December 2019

AN EXPLORATION OF THE MENTAL HEALTH HELP-SEEKING AND SELF-CARE STRATEGIES OF BLACK WOMEN: THE IMPLICATIONS FOR COUNSELOR EDUCATION, TRAINING AND PRACTICE.

Melany Jennell-Diane SIlas
Syracuse University

Abstract

Mental health is a national concern. It is estimated that 43 million adults in the United States experience mental illness in a given year (National Alliance on Mental Health, 2015). Of those 43 million adults, approximately 6.8 million people who identify as African American or Black suffer from some type of mental illness (U.S. Bureau, 2015). Black Americans experience mental health symptoms, such as depression, anxiety, and low self-esteem at alarming rates.

When addressing the concerns of mental health within the Black community, the mental health of Black women is of primary concern. Black women are more susceptible than Black men to various forms of depression and the risk factors that stem from depression such as heightened suicidal ideations **(**Pieterse, Carter & Ray, 2013; Jones & Guy-Sheftall, 2015**)**. Additionally the psychological and physical health of Black women can be impacted by the intersectional characteristics of their identities such as, race, class, gender, income, education, occupational status, religion, and sexual orientation (Boyd-Franklin, 1991; Mays, 1985; Mays, 2017; Williams, 2000).

Despite efforts within the field of counseling, Black women remain severely underserved misdiagnosed, and are the least researched within the counseling field (Borum, 2012). The purpose of this hermeneutic phenomenological study was to understand the lived experiences of Black women who have experienced mental health stress within the past year and to understand of their mental health needs, barriers to mental health care, as well as their help-seeking and self-care practices. Black women who report experiencing some form of mental health stress were solicited for participation for this study. Participants completed a demographic questionnaire, a semi-structured interview, and a post interview session with the primary researcher. Interviews were analyzed to provide insight on Black women's experience as it relates to help-seeking barriers and resources.

Findings were summarized by four themes: Perspectives of Oppression on Mental Health, Socio-Cultural Messages about Self-Care and Help-Seeking, New Perspectives about Self-Care and Help-Seeking Strategies, and Messages about Professional Counseling. Each theme was reflective the influencers of mental health for the Black women participants and the resources they perceived as valuable to managing their mental health. Implications of this study include providing information that may assist counseling practitioners and educators to understand the help-seeking strategies of Black women. This in turn may assist them in creating culturally valuable counseling strategies that may be implemented within counselor training and practice. Additional implications include providing data to improve counselor training and practice for current and future counselors. Lastly, this study may help in the transformative care for Black women in the area of mental health as well as the creation and implementation of relevant theoretical counseling strategies employed by practitioners when serving Black women.

AN EXPLORATION OF THE MENTAL HEALTH HELP-SEEKING AND SELF-CARE STRATEGIES OF BLACK WOMEN: THE IMPLICATIONS FOR COUNSELOR EDUCATION, TRAINING AND PRACTICE.

by

Melany J. Silas

B.A. University of Rochester, 1999
M.S. University of Rochester, 2001
M.Div. Colgate Rochester Crozer Divinity School, 2006

Dissertation

Submitted in partial fulfillment of the requirements for the degree of

Doctor of Philosophy in *Counseling and Counselor Education*.

Syracuse University

December 2019

Dedication

This dissertation is dedicated to my mother, Anita L. Silas, who never really got her chance to live…I take you with me everywhere I go! To my Dad, Dolphan B. McFadden, thank you for always pushing me to be my best self and speaking life over my destiny! To my Grandparents, Joseph G. and Ida M. Silas, I am more than honored to be your legacy…thank you for raising me and teaching me how to persevere! To my daughter Nyah Anita, I pray you know that all things are possible and that your capabilities are endless! I love you more than the breath I breathe.

To every Black girl and woman transitioning in an out of life's seasons…it doesn't matter where you start or even how long it takes; it doesn't matter what other people are doing or how they feel about your journey…you are your only competition…your voice is the only voice that matters…and you determine what the end will be. Fear Not…Dream Big…and Go For It!

Acknowledgments

There is an African Proverb that states, “It takes a village to raise a child.” Well I say, “It takes a village to earn a PhD!” There are so many people in my village that I would be remiss if I did not acknowledge them both individually and collectively. I don’t have bootstraps to pull myself up with, but I have a community of people who never let me down, drown, fail or fall. To my family and friends…way too many to name….thank you! Thank you for watching Nyah, listening to me vent, encouraging me along the way, lifting me up, rebuking my fears, and loving my through all of it. Thank you for being the best cheerleaders I could ever ask for. Thank you for speaking life over my destiny and purpose and for just being the core of my village. I love each of you so very much!

Thank you to my Sorors of the Rochester Alumnae Chapter of Delta Sigma Theta Sorority, Inc. Thank you for your encouragement, your love, your support and your sisterhood. I am truly a member of the absolute BEST Sorority that there is!

To my advisor, doctoral chair, colleague and big Brother, Derek X. Seward, PhD…words cannot express the level of dedication, commitment, fortitude, patience and determination that you exhibited in this 11 year journey. You were steadfast in pulling, pushing, dragging, and propelling me to the finish line with excellence. You extended grace and empathy where necessary, yet demanded quality and scholarship by any means necessary. I could not have done this without you and I am forever grateful for every ounce of energy you spent on me.

To Melissa M. Luke, PhD, thank you for being a steadfast committee member whose brilliance I certainly admire. You were the whisper that reassured me along the way, lessening my anxiety and gently challenging me to rethink, reframe and reposition my thoughts. You had this way of making me believe I had everything I needed inside of me, even when I felt otherwise. Thank

you for teaching me how to dance to my own doctoral rhythm and to find renewed strength in my legs and feet with each and every step forward.

To Jeannine Dingus-Eason, PhD, thank you for always being a big Sis/Soror. As an academic you dwell in excellence. On this doctoral journey you served as a model, teacher, advisor, coach, and drill sergeant. I could not imagine finishing this journey without you!

To my collective doctoral committee, to include the above mentioned names, along with Dawn Johnson, PhD, Kal Alston, PhD and Carrie Smith, PhD…thank you for pushing me beyond myself. You set the bar high and had the confidence that I could achieve that and more.

Thank you to the sixteen participants who volunteered to be a part of my study. Your voices are so very significant. I believe that so many Black women will be healed through your willingness to share your perspectives and experiences. Thank you will never be enough!

To my daughter, the future Dr. Nyah Anita, thank you for being the best blessing of my life. You have always been my driving force and my most treasured supporter. Just knowing that you were watching me, helped me to stay the course. I pray that you embody the same tenacity or greater to fulfill your own purpose. Whatever you set your mind to…SO IT IS!

Table of Contents

Chapter 1: Introduction

Mental health is a national concern. One in five Americans will be diagnosed with some form of mental health concern in their lifetime (National Institute of Mental Health, 2017). Poor mental health symptoms include low-self-esteem, depression, anxiety, psychosomatic disorders, and addictive behaviors (World Health Organization, 2017). The impact of poor mental health can lead to increased mental instability and suicidal ideations (National Institute of Mental Health, 2017).

Depression is the leading mental health issues in the United States (World Health Organization, 2017). According to the National Institute of Mental Health (2017), depression is defined as a condition in which persons may feel discouraged, sad, hopeless, or unmotivated. These symptoms must be present for a period of at least two weeks to be diagnosable. When symptoms of depression persist for longer periods of time, suicide can be the last resort to alleviate these feelings of depression (National Institution of Mental Health, 2017).

Another mental health issue that can be closely related to depression is anxiety. Anxiety is also a natural response to stress. The Anxiety and Depression Association of America (2019) reports that 73% of Americans report feeling ongoing stress from a variety of sources such as home, work, personal health, income worries and more. This stress can in turn be related to symptoms of anxiety, including feeling fatigue, restlessness, lack of concentration, and intense worrying (The Anxiety and Depression Association of America, 2019). Depression and anxiety are twice as likely to impact women as men, with the prevalence being higher for Black Americans (World Health Organization, 2017; Williams, Neighbors, Nesse, Abelson, & Sweetman, 2007; Carr, Szymanski, Taha, West, & Kaslow, 2014). Depression and anxiety

within Black women, can be more chronic and the symptoms more severe than their White counterparts (Anxiety and Depression Association of America, 2019).

Historically, Black Americans have been impacted by poor mental health due to racism, sexism, poverty, and social injustices (Pieterse, Carter & Ray, 2013; Carr et. al, 2014, Anxiety and Depression Association of America, 2019). Black women specifically have had significant challenges when experiencing poor mental health and are confronted with even greater challenges in finding resources to assist with mental health care (Pieterse et al., 2013). Due to the alarming rates in which Black women are impacted by mental health issues, and the documented obstacles to effective treatment, helping professionals should consider exploring ways in which this population can be better served.

The remainder of Chapter 1 will detail several ways in which Black Americans have been challenged in the area of mental health. This information pertaining to Black Americans will provide foundational support and context for thinking about Black women and their mental health needs. Additionally, a brief exploration of Counselor Education as it relates to multicultural counseling competencies are addressed. Lastly, Chapter 1 explains the research rationale, provides the research question, and explores Black Feminist and Womanist Theory as a theoretical lens for this dissertation study. Chapter 1 concludes with an introduction to Chapter 2 and glossary of terms.

Black Americans and Mental Health

Historically, mental health has been an ongoing issue for Black Americans (Williams, & Williams-Morris, 2000). Black Americans have encountered social challenges including racism, discrimination and limited access to mental health care (Heath, 2006; Snowden, 2001). Racism and racial discrimination create additional stress for people of racial and ethnic backgrounds

(Snowden, 2001; Borum, 2012). Racism has had a pervasive and adverse impact on health, specifically for some within the Black community (Williams Williams-Morris, 2000). Repeated exposure to acts of racism and discrimination can lead to experiences of trauma and can result in reduced self-esteem and internalized hatred (Beal, 2008; Mama et al., 2016). Other ailments stemming from racism and trauma include physical ailments such as a higher probability for heart issues, high blood pressure, cancers, and stroke (American Psychological Association, 2017). Counseling and therapeutic resources for Black Americans have been limited and some methods have been inefficient in addressing mental health needs (Smith, 2015).

When considering the traditional counseling therapeutic models and the implementation of such models within diverse populations, there remains a gap between what is needed and what is offered to populations of color, including Black Americans. Traditional psychology and counseling theories used within mental health fields were not created based on the multicultural values and experiences associated with racial and ethnic minority populations (Smith, 2015). Theorists ignored the influences of sociopolitical oppression, discrimination, and systemic disempowerment of the daily experiences for many racial minority groups in the U.S., including that of Black Americans (Malott & Schaefle, 2015). The influences of sociopolitical oppression have resulted in persistent mental health care and counseling challenges for Black Americans both historically and currently (Smith, 2015).

The implications of sociopolitical oppression has resulted in the compromised physical, mental, emotional, and economic state of some Black Americans. Racism and discrimination impacts heart rate and blood pressure negatively as well as increases other physical ailments among Black Americans (American Psychological Association, 2017). The effects of racial and discriminatory oppression can result in lowered self-esteem and can also induce symptoms of

depression and anxiety (Malott & Schaefle, 2015). The financial effects of racial and discriminatory oppression has historically been systemic, which has resulted in part to a lack of employment for Black Americans along with the increased probability of poverty for some Black families (Beal, 2008; Pieterse, et al., 2013). Black Americans have shown both physical and mental signs of stress due to sociopolitical oppression, which has proven to cause higher rates of chronic diseases such as hypertension and altered cardiovascular functioning (Malott & Schaefle, 2015). Additionally, Black Americans self-report having poorer health statuses, multiple manifestations of psychological stress, depressive and anxiety symptoms, as well as reduced mental well-being than their white counterparts due to sociopolitical oppression (Malott & Schaefle, 2015). The stress experienced from individual, institutional and cultural social injustices (Jones, 1997), along with limited access to mental health resources and their lack of effectiveness, negatively impact the overall mental health and quality of life for Black Americans (Nadal, 2014). Black communities need the proper mental health care and access to effective mental health resources, to effectively manage their overall wellbeing.

Historically, traditional forms of counseling such as Western - European, one to one, and office-bound sessions are sometimes incompatible with the cultural needs of clients of color, and specifically within Black communities (Smith & Wermeling, 2007). Over the past few decades the counseling profession has increased its efforts toward serving communities of color through counseling research, training, and treatment practices (Smith, 2015). However, treatment models that effectively serve Black communities are still needed (Alegria et al., 2002; Jones & Guy-Sheftall, 2015). Some Black Americans are still confronted with a number of barriers that prevent access or quality therapeutic care specific to their needs.

Research shows that clients of color tend to have higher dropout rates compared to that of their White counterparts (Jones & Guy-Sheftall, 2015). More specifically, Black Americans have even higher dropout rates as compared to other clients of color, with less successful treatment outcomes due largely to client-counselor mistrust (Smith & Wermeling, 2007). The historical medical mistreatment of the Black community such as the Tuskegee experiments and cases such as Henrietta Lacks, may also serve as a barrier for trust (Gamble, 1997; Dimaano &Spigner, 2017)**.** When looking more closely within the Black American community, there is a greater gap between responsive services and the counseling needs of Black women. Among a number of barriers, stigma surrounding mental health may play a huge role in limiting help-seeking behaviors among Black women (Snowden, 2001; Van Hook, 1999). In addition to stigma along with the lack of primary care physician referrals may also serve as a barrier to Black women receiving proper mental health services. Additionally, Black women are least likely to seek treatment from White women counselors due to feelings of being misunderstood, and a lack of trust and judgement (Anderson, Robins, Greeno, Cahalane, Copeland, & Andrews, 2006). These factors can serve as additional barriers for Black women receiving the proper mental health care needed for mental wellbeing (Gallo, Bogner, Morales, & Ford D. 2005; Skaer, Sclar, Robison, & Galin, 2000).

Black Women and Mental Health

Black women are under-researched and undertreated for mental health stress (Barlow, 2016). Black women also have high rates of psychological misdiagnosis (Barlow, 2016). High rates of misdiagnosis along with Black women being under represented in research samples may contribute to further deterioration of Black women's mental health. Black women not only endure the same societal issues of their male counterparts, but they also experience another layer

of stress due to the double marginalization of being both Black and a woman (Crenshaw, 1989; Crenshaw & Allen, 2014; Crenshaw, 2011). The impacts of double marginalization, racism, and discrimination, along with functioning within multiple communal and familial roles may leave Black women more susceptible to the negative impacts caused by these stressors without proper supports to recover **(**Pieterse, Carter & Ray, 2013; Jones & Guy-Sheftall, 2015**;** Barlow, 2016).

Black women's psychological health can be largely impacted by the multi-layered forms of identity, including race, gender, income, education, occupational status, religion, and sexual orientation (Atkins, 2004; Smith & Wermeling, 2007). Carr et al. (2014) conducted a quantitative study examining if racism was a predictor of depression on low income African American women who sought counseling. The researchers found that in Black women sexual, objectification, racism and misogyny were all related to more depressive symptoms. The multiple oppressions that some Black women face, sometimes left them feeling isolated, alienated, and rejected due to the bombardment of racism, classism, sexism, and heterosexism (Grote, Bledsoe, Wellman & Brown, 2007; Jones & Guy-Sheftall, 2015). Feelings of isolation, alienation, and rejection may be a gateway to experiencing symptoms of depression. Without effective mental health treatment, depression may be lead to decreased mental health and can lead to more detrimental forms of depression such as suicidal ideations for Black women.

Suicidal ideation can be a result from prolonged depression within any racial population. Although depression is sometimes not culturally recognized within the Black community, it is still a risk factor for Black women. Borum (2012) conducted a qualitative study examining the perception of depression, suicide risk and protective factors of Black women. Borum (2012), found that poor psychological wellbeing was the result of those who experienced disenfranchisement, loneliness, and internalized oppression. The research also found that

utilizing a Womanist theoretical framework which incorporated spiritual and communal supports were found to be protective factors, in addition to having pride in Black culture and heritage (Boyd-Franklin, 1991; Adksion-Bradley, Johnson, Sanders, Duncan, & Holcomb-McCoy, 2005; Woods-Giscombe, 2010). In terms of Black women seeking professional help, it is suggested that Black women are more likely to reach a point of crisis before seeking or receiving help, and as a result, they may receive the wrong type of services (Carrington, 2006; Borum, 2012). This may be in part, the rationale for Black women having higher risks for developing more symptoms of depression, which may place them at higher risk for suicidal thoughts, decreased mental health as well as decreased overall physical health and wellbeing.

The Center for American Progress (2013) report that Black women are more susceptible to physical health ailments such as hypertension, heart disease, stroke, HIV infection, maternal death and other chronic and communicable disease. When considering mental health disparities, Black women also suffer from depression and negative mental wellbeing more than their White counterparts (National Alliance on Mental Illness, 2005). When considering the help-seeking strategies of Black women, gaps presently exist in understanding their needs and the information necessary to inform counseling professionals on how to accurately and effectively serve this population.

The limited ways in which the counseling field understands the help-seeking strategies of Black women continue to be a barrier to them receiving the psychological care needed. Barlow (2016) estimated that only 12 percent of Black women who report experiencing stress seek help for stress, and that over 35 percent never seek treatment for mental health ailments such as depression (Barlow, 2016). Although Black women experience high rates of physical and mental health ailments, gaps in access to treatment in comparison to Black men and their White women

counterparts still remain. It is reported that Black women may be the most underserved, misdiagnosed, and undiagnosed group specifically in the area of mental health (Immerman & Mackey, 2003; Corrigan, Watson, Byrne, & Davis, 2005; Wafula & Snipes, 2014; Barlow, 2016). Additionally, barriers that further compound this problem for Black women in counseling include low access to counseling services (Alegria et al., 2002; Jones & Guy-Sheftall, 2015), counselor/client mistrust (Queener & Martin, 2001) and the lack of integration of culturally consistent values within the therapeutic session (Jones & Guy-Sheftall, 2015). It has been and continues to be evident that there are gaps in addressing the needs of Black women. Moreover, there has been a lack of resources, and a lack of culturally relevant therapeutic strategies that Black women value to counteract the psychological stress that they endure daily (Jones & Guy-Sheftall, 2015; Jones, 2015).

The lives of Black women are varied and may encompass a variety of factors that may influence mental stress. Mental stress may stem from balancing family, occupational, and community responsibilities. These factors alone may increase the susceptibility to depression and other mental health issues (Abrams et al., 2014; Jones & Guy-Sheftall, 2015). Additionally, the internalization of societal stereotypes and negative concepts of womanhood for Black women may also be contributors to mental health ailments deriving from stress (Jackson & Green, 2003). For example, Black women endure negative media projections of their beauty, as well as disparaging stereotypes that influence societal norms of their worth, which may increase the likelihood of Black women experiencing elements of mental health stressors that are specific to their identity as Black women (Adisa, 1990). Adisa summarized this experience:

> Stress is hemmed into their dresses, pressed into their hair, mixed into their perfume and painted on their fingers. Stress from deferred dreams, the dreams not voiced; stress from

> the broken promises, the blatant lies; stress from always being at the bottom, from never being thought beautiful, from always being taken for granted, taken advantage of; stress from being a Black woman in a White world. (pp 13-14)

Some Black women may also find themselves overwhelmed by the oppression that stem from within their communities. Black women can overextend themselves attempting to meet the needs of family and community, falling into the Strong Black Woman Schema stereotype (Heath, 2006; Seward & Luke, 2019). The Strong Black Woman Schema is characterized as inherently requiring a sacrifice of leisure time and self-care, while braving the varied struggles of life, which impacts mental, emotional, spiritual, and physical health (Heath, 2006; Comas-Diaz & Greene, 1994; Seward & Luke, 2017). Poussaint and Alexander (2000) assert that "the great strength that has allowed Black people to survive slavery and discrimination, and the notion that black women can easily handle burdens that would psychologically crush others, has been oversold (p.102)." Cultural images such as the Strong Black Woman Schema may also serve as barriers and negatively influence the mental health of Black women. Therapeutic strategies that account for and address the historical and cultural stressors of Black women are needed.

Historically, Black women have relied on cultural and spiritual elements for therapeutic healing. Theorists have suggested that Black women need Black Feminist and Womanist strategies that are culturally familiar and acceptable resources for healing, including using religious and spiritual leaders for counseling, communal groups, and sister circles (Adksion-Bradley, et al., 2005; Taylor, Ellison, Chatters, Levin & Lincoln, 2000; Molock et al., 2007). Some researchers attest to Black Feminist and Womanist theory being a valuable tool in counseling which speaks to the cultural influences valued by Black women (Rogers, 2017). These theories centralizes the voices and experiences of Black women as a measure to provide

validation and honor to their multidimensional lives (Rogers, 2017). Although theorists suggest that counselors should partner with communities of color to establish trusting relationships, much more work needs to be done to bridge these relational gaps (Adksion-Bradley et al., 2005; Taylor, Ellison, Chatters, Levin & Lincoln, 2000; Molock et al., 2007). Gaining trust through spiritual and religious gatekeepers might position counselors to appropriately meet the needs of some Black women (Williams & Frame, 1999). To better help Black women manage the impact of stress, counseling practitioners may need to reconsider their multi-layered cultural identities and experiences of Black women (Adksion-Bradley et al., 2005; Thomas, Witherspoon, & Speight, 2008; Woods-Giscombe, 2010). Creating and developing culturally relevant strategies along with collaborating with historically relevant sources of healing for Black women may be transformational not only for the mental health of Black women but for the growth and development within the counseling field itself.

Attempts to Address Cultural Issues in Counseling

The counseling field has made efforts to address the psychological and mental health needs of communities of color. Over the past 40 years, several theories have been developed and implemented to further integrate multicultural strategies into counseling practice (D'Andrea & Heckman, 2008). Theorists have thought about new ways of integrating multicultural strategies in counselor education, and clinical practice (D'Andrea & Heckman, 2008), in the hopes of expanding knowledge, developing new and effective skills, and increasing the awareness of practitioners within the counseling field. These contributions have initiated discussions within the counseling profession to think more broadly about multicultural counseling, and how to increase research related to the empirical implementation of the conceptual strategies (Jones, 2015; Constantine, Hage, Kindaichi, & Bryant, 2007).

Foundational efforts of education and training around multicultural strategies were focused on implementing Multicultural Counseling Competencies (MCC) (Arrendondo et al. 1996; Sue, Arredondo & McDavis, 1992). MCC's were believed to be necessary for counselors to effectively work with diverse cliental. There were three areas of competency: (1) counselor awareness of their own biases; (2) counselor knowledge of client worldviews; and, (3) counselor skill to deliver culturally aligned interventions (Malott & Schaefle, 2015, Arrendondo et el., 1996, Sue, Arredondo & McDavis, 1992). Ideally, mastery in all three areas of competency can better serve clients of color. However, further work in MCC is still needed to effectively understand diverse client's worldviews, their lived experiences and what they believed is needed for mental wellbeing.

Theorists found that counselor knowledge of client worldview should be expanded to include an understanding of the interactions of sociocultural identities of clients of color and how their identities influenced the counseling process (Leach, Aten, Boyer, Strain & Bradshaw, 2010). Sociocultural identities include race, ethnicity, economic status, ability, religion, spirituality, gender, and sexual orientation. Counselors should not only have theoretical competence but should have historical and current sociocultural awareness and knowledge of the experiences of communities of color (Malott, 2010). Counselors should also be aware of racist and inhumane treatment of communities of color within medical institutions and health facilities that may impact counselor – client connectedness (Gamble, 1997; Dimaano &Spigner, 2017). In doing so, counselors can facilitate trust and comfort with a display of awareness regarding historical incidents leading to present day issues of inequity. Additionally, counselors should have knowledge and awareness of the significance of race, racial privileges/oppressions, White norms, personal biases, and systemic racism, and have the skills to implement cross-racial case

conceptualization into counseling practice (Ridley, 2005, Sue, Nadal, Capodilupo, Lin, Torino, G., & Lin, 2008).

Counselors and researchers could think more on how to expand their studies and strategies as well as examine the effectiveness of their current practices when addressing the needs of underserved and unrepresented populations (D'Andrea & Heckman, 2008). Although the Multicultural Counseling Competencies (Arrendondo et el., 1996, Sue, Arredondo & McDavis, 1992) were instrumental in moving the profession of counseling toward a more culturally aware practice, there was still a growing need to address a more inclusive and broader understanding of culture and diversity that incorporated intersectionality (McCall, 2005). Recently, Multicultural and Social Justice Competencies in Counseling (Ratts et. al, 2016) were established to address the intersectionality of client identities and sociocultural experiences. Within this new theoretical lens, counselors are called to (1) understand the complexities of diversity and multiculturalism in the counseling relationships; (2) recognize the negative influence of oppression on mental health and wellbeing; (3) understand individuals in the context of their social environment; and, (4) integrate social justice advocacy into practice (Ratts et al., 2016). While the MCSJCs have generated considerable attention, there remains a need to examine the experiences of Black women in light of if, how, where, and when MCSJCs are evidenced in practice.

Counselors have been encouraged by professional counseling organizations and education programs to draw from a multicultural counseling framework that will assist them in meeting the needs of their clients who suffer from issues surrounding discrimination and racism rather than from traditional theoretical models (Cates & Schaefle, 2010). Some traditional counseling theories may influence counselors to view diverse client's experiences as pathological

or delusional instead of acknowledging and affirming their lived experiences of racism and discrimination (Clarkson & Nippoda, 1997). The impact of oppression and marginalization for communities of color has proven to be a factor in mental health stress and has caused psychological injury (Marlott & Schaefle, 2015).When clients are forced to prove or defend their experiences within the counseling experience, it may further complicate their ability to heal and compound their trauma. Additionally, multicultural approaches have been developed to tend to the counselor – client relationships with the attempt to bridge the gaps that may exist in other approaches.

Theoretical approaches, such as Relational-Cultural Therapy (Bryant-Davis & Ocampo, 2005b; Malott & Schaefle, 2015), focus on the effects of normative or prescribed social roles such as race, ethnicity, and gender, as well as the client-counselor relationship as the central foundation of healing for the client (Comstock, Hammer, Strentzsch, Cannon, Parsons, & Salazar, 2008). In addition to Relational-Cultural Therapy, a Trauma Informed Care framework (Bryant-Davis & Ocampo, 2005b; Malott & Schaefle, 2015) allows counselors to recognize historical and ongoing experiences of racism as traumatic for communities of color. General trauma-based techniques can be used to explore the impact of trauma and foster healing for the client (Bryant-Davis & Ocampo, 2005b; Malott & Schaefle, 2015). Although models such as these aim to assist counselors to be more effective in practice with communities of color, it is still unclear or unknown how these models meet the needs of clients of color specifically or how counselor training translate to professional counseling for communities of color.

Effective counselor training may also be necessary to successfully implement multicultural strategies in counseling practice (Cates & Schaefle, 2010)**.** Historically, counseling programs have covered multicultural issues in counseling through a single course (Dinsmore &

England, 1996). Studies show that single course models were not sufficient in establishing an understanding of multicultural competency (Holcomb-McCoy, 1999; Cates & Shaefle, 2010). The current model in multicultural training does not provide counselors with a breadth and depth in skillset where they could feel confident in practicing (Cates et al., 2007). Additionally, the concept of infusing multicultural strategies within all components of the counseling training has been discussed, however, past research shows that infusion of multicultural strategies has occurred in small percentages within Counseling programs (Cates & Schaefle, 2010). Increased training, competency and comfort level of practitioners are needed to effectively transform the counseling experience for clients of color.

Efforts to increase training and embed multicultural counseling competencies in practicum and internship courses has been suggested, however, the implementation of these suggestion has been lacking within counseling programs nationally (Cates & Schaefle, 2010). Recently, the incorporation of cinema education was used to supplement students' multicultural training and lack of diversified learning environment (Shen, 2015). This was an attempt to meet the requirements of professional accreditation organization such as American Psychological Association (APA, 2013), the American Counseling Association, the Council for Accreditation of Counseling and Related Educational Programs (2014), requiring counseling practitioners and counseling training programs to be more diverse in their cultural learning experiences, to be more culturally sensitive, mindful and skillful (Shen, 2015). Although attempts to address multicultural competencies have been made over the past 40 years, therapeutic strategies continue to be less effective for populations of color collectively. Lastly, counselors have been encouraged to make better community connections with populations of color.

The United States Census Bureau (2012) predicts that with the next 30-40 years, racial and ethnic minority groups will make up the majority of the American population. Continuing to ignore social and racial disparity in mental health for underserved populations can be devastating. Socioeconomic deprivation and racial discrimination have been associated with higher psychological distress and these communities are two times more likely to be at risk for experiencing poor mental health (Smith, 2015). More specifically traditional counseling practices have ignored the influences of sociopolitical oppression, discrimination and systemic disempowerment for Black Americans (Smith, 2015). Similarly, the lived experiences and multilayered identities of Black women has not been effectively addressed within the counseling field or within multicultural counseling training and practice (Williams & Wiggins, 2010; Beal, 2008). It is imperative for counselors to be aware of the social injustices that permeates the lives of some clients of color, particularly Black women.

Despite multicultural counseling training and practice efforts, Black women may still remain underserved, misdiagnosed and under-researched and most psychologically impacted population (Immerman & Mackey, 2003, Corrigan et al., 2005 & Barlow, 2016). The need for a therapeutic practice that speaks to the specific needs of Black women is paramount. Utilizing a theoretical framework to meet the mental health and cultural needs of Black women may be beneficial.

Black Women's Theoretical Framework

Black Feminist and Womanist Theories through the lens of Standpoint Theory, provide an opportunity for Black women to voice their needs to facilitate healing. Standpoint Theory derives from the notion that social position informs knowledge (Collins, 1990). Using a theoretical framework such as this, shifts the focus from historical traditional counseling

theories, to one that centralized the voices of the marginalized, which may assist helping professionals to close the gaps in meeting the mental health needs of Black women.

Black Feminist Theory.

Black Feminist Theory emerged from a thought that traditional Feminist perspectives did not speak to or for the lived experiences of Black women (Collins, 1990; Collins, 1996; Williams, 2005; Jones & Guy-Sheftall, 2015; Williams &Wiggins, 2010**)**. Black Feminism challenges the traditional feminist assertion that it represents and speak for all women. The need for a platform was necessary to speak to the multidimensional and multilayered lives of Black women (Frame & Williams, 1996; Jones, 2015). Scholars argued that Feminist thought and theory excluded and devalued the realities of Black women and therapeutically could not meet their needs (Collins, 1990; Brown, 2010; Jackson & Greene, 2003). Black Feminists assert that Feminist theories can stem from racist practices which tend to focus on the lives of white-middle class women and excludes Black women's experiences (Comas-Diaz, 2011). Black feminist scholars challenged the status quo of feminist theory and therapy to include elements of race, class, and sexual orientation along with the development of Black feminist perspectives (Boyd-Franklin, 1991; Mays, 1985; Williams, 2000). Additionally, Black Feminist Theory challenges Feminism to address forms of marginalization and discrimination (Guy-Sheftall, 1995).

Black Feminism challenges traditional counseling methods of healing that focus on White, male-centered, middle class, heterosexual normative counseling and speaks to the multidimensional lived experiences of Black women (Jackson & Greene, 2003). Black Feminism reshapes the therapeutic process to address and advocate for psychological methods and practices that speak to the multiple oppressions that Black women face (Sparks & Parker, 2000). It is grounded in the concept of the intersectionality of Black women's' experiences as both Black and

woman while navigating inequities and inequalities surrounding race, gender, capitalism, oppression, political activism and consciousness (Combahee River Collection Statement, 1977). Black Feminist practices emphasize changing the narrative of Black women from negative societal images and assist them in raising awareness and consciousness regarding their socially constructed identities (Boyd-Franklin, 1991; Braun Williams, 2000; Heath 2006; Jones & Guy-Sheftall, 2015)**.** Black Feminism is the interchangeable voice that gives validation and authentication to the cultural, spiritual, and historical lives of Black Women (Rogers, 2017).

Therapeutically, it is suggested that Black Feminism can be used to provide a safe space in which Black women can form their own narratives (Williams, Frame, & Green 1999). Theorists also assert that empowering Black women to create strategies to navigate successfully around structural and systemic constraints of life can help them reach a place of healing (Jones, 2015; Jones & Guy-Sheftall, 2015). Black Feminists suggest the development of therapeutic practices and methods that meet the needs of Black women which can be imperative to their improving mental health (Young, Wiggins-Frame, & Cashwell, 2007). In doing so, Black Feminist therapeutic strategies foster elements of resilience and a feeling of empowerment which decrease the impacts of psychological stress and promote positive well-being (Young, Wiggins-Frame, & Cashwell, 2007; Woods-Giscombe, 2010).

Womanist Theory.

Coined by Alice Walker (1983), Womanist Theory centralizes the voices and experiences of Black women as a measure to provide validation and honor to their multidimensional lives (Rogers, 2017). Womanist Theory is suggested as an alternate strategy in the counseling field to meet the needs of Black women's mental health. Womanism conceptually integrates the cultural, spiritual and communal components that are relevant in the lives of Black women to bring them

to a place of wholeness and healing (Few, 2007). The theory also highlights the importance of community as a survival strategy for Black women (Williams, Fame, & Green, 1999). Additionally, Womanist theory acknowledges the historical experiences of some Black women utilizing internal and communal sources of wellbeing such as self-determination, community, and social responsibility (Collins, 1990).

Like Black Feminist Theory, Womanist Theory challenges the notion that Feminist Theory speaks for all women regardless of race and ethnicity (Few, 2007). Womanist scholars support therapeutic interventions that promote and emphasize the need for affirmation of Afrocentric values as well as the need to self-define and self-evaluate (Collins, 1991). The use of storytelling, spoken word, music, art and spiritual techniques are central themes embedded in the conceptual strategies of Womanist practice and should be integrated into therapeutic interventions (Hills-Collins, 1991). Scholars further assert that a Womanist worldview stems from a both/and model of existence (i.e. black and female) of Black women instead of an either/or state of being (Williams, Frame, Green, 1999). The focus on interdependence, interconnectedness of heritage, history, and community are vital to the therapeutic process (Borum, 2012). In essence, Womanist Theory provides an intersectional framework as one of its foundational components (Settles, 2006; Settles et al, 2008). Womanist theoretical strategies and techniques should be considered as viable options and incorporated into mental health training and counseling practice to serve Black women (Few, 2007; Jones & Guy-Sheftall, 2015).

Rationale for Study

Research suggests that many contemporary therapeutic models may be culturally inappropriate and inadequate to meet the multifaceted mental health needs of Black women (Jones, 2008). Scholars have agreed that the mental health field must address and rethink

practice models, discuss culturally based theoretical strategies, and incorporate multicultural conceptual strategies into training in order to meet the needs of Black women (Lum, 2010; Comas-Diaz, 2011; Sue & Sue, 2013). Counseling practices and interventions that consider the lived experiences and needs of Black women may help to better serve this population collectively (Husband, 2000; Jones & Guy-Sheftall, 2015). Currently, within the counseling field, research focused on Black women tends to focus on specialized populations such as those who are drug addicted, HIV infected, domestic violence victims, impoverished or college students (Jones & Guy-Sheftall, 2015 Alang, 2016; Borum, 2012). Additionally, there a lack of empirical studies that explore the lived experiences of Black women concerning their mental health or self-care. There remains a need to implement Womanist and Black Feminist strategies that provide an opportunity for Black women to voice their lived experiences and cultural values as it pertains to their mental health needs (Jones, 2015, Jones & Guy-Sheftall, 2015; Barlow, 2016).

Purpose of Study

The purpose of this study was to understand the lived experiences of Black women's mental health and their help-seeking practices. Help seeking practices could include social, cultural, religious, professional, personal or clinical resources that Black women intentionally engage to reduce stress related symptoms. The study explored the impact of stressors on their mental health, the resources practiced and valued by Black women participants and the impact of those resources on their mental health and wellbeing. Additionally, this study explored the current self –care strategies and the barriers to those strategies as voiced by Black women. Lastly, the study provided the opportunity for Black women to talk back to the counseling profession with suggestions on how to better provide access to services to Black women as well

as voice their unmet needs that counselors should consider. Exploring the voiced experiences and needs of these participants may be helpful in designing Black Feminist and Womanist strategies that better meet the mental health needs of Black women. This research study, selected participants that identified as Black women, were18 years old and older, and had experienced any form of mental health stress within the last year. A hermeneutic phenomenological approach was used to explore how Black women perceived their experiences as Black women and their understanding as to how their experiences influenced their mental health. This phenomenological approach was selected to understand the self-care resources and strategies used, including the use of clinical counseling as it considers the socio-cultural and historical influencers that contribute to decision making of Black women.

Reflexivity Statement

Qualitative research is interpretative research and therefore requires explicit identification of reflexivity (Creswell & Creswell, 2017). The researcher gave considerable thought to her own experiences and identified her position or experiences that were related to the overall study and with the participants (Creswell & Creswell, 2017, Tesch 1990). The researcher's positionality as a Black woman along with other aspects of her identity that may have coincided with that of participants provides a foundational interest as to why the researcher conducted the study. The researcher identified as a Black woman. She earned a Bachelor Degree in Health & Society, a Master's Degree in Counseling and Human Development, and a Master's Degree of Divinity. She is a tenured Professor at a two-year institution and over the years she has been active in her community serving as a minister, a playwright, an educator, and a motivational speaker. Her interest in both the mental and physical health of Black women and the self-care and help-

seeking strategies speak to her educational, professional and religious background. All of these factors may beneficial to the overall study.

