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When Being Strong Hurts: Trauma and the Strong Black Woman Stereotype

Cynthia Nicole White

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by

Cynthia Nicole White

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Accepted by:

Suzanne C. Swan, Major Professor

Jason L. Cummings, Committee Member

M. Michele Burnette, Committee Member

Bret Kloos, Committee Member

Cheryl L. Addy, Vice Provost and Dean of the Graduate School

DEDICATION

To my grandmother, Grampy, I finally did it ☺

“Unable are the loved to die, for love is immortality”- Emily Dickinson

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"He didn't bring me this far to leave me." I often reminded myself of that on this long journey, and God has once again come through for me. I am blessed to have the opportunity to do this work.

To my parents, sharing this moment with both of you makes it even sweeter. There are no two greater cheerleaders, role models, or people on this earth. I'm so grateful for your continuous love and support.

Dr. Suzanne Swan, thank you again and again for your consistent attentiveness over these 5 years. Thank you for always viewing me as a person first, and student second; for hurting with me when I needed it, and celebrating with me when the time came.

Finally, I stand on the shoulders of so many incredible Black women who have come before me and I wouldn't dare weigh them down for nothing. "Bringing the gifts that my ancestors gave, I am the dream and the hope of the slave"- Maya Angelou. May we continue to rise.

ABSTRACT

There are several research studies which suggest that, when confronted with stress or trauma, Black women in the United States seek help less than other populations, particularly White women. Part of the reason for this reluctance towards help-seeking may be explained by the American cultural stereotype of the Strong Black Woman (SBW). The Strong Black Woman is one who overcomes all obstacles, remains strong despite problems, and sacrifices herself for others. Research on the Strong Black Woman stereotype is scarce, but the limited research that exists found that the stereotype consists of 3 factors: Mask of Strength, Self-Reliance/Strength, and Caretaking. Mask of Strength refers to emotional invulnerability and hiding one's struggles, Self-Reliance/Strength is the practice of trying to be strong and self-sufficient, and Caretaking is the act of caring for others and emphasizes helping others. Additionally, studies have found that many Black women endorse the characteristics of the stereotype as applying to themselves, referred to here as self-endorsement. While aspects of the stereotype are positive, studies have also found some negative effects of self-endorsement. Previous studies have found that self-endorsement of Strong Black Woman positively correlated with depression, eating disorders, and lower intention to seek help. The current study hypothesized that Black female college students' self-endorsement of SBW would negatively affect the relationship between experiencing traumatic life events and help-seeking in response to those events. Contrary to the hypotheses, the SBW scale did not significantly predict help-seeking or intention to seek help. Instead, the three SBW subscales had both positive

and negative effects. Specifically, the Self-Reliance and Caretaking subscales positively predicted help-seeking, such that higher scores on those subscales were related to greater help-seeking after a traumatic event. In contrast, the Mask of Strength subscale negatively predicted formal help-seeking and intention to seek help, indicating that participants who believed they need to appear strong at all times tended not to seek help after a traumatic event, and to state that they were not likely to seek help in the future. The findings indicate that a more nuanced approach is needed when studying SBW or working in clinical settings with clients who endorse the stereotype. It may be helpful to bolster certain aspects of the stereotype, such as the desire to be a good caretaker, while redefining other aspects, such as emotional invulnerability.

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CHAPTER 1

INTRODUCTION

1.1 Overview

The Strong Black Woman (SBW) image is one who overcomes all obstacles, remains strong despite problems, and sacrifices herself for others. The image has historical roots in slavery and is unique to women of African descent living in the United States (furthermore referred to as Black women). While the image can be externally pushed upon Black women, some endorse the characteristics of the stereotype as applying to themselves, referred to here as self-endorsement. Given this unique image, utilizing an intersectional lens is important for the study of Black women because it provides both a racial and gendered understanding of their experiences. Intersectionality is the acknowledgement of various social identities contributing to an individual's experience of self and their interactions with people and systems. These various social locations also have a unique relationship in terms of oppression of different groups and situate an individual within society (Crenshaw, 1994; Cho et al., 2013). The current paper focuses on racial and gender identity because these are traditionally most pertinent to historical stereotypes of Black women. However, this does not undermine the importance and influence of other identities such as sexual orientation, class, religion, ability, etc.

While Black women share gender with White women and race with Black men, there are notable differences. Some research suggests that Black women may be more

likely to experience certain types of trauma such as sexual assault (Black et al., 2011), intimate partner violence (Cho, 2013; Tjaden & Thoennes, 2000), natural disasters, and sudden or unexpected death of a loved one (Hetzel-Riggin & Roby, 2013) than their White peers. From a social perspective, in certain contexts they are viewed as primarily Black (i.e. during Black political movements) and in others as primarily women (i.e. when they are with their children). The blending of these two identities has long proved hard to do for Black women. In a speech at the 1851 Women's Convention in Akron, Ohio, Sojourner Truth proclaimed:

> That man over there says that women need to be helped into carriages, and lifted over ditches, and to have the best place everywhere. Nobody ever helps me into carriages, or over mud-puddles, or gives me any best place! And ain't I a woman? Look at me! Look at my arm! I have ploughed and planted, and gathered into barns, and no man could head me! And ain't I a woman? I could work as much and eat as much as a man - when I could get it - and bear the lash as well! And ain't I a woman? I have borne thirteen children, and seen most all sold off to slavery, and when I cried out with my mother's grief, none but Jesus heard me! And ain't I a woman? (Truth, 1851)

Through imagery, Sojourner was portraying the effects of racialized gender. Society places different expectations on women based on their race. These contrasting societal expectations may lead Black women to respond differently following difficult or traumatic events. For instance, they may feel that certain resources are not applicable to them, or they may fear repercussions if they ask for help.

The current study seeks to explore a cultural stereotype unique to Black women, the Strong Black Woman stereotype. This stereotype includes the racial assessment of Black people as strong and the gendered perspective of women as caring, and is rooted in the belief that Black women can handle tough situations. This belief may lead Black women to downplay their struggles or feel that they have to suffer in silence. The purpose of this study is to assess if the SBW stereotype negatively effects help-seeking for Black women who have been exposed to trauma.

1.2 Strong Black Woman Stereotype

As previously stated, Black women are different from both Black men and White women. One way in which they are different from the two aforementioned groups is the stereotype of the Strong Black Woman (SBW). This stereotype includes the racial assessment of Black people as strong and the gendered perspective of women as caring (Romero, 2000). The SBW image is sometimes called Superwoman, Modern Mammy, Black Lady, and Sojourner Syndrome (Collins, 2004; Mullings, 2002), but the stereotype always includes strength and caregiving (Donovan & West, 2015). In terms of strength, a SBW is effortlessly resilient, and easily handles stress and trauma. The challenges of life that would typically break a person, only make her stronger. She is independent, has self-control, and a tireless work ethic. She does not need much emotional or financial support because she finds her own way to complete her responsibilities. In terms of caregiving, a SBW is known for sacrificing for others. She provides emotional, spiritual, and financial support for not only her immediate family, but also others in the community. People seek support from her because of her wisdom and her willingness to help without resentment or anticipation of reciprocity (Donovan & West, 2015). Stereotypes are typically thought

of as something that those who are targets of the stereotype resent or try to prove false, but SBW is unique from other stereotypes because of its heavy self-imposed component. It is not uncommon for Black women themselves to promote the SBW stereotype (Beauboeuf-Lafontant, 2009).

Historical significance. The SBW trope has existed for many years. The stereotype began during slavery when Black women were deemed strong enough to work in the fields alongside men, but were also expected to care for the master's wife and children (Harrington et al., 2010; Collins, 2000). Beauboeuf-Lafontant argues that SBW fits in with the larger theme of American successful individualism and self-made personalities (2009). Because the SBW image has existed for so long, it is part of the individualist trope that anyone can succeed if they just work hard enough, no matter the obstacles they face. The SBW is expected to carry the weight of the world, without the slightest complaint. Given her strength, she cannot be considered a victim no matter how extreme the suffering; she is a "superwoman" (Beauboeuf-Lafontant, 2009). Characterizing Black women as naturally strong allowed White male slave-owners to force Black women into the fields, while still holding the belief that White women were weak and needed to be cared for and protected (Collins, 2000; Harrington et al., 2010; West et al., 2016). Without the SBW trope, White southerners would not have been able to justify these staunch differences in womanhood. While SBW has existed for years, researchers did not start exploring theoretical and empirical implications until the 1960s.

Promotion of the stereotype. In her 2009 pivotal book, *Behind the Mask of the Strong Black Woman*, Tamara Beauboeuf-Lafontant used feminist voice-centered qualitative methodology to explore 58 Black women's perspectives on gender and the

SBW image. Beauboeuf-Lafontant found that the majority of women endorsed SBW and explained that the image was passed down to them by their mothers and other significant Black women in their lives growing up (2009). Traci, a 43 year old divorced mother explained that she was taught not to show her feelings and to hide any emotions she had. Even if she faced a major barrier, she was supposed to "overcome it, deal with it, and go ahead on" (Beauboeuf-Lafontant, 2009). Black girls see their mothers exuding these qualities and "making a way out of no way", so for many this is all they know; it is considered normal. Black girls then try to imitate what the women before them have done. Rita, a thirty-five year old graduate student explains that growing up she learned crying was associated with weakness:

> [Being strong is] almost ingrained in you from day [one]. You know, you don't cry easily. If something happens, you get up. You don't cry. You don't let it bother you. "Get over it." You know, I don't know how many times I've heard that. "Oh, you'll be alright." And, in fact, you know, that's also why when we think of White women, stereotypically . . . we think of them as being weak because they cry all the time. (Beauboeuf-Lafontant, 2009, p.77)

In another examination of SBW, Taylor-Lindheim conducted a mixed-methods dissertation study of 50 college-educated Black women in Los Angeles. The women completed an online survey that consisted of four psychological assessments and six open-ended short answer questions. The aim of her study was to see how SBW was related to stress, depression, and perceived racism. She used both a quantitative measure of SBW (The SBW Cultural Construct Scale; Hamin, 2008) and qualitative questions such as "what does SBW mean to you" and "who were the SBW examples in your life".

Taylor-Lindheim hoped that the short answer questions would lead to greater understanding of the stereotype's themes. In the qualitative portion of the study, all of the women reported that their SBW role model was their mother, followed by grandmothers (38 of the women), then great aunts (29 of the women; Taylor-Lindheim, 2016). By passing down the characteristic of toughness, Black mothers are attempting to protect their daughters from the pain of a prejudiced society. They want their daughters to grow up understanding that they should not expect assistance or empathy from anyone. Although this way of thinking imposes great expectations on Black girls, their mothers' evaluation of the world is not irrational. Black women have historically (and continue to) endured mistreatment and attack on their bodies from both the larger society and within their own communities. These walls of protection that they have worked so hard to build act as fortifications from the world that aims to break them down. Black mothers often instill SBW in their daughters to protect their humanity and give them the strength they will need. These mothers are trying to help their daughters overcome historical mistreatment and trauma.

The current study seeks to further the literature on SBW by connecting the stereotype to the experience of trauma and subsequent help-seeking. Because a major aspect of SBW is strength and self-reliance, this may lead Black women to try to solve their problems on their own without asking for help. While this might be a successful strategy for some problems, positively coping with the effects of a traumatic event often necessitates the involvement of other supportive people or resources.

1.3 Traumatic Life Events

According to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-V), exposure to serious injury, threatened death, or sexual violence is a traumatic event (American Psychiatric Association, 2013). This can include events such as a natural disaster, serious car accident, physical assault, exposure to a war zone, or a sudden violent death of a loved one. A 2016 multinational study of over 68,000 adults from 24 countries found that on average, over 70% of participants report experiencing a traumatic event over their lifetime. This percentage increased to 82% for US adults (Benjet et al., 2016). Research with US college populations has determined that 63-77% of college students report experiencing at least one traumatic event over their lifetime (Martin et al., 2013; Pickett et al., 2016; Read et al., 2017).

For example, Pickett et al. (2016) surveyed 947 college students at a large Midwestern university. The majority of the sample was female (82.7%) and White (80.4%), followed by Black (7.8%), and "Other" (6%). The researchers found that 64.6% of the students reported experiencing at least one traumatic event according to the Traumatic Life Events Questionnaire. The most highly endorsed traumas were unexpected death of a loved one, loved one survived a life-threatening illness, being stalked, witnessing family violence in childhood, and being physically threatened or threatened death, respectively. Prevalence rates by race were not reported.

