Journal of Racial and Ethnic Health Disparities (2023) 10:2957–2969
https://doi.org/10.1007/s40615-022-01472-7

The Strong Black Woman Archetype and Therapeutic Outcomes: Examining Relationships Among Women with Childhood Sexual Abuse Histories

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Received: 25 August 2022 / Revised: 31 October 2022 / Accepted: 21 November 2022 / Published online: 5 December 2022

Abstract

The Strong Black Woman archetype (SBWA) describes a cultural pattern where Black women are expected to and present as physically and mentally strong, regardless of past and ongoing stressors. The SBWA has served the historical purpose of aiding survival for Black women throughout years of racial and gender oppression. However, the practice has also been associated with adverse mental health and with behaviors, such as self-silencing, that could impede therapeutic process. The purpose of this empirical study was to investigate the relationships between adherence to the SBWA and therapeutic outcomes (i.e., satisfaction with therapy, satisfaction with therapist, perceptions of one's global improvement in therapy) among Black women with childhood sexual abuse histories—a subpopulation at increased need for mental health treatment and who may be susceptible to high levels of adherence to the SBWA. Black adult female participants ($N = 103$) completed an online survey including a demographic questionnaire, an assessment of SBWA endorsement, and treatment outcomes from their current or most recent therapy experience. Three hierarchical linear regressions were conducted with SBWA as the independent variable and (i) satisfaction with therapist, (ii) satisfaction with therapy, and (iii) global improvement as the dependent variables. Consistent with our hypotheses, we found that SBWA inversely predicted satisfaction with therapy and the therapist. While the relationship between SBWA and global improvement was statistically significant, the finding was not practically significant. Still, our study findings suggest that higher levels of SBWA predict less favorable therapy outcomes. Future research directions and clinical implications are discussed.

Keywords Strong Black woman · African American women · Mental health disparities · Childhood sexual abuse · Treatment outcomes

Poor access to and underutilization of mental health treatment by African Americans has been a longstanding issue thought to be a major factor in mental health disparities in the USA (Cook et al., 2016; Snowden 2012). Despite being more open to accessing mental health treatment compared to Black men (Ward et al. 2013), Black women are still accessing mental health treatment at disproportionately lower rates compared to White women and are believed to benefit less from treatment than female peers of different races (Assari 2018; Richards 2021). This disparity may be in part because of factors that impact Black men as well, including cultural mistrust and stigma toward/around seeking mental health care, a preference for but lack of available Black therapists, and poor cultural competencies among therapists of other racial/ethnic backgrounds (Hines-Martin et al. 2003; Ward et al. 2009). However, other factors to successful access of treatment and outcomes may be unique to Black women.

Existing literature suggests that culturally specific characteristics can be understood as contextual factors that may explain the disparities in mental health treatment for African Americans broadly (Abernethy et al. 2006; Constantine et al. 2008; Williams 2005) and African American women specifically (Abrams et al. 2019; Ashley 2014). When understood as factors that may influence the behaviors of the client during treatment, an understanding of culturally

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specific characteristics and how they may impact treatment success can enhance culturally competent care for African Americans. To understand cultural and racial influences that may be linked to treatment outcomes, such as satisfaction with therapy and the therapist, it is imperative that researchers examine factors that often shape the identities of Black women, such as the Strong Black Woman archetype (SBWA). Unique to the experiences of Black/African American women, the SWBA is a cultural schema that encourages displaying of strength and independence (Abrams et al. 2019; Romero 2000). While the SBWA serves as a protective factor against racism and sexism (Debnam et al. 2022; Thomas et al. 2004), it has also been linked to depression (Donovan and West 2015)and anxiety (Watson and Hunter 2015). The SBWA may be an important factor that impacts treatment outcomes and has the potential to aid conceptualizations of efficacious treatment for Black women. In the context of the Common Factors Theory, the current study sought to investigate the relationships between endorsement of the SBWA and therapeutic outcomes among a sample of Black female survivors of childhood sexual assault—a subpopulation of Black women with an increased need for mental health care.

Literature Review

Common Factors Theory

The common factors theory (CFT) proposed by Fischer and colleagues (1998) posits a set of four common factors that exist across various types of psychotherapies (e.g., CBT, psychodynamic) and, when combined, can account for the curative properties of any given treatment. The CFT emerged from a need to organize and make sense of the growing amounts of research on multiculturalism in psychology in the late 1990s and as a way of integrating psychotherapeutic factors implicated in treatment success (e.g., client-therapist relationship) with important culturally relevant factors (e.g., client's cultural worldview). Fisher et al. (1998) believed the CFT could help provide a foundation for examining which specific cultural factors predict treatment success. The authors identified the therapeutic relationship, a shared worldview between the client and therapist, clinical intervention(s), and client characteristics as four central factors that contribute to overall treatment success. That is, a client's values, beliefs, and experiences contribute to whether therapy is successful (Leibert 2011). At the same time, efficacious therapy is a function of the extent to which clinicians can understand their clients' cultural backgrounds and the ways it may impact treatment.

