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The Strong Black Woman, Depression, and Emotional Eating

Michelle Renee Offutt

University of South Florida, moffutt@health.usf.edu

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The Strong Black Woman, Depression and Emotional Eating

by

Michelle R. Offutt

A dissertation submitted in partial fulfillment
of the requirements for the degree of
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Department of Nursing
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University of South Florida

Major Professor: Susan C. McMillan, Ph.D.
Frances M. Sahebzamani, Ph.D.
Jeffrey D. Kromrey, Ph.D.
Versie M. Johnson-Mallard, Ph.D.

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Dedication

This dissertation is dedicated to my children: Dena, David, Angela and Jordan, and to my Mother, Virginia Atlas.

Dena, David, and Angela, in the lowest times during the last few years, you were always there. I am now so thrilled to provide you with this small moment of pride and joy.

Jordan, we both know that your persistence is the reason I started this journey. You were an instrument that changed my entire life. I will forever be grateful for the “push” to just do it.

Finally, to my Mama - your vision can only see me as brilliant and successful. Thanks to your unflagging faith, I tend to become that woman who you see.

I love all of you beyond measure!

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Abstract

Black women suffer from overweight and obesity at an alarming rate: eighty percent of all black women are overweight or obese. This trend may lead to greatly increased morbidity and mortality, increasing healthcare costs and loss of healthy years of life. There are many possible factors thought to contribute to obesity in black women, however the cultural persona of the Strong Black Woman (SBW), an ideology that promotes unflagging toughness and denial of self-needs, may be the basis for behaviors that contribute to steady state obesity in this group. The purpose of this study was to investigate the relationships between the SBW persona, depression, and emotional eating.

Two predominately black churches in South St. Petersburg, Florida were included. A total of sixty-six women consented to participate during their monthly women's fellowship meeting. Each woman was asked to complete a packet of three instruments. The Strong Black Woman Cultural Construct Scale, a 22-item instrument was scored on a 5-point Likert-like scale with total scores on the inventory ranging from 22 to 110. The mean total score for this inventory was 74.62, with an SD of 8.70. The SBWCCS has 3 subscales, measuring Affect Regulation, Caretaking, and Self-Reliance. Affect Regulation is a 7-item subscale with scores that range from 7 to 35. The mean total score for Affect Regulation was 21.35, with an SD of 4.39. Caretaking is an 8-item subscale ranging from 8 to 40 points. The mean total score for Caretaking was 25.11, with an SD of 4.47. The Self-Reliance subscale has scores ranging from 7 to 35, and had a mean of

28.17, with an SD of 3.31. The Emotional Eating scale, a 25 item inventory rated on a five-point Likert-like scale, has a score range of 25 to 125 points. The mean score for this inventory was 49.36, with a SD of 19.42. The Center for Epidemiological Study-Depression Scale, a 20-item inventory has scores that range from 0-60 points. The mean score for this inventory was 14.06, with a SD of 9.05.

Pearson Product Moment Correlations were run to determine if there were any relationships/interactions among the 3 variables and the subscales. No relationships were found between SBW and Depression, or between SBW and Emotional Eating. However the relationship between Depression and Emotional Eating was statistically significant ($r=0.27, p<.05$). No relationships were found between the three subscales and emotional eating, nor was there a relationship between depression and caretaking or depression and self-reliance. However, the relationship between Depression and Affect Regulation was statistically significant ($r=0.28, p<.05$).

The findings regarding the relationships between SBW and depression, and also SBW and Emotional Eating were inconsistent with the current literature, suggesting that either response bias or some other source of bias interfered with the relationships. However, the significant relationships between Depression and Emotional Eating, along with Depression and Affect Regulation, were consistent with previous studies. Further research is needed to determine if there is response bias due to questions on the instruments being at odds with strong identification with the SBW persona and also to determine levels of depression in this population. A more complete understanding of these relationships is needed before culturally specific interventions for psychosocial factors supporting obesity in black women may be developed.

Chapter 1: Introduction to the Study

Obesity in America is a national crisis that shows no signs of abating. A short article in the January 18, 2011 issue of *Scientific American Magazine* starkly observed that obesity is poised to overtake smoking as the single greatest factor contributing to early death (Freedman, 2011). Statistics reported by the Centers for Disease Control (CDC) reveal that over a third of Americans are overweight, and the rates of overweight in individuals are also increasing every year. A recent study in the *Journal of the American Medical Association* reported that obesity causes over 160,000 “excess” deaths each year (Freedman, 2011, para. 1). Health care costs associated with morbidity and mortality are staggering; Freedman (2011) noted for a person 70 pounds overweight or more, the added medical costs over the course of a lifetime are approximately \$30,000 more than for an average weight person. Muenning, Jia, Lee and Lubetkin (2008) provided the interesting and alarming fact that obesity is responsible for the annual loss of more than seven million healthy years of life in the U.S. alone (p. 501).

While obesity rates have soared over the last three decades across most demographic groups in America, the rates of increase have remained largely consistent for all groups except black women. Black women have shown a significantly higher increase in overweight and obesity prevalence in recent years. Roughly 80 percent of black women are affected by overweight and obesity. While it is true that women with low income appear to have the greatest likelihood of being overweight or obese, black

women at all socioeconomic levels suffer from overweight and obesity, defined as a BMI greater than 25 and 30, respectively (Office of Minority Health, 2009).

The health impact of obesity in black women is staggering. Obesity is known to be a risk factor for many types of cancer such as non-Hodgkin lymphoma, multiple myeloma, breast, cervical, ovarian, colorectal, esophageal, gallbladder and cancers of the pancreas, stomach, liver, and kidney. It is expected that nearly 169,000 new African American cancer cases will be diagnosed in 2011 and 65,540 African Americans will die from cancer during that same time period (American Cancer Society, 2011). Type II diabetes is associated with overweight in 80 percent of all cases diagnosed, and levels of new cases are rapidly rising in this group due to increasing weight. One in four African American women over the age of 55 has diabetes. In 2011, diabetes was the leading cause of blindness in African Americans. African American people with diabetes experience more end-stage renal disease and die of the disease at a rate that is 40 percent higher than other ethnic groups (American Diabetes Association, 2011). Hypertension, the silent killer long known to be mediated by body weight, is found in 80 percent of all African Americans over the age of 45 (Centers for Disease Control and Prevention, 2009). It is the forerunner to stroke, which occurs twice as often in African Americans as in white Americans, and at an earlier stage of life. Half of all African American will die from either stroke or heart disease (National Stroke Association, 2009).

Murry, Owens, Brody, Black, Willert and Brown (2003) stated that “health behaviors do not occur in a vacuum [and this] suggests the need for more consideration of how contextual factors (e.g. race/ethnicity, social class, sex, and social, family, and personal stressors) affect the health functioning of women,” (para. 11). This observation,

coupled with the alarming rate of obesity in the black female population, underscores the need for research on what may be driving the obesity rates and increases in this specific population. One theory is that the iconic image of the Strong Black Woman, and the messages black women internalize regarding their identity as related to the Strong Black Woman construct, may be negatively impacting black women's psychological and physical wellbeing.

Strong Black Woman (SBW) is a term that is commonly utilized within the black community. In this instance, strong refers to a common emotional trait that is generally prized among black women (Romero, 2000). Strength is as much an expected personal trait as melanin in the skin is an expected physical one. Strong Black women are not born into strength, but are socialized into a specialized sisterhood, beginning early in their childhood. They learn the boundaries of behavior through filial imprinting on the strong women present in their family line (Thompkins, 2004). Strength is considered an essential, non-negotiable requirement. It is believed that a black woman needs to be strong because it is her job to provide the glue that holds her family and her community together against the onslaughts inflicted by poverty and racism. No doubt, women of other racial and ethnic groups have experiences that would lead them to self-identify as strong and nurturing as well. However, the basic difference for African American women is rooted in the historical context and social construction of her images as they developed through slavery and beyond (Romero, 2000).

Though the phenomenon of the Strong Black Woman has long been a commonly accepted and well-known entity within the African American community, there has been a dearth of information on the concept in the scholarly literature. In 2000, Romero

became the first to conceptualize the Strong Black Woman. Romero was able to refine the concept to its essence of two major core beliefs: the first theme is that the SBW is strong, relies on her own strength, and is self-contained. The second theme says that it falls to the SBW to nurture and preserve the family. Romero states that early on in their development, many black women internalize the standard that they should not expect anyone to meet their needs. Instead they are urged to become fully self-sufficient as early as possible in life, first on a psychosocial basis and then as they reach maturity, on a financial basis as well.

It should be said that in and of itself, the image of the SBW is not necessarily a negative. Indeed, becoming a Strong Black Woman involves acquisition of a certain amount of cultural pride and self-confidence. Rather, it is when that image becomes iconic, to the exclusion of consideration for the woman beneath the concept that negative consequences occur. “Black girls don’t cry. They shake and bend and explode, but they never break. In all the black and white stills of Rosa Parks, arrested in Montgomery because she was tired and dared to sit, she sheds no tears. She is strong. She is unflappable.” (Jones & Shorter-Gooden, 2003, p. 18) The value of reaching a state of unshakable strength is so highly prized that to this day, one of the worst insults you can level at a black Women is to call her weak (Beauboeuf-Lafontant 2005).

It is isolation that is the most problematic aspect of the SBW image, particularly because the black woman is often socialized to accept solitary action as a cultural directive. She then feels pressure to do it all, and when she cannot, her self-esteem suffers. She can only conclude that she is falling short of achieving the very essence of what she has been socialized to believe a black woman contains. (Harris-Lacewell, 2001).

This perceived failure can lead to guilt and shame, followed by an increase in stress, a decrease in self-esteem and growing depression, which in turn can affect food consumption. A classic study by Walcott-McQuigg, Sullivan, Dan, and Logan (1995) linked feelings of depression and being overwhelmed by tasks with how women eat. The study found that women overwhelmed with maintaining the SBW persona have little time to invest in maximizing eating patterns for health and well-being, nor with structuring their diets to support an ideal body size.

There has been a dearth of research examining the possible effect of the SBW façade on the rates of depression and obesity in the population. This quantitative study investigated the relationships of the Strong Black Woman persona, depression, and emotional eating within this group.

Primary Aims

The purpose of this quantitative study was to examine the social psychological process of the Strong Black Woman persona as a possible influence upon depression and emotional eating in African American women. The findings of the study provide significant insight into the psychosocial processes that support overweight and obesity within the population. The study explored the research question, “Is there a relationship between the psychosocial phenomenon of the Strong Black Woman and overweight or obesity in African American women?” The specific aims of the study were to explore the relationship between Strong Black Woman ideology and depression in African American women and to explore the relationship between Strong Black Woman ideology and emotional eating in African American women.

Research Questions

The following research questions were addressed in this study:

1. Is there a relationship between SBW ideology and depression in black women?
2. Is there a relationship between SBW ideology and emotional eating in black women?
3. Is there a relationship between depression and emotional eating in black women?

Definition of Terms

1. Strong Black Woman – a psychosocial belief in an inner, unlimited strength to withstand adversity. The strong black woman also is a caretaker who always puts others ahead of herself. Denial of her own needs or weaknesses is an integral part of the syndrome (Romero, 2000, Thompkins, 2004).
2. Emotional Eating – tendency to eat in response to negative emotions such as feeling lonely, depressed, or disappointed. Emotional eaters resort to specific comfort foods, often sweet, highly caloric foods such as a hot fudge Sunday. This differs from binge eating which is a pattern of disordered, uncontrollable eating marked by consuming large quantities of food in a short time (Nguyen-Rodriguez, Unger, & Spruijt-Metz, 2009).
3. Depression - loss of interest and enjoyment, and reduced energy leading to increased fatigue and diminished activity. Marked tiredness after only slight effort is common. Other common symptoms are reduced concentration and attention, reduced self-esteem and self-confidence, ideas of guilt and unworthiness, bleak

and pessimistic views of the future, and disturbed sleep (World Health Organization, 1992)

Significance to Nursing

This study assessed levels of the Strong Black Woman Ideology in the participants, along with the presence of depression and emotional eating behavior. The research supposition was that women with higher levels of SBW identification would also show the presence of depression and emotional eating, and that these three would be related in some fashion.

The results of this study provide information not present in current literature to better understand factors that may be contributing to the continuing rise of obesity rates in this population. This increased understanding could provide guidance towards methods of more effectively addressing treatment approaches in the future.

Chapter 2: Literature Review

This review chronicles literature exploring the impact of the Strong Black Woman message on black women's health beliefs and practices. The review will first highlight literature on obesity in black women, followed by an exploration of documentation involving race and health. Studies concerning depression and then emotional eating are discussed. Finally, literature regarding the Strong Black Woman persona and how it intersects with physical image, health beliefs, depression, and emotional eating are discussed.

Obesity Rates

Obesity presents one of the greatest challenges in American health care. It is the second-leading cause of preventable death in the U.S. and is responsible for the much of the morbidity and disability seen in the overall population (Yun, Zhu, Black & Brownson, 2006). While obesity rates in the U.S. have continued to climb steadily since the early 1970s, perhaps the most marked feature of this obesity epidemic is the growing racial and gender disparity seen in the population (Burke & Heiland, 2008; Wee, et al., 2005). Statistical data gathered by the Centers for Disease Control (CDC) demonstrate that for Americans between the ages of 20 and 74 years old, obesity rates for white males, black males, and white females have increased somewhere between 14% and 17% for each cohort between 1976 and 2004, with all three groups reporting obesity prevalence in 2004 at almost the exact same level (between 31% and 31.5%). The data indicates rates

of obesity remained largely consistent for white men and black men, and the prevalence of obesity is approximately equal for both cohorts of men, making it one of the few areas in which these two groups have achieved parity. However, it is quite a different situation when one compares the obesity rates for black women versus those of white women, or those of black women compared to black men. Between 1976 and 2004, black women demonstrated a 20% increase in obesity prevalence, a substantially faster acceleration in obesity rate increase than seen for any other population. This is particularly disturbing when one considers that at the starting point of the data collection reported (1976 to 1980), black women reported obesity rate prevalence twice that seen for any other population. The last block of data collected by the CDC reveals that over half of the black female population in America (51.6%), is clinically obese (Burke & Heiland, 2008, p. 79).

In an effort to arrive at some explanation for the significant growth in obesity prevalence among black women, Burke and Heiland (2008) drew on data collected through the National Health and Nutrition Examination Surveys (NHANES) and the Behavioral Risk Factor Surveillance System (BRFSS) to try and assess the “incentives”, economic, health-related, and socio-cultural, that could be contributing to the disproportionately high rates of obesity in this cohort. The researchers employed multivariate and regression analyses to determine relationships between BMI and obesity and the factors associated with the incentive categories.