Research Design and Questions

Phenomenology focuses on the human experience as it is lived, with a particular focus on the smaller aspects of lived experiences (Laverty, 2003; Polkinghorne, 1983). Hermeneutic phenomenology focuses on the essence of being human, and also pays particular attention to the historical, social and cultural background of the human experience. Hermeneutic phenomenology highlights a person's cultural, social and historical aspects of their identity, which influence their perception and ways of knowing and experiencing themselves and the world around them (Koch, 1995). Hermeneutic phenomenology rests on a concept called pre-understanding, which means that one cannot separate themselves from and must always be considered within the understanding and exploration of historical, social and cultural experiences (Koch, 1995).

Following this phenomenological approach, this study explored the meaning making of events in the lives of Black women as it relates to their mental health and self-care practices. Hermeneutic phenomenology required the researcher to focus on the meaning that participants provided to describe their own experiences as they understand themselves (Bynum & Varpio, 2018). This focus was especially important in exploring the lives of Black women's mental health stressor, valued resources that produced positive mental health, current self-care strategies and barriers to those self-care strategies. Womanist and Black Feminist Theory suggest that only through the voiced experiences of Black women can relevant practices and strategies be developed to address their cultural and intersectional needs (Jones, 2008; Thomas et al., 2008; Woods-Giscombre, 2010).

When considering research on Black women, the hermeneutic phenomenological approach corresponds with Black Feminist and Womanist perspectives in that the experiences of participants and the meaning making of those experienced, voiced by participants was paramount to both the research method and theories that guided the research. Womanist Theory centralizes the voices and experiences of Black women to provide validation and honor to their multidimensional lives while taking account their historical, social and cultural selves (Rogers, 2017). Empirical data gathered from this phenomenological research study may provide insight into incorporating valued resources and strategies in counseling training and practice to better serve Black women in the area of mental health. Womanist theory is guided by the foundational premise to understand participants through their cultural values. Thus, the Womanist theoretical framework mirrors the goals of the hermeneutical phenomenology method.

Hermeneutic phenomenological research corresponds with Black Feminist Theory in that it searches for a more in-depth understanding and insight of everyday experiences of its participants while exploring the various factors that influence their sense of being (Morrisette, 1999). Hermeneutic phenomenology centralizes the lived experience of participants and invites them to share their understanding of those experiences (Jardin, 1990). Black Feminist theory explores ways to reconstruct negative self-images of Black Women and provide tools to raise awareness and consciousness of their socially constructed identities (Boyd-Franklin, 1991). Black Feminism is the interchangeable voice that gives validation and authentication to the cultural, spiritual, and historical lives of Black women (Rogers, 2017).

The three guiding questions that this study explored are:

1. In what ways are Black women's mental health stress influenced by their experiences of being a Black women?

2. What perceived barriers do Black women believe exists that may prevent them from help-seeking or employing self-care?
3. What methods of help-seeking do Black women employ to help manage their mental health stress?

This research study provides a space for Black women to voice their own experiences as it relates to mental health stressors and the impact of those experiences. Additionally, the study explored participant valued resources, self-care strategies, barriers to those strategies and counseling experiences. This research may help to identify culturally relevant resources that are not currently used to better serve Black women. Additionally, this research may identify barriers that perpetuate the lack of treatment and misdiagnosis of Black women within the mental health field. Overall, data from this research may provide information that may provide more resources and access to resources in the area of mental health for a population which is currently underrepresented in research.

Although Black women born in the United States and Black women who represent the diaspora may display differences culturally, they also represent different voices and ways of knowing as described through Womanist theory. Therefore, the term Black women are used to describe African American women and Black women of the diaspora respectively. The next section will include a glossary of terms provided to assist in the exploration and further understanding of Black women's help seeking strategies.

Glossary of Terms

The following terms will be used throughout this dissertation.

Black Women – For this paper, Black Women is used to represent African American or as Black women who represent the diaspora, who currently reside within the United States.

Black Feminism – Was birthed from a notion that Feminist perspectives did not speak to or for the lived experiences of Black women. Black Feminism challenges the traditional feminist assertion that it represents and speak for all women (Jackson & Greene, 2003).

Black Self-Love – Black Feminist scholars, collectively define Black Self-Love as "the healthy love for ourselves, our sisters and our community which allows us to continue our struggles and work" (Pough, 2003).

Intersectionality - Concepts that paradigms such as race, class and gender cannot be understood as categories of identities that function independently of one another but rather thy are mutually constituted (McCall, 2005; Shields, 2008). It is this concept that identities are organized at the complex intersection of both membership and meaning (Wilkins, 2012).

Poor mental health - Symptoms include low-self-esteem, depression, anxiety, psychosomatic disorders, and addictive behaviors. Concerns the issues of medical maintenance, spirituality, culture and ethics (Heath, 2006; World Health Organization, 2017).

Racism – The beliefs, attitudes, and individual and systemic approaches that degrade people based on the color of their skin that is the deployment of power against groups perceived as inferior at both institutional and individual levels and through intentional and unintentional actions (Jones, 1997; Williams & Williams-Morris, 2000; Graham et. al, 2016).

Self-Care - In health care, self-care is any necessary human regulatory function which is under individual control, deliberate and self-initiated. Some, place self-care on a continuum with health care providers at the opposite end to self-care. In modern medicine, preventive medicine aligns most closely with self-care (Barnett, Baker, Elman, Schoener, 2007).

Stigma – An attribute that is deeply discrediting and incongruous with our stereotypes of what a given type of individual should be. (Goffman, 1963, p.3; Campbell & Mowbray, 2016).

Strong Black Woman Syndrome – A stigma associated with Black women insinuating a sacrifice of well-being both physically and mentally. It is associated with carrying a heavy load often at the expense of wellbeing (Heath, 2006).

Womanist Theory – Coined by Alice Walker (1983), Womanist Theory centralizes the voices and experiences of Black women as a measure to provide validation and honor to their multidimensional lives (Rogers, 2017).

Chapter Summary

Chapter 1 explored the proposed study's rationale, which is to understand the lived experiences of Black women, the impact of mental health and their help-seeking practices. It provided an overview of the needs of the Black community, specifically that of Black Women and their mental health needs and help seeking strategies. Chapter 2 will review literature relating to Black women and mental health, along with definitions and terms that correspond with the study. Chapter 2 reviews the conceptual and empirical literature with specific attention to research that speak to the current dissertation study. Within the critical review of core research, this chapter explores the gaps and limitations within the literature, and provides suggestions for further study.

Chapter 2: Review of Literature

Chapter 2 explores the conceptual and empirical literature around the mental health of Black Women. The historical effects of racism and discrimination that have resulted in adverse physical, emotional and economic impact on the Black community. Due to the intersectionality of their lived experiences, Black women experience depression and other mental health issues at higher rates than Black men and their white counterparts (Mama et. al., 2016; Pieterse et al., 2013). Although efforts within the counseling field have attempted to meet the counseling needs of people of color by rethinking Multicultural Counseling practice and training (Lum, 2010; Comas-Diaz, 2011; Sue & Sue, 2013), gaps between counseling strategies and those that are relevant to communities of color still remain. The mental health care of Black women in particular are still needed as this population continues to be underserved within the counseling field (Barlow, 2016).

This chapter will explore the concept of the "Strong Black Woman" schema and the role it has played in the lives of Black women from past to present (Heath, 2006). It also explores the historical and cultural impacts of mental health on the Black community with specific attention to Black women. A review of the counseling resources that are available and accessible to Black Americans and Black women specifically, will be explored. Finally, theoretical perspectives that focus on the voiced experiences of Black women are summarized to establish the connection between the articulated research problem and that of the proposed research study. Topics that are covered include stigma, cultural barriers, historical and current social barriers along with multicultural counseling perspectives and practices. The review of literature and research within this section will assist in exploring the theoretical, historical and empirical lens that will guide the research study.

A Mental Health Overview of Black Americans

Historically, from slavery until present day, Black Americans have been subject to inhumane treatment, severe psychological stressors, racism, discrimination, and severe social, economic, and health disparities with little or ineffective supports (Pieterse et al., 2013). When assessing the mental health of Blacks, Mama et al., (2016) found that low social status and low social support were associated with increased levels of perceived stress, depressive symptoms, and perceived racial discrimination. This quantitative study used questionnaires on psychosocial factors to include: stress, depressive symptoms and racial discrimination to assess social environment, and psychosocial factors of 1467 Black men and women using a Perceived Stress Scale, Center for Epidemiologic Studies Depression Scale, the Day to Day Unfair Treatment Scale, and Medical Outcome Survey. The study suggests that resource poor environments predict poor mental health. Additionally, these psychosocial factors (depressive symptoms, stress, and racial discrimination) significantly impacted the overall mental health wellness of Blacks. Mama et al. (2016) also found that for Black Americans with higher socio-economic status and education, chronic psychosocial stressors including depressive symptoms continued to impact the health and well-being of Black Americans, which deemphasized the role of their socioeconomic position. More consideration and research is needed to explore the psychosocial impacts of mental health for Black Americans. However, there is a greater need to study the implications specifically for Black Women. Although research on the mental health of Black Americans is noteworthy, some do not give the necessary attention to the differences in mental health between Black men and women (Thomas, 2004; Heath, 2006) which is significant in addressing the mental health needs of Black women specifically. These difference may also

indicate a difference in the ways in which counseling practitioners address the needs of Black women.

A Mental Health Overview of Black Women

When discussing the mental health of Black women, there is much work to be done in understanding how Black women navigate negative influences such as racism, sexism, socio-economic and community stressors. Research suggests that Black women generally do not seek professional counseling or help as a means to manage their stress (Borum, 2012; Watson & Hunter, 2015). On average, it is estimated that only 12 percent of Black women who experience mental health stressors such as depression, enroll in treatment services to reduce symptoms (Fripp & Carlson, 2017). This means that 88 percent of Black women who could benefit from mental health services have an opportunity to receive them. Barriers such as lack of economic resources, cultural mistrust, and lack of primary care physician referrals and lack of pastoral referrals are some of the factors that contribute to the lack of services received by Black women (Borum, 2012; Merritt-Davis & Keshavan, 2006; Watson & Hunter, 2015; Silas, 2011).

Additionally, cultural factors play a key role in ethnic groups decisions to seek psychological services (Obasi & Leong, 2009; Watson & Hunter, 2015). These same cultural factor differences may also determine the help-seeking behaviors of Black women. Cultural values, beliefs, and practices within the Black community, have both positive and negative influences on the mental health of Black women (Coker, 2004; Heath, 2006). A variety of cultural and social factors influence Black women's experiences inform and impact their mental health. An ascribed and internalized personal need to be self-reliant and strong may lead to self-silencing as a response to stress (Heath, 2006; Watson & Hunter, 2015). Black women endure multiple oppressions that are associated with racism, sexism, and classism (Grote, Bledsoe,

Wellman, & Brown, 2007; Jones & Sheftall, 2015). The intersectionality of being both Black and woman, along with varying levels of class may influence the overall mental health of Black women (Heath, 2006).

Black women report experiencing alienation and isolation associated with their intersectional identified "isms" (Boyd-Franklin, 1991; Jones, 2008; Woods-Giscombe, 2010, Jones & Guy-Sheftall, 2015). Chang (2017) conducted a quantitative study to explore gender differences in loneliness and adverse affective conditions such as depression and anxiety in a sample of 168 Black American college students. The authors found that gender was a moderator for feelings of loneliness and depression. Black women were found to be more anxious and depressed when lonely than Black men. Traits such as loneliness may have more of a negative impact on the overall mental health of Black women than that of Black men. Research suggests that positionality of Black women in society may leave them vulnerable to increased discrimination and sexism and might contribute to the increased levels of loneliness (Chang, 2017). Chang (2017) describes Black women as having a double minority identity to explain the intersectionality of their existence. The study results suggests that interventions that speak to the cultural and social aspects of Black women should be considered to help to mitigate their feelings of loneliness and depression and protect overall mental health. Limitations of the study reflects the findings from college-age students and may not represent Black women in careers with more life experiences. Research exploring the experience of Black women with higher levels of education and more life experience than that of traditional college age students may yield differing results.

Factors associated with discrimination, racism, stigma, and cultural expectations combined with other barriers, such as limited access to mental health facilities, and mistrust,

contribute to Black women's absence in mental health treatment (Sutter & Perrin, 2016; Pattyn et al, 2014; Fripp & Carlson, 2017). Stressors as it relates to racism, discrimination, and health are generally derived from an intersection of social roles such as race, class, age and gender (Maddox, 2013). If exposed for long periods of time, acute stressors can cause severe problems in both mental and physical health (Maddox, 2013). Historically, Black communities have been identified as a population that has been exposed to a history of chronic stress due to discrimination and racism (Maddox, 2013, Carr et.al, 2014). Because Black women have played an integral role in the survival of the Black community, the chronic stress of discrimination and racism may impact them in ways that have gone unaddressed. Although not yet explored in the literature, acknowledging the impact of chronic stress within Black communities may provide an understanding of the lived experiences and the impact of stress on Black women. Future research understanding the lived experiences of Black women will be pivotal in creating the necessary and adequate services to support the mental health and wellness of Black women.

Perceived racism and discrimination in the United States has had an adverse impact on the mental health, the physical wellbeing and the overall life dissatisfaction Black women (Cokley, Hall-Clark, & Hicks, 2011; Borum, 2012). Maddox (2013) investigated the psychological distress of 133 Black and White professional women and 360 non-professional women. Using the Kessler Six (K6) Psychological Distress Scale to assess emotions such as: sad, nervous, restless, hopeless, worthless and feeling as every effort was exhausting). Another one item scales measured the association between perceived discrimination, workplace racial composition, psychological distress, life satisfaction, and job dissatisfaction. Maddox (2013) found that professional Black women had a significant correlation between job dissatisfaction and race as compared to non-professional Black women. Maddox (2013) suggests that when a

decrease in the frequency of discrimination transpires, it increases the positive mental health experienced among professional Black women. The study also identified the need for more research exploring the mental health of Black women with higher socioeconomic status. Overall for both black and white women, professional and non-professional, discrimination impacted mental health. However, Black women professionals although having experienced high levels of job dissatisfaction, did not have higher reports of discrimination. Maddox (20130, suggests that Black women with higher socioeconomic status are less likely to report discrimination, to secure financial security, although discrimination exists. The reality of Black women masking weakness with strength as a model of resiliency along with self-silencing further confirms the need for specific cultural strategies to help Black Women address mental health needs. Maddox (2013) suggests further research on the perceived stress of Black women with higher SES and the impact on mental health.

Professionally, Black women who work in predominately White professional environments are subject to higher levels of mental health stress (Jackson & Stewart, 2003; Maddox, 2013). Even with increased educational, economic, and social status, Black women are plagued with stress, feel overburdened, over-extended, and may be incapable of recovering from the stress that impacts them (Heath, 2006). Professionally, some Black women may be confronted with being the only racial and gender minority within their work environment, which may also contribute to isolation and psychological stress (Maddox, 2013). Stress from harassment, exclusion, racial profiling, stereotyping, and as being perceived as inferior within their workplace can be a barrier for Black women professionally (Hall, Everett, & Hamilton Mason, 2012; Maddox, 2013). Few studies have investigated the professional level and socio-economic status of Black women and how this impacts mental health or how stress attributes to

poor mental health (Maddox, 2013). Research exploring the lived experiences of Black women within higher education and professional statuses may be needed. Results may provide empirical support on the impact of stress on the mental health of professional Black women.

Mental Health Stigma and the Black Community

Stigma devalues a person's sense of sense of worth and creates unique stressors on the psychological and emotional wellbeing (Major & O'Brien, 2005; Hatzenbuehler et al., 2009). Stigma contributes to more illness and physical ailments in Black Americans than any other racial group (Hatzenbuehler et al., 2009). For Black Americans, stigma may serve as a barrier to seeking therapeutic services. Perceived stigma with the client counselor relations can cause barriers such as mistrust which can hinder mental health treatment (Campbell & Mowbray, 2016). Fripp and Carlson (2017) conducted a linear regression quantitative study on 126 Black and Latino Americans to assess how their attitudes influenced their help seeking behavior. They found that stigma significantly impacted help seeking behaviors and compromised the likelihood of minority clients completing counseling sessions. Black and Latino clients are at high risk for lack of participation in counseling session as well as for premature treatment drop-out and termination of mental health services. Lack of participation is attributed to mistrust, stigma, misdiagnosis and feeling culturally misunderstood (Lester, Resick, Young-Xu, & Artz, 2010; Fripp & Carlson, 2017). Limitations of this study include lack of assessment differences between Blacks and Latino clients along with no distinct data for Black Women within the Black American population. Although studies may account for commonalities between Black and Latino clients, Black men and women may be impacted differently by socio-historical accounts of stigma (Fripp & Carlson, 2017). Research exploring the distinct experiences of Black women

and the impact of stigma may be necessary to understand possible barriers to professional counseling.

Black Women's Theoretical Framework

Black Feminist and Womanist Theories through the lens of Standpoint Theory is the proposed theoretical lens for this dissertation study. Standpoint theory's theoretical perspectives centralizes the experiences and emphasizes the perspective of Black women. (Collins, 1990, hooks, 2016; Barlow, 2016). This theory serves as a foundation to explore Black women's mental health. These approaches were developed with the intention of hearing Black women and exploring their lived experiences and from their standpoint (Heath, 2006; hooks, 2016; Barlow, 2016). This dissertation study will explore the help-seeking strategies and cultural influences that influence mental health.

Black Feminist and Womanist Theories have suggested conceptual strategies that can be integrated into therapeutic practice when serving Black women (Nash, 2013). Both theories incorporate culturally relevant strategies that reflect the multidimensional experiences of Black women. The following section reviews Black Feminist and Womanist Theories. The foundational principals of both theories along with the concepts of Black Self-Love emerging from Black Feminist Theory will be explored. Lastly, suggested benefits of each approach will be discussed along with perceived gaps in caring for the mental health of Black women.

Black Feminist Theory

Black Feminist Black Self-Love.

The concept of Black Self-Love emerged from Black Feminism as a strategy to heal and empower Black women psychological and communally (hooks, 2016; Barlow, 2016). Black Self-Love is a conceptual strategy that Black Feminists suggest using within research to get

empirical data (Nash, 2013). The traditional concept of self-love is transformed from the external love of others to the practice of personal self-love (Jones & Sheftall, 2015). Black Feminist Theory suggests that Black Self-Love is a personal act of social justice (Nash, 2013) and self-care (Barlow, 2016) mitigating mental health stressors (Jones & Guy Sheftall, 2015). The Combahee River Collective (1983), comprised of Black Feminist scholars, collectively define Black Self-Love as "the healthy love for ourselves, our sisters and our community which allows us to continue our struggles and work." (p. 267**)** It is a message and therapeutic practice which propels the idea of self-empowerment and focuses on Black women redefining themselves from the negative images of society (Pough, 2003). Black feminist scholars such as Patricia Hill Collins, Chela Sandoval, Traci West and bell hooks, suggest the use of Black Self-Love in therapy (Collins, 1991; hooks, 1981; Nash, 2013). These scholars argue that the love of black women by self and by other Black women is in and of itself a political and therapeutic act: "According to this scholarly tradition, love is a politics of claiming, embracing, and restoring the wounded Black female self" (Collins, 2004, p.250).

Additionally, Black Feminist Theory argues that "personal is political," (Jones & Guy-Sheftall, 2015, p. 346). Black Feminist Theory speaks to the multifaceted experiences of Black women that are both personal and communal. Black Feminism speaks to the need for both individual and societal transformation for any long-lasting healing to occur, addressing change through a political, economic and social justice lens (Rogers, 2017). Black Feminism addresses structural and systemic issues of access and affordability of care (Jones, 2015; Nash, 2013). Black Feminists suggest that counselors employ Black Feminist strategies within therapeutic practice as well as address issues such as the cost for services, accessibility, minimization of power differentials, acknowledging and validating Black women's experiences. It is necessary

for counselors to recognize the multiple layers of oppression that some Black women face to ensure proper treatment and diagnosis (Jones, 2015).

Black Feminist strategies for counselor practice have been mostly conceptual in nature. Strategies have been used in specialized communities such as substance abuse clients. Roberts, Jackson and Carlton-LaNay (2000), used Black Feminist strategies combined with substance abuse treatment, to explore the impact of negative images of Black women such as "Mammy," "Matriarch," and "Jezabel," that demean and devalue the identity of Black Women. Using the Conscious Raising technique, participants explored and employed Black Feminist strategies to redefine themselves as a strategy of Black Self-Love and empowerment. Research in the field of counseling should use Black Feminist strategies to explore conceptual strategies within the mental health and treatment of Black women (Jones & Sheftall, 2015). This dissertation study has explored the mental health of Black women as they experience social and cultural stressors that may impact their psychological and emotional wellbeing. This research may provide insight into the types of oppressions that Black women believe influence their wellbeing and that may serve as barriers to help – seeking behaviors.

Empirically, there have been limited research studies to examine the effectiveness of Black Feminist strategies integrated into practice. (Jones, et al., 2005; Ward, 2015; Williams, 1999; and Woods-Giscombe, 2008). Suggested themes that include Black Feminist therapeutic interventions involve employing strategies that include spiritual agency, community, self-determination, and empowerment through interpersonal connection (Lani, 2014). Black Feminist strategies confront pervasive mental health factors impacting Black women such as emotional isolation, stress, and internalized oppression (Wilkins, 2012).

Additionally, when addressing the needs of Black women, culturally relevant models of training and practice must be developed from a health-promoting behavior perspective (Borum, 2012). At present, limited research on specialized populations employing Black Feminist strategies exist with counselor practice to support Black women's mental health (Rodgers, 2017; Jones 2015; Lani, 2014). With empirical data lacking, the counseling field may further marginalize an already underserved population in the area of counseling and mental health.

Womanist Theory.

Womanist Theory is suggested as an alternate strategy in the counseling field to meet the needs of Black women's mental health. Womanism conceptually integrates the cultural, spiritual and communal components that are relevant in the lives of Black women to bring them to a place of wholeness and healing (Few, 2007). Womanism also highlights the importance of community as a survival strategy for Black women (Williams, Fame, & Green, 1999). Williams, Frame, and Green (1999), suggests that strategies for therapeutic intervention such as bibliotherapy, bible stories, group counseling, narrative counseling and other community resources might be helpful for Black women. These strategies encourage Black women to use their worldview and insight to create new ways of behaving, feeling, and being (Williams et al., 1999). Group counseling and community resources are suggested to be culturally and spiritually relevant in the lives of Black women, with the goal of empowering (Williams et al., 1999). Many studies that have used Womanist methods include strategies such as ethnographies, narrative work, music, prayer and spiritual supports (e.g., church groups, women's groups, etc.); however, these studies are limited to specialized groups such as domestic violence victims, drug abusers, homeless women and college students (Roberts, Jackson & Carlton –LaNey, 2000; Braun-Williams, 2000; Borum

2012). While these conceptual strategies are beneficial to the helping profession, the implementation of those strategies are limited and under researched to date.

Black Women & Stigma

Historically, race, class, and gender have been used to manipulate, control, and systemically justify unequal and inequitable social arrangements (Collins, 2004; Wilkins, 2012). Likewise, stereotypical constructs of Black women as matriarchs, mammies, welfare mothers, and jezebels have controlled the global images and perceptions of Black women, which has in turn, justified persistent racial oppression (Collins, 2004; Wilkins 2012). As a result, Black women have been misconstrued as being inferior, sexual deviants, aggressive, violent, and less intelligent (Health, 2006). Black women have been confronted with these types of demeaning and dehumanizing images which may cause them to struggle to make sense of their own experiences and identities (Wilkins, 2012). The intersection of their identities, coupled with systemic social barriers, may create more difficulties to break out of stereotypical roles that have been historically assigned to Black women (Collins, 2004; Wilkins, 2012).

Black women are constantly reminded of their lack of value, as it has historically been and continues to be projected through mainstream images and messages about beauty (Comas-Diaz & Greene, 1994; Heath, 2006). The constant bombardment of White, European American standards of beauty verses the inferiority of Black beauty can have adverse impacts on Black women and their sense of self-worth (Brown & Keith, 2003; Brown et al., 2003; Heath, 2006). Black women experience varying degrees of mental health stress associated with racism, stigma and negative social images. When addressing issues of inferiority and low self-worth within therapy, some Black women experience feeling dismissed as if their concerns are figments of their imagination or an exaggeration of their experiences (Nechas & Foley, 1994; Heath, 2006).

The stress of a devalued identity may negatively impact the mental health of Black women (Miller & Kaiser, 2001, Hatzenbuehler, Nolen-Hoeksema & Dovidio, 2009). The devalued perception by counselors of Black women, can play a crucial role in deterring Black women from seeking mental health treatment (Pattyn, Verheaeghe, Sercu, & Bracke, 2014, Fripp & Carlson, 2017). Black women need safe spaces where they can feel valued and empowered to create and embody their own narratives. Audre Lorde (1982) states it best, "If I didn't define myself for myself, I would be crunched into other people's fantasies for me and eaten alive." (p.140). It is a necessity for Black women to define themselves, for themselves. A core factor of healing for Black women may be within their ability to describe their lived experiences, along with identifying their mental health needs and care needed to heal and thrive, which was the aim of this study.

The Strong Black Woman Schema

The Strong Black Woman Schema **(**Davis, 2015**)** has traditionally ascribed Black women as the matriarch of the Black family. The Strong Black Woman Schema suggests that Black women are considered the foundation and glue that maintains and uplifts the Black community, church, and family (Heath, 2006). This matriarchal role implies that Black women possess a social and political power that does not match the reality of many lives (hooks, 1981; Heath, 2006). hooks (1981) assert, "The designation of the Black woman as a matriarch is a cruel misnomer because it ignores the profound traumas that Black women must have experienced when they had to surrender their child-bearing to alien and predatory economic interest" (p. 72). Although the concept and role of The Strong Black Woman Schema derives from slavery, its current cultural relevance denotes the type of perseverance needed to survival that Black women had to employ for generations.

Historical concepts of Strong Black Woman derive from North American chattel slavery and the rationalization that Black women were superior in strength, both psychologically and physically, to that of white women and equal to that of Black men (Harris-Lacewell, 2001; Jones, 1982; Abrams, Maxwell, Pope & Belgrave, 2014). This historical narrative served the majority conscious of Americans and further solidified the social and unjust behaviors and images of Black Women. For hundreds of years systemic, cultural, institutional barriers and other oppressive barriers have divided Black families and created infrastructures almost impossible for Black communities to survive (Abrams et al., 2014; Collins 2005, Schiele, 2005). The U.S. Census (2010) report that 50.4% of all Black children lived in a single mother household. These circumstances along with increased violence in neighborhoods, higher unemployment rates and high incarceration and murder rates of Black men have debilitated the overall progression of this community and forced Black women to survive through a role of strength and self-sufficiency (Woods-Giscombe, 2010; Abrams et al., 2014). Black women have been forced to work multiple jobs as they try to maintain their homes and parent their children (Watson & Hunter, 2015). These types of survival strategies are built on mental, physical, emotional, spiritual, and behavioral sacrifices, including help-seeking for mental health stressors. Black women's determination to survive has sometimes relied on the Strong Black Women Schema to fuel their internal drive for survival, but at a significant cost.

A central component of identity and womanhood for Black women is this notion of strength and the ability to conquer oppression and difficult circumstances (Abrams, Hill, Maxwell, 2018; Woods-Giscombe, 2010; Watson & Hunter, 2015). This quote of Marcia Ann Gillespie speaks to the sacrificial, aspects of the Strong Black Woman Schema, identifying its existence from slavery to present day:

> She is fearless foremother: Harriet [Tubman] stealing back into the pit of slavery boldly leading us to freedom; Sojourner [Truth] the abolitionist refusing to be cowed…She's that mama men love to brag about who sacrificed all for them. The do it all mother, always on call, raising children, sustaining households, working both outside and inside the home…the community mother…the determined sister…we have named her "Strong Black Woman. (Parks, 2010, p. viii)

The Strong Black Woman Schema internalizes the concept that Black women can bear all of life with their physical and mental health intact (Comas-Diaz & Greene, 1994, Heath, 2006). This assumption is detrimental to the overall health and wellness of Black women. Watson and Hunter (2015) conducted a quantitative study with 95 Black women to understand if their concept of the Strong Black Woman Schema produced more anxiety and depression. The study also investigated whether participant's thoughts around seeking psychological counseling, impacted their stress and anxiety levels. Research found that the Strong Black Woman Schema produces adverse psychological outcomes for Black women such as difficulty regulating emotions, which includes self-silencing. Self-silencing has been linked to increased distress and rumination which may increase risks for depression. Additionally, the authors found that perceived stigma from seeking psychological therapeutic resources caused participants to experience anxiety. Addressing concerns of stigma and shame for Black women may assist in decreasing anxiety in help-seeking behaviors. Data stemming from this proposed dissertation on the lived experiences of Black women addressing their perceived barriers could assist clinicians building strategies to help to dismantle these types of barriers of mental health care. Research on help-seeking disparities along with an understanding of how stressful life experiences influence

help-seeking behaviors would be transformational in the types of care created for Black Women and may influence Counseling training and practice.

The Strong Black Woman Schema is not the only term that exists in describing this concept of super humane abilities of Black women. Terms such as Super Woman and the Sojourner Truth Syndrome also denote a sacrificial sense of being of Black women (Wallace, 1990). Abrams, Maxwell, Pope and Belgrave (2014) conducted a qualitative study to understand the multidimensionality of Black womanhood as described by their participants. Eight focus groups were separated by participant age which coincided with possible life experience. The**y** used interpretive paradigmatic framework to explore the thoughts, perception and beliefs of Black women. The analysis helped to understand the varied roles of Black women characterized through schemas such as the "Super Women Schema," "The Strong Black Woman Schema" and the "Sojourner Truth Syndrome" and its connection with mental health. The paradigm maximizes subjectivity by understanding the world through the personal experiences of others as a participant rather than a spectator. The paradigm allows the researcher to engage and be involved in the research process which mimics that of the participants. The study found that Black women embraced these schemes and related them to their identities and responsibilities as Black women.

The study also found that positive associations with these schemas were used as coping mechanisms and contributed to participant resilience. Resilience, is seen as a protective factor against depression (Abrams et al., 2014). While this study discusses the positive impact of these schemas, long-term impacts from operating within these schemas may also negatively impact psychological and physical health due to lack of self-care. Limitations include, the use of focus group rather than individual interviews, the geographic location of the participants, and participants understanding of the concept of Strong Black Women. Abrams et al., 2014

suggested conducting a study to explore how the identification of these schema influence self-care health promotion, health compromising and help-seeking behaviors of Black women. The proposed dissertation research study will conduct individual interviews exploring the self-care and help-seeking strategies of Black women.

Some Black women feel an intense sense of obligation to uphold the matriarch or Strong Black Women Schema when serving family and community and can experience a greater sense of isolation and negative impact on their mental health (Abrams et al., 2018; Heath, 2006, Woods-Giscombe, 2010). Although the concept of the Strong Black Woman schema communicates self-sufficiency, invulnerability, and perseverance while coping with racial and gender oppression, the overall impact can be detrimental to the mental, emotional and physical health of Black women (Bryant-Davis & Ocampo, 2005). Exploring the internal and cultural obligation of Black women to function within this schema is one of the core rationales for this proposed study and is vital to understand Black women's perspective of their own experiences in addition to their current mental health needs.

Black women can experience a sense of failure if they do not meet the standards of the Strong Black Woman Schema (Watson & Hunter, 2014; Woods-Giscombe, 2010; Watson & Hunter, 2015). A need to fit this Strong Black Woman standard may further impact their psychological well-being (Watson & Hunter, 2015). Feelings such as "weak" or "failure" as it relates to this cultural aspect of womanhood and identity may also contribute to behavior patterns of not seeking help in moments of mental distress (Watson & Hunter, 2014; Watson & Hunter, 2015). It may also speak to a cultural fear of being stigmatized if psychological services are needed (Watson, & Hunter, 2015). These types of cultural barriers may also interfere with Black women employing other methods of self-care.

Black women functioning under burdens with this idea of invincibility are a cause of concern for their overall psychological and physical wellbeing (Woods-Giscombe, 2010). Perceptions of Black women as superwomen or unbreakable contributes to self-neglect and pervasive stress (Abrams et al., 2014). Perceived stress in Black women is linked to chronic stress, which has a direct correlation to severe psychosocial risk factors such as cardiovascular disease, high blood pressure and increased heart rate (Williams & Cashion, 2008; Woods-Giscombe, 2010; Abrams et al., 2014). Focusing on the needs of others and not on the needs of self, transfers this perceived communal strength into a personal weakness. Conversely, if Black Women forego communal and familial responsibilities the impact may be further detrimental to both Black women and the people they love. This proposed study seeks to not only explore the experiences of Black Women as they perceive their realities, but may also answer these conflicting thoughts of communal care and self-care.

Black women have used the Strong Black Woman Schema to exhibit strength and self-reliance in response to stressors (Beauboeuf-Lafontant, 2007; Black & Peacock, 2011; Woods-Giscombe, 2010; Watson & Hunter, 2015). This cultural belief that Black women are obligated to serve in multiple roles and possess the ability to support community, family, and church independently, may leave Black women in a much more vulnerable and destructive space, with little or no thought of self-care (Abrams et al., 2014; Parks 2010). Employing the Strong Black Woman Schema may leave Black women feeling as though self-care, counseling and other forms of self-preservation, are just luxuries compared to the necessity of keeping family and community together (McConnell, Renaud, Dean, Green, Lamoreaux, Hall, Rydell, 2005; Abrams et al, 2014). Historically, some Black women have employed culturally based social supports such as sister circle spirituality, prayer and community connectedness as a coping mechanism

rather than traditional counseling services (Borum, 2012; Carrington, 2006; Waite & Killian, 2008; Bryant-Davis & Ocampo, 2005).

Exploring concepts such as the Strong Black Woman Schema and its influence on Black women is vital to understanding self-sacrificing and self-silencing behaviors and the impact it has on help-seeking behaviors of Black women. (Abrams et. al, 2014). The current dissertation study may assist in understanding valuable cultural norms perpetuate current barriers for Black women seeking non-cultural forms of care such as counseling. It may also provide cultural suggestion that can be combined with traditional counseling strategies to enhance the counseling experience of Black woman. Transforming the therapeutic experience for Black women may increase their help-seeking behaviors, increase culturally relevant resources, lower their rates of misdiagnosis and build trust within the counseling process.

Black Americans and Professional Counseling

Black Americans have a high rates of chronic depression and physical ailments caused by depression (World Health Organization, 2017; Williams et al., 2007; Carr et al., 2014). Alang (2016) conducted a 12-month ethnography on mental health in a predominately Black disadvantaged neighborhood in the mid-west. The purpose of the research was to explore whether participants responded too, or described experiencing depression as it is clinically defined. Researchers found that Black participants within the study did not respond to or describe depression as it is defined clinically. Expressions of depression as seen within the study did not mirror the traits identified by the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013). Participants in the study discussed the need to be strong for family and that depression was a sign of weakness and would not be recognized. The research also implied that other contributing factors increase the likelihood of

depression or poor mental health within Black communities, such as poverty and unemployment. The findings suggest the need for client-centered treatment that corresponds with the culture and needs of the client. Noted in the study's limitations was the need for further research around how age, gender, education, current and past mental health services used might produce varying findings. This study did not account for the differences between black men and black women, which further silences the needs and care of Black women who may have layering responses to depression. The proposed dissertation study seeks to account for gender, education, current and past mental health services usage in exploring the mental health of Black women.

When Black participants do seek psychological care, they tend to receive poor quality care and their mental health needs continue to go unmet (Ward & Brown, 2015; Jones & Sheftall, 2015; Heath, 2006; Watson & Hunter, 2015). Black participants are more likely than Whites to have higher rates of attrition, especially when treatment is not culturally relevant (Ward & Brown, 2015). There is a growing body of culturally relevant treatment for clients of color that may one day meet their needs (Ward & Brown, 2015), yet for Black women specifically, research informing relevant treatment is still needed.

Black Women and Professional Counseling

Despite the negative impact of depression in the lives of Black women, studies show that Black women have a low rate of employing medical or psychological care (Ward & Brown, 2015). The impact of mental health stressors remains a source of concern for Black women. As mentioned in Chapter I, Black women are underrepresented in research and have a high rate of misdiagnosis (Barlow, 2016). Borum (2012) conducted a qualitative study to explore suicide, depression and the protective factors against suicide in the lives of Black women. The study conducted with 40 participants enrolled in a predominately White University. The study explored

this phenomenon using a Womanist intersectional framework to understand the behaviors, coping mechanism and protective factors that Black Americans use to heal and love themselves and to commune with others (Borum, 2012). Borum found that Black women use spirituality and elements of a womanist framework to combat feelings of depression and ideations of suicide. The theme "Know Thyself" (P. 323) emerged where participants mentioned the use of Black Self-Love which provided strength to push forward through times of difficulty (Borum, 2012). Implications for practice included providing space for Black women to define themselves as well as their own mental health needs.

It is vital that future research include a Womanist framework that may mediate the dialogue between Black women and mental health professionals. This may dismantle barriers within the clinical session that may exist and impede the overall counseling process for both the counselor and the client (Barlow, 2016). The literature notes that some counseling practitioners may present patterned responses when serving Black patients, regardless of their circumstances (Pieterse et al., 2013). Not being heard or understood may be a rationale that may lead to mental health misdiagnosis of depression, over-diagnosis of schizophrenia, and over-medication of Black women (Barlow, 2016; Heath 2006). This awareness, ability, and willingness of therapist to manage their cultural inadequacies are paramount to effectively serve the mental health needs of Black women as well as to establish trust within therapy sessions (Toldson & Toldson, 2001; Health, 2006). The lack of cultural awareness and training has been a constant concern for serving the Black community in general and the Black women specifically (Coker, 2004; Abernethy, 2006; Toldson & Toldson, 2001, Heath, 2006). The use of intentional cultural dialogue, and a Womanist or Black Feminist theoretical lens within counseling practice may be

transformational in caring for Black women and may mirror the valued historical traditions they value.

