.1 to determine the minimum sample size. Based on the analysis, the study required 68

participants to identify a statistically significant relationship in the multiple regression analysis. I collected an additional 10% of surveys to ensure there were enough data to make up for missing or incomplete surveys.

Demographics

There were 78 Black/African American women from no self-defined area of the United States who anonymously volunteered to participate in this study. Black women from various backgrounds and adoption of SBWS were the target population.

The G-SWS-Q was used to assess the individual's level of SWS adoption with a minimum score of 15. This questionnaire was vital to study the effects of SWS adoption and the effect on self-silencing and self-neglect behaviors on disordered eating and stigma toward seeking help from behavioral health services. The maximum score for adoption was 101 with a mean of 72.26 and standard deviation of 16.010. All participants met the criteria for SWS adoption.

As shown in Table 1, the participants were Black/African American women. Those 22–35 years of age and younger comprised 27.1% of the sample. Participants aged 36–44 comprised 20.5% of the sample. Participants aged 45–64 comprised 69.6 % of the sample. Finally, participants aged 65–68 comprised 3.9% of the sample. Table 1 illustrates that 87.2% of the participants identified as heterosexual, 10.3% identified as bisexual, and 2.6% identified as lesbian. Regarding marital status, 59% were married, 14.1% were divorced, 1.3% were separated, and 25.6% were single. Regarding number of children, 26.9% did not have children, 62.9% had 1–3 children, and 10.2% had 4–6 children. The sample's highest level of education included 17.9% with some college,

10.3% with an associate's degrees, 1.3% with vocational degrees, 20.5% with bachelor's degrees, 43.6% with master's degrees, and 6.4% with doctoral degrees. In the category of household income, 3.8% of the participants earned $0–$24,999, 12.8% earned $25,000–$49,000, 28.2% earned $50,000–$74,999, 16.7% earned $74,999–$99,000, and 38% earned $100,000 and above.

Table 1

Sample Demographics

Demographic	Category	*n*	%
Gender	Male	0	0
	Female	78	100
	Nonbinary	0	0
	Gender not listed	0	0
Age	18–34 (early adulthood)	14	18.10
	35-44 (early middle)	16	20.50
	45-64 (late middle)	45	58.10
	65-75 (late adulthood)	3	3.90
Race/ethnicity	American Indian or Alaskan Native	0	0.00
	Asian/Pacific Islander	0	0.00
	Black or African American	78	100.00
	Hispanic	0	0.00
	White	0	0.00
	Multiple ethnicity	0	0.00
Language	English	78	100.00
	French	0	0.00
	Spanish	0	0.00
Children	0	21	26.90
	1	19	24.40
	2	18	23.10
	3	12	15.40
	4	3	3.80
	5	4	5.10
	6	1	1.30
Sexual orientation	Heterosexual	68	87.20
	Lesbian	2	2.60
	Homosexual	0	0.00
	Bisexual	8	10.30
	Pansexual	0	0.00
	Other	0	0.00
Marital status	Single	20	25.60
	Married	46	59.00
	Divorced	11	14.10
	Separated	1	1.30
	Widowed	0	0.00
	Domestic partnership	0	0.00
Highest level of education	None of the above	0	0.00
	High school diploma/GED	0	0.00
	Some college	14	17.90
	Associate's degree	8	10.30
	Vocational degree	2	1.30
	Bachelor's degree	16	20.50
	Master's degree	13	16.28
	Doctoral or PhD	5	6.40
Income	$0 to $24,999	3	3.49
	$25,000 to $49,999	10	17.44
	$50,000 to $74,999	22	26.74
	$75,000 to $99,000	13	16.28
	$100,000 and above	30	38.37

Descriptive Statistics for Study Variables

The two independent variables used in testing the hypotheses in the study were self-silencing and self-neglect. Self-silencing was measured by STSS, which is a 31-item scale that has six subscales. This assessment included a five-point Likert response scale with the following responses *strongly disagree* =1, *somewhat disagree* = 2, *neither agree nor disagree* = 3, *somewhat agree* = 4, and *strongly agree* = 5. High scores for self-silencing indicated a Black woman's propensity toward internalizing emotions to maintain a relationship. The Mammy subscale, a 5-item Likert-type scale of the SRBWS, was used to measure self-neglect behavior. The participants' responses were rated on a 4-point Likert scale including 1 = *strongly agree*, 2 = *agree*, 3 = *disagree*, and 4 = *strongly disagree*. High scores for self-neglect indicated a Black woman's propensity to neglect personal needs for the sake of nurturing others. As shown in Table 2, the sample mean score for self-silencing behavior was 86.17 (*SD* = 24.597). For self-neglect behavior, the sample mean score was 16.73 (*SD* = 3.695).

Table 2

Descriptive Statistics for Variables

Variable	*N*	Range	Minimum	Maximum	*M*
SS	78	96.00	47.00	143.00	86.17
SN	78	14.00	10.00	24.00	16.73
DE	78	104.00	99.00	203.00	145.87
SBH	78	25.00	5.00	30.00	14.32

Valid *N* = 78, SS = self-silencing, SN = self-neglect, DE = disordered eating, SBH = stigma towards...

The two dependent variables used in testing the hypotheses were disordered eating and stigma toward seeking help from behavioral health services. Likert-type scales

were employed as a source of measurement for the survey questions. The EBPQ was used to measure the dependent variable, disordered eating; the 51-item questionnaire included a scale with 1 designating *strongly disagree*, 2 *disagree*, 3 *neutral or not applicable*, 4 *agree*, and 5 *strongly agree*. High scores were indicative of disordered eating patterns. Stigma toward seeking help from behavioral health services was measured by the ATSPPHS-SF, a 10-item questionnaire that included a 4-point Likert-type scale that included 0 = *disagree*, 1 = *partly disagree*, 2 = *partly agree*, and 3 = *agree*. Five of the 10 items (2, 4, 8, 9, 10) were reverse scored. Higher scores indicated positive attitudes toward seeking professional psychological help. As shown in Table 2, the sample mean for disordered eating was 145.87 (*SD* = 18.702). The sample mean for stigma toward seeking help from behavioral health services was 14.32 (*SD* = 2.863). Table 2 displays the descriptive statistics of all variables for range, minimum, maximum, mean scale scores, standard deviation, and variances for independent variables self-silencing and self-neglect and dependent variables disordered eating and stigma toward seeking help from behavioral health services.

Assumption Testing

I used a multiple regression model that required analyzing six assumptions: linearity, multicollinearity, independence, homoscedasticity, multivariate normality, and no influential cases that biased the model.

Linear Relationship

The assessment of linearity was conducted through SPSS scatterplots for each independent variable and the relationship to each dependent variable. Figures 1, 2, 3, and

4 illustrate the relationships. The scatterplot and correlation between self-silencing and disordered eating were found to have a correlation (r = .440). Additionally, there was a correlation between self-neglect and disordered eating (r = .320). As shown in Table 3, there was a linear relationship between the independent variable and dependent variable, which suggested a significant correlation. However, for stigma toward seeking help from behavioral health, the relationship was not linear (see Table 4).