Prevalence of traumatic life events among black college women. Although rates of traumatic experiences among college students are becoming more established, few estimates of general trauma among Black college women exist. The majority of these

studies focus on sexual assault or intimate partner violence (IPV) and the findings are mixed. For example, Gross and colleagues (2006) asked 903 college women at a southeastern university about their experiences with sexual assault. They found that similar to national averages, roughly one-fourth of the college women reported being victims of sexual assault. Interestingly, the prevalence rate varied by race with significantly more Black women (36%) reporting assault than White women (26%). In particular, Black women reported higher rates of physically forced sexual intercourse than White women. On the other hand, Krebs et al. (2009) found no racial differences in physically forced or incapacitated sexual assault among a sample of 3,643 White and 882 Black college women at Predominantly White Institutions (PWIs; incapacitated sexual assault was defined as being passed out, drugged, drunk, or asleep when the assault occurred).

The largest study to examine IPV among Black college women, the Campus Sexual Assault Study (CSA), was conducted by Barrick and colleagues (2013) to better understand the occurrence of violence against women on various types of campuses. The Historically Black Colleges and Universities (HBCU) arm of the study took place on the campus of four HBCUs (HBCU-CSA). The HBCU-CSA study had a sample of 3,951 women; 87% (3,415) of whom were Black women. Seventeen percent of HBCU women indicated physical IPV in the last year; additionally, more Black women in the sample reported IPV in the past year than White women, but the small variability of race in the sample makes it hard to generalize this finding (only 2% of the HBCU-CSA sample were White women). Similar to the Barrick et al. (2013) study, a 2008 study of 301 Black women at Tennessee State University found that 18.3% of the women reported that they

had been in an abusive relationship at some point in their lives (Ross, 2008). The aforementioned study is limited, however, because it only used a single question to determine abuse- "Have you been in an abusive relationship?" whereas most studies use measures with multiple items to determine IPV prevalence rates.

As mentioned, the research on trauma experienced by Black college women is limited and mostly focuses on sexual assault and IPV. However, there are a few studies that look at other types of traumatic events (e.g. Waters, 2016; Boyraz et al., 2013). Hetzel-Riggin and Roby (2013) assessed the prevalence of various types of trauma and gender effects among college undergraduate students at a Midwestern university (n=1,503). The sample was 58% women and 8.4% Black. The researchers found that Black participants were more likely to report experiencing both a natural disaster *and* sudden/unexpected death of a loved one compared to their White peers. They were also more likely to report experiencing both a sudden/unexpected death of a loved one *and* interpersonal violence than their White counterparts (Hetzel-Riggin & Roby, 2013). In the article, the authors did not examine differences between Black women and other groups. Another study on trauma among college freshmen found that 72.8% of the Black women in the sample reported being exposed to a traumatic event (n= 423 Black women; Boyraz et al., 2015). This is consistent with the national averages reported above. The forms of trauma mentioned here are those traditionally discussed in the literature; however, in recent years, researchers have begun to consider unique ways that racial minorities experience trauma (e.g. Williams, Ching, Printz, &Wetterneck, 2018; Carter, 2007).

1.4 Racialized trauma. There are certain experiences unique to racial minorities that may not fit seamlessly into the DSM-V criteria for what constitutes a traumatic experience. A person may have a traumatic reaction to certain racial acts. Williams and colleagues defined racial trauma as:

> A traumatic response to race-related experiences that are collectively characterized as *racism*, including acts of prejudice, discrimination, or violence against a subordinate racial group based on attitudes of superiority held by the dominant group (emphasis is the original authors'; 2018).

The current DSM-V definition of trauma may not take into consideration low level repeated experiences of racism that are often uncontrollable and lead to distress like that of traditional traumas (Malcoun, Williams, Nouri, 2015). The ongoing nature of racism forces people to relive traumas related to their race and cultural history (Helms et al., 2011). This also means that racial trauma may not fit the definition of a discrete event which is how the current DSM recognizes trauma. Repeated incidents of racism as traumatic may have more of a "last straw" type of effect, meaning that something seemingly minor can trigger trauma symptoms due to the cumulative effect of small actions. Consequently, individuals may not be able to link their trauma symptoms to a singular event and could therefore be missed on a traditional trauma screener (Malcoun et al., 2015).

One article noted the similar psychopathology between victims of racism and rape victims (Bryant-Davis & Ocampo, 2005). Dissociation and shock are common reactions of rape victims and were also found among victims of racism. These reactions prevented

them from dealing with the situation. Following the event, both types of victims may blame themselves and feel shame because they weren't able to do anything to stop the incident (Bryant-Davis & Ocampo, 2005). Malcoun and colleagues note that race-based traumas can include, "witnessing ethnoviolence or discrimination of another, historical or personal memory of racism, institutional racism, microaggressions, and the constant threat of racial discrimination" (2015). Experiences of racism and discrimination such as those noted above are widespread in the US. Lee and colleagues conducted a national study of over 3,000 people and found that 43.5% of participants reported experiencing discrimination from time to time or regularly (2019). When divided by race, 73% of Black, 71% of Pacific Islander, 59% of Asian, 53% of American Indian, 49% of Hispanic, and 34% of White participants reported experiences of racism (Lee et al., 2019).

Given the high rates of both traditional and racial trauma exposure, it is necessary to look at what people do afterward and how they cope with the experience. For instance, do people enlist the help of others such as a friend or professional, or do they try to deal with the traumatic experience and its effects by themselves? Supportive sources of help can lead to positive coping following of trauma (Waldrop & Resick, 2004); therefore, the current study analyzes whether Black women seek help after trauma, and if so, what type of help.

1.5 Strong Black Woman Stereotype and Help-seeking to Cope with Trauma

Theoretical Background. Help-seeking is "any communication about a problem or troublesome event which is directed toward obtaining support, advice, or assistance in

times of distress . . . and includes both general discussions about problems and specific appeals for aid" (Gourash, 1978). It is a highly adaptive behavior that has positive impacts across the lifespan (Lee 1999; Rickwood et al., 2005). There is not a clear singular theory of trauma and help-seeking behaviors. Instead, there are several partial theories explaining why women seek help.

Liang and colleagues (2005) created a theoretical model of help-seeking (see Figure 1.1). Although the first level of the model (problem recognition and definition, decision to seek help, and support selection) is presented as discrete stages, the process is not necessarily linear. There are double-headed arrows between the different stages because each stage informs the other, creating a continuing loop (Liang et al., 2005). The top tier of the framework indicates that individual, institutional, and systemic forces affect the help-seeking process at every stage. Each of these influences have the potential to be supportive of help-seeking, or a barrier to asking for help. Rickwood and colleagues' (2005) well-known Help-Seeking Model is similar to the Liang model in that it recognizes four different stages of help-seeking: 1) recognition/appraisal of the problem, 2) expressing the need for help, 3) knowledge and accessibility of help, and 4) willingness to disclose personal information. This model however does not explicitly include barriers to help-seeking.

Types of and Engagement in Help-seeking. Researchers generally conceptualize help-seeking as being composed of informal and formal behaviors (Neighbors & Jackson, 1996; Van Hook, 2000; Liang et al., 2005; Anyikwa, 2015). These two types of help-seeking fall under the support selection stage of the Liang et al. model. Formal help-seeking is assistance from a professional who has an established and

recognized role in providing advice or assistance (Rickwood & Thomas, 2012). This would include going to a professional such as the police, the hospital, or a therapist following trauma. Informal help-seeking includes talking to family or friends, praying, reading a self-help book, and looking online for information and resources. Rickwood and colleagues (2007) note that help-seeking for mental health problems typically starts with informal help-seeking before again proceeding through the help-seeking stages and ending in formal help-seeking.

Based on the National Survey of Black Americans, a 13-year longitudinal study of over 2,000 Black American men and women across the U.S., Jackson and Neighbors found that in general, Blacks were less likely to seek formal help for any type of problem than Whites (1996). More specifically, in a qualitative study of Black female IPV survivors, seeking formal help from a therapist was not their first choice because of finances and reported cultural insensitivity (Few & Bell-Scott, 2002). Several of the women noted the importance of connecting with other Black women because of shared culture. Given this reasoning, these women may have preferred informal sources of support from racial peers. An Australian national study, which included various races, corroborates this pattern of low formal help-seeking, particularly for college aged women (Slade, Teesson, & Burgess, 2009). The study found that those aged 16-24 years old were least likely to seek help from a professional for mental health problems.

While the aforementioned studies have added to the knowledge base on help-seeking behaviors, much more is needed, particularly for Black college women. No published studies were found examining the help-seeking behaviors of Black college women at PWIs following traumatic events. Only one study, conducted by Lindquist et

al. (2016), examined help-seeking for victims of sexual assault at HBCUs using the HBCU-CSA data. The researchers found that the majority of victims engaged in informal help-seeking. Most of the students told someone close to them about the incident (69% for physically forced and 55% for incapacitated sexual assault victims). However, very few sought medical care or went to a victim crisis center (14% of physically forced and 7% of incapacitated assault victims), contacted law enforcement (10% and 3%, respectively), or sought mental health treatment (13% and 4%, respectively; Lindquist et al., 2016). In another study, Rhodes and colleagues (2010) studied 392 college students in New Orleans, LA who survived Hurricane Katrina and assessed their resilience following the traumatic event. They discovered that following Katrina, 13.8% of the participants had "probable serious mental illness", yet only 9.2% of these participants saw a mental health professional in the year after Katrina (Waters, 2016). The sample was majority female (95%) and Black (84%). These findings are consistent with other existing research such as Boyraz et al. (2013) who found that only 13% of their Black and majority female college student sample sought psychological help following trauma. The findings from each of these studies suggest a possible preference for informal versus formal help for Black college women.

1.6 The Current Study

It is possible that Black women may be less likely to seek help because they subscribe to or are forced to believe that Black women are resilient and should deal with problems on their own (Bent-Goodley, 2013; Crenshaw, 1994; Few & Bell-Scott, 2002). In other words, they are in a position in which they have to live up to the Strong Black Woman stereotype. In the only existing study to relate SBW to help-seeking, Woods

(2014) studied 240 undergraduate Black women on their self-endorsement of Strong Black Woman, symptoms of depression, and intention to seek help. She found that those who strongly endorsed SBW were less likely to report intention to seek help for depression.

While Woods' 2014 study added to the SBW literature, there are several limitations. One limitation is that she assessed for intention to seek help, but not actual help-seeking behavior. While there is a link between intention and behavior, intention alone does not always predict behavior (e.g. Limayem, Hirt, and Chin, 2001). Another limitation is that Woods exclusively studied depression. Thus, no study to date has examined the relationship between self-endorsement of Strong Black Woman and actual help-seeking. Furthermore, no study has examined the possible effect of Strong Black Woman self-endorsement on help-seeking for Black women who have experienced trauma.

The proposed study would be the first quantitative study to explore how self-endorsement of Strong Black Woman affects Black women's help-seeking behavior following a traumatic event (including both traditional and racial trauma). This is an imperative step forward in advancing the literature on the SBW stereotype. Unlike previous studies, this study covers a range of traumatic events that a number of Black women will experience over their lifetime. Additionally, there are several advantages of using a college population of Black women to examine these research questions. First, this sample will allow the study to focus on variations in help-seeking among a population in which all members have the same resources available to them through the university (e.g. resident mentors, student health, counseling center). This eliminates a

confound with help-seeking that could emerge in, for example, a community sample in which some people have many resources available to them and others have few. Additionally, the majority of mental health disorders develop by age 24 (Kessler et al., 2005), making the emerging adult years a critical time period. Untreated mental illness among college students has several negative effects such as poor academic performance (Kessler et al., 1995) and substance use (Weitzman, 2004).

1.7 Aims & Hypothesis

The current study builds upon prior literature and addresses the noted limitations. The **aim** of this study is to determine whether self-endorsement of Strong Black Woman negatively effects help-seeking for Black women who have experienced a traumatic event. Specifically, I conducted a quantitative cross-sectional study to assess the relationship between traumatic life events, Strong Black Woman endorsement, and previous help-seeking behavior (see Appendix A). I also assessed for intention to seek help as a way to capture potential future behavior. My hypotheses were:

1) Greater self-endorsement of SBW full scale will be related to less help-seeking following exposure to a potentially traumatic event (both traditional and racial).

2) Greater self-endorsement of SBW full scale will be related to less intention to seek future help following exposure to a potentially traumatic event (both traditional and racial).