Conclusion

This chapter provided the foundational support needed for this dissertation research study. The literature calls for more culturally relevant opportunities for Black women to be aware of themselves and to speak to that awareness. Distinguishing the needs of Black women from that of Black men and their White women counterparts is essential to further understand the needs of Black women. Despite the efforts of the counseling profession in creating culturally sensitive counseling theories, there is still a need for strategies that focus on the centered perspectives of Black women that speak to the inner working of their identities and the cultural and social factors that influence and their self-care and help-seeking behaviors. Chapter 3 outlines the methodological framework that was used to explore the phenomena of mental health and help-seeking strategies of Black women. Creswell & Creswell (2017) data collection, data analysis and data interpretation research steps were used in this hermeneutic phenomenological research study.

Chapter 3: Methodology

The purpose of this phenomenological dissertation study was to explore the impact of mental health stressors and the help-seeking and self-care practices of Black women. A phenomenological approach was used to explore how Black women perceive *being* a Black woman and how those experiences influenced their mental health. Additionally, this phenomenological method of inquiry was used to understand the meaning making of Black women's experiences as well as to explore their valued resources. This chapter details the rationale for employing this particular research method and explains the research process.

Hermeneutic Phenomenology: Research Approach

Hermeneutic phenomenology is a qualitative methodological approach that focuses on the human experience as it is lived, with a particular focus on the historical, social and cultural background of participants (Laverty, 2003; Polkinghorne, 1983). Hermeneutic phenomenology recognizes a person's cultural, social, and historical aspects of their identity, which influence their perception and ways of knowing and experiencing themselves and the world around them (Koch, 1995). Hermeneutic phenomenology rests on a concept called pre-understanding, which means that one cannot separate themselves from and must always be considered within the understanding and exploration of historical, social and cultural experiences (Koch, 1995). The researcher's interpretation of data must involve an understanding of a person's historical and cultural development, and its influence on identity (Polkinghorne, 1983).

Hermeneutic phenomenology seeks to understand how participants make meaning of their experiences as they relate to the world with significant consideration of the cultural, historical, and social aspects of their being (Koch, 1995). This dissertation study was designed to explore the meaning and events in the lives of Black women as it relates to mental health and the

stressors that impacted their mental health positively or negatively. Hermeneutic phenomenology requires the researcher to focus on the meaning that participants ascribed to their own experiences as they sought to understand themselves in relation to phenomena (Bynum & Varpio, 2018). This focus is especially important in exploring the lives of Black women. Womanist and Black Feminist scholars (Jones et al., 2005; Thomas et al., 2008; Woods-Giscombre, 2010) suggest that only through the voiced experiences of Black women can relevant practices and strategies be developed to address their cultural and intersectional needs. Hermeneutic phenomenology was the most appropriate method for this study because it considers the historical and socio-cultural aspects of the participants which may impact the ways in which Black women address their mental health needs.

Participants

Phenomenological research suggests 2-10 participants are needed to reach saturation, which refers to reaching a point in data analysis where no new themes emerge for the researcher (Creswell & Creswell, 2017; Polkinghorne, 1989; Hayes & Wood, 2011). Sixteen women, who met the study inclusion criteria, agreed to participate. Participants were recruited via snowball sampling (n=2) after initial forms of recruitment such as using email blasts (n=9), and social media posts (n=5). All participants self-identified as Black and one participant self-identified her ethnicity as Jamaican. The participants ranged in age from 18 to 79 years old. All but one participant self-identified as heterosexual, while one participant did not indicate a sexual orientation. Participants' education level ranged from Skilled Trades to Doctorate degrees. Most of the participants (n = 13) held earned college degrees, with the remaining participants possessing a high school diploma (n=2) and a skilled trade degree. In terms of income, participants reported having income under $20,000 to over $100,000. All participants self-

reported that spirituality had some importance in their lives with 14 participants reporting that it was a very important component within their lives.

Participant Summaries

Agnes, Participant 1, is 43 years old, resides in Greater Riversedge, and identifies as a heterosexual, Black woman. She is married with children and her husband suffers from schizophrenia. She has earned a Master's Degree and her annual income is $40,000 - $59,000. She considers spirituality very important in her life. She reports having experienced mental health issues such as anxiety, and depression within the last year. Her response to her mental health issues over the past year has been over working herself. She has received counseling in the past and has had 1-3 sessions overall, and reports that the counseling was not helpful. Agnes stated, "This therapist told me that I needed to write my worries down on a sticky note and put it in a jar. I was even more anxious just thinking about all of my worries being in one place where I could see them. It was not helpful." Agnes reported that she is unsure what would prompt her to seek or consider professional counseling. She defined mental health, self-care and help-seeking in the following ways, "Mental health is being able to effectively manage and process feelings. Self-Care is just that…taking care of yourself and Help-Seeking is being able to get help when needed."

Fancy, Participant 2, is 48 years old, resides in Greater Riversedge, and identifies as a heterosexual, Black woman. She is married with two sons and two daughters. She has earned a doctorate degree and her annual income is $80,000 - $99,000. She is employed as an administrator in education. She considers spirituality very important in her life. She reports having experienced mental health issues such as anxiety, stress and grief within the last year. The types of resources used over the past year in managing her mental health has been: talking to

someone, taking time to relax, doing something that makes her smile or makes her feel happy. She has never received counseling and reports what symptoms needed to be present for her to consider counseling. She stated, “I would need to be at my breaking point.” She defines mental health, self-care and help-seeking in the following ways, “Mental Health is making sure you are healthy through your mind and thinking. Self-Care is taking care of one self. Taking care of your body physically and mentally treating your body well, and Help-seeking is going to someone or someplace for support.”

Tammy, Participant #3, is 43 years old, resides in a suburb of Greater Riversedge, and identifies as a heterosexual, Black woman. She is divorced with 4 children. She has earned a bachelor degree and her annual income is $40,000 - $59,000. She is employed as a case worker for an educational agency. She considers spirituality very important in her life. She reports having experienced mental health issues such as depression and eating disorder within the last year. The types of resources used over the past year in managing her mental health have been prayer and talking with someone. She has received counseling in the past with 4 -7 sessions overall. Tammy reports that the counseling was helpful in that “it helped me prioritize the clutter in my head.” Tammy reported that the following symptoms were necessary for her to consider professional counseling, “I felt like I was drowning.” She defines mental health, self-care and help-seeking in the following ways, “Mental health is the state of emotional well-being. “Self-care is time for me and Help-seeking is going out to find help.”

Nicole, Participant 4, is 33 years old, resides in Greater Riversedge, and identifies as a heterosexual, Black Jamaican woman. She is single with no children. She is an entrepreneur, owning two businesses. She has earned a high school diploma and her annual income is over $100,000. She considers spirituality very important in her life. She reports having experienced a

mental health issue such as anxiety within the last year. The types of resources used over the past year in managing her mental health have been taking time off from work, delegating some of her responsibilities, limiting caffeine intake, meditation, improving her diet, practicing mild exercise, getting 6-8 hour of sleep per night, talking to trusted people, and improving her time management. She has never received counseling in the past. Nicole reports that the following when asked when she would consider seeking professional counseling, "I believe that even if there are no physical symptoms there may still be underlying issues. I think it will be a benefit to sort through my thoughts and emotions with a professional." She defines Mental health, Self-care and Help-seeking in the following ways, "Mental health is a person's state of psychological and emotional wellbeing. Self-care is regularly investing time in mental, spiritual, emotional, financial and physical activities that improve my overall health and Help-seeking is researching or asking for guidance and/or assistance from others who are skilled in an area of need."

LadeeTee Participant 5, is 44 years old, resides in a suburb of Greater Riversedge, and identifies as a heterosexual, Black woman. She is divorced with one son. She assists clients with claims for an insurance company. She has earned a Bachelor Degree and her annual income is $40,000 - $59,000. She considers spirituality very important in her life. She reports having experienced mental health issues such as anxiety, depression (clinical or non-clinical) and grief within the last year. The types of resources used over the past year in managing her mental health have been prayer, attending church, journaling, self-reflection, and health social interactions (community) in the form of female relationships. She has received counseling in the past having had more than 12 sessions overall; however LadeeTee reports that the counseling was not helpful. She stated, "In my opinion it was often limited to me just talking about my frustrations without providing ample solutions or tools to help me implement changes behavior or better

perceptions. LadeeTee reported that the following symptoms must be necessary to consider professional counseling, “Inability to focus or concentrate, a strong feelings of failure or hopelessness.” She defines mental health, self-care and help-seeking in the following ways, “Mental health is the state of well-being as it pertains to the mind, and the regulated way that a person’s thoughts life maintains a certain level of sanity. Self-care is the act of paying close attention to one’s own individual needs and then responding in a way that provides those specific needs to ensure mental, emotional and physical support, and Help-seeking is the conscious choice to pursue and obtain assistance where it is needed.”

Free, Participant 6, is 49 years old, resides in Greater Riversedge, and identifies as a heterosexual, Black woman. She is single with no children and works in Education. She has earned a Bachelor Degree and her annual income is $60,000 - $79,000. She considers spirituality something important in her life. She reports having experienced mental health issues such as anxiety, depression, grief and panic disorder within the last year. The types of resources used over the past year in managing her mental health have been social withdrawal, professional counseling, confiding in close friends, meditation and self- reflection. She also self-soothes with treats, uses shopping, and works on personal projects/goals to manage. She has received counseling in the past and has had more than 12 sessions overall. Free reports that the counseling was helpful. She identified the following symptoms to consider professional counseling, “Feelings of depression or if I notice I am in a constant state of anger/dissatisfaction.” She defines mental health, self-care and help-seeking in the following ways, “Mental health is a personal state of emotional well-being. Self-care is intentional actions to ensure personal emotional well-being and Help-seeking is actions taken to enlist others to assist in the pursuit of personal emotional well-being.”

Brandi, Participant 7, is 43 years old, resides in a Greater Riversedge, and identifies as a heterosexual, Black woman. She is married with three children and works as a program coordinator. She has earned a bachelor degree and her annual income is $40,000 - $59,000. She considers spirituality very important in her life. She reports having experienced a mental health issue such as anxiety. The types of resources used over the past year in managing her mental health has been: support systems, prayer, and going to see a medical doctor. She has never received counseling in the past. Brandi did not report any necessary symptoms in order to consider counseling. She defines mental health, self-care and help-seeking in the following ways, "Mental health is your state of wellbeing as it relates to your mind. Self-care is taking the proper measures to take care of yourself as it relates to getting the proper amount of rest, taking vacations, relaxing, eating healthily, etc. Help-seeking is a person's attempt to acquire assistance to deal with their mental state outside of themselves."

Jael, Participant 8, is 33 years old, resides in Greater Riversedge, and identifies as a heterosexual, Black woman. Jael is married with one child and she works in program director. She has earned a master's degree and her annual income is $40,000 - $59,000. She considers spirituality very important in her life. She reports having experienced mental health issues such as depression, and grief. Jael describes the types of resources used over the past year in managing her mental health, "I have a very supportive husband and family. I am also very rooted in my faith and have Jesus Christ as my anchor for mental and emotional stability." She has received counseling in the past and reports having engage in approximately 8-11 sessions. Jael also reports counseling was helpful in graduate school and during her premarital sessions when she needed assistance with anxiety that stemmed from the transitioning from one state to another. Jael reported that the following symptoms must be present to consider counseling,

"Unmanageable anxiety." She defines mental health, self-care and help-seeking in the following ways, "Mental health is mental and emotional well-being and stability. Self-care is protected time to rebalance and refresh my whole being (mind, body and spirit) and "Help-Seeking is a process of reaching out for help to address mental health needs."

Nicki, Participant 9, is 37 years old, resides in Greater Riversedge, and identifies as a heterosexual, Black woman. She is single with no children and works in education as a program coordinator. She has a master's degree and her annual income is $40,000 - $59,000. She considers spirituality very important in her life. She reports having experienced mental health issues such as depression, grief and stress. The types of resources used over the past year in managing her mental health has been: talking to people, listening to music, and keeping engaged in activities. She has never received counseling in the past. Nicki reported that the following symptoms must be present to consider counseling, "Being in a depressed state and not feeling like myself. I'm actually looking into seeing a therapist." She defines mental health, self-care and help-seeking in the following ways, "Mental health is a person's mental and psychological wellness. Self-care is what is being done by a person to make sure they are in a good place mentally and physically. Help-seeking is looking for different resources that can assist you."

Miki, Participant 10, is 50 years old, resides in Greater Riversedge, and identifies as a heterosexual, Black woman. She is single with children and works in education. She has earned a bachelor's degree and her annual income is $40,000 - $59,000. She considers spirituality very important in her life. She reports having experienced a mental health issue related to grief within the last year. The types of resources used over the past year in managing her mental health have been prayer, and talking with loved ones and friends that could relate. She has received counseling in the past and has had more than 12 sessions overall and reports that the counseling

was helpful. Miki stated that “depression” must be present for her to consider professional counseling. She defines mental health, self-care and help-seeking in the following ways, “Mental health is a person’s condition with regard to psychological and emotional wellbeing. Self-care is when you take time to take care of your individual mental, physical and emotional need, and Help-Seeking is when a person looks for help from professionals, peers and family.”

Laura, Participant 11, is 72 years old, resides in Greater Riversedge, and identifies as a heterosexual, Black woman. She is a widow and has a son. She works in higher education. She has earned a master’s degree and her annual income is over $100,000. She considers spirituality very important in her life. She reports having experienced a mental health issue such as anxiety within the last year. The types of resources used over the past year in managing her mental health have been prayer, thoughtfulness, talking to others, some isolation. She has received counseling in the past and has had more than 12 sessions overall. She reported that the counseling was helpful - “A place with judgement, trust, and quiet to hear my own thoughts repeated.” Laura reports that the following symptom must be present to consider professional counseling: “feeling paralyzed.” She defines mental health, self-care and help-seeking in the following ways, “Mental health is stability in a world of distractions. Self-care is assessment of personal needs and implementing care for those needs and Help-seeking is understanding that I do not know everything and taking care of myself by searching for appropriate support.”

Empowered, Participant 12, is 54 years old, resides in Greater Riversedge, and identifies as a heterosexual, Black woman. She is married with children and works in higher education. She has earned a master’s degree and her annual income is $80,000 - $99,000. She considers spirituality very important in her life. She reports having experienced mental health issue such as grief and depression within the last year. The types of resources used over the past year in

managing her mental health have been "self-care and sister love." She has received counseling in the past and has had approximately 4-7 sessions overall. Empowered reported that the counseling was not helpful. Empowered shared that the following symptoms must be present to consider professional counseling: "If I am unable to *shake* the feeling, or I find myself stuck without directions." She defines mental health, self-care and help-seeking in the following ways, "Mental health is the state of being – such as your emotion or mood. Self-care is taking care of oneself. Help-seeking is reaching out for assistance."

Alexis, Participant #13, is 34 years old, resides in Greater Riversedge, and identifies as a heterosexual, Black woman. She is married with children and works within the health field. She is an licensed professional nurse and her annual income is $40,000 - $59,000. She considers spirituality somewhat important in her life. She reports having experienced mental health issues such as anxiety, depression, and grief. She discussed her awareness and management of her mental health over the past year: "I caught myself slipping, but I am able to identify the signs and am thankful that I can work through them. Sometimes it consists of not eating, not sleeping well or feeling the immense pressure of the world being on my shoulders, but I like to zone out. I also drink alcohol and while I know that is not a long-term solution it does help me to relax." She has received counseling in the past and reports having engaged in more than 12 sessions. Alexis also reported that counseling was helpful, "It was hard to find the right person that you can connect with but having someone objectively listen and ask the right questions and help re-direct your thoughts is beneficial." Alexis reports that the following symptoms must be present to consider counseling, "My main concern is finances. Most insurances do not cover it so being able to afford it is a serious issue for me. Otherwise, I have to be what is considered being beyond the point of redemption to actually make the call." She defines mental health, self-care

and help-seeking in the following ways, “Mental health is how a person is able to manage their feelings and day to day interaction. Mental health is also associated with depression, anxiety, stress and thoughts of hurting oneself. Self-care is being able to take care of yourself in whatever way is meaningful to you as an individual. It could be quiet time, reading, spa time, time with friends or it is whatever helps someone feel at peace. Help-Seeking is researching, making phone calls or asking trusted people how to get through an issue and seeking help from someone else.”

Twinnie, Participant 14, is 55 years old, resides in Greater Riversedge, and identifies as a heterosexual, Black woman. She is married with children and works in sales. She has earned a bachelor degree and her annual income is $20,000 - $39,000. She considers spirituality very important in her life. She reports having experienced mental health issues such as anxiety, depression, and grief within the last year. The types of resources used over the past year in managing her mental health have been “Self-care and exercising.” She has received counseling in the past and has had approximately 4-7 sessions overall. Twinnie reports that the counseling was helpful with dealing with stress and life related topics and a considerable change in her job/career. Twinnie reported that the following symptom must be present to consider professional counseling: “Anxiety, depression and feeling overwhelmed.” She defines mental health, self-care and help-seeking in the following ways, “Mental health is a person’s emotional and psychological state of mind. Self-care is trying to take care of one’s self without any outside or professional help, and Help-seeking is the use of outside or professional help.”

Nana, Participant 15, is 18 years old, resides in Greater Riversedge, and identifies as a heterosexual, Black woman. She is a college student, single with no children. She has a high school degree and her annual income is under $20,000. She considers spirituality very important in her life. She reports having experienced mental health issues such as anxiety, within the last

year. The types of resources used over the past year in managing her mental health has been: taking a "self-care day." She has never received counseling. Nana did not indicate any symptoms that would prompt her to consider counseling. She defines mental health, self-care and Help-seeking in the following ways, "Mental Health is a state of mind that your body is in, such as [where one is] physically, mentally and emotionally. Self-Care is taking time to yourself and making sure your body is nourished and Help-seeking is looking for someone, a shoulder to lean on."

Mo, Participant 16, is 49 years old, resides in Greater Riversedge, and identifies as a heterosexual, Black woman. She is single with two children and works in sales. She has earned a bachelor's degree and her annual income is $80,000 - $99,000. She considers spirituality very important in her life. She reports having experienced mental health issues such as anxiety, depression, grief and panic disorder within the last year. The types of resources used over the past year in managing her mental health has been: prayer, meditation, Church, therapy, exercises, massage and talking with friends. She has received counseling in the past and has had more than 12 sessions overall. She reports that counseling was helpful, "Counseling has helped me out things into proper perspective and prioritize my needs and wants." Mo reported that the following symptoms must be present to consider professional counseling, "External manifestations like eczema, alopecia, hives, panic attacks, sleeplessness, and overeating." She defines mental health, self-care and help-seeking in the following ways, "Mental health is a person's emotional condition and wellbeing. Self-care is steps one takes to care for themselves and Help-seeking is when one looks outward for support."

Sampling Procedures

After receiving Institutional Review Board approval, recruitment of participants began. Purposeful sampling and snowball sampling were used in this phenomenological study. Purposeful sampling is defined as the selection of participants who represent information-rich examples for a specified research study (Creswell & Creswell, 2017). Snowball sampling is defined as research participants recruiting other participants for the research study (Creswell & Creswell, 2017). Snowball sampling is used to recruit other participants that meet the study criteria. Participants for this study (1) identified as a Black woman or as a Black American woman, (2) were 18 years of age or older, and (3) experienced a self-identified mental health stressor within the last year. The purposeful selection of Black women who experienced a mental health stressor within the last year was relevant in exploring whether professional counseling was a self-selected help seeking strategy. This purposeful sampling was also relevant to explore the current help-seeking and self-care practices of Black women as well as the perceived barriers to help-seeking behavior. Snowball sampling was used to ensure recruitment of potential participants who met the study criteria.

This dissertation study recruited Black women from the Greater Riversedge area located in the northwest of the United States. Riversedge has a population of over 208,000 residents. It is considered the one of the largest cities in its state. The city is approximately 41% Black and approximately 51% Female (Census Bureau, 2018). Participants were recruited through several means. A participant solicitation email (Appendix A) and flier (Appendix B) were sent to the presidents of the five local Black Greek graduate chapter Sororities with a request to distribute the recruitment flier and information to their active membership. Predominantly Black Greek Letter Sororities have been established at four year colleges and universities nationally (National Panhellenic Council, 2018). These organizations have graduate chapters that serve nationally

within their local communities. Black women in these organizations within the Riversedge community represent some of the professional and college educated women within the Black community. Riversedge Sorority chapters include Iota Delta Chi Sorority, Inc., Psi Alpha Omega Alpha Sorority, Inc., Epsilon Zeta Phi Sorority, Inc. (two chapters), and Gamma Sigma Zeta Sorority, Inc.

The participant solicitation request email (Appendix A) and flier (Appendix B) were also sent to other local Black women organizations whose members are likely to possess a college education. Black women will be recruited from the Riversedge Chapter of the Friendship, Incorporated, Riversedge Chapter of the Black Women Educators Forum, and Black Women's Community Forum. These organization are comprised by women who have graduate degrees along with possible higher income levels. All of the groups represent Black women who typically have higher socio-economic levels, which may provide data on counseling as a help seeking resource or if finances may be a contributing factor to help-seeking resources. Recruitment through these Black women networks may have increased the likelihood of gaining participants who fit the inclusion criteria of seeking Black women who may have varying experiences with mental health stress. Members interested in the study, contacted the researcher directly.

In addition, the participant solicitation request email and flier (Appendix A & B) were sent to the following local churches: Church of Faith Center (Nondenominational), Glory Glory International (Nondenominational), Hill of Zion Baptist Church, St. Paul Community Church, New Christian Methodist Episcopal Church (CME), and Wellspring African Methodist Episcopal Church (AME). Recruitment from these churches provided another element of diversity, which included participant's religious and spiritual values. The participant recruitment

email and flier was sent directly to church pastor's offices to be posted on the bulletin boards or within church announcements. These particular churches were chosen to account for differences in size, location, and spiritual/religious denomination. These congregations ranged in size from approximately 50 – 400 parishioners, and span the city geographically, residing in the eastern, western, central, northern and southern areas of the city. Spirituality is an essential component to the healing of Black women specifically (Williams, Frame, & Green, 1999). Purposeful recruitment from Black Churches provided an opportunity to explore and add to the discourse of the help – seeking strategies of Black women. Lastly, recruitment via social media was conducted through the primary researcher's Facebook page (Appendix C) via a public post that was conducted as a means to recruit any other persons that fit the recruitment identifiers that may not have been reached through sorority, professional networks, and local churches.

The research study process involved participants completing an electronic consent (Appendix D), a demographic questionnaire (Appendix E), a pre-interview Survey (Appendix F), an oral consent (Appendix G), a semi structured interview (Appendix H), and follow-up email (Appendix I). Some participants were asked to engage in a follow-up post interview via the follow-up email portion of the study (Appendix I). These participants were asked additional information to ensure clarity of information for the researcher or to go more in depth about information they provided within the semi-structured interview. Each participant also received national and local counseling resources (Appendix J) to use as a resource if they needed after the study or anytime in the future. Multiple data collection methods helped to ensure enough data was collected to fully explore the three main research questions.

There were three phases to the research process. Within phase I, potential participants responded to the Participant Solicitation Research Email (Appendix A), The Research Flier

Email Correspondence (Appendix B), or the Social Media Research Participant Recruitment Post (Appendix C). Participants were required to go to the research study's survey monkey link and complete the electronic consent form (Appendix D). The Electronic Consent Form summarized the purpose of the study, the process of data collection, confidentiality, benefits and risks to participating in the study, and participant rights and the right to terminate or withdraw from the study at any time. Additionally, the Electronic Consent Form included contact information of the Institutional Review Board. Each participant was also directed to save a copy of the electronic consent for their records and provided a space to confirm consent by typing their name within electronic consent. Participants were asked to provide a pseudonym after confirming consent, to be used for the rest of the data collection process. I kept a confidential and secure record of participant's name and pseudonym for record keeping. Participants' completed electronic consent forms and consent was verified by the researcher via an oral consent prior to starting Phase II (Semi-Structured Interview) of the research study.

All participants completed the Demographic Questionnaire (Appendix E), which consists of 11 questions pertaining to name, age, gender, sexual orientation, country of origin, race, ethnicity, education level, income, spiritual or religious importance, and recruitment information. When rating the importance of spirituality in their lives, nearly all participants (n = 14) reported Spirituality as very important. The remaining two participants reported that spirituality was somewhat important in their lives.

Data Collection

Following the Demographic Questionnaire (Appendix E), participants completed the Mental Health Incidents Questionnaire (MHIQ) (Appendix F). The MHIQ is a seven item qualitative questionnaire developed by the researcher to assess the mental health experiences of

the participants. Participants were asked to define the terms mental health, self-care and help-seeking from their perspective, identify mental health stressors they have experienced, identify what types of mental health resources have been used, the length of time the resources were utilized, and the effectiveness of those resources. Participants provided lay definitions of each term, which may not reflect clinical definitions or attributes (i.e. Diagnostic and Statistical Manual of Mental Disorders; American Psychiatric Association, 2013). Lastly, participants were also asked to identify if professional counseling was a resource to manage mental health stress.

When defining mental health, all of the participants used terms and phrases such as, mental and emotional wellbeing, mind-body connection, effective management of feelings to maintain stability and sanity. Each of the participants defined self-care using phrases and terms that represented acts of wellness to meet their physical, emotional, mental and spiritual needs. Next, each participants, defined help-seeking in their own words, indicating that self-help was ultimately seeking additional personal or professional support to care to manage mental and emotional wellbeing. When reporting their experiences with mental health issues, participants were able to identify more than one mental health issue that they experienced within the past year. All participants identified having experienced some form of mental health issue including anxiety (n = 11), 10 participants who experienced depression (n = 10), grief (n = 9), panic disorder (n = 2), general stress (n = 2), and an eating disorder (n = 1).

Participants also reported their past experiences with counseling service. Eleven participants indicated having received professional counseling, while five participants reported never receiving counseling services. The participants who received professional counseling in the past, reported receiving a varied number of counseling sessions with one or more counselors. One participant experienced 1-3 sessions of counseling, three participants experienced 4-7

sessions of counseling, one participant experienced 8-11 sessions of counseling, and six participants experience more than 12 sessions of counseling. Within the 11 participants 8 participants perceived their counseling services as helpful, while 3 participants indicated that counseling was not helpful. Lastly when all participants were asked to report what symptoms must be present to consider professional counseling, 2 participants provided no answer, and 14 participants provided answers indicating that an extreme need mentally and emotionally needed to exist, including experiencing physical ailments or being mentally and emotionally overwhelmed.

The last portion of the MHIQ (Appendix F) requested that participants provide contact information for the researcher to begin Phase II of the dissertation research study, the Oral Consent (Appendix G) and The Mental Health Care Influencer Questionnaire (MHCIQ) (Appendix H). The researcher called or emailed each participant to schedule a telephone or person-to-person interview. All participants requested a phone interview. This communication also included the Researcher providing a free teleconferencing number to accommodate audio recording. Each participant called in at the individually scheduled time to complete the MHCIQ (Appendix H). The Researcher confirmed the electronic consent (Appendix D), provided in Phase I, read the oral consent (Appendix G), and requested permission to record prior to starting the MHCIQ (Appendix I). Once the participant confirmed consent and audio recording the MHCIQ (Appendix I) began.

The Mental Health Care Influencer Questionnaire (MHCIQ) (Appendix I), is a semi-structured interview, which is one of the methods used for data collection within phenomenological research. Consistent with Black Feminist and Womanist thought, The Mental Health Care Influencer Questionnaire (MHCIQ) (Appendix I) is a five item qualitative

questionnaire developed by the researcher to assess the socio-cultural impacts of mental health of the participants, as well as their help-seeking and self-care strategies. Womanist and Black Feminist theorists suggest the importance of Black women articulating their own experiences, naming, and defining themselves (Rogers, 2017; Jones, 2015). The semi-structured interview protocol was developed from a review of counseling and mental health literature from a Womanist and Black Feminist theoretical lens (See Chapter 2). The semi-structured interview (Appendix I) provided an opportunity to explore the experiences of Black Women as they understand it. Semi-structured interviews are a method which is comprised of a number of set questions that each participant was asked (Creswell & Creswell, 2017; Merriam, 1998). All participants were asked the same questions listed on the interview protocol (Appendix I). Participants were presented with follow-up questions based on the information provided to ensure clarity and to expand the discussion when necessary. Follow up questions included but not limited to, "can you tell me more about that experience," or "can you please provide an example?" These questions provided an opportunity to further explore and understand the lived experiences of the Black women participants (Hill Collins, 1990; Williams, 2005; Jones & Guy-Sheftall, 2015; Williams &Wiggins, 2010). The researcher developed the first question from the literature pertaining to Black women sense of identity and the ways in which they perceive their own mental health (Chang 2017; Barlow, 2016; Ward & Brown 2015).

This question investigated the ways in which Black women experienced and navigated societal factors that impacted their mental health. The Researcher developed additional questions that explored Black women's help-seeking strategies. These questions explored how Black women perceive concepts such as self-care and help-seeking and how they utilized these concepts to in their mental health and well-being. Help seeking is in direct opposition with the

Strong Black Woman Schema, and the sacrificing behavior that Black women may employ daily (Abrams, Maxwell, Pope, & Belgreave, 2014; Watson & Hunter, 2015). These questions explored the ways in which Black women address their needs as they function in culturally defined roles as opposed to focusing on the challenge of their roles as they may experience it. The final question provided an opportunity for Black women to provide suggestions on how counselors can meet their mental health needs. This data may be vital in addressing the unmet mental health needs of Black women for clinicians and educators. The MHCIQ semi-structured interviews ranged from approximately 15 to 55 minutes. All interviews were audio-recorded by the researcher and transcribed by a confidential transcription company.

The Post Interview Follow-Up Session (PIFUS) was phase III of the research data collection process. It and had two parts. Part I, PIFUS was conducted via email for each participant after step three of the analysis process which is described late in this chapter. The researcher provided a summary of the participant's individual interview (MHCIQ) which represented the general messages, ideas and concepts of their interviews for their review. Participants were asked if the summary was an accurate reflection of their interview. Participants had the opportunity to write and send additions via email to the researcher. Additionally, eight key participants were asked to participate in a follow up person to person or phone interview for further clarification of their data. These key participants were selected based on the information provided in the MHCIQ that the researcher deemed necessary to explore further. This is considered part II of the PIFUS. Phase III of the research study, which included two parts took approximately 15 minutes each.

Data Analysis

The researcher followed the steps of Creswell and Creswell (2017) to analyze the data. The focus of the data analysis process was to make sense of the data. This was conducted by

segmenting the data, taking the data apart and then putting the data back together in a manner that best represents the messages of the participants. The data analysis process involved seven steps (Creswell & Creswell, 2017). The Data Analysis Coding Table (Appendix K), is reflective of the data analysis process conducted in this study. Immediately following each interview, the researcher had the interview transcribed through a transcription company. Transcribed data was sent back to the researcher on average between 4-12 hours after submission. While transcription was being completed, the researcher reviewed field notes and memos written from each interview along with the recorded audio. Field notes were qualitative notes taken by the researcher pre or post the interview process (Creswell and Creswell, 2017). Memos were reflective thoughts of the primary researcher that emerge while analyzing the data (Creswell & Creswell, 2017, Tesch 1990). Memos also included jots from the primary researcher that denote hunches, thoughts or considerations that may need to explored later within the process (Creswell & Creswell, 2017, Tesch 1990).

Step One of the analysis process required the researcher to listen to the interview recordings immediately following each interview to become familiar with the data. This was necessary for the researcher to listen to the content of the data again, as well as to review and add to field notes taken during the interview to ensure accuracy. This initial step helped the researcher to create a deeper level of familiarity with the data. The researcher listened for tone and language nuances, and became familiar with any general messages expressed by participants. This step required the researcher to memo continuously to become aware of use of metaphors used by the participant during the course of the interview. Once the transcribed interview was received the researcher checked the transcript for accuracy against the audio. The researcher then

used the margins for additional memos within the transcribed document to create another layer of data analysis in conjunction with previous field notes and memos.

After the initial step of reviewing the data several times and making additional notes on the transcribed document and within the memo, the researcher transitioned to Step Two of the process which is called the winnowing (Creswell & Creswell, 2017, Tesch 1990). Due to the rich nature of the raw data, winnowing was required to sift the data. As a part of the winnowing process the researcher read thoroughly each transcribed set of data as each interview was conducted. Within this step the researcher asked, "What messages is the participant sharing?" and "What is this document as a whole about?" This step helped the researcher understand the general messages that the participant was conveying within the interview. The researcher used the margins of the interview transcript to record identified topics or general messages within the interview (Creswell, 2008; Creswell 2017, Tesch 1990). The researcher did this by reviewing all data points including field notes, memos, audio recordings and transcript to convey the depth and credibility of the general themes that the researcher has identified. The researcher identified four general topics categorized from the research interview questions during this initial process analyzing the contents of the raw data. Grouping the data according to the research interview questions, helped the researcher to formulate structure of the data.

Winnowing was a constant conversation between the researcher and the transcribed document. The researcher is looking for general topics that emerge from the content of the raw data having played close attention to the emotion of the participant. Within step two, the researcher used open coding to identify general topics within each sentence. Open coding provided an opportunity for the researcher to recognize concepts that emerge from the raw data, which begins the initial development of themes generated at the end of the analysis process

(Creswell & Creswell, 2017 Tesch 1990). Open coding required the researcher to use triple spacing to provide room to conduct open coding with the document for each sentence. Triple spacing in the Word document of a transcribed interview allowed more room between each sentence to provide space for the researcher to write field notes, topics, general themes or codes for later in the process. Emerging concepts were written above, below or on the sides within the transcribed document. The researcher identified 188 subtopics within the general topics. The first general topic, Oppression, had 55 subtopics. The second general topic, Self-Care had 35 subtopics. The third general topic, Barriers, had 38 subtopics and the fourth general topics, Counseling, had 60 subtopics. These subtopics were further analyzed and clustered within step three of the analysis process.

Step three within the analysis process is clustering (Creswell & Creswell, 2017). Clustering involved making lists of the topics identified in the winnowing process. The researcher reviewed the list of topics that were similar and grouped them based on similarities, ideas, concepts or general messages (Creswell & Creswell, 2017; Tesch 1990). Within step three the researcher took another in-depth review of the transcribed data and established a framework to identify similarities and differences within the data. The researcher accounted for any new emerging topics identified within the transcribed document within this step. The 118 winnowed subtopics were clustered into 27 collective concepts within the four general topics (Oppression (6), Self-Care (6), Barriers (6), and Counseling (9)). When clustering was complete, the researcher created a member check summary of the interview of each participant, which indicated a general message or concept that emerged for the researcher within the data analysis process. Each member check summary entailed a brief report of the participant's individual demographic information, their definition of mental health, self-care and help-seeking as

reported on the Mental Health Incidents Questionnaire (MHIQ) (Appendix H), and a summary from their Mental Health Care Influencer Semi-Structured Interview (MHCIQ) (Appendix I). Each participant summary included concepts from their interviews only.

Member checking, also known as participant validation helps to establish creditability of the results as defined by the researcher, which attests to the accuracy of the study (Guba & Lincoln, 1981; Morrow & Smith, 2000; Tobin & Begley, 2004). A narrative accuracy check was used to conduct the member checking (Holosko, Thyer, & Danner, 2009). Participants were sent a member check summary included demographic information, information gathered from the MHIQ (Appendix H), and selected data from the MHCIQ (Appendix I) associated with topics that emerged during the data analysis process. The researcher conducted a member check with each participant, and ensured the general messages and concepts were an accurate interpretation of what the participants intended to convey. Most participants (n=13) responded to the email confirming accuracy of summary and the remaining participants provided edits to ensure clarity of data. Changes that the three participants included pertained to providing clarity on a particular question. All edits were included in the data; however, they did not change the general messages or concepts submitted by the researcher to the participant.

Phase III of the research data collection process also provided an opportunity for the researcher to conduct an additional interview with eight key participants who provided clarifying information within their interviews. The researcher wanted to know more information about the counseling experiences of four participants, the definition of post-traumatic stress syndrome as articulated with interviews by two participants, and clarity on language around suppression and oppression two more participants. More clarity was needed by the researcher to understand their messages about help-seeking, the socio-cultural impact around help-seeking and impacts of

oppression on mental health. The researcher repeated the analysis process with the additional information from all eight participants, to ensure proper analysis of the new data. The second interview with the eight participants was conducted via email and was Part II of Phase III. Additional information provided by the eight participants were also emailed to the researcher, so no further transcription was required.

Step four in the analysis process is considered the coding process (Creswell & Creswell, 2017). In this step, the researcher developed a code book which was a tool used to record codes developed throughout the analysis process (Creswell & Creswell, 2017). Using the 29 clustered topics established in step three, the researcher created an abbreviated code that represented each topic. For example, the clustered topic Personal Resources would be coded PR Personal resources were represented by topics that discussed using religious and cultural sources such as praying, talking with a pastor, talking with other Black women. Personal resources also included other practices such as journaling or engaging in a physical activity to reduce mental health stress. These topics were clustered together to represent Personal Resources. The researcher used the codes to organize text within the member checked participant summaries to represent each topic. The researcher inserted codes within the margins of the summaries to indicate which clustered topic was represented. This coding process assisted in organizing the data into the existing codes as well as assisted with identifying any other emerging messages and topical clusters that were not identified during step two and three. When more topics emerged, the researcher reviewed all transcribed data to ensure that all data was accounted for with the new topics.