Table 3

Correlation Matrix for Multiple Regression of Self-Silencing and Self-Neglect and Disordered Eating

Correlation	n = 78	Disordered eating	Self-silencing	Self-neglect
Pearson correlation	Disordered eating	1.00	.440	.320
	Self-silencing	.440	1.00	.698
	Self-neglect	.320	.698	1.00
Sig. (1-tailed)	Disordered eating		<.001	.002

Table 4

Correlation Matrix for Multiple Regression of Self-Silencing and Self-Neglect and Disordered Eating

Correlation	n = 78	Stigma towards…	Self-silencing	Self-neglect
Pearson Correlation	Stigma towards…	1.00	-.040	-.072
	Self-silencing	-.040	1.00	.698
	Self-neglect	-.072	.698	1.00
Sig. (1-tailed)	Stigma towards		.365	.265

Figure 1

Scatterplot of the Linear Relationship Between Self-Silencing and Disordered Eating

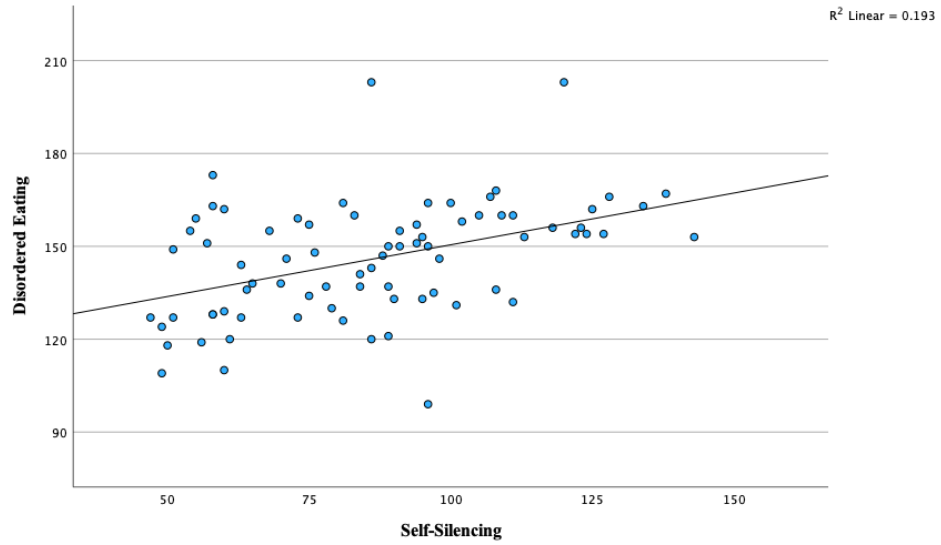


Figure 2

Scatterplot of the Linear Relationship Between Self-Silencing and Disordered Eating

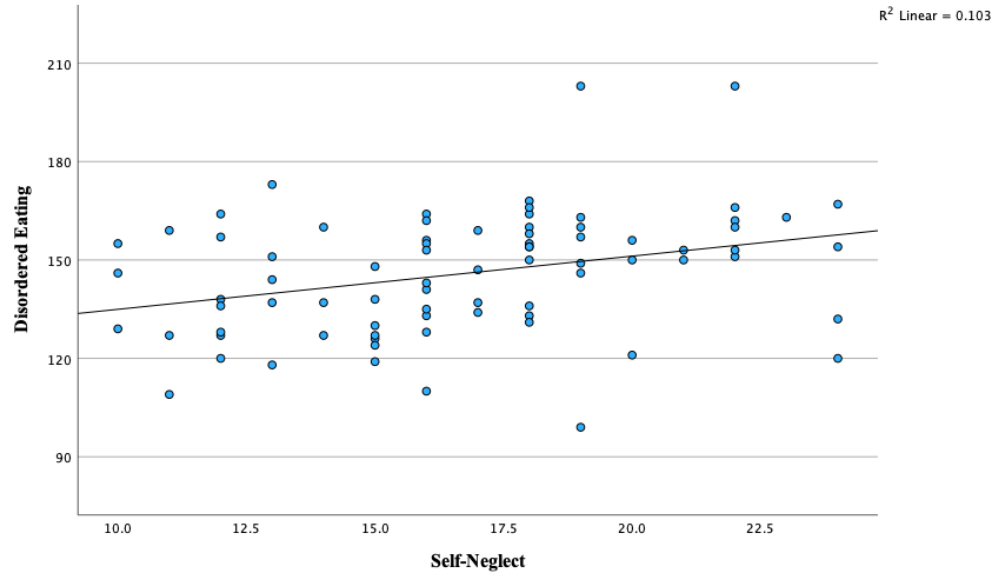


Figure 3

Scatterplot of the Linear Relationship Between Self-Silencing and Stigma Toward Seeking Help From Behavioral Health Services

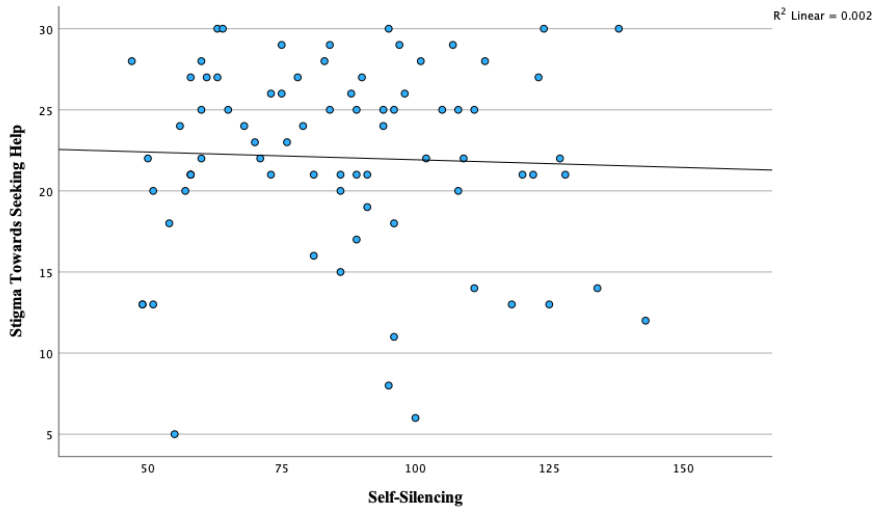
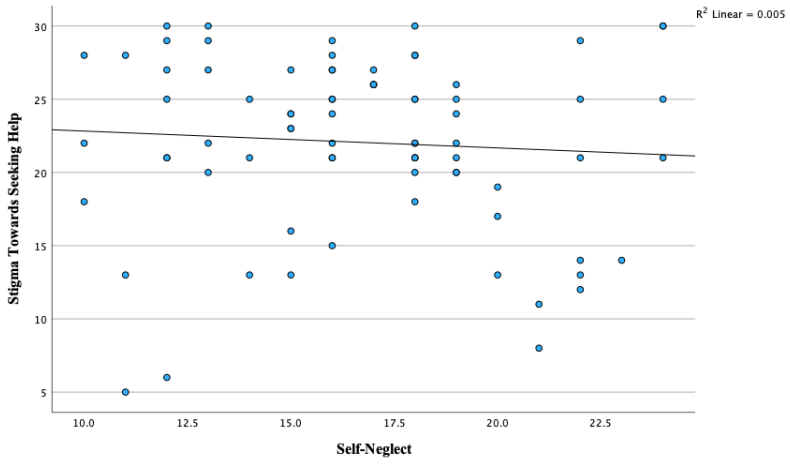