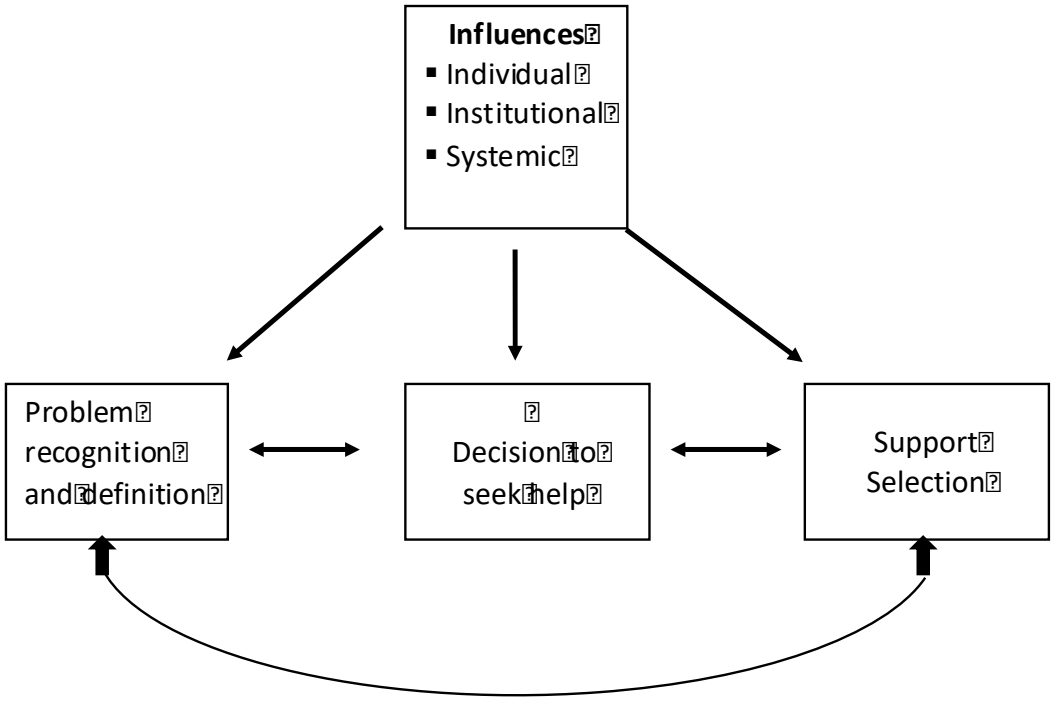

Figure 1.1 Theoretical Model of Help-seeking
Note. Figure adapted from Liang et al. (2005)

CHAPTER 2

METHODS

2.1 Data Collection

The data for this study was collected using a snowball sampling strategy. Participants were recruited from in person and online advertisements, fliers, and the University of South Carolina (USC) Psychology Department subject pool. I recruited participants with the help of a Black female undergraduate research assistant. I sent emails to Black female sorority groups, service groups, and social groups with information about the study and a website link to learn more about me and my motivation for the study. I also asked participants to share the study link with other Black USC undergraduate and graduate school women. Additionally, I reached out to various faculty across the university asking them to share the study with their classes. Finally, I recruited students using the university's SONA research participant pool which allows students to earn extra credit by participating in research studies.

2.2 Inclusion Criteria & Target Population

The target population for this study was both undergraduate and graduate college women between the ages of 18-40 at USC who identify as Black or African American. Because the study focuses on a Black cultural stereotype, individuals were excluded if they did not identify as Black or African American. Individuals who were not enrolled at USC and were not aged 18-40 were also excluded.

2.3 Procedure

Participants completed the study by clicking on an online link which took them to the Qualtrics survey. After clicking the link, participants were given a brief summary of the study. After reading the informed consent text, if participants wished to voluntarily continue, they were presented with a demographic questionnaire designed to assess the aforementioned inclusion criteria. The questionnaire took approximately one minute to complete.

Students who did not meet the inclusion criteria were presented with text explaining this and were not be able to complete the study. Participants who met criteria and completed the survey were given information on campus mental and physical health resources on the final page. After completion of the survey, participants were given the option to click a link to another page where they could submit their email address to be entered to win 1 of 45 $20 Amazon gift cards. Email addresses were not linked to participant data. Following distribution of gift cards, I discarded participant email addresses. See Appendix B for a description of the protection of human subjects and the informed consent.

2.4 Measures

All of the measures described below can be found in Appendix C.

Demographic information. In order to obtain necessary information about participants' demographic characteristics, a demographic questionnaire was administered. The measure was a revised version of the one used in Coker et al. (2015). Students were asked if they are a Black woman, along with their age, year in school (undergraduate freshmen-senior or graduate student), their parents' highest educational attainment,

current relationship or marital status, membership in a sorority or fraternity, and employment status. As previously stated, due to the inclusion criteria, only students who identified as Black women and were between the ages of 18-40 were allowed to proceed to the study (see Procedure section).

Strong Black Woman. The Strong Black Woman stereotype was measured using the Strong Black Woman Archetype Scale (Woods, 2014). The scale's initial pool consisted of 63 items which were modified from other existing SBW scales (Hamin, 2008; Thomas, Witherspoon, & Speight, 2004), a general measure of self-sacrifice (the Silencing the Self Scale; Jack & Dill, 1992), and some were created by Woods. Woods tested the items on a sample of 234 female college students (143 Black; 91 White). The final scale includes 36 items and was evaluated using exploratory factory analysis. Questions include: "If I fall apart, I will be a failure", "Women of my race have to be strong to survive", "I have too many responsibilities to spend time feeling sorry for myself", and "People often expect me to take care of them" (Woods, 2014). Response options are on a 5-point Likert scale and range from never to almost always. The factor analysis in Woods' validation study yielded three factors: mask of strength, care-taking, and self-reliance. The scale's total reliability in Woods' study was .91 and the subscales ranged from .77-.92 using Cronbach's alpha**.** This scale is superior to prior measures of SBW because of its improved internal consistency and positive factor correlations. Additionally, in Woods' validation study, Black women were more likely to endorse the mask of strength and self-reliance ideals than their White peers, showing preliminary evidence of the measure's ability to distinguish between cultural gender ideals. (Woods,

2014). The means of item responses were calculated to generate subscale and total scores, with higher scores indicating greater self-endorsement of SBW.

Traumatic Life Event. The experience of a traumatic life event was measured using a revised version of the Life Events Checklist-5 (Weathers et al., 2013). The Life Events Checklist for *DSM-5* (LEC-5) is a self-report measure that was created to asses for exposure to potentially traumatic events. Sixteen events that studies have shown can result in PTSD or distress are included in the measure along with 1 item to assess for a stressful event not included in the first 16 items. The current study used response items about direct exposure to each of the listed events before and after starting college (e.g. "Happened to me before beginning college", "Happened to me after beginning college"). While there is no formal scoring procedure and the measure yields no total score other than indicating that an event has occurred, the current study coded responses as 0 for no traumatic event or trauma exposure prior to starting college and 1 for 1 or more traumatic events since starting college. The original scale (LEC) was created in accordance with the DSM-IV; the LEC-5 has minimal changes and is in accordance with the DSM-V. Psychometric properties are not currently available for the LEC-5, but given the minimal changes from the original LEC, few psychometric differences are expected (National Center for PTSD, 2018). When administered to an undergraduate college population, the LEC has been found to have adequate temporal stability, appropriate convergence with another established measure of trauma history (the Traumatic Life Events Questionnaire), and was correlated with similar variables that have been found to be related to traumatic exposure, similar to the Traumatic Life Events Questionnaire (Gray et al., 2004). The mean Cohen's kappa coefficient (a statistic that measures agreement among categorical

or qualitative variables) for the LEC-5 was .61 and the retest correlation was $r = .82$, $p < .001$ (Gray et al., 2004). Trauma exposure assessed by this measure will be referred to as "traditional trauma".

Racialized Trauma. Five items were developed for this study to assess for experiences of racial trauma. The items were developed based on the types of racial trauma described by Williams et al. (2018) and the Race-Related Events Scale (Waelde et al., 2010). The response options and coding scheme are the same as the LEC-5 above. Participants indicated whether they experienced the event "Before starting college", "After starting college", or "Never happened". See Appendix C for a list of the items.

Help-seeking. The General Help-Seeking Questionnaire is one of the most commonly used measures to assess intentions to engage in help-seeking (Rickwood et al., 2012). The measure has 10 items that assess for both formal (e.g. mental health professional or doctor) and informal (e.g. partner or friend) sources of help using a 7 point Likert scale ranging from 1 ("extremely unlikely") to 7 ("extremely likely"). Higher scores imply higher intention to seek help. The General Help-Seeking Questionnaire has been found to have adequate reliability with a Cronbach's alpha range of .70-.85 and test-retest reliability over a three-week period of .86-.92 for various problem types (e.g. Help-seeking for suicidal problems vs. personal-emotional problems; Wilson et al., 2005). The current study used a revised version of this scale in order to better reflect the resources available on USC's campus. For example, USC's Sexual Assault Violence Intervention & Prevention office, along with Resident Mentors were added as sources of help. Additionally, the instruction language was modified to match the LEC-5's wording of "difficult or stressful event(s)". See Appendix C for all changes.

The Actual Help-Seeking Questionnaire was adapted by Wilson et al. (2005) from an earlier measure created by Rickwood & Braithwaite (1994) to assess recent actual help-seeking behavior. It was created to mirror the General Help-Seeking Questionnaire with the exception of the question stem changing from intention to seek help, to asking if help was sought. The measure has 10 items and asks if help was sought from informal and formal sources. Respondents indicate either "yes" or "no" for each source of help. Those who have sought no help will be coded as 0 and those who sought help from one or more sources will be coded as 1. While specific reliability statistics were not reported, Wilson et al. (2005) and Rickwood et al. (2005) both report that the measure has adequate reliability and validity. Because this measure mirrors the General Help-Seeking Questionnaire, reliability in this study is expected to be comparable. Similar to the measure above, the scale was revised in order to better reflect the resources available on USC's campus (See Appendix C).

Data Quality Items. Individuals completed the entire survey were given an item at the end which reads "There may be various factors that impact how someone responds to questionnaires. It is helpful for us to know how accurate your responses were. Is there any reason that we should not include your responses in our analyses? For example, careless responding or not being honest?" Responses to this question will not impact participant payment.

Finally, an open-ended question was given after all other questions for participants to add additional information if they so choose. The question read: "Is there any additional information you wish to add regarding the topics in this survey?"

2.5 Data Analytic Approach

All analyses were conducted using IBM SPSS Statistics. Descriptive statistics were calculated for key study variables. My hypotheses were that greater self-endorsement of SBW (total scale) would negatively affect the relation between trauma exposure and actual help-seeking or intention to seek help, respectively. I evaluated these two hypotheses using hierarchal regression for both traditional trauma and combined trauma of both traditional and racial trauma exposure. See Appendix A for a conceptual diagram and steps of the hierarchal regressions.

2.6 A Priori Power Analyses

Based on a power analysis using the G*Power 3 analysis (Faul, Erdfelder, Lang, & Buchner, 2009), a sample of 68 women (alpha of .05) would have adequate power (β = .8) to detect a medium effect (f_2 = .15 or greater). Since prior research shows that ~65% of college students experience at least one traumatic event over their lifetime, a total sample of 105 participants should provide the 68 trauma exposed participants required by the power analysis.

2.7 Normality Assumption

To check for the assumption of normality, histogram graphs and Q-Q plots were created for each of the key study variables (See Appendix D). Based on both figures, the data appeared to be relatively normal, indicating that additional manipulation of the data was not necessary.

CHAPTER 3

RESULTS

3.1 Demographics

The initial sample included 117 participants. Six participants were not able to participate due to not meeting the inclusion criteria of identifying as a Black women at USC between the ages of 18-40. Seven participants did not complete the SBW scale. The current study focuses on the subsample of 69 participants who experienced either type of trauma since starting college. Sixty-six participants reported experiencing traditional trauma and 25 reported experiencing racial trauma since beginning college. See Figure 3.1 for a sample breakdown. Less than 5% of the final sample had missing data and therefore those cases were removed (Schafer, 1999; Alice, 2018). The average age was 22.58 (*SE* = 4.831; Minimum = 18; Maximum = 40). Less than 2% of the sample were Freshmen (1.4%), 23.2% were Sophomores, 17.4% Juniors, 24.6% Seniors, and 33.3% were Graduate students. Most of the students had at least one parent who had some college schooling (82.4%). Descriptive statistics of the demographic variables are displayed in Table 3.1.