Step five involved establishing categories (Creswell & Creswell, 2017; Tesch 1990). The clustered topics were reviewed more several times to find additional similarities, and then the

researcher collapsed them into categories. During this portion of the process, when the researcher reviewed the clusters and found that two or more clusters could be combined, the researcher identified a descriptive word that represented the similar clusters, and used this descriptive word to create the categories. For example, a cluster with a descriptor of limitations to counseling and a second cluster with the descriptor cultural stigma would be grouped into a category with the descriptor of Barriers. Although limitation to counseling could include location of counseling services or financial funding for counseling, the concern for cultural stigma (church expectations, family expectations, personal expectations of being a strong Black women) all serve as barriers to self-care or help-seeking for Black women. The researcher physically cut out transcribed clusters and taped them on a large post-it notes (e.g., wall mounting), to further visualize the categories. Each data set was identified with a participant number to ensure proper identification once cut out. The researcher wrote the proposed category at the top of the post it and then taped cut out portions of transcribed clusters that coincide with that category. Once all the clusters were assigned a category, the researcher moved to phase six of the data analysis process.

Step six required taking the collapsed categories from step five and identifying themes (Creswell, 2017; Tesch 1990). The researcher created a descriptor and a summary definition, which served as an abbreviation of the emerging themes. If a theme was entitled “Self Help” the researcher used the abbreviation descriptor, “Self,” to represent the theme and collapsed any categories within the theme that fit the descriptor definition. The researcher recorded all themes and abbreviated codes within the code book. Lastly, the researcher placed the new themes in alphabetical order within the code book.

Step seven required the researcher to ensure that all sets of data were organized under each theme. The researcher conducted a final review of data to ensure that all categories had

been identified and placed under the appropriate theme. The researcher reviewed each category and the data under each category to ensure that the proper theme reflected the messages within those data sets. The researcher reviewed the steps taken, all of the data, and how the data was divided up to this point to ensure accuracy of placement. This step by step data analysis and interpretation process shaped the summary of the overall findings.

Researcher Subjectivity

The researcher gave considerable thought to her own experiences and identified her position or experiences that were related to the issues of the participants (Creswell & Creswell, 2017, Tesch 1990). Her expectation while conducting this research was to engage other Black women who had experienced some form of mental health stress and who were willing to discuss the impact of those experiences. Additionally, she anticipated that this study may attract women that may have experienced her within one or more of her roles within the Riversedge community (pseudonym). This previous experience, she believed garnered a sense of trust between her and the participants who volunteered for this study. This feeling of trust assisted in establishing an atmosphere in which participants reported feeling comfortable in sharing their lived experiences. Each participant wanted to continue the dialogue after the recording ended. The additional conversations lasted approximately 20-30 minutes after the MHCIQ (Appendix I), was completed and the recording stopped. The researcher continued taking field notes during this portion of the non-recorded discussion. Participants wanted to talk more about their experiences and the meaning that they made from them. This additional dialogue helped some participants gain a deeper awareness of generational themes that they had not noticed previously within the recorded portions of the interview. The field notes and memos taken from these non-recorded

portions of their interview where also coded and used as integral data points used within the analysis process.

The researcher also acknowledged that previous experience with her may have also garnered a level of nervousness or apprehension within the interview process for a few participants. The researcher believed this was apparent when they wanted to ensure they were saying the right things. The researcher ensured them there was no right or wrong answer to any of the questions. She wanted them to be free to share their truth as they experienced it. The researcher intended to explore the lived experiences of other Black women to understand how their experiences, the impacts of those experiences, their valued support systems and current self-care strategies influenced their mental health. She also intended to explore the ways in which they perceived help-seeking, their experiences with professional counseling, and what they deemed relevant for their own mental health care. Lastly, the researcher explored how these participants thought that mental health professionals could assist them with their mental health care.

The researcher believed that Black Feminist Theory and Womanist Theory reflected her own worldview as a Black women. Additionally, previous research conducted by the researcher pertaining to counseling in the Black community, served as a foundation to this current work. Black Feminist and Womanist Theories shaped how this researcher came to see this and previous work surrounding Black women and mental health specifically. She believed that the voices of Black women have been marginalized within the discussions pertaining to mental health. She also believed that there are significant messages have not been heard, within the lived experiences of Black women as it pertains to mental health stress and help seeking strategies. If these messages continue to go unheard, Black women's mental health and wellbeing will likely

continue to remain in the background rather than in the forefront of training institutions and clinical practices of counseling professionals.

The researcher facilitated all the interviews with an awareness and maintenance of her own experiences as a Black woman. She listened intently as participant's share their lived experiences as Black women and their perspectives about mental health. The researcher understood each participant experience as a unique and sought to understand each participant and their voiced experiences as such. This enabled the researcher to explore the lived experiences of each participant individually and to compare them collectively. This opportunity enabled the researcher to further understand Black women a part from her own experiences as a Black women as well as expanded her professional understanding of Black women, their help seeking behaviors and self-care strategies. The researcher also took great care to confront and manage any assumptions or biases that emerged within her throughout the study, data collection and analysis process. She used a journal as a reflection tool of her own thoughts and experiences during the process. She kept a journal to ensure that her own thoughts and assumptions did not impede her analysis process. There were moments where she cried in empathy as a result of immersing herself into the data. The journal helped her to release thoughts and feelings and became a reflection of how she was influenced by the dissertation study and the participants (Creswell & Creswell, 2017).

Credibility

Credibility refers to process in which the researcher checks for whether or not the study researched or explored what was intended (Creswell & Creswell, 2017). Credibility ensures that the study explored what was intended which establishes trustworthiness. In qualitative research, credibility is reflective of the integrity and skills of the researcher. For this particular study, one

point of credibility was established through member checking, which was employed by allowing each participant to review their narrative summary along with associated topics, which was provided by the researcher to ensure the accuracy of data (Guba & Lincoln, 1981; Morrow & Smith, 2000; Tobin & Begley, 2004). This was conducted in both Phase III of the research process and at the end of step three of the data analysis process. The researcher emailed the written summary for participant's review and thirteen participants confirmed accuracy, two participants provided additional information at the request of the researcher. Within member checking, three participants submitted edits to one data set via email to ensure clarity of information provided. Member checking provided the participants an opportunity to respond, add or delete anything they felt did not accurately reflect what they intended to convey (Creswell & Creswell, 2017). The second point of credibility was the use of researcher reflexivity. The researcher continued to be reflective of her background and experiences to be more aware of when these aspects may have influenced the data analysis process overall Creswell & Creswell, 2017).

Additionally, the researcher used memos to capture reflective thoughts and inferences of data throughout the analysis process. The researcher kept a journal to record any personal assumptions or subjectivities as a measure to not impede the analysis process (Creswell & Creswell, 2017). The researcher also used field notes to account for additional information provided by participants that was not recorded. These field notes were integrated into the analysis process to account for and to help give meaning to the messages expressed by participants (Creswell & Creswell, 2017).

The researcher ensured saturation of data by conducting more interviews even when redundancy of data was initially observed, both within the interviews themselves and within data

analysis process. The researcher found that although there were mounting topics that were similar in nature that emerged during the analysis process, no new topics emerged from the data itself. Saturation was met when no additional emerging themes were found including within the post interview data collection points. The third point of credibility established was the triangulation of data that was conducted by the researcher (Tesch, 1990). Data points included the pre-interview survey, the semi-structured interview, the non-recorded post interview dialogue with each participant, the researcher field notes and memos. This data points helped the researcher to ensure accuracy and truth within the data itself. Lastly, qualitative trustworthiness was established through ensuring transcribed interviews matched audio recordings of interviews, and reviewing all points of data to ensure consistency with codes and themes during the analysis and interpretation process (Creswell & Creswell, 2017).

Conclusion

This chapter outlined the population, participant identifiers and sample size, along with the methodological inquiry, data collection and analysis processes that were used to explore the mental health of Black Women. This study explored the needs of Black women as it related to their mental health, the influencers of their mental health, perceived valuable support systems, help-seeking behavior, self – care strategies, barriers to self-care and help-seeking as well as perceived resources needed to better serve their mental health needs. Chapter IV will present the findings of this study. It provided exhaustive detail of themes, meaning and implications for discussion.

Chapter 4: Findings

Chapter 4 reports the findings of this study, which explored the lived experiences of Black women as they discussed their mental health issues, the impact of mental health stressors, their current help-seeking, and self-care practices and the historical and current barriers to those practices. Findings also included participants' perspectives on professional counseling and their perceived access to effective and relevant resources. There were 16 participants total. The demographic information of each participants is identified on the Participant Demographic Information Tables 2 and 3 (Appendix L and M). This research study had three guiding questions:

1. In what ways are Black women's mental health stress influenced by their experiences of being a Black women?
2. What perceived barriers do Black women believe exists that may prevent them from help-seeking or self-care practices?
3. What help-seeking and self –care strategies do Black women perceive as valuable to manage their mental health stress?

Four themes emerged from the data analysis, Perspectives of Oppression on Mental Health, Socio-Cultural Messages about Self-Care and Help-Seeking, New Perspectives about Self-Care and Help-Seeking Strategies, and Messages about Professional Counseling. Each theme was reflective of the three main guiding questions of the study, which explored the influencers of mental health for the Black women participants and the resources they perceived as valuable to managing their mental health. Each theme derived from the data collected through the research process. Data was organized by topics and these topics were clustered and formed

into categories. The categories were further developed and shaped into themes. Chapter Four concludes with a summary of the results.

The first theme, Perspectives of Oppression on Mental Health, included participants' reported experiences of racism, sexism, classism, oppression or any form of social injustice. The first theme has three subthemes, Acts of Oppression and Mental and Emotional Responses to Oppressive Experiences, which denotes the ways in which oppressive encounters impacted participants; Intersectionality as a Rationale for Oppressive Experiences, which represents the perceived motivation for oppressive experiences as reported by participants; and The Impact, Internalization and Behavioral Responses to Oppressive Experiences, which represents the ways in which oppressive experiences impacted the mental health of participants. All 16 participants reported experiencing some form of oppression and discussed the ways in which those experiences impacted them mentally, physically, emotionally, socially, spiritually, or professionally.

The second theme, Socio-Cultural Messages about Self-Care and Help-Seeking, represents the gratifying, yet detrimental ways in which Black women perceived, made meaning of and functioned within socio-cultural and traditional roles. The second theme has two subthemes, The Strong Black Woman and the Super Woman Schemas, which represents the ways in which participants are influenced by these schemas; and What Goes on in this House, Stays in in this House, which represents the socio-cultural messages that influenced the help-seeking and self-care practices of participants. All sixteen participants discussed the ways in which the schemas and cultural beliefs about mental health influenced their journey in managing their mental health.

The third theme, New Perspectives about Self-Care and Help-Seeking Strategies, reflects the current strategies of help-seeking and self-care of participants. There are two subthemes, Valued Self-Care Practices which presents participants' current strategies of self-care, and Sister to Sister, which consists of messages of encouragement to from participants to other Black women to practice self-care and help-seeking strategies.

Finally, the fourth theme, Messages about Professional Counseling shares participants' reported experiences and perceptions of counseling. Four subthemes emerged: Perceived Benefits and Barriers to Counseling, which denotes the ways in which participants' perceived counseling services as useful or not; Counselors as a Safe Space, represents participants' expressed valued counseling characteristics; Counseling is Community Outreach, which denotes the need for increased counselor – community interaction; and Counseling is Solution Focused, which represents the ways in which participants desired to be co-partners within the counseling session.

Perspectives of Oppression on Mental Health

The initial theme discussed the ways in which participants experienced oppression and the influence of those experiences on their mental health. Each participant was asked to provide any example of a racist, sexist, or oppressive encounter that they experienced. All 16 participants provided more than one account of some form of oppression. Participants also discussed their perceived rationale for the oppressive events, such as their intersectional identities, and their responses to those events as displayed behaviorally and as felt internally. This initial them represents the ways in which participant's make meaning of the oppressive experiences and how those experiences have shaped their mental health.

There are three subthemes within this initial theme: Acts of Oppression & the Mental and Emotional Responses to Oppressive Experiences, Intersectionality as a Rationale for Oppressive Experiences, and The Impact, Internalization and Behavioral Responses to Oppressive Experiences. These subthemes helped to categorize those experiences and to better understand the impact of the oppressive events on their mental health.

Acts of Oppression and the Mental and Emotional Responses to Oppressive Experiences.

The first subtheme, Acts of Oppression & the Mental and Emotional Responses to Oppressive Experiences, summarized the 73 accounts of professional, educational, social and personal acts of oppression or social injustice as reported by the participants. Participants reported 11 different forms of oppression including, being bullied, excluded, retained from promotions, ignored, physically assaulted, verbally assaulted, rejected, sexually harassed, unsupported, and silenced. A few participants discussed the ways they felt like they had suffered from vicarious trauma. Vicarious trauma was defined by participants as being significantly impacted by the historical mistreatment of the Black community. These instances of oppression had mental, emotional, physical, social and spiritual influences on participants. A few of the participants described events that occurred within their middle to early adolescent years of development. These events were influential for participants as it may have marked their first incidents of oppression. Additionally, as reported, participants believed that these moments were significant in terms of how they developed mental health issues and challenged their sense of identity.

Participant Mo described her first encounter with oppression. She reported being physically assaulted as a child by older children,

> I was about five years old, I was at a private school on the north side of Chicago, and I was in the pool, and several other kids, older kids, were trying to drown me and calling me out of my name, calling me the N word. And from that, I was really impacted because I didn't go swimming for years and years and years.

Mo reported her account of physical, verbal and emotional assault as a five year old. She perceived her experience as traumatic and felt that she lost a significant sense of peace, safety and innocence as a Black girl. Mo further reported that her experiences were overlooked and her attackers were not held accountable for their action. This further compounded her feeling of loss and lack of safety.

Similarly, participant Miki shared her oppressive experience. She remarked that an incident as a child, still influences her mental health,

> This was the biggest impact for me. And so just to give you a little background, my father was an airman in the Air Force at this time, we're living in Mississippi. One day my mother took myself and my brother to the beach and we were just walking along the beach and a pickup truck with several white men were in the truck and my mother saw them from afar and she got a little nervous and they yelled out, Hey, the N word. Get off of our beach. I was shocked.

Miki reported a significant change in self-perception as a Black girl. Her sense of knowing herself as free, beautiful and safe was transformed by the fear she experienced. Miki also reported that she felt as though she suffered from post-traumatic stress disorder which she attributed not only to the initial oppressive act but also from others that followed. She explained that “these experiences were a regular reoccurrence in the South and were left unchecked socially,” therefore she still feels more vulnerable in the South than in the North. Miki defined

post-traumatic stress disorder as an emotional wound that created as sense of fear. This fear could be retriggered by anything that resembled the initial traumatizing event.

Likewise, participant Nicki, described her encounter with oppression within her group of Girl Scout friends,

> When I was in third grade and was at a Girls Scout meeting I had a group of friends. We all got into an argument and everyone had been saying things like 'You're sorry, you suck,' all that stuff, typical kid stuff and then, 'you're a N-word' came out and everybody got quiet. Even being 8 years old, you kind of knew, that was not the thing that should've been said. I would think, that's really the first time where it was like, 'Okay, even though y'all have been friends and you knew that you are Black, but now you really know that you are Black.' I'm not going to lie, it hurt.

The oppressive incident that Nicki reported was considered by the participant as a verbal attack. The derogatory word had a jarring impact on her self-perception and the ways in which she navigated that friendship. She reported having a deeper knowing of what it meant to be Black within that friendship, which meant she was deemed as inferior by her White friend. She recognized the hurt as a reaction to this loss of equality and she reported that she didn't know what to do with those feelings. She discussed internalizing the hurt and keeping it from her parents and anyone else.

In addition to participant Nicki, the other participants collectively highlighted experiences in which the oppressive events impacted their mental health. Some of the ways in which participants responded to the oppressed experience was described as feeling broken, beat down, anxious, defeated, demoralized, depressed, drained, frustrated, angry, overwhelmed and hurt. Participant Twinnie, described a mental health break that occurred after years of oppression

on her job. She shared losing aspects of her mental and physical health after enduring chronic oppression professionally. She was one of the only Black female employees within the department and her constant effort to perform in a White male dominated field impaired her health significantly.

> I was so depressed from my job and just worn out. I felt like I had been beat down from just being hammered on. I was just so tired, so beat down. I took time off. I was sick. I stayed out for three months. My doctor told me mental stress. I have fibromyalgia and I never had any issues with it before until that time I was so stressed, that I guess I must have triggered the nerve endings in the body that if you touched me, I hurt.

Twinnie reported being scrutinized often and passed over for promotions. She explained how she was always given the most difficult or unwanted tasks than any of her colleagues. She reported not being heard by her superiors, and when she tried to make them aware of the inequality she felt, she was further ignored. Her lack of voice increased her anxiety, which increased her sense of mental and emotional stress. She repeated the phrase, "feeling beat down" throughout the interview to convey how broken she felt within that environment.

Participant Free shared her mental and emotional responses to her oppressive encounters at work,

> I am a graduate of an HBCU (Historically Black College or University), which some think are inferior to predominately White institutions. I am a minority, African-American and I'm female, and am typically given lesser assignments or presumed to not have the same level of comprehension or more than my colleagues, who I possess more experience and exposure than they do. It makes me feel less valuable. It makes me feel angry, sad

> and like I had to work harder. As a result I was exhausted and stressed and it led to depression.

Free summarized her oppressive experiences, the impact of those reoccurring experiences on her mental health, as well as the rationale for those experiences. Each participants attributed multiple forms of their identity as being the basis for their oppressed experiences.

Intersectionality as a Rationale for Oppressive Experiences.

In every instance of injustice reported, participants identified intersectional elements of their identity as being a factor for the oppressed experience. Participants cited ageism, classism, racism, and sexism as contributing factors of their maltreatment. Participant LadeeTee expressed frustration while navigating her environment as a Black woman in a White male dominated environment.

> So, being a woman of color, I actually have those two strikes against me. I'm not only a person of color, but I'm also a woman in an industry that is very male dominated. I find that the level of respect given to me is not the same as some of what circulates the office. I tend to find myself always trying to prove that I am well-versed, I'm intelligent, I'm educated and I have 17 plus years in this industry. So, it's very frustrating, particularly because the majority of my co-workers are Caucasian male. It is a frustrating thing when you know you're going every day into an environment that doesn't totally accept you. So, mentally speaking, it's draining, it's very, very taxing and it makes for a difficult work day, most of the time, for me.

LadeeTee expressed feeling disrespected and treated as inferior, which impacted her mental health and her sense of worth. Being disenfranchised within her professional sphere due to her race and gender contributed to her sense of deficiency. Similarly as participant Free, participant LadeeTee was influenced to exert more energy to prove her worth and capabilities, which led to

increased stress. Participant LadeeTee also reported feeling mentally taxed, which further compromised her overall physical and mental health.

Participant Nicole B. shared her encounter with sexism and racism and expressed a perpetual sense of being stifled, which led to loss of drive and creativity.

> When I was going to school for architectural drafting and design, I was the only African American student in one of my main classes and I was also the only woman. I realized during that time, I wasn't getting a fair chance in the course. When I had an opinions about a subject or an idea that I thought should be implemented into some of the designs, my professor and my classmates disregarded my input. I felt like my opinion and ideas did not matter. I was in a predominantly White male field and my ideas weren't respected. Over time, after continuously pushing myself but lacking support, I was slowly being deterred from going and I eventually I lost enthusiasm. It was like a burden each day, I felt pretty badly.

The constant exclusion along with the reoccurring daily encounters of being dismissed and ignored, became draining for Nicole. Her loss of enthusiasm and drive in the course was ultimately a result of feeling that she did not have a presence or a voice within that environment.

The Impact, Internalization and Behavioral Responses to Oppressive Experiences.

Participants reported internalizing the multiple messages of inferiority. The oppressive events challenged their worth and identity of being black, in addition to their self-image and self-perception as a Black girl or woman. Internalization for participants were demonstrated in forms of loss of esteem, loss of drive personally and professionally, loss in self-efficacy, which influenced their ability to achieve and excel. Additionally, participants questioned their beauty as a Black girl or woman due to socially constructed forms of beauty. They reported that they felt

inferior or not good enough. They shared that they were constantly bombarded with messages of inferiority.

LadeeTee shared her first encounter that influenced her self-perception and self-image negatively,

> There was someone in my class. He was very violent and very negative. This person was very vocal about me and about my features and that is my first memory of just being conscious of my looks in comparison to others. It was particularly my nose. I have a wider nose than probably most people and so that was something that I heard often. It's been picked on a lot. Like I said, I wasn't even conscious of it until he brought it to my attention. Prior to that I probably was just fine, but now that this was being said, I thought, "Oh, wait a minute. Let me ... Maybe ... Wow, okay. He's right." So, that whole focus shifted my inner confidence and it shifted it in a negative way. Even my hair! I was the only little Black girl being compared to all of the White features.

LadeeTee reflected on how her self-image was challenged and the ways in which it impacted her self-esteem. The internalization of the oppression reshaped her thoughts of herself, which impacted her sense of her own beauty. Participant Jael, had an parallel experience while in elementary school,

> When I was in elementary school, I went to an all-white school. I went to an all-white school up until the fifth grade. There were times that I would get on the school business and all the white girls would look like they just, like their hair was still wet, and I used to really wish that I could wear a pony tail with my hair wet. I remember one time my mom pressed my hair, and she spent all Saturday pressing it. I woke up the next morning and decided I wanted to wash my hair because I want to wear it wet like the other white girls

> to school. Obviously, it shrank, and my mom freaked out. In that moment, I realized I'm not like everybody else at my school. I didn't feel beautiful. I didn't like my hair. That was over 20-something years ago, so natural wasn't big then. Girls weren't wearing afro. Now, it's like if you're natural, people perceive that as a form of beauty, but, for me, the afro was not beautiful.

The reality of being different and unaccepted within an environment where participants were the minority, was significant to how they internalized being a Black girl or woman. Participants repeated the feeling of being inferior as they shared their experiences. When those messages of inferiority were internalized, behavioral responses followed.

Participants shared how internalized messages impacted their behavioral responses. Participants discussed becoming defensive, working harder to prove worth, suppressing feeling of anger and frustration as to not fall into the angry Black women stereotype. Participants define the angry Black woman stereotype as a label provided by society to characterize a Black woman when she displayed any ability to advocate for herself. In an attempt to circumvent an additional opportunity to be marginalized or singled out, participants withdrew themselves or attempted to silence themselves to survive.

Participant Alexis shared her own encounter with being labeled as an angry Black women,

> So I've been in management for years and find myself frequently in different meetings where I would be expressing myself, articulating my thoughts, my feelings on a particular subject or issue and had been flat out told by my bosses that I was coming off as aggressive, that I was not coming off as a team player. That repeated kind of interaction was very defeating. I began to not be myself any more. I started to definitely decline in

work performance because I felt that any time I challenged or presented new ideas that I continued to give this perception that was not at all what I intended. It was demoralizing.

Alexis experienced anxiety, depression and grief over the past year due to her work environment. These types of reoccurring incidents negatively influenced her self-esteem, self-determination and self-actualization.

Participants in this study varied across age groups and personal as well as professional experiences, yet their narratives were similar in the ways in which oppressive events negatively impacted their mental health. The chronic oppression, such as ignoring their presence, dismissing their voice, undermining their decisions, embarrassing them in front of others, and making them feel undervalued and ineffective, chipped away at their sense of identity, worth, ability and desire to excel. Participant Free discussed this sense of deflation that happened when she encountered oppression on her job,

> I was chosen to start training for management but when I started in the new area I wasn't allowed to do what other salary workers were doing. I went to HR, brought it to their attention, I had documentation, and no one did anything. But the fact that they were all white, even the HR lady. And then from that point on, I became deflated. I at first thought that it was no big deal. In your mind, you'd be like, "Oh, whatever." But what I found was that I started being very short-tempered. I started doubting who I was. I started second guessing my voice. I started restricting my movements. I started just separating myself from the opportunities. And then once I noticed I started doing that, I realized that it really impacted me. I became depressed. But of course, I wouldn't give it a title because we're Black. We don't get depressed.

Free internalized the lack of support within her professional environment to the point that she became discouraged in excelling. Free expressed that the chronic stress of her oppressive environment led to her being depressed.

Like participant Free, participants discussed other ways in which their oppressive events had an overall impact on their physical and mental health. Collectively, participants reported that they experienced being depressed, developed anxiety, and suffered from panic disorders, eating disorders, high blood pressure, stress induced ailments and post-traumatic stress disorder. Participants further explained that the chronic stress experienced, negatively impacted their overall physical and mental health. Participants reported being chronically stressed in addition to the above mentioned mental health responses. Some also reported that they suffered from severe mental anguish, which participants denoted as having suicidal ideations, feeling as though they would break mentally, and being tormented by reoccurring negative thoughts.

In summary, participants shared their experiences of oppression and the varied ways in which these act of oppression influenced the mental health of participants. Participants identified the mental, emotional, social, physical and professional ways in which oppressive events influenced them. They shared coping mechanisms that were similar to the cultural coping mechanism modeled within their familial spheres.

Socio-Cultural Messages about Self-Care and Help – Seeking

The second theme, Socio-Cultural Messages about Self-Care and Help-Seeking, reflected the socio-cultural messages as expressed by participants and the ways in which these messages influenced their perceptions of mental health and self-care. Additionally, the second theme includes the ways in which participants identified and made meaning of the messages that prevented effective restoration practices. There are two subthemes within the second theme. The

first subtheme is entitled, “The Strong Black Woman” and the “Super Woman Schemas.” This subtheme described the ways in which historical and cultural roles still exist for Black women and the ways in which these roles influence their self-care practices. The second subtheme is entitled, “What goes on in this house stays in this house.” This particular subtheme includes the cultural and spiritual messages about self-care and mental health that the participants reported as being passed down from generation to generation. Additionally it discussed the ways in which these messages have influenced participants in how they have addressed their mental health.

The Strong Black Woman & Super Woman Schemas.

All sixteen participants discussed the concept of the Strong Black Woman, or Super Woman Schemas, and how these themes have influenced their own sense of identity. The Strong Black Woman and Superwoman Schema are used interchangeably in this section. Participants used both terms to reflect a combined sense of identity and responsibility as it relates to the schemas. Participants used the terms to describe the historical strength and the sacrificial servitude of Black women that have been socially and culturally ascribed to them. As these schemas are discussed, the participant’s display a struggle between strength and vulnerability as well as the desire to self-sacrifice verses the need for self-preservation.

Participant Nicole discussed how the Strong Black Woman and Super Woman Schemas have been experienced within her ethnic heritage. Nicole, was the only participant to identify as racially Black and ethinically Jamaican. She communicated the cultural norms that are valued within her culture that are similar to the cultures,

> Culturally I feel like, as a people (especially within my Caribbean background) I was taught all my life to work, work, work, work, work. You have to continuously work! You have to achieve all these things, do several these things at once, and accomplish major

> things. Yes, we do have to do that but I would have appreciated being taught or even seeing from the women that were around in my younger years, emphasizing the importance of self-care. I saw women working hard, taking care of children and being wives that catered to their husband's needs.

Nicole discussed the verbal and nonverbal cues she received while growing up, which shaped her own work ethic as well as her values around self-care. The verbal and nonverbal messages passed down from generation to generation, influenced the ways in which Black women have perceived their mental health. The socio-cultural messages around work and caring for family that Nicole received, are similar to other participants within the study.

Participant Free described the socio- cultural messages by which she had been socialized. She shared, "We always feel like we have to be Superwoman, and get everything right and bear everybody's problems, and solve everything and barely do anything for ourselves." Participants suggested that these messages have also influenced the ways in which they perceive or practice self-care. Participant Nana, a college student, explained the constant tug to give into both cultural and social barriers and her effort to combat those socio-cultural expectations. "I think that we suffer from, cultural barriers, as black women, we tend to think that we have to take on so much." Nana described the expectations of Black women and how these messages have been normalized at their expense.

Participants shared how these cultural messages have been internalized and passed on from generation to generation. Participants referenced modeled behavior when discussing their mothers or other women within their family. They reported that they learned self-sacrificing behavior from the women within their family. Participant Mo, reflected on her own generational connections and how it has influenced her.

> I've been a person that always put others first. I think it comes from my mom, who was a nurse by trade, and so that was what she did as a profession. And she carried that into her personal life. She was the oldest girl of 13 children and taking care of everybody. And I call it a disease. I think the disease got passed down to me.

Here Mo describes her inheritance of servitude to family and community as a disease. The need to be everything to everyone is expressed as a learned role and somewhat of an embraced value. Participant Fancy shared her conflicted perspective around the Strong Black Woman and Super Woman Schemas. Within participant Fancy's narrative, there is a sense of pride yet a sense of dismay in functioning fully in these roles. Fancy stated,

> I think as a black woman, mother, wife, sister, daughter, you still feel a sense of responsibility. As the woman of the house, as black woman, we hold the care of others always on our shoulders, regardless. That's just how we're built. And then there's always community responsibility. This means that you are involved in your community, and you do different activities. These activities involve the different organizations in your community, so I have multiple leadership roles. Now you don't want to feel as if you're inadequate to do these jobs, because again, you're the shoulder for others. You want to be seen, unfortunately sometimes as superwoman. You can do it all. I think unfortunately, historically speaking, Black women have always had to kind of hold it all together, because we've been seen as the strong ones, the ones that can take care of everybody else. That gives us a sense of gratitude, a sense of need, and a sense of feeling wanted. That is the reward for the stress or the Superwoman syndrome.

While understanding and experiencing the detriment of cultural and familial expectations and norms such as the Super Woman Schema, participant Fancy provided what is inherently

understood within the culture. She reported that Black women are considered the pillars and foundation of the family. She also remarked that the reward of serving within the schemas is a badge of womanhood. Participants recognized juggling multiple tasks as one of their main struggles.

Confirming the concept of modeled behavior and generational cues, participant Twinnie revealed that the admiration for her mother fueled an unconscious desire to emulate her. This further demonstrated the cultural value and need to function within those cultural roles regardless of the personal cost. The role symbolized an unwritten and cultural rites of passage for Black women. Twinnie idolized her mother for her strength. Twinnie stated, "I tell you honey, that's the strongest woman I know. All the stuff that my mama has had to go through, I'm like, 'What?' Yeah, I want to be like her. Maybe that's why I'm the way I am. Oh my God." Twinnie's idolization of her mother influenced her to be the next generation pillar to her family. While functioning in this role as Super Woman within her familial sphere, Twinnie became the financial support for her siblings, nieces and mother. When Twinnie changed professions, this also decreased her finances. She made a decision to stop sacrificing financially for her household, and for the sake of her extended family, but felt a tremendous amount of guilt about doing so,

> I used to feel guilty, by not helping my nieces to pay their rent, or pay their car insurance. I would also help my siblings…I feel so guilty when I say 'No,' because I always helped them and I felt bad because I had the money.

Twinnie expressed a sense of torment while reflecting on what might happen to family if she pulled her support away. The anguish she presented confirmed the struggle that some Black women faced when presented with the reality of choosing between expected familial and cultural

expectations to that of self-sacrifice. Collectively, participants discussed this feeling of guilt specifically when they discussed the attempt to relinquish roles or responsibilities.

Some participants communicated their perceptions of the schemas in ways that reflected a similar struggle between self-sacrifice and self-preservation. Participants such as Empowered chose self-preservation over self-sacrifice. Empowered expressed a more resolved perspective than Twinnie concerning the Schemas.

> I want to say it is our culture. As a black woman, we are taught to be 'mother-father earth' and I think that's bullshit. So we are expected to come to the church if the church needs us, or we gotta stay late at the office because oh, we got get it done, or we gotta hold it together and bring home the bacon and fry it. So I think that's still bullshit. We are taught to be everything to everybody.

Empowered voiced her frustration and her conflicting thoughts as she grappled with the social and cultural expectations of the Superwoman Schema and the negative impact that she experienced functioning within the schema. Her firm disapproval of the schema underscored her perception that the unrealistic ways in which Black Women are nurtured to self-sacrifice should be debunked. She highlighted her own struggle between being over taxed to prove validity professionally while still effectively managing her responsibilities at home.

Participants painted vivid pictures of the struggle of being Superwoman. The participants had an awareness of the sacrifices that existed while serving within the schema. They were also aware of the internal benefits and gratification that came with functioning within the schema. Participants enjoyed the rewards of functioning at high levels of stress, but ultimately payed the price with their physical health and mental sanity.

"What goes on in this house stays in this house."

This subtheme title represents the socio-cultural messages about mental health and professional counseling as quoted by participant Fancy. Participants shared concepts and stories about verbal and nonverbal cues that modeled silence as a coping mechanism for managing mental health issues. Participants expressed a common rule of hiding mental health issues and the taboo of seeking outside help aside from family or cultural resources, such as a pastor. Pariticpants discussed family cover-ups, masking problems, the stigma or taboo in seeking external help, along with verbal admonishment from family for discussing the desire to seek counseling. Additionally, some participants spoke specifically about religion, spirituality or their faith functioning as a sole external help that was deemed culturally acceptable. All participants discussed the common theme of, "What goes on in this house stays in this house."

Participant Tammy discussed how she managed her mental and emotional wellbeing, she described generational behaviors that served as barriers for her while confronting her mental health needs.

> Wow. I think that one of the barriers for me in the beginning, was just like more within my family. It really wasn't something that you talked about – mental health. Everybody had a lot of cover-ups or everybody was not dealing with something and things never got addressed. I learned how to cover up things. I learned how to put things to the back burner and never really address the issues or I never thought it was okay to confront those kind of things.

Tammy referenced the self-silencing she learned from other members of her family. Tammy learned to suppress and ignore issues, which she explained, further compromised her mental health. Participants felt overwhelmed and trapped when socio-cultural influences limited their

self-care options. Participant Alexis discussed the messages that she received about counseling specifically,

> And I think that there's still a stigma around counseling. I even remember my mother or grandmother saying, 'we don't do that' And I'm like, well why? So I think there's a lot of generational cycles in that.

Questioning historical behaviors within familial spheres can also serve as a stressor for Black women. Any indicator that they are thinking about going against the traditional family or cultural values might induce further stress in the form of arguments from family. Agnes, whose husband suffers from mental illness, discussed the lack of support and betrayal she experienced when she sought help.

> My husband suffers from mental health issues. I have to put my mental health to the side, so I can make everything okay so that it doesn't trigger his responses, and just cascade down from there. Recently I had to have him hospitalized. It was a difficult decision to do, and I thought there was going to be support from his side of the family, and it wasn't. It was a huge sense of betrayal behind it. Where they were saying to me, "Okay, now you're the problem." He needed help…I needed help…and they abandoned me.

The sense of abandonment and rejection felt by Agnes was detrimental to her own self-care. She was accused of making matters worse by hospitalizing her husband. Other participants reported that they are constantly forced to make decisions between their own mental health and the responsibility and cultural expectations of their families. Socio-cultural cues are so engrained within their lives that sometimes it becomes the most significant barrier to break. Participants reported that even if verbal familial cues of disapproval did not exist, their subconscious would send messages of disapproval when the thought of help-seeking emerged.

Participant Twinne was one of the participants who discovered the generation connection of mental health during the course of the research study interview. During the interview she was able to connect the dots of depression within her family.

> When I think about all of this, it is really a serious issue. My sister had mental health issues. She suffers from mental depression, serious depression. She seeks counseling, and medication for that. But I sit back and wonder, "Well, how does that happen?" You know? This depression thing. I know she went through some major issues herself, loss of a child, lost her house, lost her job, etc., but when I go through something, I seem to be able to pull myself out of it. I'm depressed. This is the first time I've seen the connection. When talking to my mother too, we had an aunt, now when we think about her behaviors we say, she must have been depressed too.

Participant Twinnie's epiphany revealed that there were generations of depression within her family. The participants within this research study communicated a cultural adversion to counseling as a method of self-care or help-seeking. The lack of modeling that counseling was an appropriate behavioral response to distress, was significant to participants considering counseling as a possible mental health resource. Participant Nicole shared her thoughts on counseling and the ways in which she perceived it as a resource,

> I think culturally and traditionally I viewed counseling as a last resort or something that you shouldn't engage in due to the stigma, that it's ineffective or you're 'sharing your business' with a stranger. In many Black households we were taught to keep quiet about private matters, feelings, uncomfortable situations and trauma. I'm affected by the environment I've grown up in. After hearing several narrow minded opinions about

> mental health counseling and people being falsely diagnosed for years there was preconceived doubt when it came to counseling.

Other participants affirmed participant Nicole's perspective of counseling being a last resort. Although 11 participants identified as having sought counseling in the past, when participants were asked what signs or symptoms would need to be present for them to consider counseling, the majority identified counseling as a last resort. Overall, twelve participants reported that some major behavioral, physical or emotional breakdown or brokenness would need to be present for them to seek counseling services. "I would have to be what I consider beyond the point of redemption to actually make the call."

Participant Nicole never received counseling service. Here she shares her perspective on the possibility of seeking counseling in the future. She states,

> "I've already been considering counseling for a while now. I believe that even if there are no physical symptoms there may still be underlying issues. I think it will be a benefit to sort through my thoughts and emotions with a professional."