Figure 4

Scatterplot of the Linear Relationship Between Self-Neglect and Stigma Toward Seeking Help From Behavioral Health Services



Multicollinearity

Multicollinearity occurs when there is a high correlation between two independent variables. This assumption can be tested through a two-stage process that consists of inspection of the correlations and Tolerance/VIF values (Laerd, 2015). There was an assumption that there was a very low correlation between the independent variables. Therefore, it was necessary to ensure the absence of multicollinearity. The multicollinearity analysis occurred when using SPSS and a visual inspection of the correlation coefficients and VIF results. As presented in Table 5, none of the independent variables had a correlation higher than 0.7, and the Tolerance levels were lower than 0.1, indicating there is no multicollinearity between the independent variables.

Table 5

Coefficients of Independent Variables

Unstandardized coefficients			Standardized coefficients			Collinearity statistics	
Dependent variable: eating behavior patterns							
	B	Std. Error	Beta	*t*	*Sig*	Tolerance	VIF
Dependent variable: eating behavior patterns							
(Constant)	116.043	9.04		12.84	<.001		
SS	.320	.110	.421	2.91	.005	.512	1.95
SN	.134	.733	.026	.183	.855	.512	1.95
Dependent variable: stigma toward seeking help from behavioral health services							
(Constant)	23.98	3.13		7.66	<.001		
SS	-.010	.028	-.040	-.346	.730	1.00	1.00
SN	-.115	.183	-.072	-.629	.591	1.00	1.00

Independence of Errors

To ensure that autocorrelation did not appear within the dependent variables or study outcomes, the independence of errors was assessed through a multiple linear regression analysis. The Durbin-Watson was performed with SPSS to test the autocorrelation in residuals from the regression analyses and to investigate the independence of errors from each other. Table 6 shows the Durbin-Watson for the relationship between self-silencing, self-neglect, and disordered eating is 1.92, indicating that there is no correlation between the errors. Furthermore, the Durbin-Watson for the relationship between self-silencing, self-neglect, and stigma towards seeking help from behavioral health services is 2.26, which also signifies that there is no correlation between the errors. Therefore, the Durbin-Watson statistics denote the absence of a violation in the assumption of independent errors.

Table 6

Model Summary of Residual Independence

Model	*R*	R^2	Adjusted R^2	Standard error of estimate	Durbin-Watson
1	.440[a]	.194	.172	17.01	1.92

a. Predictors: (Constant), SS, SN
b. Dependent variable: EBPQ

2	.074[a]	.005	-.021	5.96	2.26

a. Predictors: (Constant), SS, SN
b. Dependent Variable: SBH

Homoscedasticity

The homoscedasticity assumption was measured with SPSS to confirm that the regression results were consistent. The existence of homoscedasticity will be viewed by plotting the studentized residuals against unstandardized predicted values. And the points will not exhibit a pattern and demonstrate a consistent distribution (Laerd, 2015). If any of the patterns existed, there was presence of heteroscedasticity, and thus, a violation of the assumption. The scatterplots in Figures 5 and 6 represent the output of the points and show that the patterns do not exist. Thus, homoscedasticity was confirmed with the scatterplot outputs.

Figure 5

Scatterplot of DE Standardized Residual Values and Standardized Predicted Values

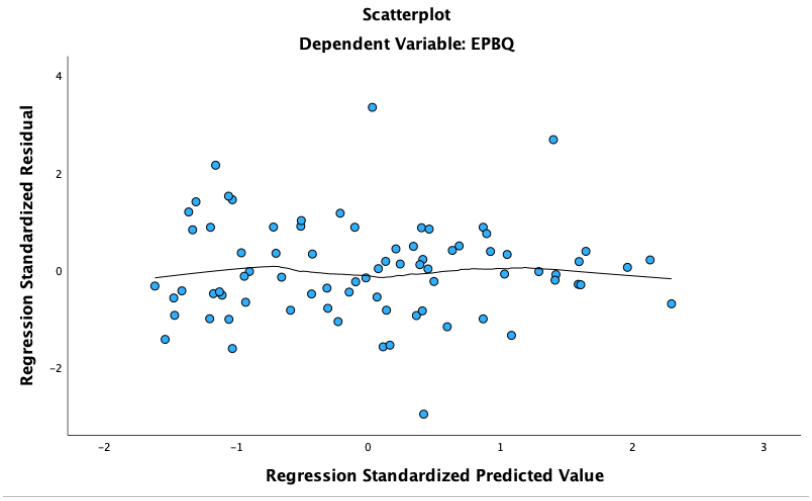
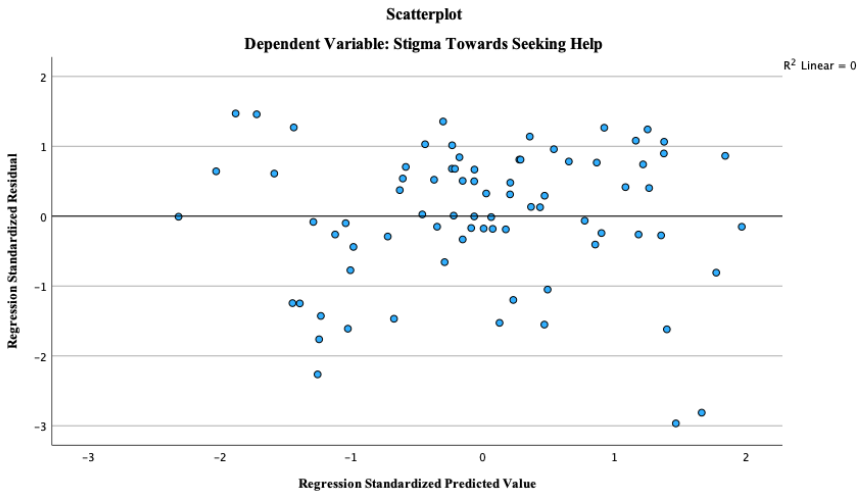


Figure 6

Scatterplot of SBH Standardized Residual Values and Standardized Predicted Values



Multivariate Normality

It was assumed that there was the presence of multivariate normality, the assumption of normal distribution of residuals in the study. This assessment was performed using SPSS for the creation of a quantile-quantile (Q-Q) plot. Figures 7 – 9 (shown below) represent straight diagonal line within their Q-Q plots. The plots are visual evidence that the assumption of multivariate normality was met and there was not a violation. The appearance of a straight line on the graphs, this denotes that the residuals are normally distributed.