3.2 Main Variables Descriptive Statistics

The mean score on the SBW scale was 2.75, meaning that most participants answered Sometimes to Frequently across the entire scale (*SD*= .46; See Table 3.2). For

the Mask of Strength subscale, 2.48 was the mean, meaning that most women said Sometimes to Frequently for these questions (*SD*= .62). On the Self-Reliance/Strength subscale, most women said Frequently to Always (*M*=3.34, *SD*= .39). Finally, most women said Sometimes to Frequently on the Caretaking subscale (*M*=2.48, *SD*= .64). Nearly all the participants who experienced a traumatic event reported seeking help in response to the trauma (95%), with informal help (94%) being utilized by more participants than formal help (62%). The most popular sources of prior help were friend (87%), family member (72%), and partner (60%). See Table 3.3 for the frequencies of each type of help. Twenty one percent of participants reported utilizing 4 different types of help, following by 3 types of help (18.8%), and 2 types of help (17.4%). The mean score on the General Help-Seeking Questionnaire, which measured intention to seek help in the future, was 3.29 (*SD*= .97) which indicates that most participants answered slightly unlikely to neither likely or unlikely for future help-seeking (See Table 3.4). Friend (*M*= 5.60, *SD*= 1.436), family member (*M*= 5.07, *SD*= 2.127), and partner (*M*= 4.78, *SD*= 2.341), respectively, were the sources of help participants said they were most likely to use in the future. The Cronbach's alpha for the SBW total scale was .89. The reliability for the SBW scales was .815 for Mask of Strength, .699 for Self-Reliance, and .839 for Caretaking. The Cronbach's alpha for the General Help-Seeking Questionnaire was .791. Reliability statistics for the two trauma measures and the Actual Help-Seeking Questionnaire were not able to be assessed because these measures were checklists.

3.3 Correlations

Correlations between the main variables were assessed using Pearson Correlations (see Table 3.5). Each of the SBW subscales were significantly related to each other and

the SBW full scale measure. There was no significant correlation between SBW and trauma exposure (r= -.021, p=.838). The mask of strength subscale approached a significant relationship with intention to seek help (r= -.234, *p*=.057). The caretaking subscale was significantly related to help-seeking (r= .270, *p*<.05). Help-seeking was significantly related to intention to seek help (r= .307, *p*<.05) and exposure to racialized trauma (r= .261, *p*<.05). Finally, experiencing a traditional trauma was significantly related to experiencing racialized trauma (r= -.283, *p*<.05).

Correlations between individual items on the SBW scale and help-seeking were also calculated (See Table 3.6). Help-seeking had a positive significant correlation to three items on the Caretaking subscale, two items on the Self-Reliance/Strength subscale, and one item on the Mask of Strength subscale. Help-seeking had a negative significant correlation with one of the items on the Mask of Strength subscale. Intention to seek help had a positive significant correlation with one item on the Self-Reliance/Strength subscale. Intention to seek help had a negative significant correlation with three items on the Mask of Strength subscale, two on the Self-Reliance/Strength subscale, and one on the Caretaking subscale.

3.4 Hypothesis One

Hypothesis one was that greater self-endorsement of the SBW full scale would be related to less help-seeking following exposure to a potentially traumatic event (both traditional and racial). All analyses were conducted with only participants who experienced trauma. Two hierarchical regressions were conducted to test hypothesis one. The first regression included only participants who experienced traditional trauma, and

the second regression included participants who experienced either traditional or racial trauma. Age, parent education, relationship status, children, and religious attendance were controlled for in all the regression analyses. In the first hierarchical regression looking exclusively at traditional trauma, SBW did not influence help-seeking (*B*=1.021, *p*=.066). The second regression included individuals who experienced both types of trauma, and again SBW did not significantly influence help-seeking (*B*=1.001, *p*=.068).

Post-hoc analyses. Post-hoc analyses were completed with hierarchical regression models in which the predictor variables were SBW subscales, instead of the single full scale measure. This time, the model did significantly predict help-seeking for those who experienced traditional trauma, $F(8)=2.545$, $p<.05$. Specifically, contrary to Hypothesis 1, the Self-Reliance (*B*=1.461, p<.05) and Caretaking (*B*=1.125, p<.05) subscales positively predicted help-seeking. The hierarchical regression that included participants who experienced both types of trauma was also significant $F(8)=2.605$, $p<.05$. In this model, the Mask of Strength subscale approached significance (*B*= -.969, p=.051), with Mask of Strength negatively related to help-seeking, as hypothesized. The other two subscales positively predicted help-seeking, again contrary to Hypothesis 1 - Self-Reliance (*B*=1.403, p<.05), and Caretaking (*B*=1.177, p<.05). See Tables 3.7 and 3.8.

Further analyses were conducted to assess for differences by type of help-seeking (informal vs. formal) and the SBW subscales. The regressions were conducted with informal or formal help as the outcome, looking at both traditional and racial trauma exposure. The SBW subscales did not significantly predict informal help-seeking (Mask of Strength *B*=.055, p=.369, Self-Reliance *B*= -.0997, p=.256, Caretaking *B*=.000,

p=.996). When formal help-seeking was the outcome variable, the model was significant ($F(8)=3.001$, $p<.01$). Consistent with Hypothesis 1, Mask of Strength ($B= -.246$, $p<.05$) negatively predicted formal help-seeking. Contrary to Hypothesis 1, Caretaking ($B=.287$, $p<.05$) positively predicted formal help-seeking. See Tables 3.9 and 3.10.

To further explore help-seeking, a dichotomous variable of low-moderate vs. high help-seeking was created. Low-moderate help was coded as 0-4 sources of help sought, and high help-seeking was coded as seeking 5 or more sources. Those who experienced any type of traditional trauma were significantly more likely to have engaged in low-moderate (68%) help-seeking than high (31%; $X_2(1)= 5.881$, $p<.05$). A Chi-square assessing the relationship between racialized trauma and help-seeking was also significant ($X_2(1)= 5.123$, $p<.05$) indicating that those who experienced racialized trauma were more likely to engage in high help-seeking (52%) compared to those who did not experience racial trauma (25%).

3.5 Hypothesis Two

Hypothesis Two stated that intention to seek help in the future, following a traumatic event, would be negatively related to self-endorsement of SBW. Two hierarchical regressions were conducted, one with participants who experienced traditional trauma and another with participants who experienced either traditional trauma or racialized trauma. SBW did not significantly predict intention to seek help in the first hierarchical regression looking exclusively at traditional trauma ($B= -.306$, $p=.235$). In the second hierarchical regression looking at both traditional and racialized trauma, SBW again did not influence intention to seek help ($B= -.299$, $p=.238$).

Post-hoc analyses. Again, post-hoc analyses were completed with the SBW subscales instead of the single full scale measure. In the model including only those who experienced traditional trauma, Mask of Strength was the only subscale to significantly predict intention to seek help (B= -.545, p<.05). This relationship was negative, which supports Hypothesis 2. The Self-Reliance (B= -.077, p= .822) and Caretaking (B= .342, p= .157) subscales were not significant. Furthermore, the hierarchical regression model predicting intention to seek help after experiencing either traditional or racial trauma was also significant $F(9)=2.191$, p<.05. Again, Mask of Strength negatively predicted intention to seek help (B= -.518, p<.05), further supporting Hypothesis 2. The Self-Reliance (B= -.079, p= .814) and Caretaking (B= .320, p= .159) subscales were not significant. See tables 3.11 and 3.12.

Supplementary analyses were conducted to assess for differences in the relationships between intention to seek informal and formal help and the SBW subscales (See Tables 3.13 and 3.14). Again, the regressions included participants who experienced either traditional or racial trauma. The SBW subscales did not significantly predict intention to seek informal help (Mask of Strength B= -.093, p=.755, Self-Reliance B= -.784, p=.066, Caretaking B=.292, p=.303). When intention to seek formal help was the outcome variable, the model was significant ($F(8)=3.023$, p<.01). Again, the Mask of Strength subscale supported Hypothesis 2 (B= -.672, p<.05) by negatively predicting intention to seek formal help. See Appendix E for additional analyses that were conducted, but are not included here.

Table 3.1 Descriptive Statistics

Construct	n (%)
Age *M* = 22.58; *SD* = 4.831; Range 18-40years	
18	2(2.9%)
19	15 (21.7%)
20	13 (18.8%)
21	8 (11.6%)
22	11 (15.9%)
23	4 (5.8%)
24	2 (2.9%)
26	2 (2.9%)
27	4 (5.8%)
28	2 (2.9%)
29	1 (1.4%)
31	1 (1.4%)
32	1 (1.4%)
39	1 (1.4%)
40	2 (2.9%)
Year in School	
Freshman	1 (1.4%)
Sophomore	16 (23.2%)
Junior	12 (17.4%)
Senior	17 (24.6%)
Graduate Student	23 (33.3%)
Parent Education	
High school graduate	8 (11.6%)
GED	1 (1.4%)
Vocational school	3 (4.3%)
Some college	16 (23.2%)
College graduate	19 (27.5%)
Master's degree	15 (21.7%)
Doctorate	3 (4.3%)
Professional degree such as MD, JD, Nursing	3 (4.3%)
Relationship Status	
Single	26 (37.7%)
Casual dating, not in a committed relationship	13 (18.8%)
Committed relationship with my partner	27 (39.1%)
Married	3 (4.3%)
Children	
Yes	3 (4.3%)
No	66 (95.7%)

Note. *N* = 69

Table 3.1 Descriptive Statistics (part 2)

Construct	n (%)
Fraternity/Sorority	
Fraternity	7 (10.1%)
Sorority	10 (14.5%)
Neither	52 (75.4%)
Employed	
Yes	53 (76.8%)
No	16 (23.2%)
Religious Services	
Never	10 (14.5%)
Once a year	3 (4.3%)
Several times a year	22 (31.9%)
Once a month	4 (5.8%)
2-3 times a month	19 (27.5%)
Once a week or more	11 (15.9%)
Traditional Trauma	66 (95.6%)
Natural disaster	15 (21.7%)
Fire or explosion	2 (2.9%)
Transportation accident	25 (36.2%)
Serious accident at work, home, or during recreational activity	8 (11.6%)
Exposure to toxic substances	3 (4.3%)
Physical assault	9 (13%)
Assault with a weapon	0 (0%)
Sexual assault	7 (10.1%)
Other unwanted or uncomfortable sexual experience	27 (39.1%)
Combat or exposure to a war zone	1 (1.4%)
Captivity	3 (4.3%)
Life-threatening illness or injury	6 (8.7%)
Severe human suffering	4 (5.8%)
Sudden violent death of someone close to you	8 (11.6%)
Sudden accidental death of someone close to you	15 (21.7%)
Serious injury, harm, or death you caused to someone else	5 (7.2%)
Any other very stressful event or exposure	28 (40.6%)
Racialized Trauma	25 (36.2%)
Police harassment or assault	22 (15.9%)
Threats to physical safety	6 (8.7%)
Fear for life or serious health issue due to medical mistreatment	7(10.1%)
Assault or fear for life due to immigration process	1 (1.4%)
Any other very stressful event or exposure	15 (21.7%)

Note. $N = 69$.

Table 3.2 Descriptive Statistics for SBW Scale

	M	SD	Range
SBW Full Scale	2.75	.4624	1.69 - 3.81
Mask of Strength	2.486	.6256	1.14 - 3.71
Self-Reliance/ Strength	3.347	.3941	2.18 - 4
Caretaking	2.487	.6363	.91 - 3.91
Scale Items	M	SD	
1. I feel pressured to appear strong, even when I'm feeling weak.	2.90	.987	
2. I do not let most people know the "real" me.	2.20	1.119	
3. I do NOT like to let others know when I am feeling vulnerable.	2.83	1.014	
4. I will let people down if I take time out for myself.	1.81	1.179	
5. I am often expected to take care of family members.	2.17	1.124	
6. I am always helping someone else.	3.17	.822	
7. I have difficulty showing my emotions.	1.99	1.078	
8. I try to always maintain my composure.	3.16	.834	
9. I am overworked, overwhelmed, and/or underappreciated.	2.75	.976	
10. It is difficult for me to share problems with others.	2.46	1.092	
11. I feel uncomfortable asking others for help.	2.75	1.035	
12. If you have a problem, you should handle it quickly and with dignity.	2.29	1.016	
13. I do not want others to know if I experience a problem.	2.55	.916	
14. I find it difficult to ask others for help.	2.57	1.105	
15. If I fall apart, I will be a failure.	2.51	1.208	
16. I tell others that I am fine, even when I am depressed or down.	2.71	1.072	
17. As I become an adult, it is important that I become financially independent and not expect a boy/girlfriend or husband/wife to support me financially.	3.78	.449	
18. At times, I feel overwhelmed with problems.	2.97	.923	
19. In order to feel good about myself, I need to feel independent and self-sufficient.	3.13	.954	
20. It is easy for me to tell other people my problems.	1.51	.901	
21. People think that I don't have feelings.	1.46	1.244	
22. The women in my family are survivors.	3.43	.737	

23. Often I look happy enough on the outside, but inwardly I feel overwhelmed and unhappy.	2.45	.948
24. I take on more responsibilities for others than I can comfortably handle.	2.35	1.069
25. I feel guilty when I put my own needs before the needs of others.	2.07	1.129
26. I believe that it is best not to rely on others.	3.12	.932
27. I often take on other people's problems	2.39	.943
28. I am strong	3.30	.845
29. I cannot rely on others to meet my needs.	2.88	1.078
30. I need people to see me as always confident.	2.88	.883
31. I am independent.	3.39	.771
32. It is important for me to feel strong.	3.43	.696
33. I expect to experience many obstacles in life.	3.26	.902
34. People often expect me to take care of them.	1.90	.957
35. Women of my race have to be strong to survive.	3.83	.452
36. Women of my race are stronger than women of other races.	3.64	.618