Unfortunately, culturally responsive mental health treatment is far less common even though populations seeking psychological services have become increasingly diverse (Asnaani and Hofmann 2012). Perceived racism, microaggressions, and unintentional bias from clinicians can impede successful therapeutic outcomes for racial and ethnic minority clients and historically oppressed groups, such as Black women (Owen et al. 2017; Owen et al. 2014; Pieterse et al. 2012; Sue et al. 2009). To minimize this, some literature suggests the solution may be in matching between therapist and clients based on identity characteristics such as gender and race,however, findings about the success of this approach are mixed (Johnson and Caldwell 2011; Tall and Ross 1991; Wintersteen et al. 2005). Further, previous analyses have demonstrated that for African American clients, the effects of racial/ethnic matching on retention rates, sessions attended, and post-treatment functional outcomes are minimal (Cabral and Smith 2011; Maramba and Nagayama Hall 2002; Shin et al. 2005). Additionally, much of the current literature on racial/ethnic matching does not consider the ways in which specific cultural client characteristics may impact therapeutic outcomes.

Examining specific client cultural characteristics may explain therapeutic mechanisms of change and provide practitioners with a greater appreciation and understanding of the diverse experiences that clients from different backgrounds have in therapy. Clients play an important role in therapy and experience firsthand the impacts of the therapeutic process. In fact, scholars have suggested that client factors play a larger role in treatment success compared to other factors (Bohart and Wade 2013, Fuertes and Williams, 2017; Wampold and Imel 2015). Additionally, treatment success is associated with a stronger degree of treatment satisfaction, which is further related to specific client characteristics (Bucher et al. 2019; Eugster and Wampold 1996; Lipton and Stewart 1999; McCracken et al. 2002). Therefore, unique client factors, such as adherence to the SBWA, stand out as important areas to not only understand but address in relation to treatment success.

Client characteristics, also called "extratherapeutic influences" in the CFT, refer to both external and internal factors that may influence behavioral and/or psychological change (Leibert 2011). Examples of external factors include social support and a secure home environment (Asay and Lambert 1999; Lambert and Andersen 1996; Leibert 2011), internal factors include mindfulness and ego strength (Asay and Lambert 1999; Lambert 1996). Empirical studies have shown that client expectations and extratherapeutic factors account for the most variability in treatment outcomes (Leibert 2011). For instance, clients who enrolled in treatment and who detailed that they were

satisfied with their treatment tend to experience more positive results (i.e., engagement, continuation) (Betancourt et al. 2003; Horvath and Bedi 2002; Quintana and Meara 1990; Safran et al. 1990; Tao et al. 2015). Additionally, client perceptions of the working alliance with the therapist and whether the client is satisfied with this relationship is further prescient of treatment success (Ardito and Rabellino 2011, Tao et al., 2015). Scholars have argued that while some client variables, such as motivation and expectations, may change throughout therapy, cultural characteristics—and the sociocultural contexts that shape and reinforce them—are more likely to be more resistant to change (Asay and Lambert 1999; Garfield 1994). The current study examines the SBWA as one client cultural characteristic that is reinforced through gendered racial oppression and may influence satisfaction with the therapist and overall treatment satisfaction for Black women.

The Strong Black Woman Archetype

Gendered racial identity refers to the intersecting manner in which one's gender and race impacts their understanding of themselves (i.e., self-concept, ego) and the world and represents an important internal extratherapeutic factor to be considered. For Black women, a doubly marginalized population, their gendered racial identities develop within a society built on intersectional oppression (Debnam et al. 2022). As a result, these women often internalize racial gendered stereotypes, such as the "Strong Black Woman" archetype, to cope with experiences of racism and sexism (Abrams et al. 2014). The SBWA is a recurrent theme whereby African American women, historically and currently, present as being physically and mentally strong, regardless of ongoing stressors and past experiences of trauma (Abrams et al. 2019; Amankwaa 2003; Baker et al. 2015; Donovan and West 2015; Etowa et al. 2017; Woods 2013). Established during the persecution of Africans, the portrayal of Black women as intrinsically resilient and strong was important for individual and communal survival (Geyton et al. 2022; West et al. 2016). Presently, through the SBWA, Black women are seen by others and often view themselves as being equipped (often more than other racial groups or genders) to endure a greater number of stressors on their own (Donovan and Williams 2002; Etowa et al. 2007; Etowa et al. 2017; Nicolaidis et al. 2010). Among these obstacles are poverty, instances of racism and discrimination, raising children in a single-parent household, sickness, and the passing of friends and family (Etowa et al. 2007). The idealized image that the SBWA posits encourages Black women to frequently view and place value on themselves as independent and capable of placing the needs of others before their own (Anglin 2006; Jones and Shorter-Gooden 2003). This strength through consistent struggle is a fundamental piece of Black women's racialized gender identity and has been linked to successful aging, positive attitudes, dignity, and perseverance (Baker et al. 2015; Beaubouef-Lafontant, 2007; Harrington 2007; Romero 2000; Wyatt et al. 2008).

While adherence to the SBWA proves beneficial during times of adversity (Etowa et al. 2007; Romero 2000), empirical investigations of the SBWA reveal that the historical method of survival and esteem for Black women is also linked to poor mental and physical health outcomes (e.g., depression, cardiovascular disease; (Abrams et al. 2014; Debnam et al. 2022; Donovan and West 2015; Watson-Singleton 2017; Woods- Giscombé, 2010). With regard to mental health outcomes, researchers have found that endorsement of the SBWA was positively associated with depression, anxiety, low self-esteem, and overall psychological distress (Stanton et al. 2017; Watson-Singleton 2017). Further, endorsement of the SBWA has been linked with decreased perceived emotional support, which may suggest that Black women with higher SBWA may not believe they can turn to others for help to manage difficult emotions or ongoing life stressors (Watson-Singleton 2017). Black women may additionally be resistant to treatment due to cultural distrust and the wariness they may have toward mental health providers because of historical and current experiences with racism and discrimination (Walton and Shepard Payne 2016; Whaley 2001).