The researchers found that, all other demographic variables (socioeconomic, physical demographics) being equal, blacks are less likely than whites to perceive themselves as overweight. Only when individuals report BMIs of 38 (severely obese) or

greater does this distinction disappear, with all cohorts self-reporting as obese. Burke and Heiland also observed a gender-racial disparity in weight self-perceptions between white women and black women (also Muennig, et al., 2008). The researchers found that among white women with a normal BMI of 23, the risk that they will misclassify themselves as overweight is 40%; conversely, there is a 30% chance that black women with a BMI of 28 (“very overweight”) will classify themselves as being “normal.”

After accounting for demographic variables such as socioeconomic status, occupation, living environment, and food prices, Burke and Heiland (2008) reported that there was no clear evidence that economic incentives accounted for differences in obesity prevalence for black women, relative to white women, black men or white men. Similarly, there was no compelling evidence that health incentives (as determined by educational level and BMI health indicator relationships) played a part in influencing differences in obesity rates. An identified potential influence is the relationship between sociocultural incentives and cultural ideas of body image and weight acceptance which may have an impact on black women. Black women may experience weaker economic and social incentives to avoid becoming obese than that seen for white women or for men. Black women were both more likely to report comfort with higher levels of overweight (though not obese) BMI than were white women, and were more likely to report themselves as underweight when they in fact maintained BMI’s consistent with the public health norms (see also, Grilo, Lozano & Masheb, 2005). Specifically, the researchers discovered that marriage and labor market penalties associated with overweight and obesity appear to more directly impact white women than black women.

The researchers concluded that while their analysis of the longitudinal data for black and white males and females yielded some direction on this question of what role various incentives might play in obesity prevalence in the different populations, still the disparity between the obesity prevalence for black women compared to the other groups remained a “puzzle”. They added that their research led to focusing the question on behavioral choices and labor-market issues. They specifically observed that black women and white women appear to be internalizing different messages about weight and desirability and they referenced research showing that magazines targeting white females prioritize messages of fitness and weight loss with an overall projection of a thin or slender body as idealized. Alternatively, images and messages in black women’s magazines have markedly fewer articles on exercise and weight-loss and tend to focus more on strength and health.

This difference in messaging, its sociocultural significance and its potential impact on black and white women’s health beliefs, body image, self-esteem, and self-identity, have been the focus of a range of studies over the last decade (Baker, 2005; Gordon, Castro, Sitnikov & Holm-Denoma, 2010; Henderson & Kelly, 2005; Huang, Phau, Lin, Chung & Lin, 2008; Njoroge, 2007; Privedera & Kean, 2008; Tirodkar & Jain, 2003; Wall, 2008). These messages have impact far beyond the media representations and both reflect and are reflected by, sociocultural structures, community standards and values, and personal beliefs (Bardone-Cone, Wishuhn & Boyd, 2009; Baugh, Mullis, Mullis, Hicks & Peterson, 2010; Campo, Cameron, Brossard & Fraser, 2004; Henrickson, Crowther & Harrington, 2010; Rayner, 2007; Ristovski, Bell, Chapman & Beagan, 2010; Rogers Wood & Petrie, 2010; Shaw, 2005; Thomas, Moseley, Stallings, Nichols-English

& Wagner, 2008). Burke and Heiland (2008) characterized the potential impact of this type of internalizing (and incentivizing) by concluding that the racial difference has been seen both as a form of distancing from white culture and its unrealistic feminine weight standards, and as a lingering memory of racist caricatures depicting black female slaves as heavy, sexless, and deviant.

Burke and Heiland's (2008) thorough analysis of the CDC obesity rates and their potential correspondence with economic, health-related, and sociocultural incentives, strongly suggests that one of the strongest relationships appears to exist for certain sociocultural incentives. Specifically, black women may be more predisposed to overweight and obesity than white women, white men, or black men, as a result of certain beliefs and perceptions related to body image and identity. Given that black women confront the "dual oppression" of gender and race marginalization in a culture defined by a white male dominant orientation (Romero, 2000; Settles, 2006), it is worthwhile to explore the particular role the relationship of race and gender may play in shaping black women's beliefs about themselves, their health, their bodies, and their role as black women. Settles (2006) study of black women exploring the intersection of race and gender and its effects on these women's identity determined that the intersected relationship was more central and predictive of their experiences and perceptions, than either their status as black or female, alone.

The iconic image of the Strong Black Woman is prominent in contemporary discussions of the American black woman's experience and the ways in which the expectations associated with this role may impact behaviors that can lead to obesity, such as emotional overeating, are explored in the coming pages.

The Intersection of Race and Health Beliefs

Changing entrenched health beliefs - particularly in regard to infusing an individual with the motivation to modify certain behaviors that might not be healthy for them, is often challenging under the best of circumstances. Menon, Block and Ramanathan (2002) demonstrated that most people engage in selective processing by choosing to hear what they want to hear – that which confirms their entrenched opinions (also, Grier & Bryant, 2005). It is not impossible to change people's minds and behaviors when it comes to unhealthy behavioral practices, but as Menon et al.'s research indicated, it is critical to tailor the message to an understanding of the individual's circumstances and to recognize that too much information directed at changing behaviors may have the effect of desensitizing the individual's ability to discern personal health risk.

The alarming and disproportionate prevalence of certain, severe health problems seen in America's black population is a source of both practical and theoretical concern. There are serious economic, social, and political implications arising from the high rates of disease and illness, and the racial disparities in good health measures further constitutes a moral and ethical challenge to American society (Geronimus, 2000).

The concept of "John Henryism" was first postulated by Sherman James, a public health epidemiologist, who identified the syndrome while examining racial disparities in disease manifestation and health care usage among black Americans. One of his subjects was an older black man who shared his name with the folk hero, John Henry, a black man who is mythologized for having defeated a steam-powered hammer in a competition. Legend has it that upon beating the machine, John Henry died, "with his hammer in his

hand.” In the case of James’ real-life John Henry – he was the embodiment of the self-made man. Having been born the son of a black sharecropper with only a second grade education, he’d learned to read and write and emerged from the sharecropper system as an owner of 75 acres of farm land by the time he was 40. In his 50s, James determined that John Henry (his last name was Martin) was suffering from severe arthritis, hypertension and peptic ulcers and yet he kept soldiering on to keep his farm and family going. Putting the pieces of Martin’s story together, James theorized that “John Henryism” as he came to call it, represented a distinct style of coping behavior related to health and other concerns that was particularly evidenced by black Americans. Individuals exhibiting John Henryism tend to expend a great deal of effort in pursuing goals as way to cope with psychosocial and environmental challenges. Researchers have recently noted that John Henryism can, in some instances, produce beneficial health outcomes, but for many who lack necessary resources, John Henryism actually appears associated with higher rates of illness, depression, and myriad other negative social, emotional and physical outcomes (Whitfield, Jonassaint, Brandon, Stanton, Sims, Bennett, Salva & Edwards, 2010).

As an article issued by the Duke University Medical Center noted research indicates that individuals with high levels of John Henryism, coupled with inadequate resources, have a much higher rate of health disorders because their continued striving may lead them to ignore health problems as they emerge, and to continue physically testing themselves at a time when their health is depleted. They may continue to work and to overtax themselves, feeling unable to take time to care for their illness or perhaps lacking the support to do so, and in continuing to try and push through their health

problems they may actually exacerbate them. This may explain what some researchers have described as “health engendering behaviors” that have been identified as possibly contributing to the greater number of health problems seen in black populations than in white ones (*“John Henryism,” key to understanding coping. . .*, 2006).

Black Women and Health Beliefs. Mirroring the general statistics on the disparity in health and wellbeing between blacks and whites, the evidence confirms that black women experience greater chronic illness and suffer greater rates of mortality related to these illnesses than to white women (Black & Peacock, 2011). Although there has been a growing amount of research considering factors that exist for black women that may impact health, ranging from social, psychological and environmental stressors, misguided health practices or beliefs, ineffective delivery of health messages to the black female community, Black and Peacock stated that no clear explanation for the race disparity had emerged. They, and others (Clarke, O’Malley, Johnston, Schulenberg & Lantz, 2009; Henrickson, et al., 2010), have suggested that the problem might be traced to particular beliefs ascribed to by black women and how these may guide daily life management decisions, including health and wellbeing.

One of the other observations made by Black and Peacock (2011) was the substantial role that spirituality and religion plays in the lives of many black women. There is literature on depression and mental illness in black populations that suggests how strong religious beliefs might inhibit well-being behaviors, particularly when it comes to counseling or other therapeutic supports for emotional and psychological distress (Ward, Clark & Heidrich, 2009). Romero (2000) reported how one black female client in her therapeutic practice expressed doubts about the counseling process saying

she thought God must have wanted her “broken” somehow – that there was a divine plan to her emotional and psychological distress and that, perhaps, seeking counseling was in its way, going against God’s will. Beaubouef-Lafontant (2005) quoted one black female writer, Meri Nana-Ama Danquah, who reported on her struggles with depression and described the incredulousness of a black female friend when she said she was seeking therapeutic intervention: “Take your troubles to Jesus, not no damn psychiatrist,” (Danquah, 1998, p. 21, as cited by Beaubouef-Lafontant, 2005, p. 108).

Black Women and Obesity

The evidence that black women are more likely to be overweight or obese and to suffer the negative health and wellbeing effects associated with the condition is substantial (Grilo, et al., 2005; Henrickson, et al., 2010; Prividera & Kean, 2008; Wee, et al., 2005). It also suggests a long-standing issue within the black community as the CDC data analyzed in Burke and Heiland’s (2008) research shows that for the last 35 years, black women have reported rates of obesity prevalence at twice the rate of white women, and black and white males. Baltrus, Lynch, Everson-Rose, Raghunathan and Kaplan (2005) provided the results of a 34-year longitudinal case study of the patterns for race, socioeconomic factors, and body weight trajectories in Alameda County, California. The final cohort covered 6,928 adults drawn from a stratified, random sample, begun in 1965 and tracking individuals 17 years and older. An initial survey was conducted and then the cohort was re-sampled four additional times (1974, 1983, 1994 and 1999). The black adults in the study showed a tendency to be heavier than their white counterparts throughout adulthood, however the researchers described the weight differential between black and white men as “modest” while the difference between black women and white

women was deemed “large,” (Baltrus, et al., 2005., p. 1598). Black women weighed more at the 1965 baseline than white females (4.96kg more) and gained 0.10 kg more *each year*, than did white women, resulting in a large percentage of the black female cohort approaching obesity at the end of the longitudinal study.

It would appear, based on the research discussed here, that the serious and disproportionately greater (relative to other populations) problem of overweight and obesity in black females is an entrenched one. This fact has implications in terms of identifying and understanding the causes underlying obesity prevalence in black female populations as well as for devising effective interventions to reduce rates of obesity. The imperative to do so is clear, as the health and well-being literature indicates. Several of the health conditions that have garnered recent research attention specifically in relation to black female populations are noted here, to illustrate the significance of the problem.

Pregnancy Risks. Pregnancy, despite being a joyful condition for many women, is attended by a host of physical challenges, some of them quite serious. The condition of overweight and obesity exacerbates the natural difficulties associated with pregnancy and may produce new and additional problems for expectant mothers (Hollander, 2008; Lewallan, 2004; Vahratian, 2009). These studies note the compelling evidence that has amassed demonstrating that overweight and obese women tend to experience more problems conceiving than do their normal-weight peers (other factors being equal) and that overweight and obese women also have a higher rate of adverse outcomes both for themselves and for their pregnancies. Hollander (2008) cited a study of Missouri women conducted between 1978 and 1997 that showed on average, obese women were 40% more likely to experience a stillbirth than were women of normal weight. For women at

the low end of the obesity scale, the stillbirth rate was approximately 30% but for the smaller pool of extremely (morbidly) obese women, the rate of stillbirth climbed to almost 60%. Hollander added that while pattern of risk was similar for black and white women, every risk category totaled greater prevalence for blacks. This is certainly related to Vahratian's (2009) report that black women have the highest prevalence of overweight and obesity among all cohorts of women of child-bearing age, identified as 20 to 44 years of age according to the 2002 National Survey of Family Growth (NSFG).

Obesity has been conclusively shown to increase a pregnant woman's risk of preeclampsia and eclampsia, chronic hypertension and diabetes. These conditions can prove problematic for an expectant mother's health and are potentially fatal to fetuses and, sometimes fatal to mothers as well. Hollander (2008) noted that the obese women in Missouri referenced by the researcher experienced stillbirths, defined as in utero fetal death at the 20 week or more gestation mark, at a rate of 8.5 versus 5.5 for normal-weight women per 1000 live births. In addition, the more obese the mother, the higher the stillbirth rate, climbing to 11.7 per 1000 live births for extremely obese mothers. The stillbirth rates among obese women also were impacted by race. Black obese women averaged stillbirth at rates of 11.4 versus 7.8 for White obese women, resulting in a stillbirth rate for obese black women that was over the twice the rate of that for their normal weight counterparts.

An interesting finding from Vahratian's 2009 analysis of statistics was that rates of obesity in black females of childbearing age were highest for those women with consistent health coverage; black women with irregular health insurance coverage reported lower rates of obesity. For white women, the correlation between health

insurance and obesity ran in the other direction such that those women with consistent coverage reported the lowest rates of obesity. The findings for black women were mirrored to a lesser degree in Hispanic populations – the more secure the health insurance, the greater the likelihood toward obesity. Vahratian's study was not designed to account for or explain such factors so the researcher speculated that this counterintuitive trend of more secure health insurance, higher rates of obesity, in black and Hispanic women might relate to cultural differences in ideal body norms derived from cultural perceptions regarding image, wellness, and financial security. In lieu of other evidence providing support for alternative interpretations, Vahratian's reading of this trend may have some authority; much of the literature discussed in this chapter suggests that a predictive relationship exists between black women's self-identity, sociocultural beliefs about body image and weight, and a tendency toward overweight and obesity (Baugh, et al., 2010; Davis, Clark, Carrese, Gary & Cooper, 2005).