Table 3.3 Types of help seeking resources utilized

	n (%)
Any Help	66 (95.6%)
Informal Sources	65 (94.2%)
Partner	42 (60.9%)
Friend	60 (87.0%)
Roommate	29 (42.0%)
Family Member	50 (72.5%)
Formal Resources	43 (62.3%)
Mental Health Professional	34 (49.3%)
Medical Professional	12 (17.4%)
Sexual Assault Services	4 (5.8%)
Online Group	3 (4.3%)
In-person Support Group	8 (11.6%)
Religious or Spiritual Peer Group	14 (20.3%)
Religious or Spiritual Advisor	8 (11.6%)
Resident Mentor	3 (4.3%)
Phone Help Line	5 (7.2%)
Police	4 (5.8%)
Other	3 (0.043%)

Table 3.4 Descriptive Statistics for General Help-seeking Questionnaire

	M	SD	Range
GHSQ Full Scale	3.286	.9672	1.47 – 5.87
Scale Items	M	SD	
Partner (e.g. boyfriend or girlfriend)	4.78	2.341	
Friend (not related to you)	5.60	1.436	
Roommate	3.93	2.106	
Family member (e.g. parent, cousin)	5.07	2.127	
Mental health professional (e.g. counselor, psychologist, psychiatrist)	3.94	2.215	
Phone help line (e.g. National Suicide Hotline)	1.75	1.363	
Online help group	2	1.586	
In-person support group (e.g. grief group)	1.97	1.446	
Religious or spiritual peer group (e.g. small group or bible study)	3.24	2.104	
Medical professional (e.g. doctor or nurse practitioner)	3.34	2.034	
Sexual assault services (e.g. Sexual Assault Violence Intervention Prevention)	2.24	1.661	
Resident Mentor	1.78	1.369	
Police	1.88	1.332	
Religious or spiritual advisor like a minister, priest, or rabbi	2.87	2.138	
I don’t plan to seek help from anyone	3.07	1.726	

Table 3.5 Correlations between main variables

	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
1. SBW	1.00													
2. Mask of Strength	.893**	1.00												
3. Self-Reliance	.685**	.468**	1.00											
4. Caretaking	.873**	.581**	.425**	1.00										
5.Tradtional Trauma	.000	.093	.041	-.142	1.00									
6. Racial Trauma	.066	-.036	.143	.113	-.283*	1.00								
7. Help-seeking	.172	.000	.225	.270*	-.138	.261*	1.00							
8. Intention to seek help	-.164	-.234	-.119	-.026	.004	.057	.307*	1.00						
9. Age	-.162	-.181	-.117	-.087	-.034	.091	.263*	.259*	1.00					
10. Year in school	-.176	-.220	-.149	-.051	-.062	.319**	.185	.092	.626**	1.00				
11. Parent education	-.141	-.128	-.053	-.144	.156	.103	.077	.071	.191	.149	1.00			
12. Relationship status	.055	-.024	.081	.111	.096	-.079	.080	.176	.310*	.143	-.007	1.00		
13. Religious attendance	-.041	-.006	.062	-.128	.055	-.145	-.003	.246*	.076	-.022	.198	.053	1.00	
14. Children	-.095	-.159	.025	-.042	.045	-.161	.033	.031	.597**	.239*	.131	.346**	.076	1.00

Note. Pearson Correlations; * $p < .05$; ** $p < .01$ (two-tailed); N = 69

Table 3.6 Correlations between SBW items and help-seeking

SBW Question	Help-seeking	Intention to seek help
Mask of Strength subscale		
1. I feel pressured to appear strong, even when I'm feeling weak.	.139	.062
2. I do not let most people know the "real" me.	.018	.165
3. I do NOT like to let others know when I am feeling vulnerable.	-.092	-.096
7. I have difficulty showing my emotions.	-.149	-.076
8. I try to always maintain my composure.	-.091	.077
10. It is difficult for me to share problems with others.	-.113	-.242*
11. I feel uncomfortable asking others for help.	.049	-.229*
12. If you have a problem, you should handle it quietly and with dignity.	-.012	-.143
13. I do not want others to know if I experience a problem.	.014	-.231*
14. I find it difficult to ask others for help.	.060	-.302**
16. I tell others that I am fine, even when I am depressed or down.	.106	-.034
20. It is easy for me to tell other people my problems. (reverse coded)	-.105	-.162
21. People think that I don't have feelings.	-.074	-.065
23. Often I look happy enough on the outside, but inwardly I feel overwhelmed and unhappy.	.100	-.135
Self-Reliance/ Strength subscale		
17. As I become an adult, it is important that I become financially independent and not expect a boy/girlfriend or husband/wife to support me financially.	.073	.111
19. In order to feel good about myself, I need to feel independent and self-sufficient.	-0.18	-.180

22. The women in my family are survivors.	.146	.023
26. I believe that it is best not to rely on others.	.297**	-.257*
28. I am strong	.158	.200
29. I cannot rely on others to meet my needs.	.045	-.267*
30. I need people to see me as always confident.	.116	-.141
31. I am independent.	.200*	.112
32. It is important for me to feel strong.	.019	.113
35. Women of my race have to be strong to survive.	.116	-.057
36. Women of my race are stronger than women of other races.	.044	.044
Caretaking subscale		
4. I will let people down if I take time out for myself.	.004	-.007
5. I am often expected to take care of family members.	.273**	.148
6. I am always helping someone else.	.181	.092
9. I am overworked, overwhelmed, and/or underappreciated.	.057	-.087
15. If I fall apart, I will be a failure.	.196*	-.021
18. At times, I feel overwhelmed with problems.	.153	-.257*
24. I take on more responsibilities for others than I can comfortably handle.	.209*	.041
25. I feel guilty when I put my own needs before the needs of others.	.173	-.103
27. I often take on other people's problems	.224*	-.184
33. I expect to experience many obstacles in life.	.131	.028
34. People often expect me to take care of them.	.183	.158

Note. Pearson Correlations; * $p < .05$; ** $p < .01$ (two-tailed); N = 69; Items are organized by subscale

Table 3.7 Hierarchical Regression for Variables Predicting Help-seeking

Variable	B	β	*t*	sr_2	*R*	R^2	ΔR^2
Step 1 $F(5)=1.374$, $p=2.47$					.323	.104	.104
Constant	-.183		-.108				
Age	.154	.361*	2.281	.079			
Parent Education	.103	.085	.651	.006			
Relationship Status	.139	.064	.475	.003			
Religious Attendance	-.038	-.029	-.228	.000			
Child	-.2090	-.211	-1.332	.027			
Step 2 $F(8)=2.545$, $p<.05$					.516	.267	.162
Constant	-6.058		-2.212				
Age	.188	.441**	2.948	.114			
Parent Education	.105	.087	.710	.007			
Relationship Status	-.031	-.014	-.111	.000			
Religious Attendance	.006	.005	.038	.000			
Child	-2.717	-.275	-1.837	.044			
Mask of Strength	-.927	-.284	-1.839	.044			
Self-Reliance	1.461	.283*	2.092	.057			
Care Taking	1.125	.349*	2.290	.069			

Note. $N=66$; *p<.05, **p<.01; Only among those who endorsed traditional trauma

Table 3.8 Hierarchical Regression for Variables Predicting Help-seeking

Variable	B	β	*t*	sr_2	*R*	R^2	ΔR^2
Step 1 $F(5)=1.282$, $p=.283$					.306	.094	.094
Constant	.311		.191				
Age	.155	.363*	2.365	.082			
Parent Education	.046	.039	.312	.001			
Relationship Status	.069	.032	.249	.000			
Religious Attendance	-.034	-.027	-.222	.000			
Child	-1.989	-.199	-1.290	.024			
Step 2 $F(8)=2.605$, $p<.05$					.511	.261	1.67
Constant	-5.390		-2.030				
Age	.180	.422**	2.924	.107			
Parent Education	.068	.058	.495	.003			
Relationship Status	-.070	-.033	-.268	.000			
Religious Attendance	.002	.002	.016	.000			
Child	-2.537	-.254	-1.754	.038			
Mask of Strength	-.969	-.295	-1.996	.049			
Self-Reliance	1.403	.270*	2.037	.052			
Care Taking	1.177	.365*	2.517	.079			

Note. $N=69$; *p<.05, **p<.01; Among those who endorsed either traditional or racial trauma

Table 3.9 Hierarchical Regression for Variables Predicting Informal Help-seeking

Variable	B	β	*t*	sr_2	*R*	R^2	ΔR^2
Step 1 $F(5)=1.429$, $p=.226$					.321	.103	.103
Constant	1.228		6.605				
Age	-.016	-.330*	-2.158	.067			
Parent Education	.011	.085	.675	.007			
Relationship Status	.032	.133	1.024	.051			
Religious Attendance	-.024	-.165	-1.340	.026			
Child	.236	.206	1.340	.026			
Step 2 $F(8)=1.084$, $p=.387$					.358	.128	.025
Constant	1.426		4.308				
Age	-.017	-.348*	-2.217	.072			
Parent Education	.012	.092	.724	.008			
Relationship Status	.035	.142	1.073	.017			
Religious Attendance	-.023	-.157	-1.242	.023			
Child	.274	.239	1.518	.034			
Mask of Strength	.055	.146	.906	.012			
Self-Reliance	-.099	-.165	-1.148	.019			
Care Taking	.000	.001	.005	.000			

Note. $N=69$; *p<.05, **p<.01; Among those who endorsed either traditional or racial trauma

Table 3.10 Hierarchical Regression for Variables Predicting Formal Help-seeking

Variable	B	β	*t*	sr_2	*R*	R^2	ΔR^2
Step 1 $F(5)=2.669$, $p<.05$					.421	.177	.177
Constant	-.444		-1.206				
Age	.030	.301*	2.053	.056			
Parent Education	.074	.265*	2.210	.065			
Relationship Status	-.024	-.047	-.377	.002			
Religious Attendance	.006	.020	.172	.000			
Child	-.072	-.030	-.206	.001			
Step 2 $F(8)=3.001$, $p<.01$					.538	.289	.112
Constant	-1.078		-1.747				
Age	.033	.325*	2.293	.064			
Parent Education	.077	.277*	2.406	.069			
Relationship Status	-.049	-.097	-.811	.008			
Religious Attendance	.018	.062	.544	.004			
Child	-.162	-.068	-.482	.003			
Mask of Strength	-.246	-.316*	-2.178	.057			
Self-Reliance	.144	.116	.897	.009			
Care Taking	.287	.375*	2.638	.084			

Note. $N=69$; *p<.05, **p<.01; Among those who endorsed either traditional or racial trauma

Table 3.11 Hierarchical Regression for Variables Predicting Intention to Seek Help

Variable	B	β	*t*	sr_2	*R*	R^2	ΔR^2
Step 1 $F(5)=2.021$, $p=.089$					.388	.151	.151
Constant	1.128		1.450				
Age	.065	.329*	2.096	.066			
Parent Education	.014	.024	.185	.001			
Relationship Status	.167	.164	1.220	.022			
Religious Attendance	.117	.190	1.494	.033			
Child	-1.139	-.248	-1.580	.037			
Step 2 $F(8)=2.031$, $p=.060$					.481	.231	.081
Constant	2.062		1.555				
Age	.062	.313*	2.006	.057			
Parent Education	-.005	-.009	-.069	.000			
Relationship Status	.143	.140	1.046	.016			
Religious Attendance	.148	.241	1.893	.051			
Child	-1.288	-.281	-1.799	.046			
Mask of Strength	-.545	-.357*	-2.191	.068			
Self-Reliance	-.077	-.032	-.226	.001			
Care Taking	.342	.228	1.437	.029			

Note. $N=66$; *p<.05, **p<.01; Only among those who endorsed traditional trauma

Table 3.12 Hierarchical Regression for Variables Predicting Intention to Seek Help

Variable	B	β	*t*	sr_2	*R*	R^2	ΔR^2
Step 1 $F(5)=2.265$, $p=.059$					.398	.159	.159
Constant	1.197		1.618				
Age	.067	.340*	2.258	.071			
Parent Education	-.006	-.011	-.089	.000			
Relationship Status	.134	.134	1.044	.015			
Religious Attendance	.139	.232	1.916	.052			
Child	-1.110	-.239	-1.584	.035			
Step 2 $F(8)=2.191$, $p<.05$					.485	.235	.076
Constant	2.082		1.629				
Age	.062	.312*	2.086	.056			
Parent Education	-.015	-.027	-.220	.001			
Relationship Status	.125	.124	.982	.013			
Religious Attendance	.166	.278*	2.295	.071			
Child	-1.233	-.266	-1.771	.042			
Mask of Strength	-.518	-.337*	-2.179	.064			
Self-Reliance	-.079	-.032	-.236	.001			
Care Taking	.320	.213	1.426	.027			