A number of factors have been identified in the relationship between SBWA and mental health outcomes and suggest higher endorsement of SBWA is linked to behaviors that may impede positive therapeutic process. For instance, researchers have found that the positive relationship between SBWA and negative psychological outcomes (e.g., depression) is mediated by self-silencing, maladaptive perfectionism, and low self-compassion (Abrams et al. 2019; Liao et al. 2020). Other researchers have found that SBWA endorsement is negatively linked with psychological openness (Nelson et al. 2020). Taken together, these findings suggest that Black women with higher SBWA endorsement may lack understanding and patience with their own emotions, have unrealistically high expectations of themselves, and may not rely on members of their community for support.

Other scholars have also found links between endorsement of SBWA and ineffective coping. For instance, some scholars have found that SBWA is positively linked with disengagement coping (e.g., avoiding stressors) and negatively associated with collective coping (Jones et al. 2021; Liao et al. 2020). Additionally, studies have found that SBWA is negatively associated with mental health help-seeking (Anyikwa 2015; Nelson et al. 2020; Watson and Hunter 2015). Despite their perhaps increased need to seek mental health treatment, higher endorsement of

SBWA in Black women with histories of trauma, such as intimate partner violence and childhood sexual abuse, is also negatively associated with mental health help-seeking (Jackson and Nuttall 2001; Monterrosa 2019). Therefore, the extant literature paints a picture whereby Black women with higher SBWA endorsement may essentially suffer in silence, being overly critical of themselves while concealing their distress from others and underutilizing potential sources of support. This point was poignantly put in Watson and Hunter's (Watson and Hunter 2015) qualitative analysis of the SBWA, where the authors write:

> A theme that was overwhelmingly represented in the data was the belief that African American women be psychologically durable. Equally represented was the belief that, according to the SBW race-gender schema, African American women should refrain from expressing too much emotion or using specific psychological wellness behaviors, like taking medication or attending counseling. Many participants discussed that expressing emotion and engaging in wellness behaviors (e.g., attending counseling, expressing emotions) would hinder their ability to efficaciously handle their life's responsibilities. (pp. 433)

Perhaps in the context of these findings, investigations of SBWA have not examined its possible direct role on therapeutic outcomes. However, this leaves a gap in the extant literature regarding what impact, if any, SBWA endorsement has on Black women who do choose to seek out therapy.

Black Women with Histories of Childhood Sexual Abuse: a Vulnerable Sub-population

Childhood sexual abuse is a major concern for Black girls and women. The World Health Organization (WHO, 2016) defined childhood sexual abuse (CSA) as engagement of a minor in sexual activities in which they do not fully understand and to which he, she, or they is/are unable to grant consent or is not yet mature enough to give informed consent. Some statistics show that 1 in 4 Black girls will be sexually abused before age 18, and between 40 and 60% of Black women report some form of contact sexual violence before age 18 (American Psychological Association, 2020). Further, Black girls/women experience the severest forms of CSA, are 34% more likely to be revictimized after an initial assault than White girls/women, and are more likely to experience depression, anxiety, and PTSD as a result (Amodeo et al. 2006; Banyard et al. 2001; Kubiak and Siefert 2008; Roodman and Clum 2001; Sedlak et al. 2010). Unfortunately, disparities in access to mental health services, engagement in therapy, and treatment of disorders that emerge from experiences of CSA, exist for African American clients when compared to their White counterparts (Das et al. 2006; Geier et al. 2015; Jones et al. 2018; Sue and Sue 2003). As a result, Black women may develop more severe and prolonged physical and psychological sequelae of the sexual assault (Bryant-Davis et al., 2005, 2013; Ingram et al. 1996; Kubiak and Siefert 2008) compared to their same gender or same race peers.

Even when compared to other Black women without sexual trauma histories, Black women with CSA histories emerge as a more vulnerable to depression, suicide attempts, PTSD, and pain-related physical health symptoms (Campbell et al. 2008; Hood and Carter 2008; Kubiak and Siefert 2008; Thompson et al. 2000). As a result, these women may be at increased need for mental health treatment. Despite the need, these same women may experience harmful barriers to accessing treatment including poor detection of disorders like depression and PTSD in Black female clients (Das et al. 2006; Geier et al. 2015; Jones et al. 2018; Sue and Sue 2003).