Diabetes and Heart Conditions. Beaubouef-Lafontant (2005) reported that interviews with 12 black female subjects revealed that two-thirds of these women had close female relatives who were obese (and several of the subjects themselves were overweight or obese) and identified a range of serious health problems experienced by their obese female family members and related to their weight: high blood pressure, stroke, congestive heart failure, diabetes, thyroid problems and kidney failure. Diabetes is particularly prevalent, with blacks aged 20 and older twice as likely to have diabetes than are whites. Murry, et al. (2003) described research indicating that endemic stress, in which daily basic stressors become exacerbated through other stressors related to an awareness of discrimination or marginalization, can produce elevated states of

psychological and physiological arousal. The researchers speculated that the endemic stress experienced by blacks, due to the disadvantages or oppression stemming from continued racism, appear to lead to greater risk of hypertension and might also contribute to the level of Type II diabetes. Their study focused specifically on diabetes in black females because these women experience the dual endemic stresses arising from racism and sexism; they stated that these “interlocking oppressions” must be regarded as potentially symbiotic in the pressures they exert over the various daily stressors black women contend with, and what mechanisms they use to cope with these pressures (Murry, et al., 2003, para. 2) . The researchers credited a 1994 report by Institute of Medicine encouraging researchers to consider the effects that social contexts, such as society community, family, and environment, can exert on the management of chronic diseases, as serving as an inspiration for their own inquiry. A number of studies reflect the impact of this report in the linking of environmental conditions, social forces, and family and community factors to health problems, particularly in black populations (Chang, et al., 2009; Cutrona, Russell, Brown, Clark, Hessling & Gardner, 2005; Geronimus, 2000; Miranda, Sidique, Belin & Kohn-Wood, 2008; Nadeem, Lange & Miranda, 2009; Reagan & Hersch, 2005).

Murry, et al. (2003) noted a link between diabetes and depression, observing that one of the physiologic manifestations of the disease, poor glycemic control, which is characterized by severe swings in blood glucose levels, can produce depression and anxiety. They cited evidence that depression and anxiety rates are two to four times higher in diabetic populations than is seen in the general population. The affective states,

in turn, can further negatively impact the diabetes condition because they may inhibit the individual's ability to observe a healthy care regimen.

Based on their review of a range of studies across social, psychological, and biomedical disciplines, Murry, et al. (2003) proposed that black women tend to internalize a message of self-reliance and resilience in the face of life's challenges. To be a strong black woman, a superwoman, is a good and necessary thing. As Murry et al. argued, while this image may help black women counter the adversities associated with the dual oppressions of racism and sexism, it can distract these women from taking care of themselves and making the necessary lifestyle changes to address chronic illness, such as diabetes and hypertension.

Depression. Although not necessarily linked to the prevalence of obesity, the experience of depression in black female populations appears to be indirectly related to the issue of obesity, with the indirect relationship flowing in both directions: depression can produce behaviors that contribute to obesity, and obesity can trigger depression due to weight-related problems that negatively impact self-esteem and affect. Depression as a form of silencing is a thread that runs through a significant number of studies on black women, and often as this silencing related to the behavior of overeating (Beaubouef-Lafontant, 2008; Black & Peacock, 2011; Harrington, et al., 2010). Beaubouef-Lafontant (2008) described silencing as a feminist perspective on depression, linking the stresses related to sexism to repressed anger, resentment, and despair. The suppression of these natural responses to discrimination is internalized as necessary to get by in society and to not rock the proverbial boat or draw negative attention to oneself. And it is the

suppression of these feelings that create depression in the individual because by silencing these feelings and not giving them voice, the individual effectively silences herself.

Silencing, and the attendant depression, also appear to occur in tandem with the experience of racism for many blacks. Birzer and Smith-Mahdi (2006) conducted a qualitative study of 15 black men and women living in Topeka, Kansas, in an effort to illustrate their lived experiences of racism. Discussing their identity as black Americans in relation to processes such as shopping, dealing with law enforcement, work, and negotiating the differences between white and black life in Topeka, the subjects revealed that discrimination based on race was pervasive in their daily exchanges. Many of the subjects described the function of silencing in these daily interactions; in many instances the individuals felt unable to directly confront the racism and, when they could do so, they often reported being unheard in their complaints.

Black women appear to be vulnerable to high rates of depression. There is also evidence that black women may be less likely to seek assistance for their depression and may engage in silencing behaviors and avoidant coping strategies, such as overeating, to manage (or rather, mismanage) their depression. Beauboeuf-Lafontant (2008) and Meinert, Blehar, Peindl, Neal-Barnett and Wisner (2003) noted that for many years, research on female depression centered on the experience of white women, but they and others discussed how a growing focus on the particular problems and experiences of black women is emerging in the research literature. A number of studies considered for this review reflect this trend and are discussed briefly here to illuminate the ways in which the juncture of race and gender may define a different experience of depression and different approaches to addressing, or ignoring, it.

Nicolaidis, Timmons, Thomas, Waters, Wahab, Mejia and Mitchell (2010) sampled 30 black women recruited through community-based organizations in Portland, Oregon. The women all evidenced depressive disorder and had histories as victims of violence. Of these 30, 87% reported having received treatment for depression at some point in their lives but less than half were involved in any form of treatment intervention at the time of the study. Based on structured interviews conducted across four focus groups in which the study sample was subdivided, the researchers isolated 12 themes related to these women's experience of depression and violence. Several of the themes most salient to the issues in this current study deal with views of the health care and social systems. Many of the women reported being exposed to messages that institutionalized health care was to be avoided unless absolutely necessary. The women stated that their families reinforced the idea that problems (physical, emotional, psychological) should be handled by the individual alone. Other women identified the lingering influence of racism in exhibiting a mistrust of health care institutions, which they associated with white culture and discriminatory practices (also, Ward, et al., 2009).

The women in Nicolaidis' et al. (2010) studied identified depressive symptoms such as hopelessness, anhedonia, loss of energy, sadness, guilt, and in some instances, suicidal ideation or suicidality. However, for many of the women, antidepressants were not considered an option; some of the women expressed resistance to being "doped up" while others cited the need to remain strong and resilient and identified medication as a sign of weakness (Nicolaidis, et al., 2010, p. 1473). On a related note, many of the depressed black woman interviewed also expressed a desire toward self-care and self-counseling through their depressive symptoms. Some of the women also expressed

mistrust of therapists, often along the lines of resistance to a white dominated culture and health practice, but more of the women were receptive to the potential for therapeutic intervention than were receptive to the use of antidepressants. In terms of desirable depression care, the women consistently expressed a preference for black counselors and therapeutic staff, preferably professionals who had personal experience of the issues (depression and violence) with which these women were struggling.

A study of racial identity and depression in black women was presented by Settles, Navarrete, Pagano, Abdou and Sidainius (2010). The researchers surveyed 379 black women, age 18 and older to assess the effects of black identity, self-esteem and depression. They administered the Multidimensional Inventory of Black Identity (MIBI), the Beck Depression Inventory and Rosenberg's 10-item self-esteem scale to determine whether moderating effects existed for these factors. The researchers found that black women who had high private regard for blacks demonstrated low rates of depression; this was also true for black women who reported high public regard for blacks. Their depression rate was very low. However, black women who reported low public regard on the racial identity measure were prone to greater depression, thus the negative attitudes of the larger society significantly impacted them. Interestingly, the two types of regard did not appear to have a direct impact on one another. Black women reported lower rates of depression if they only experienced high levels of one form of regard (public or private) and not the other; the outcome of positive regard was beneficial either way.

Racial centrality, defined as the extent to which race is at the core of a person's self-identity, did not play a role in the relationship of public regard to depression, either

positively or negatively. However, racial centrality was a mitigating factor in terms of private regard. For women with high racial centrality – a strong identification as a black American – higher levels of private regard correlated directly with lower rates of depression. However, women with high racial centrality who reflected lower rates of private regard demonstrated a tendency toward higher rates of depression. This makes intuitive sense when one breaks it down to basics; a woman who strongly identifies as black, but holds low positive views about blacks in general or about being black in American life is more likely to experience depression than either black women with high private regard, and women with moderate to low racial centrality and either high or low private regard. Settles, et al. (2010) expressed a sense of optimism about these findings in terms of providing direction for treating depressed black women. They observed that if positive private regard appeared to play a fundamental role in alleviating depression, anti-depression interventions might concentrate on connecting black women more concretely and positively to other black people, fostering a sense of belonging. The beneficial aspects of this approach might be particularly salient for black women with a high level of racial identity.

Self-esteem was also found to play a significant role in mediating depression related to private and public regard. In the case of private regard, the relationship was direct and consistent with high self-esteem tracking with high private regard and both linked to low depression. The effects of high self-esteem partially mediated public regard's impact on depression. Women with high self-esteem who reported low public regard experienced some ameliorating effects on depression, but depression was still a factor when both high self-esteem and low public regard coexisted. Settles, et al. (2010)

speculated that the effects of low public regard, such as the black female subjects' experience of incidents of discrimination or racism presented real-world obstacles that couldn't be directly circumvented through high self-esteem. Rather, black women with high self-esteem appeared to be somewhat more protected from the ill effects of low public regard, than were black women with low self esteem, but they were not entirely insulated from the depressive effects arising from the low public regard.

Cutrona, et al. (2005) explored the relationship of such variables as environmental context – neighborhood sociodemographic factors, degree of social disorder, levels of social support available to members of the community, and depression in black women. They conducted a two-year longitudinal analysis of a sample of 631 black women drawn from a large-scale study of blacks living outside of large urban areas, called the Family and Community Health Study. They found that black women living in the most economically disadvantaged neighborhoods with high rates of social disorder were more prone to depression than were black women living in “better” neighborhoods. This remained true even when considering factors related to familial and social supports available to the women. Thus, environmental conditions strongly impacted depression prevalence. However, the researchers also found that women in better neighborhoods were less likely to attribute their depression, if experienced, to negative life events, as the women in the poorer neighborhoods did. Thus, these women became depressed even though they were apparently not experiencing negative life events. The researchers observed that many of these better neighborhoods were dominantly white, making the women minorities in their own neighborhood. This result led them to suggest that greater

study was needed on the potential for depression to occur among black females in relation to making their home in a predominantly white neighborhood.

Miranda, et al. (2005) explored differences in depression rates between several groups of black women: those born in the U.S. and those born in Africa or the Caribbean, but who had immigrated to America. The quantitative analysis drew data from the Women, Infants and Children (WIC) federal assistance program and gathered mental health problem information through the Primary Care Evaluation of Mental Disorders (PRIME-MD) survey. Their large sample was predominantly composed of U.S.-born black women (7,965) but there were significant samples for women born in Africa (913) and those born in the Caribbean (273). The U.S. born black women manifested starkly higher rates of depression, 2.49 times greater than the Caribbean-born blacks and 2.94 times greater than African-born black women. The differences suggest that endemic stresses related to racism may have a greater impact on U.S.-born black women. Miranda et al. suggested an explanation might be that black women born in other countries that are black-dominant cultures and societies may be exposed to protective factors which insulate them to a greater degree from the effects of racism and discrimination they may encounter in America. One notable discovery was that alcohol and drug abuse problems were negligible across all three cohorts with less than 1% of the women reporting substance abuse. As the researchers noted, substance abuse rates in white populations and, to some degree in black male populations, suggest a much greater correlation between depression and substance problems. The difference for black women suggests that they resort to other mechanisms in response to mental health problems.

Emotional Eating

Harrington, Crowther and Shipherd (2010) noted that much of the research on eating pathology has been performed on populations of white women. The predictors of eating disorders often identified for these populations include mortification about body and physical development, impulsivity and affect management dysfunction. Harrington, et al., speculated that the issues might be slightly different for black women who engage in dysfunctional eating behaviors, suggesting that trauma might contribute to the formation of such patterns. To this end, the researchers considered binge eating as it might relate to a correlation of two factors – overeating and trauma – and cited binge eating research conducted by Deaver, Miltenberger, Smyth, Meidinger and Crosby, and a study by Gershuny and Thayer (2003, and 1999, respectively, as cited by Harrington, et al., 2010, p. 470). Perhaps differently from anorexia nervosa and bulimia, binge eating represents a loss of control over the eating behavior because the act is compulsive. These binge eating studies suggest that the compulsive eating arises from a desire to silence other thoughts or concerns; the act of eating is emotionally-numbing and provides a brief escape from the myriad concerns which are proving overwhelming. Harrington, et al. notably suggested that “self-silencing” (prioritizing others’ needs above one’s own and adopting external standards of self-evaluation), may also play a key role (Harrington, et al., p. 470).

Binge eating and its likely outcome, obesity, have been shown empirically to have a link to childhood mistreatment. The behavior of emotional overeating, or binge eating, occurs at higher rates in black populations than white ones (Striegel-Moore, Dohm, Hook, Schrieber, Crawford, & Daniels, 2005; Striegel-Moore, Wifley, Pike, Dohm &

Fairburn, 2000; Triffleman & Pole, 2010). Striegel-Moore, et al., (2000) compared two populations of women – one white, one black, drawn from a large region in central New England – in order to assess the prevalence of recurrent binge eating behaviors. The sample included 1628 black women and 5741 white women who responded to phone interviews seeking information on overeating (and loss of control) and purging (vomiting) behaviors, and the use of diuretics or laxatives. Respondents were also surveyed using a modified version of the General Health Questionnaire (GHQ) to ascertain presence of psychological distress related to mood or anxiety symptoms. Descriptive data on height and weight was solicited and used by the researchers to arrive at approximate BMIs for the subjects.

Striegel-Moore, et al.'s (2000) findings indicated that the rates for black women and white women engaged in binge eating at least once during a given three-month period were essentially equivalent at 8.4% and 8.8%, respectively. However, when the researchers adjusted for recurrent binge eating behavior (defined as a minimum of twice a week on average over that same three month period) significantly more black women reported recurrent binge eating behavior (4.5%), than did white women (2.6%). Both cohorts engaged in purging at similar rates, however black women showed a much greater rate of laxative (2.1% versus 0.8%), diuretic (2.9% vs. 1.7%), or fasting strategies (4.1% vs. 2.7%) than did the white women in the study. The projected BMI scores for the cohorts suggested that the recurrent binge eaters, regardless of race, were overweight. The researchers also reported that the women reporting recurrent binge eating were also the subjects to report the most significant levels of psychological distress.