Note. $N=69$; *p<.05, **p<.01; Among those who endorsed either traditional or racial trauma

Table 3.13 Hierarchical Regression for Variables Predicting Intention to Seek Informal Help

Variable	B	β	*t*	sr_2	R	R^2	ΔR^2
Step 1 $F(5)=1.305$, $p=2.74$					.313	.098	.098
Constant	4.802		5.249				
Age	-.027	-.113	-.724	.008			
Parent Education	-.050	-.076	-.597	.005			
Relationship Status	.368	.307*	2.316	.081			
Religious Attendance	.056	.079	.629	.006			
Child	-.301	-.054	-.347	.002			
Step 2 $F(8)=1.391$, $p=.220$					.404	.163	.065
Constant	7.095		4.445				
Age	-.038	-.160	-1.022	.015			
Parent Education	-.049	-.075	-.592	.005			
Relationship Status	.369	.308*	2.325	.079			
Religious Attendance	.084	.117	.926	.013			
Child	-.134	-.024	-.154	.000			
Mask of Strength	-.093	-.051	-.313	.001			
Self-Reliance	-.784	-.270	-1.876	.052			
Care Taking	.292	.163	1.039	.016			

Note. $N=69$; *p<.05, **p<.01; Among those who endorsed either traditional or racial trauma

Table 3.14 Hierarchical Regression for Variables Predicting Intention to Seek Formal Help

Variable	B	β	*t*	sr_2	*R*	R^2	ΔR^2
Step 1 $F(5)=3.237$, $p<.05$					.461	.212	.212
Constant	-.114		-.140				
Age	.101	.454**	3.110	.127			
Parent Education	.010	.016	.134	.000			
Relationship Status	.049	.043	.349	.002			
Religious Attendance	.169	.250*	2.128	.059			
Child	-1.404	-.268	-1.830	.044			
Step 2 $F(8)=3.023$, $p<.01$					.546	.298	.085
Constant	.259		.187				
Age	.098	.437**	3.052	.115			
Parent Education	-.002	-.003	-.029	.000			
Relationship Status	.036	.032	.261	.001			
Religious Attendance	.196	.290*	2.499	.077			
Child	-1.632	-.311*	-2.164	.058			
Mask of Strength	-.672	-.387*	-2.611	.084			
Self-Reliance	.177	.065	.489	.003			
Care Taking	.331	.195	1.358	.023			

Note. $N=69$; *p<.05, **p<.01; Among those who endorsed either traditional or racial trauma

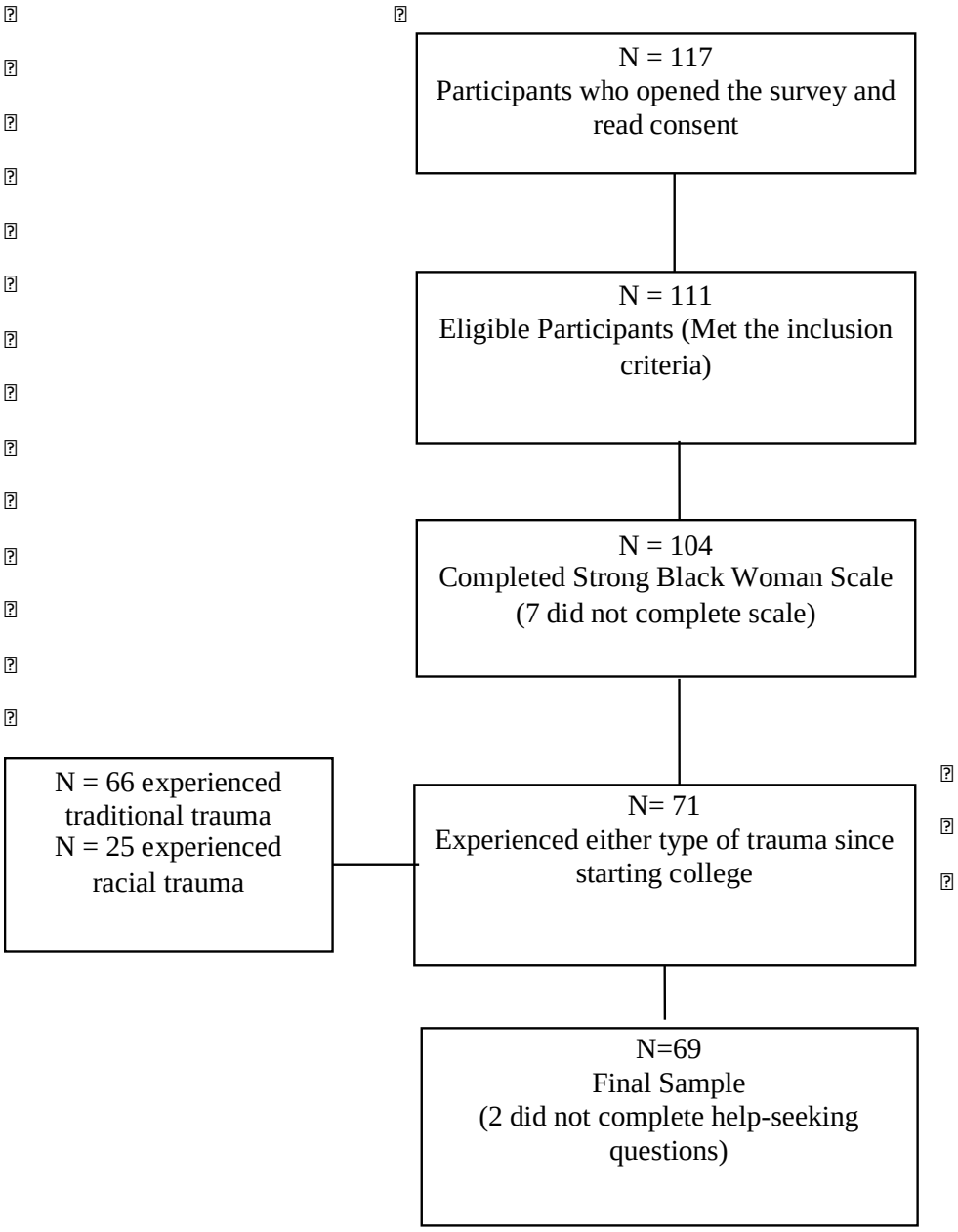

Figure 3.1. Flowchart illustrating process of identifying final analytic sample.

CHAPTER 4

DISCUSSION

The Strong Black Woman Stereotype has existed for many years and has been written about in opinion pieces, books, and qualitative studies (e.g. Romero, 2000; Beauboeuf-Lafontant, 2009; Collins, 2000); however, the number of quantitative studies remain few. Furthermore, the research literature on the relationship between SBW and help-seeking is extremely limited. The purpose of this study was to test the relation between SBW and help-seeking for those who experienced a traumatic event. This was the first quantitative study to assess exposure to trauma in relation to SBW, and the first to assess help-seeking and SBW.

Overall, the results of this study provide evidence that SBW is more nuanced than previously thought. The stereotype has three components- Mask of Strength, Self-Reliance, and Caretaking- that are related to one another, but function differently in their relation to help-seeking and intention to seek help. The models with the SBW full scale did not significantly predict help-seeking, however, the results varied when analyses were conducted with the SBW subscales. This suggests that the stereotype relates to both positive and negative outcomes.

The Mask of Strength subscale had a negative relationship with formal help-seeking and intention to seek help, thus supporting Hypotheses 1 and 2. This finding is supported by prior literature that the stereotype stifles Black women's ability to express their feelings and needs (e.g. Beauboeuf-Lafontant, 2009). The current study also

corroborates Woods' (2014) finding that those who strongly endorsed SBW were less likely to report intention to seek help. Mask of Strength promotes emotional invulnerability and requires Black women to hide their struggles from others in an effort to appear strong. This aspect of SBW is consistent with the literature on masculinity and how men often hide weaknesses. Research suggests that men who ascribe to traditional concepts of masculinity are likely to have greater barriers to help-seeking (see Vogel & Heath, 2016 for review). Traditional masculine values promote self-reliance and stoicism, which often prevents men from seeking help (Addis & Mahalik, 2003). Both Mask of Strength and traditional masculinity encourage people to hide their vulnerability. This practice of hiding weakness can interfere with both a person's acknowledgement that help is needed, and the actual behavior of seeking out help. SBW researchers may find it helpful to refer to the masculinity research to analyze commonalities between the constructs. For example, established mediators, such as self-stigmatization (Vogel et al., 2011; Levant et al., 2013), between masculinity and help-seeking may also exist between Mask of Strength and help-seeking. In the aforementioned studies, self-stigma is defined as one's belief that their self-esteem will be threatened by seeking mental health treatment. Further analysis should test this.

An unexpected finding was that the Self-Reliance/Strength and Caretaking subscales positively predicted help-seeking. Regarding Self-Reliance/Strength, this finding may indicate that participants are redefining what they believe it means to be strong. Rather than strength meaning that you handle problems on your own, participants may believe that being strong means acknowledging when you need help. Additionally, they may feel empowered when they seek help because they have overcome barriers to

help-seeking, such as time, money, or stigma. Conversely, it is also possible that seeking help led them to feel more self-reliant, confident, and strong.

Similarly, those who subscribe to the caregiver role may recognize that if they are unwell or overwhelmed, then they are not able to successfully help others. Because there were so few participants who had children, this caregiver role seems to extend to other family members and the community at large. This is consistent with prior literature (e.g. Donovan & West, 2015) in which women talk about caring for those beyond their immediate family, such as non-biological children and non-relatives in the community. Participants in the current study may have taken on the caregiver role for their siblings, extended family, or friends.

Study participants engaged in more help-seeking than prior studies have found (e.g. Carter & Forsyth, 2010; Lindquist et al., 2016; Waters, 2016). In the present study, nearly all participants sought at least one form of help (95%). Conversely, Carter and Forsyth (2010) found that only 57% of their sample sought help to deal with a "memorable encounter with discrimination", the other 43% of their sample reported not seeking any type of help (58% of their sample identified as Black). Similarly, Waters (2016) studied a sample of college students after Katrina, 95% were female and 84% were Black, and found that of those who had "probable serious mental illness", only 9.2% saw a mental health professional in the year after the hurricane. The current study's findings are likely different from previous literature because colleges have recently increased campaigns to promote help-seeking among their students (e.g. Columbia Health, 2019; Murphy & Hennessey, 2017). Many counseling centers now have online services, there are campus peer help groups, and more faculty are including resources in

class syllabi. For example, in 2017, Columbia University partnered with the Jed Foundation to enhance student wellbeing and a major part of the campaign was to decrease help-seeking stigma by promoting campus services. They have done this by creating student groups, presenting at student orientations, and placing posters around campus that dispel stigma and list resources (Columbia Health, 2019). The findings in the current study may be showing the positive effect of some of these types of recent campus initiatives.

Consistent with prior literature, participants were more likely to engage in informal (94.2%) than formal help (62.3%) following a traumatic event (e.g. Lindquist et al., 2016; Carter & Forsyth, 2010). Women may feel more comfortable reaching out to friends, family, or a partner. Additionally, seeking advice from someone they know may seem less daunting than going to a stranger. Despite this, the finding that 49% of participants saw a mental health professional is encouraging, and may represent a shift towards lessening mental health stigma, at least in college populations.

Although there were not many differences between traditional and racial trauma, one difference was that those who endorsed racial trauma were more likely to engage in high help-seeking (52%) than those who did not experience racial trauma (25%). Racial trauma is a traumatic response to racism, particularly racism from the dominant racial group (Williams et al., 2018). It is possible that racial trauma is experienced as more of a collective or community type of trauma, because everyone in the race has the potential to experience distress due to prejudice, discrimination, or violence. Even if people would not categorize their experience with racism as traumatic, it's still possible that they can relate to a community member's frustrations. Because racial trauma is experienced more

collectively than other forms of trauma, people may be more comfortable talking about it with others. It is also conceivable that this form of trauma leads to less self-blame or guilt than other forms of trauma, and this could affect help-seeking. Further research should test this theory. Another related finding was that age and racial trauma were positively correlated, suggesting that as Black women get older, they are more likely to have experiences of racial trauma.