Black women with histories of CSA may also experience specific difficulties receiving the full benefits of therapy when it is accessed. Black women with histories of CSA exhibit low self-compassion/empathy, low levels of patience with emotions, and low actual or perceived social support (Donovan and Williams 2002; Neville et al. 2004; Sigurvinsdottir and Ullman, 2015). Therefore, these women may struggle with typical therapeutic practices such as identifying and tolerating difficult emotions and finding empathy for themselves. Further, one study has linked SBWA with high levels of SBWA (Harrington et al. 2010), suggesting that Black women with CSA histories may also be vulnerable to higher levels of SBWA—and thus expect themselves to be able to handle stressors alone. This may disrupt their ability to rely on therapeutic support—even when it is available to them. Supporting this notion, Harrington and colleagues (2010) found that trauma exposure was linked with increased SBWA endorsement, but also increased self-silencing (i.e., silencing certain emotions, thoughts, or behaviors to maintain relationships or the status quo) and emotional inhibition. Therefore, Black women with CSA histories may experience the double burden of lacking compassion and empathy for themselves while also denying or silencing their pain even to providers who attempt to help them. When considered as factors that may impact the behaviors of the client during the therapeutic process, an understanding of culturally specific characteristics, like the SBWA, and their influence on treatment outcomes can be essential for the delivery of culturally competent care for Black women, especially women with trauma histories who may be at an increased need for treatment (Abernethy et al. 2006; Williams 2005).

The Current Study

The current study aimed to examine the relationships between endorsement of the SBWA and treatment outcomes (i.e., satisfaction with therapist, satisfaction with therapy, and overall global improvement) in a sample of Black/African American women with histories of CSA who have sought treatment. Given that treatment satisfaction plays an important role in achieving successful treatment outcomes (Betancourt et al. 2003; Horvath and Bedi 2002; Quintana and Meara 1990; Safran and Segal, 1990; Wyatt 2008), we aimed to examine whether adherence to the SBWA was associated with satisfaction with therapy and the therapist, along with participants' overall perception of the improvement of their symptoms (i.e., global improvement). We hypothesized that greater identification with the "Strong Black Woman" archetype would be negatively/inversely related to all three aforementioned treatment outcomes.

Method

Participants

A total of 183 participants elected to participate in this online survey, advertised as a study examining the therapy experiences of Black/African American female survivors of childhood sexual assault/abuse. Participants were recruited primarily through the research experience program at a minority-serving institution in the Northeast region of the USA, which grants undergraduate students enrolled in entry-level Psychology classes course credit for research participation. In addition, announcements about the study were posted on various social media platforms (various CSA and Black women's groups and hashtags on Facebook, Twitter, and Instagram). Inclusion criteria included (a) self-identification as Black/African-American/Afro-Caribbean and female, (b) being 18 years or older, (c) having sought therapy in the past five years and attended three or more individual or group therapy sessions, and (d) having had an experience of childhood sexual abuse (defined as one or more experiences of childhood sexual abuse/assault before age 18 in the study announcement and informed consent form) that was disclosed in therapy. Of those who began the survey, 11 participants only partially completed the survey, and 69 failed to meet the study inclusion criteria (e.g., identified with another racial or gender group, no history of CSA) and thus were excluded from the final sample. The final sample consisted of 103 participants, all of whom identified as Black, African American, or Afro-Caribbean, and as cisgender female. No participants in this sample identified as transwomen.

Table 1 displays descriptive statistics for variables in the current study sample. Participant ages ranged from 18 to 56 years ($M = 30.67$, $SD = 8.94$). A total of 95 individuals received treatment specifically for their experience(s) of CSA, whereas seven individuals disclosed their CSA experience while enrolled in therapy for another reason.

Reflexivity Statement

Historically and presently, it remains important for researchers to consider and examine how their identities and lived experiences shape their approach to their scholarship. The first author identifies as a Brown, South-American cisgender woman and a Master's graduate. The second author identifies as a Black and African-American cisgender woman and assistant professor of psychology. Both authors share research interests in increasing access and equity in the provision of mental health services for historically underserved racial and ethnic groups in mental health care. Therefore, the authors considered how their own identities, lived

Table 1 Study sample characteristics ($N = 103$)

Variable	Total sample mean (SD) or %
Age	
18–56 years old	30.67 (8.94)
Socioeconomic status	
Lower class	8 (7.8%)
Working class	50 (48.5%)
Middle class	33 (32%)
Upper middle class	12 (11.7%)
Total	62
Education	
Some high school, no diploma	1(1%)
High school diploma/GED	3 (2.9%)
Some college credit, no degree	13 (12.6%)
Associate degree	17 (16.5%)
Bachelor's degree	42 (40.8%)
Master's degree	20 (19.4%)
Doctorate degree	7 (6.8%)
Sexual orientation	
Heterosexual	73 (70.9%)
Gay or lesbian	4 (3.9%)
Bisexual	24 (23.3%)
Prefer not to answer	2 (1.9%)
Type of therapy	
Face-to-face therapy	80 (77.7%)
Teletherapy	17 (16.5%)
Text therapy	4 (3.9%)
Group therapy	2 (1.9%)

experiences, and clinical and research interests individually and collectively influenced their approaches to building a framework for this study, along with their methodological choices throughout. Among many things, the authors frequently discussed how their hypotheses, racial and ethnic identities, and past experiences as clients and therapists influenced the development of this project and paper.

Procedure

Prior to recruitment, institutional review board (approval was obtained. Data was collected through Qualtrics, an online survey software tool, and the consent and survey completion process were done entirely online. Once interested, participants accessed the survey using an anonymous link or QR code (embedded into electronic survey announcements) and were asked to complete a screening to ensure that the inclusion criteria were met. Participants who did not meet the study criteria were not allowed to proceed to the rest of the survey. Participants were asked to provide informed consent before proceeding to the survey. Due to the sensitive nature of this research and the possible adverse consequences of being asked to report negative and traumatic experiences, a debriefing sheet was provided to participants at the end of the survey that included resources for those with histories of CSA, links to finding mental health services, and the national suicide hotline.