Figure 7

Scatterplot of SBH Standardized Residual Values and Standardized Predicted Values

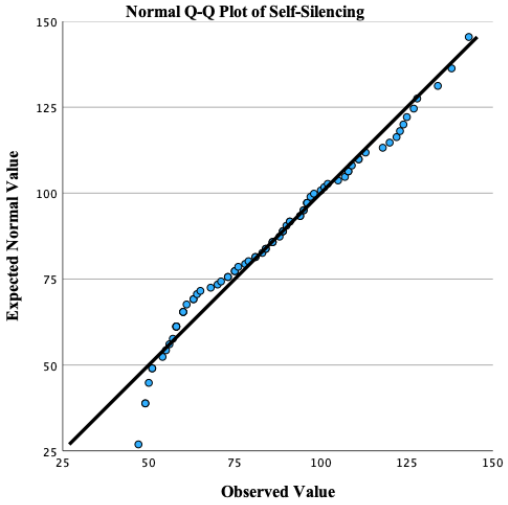


Figure 8

Q-Q Plot Assessing Normality of Self-Neglect

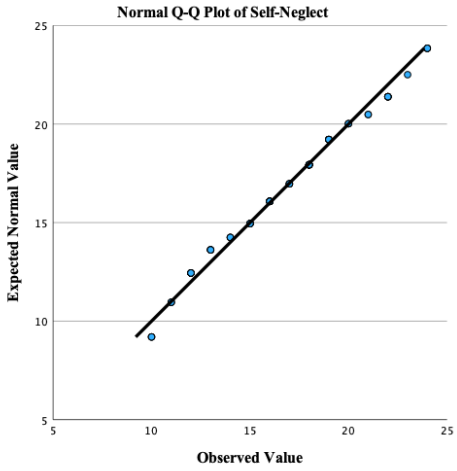
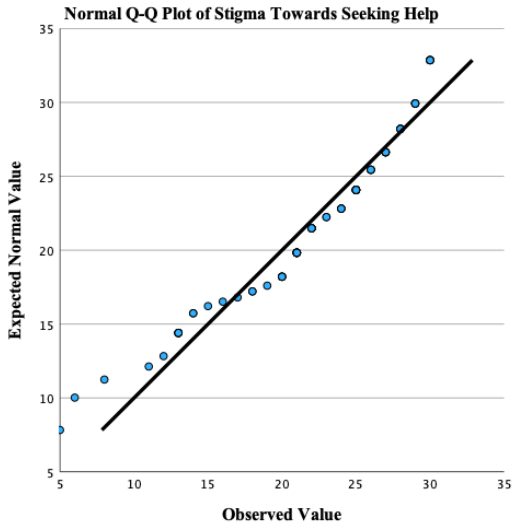


Figure 9

Q-Q Plot Assessing Normality of Stigma Toward Seeking Help From Behavioral Health Services



No Influential Biasing

The last assumption is that none of the individual outliers influenced the direction of the analysis. Therefore, Cook's Distance measures the influence, and any value of 1 indicates influential bias (Laerd, 2015). The data in Table 7 and Table 8 validated that individual cases did not influence the data because none of the values were greater than 1.

Table 7

Residual Statistics

	Minimum	Maximum	Mean	Std. deviation
Cook's distance	.000	.117	.013	.024

a. Dependent Variable: Disordered Eating

Table 8

Residual Statistics

	Minimum	Maximum	Mean	Std. deviation
Cook's distance	.000	.154	.015	.027

a. Dependent Variable: Stigma Towards Seeking Help from Behavioral Health Services.

Results

Two multiple regression analyses were conducted as the primary focus on the two research questions. The first analysis examined the dependent variable, disordered eating and the predictor variables of self-silence and self-neglect. The second analysis examined the dependent variable, stigma towards seeking help from behavioral health services and the predictor variables of self-silence and self-neglect. The results of the analyses are below.

Disordered Eating

The multiple regression analysis examined the predictor variables, self-silencing and self-neglect and the outcome variable, disordered eating. As shown in Table 9, the model was statistically significant as indicated by an F-statistic of 9.00 with a p-value less than .001, F (2, 75), suggesting that the model explains a significant portion of the variance in disordered eating scores. The adjusted R^2 value of .172 further illustrated that the model can account for 17.2% of the disordered eating assessment scores' variability, emphasizing the predictor's impact. Self-silencing was a significant predictor of Black women's disordered eating, partial $r = .318$, $p = .005$, $\beta = .320$. On the contrary, self-neglect was not a significant predictor of disordered eating, $r = .021$, $p = .855$, $\beta = .134$.

Table 9

Model Summary for Multiple Regression of Self-Silencing and Self-Neglect Behavior on Disordered Eating

Model	*R*	R^2	Adjusted R^2	Standard error of estimate
1	.440[a]	.194	.172	17.02

a. Predictors: (Constant), SS, SN
b. Dependent Variable: DE

Table 10

ANOVA Statistics for Multiple Regression of Self-Silencing and Self-Neglect Behaviors on Disordered Eating

Model 1	Sum of squares	*df*	Mean square	*F*	Sig.
Regression	5212.74	2	2606.3	9.00	<.001[b]
Residual	21719.98	75	289.60		
Total	26982.72	77			

a. Predictors: (Constant), SS, SN
b. Dependent Variable: DE

Table 11

Coefficients for Multiple Regression of Self-Silencing and Self-Neglect Behaviors on Disordered Eating

Model Part		Unstandardized β	Coefficients std. error	Standardized coefficients beta	*t*	Sig.	Zero-order	Correlations partial	Part
1	(Constant)	116.04	9.04		12.84	<.001			.
	Self-silencing	.320	.110	.421	2.91	.005	.440	.318	.301
	Self-neglect	.134	.733	.026	.183	.855	.320	.021	.019

a. Dependent Variable: DE

Stigma Toward Seeking Help From Behavioral Health Services

The multiple regression analysis examined the predictor variables, self-silencing and self-neglect, and the outcome variable, stigma towards seeking help from behavioral health services. As shown in Tables 12 and 13, the model was non-significant as indicated by an *F*-statistic of .204 with a *p*-value larger than .05 at .816, $F(2, 75)$, suggesting that the model does not explain a significant portion of variance in the stigma towards seeking help from behavioral health scores.

Table 12

Model Summary for Multiple Regression of Self-Silencing and Self-Neglect Behavior on Stigma Toward Seeking Help From Behavioral Health Services

Model	*R*	R^2	Adjusted R^2	Standard error of estimate
1	.074[a]	.005	-.021	5.96

a. Predictors: (Constant), SS, SN
b. Dependent Variable: SBH

Table 13

ANOVA Statistics for Multiple Regression of Self-Silencing and Self-Neglect Behaviors on Stigma Toward Seeking Help From Behavioral Health Services

	Sum of squares	*df*	Mean square	*F*	Sig.
Regression	14.495	2	7.248	.204	.816[b]
Residual	2667.30	75	35.56		
Total	2681.80	77			

a. Predictors: (Constant), SS, SN
b. Dependent Variable: SBH

Summary

This quantitative study used data that was collected from 78 participants to analyze two research questions using simple and multiple linear regression. The independent variables used in the study were self-silencing and self-neglect. While the dependent variables were disordered eating and stigma towards seeking help from behavioral health services for the analyses. The first research question addressed the extent of the relationship between self-silencing, self-neglect, and disordered eating. The

multiple regression analysis found that self-silencing and self-neglect are predictors of disordered eating. An examination of the partial correlations for unique variance indicated that self-silencing was significant, while self-neglect was not. For research question 2, the multiple regression analysis between self-silencing, self-neglect, and stigma toward seeking help from behavioral health services indicated that there was no relationship between the variables.