Within the twelve participants who identified counseling as a last resort, eight of them received counseling in the past, and thought that it was helpful. There was one participant who experienced counseling in the past but, did not find it helpful and could not provide a rationale as to when she would seek counseling again. Participant narratives around help-seeking, reveal that cultural and internal issues serve as help-seeking barriers.

Participant Fancy discussed the taboo of counseling within the Black community as a way to shed light on the barriers to help-seeking that exist from her perspective,

> Culturally, at one point, this all was taboo. In the African American culture you don't need to seek counseling. What's wrong with you? You have to see a counselor? You keep

> your problems at home, and nobody else knows what's going on. My mother used to say growing up, years ago, 'You don't tell my business.' Or, 'What happens in this house, stays in this house.' I think that's something that was a cultural barrier for us as African Americans.

In addition to feeling like counseling was culturally taboo, participants also discussed the religious or spiritual perspectives of seeking help. These spiritual messages concerning mental health were also embedded within familial socio-cultural traditions. Religious messages negatively connected to help seeking was mentioned by most participants. Participants repeated messages about faith that required a deeper level of prayer, fasting and faith to combat and manage mental health issues. Participant Brandi Taylor shared her thoughts on mental health and identified spirituality as a possible barrier to help-seeking.

> I do see there is a stigma that comes with seeking out counseling, or going to talk through a situation, especially in churches. I mean, now we're doing more education around it, to sorta promote mental health, but a lot of times it was just like pray about it.

Likewise, participant Nicole discussed the benefits of her faith but also acknowledged the lack of support to address mental and emotional health.

> I think culturally we've disregarded several cases of mental instability or caused further confusion by trying to address mental or emotional issues with a spiritual remedy. Although I believe the basis and fuel for all things start with our faith, in many cases there is a need for clarity and practicality for best results.

Agnes shared more deeply about her extended family and her husband's mental health. She reported that their perceptions on mental health were very much connected to their faith.

> My in-laws for example, they don't acknowledge mental illness. They look at it as a demon, or spirit, or whatever. They connect it to being spiritual. I think that's what hurts a lot of African-American people who suffer from mental illness, because I feel like we've been taught, 'You got to pray this away.' And it's not that.

Agnes reflects on how the limited cultural resources, limited her own mental health as well as the mental health of her family.

Participants reported that Black women are bonded through loyalty and spiritual beliefs in ways that shaped their daily lives. As reported by participants, these valued cultural traditions impact daily decisions on how to care for and manage their mental health. Participant LadeeTee shared the cultural message of prayer over counseling. She also encountered this religious cultural tradition as she reflected on her own mental health needs. Her own mental health needs forced her to break away from the cultural expectation,

> If you need help mentally and emotionally, you should seek counseling. If you're made to feel like, 'Oh, you're not believing God,' or, 'You just need to fast more. You just need to pray more,' then you might forsake going to see a counselor and that may be your best source of help. I've had to come to that understanding really only through personal experience…where I realized I was going to be in big trouble if I didn't get in a counselor's office.

Participant LadeeTee remarked that while Black women are not getting their mental health needs met socially through counseling, those needs still went unmet in valued spaces culturally and spiritually, such as through family or spiritual resources. Participants communicated that if the only option spiritually is faith and prayer, they have been left with no alternatives when those resources were not sufficient in managing their mental health.

Participant narratives described the ways in which socio-cultural messages influenced their self-care strategies. These messages sometimes served as barriers to participants establishing and practicing restorative strategies. Lastly, participants discussed familial, spiritual and communal expectations and the ways in which those expectations challenged their mental health needs. They expressed the desire for alternate choices of help-seeking to better help them to manage their overall mental health and wellness.

New Perspectives about Self-Care and Help Seeking

This third theme described the ways in which participants discussed their own self-care practices. It also includes the new messages about self-care and help-seeking that they believe every Black woman should know. New messages pertaining to self-care included seeking activities that brought joy and peace to their lives. The first subtheme within the third theme, Valued Self-Care Practices, conveys a variety of ways in which participants managed their mental health stress. Some described the ways in which these practices challenged the historical socio-cultural norms in which they were socialized. The second subtheme is entitled, Sister to Sister, which shared messages of encouragement to other Black women about self-care and help seeking.

Valued Self-Care Practices.

Participants were asked to provide current self-care and help-seeking strategies that they believed were valuable to them in managing their mental health. All of the participants reported at least one method of self-care that they currently use to manage mental health. Many described their practices as restorative. Methods of self-care were described as an opportunity to be kind to themselves. Participant Alexis began her dialogue and acknowledged that what she currently practiced was in direct opposition with what she was taught culturally. She discussed the struggle

of having to defend her self-care decision to her family, whom she claimed never spoke about self-care, let alone practiced it. Alex states,

> But I think that you're always, for some reason you're just taught to always be strong, and always be present for everything. And nobody ever says or teaches you it's okay to take an hour for yourself a couple times a week. Or it's okay to go sit in a room and read a book. Nobody ever really talks about that. And even in the beginning when I started to kind of like branch off, and do more things for myself, my friends and family would be like how can you do this, and how can you afford to do that? And I'm like, not that I'm making a million dollars, but if you make your health a priority then you budget for it and plan accordingly, like anything else in your life. So I found that I was constantly defending myself. I would go and have a nice night out with my friends and post pictures, my mom would be like oh my gosh, you need to be at home with your kids. What are you doing? You are a mother. You are a wife. And I'm like I need a life outside of those roles for my own sake.

Participant Alexis fought with family to establish self-care strategies for herself. She mentioned the dual struggle of fighting with the world as mentioned in theme one and with family about self-care as mentioned in theme two. Theme three displays the new path participant Alexis created for herself to manage her mental health.

Other participants shared various ways in which they nurtured themselves. Some shared routines that started their day. Participant Empowered shared her commitment to start her day with meditation and reflection, which she reported, helped her to center herself for the day mental, emotionally and spiritually,

> ‘So every morning, I don't care how late I am, I don't care what's going on, I start off with a half hour of just pure quiet time, or I am spiritually reflecting and listening to where and when I'm supposed to be.’

Participant Empowered embraced the idea of giving to herself first. The act of giving to herself before giving herself to others reflected the change in how participants perceived themselves as worthy. Participants reported that acts of validation affirmed their sense of worth, which could help them to cope with chronic stressor they encountered within their professional and familial obligations.

LadeeTee shared her Valentine’s Day act of self-love. Although not currently in a relationship, LadeeTee described the simple, but significant act of kindness and love to herself. LadeeTee shared,

> I bought myself some flowers today because I just was having one of those days where I just felt like, "Blah." I looked at the flowers and I thought, "You know what? I'm going to let myself know that I'm worthy of having these. Another self-care practice that immediately comes to my mind is journaling. I cannot tell you the power of journaling in my life. It has literally been my release.

LadeeTee shared this self-care activity as a strategy for improving her mental health.

Participants discussed 25 ways in which they engaged in self-care activities. The activities covered every sphere of wellbeing, physical, mental, emotional, social and spiritual. Participants shared activities such as, exercise, massage, music, prayer, mediation, self-reflection, fellowship with family and friends, and travel.

When participant Nana, the youngest participant within the study, shared her self-care routine, she mentioned that she was encouraged by her mother to establish this routine.

Participant Nana established two days out of the week for self-care. She did this to prevent herself from becoming overwhelmed with classes and club commitments,

> I typically try to take two days out of the week to myself away from my friends, away from everything that I have going on. I just take two days in my room to just reevaluate my week, my day, take a nice shower, grab something to eat, and just make sure I'm taking care of myself, getting the proper rest, so that I'm not getting overwhelmed.

Nana shared that her perception of self-care was fostered by her mother. She reflected that her mother wanted her to establish a different strategy of care than what she was taught. Nana's strategies of self-care transforms the historical socio-cultural norms that her mother's generation both embraced and endured. Nana was validated and encouraged to acquire a new way of thinking and behaving by her mother, opposed to Alexis' mother. Participant Alexis felt the need to defend her new behavior of self-care.

Additionally, participant Nicole described two ways in which she practices self-care to manage her mental health stress. Like participant Empowered, she has an established routine each morning. Additionally, she reported that she is intentional about the energy or company that she surrounds herself,

> I try to do something every day to help relax my mind and keep my balanced. In the morning I have a regimen, I try to get up, get a cup of tea or coffee and go back into my bed. I'll then relax, pray and sit silence for a moment before I officially start the day. I noticed that this helps me stay calm throughout the day, it keeps me sane. I also try to avoid people that I found were negative or had a pessimistic view on life. Just overall…I felt like everything ties together, so I try to keep all things peaceful and positive around me, especially at stressful times.

Participants explained that even though self-care was not something that was culturally taught it became an act of self-preservation. Participant Tammy described her own break away from the norm as did participant Alexis and the how counseling is one of her methods of self-care.

> I got to a point where I was okay to stand up to those stigmas. But I think the most rewarding thing is, that if I'm at a place where I can't move forward, I know that I can just seek out professional help. Apart from seeking help from a mental health provider, I try to do research to develop ways to make additional changes in my life.

Participant Tammy explained that the historical methods of masking problems were not effective. She found courage to go against the status quo and risk scrutiny within their socio-cultural spheres to seek help.

When discussing self-care, other participants described getting massage memberships, and going back to the gym. They connected physical health to their mental health. Participant Agnes shared, “I believe that mental health is connected to physical health too. I think that we need an all-inclusive plan of care for mental health.”

Another tool of self-care described was the use of affirmations. Participants Agnes, LadeeTee and Brandi used self-affirmations as a tool for self-care. LadeeTee described how powerful this tool was for her. Self-affirmations mended her internally after she reportedly felt broken.

> Self-affirmation is another tool that I use personally because being in a place where I was just a few years ago, physically, mentally, emotionally, just broken. Not frustrated, but broken. I had to pull myself out of a deep, dark pit and I realized that no-one was coming to save me. It was just me and that's it. It was either, die there, or figure out a way to

> climb out. I have to attribute, of course, God, but me taking His word and speaking it and saying it and reciting it…it saved me.

LadeeTee expressed that using a combination of her spirituality, a socio-cultural valued resources, and self-affirmations, helped to move her from a hurting place to a healing place. Participants verbalized needing to engage in self-care practices regularly and that it helped stabilize them mentally.

Participants Free and Laura, shared their own journey of self-care. They defined self-care as finding and creating their own joy, which is different from the academic definition. Participant Laura, the oldest participant in this study responded, with a unique kind of wisdom,

> First of all, I believe in having fun. I've never had a problem getting on a plane or driving somewhere. I've driven across country seven times, and one of those times I did it by myself. People will say that's being adventurous. I just say it is just getting out there and doing what I want to do when I want to do it."

Laura embraced her need to explore and found a sense of joy that revived her. She practiced this rule of self-care and found ways to thrive beyond oppressive situations.

Likewise, participant Free described her self-care with the same energy as participant Laura,

> I try to make sure the projects that I do engage in, are things that really edify my spirit and make me feel good about me. That gives me that validation that I'm not necessarily getting in the stress-filled environment. Again, self-reflection, kind of separating from it all. I take responsibility for my self-care. If I can't control other factors. It's on me to take care of me.

Laura and Free described a sense of control that they created over their lives and were able to manage daily stressors more effectively. They found that it provided a necessary break from stressful routines. Participants reported that these moments of self-care gave them an opportunity to just be. They reported that taking a little time for themselves or setting and maintain boundaries, became a priority.

Participant Brandi and Agnes described the ways in which they implemented their own boundaries. They discussed that establishing boundaries helped them to better care for their families. Brandi reported,

> I really am cognizant of the time that I give. You have to set boundaries. No, I'm not checking emails. No, I am not working. If I say I'm getting off at 5:30, then I'm sticking to that. If I say I'm going in at 9:00am, I'm going at that time. So really, what works is having a checks and balances in place. I have people call and check in on me to make sure I'm sticking to my plan.

Participant Brandi, established professional boundaries which helped to create a sense of control in her life. She exercised these same boundaries with community projects, which helped establish an additional layer of balance for her.

Participant Agnes shared a similar perspective pertaining to boundaries as participant Brandi. Participant Agnes commented,

> I would have to say that African-American women need to really seek out, and ensure that they are doing a lot of self-care. We have to make sure that we are taking care of ourselves because we have so much to do. There's so many people and so many things that's dependent on us, that if we don't take care of ourselves, we can't take care of them.

Agnes shared her desire to not only care for herself, but to better care for others. The sense of connectedness to self-care and communal care was significant for participants. Agnes' reflection represented some of the same messages that other participants shared about what they really wanted other Black women to know about self-care and help-seeking. As the participants shared their own practices, they also shared words of encouragement for other "Sisters" dealing with the same type of trauma and grief from chronic oppression. When participants used the term "sisters," they were referring to other Black women collectively. They spoke about breaking the silence and suffering caused by generational cues around counseling and recognized the influence of the Super Woman and Strong Black woman Schemas had. Participants' messages urged other Black women to shed the weight of those Schemas. The next subtheme, Sister to Sister, highlighted the messages participants offered to other Black women.

Sister to Sister.

As participants shared their valued self-care practices, they also shared their hopes for other Black women. Participants wanted other Black women to know that they were not alone in the struggle of coping with oppression and balancing socio-cultural roles of strength in the midst of mental and emotional vulnerability. Participant Free began her message with the following sentence, "Self-care is not selfish."

Participant Free voiced a type of dismantling of historical expectation and perceptions as it related to caring for self aside from others. She continues,

> Well, we all know that the black woman, suffers from the Superwoman syndrome which is damaging for us mentally and that is the biggest worry, for me and my sisters. It's okay if you're not perfect. It's okay if you don't aspire to be all these grandiose things. It's okay to just be you.

Participant Free indicated a level of validation that participants in this study underscored as lacking in their daily encounters. Her message relayed that being perfectly imperfect is acceptable and challenged the oppressive messages of worth or value experienced within other social spheres.

Participants continued sharing messages of self-care and added additional messages pertaining to Black women interconnectedness. Nana, described the conversations that she had routinely with her friends. This message of solidarity, interconnectedness and shared responsibility, somewhat dismantled the independence and solo strength of the Super Woman and Strong Black woman Schema.

> I tell my friends, 'We're learning how to teach each other that it's okay to lean on one another and we don't have to take on everything by ourselves and wait until everything explodes to wanna tell each other what's going on. We're friends for a reason, to lean and help each other.'

Messages of communal care and accountability, helped Nana and her friends to maintain their individual self-care routines.

Participant Nicki, talked about the importance of interdependence. Nicki addresses the sense of shame that socio-cultural spheres incited in Black women. Nicki directly challenged those historic messages of shame and silence. She offered a new perspective of care and healing for Black women with the help of other Black women.

> I think we need not to be ashamed to go and get help when needed or to take care of ourselves. And I also think that Black women need to be a better support for one another. If we see that our friend needs help, we need to check on her to make sure she is moving

in the right direction. We have to move past the silence and the "survive through it" mentality.

Participant Miki's comments, followed a similar line of thinking about Black women relationships, "I think it is a community thing, us saying as Black women, 'I am my sister's keeper!' Other participants mentioned the same phrase when offering thoughts to other Black women. Participant Mo talked about the power of shared experiences among Black women. She suggested that all Black women are impacted mentally and emotionally and the ways in which they are impacted are not isolated. She suggested that when Black women share their experiences with one another, that within that vulnerability, strength would emerge. "It's a validation that you're not alone, you're not crazy, and you're not the only one. There are so many "me too's." There are so many of us who have similar experiences. So when you open up to someone to confide in it gives you validation and confidence."

The participants suggested that both personal and communal self-care was vital to them. They reported that these messages don't negate the weight of the world that exist for Black women, however they do provide an alternative solution to Black women to manage their own mental health in the midst of those responsibilities. As participants reflected on their own self-care practices, they also discussed the necessary qualities that they valued within the counseling process. Theme four discussed the many ways in which participants perceived professional counseling and the ways in which they believe counseling and counselors could be more effective in meeting their mental health needs.

Messages about Professional Counseling

Theme four, Messages about Professional Counseling, discussed the ways in which participants perceived and experienced professional counseling. Within this theme, participants

shared their perspective on what was beneficial to them in the counseling session and within a counselor. There are four subthemes within the fourth theme. The first subtheme is entitled, Perceived Benefits and Barriers to Counseling, which shared participant's thoughts on the helpfulness of counseling and the ways in which they experienced barriers to accessing counseling. The second subtheme, Counselors as a Safe Space, communicated the ways in which participants described valued qualities that mental health counselors should possess to meet their mental health needs. The third subtheme, Counseling is Community Outreach, discusses the ways in which counselors could build trust to assist in dismantling the taboo messages ingrained within participant's cultural spheres. The fourth subtheme, Counseling is Solution Focused, informed counselors of participants desire to receive practical tools and strategies that they could implement as a part of their therapeutic process.

Perceived Benefits and Barriers to Counseling.

This subtheme reflected the perceived benefits and barriers of professional counseling as reported by the research participants. When participants were asked specifically about professional counseling, 11 of the 16 participants reported that they received counseling. Three of the six participants who had not ever received counseling reported that they thought about getting counseling, but had not done so as of yet. The last three participants did not indicate any desire or thoughts about receiving counseling and indicated using their current support systems, such as friends and family, as a way of managing mental health stress. Participant Tammy discussed her experience with a counseling professional after experiencing grief and depression,

> And I think that once I start talking to someone, once I start talking to a professional, then it became clearer. All of these things were beginning to pile up and they were coming to a boiling point, and it was like I felt hopeless, helpless. All of these emotions began to

> really flood me, but I was able to process some of those things and was able to let go of a lot of things. Not holding on to feelings, not holding on to hurts, past hurts, disappointments, things of that nature.

Tammy discussed feeling overwhelmed with emotions and how counseling was able to help her sort through those emotions in ways that she was not able to do on her own. She used counseling as a way to dump and sort her feelings, thoughts, and past wounds to understand them and have a sense of relief. Participants who had experienced counseling and found it helpful, cited 11 ways in which they found counseling to be helpful. Some examples provided were that counseling required them to dig deep and be reflective. Other examples included was that counseling helped them to attain balance and to let go of past hurts.

Participant Laura discussed her own experiences with counseling. Laura has a counseling degree. While training to become a counselor, Laura found that counseling was necessary for her own mental health so that she could properly serve future clients. She shared some lessons that she learned within her counseling program that helped to navigate the socio-cultural need to be everything to everyone.

> That was one of the best things that I could have done was to get into the counseling program and to dig deeper, and to understand some very basic things like you can't take care of people, but you can care for them. You can only go as far in counseling as you're willing to go yourself. I mean, those two basic things were phenomenal for me.

Laura discussed her counseling program and her own counseling as a learning experience. What she learned included ways in which she could reframe her role in caring for the people she valued. This was especially important as all of the participants expressed navigating the Super Woman and Strong Black Woman Schemas. Laura and participant Free shared related

perspectives about counseling. They both discussed a shared responsibility within the counseling process. Free stated, “I also feel like it's (counseling) only as valuable as I make of it. If I don't do that self-reflection prior to the session, it's not as productive for me. It definitely takes time outside of the counseling session to really get to the core of the issues for the fears and insecurities.” Free indicated an awareness and need to be a part of own healing. She found that the work done outside of the counseling office was just as important as the work done within the counseling office.

Participant Alexis shared her thoughts about when she perceived counseling could be an appropriate tool in managing her mental health.

> Counseling is not just for when you're in a bad place, but it can also help when you're in a good place. For example, if you're a religious person, you don't just pray when things are bad, you also continue to pray and keep that faith while things are going okay. Same with counseling.

Using a socio-cultural familiar example, Alexis compared the practice of prayer to therapy. She suggested that using therapy could be a part of a regular self-care routine. She also suggested that self-care was not a one time or emergency act. Self-care as reported by these few participants became a part of their life style. Participant LadeeTee discussed the necessity of long term counseling, “Sometimes there are deep-rooted habits that are not going to just change in the course of a week, or a day, or a session. It's going to take some continual chipping away. LadeeTee reflected on the suppressed losses, and grief, that had transpired for her over the years.

In addition to discussing benefits of counseling, participants also discussed factors that became barriers for continuing counseling within the counseling process. Barriers identified by participants included, the process to accessing counseling services, counselor behavior within

counseling sessions and counseling environment. Participant Empowered, discussed her journey in finding a counselor. She tried several counselors in her local areas for couples' therapy with her husband and was unable to find a suitable match. She defined this term as a counselor that was able to meet the needs and be relatable to both her and her husband. She was referred to another counselor by a friend, which was successful, however the counselor resided in the neighboring city, over an hour away. Additionally, she discussed perceived barriers with obtaining a counselor for herself. She reported using the counseling appointed services through her job, however, they were not able to help her find a counselor of color or someone with the cultural competence that she deemed valuable. She expressed the following,

> So I'd say a challenge or barrier is that I find it very hard to find competent mental health, counselors. Even when I go look for someone from EAP or whatever, you go through about 50 counselors before you find someone that you click with or that is culturally competent.

Participants Empowered discussed the process to finding a counselor to be exhausting and discouraging. If one counselor did not work for her, she found herself starting the search process for a counselor all over again. It also forced her to become transparent with yet another counselor, and she reported that sharing again became overwhelming for her. The thought of sharing information with another stranger caused anxiety and awakened internal taboo messages about help-seeking. Empowered reported that not finding culturally competent or present counselors made help-seeking more difficult.

In additional to appropriate counselor-client fit, participant Free, discussed counselor racial background as a barrier,

> If a counselor is African-American, my biggest concern…and this is why I didn't choose that type of counselor, is because we live in a small community. I wouldn't want my business getting out in the street. I know that they say everything is confidential, but you just never know.

Free expressed concern of being exposed to the community for help-seeking. She expressed concern around information being shared to other Black counselors. This perceived barrier became a hindrance to participant Free seeking same race therapists. Adversely, this reiterates participant Empowered's concerns about the limited number of counselors of color in the area. The two participants were confronted with related perceived barriers, and although in different ways, each were in some ways hindered by those barriers.

Participant Alexis described her experience with counseling and the barriers that she perceived influential to her. Alexis in part discussed the processes to getting to a counselor and also discussed location as being a significant issue to obtaining counseling services,

> There's a lot of different barriers, such as insurance or going to your primary care to get a referral. The process to get to counseling is something that some people are not going to know how or be willing to navigate. And location is another thing. Are there counseling services that are on the bus line? I don't want to go to some obscure office out in the suburb. When I was going to counseling before, the counselor was in the suburb and that is a whole other dynamic.

Alexis expressed that access to counseling was a significant barrier in help-seeking. She found the process of getting to counseling to be complicated and frustrating. She reported that having to engage in difficult referral and insurance processes increased the probability for her to discontinue the help-seeking process. In addition to navigating the system of insurance and

primary referrals, physical access to counseling became an additional barrier for Alexis. Participants reported that these types of barriers increased their emotional stress as they became frustrated with the process overall. Some participants decided that they would not continue with counseling and relied on other sources of self-care even if those tools were not as effective as they needed.

Lastly, participants identified time and finances as significant barriers to counseling. LadeeTee, who has seen a few counselors and is still trying to find a counselor to meet her mental health needs, discussed time management and finances as a barrier to help-seeking, "There are financial barriers and there are time management barriers. I think, for me, that's probably one of the biggest things, is feeling like I need a few more hours in the day. Especially being a single mom." Similarly, Brandi, married, mom of four, discussed finances and time as hindering factors to making counseling a self-care resource, "I work two jobs quite a bit since I've had my last two kids. So with that, time is a factor because you're rushing from here to there, to get to another job, or to meet another task." Even as a single woman with no children, participant Nicki discussed finances as a factor that impeded her from making counseling a self-care resource. Nicki reported, "Finances for sure is a barrier. Working in my field, you're not really making that much, and then with my current situation, having to help out with family medical expenses, it is even more of a burden."

Participants struggled with balancing the responsibilities of home, work and personal self-care. Participants desired ways to access counseling within their community in ways they perceive as seamless. They conveyed that frustrating processes and limited access to services within community spaces that they frequent, may further limit the mental health care that Black women receive.

Counselor as a Safe Space.

Participants were asked to provide insight on what they valued within a counselor and within the counseling session. All of the participants shared at least one suggestion that counselors should consider to effectively meet their personal mental health needs. Participants who had already experienced counseling were very vocal about the qualities of a counselor that they valued and that they found significant in establishing a trusting counseling atmosphere. Other participants who had yet to experience counseling, discussed attributes that they deemed relevant to help them within the counseling process.

Participants' main suggestions revolved around counselor cultural training. Participant Tammy reported, "There's no cultural support and understanding." This statement reflected the thoughts of other participants as well. Participants discussed their desire for counselors to have more than an education-based knowledge about who they are as Black women. Participants expressed the need for counselors to be present, committed and in tune with who they are as people. Participant Empowered noted,

> We aren't just numbers! I told a counselor once, those statistics that you're reading about, those are my sisters. Those are my aunts. That's my mother. Those are my daughters. We are not a fact that you read. These numbers are our family members, our community.

Empowered expressed the need for counselors to express a real sense of empathy to their clients. She discussed her frustration when speaking with a counselor who she perceived as not being empathetic or present within her counseling process. While Empowered was fully invested within the counseling session, she felt that her counselor was distant, and unresponsive in ways that were relevant to her. She felt unheard. Empowered continued, "Sometimes counselors are physically there... but they're not present. I realized after talking for 20 minutes that this lady

wasn't even hearing me beyond what I was saying." Empowered frustrated by the perceived lack of commitment of the counselor, ended the session early and never returned. From Empowered's perspective, cultural intuitiveness happens when a counselor is able to connect deeply with the client in a way that clients feel authentically understood. This meant for Empowered, that counselors have to see her as real individual that counselors should authentically engage, instead of negative or at-risk statistics that they may find in research.

Participants continued this thought about cultural intuitiveness and responsiveness and suggested that perhaps more counselors that looked like them would be helpful. Tammy once again provided some insight,

> I think that there needs to be more people of color in this field. Someone who understood me, someone who looked like me, someone who did not make me feel bad for my culture and where I'm coming from. Someone that won't make me feel ashamed of the ways in which I was raised. It's like sometimes you are made to feel as though your culture, your understanding, your thought process is all wrong. I don't need any more of those kinds of messages.

Participants conveyed that they don't want to encounter the same struggles in the counseling session that they encounter in the world. Participants reported that counselors who do not engage, empathize or seek to understand them, create another layer of marginalization for them.

Participants expressed their need to feel safe within the counseling session. Some perceived that not only were counselors not present and lacked intuitiveness about who they were as Black women, but they also lacked presence within the session. When participants are confronted with daily oppression and chronic stress and they fight against socio-cultural messages of help-seeking outside of the community, only to come to a counseling space where

they still feel marginalized, it becomes another blow to their mental and emotional wellbeing. Participant Alexis stated pointedly,

> It's like if you're not fighting one thing in the work place, or out in the community, it's like there's never a safe haven. Like you don't ever have any place where you can be 100% authentic, and someone just gets you and they're just kind of like okay, bring it in. Where they are like "I get it, I get you and it's okay and I'm here to help you work through it." Will counseling ever be like that for us?

Participants shared the significance of finding spaces that they could be fully transparent and authentic in ways they could not be in the worlds in which they work or serve. Participants also required that counselors be just as connected, just as committed and just as vulnerable within the process. Participant Laura, who has served as a counselor in Higher Education for years and who champions the notion of Black women using counselors as resource remarked, " We have to understand that everybody comes with their own shit on both sides…the counselor and the counselee, and we have to always be aware of what our own shit is." Laura described her understanding and perception of the basic rules of the counseling process. Yet, she reported that she perceived that counselors did not adhere to those rules.

Participant Brandi, stated, "Counselors really need to build relationships with people. And I don't know if time allows for that in that profession." This statement represents a sense of disconnectedness that Brandi anticipates she will encounter within the counselor-client relationship. Her perception that counseling lacks relationship building qualities within the counseling session, stems from the lack of relationship that she feels she experiences currently between counselors and the community. The next subtheme, Building Communal Relationships, unpacked the thoughts of participants around counselors and their lack of presence within the

community. The lack of perceived presence, physical investment and emotional connectedness of counselors within the community could also serve as a barrier in establishing a counselor – client socio-cultural bond.

Counseling is Community Outreach.

Counseling is Community Outreach, reflects participant's need for counselors to establish trusted relationships with the Black community. While participants discussed building bonds within the counseling session, they also expressed the need for connection, communication and education within their communities. Participants thought it vital that counselors understood the socio-cultural barriers that existed for them. In doing so counselors would understand that establishing relationships within the community and with community gatekeepers might be helpful in dismantling barriers that prevent participants from engaging in help-seeking behaviors. Participant Nicole suggested the following,

> I would suggest that mental health advocates find ways to get the word out more. Advertise positive results, reference cases where black women in America overcame their problems and the time-frame and methods that were used. We barely talk about counseling let alone as a valued remedy for stress and trauma in our communities.

Nicole implored counselors to find ways to market the benefits of counseling for Black women within their community spheres. She remarked, the significance of marketing the benefits within the community may assist in challenging historical cultural messages about help-seeking. It further indicated a way in which counselors themselves can be partners with Black women within the help-seeking process.

Participants reported that relationship building is representative of what is valued by counselors. There is a need for counselors to commit and invest, both inside and outside of the

counseling office. Participant Alexis discussed the need for education within the community and partnering with community stake holders. She suggested that these stake holders are valued and respected members of the community. She suggested that if counselors invested in relationships with trusted community pillars, it may create a relationship between counselor and community that does not currently exist,

> Maybe counselors should spend time educating people and communities. I also think that integrating education alongside some of our community stakeholders…our elders, the people that are kind of like gatekeepers within our community.

Alexis provided an additional tool in dismantling the historical, socio-cultural norms within the community. Collectively, participants' remarks indicated that they perceive that a positive counselor - community relationship would assist in dismantling community barriers that hinders help-seeking. Participants suggested that when counselors establish relationships with valued community leaders and gatekeepers that this may lessen the taboo messages that currently exist within the community. Miki identified the barriers directly and suggested partnerships are vital for help-seeking to be acceptable resources for Black women to consider, "There is an imminent need for some kind of outreach. Counseling is still taboo within the community." Lastly, participants Fancy and Nicki offered additional suggestions on counselor-community relationship building. Fancy stated, "I think that counselors should be involved in volunteer work within organizations and programs that involve Black women and girls. Even if you are a counselor of color, you still need to build relationships." Similarly Nicki stated, "Counselors could try building support groups within our communities. And they could try to use our language when talking about counseling in general."

Participants shared the importance of counselors being co-partners with them in creating a different perspective of professional counseling within their communities. Participants reported that counselors can help to end the stigma in counseling, which would help Black women consider professional counseling as an option of care. The fourth and final subtheme in theme four, is Counseling is Solution Focused. This subtheme explored the ways in which participants perceived counseling strategies within the counseling sessions and offered suggestions on what they believed met their needs.

Counseling is Solution Focused.

The final subtheme of theme four, Messages around Professional Counseling, is Counseling is Solution Focused. This subtheme, explored the ways in which participants identified what was helpful and effective for them. When participants were asked to share messages that might help counselors' better server their needs, solution focused counseling tools and methods were the primary responses received by participants.

Participants shared their perspectives on what makes counseling relevant and effective to meet their needs. Participant Empowered, had experienced several counselors and was able to find one suitable counselor an hour away from home. She remarked the following in regards to what she felt was relevant to her within a session,

> Someone that actually could listen to you and actually verbalize what you're going through. I'm not looking for someone to give me an answer, but I am looking for someone who can point you into a specific direction. Or even provide a few different directions that I can choose from in making my world better.

She went on to report that the couples therapy was great because the counselor gave them an alternate way to perceive their marriage and then provides tools that they could use to engage

one another differently. She reported that those tools helped them and they felt like they were dating all over again.

LadeeTee, another avid supporter of counseling discussed her frustration with each counselor that she had experienced so far,

> I have experienced counseling quite a bit, my frustration at times is knowing that I'm being heard, but not being given tools. So, I've gone to several different counselors because I particularly like Christian counselors. Sometimes you find yourself in cycles, I feel there has to be some sort of a game plan that lets me feel like, not only did you hear me, but now how can we fix this?

Participant LadeeTee expressed the value in listening, and the value in receiving concrete ways to change behaviors. Participant Jael also experiences couples counseling with her husband and found it helpful in some ways. She experienced individual counseling and also wanted ways in which she could be an active participant in her healing. She expressed the desire to control her process instead of being controlled by it,

> I think that I would suggest that counselors start to focus on the things that we can control and not make it seem like people are just out of control and need medication or some type of diagnosis to make sense or to give meaning to what they are experiencing.

Jael challenged the counseling process as she has experienced it, and also spoke to the fears within her community of labels and diagnosis. She perceived these labels could be more detrimental to her and her community. Participant Jael urged counselor to find ways in which Black women could be co-healers within the counseling process. The lack of control may trigger feelings of vulnerability and may produce a sense of being unsafe.

Laura encouraged counselors to step out of the theoretical box by taking risks to find untraditional solutions for an untraditional client,

> Take it out of the theoretical. I guess what I'm saying is find the keys to unlock whatever you need to unlock in that person. Don't be afraid to step into something, or to give somebody a clue of who you are personally outside of the counselor role. I think you get more from them, and you build a relationship that becomes a little more trusting.

Participant Laura indicated that self-disclosure may be a relationship building methods that communicates that clients are not alone in their experiences. It also indicates that the client is not the only person who is transparent and vulnerable in the counseling process. Participant Agnes, shares a similar perspective. She shares what she considers as relevant to her, within the counseling process,

> I think that counselors should just give me examples on how they were able to manage their depression and/or anxiety. I would appreciate the transparency of it. But if you say, "Hey, I went through something similar. These are the things that I used to help me. Perhaps, they (these strategies) will be able to help you." I think some ways to help me get over a lot of things, is just by connecting with someone who's had that experience before. Yeah, I want someone who can relate to my experiences in some way.

Agnes expressed the desire for counselors to be connected, empathetic and transparent. Participant Agnes felt this to be significant because she does not have supports within her family or within her community spheres to discuss mental health issues.

Finally, LadeeTee expressed, “Counseling me through, is validating the fact that I am where I am, not making me feel bad for where I am, or who I am, but validating my experience, "Okay, this is where you are, but now, how do we move on from here?" Participants communicated their

need for counselors to get them from their lowest points to a space where they can mentally breathe.

In this chapter, participants reported the significant ways in which oppression impacted their mental health. They expressed their connection with socio-cultural traditions and messages despite the damaging impact they have experienced from embodying those messages. They have shared their current self-care practices and relayed messages of care to other Black women. Their messages of hope and encouragement to other Black women was intended to encourage other Black women to shed the Super Woman and Strong Black Woman Schemas. Finally participants shared messages specifically around professional counseling and the ways in which practitioners could re-evaluate the ways in which they have engaged Black women within counseling sessions, and the Black community. Chapter 5 will serve as a discussion of the data presented in chapter 4, as well as provide suggestions for future studies.

Chapter 5: Discussion

The purpose of this qualitative hermeneutic phenomenological study was to explore the ways in which the mental health of Black women was impacted by mental health stressors, as well as to explore their self-care and help-seeking strategies. Hermeneutic phenomenology considers the historical, social and cultural background and histories of the participants studied (Koch, 1995). It also recognizes the ways in which participants backgrounds and aspects of their identity are influenced by the world around them (Koch, 1995). Participants within this research study reported that their mental health were largely impacted by multiple oppressive encounters socially, professionally, and culturally. Additionally, participants reported that they felt limited in exercising self-care or help-seeking strategies at some point in their lives by their cultural connections and help-seeking encounters. Lastly, this study found that although participants discussed a number of ways in which they attempted to mitigate the impact of stress on their mental and physical health, these strategies may be unsuccessful with addressing the mental and physical ailments that were mentioned within the study.

This chapter is a discussion of highlighted findings, its connection with previous literature and the ways in which this study may provide further information as it relates to the mental health, self-care and help-seeking strategies of Black women. This chapter includes a discussion of the major findings as related to the three research question that guided the study. Within the overall discussion, the four themes that emerged from the data will also be discussed as they relate to each research question. Also included throughout the discussion are connections to Black Feminist and Womanist Theories.

While mental health stressors, self-care practices and help-seeking strategies varied among research study participants, four common themes were prominent in understanding their

influence on the mental health of Black women. There were three guiding research questions from which these themes emerge:

1. In what ways are Black women's mental health stress influenced by their experiences of being a Black women?
2. What perceived barriers do Black women believe exists that may prevent them from help-seeking or self-care practices?
3. What help-seeking and self –care strategies do Black women perceive as valuable to manage their mental health stress?

The data that emerged from the study, provide information to address each of the three research questions. The four themes that emerged from the study are also used to explain the data as it relates to the research questions. The four themes reflected the findings in chapter 4 of this dissertation: (a) Perspectives of Oppression on Mental Health, (b) Socio-Cultural Messages about Self Care and Help-Seeking, (c) New Perspectives about Self-Care and Help Seeking, and (d) Messages about Professional Counseling. All of these factors contribute to the mental health and self-care of Black women.

The Experiences of Black Women and the Impact on Mental Health

When considering the experiences of Black women and how these experiences have impacted their mental health, this study found that the Black women reported being bombarded by historical, social and cultural messages within their personal and professional lives. According to previous literature this is not uncommon for Black women (Coker, 2004; Heath, 2006, Pieterse et al., 2013). These experiences, as reported by participants, were factors in developing poor mental and physical health symptoms. Participants reported their experiences and the impact of those experiences on their mental health. Participants discussed oppressive

events that occurred daily within their careers, periodic experiences of oppression socially as it related to their intersectional identities, as well as discussed the pressure culturally to balance home, work and community obligations (Mama et al., 2013; Pieterse et al., 2013). Collectively, these experiences negatively impacted participant's mental and physical health.