As a response to trauma, compulsive overeating or binge eating, may be a way for individuals to attempt to regulate their emotions. The affect regulation model of binge eating holds that compulsive eating occurs when it is triggered by a negative memory or an intense emotional response. Harrington, et al. (2010) also referenced research showing that self-silencing also served as a trigger for overeating. Franko, et al.'s (2005) study on depression and coping behaviors like smoking and eating disorders in black and White adolescent female populations indicated that the greater the girls' degree of depression, the greater the experience of an eating disorder. However, the findings of Striegel-Moore, et al.'s (2000) research indicates that recurrent binge eaters report the highest degrees of psychological distress. This sets up a situation in which causation is unclear – does depression trigger emotional overeating? Or does emotional overeating trigger depression? This may speak more to correlation effect rather than direct causal one.

Coping Behaviors. Murry, et al. (2003) observed that the coping behaviors associated with the superwoman image (Beauboeuf-Lafontant, 2005; Harrington, et al., 2010), trying to achieve perfection through management of others' needs and expectations, have been shown to increase stress in women and negatively impact psychological and physiological wellbeing, producing greater distress, depression and anxiety, and increasing the risk of high blood pressure and the cascade of health problems that proceed from this condition. The typical coping behaviors associated with a superwoman image are avoidant in nature, taking the emphasis off self and placing it on others. Distraction, generalized anger, and denial are avoidant coping strategies that have been linked to poor blood pressure regulation and to poor glycemic control. Further,

research has indicated that patients with diabetes, hypertension, and arthritis experience poorer adjustment when they engage in avoidant coping. There is evidence that black women who engage in active problem-focused coping strategies are better able to manage stressors in their lives. Resolving stresses through a direct approach may be linked to lowered blood pressure levels in black women dealing with endemic stress (Williams, Spence & Jackson, 1997).

There are relatively few studies exploring coping behaviors in black women, and fewer still exploring the connection between black women's beliefs about mental health issues and the barriers to getting treatment. Ward, et al. (2009) employed the Common Sense Model (CSM) in their analysis of black women's beliefs regarding mental illness to identify and explain patterns of coping behavior exhibited by a sample of black women. The CSM postulated that individuals based choices on the "representations" of health threat or illness that they construct, informed by their own observations, experience, values, education, cultural traditions, community norms, and relations with family and friends (Ward, et al., 2009, p. 1592). The general categories of representation captured by the CSM are *identity*, *cause*, *timeline*, *consequences*, *cure or controllability*, *illness coherence*, and *emotional representation*.

Ward, et al. (2009) sampled a group of 15 black women divided into age-based cohorts; five women comprised the young group (25 to 45 years of age), five more comprised the middle-age group (46 to 65 years), and the last five made up the older group (66 to 85 years). Over half of the sample reported that they had been diagnosed with some type of mental illness, with depression being the most common mental illness to appear. In the young cohort, four of the five subjects reported some form of mental

illness, while two women each in the other two cohorts also reported mental illness. The researchers conducted semi-structured, face-to-face interviews with the questions derived from the CSM representations. The researchers also obtained background information via a demographic questionnaire.

Many of the young and middle-aged women attributed depression and other mental illness to culturally specific *causes* such as racism, sexism, the effects of dual oppression, and the historical weight of discrimination against blacks in the U.S. While many of the women acknowledged the difficulty of mental illness and the potential for it to be addressed through treatment, there was a clear rejection of medications as a way to treat the illness, echoing the findings of Nicolaidis, et al.'s (2010) study. Ward, et al. (2009) reported that in terms of arriving at *illness coherence* and *emotional representation* the subject of black women's strength was raised by many of the subjects. The preferred coping strategy that emerged in the interviews with these women was to essentially deny or ignore the mental illness, and to engage in efforts to normalize the condition by accepting it as a natural condition in life. When the disturbances associated with such illness became too difficult to ignore or carry many of the women cited informal support networks or slightly more structured community support networks. Many of the women also noted religious or spiritual support pursued through contact with a pastor or church community, or through private prayer and/or reading of the bible. It is interesting to note that the women in the Ward et al. (2009) study were offered the opportunity to participate in a debriefing session following their participation in the research effort. The debriefing session was explained to them as an opportunity for them to discuss what the study was about, any thoughts or concerns that came up for them, and

referrals to any mental health intervention or counseling services they might be interested in, if needed. Only one of the black female study subjects opted to take advantage of the debriefing.

Meinert, et al. (2003) reported a similar finding from their research on black women coping with mental illness or distress. The majority of the women they surveyed cited prayer and other expressions of spirituality as the coping strategies they frequently employed in efforts to manage their pain. The researchers described a community-based group for black women who'd lost a child to violence or had similar tragedies. The women subscribed to the statement “we take care of our Sisters, and we don't have time to be depressed’,” according to the researchers (Meinert, 2003, “NIH Element #1,” para. 2). This perspective is consistent with the superwoman, or Strong Black Woman, image.

The Strong Black Woman

The most salient characteristic of the icon of the Strong Black Woman is her strength. Romero (2000) discussed studies noting that young black women used the term strong in describing their self-identity with great frequency. Asked to explain the description, these young women generally reference one or both of two variants on the theme of strength. The first is that they are strong in persevering over societal gender and race bias and in embracing their role as demographic outliers in the culture of American life. A second intention of the term strength as a self-identity for many of these young women was the idea that they possessed an unshakeable sense of self that they maintained regardless of other influences.

Another key feature of the Strong Black Woman's identity is the nurturer, not just of the family, but of the larger black community. In intimate relationships, this has led to

the evolution of a notion of family in which the black woman is dominant. The extreme expression of this idea is the role of the single black mother in American culture.

Arguably, one of the enduring legacies of racism in America is the disenfranchisement of blacks from equal opportunity to improve their conditions (Wyatt, 2008). It was less than 50 years ago that the last vestiges of institutional segregation were swept away and since that time, blacks have realized significant mobility in society in terms of economic, cultural, political, and educational achievements; the 2008 election of Barack Obama to the office of President is commonly regarded as the proof of American society's triumph over its disturbing race relations since the nation was first established. However, as indisputably significant as Obama's presidency is, it does not mitigate the fact that black men constitute a disproportionately high number of the inmates in American prisons. Black men continue to have the highest incarceration rate and, not incidentally, the lowest high-school graduation rate of all race and ethnic groups in America (Davis, 2006). With black men, particularly in the lowest socio-economic groups, significantly marginalized in their potential to develop an identity as providers, black women have largely assumed that role within the black culture (Wyatt).

Romero (2000) suggested that the Strong Black Woman may actually be drawn romantically to men they believe may need "fixing", devoting themselves to making these men "better" (p. 231). Wyatt (2008) described the "binary" definitions of Strong Black Woman and weak black man – and noted that the converse of the relationship (strong man, weak woman) is perceived as the traditional white gender dynamic of a powerful and dominant white male and a submissive, yielding white female and that this dynamic becomes the culturally idealized one for being the dominant message.

Acceptance of this construct brings an internalization of the idea that the weak black man is not the real male, and that the Strong Black Woman is not authentically female. This internalization can lead to processes of self-loathing or acceptance of racial and gender distinctions (separatism) associated with the construct.

Intended to be an empowering image, the Strong Black Woman has, over time, proved a complicated and perhaps dangerous model for black women to emulate. Triffleman and Pole (2010) described how aspects of Strong Black Woman ideology have been taken to create the sense of black women as the ultimate ubersurvivors: women not disturbed or daunted by any manner of adversity. While that may sound like an ideal to aspire to, it doesn't sound like a particularly human one. Perfection, while generally held to be a lovely thing in theory, is something entirely unnatural. Flaws are natural, imperfection is truthful, pain is part of life, and sometimes it is necessary for the strong to allow others to carry them for a while if for no other reason than to give them a brief respite while they recharge in order to resume their strength. But for black women who internalize the Strong Black Woman (superwoman) message, any emotional expression or behavior that falls short of a demonstration of untouchable strength may appear to be a failure that can negatively impact their self-identity. For all its purported strength, the Strong Black Woman demands may result in tremendous and devastating frailty in spirit and health.

Physical Image. The image of the Mammy, the strong, nurturing and self-sacrificing caretaker, was a dominant image during the slave years and following the Civil War. Aunt Jemima, the quintessential Mammy, adorned Quaker Oats' pancake mix and syrup bottles for almost a century, and was pictured as a large, beneficently smiling,

black woman wearing a kerchief and apron – an archetype of docile servility to others (meaning, white families). It was not until 1989 as the 100th anniversary of the Aunt Jemima trademark approached, that Quaker Oats updated her image to lose the kerchief and to depict Jemima in a somewhat contemporary hairstyle and wearing pearl earrings, an update intended to be more in keeping with the image of a mother and homemaker, rather than a maid or other servant. But the influence of the Mammy image extended, and was reinforced, well beyond Quaker Oat's advertising mascot, and permeated American culture at all levels, with the Mammy an immediately recognizable image in the nation's films and television programs, literature, and textbooks. Romero (2000) contended that one of the effects of the Mammy stereotype was that black women internalized the message that their role was to put the needs of others first, meaning that they had to provide for and take care of themselves and not expect to be cared for by anyone else.

Harrington, et al. (2010) suggested that the notion of the Strong Black Woman can be traced back to slavery and the idea that black women were inherently more physically capable than white women. This was not an advantage, however. The stereotype that black women had a physical and psychological resilience that exceeds that of white women reinforced the argument that black women were naturally predisposed to hard, physical labor. It was also believed that when separated from their children who were sold into slavery it was not meaningful in the same way that a white woman would experience separation from her children. The Mammy image transcribes the progression of the "Strong black slave woman" to the image of the Strong black "matriarch," (Wyatt, 2008, p. 60). Wyatt observed that in some quarters, the idea of the strong black matriarch

is tied to “deviancy” and “pathology” because the Strong Black Woman is perceived as reinforcing a dominant-female paradigm, contrary to the powerful male paradigm of the dominant (white) culture. One description by Wyatt, neatly captures what some social researchers see as pathology at the heart of low-income black communities: black women are excessively aggressive and unfeminine matriarchs who emasculate their partners and husbands. A natural reaction from the men is to either desert their partners or refuse to marry the mothers of their children (Wyatt, 2008). This has led, Wyatt stated, to a twisted gender dynamic between black females and black males in which if the black male is to assert his masculinity, he must find a way to dominate the Strong Black Woman who, he may perceive, is responsible for holding him back in society.

Beauboeuf-Lafontant (2005, 2008, 2009) has written extensively on the iconographic properties and practical realities of the Strong Black Woman. One of her many compelling observations, which she supports via the literature on black women in American society, is how potent the physical sense of what it means to be a Strong Black Woman can be and the various influences on shaping that sense. The researcher describes a black female Atlas, carrying the world on her shoulders, denatured from her femininity through her prowess of managing everything and not needing anyone. Across her writings, Beauboeuf-Lafontant also noted symbolic descriptions of black women as mules or animals that carry a burden, further dehumanizing and desexualizing them. The converse of this lies in the Black Superwoman image, another commonly employed one, in which the Strong Black Woman’s femininity may be compromised but her essential womanliness is affirmed in her life-giving capacity and her Earth-mother (Atlas-like) instincts to assume the burden of caretaking and nurturing all others. With these images

come ideas of solidity, power through armoring oneself from vulnerability, what Beaubouef-Lafontant identified as being in the “warrior mode,” (2005, p. 107). The researcher observed that these conflicting messages have merged and become entrenched, such that black women in America are often presented with images of themselves as both “highly sexualized” and “undesirable” (p. 114). This has produced the need to create a “self-affirming image of black women” (p. 113), which is identified with the current projection of the Strong Black Woman. In some ways, this process mirrors the co-opting and ownership of the highly charged term “nigger.” While it is a word that is now socially-unacceptable for whites to use, it is a word that is used freely among blacks in America, sometimes pejorative, sometimes affectionate. The fact is that the co-opting of the word is an attempt to denude it of its history and power as a negative definer of black people. The morphing of the Strong Black Woman iconography over the past two centuries, from slavery through present-day employment of the idea, suggests a similar progress.

Health Beliefs. Black and Peacock (2011) speculated that one of the possible factors in racial disparities in health and well being between black women and white women, with black women reporting disproportionately greater rates of chronic illness and secondary health problems, may be the result of “daily life management” approaches that they described as representing a “Strong Black Woman script,” (p. 144). To consider ways in which this script played out in publications and online sources targeting black women, and to attempt to assess the impact this script had on their health and well-being determinations, Black and Peacock reviewed 20 magazine articles and 10 blogs utilizing the phrase “Strong Black Woman.” The magazine articles were published between 1996

and 2006 and the blogs were selected based on certain criteria designed to ensure a degree of blog visibility. After importing content from the 20 articles and the 10 blogs selected into the ATLAS.ti (5.5.9) software, the researchers identified such themes as role management, coping and self-care and directed the software to identify relationships to these themes within and across articles. One of the interesting observations was that the Strong Black Woman script was supported by 60% of the magazine articles – a majority, but not a substantial one, particularly given the fairly traditional perspective that dictates most mainstream magazine publishing. More pronounced was the finding that 70% of the blogs were critical of the Strong Black Woman image and message. In these cases of rejection of the Strong Black Woman model, Black and Peacock (2011) identified strains of “exhaustion” expressed with the notion and the language of “recovery” associated with rejecting the Strong Black Woman construct. Even more striking, was the finding that while this resistance was referenced in pieces dealing with intimate partner and/or parenting relationships, the greatest number of articles challenging the Strong Black woman construct specifically addressed issues of physical health and mental well being.

Black and Peacock (2011) also identified links between self-silencing behavior, one of those thought to contribute to compulsive (binge) eating (Harrington, et al., 2010), and the Strong Black Woman image. Coping was described as keeping on a “game face” and maintaining a “mask” from the Strong Black Woman perspective and there was widespread distress over the notion that black women should have to hide their suffering in order to provide care or reassurance to others. Related to this were the reports of low self-care associated with Strong Black Woman behaviors. Some noted that it was not just a matter of self-sacrifice, it was often a matter of self-neglect, which some of the writers

the researchers surveyed tied directly to depression or suicide in their community of black females. Others readily identified extreme fatigue and overeating behaviors as symptomatic of the health downside of the Strong Black Woman image.