Measures

Demographic Questionnaire In a 16-item questionnaire, participants were asked to report their race/ethnicity, age, gender, sexual orientation, and educational background. In order to provide more descriptive information about the sample, participants were provided with a comprehensive definition of CSA and were asked: Have you had an experience of childhood sexual abuse, and if so, how many times? To prepare demographic variables for analyses, categories with small *n*'s (i.e., highest level of education, sexual orientation, and mode of therapy) were collapsed. Therefore, "some high school," "high school graduate," and "some college credit" were combined (i.e., some college or below), and "master's degree," "professional degree," and "doctorate degree" were combined (i.e., master's degree or higher). Participants who identified as "gay or lesbian" or "bisexual" were collapsed together. The mode of therapy was collapsed into two categories: face-to-face therapy (combination of face-to-face individual and group therapy) and text/virtual therapy (Talkspace or text, Skype, or teletherapy).

The Strong Black Woman Archetype In order to assess the degree of endorsement of the SBWA, participants completed the Strong Black Woman Archetype Scale (Woods 2013). This is a 36-item instrument used to measure SBW cultural attitudes. Each item is rated on a 5-point scale as follows: never = 1, rarely = 2, sometimes = 3, frequently = 4, and almost always = 5. Sample items from the SWBA Scale include "I do not let most people know the 'real' me","Women of my race have to be strong to survive"; and "I have difficulty showing my emotions." For the current study, item responses were summed to create one total score, with higher scores representing a stronger endorsement of the Strong Black Woman archetype overall. In previous studies, the total score Cronbach alpha has ranged between 0.77 through 0.92 (Woods 2013). In the present study, the SBWA scale had a Cronbach's alpha of 0.90. Previous studies have found support for the validity of the SBWAS; subscales of the SBWA scale (i.e., mask of strength/emotional invulnerability, caretaking/self-sacrifice, and self-reliance and strength) were positively related to the Stereotypic Roles for Black Women Scale (Thompson 2003) and Strong Black Woman Cultural Construct (Hamin 2008) scales that measured similar constructs (Woods 2013).

The Satisfaction with Therapy and Therapist Scale-Revised Used to measure the three primary outcome variables: *satisfaction with therapy*, *satisfaction with therapist*, and participant perceptions of their *global improvement*in therapy in the current study; the Satisfaction with Therapy and Therapist Scale-Revised (STTS-R) (Oei and Green 2008)is a 13-item instrument that assesses the client's perception of the therapist's listening, the client's freedom of expression, and the willingness of the client to return to the clinic/practice. Item responses are on a Likert scale (i.e., 1 = strongly disagree, 2 = disagree, …, 5 = strongly agree). In the initial study that utilized this scale, the Cronbach's alpha for the total scale was 0.93 (Oei and Green 2008). In this study, the authors utilized three subscales from this measure to examine satisfaction with therapy (i.e., "I am satisfied with the quality of the therapy I received",6 items, $\alpha = 97$), and satisfaction with the therapist (i.e., "The therapist provided an adequate explanation regarding my therapy"; 6 items, $\alpha = 0.97$), as well as global improvement ("How much did this treatment help with this specific problem?"; single-item). The global improvement item was rated on a 5-point scale as follows: 1 = made things a lot worse, 2 = made things somewhat worse, 3 = made no difference, 4 = made things somewhat better, and 5 = made things a lot better. Higher scores indicated greater symptom relief. The use of one global single-item measure has been cited as superior to multiple items that cover several specific features (Christophersen and Konradt 2012; Scarpello and Campbell 1983)and has successfully discriminated between high and low levels of global improvement in previous studies (e.g., (Oei and Green 2008). High correlations between

scores on the original STTS scale and the total score of the STTS-R (i.e., measure of global improvement), and both the Zung Self-Rating Depression Scale and the Beck Anxiety Inventory and the total score of an STTS-R item provide support for the validity of the measure (Oei and Green 2008).

Statistical Analyses

Using IBM SPSS Version 27, we examined all study variables for univariate normality and found that each variable was within acceptable skewness and kurtosis ranges (i.e., skewness between ± 1 and kurtosis between ± 2). Descriptive statistics and bivariate correlations were conducted to describe participants' characteristics and relationships between predictor and outcome variables. After examining descriptive statistics, we sought to explore any impact that participant demographic variables and the modality of therapy (e.g., face-to-face, virtual) might have had on the endorsement of the SBWA and therapeutic outcomes (e.g., satisfaction with therapy). A series of multivariate analyses of variance (MANOVAs) were conducted to determine if age, socioeconomic status, highest level of education, sexual orientation, frequency of CSA, perpetrator type, and mode of therapy (i.e., face-to-face, or virtual) influenced any of the main study variables of interest.