Participants reported that they were greatly impacted by chronic daily stressors that impacted their mental as well as their physical health. Participants reported that they experienced anxiety, chronic stress, depression, eating disorders, disenfranchised grief, high blood pressure, mental anguish (including suicidal thoughts), panic disorders, post-traumatic stress disorder, and survivor's guilt, due to daily oppressive encounters professionally and socially. In part, findings are supported by previous literature in terms of identifying how Black women are impacted by stressors (Pieterse et al., 2013; Mama et al., 2016). Conversely, the findings raise questions as to why some stress responses such as eating disorders, as reported by this study's participants are not identified within literature.

Additionally, when participants identified the types of oppressive encounters that impacted their mental health, participants identified a number of varying forms of oppression, such as suffering from vicarious trauma, being bullied, professionally excluded, retained from promotions, ignored, physically assaulted, verbally assaulted, rejected, sexually harassed, unsupported, and silenced. Finally, when participants identified their thoughts on the rationale for oppressive experiences, they perceived that these experiences were caused by their intersectional identities, of being both Black and a woman. These findings were also supported by previous literature (Boyd-Franklin, 1991; Jones, 2008; Wood-Giscombe, 2010).

It is understood that exposure to long periods of acute stressors could cause severe problems within mental and physical health for Black women (Maddox, 2013; Carr et al. 2014).

Long periods of acute stress can result in Black women feeling depressed, anxious and suffering from physical symptoms, such as obesity and other chronic diseases from acute or chronic stress (Maddox, 2013). When chronic stress is compounded with racism, it can be further damaging to Black women specifically. Pieterse et al. (2013) conducted a study to understand racism related stress and psychological functioning of Black women. Having interviewed 118 Black women, they found that Black women's response to racist stress related events was compounded by other variables such as sexism. Additionally, they found that the frequency of racist incidents was related to psychological distress. Racism is defined as an insidious process that inflicts damage that is not readily apparent at all times (Pieterse et al., 1994, p. 43). Blacks have been subjected to severe psychological stressors including racism and other forms of discrimination (Frip & Carlson, 2016). Stress from being racially stereotyped, excluded professionally, harassed and deemed inferior is a frequent occurrence for Black women (Maddox, 2013). Additionally, Black women's intersectional identities is an identified factor in oppressive encounters which has negatively impacted the overall mental health and wellness of Black women (Health, 2006; Grote, Bledsoe, Wellman, & Brown, 2007; Jones & Sheftall, 2015).

Historically, Black women have been harmfully impacted by discrimination and severe psychological stressors (Maddox, 2013). This dissertation study provided additional insight on the impact of chronic oppressive encounters due to their intersectional identities. Participants shared that these other forms of mental health issues stemmed from both social and professional chronic stress, as well as cultural expectations and stigma. Participants' shared additional forms of mental and physical health issues such as eating disorders, disenfranchised grief and survivor's guilt that were connected to other mental health issues such as depression and anxiety. Fripp and Carlson (2017), conducted a study on the attitude of help-seeking as it relates to

stigma, of 129 African American and Latino/a adults, who were currently receiving mental health services. They found that African American and Latino/a adults were less likely to exhibit help-seeking behaviors if they perceived that they would be stigmatized by helping professionals, society at large or cultural supports. If Black women are experiencing compounded mental health issues, they may be further underserved and marginalized in the area of mental health (Barlow, 2012).

Furthermore, this dissertation study found that participants experienced layered mental health stress from oppressive encounters such as racism and discrimination. These findings reflect previous author's assertions pertaining to oppressive encounters in the lives of Black women (Borum, 2015; Watson & Hunter, 2015; Chang, 2017). Although racism and discrimination have been identified as main oppressive events (Pieterse, 2013; Maddox, 2017), this study challenges and expands the list of identified forms of oppression within discriminatory and racist acts. The underlying oppressive acts such as being sexually harassed, silenced, bullied and suffering vicarious trauma socially, may provide more breadth and depth as to how Black women are impacted by stress related events associated with their intersectional identities. Black Feminist Theory supports this notion and recommends strategies be developed and implemented that speak to the intersectional lives of Black women (hooks, 2016; Barlow, 2012; Nash, 2013). These oppressive acts were also reflective of the ways in which Black women were impacted. While mental anguish was identified by some participants who experienced oppressive encounters, others described the impact of oppressive events in different ways. They reported feeling agitated, angry, anxious, beat down, broken, confused, defeated, demoralized, depressed, disappointed, disrespected, drained, exhausted, fearful, frustrated, grief-stricken, hurt, overwhelmed, sad, shocked, and uncomfortable. These findings challenge the current literature

to be more exhaustive when describing the ways in which Black women are impacted by various stressors.

Moreover, participants in this study discussed how they felt limited in expressing these feelings and responded behaviorally by being defensive, exerting more energy to prove worth, or went into what they considered survival mode. Participants expressed that they suppressed their feelings as a behavioral response to oppressive experiences. This was the most common response indicated by study participants and is consistent with previous literature (Jackson & Stewart, 2003; Maddox, 2013; Heath, 2006; Hall et al., 2012). Suppression as described by participants caused a numbing or callused response internally. Some participants reported that they were initially unaware of the numb or callused responses to suppressing feelings. Some mentioned that after behavior changes, such as loss of interest on the job, lack of drive, increased silence in meetings and behaving abnormally, as if in shrunken state, that they were unaware of these behaviors until identified by a trusted friend or colleague which expands on previous literature.

Self-silencing and suppression have been identified as a coping responses of Black women when dealing with oppressive encounters (Heath, 2006; Watson & Hunter, 2015). The accumulation of stress erodes their self-esteem, self-efficacy and health (Jones, 2008). The initial lack of awareness to these kinds of coping behaviors may suggests that some Black women may need tools to help them become aware of their own internal responses to oppression. Once an awareness is formed, alternate ways of coping can be implemented.

Finally, participants discussed ways in which they internalized oppressive experiences, such as feeling inferior, experiencing loss of drive, loss of esteem and loss of self-efficacy as a result of their intersectional identities within professional and personal spheres of oppression. Historically, Blacks have been perceived as inferior by others within racially discriminated

occurrences, (Hall, Everett, & Hamilton Mason, 2012; Maddox, 2013). Interestingly participants identified inferiority as an internalized perception of self when impacted by oppressive events. The internalized inferiority by Black women may reflect the struggle that some may have when confronted with how they make meaning of their identities and experiences (Wilkins, 2012).

Multiple Responsibilities with Family and Community

Participants reported that socio-cultural messages also influenced their mental health. When describing the cultural messages and expectations that impacted their mental health, participants used the terms Superwoman and Strong Black women to describe the multiple roles that they have within their families and within their community. The Strong Black Women and Super Women Schema are terms previously associated with Black women (Seward & Luke, 2017; Davis, 2015; hooks, 1981). Participants used the terms interchangeably to include the expectation of caring for family and community. The Superwoman schema also reflected the mental, emotional and physical strength ascribed to Black women specifically, to handle multiple responsibilities for family and community (Seward & Luke, 2017; Harris-Lacewell, 2001; Jones, 1982; Abrams et al., 2014). Participants reported that family members and friends relied on them heavily. These findings also reflected past literature that discussed the interdependence of family and community on Black women (Abrams et al., 2014; Collins, 2005). Black women within this study expressed that most times, they felt insurmountable levels of stress associated with attempts to manage and balance multiple responsibilities and problems. Moreover, participants discussed immense internal pressure and expectation of responsibility for family and community, which made it difficult to break free from the unrealistic expectations of these schemas.

Historically, Black enslaved women labored at great personal expense to care for multiple responsibilities (Collins, 2004; Nelson et al., 2016). The Strong Black Woman Schema

derived from this time period and has transformed itself from a social structural enforced attribute to a culturally ascribed characteristic of Black women by others and of themselves (Woods-Giscombe, 2010; Collins, 2004; Nelson et al., 2016). Nelson et al. (2016), conducted a qualitative study exploring 30 Black women to explore how participants conceptualized the Superwoman and Strong Black Woman concepts. They found that participants identified five characteristics that described the role of these concepts: independent, taking care of family and others, hardworking and high achieving, overcoming adversity, and emotionally contained. Participants reflected a level of ambivalence when identifying with the schemas. The study indicated that participants were uncertain about their relationship with the roles as modeled by other women within their families. Some participants found that the concepts empowered and gave meaning to their identities while others rejected the concepts due to the inherit perception and expectation of constant strength for Black women (Nelson et al., 2016).

Although Nelson et al. (2016) discussed the rejection of the Superwoman and Strong Black Woman Schemas the participants within the study felt extreme guilt and failure when attempting to change generationally modeled behavior of self-sacrifice. Black women have sometimes felt a sense of failure when attempting to avert the traditional roles of the Superwoman and Strong Black Woman Schemas (Watson & Hunter, 2014; Watson & Hunter, 2015). In addition to guilt and feelings of failure, a few participants experienced verbal attacks and family rejection as they attempted to move from cultural expectations of self-sacrifice into new ways of exhibiting personal boundaries, and a healthy life balance. These findings expands the current literature in identifying the ways in which Black women feel culturally oppressed. Some participants were reprimanded by close family and friends when they took time for themselves. They were confronted with verbal admonishment for spending time away from

family or engaging in activities that supported external help-seeking. Finally, all participants within this research study expressed their desire to shed or break free from the expectation of the Strong Black Woman and Superwoman schemas to establish strategies of self-care and help-seeking which also coincides and challenges the historical perspective of the importance of functioning with the Strong Black Woman Schema.

Lastly, this study found that Black women used the Strong Black Woman Schema and Superwoman schema interchangeably as a source of resilience as well as a source of validation. These findings also reflect previous literature (Abrams et al., 2018; Woods-Giscombe, 2010; Watson & Hunter, 2015). Study participants discussed their reliance on spiritual or religious help-seeking including fasting and praying through mental anguish. This is reflective of Black Feminist theory that discusses spiritual agency as source of healing (Nash, 2013). They also discussed navigating through traumatic experiences or heavy burdens without external help-seeking due to their own internal expectations or those generated through their familial and cultural backgrounds. These multidimensional dynamics created a new lens through which this researcher used to further understand these combined cultural influencers of strength and sacrifice.

The participants exemplified a kind of martyrdom or savior behavior. The researcher created the term, “Sista Savior Schema” to reflect the rescuing, redeeming, and restorative behavior of Black women participants (hooks, 1981; Heath, 2006), while addressing the martyr behavior of sacrifice as noted within the participant interviews (Davis, 2015; Seward &Luke, 2017), along with previous literature and statistics concerning Black women’s mental and physical health (Barlow, 2012; Borum, 2012). It is also reflective of the historical use of cultural and religious methods of help-seeking, aside from therapeutic care. Lastly, “Sista Savior

Schema" is historical socio-cultural role designated to Black women since the time of slavery, and has been passed down from generation to generation post slavery (Harris-Lacewell, 2001; Abrams eta al., 2014). This sacrificial servitude role has been inherited as reported Black women participants within this study, along with the struggle to free themselves of this role.

Although participants discussed the ways in which oppressive encounters and culturally ascribed roles impacted their mental health, they also identified some cultural messages that functioned as help-seeking and self-care barriers. The next section will address the second research question as it relates to the barriers to self-care and help-seeking as perceived by research participants.

Barriers to Help-Seeking and Self-Care Practices

The second research question focused on perceived barriers to self-care and help-seeking. These perceived barriers served as obstacles from establishing and maintaining self-care and help-seeking strategies to reduce mental and physical health stress. While identifying perceived barriers, participants discussed socio-cultural limitations pertaining to self-care practices and help-seeking outside of cultural approved resources. Additionally, they discussed the perceived barriers to accessing help-seeking resources as well as barriers within help-seeking environments.

Participants acknowledged cultural and social stigma as a barrier to help-seeking. They identified historical taboo messages that have been passed down from generation to generation. These taboo messages encouraged participants to rely heavily on approved family and religious resources for mitigating mental and emotional stress. These findings were supported by literature which discussed cultural and religious traditions (Borum, 2012; Carrigan, 2006; Waite & Killian, 2008). Moreover, participants discussed the relevance of the lack of modeled self-care and help-

seeking behavior from other Black women within familial spheres. The lack of self-care strategies modeled by other Black women, along with inherited coping behaviors such as self-silencing and masking mental health problems like depression, was detrimental for study participants. These findings both reflect and further expand literature in that participants discussed the concept of internalizing generation cues such the Strong Black Woman Schema, yet also discussed the concept of the lack of modeling as it relates to self-care.

The ways in which Black women perceived help-seeking was largely due to the historical socio-cultural messages that that fostered their thinking (Heath, 2006; Obasi & Leong, 2009; Ward, 2005; Watson & Hunter, 2015). Black women have been highly influenced by the Superwoman and Strong Black Woman Schema which attributed to self-sacrificing tendencies as well as self-silencing as a coping mechanism to socio-cultural expectations (Davis, 2015; Woods-Giscombe, 2010, Abrams et al., 2014). Over time, Black women have been labeled matriarchs of their families and communities, which implied the ascribed expectation of self-sacrificing as their role and responsibility as Black women (Abram et al., 2014).

Interestingly, participants' desired for all Black women to break free of the historical constraints of self-sacrificing, self-silencing and limited help-seeking resources. This is reflective of both the Black Feminist and Womanist theories that assert Black women practice self-love and self-care (hooks, 2016; Barlow; 2016; Hash, 2013; Pough, 2008). Participants expressed messages of courage, to inspire other Black women to practice and maintain self-care strategies. Additionally, despite the taboo messages surrounding counseling, participants discussed seeking traditional methods of therapeutic counseling and encouraged other Black women to do the same which also expands the current literature in understanding the perspective of Black women's perspectives of counseling. Within those inspirational messages of encouragement, was the

acknowledgement that cultural taboos still existed, along with the guilt and admonishment for going against the cultural status quo. While participants championed a different form of self-care outwardly, the shame of cultural disappointment still existed internally (Collins, 2004; Wilkins, 2012). While Black Feminist and Womanist theories encourage self-love and self-care, participants shared experiences of exclusion by their cultural and familial spaces as a result of exhibiting self-preserving or self-care behaviors and from seeking mental health resources aside from traditional culturally resources. These findings challenge the theories in terms of how family and community might respond to Black women establishing boundaries of care for themselves.

Messages about Professional Counseling

An additional barrier to self-care practices and help-seeking are the ways in which participants experienced counseling or the ways in which they perceive helping professionals. Participants discussed ways in which counselors served as barriers within the counseling process. Some of the ways in which participants discussed barriers within counseling included, counselor – client relationship, counselor and community relationship, counselor access and counselor diversity. These are barriers that have been identified in previous literature (Sutter & Perrin, 2016; Pattyn et al., 2014; Fripp & Carlson, 2017; Jones, 2015). All of the participants expressed ways that the counselor-client relationship could be improved.

Aside from socio-cultural messages pertaining to help-seeking, this dissertation study found that participants identified the counselor –client relationship as a factor in their help-seeking behaviors. Participants who experienced counseling in the past, reported feelings of mistrust, lack of counselor presence, lack of counselor cultural competence, lack of perceived counselor investment within counseling sessions and perceived counselor bias toward Black

women participants. Feeling of mistrust has been common among Black women and counseling practitioners (Nichols & Foley, 1994). These characteristics as reported by participants were some of the driving qualities that impacted their decisions to discontinue therapy as well as become more reluctant to seeking professional counseling. These findings also reflect previous literature (Miller & Kaiser, 2001; Hatzenbuehler et al., 2009). Participants expressed the desire for counselors to possess a sense of intuitiveness to better meet the needs of their Black women clients. They also discussed the desire for counselors to be more empathetic to the multiple oppressions, and socio-cultural barriers that currently and historically impacted Black women participants. Black clients have identified lack of cultural competency, lack of trust and lack of counselor-client connectedness as barriers to help-seeking (Fripp & Carlson 2017; Ward & Brown, 2015; Jones & Sheftall, 2015; Watson & Hunter, 2015; Merritt-Davis & Keshavan, 2006; Campbell & Mowbray, 2016). Participants within this study confirm that these barriers currently exist for them.

In terms of mitigating socio-cultural barriers, participants expressed the need for counselors to be more present within Black communities. Developing trusting counselor – community relationships with valued community leaders, gatekeepers and community members was significant to participants. Participants perceived that increased counselor visibility would help to mitigate the taboo cultural messages that participants experienced when considering professional counseling. Additionally, participants noted using cultural language and culturally relevant examples to educate Black communities about the expectations and benefits of counseling. These findings are supported by Womanist and Feminist theories which suggest incorporating community and culturally relevant strategies to better serve Black women. They

reported that having increased education and relatability could reduce the stigma of help-seeking and assist with building trusting community relationships.

Culture has been considered a social determinant of mental health and help seeking, especially in Black communities (Campbell & Long, 2014). What stood out within this dissertation study, is that participants believed that a part of the helping profession's responsibility to current and future Black women clients, is to assist in dismantling the stigma and taboo of external help seeking that perhaps former health and mental health practitioners helped to establish. There is a perception of participants that helping professionals should be leaders in engaging, educating and fostering these community partnerships, especially as it pertains to marginalized groups within the counseling field. Ratts et al. (2016) updated and redesigned the Multicultural Counseling Competency (MCC) to be more inclusive of the varying layers of identities that are associated with clients. The Multicultural and Social Justice Counseling Competencies (MSJCC) was developed in part to better address the expanding roles of professional counselors to include social justice advocacy within counseling practice. This included recognizing the harmful impact of oppression on mental health and wellbeing of marginalized groups as well as understanding clients in the context of their environment. According to Ratts et al. (2016), MSJCC was also important in identifying if counselors should address mental health issues for marginalized clients intrapersonally (individually) or interpersonally (family, friends, and support systems), institutionally (schools, churches, businesses and community organizations), communally (addressing the norms and values of a community) or via public policy (local, state, federal laws and policies).

The relevance in further understanding this need of counselor-client-community connectedness is that within this study Black women have articulated the need to be physically

and emotionally connected to their communities while utilizing external forms of help seeking resources. Black Feminism and Womanist theories have discussed the importance of community for Black women and the healing that derives from their connectedness with community (Collins, 1996; Williams, 2005; Jones & Guy-Sheftall, 2015; Williams &Wiggins, 2010**)**. The counselor – client connectedness is not exclusive of the counselor – community and client – community connectedness. Each component should be reflective of the other. If counselors were more connected with client communities, it could assist in counselor – client connectedness within the counseling session. Clients may be more trusting of counselors who are connected with their communities and likewise, counselors may develop a deeper level of understanding of their clients, their cultural values and may be more intuitive about their counseling needs. The reverse is also true. If counselors remain unconnected to client communities, gaps and deficiency in counseling services and counselor-client relationship may remain.

Participants expressed the need for increased counselor diversity. The lack of diversity within the counseling field has been an ongoing discussion within literature (Ward & Brown, 2015; Barlow, 2015; Roldson & Toldson, 2001). The lack of counselors of color has also been a concern within the counseling field (Cabral & Smith, 2011). Participants noted that within their geographic location, there was a lack of counselors of color. They noted that their search for counselors of color was limited within national counselor databases, within employment counseling services such as EAP, and within their own communities. Limited Black women counselors specifically, served as an additional barrier to help-seeking for research participants. This further extends the literature in terms of identifying other system barriers that might limit access to help-seeking resources (Borum, 2012; Merrit-Davis & Keshavan, 2006).

Finally, Black women participants needed to feel supported by their community, needed a culturally intuitive counselor, needed to feel safe within the therapeutic process and needed to have access to services in ways that would not further marginalize or increase their perception of being oppressed or victimized. All of these components are expressed in the way in which Black women serve members of their own families and communities and in the ways they make meaning of those interactions (Collins, 1996; Williams, 2005; Jones & Guy-Sheftall, 2015; Williams &Wiggins, 2010**).** Black women have created a sense of connectedness within their communities, have served as safe spaces for their families and friends and have provided open access that have benefited those they serve (Collins, 1996; Williams, 2005; Jones & Guy-Sheftall, 2015; Williams &Wiggins, 2010**)**. The ways in which help seeking resources are available and are able to serve Black women should reflect what Black women deem as valuable as well as reflect the ways in which Black women serve the people within their own environments.

Valued Methods of Managing Mental Health

The third research question surrounded understanding the self-care and help-seeking strategies that Black women deemed as valuable to addressing their mental health stress. These findings extend the current literature in understanding the concept of self-care as perceived by Black women. These findings also challenge the notion of self-care as defined by previous literature compared to the definition provided by participants (Barlow, 2016). Participants noted a number of self-care strategies to assist in reducing mental health stress. Practices such as journaling, self-affirmations and fellowship with family and friends were the most noted forms of self-care practices. Self-affirmations (religious and non-religious), journaling and fellowship were used the most as methods to combat negative professional, social and internal messages of

inferiority by research participants. In addition, participants reported intentionally engaging in activities that generated a sense of joy despite cultural stigmas. While participants labeled these activities as self-care, they may be more reflective Black Feminist theorist describe as self-love (Nash, 2013). Self-care has been defined by Black Feminist as a means to mitigate health stressors (Barlow, 2016). The types of self-care strategies that participants valued, provided a temporary relief, however none of the practices had any long term stress relieving affects associated with them as indicated by past literature (Barlow, 2016). Additionally, these practices did not compensate or address the internal need to heal impacts of trauma, or manage grief, depression, or other detrimental effects of chronic stress. While these self-care practices are deemed by Black women as valuable, they may not serve Black women in the ways that may be most impactful in dealing with their mental and physical health disparities.

Still, practicing self-care coincided with Black Feminist and Womanist Theories as it related to using Black Self-Love as a strategy to heal and empower Black women psychologically (hooks, 2016; Barlow, 2016). These acts of self-love reflected a sense of social justice from the oppressive encounters that participants experienced professionally and the barriers constructed via historical socio-cultural experiences and expectations (Jones & Sheftall, 2015). Although socio-cultural stigmas has served as barriers for Black women in the past, the need for self-preservation as indicated in Womanist and Black Feminist theories have become more important (hooks, 1981; Heath, 2006).

Furthermore, participants discussed the need for more self-care practices by other Black women which corresponded to previous research describing self-love as a claiming, embracing and restorative strategy of Black women (Collins, 1990; Nash, 2013; Pough, 2003). The messages of self-care from participants to other Black women, imply that other Black women

may feel alone or isolated in their journey of self-care. The relevance of this data demonstrated that Black women have engaged in self-care and restoration practices unidentified in current literature. Additionally, it demonstrated a need for traditional therapeutic resources to rethink the ways in which counseling services are offered. Womanist and Black Feminist literature discussed the value of groups and fellowshipping for Black women (Jones and Warner, 2011; Jackson, 2010; Boyd-Franklin, 2010)**.**

Finally, participants identified the need for more solution focused counseling strategies within counseling sessions. This included counselors being more intuitive to the needs of participants in addition to providing pragmatic tools that participants could incorporate as a part of their healing process. Participants expressed the value of learning from others through strategies such as in narrative counseling. Participants expressed a desire to be partners within their counseling process, which is reflective of Womanist and Black Feminist theories. Narrative counseling has been identified within Womanist theory as valued strategy in the healing of Black women (Williams & Wiggins Frame, 1999). Additionally, Black Feminism suggests that power differentials be minimized within counseling spaces to form a partnership between counselors and clients (Jones, 2015). The significance of partnership within the counseling session denotes a sense of empowering Black women within counseling sessions. This correlates with Black Feminist and Womanist theories in that Black women value opportunities to heal themselves and to create strategies to break negative cycles (hooks, 2016; Barlow, 2016). These characteristics are culturally relevant to Black women within their roles as fixers within familial and communal spheres.

Chapter 6: Limitations, Implications, and Recommendations

The purpose of this qualitative hermeneutic phenomenological study was to explore the ways in which the mental health of Black women was impacted by mental health stressors, as well as to explore their self-care and help-seeking strategies. Chapter 6 concludes this dissertation study with a discussion of the limitations, implications and recommendations for future research, followed by a brief summary of the overall study. The implications of this dissertation study include areas within Counselor Education, Training, and Practice, as well as Black women and Black communities. The implications presented could assist in further developing the ways in which the counseling field addresses Black women and their mental health. It could also assist Black women and Black communities in dismantling barriers to self-care and help seeking.

Limitations

Although the data was collected, analyzed and interpreted in a valid manner, there are several limitations to this study that should be considered. Some of the limitations that are discussed in this section is: participant selection, participant self-reporting, the potential impact of recording participants, participant and researcher multiple relationships and researcher bias. One or more of these factors may have been important influencers within the study. Each will be discussed as possible limitations within the study.

In terms of selection of participants, all 16 participants were from the same city located in the northeast of the United States. Findings may be different from Black women in other areas nationally and within bigger cities or smaller rural towns. Additionally, other intersectional identities such as sexual orientation, religion, and SES were not addressed within this study. Findings may have included other oppressive encounters if participants identified as LGBTQ or

Muslim. Moreover, a larger sample may provide a broader participant age range than was secured in this current study. More participants in these age ranges could change the findings within other research studies.

Additionally, in terms of limitation pertaining to participants, the study relied on the self-reporting of participants. Participants may have been impacted by their inability to relax or fully disclose within the interview sessions, which may have impacted the information that was shared. Furthermore, the researcher did not anticipate the number of continued interviews that occurred after audio recording of interviews stopped. Participants may have felt more relaxed and free to express more aspects of their experience once the recording was no longer a perceived barrier (Al-Yateem, 2012).

Another limitation to consider is that the participant and researcher multiple relationships. Within qualitative research, researchers can function within either an insider or outsider status (Dwyer & Buckle, 2009). A researcher with an insider status would share the roles, experiences and characteristics of the participants, whereas an outsider would be without those commonalities (Dwyer & Buckle, 2009). Due to the researchers insider status, some participants may have felt hindered within the interview and may not have been as transparent with some of the pre-interview information or within the semi-structured interview. Conversely, other participants may have felt more willing to be transparent with the researcher. Participants may have allowed themselves to be more vulnerable in sharing their narrative with another Black woman whom may have shared similar experiences. The findings of this study may have been different if there were multiple researchers who were diverse in gender, race, age, sexual orientation, reliion and familiarity with participants.

Implications for Counselor Education, Training, and Supervision

This dissertation study highlights a number of implications for counselors in education, training and supervision to consider. Within counselor education, counseling programs may want to consider increasing the ways in which counseling students address multicultural issues in counseling, especially as it relates to serving Black women clients. Addressing the multiple ways in which the mental health of Black women are impacted by their social and personal spheres is paramount. To assist in this effort, the Multicultural Social Justice Counseling Competencies were established to train counselors and to inform practitioners on the multiple identities of marginalized clients (Ratts et al., 2016). Additionally, MSJCC encourages counselors to recognize the larger cultural ecosystem that influences client identities (Ratts, et al., 2016). In an effort to implement MSJCC, it may be helpful to provide counseling students with specific internship experiences within Black communities. To ensure the effectiveness of such internships, it would be necessary for counselor training programs to make significant efforts to connect with Black communities leaders and gatekeepers to foster respectful, reliable and trustworthy relationships with the community. Once these trustworthy relationships have been established, counseling students could engage in internships that continue to facilitate engagement with Black communities, and with Black women specifically. Efforts such as these by counseling programs could help facilitate relationships with future and existing practitioners with their clients as well as help dispel taboo messages about counseling within Black communities.

If counselors desire to increase their effectiveness among Black women clients, counselor – client – community connectedness must be addressed. Counselor – client – community connectedness is a term that emerged within this dissertation study. It is reflective of one of the mental health barriers identified by Black women that still must be addressed. Black women

believe that the counselor - client relationship is directly associated with the client – community and counselor – community relationships. The effectiveness of this triad relationship is paramount in dispelling taboo beliefs as it relates to counseling. It may also assist in increasing the professional help seeking behavior of Black women aside from their traditional and cultural methods of self-care. Counseling practitioners and counselor training programs may need to be more intention about finding ways to cultivate this triad relationship to foster a safe place both communally and within counseling sessions for Black women.

Phenomenology explores the lived experiences of participants with a focus on the ways in which participants convey those experiences (Koch, 1995**)**. The language in which Black women participants used to express their perception, internalization and overall impact of those stressors was relevant within this study. Black women's description of how stressors have impacted their mental health was different than what has been described in previous literature (Jones, 2008**)**. Generalized clinical terms, such as racism-related stress, anxiety and depression are often used to summarize the multiple layers of social oppression and cultural silencing that Black women endure. These summaries sometime limit the understanding of the experiences of Black women by mental health educators and practitioners. Black women use descriptors such as mental anguish, broken, and demoralized to describe the ways in which oppressive encounters have impacted them. Additionally, Black women listed additional forms of mental health issues which plague their wellbeing, such as eating disorders, disenfranchised grief, survivor's guilt and panic disorders. If these descriptors or additional mental health issues are not considered by mental health programs and practitioners, this may limit the ways in which mental health programs train and supervise future practitioners, and how practitioners engage Black women clients presently. Additionally, these limited ways of knowing Black women's experiences and

how these experiences influence their mental health, may also hinder practitioners in being more empathetic with Black women clients. These factors should also be further considered within counseling research, training and supervision.

In addition to developing community relationships and being cognizant of language, counseling education programs may consider incorporating Black Feminist and Womanist theories into existing counseling curriculum. Students trained in counseling strategies that incorporate person-centered relational dynamics with a solution focused approach attentive to cultural values may be helpful in serving Black women clients. Counseling programs could include courses such as Black Women's Mental Health and Wellness (e.g. Silas, 2018; Monroe Community College, 2018). This course discusses the disproportionate rates of mental and physical health of Black women as well as addresses the socio-historical and cultural factors that impact their health. The course uses the intersectional identities of Black women as the foundation from which all other topics derive. A course such as this could be used as a mandatory program elective within counseling programs and professional development for current practitioners.

In addition to counseling programs making efforts to better prepare their students to serve Black women clients, professional counseling associations might consider developing specific emerging leaders and new counselor workshops and trainings specific to Black women and mental health. Counseling associations might also consider continuing education workshops and trainings, specific to the mental health of Black women for all counselors. Creating spaces for proposals, poster sessions, and workshops with master practitioners working with Black women clients could further strengthen the work of mental health practitioners at all levels. Additionally, counseling programs could encourage counseling students and practitioners to participate in

conferences directly related to serving Black women. Conferences such as, Blacks in Mental Health Symposium (www.blackmhsymposium.com) is currently in its 4th year of service and could be used as a professional development for students, practitioners and educators. Professional development opportunities could mitigate the fears and sense of inadequacy that counseling students and practitioners might feel when serving Black women clients.

Counseling programs may consider offering incentives to increase the number of Black students who apply and finish counseling programs. These incentives might increase the numbers of Black practitioners within the counseling field. Increasing and maintaining Black students, may be significant for counseling education programs to consider in terms of program recruitment and sustainability. Increased numbers of Black counselors within Black communities specifically, may reduce the fear of vulnerability within the counseling session between counselor and client (Cabral and Smith, 2011). Additionally, increasing the number of Black counselors may decrease the likelihood of current counselor practitioners possibly sharing clients in smaller cities. This would help to mitigate the concerns of Black women who fear lack of confidentiality due to limited Black counselors within their communities.

Implications for Counselor Practice

As for counselor practitioners, in addition to an increased effort to build community bonds within Black communities, they may want to consider accessibility and further developing the counselor – client relationship with the counseling session. Counseling practitioners should make concerted efforts to meet clients within their community and within their neighborhoods for counseling sessions to address accessibility. Additionally, establishing ways in which clients could receive low cost or free counseling services, as well as reduce systemic barriers to clients connecting with counselors such as EAP and primary care referrals processes. Counselors may

also consider online counseling which may mitigate access barriers to counseling for Black women (Bruss & Hill, 2010). Counselors should explore additional strategies that are valued by Black women and that include Black women within the counseling process to form a counselor-client working alliance. Black women described feeling unheard and emotionally disconnected from counselors. Counselors should check-in with clients either during or at the end of the session to determine if they are meeting the perceived needs of the client to attend to these experiences. Helping professionals could assist with addressing internalized inferiority in Black women, while using culturally valued tools such as scripture and Black narratives to affirm worth and identity (Jones & Ford, 2009; Greene, Boyd-Franklin, & Spivey, 2013). These experiences should be considered by counseling practitioners as they engage with Black women clients. Efforts to acknowledge their life experiences without being dismissive or patronizing is vital in establishing a sense of trust and understanding for Black women clients. Lastly, when considering their life experiences, counselors may need to consider the age of clients which may impact their perspectives on generational and cultural messages around help-seeking, self-care and mental health.

Counselors should also consider expanding their current therapeutic strategies to include Black Feminist and Womanist theories. These theories could serve as the foundation to create strategies that foster the self-care and self-love practices of Black women. These types of strategies would incorporate cultural factors valued by Black women. New culturally valued strategies could transform the ways in which counselors address the mental health of Black women. Furthermore, counselors can develop strategies that incorporate ways in which Black women can feel humanized, valued, empowered, and that facilitate a sense of validity and worth. Black women also desired therapeutic tools that could they could use to reduce mental health

stress as well as break poor self-care behaviors. From these strategies, other therapeutic tools that Black women could embed into their daily lives may also emerge. Counselors could create strategies that help Black women move from basic levels of self-care and self-love such as manicures, pedicures, meditation and massages, to deeper levels of self-care that require cognitive and behavioral transformation. If Black women are able to make effective behavior changes in terms of trading the "Sista Savior" schema as defined earlier, it may assist in decreasing negative mental and physical health statistics.

Also, in terms of creating strategies that meet the needs of Black women therapeutically, counselors should be aware of the lack of fragility that Black women are assigned within their normal spheres of existence. Providing a space where Black women feel as though their fragility and vulnerability can be safely acknowledged and addressed is paramount. Black women are historically and culturally ascribed to being strong and unaffected by life circumstances. Furthermore, some Black women are bombarded with various elements of loss, grief, self and community silencing, along with experiences of trauma. Some Black women have rarely been provided the space to be authentically human when impacted by trauma, loss, stress and illness. If helping professional are to be effective in serving Black women clients, coping mechanism such as suppression and self-silencing must be addressed. Identifying and naming the suppressed feelings that Black women participants identified may be very important in terms of unpacking those emotional and mental responses within therapeutic environments. It may also address the self-silencing behavior that is connected to suppressing feelings. Counselors can establish an atmosphere within the counseling process that normalized Black fragility, grief and even anger. This may assist Black women in reframing their perception of themselves and the ways in which they navigate their mental and emotional health. Meeting the mental health needs of Black

women also means finding ways to decrease the feelings of anxiety and guilt that they experience from breaking the self-silencing and self-sacrificing cycles. Counselors may also want to find ways to address the "Sista Savior Schema" as defined within this study discussion, as a way to address the concurrent ways in which historical socio-cultural and religious expectations influence the mental health needs of Black women.

In this study Black women reported oppressive and overwhelming stressful experiences within their professional and communal spheres. The chronic stress that participants reported, highlighted a lack of resources available to Black women to mitigate their mental health stress. Providing tools, such as workshops related to self-care and help-seeking for Black women outside of the traditional counseling structure and within Black communities, may be helpful in serving immediate needs of stress and work-life-communal imbalance. This may also engage Black women who would not normally connect with a professional counseling.

These community based workshops may also help foster the counselor-community relationship. Workshops could be used as educational tools to inform the community of the types of counseling services available. It may also inform communities on what can be expected from a counselor – client relationship. Finding ways to address Black women without using clinical or traditional counseling language may be beneficial in relating to Black women. Additionally, forming peer groups for women may be ideal in addressing mental health stress of Black women, while meeting their cultural needs of fostering community with one another. Furthermore, peer groups could foster a sense of interdependence for Black women with other Black women. This could help create a partnership that encourages Black women to establish healthy self-care practices together. Along with community based workshops, counselors may need to acknowledge and address the risk of communal disapproval for Black women clients seeking

help aside from cultural traditions. Counseling practitioners should find ways to bridge the mental health divide between the valued cultural backgrounds of Black women and the traditional world of counseling resources.

Overall, counselor education, training, supervision and practice can have significant implications for the experiences of Black women within counseling environments. Increasing counselor – client – community relationships may be a significant factor in building bridges where there are currently great divides. When practitioners and counseling associations make strides toward serving Black women specifically, it may decrease the negative impact of chronic stress and traditional cultural expectations as it relates to help-seeking.

Implications for Black Communities and Black Women

While participants expressed their need for counselors to be more accessible, empathetic and connected with their communities, participants also shared messages to be shared with other Black women and their community in general. Black communities should consider creating community platforms for discussion around mental health and wellness. If counselors were connected to Black communities, they could assist communities to create platforms within churches, within Black women's organizations, community health initiatives as well as provide tools that could be used within family discussions. The Black community should also consider gathering trusted counselors to discuss the ways in which the community could build more accessible and culturally appropriate counseling for members of the community. Additionally, if counselors were connected with communities, Black communities could consider partnering with these trusted counselors and establish counseling services within frequented spaces such as churches. This would assist community leaders and gatekeepers to dispel the taboo message of

counseling and serve as a partner with counselors to mitigate the marginalization of Black women as it relates to their mental health.