Chapter 5 will provide a restatement of the purpose of the study and an interpretation of the findings from the analyses, in addition to a discussion of the theoretical framework. There will also be a discussion about the limitations of the study, generalizations, validity, and reliability of the study. Furthermore, recommendations will be given to promote future research on the development of mental health interventions for Black women. Finally, there will be implications for methodological, theoretical, positive social change, and current practice.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to examine the extent of the relationship between self-silencing, self-neglect, disordered eating, and stigma toward seeking support from behavioral health services among Black women who adopt SBWS. In this study, I used a survey method with a correlational nonexperimental design. Researchers had reported that the SWS characteristics are a self-protective measure for Black women because they endure sexism and racism in their communities and in external settings (Burke et al., 2020; Fehrenbacher & Patel, 2020; Warner et al., 2018). Previous studies focused qualitatively on the SWS; however, the current quantitative study focused on self-silencing and self-neglect characteristics of SWS to extend the previous research.

Key Findings

Self-Silencing, Self-Neglect, and Disordered Eating

The first research question addressed the possible relationship between self-silencing, self-neglect, and disordered eating in Black women aged 18–75 who adopt SWS. Results from the multiple regression analysis indicated that self-silencing and self-neglect were predictors of disordered eating. The partial correlations for unique variance indicated that self-silencing was significant while self-neglect was not.

Self-Silencing, Self-Neglect, and Stigma Toward Seeking Help From Behavioral Health Services

The second research question addressed the possible relationship between self-silencing, self-neglect, and stigma toward seeking help from behavioral services in Black women aged 18–75 who adopt SWS. Results from the multiple regression analysis

indicated no significant relationship between the variables. Most participants scored above the mean score, which indicated that participants did not have stigma toward seeking support from behavioral health services.

Interpretation of the Findings

Prior to the current study, there was a lack of understanding of the impact of gendered racism and the protective identity of SWS components of self-silencing and self-neglect behaviors on disordered eating and stigma toward seeking behavioral support in Black women. SWS as a strength-based schema has associations with anxiety and depression, sleep deprivation, self-care, an increase in disordered eating, and a decrease in health-seeking behaviors (Abrams et al., 2018; Black & Wood-Giscombe, 2012; Harrington et al., 2010; Watson & Hunter, 2015; Woods-Giscombe et al., 2019; as cited in Harris et al., 2022). Salami et al. (2019) reported that as Black women increasingly identified with their cultural worldview as a means of protecting against racism, there was an increase in disordered eating.

However, there is a lack of cultural relevance in BE assessments about LOC (loss of control), which lends to the lack of diagnosis in Black women (Raheb-Raukis & Jarosz, 2018). Allen et al. (2019) found that emotional suppression through self-silencing and self-neglect correlated with disordered eating. Similarly, M. K. Jones et al. (2021) found that the solid gendered racial identity of SBWS and the disconnecting coping style of self-silencing and self-neglect led to adverse psychological outcomes. Moreover, Hambrook et al. (2011) discovered a link between the core psychopathology of disordered eating and the propensity toward self-silencing behaviors as determined by

external perceptions. Talavera et al. (2019) added that the act of self-silencing is a means of maintaining harmony in the group but produces personal struggles with anxiety and depression.

Subsequently, minority women will engage in the coping mechanism of self-silencing when they become stressed by a cultural mismatch in a larger group. There is a relationship between SBWS and psychological distress. Nevertheless, the self-silencing component of SBWS as a product of externalized perceptions is an isolated mechanism that leads to depression (Abrams et al., 2018). Additionally, as a resource for buffering traumatic experiences, self-silencing as a protective measure of SBWS has direct implications for BE as a component of disordered eating (Harrington et al., 2010). Conversely, Perez et al. (2023) conducted a study on SWS as a protective mechanism for chronic psychosocial stress in Black women and an instigator for poor psychological health and found that self-silencing and self-neglect mechanisms of SWS were predictors of adverse psychological health. This was incongruent with my results because I found a relationship between self-silencing and disordered eating but no relationship between self-neglect and disordered eating.

Black communities are known for stigmatizing mental health and seeking support from behavioral health services because it delineates weakness. As the defined minority across sexual, gender, and religious identities, Black women often experience stigma toward seeking help from behavioral health services (Curtis-Boles, 2019). Villatoro et al. (2017) contended that gender differences with a combination of the intersectionality of gender, race, and SES inhibit the perception of the need for mental health services.

Erving et al. (2020) found that although SWS may help with some stress exposure, chronic stress will negatively impact the mental and physical health of Black women.

Despite having access to psychological resources, Black women will seek spiritual and social support. J. C. Hall et al. (2021) found that although Black women have a positive attitude toward mental health, they often feel a need to remain strong despite psychological distress because they feel stigma from their community and peers. Additionally, as Black women compared the privilege of work benefits to their parents and grandparents, time off from work and SWS possession helped them through stressful events. In my study, I did not find a relationship between self-silencing, self-neglect, and stigma toward seeking support from behavioral health services. Nelson et al. (2020) found that although Black women endorsed mental health utilization, most of their participants would not seek support based on a cultural history of mistrust in the health community and questioned whether symptoms were severe enough. However, only a minority of participants saw therapy as a means of self-care despite cultural stigma.

Findings from my study showed a relationship between self-silencing and disordered eating. Black women who use self-silencing behaviors of SWS as a source of protection against gendered racism are at a higher risk of developing disordered eating. My results showed a relationship between self-silencing and disordered eating. However, my results did not indicate a relationship between self-neglect and disordered eating. Additionally, my study did not find a relationship between self-silencing, self-neglect, and stigma toward seeking support from behavioral health services. My research differs from previous studies because I isolated self-silencing and self-neglect components of

SWS instead of using the entire schema to assess relationships. Additionally, my focus was not on one diagnosis of disordered eating but on the entire pathology. Furthermore, stigma toward seeking support from behavioral health services does not equate to mental health utilization.

Theoretical Interpretation

The current study was framed using the theories of self-silencing and intersectionality. Jack (1991) noted that the theory of silencing the self provides a framework that highlights a link between women's depressive symptomology and their roles in romantic relationships. As a social construct, the theory of self-silencing proposes that women are impacted psychologically by social roles in relationships that require emotional suppression and self-neglect. This theory applies not only to romantic relationships in Black women but also to sacrifices of self in intercultural and outer-cultural relationships. My results indicated that Black women are mentally impacted because of self-silencing behaviors. Participants with higher levels of self-silencing behaviors had higher levels of disordered eating. Conversely, although participants scored high on self-silencing, there was not a decrease in stigma toward seeking support from behavioral health services.