To evaluate the relationships between SBWA and treatment outcomes, three separate, two-step hierarchical regressions were conducted for each of the outcome variables: (1) satisfaction with therapy, (2) satisfaction with the therapist, and (3) global improvement. For all analyses, step 1 included the covariate of sexual orientation. Step 2 included SBWA. Model fit for each step was evaluated with the F statistic and an increase in variance accounted for as evidenced by a change in R^2 and beta weight. All assumptions for homogeneity of variance and linearity were met. We further examined standardized residuals for homoscedasticity and outliers (residual of ± 3 or greater). Residuals were normally distributed as assessed by a visual inspection of the normal probability plots and histograms. Durbin-Watson tests supported the independence of errors across all models (range = 1.78 to 2.36). The study used an alpha level of 0.05 for all statistical tests.

Results

Preliminary Analyses

Bivariate correlations were conducted on the main study variables: endorsement of the SBWA, satisfaction with therapy, and satisfaction with therapist. Global improvement was measured with a single-item and therefore was not included in bivariate correlations. We found statistically significant moderate negative correlations between endorsement of the SBWA and satisfaction with therapy ($r = -0.31$, $p < 0.001$) and satisfaction with therapist ($r = -0.35$, $p < 0.001$). Bivariate correlations and descriptive statistics for each study variable can be found in Table 2.

In the first MANOVA, age intervals (i.e., 18–24, 25–34, …), level of education, sexual orientation, mode of therapy, perpetrator type, and SES were entered as independent variables, while the overall satisfaction with therapy score was entered as the dependent variable. The MANOVA revealed there was no significant effect of age, highest level of education, modality of therapy, frequency of CSA, perpetrator type, or SES on overall satisfaction with therapy score. Sexual orientation, $F(4, 198) = 2.87$, $p < 0.05$; Wilks' $\Lambda = 0.89$; partial $\eta^2 = 0.08$ emerged as the only significant independent variable at the multivariate level. More specifically, when compared to individuals who identified as heterosexual ($M = 28.05$), individuals who identified as non-heterosexual had on average much lower satisfaction with therapy ($M = 18.82$). In the second MANOVA, age, highest level of education, modality of therapy, frequency of CSA, perpetrator type, and SES served as IVs, and the SBWA total score was the dependent variable. The MANOVA revealed there was no significant effect of age, highest level of education, modality of therapy, frequency of CSA, perpetrator type, SES, or sexual orientation on endorsement of the SBWA. Consequently, sexual orientation was entered as a covariate in primary analyses.

Primary Analyses

To examine the relationship between endorsement of the SBWA and therapy outcomes, we conducted a series of hierarchical linear regressions with SBWA endorsement as the independent variable, therapy outcomes (i.e., satisfaction with therapy, satisfaction with therapist, and global improvement) as dependent variables, and sexual orientation as a covariate. Table 3 contains the results from the two-step hierarchical regression analyses predicting therapeutic outcomes from SBWA. In the first regression, sexual orientation was entered as a predictor, or independent variable, in step 1. SBWA scores were added in step 2 as an independent variable, and satisfaction with therapy was entered as the outcome, or dependent variable. While sexual orientation in step 1 failed to account for significant variance in satisfaction with therapy, SBWA in step 2 significantly predicted satisfaction with therapy (ß = −0.11, R^2 change = 0.12, $F(2, 100) = 7.4$, $p < 0.01$), accounting for 13% of the variance in satisfaction with therapy scores. In the second regression, sexual orientation was entered as

Table 2 Descriptive statistics and bivariate correlations for main study variables ($N = 103$)

	Mean *(SD)*	Skewness	Kurtosis	Range		α	1	2	3	4
(1) SBWA	138.27 *(17.42)*	−0.03	−0.97	107	171	0.9	—			
(2) Age	30.67 *(8.94)*	1.18	0.96	18	56	—	0.045	—		
(3) Satisfaction wt. therapy	18.43 *(5.35)*	0.04	−0.96	6	30	0.97	−0.31**	−0.03	—	
(4) Satisfaction wt. therapist	18.7 *(5.1)*	0.23	−0.6	6	30	0.97	−0.35**	0.02	0.95**	—
(5) Global improvement	3.36 *(1.06)*	0.1	−0.61	1	5	—	−0.36**	0.08	0.81**	0.79**

SBWA Strong Black Woman archetype

**Correlation is significant at the 0.01 level (2-tailed)

a predictor variable in step 1, SBWA scores were entered in step 2, and satisfaction with the therapist was entered as the outcome variable. Sexual orientation failed to account for significant variance in satisfaction with the therapist, but SBWA in step 2 (ß = −0.11, R^2 change = 0.12, $F(2, 100) = 9.14$, $p < 0.01$) accounted for an additional 15% of variance in satisfaction with therapist scores.

In the third and final regression, sexual orientation was entered as a predictor variable in step 1 but failed to predict a significant variance in global improvement, the outcome variable. However, SBWA scores—entered in step 2—predicted a statistically significant percentage of the variance in global improvement scores (ß = −0.02, R^2 change = 0.14, $F(2, 100) = 8.15$, $p < 0.01$). However, the negligible Beta weight indicates that this finding is likely not practically significant.