Black women may need to consider the ways in which they practice self –care. Current self-care practices as reported by participants, serve the needs of participants temporarily. Black women identified getting services such as massage, pedicure, manicure and using journaling as tools for self –care. However, these tools provide relief from stress temporarily, but do not attend to the impact of long-term chronic stress associated with their intersectional identities. Current self-care practices may even be viewed as an alternate form of masking the effects of chronic oppression and stress. Also, there is a need to explore root causes of stress which makes basic self-care efforts limited. Currently, basic self-care efforts may only be serving as a band aid. Although these self-care practices may provide a sense of momentary escape, they may not address the mental distress such as grief, mental anguish, depression or feeling broken as reported by participants. Black women may need to consider alternate strategies of self-care that help to mitigate the impact of daily chronic stress, such as establishing new professional and cultural boundaries. Furthermore, Black women may want to consider the "Sista Savior Schema" which emerged within this research study and find ways to shed the martyrdom role. Establishing boundaries that create space for self-care may be significate in changing the tendency to function within the Sista Savior Schema. Furthermore, acknowledging self-sacrificing behaviors within cultural expectations may assist Black women in finding intentional ways to address this behavior directly. Lastly, Black women may also consider the ways in which their modeled behaviors influence the next generation of Black girls and young women.

Future Research

Research that specifically addresses the multi-layers of oppression and mental anguish especially by Black women is still needed. In order for Black women to move beyond emotional suppressive methods of surviving, the ways in which their mental health is treated professionally must be considered. Further research in the area of counselor and Black community relationships is also suggested. A recommendation for future research includes empirical research that integrates solution focused strategies within counseling for Black women. Study participants who experienced clinical counseling desired practical tools that they could use to mitigate mental health stressors. The participants wanted to be co-healers in their counseling journey. They needed to feel empowered both in and out of the counseling session in breaking the reoccurring cycles of mental anguish, depression, anxiety and in changing unhealthy coping mechanism when confronted with mental health stressors. Research that explores various solution focused strategies and tools that Black women can implement are also needed. Additionally, a comparison of such strategies to assess effectiveness is also needed.

Additional research around the "Sista Savior Schema," is necessary. This research could explain whether other Black women express the co-current characteristics that combine socio-historical, religious and cultural roles. One way to accomplish this is to create research groups of Black women to discuss the concept of "Sista Savior Schema" to explore the ways in which they view this schema as well as how they describe the implications and consequences of this schema. Additionally, research around the "Sista Savior Schema," that focus on discourse analysis could also be examined (Shaw & Bailey, 2009). Lastly, future research is also necessary to further understand the mental anguish of Black women as they experienced and described it. This may help address other impacts of oppression, racism and chronic stress such as suicidal ideations coupled with anxiety and depression in Black women.

Conclusion

This dissertation research study used Black women's phenomenological experiences of mental health oppression, socio-historical and systemic barriers to highlight ways in which counselor educators and practitioners could address the mental health and wellbeing of Black women. The dissertation findings suggested Black women have a range of unmet needs related to treatment of their stress and mental health. Further, findings suggested that the counseling field should re-evaluate and consider new ways to meet the needs of Black women. In doing so, counselors may better serve this marginalized population and perhaps increase the effectiveness of meeting the needs of other communities of color. There were also implications for the Black community and Black women themselves. Black communities may need to consider the ways in which harmful socio-historical roles and expectations from slavery may have been passed down and transformed into as cultural traditions. In like manner, Black women may want to consider the sacrificial and savior roles that have been ascribed to them historically and develop ways in which they can transform and reinvent their familial and communal roles without modeling self-sacrificing and martyrdom behaviors.

Appendices

Appendix A

Participant Solicitation Request Email

Greetings,

My name is Melany J. Silas, and I am a doctoral candidate in the Counselor Education and Supervision Program at Syracuse University. I am requesting that you pass this invitation to participate in a research study to your constituents. This study aims to investigate the lived experiences of Black women's mental health, their help-seeking and self – care practices. I have attached the research flier for your review and for distribution.

If anyone that meets the participant qualifications is interested in participating in this study, I can be contacted via email at mjsilas@syr.edu.

The Institutional Review Board at Syracuse University has approved this project. If you have any questions regarding the study you may contact me at mjsilas@syr.edu or my dissertation chair Dr. Derek X. Seward at dxseward@syr.edu.

Thank you for your consideration.

Sincerely,

Melany J. Silas, MS, M.Div, ABD

Doctoral Candidate

Counselor Education and Supervision

Syracuse University

Appendix B

Email Research Flier Correspondence

RESEARCH STUDY PARTICIPANTS NEEDED

Black Woman and Mental Health

Syracuse University

Greetings,

My name is Melany J. Silas, and I am a doctoral candidate in the Counselor Education and Supervision Program at Syracuse University. I would like to invite you to participate in my research study. This study aims to investigate the mental health, help-seeking and self – care practices of Black women.

Please consider being a part of this study if you are 18 years of age or older, identify as a Black or African American women, and have experienced some form of mental health stress in the past year. *Please consider passing this along to other women who fit the above criteria.*

Participation in this study involves participating in a demographic questionnaire, a pre-interview questionnaire, and a semi-structured interview which will be recorded. The study participation will take approximately 60 to 90 minutes with a post – interview follow up session that is estimated to be approximately 30 min. Your information will be kept confidential. Your decision to participate in this study is completely voluntary. If you are interested in participating in this study, please contact me via email at mjsilas@syr.edu in order to receive and complete the screening process and informed consent.

The Institutional Review Board at Syracuse University has approved this project. If you have any questions regarding the study you may contact my at mjsilas@syr.edu or my dissertation chair Dr. Derek X. Seward at dxseward@syr.edu.

Thank you for your consideration.

Sincerely,

Melany J. Silas, MS, M.Div, ABD

Doctoral Candidate

Counselor Education and Supervision

Syracuse University

Appendix C

Social Media Post for Recruitment

VOLUNTEERS NEEDED

Research Study: Black Women and Mental Health

Participants Needed:

1. Must identify as a Black Woman or Black American Woman
2. 18 years of age of older
3. Must have experienced some form of mental health stressor within the last year.

Participation in this study involves participating in a demographic questionnaire and a pre-interview questionnaire estimated to take approximately 30min. The study also involves a semi-structured interview that will be recorded and is estimated to take approximately 60min. Lastly, the study involves a post-interview follow up session which is estimated to take approximately 30 min.

If you are interested in participating in this study, please contact me via email at: mjsilas@syr.edu

Appendix D
Electronic Consent

COUNSELING AND HUMAN DEVELOPMENT
400 Sims Hall
315-443-9623

Black Women and Mental Health Study

My name is Melany J. Silas, and I am a graduate student at Syracuse University. Dr. Derek X. Seward, Associate Professor at Syracuse University, is my dissertation chair and research study supervisor. I am inviting you to participate in a research study. I am interested in learning more about the lived experiences of Black women's mental health and their self-care practices. You will be asked to fill out a demographic questionnaire and a pre-interview questionnaire which will take approximately 30 minutes. Directly following you will be asked to participate in a semi-structure interview. This will take approximately 60 min of your time. Lastly, you will be asked to participate in a post follow up session which will take approximately 30 minutes. All information will be kept confidential.

You will be assigned a pseudonym to your responses and each participant will be identified using a pseudonym. Only my faculty advisor and I will have the key to indicate which pseudonym belongs to which participant. In any articles I write or any presentations that I make, I will not reveal details that identify who you are.

Involvement in the study is voluntary, so you may choose to participate or stop participation at any time during the research process. Please feel free to ask questions about the research and I will be happy to explain anything in detail if you wish.

The study requires audio recording of our in person or telephone interview. Audio recording is necessary for data analysis purposes only. The recordings will be retained until transcribed and will be erased when the study is complete, and only I and Dr. Seward will have access to these recordings.

The benefits of this study is that you may increase or reaffirm your own awareness of the importance of practicing self-care and accessing mental health resources. Participants will have the opportunity to help the researcher to understand Black women's mental health, the barriers to mental health resources and information pertaining to current help-seeking and self -care practices. Lastly, participants will have the benefit of offering suggestions that they value as resources in the support of positive mental health wellbeing.

The risks to you of participating in this study are some possible emotional discomfort when reflecting on themes such as grief, depression or anxiety. These risks will be minimized by offering national and local counseling resources. If you do not want to take part, you have the

right to refuse to take part, without penalty. If you decide to take part and later no longer wish to continue, you have the right to withdraw from the study at any time, without penalty.

Contact Information:

If you have any questions, concerns, complaints about the research, contact Melany Silas at 585-732-9249, the Chair of research, Derek X. Seward, PhD at 315-443-9623. If you have any questions about your rights as a research participant, you have questions, concerns, or complaints that you wish to address to someone other than the investigator, if you cannot reach the investigator, contact the Syracuse University Institutional Review Board at 315-443-3013.

All of my questions have been answered, I am 18 years of age or older, and I wish to participate in this research study. Please print or save a copy of the consent for your records.

(Survey Monkey Consent Directions):

I have read the electronic consent, I affirm that I meet the requirements of the study and consent to participation within the study.

If you consent to this electronic consent, please type your name below:

Appendix E
Demographic Questionnaire

Recipients will be asked to answer the following questions via survey monkey or qualitative data repository.

1. Please provide your full name:
2. Please provide your age:
3. Please specify your gender:
4. Please indicate what country you were born in: _____
5. Please indicate the Race that best describes you – check all appropriate options
    a. Black American or Black
    b. Hispanic
    c. White
    d. Asian
    e. Native American
    f. Other (please indicate) _____
6. How would you describe your Ethnicity (West Indian, Hattian, African American, Nigerian, Jamaican, etc) _____
7. Please select the highest education level attained
    a. High School Diploma
    b. Bachelor's Degree
    c. Master's Degree
    d. Doctorate Degree
8. Please indicate your annual income range:
    a. Under $20,000
    b. $20,000 – 40, 000

c. $40,000 - $60,000

d. $60,000 - $80,000

e. $80, 000 - $100,000

f. $100,000 +

9. How would you rate the importance of religion or spirituality in your life:

    a. Not important at all

    b. Not very Important

    c. Neutral

    d. Somewhat Important

    e. Very important

10. Please indicate how you were recruited for this study: (Sorority, Church, Women's Club, Social Media, etc.)

    _____

Appendix F

Pre-Interview: Mental Health Incidents Questionnaire

1. Define the term “mental health” as you understand it.
2. Define the term “self-care” as you understand it.
3. Define the term “help-seeking” as you understand it.
4. Please identify all of the mental health issues you have experienced within the last year:
    a. Anxiety
    b. Depression (clinical or non-clinical),
    c. Grief
    d. Bi-Polar Disorder
    e. Schizophrenia
    f. Panic Disorder
    g. Eating Disorders
    h. Other _____
5. Please indicate how you managed through this mental health stress?
6. Have you ever received professional counseling (Psychologist, Psychiatrist, Counselor Therapist; Social Worker Therapist; etc.)?
    a. If yes, please indicate which type of helping professional you used and how long ago you used their services?
    b. How many session did you attend?
    c. Was the counseling helpful?
        i. If so, in what ways?
        ii. If not, please explain.
7. What symptoms must be present for you to consider professional counseling?

Appendix G

Oral Consent

COUNSELING AND HUMAN DEVELOPMENT
400 Sims Hall
315-443-9623

Black Women and Mental Health

My name is Melany J. Silas, and I am a graduate student at Syracuse University. I am inviting you to participate in a research study. Involvement in the study is voluntary, so you may choose to participate or not. This sheet will explain the study to you and please feel free to ask questions about the research if you have any. I will be happy to explain anything in detail if you wish.

I am interested in learning more about the lived experiences of Black women's mental health and their self – care practices. You will be asked to fill out a demographic questionnaire and a pre-interview questionnaire which will take approximately 30 minutes. Directly following you will be asked to participate in a semi-structure interview. This will take approximately 60 min of your time. Lastly, you will be asked to participate in a post interview follow up session which will take approximately 30 minutes. All information will be kept confidential.

I will assign a number to your responses, and only my faculty advisor and I will have the key to indicate which number belongs to which participant. In any articles I write or any presentations that I make, I will use a pseudonym for you, and I will not reveal details that identify who you are.

Your study data will be kept as confidential as possible, with the exception of certain information we must report for legal or ethical reasons such as the intent to hurt yourself or others.

The study requires audio recording of our one –to – one interview. Audio recording is necessary for data analysis purposes only. The recordings will be retained until transcribed and will be erased when the study is complete.

The benefit of this research is that you will be helping us to understand Black women's mental health, barriers to mental health resources and information pertaining to current help-seeking and self – care practices.

This information should help us to provide valuable insight for counseling professionals on how to further engage current or future Black women clients as well as reach those who may normally not seek counseling services. By taking part in the research you may experience the following benefits: increased awareness of the importance of self-care and mental health resources. The risks to you of participating in this study are some possible emotional discomfort when reflecting on themes such as grief, depression or anxiety. These risks will be minimized by offering local

counseling resources. If you do not want to take part, you have the right to refuse to take part, without penalty. If you decide to take part and later no longer wish to continue, you have the right to withdraw from the study at any time, without penalty.

Contact Information:

If you have any questions, concerns, complaints about the research, contact Melany Silas at 585-732-9249 or the Chair of research, Derek X. Seward, PhD at 315-443-9623. If you have any questions about your rights as a research participant, you have questions, concerns, or complaints that you wish to address to someone other than the investigator or if you cannot reach the investigator, contact the Syracuse University Institutional Review Board at 315-443-3013.

Do you have any questions?

Are you 18 years of age or older?

Do you wish to participate in this research study?

Have you received a copy of the consent form?

Do you agree to be audio recorded?

Appendix H

Mental Health Care Influencer Questionnaire
Interview Protocol (In person or telephone)

Hello,

Thank you for taking the time to speak with me today about mental health and help-seeking. My name is Melany J. Silas and I am a PhD candidate at Syracuse University in the Counseling Education and Supervision Department. Please note, I will be audio recording our interview today as outlined in your consent form. I am interviewing several women about their experiences with mental health and their help-seeking and self-care practices that they currently employ. Everything that you tell me today will be kept confidential. This means that I will not use your name or any information that will link this information back to you. I am here to learn about the experiences of Black women and what impacts their mental health positively or negatively. Once the interview is complete, I will provide a summary of findings to you in a post-interview follow-up session to ensure accuracy of your interview. Do you have any questions for me before we begin? Is it ok to audio record the interview? (If yes) Let's begin. (If no). Thank you very much for your time.

Interviewee Pseudonym_____

Interviewer _____

Date/Time of Interview _____

The research interview consists of five (5) core questions. Follow up questions may or may not be asked during the interview to gain a better understanding from the core question such as: “tell me more,” or “can you provide an example”, however all core interview questions will be asked.

Questions:

1. When considering factors such as racism, sexism, classism, social injustice and oppression, how have you experienced these as influencers of your mental health and overall wellbeing?
2. When considering factors such as racism, sexism, classism, social injustice and oppression, what has been your source(s) of survival as a Black women?
3. In terms of your mental health and wellness, tell me about your self-care or help seeking strategies and how often do you employ them.
4. What personal, professional, social or cultural barriers have you experienced as it relates to help-seeking or self-care?
5. If you could provide suggestions to counselors on how to meet your mental health needs, what would you suggest?

This concludes our interview. Thank you very much for your time.

Appendix I

Post Research Follow-Up Email

Hello,

Thank you for taking the time to participate in my study on Black Women and Mental Health. Please review the attached summary. I would like to know if I have captured your thoughts and experiences as you have expressed. Please let me know if something is missing or misconstrued that you feel is vital to your own experiences. In addition, please let me know if you would like to expand on a topic. Please feel free to reply to this email or schedule a post-interview session to communicate your additional thoughts. Feel free to ask any questions that you may have.

Once again, just for your information, the Institutional Review Board at Syracuse University has approved this project. If you have any questions regarding the study you may contact me at mjsilas@syr.edu or my dissertation chair Dr. Derek X. Seward at dxseward@syr.edu.

Thank you once again for your participation.

Appendix J
Counseling Resources

Local Counseling Services – Rochester, NY

Sankofa Family Counseling Services
1400Portland Ave, Suite 55
Rochester, NY
(585) 355-4927

Agape Counseling Services:
21 Willow Pond Way #103,
Penfield, NY 14626
(585) 385-6030

Moynihan Counseling
18 Harvard St,
Rochester, NY 14607
(585) 210-8711

Appendix K
Data Analysis Coding Table

Table 1

Data Analysis Coding Table

Data Analysis Steps 1-3	Data Analysis Steps 4-6	Data Analysis Step 7
General Topic: Oppression (55 Subtopics/ 506 ROF) 1. Mental & Emotional Responses to Oppressive Experiences 2. Impact of Chronic Oppressive Experiences 3. Acts of Oppression 4. Rationale for Oppressive Experiences 5. Behavioral Responses to Oppressive Experiences 6. Internalization of Oppressive Experiences	Clustered Subthemes: 1. Acts of Oppression and Mental & Emotional Responses to Oppressive Experiences 2. Intersectionality as a Rationale for Oppressive Experiences 3. The Impact, Internalization and Behavioral Responses to Oppressive Experiences.	Identified Theme: Perspectives of Oppression on Mental Health
General Topic: Self-Care (35 Subtopics/174 ROF) 1. Self-Love/Self-Care Meaning 2. Sister to Sister 3. Physical Care 4. Mental & Emotional Care 5. Social Care 6. Spiritual Care	Clustered Subthemes: 1. Sister to Sister 2. Valued Self- Care Practices	New Perspectives about Self-Care and Help Seeking
General Topic: Barriers (38 Subtopics/335 ROF) 1. Super Woman and Strong Black Woman Schema 2. Cultural Barriers 3. Time and Money Constraints 4. What happens in this house stays in this house 5. Self-Sacrificing Behavior 6. Generational Cues	Clustered Subthemes: 1. Super Woman and Strong Black Woman Schema 2. What happens in this house stays in this house	Socio-Cultural Messages about Self-Care and Help – Seeking
General Topic: Counseling (60 Subtopics/357 ROF) 1. Benefits of Counseling 2. Barriers to Counseling 3. Barriers to Accessing Counseling Services 4. Response to Barriers 5. Barriers with Counselor in Counseling Session 6. Solutions Needed 7. Safe 8. "Gets me" 9. Community and Counseling	Clustered Subthemes: 1. Perceived Benefits and Barriers to Counseling 2. Counselors as a Safe Space 3. Counseling is Community Outreach 4. Counseling is Solution Focused	Messages about Professional Counseling

Note. ROF= Rates of Frequency

Appendix L

Participant Demographic Information Table Part 1

Table 2

Participant Demographic Information

Age	Sexual Orientation	Marital Status	Race	Ethnicity	Education	Income	Religious	Mental Health Issues	Counseling	Number of Sessions	Counseling Helpful
43	Heterosexual	Married	B	US	Masters Degree	40-59k	Very Important	Anxiety, Depression	yes	1 - 3 Sessions	No
48	Heterosexual	Married	B	US	Doctoral Degree	80-99k	Very Important	Anxiety, Grief, Stress	no	n/a	n/a
43	Heterosexual	Divorced	B	US	Masters Degree	40-59K	Very Important	Depression, Eating Disorder	yes	4-7 Sessions	Yes
33	Heterosexual	Single	B	Jamaican	General Education Diploma	100K+	Very Important	Anxiety	no	n/a	n/a
44	Heterosexual	Divorced	B	US	Bachelors Degree	40-59K	Very Important	Anxiety, Depression, Grief	yes	12+ Sessions	No
49	Heterosexual	Single	B	US	Bachelors Degree	60-79k	Somewhat Important	Anxiety, Depression, Grief, Panic Disorder	Yes	12+ Sessions	Yes
44	Heterosexual	Married	B	US	Bachelors Degree	40-59k	Very Important	Anxiety	no	n/a	n/a
33	Heterosexual	Married	B	US	Masters Degree	40-59k	Very Important	Depression, Grief	yes	8-11 Sessions	yes

Note. This table represents demographic information for participants 1 through 8

Appendix M

Participant Demographic Information Table Part 2

Table 3

Participant Demographic Information

Age	Sexual Orientation	Marital Status	Race	Ethnicity	Education	Income	Religious	Mental Health Issues	Counseling	Number of Sessions	Counseling Helpful
37	n/a	Single	Black	US	Masters Degree	40-59k	Very Important	Depression, Stress	No	n/a	n/a
50	Heterosexual	Single	Black	US	Bachelors Degree	40-59k	Very Important	Grief	Yes	12+ Sessions	yes
72	Heterosexual	Single	Black	US	Bachelors Degree	100k+	Very Important	Anxiety	yes	12+ Sessions	yes
54	Heterosexual	Married	Black	US	Masters Degree	80-99k	Very Important	Depression, Grief	yes	4-7 sessions	No
34	Heterosexual	Married	Black	US	Licensed Practical Nurse	40-59k	Somewhat Important	Anxiety, Depression, Grief	yes	12+ Sessions	yes
55	Heterosexual	Married	Black	US	Bachelors Degree	20-39k	Very Important	Anxiety, Depression, Grief	yes	4-7 Sessions	yes
18	Heterosexual	Single	Black	US	High School Diploma	20k-	Very Important	Anxiety	no	n/a	n/a
49	Heterosexual	Single	Black	US	Bachelors Degree	80-99k	Very Important	Anxiety, Depression, Grief, Panic Disorder	yes	12+ Sessions	Yes

Note. This table represents demographic information for participants 9 through 16

References

Abernethy, A., Houston, T., Mimms, T., & Boyd-Franklin, N. (2006). Using prayer in psychotherapy: Applying Sue's differential to enhance culturally competent care. *Cultural Diversity & Ethnic Minority Psychology, 12(1), 101-114.*

Abrams, J., Hill, A. & Maxwell, M. (2018). Underneath the Mask of the Strong Black Woman Schema: Disentangling Influences of Strength and Self-Silencing on Depressive Symptoms among U.S. Black Women. *Sex Roles, 80(9-10), 517-526.*

Abrams, J., Maxwell, M., Pope, M., & Belgrave, F. (2014). Carrying the world with the grace of a lady and the grit of a warrior: Deepening our understanding of the "Strong Black Woman" schema, *Psychology of Women Quarterly, 38(4), 503-518.*

Adisa, O. (1990). *Rocking in the sun light: Stress and Black women*. (pp. *11-14)*. Seattle WA: Seal Press.

Adksion-Bradley, C., Johnson, D., Sanders, J., Duncan, L., & Holcomb-McCoy, C. (2005). Forging a collaborative relationship between Black Church and the Counseling profession. *Counseling and Values, 49 (2), 147-154.*

Al – Yateem (2012). The effect of interview recording on quality of data obtained: a methodological reflection, *Nurser Researcher, 19 (4), 31-35.*

Alang, S. (2016). Black folk don't get no severe depression: Meaning and expressions of depression in a predominately black urban neighborhood in Midwestern United States, *Social Science & Medicine, 157(2016), 1-8.*

Alegria, M. Canino, G., Rios, R., Vera, M., Calderon, J., Rusch, D. & Ortega, A. (2002). Inequalities in us of specialty mental health services among Latinos, Black American, and non-white Latino. *Psychiatric Services, 53, 1547-1555.*

American Counseling Association (2014). Retrieved from

https://www.counseling.org/

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Psychological Association. (2013). Guidelines and principles for accreditation of programs in professional psychology. Retrieved from https:// www.apa.org/ed/accreditation/about/policies/guiding-principles.pdf

American Psychological Association. (2017). Physiological & Psychological Impact of Racism and Discrimination for African-Americans. Retrieved from http://www.apa.org/pi/oema/resources/ethnicity-health/racism-stress.aspx

Anderson, C., Robins, C., Greeno, C., Cahalane, H., Copeland, V., & Andrews, R. (2006). Why lower income mothers do not engage with the formal mental health care system. *Qualitative Health Research, 16, 926-943.*

Anxiety and Depression of America (2019). Retrieved from https://adaa.org/about-adaa/press-room/facts-statistics

Arredondo, P., Toporek, R., Brown, S., Jones, J., Locke, D., Sanchez, J. & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24, 42-78.*

Atkinson, D. R. (2004). *Counseling Americans minorities* (6th ed.) New York: McGraw – Hill.

Babbie, E. (1995). *The practice of social research* (7th ed.). Belmont, CA: Wadsworth.

Barlow, J. (2016). #WhenIFellInLoveWithMyself: Disrupting the gaze and loving our black womanist self as an act of political warfare. *Meridians: feminism, race, transnationalism, 15(1), 205-217.*

Barnet, J., Baker, E., Elman, N., & Schoener, G. (2007). In pursuit of wellness: The self-care imperative. *Professional Psychology: Research and Practice, 38 (6), 603a.*

Beal, F. (2008). Double Jeopardy, *Feminism, Race, Transnationalism, 8(2), 166-176.*

Beauboeuf-Lafontant, T. (2007). You have to show strength: An exploration of gender, race and depression. *Gender and Society, 21, 28-51.*

Black, A., & Peacock, N. (2011). Please the masses: Messages for daily life management in Black American women's popular media sources. *American Journal of Public Health, 101, 144-150.*

Borum, V. (2012). Black American women's perception of depression and suicide risk and protection: A Womanist exploration, *Journal of Women and Social Work, 27(3), 316-327.*

Boyd-Franklin, N. (1991). Recurrent themes in the treatment of Black American women in group psychotherapy. *Women & Therapy, 11(2), 25-40.*

Braun-Williams, C. (2000). African American women, Afrocentrism and Feminism. *Implications of Therapy, 22(4)1-16.*

Brown, D., Keith, V. (2003). The epidemiology of mental disorders and mental health among African American women. In: Brown, D., Keith, V., editors. In and out of our right minds: The mental health of African American women. *New York: Columbia University Press, pp. 23–59.*

Brown, D., Keith, V., Jackson, J., Gary, L. (2003). (Dis)respected and (dis)regarded: Experiences of racism and psychological distress. In: Brown, R., Keith, V., editors. In and out of our right minds: The mental health of African American women. *New York: Columbia University Press; pp. 83–98.*

Brown, L. (2010). Feminist Theory. *Washington, DC: American Counseling Association.*

Bruss, O., & Hill, J. (2010). Tell me more: Online verses face-to-face communication and self-disclosure. *Psi Chi Journal of Undergraduate Research, 15 (1).*

Bryant-Davis, T., & Ocampo, C. (2005b). The trauma of racism: Implications for counseling, research and education. *The Counseling Psychologist, 33, 574-578.*

Bynum, W., & Varpio L. (2018). When I say hermeneutic phenomenology. *Medical Education, 52(3), 252-253.*

Cabral, R. & Smith, T. (2011). Racial/ethnic matching of clients and therapists in mental health services: a meta analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology, 58(4), 537-54.*

Campbell, R., & Long, L. (2014). Culture as a social determinant of mental health and behavioral health: A look at culturally shaped beliefs and their impact on help-seeking behaviors and service use patterns of Black Americans with depression. *Best Practices of Mental Health, 10(2).*

Campbell, R. & Mowbray, O. (2016) The Stigma of Depression: Black American Experiences, *Journal of Ethnic & Cultural Diversity in Social Work*, 25:4, 253-269.

Carr, E., Szymanski, D., Taha, F., West, L. & Kaslow, N. (2014). Understanding the link between multiple oppressions and depression among Black American women: The roles of internalization, *Psychology of Women Quarterly,* 38(2), 233-245.

Carrington, C. (2006). Clinical depression in Black American women: Diagnosis, treatment, and research. *Journal of Clinical Psychology, 62, 779-791.*

Cates, J. & Schaefle, S. (2010). Infusing multicultural training into practicum, *Journal of Counseling Research and Practice, 1(1), 32-41.*

Cates, J., Schaefle, S., Smaby, M., Maddux, C., & LaBeauf, I. (2007). Comparing multicultural with general counseling knowledge and skill competency for students who completed counselor training. *Journal of Multicultural Counseling and Development, 35(1), 26-39.*

Center for American Progress (2013). Retrieved from https://www.americanprogress.org

Chang, E. (2017). Relationship between loneliness and symptoms of anxiety and depression in Black American men and women: Evidence for gender as a moderator, *Personality and Individual Differences, 120(2018), 138-143.*

Clark, R., Anderson, N., Clark, V., & Williams, D. (1999). Racism as a stressor for Black Americans: A biopsychosocial model. *American Psychologist, 54, 805-816.*

Clarkson, P., & Nippoda, Y. (1997) The experiences influence or effect of cultural/racism issues on the practice of counseling psychology – a qualitative study of one multicultural training organization. *Counseling Psychology Quarterly, 10(4), 23.*

Coker, A. (2004). Counseling African American women: Issues challenges and intervention strategies. *Perspectives on Counseling, 13, 129-136.*

Cokley, K., Hall-Clark B., & Hicks, D. (2011). Ethnic minority majority status and mental health: The mediating role of perceived discrimination. *Journal of Mental Health Counseling, 33(3), 243-263.*

Collins, P. (1990). *Black feminist thought*. New York, NY: Routledge, Chapman & Hall.

Collins, P. (1991). *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. New York: Routledge.

Collins, P. (1996). What's in a name? Womanist, Black feminism, and beyond. *Black Scholar, 26(1), 9.*

Collins, P. (2004). *Black sexual politics: Africa Americans, gender and the new racism.* New York: Routledge.

Collins, P. (2005). *Black sexual politics: Black Americans, gender, and the new racism.* New York, NY: Routledge.

Comas-Diaz, L. (2011). Multicultural approaches to psychotherapy. *History of Psychotherapy: Continuity and Change, 243-267.*

Comas-Diaz, L. & Greene, B. (1994). *Women of color: Integrating ethnic and gender identities in psychotherapy.* New York: Guilford Press.

Combahee River Collective. (1977). *The Combahee River Collection statement. Home Girls: A Black feminist anthology.* (pp.264-274). New Brunswick, NJ: Rutgers University Press.

Comstock, D., Hammer, T., Strentzsch, J., Cannon, K., Parsons, J., & Salazar, G. (2008). Relational-cultural theory: A framework for bridging relational, multicultural, and social justice competencies. *Journal of Counseling & Development, 86, 279-287.*

Constantine, M., Hage, S. Kindaichi, M. & Bryant, R. (2007). Social justice and multicultural issues: Implications for the practice and training of counselors and counseling psychologist. *Journal of Counseling Development, 85 (1), 24-29.*

Corrigan, P., Watson, A., Byrne, P., & Davis, K. (2005). Mental Illness Stigma: Problem of Public Health or Social Justice? *Journal of Professional Roles and Responsibilities, 50(4), 363-368.*

Council for Accreditation of Counseling and Related Educational Programs. (2014). 2009 standards. Retrieved from http://www.cacrep.org/wp-content/uploads/ 2013/12/2009-Standards.pdf

Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *University of Chicago Legal Forum*: Vol. 1989 , Article 8.

Crenshaw, K. (2011). Black women still in defense of ourselves. *Nation, 293(17), 14-15.*

Crenshaw, K., Allen, W. (2014). Don't let the gender gap overshadow deeper racial and economic disparities. *Chronicle of Higher Education, 61 (9), B24-B25.*

Creswell, J. W. (2008). *Educational research: Planning, conducting and evaluating quantitative and qualitative research* (3rd ed.). Upper Saddle River, NJ: Pearson Education.

Creswell, J. & Creswell, D. (2017). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches* (5th ed.). Thousand Oaks, CA: Sage.

D'Andrea, M., & Heckman, E. (2008). A 40 year review of multicultural counseling outcome research: Outlining a future research agenda for the multicultural counseling movement, *Journal of Counseling and Development, 86, 356-363.*

Davis, S. (2015). The "strong Black woman collective": A developing theoretical framework for understanding collective communication practices of Black women, *Women's Studies in Communication, 38, 20-35.*

Dimaano, C., & Spigner, C. (2017). Teaching from the immortal life of Henrietta Lacks: Student perspectives on health disparities and medical ethics. *Health Education Journal, 76(3), 259-270.*

Dwyer, S. & Buckle, J. (2009). The space between: On being an insider-outsider in qualitative research, *International Journal of Qualitative Studies, 8 (1), 54-63.*

Few, A. (2007). Integrating Black consciousness and critical race feminism into family studies research. *Journal of Family Issues, 28, 452-473.*

Frame, M., & Williams, C. (1996). Counseling African Americans: Integrating Spirituality in Therapy. *Counseling & Values, 41 (1), 16.*

Frame, M., Williams, C., & Green, E. (1999). Balm in Gilead: Spiritual dimensions in counseling African American women. *Journal of Multicultural Counseling & Development, 27(4), 182-193.*

Fripp & Carlson, (2017). Exploring the Influence of Attitude and Stigma on Participation of Black American and Latino Populations in Mental Health Services. *Journal of Multicultural Counseling & Development, 45(2), 80-94.*

Gallo, J., Bogner, H., Morales, K., & Ford D. (2005). Patient ethnicity and the identification and active management of depression in late life. *Archives of Internal Medicine, 165, 1962-1968.*

Gamble, V. (1997). The Tuskegee Syphilis study and women's health. *Journal of the American Medical Women's Association, 52 (4), 195-196.*

Giorgi, A. P., & Giorgi, B. M. (2003). The descriptive phenomenological psychological method. In P. M. Camic, P., Rhodes, J., Yardley, L. (Eds.), *Qualitative research in Psychology: Expanding perspectives in methodology and design (pp. 243-273).*

Goffman, E. (1963) Stigma. Notes on the Management of Spoiled Identity. *Englewood Cliffs: Prentice-Hall.*

Graham, A. (2016). Womanist preservation: an analysis of Black women's spiritual coping, *International Journal of Transpersonal Studies, 35(1), 106-117.*

Graham, J., West, L., Martinez, J., & Roemer, L. (2016). The mediating role of internalized racism in the relationship between racist experiences and anxiety symptoms in a Black American sample, *Cultural Diversity and Ethnic Minority Psychology, 22(3), 369-376.*

Grote, N., Bledsoe, S., Wellman, J., & Brown, C. (2007). Depression in Black American and white women with low income: The role of chronic stress. *Social Work in Public Health, 23, 59-88.*

Guba, E.G. and Lincoln, Y.S. (1981) *Effective Evaluation*. San Francisco, CA: Jossey-Bass.

Hall, J., Everett, J., and Hamilton-Mason, J. (2012). Black women talk about workplace stress and how they cope. *Journal of Black Studies, 43(2), 207-226.*

Harris-Lacewell, M. (2001). No place to rest: Black American political attitudes and the myth of Black women's strength. *Women and Politics, 23, 1-34.*

Hatzenbuehler, M., Nolen-Hoeksema, S., & Dovidio, J. (2009). How does stigma "Get under the skin"?, *Association for Psychological Science, 20(10), 1282-1289.*

Hays, D., & Wood, C. (2011). Infusing qualitative traditions in counseling research designs, *Journal of Counseling & Development, 89, 288-295.*

Heath, C. (2006). A womanist approach to understanding and assessing the relationship between spirituality and mental health, *Mental Health, Religion & Culture, 9(2), 155-170.*

Holcomb-McCoy, C., & Myers, J. (1999). Multicultural competence and counselor training: A national survey. *Journal of Counseling and Development, 77(3), 294-303.*

Holloway, I. (1997). *Basic concepts for qualitative research.* Oxford: Blackwell Science.

Holosko, M., Thyer, B., & Danner, J. (2009). Ethical guidelines for designing and conducting evaluations of social work practice. *Journal of Evidence-Based Social Work, 6(4), 348-360.*

hooks, b. (1981). *Ain't I a woman: Black women and self-recovery*. Boston: South End Press.

Husband, C. (2000). Recognizing diversity and developing skills: The proper role of transcultural communication. *European Journal of Social Work, 3, 225-234.*

Immerman, R.S., & Mackey, W. C. (2003). The depression gender gap: A view through a biocultural filter. *Gender, Social and General Psychology Monographs 129(1), 5-39.*

Jackson, L. C., & Green, B. A. (2003). Review of psychotherapy with Black American Women: Innovations in psychodynamics perspectives and practice. *The Psychoanalysis Quarterly, 72, 524-526.*

Jackson, P., & Stewart, Q. (2003). A research agenda for the Black middle class: Work, stress, survival strategies and mental health. *Journal of Health and Social Behavior, 44(3), 442-455.*

Jardin, D. (1990). Awakening from Descartes' nightmare: On the love of ambiguity in phenomenological approaches to education. *Studies in Philosophy and Education, 10, 211-232.*

Jones, J. (1982). My mother was much of a woman: The Black women, work, and the family under slavery. *Feminist Studies, 8, 235-269.*

Jones, J. (1997). *Prejudice and racism* (2nd ed). New York, NY; McGraw Hill.

Jones, L. (2008). Depression in African American women. *Journal of Women and Social Work, 23(2), 134-143.*

Jones, L. (2015). Black Feminisms: Renewing Sacred Healing Spaces. *Journal of Women and Social Work, 30(2), 246-252.*

Jones, L., Guy-Sheftall, B. (2015). Conquering the Black girl blues. *National Association or Social Workers, 60(4), 343-350.*

Jones, L. & Warner, L. (2011). Evaluating culturally responsive group work with Black women. *Research on Social Work Practice, 21, 737-746.*

Koch, T. (1995). Interpretive approaches in nursing research: the influence of Husserl and Heideggar. *Journal of Advanced Nursing, 21(5), 827-836.*

Lani, J. (2014). Black Feminisms: Renewing sacred healing spaces. *Afflila 30(2), 246-252*

Laverty, S. (2003). Hermeneutic Phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2(3), 21-35.*

Leach, M. M., Aten, J. D., Boyer, M. C., Strain, J. D., & Bradshaw, A. K. (2010). Developing therapist self-awareness and knowledge. In M. M. Leach & J.D. Aten, *Culture and the therapeutic process: A guide for mental health professionals, 13-36. New York: NY: Routledge*.