3.1. Clinical Implications

Given the nuanced findings, providers should not make assumptions about the helpful or unhelpful nature of SBW. Instead, they should work to better understand how clients define the stereotype and which aspects they may ascribe to. It may be helpful for providers to promote Caretaking by reminding Black women that if they want to fulfill their value of helping others, then they must also help themselves. Being reminded of their role as a caregiver may help women to care for themselves. Additionally, women might benefit from being reminded of their prior strength and self-reliance; however, providers will need to be careful to make sure women are redefining strength from "do everything myself" to "ask for help when needed". For example, when a woman does not have confidence in her ability to solve problems or if her situation changes and she no longer has a support system, self-reliance would be helpful to promote. The provider could help her recognize her strengths and help her identify ways that she's overcome hardship in the past. This practice would promote increased self-efficacy, which can be damaged by trauma (Benight & Bandura, 2004). Encouraging self-reliance may be most helpful depending on what is going on in a woman's external world (see Donovan & West, 2015).

On the other hand, providers should be aware of the consequences of Mask of Strength. Black women need to know that hiding their emotions or struggles is often not a helpful long-term practice. Providers should take a nonjudgmental stance and validate Black women's concerns with emotional vulnerability. Utilizing approaches such as Motivational Interviewing (for overview, see Center for Substance Abuse Treatment, 1999) could help Black women determine the costs and benefits of changing their behavior of masking their hurt. Providers could connect behavior change to women's values, such as being a supportive partner or being a genuine person. Furthermore, it is important for providers to keep in mind that this aspect of SBW may lead to underreporting of symptoms or downplaying distress (Watson & Hunter, 2015). A culturally competent assessment and open discussion of racial stereotypes will be helpful to increase rapport and minimize underreporting.

In a recent study, Liao and colleagues (2020) found that promoting self-compassion may reduce the negative effects of SBW. If an intervention works to redefine emotional vulnerability as an act of self-compassion or self-love, that may increase Black women's willingness to be open. Self-compassion could be explained as a way to sustain one's strength (Liao et al., 2020). This is something that can be practiced privately through the use of resources such as self-compassion meditation videos, or journaling.

Providers should also capitalize on the aspect of SBW that connects women to their heritage and other women in their lives. A therapist could help a client connect their SBW ideals to their ancestors. Women may find it comforting to reminisce and re-connect with prior generations, especially those still living (see Taylor-Lindheim, 2016). Given the finding in this study that so many participants engaged in informal help-

seeking, providers can bolster this kind of help-seeking by working with Black women to identify supportive people in their life. Finally, it could be beneficial for Black women to be validated in the discrimination and obstacles they face that often force them to adopt SBW ideals. Taking time to reflect on the hardships they have faced and appreciate their own resilience could be a therapeutic process.

Lastly, college campus providers, particularly at PWIs, should continue to work to make their services accessible to Black women. They could tailor their promotional efforts by meeting with Black sororities, Black affinity groups, and community stakeholders (West et al., 2016) to acknowledge SBW and address potential consequences of emotional invulnerability.

3.2 Limitations

Firstly, the data was cross-sectional which does not allow for causal inferences. It's possible that SBW affected help-seeking or vice versa. A longitudinal study would help confirm the direction of the relationship. Secondly, the study only collected help-seeking data from those who endorsed a traumatic experience, and thus was not able to compare help-seeking between those who experienced a trauma and those who did not. The third limitation is the sample size, as a larger sample size would have allowed for the detection of smaller effects. Additionally, the study sample included only Black college women at a PWI. The findings may not generalize to a community sample, as college campuses often have resources that are not as readily available in the community. The results should also not be generalized to HBCUs, because at these institutions, Black women are not the racial minority and therefore may experience cultural stereotypes

differently. The study should be replicated with a larger sample that includes women not in college, and women at various types of institutions. This would allow researchers to determine if the findings are specific to education level, socioeconomic status, college campus resources, or raced based institutions.

3.3 Conclusion

The current study underscores the importance of looking at the nuances behind the SBW stereotype, and stepping outside of the good vs. bad dichotomy. This is an understudied topic, particularly as it relates to trauma and help-seeking for Black women. While there is research on prevalence rates of trauma and help-seeking, we need to move beyond this to better understand the mechanisms behind the relationship, particularly for women of color. Both researchers and providers need to be aware of the impact SBW has on Black women's lives, and work to understand how we can bolster helpful aspects of the stereotype, while redefining others that may not be helpful.

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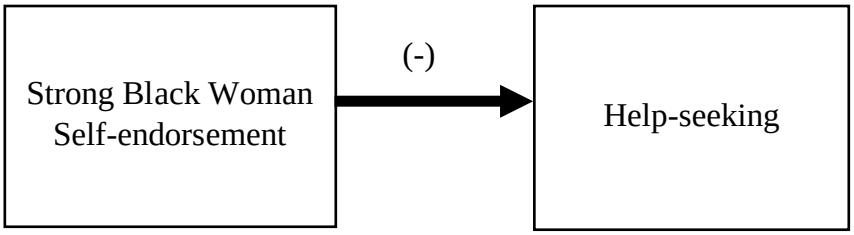
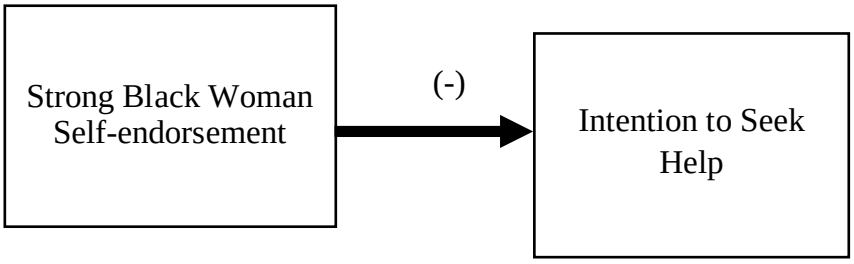
APPENDIX A

CONCEPTUAL DIAGRAMS





APPENDIX B

PROTECTION OF HUMAN SUBJECTS & INFORMED CONSENT

Potential risks. Participation in the study has minimal risks. Due to the sensitive nature of the data collected (e.g. experience of trauma), a security breach is a possible risk. However, this risk is very low because no identifying information will be linked to participant data and all identifiers will be deleted once participants have received their incentive. An additional risk is emotional distress from participants recounting traumatic events. I will minimize this risk by giving participants the option to withdraw at any time or skip questions they do not choose to answer. Additionally, the end of the survey will include campus and community resources for students should they feel distressed.

Potential benefits. The potential benefits to individual students are minimal. Participants will be compensated for completion of the study. The study compensation rate of $8 was deemed fair to complete the roughly 20-minute survey, thus reducing the risk of undue influence.

Being presented with campus resources may prompt a student to seek out mental or physical health services from those sources. The present study will benefit the future USC and broader college community, particularly Black students, since the data acquired has potential to inform future student services. However, this is likely not an immediate benefit to study participants.

Confidentiality. To protect the identify of each participant, the data collected for this study will remain anonymous; I, as the investigator, will not be able to link data to

identifying information. Data will be collected via Qualtrics and will only be accessible to research staff who have been given a password for the Qualtrics account. Once downloaded, the dataset will be stored on a password-protected hard drive.

INFORMED CONSENT

KEY INFORMATION ABOUT THIS RESEARCH STUDY

Thank you for your interest in participating in this study. This study is being conducted by Nicole White. I am a graduate student in the Department of Psychology at the University of South Carolina and this research is for my dissertation. The goal of this study is to explore: 1) cultural and personality traits, and 2) scary or stressful things that sometimes happen to people. Your participation is completely voluntary. If you choose to participate, you will be asked to complete a 1 minute screening survey to evaluate whether you are eligible for the study. This survey includes questions about your demographic characteristics and relationship history.

If, based on your responses to the screening survey, you are eligible for the study, you will be invited to complete a lengthier survey. Only individuals who are deemed eligible based on their responses to the screening survey will be invited to complete the full survey. The full survey takes approximately 25 minutes to complete and you will have a chance to win a $20 amazon gift card if you chose to complete it. Please complete each question as thoroughly and honestly as possible. There are no right or wrong answers.

This survey includes questions about your attitudes, scary or stressful event history, and behavior. It also includes questions you may find upsetting such as questions about your experiences with violence. Please review the important information below so that you can make an informed decision about whether to participate.

Confidentiality

We take your confidentiality seriously. The data collected from this study are considered anonymous because your responses cannot be linked to personally identifiable information. I will have access to the email you provide (if you so choose) in order to process your payment. However, I will not be able to pair your email with your responses or other identifiable information. Additionally, the survey questions will not ask for identifiable information such as your name.

Payment

If you qualify for the study, you will have a chance to win 1 out of 45 $20 amazon gift cards. In order to be paid, you must complete the survey.

Voluntary Participation

You are not at all obligated to participate in this study. You may withdraw from the study at any point but will not receive compensation unless you complete the whole study.

Risks and Benefits

A benefit of participating is that you will be paid to complete the survey. A potential risk is that some individuals may find the questions in the survey upsetting. In case you do feel upset by these questions, at the end of the study you will be provided with a list of

resources including information about people that may be able to help you with these feelings. Additionally, you are free to withdraw from the study at any time. Another risk is a possible data breach. However, we will take great measures to protect your responses and they will never be linked with information that could be used to identify you.

Contact Information

If you have questions or concerns about this study, you can contact Nicole White at Nwlab01@gmail.com. You can also contact Suzanne Swan (a Psychology professor overseeing the research) at swansc@mailbox.sc.edu or 803-777-4200. If you have questions about your rights as a research participant, you can also contact the University of South Carolina's Office of Research Compliance at 803-777-709

APPENDIX C

STUDY MEASURES

Note: Participants did not see the measure names displayed here (e.g., Demographic Questionnaire).

Demographic Questionnaire

1. Do you consider yourself to be a Black or African American woman?

- **a.** Yes
- **b.** No [screen out]

2. How old are you?

- **a.** 17 or younger [screen out]
- b. 18
- c. 19
- d. 20
- e. 21
- f. 22
- g. 23
- h. 24
- i. 25
- j. 26
- k. 27
- l. 28

m. 29

n. 30

o. 31

p. 32

q. 33

r. 34

s. 35

t. 36

u. 37

v. 38

w. 39

x. 40

y. 41 or older [screen out]

3. Are you a student at the University of South Carolina?

a. Yes

b. No [screen out]

4. What is your year in school?

a. Freshmen

b. Sophomore

c. Junior

d. Senior

e. Graduate Student

5. What is the highest level of schooling your mother or father has completed? (select whichever is higher)

a. Some elementary, middle, or high school

b. High school graduate

c. GED

d. Vocational school

e. Some college

f. College graduate

g. Master's degree

h. Doctorate

i. Professional degree such as MD, JD, Nursing

6. Which of the following best describes your relationship status? By "relationship", we mean anything from a casual to a committed relationship, including all of the following: Having an open relationship in which you are also dating other people, going out on dates with someone, being in a committed relationship with a partner, or being married.

a. Single

b. Casual dating, not in a committed relationship

c. Committed relationship with my partner

d. Married

e. None of the above

7. Do you have children?

a. Yes

b. No

8. Are you…

a. In a fraternity

b. In a sorority

c. Neither

9. Are you currently employed?

a. Yes

b. No

10. How often do you attend religious services?

a. Never

b. Once a year

c. Several times a year

d. Once a month

e. 2-3 times a month

f. Once a week or more

11. Have you taken this survey before?

a. Yes [screen out]

b. No

Strong Black Woman Archetype Scale

Note. Response options are a 5 point scale: 0= Never, 1=Rarely, 2= Sometimes, 3= Frequently, 4= Almost Always

1. I feel pressured to appear strong, even when I'm feeling weak.
2. I do not let most people know the "real" me.
3. I do NOT like to let others know when I am feeling vulnerable.
4. I will let people down if I take time out for myself.
5. I am often expected to take care of family members.
6. I am always helping someone else.
7. I have difficulty showing my emotions.
8. I try to always maintain my composure.
9. I am overworked, overwhelmed, and/or underappreciated.
10. It is difficult for me to share problems with others.
11. I feel uncomfortable asking others for help.
12. If you have a problem, you should handle it quickly and with dignity.
13. I do not want others to know if I experience a problem.
14. I find it difficult to ask others for help.
15. If I fall apart, I will be a failure.
16. I tell others that I am fine, even when I am depressed or down.
17. As I become an adult, it is important that I become financially independent and not expect a boy/girlfriend or husband/wife to support me financially.

18. At times, I feel overwhelmed with problems.
19. In order to feel good about myself, I need to feel independent and self-sufficient.
20. It is easy for me to tell other people my problems.
21. People think that I don't have feelings.
22. The women in my family are survivors.
23. Often I look happy enough on the outside, but inwardly I feel overwhelmed and unhappy.
24. I take on more responsibilities for others than I can comfortably handle.
25. I feel guilty when I put my own needs before the needs of others.
26. I believe that it is best not to rely on others.
27. I often take on other people's problems
28. I am strong
29. I cannot rely on others to meet my needs.
30. I need people to see me as always confident.
31. I am independent.
32. It is important for me to feel strong.
33. I expect to experience many obstacles in life.
34. People often expect me to take care of them.
35. Women of my race have to be strong to survive.
36. Women of my race are stronger than women of other races.