Beauboeuf-Lafontant (2008) interviewed 58 black women to identify themes in their coping strategies. Through these subjects responses she identified *accommodation*, *muted critique*, and *acknowledged vulnerability* as common aspects of these women's experience. Many of the women voiced experience with depressive features however the researcher reported that discussion of depression is muted or silenced. As she noted, depression "directly challenges the tenets of strength, the bedrock of black women's identity," (p. 401). She also posited that this commitment to appearing strong and muscling through adversity may complicate black women's ability to even recognize and acknowledge their depression. The depressed black women interviewed by Nicolaidis, et al. (2010) echoed this difficulty, reporting that the Strong Black Woman iconography had hampered their ability to recognize their own depression, and inhibited their receiving support from others in their community for either recognizing their depression or their efforts to find treatment for it. One woman, quoted by the researchers, poignantly captured the struggle and the pain of this, stating she internalized the message that "Somebody's worser off than we are,' so we just got to deal. So that's where the mask came in. 'I'm a strong black woman,' so I got to be strong and inside you're breaking down," (Nicolaidis, et al., 2010, p. 1473).

Murry, et al. (2003) linked the effort to fulfill the role of the Strong Black Woman as contributing to poorer self-health maintenance in black women with diabetes. They contended that the Strong Black Woman regards herself as both a caregiver for her family

and for her community, and is also expected to be self-sacrificing in order to live out that powerful matriarchal function. The authors described how a black woman with diabetes, for example, may experience role conflict between her image of her Strong Black Woman self, and the woman with a chronic illness that requires specific attention and care. Prioritizing her family's needs, their food preferences, and their notions of family food sharing and celebrations, may take precedence over her understanding that she needs to take care of herself.

A 2010 documentary film about unhealthy food consumption, *Chow Down*, featured just such a woman, Garnet Hall. Hall, an engaging black woman in her early 50s had been diagnosed at age 45 with Type II diabetes that quickly escalated to produce complications because, by her own admission, she had failed to observe her medication regimen. These complications resulted in her doctor putting her on a low-fat plant diet – a fairly extreme nutrition plan designed to reduce her morbidity and mortality risk. The film shows Hall with her warm and likeable family, a husband and two teenagers (one son, one daughter), all of whom appear to be overweight. At the outset of Hall's diet, her family commits to supporting her, saying they will all follow her eating plan. The documentary reveals how one of the first meals she produces for her family and which they all seat down to eat together at the dining room table, prompts her teenage son to head to the kitchen, after a half-hearted attempt to eat the labor-intensive vegetable-based meal Hall had prepared, and to return from the kitchen with a microwave burrito, which he then eats in front of his mother, father and sister. Shortly after, his sister does the same thing.

The film charts how Hall's family – all the while loving, funny and expressing concerns for Hall's health – abandon the diet. Hall initially takes a stand and leaves them to engage in their own food preparation while she continues the time-consuming work of preparing her diet meals. However, within a matter of days, Hall is preparing two sets of meals – one for her family and one for herself – and within just weeks, Hall abandoned the diet saying there were too many obstacles to her following it and that she would attempt it again down the road. Despite having experienced extreme issues related to her diabetes, and despite Hall's clear intention at the outset to remain on the challenging diet to help her negotiate her illness, Hall's role as a Strong Black Woman held sway. She would sacrifice herself before she would sacrifice the needs or desires of her family. The film maintains a light tone and there is no sense of condemnation toward either Hall or her family, and Hall appears to express little herself. She merely is resigned to the situation, only once displaying a measure of dismay that she quickly suppresses, that her family had promised to support her, and then was not there for her when she most needed their help. Hall's story presents a stark, real-life example of how the Strong Black Woman image, and how the stresses identified by Murry, et al. (2003) and others (Beaubouef-Lafontant, 2005, 2008, 2009; Harrington, et al., 2010), can come into direct conflict with the black woman's ability to adequately take care of her own health.

Mental Health and Depression. Romero (2000) identified the identity of the SBW as a paradox – an embrace of an image intended to fortify against the offense of the “dual oppressions of racism and sexism” that prevents black women from acknowledging their needs and vulnerabilities (p. 225). Consequently, she observed, many black women who have been acculturated with the Strong Black Woman identity often present with

manifestations of emotional and psychological disorders such as eating and sleep disorder, depression, and anxiety. This notion of being strong and not evincing any weaknesses which others could take advantage of has shaped the development of many black women. By maintaining themselves in the face of societal neglect, not expecting others to take care of or provide for them, and understanding the function of caretaker in their community as largely falling to them, creates an expectation that the Strong Black Woman will always be in control. Thus, crying is a behavior that is regarded with suspicion or contempt, and Romero observed that even the language black women use to describe the act, “breaking down” and “falling apart” are not employed for melodramatic effect but because the idea of a black woman crying in front of others (aside from her most immediate family or friends) is so rare that when it occurs it is understood to be an example of that black woman losing her sense of self and her power. She is, thus, breaking down her Strong Black Woman identity through the basic act of crying, Romero contended.

Examination of the problem of mental illness in America’s black population is only now beginning to receive the type of research attention the statistics demand. Ward, et al. (2009) referenced studies showing that approximately a quarter of the nation’s black population has been diagnosed with mental illness. The rates among black women are disproportionately higher than they are for men. One astounding statistic was provided by the 2003 California Black Women’s Health Project through a national survey the organization conducted; it showed that 60% of black women exhibit clinical symptoms of depression (Ward). Despite this prevalence, black women are much less likely than white women to access mental health services.

Given the degree to which the Strong Black Woman needs to retain the appearance of control, Romero (2000) stated she can present a serious challenge in situations where therapeutic intervention is indicated. The mental health issues of the Strong Black Woman may be difficult to identify because the typical Strong Black Woman is masterful at masking her feelings and needs. Among the feelings often suppressed by the Strong Black Woman are pain, shame, pride, fear, anger and loneliness. When negative feelings like this are consistently buried and not given legitimate expression, they will curdle and turn on the person suppressing them, often manifesting in physical symptoms or psychological conditions that may further obscure the cause-and-effect nature of what's happening for the individual. The evidence suggests that women who attempt to live by what they perceive as the Strong Black Woman dictates are particularly vulnerable to a range of issues that, troublingly, their very embrace of the identity hinders them from seeking help to address (Beaubouef-Lafontant, 2009). Wyatt (2008) quoted one writer on Strong Black Womanhood who observed that if she "slipped and began to tell friends or family how bad she actually felt, 'it seemed like I could barely get the words out before somebody reminded me I was a STRONGBLACKWOMAN'," (Wyatt, 2008, p. 57). The constellation of health issues that can emerge as a result of this belief system are potentially serious and may be difficult to address at their root, given the Strong Black Woman's innate resistance to exposure and assistance-seeking behaviors.

From the Strong Black Woman's perspective, depression is the province of white women – a luxury that black women can't afford because no one else will take care of them. The belief is also a reflection of the internalization of the binary gender construct

of weak black male/Strong Black Woman, and powerful white male/submissive white female (Wyatt, 2008). Carole Gilligan's seminal 1982 work *In A Different Voice*, describing the emotional and psychological development of young women in American society indicated that adolescent girls go through a process of losing confidence and sacrificing their authentic selves, resulting in low self-esteem, in order to make themselves more acceptable to dominant culture messages supporting the dominant gender binary of strong male/weak female. One of the most interesting developments arising from Gilligan's study was research suggesting that African American girls, and to a lesser degree, white females from low-socioeconomic backgrounds, were much less inclined to lose their self-esteem or give up their authentic voice in order to aspire to the dominant gender binary. Gilligan and others have interpreted this finding as evidence of these outlier girls' awareness that they weren't likely to benefit from dominant culture imperatives, regardless of whether they embraced or rejected them; thus, there was no advantage to them giving up their sense of selves in order to accord with some idealized sense of femininity that might bring societal rewards. What would bring about "rewards" for young black women would be conforming to values or behaviors reinforced within the black community and therefore, the influence of the Strong Black Woman and the emphasis on her legendary coping abilities, would be more salient to the experience of young black women. In fact, there is evidence to this end that black girls and women spurn perceived weakness as a white female trait, borne of a sense of privilege, and therefore at odds with their self-identity (Beaubouef-Lafontant, 2009).

Emotional Overeating. The subject of overeating behaviors appears in a substantial amount of the literature discussing the experience of the Strong Black Woman

(Beaubouef-Lafontant, 2009). Beaubouef-Lafontant (2005) stated that the construction of strength as central to the Strong Black Woman has not actually conferred power or strength to black women but instead produced a “body problem” most commonly typified by black women compulsively overeating (Beaubouef-Lafontant 2005).

Beaubouef-Lafontant (2005) reported on a study of depression and overeating in a population of black women. She interviewed 12 black women, between the ages of 19 and 46 with a mean age of 27.4 years, who were enrolled at a large urban university in the southern U.S. The women represented a range of body types and weights, and five of the women self-identified as overweight or obese. Four of these women, as well as four of the non-obese subjects, identified issues of overweight or obesity among many of the other women in their immediate family (mothers, sisters, grandmothers). Most of the women described their understanding of their role to become Strong Black Women as emanating from the behaviors of the women they saw immediately around them – women who rarely cried, who prized fortitude in the face of challenges, and who urged their female children to tough it out and be strong in their coping skills and in their dealings with others. Beaubouef-Lafontant called this “the performance of strength” (p. 105) and this phrase captures the insidious aspects of the message underlying the Strong Black Woman myth, she suggested. Rather than realize actual strength by utilizing mechanisms that ensure Strong Black Women are taking care of themselves emotionally, psychologically and physically, the pantomime of strength, stoicism, and assertiveness is emphasized and this show becomes the feature of strength that is most meaningful, despite the negative consequences it may have in entrenching depression, self-doubt, frustration and isolation.

As the women in Beauboeuf-Lafontant (2005) described their experiences growing up as black women, they almost universally expressed that the role of the strong woman was projected on them by others; as the researchers noted, none of the women described coming to that identity on their own. Rather, they described various instances in which their strength was called out by others, or overall messaging they internalized that reinforced their responsibility to care for themselves and others. Echoing the observation noted above by Romero (2000) that crying is a behavior outside the bounds of traditional Strong Black Woman expression, one of Beauboeuf-Lafontant's subjects reported that an unexpected bout of crying during a particularly trying time in her life, prompted her girlfriend to offer going to the hospital as an immediate solution because the subject "never" cried and her girlfriend was frightened by her emotional release and figured she must have been terribly ill to engage in crying. The other women in the study similarly related rarely, if ever, seeing their closest female relatives (and certainly not black women outside of their immediate circle) cry as release from stress or anxiety or frustration; it simply was not acceptable behavior.

The overweight women in Beauboeuf-Lafontant's (2005) study described the act of eating as an escape, an "exit" (p. 115), from having to carry out the performance of strength that was overwhelming them and making them doubt themselves and their abilities. These women used phrases that capture the reality of compulsive eating. They described engaging in eating thoughtlessly, and not really tasting the food. One of Beauboeuf-Lafontant's subjects described the revelations that regular exercise brought into her life. Ordered by her doctor to commit to regular walking in order to manage her own high blood pressure and in an effort to avoid full-blown diabetes, this subject

described how walking liberated her, to think freely, to think differently, to begin to change the way she thought about her role in the world. She began taking care of herself and described how her sense of her own strength shifted from the performance of it for others, to recognition that she was vulnerable, and deserved to focus attention on healing herself and when she did so, she felt herself become both physically and emotionally stronger in the most authentic sense.

One of the other women in the Beaubouef-Lafontant (2005) study described how her overeating behaviors were an extension of her anger and despair in being used by the White professionals in the school she worked at to exercise her authority (as a large, black woman) or difficult students, but did not value her authority beyond that function – she felt ignored and that her contributions were not valued. An incident of overeating in the school that she related poignantly suggests how with each bite she was stifling rage at her perceived invisibility. Another woman, identifying the overeating behaviors of her overweight female family members suggested that the private, sometimes secret, act of eating constituted the only moments when these Strong Black Women gave attention to themselves, found a moment of quiet (“You eat and you relax, you know” one reported, p. 118). This subject, who reported having numerous obese female family members, identified that they were depressed and said they couldn’t possibly let themselves go to the degree they had unless they were ill. Beaubouef-Lafontant provided a challenge to this subject’s interpretation of the overeating behavior, stating that it may be “an act of trying to hold onto one’s self,” (p. 119). This interpretation is somewhat consistent with another possibility and that is that overeating is an act of resistance – a way to voice

frustration about being overloaded with responsibilities and expectations associated with the Strong Black Woman role.

It is Beauboeuf-Lafontant's (2005) thesis that overeating in Strong Black Women is not about an intention to let themselves go. Instead, she frames it as an intention to hold onto oneself by attempting to grapple with the challenges attendant on the performance of strength – rather than the actual finding and holding of healthy and supportive strength. The researcher drew a connecting line from such eating disorders as anorexia nervosa and bulimia which, she stated have been linked empirically to efforts to resist loss of self, to the overeating behaviors in response to emotional needs, that were described by many of her subjects for themselves or for their family members. Binge eating might be viewed as a form of “self-nurturance” – one of the few culturally acceptable and sanctioned options available to black women (Triffleman & Pole, 2010). This fact, coupled with previously noted body image differences noted for blacks and whites and particularly between black women and white women suggests that the typical result of binge eating – significant weight gain – does not carry the same degree of punitive effect in black culture as it does in white culture. Indeed, as noted earlier in the chapter, black women generally report greater body satisfaction at higher weights than do white women (Burke & Heiland, 2008; Henrickson, et al., 2010; Muennig, et al., 2008).

An examination of the prevalence of binge eating in a population of black trauma survivors was performed by Harrington, et al. (2010). They surveyed 179 black women recruited from a variety of environments and representing a range of socio-economic backgrounds. Each woman reported that she was a trauma survivor, someone who had witnessed family violence before the age of 16, been the victim of rape or sexual

harassments, suffered emotional abuse or neglect, suffered physical abuse or an attack, had experienced a serious accident or had an accident related injury. The researchers administered a wide range of instruments, including several trauma measures, the Binge Eating Scale, the Eating Disorder Diagnostic Scales, emotional inhibition and self-silencing assessments, and two subscales (the “Mammy” and the “Superwoman”) of the Stereotypic Roles for Black Women Scale, in order to assess for relationships between trauma, binge eating behaviors, and Strong Black Woman beliefs. They then performed six separate exploratory factor analyses to arrive at primary constructs.