Moreover, intersectionality is beneficial for investigating the root causes of inequities at the intersection of race, gender, and social class (Bauer & Scheim, 2019). The hypothesis from the intersectionality theory suggests that there is a psychological impact on an individual who experiences stress from gendered racism. This theory addresses the adverse impact of policies, laws, and systems on social constructs. Because

SWS is a product of intersectionality, I measured self-neglect with the subscale of G-SWS to measure the impact of the cultural mandate of caring for others over self (self-neglect).

Limitations of the Study

There were several limitations in the execution of this study. The limitations included the online data platform, sampling, and recruitment. The initial limitation of the study was the quantitative survey method. Although conducting the survey through an online platform was cost-effective, expedited data collection, and ensured data quality, it was vulnerable to selection bias. Also, although participants were guaranteed anonymity, they could have provided answers that may not have been truthful and reflective of their beliefs. This absence of truthful responses may have affected the internal validity and created limitations for the study results. Also, the survey length may have deterred participation due to the time requirement of approximately 20 minutes. Finally, using a nonprobability, purposive sampling method to obtain the required sample size and to select specific characteristics for the study may have limited the generalizability of findings to other populations.

Recommendations

The findings of this study create opportunities for future research, particularly regarding the lack of statistical significance between self-silencing, self-neglect, and stigma toward seeking help from behavioral health services. Future studies might consider measuring stigma toward seeking help from behavioral health services by using an inventory that is normed with the Black female population. Because my participants

possessed a positive attitude toward seeking help from behavioral services, it may be conducive for future studies to measure the actual behavior toward seeking help from behavioral health services because the ATSPPHS-SF measures only attitudes.

Self-silencing and self-neglect were positively related to disordered eating. This means that increased behaviors of self-silencing and self-neglect indicated an increased propensity toward disordered eating. Future research could examine the specific aspects of the relationship between self-silencing, self-neglect, and disordered eating. Such insights could be instrumental in designing and implementing preventative and supportive interventions to help Black women become more aware of the adverse effects of self-silencing and self-neglect behaviors while providing them with the tools to navigate their mental health journeys.

Implications

In this study, I explored the predictive factors of self-silencing and self-neglect on disordered eating and stigma toward seeking help from behavioral health services among Black women who adopt SWS. The results revealed that self-silencing and self-neglect did not significantly predict stigma toward seeking help from behavioral health services. However, the variables were significant predictors of disordered eating. The study results highlight the association between self-silencing and the adverse effects of disordered eating within this demographic. Goode et al. (2020) suggested it is essential to enrich Black women's mental well-being and create conceivable strategies for preventing disordered eating. The current study's implications for positive social change are limitless, including advocating for national, state, and community-level support on

continuing research, didactics, and creating interventions about the protective and harmful aspects of self-silencing behaviors of SWS on disordered eating. This research contributes to filling the gap in the literature on the experiences of Black women who adopt SWS, highlighting the need for interventions to create positive strategies for coping with stressors to protect their mental health.

Conclusion

I recruited a sample of 78 Black women through social media and recruitment flyers throughout the United States to examine the predictive factors of self-silencing and self-neglect on disordered eating and stigma toward seeking help from behavioral health services. I employed multiple linear regression analyses based on four Likert scale surveys: STSS, the Mammy subscale of the SRBWS, EBPQ, and ATSPPHS-SF. The findings revealed no significant relationship between self-silencing, self-neglect, and stigma toward seeking help from behavioral health services. Therefore, this research contributes to the dialogue on disordered eating and stigma toward seeking help from behavioral health services within the Black female community. Findings bring attention to the importance of including Black women in studies involving mental health wellness, coping mechanisms, disordered eating, and stigma toward seeking help from behavioral health services, which may foster positive social change.

Aside from its contributions, the current study had limitations, strengths, and areas for growth while offering new actions for future research to draw attention to the aspects of disordered eating and stigma toward seeking help from behavioral health services in Black women who adopt SWS. Additionally, the study encouraged

researchers to explore self-silencing and self-neglect and other predictors of disordered eating and stigma toward seeking help from behavioral health services to provide the APA and mental health graduate programs with a foundation of diagnostic criteria and modalities that foster the support for Black women. As the conversation surrounding Black women and mental health continues to thrive, this study serves as a prompt for the continued conversation of the self-silencing and self-neglect behaviors that influence adverse coping mechanisms in Black women who adopt SWS. The findings advocate for recognizing an intersectional approach for Black women in diagnostic criteria, interventions, and areas of support for behavioral health and removing the stigma surrounding seeking help.

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Appendix A: Recruitment Flyer

Seeking participants for a research study on Black women and health

- Has the need to be strong and a caregiver for others caused you to keep quiet for the relationship's sake?

- Have you experienced the need to eat on unhealthy foods as a means of coping with stress from taking care of others, wanting to be strong, and racism towards your gender and race?

- Have you experienced the need to speak to a psychological professional, but question if it is the right thing to do?

Eligibility Requirements:

- Must be a Black/African American woman.
- Must be between the ages of 18 – 75 years old.

Participation may include:

- Completion of informed consent form.
- Completion of 20 – 30-minute survey.
- Chance to refer other Black women who are interested in the topic of study.

This research is being conducted by VeAnda Hemphill, LPC, CPCS, MS, MA, PhD candidate of Walden University College of Social and Behavioral Sciences. For any questions regarding participation in this study, please contact Dr. Patricia Loun, chairperson at patricia.loun@mail.waldenu.edu or the Internal Review Board at irb@mail.waldenu.edu.

Appendix B: Demographic Questionnaire

Please answer the following questions:

1. Which best describes your gender?
    - Man
    - Woman
    - Non-binary
    - A gender not listed here (please specify)
      [ ]

2. What is your age? _____

3. What is your race or ethnicity?

    - Asian
    - African American or Black
    - Hispanic or Latino
    - Middle Eastern or North African
    - Multiracial or Multiethnic
    - Native American or Alaskan Native
    - Native Hawaiian or other Pacific Islander
    - White
    - Another race or ethnicity, please describe below:

[ ]

4. What was the primary language spoken in your childhood home? (Please choose only one.)

    - Chinese
    - French
    - English
    - German
    - Spanish
    - Other/multiple languages (please specify.)
      [ ]

5. Do you have any children? _____ If so, how many? _____

6. What is your marital status?

    - Single
    - Married
    - Divorced
    - Separated
    - Widowed
    - In a domestic partnership

7. What is your highest level of education?
    - None
    - High School Diploma or GED
    - Some college, not completed
    - Associate degree
    - Vocational degree (e.g., welding, cosmetology school.)
    - Bachelor's degree
    - Master's degree
    - Doctorate degree

8. What is your approximate average household income?
    - $0 to $9,999
    - $25,000 to $49,999
    - $50,000 to $74,999
    - $75,000 to $39,999
    - $40,000 to $99,999
    - $100,000 to $124,999
    - $125,000 to $149,999
    - $150,000 to $174,999
    - $175,000 to $199,999
    - $200,000 and up

Appendix C: Permission to Use G-SWS-Q

Dear Veanda,

Thanks so much for your inquiry related to using the SWS Questionnaire.