Table 3 Hierarchical multiple regression analyses predicting satisfaction with therapy, satisfaction with the therapist, and global improvement from Strong Black Woman archetype (SBWA)

Satisfaction with therapy					
Predictor	β	R^2	Δ R^2	Δ F	*df*
Step 1		0.02	0.001	2.3	101
Sexual orientation	0.82				
Step 2		0.13	0.11	12.24**	100
SBWA	−0.11				
Satisfaction with the therapist					
Predictor	β	R^2	Δ R^2	Δ F	*df*
Step 1		0.02	0.01	2.02	101
Sexual orientation	0.73				
Step 2		0.13	0.12	15.95**	100
SBWA	−0.11				
Global improvement					
Predictor	β	R^2	Δ R^2	Δ F	*df*
Step 1		0.01	0.01	0.51	101
Sexual orientation	0.08				
Step 2		0.14	0.14	15.72**	100
SBWA	−0.02				

SBWA Strong Black Woman archetype

**$p < .01$

Discussion

Historically and presently, the "Strong Black Woman" archetype is recognized as an important culturally specific characteristic that shapes many Black women's identities, psyche, and behaviors. However, limited work has considered the influence of SBWA endorsement on Black women's treatment outcomes. Black female survivors of CSA are a population that may be at an increased vulnerability to endorsement of the SBWA and increased need for mental health treatment, and thus served as the sample for this study. We found an inverse relationship between SBWA and therapeutic outcomes, suggesting that higher endorsement of the SBWA is related to less positive therapy outcomes in our sample—specifically less satisfaction with the therapist and therapy overall. Our findings point to the importance of examining cultural characteristics in Black women and the therapeutic implications of their adherence. While these findings apply to Black women with histories of CSA, they also highlight the importance of examining the cultural perspectives (SBWA) of Black women more broadly. The goal is to begin conceptualizing new and more inclusive therapeutic interventions.

Our study findings are consistent with previous literature which shows that endorsement of the SBWA may be related to adverse outcomes for Black women's mental health and overall improvement. Specifically, previous studies have found that SBWA is related to increased stress and negative affect, and masking and inhibiting one's true emotions, as well as decreased mental health help-seeking (Beauboeuf- Lafontant, 2007; Harrington et al. 2010; Romero 2000; Woods-Giscombé, 2010; Taylor-Lindheim 2016; Thomas et al. 2004; Thompson 2003; West, Donovan, and Daniel, 2016). In the current study, we expand upon this literature by showing that SBWA is inversely related to satisfaction with therapy and satisfaction with the therapist, highlighting how SBWA goes beyond negatively impacting affect expression and help-seeking. Ultimately, SBWA endorsement may also compromise the ways a Black woman can benefit from or navigate within therapeutic encounters.

The results highlight the role that specific client characteristics play in successful therapeutic outcomes. Through the lens of the CFT, of the factors that are viewed as influencing therapy success, client characteristics have been recognized as perhaps the most important (Bohart and Wade 2013; Fuertes and Williams, 2017; Wampold and Imel 2015). The results of this study suggest that the SBWA, a specific cultural characteristic of Black women, may interfere with the client's perceptions of the working alliance with the therapist, in turn, impeding clinical progress. In therapy, clients are expected and often encouraged to disclose their personal thoughts and feelings (Farber 2006). However, clients with the tendency to self-silence adhere to maladaptive perfectionism, and who have low self-compassion are more likely to have fewer facilitating disclosures and more dishonest disclosures (Abrams et al. 2019; Liao et al. 2020; Love and Farber 2019).

Due to the cross-sectional design of the study and our inability to make causal statements, it is possible Black women's outcomes in therapy impacted their endorsement of SBWA. For example, a Black woman who disclosed their CSA in therapy but felt unsupported or that therapy was ineffective could develop the belief that they must manage their feelings independently—resulting in higher SBWA endorsement. However, this explanation is unlikely in the context of existing literature which suggests SBWA is a pervasive cultural norm among Black women that is likely a result of gendered racial socialization of Black girls and thus precedes interactions with mental health professionals (Davis and Jones 2021). A more likely explanation for our findings is that Black women with higher endorsement of SBWA may be concealing or underreporting distress, which in turn may lead to poorer therapy outcomes and satisfaction with therapy. Previous literature on self-disclosure in therapy for Black/African Americans may support this, generally showing lower self-disclosure in African Americans compared to their White counterparts, particularly in therapy and about past traumas (Consedine et al. 2007). While all participants in the current sample reported disclosing their CSA to the therapist, as Black female survivors of trauma, they may have been doubly at risk for minimizing the severity of their CSA or levels of distress. Thus, therapists working with clients with greater endorsement of the SBWA may need to pay particular attention to and promote honest disclosure and engagement in psychotherapy.

Clinical Implications

The findings of this study are important for mental health practitioners who work with Black women in general, and those with abuse histories. Acknowledging that the SBWA label is a multidimensional construct that Black women adhere to, whether they experience stress-inducing events such as CSA or not, is the first step toward recognizing that cultural factors impact stress-coping behaviors, self-reliance, and behaviors in therapy. In knowing the impact of adherence to the SBWA on therapeutic outcomes, counselors can adjust outreach techniques and facilitation style to best align with the culturally specific concerns and needs of Black women. Mental health professionals who are aware of the influence of SBWA on satisfaction with therapy and satisfaction with the therapist may be better able to assess/anticipate, validate, and disrupt client behaviors, such as minimization of emotions, that can lead to poor outcomes or early termination. That is, Black female clients who adhere to this archetype may be ambivalent toward treatment as they may have the desire to appear strong and deal with their struggles independently (Anglin 2006; Donovan and Williams 2002; Etowa et al. 2007). Should the client express this ambivalence and/or apprehension toward therapy, the practitioner should validate these feelings while also providing encouragement. Exploration of such feelings may strengthen the therapeutic relationship. Importantly, clinicians unaware of the SBWA may misinterpret/underestimate the client's expressed levels of distress.