Based on the relationships yielded by the factor analyses, the researchers found a significant relationship between trauma exposure and the level of Strong Black woman ideology internalization. This relationship in turn, predicted the likelihood of binge eating as a mechanism of emotional regulation. Triffleman and Pole (2010) called the Harrington, et al. study “an excellent example of the rare quantitative study incorporating a culturally specific African American construct in a trauma-focused framework,” (p. 492). Harrington et al. (2010) noted that whereas previous research had indicated the relationship of overeating to emotional regulation, this study provided the first empirical evidence for the applicability of the affect regulation model of binge eating to the experience of black women trauma survivors. The difference, the researchers observed, was that among the black women, greater internalization of the Strong Black Woman image was correlated with both greater incidence/degree of trauma, and with overeating behavior. They speculated that the Strong Black Woman profile might provide a form of socially-acceptable cover to black woman struggling to cope with various emotional and psychological challenges and who feel unable to express their distress emotionally for

fear of counteracting or disproving their strength (and thereby, losing their identity as Strong Black Women). Thus, overeating that (temporarily) mitigated the effects of feeling helpless or vulnerable was a way to assert control and, as Beauboeuf-Lafontant (2005) argued, a way to hold on to self (the self of the Strong Black Woman).

Harrington, et al. (2010) suggested that the effects of the Strong Black Woman image and its relationship to overeating behaviors and thus, overall health status, of black women might be considered a variant on John Henryism. They stated that with both, an “extreme internalization of an originally positive cultural symbol can have detrimental effects if striving for unbalanced or unrealistic ideals is expected,” (Harrington, et al., 2010, p. 476). The Strong Black Woman message is intended to foster resilience and perseverance in the face of significant obstacles, many of them associated with the dual oppression of gender and race. Given the degree to which Strong Black Woman iconography has taken hold in the black American community one must acknowledge that the image has probably been a useful construct for black women at various points over time. However, it would seem that the image of the Strong Black Woman is not useful when it comes to black women’s health. The most obvious example of this may be in the behavior of emotional overeating as a way to silence the depressive feelings that a Strong Black Woman must prevent herself from giving voice to if she is to remain strong. This behavior, coupled with a black cultural resistance such as John Henryism, to pursuing health supports or medical intervention, appears to leave black women who ascribe, at least in part, to Strong Black Woman ideology, susceptible to a host of negative consequences related to both their reflective resistance to prioritizing their own

self-care and to the negative physiological and psychological effects attendant on obesity and depression (hypertension, diabetes, cancer, stroke, cardiovascular disease).

The icon of the Strong Black Woman may have served her purpose in enabling black women to maintain and succeed in a dominant white culture that, over the centuries, has often been neutral and unengaged with her struggle at best, and hostile at worst. But it may be that the Strong Black Woman has overstayed her welcome as a workable concept and that black women are in need of a new model, an idea of the black woman as capable and strong, but also worthy of attention and care and nurturing, who can serve herself and others best by respecting and honoring her own needs without sacrificing them to the idea of serving someone else's needs.

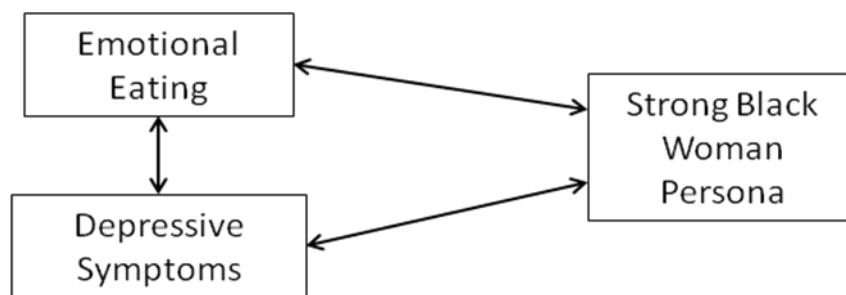


Figure 1. **Conceptual Framework**

Based on the review of the literature, it is hypothesized that relationships exist among the Strong Black Woman persona, emotional eating, and depressive symptoms (Figure 1). The purpose of this study is to evaluate those relationships.

Conclusion

The disproportionately high rate of obesity and overweight in the black female population is a source of great concern for its implications on health care costs, accessibility of services, and the morbidity and mortality rates for black women (Baltrus, et al., 2005; Prividera & Kean, 2008; Wee, et al., 2005). There is also a moral and ethical dimension to the issue as black women battle a sense of dual oppression in American society and the high rate of obesity may be further marginalizing them from benefits realized by others in society (Birzer, et al., 2006; Burke & Heiland, 2008; Chang, et al., 2009; Cutrona, et al., 2005). Many of the studies discussed in this chapter draw a connection between black female overweight and obesity and high rates of depression and anxiety (Beauboeuf-Lafontant, 2008; Meinert, et al., 2003; Miranda, et al., 2005; Nicolaidis, et al., 2010; Ward, et al., 2009). These too are a source of concern for they suggest that black women are unduly effected by, and struggling to cope with, mental illness that often goes unreported and untreated.

The literature review indicates that the black women are especially susceptible to the message that they must sacrifice their own needs to support and care for others in their family and community (Beauboeuf-Lafontant, 2005; Black & Peacock, 2001; Clarke, et al., 2009; Henrickson, et al., 2010). This message appears to be a key facet of Strong Black Woman imagery – a construct that has been employed by individual black women to assert a sense of strength and control over their surroundings, while it is often employed by others (the black community at large, and reflected to some degree in stereotypical expectations of some whites) to place the black woman in a position to be a caretaker (mother, nurse, Mammy, maid) (Bardone-Cone, et al., 2009; Beaubouef-

Lafontant, 2008; Harrington, et al., 2010; Romero, 2000; Wyatt, 2008). In this role, the Strong Black Woman is long-suffering, uncomplaining and strong. The compelling evidence of so much of the research discussed in this chapter suggests that the Strong Black Woman is just barely remaining upright, carrying the world on her shoulders, Atlas-like (Beauboeuf-Lafontant, 2005). The rates of physical, emotional and psychological morbidity are disproportionately high for black women and it seems logical to assume that the need to push onward with the Strong Black Woman ideology is perhaps contributing to making black women ill (Mazzeo, et al., 2008; Murry, et al., 2003; Yun, et al., 2006).

As Murry, et al. (2003) and others have observed, health behaviors do not arise from a total void. It is necessary to consider the ways in which culturally reinforced messages are shaping black women's health beliefs and self-care practices (Beauboeuf-Lafontant, 2008; Black & Peacock, 2011; Romero, 2000; Ward, et al., 2009). This study focuses particularly on the issue of obesity and looks at how overeating – a clear contributor to overweight and obesity (Burke & Heiland, 2008; Franko, et al., 2005; Striegel-Moore, et al., 2005; Stiegel-Moore, et al., 2000) – may be an example of a Strong Black Woman coping strategy that is maladjusted and not well-serving the women trying to live up to the image (Beauboeuf-Lafontant, 2005, 2009; Harrington, et al., 2010; Henrickson, et al., 2010; Romero, 2000; Triffleman & Pole, 2010).

Chapter 3: Methods

Chapter Three describes the methods used in the study. A description of the study design, with all its components, as well as the research process, is included. Details about the sample, instrumentation, data collection, and an overview of the data analysis are included. Finally, ethical considerations governing the study are presented.

Research Design

This study investigates the relationships between the Strong Black woman persona, depression, and emotional eating. It was expected that woman who embrace a higher level of SBW ideology would also garner a higher score when administered a measure of depression. The same women would also be more likely to cope with their depression using food, a behavior referred to as emotional eating.

Research Questions

1. Is there a relationship between SBW ideology and depression in black women?
2. Is there a relationship between SBW ideology and emotional eating in black women?
3. Is there a relationship between depression and emotional eating in black women?

The research utilized Pearson Product Movement Correlations, seeking to discover the strength and direction of relationships between the independent and dependent variables.

The Sample and Sampling Strategy

Participants in this dissertation research were adults who self-identified as black women. In order to be included in the study they had to be at least 18 years of age. There was no upper limit on age for inclusion. Study participants were recruited at two churches in St. Petersburg, FL that have large black memberships.

Instrumentation and Data Collection Procedures

There were three quantitative instruments used to collect the dissertation data. They were combined in one packet for ease of administration to the sample participants.

The Strong Black Woman Cultural Construct Scale. Strong Black Woman Ideology was measured using The SBWCCS (Hamin, 2008). The Strong Black Woman Cultural Construct Scale is based on a revision of Thompson's (2003) Strong Black Woman Attitudes Scale that was conducted by Hamin in partial fulfillment of doctoral requirements..

The SBWCCS is a twenty-two item instrument. Each item is rated on a five-point scale: never=1, rarely=2, sometimes=3, frequently=4, and almost always=5. There are no reverse scored items. Scores are obtained by summing item scores. There are three scale scores: Affect Regulation (7-35 points), Caretaking (8-40 points) and Self-Reliance (7-35 points). The range for the total score is 22-110 points. Higher scores indicate a greater identification with SBW ideology.

The reliability or internal consistency of the instrument was documented with an alpha coefficient of $r = .76$ (considered an acceptably high coefficient) for the total scale, and with a similar alpha for the three subscales (Affect Regulation, $r = .75$, Caretaking $r = .69$, and Self-Reliance $r = .62$). The instrument was created using a community sample of

women who self-identified as being of African descent and all measures were normed on black samples. Validity was assessed using Varimax Rotation factor analysis. The factor analysis supported the use of three subscales as separate scales, and explained 30 percent of the variance. Chronbach's alpha for the subscales were .75 for caretaker, .69 for affect regulation, and .62 for self-reliance. This implies that reliability of the affect regulation and self-reliance subscales are lower than the value of .7 that is traditionally accepted, however, Haman points out that values below .7 can be expected when measuring complex psychological constructs (Haman, 2008).

Center for Epidemiological Study-Depression Scale.

Depression was measured using the Center for Epidemiologic Studies Depression Scale (CES-D), an instrument developed by Radloff for the purpose of evaluating depressive symptomatology in community populations (Radloff, 1977). The scale is a composite of 20 items that were selected from several well known inventories, including the Zung Self-Rating Depression Scale, the Beck Depression Inventory, the Raskin Scale, and the Minnesota Multiphasic Personality Inventory Depression Scale (Radloff & Locke, 2000).

The twenty item scale contains four items that are positively worded and then reverse scored in order to control for response bias. Items are rated on a four-point scale, where participants are asked to rate how often those feelings have occurred in the past week: 0=rarely/less than a day, 1=sometimes/a couple of days, 2=moderate/a few days, and 3=most of the time/up to a week. Scores on four of the items are reversed, and then all item scores are summed. Scores can range from 0-60. A score of 16 or more indicates the likelihood of depressive illness.

Reliability or internal consistency of this scale is reported as high across a variety of subgroups, with an alpha of .85 in community samples and .90 in psychiatric samples. The authors report that studies of African Americans, Anglo Americans and Mexican Americans did not vary in terms of internal consistency (Radloff & Locke, 2000). This scale is suggested for use only as an initial screening tool for symptoms of depression. It should not be used for clinical diagnosis of depression (Radloff, 1977). Validity was empirically evaluated by correlating the tool with the Hamilton Rating Scale for Depression and the Raskin Scale and it was found to be highly correlated.

Emotional Eating Scale. The presence of emotional eating behavior was measured by the Emotional Eating Scale (EES). The EES is a twenty-five item rating scale in which 1= no desire to eat, 2= small desire to eat, 3= moderate desire to eat, 4= strong desire to eat and 5= overwhelming desire to eat. Scores are obtained by summing score and the lowest score is 25 while the highest is 125.

Reliability or internal consistency is documented with a Cronbach's alpha of 0.81 for the overall scale and alphas of 0.72 to 0.78 for the three subscales (Arrow, Kenardy, & Agras, 1995). Though the scale was originally validated with obese clinical samples, Waller and Osman (1998) conducted a study using nonclinical participants that further supported the aforementioned reliability values. The resultant alpha was even higher at 0.93 than it was in the clinical population. The instrument is considered a valid and reliable instrument for use in both clinical and community (eating disordered and non eating disordered) populations (Waller and Osman, 1998).

Procedures

The dissertation research was conducted one-on-one at dinners in community area churches in conjunction with regular monthly church women's meetings. The dinners were announced via a flyer in the church bulletins and by the church pastors who encouraged participation in the event.

Women who attended the event had a one-page sheet read to them that explained in detail how the study would be completed and discussed their right to refuse participation without penalty of any sort. Women who wished to participate were then able to indicate consent by either completing the survey or simply leaving it unopened. Participants were asked to self-report height and weight. Anonymity was protected as the completed instruments were submitted in an unmarked envelop and there was no identifying information on the instruments when they were submitted. All surveys that were distributed were filled out by a participant. None were returned unopened.

There were four packet components to be completed for study inclusion: (a) demographic information, (b) Strong Black Woman Cultural Construct Scale, (c) Center for Epidemiologic Studies Depression Scale and (d) the Emotional Eating Scale.

Data Analysis

Descriptive statistics were generated on demographic information including age, relationship status, family composition, educational level and language spoken in the home. The variables in the study which compose the primary statistical analysis are presented in descriptive format as well. Statistics include frequencies, measures of central tendency, variation and percentages, where appropriate.

The primary statistical analysis was Pearson Correlations executed by using Statistical Package for the Social Sciences (SPSS) software program. The first dependent variable in the study was depression as measured by the *Center for Epidemiological Study-Depression Scale* which has a range of scores between zero and 60. The second dependent variable was Emotional Eating measured by the *Emotional Eating Scale* which has a possible range of scores between 25 and 125. The independent variable was the Strong Black Woman Cultural Construct Score. The alpha level was set at $p < .05$.

Ethical Considerations

There were no elements of deception in this study. Each participant was provided with contact information for the researcher so that all questions or concerns involving the study could be promptly addressed. Each participant had the option of receiving a \$10 gift card as compensation for filling out the survey. Participants received their gift cards on the spot when their envelopes were submitted.

Chapter 4: Results

This study investigated the relationship between the Strong Black woman persona, depression, and emotional eating. It was expected that women who embrace a higher level of SBW ideology were also likely to garner higher scores when administered a measure of depression. The same women were also anticipated to be more likely to cope with their depression using food, a behavior referred to as emotional eating.

Research Question 1 asked: Is there a relationship between SBW ideology and depression in black women?

Research Question 2 asked: Is there a relationship between SBW ideology and emotional eating in black women?

Research Question 3 asked: Is there a relationship between depression and emotional eating in black women?

The sample is described and demographic variables of the sample are presented first. Descriptive statistics are presented next. Finally, correlation results for each Research Question are presented.

Sample

There were 66 black women in the research study. The demographic profile of the sample was as follows: All of the women (100%) self-identified as black women. The women also self-identified as African American with two exceptions: one who described

herself as biracial black and one who self-identified as Caribbean American. Almost half of the women were married. (47%) but large segments were single (23%) or divorced (20%). Six percent were widows and 4% had partners. Most of the sample (83%) had children.