I am copying Andrew Bradford who can assist you with this process.

I wish you the best with your research and look forward to staying in touch.

Sincerely,
Cheryl Giscombe

Appendix D: Giscombe-Superwoman Schema (G-SWS)

Instructions: The following is a list of items that may or may not be relevant for you. Some of the questions may sound familiar, but each is important. Please read and complete each item to the best of your ability using the response scale provided.

Never	Rarely	Sometimes	All the time
0	1	2	3

1. I try to present an image of strength.	0 1 2 3
2. I have to be strong.	0 1 2 3
3. I feel obligated to present an image of strength at work.	0 1 2 3
4. I feel obligated to present an image of strength for my family.	0 1 2 3
5. I display my emotions in privacy.	0 1 2 3
6. I keep my feelings to myself.	0 1 2 3
7. My tears are a sign of weakness.	0 1 2 3
8. I keep my problems bottled up inside.	0 1 2 3
9. I hide my stress.	0 1 2 3
10. Expressing emotions is difficult for me.	0 1 2 3
11. It's hard for me to accept help from others.	0 1 2 3
12. I have a hard time trusting other.	0 1 2 3
13. I wait until I am overwhelmed to ask for help.	0 1 2 3
14. Asking for help is difficult for me.	0 1 2 3
15. I resist help to prove that I can make it on my own.	0 1 2 3
16. If I want things done right, I do them myself.	0 1 2 3

17. I accomplish my goals with limited resources.	0 1 2 3
18. It is very important to me to be the best at the things I do.	0 1 2 3
19. No matter how hard I work, I feel like I should do more.	0 1 2 3
20. I put pressure on myself to achieve a certain level of accomplishment.	0 1 2 3
21. I take on roles and responsibilities when I am already overwhelmed.	0 1 2 3
22. I take on too many responsibilities in my family.	0 1 2 3
23. I put everyone else's needs before mine.	0 1 2 3
24. I feel obligated to take care of others.	0 1 2 3
25. When others ask for my help, I say yes when I should say no.	0 1 2 3
26. I neglect my health (e.g., I don't exercise or eat like I should).	0 1 2 3
27. I neglect the things that bring me joy.	0 1 2 3
28. I feel guilty when I take time for myself.	0 1 2 3
29. The struggles of my ancestors require me to be strong.	0 1 2 3
30. I keep my problems to myself to prevent burdening others.	0 1 2 3
31. I do things by myself without asking for help.	0 1 2 3
32. The only way for me to be successful is to work hard.	0 1 2 3
33. I am a perfectionist.	0 1 2 3
34. There is no time for me because I am always taking care of others.	0 1 2 3
35. I have to be a strong because I am a woman.	0 1 2 3

Appendix F: Silencing the Self Scale

Please circle the number that best describes how you feel about each of the statements listed below. If you are not currently in an intimate relationship, please indicate how you felt and acted in your previous intimate relationships.

Strongly disagree	Somewhat disagree	Neither Agree nor disagree	Somewhat agree	Strongly agree

---

1. I think it is best to put myself first because no one else will look out for me.
   1 2 3 4 5

2. I don't speak my feelings in an intimate relationship when I know they will cause disagreement.
   1 2 3 4 5

3. Caring means putting the other person's needs in front of my own.
   1 2 3 4 5

4. Considering my needs to be important as those of the people I love is selfish.
   1 2 3 4 5

5. I find it is harder to be myself when I am in a close relationship that when I am on my own.
   1 2 3 4 5

6. I tend to judge myself by how I think other people see me.
   1 2 3 4 5

7. I feel dissatisfied with myself because I should be able to do all the things people are supposed to be able to do these days.
   1 2 3 4 5

8. When my partner's needs and feelings conflict with my own, I always state mine clearly.
   1 2 3 4 5

9. In a close relationship, my responsibility is to make the other people happy.
   1 2 3 4 5

Strongly	Somewhat	Neither Agree	Somewhat	Strongly

disagree	disagree	nor disagree	agree	agree

10. Caring means choosing to do what the other person wants, even when I want to do something different.
    1 2 3 4 5

11. In order to feel good about myself, I need to feel independent and self-sufficient.
    1 2 3 4 5
12. One of the worst things I can do is be selfish.
    1 2 3 4 5

13. I feel I have to act a certain way to please my partner.
1 2 3 4 5

14. Instead of risking confrontations in close relationships, I would rather not rock the boat.
1 2 3 4 5

15. I speak my feelings with my partner, even when it leads to problems or disagreements.
1 2 3 4 5

16. Often when I look happy enough on the outside, but inwardly I feel angry and rebellious.
1 2 3 4 5

17. In order for my partner to love me, I cannot reveal certain things about myself to him/her.
1 2 3 4 5

18. When my partner's needs or opinions conflict with mine, rather than asserting my own point of view, I usually end up agreeing with him/her.
1 2 3 4 5

19. When I am in a close relationship I lose my sense of who I am.
    1 2 3 4 5

20. When it looks as though certain of my needs can't be met in a relationship, I usually realize that they weren't very important anyway.
1 2 3 4 5

Strongly disagree	Somewhat disagree	Neither Agree nor disagree	Somewhat agree	Strongly agree

21. My partner loves and appreciates me for who I am.
1 2 3 4 5

22. Doing things just for myself is selfish.
1 2 3 4 5

23. When I make decisions, other people's thoughts and opinions influence me more than my own thoughts and opinions.
1 2 3 4 5

24. I rarely express my anger at those close to me.
1 2 3 4 5

25. I feel that my partner does not know my real self.
1 2 3 4 5

26. I think it's better to keep my feelings to myself when they do conflict with my partner's.
1 2 3 4 5

27. I often feel responsible for other people's feelings.
1 2 3 4 5

28. I find it hard to know what I think and feel because I spend a lot of time thinking about how other people are feeling.
1 2 3 4 5

29. In a close relationship I don't usually care what we do, as long as the other person is happy.
1 2 3 4 5

30. I try to bury my feelings when I think they will cause trouble in my close relationship(s).
1 2 3 4 5

31. I never seem to measure up to the standards I set for myself.
1 2 3 4 5

Appendix G: Permission to Use SRBWS

Dear Researcher:

I am forwarding a copy of the Stereotypic Roles for Black Women Scale. We ask that if you use the scale, if you would forward a copy of the raw data to us for a cross-validation study of the scale.

Sincerely,

Anita Thomas, Ph.D.

Appendix H: Stereotypical Roles of Black Women Scale (SRBWS)

Attitudes and Beliefs Scale

Directions: This is a scale to determine attitudes and beliefs. There are no right or wrong answers. Please use the following scale to complete the questions.