Furthermore, providing a non-judgmental space where clients can process as well as unload their feelings and possible tension related to the SBWA and how this may manifest in their everyday lives is fundamental for empowering Black women. The therapeutic process should address the presentation of strength to aid these women in becoming mindful of spaces in which they may rely on their strength, where invoking strength may be advantageous, and where vulnerability may be necessary. For Black women, displaying strength is a form of physical and psychological resilience, allowing them to survive past and current traumas, all while protecting themselves, their families, and the community (Geyton et al. 2022; West et al. 2016). Nevertheless, constant adherence to this one idea of strength can be harmful and may not allow clients to see vulnerability and help-seeking as strengths as well. That is, within the context of the SBWA, a stereotype of Black women's strength as self-reliant, self-sacrificing, and maternal provides little room for a healthy formation of strength. The inclusion of self-care, emotional expression, interdependence, and acceptance of formal and informal care can significantly expand a client's view of what it means to be strong. This discussion is critical when helping clients who have felt overlooked and alone in their struggles due to their marginalized identities.

Past work has indicated that racial congruence between the client and therapist yields some improvement on treatment outcomes, such as satisfaction with the therapist, for Black women (Cabral and Smith 2011; Scharff et al. 2021).

Though research is still needed to understand the potential mechanisms behind treatment outcomes when there is racial congruence, it is sensible to assume that this may be a result of clients' belief that racial similarity leads to shared understanding. Therefore, it is critical that mental health practitioners, both Black and non-Black, recognize that internalized stereotypes about Black women may contribute to the ways these clients express themselves and engage with the therapeutic process. Being racially conscious, attentive, and responsive to cultural characteristics can result in Black women being more engaged, open, and satisfied with the therapeutic experience.

Limitations and Future Directions

As mentioned, the use of a correlational, cross-sectional design in this study does not allow us to make causal statements about the direction of the impact of SBWA on therapeutic outcomes. It may be that poorer therapeutic outcomes lead to increase SBWA, as discussed. Future studies should make use of longitudinal designs that allow for the examination of causality. Secondly, the use of a one-item measure did not allow us to estimate the internal consistency of our global improvement measure, perhaps leading to the negligible impact of SBWA on this outcome variable in this study. Future investigations in this area may utilize more robust measures of improvement throughout therapy and help to accurately assess the practical significance of the relationship between SBWA and global improvement (Peeters 2016). Finally, the current study sample was made up of self-selected, highly educated, and high SES Black women. This may limit the generalizability of our findings and make our findings less applicable to lower SES and less educated Black women, a point of concern given that low-income Black women are more likely to have histories of CSA compared to high-income Black women and women of other racial groups (Kim and Drake 2018). Future studies should take advantage of a variety of recruitment strategies, perhaps targeting a Black community–based sample.

An important focus of inquiry moving forward is for studies to investigate the process by which SBWA impacts therapeutic outcomes. Including measures of self-disclosure, avoidance, and withdrawal within therapy may help clarify the relationship between SBWA and outcomes. Even more, exploration of therapy-related beliefs and thought processes (e.g., belief that therapy can alleviate symptoms, therapy ambivalence, mistrust of the therapeutic process) should also be explored. The broader CSA literature also suggests that peri—and post—CSA factors like self-blame, self-disclosure to caregivers, and caregivers' responses are important distal factors that impact later treatment outcomes in this population (Sciolla et al. 2011). Thus, these factors should be considered in future investigations.

Conclusion

In sum, the findings of this study suggest that therapeutic outcomes may be impacted by Black women's adherence to Strong Black Woman archetype. Importantly, this was observed in a sample of Black women who have had experiences of CSA—a population in great need of therapeutic intervention. These findings underscore the need to identify and address cultural factors such as adherence to the SBWA in therapy with Black women. It is crucial to understand that mental health frameworks, such as treatment approaches, counseling education and training, and research, should be progressing toward encompassing ethnic and cultural components as well as sensitivity to the needs of oppressed populations such as Black women. Although Black women navigate through complex experiences and expectations that may encourage them to rely on the SBWA, in the context of therapy, adherence to this may hinder these women from reaping the full benefits of intervention. The present study elucidates how reliance on the SBWA could decrease satisfaction with therapy and the therapist. Increasing consciousness about how Black women's cultural characteristics play a role in therapeutic outcomes may aid in enhancing access to as well as utilization of culturally informed mental health services.

Author Contribution All authors contributed to the study conception and design, data collection and analysis, and manuscript preparation. All authors read and approved the final manuscript.

Declarations

Ethics Approval This study involved research with adult human participants. Consent was obtained from all individual participants included in the study. This study received approval by the Institutional Review Board John Jay College of Criminal Justice (No. 2019–0936).

Consent to Participate Informed consent was obtained from all individual participants included in the study.

Research Involving Human Participants and/or Animals This study involved research with adult human participants. This study received approval by the Institutional Review Board at John Jay College of Criminal Justice (No. 2019–0936).

Competing Interests The authors declare no competing interests.

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