The highest level of education item achieved diverse results (Table 1). Similar numbers of women reported a high school diploma, an associate degree or vocational training. Slightly more of the women had bachelor's degrees. Advanced degreed individuals reported a Master's (14%) or a doctorate (5%).

Table 1
Frequency and Percent of Women by Educational Levels

	Frequency	Percentage
None	1	1%
High School Diploma	12	18%
Associate Degree	11	17%
Vocational Degree	10	15%
Bachelor Degree	14	21%
Master Degree	9	14%
Doctorate	3	5%
Refused to respond	6	9%

Similarly, the range of reported household income also achieved diverse results (Table 2). Participant income levels had 54 percent falling below the U.S. median

household income of \$50, 502 and 45 percent who were at, or above the U.S median household income (US Department of Commerce, 2013)

Table 2

Frequency and Percent of Women by Income Levels

Dollars	Frequency	Percent
Below 10,000	7	10%
10- 19,999	2	3%
20-29,999	11	17%
30-39,999	9	13%
40-49,999	7	11%
50-59,999	5	8%
60-69,999	8	12%
70-79,999	6	9%
80 or more	10	15%
Refused to respond	1	1%

In terms of physical characteristics, the average height of the sample was 5 feet 4 inches tall with a range of 4 feet 9 inches to 6 feet tall. The average weight was 198 pounds with a range of 110 to 310 pounds. Ninety- nine percent indicated that they were never diagnosed with an eating disorder.

Descriptive Data

As preliminary analyses, descriptive statistics were generated on the study variables. Scores on the SBW inventory ranged from a low of 65.92 to a high of 83.32. The Emotional Eating survey had scores that ranged from 29.94-68.78. Depression

inventory scores ranged from 5.01 to 23.11. Inventory results from the sample displayed a wide range of scores, with the exception of scores from the SBW inventory. The group SBW scores were more closely clustered, thus indicating that group has more commonality in the area of acceptance of SBW ideology. Table 3 reports the means (M) and standard deviations (SD) for the variables SBW, emotional eating (EE) and depression (DEP).

Table 3
Means and Standard Deviations for Study Variables

	N	M	SD
Strong Black Woman	66	74.62	8.70
Emotional Eating	66	49.36	19.42
Depression	66	14.06	9.05

Descriptive statistics were also generated on the SBW subscales. Affect regulation scores ranged from a low of 16.96 to a high of 25.79. Caretaking scores ranged from 20.64 to 29.58. Scores on the Self-Reliance subscale ranged from 24.86 to 31.48.

Table 4
Means and Standard Deviations for SWB Subscales

	N	M	SD
Affect	66	21.35	4.39
Caretaking	66	25.11	4.47
Self Reliance	66	28.17	3.31

Relationships Among Variables

Pearson Product Moment Correlations were executed to determine the relationships among the key variables in the dissertation research. Table 5 presents the correlation matrix table.

Table 5
Correlation Matrix – Study Variables and Demographics

	SBW	DEP	EE	ED	AGE	INC
SBW	1.00					
DEP	.21	1.00				
EE	.21	.27*	1.00			
ED	.27*	-.10	-.01	1.00		
AGE	.15	-.21	.04	-.30*	1.00	
INC	.15	-.25*	.00	.54**	-.03	1.00

*p<.05 **p<.01

Correlations were also generated on the three subscales and the study variables. The results of these correlations are presented in Table 7.

Table 6
Correlation Matrix – Subscales and Study Variables

	SBW	DEP	EE	AFF	CARE	S-R
SBW	1					
DEP	.21	1				
EE	.21	.27*	1			
AFF	.80**	.28*	.14	1		
CARE	.74**	.20	.20	.38**	1	
S-R	.57**	-.10	-.10	.26*	.10	1

*p<.05 **p<.01

SBW and Depression. The correlation results indicated there was no significant relationship isolated between the SBW persona and depression. The correlation between SBW ($r=.21$) and depression was very weak.

SBW and Emotional Eating. There was no significant relationship found between the SBW persona and emotional eating behavior. SBW was weakly correlated at ($r=.21$) with emotional eating.

Depression and Emotional Eating. Depression was found to be positively significantly correlated at ($r=.27$, $p<.05$) with emotional eating behavior. However, the strength of the correlation was weak.

Emotional Eating and the SBW Subscales. Emotional eating and affect regulation were not found to have a significant relationship. The Pearson Correlation for these two scales scored as insignificant ($r=.14$). The association between emotional

eating and caretaking was very weakly positive but not significant ($r=.20$). The relationship between emotional eating and self-reliance ($r=.10$) was not significant.

Depression and the SBW Subscales. Depression and caretaking had a very weak positive association ($r=.20$) that was not statistically significant. Depression and self-reliance were negatively associated but the relationship was not significant ($r= -.10$). However, depression and affect regulation was found to have a significant positive correlation ($r=.28$), though the strength of the correlation was weak.

Other Findings. The SBW persona was found to have a significant but weak positive correlation with education at ($r=.27, p<.05$). Depression and income had a weak negative correlation ($r= -.25, p<.05$). Education and age were discovered to have a weak negative correlation ($r= -.30, p<.05$). Finally, education and income were positively correlated ($r=.54, p<.01$).

Chapter 5: Discussion

Obesity rates remain arguably the biggest health threat looming on the horizon of America's future. There has been an upward trend in the weight of the U.S. population since the 1970s. No group within the population has been more negatively impacted by this trend than black women, with a disturbing 20 percent increase in obesity prevalence over a 28 year span. Statistical data from The Center for Disease Control estimates more than 50 percent of black women are clinically obese (Burke and Heiland, 2008).

Current research has failed to isolate clear causal factors to account for the disparity in obesity prevalence but researchers have noted difference in behavioral choices and internalized messages concerning weight in black women as opposed to white women. (Burke and Heiliand, 2008; Grilo, Lozano and Masheb, 2005).

This study aims at addressing the dearth of information in the present literature concerning psychosocial factors which may support the occurrence of obesity in black women - specifically, the phenomenon of the Strong Black Woman persona, a psychosocial belief in an unlimited inner strength that provides immunity from adversity. SWB also confers the ability to deny self-needs and weaknesses at will in order to care for the needs and desires of others (Romero, 2000; Thompson, 2004)

Though the knowledge of, and belief in Strong Black Womanhood has been traced through the black cultural landscape all the way back to emancipation, the persona was never conceptualized within the literature until first brought forward by Romano in 2000.

Consequently, there have been few researchers who have attempted to measure aspects of this construct within the population.

This study explored the following:

Research Question 1 asked: Is there a relationship between SBW ideology and depression in black women?

Research Question 2 asked: Is there a relationship between SBW ideology and emotional eating in black women?

Research Question 3 asked: Is there a relationship between depression and emotional eating in black women?

The sample is described and descriptive data is presented. A summary of the findings, discussion of limitations, direction for future research, and implications for the practice of nursing follows.

Sample

Convenience sampling is the type of sampling that was used in this study as it encompasses the person who is readily available to be studied. Specifically, Merriam (1998) characterized this type of sampling technique as being based on time, money, location, and site or participant available. Convenience sampling is regularly used in exploratory research to collect data that can be generally translated to the population being studied. It has the advantage of being cost and time effective, allowing a gross result to be generated without incurring the difficulty and expense of using a random sample (StatPac 2007).

This sampling method enables the researcher to act within a certain period and under conditions that facilitate data collection. By its nature, convenience sampling

sacrifices generalizability and therefore, may not provide sufficient representation of the target population. This means that those selected for the study may only partially represent the population being investigated. As such, replication may be necessary to fully validate study results (Keppel & Zedeck, 2001). Despite its deficiencies, convenience sampling may be the best method of obtaining a sample when time and conditions prohibit random sampling (Neuman, 2003).

There were 66 women in this research study that self-identified as black women. The women were all members of two local churches who regularly attend women's group events presented by the church. Within this sample, 40 percent of the women identified as having attained a bachelors degree or higher. This far exceeds the national average among black women, which is less than 19 percent. It naturally follows that the sample also exceeded the national average in terms of household income, because education levels are positively correlated with higher income. This likely affects the ability to generalize as well to other samples of black women or to the population as a whole.

Descriptive Data

The women completed three scales, measuring SBW ideology, depression, and emotional eating behavior.

The Strong Black Woman Cultural Construct Scale. Scores on the SBW range from 22 to 110. Within this sample, scores ranged from a low of 66 to a high of 83, with a mean of 74.62. This instrument also has three subscales.

The image of the SBW is firmly implanted in nearly all black females in America, and with good reason. The larger society holds several prominent images of black women that are inarguably negative: The smart mouthed, sharp tongued, female with perpetual

bad attitude, the large, one dimensional Mammy, and fat, lazy, but obnoxiously fertile welfare queen (Beauboeuf-Lafontant 2007). Within black society, the negative stereotypes are combated by raising young women to believe they can withstand all things. They are socialized to see themselves as independent, nurturing, instantly adaptable to any situation life presents, and above all, strong. The SBW image has a very high status within the community, and also is well accepted within the larger society. Holding fiercely with both hands to the image of the SBW neutralizes the ability of black women to perceive their own needs. They become oblivious to their own pain. Overall scores on the survey were moderate among the women in the sample, in keeping with this overarching socialization model.

The Center for Epidemiologic Studies Depression Scale. Scores on the CES-D can range from 0 to 60. Scores of 16 or higher are positively correlated with depressive illness. Scores in this sample ranged from a low of 5 to a high of 23, with a mean of 14.06.

There are several reasons why depression may not have been as prominently detected in this sample. Depression often results in a quandary for black women. When a woman has been acculturated in the mold of strong black womanhood, something as common and expected as the behavior of crying as a coping mechanism for depression represents an unacceptable loss of her power and an assault to her sense of identity as a black woman. Acknowledging her distress and seeking treatment is a behavior that the SBW is highly unlikely to undertake. Further, should the woman turn to other women and actually let down her guard long enough to admit her distress, she will most certainly be reminded almost immediately that she is a strong black woman and therefore should not

be giving in to those feelings. Depression is most definitely a state that does exist, but it is a domain where women of other races reside (Wyatt, 2008). Thus the black woman must find a way of reliving the pressure of negative emotions in ways that will not cause her to lose face or feel out of control.

Studies in the literature (Ward, Clark & Heidrich, 2009; Black and Peacock, 2011; Clarke, et al., 2009) have identified a tendency in black women with strong religious beliefs to accept depression as a state in life they must accept and cope with in an independent fashion, shunning counseling or other therapeutic treatment. For some, even admitting depression is tantamount to denying the power of God to provide what you need. This point of view has traditionally been encouraged by the church which remains a strong voice within the black community, and by other strong black women who may be within the circle of influence. Depression is seen in the black community as the kind of weakness that a SBW would not only deny, but may actually be unable to perceive within herself. Furthermore, when given an inventory and informed they have been identified as depressed, researchers have found that many black women are less likely to seek out treatment of any kind for depression, as use of medications is seen to undermine the ability to regard oneself as strong and resilient. (Nicolaidis et al. 2010). These are behaviors that are frequently reinforced by families and within the black community, where women are encouraged to handle their own problems without assistance. Within the culture, there are frequently found vestiges of mistrust for healthcare systems that are seen as being run by a dominant white culture that cannot be relied upon to be fair and equitable in administration of healthcare services (Ward, et al., 2009). One subject expressed what may be a common underlying fear of being identified

by a healthcare professional (especially a white one) as having “something wrong with my mind” if she acknowledged she frequently had periods where she felt “down.”

The Emotional Eating Scale. Scores on the EES can range from 25 to 125. The women in the sample scored from 30 to 68, with a mean of 49.36.

Much of the research in the literature regarding emotional eating has been conducted on samples consisting only of white women, but there have been studies that compared cohorts of white women and black women on binge eating behaviors. Black women had higher incidences of both binge eating and purging via laxative and diuretic abuse, and black women were more likely to report higher levels of psychological distress as a result of disordered eating (Striegel-Moore et al, 2000). Studies have shown that compulsive eating behaviors may be used by women in an attempt to regulate emotions (Harrington, et al., 2010). These studies serve to underline that the actual incidence of emotional eating may be higher in black women than indicated by the responses of this sample.

It is not surprising to consider eating as a safe way to relieve emotional pressure. The act of caring for others, which is central to the identity of black womanhood, can frequently segue to food. Researchers have found that SBW often use the act of eating to dispel a variety of unpleasant emotions. Through eating, the woman can nurture herself and thus eventually regain her control (Beauboeuf-Lafontant, 2005).

A limitation of this study that may affect scoring on this instrument may be in the acceptance of eating in the face of distress as a normal and acceptable learned behavior within the black culture.

Relationships Among Variables

Is there a relationship between SBW ideology and depression in black women? The relationship between depression (as measured by the Center for Epidemiologic Studies Depression Scale) and the SBW persona was not significant in black women within the sample. This finding is inconsistent with the body of literature documenting vulnerability to high occurrence of depression in black women (Beauboeuf-Lafontant, 2008).

The SBW scale is structured to capture the presence of the ideology within the women. A limitation of this study is that even this scale, constructed and validated within a large black sample, may be subject to some degree of social desirability bias during completion. There are several answers on the scale that the women could possibly have perceived as a threat to a self-perception of strength. A question such as “I do not like to let others know when I am feeling vulnerable” requires the women to acknowledge a feeling that they would normally deny as it runs contrary to strong black womanhood. Examples of other questions that could be subject to social desirability include, “At times I feel overwhelmed with problems” and “I take on more responsibilities than I can comfortably handle.”

Given that the women in the sample very likely carry some level of aversion to acknowledging depression, especially when they subscribe to the SBW persona. A similar limitation of the study is likely found in the wording of the CES-D scale. Questions that are overt in their wording and intention could easily create a conflict in terms of answering with frank introspection. Some examples would be: “I had crying spells; I felt depressed; I thought my life had been a failure.”

Further research into the important relationship between SBW persona and Depression is needed. In addition, the influence of social desirability and response bias should be further investigated in terms of isolating SBW ideology in the population.