Strongly disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

---

1. Black women are often loud and obnoxious.	1 2 3 4 5
2. Black women are all about sex.	1 2 3 4 5
3. Black women have to be strong to survive.	1 2 3 4 5
4. Black women need to nag others to get a response.	1 2 3 4 5
5. Black women used sex to get what they want.	1 2 3 4 5
6. Men can be controlled with sex.	1 2 3 4 5
7. If given a chance, Black women will put down Black men.	1 2 3 4 5
8. Black women are often treated as sex objects.	1 2 3 4 5
9. I am often expected to take care of family members.	1 2 3 4 5
10. If I fall apart, I will be a failure.	1 2 3 4 5
11. Black women are usually angry with others.	1 2 3 4 5
12. I often put aside my own needs to help others.	1 2 3 4 5

13. I often feel ignored by others. 1 2 3 4 5

14. I find it difficult to ask others for help. 1 2 3 4 5

15. I feel guilty when I put my own needs before others. 1 2 3 4 5

Strongly disagree	Disagree	Undecided	Agree	Strongly Agree
1	2	3	4	5

---

16. I do not want others to know if I experience a problem. 1 2 3 4 5

17. People often expect me to take care of them. 1 2 3 4 5

18. People respond to me more if I am loud and angry. 1 2 3 4 5

19. I tell others that I am fine when I am depressed or down. 1 2 3 4 5

20. People treat me as if I am a sex object. 1 2 3 4 5

21. It is difficult for me to share problems with others. 1 2 3 4 5

22. I should not expect nurturing from others. 1 2 3 4 5

23. I am hardly ever satisfied. 1 2 3 4 5

24. Black women are out to get your man. 1 2 3 4 5

25. I often have to put someone in their place, read them or check them. 1 2 3 4 5

26. Young Black women are gold-diggers. 1 2 3 4 5

27. I often threaten to cuss someone out. 1 2 3 4 5

28. Sex is a weapon. 1 2 3 4 5

29. I am overworked, overwhelmed, and/or underappreciated. 1 2 3 4 5

30. Black women are demanding. 1 2 3 4 5

31. I am always helping someone else.	1 2 3 4 5
32. I will let people down if I take time out for myself.	1 2 3 4 5
33. It is easy for me to tell other people my problems.	1 2 3 4 5
34. I feel guilty if I cannot help someone.	1 2 3 4 5

Scoring Instructions- Stereotypic Roles for Black Women Scale (34 item scale)

To score, calculate mean scores for each subscale.

Mammy Items-12, 15, 17, 22, 34

Sapphire Items-1, 4, 7, 11, 13, 18, 23, 25, 27, 30

Jezebel Items-2, 5, 6, 8, 20, 24, 26, 28

Superwoman Items-3, 9, 10, 14, 16, 19, 21, 29, 31, 32, 33R

Appendix I: Eating Behavior Patterns Questionnaire (EBPQ)

Read each item and think if you agree or disagree that the item describes you and your eating habits. Place an "x" in the box that best describes your level of agreement with each statement. If a statement does not apply to you (for example a question asks about what you do at work and you do not have a job), then mark the Strongly Disagree box.

	Strongly Disagree	Disagree	Neutral N/A	Agree	Strongly Agree
1. I stop for a fast food breakfast on the way to work.					
2. My emotions affect what and how much I eat.					
3. I use low-fat food products.					
4. I carefully watch the portion sizes of my foods.					
5. I buy snacks from vending machines.					
6. I choose healthy foods to prevent heart disease.					
7. I eat meatless meals from time to time because I think that is healthier for me.					
8. I take time to plan meals for the coming week.					
9. When I buy snack foods, I eat until I have finished the whole package.					
10. I eat for comfort.					
11. I am a snacker.					
12. I count fat grams.					

13.	I eat cookies, candy bars, or ice cream in place of dinner.					
14.	When I don't plan meals, I eat fast food.					
15.	I eat when I'm upset.					
16.	I buy meat every time I go to the grocery store.					
17.	I snack more at night.					
18.	I rarely eat breakfast.					
19.	I try to limit my intake of red meat (beef and pork).					
20.	When I am in a bad mood, I eat whatever I feel like eating.					
21.	I never know what I am going to eat for supper when I get up in the morning.					
22.	I snack two to three times every day.					
23.	Fish and poultry are the only meats I eat.					
24.	When I am upset, I tend to stop eating.					
25.	I like to eat vegetables seasoned with fatty meat.					
26.	If I eat a larger than usual lunch, I will skip supper.					
27.	I take a shopping list to the store.					
28.	If I am bored, I will snack more.					

29.	I eat at church socials.					
30.	I am very conscious of how much fat is in the food I eat.					
31.	I usually keep cookies in the house.					
32.	I have a serving of meat at every meal.					
33.	I associate success with food.					
34.	A complete meal includes a meat, a starch, a vegetable, and bread.					
35.	On Sunday, I eat a large meal with my family.					
36.	Instead of planning meals, I choose what is available and what I feel like eating.					
37.	If I eat a larger than usual lunch, I will replace supper with a snack.					
38.	If I am busy, I will eat a snack instead of lunch.					
39.	Sometimes I eat dessert more than once a day.					
40.	I reduce fat in recipes by substituting ingredients and cutting portions.					
41.	I have a sweet tooth.					
42.	I sometimes snack even when I am not hungry.					
43.	I eat out because it is more convenient than eating at home.					

44.	I hate to cook.					
45.	I would rather buy take out food and bring it home than cook.					
46.	I have at least three to four servings of vegetables per day.					
47.	To me, cookies are an ideal snack food.					
48.	My eating habits are very routine.					
49.	If I do not feel hungry, I will skip a meal even if it is time to eat.					
50.	When choosing fast food, I pick a place that offers healthy foods.					
51.	I eat at a fast food restaurant at least three times a week.					

Appendix J: Attitude Towards Seeking Professional Psychological Help Scale, Short Form (ATSPPHS-SF)

Please check the response that applies to you.

1. If I believed I was having a mental breakdown, my first inclination would be to get professional help.

____ Disagree ____ Partly Disagree _____ Partly Agree ____ Agree

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

____ Disagree ____ Partly Disagree _____ Partly Agree ____ Agree

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

____ Disagree ____ Partly Disagree _____ Partly Agree ____ Agree

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help.

____ Disagree ____ Partly Disagree _____ Partly Agree ____ Agree

5. I would want to get psychological help if I were worried or upset for a long period of time.

____ Disagree ____ Partly Disagree _____ Partly Agree ____ Agree

6. I might want to have psychological counseling in the future.

____ Disagree ____ Partly Disagree _____ Partly Agree ____ Agree

7. A person with an emotional problem is not likely to solve it alone; he or she *is l*ikely to solve it with professional help.

____ Disagree ____ Partly Disagree _____ Partly Agree ____ Agree

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

____ Disagree ____ Partly Disagree _____ Partly Agree ____ Agree

9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

____ Disagree ____ Partly Disagree _____ Partly Agree ____ Agree

10. Personal and emotional troubles, like many things, tend to work out by themselves.

____ Disagree ____ Partly Disagree _____ Partly Agree ____ Agree