Lester K, Resick PA, Young-Xu Y, Artz C. (2010). Impact of race on early treatment termination and outcomes in posttraumatic stress disorder treatment. *Journal of Consultation Clinical Psychology, Aug;78(4):480–489.*

Lorde, A. (1982). *Sister Outsider: Essays & Speeches*. New York, NY: Crossing Press/Random House.

Lorde, A. (1988). *A Burst of Light*. Firebrand Books, New York.

Lum, D. (2010). *Culturally competent practice: A framework for understanding diverse groups and justice issues*. 4th Edition, Pacific Grove: CA Cengage Learning.

Maddox, T. (2013). Professional women's well-being: The role of discrimination and occupational characteristics, *Women's Health, 53(7), 706-729.*

Major, B. & O'Brien, L. (2005). The social psychology of stigma. *Annual Review of Psychology, 56, 393-421.*

Malott, K. M. (2010). Multicultural counselor training in a single course: Review of research. *Journal of Multicultural Counseling and Development, 38, 51-63.*

Malott, K. & Schaefle, S. (2015). Addressing clients' experiences of racism: A model for clinical practice, *Journal of Counseling & Development, 93, 361-369.*

Mama, S., Li, Y., Basen-Engquist, K., Lee, R., Thompson, D., Wetter, D., Nguyen, N., Reitzel, & L., McNeiill, L. (2016). Psychosocial mechanisms linking the social environment to mental health in Black Americans, *PLoSONE 11(4), 1-12.*

Merritt-Davis, O., & Keshavan, M. (2006). Pathways to care for African Americans with early psychosis. *Psychiatric Services, 57(7), 1043-4.*

Molock, S., Barksdale, C., Matlin, S., Puri, R., Cammack, N., & Spann, M. (2007). Qualitative study of suicidality and help seeking behaviors in African American adolescents. *American Journal of Community Psychology, 40(1/2), 52-63.*

Morrow, S. L., & Smith, M. L. (2000). *Qualitative research for counseling psychology. In S. D. Brown & R. W. Lent (Eds.), Handbook of counseling psychology (3rd ed., pp. 199-230).* New York: John Wiley.

Mays, V. (2017). Anna Julia Cooper's Black feminist love-politics. *Hypatia 32(1), 35-53.*

Mays, V. (1985). Black women and stress: Utilization of self-help groups for stress reduction. *Women & Therapy, 4(4), 67-79.*

McCall, L. (2005). The complexity of intersectionality: Signs. *Journal of Women in Culture and Society, 30(3), 1771-1800.*

McConnell, A., Renaud, J., Dean, K., Green, S., Lamoreaux, M., Hall, C., & Rydell, R. (2005). Whose self is it anyway? Self ascpect control moderates the relation between self-complexity and well-being. *Journal of Experimental Social Psychology, 41, 1-18.*

Merriam, S. B. (1998). *Qualitative research and case study applications in education.* San Francisco, CA: Jossey-Bass.

Merritt-Davis, O. & Keshavan, M. (2006). Pathways to care for Black Americans with early psychosis. *Psychiatric Services, 57, 1043-1044.*

Miller, C. & Kaiser, C. (2001). A theoretical perspective on coping with stigma. *Journal of Social Issues, 57, 73-92.*

Monroe Community College. (2018). HEG 211: Black Women's Mental Health and Wellness Course Syllabus. Rochester, New York: Melany Silas.

Morrissette, P. (1999). Phenomenological data analysis: A proposed model for counsellors. *Guidance and Counseling, 15(1).*

Nadal, K., Griffen, K., Wong, Y., Hamit, S., & Rasmus, M. (2014). The impact of racial microaggressions on mental health: Counseling implications for clients of color. *Journal of Counseling & Development, 92, 57-66.*

Nash, J. (2013). Practicing love: Black feminism love-politics, and post-intersectionality. *Feminism, Race, Transnationalism 11(2), 1-24.*

National Alliance on Mental Health (2005). Retrieved from https://www.nami.org

National Institute of Mental Health (2017). Retrieved from https://www.nimh.nih.gov/index.shtml

National Panhellenic Council (2018). *Retrieved From* https://www.nphchq.org/quantum/

Nechas, E., & Foley, D. (1994). *Unequal treatment: What you don't know about how women are mistreated by the medical community.* Ithaca, NY: Simon & Schuster.

Nelson, T., Esteban, C., and Adeoye, C. (2016). Rethinking Strength: Black women's perceptions of the "Strong Black Woman" role. *Psychology of Women Quarterly, 40(4), 551-563.*

Obasi, E. M., & Leong, F. T. L. (2009). Psychological distress, acculturation, and mental health-seeking attitudes among people of African descent in the United States: A preliminary investigation. *Journal of Counseling Psychology*, *56*(2), 227-238.

Park, S. (2010). *Fierce angels: The strong black woman in American life and culture.* New York, NY: One World/Ballantine Books.

Pattyn, E., Verhaeghe, M., Sercu, C. & Bracke, P. (2014). Public stigma and self-stigma:

differential association with attitudes toward formal and informal help seeking. *Psychiatric Service, 65(2), 232-8.*

Pieterse, A., Carter, R., & Kilynda, V. (2013). Racism-Related Stress, General Life Stress, and Psychological Functioning Among Black American Women. *Journal of Multicultural Counseling and Development, 41(1).*

Polkinghorne, D.E. (1983). *Methodology for the human sciences: Systems of inquiry.* Albany, NY: State University of New York Press.

Pough, G. (2003). *Do the ladies run this? Some thoughts on Hip Hop Feminism. In catching a wave: Reclaiming feminism for the 21st century.* Boston, MA: Northeastern University Press.

Poussaint, A. F. & Alexander, A. (2000). *Lay my burdens down: Suicide and the mental health crisis among Black American.* Boston, MA: Beacon Press.

Queener, J., & Martin, J. (2001). Providing culturally relevant mental health services: Collaboration between psychology and the Black American church. *Journal of Black Psychology, 27, 112-122.*

Ratts, M., Singh, A., Nassar-McMillian, S., Butler, S., & McCullough, J. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession, *Journal of Multicultural Counseling and Development 44, 28-48.*

Ridley, C. (2005). *Overcoming unintentional racism in counseling and therapy: A practitioner's guide to intentional intervention.* 2nd Edition, Thousand Oaks, CA: Sage.

Roberts, A., Jackson, M., & Carlton-LaNey, I. (2000). Revisiting the need for feminism and Afrocentric theory when treating Black American female. *Journal of Drug Issues, 30, 901-918.*

Rogers, S. (2017). Womanism and Afrocentricity: Understanding the intersection. *Journal of Human Behavior in the Social Environment, 27(1), 36-47.*

Schiele, J. (2005) Cultural oppression and the high risk status of Black Americans. *Journal of Black Studies, 35, 802-826.*

Settles, I. (2006). Use of an intersectional framework to understand Black women's racial and gender identities. *Sex Roles, 54, 589-601*.

Settles, I., Pratt-Hyatt, J., & Buchanan, N. (2008). Through the lens of race: black and white women's perception of womanhood. *Journal of Psychology of Women, 32(4), 454-468.*Shen, Y. (2015) Cultivating multicultural competent counselors through movies. *Journal of Creativity in Mental Health, 10, 232-246.*

Seward, D. X., & Luke, M. (2017). Superwoman squeeze. In K. L. Nadal (Ed.), *The SAGE Encyclopedia of Psychology and Gender*. dx.doi.org/10.4135/9781483384269.n

Shaw, S., & Bailey, J. (2009). Discourse analysis: what is it and why is it relevant to family practice? *Family Practice, 26 (5), 413-419.*

Shen, Y. (2015) Cultivating multiculturally competent counselors through movies. *Journal of Creativity in Mental Health*, 10:2, 232-246.

Shields, S. (2008). An intersectionality perspective. *Sex Roles, 59, 301-311*.

Silas, M (2011). Identifying the Referral Practices of African American Christian Pastoral Counselors of Congregants to Community Clinical Services and the Possible Implications for Counselor Training and Clinical Practice. *Unpublished Manuscript.*.

Silas, M. (2018). HEG 211: *Black Women's Mental Health and Wellness*, [Syllabus]. Retrieved from: www.monroecc.edu

Skaer, T., Sclar, D. Robison, L., & Galin, R. (2000). Trends in the rate of depressive illness by ethnicity/race. *Clinical Therapy, 22, 1575-1589.*

Smith, J. (2015). Mental Health Care Services for Black Americans: Parity or Disparity. *The Journal of Pan Black Studies, 7(9), 55-63.*

Smith, J. R., & Wermeling, L. (2007). Counseling preferences of Black American Women. *Adult-span Journal, 6(1), 4-14.*

Snowden, L. (2001). Barriers to effective mental health services for Black Americans. *Mental Health Services Research, 3, 181-187.*

Sparks, E., & Parker, A. (2000). The integration of feminism and multiculturalism: Ethical dilmmas at border. Practicing feminist ethics in psychology, *203-224, Washington, DC: American Psychological Association.*

Sue, D., Arredondo, P., & McDavis, R. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20, 60-88.*

Sue, D, Nadal, K., Capodilupo, C. Lin, A., Torino, G., & Lin, A. (2008). Racial microaggressions against Black Americans: Implications for counseling. *Journal of Counseling and Development, 86, 330-338.*

Sue, D. & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice*. 4th Edition, New York, NY: John Wiley & Son.

Sutter, M., & Perrin, P. B. (2016). Discrimination, mental health, and suicidal ideation among LGBTQ people of color. *Journal of Counseling Psychology, 63*(1), 98-105.

Taylor, R., Ellison, C., Chatter, L., Levin J., & Lincoln, K. (2000). Mental Health Services in Faith Communities: The role of clergy in Black Churches. *Social Work, 45(1), 73-87.*

Tesch , R. (1990). *Qualitative research: Analysis types and software tools.* New York, NY: Routledge Falmer.

Thomas, V. (2004). The psychology of Black women: Studying women's lives in context. *Journal of Black Psychology, 30, 286-306.*

Thomas, A., Witherspoon, K., & Speight, S. (2008). Gendered racism, psychological distress, and coping styles of Black American women. *Cultural Diversity and Ethnic Minority Psychology, 14, 307-314.*

Tobin, G.A. and Begley, C.M. (2004) Methodological Rigor within a Qualitative Framework. *Journal of Advanced Nursing, 48, 388-396.*

Toldson, I., & Toldson, I. A. (2001). Biomedical ethics: An Black-centered psychology perspective. *Journal of Black Psychology, 27, 401-423.*

United Stated Census Bureau (2018). Retrieved from https://www.census.gov/

Van Hook, M. (1999). Women's help-seeking patters for depression. *Social Work Health Care, 29, 15-34.*

Verhaeghe, P., Sercu, C., & Bracke, P. (2014). Public stigma and self-stigma: differential association with attitudes toward formal and informal help seeking. *Journal of Psychiatric Services, 1;65(2):232-8.*

Wafula, E. & Snipes S. (2014). Barriers to health care access faced by Black immigrants in the U.S.: Theoretical considerations and recommendations. *Journal of Immigrant and Minority Health, 16(4), 689-698.*

Waite, R. & Killian, P. (2008) Health beliefs about depression among Black American women. *Perspectives in Psychiatric Care, 44, 185-195.*

Walker, A. (1983). *In search of our mothers gardens: Womanist prose*. San Diego, CA: Harcourt Brace Jovanovich.

Wallace M. (1990). Black macho and the myth of the superwoman. *London: Verso*

Ward, E. & Brown, R. (2015). A culturally adapted depression intervention for Black American adult experiencing depression: Oh happy day. *American Journal of Orthopsychiatry, 85(1), 11-22.*

Ward, E., & Madison, R. (2015). A culturally adapted depression intervention for Black American adults experiencing depression: Oh happy day, *American Journal Orthopsychiatry, 85(1), 11-22.*

Watson, N., & Hunter, C. (2014). I had to be strong: Tension in the Strong Black Woman schema. *Journal of Black Psychology, 42(5), 424-452.*

Watson, N., Hunter, C. (2015). Anxiety and depression among Black American women: The costs of strength and negative attitudes toward psychological help-seeking, *Cultural Diversity and Ethnic Minority Psychology, 21(4), 604-612.*

Wilkins, A. (2012). Becoming Black women: Intimate stories and intersectional identities, *Social Psychology Quarterly, 75(2), 173-196.*

Williams, B. (2000). Black American women Afrocentrism and feminism: Implications for therapy. *Women & Therapy, 22(4), 1-16.*

Williams, C. (1999). Black American women, Afrocentrism, and feminism: Implications for therapy. *Women & Therapy, 22, 1-19.*

Williams, C. (2005). Counseling Black American women: Multiple identities- multiple constrains, *Journal of Counseling & Development, 83, 278-283.*

Williams, C., & Frame, M. (1999). Constructing new realities: Integrating Womanist traditions in Pastoral Counseling with African American women. *Pastoral Psychology, 47(4), 303-314.*

Williams, C., Frame, M., & Green E. (1999). Counseling groups for Black American women: A focus on spirituality. *Journal for Specialist in Group Work, 24, 260-273.*

Williams, D., Gonzalez, H., Neighbors, H., Nesse, R., Abelson, J., Sweetman, J. (2007). Prevalence and distribution of major depressive disorder in Black Americans, Caribbean Blacks, and Non-Hispanic Whites: Results from the national survey of American life. *Archives of General Psychiatry, 64, 305-315.*

Williams, C., & Wiggins, M. (2010). Womanist spirituality as a response to the racism-sexism double bind in African American women. *Counseling & Values, 54(2), 175-186.*

Williams, D, & Williams-Morris, R. (2000). Racism and mental health: The Black American experience. *Ethnicity and Health, 5, 243-268.*

Williams, S. & Cashion, A. (2008). Negative affectivity and cardiovascular disease in Black American single mothers. *The Abnf Journal: Official Journal of the Association of Black Nursing Faculty in Higher Education, Inc., 19, 64-67.*

Woods-Giscombe, C. (2010). Superwoman schema: Black American women's views on stress, strength and health. *Qualitative Health Research, 20, 668-683.*

Woods – Giscombe, C. & Lobel, M. (2008). Race and gender matter: A multidimensional approach to conceptualizing and measuring stress in Black American women. *Cultural Diversity and Ethnic Minority Psychology, 14, 173-182.*

World Health Organization (2017). Retrieved from http://www.who.int/en/

Young, J., Wiggins-Frame, M., & Cashwell, C. (2007). Spirituality and Counselor competence:

A national survey of American counseling association members. *Journal of Counseling & Development, 85(1), 47-52.*

Melany J. Silas
Curriculum Vitae

28 Green Clover Dr. * Henrietta NY 14467 * 585-732-9249 *msilasphd@gmail.com

Education

Syracuse University, Syracuse, New York
Doctor of Philosophy, Counselor Education and Supervision
Dissertation Focus: Black American Women and Mental Health, December 2019
Colgate Rochester Crozer Divinity School, Rochester, New York
Master of Divinity, May 2006
University of Rochester, Rochester, New York
Master of Science, Counseling & Human Development, May 2001
University of Rochester, Rochester New York
Bachelor of Arts, Health & Society, May 1999

Higher Education Teaching & Administration Experience

Monroe Community College, *Rochester, NY,* August 2002—Present

Full Professor (Health Studies)

- Course Created: Black Women's Mental Health & Wellness (SUNY Social Science Designation)
- Course Developed: Death and Dying (SUNY Western Civilization Designation)
- Courses Taught: Black Women's Mental Health and Wellness; Emotional Wellness; Death & Dying; Issues in Child Health and Development;
  Foundations of Health and Wellness; Women's Health; Stress Management
- Provide program guidance to students matriculated in the Health Studies program

Adjunct Coordinator 2002 - Present

- Hire, supervise and evaluate adjunct faculty teaching health studies and physical education courses
- Assign courses for spring, summer, fall and winter semesters for adjunct faculty
- Coordinate bi-annual professional development trainings
- Coordinate adjunct hiring process and department orientations

Course Coordinator 2002- Present

- Provide instructional guidelines and all course changes to faculty teaching Death & Dying
- Provided instructional support for all faculty teaching the following courses: Emotional Wellness, Death & Dying, Issues in Child Health & Development, Foundations of Health and Wellness
- Developed assessment and evaluation measures for course curriculum
- Responsible for the following: curriculum development, faculty semester scheduling, text information, course assessment, course marketing, end of semester meetings, course projections and enrollment reports

Dual Credit Supervisor 2002-2008

- Hire, supervise and evaluate high school dual credit instructors in the following districts: Gates Chili Schools, Rochester City Schools, Rush Henrietta Schools
- Manage student enrollment across districts

- Provide assessment of curriculum, ensuring curriculum quality
- Function as liaison between Health & Physical Education department and college dual credit office

Leadership Studies Program Coordinator 2008 - 2016

- Developed four courses for Leadership Program: Organizational Leadership, Leadership & Diversity, Leadership in the Local and Global Community, and Leadership and Decision Making
- Coordinate program master schedule
- Developed and implemented two-year phase sequence for certificate
- Developing partnerships with four-year institutions to articulate program from a certificate to a degree program

Service to College (Past 7 years)

- Member/Subcommittee Leader – Diversity Council – 2018 - Present
- Chair - African American Affinity Group –2016 to Present
    - Black Women's Mental Health and Wellness Summit
    - Professional Development Week – "A Seat at Conversation's Table: Academic Leadership in a New Millennium." - 2018
    - Professional Develop Week – "Udok Hope: Strategizing Intervention in Doro Refugee Camp." – 2018
    - Black Scholars Series – Black Women Scholars 2018
    - Film & Discussion (Co-Coordinator) – "I'm not Racist! Am I?" - 2017
    - Affinity Groups Collaborative Professional Development Workshop "Exploring Diversity & Personal Bias" – Co-Chair - 2017
    - AAAG Professional Development Workshop "I am Not Your Mama, Do Your Work: The Plight of the Black Female Academic as Surrogate Mother" (T. Graham) & "In(di)visible, With Liberty and Justice For All?: The invisible history of Transgender and gender non-conforming Americans in LGBTQ rights movements." (J. Wilkie) - 2017
    - AAAG Meetings
    - AAAG Professional Development Series (Group Development)
- Researcher – Diversity, Equity & Inclusion Student & Faculty Orientation Curriculum – 2017-2018
- Member – Diversity, Equity & Inclusion Task Force (Equity in Hiring) – 2018
- Co-Chair – Chief Diversity Officer Hiring Committee – 2018
- Grievance Advisor @ MCC Downtown Campus – 2017 - Present
- Wellness Committee Member – 2017 - Present
- New Downtown Campus Leadership Hub – Researcher (Assigned by Dean) – 2015 – 2016
- Middle States – Standard 13 Committee Member 2015 – 2016
- Pillars of Hope – City of Rochester Program MCC Team – Coordinator and Co-Chair – 2014 - 2015
- TCC/DCC Workshop Facilitator – 2013 – 2014

- Alice Young Internship Professional Development Committee Member/Facilitator – 2013 – 2014
- Physical & Mental Health Day (HPE & DST) – 2013

College and Community-wide MCC Diversity Council Partnered Events (Past 5 years)

- Creator/Coordinator: Black Women's Mental Health Summit - 2019
- Coordinator: MCC Spring Diversity Conference - 2019
- Creator/Coordinator: An Evening with Angela Davis – 2016
- Written & Produced: *For Such A Time As This* Choreopoem – 2015
- Project Chair/Coordinator: "What's My Fate? From the Schoolhouse to the Jailhouse" – Judith Brown Dianis – 2015
- Project Chair/Coordinator: *The New Jim Crow* Community Discussion & Panel – 2014
- Producer & Director: Diversity Video – (Participants: Univ. of Rochester, MCC Diversity Committee, City of Rochester, Trillium Health, The In-Control Program, Latinas Soy Unidas, The Women's Foundation of Genesee Valley) – 2014
- Creator/ Coordinator: Celebration of Diversity Event with Keynote Sheryl Lee Ralph – Co-Coordinator
- Creator/Coordinator: *Sisters Do You Hear Me?* HIV/AIDS Choreopoem – 2013
- Creator/Coordinator: *Love's Journey* Choreopoem on Relationships and Domestic Violence –2012

Service to Department (Past 7 years)

- Adjunct Orientation/Training Coordinator – 2019 - Present
- Created Course: HEG 211 – Black Women's Health & Wellness – MCC Gen Ed Approved & SUNY Gen Ed Approved (Social Science) - 2018
- Chair – Adjunct Hiring Committee – 2018
- HED 115 Curriculum Revision for SUNY General Education Approval – 2017
- General Education Learning Outcome Course Inventory Restructure (HED 115, LDS 101, LDS 102, LDS 103, LDS 202, LDS 204) – 2016–2017
- HED 115 Course General Education Assessment – Coordinator 2017
- Adjunct Hiring Pool – Committee Member – 2013 – 2014
- Retention, Tenure & Promotion Committee – Member – 2013 to 2017
- Semester Course Meetings (HED 115, 130, 116) – Facilitator/Attendee -2012 to Present
- Health Studies Program Advising– Faculty Advisor – 2012 to Present
- Campus Wide Enrollment Days – Faculty Advisor – 2012 to Present
- Departmental Pars – Faculty Advisor – 2012 to Present
- Adjunct/Course Coordinator (HED 115) – 2012 to Present
- Adjunct/Program Coordinator (All LDS courses) – 2012 to Present
- Health Studies Meetings – Attendee/Contributor – 2012 to Present
- Department Meetings – Attendee/ DCC Representative – 2012 to Present
- DCC Faculty Meetings – Attendee/ HPE Representative – 2012 to Present
- Department Policy Committee – Member – 2012 to 2016
- Health Studies Program Assessment Committee Member 2014 - 2015
- Partnered with Liberal Arts to further solidify a Leadership Concentration – Facilitator – 2012 – 2013

- Adjunct Pool – Hiring Chair – 2012 – 2013
- HPE Credit Committee – Member 2012 – 2013

Service to Students (Past 7 years)

- Latino HIV/Aids Awareness Day – Creator/Coordinator – Damon Campus 2012 – Present
- Black HIV/Aids Awareness Day – Creator/Coordinator – Damon Campus 2012 – Present
- World HIV/AIDS Awareness Day @ DCC with Keynote Mayor Lovely Warren – Coordinator, 2016
- HIV & STD Monthly Testing @ DCC Partnered with Trillium Health – Coordinator – 2013 –2015
- World AIDS Community College Event – 2015
- TRUTH - Student Sharing Group Partnered with Counseling and Advising @ DCC – Weekly Facilitator – 2012 - 2013
- Physical and Mental Health Awareness Activity Day HPE & Delta Sigma Theta Sorority – Coordinator 2013
- Stress Management Workshop – Violence Prevention Week @ DCC – Facilitator – 2012
- Wellness Week Healthy Living Panel Partnered with DCC Wellness Committee, Wellness Center and SEGA – 2012

Syracuse University, *Syracuse, New York,* August 2008-2013

Graduate Assistant-Instructor and/or Adjunct Co-Instructor

- Multicultural Issues in Counseling
- Developmental Issues in College-Age Students
- Internship

Graduate Assistant- Supervision

- Provide supervision for Master level counselors working in school and community settings

Counselor

- Provided spiritual counseling during advanced practicum and internship courses to local church congregants.

Student Research and Papers (Spirituality in Counseling)

- *Spirituality in Counseling: African American Women in Higher Education and Spiritual Ways of Coping with Stress*
- *Viktor Frankl and Logothereapy*
- *Spiritual Issues in Counseling Supervision*
- *Spirituality in Counseling: Exploring Indigenous Aspects of Spirituality within Dominican Republican Population*
- *Spirituality in Counseling: How African American Single Parent Utilize Religion and Spirituality*
- *Spirituality in Counseling Literature Review*

Rochester Family Mission & The Rochester Institution of Christian Education, *Rochester, NY,* August 2001 – 2008

Adjunct Professor

- Provide instruction for the following courses: Spiritual Counseling, Evangelism, and Theology and Ethics

Board Member

- Co-Chair of overseeing the development of the Rochester Institute of Christian Education
- Maintain partnership between RICE and Roberts Wesleyan College, ensuring credit transferability
- Assisted with development and implementation of new course for future articulation with Roberts Wesleyan College
- Assisted with national accreditation process for RICE
- Assess and develop overall program ensuring quality of courses and student preparedness
- Assist with fundraising and gifts solicitation for institution

Family Counselor

- Provide individual counseling for urban adults and youth in crisis.

Publications/Productions/Conferences (Created/Developed/Implemented)

- Journalist: "Black Women's Mental Health" Boss Woman Magazine – 2019
- Created/Coordinator: Women and Girls Empowerment Summit – 2019
- Created/Coordinator: Black Women's Mental Health Summit - 2019
- Creator/Coordinator: Empowerment Summit with Angela Davis – 2016
- Creator/Coordinator: Evening of Empowerment with Mathew Knowles - 2015
- Written/Produced: For Such A Time as This Production - 2015
- Written/Produced: Girls Empowerment Summit with Keynote Cynthia Bailey – 2015
- Created/Coordinated: Women & Girls Empowerment Weekend with Sheryl Lee Ralph (Honored Women in the community including Mayor Lovely Warren) (Partnered with Rochester City School District & City of Rochester) – Coordinator – 2014
- Author: HIV/AIDS: Infected & Affected Workbook – 2014
- Written/Produced Production: Sisters Do You Hear Me (HIV Infected/Affected) – 2013
- Written/Produced Production: *So I Press* @ Mt. Olivet Baptist Church – 2013
- Written/Produced: *RIT Gospel Fest* Production: Intentional Worship – 2013
- Created/Coordinated: Women & Girls Empowerment Weekend in Partnership with the City of Rochester & Rochester City School District – 2013
- Written/Produced: *I Am…* Choreopoem on Self-Esteem and Empowerment – (Partnered with Rochester City School District & City of Rochester) 2013
- Journalist: "Knowledge is Power" Our Voice Magazine – 2013
- Journalist: "Nuggets of Wellness for the Holidays" Our Voice Magazine – 2013
- Journalist: "Artistic Expression: A Voice of the People" – Our Voice Magazine - 2013
- Written/Produced: *We've Come this Far By Faith* Choreopoem – Douglass Leadership House – University of Rochester - 2013
- Created/Coordinated: Young Women of Color Conference – served 100 girls with a free conference (Partnered with Rochester City School District & City of Rochester) – 2012
- Written/Produced Production: Love's Journey - 2011
- Written/Produced: Black Girls Anthem Choreopoem @ Geva Theater - 2011

Professional & Community Presentations/Panels/Keynotes

- Co-Presenter – Boss Women Conference - 2019
- Facilitator – RIT – Self-Care: Getting Back to Balance - 2019
- Facilitator – Legacy House - Vision Board Goal Setting Workshop - 2019
- Keynote – YWCP – Cool Women Hot Jobs - 2019
- Interviewee – Soul stainable Radio Show – Mental Health and Self-Care - 2019
- Keynote - Zion Hill Missionary Baptist Church – Mother's Day Brunch - 2019
- Keynote – Emmanuel Missionary Baptist Church – Women's Day Speaker - 2019
- MC/Facilitator –HBCU College Fair Workshop Panel Session - 2018
- Workshop Presenter – Youth for Christ Conference– Youth and Social Media - 2018
- Co-Keynote – Rochester City Life Conference (Mayor Warren) – The Power in Sisterhood and Healthy Relationships - 2018
- Keynote – Ithaca College – Emerging Leaders Conference - 2018
- Keynote – Zion Hill Missionary Baptist Church Anniversary - 2018
- Keynote – Colgate Rochester Crozier Divinity School – Webinar Black Women and Mental Health - 2018
- Keynote – St. Luke Tabernacle Community Church - 2018
- Panelist: "Diversity, Equity, Inclusion and Inclusive Pedagogy Workshop" Teaching Creative Curriculum's Winter Teaching Institute Series – 2018
- Keynote: "What is Covering your Light" Mt Olivet Baptist Church (Albany NY) - 2018
- Keynote: "The Power of A Mother" Church of Love Faith Center 2018
- Diversity, Equity & Inclusion Faculty Innovation Group Contributor – 2017-2018
- Trauma Informed Teaching – Hillside Superintendence Conference Workshop Presenter - 2017
- Presenter: "Emotional Wellness, Forgiveness and Healing – *Soulstainable Living* Radio Interview

(WAYOFM) – 2017

- Presenter: "How to be an Effective Community Leader and Board Member" African American Leadership

Development Program – 2016

- Panelist Presenter: HBCU College Fair – Girl Talk: "Imagine A Future – Media Images of Beauty" 2016
- Presenter: "Empowering Mothers" Healthy Baby Network Keynote – 2015
- World AIDS Community Event – Presenter – 2015
- Co-Presenter: "Grief & Loss: Implications of Depression" – Mental Health and Depression Within African

American Community – 2015

- Presenter: "Black and Woman: Changing the Narrative" (Keynote & Panel with Mayor Lovely Warren) –

Colgate Divinity School – 2015

- Presenter: "Self-Care" Women's Empowerment – Girl Talk – Keynote – 2015

- Presenter: “We Shall Never Forget” Community World AIDS Awareness Day – Finger lakes Region – 2015
- Presenter: “Girl Talk” The Villa - Girls Behavior Change Summit Session (8 Weeks) – 2015
- Presenter: “She Birthed a Nation” Victory Living Mother’s Day Service – Keynote Speaker - 2014
- Presenter: “Empowered to Lead” Nathaniel Rochester Community School Girls Empowerment Workshop

– 2014

- Mistress of Ceremony: Black Girls Roc Awards – 2014
- Presenter: DCC/TCC Professional Development – (Stephen Brookfield’s book, *Teaching for Critical Thinking*.

Chapter 9, “Misunderstandings, Challenges, and Risks.” – 2014

- Presenter/Panelist: “Life as A Professor” – Cool Women Hot Job – Young Women College Prep – 2014
- Presenter: “This is just the Beginning” Early College High School – Graduating Keynote Speaker – 2014
- Presenter: “Changing the Community” 2014 Founder’s Day (Delta Sigma Theta Sorority, Inc.) Luncheon –

2014

- Presenter: “Faith Without Works is Dead” Scholarship Sunday Keynote – Trinity Emmanuel Presbyterian

Church – 2013

- Presenter: “Embrace Your Artistic Voice” Bethel Christian Fellowship Café Aviv – Featured Poet – 2013
- Presenter: “Education is the Key” Scholarship Sunday Keynote – Mt. Vernon Church – 2013
- Presenter: “The Power in Every Woman” Women’s Day Keynote – Victory Living Church – 2013
- Presenter: “Branding Yourself in Leadership” Women’s Conference – P. Meeks – 2013
- Presenter: “Celebrating and Pressing Forward” 100 Year Anniversary of Delta Sigma Theta Sorority

Sunday Service (Rochester)- St. Luke Tabernacle Community Church – 2013

- Presenter: Featured Poet – Tajze Lounge – 2013
- Presenter: “The Role and Influence of Black Women in Helping to Shape the African American Community

Over the Last 150 years.” 1st Annual City of Rochester Black Heritage Conference – 2013

- Presenter: “How to Stay Balanced and Reduce Stress Daily” WDKX Women for Women Panelist – 2013
- Poet: “MCC Bridging the Gap Between Community and Service” – 2012

- Presenter: “A Woman Called on Purpose” Women’s Conference Keynote – Bethesda Church - 2012
- Presenter: “Believing in the God in You” - Youth Sunday Keynote – Trinity Emmanuel Presbyterian

Church – 2012

- Featured Poet “Black Girls Anthem”– Arts Showcase – Church of Love Faith Center – 2012
- Presented: “Young, Black and Educated” Meliora Weekend Panelist – Office of Minority Student Affairs

University of Rochester – 2012

- Panelist Speaker – Minority Student Affairs Meliora Weekend – Univ. of Rochester, 2011
- World AIDS Day Keynote, 2011
- Panelist Speaker – START Program- Univ. of Rochester, 2011
- AALDP Community Presentation @ Boabob Cultural Center, Poet, 2011
- St. Luke Tabernacle Women’s Retreat, Keynote, 2011
- Social Justice in Urban Schools, Syracuse University, 2008
- Martin Luther King Jr. Day, Keynote, ABVI, January 2006, January 2007
- Greece Central School District, Keynote, *How to Maintain Overall Wellbeing*, March 2006
- Greece Central School District, Workshop, *Stress Management*, March 2006
- New York State School Counselor Association, Workshop Presenter, *Self-Care,* November 2005
- B. HEIRS Women’s Retreat, Keynote, *Tapping into the Power Within*, October 2005
- Good Grades Pay, Graduation Keynote, *A Diamond in the Rough*, July 2005
- Unity Health: Positively Alive Women’s Conference Keynote, *Still I Rise*, May 2005
- Unity Health: McCree Muller Professional Development Keynote, *The Purpose Driven Helping Professional,*

July 2005

- Colgate Rochester Crozer Divinity School, Seminar, *Self Care for Professional Clergy*, April 2005
- Willing Workers Conference Keynote, *Individual and Community Empowerment*, April 2005
- Monroe County School Counselor’s Association Annual Conference Keynote, *The Purpose Driven Counselor*, January 2005
- New York State School Counselor’s Association Keynote, *It Takes A Village to Raise A Child*, November 2004

Consultant Work

- Trainer – Rochester City School District – Race Equity Conference - 2019
- Diversity Trainer/Consultant – Hillside Children’s Center - 2018
- Curriculum Developer/Facilitator - The Villa Girls Group Emotional Wellness Group – 2015, 2016
- Diversity Consultant/Presenter: Rush Henrietta Central School District — 2013, 2014

- Presenter/Trainer: Rochester City School District on Empowering Young Women with Faculty – 2012, 2013
- Consultant/Presenter: Emotional Wellness Training & Curriculum Development – Action For A Better

Community – 2012

- Presenter: Youth Empowerment Series – Professional Development for Rochester City School District

Teachers and Staff – Facilitator/Trainer – 2012

Community Involvement (Leadership Roles)

- Associate Minister – St. Luke Tabernacle Community Church 2004 - Present
- Ministry Team Member - City of Rochester Mayor Pastoral/Minister Team – 2015 - Present
- Finance Chair – Rochester Alumnae Chapter of Delta Sigma Theta Sorority, Inc. 2018 - Present
- President - Rochester Alumnae Chapter of Delta Sigma Theta – 2014 to 2018
- Co-Coordinator – Girls Only HBCU College Fair Workshop – Staying Safe (Safe Cyber Activity; Sex

Trafficking; Interpersonal Violence; Healthy Relationships – 2017

- Mentor/Project Coordinator - Mayor's Red Carpet Girls Event – 2016, 2017
- Co-Coordinator - Cancer Awareness Activities Co-Coordinator – 2016, 2017
- PAD Initiatives for Homeless Women – Co Coordinator – 2017
- Coordinator - DM Williams Funeral Home Remembrance Banquet – 2012 – 2016
- Active Member - LINKS, Incorporated Rochester (NY) Chapter – 2016 – 2017
- Co-Coordinator - Heart Disease Awareness Activity Day – 2016
- The Rochester Poverty Initiative – Community Engagement – Committee Member, 2015 –2016
- The Rochester Poverty Initiative Writing Committee – Co-Chair, 2016
- Board Member – Young Audiences of Rochester – 2014–2015
- Chair- Delta Sigma Theta Sorority, Inc., Delta Academy & Delta G.E.M.S Youth Group (girls 11-18) – 2012-

2014

- Chair - Delta Sigma Theta Arts & Letters Committee – 2004 – 2008/ 2012-2014
- Member/Subcommittee Chair - Black and Puerto Rican Arts Festival Committee – 2013 – 2014
- Co-Coordinator - Sickle Cell Awareness Activity Day – 2014
- Coordinator: Black Women Professor's Forum dialogue with Douglass Leadership House at University of

Rochester – 2012 – 2013

- Committee Members - Urban League Black Scholars' Health Scholarship Committee Member– 2012 – 2013
- Board Member, University of Rochester Christian Fellowship, 2010- present
- Associate Minister, St. Luke Tabernacle Community Church, September 2003—2012
- Sponsor, Successful Pathways Inc., Rochester NY, 2002—2005

Professional Affiliations

- Delta Sigma Theta Sorority, Inc. (International)
- LINKS Incorporated (International)
- Black Women's Professors Forum (Local)
- Black Women's Leadership Forum (Local)
- University of Rochester Christian Fellowship Board (Local)
- American Counseling Association (National)

Awards & Honors (Past 7 years)

- Chapter Jewel Award – Rochester Alumnae Chapter of Delta Sigma Theta Sorority, Inc. - 2018
- Chapter Service Award – Rochester Alumnae Chapter of Delta Sigma Theta Sorority, Inc. – 2017
- ROC Community Leader Award – ROC Award – 2017
- Zeta Phi Beta Community Leader/Sisterhood Award – 2016
- Artist Award LINKS, Incorporated – Rochester (NY) Chapter – 2015
- "Woman Who Inspires" Award – Breakthru Magazine Award – 2014
- Arts & Culture Champion Award Nominee – 2nd Annual Community Champions Awards Banquet (honored for her original Choreopoem/Stage play "Sisters Do You Hear Me?" – A production surrounding the impact of HIV on women who are both infected and affected.) – 2014
- "Outstanding Alumni Award – University of Rochester – 2012
- Poetry honored at City Hall – Day of Impact Against Domestic Violence – 2012
- "Woman of the Year" Black Heritage Commission (City of Rochester) Award – 2012