Is there a relationship between SBW ideology and emotional eating in black women? No significant relationship between the SBW and emotional eating was found within the sample. Although the SWB mean was moderately high, the EES score was low. The difference in scoring between the two variables yields less opportunity for a strong correlation to emerge, despite the relatively high SD on the SWB. One reason for the low EES score may be that the women likely may not recognize the emotions identified by the Emotional Eating scale as being connected with their urges for food at times of distress, even though studies have identified that binge eating occurs at higher rates in black populations than white ones (Triffleman and Pole, 2010). And again, the language of the scale may also have some effect due to social desirability bias. It may be difficult for a woman who identifies closely with SBW to find a comfort level in acknowledging feeling “inadequate, on edge, or helpless.”

Is there a relationship between depression and emotional eating in black women? The Research Question was supported by a weak but positive statistical result. This result is inconsistent with studies that commonly show a much higher prevalence of both depression and those showing a higher prevalence of emotional eating in black women. There are several factors that could account for the low amplitude of the score. As previously stated, it is possible response bias related to the overt questioning of the instruments could be regarded as threatening to the SWB self-image. Still another possible factor is the order in which the instruments were filled out. The women first

filled out the SWBCC, then the EES, and finally the CES-D. It is possible that filling out the SWBCC first may have brought to the forefront the principles of the persona and thus influenced responses on the EES and CES-D which followed.

Finally, it must be noted that all of the women were active members of closely bound, supportive church groups and consider themselves to be women of strong faith. It is possible that scoring on any or all three of the instruments could have been influenced by the supportive relationships within the woman's group, from the leadership of the church, and from their intrinsic faith.

The population is highly understudied in terms of these issues, and there is a gap in the literature in terms of investigating the relationship between depression and emotional eating in the Strong Black Women.

Implications for Nursing Practice

Clinical Practice. Depression in black women is frequently undiagnosed and highly undertreated, for all of the reasons this discussion has highlighted. The face of depression that is found in medical publications may not fit the black woman who is depressed. She may not realize her own depression, or if she does suspect she is depressed, she may be very reluctant to show weakness by admitting it to her health care practitioner. It behooves nurses and nurse practitioners to have a high index of suspicion for depression in black women, especially those who report with somatic symptoms. Denial, avoidance, irritation, and even indignation may be part of the initial response but those reactions may well come from fearing loss of control. Careful questioning and encouraging the woman to verbalize what she is feeling can lead to better outcomes in terms of meeting treatment needs.

Education. Cultural competency has come to the forefront of many nursing programs. However, heightened awareness alone does not increase practitioner competency in dealing effectively with actual cultural differences. As this study has indicated, black women may have increased resistance and decreased awareness of the degree and origin of their own distress. It is crucial to add to text and programs more updated information about how the mindset of differing cultures affects treatment. The strong black woman persona is an important element in treating black women – not just for obesity, but for all medical conditions. Understanding this phenomenon will increase efficacy in treatment and will likely increase collaboration and compliance from the woman.

Future Research

Further verification of the instruments is needed to assure that they are capturing the concepts we are attempting to study as efficiently as possible and that the instruments are really valid in black women. Attempting to discover if there are common stressors that may be causing the depression would be helpful in designing interventions to address patient need. There is some question as to whether the women realize depression within themselves. A future study might involve a pretest for depression, an intervention that talks about depression, denial, and perhaps somatic manifestations of depression, followed by a posttest for depression. In the same vein, a similar intervention regarding the strong black woman phenomenon may also increase the ability to detect the presence and strength of the ideology in the population. The development of effective interventions for obesity may well center on discovering through research how to design more culturally relevant approaches to the obesity fight.

Conclusions

The history of black women in America has been complicated by slavery, racism, the fracturing of the family unit, and financial instability. In many instances it is the black woman who is thrust into the role of family head in a matriarchal structure. Yet given her last place ranking in the dominant culture power structure, in many cases the matriarch is queen of practically nothing at all.

Understanding the complicated nuances of the black experience could easily take a lifetime of study. Translating those themes to instruments that can capture and measure perceptions that the women do not readily share can be a daunting task.

The SBW persona was found to be present in moderate levels in the sample group with a mean of 74 (67% of the maximum), a finding that may have been unexpected due to the fact that both the income and education of the sample was above the national average among black women and. It follows that a higher than average income and educational level would give the women of this sample group more access to support systems and thus more options to reduce perceived psychosocial stress. The fact that these women still scored at a moderate level likely indicates the continuing universality of SBW ideology within the culture.

Within this sample, both the CES-D and EES inventories produced scores lower than expected. The CES-D had a mean of 14 (23% of the maximum score) and the EES had a mean of 49 (39% of the maximum score). Whether due to increased education and income, response bias, faith and peer support or other means – somehow these women appear to be suffering depression and emotional eating at levels that are less than national studies have found in the general population. Future work must discover if the women

truly do have less incidence or if for other reasons, their levels are not being accurately captured by instrument design.

The results of the present study are of low amplitude, yet they are still significant because although they do not identify a relationship between SBW, Depression, and Emotional Eating, they do reveal a relationship between emotional eating and depression in the black women of this sample group. The level identified is low, but is still both positive and significant, indicating there is a need for further research in this area.

The study of obesity and coping behaviors in black women is growing as a research emphasis. However, empirical research about SBW ideology and its effects upon coping behaviors in black women is still in its infancy. More study is needed to understand the role of the SBW and how that persona affects the health of the women who assume that role.

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Appendix A: Participant Consent Script – Oral

Hello. My name is Michelle Offutt. I am a student at the University of South Florida. As part of my doctoral dissertation program, I am conducting a research study about Black women, emotions, and how eating might be connected. It will involve filling out a page with some general information about you, and also three surveys. You will be asked to provide your height and weight on the general information form. You do not have to tell anyone about those numbers – just fill them in on your general information sheet.

Let me tell you about the surveys. The first survey is about your attitudes towards being a Black woman. The second survey involves depression. The third survey is about how eating is connected to emotions. It should take somewhere between 30-60 minutes to finish all three parts. In return for being in the study, you will receive a WalMart gift card for shopping.

All of your responses will be confidential. You will be given a packet with all of the survey items. The surveys will remain completely anonymous. PLEASE do not place your name on the surveys. When you have finished completing the surveys, please put them back into the envelope and seal it. Then put them in this big box over here (point to box). At that time, you will receive your gift card. The envelopes

will remain sealed until all of the completed surveys are collected so that it is not possible to tell which is yours. The only people who will look at your answers will be the statistical expert and me. In any write ups or presentations I might make concerning the results, I will only report data in terms of group scores.

It is important to try to answer every question, even if you have to make a guess as to the best answer. Only complete surveys will help me towards my goal. While your cooperation in answering the questions is greatly appreciated, you do not have to answer any question that you don't want to answer for any reason. You are also free to withdraw from the study at any time. Should you decide not to participate, or should you want to withdraw without completing the study, it will in no way affect your standing with this women's group. Participation in the study is not a requirement for you to continue your group membership.

If you have any questions during the study about what something means, I'll be happy to answer them for you. If you have any questions or concerns that you would like to bring up after the study is over, feel free to contact your women's group leader, myself, or my advisor, _____. Our contact information is attached to your survey packet, and that information is yours to keep. Should you have questions about your rights as a participant of a research study, you may contact the USF Division of Research Integrity and Compliance at (813) 974-5638.

Do you have any questions you would like to ask at this time? If you would like to ask your questions privately, please feel free to come forward or signal by waving your hand and I can answer your questions privately.

Before we proceed, I need to tell you that everyone participating in the survey must be at least 18 years old. If you are not at least 18 years old, you may not complete a survey packet. Do you want to participate in the study that I have described? If so, please complete the survey packet. If you do not want to complete the survey, you may simply pass in the unused packet.

QUESTIONS OR CONCERNS?

If you have further questions or concerns, please feel free to call or email the following:

Or contact _____ through the church office.

Appendix B: Demographic Questionnaire

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

A1. What is your birthdate? _____

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

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

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

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

A6. What is your marital/relationship status (circle one)?

Single Have a Partner Married Divorced Separated Widowed

A7. What is your current height? _____

A8. What is your current weight? _____

A9. If you are currently in college, what is your classification? (Please circle. If not in college, go to A8)

Freshman Sophomore Junior Senior Graduate student

A10. If you are **not** currently in college, what is the highest education degree that you have obtained?

A. None

B. High school diploma

C. Associate degree

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

E. Bachelor's degree

F. Master's degree

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

A11. What race do you consider yourself to be? _____

A12. Think of which racial subgroup best describes you and circle the category which is closest.

A. African American

B. Caribbean American

C. Biracial (with one parent of African Descent)

D. Black Hispanic

E. Other (specify: _____)

A13. Have you ever been diagnosed with an eating disorder? _____.

A14. Have you ever been diagnosed with depression or any other mood disorder?
_____.

A15. Think of all of the income from persons who live in your home. Please circle the category (A,B,C, etc.) which is closest to your household income last year (to Jan. 1).

A. \$10,000 or below

B. \$10,000 to 19,999

C. \$20,000 to 29,999

D. \$30,000 to 39,999

E. \$40,000 to 49,999

F. \$50,000 to 59,999

G. \$60,000 to 69,999

H. \$70,000 to 79,999

I. \$80,000 or more

Appendix C: SBW Cultural Construct Scale

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

1. **I believe that it is best not to rely on others.**
Never Rarely Sometimes Frequently Almost Always
2. **I feel uncomfortable asking others for help.**
Never Rarely Sometimes Frequently Almost Always
3. **I have difficulty showing my emotions.**
Never Rarely Sometimes Frequently Almost Always
4. **I do not like to let others know when I am feeling vulnerable.**
Never Rarely Sometimes Frequently Almost Always
5. **I believe that everything should be done to a high standard.**
Never Rarely Sometimes Frequently Almost Always
6. **I am independent.**
Never Rarely Sometimes Frequently Almost Always
7. **I take on more responsibilities than I can comfortably handle.**
Never Rarely Sometimes Frequently Almost Always
8. **I believe I should always live up to other's expectations.**
Never Rarely Sometimes Frequently Almost Always
9. **I should be able to handle all that life gives me.**
Never Rarely Sometimes Frequently Almost Always
10. **I am strong.**
Never Rarely Sometimes Frequently Almost Always
11. **I need people to see me as always confident.**
Never Rarely Sometimes Frequently Almost Always

- 12. I like being in control in relationships.**
 Never Rarely Sometimes Frequently Almost Always
- 13. I cannot rely on others to meet my needs.**
 Never Rarely Sometimes Frequently Almost Always
- 14. I take on others' problems.**
 Never Rarely Sometimes Frequently Almost Always
- 15. I feel that I owe a lot to my family.**
 Never Rarely Sometimes Frequently Almost Always
- 16. People think that I don't have feelings.**
 Never Rarely Sometimes Frequently Almost Always
- 17. I try to always maintain my composure.**
 Never Rarely Sometimes Frequently Almost Always
- 18. It is hard to say, "No," when people make requests of me.**
 Never Rarely Sometimes Frequently Almost Always
- 19. I do not like others to think of me as helpless.**
 Never Rarely Sometimes Frequently Almost Always
- 20. I do not let most people know the "real" me.**
 Never Rarely Sometimes Frequently Almost Always
- 21. In my family I give more than I receive.**
 Never Rarely Sometimes Frequently Almost Always
- 22. At times I feel overwhelmed with problems.**
 Never Rarely Sometimes Frequently Almost Always

Appendix D: Emotional Eating Scale

We all respond to different emotions in different ways. Some types of feelings lead people to experience an urge to eat. Please indicate the extent to which the following feelings lead you to feel an urge to eat by checking the appropriate box.

	No desire to eat	A small desire to eat	A moderate desire to eat	A strong desire to eat	An overwhelming urge to eat
Resentful					
Discouraged					
Shaky					
Worn out					
Inadequate					
Excited					
Rebellious					
Blue					
Jittery					
Sad					
Uneasy					
Irritated					
Jealous					
Worried					
Frustrated					
Lonely					
Furious					
On edge					
Confused					
Nervous					
Angry					

Guilty					
Bored					
Helpless					
Upset					

Appendix E: Center for Epidemiologic Studies - Depression Scale

Circle the number of each statement which best describes how often you felt or behaved this way – DURING THE PAST WEEK.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of the time (3-4 days)	Most or all of the time (5-7 days)
During the past week:				
1) I was bothered by things that usually don't bother me	0	1	2	3
2) I did not feel like eating; my appetite was poor	0	1	2	3
3) I felt that I could not shake off the blues even with help from my family and friends	0	1	2	3
4) I felt that I was just as good as other people	0	1	2	3
5) I had trouble keeping my mind on what I was doing	0	1	2	3
6) I felt depressed	0	1	2	3
7) I felt that everything I did was an effort	0	1	2	3
8) I felt hopeful about the future	0	1	2	3
9) I thought my life had been a failure	0	1	2	3
10) I felt fearful	0	1	2	3
11) My sleep was restless	0	1	2	3
12) I was happy	0	1	2	3
13) I talked less than usual	0	1	2	3
14) I felt lonely	0	1	2	3
15) People were unfriendly	0	1	2	3
16) I enjoyed life	0	1	2	3

17) I had crying spells	0	1	2	3
18) I felt sad	0	1	2	3
19) I felt that people disliked me	0	1	2	3
20) I could not get “going”	0	1	2	3

Appendix F: IRB Approval



DIVISION OF RESEARCH INTEGRITY AND COMPLIANCE
Institutional Review Boards, FWA No. 00001669
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799
(813) 974-5638 • FAX (813) 974-5618

December 10, 2012

Michelle Offutt
College of Nursing
1110 49th Avenue N
St. Petersburg, FL 33703

RE: **Expedited Approval** for Initial Application
IRB#: Pro00009704
Title: The Strong Black Woman, Depression, and Emotional Eating

Dear Ms. Offutt,

On 12/8/2012 the Institutional Review Board (IRB) reviewed and **APPROVED** the above referenced protocol. Please note that your approval for this study will expire on 12/8/2013.

Approved Items:
Protocol Document(s):
[Proposal](#)

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review category:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your study qualifies for a waiver of the requirements for the documentation of informed consent as outlined in the federal regulations at 45CFR46.116 (d) which states that an IRB may approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent, or waive the requirements to obtain informed consent provided the IRB finds and documents that (1) the research involves no more than minimal risk to the subjects; (2) the waiver or alteration will not adversely affect the rights and welfare of the subjects; (3) the research could not practicably be carried out without the waiver or alteration; and (4) whenever appropriate, the subjects will be provided with additional pertinent information after participation.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

A handwritten signature in black ink that reads "John A. Schinka, Ph.D.". The signature is written in a cursive style with a large, stylized "J" and "S".

John Schinka, PhD, Chairperson
USF Institutional Review Board