Strong Black Woman Archetype Scale separated by factors

Table 1.5 Extracted Factors and Their Item Loadings

Items	Factor Loadings	% of Variance
Factor 1: Mask of Strength/Emotional Invulnerability (14 items)	.56	15.48
1. I feel pressured to appear strong, even when I'm feeling weak.	.67	
2. I do not let most people know the real me.	.57	
4. I do NOT like to let others know when I am feeling vulnerable.	.74	
8. I have difficulty showing my emotions.	.74	
9. I try to always maintain my composure.	.34	
11. It is difficult for me to share problems with others.	.77	
12. I feel uncomfortable asking others for help.	.54	
13. If you have a problem, you should handle it quietly and with dignity.	.38	
14. I do not want others to know if I experience a problem.	.60	
15. I find it difficult to ask others for help.	.66	
17. I tell others that I am fine, even when I am depressed or down.	.57	
21. It is easy for me to tell other people my problems. (reverse coded)	.57	
22. People think that I don't have feelings.	.50	
24. Often I look happy enough on the outside, but inwardly I feel overwhelmed and unhappy.	.48	
Factor 2: Self-Reliance & Strength (11 items)		7.92
3. Women of my race have to be strong to survive.	.52	
18. As I become an adult, it is important that I become financially independent and not expect a boy/girlfriend or husband/wife to support me financially.	.66	
20. In order to feel good about myself, I need to feel independent and self-sufficient.	.31	
23. The women in my family are survivors.	.37	
27. I believe that it is best not to rely on others.	.63	
29. I am strong.	.46	

Table 1.5 (cont'd)

Items	Factor Loadings	% of Variance
Factor 2 (continued): Self-Reliance & Strength (11 items)		
30. I cannot rely on others to meet my needs.	.70	
31. I need people to see me as always confident.	.39	
32. I am independent.	.42	
33. It is important for me to feel strong.	.67	
35. Women of my race are stronger than women of other races.	.30	
Factor 3: Care-Taking/Self-Sacrifice (11 items)		6.10
5. I will let people down if I take time out for myself.	.37	
6. I am often expected to take care of family members.	.61	
7. I am always helping someone else.	.39	
10. I am overworked, overwhelmed, and-or under-appreciated.	.49	
16. If I fall apart, I will be a failure.	.31	
19. At times I feel overwhelmed with problems.	.37	
25. I take on more responsibilities for others than I can comfortably handle.	.54	
26. I feel guilty when I put my own needs before the needs of others.	.32	
28. I often take on other people's problems.	.38	
34. I expect to experience many obstacles in life.	.37	
36. People often expect me to take care of them.	.66	

Note. Tables from Woods, 2010.

Life Events Checklist- Adapted

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. If an event has happened to you, please check the corresponding box to the right.

Note. There were response boxes next to each item with the option to check: "Happened to me before starting college", "Happened to me after starting college", or "Has never happened to me". If a student did not endorse any of these or the racialized trauma events, then they did not receive the help-seeking questions.

1. Natural disaster (for example, flood, hurricane, tornado, earthquake)
2. Fire or explosion
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)
4. Serious accident at work, home, or during recreational activity
5. Exposure to toxic substances (for example, dangerous chemicals, radiation)
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat or harm)
9. Other unwanted or uncomfortable sexual experience
10. Combat or exposure to a war zone (in the military or as a civilian)

11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)
12. Life-threatening illness or injury
13. Severe human suffering
14. Sudden violent death (for example, homicide or suicide of someone close to you)
15. Sudden accidental death of someone close to you
16. Serious injury, harm, or death you caused to someone else
17. Any other very stressful event or exposure

Racialized Trauma Questionnaire

Note. Same response options as Life Events Checklist.

1. Police harassment or assault because of my race or ethnicity
2. Threats to physical safety because of my race or ethnicity (e.g. pushed, hit, threatened with weapon, something thrown at you, chased after)
3. Fear for life or serious health issue due to medical mistreatment because of my race or ethnicity
4. Assault or fear for life due to immigration process because of my race or ethnicity
5. Any other very stressful event or exposure experienced because of my race or ethnicity

Actual Help-Seeking Questionnaire- Adapted

Below is a list of people who you might seek help or advice from after experiencing a difficult or stressful event. Select any of these who you have gone to for advice since beginning college for help with the difficult or stressful event(s) you mentioned in the prior questions. If you selected more than one event, include all sources of help or advice.

Note. Responses were select all that apply

1. Partner (e.g. boyfriend or girlfriend)
2. Friend (not related to you)
3. Roommate
4. Family member (e.g. parent, cousin)
5. Mental health professional (e.g. counselor, psychologist, psychiatrist)
6. Phone help line (e.g. National Suicide Hotline)
7. Online help group
8. In-person support group (e.g. a grief group)
9. Religious or spiritual peer group (e.g. small group or bible study)
10. Medical professional (e.g. doctor or nurse practitioner)
11. Sexual assault services (e.g. Sexual Assault Violence Intervention and Prevention (SAVIP) or Sexual Trauma Services (STSM))
12. Resident Mentor
13. Police
14. Religious or spiritual advisor like a minister, priest, or rabbi

15. Other [please specify]

16. I did not seek help from anyone

General Help-Seeking Questionnaire- Adapted

Below is a list of people who you might seek help or advice from if you were experiencing a difficult or stressful event. Please circle the number that shows how likely it is that you would seek help from each of these people in the **next 4 weeks** for the difficult or stressful event(s) you mentioned in the prior questions. If you selected more than one event, include all sources of help or advice you would go to.

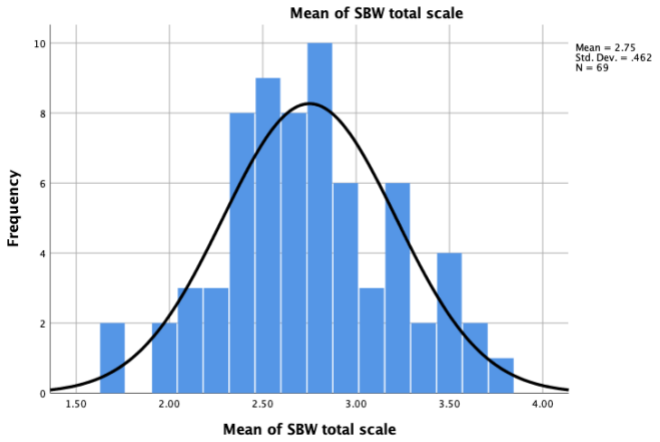
Note. The response scale for each item was: 1= Extremely unlikely, 2= Moderately unlikely, 3= Slightly unlikely, 4= Neither likely nor unlikely, 5= Slightly likely, 6= Moderately likely, 7= Extremely likely

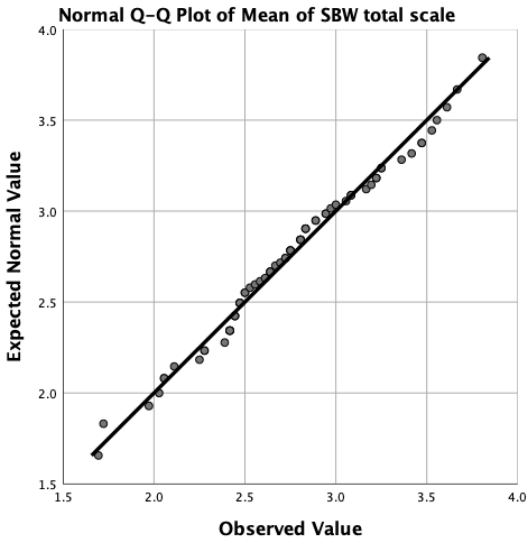
1. Partner (e.g. boyfriend or girlfriend)
2. Friend (not related to you)
3. Roommate
4. Family member (e.g. parent, cousin)
5. Mental health professional (e.g. counselor, psychologist, psychiatrist)
6. Phone help line (e.g. National Suicide Hotline)
7. Online help group
8. In-person support group (e.g. a grief group)
9. Religious or spiritual peer group (e.g. small group or bible study)
10. Medical professional (e.g. doctor or nurse practitioner)

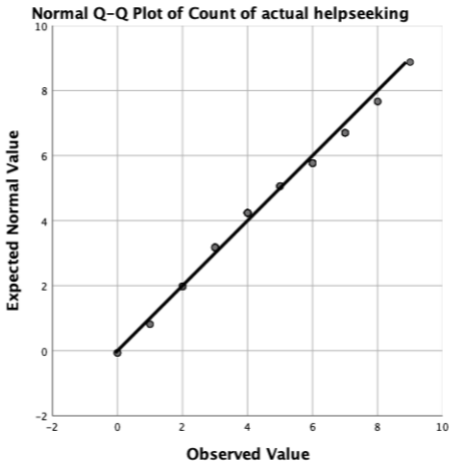
11. Sexual assault services (e.g. Sexual Assault Violence Intervention and Prevention (SAVIP) or Sexual Trauma Services (STSM))
12. Resident Mentor
13. Police
14. Religious or spiritual advisor like a minister, priest, or rabbi
15. Other [please specify]
16. I did not seek help from anyone

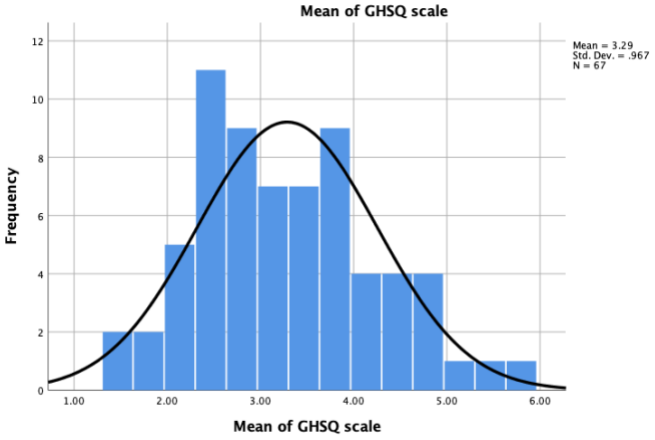
APPENDIX D

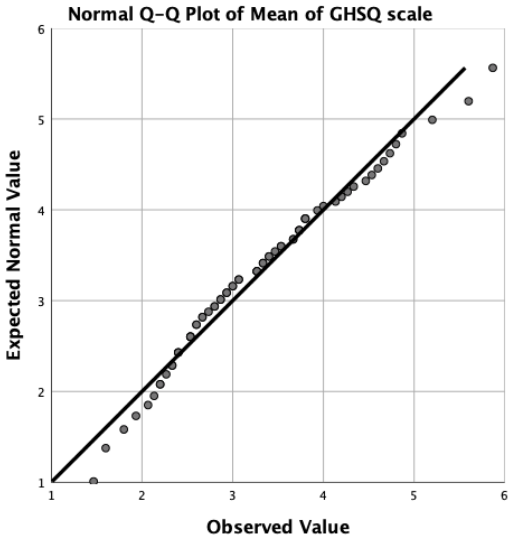
HISTOGRAM AND Q-Q PLOTS TO ASSESS FOR NORMALITY








Mean of GHSQ scale
Mean = 3.29
Std. Dev. = .967
N = 67
Frequency
12
10
8
6
4
2
0
1.00
2.00
3.00
4.00
5.00
6.00
Mean of GHSQ scale


Normal Q-Q Plot of Mean of GHSQ scale
Expected Normal Value
6
5
4
3
2
1
1
2
3
4
5
6
Observed Value

APPENDIX E

ADDITIONAL ANALYSES THAT WERE RUN BUT NOT INCLUDED

To further explore types of trauma, trauma was divided into those typical of intimate partner violence (physical assault, sexual assault, and unwanted sexual experiences; n=29) and all others (n=40). There was no difference between these two types of trauma and low-moderate vs. High prior help-seeking ($x^2(1)= .219$, p= .640; low-moderate help is coded as 0-4 sources of help sought, high help is 5 or more sources). There was also no difference between these two types of trauma and low vs. High intention to seek help ($x^2(1)= .476$, p= .490 (low-moderate intention to seek help is extremely unlikely to neither unlikely nor likely, high intention to seek help is slightly likely to moderately likely). Additionally, traditional and racialized trauma did not significantly differ in low vs. High intention to seek help ($x^2(1)= .496$, p= .481; $x^2(1)= .662$, p=.662, respectively).

Each of the hierarchical regressions were also run with only those who experienced racial trauma; however, none of the models were significant. The SBW full scale and subscales were also not significant. Ultimately, running the models with this subgroup did not change any of the results.